HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 27th November, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 27th November, 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 - 12)

4. Kent Health & Wellbeing Board Annual Report 2014/15 (Pages 13 - 36) 10:05

5. NHS preparations for winter in Kent 2015/16 (Pages 37 - 44) 10:45

6. North and West Kent Neurorehabilitation Service (Written Briefing) (Pages 45 - 52)

7. Date of next programmed meeting – Friday 29 January 2016 at 10.00

   Proposed items:

   - Emotional Wellbeing Strategy for Children, Young People and Young Adults
   - North Kent: Adult Community Services
   - North Kent: Emergency and Urgent Care Review and Redesign (Long Term)
   - Patient Transport Services

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

19 November 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, 9 October 2015.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mrs P Brivio, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr A H T Bowles (Substitute for Mr A J King, MBE), Mr A Terry (Substitute) (Substitute for Mr H Birkby), Cllr Mrs M Peters, Cllr Mrs M Ring and Cllr M Lyons

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

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

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

(2) Cllr Lyons declared an interest as Governor at East Kent Hospitals FT. He confirmed that it was neither a Disclosable Pecuniary Interest nor an Other Significant Interest.

44. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 4 September are correctly recorded and that they be signed by the Chairman.

45. Dates of 2016 Committee Meetings
(Item 4)

(1) The Committee noted the following dates for meetings in 2016:

Friday 29 January
Friday 4 March
Friday 8 April
Friday 3 June
Friday 15 July
Friday 2 September
Friday 7 October
Friday 25 November

46. East Kent Hospitals University NHS Foundation Trust: Update
(Item 5)

Rachel Jones (Director of Strategy and Business Development, EKHUFT) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Members of the Committee then proceeded to ask a series of questions and make a number of comments.

(2) In response to a specific question about cancer referrals and staffing levels, Ms Jones explained that the volume of referrals was increasing with an aging and growing population and the requirement to accommodate patient choice. The Trust was working with primary care to improve the cancer pathway. The Trust was recruiting additional nursing staff and fast tracking their training to enable them to become chemotherapy nurses. She reported that the Trust would have safe staffing levels within eight to twelve months. She stated that it was the Trust's responsibility to create a positive and fit for purpose working environment to attract and retain staff. Ms Carpenter reported that the current situation was complex and the commissioners were supporting the Trust with their recovery plan. She highlighted the need for all services to be sustainable and responsive.

(3) Members enquired about the Trust's financial position. Ms Jones explained that the majority of NHS Trusts were struggling financially; there was a reported £2 billion gap nationally. She noted that the Trust had not achieved concurrent savings and had invested significant capital in developing services prior to the deterioration of the Trust's financial position. The Trust was reducing its use of agency staff due to rising costs, quality and safety concerns; there was evidence which showed the use of agency staffing can led to poor quality and outcomes. She reported that there was new national regulation to tackle expensive off-framework agency staffing. Ms Carpenter noted that there would be no additional funding for the health service. She explained that there was an expectation by the public to be seen by a specialist in a specialist centre with specialist kit.

(4) A number of comments were made about engagement around reconfiguration. Ms Jones explained that the Trust had undertaken a first phase of engagement which focused on the drivers for change; the public were not surprised about the need for change. She reported that the decision making would be difficult but the local health system was working together to develop a range of sustainable options and engage with the public. She noted that there was a drive locally and nationally to ensure that patients was treated in an appropriate setting. Ms Carpenter stated that the CCGs were committed to delivering the majority of care as close to home as possible. She noted that reconfiguration was not the same as making cuts to services.

EKHUFT Clinical Strategy
(Item 5a)

(1) RESOLVED that:

(a) there be ongoing engagement with HOSC as the Trust's clinical strategy is developed including a return visit to the Committee prior to public consultation to enable the Committee to determine if the options for proposal are a substantial variation of service.

(b) there be ongoing engagement with HOSC as the East Kent Health and Social Care Strategy Board is developed and the Board be invited to submit an update to the Committee at an appropriate time.

(c) the Committee thank the Trust's staff for their hard work and dedication to deliver high quality care for the residents of East Kent.

EKHUFT Finance Update
(Item 5b)

(1) RESOLVED that the report on the Trust's current financial position be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

EKHUFT Chemotherapy Services
(Item 5c)

(1) RESOLVED that the report on the chemotherapy services in East Kent be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

47. NHS South Kent Coast CCG and NHS Thanet: Integrated Care
(Item 6)

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG), Alison Davis (ICO Programme Director on behalf of KCC, NHS South Kent Coast CCG and NHS Thanet CCG) and Rachel Jones (Director of Strategy and Business Development, EKHUFT) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Carpenter began by outlining the CCGs' vision for integrated health and social care through an Integrated Care Organisation (ICO) where patients were able to access and receive high quality coordinated services as close to home as possible; at present the provision of out-of-hospital care was highly fragmented. In the South Kent Coast CCG an ICO operational model was beginning to be implemented; GPs were working with their local communities to develop new integrated services and redesign the service model for their area. A number of work streams had been established including finance, contracting and service redesign. The CCG was working closely with Kent County Council to establish integrated health and social care commissioning. The CCG was looking to develop the local Health and Wellbeing Board to commission all integrated care on behalf of the CCG. She noted that a compact agreement had been signed by all partners, commissioners and providers which would help to drive the ICO forward as quickly as possible.

(2) In response to a specific question about GP workforce, Ms Carpenter explained that GPs were fully engaged with the new model of care; GPs were looking to leave a legacy by creating an environment where future GPs would like to work. Broader multidisciplinary teams were being developed to support General Practice including paramedics which was being piloted in Folkestone. She reported that Health Education England was working with the University of Kent to model long term workforce patterns. She noted that the East Kent CCGs' were hosting a careers fair in Dover, which all Year 9 – 13 students would be invited, to inspire young people in East Kent to work in health and social care.

(3) RESOLVED that there be ongoing engagement with HOSC as plans are developed with a return visit to a meeting of the Committee at the appropriate time.

48. Kent and Medway Specialist Vascular Services Review
(Item 7)

Oena Windibank (Programme Director, NHS England South (South East) was in attendance for this item.

(1) The Chairman welcomed Ms Windibank to the Committee. Ms Windibank began by outlining the background to the review; she explained that vascular services were specialised and commissioned by NHS England. She stated that a national specification was published in 2013 following concerns about the outcomes for patients in England and Wales receiving vascular services. She reported that Kent and Medway residents currently received specialised vascular care from two units within Kent: Medway NHS Foundation Trust in Gillingham and East Kent Hospitals University NHS Foundation Trust in Canterbury. She noted that a significant proportion of residents in North and West Kent were able to receive their care at St Thomas' Hospital, London. The review was commenced in response to commissioner led derogation by both Kent and Medway providers. The derogation related to non-compliance against the national specification. There were concerns about the number of specialist procedures being carried out and the shortage of surgical consultants and interventional radiologists; an inadequate number of specialist procedures led to poor outcomes.

(2) Ms Windibank reported that a deliberative event in November would be taking place to test the options development and appraisal. She stated that a clinical reference group was supporting and advising the Vascular Review Programme Advisory Board. The group was developing the clinical models for appraisals and leading on detailed modelling to understand some of the challenges including workforce, financial planning and demographic change. She advised that there were two emerging models: a central hub with 24/7 specialist workforce for all inpatient activity with outpatient services being provided at spokes as set out in the national specification or a two centre collaborative model run by two providers on two sites. She stated that the Medway HASC had considered the review to be significant service change and a Joint Health Overview and Scrutiny Committee with Medway would need to be formed if the Kent HOSC considered it to be substantial too.

(3) A number of comments were made about the inclusion of travel times in the public consultation. Ms Windibank reported that the Clinical Reference Group was working with SECAmb to establish travel times and review the transfer times for emergency vascular services.

(4) RESOLVED 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.

49. West Kent: Out of Hours Services Re-procurement (Written Update)
(Item 9)

(1) The Committee received a report from NHS West Kent CCG which provided an update on the reprocurement of Out of Hours services in West Kent.

(2) RESOLVED that the report be noted and NHS West Kent CCG be requested to provide an update to the Committee at the appropriate time.

50. Date of next programmed meeting – Friday 27 November 2015 at 10:00
(Item 10)

(1) Members of the Committee noted the date of the next meeting and Ms Adam stated that there were two substantive items scheduled: Health and Wellbeing Board Update and North Kent Urgent and Emergency Care.

(2) Ms Adam undertook to confirm the membership and proposed dates of the Joint Health Overview and Scrutiny Committee to the group representatives.

(3) The meeting adjourned until 11.17 and reconvened at 11.23.

51. Public Health Transformation
(Item 8)

Karen Sharp (Head of Public Health Commissioning, Kent County Council) was in attendance for this item.

(1) The Chairman welcomed Ms Sharp to the Committee. Ms Sharp introduced Public Health's programme of work and proceeded to give a presentation (attached as a supplement to the Agenda pack) which covered the following key points:

- Drivers for Change
- Timeline
- Review of outcomes and performance for smoking; healthy eating, physical activity and obesity; alcohol and substance misuse; wellbeing; and sexual health & communicable disease
- Market engagement
- Key themes of transformation

- Revised local public health model

(2) Members of the Committee then proceeded to ask a number of questions and make a number of comments. In response to a specific question about the value for money of smoking cessation services, Ms Sharp explained that people were most likely to give up smoking if accessing a smoking cessation service; she acknowledged that these may not always be value for money and providing interventions in a different way could be more successful. She highlighted a motivational insight case study of a group of young women in Sheerness who were smoking in pregnancy. They were reluctant to access a dedicated smoking cessation service and were not aware of the long term effects of smoking. She considered that it may be more appropriate for professionals to deliver smoking cessation services to these young women in trusted environments such as Children Centres.

(3) Members enquired about engagement with the public and Troubled Families. Ms Sharp explained that the pilot of mobile NHS Health Checks had been effective in capturing people who might not have previously accessed a health check. She stated that it was an opportunistic approach which caught people in areas of high footfall. She reported that Public Health was looking at other ways to engage with the public using Mosaic data to profile how different groups were receptive to public health messages. She explained that Public Health was working collaboratively with different organisations to engage with the public such as the inclusion of public health articles in district council funded publications. She noted that people had to be motivated to make a positive change to their health behaviour; communities did not respond well to being told that their health behaviours were poor. She reported that engaging with Troubled Families was a key area; she acknowledged that many Troubled Families had serious health challenges and needed support to access basic services such as registering with a GP and dentist.

(4) A number of comments were made about access to sexual health services. Ms Sharp explained that there were no plans to reduce provision of universal and specialist sexual health services. She noted the importance of early help services in preventing escalation to specialist intervention. Public Health was looking to at areas to integrate health improvement services and encourage motivation to change through the use of health trainers.

(5) RESOLVED that the report be noted and the Director of Public Health be requested to provide an update on the Public Health Transformation to the Committee at the appropriate time.

EXEMPT ITEM

52. Motion to exclude the Press and Public

(1) RESOLVED that under Section 100A of the Local Government Act 1972 the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of part 1 of Schedule 12A of the Act.

53. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Exempt Appendices to Item 11)

(Item 12)

Karen Sharp (Head of Public Health Commissioning, Kent County Council) and Dave Holman (Head of Mental Health Programme Area and Sevenoaks Locality Commissioning, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Holman began by providing an update on the draft service specifications; the service specifications were at an early stage and changing daily. The draft specifications had been presented to all Kent and Medway CCGs and would be finalised in December 2015. He reported that a joint contract procurement board had been established and would be chaired by Ian Ayres and Andrew Ireland; the board would sign off the final specifications. Ms Sharp highlighted page 135 in the Agenda pack which set out the differences between the current and new model. She reported that new model had been developed by Kent County Council and NHS West Kent CCG and outlined a whole system approach to emotional wellbeing and mental health. Mr Holman confirmed that the Mental Health specification was for the additional and specialist level of Children and Young People Mental Health Services (ChYPS) previously referred to as Tier 2 and 3 Child and Adolescent Mental Health Services (CAMHS). He noted the involvement of UCL in developing Key Performance Indicators and the support of NHS England.

(2) Members of the Committee then proceeded to ask a number of questions and make a number of comments. A Member stated the need for an executive summary for each specification and enquired about eating disorders services as part of the specification. Mr Holman explained that an all age care pathway for eating disorders was being developed. He reported that NHS West Kent CCG, Kent County Council and Sussex Partnership NHS Foundation Trust had submitted a bid to NHS England for an allocation of the £30 million Future in Mind funding to improve eating disorder services. He noted that the current age and need criteria for eating disorder services was high; the criteria needed to ensure that young people could access services. He stated that he would highlight eating disorders services in the next revision of the service specification. He reported than an Executive Summary was being developed as a result of feedback from the CCGs. Ms Sharp explained that services would be provided in a universal setting such as schools and GP surgeries as a result of feedback from children and young people who participated in the consultation.

(3) Members raised concerns about the lack of performance indicators particularly around capacity and details of how performance would be measured in the service specifications. Mr Holman explained that performance indicators were being developed and would be included in the final specifications. Ms Sharp stated that the capacity would be built in as part of the contract; investing in preventative and universal services would reduce the demand on intensive and specialist provision as early help services would support more children and young people and help to prevent their needs from escalating. She noted that Kent County Council and NHS West Kent CCG had been awarded National Lottery funding to train teachers to teach and build resilience in children and young people.

(4) In response to a specific question about crisis care, Mr Holman explained that there was one Section 136 Place of Safety in Kent which was located in Dartford. He reported that the CCG was in negotiations to install a further two Places of Safety including a children's only Place of Safety following a successful pilot in Sussex. He reported that since the development of the Kent and Medway Mental Health Crisis Concordat there had been better engagement with the Police and improved access to liaison psychiatry within Accident & Emergency. He noted that Sussex Partnership NHS Foundation Trust had developed a home treatment service and was seeing all urgent referrals within 24 hours as specified in the contract.

(5) A Member made reference to the specialist services in the specification and enquired about the demand for services. Mr Holman explained that the rise in demand for mental health and wellbeing services was a very difficult and growing issue affecting society. He stated the importance of enhancing universal services to reduce demand on specialist services. He reported that all the specialist multidisciplinary services listed in the service specification were already part of the current contract and were funded by the CCG.

(6) The Committee resolved to go into open session to discuss their recommendation.

UNRESTRICTED ITEM

54. Emotional Wellbeing Strategy for Children, Young People and Young Adults
(Item 11)

(1) RESOLVED that:

(a) NHS West Kent CCG be requested to provide the Committee at its November meeting with an Executive Summary of the specifications, key performance indicators within the contract and details of how these would be measured.

(b) the Committee defer making a determination on whether the NHS service specification was a substantial variation of service until the November meeting.

From: Roger Gough – Cabinet Member for Education and Health Reform

To: **Health Overview and Scrutiny Committee 27 November 2015**

Subject: **Kent Health and Wellbeing Board Annual Report 2014-2015**

Summary: The Kent Health and Wellbeing Board is required to report annually to Kent County Council summarising how it has discharged its statutory duties and associated functions. The report has been scheduled for the County Council meeting of 10 December 2015 and was taken to the Kent Health and Wellbeing Board on 18 November for agreement prior to presentation to County Council.

The following annual report is the one presented to the Health and Wellbeing Board. There will also be a presentation.

Recommendations – The Health Overview and Scrutiny Committee is asked to:

Note the report and ask that the Chairman of the Health and Wellbeing Board attend in future years to present the Health and Wellbeing Board annual report.

1. Background

(a) The Kent Health and Wellbeing Board was established following the enactment of the Health and Social Care Act 2012. From 1 April 2013 it became a committee of Kent County Council, prior to April 2013 the Health and Wellbeing Board operated in shadow form.

(b) Under the terms of reference for the Board it is required to submit an annual report to the County Council detailing how it has met its statutory obligations and performed other important functions that fall within its terms of reference. The report is not intended to be a comprehensive review of the Health and Social Care system in Kent but should focus on the work of the Board itself.

2. The Report

(a) The attached report details the activity of the Board during the period April 2014 to March 2015. Particular attention is given to how the Board discharged its statutory responsibilities as required under the Health and Social Care Act 2012.

(b) Appendices to the report give detail on the agenda items considered, the terms of reference the Board operates within, and the structure of the Board and its subgroups and committees. Other sections of the report describe

initiatives that have been developed with the involvement of the Board during the year.

3. Recommendations

(a) The Health Overview and Scrutiny Committee is asked to:

- Note the report and ask that the Chairman of the Health and Wellbeing Board attend in future years with the Health and Wellbeing Board annual report.

Background Documents

None

Contact details

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The Kent Health and Wellbeing Board 2014-2015

1. Introduction

This is the annual report for the Kent Health and Wellbeing Board for 2014/15. During this time the health and social care system experienced serious challenges including rising demand and limited resources. These challenges have fuelled the necessity for finding alternative ways to provide the services and care people need whilst increasing the quality of care they experience. Government policy has also driven the requirement to integrate the services we jointly provide and the ways in which they are commissioned.

The Kent Health and Wellbeing Board is at the forefront of these developments and has attracted significant national attention for how it has gone about its business.

2. The changing world of health and social care

As people enjoy longer lives, thanks in large part to advances in medical treatments, they also acquire long-term conditions that mean they need more help and support. In Kent population forecasts between 2010 and 2026 highlight that the number of 65+ year olds is to increase by 43.4% yet the population aged below 65 is only forecast to increase by 3.8% This will mean that Kent will have a relatively smaller population aged 20-49 years and considerable pressures on health and social care services as a result of services required for an ageing population.

Health and social care services will need to change to meet these different circumstances and the increased pressures they generate. This will affect the way services and care are funded, commissioned and provided. The Kent Health and Wellbeing Board brings together the key decision makers from across the County so that a more sustainable model of health and social care can be developed based, on integration. It is designed to improve the quality of care people receive and hopefully reduce costs, with more people living independently within the community, leading to less reliance on expensive and unnecessary hospital admissions.

Major initiatives from NHS England have been launched to find ways to meet these challenges such as the Health and Social Care Integration Pioneer Programme, the Better Care Fund and the Five Year Forward View and all have come within the scope of the Kent Health and Wellbeing Board.

3. The role of the Kent Board and its membership

The Kent Health and Wellbeing Board is a statutory body established by the Health and Social Care Act 2012 as a formal committee of the County Council. The Kent Board is composed of all the organisations that are responsible for the planning and commissioning of health and social care services in the county. The Act specified a minimum membership that in Kent has been extended to include representatives of

district councils, recognising we operate in a two tier authority area where district colleagues are critical partners.

The member organisations and their representatives are:

Kent County Council
Chair of the Board, Leader, Cabinet Members for Adult Social Care and Children's services, Director of Adult Social Care and Children's services, and Director of Public Health, Director of Clinical Engagement

Seven Clinical Commissioning Groups
The Accountable Officer and CCG Board Chair

Healthwatch Kent County Council
Chief Executive

NHS England
Area Team

Three representatives from District Councils
Selected by the Leaders of Kent councils

Under the Health and Social Care Act 2012 the Kent Board has five responsibilities:

- To ensure that a Joint Strategic Needs Assessment that identified the health priorities for the population is produced
- To ensure that a Pharmaceutical Needs Assessment is produced
- To ensure that a Joint Health and Wellbeing Strategy, based on the Joint Strategic Needs Assessment is produced
- To ensure that the commissioning plans of the CCG's and Kent County Council (social care and public health) properly reflect the needs identified in the Joint Strategic Needs Assessment and the priorities within the Joint Health and Wellbeing Strategy
- To promote the integration of health and social care

The Kent Health and Wellbeing Board is chaired by KCC Cabinet Member for Education and Health Reform, Cllr Roger Gough, and meets every two months. It met 6 times between April 2014 and March 2015. The Board does not have any dedicated resources and is administered as a Committee of Kent County Council by Democratic Services, a Secretariat of KCC.

The terms of reference for the Kent Health and Wellbeing Board are attached to this report as Appendix 2.

4. Substructures

In a county the size and complexity of Kent it is not possible for the Board to fulfil its responsibilities without a supporting structure where a lot of its work is conducted. In Kent a district based health and wellbeing board in Dover and Folkestone was established by the Department of Health in the period prior to the formal introduction of health and wellbeing boards as part of the “pathfinders” programme. To facilitate the work of the County level board Kent, uniquely, decided to expand this model and there are now seven local health and wellbeing boards, based on CCG geography, and with full representation from all relevant district councils that are formal subcommittees of the Kent board.

Other subgroups have been established to assist the Kent board for specific purposes.

The Kent Children’s Health and Wellbeing Board focusses on issues relevant to our younger population.

The Kent Health and Social Care Integration Pioneer Steering Group is responsible for delivering the NHS England integration pioneer programme of which Kent was a founder member.

The Better Care Fund Assurance Group monitors the progress of the Better Care Fund (see below) plans developed to promote integration

The Multi-Agency Data and Information Group brings together the relevant data, information and intelligence from a variety of organisations to inform the business of the Board

Task and Finish groups are established as required. For example a group looking at workforce issues is currently meeting having been agreed in 14/15 to meet in 15/16.

5. The work of the Board

The Board successfully fulfilled its statutory requirements (as described above) in 2014/15.

To ensure that a Joint Strategic Needs Assessment (JSNA) that details the health needs of the population is produced.

The Board has received regular reports concerning development of the JSNA that was first completed in 2014. The JSNA is now due for substantial revision, having completed its first cycle, and this process has started. The new JSNA will be presented to the Board at its meeting of May 2016.

The current Kent Joint Strategic Needs Assessment can be found at:

http://www.kmpho.nhs.uk/jsna/

To ensure that a Pharmaceutical Needs Assessment is produced.

The Pharmaceutical Needs Assessment for Kent was presented to the Board at its meeting of 18th March 2015 following interim consideration at the meeting of 17th September 2014.

The current Pharmaceutical Needs Assessment for Kent can be found at:

http://www.kmpho.nhs.uk/reports-and-strategies/pharmaceutical-needs-assessments/kent-pharmaceutical-needs-assessments/

To ensure that a Joint Health and Wellbeing Strategy that reflects the needs identified in the JSNA is produced.

A new edition of the Joint Health and Wellbeing Strategy for 2014 - 2017 has been produced and was published in July 2014. This strategy builds on the initial one year strategy that was published in 2013.

The current Kent Joint Health and Wellbeing Strategy can be found at :

http://www.kent.gov.uk/__data/assets/pdf_file/0014/12407/Joint-Health-and-Wellbeing-Strategy.pdf

To confirm that the commissioning plans of the Clinical Commissioning Groups (CCGs), and the local authority (social care and public health) correspond with the priorities of the Joint Health and Wellbeing Strategy

The commissioning plans of the seven Clinical Commissioning Groups in Kent were presented to the Board and agreed at its meeting of 18th March 2015. Commissioning plans for Adult Social Care and NHS England, were considered and agreed at the meetings of 26th March 2014 and 20th May 2015. Children's Services and Public Health commissioning plans were agreed by the board at the meeting of 28th May 2014. These reports can be found at the following locations:

https://democracy.kent.gov.uk/documents/g5465/Public%20reports%20pack%2026th-Mar-2014%2018.30%20Health%20and%20Wellbeing%20Board.pdf?T=10

https://democracy.kent.gov.uk/documents/g5466/Public%20reports%20pack%2028th-May-2014%2018.30%20Health%20and%20Wellbeing%20Board.pdf?T=10

https://democracy.kent.gov.uk/documents/g5833/Public%20reports%20pack%2020th-May-2015%2018.30%20Health%20and%20Wellbeing%20Board.pdf?T=10

To promote the integration of health and social care services

The Board has devoted a lot of time to this responsibility. In particular it has overseen the introduction and implementation of the Better Care Fund. This programme was announced by government in 2013 to promote the pooling of budgets and the development of joint initiatives by health and social care organisations designed to reduce demand for hospital services. Implementation has required establishing statutory s75 agreements (pooled budget arrangements) with

each of the seven CCGs in Kent that have brought £101 million of existing CCG budgets together.

The Kent proposals for the Better Care Fund were considered and endorsed by the Health and Wellbeing Board at the meetings of :

16th July 2014; 17th September 2014; 28th January 2015; and 18th March 2015.

The Better Care Fund plans can be found at:

http://www.kent.gov.uk/__data/assets/pdf_file/0015/12471/Better-Care-Fund-introduction-and-vision.pdf

The Board is also responsible for the Health and Social Care Integration Pioneer programme in Kent. This is a government initiative designed to bring all health and social care organisations in the county together to identify opportunities for more integrated working that is intended to improve the experience of patients whilst reducing costs. The Integration Pioneer programme should also identify the barriers that prevent organisations achieving the integration they aspire to.

The Kent Health and Social Care Integration Pioneer programme has reported progress to the Health and Wellbeing Board at the meetings of 19th November 2014 and 28th January 2015

The latest annual report for the Kent Integrated Care and Support Pioneer Programme can be found at:

http://www.local.gov.uk/documents/10180/6927502/Integrated+Care+Pioneer+Programme+Annual+Report+2014/76d562c3-4f7d-4169-91bc-69f7a9be481c

Kent's approaches towards the Better Care Fund and the Integration Pioneer programme have both attracted national recognition and have been cited as examples of good practice. Our Integration Pioneer programme has also developed an international reputation and is working in partnership with other countries in Europe and Japan.

Other national initiatives are also being trialled in Kent including the Prime Minister's Challenge to transform primary care services currently being implemented in Folkestone. This has successfully demonstrated how targeted investment can be used to develop co-operation between practices to deliver an 8:00 a.m. to 8:00 p.m. GP service for the area. The new working practices this entails may also be helpful in retaining and recruiting GPs who find them attractive.

6. Five Year Forward View – Vanguard Programme

The Board is involved with the development of the "New Models of Care" being developed as part of the NHS England Five Year Forward View and how they are being implemented in Kent.

During 2014/15 developments at Whitstable Medical Practice (Estuary View) were recognised as one of 29 examples across the country within the Vanguard programme associated with the NHS England Five Year Forward View. This is a major initiative that has the potential to transform the delivery of primary, hospital and social care and provide a model for other areas to adopt.

7. Other business

Apart from its statutory responsibilities the Kent Health and Wellbeing Board has also concerned itself with a number of other issues such as maintaining oversight of the implementation of the Joint Health and Wellbeing Strategy.

The five outcomes of the Joint Health and Wellbeing Strategy are:

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

The Kent Health and Wellbeing Board monitors progress and performance against key indicators for each of the five outcomes, tending to focus on specific outcomes at particular meetings. To this end the Board has received reports and presentations on key issues throughout the year including dementia, learning disability, mental health and children and young people. Progress on all outcomes will continue to be reported to the Board in 2015/16 and beyond. Key indicators are also contained within the Assurance Framework (see below). In addition the local Health and Wellbeing Boards also maintain an oversight of how these outcomes are being delivered at a CCG level.

Winter 2014/15

The pressures on the system generated by the changing demography of Kent residents became starkly apparent over the winter of 2014/15. Trends that have been observed over a number of years tested the system with an increased demand for hospital admissions from very old, frail and sick people. Bed occupancy rates in three of our four acute hospital trusts were significantly above 90% and the number

of bed days identified as due to delayed transfers of care increased by 15% in the Winter quarter.

Whilst largely the increased demand emanated from people who needed to be admitted to hospital it became apparent that lack of high level support services or facilities elsewhere meant that they stayed longer than necessary. The “Out of Hours” service also experienced serious difficulty. In addition demand for highly intensive home care services exceeded the ability of the market to supply them and discharging patients became increasingly difficult.

Generally the system in Kent was able to deal with the pressures, indeed better than a number of other areas of the country, but the experience provided a focus for the Board to review how Kent as a whole had coped and what lessons needed to be learnt for the coming year.

The Kent Assurance Framework

In response to the Francis report into the circumstances of the Mid Staffordshire hospital scandal and events at Winterbourne View the Board has developed an “Assurance Framework” that reports regularly on a suite of indicators designed to highlight when stresses may be appearing across the system, the indicators from the Joint Health and Wellbeing Strategy, and those relating to the Better Care Fund. In this way the Board is kept up to date with how the system is responding to the demands being placed upon it and progress towards the outcomes of the Health and Wellbeing Strategy. The Board has also commissioned Healthwatch Kent to identify and explore ways to address the key issues in the health and care system that may affect the quality of service that people experience.

8. Wider recognition and profile

The Kent Health and Wellbeing Board has been recognised nationally as an example of good practice and its views are sought regularly on how boards more generally can be effective. The Chair of the Kent Board, Roger Gough has been invited to speak at a number of events concerning Health and Wellbeing Boards. This has ensured that the Kent Board has maintained a high profile at national level.

The Board itself has hosted events related to its activities and responsibilities. The Board brought all commissioners and providers alongside representatives from KCC, the Voluntary and Community Sector and district councils to begin discussions about the Better Care Fund following its announcement. This event led directly to significant system progression including a ground-breaking Executive Programme Board in the North of the county designed to ensure effective development of new integration programmes.

A Provider Networking event took place on the 22nd September 2014, hosted by East Kent Hospitals University Foundation Trust.

In addition Simon Stevens, the Chief Executive of NHS England, welcomed an invitation to visit the Board and its wider group of stakeholders to discuss the

implementation and implications of the Five Year Forward View, shortly after its publication.

9. Endorsement, consideration and support

A number of issues have been presented to the Board for their consideration and endorsement. In 2014/15 these have included the implications of The Care Act, the Kent Accommodation Strategy that describes how Kent will meet the accommodation needs for people needing additional support, the contribution that the Kent Fire and Rescue Service can make towards people's health and wellbeing, systems resilience, and the restructure of the Early Years' Service.

10. Into 2015-2016

Tackling the big issues

The Health and Wellbeing Board has adopted a remit to try and tackle big structural issues within the system that are affecting our ability to deliver the care and treatment people need as we would wish. In a system as large and complex as health and social care there are many potential problems with the structures and processes we work within. The NHS financial system of Payment by Results is increasingly being recognised as being unhelpful to service redesign in some instances; managing the current financial situation is a challenge and the division between primary care and the acute sector can also be problematic. When Simon Stevens visited Kent he was clear that all of these needed to be addressed in order for the Five year Forward View to be able to succeed.

Above all problems related to workforce have been identified by all partners as an absolutely critical issue that is hindering the maintenance and development of the services they provide. These include difficulties in recruiting A&E Consultants, ensuring general practice is sustainable, finding sufficient and appropriately qualified nursing staff to ensure recommended safe staffing levels in hospitals, and very serious capacity problems in the social care workforce especially domicillary care.

The problems are multi-faceted and long-standing. For example the age profile of GPs working in Kent means many will be retiring in the near future. New entrants to the profession are more likely to want to work part-time and are also less inclined to adopt the traditional model of GP employment as partners in their own practice "business". This produces a number of challenges, not only in training sufficient doctors, which takes on average 7 years, but also in changing the way practices operate to accommodate the changes to working practices that new GPs will find attractive.

More broadly the whole primary care workforce is changing, requiring a different mix of skills than in the past and working in different contexts. For example GPs may need different training in order to understand the needs of greater numbers of patients with complex health issues living in the community. In some areas of Kent paramedic practitioners are now working with primary care, not just in the ambulance service. These roles are also developing in GP practices to visit patients and determine their most appropriate treatment and care, thereby reducing the pressure on GPs and also helping to avoid unnecessary hospital admissions.

Nurse recruitment is also problematic. The new training initiatives proposed by NHS England depend not only on adequate finance but often more critically on the availability of training placements which are nationally in short supply. Proposals to increase the number of nurses in any particular specialty, for example Health Visitors, may in practice lead to qualified nurses from other disciplines, especially adult hospital nursing, moving from one to another. Recruitment from abroad is actively pursued by most of our major providers but this can lead to an "internal market" within Kent to recruit and train staff from overseas and there is an additional lure towards London hospitals which can offer higher rates of pay.

Social care staff are often paid at minimum wage levels and these can be less attractive than alternative opportunities offered in the retail and catering sectors where the work is arguably less demanding as well as being better re-numerated. High property prices and cost of living can also affect the ability to recruit and train local people into lower paid jobs.

All areas of the country are struggling with these challenges but unless we can recruit and retain appropriate numbers of the right staff we will not be able to establish a high quality and sustainable system in Kent. We will need to move away from specific job roles and understand the skills needed to deliver care differently. This will also bring challenges.

The Health and Wellbeing Board received a presentation from NHS Health Education England that gave a comprehensive overview of workforce challenges and has established a working group with a specific remit to investigate the issues affecting the health and social care workforce in Kent. They are currently hearing from a wide range of stakeholders, including commissioners, providers, Healthwatch, NHS Health Education England, and NHS England to determine what we can do in Kent to improve our workforce situation. The group has received feedback from various sources across the County including a recent careers and workforce event for school pupils in East Kent. Recommendations will be reported early in the New Year.

The working group will also draw on other work being undertaken by a range of others. In particular Canterbury Christchurch University is implementing new training programmes for nurses which include experience of working in general practice to

familiarise student nurses with work in primary care. Hopefully this will lead to more nurses opting to work in primary care when they qualify.

Integration

Kent has been at the forefront of the drive towards integration. Our Integration Pioneer programme and Better Care Fund plans are nationally respected as best practice. In addition we host one of the 29 original Vanguards for New Models of Care proposed in NHS England's Five Year Forward View. These Vanguards are designed to develop and test new approaches to services and care. Based on the concept of integration the Whitstable Medical Centre is a vanguard "Multi-specialty Community Provider" (MCP) that is redefining how Primary Care operates.

As an MCP Whitstable Medical Centre is bringing a variety of services and interventions that previously have been available only in hospitals much closer to the community of patients they serve. X ray and other diagnostic tests can be done on site, obviating the need for visits to the local hospital; minor operations can be done at the centre and emergency treatment for those not requiring all the facilities of a major hospital can also be carried out. Ambulances can deliver appropriate patients straight to the Whitstable Medical Practice, reducing pressure on hard pressed Accident and Emergency Units and reducing the likelihood of people being admitted to the hospital. Plans have already been developed for a nursing and residential care home facility on-site enabling rapid access to medical assistance if required, again reducing the need for people to go to hospital when taken ill. The Vanguard is intended to explore whether this model of care is robust enough to serve the needs of a population in excess of 100,000 people and how it could be rolled out to other areas or nationally.

Integration is also happening in other ways and other places in Kent. In the North of the County Commissioners and providers are working together to redesign how they deliver their services. The Executive Programme Board for Dartford, Gravesham, Swanley and Swale is developing a range of programmes to improve the experience of people receiving care and treatment whilst using resources more effectively through joint and partnership working. The extensive development in the Ebbsfleet area, that is currently the subject of an application to the government's recently announced Healthy New Towns programme, provides a rare and exciting opportunity to design a local health and social care system from scratch.

The Better Care Fund also focussed attention on how integration was being progressed in Kent. Although its definition narrowed somewhat as it was implemented the BCF encouraged dialogue and partnership between different parts of the system. However it became apparent that, on its own, establishing the fund is not sufficient to deliver the scale and speed of integration necessary in Kent and we need to work hard at all the other aspects involved.

Similarly the Pioneer programme has provided a very useful forum to consider issues that can potentially impede progress towards better integration and produce solutions to overcome these. This has been particularly true in the very complex area of sharing information and data between different organisations within the system. Solutions generated by our Pioneer programme have been truly innovative and recognised nationally.

However, despite all the good work and progress on numerous issues much remains to be done, particularly with regard to increasing the pace of integration and evaluating and then rolling out successful programmes across the county. This will provide a major area of work for the Health and Wellbeing Board going forward.

The Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)

The Health and Wellbeing Board is responsible for the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. The updated strategy was published in 2014 and runs until 2017. The current JSNA is due for revision in 2016. The Health and Wellbeing Board continues to develop both of these to ensure they remain relevant to changing circumstances and needs of those that use them, especially commissioners who must take them into account when producing their plans and intentions.

A major event was held in June 2015 to consider how useful stakeholders were finding the JHWS. The feedback was that the strategy was broadly on track but that there were some changes in emphasis that would be helpful going forward.

The revision of the JSNA was the focus of another event held in September. A key challenge from Commissioners was that although the JSNA provided useful information it was less helpful in analysing the implications of the data to inform their decisions on investment, and disinvestment, in services. In Kent we are moving beyond the original conception of the JSNA and a working group is now looking at how a “JSNA Plus” can be developed that will include trend analysis, predictive modelling and value for money tools. A proposal on this model will be brought to the Health and Wellbeing Board in the New Year.

APPENDIX 1

Substantive agenda items taken by the Kent Health and Wellbeing Board in 2014/15

28th May 2014

Public Health Commissioning Plans
Children's Commissioning Plans
Health and Wellbeing Strategy and engagement plan
Accommodation strategy
Assurance Framework

16th July

Dementia care and support
Kent Fire and Rescue Service
Health and Wellbeing Strategy
Better Care Fund (National Review)
Potential merger Ashford and Canterbury and Coastal CCGs
Assurance Framework
Joint Strategic Needs Assessment /Joint Health and Wellbeing Strategy Steering Group report

17th September

BCF update
Quality and the Health and Wellbeing Board
Pharmaceutical Needs Assessment
Healthwatch Annual Report

19th November

Joint Health and Social Care Self-Assessment – Learning Disability
Kent Safeguarding Children Board Annual Report
Care Act
Integration Pioneer update
System Resilience
Minutes of local boards, Children and Young People's Health and Wellbeing Board and Emotional Health and Wellbeing Strategy
Delivering the Joint Health and Wellbeing Strategy – reports from local boards

28th January

Strategic Workforce issues
Early Years Restructure
Integration Pioneer update and Five Year Forward View
Assurance Framework and update on Quality
Better Care Fund s75 arrangements
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

18th March

Review of CCG commissioning plans
Better Care Fund s75 arrangements
Pharmaceutical Needs Assessment
Protocol for joint working between Health and Wellbeing Board, Children and Young People's Health and Wellbeing Board, and the Kent Safeguarding Children Board
Minutes of local Health and Wellbeing Boards

APPENDIX 2

Kent Health and Wellbeing Board

Governance Arrangements

Role

The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

• secure better health and wellbeing outcomes in Kent

• reduce health inequalities and

• ensure better quality of care for all patients and care users.

The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner.

The HWB also aims to increase the role of elected representatives in health and provide a key forum for public accountability for NHS, public health, social care and other commissioned services that relate to people's health and wellbeing.

Terms of Reference:

The HWB:

1. Commissions and endorses the Kent Joint Strategic Needs Assessment (JSNA), subject to final approval by relevant partners, if required.

2. Commissions and endorses the Kent Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA, subject to final approval by relevant partners, if required.

3. Commissions and endorses the Kent Pharmaceutical Needs Assessment, subject to final approval by relevant partners, if required.

4. Reviews the commissioning plans for healthcare, social care (adults and children's services) and public health to ensure that they have due regard to the JSNA and JHWS, and to take appropriate action if it considers that they do not.

5. Has oversight of the activity of its sub committees (referred to as Clinical Commissioning Group level Health and Wellbeing Boards), focussing on their role in developing integrated local commissioning strategies and plans.

6. Works alongside the Health Overview and Scrutiny Committee (HOSC) to ensure that substantial variations in service provision by health care providers are appropriately scrutinised. The HWB itself will be subject to scrutiny by the HOSC.

7. Considers the totality of the resources in Kent for health and wellbeing and considers how and where investment in health improvement and prevention services could improve the overall health and wellbeing of Kent's residents.

8. Discharges its duty to encourage integrated working with relevant partners within Kent, which includes:

• endorsing and securing joint arrangements, including integrated commissioning where agreed and appropriate;

• use of pooled budgets for joint commissioning (s75);

• the development of appropriate partnership agreements for service integration, including the associated financial protocols and monitoring arrangements;

• making full use of the powers identified in all relevant NHS and local government legislation.

9. Works with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

10. Considers and advises Care Quality Commission (CQC) and NHS Commissioning Board; monitors providers in health and social care with regard to service reconfiguration.

11. Works with the HOSC and/or provides advice (as and when requested) to the County Council on service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

12. Is the focal point for joint working in Kent on the wider determinants of health and wellbeing, such as housing, leisure facilities and accessibility, in order to enhance service integration.

13. Reports to the full County Council on an annual basis on its activity and progress against the milestones set out in the Key Deliverables Plan.

14. Develops and implements a communication and engagement strategy for the work of the HWB; outlining how the work of the HWB will:

• reflect stakeholders' views

• discharge its specific consultation and engagement duties

• work closely with Local HealthWatch.

15. Represent Kent in relation to health and wellbeing issues in local areas as well as nationally and internationally.

16. May delegate those of its functions it considers appropriate to another committee established by one or more of the principal councils in Kent to carry out specified functions on its behalf for a specified period of time (subject to prior agreement and meeting the HWB's agreed criteria).

Membership

The Chairman is elected by the HWB.

1. Kent County Council:

• The Leader of Kent County Council and/or their nominee*
• Executive Director for Families and Social Care*
• Director of Public Health*
• Cabinet Member for Adult Social Care & Public Health
• Cabinet Member for Business Strategy, Performance and Health Reform
• Cabinet Member for Specialist Children's Services
• Any other County Council Member necessary for the effective discharge of HWB functions

2. Clinical Commissioning Group: up to a maximum of two representatives from each consortium (e.g. Chair of the CCG Board and Accountable Officer)*

3. A representative of the Local HealthWatch* organisation for the area of the local authority.

4. A representative of the NHS Commissioning Board Local Area Team*

5. Three elected Members representing the Kent District/Borough/City councils (nominated through the Kent Council Leaders)

*denotes statutory member.

Procedure Rules

1. Conduct. Members of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non-elected representatives on the HWB (e.g. GPs and officers) will be co-opted members and, as such, covered by the Kent Code of Conduct for Members for any business they conduct as a member of the HWB.

2. Declaration of Disclosable Pecuniary Interests. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any sub committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared.

3. Frequency of Meetings. The HWB meets at least quarterly. The date, time and venue of meetings is fixed in advance by the HWB in order to coincide with the key decision-points and the Forthcoming Decision List.

4. Meeting Administration.

• HWB meetings are advertised and held in public and administered by the County Council.

• The HWB may consider matters submitted to it by local partners.

• The County Council gives at least five clear working days' notice in writing to each member of every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting.

• Papers for each HWB meeting are sent out at least five clear working days in advance.

• Late papers may be sent out or tabled only in exceptional circumstances.

• The HWB holds meetings in private session when deemed appropriate in view of the nature of business to be discussed.

• The HWB meetings will be web cast where the facilities are in place

• The Chairman's decision on all procedural matters is final.

2. Meeting Administration of Sub Committees.

HWB sub-committees are administered by a principal local authority, in the case of the Clinical Commissioning Group level HWBs, by a District Council in that area. They will be subject to the provisions stated in these Procedure Rules.

3. Special Meetings.

The Chairman may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

The Chairman is required to convene a special meeting of the HWB if they are in receipt of a written requisition to do so signed by no less than three members of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

4. Minutes.

Minutes of all of HWB meetings are prepared recording:

• the names of all members present at a meeting and of those in attendance

• apologies

• details of all proceedings, decisions and resolutions of the meeting

Minutes are printed and circulated to each member before the next meeting of the HWB, when they are submitted for approval by the HWB and are signed by the Chairman.

5. Agenda.

The agenda for each meeting normally includes:

• Minutes of the previous meeting for approval and signing

• Reports seeking a decision from the HWB

• Any item which a member of the HWB wishes included on the agenda, provided it is relevant to the terms of reference of the HWB and notice has been given to the Clerk at least nine working days before the meeting.

The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

6. Chairman and Vice Chairman's Term of Office.

The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

7. Absence of Members and of the Chairman.

If a member is unable to attend a meeting, then they may provide an appropriate alternate member to attend in their place, subject to them being of sufficient seniority to agree and discharge decisions of the Board within and for their own organisation.

The Clerk of the meeting should be notified of any absence and/or substitution at least five working days prior to the meeting. The Chairman presides at HWB meetings if they are present. In their absence the Vice- Chairman presides. If both are absent, the HWB appoints from amongst its members an Acting Chairman for the meeting in question.

8. Voting.

The HWB operates on a consensus basis. Where consensus cannot be achieved the subject (or meeting) is adjourned and the matter is reconsidered at a later time.

If, at that point, a consensus still cannot be reached, the matter is put to a vote. The HWB decides all such matters by a simple majority of the members present. In the case of an equality of votes, the Chairman shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chairman. For clarity, each Clinical Commissioning Group has one vote, irrespective of whether both the Clinical Lead and Accountable Officer for that Clinical Commissioning Group attend the HWB.

9. Quorum.

A third of members form a quorum for HWB meetings. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

10. Adjournments.

By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB decides.

11. Order at Meetings.

At all meetings of the HWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

12. Suspension/disqualification of Members.

At the discretion of the Chairman, anybody with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman, or if they breach the Kent Code of Conduct for Members.

Appendix 3

THE KENT HEALTH & WELLBEING BOARD STRUCTURE

KENT COUNTY COUNCIL

KENT HEALTH & WELLBEING BOARD

Local Health & Wellbeing Boards

- THANET
- ASHFORD
- CANTERBURY & COASTAL
- SOUTH KENT COAST
- WEST KENT
- DARTFORD GRAVESHAM & SWANLEY
- SWALE

Health & Social Care Integration Pioneer Steering Group

Kent Children's Health & Wellbeing Board

Better Care Fund Assurance Group

Joint Strategic Needs Assessment & Joint Health & Wellbeing Strategy Steering Group

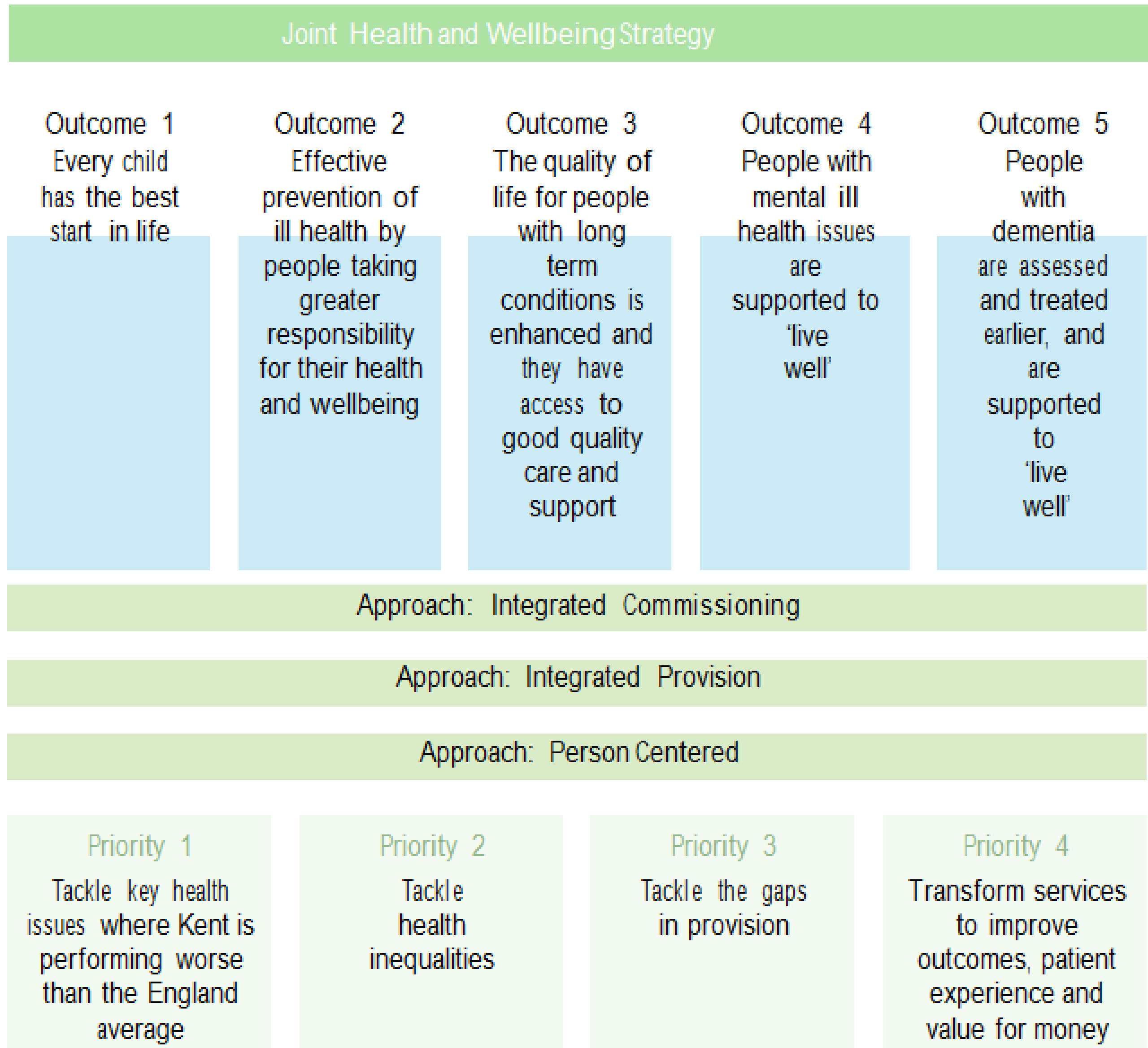
- Multi-Agency Data & Information Group

Task & Finish Groups

e.g. Workforce

Appendix 4

The outcomes will be delivered by focusing on our priorities within each of the outcome areas, whilst ensuring that any intervention is informed by the three approaches, i.e. that it is centred around the person), that it is provided in a joined up way, and where appropriate it is jointly commissioned.



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Item 5: NHS preparations for winter in Kent 2015/16

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 November 2015

Subject: NHS preparations for winter in Kent 2015/16

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

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

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1. System Resilience Groups

(a) Following the pressure experienced during the winter of 2012/13, Urgent Care Working Groups (UCWGs) were developed by NHS England as a mechanism for local health economies to bring together commissioner and provider organisations involved in urgent care. The UCWGs were charged with co-producing winter plans to deliver safe and efficient services for patients. In 2014/15 UCWGs' roles were expanded to cover elective, as well as non-elective care, as reflected in a change of name to System Resilience Groups (SRGs) (NHS England 2014).

(b) In 2014/15 an additional £700 million of non-recurrent winter funding for NHS services was allocated. The Government initially announced a £400 million fund to improve local health services (NHS England 2014):

- £350m was allocated to SRGs through CCGs, on a 'fair shares' basis (based on the population within the CCGs geographical footprint)
- £50m was held in total in a central reserve to be targeted towards national initiatives including £18m specifically directed to support ambulance trusts, £6m for NHS 111 services and £11.2m for specialised commissioning (including adult critical care and neuro-rehab beds and staffing)

(c) In November 2014 the Government announced a further £300 million to help provide more bed space; pay for additional clinical staff; increase access to GPs; and support ambulance services to meet additional demand (Department of Health 2014).

(d) In 2015/16, £350 million of operational resilience funding has been shared with CCGs as part of their baseline allocations - no additional resilience funding has been announced for this winter (Monitor 2014).

(e) In preparation for this winter, SRGs have been asked to provide assurance to NHS England on their plans to (NHS England 2015a; NHS England 2015b):

- implement high impact actions for general operational resilience
- implement high impact actions to improve ambulance performance
- implement 24/7 liaison mental health services in A&E departments

- undertake acute and out of hospital capacity and demand projections
- improve upon last year's resilience plan

2. Winter 2014/15

(a) Between November 2014 and February 2015, there were 7,063,000 A&E attendances in England - 190,000 more attendances than for the same period in 2013/14. At its peak, there were 446,000 attendances in one week (week ending December 21) – up by 9.3% on the same week for winter 2013/14. This is the highest attendance figures ever recorded for a winter period (NHE England 2015c).

(b) Emergency admissions showed a similar increase in demand: there were 1,821,000 emergency admissions in winter 2014/15 compared with 1,770,000 in winter 2013/14 - an increase of 51,000 (NHE England 2015c). 1,024 patients waited over 12 hours for admission to hospital - eighteen times over the 2012/13 figure, and over seven times the 2013/14 figure (House of Commons Library 2015).

(c) NHS 111 service faced similar unprecedented demand, dealing with 4.6 million calls in winter 2014/15 – up by one million calls or 27% on winter 2013/14. Of all the calls triaged, just 11% had ambulances dispatched and 7% were recommended to A&E (NHE England 2015c).

(d) Figures for winter 2014/15 show that since the winter 2009/10 there has been a 14.1% increase in A&E attendances, and a leap of 26.3% since the winter 2004/5. Emergency admissions have risen substantially too – winter 2014/15 figures show an increase of 8.8% on the winter 2009/10 and by 25.7% on 2004/5 (NHE England 2015c).

(e) Between November 2014 and March 2015 there were 380 A&E diverts where emergency patients had to be diverted to other hospitals due to demand - an increase of 26% on winter 2013/14. There were 133,026 incidences of ambulance handovers delayed for over 30 minutes - an increase of 62% on winter 2013/14 (House of Commons Library 2015).

(f) There were also increases in the number of bed days lost to norovirus and delayed transfer of care. 101,144 bed days were lost due to closures related to diarrhoea and vomiting/norovirus symptoms – an increase of 37% on winter 2013/14. 375,700 beds were unavailable due to delayed transfers of care - an increase of 29% on winter 2013/14 (House of Commons Library 2015).

(g) 1,407 urgent operations and 29,339 elective operations were cancelled - an increase of 24% and 32% respectively on winter 2013/14. Trusts reporting operational problems increased to an average of 12.1 trusts reported serious operational problems daily - this compares with 6.4 trusts per day in winter 2013/14 (House of Commons Library 2015).

3. Recommendation

RECOMMENED that the report be noted and NHS England provide an update about the performance of the winter plans to the Committee at its April meeting.

Background Documents

Department of Health (2014) *'NHS well prepared for cold winter pressures (14/11/2014)*', https://www.gov.uk/government/news/nhs-well-prepared-for-cold-winter-pressures

House of Commons Library (2015) '*NHS Winter Pressures 2014/15 – Weekly Update (27/03/2015)*', http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN07057

Monitor (2014) *'Operational resilience funding for 2015/16: updates (19/12/2014)'*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/423116/Operational_resilience_FAQs_FINAL.pdf

NHS England (2014) '*NHS England Board Meeting (17 December 2014) - Update on NHS preparedness for winter 2014/15 (12/12/14)'*, https://www.england.nhs.uk/2014/12/12/board-meet-17-dec14/

NHS England (2015a) *'Resilience Planning (24/04/2015)*', https://www.england.nhs.uk/wp-content/uploads/2015/04/resilience-planning-assurance-letter.pdf

NHS England (2015b) *'Preparation for winter 2015/16 (11/08/2015)*', https://www.england.nhs.uk/wp-content/uploads/2012/10/winter-readiness-letter-1516.pdf

NHS England (2015c) 'Winter Health Check - 13 March 2015 (13/03/2015)', https://www.england.nhs.uk/2015/03/13/winter-health-chck-130315/

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NHS preparations for winter in Kent 2015/16

Matthew Drinkwater, Head of EPRR, NHS England South (South East)

1.0 Purpose

This report provides a briefing to the Kent Health Overview and Scrutiny Committee, which describes the actions that are being taken by across the Health and Social Care system to prepare for winter.

2.0 Background

Historically, the effects of winter have been shown to place additional pressures on health and social care services across Kent. This is caused by a number of issues including an increase in respiratory illness, increased slips and falls and the impact of seasonal influenza.

The key vehicle for winter Preparedness and Response activities are the Systems Resilience Groups that were established in 2014. Kent has four Systems Resilience Groups covering the North, East, West and Medway and Swale. Kent County Council is a core member of each of these groups and is represented on them by an Executive Director.

3.0 System Resilience Group Assurance

NHS England expects all Systems Resilience Groups in Kent to have in place robust plans to deliver the urgent care standards and to ensure that plans are in place to effectively manage winter pressures. Therefore ahead of winter 2015/16 NHS England South (South East) has facilitated an assurance process via a self-assessment template which required System Resilience Groups to provide assurance that they have put in place preparations for the winter period. This included a review of the key actions being taken to improve on last year's plan, delivery of the national eight high impact interventions, the flu programme for staff and patients and work on Delayed Transfers of Care.

Delayed Transfers of Care can be a result of difficulties placing patients, who are considered by the hospital to be medically fit for discharge (that is patients who no

longer require an Acute Hospital bed), back into their homes with appropriate support or into NHS Community or KCC Social Care beds.

4.0 South Surge Management Framework and Systems Resilience Group Surge Management & Capacity Plans

NHS England has circulated a South Region Surge Management Framework which has been agreed by the South Region Tripartite of NHS England, Monitor and the NHS Trust Development Agency. All Systems Resilience Groups have prepared Surge Management Plans that are aligned to this Framework. NHS England South (South East) has requested that these be tested via exercise ahead of winter.

5.0 Systems Resilience Groups Surge Capacity Exercises

NHS England South (South East) ensured that each Systems Resilience Group has conducted a Surge Capacity exercise ahead of winter 2015-16. A debrief report from each exercise will be prepared and presented to each Systems Resilience Group to ensure that lessons identified are learned ahead of winter. The Systems Resilience Groups' Surge Management plans will be updated to ensure that these lessons are addressed.

6.0 Winter Reporting

NHS England, the Trust Development Authority and Monitor will be conducting winter reporting on all NHS providers of Healthcare. The full details of the content and schedule of this reporting is due to be finalised shortly. However, there is expected to be additional focus on winter reporting during the two Bank Holiday periods.

7.0 Winter Communications

All SRGs have in place plans winter communications plans that support the nationally led 'Stay Well This Winter' campaign, which is a joint initiative between NHS England and Public Health England. http://www.nhs.uk/staywell/
This campaign drives home key messages to the public which it is hoped will help take the pressure off frontline services. The messages ask the public to protect themselves as the cold weather sets in by staying warm, stocking up on prescription

medicines or checking in on friends and neighbours to make sure they are keeping well and taking up the offer of a seasonal flu vaccination where eligible.

8.0 Seasonal Flu Vaccination

Outbreaks of flu can occur in health and social care setting, and, because flu is so contagious, staff, patents and residents are at risk of infection. As a result front-line healthcare workers are offered a flu vaccination. Systems Resilience Groups have put in place measures to maximise and monitor update by eligible Health and Social care staff.

The flu vaccination is also offered free of charge to people who are at risk, pregnant women, carers and some young children to ensure that they are protected against catching flu and developing serious complications. The continued support of KCC in promoting the uptake is recognized and welcomed.

9.0 Summary

- Systems Resilience Groups, of which KCC is an integral part, have taken steps to prepare the health and social care system to manage winter pressures.
- Individual Health and Social Care organisations and System Resilience Groups have Surge Management plans.
- These Surge Management plans are currently being tested by exercise and will be amended to take account of lessons identified before the winter period.
- A strong national communications campaign is being supported and delivered locally. The NHS recognises and welcomes KCC's ongoing support to successfully deliver these important messages to the population of Kent.
- KCCs support in encouraging the update of seasonal flu vaccination is welcomed.
- A robust system of winter reporting will be put in place to identify and respond any challenges as they arise.
- In addition to the Surge Management Plans, all the members of Systems Resilience Groups have robust, well-rehearsed plans in place to manage the impact of emergencies that can result from severe weather, infectious disease outbreaks or industrial action.
- The high rates of Delayed Transfers of Care at some NHS Hospital sites are highlighted as an area where further work is required in coordination with KCC.

Item 6: North and West Kent Neurorehabilitation Service (Written Briefing)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 November 2015

Subject: North and West Kent Neurorehabilitation Service (Written Briefing)

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

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

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

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1. Introduction

(a) NHS Dartford, Gravesham and Swanley CCG and NHS West Kent CCG have asked for the attached reports to be presented to the Committee.

(b) Neurological conditions result from damage to the brain, spinal column or peripheral nerves. Some neurological conditions are life-threatening with many severely affecting quality of life and causing lifelong disability. There are 4.7 million neurological cases in England. In 2012-13, £3.3 billion was spent on neurological services representing 3.5% of total NHS programme budget spending (National Audit Office 2015)

(c) Rehabilitation is a process of assessment, treatment and management by which the individual (and their family / carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living. Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition (NHS England 2014).

(d) Specialist rehabilitation is delivered by a multi-professional team who have undergone recognised specialist training in rehabilitation, led and supported by a consultant trained and accredited in rehabilitation medicine (NHS England 2014).

(e) Following illness or injury, the majority of patients requiring rehabilitation will progress satisfactorily with the support of the local non-specialist rehabilitation services. Those with more complex needs may require referral to their local specialist rehabilitation services such as those described in the attached report; these services are commissioned by the CCGs. A small number of patients with highly complex needs may require the staff expertise and facilities of tertiary specialised rehabilitation service; these services are commissioned by NHS England (NHS England 2014).

2. Potential Substantial Variation of Service

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

(b) Where the HOSC deems the new service model 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 Dartford, Gravesham and Swanley CCG and NHS West Kent CCG.

(c) Where the HOSC determines the new service model as substantial, a timetable for consideration of the change will need to be agreed between the HOSC and the CCGs after the meeting. The timetable shall include the proposed date that the 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.

3. Recommendation

If the new service model is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the new service model for specialised neuro rehabilitation in North and West Kent to be a substantial variation of service.

(b) NHS Dartford, Gravesham and Swanley CCG and NHS West Kent CCG be invited to submit a progress report on implementation to the Committee at its March meeting.

If the new service model is *substantial*:

RECOMMENDED that:

(a) the Committee deems the new service model for specialised neuro rehabilitation in North and West Kent to be a substantial variation of service.

(b) NHS Dartford, Gravesham and Swanley CCG and NHS West Kent CCG be invited to submit a report to the Committee at its January meeting.

Background Documents

National Audit Office (2015) *'Services for people with neurological conditions: progress review (10/07/2015)'*, https://www.nao.org.uk/wp-content/uploads/2015/07/Services-for-people-with-neurological-conditions-progress-review.pdf

NHS England (2014) *'Specialist Rehabilitation for Patients with Highly Complex Needs (All Ages) (15/04/2014)'*, https://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf

Item 6: North and West Kent Neurorehabilitation Service (Written Briefing)

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NHS
West Kent
Clinical Commissioning Group

Planned Changes to North and West Kent Neurorehabilitation Service

Health Overview and Scrutiny Committee

November 2015

Patient focused,
providing quality,
improving outcomes

Introduction
This paper is to inform the Kent County Council's Health Overview and Scrutiny Committee (HOSC) of planned service changes to neurorehabilitation provision from 24 December 2015.

These service changes were originally planned for April 2016 but have been brought forward to December 2015. This follows the current provider, Kent and Medway NHS and Social Care Partnership Trust (KMPT) advising us that to keep the unit open over Christmas would be clinically unsafe.

Background
Patients in west Kent, Dartford, Gravesham and Swanley (DGS) and Medway who require a neurological intervention in a rehabilitative environment have been principally serviced by the West Kent Neuro Rehab Unit (WKNRU), Knole Centre, Darent House, Sevenoaks which is managed by KMPT.

The WKNRU is an eight bedded unit and in 2014-2015, 29 patients across West Kent, DGS and Medway accessed the service, 19 of which were from west Kent.

KMPT issued formal notice on the current contract on 2 April 2015 stating that they will no longer be providing the service from 31 March 2016. KMPT advised this was due to issues involving service quality, safety and cost meant it was not sustainable for them to continue to provide the service.

Since then we have been working alongside KMPT to develop a new, community based care model which we were anticipating implementing in April 2016.

KMPT have now brought to our attention concerns about safe staffing over Christmas. As our plans are well advanced, we have agreed with KMPT that the unit will close on 24 December 2015.

For patients, this will mean that KMPT will not accept any new referrals where a patient is not guaranteed discharge home before 24 December as this would be deemed clinically unsafe.

What will the bespoke service model look like?
It is the view of the commissioners that the best solution for these patients, who have very specialist needs, is a focus on recovery for independent living in the community with the potential for many patients to receive treatment closer to home, depending on need.

We are therefore proposing to implement a new model of care based on bespoke neurorehabilitation treatments with local, private and NHS providers in either the community or acute settings as appropriate. The CCGs will purchase these packages of care from community providers on a cost per case basis that will be invoiced as non-contract activity.

This is a more tailor made approach, which takes into account the specific needs of individual patients, and will have a more positive impact on families and carers. It also offers the potential of enabling increased access to specialists in neurological conditions when appropriate, and offering safe and high quality provision for people across the spectrum of severity.

A manager with clinical expertise will work with commissioners and providers to manage referrals and make informed decisions on the most appropriate place of care for individuals according to their particular need.

When will the new model of care be introduced?
As our original plans are well advanced, we have brought forward the introduction of the new service from April 2016 to December 2015 on the grounds of clinical safety and care quality.

Do local, private and NHS providers in either the community or acute settings have capacity to run the service?
Commissioners have approached community providers to ensure there is capacity and appropriate availability, as well as gaining assurance advice from NHS quality colleagues to ensure that these services within Kent are sufficient in terms of service delivery, safety and quality.

Benefits to patients

- A focus on recovery through independent or supported living in the community.
- Individuals can receive care closer to home and be nearer to their carers and families, depending on need.
- Patients are at the heart of the process through integrated partnership working across community, private and NHS providers and a coordinated and planned approach to managing referrals more effectively.
- Clinically informed decisions are agreed based on patient need, safety, high quality, accessible and appropriateness of care.
- Patients have increased access to specialists of neurological conditions when appropriate, and offering safe and high quality provision for people across the spectrum of severity.
- There is an increased focus on physical and mental health supporting NHS England's Parity of Esteem agenda.
- Improved health outcomes and reduced health inequalities.

Conclusion
The West Kent, DGS and Medway CCGs are confident that the new bespoke service model will improve patient care, outcomes and will have a positive impact on their families and carers.

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