HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th October, 2016

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th October, 2016, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr M J Angell (Chairman), Mrs A D Allen, MBE, Mr A H T Bowles, Mr N J D Chard (Vice-Chairman), Mr G Lymer, Ms D Marsh 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 N Heslop, Councillor J Howes, Councillor M Lyons, and Councillor C Woodward

Webcasting Notice

Please note: this meeting may be filmed for the live or subsequent broadcast via the Council's internet site or by any member of the public or press present. The Chairman will confirm if all or part of the meeting is to be filmed by the Council.

By entering into this room you are consenting to being filmed. If you do not wish to have your image captured please let the Clerk know immediately.

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 - 16)

4. Kent and Medway NHS and Social Care Partnership Trust: Update (Pages 17 - 30) 10:05

5. Medway NHS Foundation Trust: Update (Pages 31 - 42) 10:45

6. Kent Health & Wellbeing Board Annual Report (Pages 43 - 62) 11:30

7. Date of next programmed meeting – Friday 25 November at 10:00

   Proposed items:

   - North Kent: Adult Community Services
   - NHS England: Winter Preparedness 2016/17
   - Kent and Medway Sustainability and Transformation Plan
   - East Kent Strategy Board
   - Out of Hospital Care in West Kent

EXEMPT ITEMS

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

**Timings are approximate*

Benjamin Watts
General Counsel (Interim)
03000 416814

29 September 2016

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, 2 September 2016.

PRESENT: Mr M J Angell (Chairman), Mrs A D Allen, MBE, Mrs P Brivio, Mr A H T Bowles, Mr N J D Chard (Vice-Chairman), Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Ms D Marsh, Mr C R Pearman, Cllr J Howes, Cllr M Lyons, Cllr N Heslop, Cllr Chris Woodward, Mr L Burgess (Substitute) (Substitute for Mr A D Crowther) and Mrs Z Wiltshire (Substitute for Mr H Birkby)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer) and Mr A Scott-Clark (Director of Public Health)

UNRESTRICTED ITEMS

38. Election of Chairman
(Item 1)

(1) Mr Chard proposed and Mr Bowles seconded that Mr Angell be elected Chairman of the Committee.

(2) RESOLVED that Mr Angell be elected as Chairman.

(3) The Chairman stated that it was with regret that he had to inform Members of the death of Mr Robert Brookbank, Chairman of the Health Overview and Scrutiny Committee.

(4) RESOLVED that the Committee records the sense of loss it feels on the sad passing of Mr Brookbank and extends to his family and friends our heartfelt sympathy to them in their sad bereavement.

39. Election of Vice-Chairman
(Item 2)

(1) The Chairman proposed and Mr Bowles seconded that Mr Chard be elected Vice-Chairman of the Committee.

(2) RESOLVED that Mr Chard be elected as Vice-Chairman.

40. Membership
(Item 3)

(1) Members of the Health Overview and Scrutiny Committee noted the following changes to the membership of the Committee:

(a) Ms Marsh filled the vacancy following the recent death of Robert Brookbank.

(b) Cllr Woodward (Tunbridge Wells Borough Council) replaced Cllr Ring (Maidstone Borough Council) as a borough representative on the Committee in 2016/17.

(c) Cllr Heslop (Tonbridge & Malling Borough Council) replaced Cllr Peters (Dartford Borough Council) as a borough representative on the Committee in 2016/17.

41. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 5)

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

(2) Cllr Lyons declared an Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

42. Minutes
(Item 6)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 3 June 2016:

(a) Minute Number 9 – NHS Swale CCG: Review of Emergency Ambulance Conveyances. At HOSC on 29 January, a Member enquired if the closure of the A249 (Sheppey) had had an adverse impact on SECAmb. On 15 March SECAmb confirmed that there were no adverse incidents with the closure of the A249 to Sheppey and the Trust utilise the lower road bridge crossing in the event of the A249 closure.

At HOSC on 8 April, a Member stated that the query about the closure of the A249 (Sheppey) was regarding the sinkhole and not the closure of the road bridge. Mr Davies, Interim Chief Executive, undertook to clarify if there had been an adverse impact on SECAmb due to the sinkhole. On 3 June SECAmb confirmed that there had been no adverse impact.

(b) Minute Number 30 - Review of winter preparedness and BMA Industrial Action in Kent 2015/16. At HOSC on 3 June, a Member requested NHS England to provide a written briefing about the SAFER bundle which was circulated to Members on 9 June.

(c) Minute Number 31 - Darent Valley Hospital: MRSA. On 3 June the Committee agreed that the Vice-Chairman-in-the-Chair would write a letter to the Secretary of State for Health and Chief Executive of Public Health England requesting a review of the Public Health England guidance on targeted admission screening for MRSA.

Subsequently the Vice-Chairman-in-the-Chair was made aware of Public Health England data which showed that since the introduction of targeted screening in 2014 MRSA infection rates had remained steady nationally. As a result of this infomation, Mr Angell, in consultation with the group representatives, sent a letter to the Trust to say that he would not be writing to the Secretary of State for Health asking for a review of the guidance – it was felt that it was local issue regarding infection control management at the Trust (rather than the guidance).

(2) RESOLVED that the Minutes of the meeting held on 3 June are correctly recorded and that they be signed by the Chairman.

43. Patient Transport Service
(Item 7)

Ian Ayres (Accountable Officer, NHS West Kent CCG) was in attendance for this item.

(1) The Chairman welcomed Mr Ayres to the Committee. Mr Ayres began by explaining that the new contract with G4S went live on 1 July. He reported that overall mobilisation of the contract had gone well and G4S was moving to the 'business as usual' phase. He noted that there had been some teething problems for dialysis patients in West Kent, receiving their treatment from Guy's and St Thomas' NHS Foundation Trust, which was being monitored daily. There had been very few patient complaints and media enquiries in recent weeks and Trusts had reported that G4S were responsive and resolved issues. He stated that sub-contractors who had been brought in to reduce deficits of the previous provider were being stood down and the transporting of Kent and Medway patients to and from London hospitals would begin on 1 November. He explained that the CCG would be carrying out a true-up process with the provider, taking place three and six months into the contract, to look at the actual activity against the data set out in the contract; this process had been implemented following the lessons learnt from the previous contract.

(2) A number of questions were asked about the capture and reporting of performance data. Mr Ayres explained that there were three contracts: one for renal patients, one for Dartford and Gravesham NHS Trust patients and one for the rest of Kent and Medway. He noted that once data became available the CCG would be able to breakdown performance data by acute hospital and be able to identify hotspots. He noted that G4S were undertaking 6000 journeys a week including 50-80 journeys a day for patients requiring dialysis in West Kent. He reported that one or two of the renal journeys a day were disrupted which was too high but stated that this was a significant improvement from the previous provider. Mr Ayres undertook to check whether data was being captured about the number of journeys completed but were found no longer to be required due to cancellations of appointments and clinics on arrival at the place of care.

(3) RESOLVED that the report be noted and NHS West Kent CCG & G4S be requested to attend the Committee in March and provide an update including qualitative and quantitative performance data with details about the patient experience and areas of underperformance.

44. Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures
(Item 8)

Steve Orpin (Finance Director, Maidstone & Tunbridge Wells NHS Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Orpin began by explaining that Maidstone & Tunbridge Wells NHS Trust was one of five acute providers to be part of the first cohort of financial special measures. The new system of financial special measures was introduced by NHS Improvement in July 2016; providers were considered for financial special measures using a small number of criteria including those who had not agreed a control total and those who had agreed a control total but had a negative variance against the plan. He stated that the Trust was moving at pace to rapidly respond and move forward towards an agreed control total. NHS Improvement had identified support including the appointment of Simon Worthington who was Deputy Chief Executive of Bolton NHS Foundation Trust – a Trust which was in surplus and had been rated 'good' by the Care Quality Commission. He noted that the Trust was developing a high level recovery plan and would be meeting regularly with NHS Improvement who would review whether the Trust would remain or exit financial special measures.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. Members enquired about the pay bill. Mr Orpin explained that NHS Improvement had carried out a review and the Trust's pay bill, in relation to its activity, was growing faster than comparable organisations. He noted that the pay bill (5 – 10%) was growing faster than income activity (4 – 5%). The pay bill accounted for 65% of expenditure and its increase was made up of three key components.

(3) Mr Orpin stated that the first was increasing activity and demand in urgent and emergency care; there had been a 6% increase in A&E attendance in the first four months in comparison to the previous year and in August there had been an unprecedented spike of serious illness in additional to the expected increase in seasonal accidents. The second was that the human resources market was influenced by the Trust's proximity to London with staff commuting or moving to London to progress their careers in teaching hospitals. The third was workforce planning particularly for medical surgical specialities. There were shortages of nursing and medical staff in acute frontline services due to constant growth, increased pressure and organisations with quality issues locally which resulted in greater competition for staff. The Trust was working to reduce its agency and temporary staffing through recruitment and the bank process; there had been a 20% decrease in agency and temporary staffing in the previous year with no deterioration to the quality of service. He noted that the Trust was working in collaboration with the CCG to develop new services and expand provision in acute and community settings to serve patients in West Kent which were effective and efficient and provided high quality care.

(4) A Member asked about the impact of PFI, Mr Orpin explained that within the PFI there was a unitary charge paid for the PFI service. The Trust received £8 million of funding annually to cover this charge; however the actual cost of the unitary charge was £5-10 million greater than the funding received. He noted

that the Trust had to identify all additional savings and efficiencies before being able to ask for additional support for the PFI cost.

(5) In response to a specific question about timescales and exiting special measures, Mr Orpin explained that financial special measures provided the Trust with an opportunity to improve services and reduce cost. He stated that whilst the emerging plan had not been presented to the Trust Board, the Board was committed to financial recovery and delivery of quality services. He noted that the Board and Finance Committee would be holding extraordinary meetings before the planned meeting with NHS Improvement at the end of September to review progress; this would be the first opportunity were the Trust could exit financial special measures.

(6) A number of comments were made about the deficit, the costs attached to financial special measures and planning for population and demographic growth. Mr Orpin explained that the deficit was planned by the Trust and NHS Improvement had not accepted the control total which had resulted in the Trust being placed in financial special measures. Mr Orpin reported that the cost of the Financial Improvement Director and their team was incurred by NHS Improvement; it was not a cost to the Trust at the current time. Mr Orpin noted that all providers were experiencing growth and changes to demography as people were living longer with co-morbidities. He stated that the Trust was working on the current issues which would act as a cornerstone for the future. He highlighted the role of the Sustainability and Transformation Plan in planning for population and demographic growth particularly in Ebbsfleet.

(7) A number of questions were asked about the impact of special measures on staff and efficiencies. Mr Orpin explained that as part of its financial recovery plan, the Trust had actively gone out into the organisation and engaged with frontline staff about improvements to services. He reported that he was impressed with the dedication and ideas provided by the staff including energy saving measures. He noted that work was being done to identify waste at the Trust and by making staff aware of the cost of items when ordering enabled them to make an informed judgement about whether to proceed with the purchase.

(8) The Chairman asked Mr Ayres to comment. Mr Ayres stated that the Trust was in financial special measures solely for financial issues. He commended the Trust's leadership team for not accepting an unrealistic control total and stated that he had full confidence in the Trust to resolve the financial issues. He noted that the money provided to the NHS did not cover an aging and growing population or advances in technologies; year-on-year efficiencies would be required to deliver the same level of service currently provided.

(9) RESOLVED that the report be noted and the Trust be requested to provide an update to the Committee in January.

45. Kent and Medway Sustainability and Transformation Plan
(Item 9)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Michael Ridgwell (Programme Director, Kent & Medway Sustainability and Transformation Plan) 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. A Member enquired about emergency & elective care provision and patient choice. Mr Ridgwell explained that although emergency and elective services provided different services, they were intransigently linked. He noted that whilst emergency and elective services could be provided on the same or different sites, it was important that medical, rather than surgical services were co-located with emergency care. He reported that the current acute emergency medical pathway was unviable due to workforce pressures. He stated that whilst patients had the right to choose their healthcare including the use of private providers; in emergency provision it was more important to have a sustainable workforce.

(2) A number of comments were made about centralisation of services. Mr Ayres stated that a number of specialist services in Kent had already been successfully centralised including cancer and major trauma. He noted that in West Kent, the CCG was working with district and borough councils to improve primary care estates to enable community services to jointly use the same sites. He stated that it was not sustainable for the seven acute sites in Kent & Medway to continue to provide all services. Through the STP process some services would need to be centralised and some would need to be provided locally. He reported that engagement work for the Kent and Medway STP would begin in the autumn, prior to public consultation to be held after the County Council elections in May 2017. Mr Ridgwell noted that the East Kent system was further advanced and had its own timetable.

(3) In relation to the cost effectiveness of centralisation, Mr Ayres gave an example regarding the centralisation of elective care by the Epsom and St Helier University Hospitals NHS Trust. The Trust previously provided elective care specifically hip and knee replacements across five sites. Following centralisation quality had improved; there was no hospital acquired infection; length of stay had reduced; professionals were working with each other to improve services; and patient satisfaction had increased. Due to its cost effectiveness, the centralisation had also enabled Accident & Emergency centres to be maintained on the other sites. He noted that specialist centres were attractive to workforce and stressed the need to engage with local people.

(4) Members enquired about collaboration, out of hospital care, A&E attendance and population growth & decline. Mr Ayres explained that through the STP the local system was required to balance the budget collectively which may result in commissioners and providers having a surplus or deficit. Mr Ayres stated that out of hospital care and general practice had diminished over the last 20 years which had put pressure on acute providers; both community and primary care services needed to be improved going forward. He noted that there would be a clearer local and national picture regarding the STPs following a further submission to NHS England in October

(5) Mr Ridgwell explained that a large number of patients attending A&E had a primary care need and it was important for that cohort to be diverted to a more appropriate resource. He stated the importance of redesigning provision to include better access to primary care and to promote behaviour change. Mr Ayres noted that the STP was using current population and demographic

growth including 57,000 new residents to the Ebbsfleet development. He noted that there was a likelihood that there will be an overall population decline but not within the next 20 – 30 years. Mr Ridgwell added that Ebbsfleet was a new town, rather than an infill development, which meant that it provided an opportunity for new, rather than existing infrastructure, to be developed.

(6) The Chairman invited Steve Inett and Andrew Scott-Clark to comment. Mr Inett explained that Healthwatch Kent was keen to engage with the public regarding the STP. He stated that the report provided to the Committee did not do the full STP justice. He stated the importance of communicating the positives to the public particularly the reinforcement of community and primary care services. Mr Scott-Clark stressed the importance of embedding prevention into the system in order to maintain services. He noted that there was a good history of collaboration in Kent with the Catheter Centre in Ashford.

(7) RESOLVED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee in November with a detailed plan including finance.

46. East Kent Strategy Board
(Item 10)

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Swale CCG) was in attendance for this item.

(1) The Chairman welcomed Ms Carpenter to the Committee. Ms Carpenter began by explaining that since the last presentation to the Committee in June, the East Kent Strategy Board had been working closely with the Kent & Medway Sustainability and Transformation Plan to determine how best to engage with the wider plan. She noted that the Case for Change had been published on 26 July and the public engagement programme had begun including public focus groups to discuss the new models of care. She reported that the East Kent Clinical Forum had agreed the outputs of the four clinical workshops as the basis for developing future models of care and work was under way to ensure the full utilisation of NHS and local authority estates in East Kent.

(2) Ms Carpenter noted that the evaluation criteria for the long list of options were being developed and public consultation was planned to start at the end of January 2017 and conclude prior to the start of purdah for the local council elections. She highlighted that the options would be tested by the Clinical Senate on 26 October, confirmed by the Clinical Senate on 6 November and presented to the National Investment Committee at the beginning of January. She reported that the Board was exploring the development of out of hospital integrated health and care services being provided across 16 localities in East Kent.

(3) In response to a specific question about local services in Deal, Ms Carpenter explained that she was unable to give specific details but highlighted that GPs in Deal wanted the maximum number of services to be delivered locally. She

stated that the model was most advanced in Thanet with the development of Primary Care Homes; a pilot in Margate was planned for the autumn. Primary Care Homes would be a community focused model with a dedicated integrated team to manage patients with comorbidities and work with primary and secondary care practitioners; if a patient was unable to be managed in the community they would be moved to a hot ambulatory care unit.

(4) A number of comments were made about finance and public consultation. Ms Carpenter explained that the Board would not be able to go out to public consultation until the finance and costings had been completed. She noted that the financial analysis was being undertaken by a collaboration of finance leaders from East Kent Hospitals University NHS Foundation Trust, Kent County Council, Kent Community NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership. The Chairman requested that a draft copy of the public consultation be shared with the Committee before publication. Ms Carpenter undertook to provide the engagement programme and draft consultation document to the Committee.

(5) RESOLVED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee in November with a detailed plan including finance.

47. Chemotherapy Services in East Kent & East Kent Cervical Screening Programme (Written Briefing)
(Item 11)

(1) The Committee received a report from East Kent Hospitals University NHS Foundation Trust which provided an update about the Celia Blakey Centre at the William Harvey Hospital, Ashford and actions taken following the Public Health England Screening Quality Assurance Review of the East Kent Cervical Screening Programme.

(2) RESOLVED that the report on the Chemotherapy Services in East Kent & East Kent Cervical Screening Programme be noted and the Trust be invited to submit an update to the Committee in January 2017.

48. CCGs Annual Rating (Written Briefing)
(Item 14)

(1) The Committee received a report from the Kent CCGs which provided details of NHS England's assessment of their performance against the 2015/16 CCG assurance framework and a summary of their improvement plans.

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

49. All Age Eating Disorder Service in Kent and Medway (Written Briefing)
(Item 15)

(1) The Committee received a report from NHS West Kent CCG regarding the procurement of an all age eating disorder service for Kent and Medway.

(2) A Member enquired about the difference between waiting time standards between children & young people and adults. The Scrutiny Research Officer undertook to liaise with NHS West Kent CCG to provide a response.

(3) RESOLVED that:

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

(b) NHS West Kent CCG be invited to submit a report to the Committee at the conclusion of the procurement of an all age eating disorder service for Kent and Medway.

50. Dermatology Services in West Kent (Written Briefing)
(Item 16)

(1) The Committee received a report from NHS West Kent CCG which provided an update about the procurement of dermatology services in West Kent and a written briefing from King's College Hospital NHS Foundation Trust regarding the relocation of dermatology outpatient services from Orpington Hospital to Beckenham Beacon.

(2) RESOLVED that:

(a) the report on the procurement of dermatology services in West Kent be noted and NHS West Kent CCG be requested to provide an update following the mobilisation of the new provider.

(b) the written briefing provided by King's College Hospital NHS Foundation Trust regarding the relocation of dermatology outpatient services from Orpington Hospital to Beckenham Beacon be noted.

(3) The meeting was adjourned at 12:30 and reconvened at 13:50.

51. SECAmb: Update
(Item 12)

Geraint Davies (Acting Chief Executive, South East Coast Ambulance NHS Foundation Trust), Patricia Davies (Accountable Officer, NHS Swale CCG) and Helen Medlock (Associate Director of 999 and NHS 111 Commissioning for Kent and Medway CCGs) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Davies began by explaining that NHS Swale CCG was the lead commissioner for 999 and 111 in Kent and Medway. She noted that the Trust had been through a period of turmoil relating to quality, safety and performance. She stated that the Trust was developing a Unified Recovery Plan which would include clear and realistic targets. She noted that the changes being implemented by the Trust were moving in the right direction.

(2) Mr Davies explained that following a CQC inspection in May 2016, the Trust received a warning notice from the CQC with regards to governance, leadership and operations at the Trust. A two year recovery plan was being

developed to cover eight specific areas where improvement was required such as an improved culture, the roll out of electronic patient records and the move to the new headquarters. He stated that he would be the acting Chief Executive until a new substantive appointment was made; his focus during this interim period would be to take forward the concerns in the warning notice to ensure safe services. Mr Davies committed to bringing back the CQC inspection report once published.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A number of comments were made about staffing. Mr Davies explained that following an enhanced recruitment process the NHS 111 service was now fully staffed. The Trust had undertaken work to find out why staff were leaving and buddied new members of staff with experienced call takers as part of the training programme. A similar piece of work was being carried out in 999 as it was facing similar problems; the management of 111 and 999 were now sharing best practice. He stated that the Trust needed to recruit 200 paramedics and was competing against nine other Trusts; the Trust needed to be seen as an attractive organisation to recruit and retain paramedics including a clear career structure and opportunities to become a paramedic practitioner and rotate into primary and higher acuity care. He reported that there was currently a 14% turnover of paramedics.

(4) Members enquired about the structure of the Trust, the role of the CQC and dispatching multiple ambulance vehicles. Mr Davies explained that the Trust was restructuring its operation system to better engage and support staff; an operations manager would now be responsible for 15 members of staff and would be on the same rota as those staff. There would also be a clinical lead as part of the team. He noted that if the ambulance service was county based, the same operations system would have to be implemented. Mr Davies stated that the CQC played a valuable role; it was important for the organisation to receive external validation and work with commissioners to address concerns raised by the CQC. Mr Davies noted that the Trust sent more vehicles per call than other Trusts; the Trust was working to safely implement Dispatch on Disposition through the Ambulance Response Programme to enable clinicians to have time to triage the call and dispatch the correct resource. He highlighted that 999 performance was lower than performance standards and trajectory which the Trust needed to meet in order to be safe.

(5) A number of comments were made about Hear & Treat and See & Treat, and bullying and harassment at the Trust. Mr Davies explained that Hear and Treat was telephone clinical advice provided by 999 call handlers which currently represented 10 – 12% of calls and was expected to increase. He stated that See and Treat was when a clinical decision was taken at the scene to refer to elsewhere or take to hospital. He noted that there was bullying and harassment at all levels of the organisation; the Trust had a Security Manager to protect staff against the public and had taken forward prosecutions. He reported that the Trust was working with the London Ambulance Service NHS Trust to share best practice and develop policies and procedures regarding values and behaviours. He stated that recruitment was based on values and that the Trust had a whistle-blower and raising concerns process were staff were able to directly email or call senior staff including the Chief Executive.

(6) In response to a specific question about handover delays, Ms Davies explained that from a commissioner's perspective SECAmb could not tackle patient flow into the acute sector alone. She noted that West Midlands Ambulance Service NHS Foundation Trust had a policy where they walked away from a patient after 15 minutes of arrival as set out in the national standards. She noted that SECAmb had imposed a local policy of 45 minutes; NHS Swale CCG had commissioned a piece of work to look at improved flow and handover at Medway Maritime Hospital and Darent Valley Hospital. Mr Davies noted that if the Trust invoked a 15 minute policy, such as the West Midlands Ambulance Service, it could undermine the ability of an Accident & Emergency to treat and admit patients. He reported that through a phased approach by the end of the financial year, the Trust would be implementing a policy to walk away from patients if they were not able to handover patients within 45 minutes on the grounds of wider patient safety.

(7) Members enquired about finance and the use of technology. Mr Davies explained that the Trust had an NHS Improvement risk rating of 3 which meant that they were financially solvent. However in the current financial year, the Trust would need to go into deficit by £7.1 million to deliver the recovery plan which was allowed, under the terms of being a Foundation Trust, as a one-off. He stated that existing technology was already an important part of being a mobile healthcare provider; staff were able to use iPads to record electronic patient data and use videoconferencing to send video information to the burns unit at the Queen Victoria Hospital. Ms Davies noted that whilst technology led to quality and safety improvements, capital funding for technology would be challenging in the next financial year as the Trust was required to breakeven or produce a surplus.

(8) In response to a question about blue light collaboration, Mr Davies reported that there had been collaboration between the Trust and the Surrey Fire Service in providing the fire staff with training to be Community First Responders if they arrived on the scene first. He stated that there was not a strategic fit for the Trust to be co-located with other blue light services as the Trust provided a clinical and NHS service. Ms Davies highlighted the importance of collaboration between the Trust with primary and out of hospital care in creating efficiencies and improving safety and wellbeing; paramedic practitioners had been working in Swale since September 2015 and have reduced the number of ambulances by two a day to Medway Maritime Hospital. In response to a specific question about his biggest concern as acting Chief Executive, Mr Davies stated that it was having sufficient staffing to meet the demand facing the organisation.

(9) RESOLVED that the report be noted and SECAmb be requested to share the findings of the Patient Impact Review and CQC Inspection Report upon publication.

52. Healthwatch Kent: Annual Report and Strategic Priorities
(Item 13)

Steve Inett (Chief Executive, Healthwatch Kent) was in attendance for this item.

Mr Chard referred to his Disclosable Pecuniary Interest as a Director of Engaging Kent and the requirement for him to withdraw from the meeting for this item. At the invitation of the Chairman, Mr Chard remained in the meeting.)

(1) The Chairman welcomed Mr Inett to the Committee. Mr Inett introduced Healthwatch Kent's Annual Report and Strategic Priorities and proceeded to give a presentation (attached as a supplement to the Agenda pack) which covered the following key points:

- Background infomation about Healthwatch Kent
- Review of activity in 2015/16
- Feedback from the public in 2015/16
- Achievements in 2015/16
- Priorities for 2016/17 including Sustainability & Transformation Plan & Discharges

(2) A Member enquired about the expenditure relating to Engaging Kent, grants, projects and research. Mr Inett explained that the £28,000 payment to Engaging Kent went to the Directors for their time in ensuring it met its legal and contractual requirements and providing support to projects; in addition, as part of its contract with KCC at the time, Healthwatch Kent had to submit a business case to KCC when working with an external provider with a proportion of money going to Engaging Kent to fund the cost of the business case. Mr Inett stated that grants included funding to set up the Physical Disability Forum and reimbursement to Porchlight for assisting their clients to fill out a survey.

(3) A Member reminded the Committee of the legal obligations relating to Declarations of Disclosable Pecuniary Interest.

(4) RESOLVED that the report be noted and Healthwatch Kent be requested to provide an update to the Committee annually.

53. Date of next programmed meeting – Friday 7 October 2016 at 10:00
(Item 17)

(1) A Member enquired about the scope of the Sevenoaks Hospital item scheduled for 7 October. The Scrutiny Research Officer undertook to liaise with NHS West Kent CCG to provide a response.

(2) A Member requested information to be provided about the financial implications for any service change brought to the Committee for consideration.

Item 4: Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update

By: Benjamin Watts, General Counsel (Interim)

To: Health Overview and Scrutiny Committee, 7 October 2016

Subject: Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update

---

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway NHS and Social Care Partnership Trust.

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

---

1. Introduction

(a) Kent and Medway NHS and Social Care Partnership Trust (KMPT) provide mental health services in Kent including substance misuse and forensic services. The Trust was formed in April 2006 after the merger of East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust. The Trust's services are commissioned by the eight Clinical Commissioning Groups (CCGs) in Kent and Medway, Kent County Council and NHS England. The Trust covers a population of 1.7 million across 1,500 square miles. The Trust has an annual revenue of £181 million and employs 3502 staff who are located in 83 buildings on 47 sites (KMPT 2016).

2. Recommendation

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

Background Documents

KMPT (2016) *' Kent and Medway NHS and Social Care Partnership Trust Annual Report 2015-16, (04/06/2016)',* *https://www.kmpt.nhs.uk/downloads/AboutUs/AnnualReport2015-16.pdf*

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

This page is intentionally left blank

Kent and Medway NHS and Social Care Partnership Trust [KMPT]

Mental Health Update

Report prepared for:

Kent County Council [KCC]
Health Overview and Scrutiny Committee [HOSC]
07 October 2016

Version:	3.0	**Reporting Officer:**	Helen Greatorex Chief Executive, KMPT
Date:	28 September 2016	**Report Compiled By:**	Sarah Day Programme Management Office [PMO] Programme Manager, KMPT

1. Introduction

1.1 This report has been prepared at the invitation[1] of Kent County Council [KCC]'s Health Overview and Scrutiny Committee [HOSC] to provide an update about the Trust.

1.2 This report will provide a comprehensive update on four areas requested by the Committee, namely:

i. Chief Executive's 100 day reflection.

ii. Private bed use and reduction plan.

iii. Work with the community and voluntary sector.

iv. Open Dialogue (Health Foundation Innovating for Improvement Programme).

1.3 The Committee is asked to note the content of the report.

2. Chief Executive's 100 day

2.1 As the new Chief Executive, I am very grateful for the genuineness and warmth of welcome I have received, and have been impressed by the obvious commitment of everyone I have met. I can see that there is much to do, but I can also see an appetite and willingness to improve services and remove variation.

2.2 Having taken up post on 6 June 2016, my 100th day in it was Wednesday 16 September 2016. Fittingly (and completely coincidentally) this was the date of the Trust's annual staff awards celebration. The Trust celebrated some of the truly outstanding work that goes on in KMPT every day, and it was a rightly joyful and joyous event.

2.3 Listening to people who use our services, their loved ones, key partners and commissioners has helped inform my thinking about initial priorities. Some of these priorities, such as reducing private bed use and expanding the work we already do with the community and voluntary sector, are outlined in this report. Our other priorities include:

2.3.1 Working with Kent Police and our commissioners to introduce Street Triage across the county.

2.3.2 Improving Accident and Emergency [A&E] Mental Health Liaison services.

2.3.3 Redesigning our care pathway for people whose primary diagnosis is Personality Disorder.

2.3.4 Reviewing and updating our services for Older Adults.

3. Private bed use and reduction plan

3.1 The Trust experiences significant pressures on its inpatient beds. The Care Quality Commission [CQC] highlighted this in 2015 and recommended that the Kent and Medway

[1]KCC (13 September 2016) Mike Angell (Chairman, KCC HOSC) letter to Helen Greatorex (Chief Executive, KMPT).

health economy should take urgent action to improve patient flow and reduce the use of private beds.

3.2 For the 2015/16 financial year the health economy spent approximately £11m on private beds for younger adults, older adults and Psychiatric Intensive Care Unit [PICU]. This represents a poor quality experience for service users and carers, a significant cost to a health system experiencing financial pressure and a potential loss of income to KMPT.

3.3 Whilst bed utilisation trends have been shown to be volatile over a two year period, evidence highlights that bed use is impacted by:

3.3.1 The ability of Crisis Resolution Home Treatment [CRHT] teams to home treat patients and support them in a community setting thereby reducing admission.

3.3.2 The ability of CRHTs to home treat when they undertake non-home treatment roles including section 136 assessment under the 1983 Mental Health Act [MHA][2].

3.3.3 Effective management of discharge from the point of admission.

3.3.4 Effective management of delayed transfers of care [DToCs][3].

3.3.5 Enhanced levels of therapeutic intervention during an inpatient stay to speed the process of recovery and discharge.

3.3.6 High numbers of service users presenting at an emergency department [ED] when in a crisis following a KMPT intervention[4].

3.3.7 High numbers of patients with a personality disorder being admitted for long lengths of stay [LoS][5].

3.3.8 High numbers of emergency readmissions following an inpatient stay.

3.3.9 The speedy repatriation of those patients placed within private beds to improve outcomes and experience as well as reduce cost.

3.4 To improve patient flow and reduce the use of private beds (acute mental health and PICU) the Trust has implemented a Patient Flow Programme[6], which will achieve, with the opening

---

[2]Kent has one of the highest levels of section 136 detention in the country. In addition provision of liaison psychiatry services across the county is variable. Six areas of the country do not have a 24/7 liaison cover within their emergency departments, which in turn impacts on the CRHT teams providing cover and undertaking MHA assessments.

[3]DToCs are those service users who no longer require acute inpatient care and are deemed fit for discharge from a Trust bed. These service users require other health or social interventions and continue to have a significant impact on the use of external beds.

[4]c30% of ED presentations have been seen by KMPT within the previous 7 days.

[5]National Institute of Clinical Excellence [NICE] guidance indicates hospital admission is not helpful for individuals presenting with an acute personality disorder, and that where hospital admission is recommended to manage risk this is brief. The Trust interprets 'brief' as normally kept to a maximum of 72 hours.

[6]This forms one of three work steams identified as part of the Trust's Implementation of a Target Operating Model [TOM] Programme which seeks to address the unwarranted variation the Trust experiences within and across services, and to deliver improved outcomes and financial balance. The implementation of the TOM will: (1) be set within the context of the Trust and health and social care economy strategic vision; (2) be driven by a case for change based upon current levels of performance and clinical outcomes; (3) be clinically owned and led; (4) reduce unwarranted variation in performance and improve outcomes; (5) reduce workforce variation and improve operational efficiency and effectiveness; and (6) deliver long term financial sustainability.

of Pinewood[7], a reduction in private bed usage to a maximum of 15 beds by end October 2016 and a further reduction in private bed usage to 0 by end December 2016 for acute mental health and PICU beds[8].

3.5 A number of work streams have been established to reflect the whole system approach needed to deliver the change and achieve the objectives. These work streams are reflected in a programme plan - a live document updated at a minimum weekly following the weekly Patient Flow Programme Board [PFPB][9] meetings.

3.6 Appendix A provides a summary of the work streams (as at 21 September 2016).

3.7 A programme trajectory for reduction in younger adult acute and PICU private bed usage has been defined. To date significant progress has been made with both acute and PICU private bed use having been reduced in line with trajectory, however it is recognised there is still much to do.

3.8 As at 26 September 2016, acute private bed use is 23 against a trajectory of 17, and PICU 8 against a trajectory of 13.

3.9 Appendix B provides an illustrative representation of achievement against trajectory.

3.10 In addition to the positive achievement against trajectory a number of other key successes have been achieved within the work streams. Each plays a significant role in supporting the positive reduction in private bed usage and changing culture within and across services to maintain and improve this positon.

3.11 Appendix C provides a summary of key achievements and success to date (21 September 2016).

4. Work with the community and voluntary sector

4.1 The Trust is actively engaged with a number of community and voluntary sector providers. These include:

4.2 *Healthwatch Kent:* Executive level discussions are taking place between the Trust and Healthwatch to look at how the Trust can better manage patient flow. Healthwatch has undertaken a review of the Trust's services, and is due to publish a report shortly. The outcome of this review will help inform better working between the Trust, its commissioners, Healthwatch and other voluntary and community sector organisations.

4.3 *Armed Forces Network Kent and Medway:* The Trust continues to proactively engage with the Armed Forces Network to ensure that mental health services for ex-armed forces personnel are responsive, accessible and timely. This includes working with ex-military

[7]An additional capacity ward at Little Brook Hospital, Dartford which is scheduled to open in November 2016 and will see current bed stock increase by 4.
[8]Older adult beds, subject to assurance and ongoing monitoring of the success of systems already in place in ensuring no private beds are used, and forensic beds because of separate commissioning arrangements and flow processes, have been excluded.
[9]The PFPB was established on 3 August 2016 and meets weekly. It is chaired jointly by the Executive Medical Director and Executive Director Operations, with clinical leadership provided by the Associate Medical Director Acute, and with cross service line (acute, community recovery and older adult) representation at a senior level.

personnel to ensure they have access to specialist trained practitioners and champions[10] to help and support them and their families. The focus of the Armed Forces Network joint working goes beyond that of mental health only and brings together a multitude of services, including armed forces charities, police and local authorities to name but a few. This collaborative working has proven successful in improving the lives of the whole armed forces community.

4.4 *Carers First:* The Trust remains committed to promoting the principles of the Triangle of Care [11], which recognises carers are vital partners in supporting an individual's recovery. In doing so the Trust continues to focus on a number of key elements of the Triangle of Care, that include strengthening processes to ensure: (1) carers and the essential role they can play is identified at first contact or as soon as possible thereafter; (2) staff are 'carer aware' and trained in carer engagement strategies; (3) policy and practice protocols around confidentiality and sharing information are in place and adhered to; (4) a carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway provided; and (5) a range of carer support is available. Every service line now has a nominated carer champion within each team who liaises with local carers and carer groups to improve services.

4.4 *Live It Well:* The Trust remains committed to promoting the principles of the Live It Well Strategy[12] by further developing and promoting the Live It Well Library, a joint collaborative between service users, carers, external agencies and the Trust, which challenges stigma, promotes understanding, offers hope and enables people to talk about their experiences of living with mental health issues. This valuable material is now used within the Trust's staff training and development programmes. In addition, the Trust continues to actively contribute to the Live It Well website and promotes The Six Ways to Wellbeing[13] material in training material and staff health and wellbeing initiatives. The Trust collaborates with partner organisations and Live It Well events such as the forthcoming Kent Mental Health Festival 2016[14]. The Trust has worked within the planning group for this event, ensuring Trust services have a high profile and showcase their innovative work, alongside 80 other Kent wide third sector and primary care providers.

4.5 *Moving On Group:* The Trust's occupational therapy [OT] service is forging closer links with primary care colleagues and third sector providers to enable a smoother transition back to primary care. A new group programme is being developed collaboratively with service users, third sector providers and primary care, which will be fully outcomed.

4.6 In addition a number of initiatives have been and are being taken forward as part of the Crisis Care Concordat[15] work, which has seen the development of a Kent and Medway multi-agency action plan to enable the delivery of core principles and outcomes with the Crisis Care Concordat. In all cases the Concordat recommends that where a pilot shows positive

[10]The Armed Forces Network Sussex offers award winning continuing professional development [CPD] accredited Champion Training. The first round of training is scheduled to commence on 18 October 2016. eLearning, facts and updates are currently available on the Sussex website with similar scheduled to go live for Kent and Medway in September 2016. In addition an Armed Forces Mental Health Event has been scheduled for 2 March 2017.

[11]Carers Trust (2013) *The Triangle of Care – Carers Included: A Guide to Best Practice in Mental Health Care in England (Second Edition)*

[12]NHS Medway (2010) *Live It Well Strategy 2010-2015*, extended to 2016 while the Kent health and well-being economy decides its next strategic direction.

[13]http://www.liveitwell.org.uk/ways-to-wellbeing/six-ways-to-wellbeing/

[14]The first Kent Mental Health Festival 2016 is scheduled to take place on 11 October 2016 at the Leas Cliff Hall and Channel Suite in Folkestone.

[15]HM Government (2014) *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*

results to people at the point of crisis, that these pilots be expanded county-wide. The Trust is currently involved in a number of initiatives:

4.6.1 The county-wide Section 136 Group and the county-wide Concordat Group are supportive of the Shaw Trust's work with Maidstone and Mid-Kent [MMK] Mind around delivering a safe space provision in Maidstone and also in Ashford. As part of this work, there is the potential to work elsewhere if the Shaw Trust receives acceptable expressions from other local organisations in Canterbury and Faversham. This welcomed initiative, if successful, will help prevent crisis and escalation that frequently results in a section 136 being issued.

4.6.2 The Trust is now mentoring Herne Bay Umbrella, a centre that provides support for people in the Herne Bay community and surrounding areas who are experiencing mental health and / or associated learning disabilities. The Trust's Acute Clinical Quality and Compliance Lead is currently seconded to Herne Bay Umbrella for 8 hours a week to support the organisation in establishing more sustained services and express an interest to run a safe space in Herne Bay.

4.6.3 The Trust continues to work with external agencies to develop a crisis café in the Dartford area. Again this will provide an alternative to section 136 and a place within the community that provides a centralised point of support to those in crisis to help them to access the required pathway in a less restrictive manner. This initiative is being led by the Trust's North Kent on-site police officers based at Little Brook Hospital.

4.6.4 In addition the Trust's implementation of a single point of access [SPoA] service continues to enable closer working with community and voluntary sector organisations, such as Mental Health Matters Helpline and The Samaritans, by signposting people to these and other organisations as appropriate to meet an individual's needs.

5. Open Dialogue (Health Foundation Innovating for Improvement Programme

5.1 The Trust is one of four Trusts in England piloting and introducing the peer-supported open dialogue [POD] approach. This non-medicalised model focuses on what the service user and their family want[16].

5.2 Work has already commenced in Kent and Medway to participate in the largest worldwide randomised controlled trail [RCT][17] of the POD model within an NHS setting and in accordance with NICE guidelines. A grant bid has been submitted - the outcome of which is expected to be announced shortly. The Trust remains optimistic the outcome will be positive thereby enabling the Trust to be a lead delivery site attending and speaking at conferences and events worldwide[18].

5.3 In addition the Trust has also won a Health Foundation Innovating to Improvement Programme grant to support local set up and evaluation. This has enabled the Trust to continue to implement Open Dialogue at pace with the second cohort of Trust clinicians nearing the end of their POD training and the recruitment of a full time service manager and research assistant to

[16]Developed in Finland the POD model (open dialogue) has been shown to improve return to work / study rates for those with a first episode of psychosis by 78% and reduce relapse for that group by 19%.
[17]The £2.4m RCT is being led by University College London [UCL]
[18]Including Western Lapland, Ireland, Australia, USA and the UK.

drive forward the change, at a practice and system level, and to support robust analysis of the clinical outcomes.

5.4 Appendix D provides a summary of key achievements and success to date (14 September 2016).

6. Conclusion and Recommendation

6.1 The KCC HOSC is requested to note the content of this mental health update report.

APPENDIX A : PATIENT FLOW PROGRAMME WORK STREAMS (as at 21 September 2016)

Patient Flow Programme

Work stream 1: Improving gatekeeping

To ensure that every new admission has a documented plan of care, including proposed discharge date, prior to a bed being found.

Work stream 2: Daily patient flow calls

To ensure daily internal bed management calls to include all patients in external beds and their recall plans, all new admissions (after 48 hours), all patients who have exceeded their predicted length of stay, all patients on the 'to come in [TCI]' list.
Incorporates work of closed work stream 4: Ensuring specialist multi disciplinary team [MDT] review of long stay patients which also includes the work of closed work stream 8: Reviewing PCU DToCs, and closed work stream 11: Bringing patients back from private be.

Work stream 3: Improving clinical communication around private admissions

To introduce a system to ensure that the community care co-ordinator, pod consultant and inpatient consultant are immediately informed about their current patient bed admissions, and of any subsequent admissions.

Work stream 5: Improving clinical reviews for new admissions

To develop arrangements to ensure that all new admissions have a consultant psychiatrist review within 24 hours, applicable across 7 days a week (to be further developed to achieve a 14 hour review).

Work stream 6: Introducing a cluster 8 (personality disorder) admission pathway

To introduce a NICE compliant standard admission and discharge pathway for all patients admitted with a diagnosis of personality disorder.

Work stream 7: Improving care plans and crisis planning for patients with repeat admission

To ensure that robust care plans and crisis plans are in place for those patients who have more than one admission within a year.

Work stream 9: Increasing clinical site management capacity

To increase clinical site management out of hours.

Work stream 10: Funding

To ensure recovery of costs of overseas patients and those with no recourse to public funds.

Work stream 12 Approved Mental Health Practitioner [AMHP] service / outcome of section 136 assessment

To ensure greater efficiency in AMHP service and processing of section 136 assessments by implementing a culture of positive risk taking.

Work stream 13: Specialist advice and training

To ensure increase in the specialist advice and training made available to clinicians.

Work stream 14: The use of rehabilitation beds

To ensure improved interface between acute and rehabilitation services, to review admission and discharge criteria and to ensure rehabilitation beds are fully utilised.

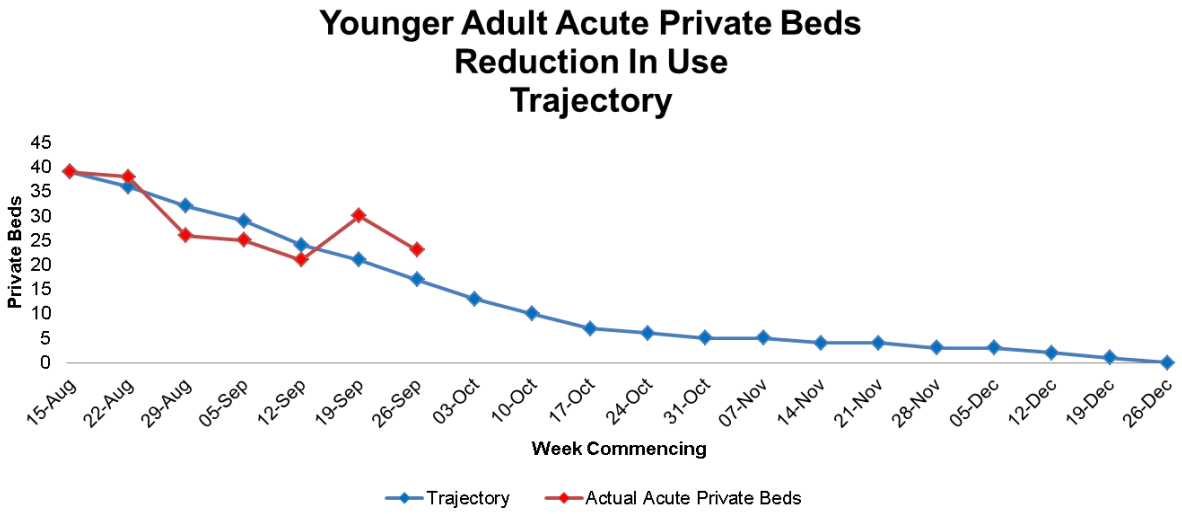
Work stream 15: Bed management process

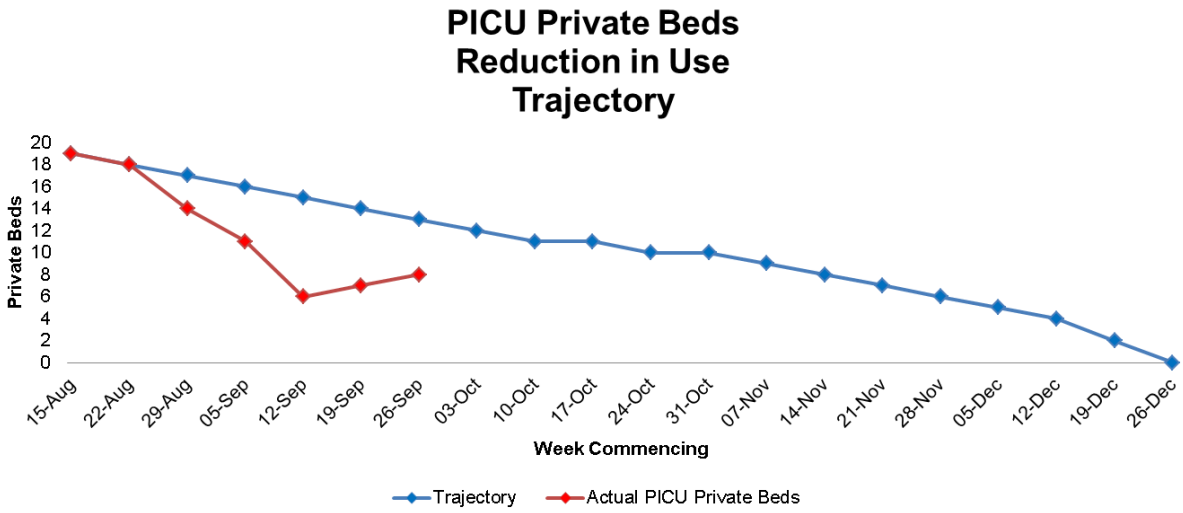
To ensure improved bed management process within the Trust through a review of current structures.

Work stream 16: Community psychological services

To ensure that repeat admission complex service users (cluster 8) are offered community psychological services as part of a focused time-limited treatment to help stabilise the individual and keep them out of hospital.

APPENDIX B : PATIENT FLOW PROGRAMME ACHIEVEMENT AGAINST TRAJECTORY (as at 26 September 2016)





APPENDIX C : PATIENT FLOW PROGRAMME ACHIEVEMENTS (as at 21 September 2016)

Work stream	Achievement
	Programme Board established and meeting weekly with cross service line representation.
	Trajectory defined with positive progress reported weekly for both acute mental health and PICU beds.
1	Implementation of gatekeeping checklist.
1	Implementation of CRHTs gatekeeping all referrals for admission.
1	Implementation of process to ensure consultants reach agreement on which patients can be discharged early in the day and not later than midday.
1	Implementation of a 'floating consultant' in East Kent to ensure no slippage in planned discharges as a result of consultant leave.
2	Implementation of daily patient flow teleconference calls with acute and community recovery representation at senior operational and clinical level.
2	Implementation of virtual discharge planning meetings utilising audio visual technologies to reduce delays in discharge planning meetings taking place.
2	Implementation of a process to ensure 'green' PICU patients are discharged to a more appropriate acute bed to meet their needs as soon as an acute bed becomes available.
3	Implementation of a robust process to ensure community care co-ordinators, community recovery pod consultants and inpatient consultants are informed about their current Trust and private bed admissions.
3	Implementation of a process to ensure all patients in private beds have a named community and inpatient consultant and that accountability of each in ensuring continuity of care is clear and agreed.
4	MDT review of long stay patients included within daily patient flow calls.
5	Implementation of a process to ensure consultant reviews take place at weekends.
6	Implementation of a personality disorder pathway and prolonged stay justification form to meet NICE guidelines.
7	Implementation of Community Recovery (improving quality and reducing variation) programme which has within its work streams dedicated focus on improving care planning and crisis planning.
10	Implementation of a robust process to ensure contracts teams is made aware of all new oversees admissions and those not eligible for recourse to public funds.
14	Rehabilitation services more responsive to referrals, responding quicker with rehabilitation teams providing in reach services to acute wards, attending bed management meetings and undertaking joint ward rounds with acute consultants.
14	Implementation of short inpatient rehabilitation programme (4 – 6 weeks) to improve patient flow.
15	Expansion of community psychological service to provide focussed intervention for complex cluster 8 service users thereby avoiding admission for these individuals.

APPENDIX D : OPEN DIALOGUE PROGRAMME ACHIEVEMENTS (as at 14 September 2016)

Achievement
Developed two POD teams in Kent – Canterbury and Medway.
Secured £65,000 from Health Education Kent Surrey Sussex [HEKSS] for training clinicians.
Secured £72,000 as part of a Health Foundation Innovating for Improvement grant award – runs for 15 months.
One of five shortlisted projects in the NHS England Positive Practice in Mental Health award in the category of Crisis Care – Award ceremony October 2016.
The Trust is identified by a number of staff in the project as one of the leading NHS Trusts nationally.

Item 5: Medway NHS Foundation Trust: Update

By: Benjamin Watts, General Counsel (Interim)

To: Health Overview and Scrutiny Committee, 7 October 2016

Subject: Medway NHS Foundation Trust: Update

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

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

---

1. Introduction

(a) Medway NHS Foundation Trust is a single site hospital based in Gillingham, Medway Maritime Hospital, which serves a population of over 400,000 across the areas of Medway and Swale (Medway NHS Foundation 2016).

(b) The hospital comprises of three clinical directorates - Acute & Continuing Care, Co-ordinated Surgical and Women & Children's. It provides clinical services to almost half a million patients a year, including 105,000 Emergency Department attendances, 62,000 admissions, 315,000 outpatients attendances and 5100 births. The Trust employs 4,286 members of staff and it is one of Medway's largest employers (Medway NHS Foundation 2016).

(c) The Trust is buddied with Guy's and St Thomas' NHS Foundation Trust (GSTT). GSTT provides support for a range of programmes and activities undertaken by Medway NHS Foundation Trust (Medway NHS Foundation 2016).

2. Keogh Review

(a) Following the publication of the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report), on 6 February 2013 Sir Bruce Keogh was asked by the then Prime Minister and Secretary of State for Health to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action was being taken (NHS England 2013a).

(b) Medway NHS Foundation Trust was one of 14 Trusts selected for the review on the basis of being outliers for two consecutive years on one of two measures of mortality: Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). (NHS England 2013a; NHS England 2013b; NHS England 2013c).

(c) In July 2013, 11 of the 14 Trusts including Medway NHS Foundation Trust were put into 'special measures'. Special measures were a new regime introduced following the Keogh Review in 2013. It involves action and scrutiny by three organisations: the Care Quality

Commission (CQC), Monitor (for NHS Foundation Trusts) and the NHS Trust Development Authority (TDA) (for NHS Trusts) (CQC 2014).

3. CQC

(a) Professor Sir Mike Richards, the Chief Inspector of Hospitals, prioritised full inspections of the 14 trusts that were in the Keogh Review (including the 11 trusts in special measures) under CQC's new inspection model for acute hospitals (CQC 2014).

(b) The CQC initially inspected Medway NHS Foundation Trust in April 2014 and led to an overall rating of inadequate. Medway NHS Foundation Trust was the only Trust in special measures found to have failed in making significant overall progress. It was recommended that the Trust remained in special measures. Further inspections took place in July 2014, August 2014 and December 2014 (CQC 2014).

(c) The CQC re-inspected the Trust in August 2015 and the inspection report was published in January 2016. The CQC rated the Trust as inadequate and recommended that the Trust should remain in special measures. The CQC has announced that an inspection of Medway NHS Foundation Trust will be taking place in November 2016.

4. Health Overview and Scrutiny Committee

(a) The Health Overview and Scrutiny Committee has considered Medway NHS Foundation Trust on 8 occasions (6 September 2013, 7 March 2014, 5 September 2014, 10 October 2014, 28 November 2014, 30 January 2015, 5 June 2015 and 4 March 2016) following the publication of Professor Sir Bruce Keogh KBE's review into the quality of care and treatment provided by 14 hospital trusts in July 2013.

(b) On 4 March 2016 the Committee considered an update from the Trust following the publication of the latest CQC inspection in January 2016. The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and Medway NHS Foundation Trust be requested to provide an update to the Committee in six months.*

5. Recommendation

RECOMMENDED that the report be noted and Medway NHS Foundation Trust be requested to provide an update to the Committee following the CQC inspection scheduled for November 2016.

Background Documents

CQC (2014) *'Special Measures: One Year On (05/08/2014)*', http://www.cqc.org.uk/content/special-measures-one-year

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (06/09/2014)*', https://democracy.kent.gov.uk/mgAp...ID=25799

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (07/03/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27666

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29237

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (10/10/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30032

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (28/11/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5401&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (30/01/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30553

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (05/06/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=32310

Kent County Council (2016) '*Agenda, Health Overview and Scrutiny Committee (04/03/2016)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=37255

NHS England (2013a) *'Professor Sir Bruce Keogh to investigate hospital outliers (06/02/2013)*', http://www.england.nhs.uk/2013/02/06/sir-bruce-keogh/

NHS England (2013b) '*Sir Bruce Keogh announces final list of outliers (11/02/2013),*' http://www.england.nhs.uk/2013/02/11/final-outliers/

NHS England (2013c) *'Rapid Responsive Review Report for Risk Summit - Medway NHS Foundation Trust (01/06/2013)*', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf

Medway NHS Foundation Trust (2016) *'Annual Report and Accounts 2015/16 (01/06/2016)', http://www.medway.nhs.uk/about-the-trust/publications/annual-reports/*

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

This page is intentionally left blank

Kent County Council: Health Overview and Scrutiny Committee

Friday, 7 October 2016

Update on Medway NHS Foundation Trust

Report from: Diana Hamilton-Fairley, Medical Director, Medway NHS Foundation Trust

Summary:

This report seeks to inform the Health Overview and Scrutiny Committee of the progress that has been made since our Trust Chairman, Shena Winning, and Chief Executive, Lesley Dwyer, attended the Committee on Friday, 4 March 2016.

Background:

The Care Quality Commission (CQC) published a report on Medway NHS Foundation Trust in January 2016, based on inspections it had carried out in August and September 2015. The CQC judged the Trust to be inadequate overall and gave three months to demonstrate real change.

The most significant development of the last six months has been the CQC's fieldwork carried out at the hospital on 28/29 March and the letter of 28 April from the Chief Inspector of Hospitals, Sir Mike Richards, to Health Secretary Jeremy Hunt, setting out his assessment, based on the fieldwork.

In Sir Mike's letter, he reported signs of considerable improvement since the CQC's 2015 inspection. Specifically, he reported that:

- The hospital was safer for patients

- Leadership had improved

- Staff engagement among senior and middle managers had improved, although low staffing levels are impacting on the morale of frontline staff.

We were naturally pleased that we had been able to demonstrate measurable improvements within the three month period. At the same time, we also recognised that there was still a huge amount to do, most notably around improving our staffing levels and increasing our efficiency.

This paper provides an update on progress since then.

Update - Trust Recovery Plan:

Following the CQC report in January, we launched a comprehensive plan to improve the hospital, based around six commitments.

These are:

- Modernising our Emergency Department, reducing the time it takes for patients to be seen and assessed.
- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.
- Accelerating our recruitment drive to bring in the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interims and agency staff.
- Continuing to improve our corporate and clinical governance, which will support both safe and high quality patient care and a productive working culture for staff.
- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional clinic appointments for patients to see specialists.
- Working closely with our healthcare partners to ensure patients receive the right care in the community, when they are ready to leave hospital.

Overview of progress in the last six months

We have reached some significant milestones since we last updated the committee in March. The hospital is safer and more responsive to the needs of our patients.

Our patients are now seen faster when they arrive at the Emergency Department, see fewer different doctors during their stay, and are discharged to home or appropriate place of care more quickly.

This progress has been acknowledged by both the Secretary of State, Jeremy Hunt, and the Health Minister, Philip Dunne, following their recent visits – and the Care Quality Commission (CQC), as referenced above.

Some of the key achievements in the past six months include:

- The percentage of patients who would recommend Medway Maritime Hospital as a place to be cared for has risen to 85.2 per cent.
- Our patients stay for less time – the average length of stay on our admissions wards has gone down from 11 days to less than three. However our length of stay for emergency admissions overall is increasing again from 6.8 days to 9.6 days because of a lack of suitable placements for our older and frailer patients in the community and/or support from social care in their own homes.
- The number of deaths in the hospital has also decreased from 118.3 to 100.1. The average across all NHS hospitals in England is 100.
- Fewer patients stay in hospital unnecessarily – 40 per cent fewer patients who are fit for discharge remain in hospital.

- More patients avoid a hospital stay – around 35 per cent of medical patients are now discharged within a day compared with 20 per cent before the introduction of our Medical Model, which is described below.
- We employ more staff in our Emergency Department – nursing vacancies in our Emergency Department have reduced from 60 per cent to 25 per cent.
- We see patients who arrive by ambulance sooner – we see around 60 per cent of ambulance patients within 15 mins – making us consistently one of the best performing NHS Trust's in the region.
- Lister Ward – Medway's ambulatory care unit – received a Certificate of Achievement recently at the Emergency Ambulatory Care National Network for being the most improved unit in the country. This is in light of the massive reductions we have delivered in the number of patients staying overnight since the unit opened in March.
- A dedicated multidisciplinary team has successfully reduced the mortality rate for patients who require emergency laparotomy surgery for severe abdominal pain to eight per cent, which is better than the national average of 10 per cent.

Some of the specific areas of progress are set out below in more detail.

Key work programmes:

Medical Model

On 14 March, we introduced our new Medical Model, a set of changes to the way patients admitted on an emergency basis are treated. The aim was to improve patient care and experience, and reduce patients' average length of stay in hospital.

Some of the benefits include:

- Through the Medical Model, patient triage has been simplified. GP referrals and patients who come to the emergency department and are in a stable condition are triaged into the ambulatory care assessment area (Lister ward).
- Those who come to the Emergency Department and are critically unwell are triaged to the admissions wards (Gundulph and Wakeley). This has allowed better flow of patients through the hospital.
- The Medical Model has reduced the numbers of patients having to be seen in the corridor within the Emergency Department. This has ensured reduced handover of cases between consultants and a more secure environment, where sick and unstable patients are reviewed appropriately.
- For those patients that are admitted, the Medical Model is reducing the number of consultants they see. This means patients should have no more than two consultants managing their care ideally, the initial admitting consultant and a subsequent specialist
- The Medical Model is helping reduce waiting times in the Emergency Department. 82 per cent of patients are now seen and treated within four hours compared to 73 per cent in March 2016.
- More than 95% of those with minor injuries are seen within four hours and 25 per cent of patients are seen by our primary care colleagues from Medway Community Healthcare. This has significantly improved patient experience.

- Thanks to the Medical Model, around 35 per cent of medical patients are now discharged within a day compared with 20 per cent before its introduction.
- In addition, there has been an increase in the number of patients on the admission wards staying less than 48 hours.

Staffing

The CQC commented on our staffing levels in its assessment in April. We have continued to step up our recruitment and retention drives with a number of activities:

- We have hosted a series of open days for potential new nurses. This has significantly increased the number of nurses applying for posts at Medway Foundation Trust. The benefit of this has been hard to realise, as we continue to have an increase in the number of patients coming to our Emergency Department or being referred by GPs.
- On 25 April, we launched our new Vision and Values. Supporting our vision 'Best of Care: Best of People' are the values: Bold, Every Person Counts, Sharing and Open, and Together.
- The Vision and Values were shaped through consultation and engagement with staff, and are designed to bring about a positive change in culture and in the way that staff interact with patients and other staff. We hope that this will result in improved morale and better retention.
- In late March, we introduced a new in-house staff bank. This offers all our existing staff the opportunity to either work flexibly or take on additional shifts. This means our staff will be called upon first, and given priority over workers who are recruited via external agencies.
- We have refurbished some of our hospital accommodation and have a rolling programme to modernise the rest of our estate over the next six months.
- We have launched a new management development programme – the first such programme at the Trust for a couple of years. We look forward to this programme resulting in greater levels of recruitment and retention in the coming months.

Emergency Department

We continue work on the redevelopment of our Emergency Department. Following the completion of the new children's Emergency Department and minors area in 2014 and 2015 respectively, this spring and summer has seen the beginning of the works to refurbish the "majors" area of the department – the area where people with major injuries and life-threatening conditions are seen.

In May, we began an eight-week programme to straighten the road in front of the Department, with the aim of improving access for ambulances. This was the precursor to the start of the main body of works to redevelop the majors area.

Once the redevelopment has been completed, the department will consist of 24 bays in majors, seven bays in resuscitation, and 10 bays in the Clinical Decisions Unit (CDU). The works are scheduled to be completed by late 2017.

However, like many other Trusts, we are still falling some way short of the national target to see, treat, admit or discharge 95 per cent of patients within four hours of arrival.

We have introduced and will continue to improve the way in which the department operates:

- We employ more staff in our Emergency Department – nursing vacancies in our Emergency Department have reduced from 60 per cent to 25 per cent.
- We see patients who arrive by ambulance sooner – we see around 60 per cent of ambulance patients within 15 mins – making us consistently one of the best performing NHS Trust's in the region.
- We have streamlined the process for taking decisions on how and when to admit patients to the wards, and enhanced learning and development for staff working in the Department, aided by the employment of a consultant nurse who is able to deliver university-accredited educational programmes.

Finance

We ended the 2015/16 financial year with a deficit of around £52 million. This was worse than both our original plan and our projections when we put together our half-year forecast in autumn 2015.

The deficit continued to grow because, in response to the CQC's findings, we took the decision to invest in initiatives to improve the quality of patient care.

The financial pressures were exacerbated by record numbers of people coming into our Emergency Department, an increase in the number of patients waiting for community support and a consequent reduction in elective activity due to the rise in emergency patients over the level we planned for. This led to a significant drop in our income and the rise in emergency patients – 12 per cent in the last six months - has meant we have had to keep beds open beyond the winter, which incurs increased unfunded staffing costs.

We are determined to stabilise our financial position. Going forward, our recovery plan will focus on delivering greater efficiency and cost reduction, while not compromising on patient safety and quality.

We are aiming to make a saving of £12.6 million in the 2016/17 financial year, representing more than four per cent of our operating costs.

We have already made a good start to the year, having met our savings target for the first financial quarter of 2016/17. This has been achieved by procuring goods and services at a lower cost than before. Our plans for the later part of the year include increased early efficiency gains in the way we deliver our services, as identified in the Lord Carter review.

We are developing a long-term financial recovery plan and look to build upon this positive momentum until we return to a secure financial footing.

Improving technology

In the coming months, we are set to introduce a range of exciting digital projects to help improve patient care and experience.

In November, we will start the roll-out of an entirely new bed management system, which will offer real-time, digital intelligence on which patients is where, within the hospital.

In practical terms, this will be made possible through the use of 42-inch digital whiteboards on the wards.

The benefits of the programme are to:

- Enable clinical staff to identify what bed space is available for patients. Once ward staff have found a suitable location, they will navigate the patient on the digital screen to their selected location.
- Offer clinicians and service managers a real-time source of information as to where any one patient is at any time.

This will be followed in December by the arrival of a new electronic observation – commonly known as “track and trigger”.

Through this programme:

- Nurses will be able to record patients’ blood pressure, pulse, oxygen levels and other observations on a smartphone or tablet – similar to an Android Phone or iPad. This will automatically be uploaded onto the software, which will alert the appropriate doctor if there is a problem with the patient.

It will mean a wider group of clinicians can intervene before the patient’s health deteriorates and reaches a critical state.

MediLead

Earlier this year, we launched an exciting new programme to support and develop talent among our junior doctors.

The MediLead programme was originally proposed by Consultant Anaesthetist, Dr Sarah Hare, to encourage junior doctors to think about innovative ways of improving the experiences our patients have.

As part of their application to the MediLead programme, each junior doctor identifies a quality improvement project that they will work on in addition to their clinical responsibilities, with the support of senior doctors, senior nurses and managers as part of their leadership development.

Projects are focused on patient safety, improving patient care and the delivery of efficient services.

Some of the current projects include:

- Improving the training and quality relating to ECGs performed by nurses and junior doctors benefiting patients in smoother diagnostics.

- Creation of bespoke paediatric equipment trolleys to ensure smooth and outstanding care for sick babies and children who need transfer to London's children intensive care units.
- Development of an innovative application for all staff to access Medway Maritime Hospital policies and procedures.
- Developing communication aides for safe handover of patient care between staff members.

Going Smoke-Free

From Monday 17 October, Medway Maritime Hospital will become a smoke-free site. This means that from this date, all patients, visitors and staff will not be able to smoke in the buildings, hospital grounds and car parks.

The purpose of going smoke-free is to protect and improve the health and wellbeing of all patients, visitors and staff who use the hospital. The move is in keeping with many hospitals and public spaces where smoking is now no longer permitted.

As part of plans to go smoke- free, the Trust has been working closely with Medway Council to offer smoking cessation support to patients, visitors and staff. This will include providing free nicotine replacement therapy to patients on wards, on-site support for staff and advice for visitors from Medway Council's Stop Smoking Service.

In addition, we have staged a number of special training sessions for staff who have expressed an interest in becoming smoke-free champions – a role where they will help remind patients and visitors that Medway Maritime Hospital is to become a smoke-free site on Monday, 17 October.

We are also working with local ward councillors and residents from neighbouring streets to address and mitigate any concerns they have about the potential increase in the number of people smoking outside their properties.

Sustainability and Transformation Plan

We continue to work with our partners to develop the Sustainability and Transformation Plan (STP) for Kent and Medway, as well as formulating our own medium to long-term clinical strategy, which aligns with the STP.

At the heart of our strategy will be a commitment to partnership and to moving away from the situation of the past few years, in which the Trust has operated largely in isolation from the rest of Kent and Medway.

We will work with providers and commissioners to improve the health and wellbeing of the population, with a focus on prevention, as well as treating ill health.

We are establishing a Trust Strategy Group which will oversee the development of the Trust's clinical strategy and ensure our aspirations are reflected in, and complementary to, the wider parts of the health system across Kent and Medway.

Phase two – Trust Recovery Programme

Our six public commitments listed earlier in the document remain at the heart of what we are trying to do – delivering the best of care, with the best of people.

As part of Aiming for BEST – phase two of the Trust Recovery Plan – we will also be focusing on the following areas as we prepare for the CQC's inspection in November:

- Unplanned Care – improving care for people requiring urgent and emergency care before, during and after hospital.

- Planned Care – improving care for non-emergency day case and cancer patients, before, during and after hospital.

- Outpatients – improving the management of appointments; improving the way we care for outpatients during their visit to hospital and bringing care closer to home by improving the use of community services.

- Health Informatics - providing the right information to our clinicians wherever and whenever it is needed; new digital solutions to help build an electronic patient record and enable a safer, faster patient experience.

- Governance and Standards (CQC) - ensuring we comply with regulatory standards and preparing the Trust for the CQC's inspection in November.

- Finance – reducing the Trust's deficit while improving its financial stability.

- Workforce – having the right people providing the right care at the right time; improving recruitment and retention; supportive culture which values everyone's contribution; and developing staff skills through increased learning and development.

- Focus on Mortality – ensuring we comply with regulatory standards and preparing the Trust for the CQC's inspection in November.

Next steps

The remainder of 2016 will be extremely busy for the Trust, as we welcome the CQC back at the end of November, continue to work on our financial recovery, develop our clinical strategy and continue to finalise the Sustainability and Transformation Plan with our partners.

We are however confident and optimistic about the challenges that we face and look forward to discussing these with the Committee on Friday, 7 October.

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

To: **Health Overview and Scrutiny Committee 7 October 2016**

Subject: **Kent Health and Wellbeing Board Annual Report 2015-2016**

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 8 December 2016 and was taken to the Kent Health and Wellbeing Board on 21 September for agreement prior to presentation to County Council. The following annual report is the one presented to the Health and Wellbeing Board.

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

Note the 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 2015 to March 2016.

(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

Background Documents

None.

Contact details

Mark Lemon
Strategic Relationships Adviser
03000 416387
Mark.lemon@kent.gov.uk

Karen Cook
Policy and Relationships Adviser (Health)
03000 415281
Karen.cook@kent.gov.uk

Kent Health and Wellbeing Board Annual Report 2015-16

1. Introduction

This is the annual report for the Kent Health and Wellbeing Board for 2015/16. During this time the health and social care system experienced serious challenges including continued rising demand and limited resources. These challenges have fueled 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. Major initiatives from NHS England have been previously 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.

Most recently, in December 2015 the Government tasked local health and social care systems to produce Sustainability and Transformation Plans (STP) that will deliver the Five Year Forward View and the Kent Health and Wellbeing Board is at the forefront of this development.

2. The structure 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. However it does function in practice and in membership as a partnership board. 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. Membership, governance arrangements and terms of reference are attached to this report in Appendix 1.

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 2015 and March 2016. A full list of agenda items considered at each meeting can be found at Appendix 2. 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.

3. 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 that are formal subcommittees of the Kent Board. They are based on CCG geography and have full representation from all relevant district councils.

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 children and young people
- 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 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 came together in 15/16.

4. Statutory Responsibilities of the Board

Under the Health and Social Care Act 2012 the Kent Board has five responsibilities and in 2015/16 has successfully fulfilled its statutory requirements as described below:

4.1 To ensure that a Joint Strategic Needs Assessment that identifies the health priorities for the population is produced

Kent's JSNA is available here:
http://www.kpho.org.uk/joint-strategic-needs-assessment .

Regular reports concerning the JSNA were received by the Board:

- An exception report was considered by the Board on 20th May 2015 highlighting key changes from the 2014-15 refresh of the JSNA
- A report came to the Board on 16 September 2015 outlining key recommendations from the Kent JSNA that may be considered by CCGs and other commissioners for 2016/17 commissioning plans.

The revision of the JSNA was the focus of an event held in September 2015. 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 concept 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.

4.2 To ensure that a Joint Health and Wellbeing Strategy, based on the Joint Strategic Needs Assessment is produced.

The updated strategy was published in 2014 and runs until 2017. It is available here:
http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/joint-health-and-wellbeing-strategy

The Board has continued to oversee the implementation of the strategy which has five outcomes:

- 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 Board monitors progress and performance against key indicators for each of the five outcomes through t**he Kent Assurance Framework.** 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

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

It was agreed that the County Board and Local Boards would develop work programmes focussed on achieving the outcomes of the strategy and built on the findings of the JSNA.

The Board has received reports and presentations on key issues relating to the strategy throughout the year including health inequalities, learning disability, mental health and children and young people. Examples include:

- **Kent & Medway Mental Health Crisis Care Concordat** brings together organisations such as Police, Health, Social Care and Public Health to improve outcomes for people experiencing a mental health crisis. The Concordat's purpose is to improve communication with and training for police officers and to put systems in place with partners that will reduce the number of detentions under Section 136 of the Mental Health Act 1983.
- **Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults 0-25 (CAMHS)** articulates a new model for the development of children's mental health services with a single point of access and seamless pathways ranging from universal early help through to highly specialist care with better transition between services. The development of this strategy was prompted by concerns expressed by the Board about the CAMHS service and has developed into a wider solution including early intervention and prevention.
- **Kent Safeguarding Children's Board Annual Report** highlighted the Strategic Priorities for 2015-18 as Early Help, children who go missing, On-Line safety and Female Genital Mutilation, child sexual exploitation, radicalisation, domestic abuse and working with parents with mental health and/or substance misuse issues. The Board noted the development of expertise and knowledge in relation to child sexual exploitation and to the issue of unaccompanied asylum seeking minors.
- **Learning Disability- Joint Health and Social Care Self-assessment Framework and update on Transforming Care (Winterbourne).** The Self-assessment Framework identifies areas of weakness in health and social care services delivered to people with a learning disability. Transforming Care is the national response to the failings at Winterbourne View Hospital. The Board agreed

    a) to support development of integrated commissioning arrangements between the Clinical Commissioning Groups and KCC to ensure all agencies continue to work together to improve the lives of people with learning difficulties;
    b) The future Joint Commissioning Plan for learning disability in 2016 should address the areas where Kent had scored a red rating (i.e. long term health conditions, breast cancer screening and bowel cancer screening);

c) The development of a Transforming Care Partnership for Kent and Medway to take forward the Transforming Care strategic plans for reducing the number of specialist in-patient beds and improving community support.

4.3 To ensure that the commissioning plans of the CCGs 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

Commissioning plans for the year of 2015-2016 for Children's Services, Adult Social Care and NHS England were considered and agreed at the meeting of 20th May 2015 and can be found here:
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=5833&Ver=4

Public Health Transformation and Commissioning plans were agreed by the Board at the meeting of 18th November 2015.
https://democracy.kent.gov.uk/documents/s60767/Item%207%20PH%20Nov%20HWBB%20report%20-%20v6.pdf

The latest commissioning plans of the seven Clinical Commissioning Groups in Kent were presented to the Board and agreed at its meeting of 16th March 2016.
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180&Ver=4

4.4 To ensure that a Pharmaceutical Needs Assessment is produced

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

The Board approved the Kent's Pharmaceutical Needs Assessment on 20th May 2015 and it is available here:

http://www.kpho.org.uk/health-intelligence/service-provision/pharmacy/pharmaceutical-needs-assessments

The Board has involved itself in consultation concerning the future of community pharmacies following the announcement by the Department of Health and NHS England in December 2015, that funding to community pharmacies would be reduced and there would be a reconfiguration of pharmacy services. This was shown to have a serious effect on smaller, independent pharmacies, typically those in villages such as Lyminge and Lenham. An announcement was made by Government in September 2016 that due to national response to the consultation the proposed changes would not be implemented as planned in October 2016.

4.5 To promote the integration of health and social care

a) Sustainability and Transformation Plan (STP)

Background to the STP: In December 2015 Government issued planning guidance outlining a new approach to help ensure that health and care services are built around the needs of local populations.

To do this, every health and care system in England was tasked with producing a multi-year Sustainability and Transformation Plan showing how local services will evolve and become sustainable over the next five years and ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

Local health and care systems came together in January 2016 to form 44 STP 'footprints' that would deliver plans that are based on the needs of local populations. The health and care organisations within these geographic footprints have been working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term. NHS England has defined the footprint for our region which brings together Kent and Medway and appointed Glenn Douglas, Chief Executive of Maidstone & Tunbridge Wells NHS Trust, as the Senior Responsible Officer.

STPs must demonstrate how new models of care will be developed and full integration of health and social care achieved by 2020. The Kent and Medway plan is being developed to address the significant challenges in our footprint to provide a sustainable health and social care system, with many of the current providers in special measures and a significant financial deficit by 2021 if we do nothing. The plan must also consider how we will work with neighbouring footprints and communities with regard to those people who may cross boundaries to use local health services, for example people from Southeast London who are served by Darent Valley Hospital and people from Kent who may use services at the Conquest Hospital in Hastings.

The Health and Wellbeing Board has been involved in the development of the STP and the chair of the Board is a member of the Kent and Medway STP steering group, as is the Chair of the Medway Health and Wellbeing Board alongside NHS providers and commissioners.

These new planning arrangements, changes to the Better Care Fund and financial settlement for the NHS announced in the autumn statement were explored at the Board meeting 16th March 2016.
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180&Ver=4

b) Better Care Fund

The Better Care Fund is a driver for integration as it promotes the pooling of budgets and the development of joint initiatives by health and social care organisations designed to reduce demand for hospital services. There has not been any additional investment but 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 approach has been commended at a national level. In the autumn statement the government announced that it intends to continue with an expanded BCF and that the BCF will be an integral part of the progress towards the requirement of full integration of health and social care by 2020. Together with the Sustainability and Transformation Plans the BCF going forward must be able to demonstrate how this will be achieved.

The Board regularly monitors implementation of the BCF plan. Papers were received on 16 September 2015: https://democracy.kent.gov.uk/documents/s59610/Item%2011%201.pdf

27 January 2016:
https://democracy.kent.gov.uk/documents/s61863/Item%206%20BCF%20and%20planning%20paper%20final%20final%20final.pdf

16 March 2016:
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180&Ver=4

c) Pioneer Programme

The national Integrated Care and Support Pioneer Programme was launched in November 2013 to assist selected authorities to progress with their health and social care integration plans at pace and scale. As one of the original Integration Pioneer sites Kent established an Integration Pioneer Steering Group (IPSG) as a sub-group of the Health and Wellbeing Board to coordinate the delivery of the objectives identified in the Kent Pioneer bid.
The Integration Pioneer Programme and team continue to support the diverse and expanding range of new models of care that are significant in the development of the STP.

The Board receives regular reports concerning these developments and papers have included progress reports relating to:

- **Encompass Vanguard Site:** The Kent Integration Pioneer is supporting the development of the Vanguard site which is providing a wide range of primary care and community services. Several members of the IPSG are members of the Vanguard Steering Group working in collaboration and supporting the establishment of the Vanguard.

The Vanguard: In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services. In March 2015 the first group of Vanguard sites were chosen.

Encompass is a group of 16 GP practices in Whitstable, Faversham, Canterbury, Ash and Sandwich which are working together to provide more local services. This will mean that patients can receive more of their care from their local surgery, without the need to travel to hospital. Locally provided care includes minor injuries unit, diagnostics and screening, consultants conducting outpatients' clinics in the community and there are plans to extend into nursing care. The population size covered by these arrangements is now 170,000 people.

- **Formation of an Integrated Care Organisation:** South Kent Coast and Thanet CCGs are leading in developing new local models for health and care services coordinated by the GP. The CCG's membership is working with more than 200 clinicians, professionals and local people to finalise the design of services that each community needs.
- **Integrated Discharge Teams** at Darent Valley consist of social care case managers, case officers and discharge coordinators providing an extended service outside of office hours to support people to leave hospital when they are well enough.
- **The Care Plan Management System** went live in West Kent in June 2016. This means moving care planning from GP systems to provide access to all of a person's care team for 2,250 people. The system was presented as good practice at a national conference hosted by NHS England.
- **Year of Care Programme** has provided a whole-system intelligence dashboard which delivers information on cost and activity across the health and social care economy. The

dashboard has been instrumental in evaluating the integration projects being delivered across the county and in supporting systems modelling for the STP.

- **International and European Work Stream**: Kent Integration Pioneers are taking the lead on behalf of the NHS and social care locally, nationally and internationally. Along with strong relationships with European partners, Pioneers have also worked with partners in New Zealand and Japan. The aim is to share transferable knowledge and learning on an international level. The impact of the UK leaving the EU is not yet known.
- **Kent Design and Learning Centre for Clinical and Social Innovation** opened in June 2016 to investigate, test and develop new technologies that can support people to remain independent for as long as possible.

d) In order to fulfil its duty relating to supporting the integration of health and social care the Board has also considered:

- **One Public Estate** (OPE) programme is designed to facilitate and enable public sector bodies to work collaboratively on property and land matters. The Board considered how the Department of Health's Local Estate Strategy and the requirement to establish local estates forums might fit with wider collaboration and integration of service commissioning and possible links with the local health and wellbeing boards and the Health and Wellbeing Strategy. A substantial amount of practical work in different localities has followed on from this.
- **Local Digital Roadmaps** are the plans for how local health and care economies will achieve their aim of being paper-free by 2020. It was agreed on 18th November 2015 that the roadmaps will be signed off by the Health and Wellbeing Board and regular progress updates will be reported to the Board
- **Workforce:** On 20 May 2015, the Board agreed to establish a task and finish group and work closely with Health Education England to look specifically at strategic workforce issues across the County. Workforce had been identified by the Board as one of the main barriers to implementing the necessary changes to the health and care system to make it both sustainable and deliver improvements to the quality and effectiveness of care. It was recognised that if the right actions could be identified, workforce would be a major enabler to deliver new models of care and the Five Year Forward View. The Group met 6 times between May and December 2015 and identified the following priority areas which were pursued in depth:

    - existing and emerging gaps
    - new models of care
    - productivity
    - recruitment and retention
    - cross-cutting – 'the Brand of Kent';

The Board agreed that joint work would continue around the issue of workforce. This aligned with the requirement to establish a Local Workforce Action Board to coordinate and support the workforce requirements of each STP. The Kent and Medway Workforce Action Board is currently under development and is building on the work of the Task and Finish Group.

5. Endorsement, consideration and support

A number of issues that either have implications for the health and wellbeing of the population or are likely to impact on the health and social care system have been presented to the Board for their consideration and endorsement. In 2015/16 these have included:

- Kent and Medway Growth and Infrastructure Framework which highlighted that within Kent and Medway approximately 160,000 new houses are planned. Medway, Dartford, Maidstone and Canterbury are highlighted as areas of significant growth with a projected increase of 304,500 people, equivalent to an 18% increase, in the population across the whole County (255,300 for Kent only). The Board was involved in shaping the development of the framework to take account of health and social care service delivery.
- Healthy New Towns scheme, which has recently started (2016) in Dartford, Gravesham and Swanley in relation to the Ebbsfleet Garden City development focused on working across capital developers, councils, social care and health to provide a healthy living space supported by innovative models of care delivery. This scheme is supported by the work of the One Public Estate programme.
- Winter preparedness: 16 Sept 2015 preparations for winter 2015-16 presented by NHS England South (South East) and 27 January 2016 review of arrangements for winter preparedness and resilience within the system with lessons learnt.
- Protocol on the working arrangements between the Kent Health and Wellbeing Board, Kent Children's Wellbeing Board and Kent Safeguarding Children Board which aims to support all three partnerships to operate effectively, being clear about their respective functions, inter-relationships and the roles and responsibilities of all those involved in promoting and maintaining the health and wellbeing of children and in keeping children safe. This is essential in order to maximise the safeguarding of children and young people, to avoid duplication and to ensure there are no preventable strategic or operational gaps in safeguarding policies, services or practice.

6. The Future: 2016-17

6.1 Sustainability and Transformation Plans- Integration at pace and scale

Health and Wellbeing Boards are increasingly seen as part of the internal governance and accountability arrangements for local health and care systems with an expectation that they will be involved in the development and sign-off of policies and strategies across a wide range of areas and of different scale and scope.
The STP is designed to have a significant impact on the progress of integration and will influence all aspects of health and social care. It provides the current framework for health and social care policy discussion. The Health and Wellbeing Board will continue to have the same statutory responsibilities that it currently has. The challenge for the Board as it goes forward will be to continue to fulfil its statutory duties and help ensure delivery of the STP.

The STP also provides the Board with an opportunity to use the innovative approaches that Kent is leading on through its Pioneer status and the progress it has made through the Better Care Fund to increase the pace and scale of integration.

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

The introduction of the STP as the guiding vision for the future of the health and social care system will impact on the production of the Joint Health and Wellbeing Strategy for 2017 onwards and the Joint Strategic Needs Assessment. These documents should reflect challenges and innovation in the system that are necessary to articulate the case for change, focus change on improving local outcomes for the population and provide the means to measure and evaluate effectiveness. This opportunity to provide a golden thread from the needs identified in the JSNA, into the new JHWS and through the STP into whole system planning will be explored by the Board during 2016/17 with a focus on agreeing a new approach to the JSNA and the Health and Wellbeing Strategy. The potential to translate

those high level intentions into local actions will also be considered as part of the Board's work for 2016/17.

6.3 The Work of the Board

In July 2016 the Board agreed to adopt a work programme that will ensure it remains focussed on its primary objectives and this will direct the work of the Board for the next year.

(a) Area 1- Assuring Outcomes for Kent

- The practice of devoting part of a meeting to reviewing progress against one of the 5 outcomes of the Joint Health and Wellbeing Strategy has been viewed as one worth continuing. This will be supported by the assurance framework report being focused on producing data to help the Board understand progress against the outcome.
- Review of commissioning plans.
- Winter planning and resilience.
- Quality

(b) Area 2 – Core Documents

- JSNA refresh (underway).
- JHWS revision (from late 2016 onwards)
- PNA (next revision due 2018)

(c) Area 3 – Promotion of Integration

- Progress of the Five Year Forward View and Sustainability and Transformation Plans
- Strategic barriers and enablers – workforce, sustainability, technology and systems
- Integration Pioneer reports and Better Care Fund
- Relationship with providers and VCS

(d) Area 4 – Notifications

- Other important issues or policy documents which the HWB will wish to become informed about and respond to. More for short and medium term planning. Recent examples, Local Digital Roadmaps, One Public Estate Initiative.

(e) Area 5 – Reports to the Board

- Health Watch Annual Report
- HWB Annual Report
- Mental Health Concordat.
- Local commissioning/policy developments, e.g. Emotional Wellbeing Strategy for Children, Young People and Young Adults, Accommodation Strategy, Growth and Infrastructure Framework.
- Local Board Minutes.
- Children's Health and Wellbeing Board minutes
- Annual report of the Kent Safeguarding Children's Board.

Appendix 1

The Governance Arrangements of the Board

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 subcommittees (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. Represents 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*
    - Cabinet Member for Education and Health Reform
    - Cabinet Member for Adult Social Care & Public Health
    - Cabinet Member for Specialist Children's Services
    - Corporate Director - Social Care, Health and Wellbeing*

- Director of Public Health*
- 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 subcommittee 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 are 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.

5. **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.
6. **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.

7. **Minutes.** Minutes of all 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.

8. **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.

9. **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.

10. **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.

11. **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.

12. **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.

13. **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.

14. **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.

15. **Suspension/disqualification of Members.** At the discretion of the Chairman, any body 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 2

Substantive agenda items taken by the Kent Health and Wellbeing Board in 2015/16

20th May 2015

Workforce
Kent and Medway Growth and Infrastructure Framework
Commissioning Plans: NHS England, Children's services and Adult Social Care
Assurance Framework
JSNA Exception Report
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

15th July 2015

One Public Estate Initiative
Kent and Medway Mental Health Crisis Care Concordat
Quality and the Health and Wellbeing Board
Local Health and Wellbeing Board minutes

16th September 2015
Healthwatch Annual Report
JSNA Recommendations Report
NHS England- Preparations for Winter 2015/16
Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25) – (CAMHS)
Kent Health and Wellbeing Board and Local Health and Wellbeing Boards Relationship and Future Options Paper
Developing the Relationship between Kent's Health and Wellbeing Board and the Voluntary Sector that recognises the important role the voluntary sector plays in the health and wellbeing of local communities and explore how that local intelligence and knowledge can be shared with Local Boards and County Board to inform commissioning
Health and Social Care Integration
Local Health and Wellbeing Board minutes

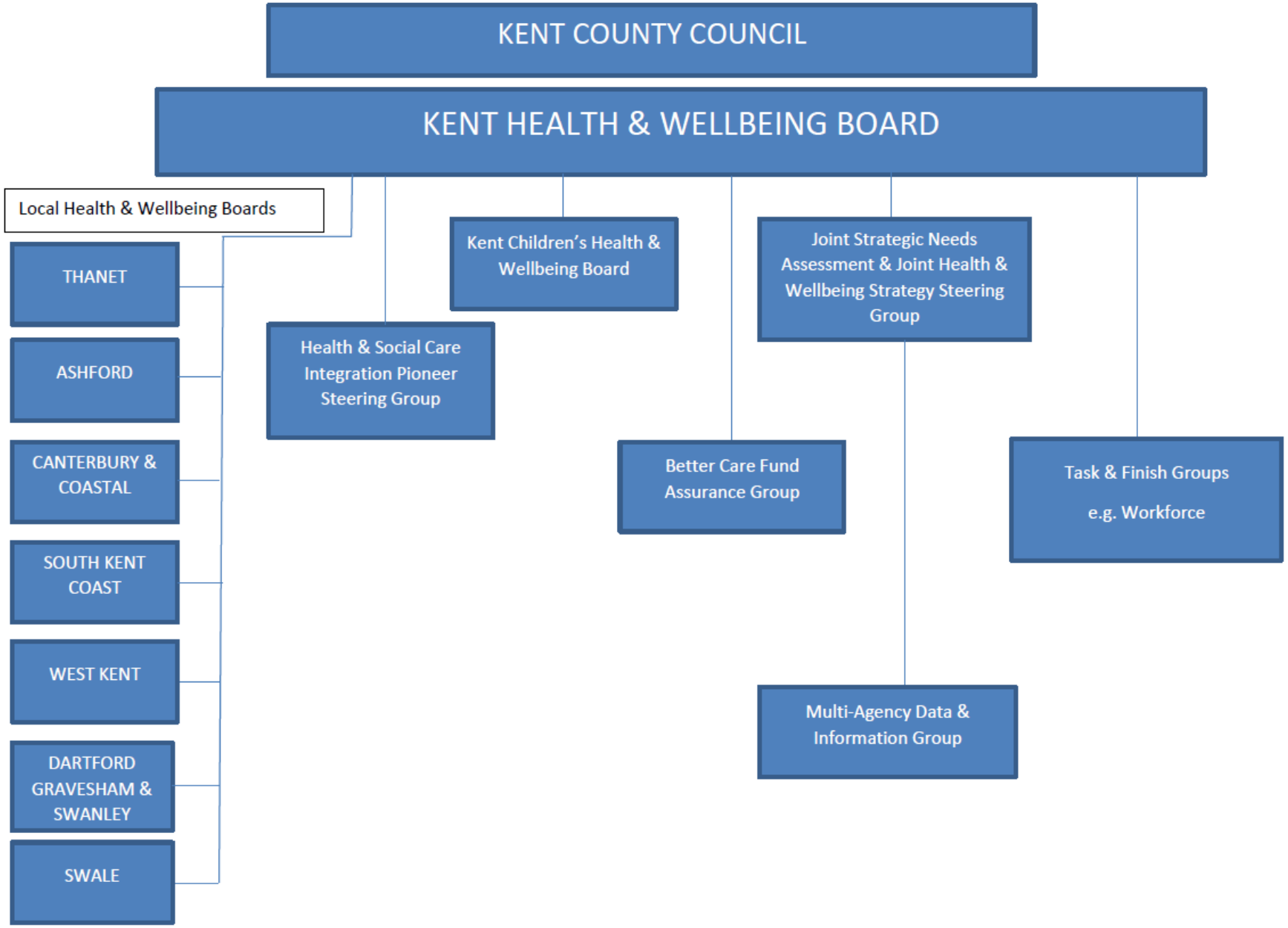
18th November 2015
Joint Health and Social Care Self-Assessment – Learning Disability
Growth and Infrastructure Framework
Public Health Services Transformation and Commissioning Plans
Assurance Framework
Kent Health and Wellbeing Board Annual report
Local Digital Road Maps
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

27th January 2016
NHS Preparations for and response to Winter 2015/16
The New Planning arrangements for Health and Social Care
New Models of Care progress report
Draft Kent Health and Wellbeing Board Work Programme
Kent Safeguarding Children's Board Annual Report
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

16th March 2016
CCG Commissioning, Operational and Transformation Plans with regard to STP
Better Care Fund
Joint Strategic Needs Assessment – outcomes of JSNA workshop
Kent Health and Wellbeing Board Work Programme- Finalised
Local Health and Wellbeing Board minutes

Appendix 3

THE KENT HEALTH & WELLBEING BOARD STRUCTURE



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.