HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 3rd March, 2017

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 3rd March, 2017, 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 (8):	Mr M J Angell (Chairman), Mr N J D Chard (Vice-Chairman), Mrs A D Allen, MBE, Mr A H T Bowles, Mr D L Brazier, Mr G Lymer, Ms D Marsh and Mr C R Pearman
UKIP (2):	Mr H Birkby and Mr A D Crowther
Labour (2):	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

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UNRESTRICTED ITEMS

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

Item — Timings*

1. Substitutes

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

3. Minutes (Pages 5 - 18)

4. Kent and Medway Sustainability and Transformation Plan (Pages 19 - 28) 10:05

5. Gluten Free Services in West Kent (Pages 29 - 34) 10:45

6. West Kent CCG: Financial Recovery Plan (Pages 35 - 50) 11:15

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*

John Lynch
Head of Democratic Services
03000 410466

23 February 2017

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, 25 November 2016.

PRESENT: Mr M J Angell (Chairman), Mrs A D Allen, MBE, Mr H Birkby, Mr D L Brazier, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Mr C R Pearman, Cllr J Howes, Cllr M Lyons and Mr B J Sweetland (Substitute) (Substitute for Ms D Marsh)

ALSO PRESENT: Mr S Inett

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

UNRESTRICTED ITEMS

59. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 7 October:

(a) Minute Number 46 - East Kent Strategy Board. On 2 September, the Committee considered an update about the work of the East Kent Strategy Board and requested that an update be presented to the Committee in November. On 24 November 2016 the Committee was notified that the East Kent strategy work had become the STP content for east Kent and that the Board would now operate as an East Kent Delivery Board to refine recommendations for how services could best be organised in east Kent in the future.

(b) Minute Number 52 - Healthwatch Kent: Annual Report and Strategic Priorities. As part of the update regarding follow-up actions taken since the previous meeting on 7 October, Members were asked to submit any questions for Healthwatch which had not been covered during the Healthwatch item on 2 September. The responses to those questions were circulated to the Committee on 22 November.

(c) Minute Number 57 - Medway NHS Foundation Trust: Update. On 7 October the Committee requested that Medway NHS Foundation Trust be requested to provide the Committee with a series of graphs to demonstrate progress since the original CQC inspection in 2014. A series of slides showing the Trust's improvements was circulated to the Committee on 22 November. Medway NHS Foundation Trust had also invited the Committee to come for a tour of the hospital to see first-hand some of the recent improvements including work to improve emergency department.

(2) RESOLVED that the Minutes of the meeting held on 7 October are correctly recorded and that they be signed by the Chairman.

60. Membership
(Item 4)

(1) Following the Council's approval of the revised proportionality statement on 20 October 2016, it was agreed that the Conservative group would gain a seat on the Health Overview and Scrutiny Committee at the expense of the Labour group.

(2) Members of the Health Overview and Scrutiny Committee note that:

(a) Mr Brazier (Conservative) had replaced Mrs Brivio (Labour) as a member of the Committee.

61. Dates of 2017 Meetings
(Item 5)

(1) The Committee is asked to note the following dates for meetings in 2017:

Friday 27 January
Friday 3 March
Friday 2 June
Friday 14 July
Friday 1 September
Friday 6 October
Friday 24 November

62. NHS preparations for winter in Kent 2016/17
(Item 6)

Pennie Ford (Director of Assurance and Delivery, NHS England South (South East)), Hazel Gleed (Head of Emergency Preparedness, Resilience and Response, NHS England South (South East)), Matthew Capper (Director of Performance and Delivery, NHS Ashford and Canterbury & Coastal CCGs), Corrine Stewart (Assistant Director of Commissioning, NHS Dartford, Gravesham and Swanley CCG), Jacqui West (Health Interface Manager, Kent County Council) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Ford began by explaining that the previously established Systems Resilience Groups had been replaced with Local Accident and Emergency Delivery Boards (LAEDB) which had a more focused remit on the delivery of urgent and emergency care. She stated that the winter pressures facing Accident and Emergency departments were really challenging and there had not been a reduction in pressure throughout the course of the year. She noted that there was a national A&E Improvement Plan which had made recommendations to be implemented locally including improving flow and discharge processes. She reported that improved discharge was particularly important for older people who began to lose function if they stayed in hospital longer than required. Mr Scott-Clark commented that, in addition to muscle wastage, the longer

patients stayed in hospital, it was more likely that they would get a hospital acquired infection.

(2) Ms Ford explained that in preparation for winter, each system had been refreshing their escalation plans and changing terminology following a national review of definitions. She reported that all systems had tested their plans including their response to snow and flooding; an increase in pressure was expected over the bank holiday period and into early January. She highlighted the national flu immunisation programme and the importance of Councils in encouraging people to take up the flu vaccination. The peak of the current winter's flu season was not known; it had been late last winter and at Christmas during the previous winter. Ms Ford invited each health economy to give an overview of their preparations for winter.

(3) Mr Capper stated that in East Kent, a whole system meeting was held at the beginning of October to review and refresh response plans, escalation triggers and terminology to ensure they dovetailed together. He noted that the cold weather and flu plan was due to refreshed within the next two weeks. In the run-up to the Christmas holidays, a super discharge week was planned where all agencies would be working together in an enhanced way to create additional capacity in the system; a follow up activity was planned for January. He reported that the implementation of GP triage model at the Kent & Canterbury Hospital, Canterbury last year had reduced the number of admissions; the CCGs with the providers were looking to replicate model as quickly and safely as possible at the William Harvey Hospital, Ashford and the Queen Elizabeth The Queen Mother Hospital, Margate. He explained that the daily escalation levels were circulated including the information about beds, workforce and A&E performance from the Single Health Resilience Early Warning Database (SHREWD).

(4) Mr Capper noted that the Out of Hours and 111 services had changed to a new provider which would provide greater efficiencies; the 111 service had recently gone live and would be responsible for providing 80% of the call cover by Christmas as part of the handover with South East Coast Ambulance NHS Foundation Trust (SECAmb). He stated that a community geriatrician resource had been developed to increase flow through acute and community hospitals as part of the Integrated Discharge Team provided by the Kent Community NHS Foundation Trust. He reported that the Discharge to Assess pilot, which carried out health and social care assessments, had been expanded alongside the Home First programme.

(5) Ms Stewart reported that North Kent had been preparing since spring to align their plans, learn from previous years and implement improvements. She stated that the North Kent CCGs had implemented SHREWD and had developed a monthly operational resilience group as part of LAEDB. She explained that in Dartford, Gravesham & Swanley, the key priority was to stream patients at the front door of Darent Valley Hospital, Dartford and assess within 15 minutes to understand their needs and direct them to alternative setting if appropriate such as the Minor Injuries Unit or the Ambulatory Ward for patients with COPD and Asthma. She reported that in Swale, the CCG was working with Medway Maritime Hospital to redirect patient from A&E to the primary care unit which had led to a 22 – 33% reduction in A&E attendance and improve discharge, with the implementation

of the Safer Care pilot which included an estimated discharge date, to reduce ambulance handover delays.

(6) Ms Stewart stated that a discharge lounge at Darent Valley Hospital had been created to enable patients fit for discharge to be moved out of beds and create capacity for new patients. The CCGs were also implementing Discharge to Assess initiatives to support frail patients return home such as the Hilton Nursing Project which provided assessments and recovery support in the patient's home; the project was currently helping to support 10 discharges a week. In Dartford, Gravesham & Swanley, a Care Navigators Pilot had been implemented with health, social care and voluntary services' support. Projects for frequent A&E attendees and palliative & end of life patients were also planned.

(7) Mr Wickings noted that West Kent had implemented SHREWD and were in daily discussions with Maidstone and Tunbridge Wells NHS Trust; he reported that there was good working relationship between the CCG and the Trust. He stated that using winter resilience money from the beginning of the year, a number of measures had been implemented including integrated COPD services, Home First service and additional support in nursing homes. He noted that GPs were working in both A&E departments with the service working better in one than the other. He stated that the CCG had assurance that preparations were going well but acknowledged that there may be difficulties in the winter period.

(8) Ms West explained that Kent County Council were partners of the LAEDBs and used SHREWD as part of its system resilience planning which included non-validated data as it was only validated once a week. She noted that the Hilton Nursing Project had also been implemented at Tunbridge Wells Hospital using CCG funding. She reported that KCC occupational therapists were providing assessments which provided additional equipment to patients post-discharge and helped to reduce their overall care package and improve patient flow. She stated that the central purchasing team were working with families able to identify homes with vacancies. She noted that Integrated Discharge Teams had been implemented on all hospital sites whose teams included KCC staff and the voluntary sector. She also stated that KCC supported Home First service and provided Enablement at Home services.

(9) The Chairman enquired about the communications plan. Ms Ford explained that there were a number of national campaigns such as the Stay Well This Winter campaign by NHS England and Public Health which encouraged members of the public to look after themselves during the winter. She reported that there were local communication campaigns which included details about alternative care provision including the use of pharmacists and using 111 as an alternative to A&E. Mr Capper noted that the communications team in East Kent were providing face-to-face information in shopping centres about alternative care provisions. He highlighted the Health Help Now app which provided users with information about their nearest health services in Kent and campaign information. He noted that as part of the national vanguard in Canterbury & Coastal CCG, a waiting list app was being developed. Ms Ford acknowledged that there were different ways to communicate with older and younger people; apps and social media were aimed at younger and working

age groups. Members gave suggestions of engaging with older people through established groups such as the Elders' Forum in Dartford; the Women's Institute and National Women's Register in Sevenoaks; and town & parish councils across Kent. Ms Ford resolved to take Members' comments about improving communication back to the LAEDBs.

(10) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about winter pressure levels remaining in the summer, engagement with the care home sector and assessments at home. Ms Ford explained that the late winter pressures last year remained into the summer which had resulted in services already being stretched going into this winter; the cause of this was unknown. She stated that the recommendations in the national A&E Improvement Plan could make a difference once implemented. Ms West stated that engagement with the care home sector; the Central Purchasing Team was speaking daily with the private sector and a Care Home Forum run by KCC and the CCGs had developed strong links with the care home sector. Ms West explained that as part of Discharge to Assess model in East Kent, patients whose needs could be safely met at home, were considered as part of Pathway 1 and were assessed within two hours of arrival at home. She noted that the Discharge to Assess team functioned within set working hours and patients were not discharged outside of these times; a similar system was due to be implemented in North and West Kent.

(11) In response to a specific question about patient and GP involvement in discharge, Ms Stewart explained that Dartford, Gravesham and Swanley CCG had recently held a four day event to look at improving discharge with health, social care and voluntary sector partners. One of the key outcomes of the event was to improve communication in and outside of hospital; a 30 day review event was planned for December. She noted that Dartford & Gravesham NHS Trust provided each patient with a booklet about the type of care they would be receiving and the estimated date of discharge. She acknowledged the importance of GPs as part of a patient's care particularly in A&E where doctors were able to see GP records and prescriptions for the patients and the provision of a telephone service which enabled GPs to speak to a senior nurse to explain the specific circumstances of a patient and receive advice about whether to refer them to the ambulatory care unit.

(12) Mr Inett stated that Healthwatch Kent had carried out Enter & View visits to all A&Es in February 2016. Patients were generally very satisfied with the service; lots of the attendees had turned up A&E as they had been unable to get a GP appointment and did not like using 111 service. He noted that Healthwatch had recently carried out a piece of work about discharge; staff were working very hard to improve discharge processes but there was a tension as there was a lack of placements in East & West Kent and difficulty in recruiting carers in North Kent to support discharge. A Member requested a wider discussion about delayed discharge of care to establish what KCC and partners could do to improve to reduce delays.

(13) A number of questions were asked about muscle wastage, pressure on services from border areas such as Bexley and the involvement of KMPT. Ms Stewart stated that Dartford & Gravesham NHS Trust had implemented the

use physiotherapists on wards to help mobilise people and ensure that they remained physically fit; a finding of the recent discharge event organised by Dartford, Gravesham and Swanley CCG was that muscle deterioration began when patients entered assessment wards. Ms Stewart reported that pressure from border areas was a significant issues; a third of the activity from Dartford & Gravesham NHS Trust came from Bexley and the surrounding areas. The CCG was working with colleagues and representatives from Bexley to align the work being carried out. She noted that the London Ambulance Service (LAS) would convey patients to Darent Valley Hospital when services in London are under pressure; the CCG had ambulance liaison meetings with SECAmb and LAS to improve communication and talk through issues. Ms Ford reported that KMPT was a crucial member of each LAEDB. A Member requested further details about SHREWD and Ms Ford undertook to provide this.

(14) RESOLVED that the report be noted and NHS England be requested to provide an update about the performance of the winter plans to the Committee at its June meeting.

63. Local Care in West Kent
(Item 7)

Gail Arnold (Chief Operating Officer, NHS West Kent CCG) was in attendance for this item.

(1) The Chairman welcomed Ms Arnold to the Committee. Ms Arnold began by explaining that the paper provided an initial overview of West Kent CCG's plans to design and implement local care, in line with the CCG's strategic vision, Mapping the Future, and the Sustainability and Transformation Plan. She stated that the CCG had begun to work with key partners and stakeholders on the proposals. She reported that the delivery of care would be undertaken in two phases. The first phase was the development of a service specification for core cluster level team which would support GP federations to provide services. She reported the likely establishment of eight clusters: Sevenoaks, Tunbridge Wells, Tonbridge, Weald and four clusters covering the Maidstone district which would act as building blocks in developing the local care and training. She noted the importance of having a critical mass of services for an effective hub of care. She reported that the specification would comprise of four work streams including the provision of mental health and social care. She explained that the service would begin to take effect in 2017/18 in an informal way; in 2018/19 it was expected that the CCG would move towards the multi-speciality community provider model (MCP). The new model of care was expected to be fully established and embedded by March 2019; the CCG was in discussions with providers about how the new model would be delivered and governed.

(2) Ms Arnold highlighted that the emergence of two GP federations in preparation for local care; the two federations had jointly set up a provider arm and were joint shareholders. It was anticipated that services would be provided by hubs of care with services collocated on the same site. The location of hubs was still to be determined, as part of discussions with local providers, but would need to serve a population of 100,000 to be cost effective and sustainable. It was

expected that hubs would provide access to diagnostics and extended opening hours with the potential to include a GP surgery to enhance medical cover on site. Ms Arnold stated that the she was engaging with 61 GP practices over the next 8 – 10 weeks; she noted that national pressures on general practice had begun to impact on the delivery of services in West Kent with a high percentage of surgeries being unable to fill GP vacancies. She acknowledged that GP surgeries were all independent businesses and all had their own plans and aspirations for the next five – 10 years.

(3) Ms Arnold noted that there had been advance discussions in Edenbridge and Sevenoaks. In Edenbridge, the CCG was looking to combine the current GP surgery, whose building has reached the end of its life, with services at Edenbridge Hospital. The strategic outline case was in the final stages of development and needed to be signed off by NHS England before formal consultation with local people and the Committee. In Sevenoaks discussions were taking place to explore the possibility of collate a GP surgery at the hospital. A stakeholder event was held to look at the wider opportunities and to identify the key work streams which will be needed to take this work forward.

(4) The Chairman enquired about the involvement of borough & district councils and the local Health & Wellbeing Boards with the proposal. Ms Arnold stated that districts had been involved in all discussions so far; the Chairs of the Patient Participant Groups and League of Friends had also been involved. Local members had been notified in Edenbridge and would be informed in due course in Sevenoaks.

(5) A number of comments were made about the availability of workforce, demographic growth in West Kent and the provision of services in Edenbridge & Sevenoaks. Ms Arnold explained that it was hoped that the reorganisation of local care would help to fill staff vacancies. She acknowledged that population growth was a problem but noted the CCG was working collaboratively with Maidstone Borough Council's planning department who provided advanced warnings on planning developments and sought the CCG's input. She confirmed that that the plans for Edenbridge and Sevenoaks were distinct from each other; the development of a hub would be for a wider population for 100,000 and part of a wider local care proposals for West Kent.

(6) Mr Inett highlighted that Healthwatch Kent was keen to be involved with the public engagement work and stated that Ian Ayres and Bob Bowes had given their agreement for Healthwatch Kent to be involved.

(7) RESOLVED that the report on Local Care in West Kent be noted and NHS West Kent CCG be requested to update the Committee at the appropriate time.

64. Gluten Free Services in West Kent
(Item 8)

Gail Arnold (Chief Operating Officer, NHS West Kent CCG) and Priscilla Kankam (Lead Pharmacist, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Kankam began by explaining that NHS West Kent CCG was looking to stop the routine

prescribing of gluten free items as part of its review into cost effective prescribing. She noted that the CCG spent £130,000 on gluten free products for 300 patients a year in West Kent with coeliac disease. Patients with other conditions which required specialist diets such as diabetes and renal failure were not prescribed food items. She reported that when gluten free items on prescription were introduced, the availability of these items was low; now there were readily available in supermarkets and a loaf of gluten free bread cost £1.60 in Asda, Tesco & Waitrose. The cost to the NHS for a loaf of gluten free bread would be £4 - £10 which included the cost of the product, dispensing fee and delivery charge. She noted that there was a small group of patients who could only have a low protein food and those patients would be allowed to be prescribed low protein products as part of the proposals. She stated that the CCG had consulted its GPs and Governing Body and a public consultation would begin on 29 November to inform the public about the issue.

(2) Members enquired about the availability of gluten free prescriptions nationally and if there was an advisory committee which provided guidance about the prescription of gluten free items. Ms Arnold stated that it was technically down to each individual GP to prescribe. Ms Kankam advised that there were lots of other gluten free products available which did not require a prescription such as potato and rice. Ms Arnold reported that there was an advisory committee which looked at the clinical conditions for gluten intolerance but did not have a role in providing guidance or criteria about prescriptions. Mr Inett commented that this change would most impact those who received free prescriptions, due to being on benefits or a low income; a loaf of gluten free bread which cost £1.40, in comparison to a normal loaf which cost 40p, would be unaffordable.

(3) There was a discussion by Members about whether this constituted a substantial variation of service. The Scrutiny Research Officer advised the Committee that there was not a definition or criteria for substantial variation of service set out in the regulations and if the Committee did determine the proposal to be substantial, a period of formal consultation between the Committee and the CCG would start. If the CCG went ahead with the proposals but the Committee did not think that the proposals were in the best interests of the local people, the Committee could make a referral to the Secretary of State for Health. The Scrutiny Research Officer noted that there were separate duties on the NHS to consult with the Committee and the public and if the Committee did determine the proposals to be substantial, the decision to consult with the public was with the CCG and not for the HOSC to determine.

(4) RESOLVED that:

(a) the Committee deems the withdrawal of gluten free prescriptions by NHS West Kent CCG to be a substantial variation of service.

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

65. Kent and Medway Sustainability and Transformation Plan (Verbal Update) *(Item 9)*

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet 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. Mr Ridgwell began by acknowledging that the draft Kent and Medway Sustainability & Transformation Plan (STP) was published on 23 November which had not given Members long to consider the documents and it was proposed that the item return to the Committee for full consideration in January.

(2) A Member requested that Mr Ridgwell provide an overview of the key service changes set out in the document. Mr Ridgwell explained that the STP was a work in progress and there were no definitive proposals; the STP required a cross organisation approach to resolve the quality, inequality and financial challenges facing the NHS. The emerging four themes from the STP was care transformation by improving prevention, local care, hospital transformation and mental health; productivity through efficiencies in shared services, procurement and prescription; creating enablers for transformation by investing in workforce, digital infrastructure and estates; and system leadership. He reported that the extended Case for Change was due to be published in the New Year along with public and stakeholder engagement.

(3) Ms Carpenter explained that the work carried out previously by the East Kent Strategy Board was part of the STP. There would be a process to set out which areas of work would be achieved on a Kent & Medway wide level and which would be specific to geographic area. She noted that workforce was an area which needed to be considered on a Kent & Medway wide level; as part of the STP it was hoped that that in partnership with the local universities that a medical school could be developed. She stated that in East Kent high level modelling for local care was being developed and she anticipated that there would be a specific consultation in 2017 for East Kent with updates brought back to the Committee.

(4) The Committee then proceeded to ask a number of questions and make a number of comments. A Member enquired about the differences between the published draft STP submission and a summary presentation which had been circulated to the Committee. The Scrutiny Research Officer clarified that the summary presentation had been presented to the South East Regional HOSC Network on 18 November. Mr Ridgwell explained that the STP was a live document and the published draft STP submission was the document submitted to NHS England on 21 October; the summary document was a shortened version of the published draft STP submission which had been condensed for the purpose of the presentation resulting in minor differences between the two papers. Ms Carpenter reported that the STP Programme Board had made the decision to publish the draft STP submission as there was nothing in the document which could prevent it from being published.

(5) In relation to a specific question about the reduction of 300 beds in East Kent, Ms Carpenter explained that as part of developing models of local care, a review of acute services with the hospital trust had identified the potential reduction of 300 beds as part of the model which needed to be discussed and debated with stakeholders including the public and the Committee. Mr

Ridgwell stated that the figure of 300 beds had been included in order to be transparent; a range of different methodologies were used which had all identified that approximately 300 beds were being used by patients who no longer required acute care. A bed audit was being carried out to identify bed capacity across the whole of Kent and Medway.

(6) A number of comments were made about the inclusion of the 'as is' model in the published draft STP submission and the STP being a work in progress. Ms Carpenter explained that the STP would look and evaluate a range of options including some that are more viable than the others. She stated that the 'as if' model was not likely to come as viable option due to the challenges which will be set out in the Case for Change. Mr Ridgwell explained that there would be ongoing dialogue with the Committee as the STP progressed. He noted that the STP acknowledged those there were significant challenges including demographic growth and these would be detailed further as part of the published Case for Change.

(7) Members requested a briefing for all KCC Members, Borough and District Councils.

(8) RESOLVED that the Committee note the publication of the draft Kent and Medway Sustainability and Transformation Plan and request that an update to the Committee be presented in January to enable full consideration of the draft Plan.

66. Mental Health Rehabilitation Services in East Kent
(Item 11)

Ivan McConnell (Executive Director of Commercial Development and Transformation, KMPT) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Carpenter began by explaining that the proposed closure of Davidson Ward was a positive change which she felt had not been conveyed in the submitted paper. She stated that the Davidson ward was one of two wards located in the St Martin's building which was an old asylum building and the suitability of the building in providing appropriate care had been questioned by the CQC; it was not best practice for patients to be treated in its current setting. The ward was a ten bedded rehabilitation ward but only had five occupants and did not provide acute care. She noted that KMPT had increased the number of community rehabilitation beds through the provision of nine beds in supported housing. She reported that there was an opportunity to invest the £10 million in community rehabilitation services, which was currently spent in out of area placements for patients in East Kent, by repatriating them to the county; eight patients from Thanet have already been identified to return locally.

(2) Mr McConnell explained that Davidson Ward was not fit for purpose and had been heavily criticised by the CQC. It was not a suitable facility for patients to undertake rehabilitation as it did not have access facilities and the Trust was unable to recruit staff to the ward. He highlighted that the guidelines stated that community rehabilitation should take place in the local community with

intensive support. He noted that there were two types of rehabilitation: services provided in the community and intensive services for post-acute discharge which were provided in three units in East Kent which were highly acclaimed.

(3) A Member enquired about engagement with partners about supported housing and out of area placements. Mr McConnell stated that nine beds in supported housing had been created which would help to mitigate the closure of the 10 bedded Davidson Ward. He noted the importance of working with partners including borough and district councils with regards to social housing and undertook to work more collaboratively with them. Mr McConnell explained that seven patients from Thanet who received intensive rehabilitation out-of-area cost £951,208 a year in locations as far away as Manchester and Newcastle; if all out-of-area patients in East Kent were repatriated and they could be treated nearer to home and £10 million would be saved which would be used to invest in local rehabilitation services.

(4) A number of comments were made about staffing. Mr McConnell explained that rehabilitation services did not always need to be undertaken by social workers and mental health professionals; a whole range of alternative staffing could be used such as peer support workers to provide support in the community. He reported the need to look at alternative models of staffing and highlighted the work of some housing providers in London who were training apprentices to become support workers. Mr McConnell stated that traditional models of care over medicalised staffing; the Trust had introduced a therapeutic staffing model which had nursing cover supported by occupational therapists; art, drama and music therapists; and psychologists to assist with the patient's recovery. He noted that the Trust had successfully been able to recruit assistant psychologists, as there were a large number of people with psychology degrees in Kent & Medway, to support rehabilitation services.

(5) A Member requested if it would be possible for the Committee to visit some of the units. Mr McConnell stated that he would be happy to facilitate a visit, but requested that there was a maximum of three people for a visit to an inpatient ward as it was disruptive to the ward; he noted that he would welcome the Members' feedback. Mr Inett noted that Healthwatch Kent had undertaken a Enter & View visit and they found that it had been a positive experience for patients; the reports were available on Healthwatch Kent's website.

(6) Mr Inett enquired about engagement with service users and careers. Mr McConnell reported that all existing service users and those who provided rehabilitation support had been engaged in dialogue with the CCG and Trust.

(7) RESOLVED that:

(a) the Committee does not deem the redesign of mental health rehabilitation services in East Kent to be a substantial variation of service.

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

67. KMPT - Transformation of Mental Health Services
(Item 10)

Ivan McConnell (Executive Director of Commercial Development and Transformation, KMPT) was in attendance for this item.

(1) Mr McConnell began by explaining that the paper was an update and appraisal to the paper presented in October and it was proposed that the Trust would return to the Committee in January with more detailed feedback. He noted that the new Chief Executive, Helen Greatorex, had set the Trust a target of reducing out-of-area beds to fifteen by October and zero by December; he reported that, as of 25 November, there were only five people in psychiatric intensive care out-of-area beds. He stated that there were no young or older people in out of area beds and this was a position that the Trust needed to sustain. He noted that the Trust currently had a bed occupancy rate of 97% which higher than the recommended rate of 85% set by the CQC and Royal College. He noted that bed occupancy was an issue that the Trust needed to work with its commissioners; the repatriation of patients from out-of-area beds had created significant quality improvements and financial savings.

(2) Mr McConnell reported that that the Trust had been working with the Police & Crime Commissioner on Section 136 detention and there were now two funded street triage pilots in Medway and Thanet. He noted that the Trust was involved with an internationally acclaimed research project to support early intervention in psychosis and had received £2 million of funding to support this; the Trust was the only Trust in the country to be involved in this project. He explained that the Trust's Board had received feedback that the therapeutic staffing model was helping patients to get out of hospital and support recover quickly. He noted that he was leading a review of community mental health teams to reduce their high caseload to 35 cases; the Trust needed to work with partners to prevent the Trust being responsible for all aspects of mental health as it was only a designated secondary care provider.

(3) Mr McConnell noted that improvement of perinatal mental health was a priority; there was currently only one consultant and three specialist nurses covering the county. The Trust had recently been successfully in being awarded £2 million of NHS England funding to support perinatal mental health including post-partum and post-natal depression. He reported that perinatal services were an attractive area of work for staff and the Trust was able to recruit staff to these posts.

(4) Members made comments about services for young people and Section 136 detention. Mr McConnell stated that whilst services for children and young people were provided for Sussex Partnership NHS Foundation Trust, the Trust provide intervention psychosis services for young people aged 14 and over and it was important that those young people were captured early to avoid deterioration later.

(5) In response to a specific question about Section 136 detention, he noted that Section 136 detentions were challenging for both the Police and Trust. He reported that Kent & Medway had the highest levels of detention in the country but one of the lowest conversation rates of detention to admission. He stated that the Trust needed to support and train the police officers to recognise

mental distress; an example of this support was allowing police officers to shadow staff on an inpatient ward and a crisis team and take the learning back to their police teams. He noted that there was a single point of access where police officers were able to call a dedicated telephone number to speak to a nurse for advice and guidance which would be supported by the implementation of the street triage pilots. He highlighted that Kent Police had one of the only mental health custody liaison services which had been rated as outstanding. He noted that if the Police & Crime Bill became an Act, A&E would no longer be a designated place of safety which would put additional pressure on the Trust. He reported that Kent had a good relationship with the Police & Crime Commissioner who was committed to making a difference.

(6) RESOLVED that the report on the Transformation of Mental Health Services be noted and KMPT be requested to update the Committee at the appropriate time.

68. East Kent Integrated Urgent Care Service (Written Briefing)
(Item 12)

(1) The Committee considered an update about the implementation of the new East Kent integrated urgent care service contract provided by Nestor Primecare Limited.

(2) A Member raised concerns about the mobilisation of the 111 service and requested that the CCGs be invited to present an update in March. Mr Inett stated that service users had reported significant problems accessing out of hours GP appointments.

(3) RESOLVED that the report be noted and the East Kent CCGs be requested to provide an update, including performance data about the GP out-of-hours service and the mobilisation of 111 service, to the Committee in March.

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Item 4: Kent and Medway Sustainability and Transformation Plan

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 March 2017

Subject: Kent and Medway Sustainability and Transformation Plan

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided about the Kent and Medway Sustainability and Transformation Plan.

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

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1. Introduction

(a) Every health and care system in England is now required to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency (NHS England 2016).

(b) To deliver these plans, local health and care systems came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within each footprints have been working together to develop STPs with the aim of delivering genuine and sustainable transformation in patient experience and health outcomes. A Kent and Medway STP footprint was established covering all eight Kent and Medway CCGs over a footprint population of 1.8 million (NHS England 2016).

(c) On 3 June 2016, 2 September 2016 and 25 November 2016 the Committee considered an update on the Kent and Medway Sustainability and Transformation Plan. On 25 November 2016 the Committee considered the draft STP submission and agreed the following recommendation:

- *RESOLVED that the Committee note the publication of the draft Kent and Medway Sustainability and Transformation Plan and request that an update to the Committee be presented in January to enable full consideration of the draft Plan.*

(d) The Chairman, in consultation with the group representatives, agreed to a request to postpone the consideration of the item until the March meeting as it was anticipated that the Case for Change would be available. At the time of Agenda publication, the Kent and Medway Sustainability and Transformation Plan's Case for Change has not been published.

2. Recommendation

RECOMMENDED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee at the appropriate time.

Background Documents

NHS England (2016) *'Sustainability and Transformation Plans (01/05/2016)'*, https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

Kent County Council (2016) *'Health Overview and Scrutiny Committee (04/03/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6257&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6259&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (02/09/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=41836

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)', https://democracy.kent.gov.uk/mgAi.aspx?ID=42584*

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Introduction

1. This paper updates the Kent Health Overview and Scrutiny Committee on progress with the Kent and Medway Sustainability and Transformation Plan.
2. NHS organisations and upper tier local authorities have worked together, with stakeholders, to develop an outline Sustainability and Transformation Plan – which includes an ambition and vision for how health and wellbeing could be enhanced amongst the local population and health and social care services could be delivered more effectively in the future. We want to achieve both better outcomes and experience for people, and to use the available funding and our workforce in more efficient and effective ways. This outline plan was submitted to NHS England and NHS Improvement on the 21st October 2016. It was published on the 23rd November 2016 with a short public facing narrative. The submission was not a detailed set of proposals around how health and social care should develop in Kent and Medway, rather it outlined the ambition for the future and the strategic direction of travel.
3. This report provides an update on the work that is now being progressed across the NHS and local authorities in Kent and Medway to further develop the outline proposals contained in the October submission.

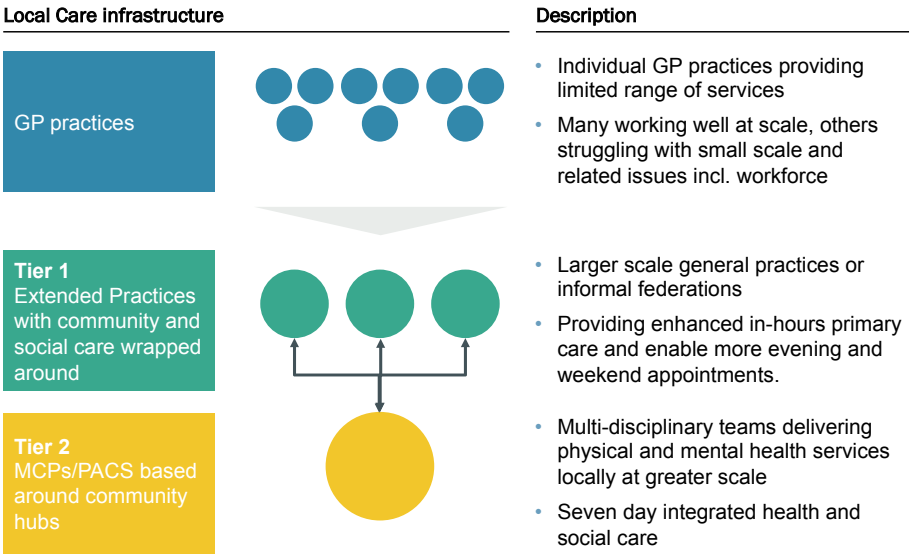
Case for Change

4. A key next step is the publication of our clinical case for change alongside a public-facing summary of this, which will provide a focus for discussions with the public and other stakeholders. This document outlines the rationale for why change is needed. Whilst there is much to be proud of about health and social care services in Kent & Medway there are several issues that we need to tackle; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care, through self-management, ill health prevention and earlier diagnosis. This case for change sets out our key challenges and is the basis for our ambition to make improvements across Kent and Medway and will make sure that we target our efforts and resources on meeting these challenges in the coming years.
5. The case for change highlights many challenges but we would like to highlight some of the key facts and figures:
    - 1,600 local people die early each year from causes considered amenable to healthcare, with people in deprived areas and those with severe mental illness more likely to be affected.
    - There are health inequalities across Kent & Medway with a difference in life expectancy of 22 years between the most deprived and least deprived areas.

- Only 2% of health and social care budgets are spent on public health care and lifestyle intervention services to reduce the risk of avoidable disease and disability. These budgets are expected to decline by 9% over the next 3 years (representing a decline of 3% per year).
- Over 1,000 (32%) people are in an acute hospital bed at any one time in Kent and Medway that do not need, and are not receiving, hospital based medical treatment and could be helped and cared for elsewhere if appropriate services were available to meet the health and care needs they do have.
- People find it difficult to access GP services and there are a low number of GPs in Kent & Medway; there would be 245 more full-time GPs if we had the same numbers as the national average - and there are 136 vacant GP posts across Kent & Medway.
- For stroke patients who require thrombolysis, no hospital in Kent & Medway delivers this specialist treatment within the national guideline recommended time of 60 minutes; in 2015/16, the worst performing trust thrombolysed just 16% of patients within 60 minutes.
- Local health and social care commissioners and providers are facing a £110m deficit in 2016/17 which will rise to £486m by 2020/21 as demand and costs rise more quickly than the available funding, if nothing changes.

Local Care

6. Local care is the term we are using for health and social care services delivered outside of a main hospital setting, close to or in people's homes, in their local communities. As the needs of our population change, and more people are living with complex and multiple chronic long-term conditions we need to adapt the way we deliver care to better suite their needs. Our aim is to keep people out of hospital, unless they really need to be there, by putting more focus on keeping people well and helping them to manage their conditions with more and better local care. Any consultation on acute hospital services will take place against a set of clear plans for how Local Care will be developed.
7. The intent remains, as outlined in the October STP submission, to develop Local Care by scaling up primary care in clusters and multi-speciality community providers (based on patients registered with a GP within a defined locality):



8. The above proposed new model of local care builds on both national and local good practice including the Encompass Vanguard in East Kent.

9. Work to better understand the challenges that health and social care face in Kent and Medway has highlighted the need to better support the elderly frail and the challenges associated with predicted increasing demand from this group of patients associated with changes in our population demographics. This has been a significant focus of the work within the Local Care workstream:

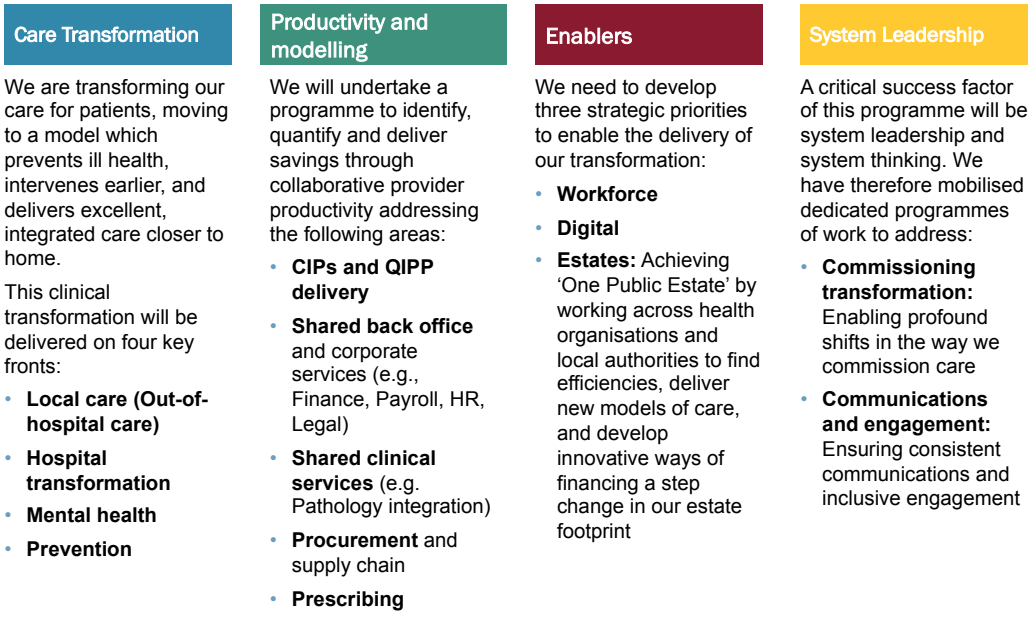
Key elements of the complex elderly care model

Supporting people to be healthy and independent	1 Care and support planning with care navigation and case management	Care navigators and case managers integrate health and social care service delivery, and work much more collaboratively with a wide range of community care colleagues in order to coordinate the care required for their patients
	2 Self-care and management	Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention and engagement
	3 Healthy living environment	Support the wider determinants of physical and mental health, wellbeing, and independence
Coordinated care for people who need it	4 Integrated health and social care into or coordinated close to the home	Patient centered, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to patients who have care plans assigned dependent on their needs
	5 Single point of access	A number called by the patient, the GP, community services and acute staff to support people with their care by gaining more efficient, coordinated access to services
	6 Rapid Response	The ability within an MDT to respond rapidly to complex patients who are experiencing a health or social care need that left unattended would result in a possible hospital admission
	7 Discharge planning and reablement	A pro-active, anticipatory service designed to target those patients who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating
Supporting services	8 Access to expert opinion and timely access to diagnostics	The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments

10. The Local Care work is now focused on the development of a CCG level toolkit that would support the development of the Kent and Medway core model in a bespoke way at a local level.

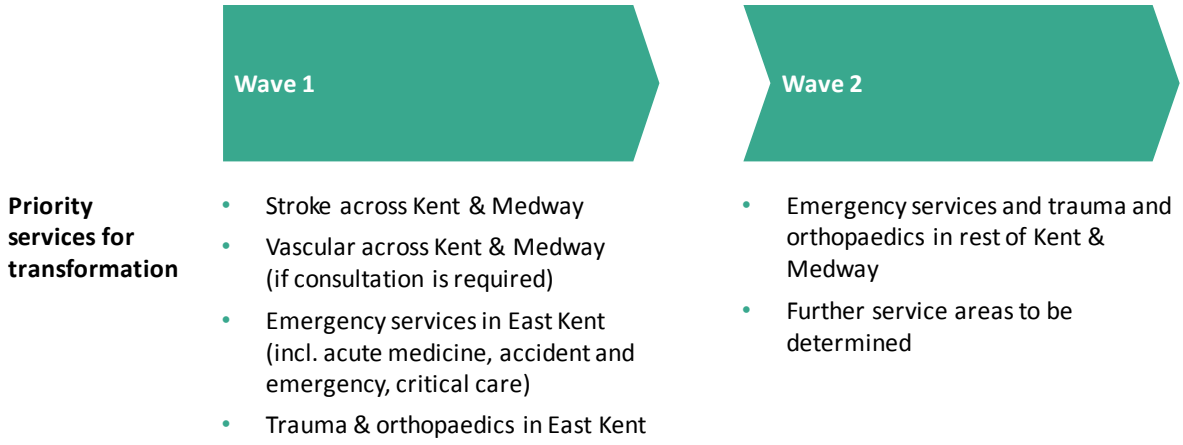
STP stocktake

11. The October STP submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:



12. Workstreams have now been established to take forward each of the above areas, comprising clinicians, leaders and practitioners from across Kent and Medway NHS and local authority organisations. They have been meeting since the autumn of 2016. The STP Programme Board took stock of the progress being made by these workstreams in its most recent February meeting. Different parts of the Kent and Medway area are at different stages in relation to their readiness and the stage of development of proposals to help make some necessary changes.

13. The STP stocktake concluded from an analysis of patient flows within Kent and Medway that there are negligible potential activity flows from East Kent to the rest of Kent and Medway. We therefore believe it is possible to consult on service change in East Kent alone, though the impact on future options in the rest of Kent and Medway will need to be considered. Therefore, two waves of public consultation are proposed but undertaken within a clear strategic framework for all of Kent and Medway:



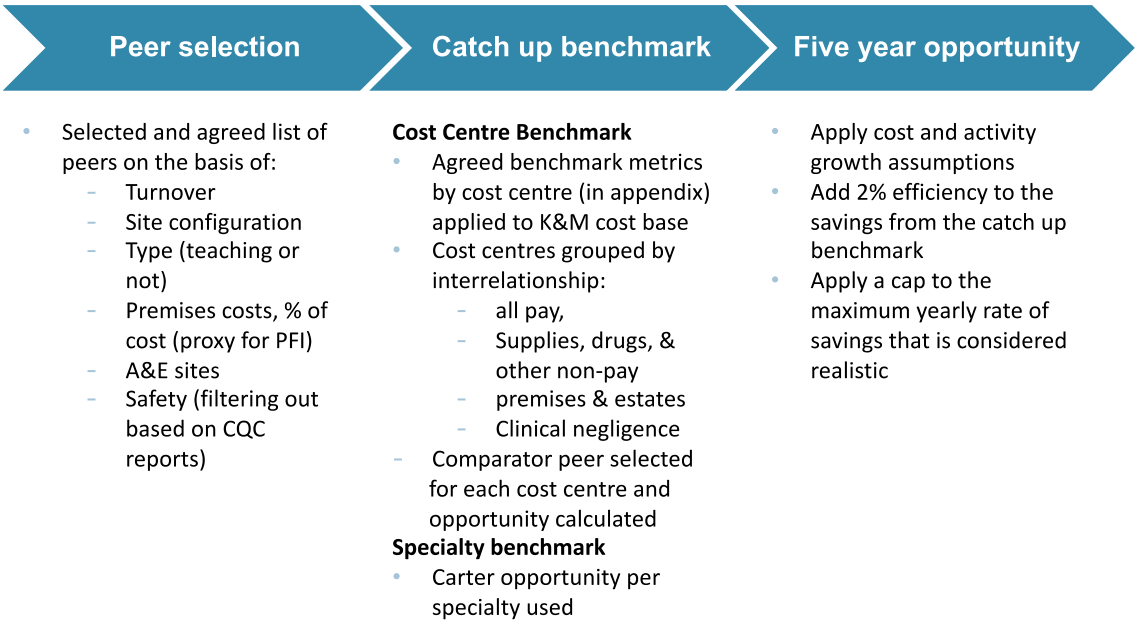
14. The critical path that sees consultation on wave 1 services taking place in the summer / autumn 2017 is being pursued by the STP Programme Board. Work to develop the strategic enablers (e.g. estates, workforce and digital) is also progressing against this timeline.

Productivity

15. Improving the efficiency of corporate services to drive efficiencies and costs savings is both a fundamental part of Lord Carter's work on unwarranted variation[1] but also a key part of the Kent and Medway STP's solution to the financial and operational challenges that face the NHS and social care services in this area in the coming years.

16. Building on the initial work in the STP, Kent and Medway has been identified as one of four national pathfinders that have been identified to explore innovative solutions to improving productivity and delivering corporate services in more efficient ways. The key focus of immediate work is the emerging approach to finance, procurement, payroll and transactional human resources. The work on productivity is initialling focusing on analysis against a number of key steps:

[1] *Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals*



17. Our ambition is to realise savings through the productivity work that can be used to help invest in the development of local care. This, along with new ways of organising and delivering local services with integrated multi-disciplinary teams of health and care professionals, will allow us to put the capacity in place to support and care for more people in their communities, and thus reduce some of the current dependence on acute hospital services. Together with some emerging proposed changes to the way we deliver our acute services in the future, this will help relieve some of the existing pressures and address some of the long-term challenges we face as described in our case for change.

Communications and Engagement

18. The communications and engagement workstream of the STP is progressing a range of key activities, including setting out a public-facing summary of the technical clinical case for change developed by doctors and social care practitioners across Kent and Medway; developing a single website that will hold information and updates about the programme and provide information for local people about how they can get involved in the development of the more detailed plans over the coming months; establishing a Patient and Public Advisory Group in partnership with Healthwatch Kent and Healthwatch Medway to bring the patient and public voice into the heart of the programme and its governance infrastructure; hosting a series of pre-consultation 'listening events' to discuss the challenges, progress already made in some areas of care and plans for the future with local people - to listen to their views and gather feedback to inform the workstreams as they develop their thinking.

Next steps

19. In summary, the next steps for the STP include:

    a. Further patient and public engagement, including launch of the public facing case for change

    b. Development of service models and identification of possible options for service configuration which will lead to the development of consultation proposals, including presentation of emerging proposals to the South East Coast Clinical Senate for review

    c. Presentation of proposals to NHS England (and NHS Improvement) seeking approval to proceed to consultation.

20. We continue to welcome the opportunity to discuss our plans and progress and consult on our more detailed proposals with HOSC members as they are developed over the coming months.

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By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 March 2017

Subject: Gluten Free Services in West Kent

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

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

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1. Introduction

(a) On 25 November 2016 the Committee considered proposals by NHS West Kent CCG to stop the routine prescription of gluten-free products for people with coeliac disease in West Kent. The Committee agreed the following recommendation:

- RESOLVED that:

  (a) the Committee deems the withdrawal of gluten free prescriptions by NHS West Kent CCG to be a substantial variation of service.

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

(b) The Chairman agreed to a request to postpone the item until the March meeting to enable the Committee to consider feedback from the public consultation.

2. Recommendation

RECOMMENDED that NHS West Kent CCG:

(a) take into account the views expressed by Committee Members when forming recommendations for the Governing Body;

(b) submit a report to the Committee when a final decision has been made by the Governing Body.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=42583

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NHS
West Kent
Clinical Commissioning Group

1.

CONSULTATION ON GLUTEN-FREE PRESCRIPTIONS

Adam Wickings

3rd March 2017

Patient focused, providing quality, improving outcomes

Introduction

1.1. For the past 30 years, the NHS has been prescribing gluten-free products to patients who have been diagnosed with coeliac disease. NHS West Kent CCG spends over £130,000 a year on these prescriptions. Prescriptions started when gluten-free foods were not as readily available as they are today and food and diets were not so widely understood and documented.

1.2. Even with much greater availability of gluten-free products in shops and online, NHS West Kent CCG has to date continued giving prescriptions for a limited number of standard gluten-free items per month for patients with coeliac disease. These standard products include: fresh and long-life bread, flour mix, plain savoury crackers, pasta and pure oats breakfast cereal. Depending on age, a patient can receive up to 18 items per month, with extra items allowed for breastfeeding women and women in the third trimester of pregnancy.

1.3. The NHS faces a very challenging financial situation. With a limited budget and an increasing demand for services, NHS West Kent CCG is evaluating every service it pays for and making decisions about the best value for all its patients. In that context it has proposed stopping prescriptions of gluten-free products. The CCG undertook a consultation to understand if West Kent residents agree with the proposals, if there are any groups who would be particularly impacted by the change and, if so, how that impact could be reduced.

2. Consultation

2.1. The CCG Governing Body launched consultation at its meeting of 29 November. A two month consultation was undertaken from 29 November 2016 to 29 January 2017. The consultation comprised a survey, a public meeting, attendance at two local Coeliac UK coffee mornings and stands at five public roadshows in shopping centres across the west Kent area. It was broadly promoted through a press release, which led to coverage on BBC Radio Kent, and emails to West Kent Health Network members, Healthwatch Kent, children's centres, care homes, children's clubs, community centres, councillors, education contacts, faith groups, churches, Gypsy and Traveller sites, leisure centres, libraries, MPs, opticians, parish councils, community pharmacies and patient participant group (PPG) chairs. A poster promoting the consultation was sent to local government gateways, GP practices and hospital waiting rooms.

2.2. During the consultation process, NHS West Kent CCG received 505 responses through the online or paper survey. Another 41 people were engaged with at a

public meeting and local Coeliac UK coffee mornings. Three letters and emails were received from the public and three from organisations.

The consultation document outlined the proposed changes and the rationale for the change. It asked a series of questions about the level of support for the proposal and if any exemptions should be made if the proposal is accepted by Went Kent CCG. It also explored whether those respondents with coeliac disease or caring for those with coeliac disease would have problems affording and accessing gluten-free products if prescriptions were to cease.

2.3. Of the 505 people who responded to the survey, 43 per cent had coeliac disease, eight per cent were the parent or carer for a child with coeliac disease, two per cent the parent or carer for an adult with coeliac disease and six per cent were responding on behalf of someone with coeliac disease. Forty one per cent neither had coeliac disease nor were carers for someone with the condition. Overall, the survey was answered by more people with/caring for someone with coeliac disease than people without.

2.4. Overall, 55 per cent agreed at least in part with the CCG's proposal to stop the routine provision of gluten-free products on prescription: 29 per cent of respondents agreed routine prescriptions should be stopped completely; 26 per cent thought there should be some exemptions if the proposal is accepted by the CCG. Just under half of respondents (46 per cent) did not agree with the proposal.

3. **Next Steps**

3.1. The CCG has now received a detailed report on the feedback from consultation. The CCG is now seeking the views of the Health Overview and Scrutiny Committee. The CCG will then form recommendations that take all views and consultation feedback into account and it is expected that a decision on next steps will be made at the Governing Body meeting in March.

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By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 March 2017

Subject: NHS West Kent CCG: Financial Recovery Programme

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

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

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1. Introduction

(a) NHS West Kent CCG has been requested to provide an update regarding its Financial Recovery Programme as a result of its Governing Body agreeing the following proposals on 20 December 2016:

1. A review of compliance with referral and treatment criterial, particularly in relation to the independent and private sector;
2. The cessation of male and female sterilisation, accepting that there would be clinical exceptions that would be considered under the CCG's IFR policy;
3. The reduction in the number and value of non-urgent planned care surgery until April 2017.

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

2. Recommendation

RECOMMENDED that the Committee:

(a) expresses disappointment about the lack of prior notice and consultation by the CCG with the Committee about these proposals;

(b) is notified, in good time, as any further proposals are developed by the CCG

Background Documents

None

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NHS
West Kent
Clinical Commissioning Group

1.

CCG Financial Recovery Plans

Adam Wickings

3rd March 2017

Patient focused, providing quality, improving outcomes

Introduction

1.1. The CCG financial plan agreed with NHS England in 2016/17 was to achieve a surplus position of 1 per cent (£5.6m), which was in accordance with the national financial framework for all CCGs. Annual budgets were established on this basis.

1.2. During the financial year, certain elements of the CCG budget have performed in excess of these agreed plans – specifically in Acute Hospital Care, and Continuing Care. The reasons for these adverse variances are multi-factorial, as follows:

1.2 a) **Acute hospital care** – activity and spend levels has been significantly in excess of planned levels, both in the NHS sector and with Independent Sector providers. Within the NHS, and specifically Maidstone & Tunbridge Wells NHS Trust, it has been a combination of high levels of urgent care activity throughout the year and aspects of planned care activity – especially outpatient appointments. Within the Independent Sector, planned care activity and cost has significantly exceeded plans.

1.2 b) **Continuing Care** – the principal reason for over spend in this area has been driven by a national directive to increase the rate payable to care homes (Funded Nursing Care). This was advised to all CCGs in the early part of 2016/17, but was not anticipated during budget setting. The cost of this directive to NHS West Kent CCG was approximately £2.5m.

1.3. It is in this context that the CCG has considered the means by which these excess costs may be managed in order to comply with the financial control total that has been agreed with NHS England. The attached Governing Body **Financial Recovery Plan** paper was considered by the CCG Governing Body in December 2016.

1.4. It is essential that the CCG does all it can to achieve the surplus in 2016/17 in order to avoid a resultant cost pressure next year as well as the additional scrutiny and reputational risk that accompanies failure to achieve planned surplus levels. The actions being taken by the CCG should be seen as preventative and geared toward the avoidance of even more significant impacts for service that might otherwise be necessary during the coming year.

2. Recovery Plan

2.1. In December 2016, the Governing Body was invited to consider additional measures that may be taken, some for immediate implementation, and some for further consideration and possible implementation in 2017/18, when the financial challenge for the NHS generally and NHS West Kent CCG will be similarly challenging.

2.2. The actions to be taken during the final quarter of 2016/17 were intended to bring excess and unplanned activity and financial performance back toward the initial plans for the CCG and to do so in a manner that ensures that patients whose need for treatment is most essential (for example, those on a cancer pathway, or who are otherwise designated as urgent by a clinician) continue to receive timely treatment. The Governing Body supported these recommendations in full.

2.3. Three measures were agreed for immediate implementation so as to address the 2016-17 financial position and these have all been implemented. All the other measures raised in the Governing Body paper are under active consideration and could only be implemented following further work and consideration of engagement or consultation.

Immediate Implementation	2016/17 PYE £000
a) Compliance with criteria	375
b) Reduction in non-urgent surgery	3,200
c) Male and Female sterilisation	30
Grand total	3,605

2.4. The CCG does not assess these three changes as service changes appropriate for consultation. The number of patients affected by the change of approach on sterilisation is relatively small and access to these services is still possible through the CCG's **Individual Funding Requests** Panel route. The approach to delaying some patients' treatments is not a service change. It means that some patients whose need is less urgent may have to wait a little longer for treatment while more urgent cases are dealt with. The approach to compliance with criteria is only an exercise in holding providers to account to work within agreed policies and contracts.

2.5. The number of patients affected by these measures is difficult to assess. Item a), compliance with criteria, will not affect patients but only affect payments to providers and item c), sterilisation, relates to around 300 patients per year. The number of patients whose treatment will have been delayed through item b) has been much affected by the A&E pressures at MTW which have led to elective surgery cancellations. In the middle of February we would estimate that at the end of March (when this initiative ends) the number of patients whose treatment may have been delayed by some days or weeks will be between 1,500 and 1,800.

3. Current Situation

3.1. As at the end of January, and based upon presumed successful implementation of the Governing Body decisions, the planned financial target is still achievable, although there are a large number of variables that will finally affect the eventual position.

4. **Next Steps**

4.1. The financial framework for the CCG during the next two years, 2017-19, are expected to be more challenging. The overall growth uplift for the NHS is lower than previous years, and the needs and expectation of the service are expected to grow. Therefore the local NHS needs to continue to examine ways in which the finite resource available can be deployed in a manner that delivers the best possible value for the taxpayer. This is the context for the wider strategic discussion across Kent & Medway (STP – Strategic Transformation Plan).

4.2. The CCG is assessing any savings opportunities in the areas outlined in the December Governing Body paper and specific proposals are under development. Any substantive proposals will be the subject of appropriate engagement and any substantive service change proposals will be considered only in the context of appropriate consultation.

NHS
West Kent
Clinical Commissioning Group

Financial Recovery Plan

This paper is for:	**Decision**
Recommendation:	The Governing body is invited to review the proposals and to confirm their support.
For further information or for any enquiries relating to this report please contact: Adam Wickings, Chief Operating officer Reg Middleton, Chief Finance Officer	

	Date: 20th December 2016
Reporting Officer: Reg Middleton	Agenda Item: 239/16
Lead Director: Reg Middleton	Version: 1

Report Summary:

The CCG Integrated Performance Report has signaled areas of the CCG commissioned services where activity and cost have exceeded planned levels. The key areas are in acute services (MTW, London and Independent Sector providers) and mental health placements. The CCG's contingency for the entire year has been consumed, and if the CCG is to achieve its planned financial position, it will be necessary to identify and secure additional cost reductions in the remainder of the year.

This paper describes a number of recommendations to secure additional cost reductions in the remainder of the year. The Governing body is invited to review the proposals and to confirm their support.

FOI status: This paper is disclosable under the FOI Act

Strategic objectives links:	Strategic Goal E: Deliver sustainable finances Strategic Goal F: Ensure robust governance Strategic Goal G: Organisational competence
Board Assurance Framework links:	Strategic Risk E: Loss of control over provider activity and system finances could result in the CCG being unable to invest in service development and ultimately breaching its statutory duties.

	Strategic Risk F: Loss of control of corporate governance could result in the CCG acting ultra-vires and becoming subject to regulatory or legal action, with resultant harm to the CCG's reputation, influence and capability, as well as possible financial harm Strategic Risk G: The CCG's failure to deliver the requirements of NHS England (including the quarterly CCG Assurance Framework and the terms of the CCG's Authorisation) could result in the CCG losing its freedom to operate independently (or ultimately being de-authorised).
Identified risks & risk management actions:	Failure for the CCG to achieve its planned financial position.
Resource implications:	As outlined in the paper
Legal implications	N/A
Equality and diversity assessment	Has an equality analysis been undertaken? ☐Yes ☒No – equality analyses will be undertaken once the proposals have been agreed.
Report history:	Second report to Governing Body on the Financial Recovery Plan.
Appendices	None
Next steps:	Subject to Governing Body support, many of the schemes will require significant work up by commissioners before implementation, including engagement with patients and local clinicians, and will have to be pursued with a high degree of clinical leadership.

Financial recovery plan – further measures
December 2016

1. Introduction

Achievement of the planned financial position of the CCG remains a very difficult challenge, with a considerable risk that it does not secure the position agreed with NHS England[1]. This could have consequences for the CCG in the following ways:

1. Potential intervention from NHS England
2. Financial outlook in 2017/18 and beyond will become yet more challenging
3. Potential that access to Quality premium in 2016/17 (payable 2017/18) is denied
4. Reputational risk

At the Governing Body in September, a package of measures was approved that were designed to reduce cost, improve health outcomes and help support an improvement in urgent care waiting times in West Kent.

Progress has been made in implementing these measures, but it was recognised at the time that the cost reduction impact of these measures was unlikely to be sufficient, and that there was a level of inherent risk associated with the schemes agreed by the Governing Body. The financial impact is expected to be seen in the final quarter of 2016/17.

Since the September Governing Body, progress has been made with the identification of other cost reductions to support the CCG position, although many of these are of a non-recurrent nature. In addition, there has continued to be a steady and ultimately significant rise in costs in some sectors – notably the Acute sector (£412k - primarily Independent Sector and Tertiary providers); Mental Health (£226k); and continuing care (£177k) which has negated the financial benefit of the cost reductions that have been realised to date. The net result is that the CCG still needs to identify further cost reductions if it is to remain on track to achieve its planned financial position.

Based upon the level of financial pressure and risk faced by the CCG, it is assessed that the CCG needs to secure an additional £4m of cost reductions before the end of the year.

The following proposals provide a range of measures that have the potential to secure the necessary cost reductions for the CCG and should be seen as a clear escalation of the steps that the CCG need to undertake in order to control its finances. They include a combination of some measures that are short term in nature and extend to the close of this financial year and others that may be applied on a sustained basis. The financial outlook for the NHS is such that the CCG will need to continue to assess the basis upon which it can offer the fullest range of access to services in order that resources can be directed to those interventions that represent the greatest possible value in terms of health outcomes.

The following table summarises the proposals outlined below. They are estimated to have the potential to achieve £3.6m during the remainder of 2016/17, assuming all are supported by the Governing Body. Some of the proposals require further work to be undertaken with an appropriate

[1] The NHS England requirement is not just for financial balance but for achievement of a surplus.

level of clinical leadership and to be supported by patient engagement and equality impact assessment work. These measures have the potential to contribute to financial sustainability in West Kent in 2017/18 but are unlikely to impact in 2016/17 to a significant degree.

	2016/17 PYE £000	2017/18 £000
Immediate implementation		
Compliance with criteria	375	375
Reduction in non-urgent surgery	3,200	0
Male and Female sterilisation	30	120
Grand total	3,605	495

2. Actions to be implemented in 2016/17

The following actions are proposed with immediate effect

Compliance with Referral and Treatment Criteria

Rationale for change

The CCG has in a place a range of criteria that are agreed across Kent and Medway and are designed to avoid expenditure on treatments that are deemed to be of limited clinical value or to be more expensive than other available options of equivalent clinical efficacy.

The scope of these service restrictions include:

- Complementary and alternative therapies
- Cosmetic Surgery
- Non health essential treatments
- Procedures of limited clinical value

The CCG has previously undertaken audits to test compliance with these criteria at Maidstone & Tunbridge Wells NHS Trust. However, many of the criteria apply to the kind of activity undertaken by private sector providers under Any Qualified Provider (AQP) contracts, and it is intended that the CCG conducts an audit of retrospective compliance with the criteria at Independent Sector providers. In the event of non-compliance with the RATC, the CCG would apply deductions from contract performance in 2016/17.

In addition it is proposed, to undertake a prospective exercise into compliance with the RATC criteria by conducting an audit of waiting lists wherever evidence suggests there may be non-compliance. Again, the CCG will advise providers that any instance of non-compliance will not result in providers being reimbursed for activity undertaken.

Impact

It is difficult to assess the potential financial impact of such an exercise ahead of undertaking the audits. As an indication, the value of activity undertaken by Independent Sector providers on activity where RATC criteria apply is estimated at just over £5m in a full year. Assuming a fairly high ratio of compliance/non-compliance of 90%/10%, a nominal sum of £500,000 has been identified in 2016/17 (to avoid double counting, assume £375,000). Dependent upon the findings and the impact of

resulting contractual penalties, it is possible that the impact in 2017/18 may be larger, but for the purpose of this report, this is not assumed to be the case.

Male and female sterilisation

The CCG is proposing to stop all male and female sterilisation (and reversals). For males this comprises of both conventional and no-scalpel vasectomy and for females this relates to blocking or sealing of fallopian tubes.

Rationale for change

The vasectomy and female sterilisation services are considered to be one of many forms of contraception and are deemed to have no or limited clinical value. Other forms of contraception are available which are recognised as being more appropriate.

Impact

As there are numerous methods of contraception available locally (both free and paid for) and with the clinical rationale deeming sterilisation to have no or limited clinical value the CCG believes this to be an appropriate restriction that would have minimal impact on both male and female patients.

The financial impact of this proposal will be limited in 2016/17, but with a larger impact in a full financial year (£30,000).

Suspension of non-urgent surgery until April 2017

Proposal

It is not intended to suspend non-urgent GP referrals, but member practices will be asked to be especially vigilant in their referral practice and take full advantage of available pathways to help reduce pressure on acute services in the winter period, reduce the level of clinical variation between member practices and practitioners, and to reduce costs for the CCG. It is also proposed to have further supportive discussions with practices that have particularly atypical referral practice where opportunities for reduced consequent expenditure could be explored.

It is proposed that secondary care providers should be asked to reduce non-urgent elective care until the end of the financial year. This will inevitably mean delays in treatment for some patients.

Within our contractual arrangement with MTW, the Trust is able to seek authorisation from the CCG to sub-contract planned care work to third parties. The Trust currently outsources a significant level of activity to the independent sector. As part of the general approach to drive down planned care activity and cost in the remainder of the year, it is proposed that the CCG should not authorise the Trust to sub-contract this work, which will mean that supply side considerations will serve to slow down activity levels. We propose in this context to undertake detailed work with the Trust on prioritisation so as to ensure that patients with long waits or urgent clinical need should not be affected.

Rationale for change

Without further action, the CCG is likely to incur more costs on planned care than it set out in its plans for the year. The approach outlined above is designed to reduce costs back toward budgeted levels but still allows for patients who have an urgent need for surgery to receive their treatment. It recognises that restricting planned care in this way does take a degree of pressure off MTW who are

experiencing considerable difficulty in terms of managing urgent care activities at present, and this is expected to continue throughout the period of January–March.

With respect to MTW, reducing the level of outsourcing in the final quarter of the financial year would result in a lower cost to the CCG of some £2.1m.

Activity and cost at all of the Independent Sector providers are running in excess of plan. If activity and cost can be brought back to planned levels over the whole year, this would have the effect of improving the CCG forecast position by some £1.1m.

Impact

These measures will result in some patients waiting longer than expected, but will not affect those who have an urgent need for treatment. It is projected that these measures could be introduced without detrimentally affecting the CCG's RTT performance, but this will be continuously monitored. The impact of this will be assessed by commissioners in collaboration with our principal provider - MTW.

3. Proposals that will require further work and clinical leadership

Further detailed analysis is now commencing as well as liaison with other CCGs that have introduced similar measures. The endorsement in principle is sought from the Governing Body so that plans might be worked up and engagement commenced with stakeholders.

Cataract criteria

Proposal

Restrict access to cataract surgery for people with mild vision difficulties.

Rationale for change

All requests for the surgical removal of cataract(s) will only be supported by the CCG where the patient's best corrected visual acuity, as assessed by high contrast testing (Snellen) is;

- Binocular visual acuity of 6/9 or worse for drivers;
- Or binocular visual acuity of 6/12 or worse for non-drivers;
- Or monocular visual acuity of 6/18 or worse irrespective of the visual acuity of the other eye;
- Or the patient's expressed wish or requirement is to continue driving but the patient does not meet the Driving and Licensing Authority (DVLA) minimum sight requirements;

Or there is a significant impact on the patient's quality of life. For example patients with cataract can experience other serious symptoms such as double vision or disabling glare from lights even though visual acuity is relatively unaffected.

The following categories of patient or ophthalmic conditions are exempt from application of the access criteria and may be referred for possible cataract surgery;

- Patients with anisometropia presenting with suspect cataract(s).

- Patients with diabetes in whom the removal of cataract is considered necessary to facilitate effective digital retinopathy
- Patients of 18 years of age or less at the date of referral;

Impact

It is expected that the majority of suspect cataract(s) will be detected initially following sight testing or eye examination, under either NHS or private contract, undertaken by a community optometrist.

Some patients with suspect cataract (s) may present initially direct to their GP. In such cases, the GP should require that their patient is referred for a sight test or eye examination, including the measurement of visual acuity, to be undertaken by a community optometrist.

Criteria for surgery

Proposal

In September the Governing Body agreed to the development of a new pathway for hip and knee replacements, which offer patients access to counselling on lifestyle choices, for example smoking and fitness.

CCG to agree the principle of extending this approach to a wider range of surgical procedures.

Rationale for change

There is clinical evidence that smokers and obese patients have a poorer outcome and/or increased risk during surgery.

For this reason, the CCG has implemented a new pathway for hip and knee replacements, which supports the direction of patients towards lifestyle services where this is appropriate. This proposal takes this a stage further, and extends the concept to other treatments, which might result in more patients not undergoing surgery, or delaying surgery.

The proposal is to introduce this as a short term financial remedy for the remainder of 2016/17, and to undertake a review thereafter.

Impact

For some patients this proposal introduces a delay in having routine surgery while they quit smoking and/or lose weight. The consequence of this is that the surgical risks to the patient are reduced resulting in a better outcome for the patient.

In-Vitro Fertilisation (IVF) and Assisted Conception (excluding those in existing treatment)

Proposal

CCG will fund 1 full cycle of IVF with or without ICSI. The full IVF cycle will consist of one fresh and one frozen embryo/ blastocyst transfer. These fertility treatments (also known as assisted conception) are for local patients, namely Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)

Policy is intended to reflect the current evidence base described by NICE.

Criteria:

- CCG will not fund IVF treatment when the woman has had three or more previous IVF cycles, whether these have been funded privately or by the NHS
- Referral for IVF is offered to women aged up to and including 41 years old. Women should be referred so that they can commence a treatment cycle before their 42nd birthday.
- Referring clinicians should be aware of the work up time required by the providing trusts, and ensure that referrals for older women are made in time for them to commence a treatment cycle before their 42nd birthday.
- The woman must have a body mass index (BMI) of between 19 and 30 at the time commencement of treatment.
- Patients must be non-smokers in order to access any fertility treatment and continue to be non-smokers throughout treatment

Rationale for change

The CCG feel that this decision supports transparency and equity of approach to the population and reduces the perception that for some people we are funding whilst for others not supporting funding at all.

Impact

The CCG also considers that withdrawing support for funding for those in the system is unfair without notification of this change in decision or approach.

Over the counter medicines

The CCG is proposing to issue guidelines and support to GPs prescribing over the counter / minor ailment medicines for conditions other than those where the clinical need can only be met by a prescription.

The CCG has embarked upon a process of pre-engagement to test patient and public views of this issue. The proposal is to issue guidelines to support the reduction in prescriptions and spend in all areas of primary care.

Rationale for change

These changes apply only to situations and minor conditions where NHS Choices recommends selfcare. For some conditions this will be related to the severity of the condition (e.g. mild acne is included but severe acne requires prescription only medicines) and/or to the duration of the condition (for example, a cough that has persisted for more than three weeks requires a GP appointment

Over the counter medicines refers to the types of medicines that can be bought over the counter either from a community pharmacy or, in many cases, a general retailer like a supermarket. Some of these medicines can only be sold under the supervision of a pharmacist, others are deemed safe

enough to be widely available from general retailers. Examples of some of the medicines included are:

- Painkillers
- Cough and cold remedies
- Antihistamines and other treatments for hay fever
- Antacids for heartburn and indigestion
- Diarrhoea – adults and older children
- Constipation
- Haemorrhoids
- Creams for vaginal and vulval infections or thrush
- Nicotine Replacement Therapy for smoking cessation
- Malaria prevention
- Threadworm
- Creams for fungal infections such as athlete's foot

Impact

The CCG will still prescribe any medicines that are available by prescription only, such as antibiotics, statins, blood pressure treatments etc. Where a treatment is needed which can only be prescribed, then the patient's regular doctor will still be able to prescribe this.

Pain treatments

To stop offering hip injections and spinal cord stimulation. Spinal cord stimulation is an NHS England commissioned service that will no longer be funded by the CCG. Where patients meet the criteria specified by NHS England, they will still be eligible for spinal cord stimulation at the designated centres.

Rationale for change

The CCG's approach to the current financial challenges is to prioritise the limited funding it has so that the local population has access to the healthcare that is most needed. This assessment of need is made across the whole population of the CCG and, wherever possible, on the basis of best evidence on what is clinically proven to work.

As a result of this, the CCG has identified procedures that are either limited clinical value or that do not cater for the wider needs of the population and therefore it has been proposed to implement these changes in order for the local health economy and services to be sustainable.

Impact

The proposed changes would mean that these forms of pain relief would no longer be funded by the CCG however there will still be numerous alternative pain relief methods available that are funded and can prescribed.

Lucentis/Avastin

Proposal

To commence all new patients entering the Wet AMD pathway with (Bevacizmub) Avastin. This drug, although not licensed as first line treatment for this condition, is widely used within the private sector and across Europe and America.

Rationale for change

There have been a number of head to head studies comparing Avastin and Ranibizumab (Lucentis) for wet AMD, including the well documented CATT and IVAN trials. The results of these studies demonstrated that there was no significant difference in outcome of visual acuity from either drug. The studies further proved that despite the lack of a licence Avastin is a safe and effective drug for the treatment of wet AMD.

Impact

Circa 230 new patients join the AMD pathway each year. The change outlined above would bring an efficiency saving of £773,000 based on the current cost of Avastin against Lucentis.