HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 24th November, 2017

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 24th November, 2017, at 10.00 am	Ask for:	**Lizzy Adam**
Council Chamber, Sessions House, County Hall, Maidstone	Telephone:	**03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (12):	Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas and Mr M Whiting
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor L Hills, Councillor J Howes, Councillor M Lyons, and Councillor T Searles

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.	EKHUFT Operational Issues (Pages 19 - 26)	10:05
5.	Kent and Medway Sustainability and Transformation Partnership (Pages 27 - 52)	10:45
6.	East Kent Out of Hours GP Services and NHS 111 (Pages 53 - 58)	11:15
7.	NHS preparations for winter in Kent 2017/18 (Pages 59 - 64)	11:45
	BREAK (12:30 - 13:30)	
8.	West Kent CCG: Over The Counter (OTC) Medicines (Pages 65 - 130)	13:30
9.	Assistive Reproductive Technologies (ART) Policy Review (Pages 131 - 140)	14:15
10.	Healthwatch Kent: Annual Report (Pages 141 - 180)	15:00
11.	Date of next programmed meeting – Friday 26 January 2018	

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

16 November 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 Wednesday, 20 September 2017.

PRESENT: Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Mr M Whiting, Cllr L Hills and Cllr T Searles

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

UNRESTRICTED ITEMS

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

(1) Mr Pugh declared an Other Significant Interest as a non-voting member of NHS Swale CCG's Primary Care Committee.

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

(3) Mrs Game declared an interest as the Chair of the QEQM Hospital Cabinet Advisory Group at Thanet District Council.

12. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 14 July 2017 are correctly recorded and that they be signed by the Chairman.

13. Children and Young People's Emotional Wellbeing and Mental Health Service and All Age Eating Disorder Service
(Item 4)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance.

(1) The Chair welcomed the guests to the Committee. Mr Ayres began by stating that the joint reprocurement of the Children and Young People's Emotional Wellbeing and Mental Health Service between the NHS and Kent County Council had been a positive step forward and could be used as a model for future commissioning. The NHS and KCC had worked with young people, parents and carers to develop a single strategy and service model which had

been used to procure the new service; historically KCC and the NHS had commissioned services separately and there had been overlap.

(2) Mr Ayres explained that the new contract for Children and Young People's Mental Health Services commenced on 1 September 2017 with services being delivered by North East London NHS Foundation Trust (NELFT); the primary school public health service element of the contract was being delivered by Kent Community NHS Foundation Trust. He stated that a key aspect of the contract was the commissioning of a single point of access to provide advice, guidance and access to all services under the strategy. He reported that the contract mobilisation had gone well; there had been few complaints and hidden waiting lists, which had been discovered during mobilisation phase, were being dealt with.

(3) A Member thanked Mr Ayres and the stakeholders for all their efforts in procuring the new service and requested an update in six months to provide assurance that the new service was working well. Members asked about capacity, waiting lists, the number of providers who bid for the contract and the use of subcontractors. Mr Ayres stated that the new contract should have sufficient capacity to meet the demand and he would be able to provide an update in six months about how the contract was performing. He reported that the new provider was working rapidly with the previous provider to clear the waiting lists. Mr Ayres noted that there were a limited number of providers who were capable of delivering a Kent wide service and had not been expecting a large number of providers to bid for the contract. The new provider had a track record of delivering high quality and innovative services. Mr Ayres stated that a provider would need permission from the CCG to use a subcontractor and would only be granted after a due diligence process had been undertaken.

(4) With regards to the new all age eating disorder service in Kent and Medway, Mr Ayres reported that the service was also being delivered by NELFT which provided opportunities to integrate services. A Member enquired if both services would be procured together in the future. Mr Ayres explained that the services had been historically been procured separately but if services were integrated and timelines aligned, it may be possible for an integrated service with a broader specification and scope to be reprocured in the future which the Committee would be kept informed about.

(5) In response to specific questions about access to specialist services, Mr Ayres noted that as part of the new service model, services should be delivered as locally as possible but recognised that some treatments were so specialist they may require travel to access them. Mr Ayres committed to providing the Committee with the number of children and young people currently in an out-of-county placement and their distance from home; in addition to the number of all-age patients accessing eating disorder services in a residential unit.

(6) Members commented about staff training, the single point of access and the provider's financial position. Mr Ayres explained that the contract required the provider to train staff and he was confident that the provider would do this; staff training would be monitored through contract management. Mr Ayres confirmed that the single point of access would be based in Kent and there were no concerns about the provider's financial position.

(7) RESOLVED that the reports on Children & Young People's Emotional Wellbeing & Mental Health Service and All Age Eating Disorder Service be noted and the CCG be invited to provide an update in six months.

14. Patient Transport Service
(Item 5)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance.

(1) Mr Ayres began by explaining that there had been problems with the previous provider and the patient transport services contract was reprocured at the earliest possible stage. He noted that patient transport services were mostly provided by commercial organisations and there were few providers of significant scale. He stated that G4S was awarded the new contract and mobilised last year; it was a quality driven procurement and G4S had the highest quality scores.

(2) Mr Ayres stated that the three elements of the contract were mobilised on 1 July 2016: Kent and Medway patient transport excluding the transport of renal patients and transport to and from Dartford and Gravesham Hospital Trust; renal patient transport; and Kent and Medway patient transport to and from DGH sites. Transport into London was not mobilised until February 2017 until a due diligence process with London trusts was carried out. He explained that the mobilisation of the renal service had some initial problems but had stabilised and was operating well; both renal transport and transport to and from Dartford and Gravesham Hospital Trust had moved into business as usual mode.

(3) Mr Ayres reported that the remaining part of the contract was being disrupted by the journeys to and from central London. Journeys to and from London represented 1 – 2 % of all journeys and were being taken out of the contract due to the small volume of journeys with the exception of journeys to and from Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. The CCG had sought independent advice to review activity to ensure that there were sufficient vehicles and staff to deliver the contract. The CCG had issued a performance notice to G4S regarding its complaints process; G4S had made significant progress and it was anticipated that the notice would be removed within a month.

(4) Mr Ayres reported that mobilisation would be completed within three – six months. He stated that it was disappointing that the mobilisation had not been quicker but noted that it had been better than the previous provider. He recognised that there had been significant failures and confirmed that a detailed analysis would be undertaken to review and understand the mobilisation.

(5) The Chair enquired about the provision of qualitative and quantitative performance data including details of the patient experience which the Committee had previously requested. Mr Ayres confirmed that this could be

shared with the Committee once the detailed analysis of data had been completed.

(6) A Member stated that delayed journeys had significantly impacted patients and their families and reported difficulties in them being able to contact G4S. Mr Ayres acknowledged that some patients had been let down very badly and he had a weekly phone call with the G4S Managing Director for Patient Transport Services to review performance. He stated G4S were required to have an onsite presence at every hospital and where the onsite presence worked well, there were fewer complaints; he reported that the onsite presence required improvement at two sites. The CCG was reviewing complaints categorised as unknown as part of it performance notice. He noted that there had been initial complaints about eligibility criteria; G4S had worked with the CCG and hospital trusts to develop a clear schedule which set out eligibility and as a result the number of complaints had been reduced. He stated that he was pleased that G4S was working collaboratively to resolve issues as they occurred.

(7) A Member expressed concerns about the performance of the current provider and its similarities with the performance of the previous provider. Mr Ayres stated that whilst he understood the concerns, he only recognised those in terms of the London activity. He explained that a key learning point from the previous contract was that inaccurate data led to difficulties with the procurement. He reported that the Kent activity in the new contract was mostly accurate; early identification of inaccuracies in the London activity had resulted in the mobilisation being delayed. Options being considered to improve transport to and from London included increasing G4S' capacity and making arrangements with the London trusts for them to provide for patients with transport.

(8) Members enquired about measures to prevent repeated failed journeys and the eligibility criteria. Mr Ayres reported that G4S monitored patients who had been let down during mobilisation to ensure that it did not happen again. He stated that CCGs were reviewing complaints to assure itself that incidents were reducing. Mr Ayres explained that there was a national specification which set out the eligibility criteria for patient transport services to patients who had a medical need that prevented them from using private or public transport. Mr Ayres confirmed that changes to the eligibility criteria had not been reduced in order to meet performance targets. He stated that G4S was able to signpost patients who were not eligible for transport to local voluntary services; it was working with KCC to get an accurate and up-to-date list of services.

(9) Members asked about contractual levers and the flexibility of trusts to see patients if they were delayed. Mr Ayres explained that the CCG was due to receive the reprofiling of the service in the next two – three weeks from G4S which could result in changes to the contract. He stated that there were a range of levers in standard NHS contract such as a removal of a service with one year notice which included a no blame clause. If the provider significantly breached its contract, CCGs can serve notice with immediate effect. There were a number of informal levels including the provision of a reference to the provider if they wish to bid for other services.. He reported that whilst trusts were being flexible and would accommodate delayed patients where possible,

patients were more likely to be delayed on their return, rather than outward, journey.

(10) In response to specific questions about the use of alternative modes of transport and volunteer drivers, Mr Ayres committed to finding out about use of trains for patient transport service journeys. He explained that although G4S did use volunteer drivers, they were mostly used as part of voluntary services. The previous provider had used volunteer drivers and it had not worked effectively. He confirmed that volunteer drivers did not require medical training as they provided care rather than medical interventions.

(11) RESOLVED that:

(a) the report on Patient Transport Services be noted;

(b) NHS West Kent CCG be requested to provide an update in six months with:

(i) qualitative and quantitative data including the details about patient experience and areas of underperformance;

(ii) feedback from the action plan regarding complaints.

15. West Kent CCG: Out of Hours (OOH) GP Relocation
(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance.

(1) Mr Wickings began by explaining the 2013 Keogh Urgent and Emergency Care Review provided opportunities for primary care input into emergency departments. In 2015 the CCG began to co-locate GP Out of Hours (OOH) services within the two Emergency Department at the Maidstone and Tunbridge Wells NHS Trust hospital sites but it was only achieved at the Maidstone site.

(2) Mr Wickings stated that following the securing of capital funding, the CCG was now proposing to relocate GPs from Cranbrook and Tonbridge OOHs bases to be part of co-located primary care service at the Tunbridge Wells site; patients would no longer be able to walk-in to Tonbridge Cottage hospital base. He stated that a roving OOH GP car would be retained to visit patients who were unable to travel. He reported that the move to the Tunbridge Wells site provided a number of advantages including improved GP rota fill, greater clinical input and integration within the emergency department.

(3) A Member enquired about minor injury units. Mr Ayres explained that there was a move to integrate minor injury services as part of primary care. The model was being explored in Edenbridge and Hawkhurst; GPs in Hawkhurst were looking to move into the community hospital site which would enable them to provide minor injury services. Minor injury services were part of the West Kent integrated urgent care proposals which included the creation of Urgent Care Centres and the reprocurement of 111 service supported by an enhanced Integrated Clinical Advice Service.

(4) In response to questions about the use of technology, Mr Wickings stated that the emergency departments were already able to view GP records. The CCG was exploring the use of apps to signpost and provide advice and information.

(5) Members asked about the procurement of the 111 service and the timescale for the integrated urgent care proposals. Mr Wickings confirmed that there would be a Kent & Medway wide procurement of the 111 service and he would be the Senior Responsible Officer. He stated that the CCGs were proposing to implement the changes to the OOH service whilst they continued to engage with patients and public on their wider proposals for integrated urgent care model. He committed to sharing information with the Committee as the proposals were developed.

(6) RESOLVED that:

(a) the Committee agrees with its original decision that the co-location of out-of-hours services within an emergency department is not a substantial variation of service.

(b) West Kent CCG be invited to submit a report to the Committee in six months including an update about the relocation of the Sevenoaks OOH base.

16. West Kent CCG: Gluten Free Services (Written Briefing)
(Item 7)

(1) The Committee considered an update report by NHS West Kent CCG about its Governing Body decision to no longer routinely prescribe gluten-free food from 1 September for people with coeliac disease in West Kent.

(2) A Member commented that the decision would particularly affect low income families on universal credit.

(3) RESOLVED that the CCG's decision to no longer routinely prescribe gluten-free food for people with coeliac disease in West Kent be noted.

17. West Kent CCG: Financial Recovery Plan (Written Briefing)
(Item 8)

(1) The Committee considered an update about NHS West Kent CCG's Financial Recovery Plan which contained details about its 2016/17 outturn and 2017/18 control totals and plans.

(2) RESOLVED that the Committee:

(a) noted the report regarding the Financial Recovery Plan;

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

18. West Kent CCG: Dermatology Services (Written Briefing)
(Item 9)

(1) The Committee considered an update about the mobilisation and performance of the West Kent Dermatology Service which had commenced in April 2017.

(2) RESOLVED that the report on the mobilisation of the West Kent Dermatology Service be noted.

19. Mental Health Rehabilitation Services in East Kent (Written Briefing)
(Item 14)

(1) The Committee considered a letter from Helen Greatorex, Chief Executive, Kent & Medway NHS and Social Care Partnership Trust regarding the outcomes for patients who had been on the Davidson ward at St Martins Hospital, Canterbury which had closed.

(2) RESOLVED that the letter from KMPT, regarding the outcomes of patients who had been on the Davidson ward, be noted.

20. SECAmb Regional Scrutiny Sub-Group (Written Briefing)
(Item 15)

(1) The Scrutiny Research Officer stated that in September 2016 the Care Quality Commission (CQC) published its inspection report on South East Coast Ambulance Service NHS Foundation Trust (SECAmb) which rated the Trust as 'inadequate' and recommended that it be placed in special measures.

(2) She advised that at the request of the Trust, NHS England and NHS Improvement and in recognition of the logistical difficulties of SECAmb reporting to each of the six health scrutiny committees in the Trust's area, a SECAmb Regional Scrutiny Sub-Group was established to monitor the Trust's development and progress against its improvement plan at a separate joint meeting.

(3) She highlighted that the sub-group had met on three occasions: 20 December 2016, 20 March 2017 and 26 June 2017. The sub-group was comprised of two representatives from each of the six health scrutiny committees. The Kent representatives were Mrs Chandler and Mr Angell.

(4) She confirmed that the Agenda and papers would be shared with the Committee in advance of future meetings to enable Members to have the opportunity to propose questions for the Kent representatives to ask. The notes of the meeting would be shared with the HOSC and it was proposed that they were published as part of a future Agenda.

(5) RESOLVED that:

(a) the establishment of the SECAmb Regional Scrutiny Sub-Group be noted;

(b) the Committee considers the notes of future SECAmb Regional Scrutiny Sub-Group meetings as part of its Agenda;

(c) SECAmb be requested to attend a meeting of the Committee where deemed appropriate by the Kent representatives on the Sub-Group.

(6) The meeting was adjourned at 11:45 and reconvened at 13:15.

21. CCG Annual Rating
(Item 10)

Mike Gilbert (Assistant Accountable Officer, NHS Swale CCG and NHS Dartford, Gravesend and Swanley CCG) was in attendance for this item.

(1) The Chair welcomed Mr Gilbert to the Committee. Mr Gilbert began by explaining that NHS Dartford, Gravesend and Swanley CCG had been invited to present to the Committee following it being rated as inadequate and placed in financial special measures by NHS England in their annual assessment of CCGs. Four areas of concern had been identified by NHS England: the first two areas related to the non-delivery of the NHS constitutional standards on A&E 4 hour and 62 day referral to treatment cancer targets which were not unique to the CCG. The second two areas related to the CCG's deficit of £13.5 million in 2016/17, which was the primary reason for the rating, and the leadership capacity of the CCG which was shared with NHS Swale CCG. Mr Gilbert stated that the CCG accepted the rating and was working with NHS England to make improvements, particularly in relation to its financial performance.

(2) Mr Gilbert outlined the actions being taken by the CCG. He reported that the CCG had a financial recovery plan which had been in place since last year; a review at the start of the financial year had identified further efficiencies and the forecasted deficit was £7.3 million in 2017/18. He stated that there had been a number of appointments to the Governing Body including a Chief Operating Officer, Deputy Chief Nurse and additional GP clinical leads. He noted that a number of efficiency schemes had been introduced including a campaign to reduce medicine waste which was anticipated to make £2 million of savings. He highlighted that the CCG was working with GPs on clinical appropriateness of referrals into secondary care; there had been a 9% growth in activity at Darent Valley Hospital. He stated that the CCG was in contractual management discussions with its providers to review, refine and renegotiate contracts to ensure effectiveness and value for money; in some circumstances the CCG may need to decommission services. He stated that the CCG recognised that it was living beyond its means, he highlighted the impact of growth on the area with the creation of the garden city with 60,000 residents moving into the area in the next 10 – 12 years and the importance of funding allocations to reflect this.

(3) The Chair enquired about the increase in hospital activity and the impact of services being shifted from the acute to community as proposed in the STP. Mr Gilbert explained that there had been a significant increase in activity going to London providers and Darent Valley Hospital; for every patient treated in London, a market forces factor was paid in addition to the national tariff. Whilst the CCG recognised patient choice, it was reviewing with GPs, when offering choice, that routine services provided in London were more expensive. Mr Gilbert reported that the shift of services from the acute to community would

require and enable significant investment and integration of community services through local hubs.

(4) Members asked about the CCG's relationship with NHS England, joint commissioning with social care and the community services contract with Virgin. Mr Gilbert explained that the CCG had a good working relationship with NHS England locally who recognised the impact of growth in the CCG's area; both organisations were working together to identify and address issues faced by the CCG. He confirmed that the CCG had had joint commissioning arrangements, for learning difficulties, mental health and some children services, with Kent County Council for the last 18 months; further joint commissioning of adult social care was required. He stated that the CCG had awarded a seven year block contract for community services to Virgin; the contract was performing at the level it was commissioned and did not cost more than the previous contract.

(5) In response to questions about the joint executive team, over-performance of providers and audit of GP referrals, Mr Gilbert reported that NHS Swale CCG and NHS Dartford, Gravesend and Swanley CCG had a joint executive team which worked for both Governing Bodies; the recently appointed Turnaround Director and Chief Operating Officer worked across both organisations. He explained that providers such as Dartford & Gravesham NHS Trust were paid per patient and the CCG was required to pay for any activity above the planned level which resulted in underfunding. The CCG was working with the Trust to ensure that it met its targets whilst keeping activity within the planned level. He reported that audits were carried out as part of routine contract management checks.

(6) Members enquired about the commissioning of specialist services, budgeting and funding allocations. Mr Gilbert explained that NHS England commissioned specialist services so were not included in the CCGs' baselines. He noted that it was more difficult to budget for non-elective activity as there were a number of factors which influenced activity such as winter pressures. He reported that NHS Swale CCG also had a small deficit for the first time in its history. He stated that NHS England set allocations based on a 1% growth in the CCG area; the CCG asked for this to be reviewed as it was based on historic ONS data which did not reflect growth in its area. He stated that whilst the CCG had made representations to NHS England and its local MPs about its funding, the CCG recognised that it had to operate within its current allocation and demonstrate efficiency; as an example the CCG was exploring the use of technology between GPs and consultants to improve the effectiveness of outpatient appointments.

(7) Members asked about workforce, special measures and the rationalisation of services. Mr Gilbert explained that due to its proximity to London staff were attracted to London's world renowned specialist centres and pay weighting; staff who worked at Darent Valley Hospital received a fringe waiting. He noted that Dartford & Gravesham NHS Trust and Guy's and St Thomas' NHS Foundation Trust were working together as part of a vanguard to rotate staff between their sites. It was hoped that the health developments as part of the Ebbsfleet garden city would attract staff to work, live and train in North Kent. An area of particular concern was GP workforce which had an increasing workload and the CCG was working with them on their sustainability. He

stated that the CCG was determined to turn itself around and get out of special measures this year but recognised that there was a significant amount of work to do. He reported that the CCG would have to make difficult decisions which could include the rationalisation of services; any decision around this would be done in discussion with local people and may require consultation. A Member requested that the CCG present to the Committee at the earliest stage about service change proposals.

(8) RESOLVED that:

(a) the report be noted and the Kent CCGs be requested to provide an update to the Committee annually;

(b) NHS Dartford, Gravesham & Swanley CCG be requested to provide an update on its financial recovery plan at the appropriate time.

Mr Pugh, in accordance with his Other Significant Interest as a non-voting member of NHS Swale CCG's Primary Care Committee, withdrew from the meeting following Mike Gilbert's presentation and took no part in the discussion or decision.

22. East Kent Out of Hours GP Services and NHS 111
(Item 11)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance.

(1) The Chair welcomed Mr Perks to the Committee. Mr Perks began by assuring the Committee that the East Kent CCGs were working closely with the provider Primecare; a robust plan to address the issues identified by the CQC had been developed and was being monitored by the CCGs. The CQC would be reviewing the three warning notices covering safe care and treatment, good governance and staffing during the following week. He stated that there had been some difficulties with contract which the CCGs were seeking to resolve with Primecare. He confirmed that Primecare would be leaving the contract early on 7 July 2018.

(2) In response to a specific question about the CCG's oversight of the provider, Mr Perks stated that he took personal responsibility for overseeing the provider and its improvement plan; he was confident that the plan was achievable. He explained that regular contract management had identified concerns prior to the CQC inspection which had resulted in a performance notice being issued. He noted that a review of the procurement was also being undertaken. The CCGs were one of the first to combine 111 and care navigation services and there had not been a national specification at the time of procurement; the navigation service element of the contract had never been mobilised. He explained that the CCGs had worked closely with Primecare during mobilisation and there had been a phased implementation of the 111 service. He reported that Primecare was committed to addressing the concerns and he was confident that the actions being taken would resolve these; he anticipated that the CQC would confirm this at its next meeting.

(3) Members enquired about financial sanctions and staffing. Mr Perks explained that whilst it was possible to apply financial sanctions, in this instance, it would prevent the provider in making the necessary changes due to resourcing challenges. Mr Perks stated that there had been problems with the management during the mobilisation and Primecare had not engaged with local GPs as the previous provider had done. He reported that Primecare had subsequently appointed a medical director to build relationships with local GPs. The CCGs were monitoring the level of staff cover being provided; if the 111 or out-of-hours service did not work effectively, it could have implications on the wider system such as increased A&E attendance.

(4) A Member asked about the potential of bringing the service in house. Mr Perks stated that consideration was being given to out-of-hours services becoming part of seven day working in primary care but it required significant GP resource which was not currently available. The provider had been contracted to integrate 111, out-of-hours and care navigation services but had not been able to make the partnership arrangement required to do this; partnership working would be a focus of a future contract award. Mr Perks reported that a joint procurement of a Kent & Medway 111 service, to go live in April 2019, had been agreed. The East Kent CCGs were developing interim arrangements between the Primecare contract ending in July 2018 and the start of the new contract.

(5) A number of comments were made about performance. Mr Perks explained that 111 service was subject to local and national performance standards such as the percentage of calls addressed by clinicians. He stated that the contract required doctors to be on call but the provider had struggled with its fill rate; there had been a number of hours at the weekend where out-of-hours doctors had not been in place. He stressed the importance of the provider improving its relationship with local GPs so they could work in partnership to improve the service.

(6) RESOLVED that:

(a) the report be noted;

(b) the East Kent CCGs be requested to provide a written update to the Committee in November and a verbal update in January;

(c) the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.

23. Local care in East Kent
(Item 12)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance for this item.

(1) Mr Parks began by explaining that the paper set out the four different approaches to the local care model in East Kent. As part of the model, CCGs were investing in community services to enable more care to be provided out of hospital; this had been evidenced in the Canterbury & Coastal CCG area where a catheter clinic in the community had lowered acute admission rates.

He reported that the management teams of the East Kent CCGs were working together to share learning.

(2) A Member requested an update about the reinstatement of acute medicine at the Kent & Canterbury Hospital. Mr Perks reported that the Trust was making progress with its recruitment and had asked Health Education England to reassess the situation before Christmas. He stated that the challenges in East Kent were not unique; he had attended a meeting of the 80 trusts with the worst A&E performance, including organisations in Lincolnshire, East Sussex and Dorset, which had a similar geography with a mix of rural and urban areas and faced difficulties in recruiting junior doctors. Mr Perks committed to provide an update about the local care models in Faversham and Sandwich.

(3) Members enquired about public engagement, minor injury services and investment in public transport. Mr Perks explained that a range of engagement methods had been used including public meetings and a survey which had received 1200 responses. He recognised that there were groups of people, such as the young and the working age population, which had not been reached. Mr Perks stated that whilst there was a national design for urgent care. In Canterbury, there were minor injury units (MIU) in Faversham and the recently opened unit in Herne Bay which were well used; in East Kent there were 290 MIU attendances a day, in addition to 550 – 570 A&E attendances. He noted that minor injury and illness services would be developed as part of the community hubs. Mr Perks noted that EKHUFT had invested in additional public transport as part of its outpatients reconfiguration and it was being looked at by the Trust as part of its future plans.

(4) Members asked about forecasting, x-ray facilities at Estuary View Medical Practice and the impact of the GP closure in Folkestone. Mr Perks stated that ONS data did not reflect growth in Ashford which impacted on the CCG's financial allocation. Mr Perks noted that there was an x-ray pipe between the Estuary View Medical Practice and the hospital which enabled images to be sent to and reviewed by a radiographer. Mr Perks noted that whilst he could not specifically comment on the GP closure in Folkestone as it was not in his area, it was important that primary care increased its scale in order to be sustainable. He noted that large practices such as the Estuary View Medical Centre, which served a population of 32,000 and had 30 partners, did not have problems recruiting staff. He stated that whilst some GPs felt the current value of the GMS contact made it difficult to deliver quality services, it was beginning to be demonstrated that primary care was able to provide enhanced community services through mergers and networks.

(5) RESOLVED that the report on Local Care in East Kent be noted and an update be presented to the Committee in six months.

24. Ashford CCG and Canterbury & Coastal CCG: Financial Recovery Plan
(Item 13)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance for this item.

(1) Mr Perks began by explaining that the financial recovery plan was fundamental to enable the delivery of local care model. A memorandum of

understanding regarding the implementation of model was due to be signed by partner organisations including East Kent Hospitals University NHS Foundation Trust (EKHUFT). The focus of the plan was based on ambitious Quality, Innovation, Productivity and Prevention (QUIPP) savings. The recovery actions were all red rated and remedial actions were being implemented to get the plan back on track; if sufficient progress was not made, rationalisation of services may be considered, to maintain the financial balance.

(2) In response to a specific question about reserves and the length of the plan, Mr Perks explained that the CCGs were required to hold a reserve and have a 1% surplus; reserves were being deployed to help manage the risk in the plan. The financial recovery plan was linked to transformation of services which were required to implement to the STP. Mr Perks noted that it was a two-year financial recovery plan which covered the NHS Ashford CCG and NHS Canterbury & Canterbury CCG areas. He reported that NHS Ashford CCG had a small deficit and had not achieved a 1% surplus for three years which had been managed through non-recurrent fixes. Through the plan, the CCG would achieve financial balance by 2019/20.

(3) RESOLVED that the report on financial recovery in Ashford and Canterbury CCGs be noted and an update presented to the Committee in January.

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Item 4: EKHUFT Operational Issues

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: EKHUFT Operational Issues

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

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

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1. Introduction

(a) On 29 January 2016 the Committee considered proposals to reclarify the model of care provided by the Emergency Care Centre at the Kent & Canterbury Hospital, Canterbury due to regulatory action by Health Education Kent Surrey and Sussex (HEKSS).

(b) On 3 June 2016 the Committee considered an update on the implementation of the new model of care at the Emergency Care Centre.

(c) On 21 March 2017 the Committee was notified by the Trust that HEKSS had recommended the removal of a cohort of junior doctors from the Kent and Canterbury Hospital to the other main hospital sites in Ashford and Margate.

(d) On 10 April 2017 the former Committee was notified by the Trust that hyper acute stroke services would be temporarily moved from the Kent and Canterbury Hospital to the other main hospital sites in Ashford and Margate.

(e) On 13 June 2017 the new Committee was notified by the Trust that from 19 June there would be an emergency transfer of urgent care services from the Kent and Canterbury Hospital site on a temporary basis following the removal of the junior doctors.

(f) On 14 July 2017 the Committee considered a formal update about the emergency transfer of acute medicine from the Kent & Canterbury Hospital site on a temporary basis. The Committee agreed the following recommendation:

- *RESOLVED that the reports be noted and East Kent Hospitals NHS University Foundation Trust be requested to:*

  (a) provide an update to the Committee on its response to regulatory action and emergency transfer of services;

> (b) *present an update to the Committee about its long term strategy for acute sustainability in East Kent.*

(g) The Chair has requested an update from the Trust on:

- the appointment of Susan Acott as interim Chief Executive and recruitment of a permanent Chief Executive;
- the reinstatement of services at Kent & Canterbury Hospital;
- A&E performance (including 4 hour target and admissions);
- the Trust's financial recovery plan;
- staff recruitment and morale.

(h) East Kent Hospitals NHS University Foundation Trust has asked for the attached reports to be shared with the Committee:

Kent & Canterbury Hospital Report	pages 21 – 22
Emergency Care Report	pages 23 – 24
Additional Update Report	pages 25 – 26

2. Recommendation

RECOMMENDED that the reports be noted and East Kent Hospitals NHS University Foundation Trust be requested to provide an update at the appropriate time.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (29/01/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=36905

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 (2017) '*Health Overview and Scrutiny Committee (14/07/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=44858

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NHS
East Kent
Hospitals University
NHS Foundation Trust

Emergency Transfer of acute medicine - Kent & Canterbury Hospital

1. Background

1.1 East Kent Hospitals announced on 21 March that Health Education England (HEE), which oversees junior doctor training, required the Trust to move 38 junior doctors in acute medical specialities at the Kent & Canterbury Hospital (K&C) to the Trust's other two hospitals at Ashford and Margate.

1.2 This was because a shortage of permanent specialist consultants and a heavy reliance on locum doctors had impacted on their supervision and training. As a teaching trust, EKHUFT has to make sure that junior doctors have access to senior doctors to support them.

1.3 The Trust has struggled to recruit and retain permanent specialist consultants and has been regularly briefing the Health Overview and Scrutiny Committee on these pressures.

1.4 On 19 June 2017 half of the junior doctors were moved from K&C to the William Harvey Hospital (WHH) in Ashford and half to the Queen Elizabeth The Queen Mother Hospital (QEQMH) in Margate.

1.5 On Friday, 9 June, the Trust's Board made the decision to move some services at K&C to its other two sites. This is because without the junior doctors the Trust could not continue to provide those services safely. This is called an emergency transfer of services. It can only be made on a temporary basis and does not require public consultation because it is an emergency move made to ensure services and patients are safe.

2. What this means for patients

2.1 The changes affected up to 35 people per day who required urgent medical care for conditions such as heart attack, stroke and pneumonia. Hyper acute stroke services were moved on 10 April 2017. Patients are no longer brought to the K&C Urgent Care Centre by ambulance as an emergency. They are now taken by ambulance straight to Margate or Ashford.

2.2 The majority of services at the K&C are not affected. For example, chemotherapy services, renal, vascular, urology services and outpatient clinics are not affected. There continues to be a well-used 24/7 minor injury and illness service at the hospital. Patients who have a planned operation or outpatient appointment, an x-ray, blood test or therapy session at the K&C, are seen and treated as usual.

3. Actions to create capacity at Margate and Ashford

3.1 The Trust planned carefully and worked closely with commissioners, the ambulance service and other NHS and social care providers, with oversight from its regulators, to ensure the emergency transfer was safe and effective.

3.2 Measures at the other two sites have included providing more capacity for patients in the community; faster discharge when patients are ready to leave hospital; improved patient pathways; increased ambulatory care for patients who can go home the same day and the physical expansion of the two A&E departments to reduce crowding.

3.3 If patients are medically fit to leave our hospitals in Margate or Ashford but need to remain in hospital we may transfer them to the K&C to continue their rehabilitation. This decision would include an assessment of clinical need and where patients live. This will only happen if patients are well enough, and by using properly qualified staff and transport by ambulance.

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3.4 As a result of the emergency transfer, 24 beds at K&C are not currently needed and have closed. At WHH eight inpatient beds have been changed from inpatient to ambulatory care beds, at QEQM 7 beds have been changed from inpatient to ambulatory care beds.

4. Reversing the changes

4.1 The changes can only be reversed if Health Education England and the General Medical Council (GMC) decided to bring back the junior doctor posts that they moved from Kent & Canterbury Hospital. To do this they would need to be satisfied that sufficient permanent consultants in acute and speciality medicine had been recruited and were able to provide appropriate supervision and training for junior doctors.

4.2 The Trust has been running rigorous recruitment campaigns, including advertising in consultant posts in NHS Jobs, the British Medical Journal, through specialist agencies, and on social media. We have advertised 14 times in the BMJ in the last year and six times since the changes in June, including a full page advertising 15 different consultant posts. We are also out to advert for 15 more doctors including A&E, heart, respiratory, stroke, diabetes, acute medicine and geriatrics.

4.3 In the last year we have advertised for 74 different consultant roles. We have had some success and recruited 55 new consultant doctors to work in our hospitals, 22 since the changes in June. There are still 10 consultant vacancies in acute and speciality medicine.

4.4 We have also recruited ten permanent middle grade doctors to work in our A&E departments, six have started and four are joining over the next few months. We have seven more in the pipeline, subject to clearances.

4.5 Recruitment takes time, there is a national shortage of doctors, especially in acute and specialist medicine. However since the move of services, with more sustainable rotas, we have seen an increase in the number of applicants for some specialty posts. One of the main reasons we are struggling to recruit enough permanent staff is because running services across too many sites makes the posts unattractive to potential applicants.

5. Improving healthcare in East Kent for the future

5.1 This situation is an illustration of why there needs to be a move to a more sustainable way of providing hospital care in the future, with more capacity across health and social care locally. This will mean we can recruit more permanent staff, patients will be seen more quickly because staff and services are not stretched so thinly and with more doctors available we can consistently provide the standards of services we want for patients.

5.2 It is important that we get to public consultation as quickly as possible so that we can provide certainty for the public, our own staff and future employees. The emergency transfer of services may still be in place when we reach public consultation next Spring. If this is the case, the Trust will focus on implementing any longer-term reconfiguration once the final decision is made on where and how services are provided.

5.3 The NHS in east Kent continues to press for a medical school for Kent and Medway and raised this with east Kent MPs in recent weeks. The most important factors in attracting doctors are hospital services that deliver the best care, offer attractive services, manageable rotas and working conditions for staff. This is the Trust's vision for its hospitals and having a Medical School locally will add to that attraction.

14 November 2017

Emergency Care whole-system improvement plan

1. Background

1.1 The NHS in east Kent is committed to improving the A&E 4 hour performance standard (the waiting time for patients to be seen, treated and admitted to a hospital bed or discharged).

1.2 All patients are triaged on arrival and the most critically ill patients are prioritised. However waiting in an emergency department for a long time is not the standard we want for any of our patients. We are addressing this as a matter of urgency as a whole health system through an improvement plan, which includes a number of immediate actions, as well as medium and longer-term strategies, to ensure there is improvement now and that progress is sustained up to and throughout winter.

1.3 Staff are working extremely hard to provide good care for patients. The Trust and CCGs are carefully monitoring services to ensure that patients are receiving good, safe standards of care, despite the pressure the departments are under.

2. The Improvement Plan

2.1 The NHS in east Kent is delivering a whole system emergency care improvement plan. It was launched on 26 September 2017 and contains immediate actions (within 4 weeks), medium (by December) and longer-terms plans, to ensure that progress is sustained.

2.2 The plan focuses on:

- Admission avoidance - ensuring that patients have access to appropriate support in primary and community care and attend A&E only when emergency treatment is necessary.
- Decongesting the emergency departments to make the experience for patients more comfortable and safe and make it easier for them to be seen and treated. This includes an £800,000 investment to improve our environment and facilities to increase the space in the departments and allow patients to be directed to the most appropriate service including a GP on site.
- Improving patient flow within and out of our hospitals, including the introduction of an electronic bed management system; ensuring patient discharges are planned well in advance and patients are discharged with appropriate packages of support as soon as they are ready to leave hospital and carrying out assessments in the most appropriate place where patients are no longer receiving acute hospital treatment.
- Recruiting substantively and increasing our workforce, including extending services like access to therapists and a 7-day cardiac catheter laboratory for routine procedures so they can be discharged without unnecessary delay.
- Communicating to the public appropriate alternatives to A&E and prevention. This includes providing clear information to the public about how they can use alternatives such as minor injury units for faster care, when it’s not an emergency and how to stay well through winter by having the flu vaccine and getting early advice from your GP and pharmacy.

2.3 A staff-led, 12 week, rapid improvement programme, to kick start improved flow throughout the hospital, has resulted in steady week-on-week improvement in the 4 hour performance standard.

2.4 Last week East Kent Hospitals University NHS Foundation Trust averaged 80% compliance against the four-hour standard. This is compared to 70% for September.

2.5 The Trust is aiming to continue on this trajectory of improvement including an above 80% performance for the whole month of December.

3. Recruitment

3.1 One of the challenges in getting patients seen quickly, is having the right workforce available 24/7. This remains a challenge for the NHS nationally. The Trust is still covering a high percentage of vacant posts with temporary staff and continues to face peaks in patient attendance at certain times of the day and week.

3.2 The Trust continues to recruit more doctors to work in all of our hospitals and has had some success in recruiting. In the last year the Trust advertised for 74 different consultant roles and recruited 55 new consultant doctors, including geriatricians, A&E and cardiac doctors, and specialist surgeons. It is also out to advert for 15 more doctors including A&E, heart, respiratory, stroke, diabetes, acute medicine and geriatrics.

3.3 The Trust has also recruited ten permanent middle grade doctors to work in our A&E departments, six have started and four are joining over the next few months. We have seven more in the pipeline, subject to clearances. There are still 10 consultant vacancies in acute and speciality medicine. We are actively recruiting to nursing posts and have successfully recruited to increased Emergency Nurse Practitioner posts to improve the service we provide for patients attending with minor injuries. We are exploring alternative roles and have recently recruited healthcare assistants to assist the nursing team in providing comfort care to our patients.

4. Long-term sustainability

4.1 We urgently need to move to a more sustainable way of providing hospital care in the future, with more capacity across health and social care locally and where patients are cared for in the right place at the right time, whether that's in a hospital bed, in a community setting or at home. The NHS in east Kent and social care partners across the whole system want to introduce a model of care that is best suited to deliver local care, avoid people coming to A&E when there is a more appropriate alternative and manage long-term conditions effectively.

4.2 East Kent's clinical strategy, once implemented following public consultation, is key to long-term improvement, providing sustainable services and improving 4-hour and other performance. The strategy will deliver more local care options, manageable rotas, co-location of specialist services and teams and certainly for staff, making east Kent a more attractive place to work.

4.3 This model of care will include capital investment to provide modern and more spacious A&E facilities as the current departments are too small and are badly designed in terms of patient flow. National modelling of patient numbers, resources and our ability to recruit sufficient staff, means that there cannot be three A&E departments in east Kent.

9 November 2017

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals briefing

The Trust has been asked to update the Health Overview and Scrutiny Committee on the following areas. Data is taken from the Trust's September performance report.

1. **The appointment of a permanent Chief Executive and Chair**

1.1 Susan Acott is the interim Chief Executive of the Trust. She joined the Trust on 16 October 2017 on secondment from Dartford and Gravesham NHS Trust, a post she has held for eight years. Susan has significant NHS leadership experience, having also held senior positions in the NHS in Manchester, Merseyside, York and London. Gerard Sammon, Dartford and Gravesham NHS Trust's Director of Strategy and Planning, is currently interim Chief Executive at Dartford. Susan will return to Dartford and Gravesham NHS Trust at the end of her secondment at East Kent.

1.2 The Trust also has an interim Chairman, Dr Peter Carter OBE. Peter has been Chief Executive of the Royal College of Nursing and Central and North West London NHS Foundation Trust. He has been consistently ranked by the Health Service Journal as one of the top 100 most influential people in health and was awarded an OBE in 2006 for his services to the NHS. Peter was interim Chair at Medway Foundation Trust from 1 November 2016 to 31 March 2017. He joined East Kent Hospitals on 17 October.

1.3 Peter Carter, Interim Chairman has met with both the Council of Governors Nominations and Remuneration Committee and the Board's Nomination Committee to start the recruitment process for the substantive Chairman and Chief Executive. Harvey Nash has been engaged to support the process and they are actively seeking suitable candidates for both roles.

1.4 The timeline takes account of the Christmas and New Year holidays with interview dates set in early January 2018 for the Chairman and early February 2018 for the Chief Executive.

2. Staff recruitment and morale

2.1 There has been some success in recruiting to substantive roles as described in the accompanying HOSC papers and the focus remains on recruiting to particularly hard to fill roles to replace agency staff. We are also identifying new ways and methods of attracting applicants, including creating new positions.

2.2 Staff engagement is a priority for the Trust and has been recognised as an area of significant improvement by the Care Quality Commission.

2.3 Staff morale is measured in a number of ways. Staff turnover for September was 12.8% which is below the national rate for the public sector, which is currently at around 15%. In particular we have seen a significant decrease in the number of new starters leaving the Trust over the past year, achieved through improved induction and early engagement. The percentage of staff who would recommend the Trust as a place to be treated was 70% during Quarter 2. Sickness absence has remains stable at 4% which although above the Trust target is in line with the national average for public sector workers.

2.4 Statutory training is at 90% which is above the Trust's target of 85%. The Trust staff appraisal rate remained at 81.5% in September and there is work be undertaken to improve this position which is below our 90% target.

2.5 Other measures which indicate good staff engagement are the number of staff taking part in the annual staff survey, at the time of writing we were at 36.8% with three weeks to go for staff to complete the survey. Our target is to have 50% of colleagues complete the survey. The other measure is uptake of the flu vaccine which protects not only staff but also patients and their families. Uptake of the flu vaccine by staff with patient contact is 58.3%.

3. Financial recovery plan

3.1 The Trust is working with NHS Improvement (NHSI) as a Trust in financial special measures. Our financial recovery plan has been received and accepted by NHSI and is for an overall £18.9m deficit target by the end of this financial year. The Trust started the current financial year with a £31.4m deficit.

3.2 At Month 6, the Income and Expenditure deficit was £11.8m against a plan of £12.4m, which is £0.6m better than plan.

3.3 The Trust has a £32m savings (cost improvement programme) target for 2017/18 and is slightly ahead of plan with £12.1m reported year to date against a target of £11.8m.

15 November 2017

Item 5: Kent and Medway Sustainability and Transformation Plan

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: Kent and Medway Sustainability and Transformation Partnership

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

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 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, 25 November 2016, 3 March 2017 and 14 July 2017 the Committee considered an update on the Kent and Medway Sustainability and Transformation Plan and Partnership. On 14 July 2017 the Committee considered an update regarding the service models and hurdle criteria.

2. Recommendation

RECOMMENDED that the report on the Kent and Medway Sustainability and Transformation Partnership 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 (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*

Kent County Council (2017) *'Health Overview and Scrutiny Committee (03/03/2017)'*, *https://democracy.kent.gov.uk/mgAi.aspx?ID=43699*

Kent County Council (2017) *'Health Overview and Scrutiny Committee (14/07/2017)'*, *https://democracy.kent.gov.uk/mgAi.aspx?ID=44859*

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Transforming health and social care in Kent and Medway

Kent and Medway Sustainability and Transformation Partnership

Kent Health Overview and Scrutiny Committee

24 November 2017

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Context

Local Care

East Kent

Stroke service review

Winter planning

Productivity

System transformation

The case for change – what STPs were tasked to address

Health and wellbeing

- **Population changes,** with significant growth in the number of over 65s; an aging population means **increasing demand for health and social care**.
- **Health inequalities,** with the health gap growing in many areas and the main causes of early death are often preventable.
- A significant number of the population **living with (often multiple) long-term health conditions**, many of which are preventable.

Quality of care

- Many individuals treated **in hospital beds who could be cared for elsewhere if services were available;** being in a hospital bed **for too long is damaging for many patients.**
- We are **struggling to meet performance targets** for cancer, dementia and A&E.
- Many providers are in 'special measures' because **of financial or quality pressures** and numerous local nursing and residential homes are **rated 'inadequate' or 'requires improvement'**.

Sustainability

- Already facing **significant financial pressures** and the position is generally deteriorating.
- Our **workforce is aging** and we have difficulty recruiting in some areas (across both primary and secondary care / health and social care); not just about professional

  staff but growing problems with recruitment of domiciliary care staff.

SOURCE: Kent and Medway 5yrFV

We are pursuing transformation around four themes

1. Care Transformation
- Prevention
- Local (out-of-hospital) care
- Hospital transformation (stroke and East Kent)
- Mental health

2. System Leadership
- System / commissioning transformation
- Communications and engagement

3. Productivity
- CIPs and QIPP delivery
- Shared back office
- Shared clinical services
- Procurement and supply chain
- Prescribing

4. Enablers
- Workforce
- Digital
- Estates

Covered in this paper

SOURCE: Kent and Medway STP October 2016 submission

Developing plans in each locality

- Agree the **local vision and care model against the Kent and Medway framework**

- Progress **implementation** – fully in place by 2021

- Multi-disciplinary team **(MDT) working** in year one, various levels of maturity

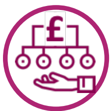
Stage one: local vision and care model

- CCGs, providers and local authorities **working together**
- Based on the **STP investment** case
- Vision and implementation place supported by **detailed analysis**
- **Costs and phasing agreed** by all partners
- **Aligned with provider plans** and QIPP* plans

QIPP – Quality, innovation, productivity and prevention plans to improve efficiency and effectiveness

Supported by enabling workstreams

- **Enabling workstreams** – one STP strategy, local implementation
  - Communications and engagement
  - Clinical leadership and governance
  - Workforce
  - Estates
  - Digital
  - Commissioning



East Kent

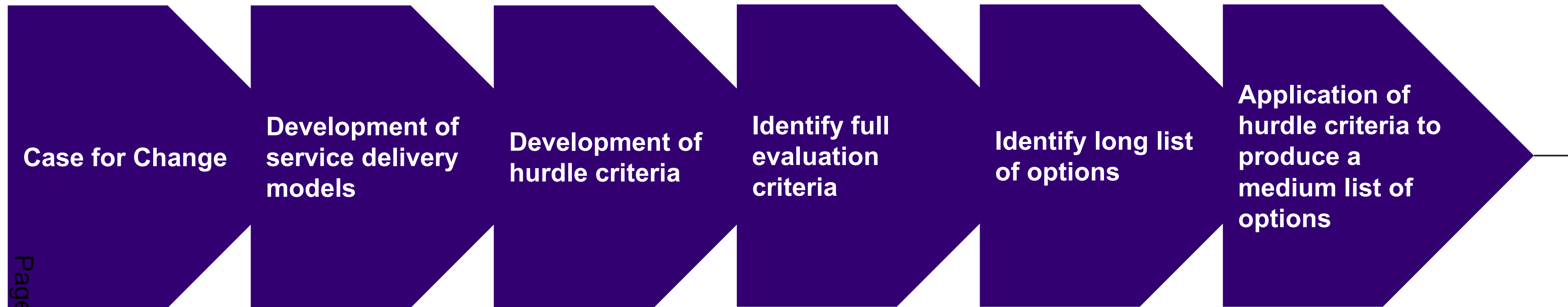
- **Case for Change** established – ‘do nothing’ not an option. Progression of the strategic changes offers sustainable solutions to the current challenges across patient pathways such as urgent care, workforce challenges and quality of services.
- Public support for the development of new local care models that support changes of hospital care
- Public **listening events** undertaken in spring and autumn were broadly supportive of the proposed changes . Key themes to address further included: developing local care; transport and access; specialist centres
- EKHUFT has developed a strategy for the future provision of acute services on the “Keogh” model for urgent care.
- **‘New build’ offer** from Canterbury developer – due diligence in progress

Next steps

- Further work on the options including applying final evaluation criteria
- Oversight and governance of decision making to be provided by the Sustainable Acute Medical Care in East Kent Joint Committee
- NHS England scrutiny and assurance processes
- Detailed work on the timeline through to consultation co-ordinating the development of the detail and ongoing engagement with stakeholders
- Continuing to speak to stakeholders, the public and campaign groups

Public consultation

In moving to public consultation, we are following a process that covers a number of stages



NB - This stage involves multiple stakeholder reviews as part of the agreed evaluation process

*PCBC = Preconsultation Business Case

Stroke

In Kent & Medway there are four acute trusts providing general acute stroke services at the acute hospital across Kent and Medway

Currently no sites have a specialist hyper acute stroke unit (HASU)

The Case for Change identified the key issues with the current service provision for stroke across K&M

- **No hospitals** provide 7 day consultant ward rounds
- Recommended patient volumes should fall between 500 and 1,500 confirmed stroke admissions per year but patient volumes in each acute hospital are **below the 500 patient threshold**
- In one K&M hospital, **fewer than 50% of patients receive thrombolysis within 60 mins** and overall K&M hospitals are are below the national average
- Generally **< 50% of all patients are being admitted within 4 hours** and performance is below national average

Source: Kent & Medway Case for Change (2017)

To improve the quality of stroke service provision, a future delivery model for stroke has been designed based on best practice and with strong clinical support

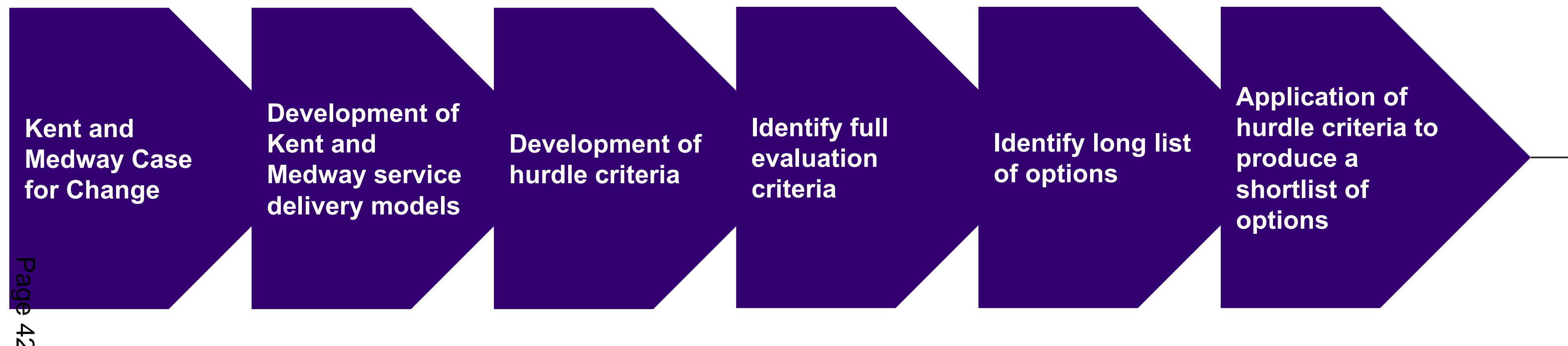
This includes:

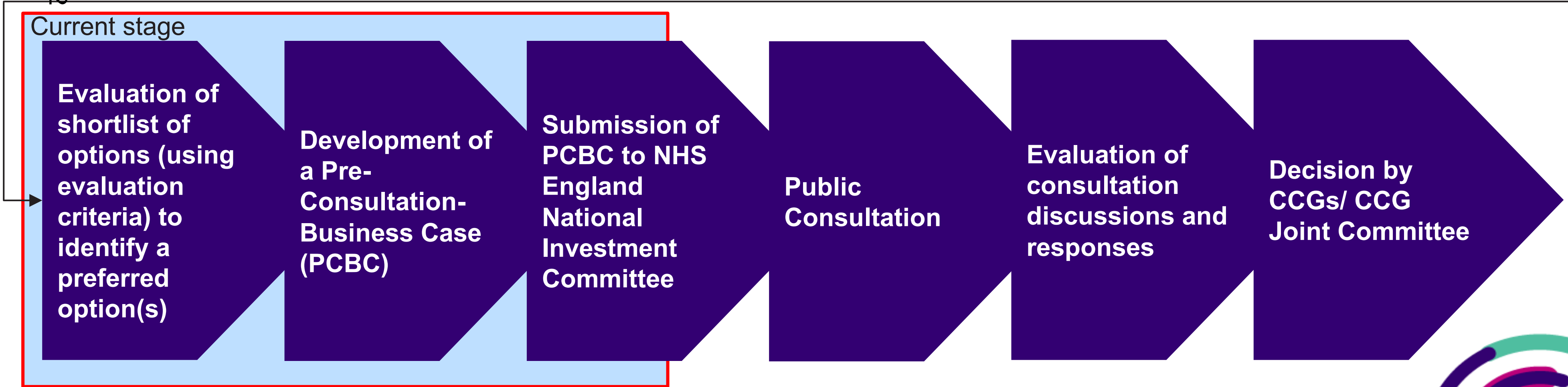
- 7 day specialist consultant-led stroke service available
- Combined Hyper Acute Stroke Units (HASUs) and Acute Stroke Units (ASUs) to help recruit and retain specialist staff and to use our existing workforce most efficiently
- Direct access from ambulance transfers to the stroke assessment unit
- Early Supported Discharge available for min 50% of patients
- Improved rehabilitation services available
- Potential development of a centre able to deliver mechanical thrombectomy
- Co-location of stroke services with other critical, related services to improve patient outcomes and support staff

SOURCE: Kent & Medway Review of Stroke Services (2015 /2016); The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014]; Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

Public consultation

In moving to public consultation, we are following a process that covers a number of stages





NB - This stage involves multiple stakeholder reviews as part of the agreed evaluation process

Revised timeline to consultation

October					November				December				January					February				March	
02	09	16	23	30	0 6	13	20	27	04	11	18	25	01	08	15	22	29	05	12	19	26	05	12

PCBC Development

- 11/10 CCG Chairs and AOs *Review evaluation*
- 25/10 Stroke SRO sign off of CS materials
- 26/10 IIA report finalised
- 30/11 - 15/12 Finalise PCBC based on CS feedback
- 16/12 Final PCBC issued to JC

12/12 JHOSC

CCG Joint Committee

- 26/10 – 15/11 (date TBC) Informal JC workshop *Sign off CS materials*
- 22/12 Informal JC workshop *Sign off draft PCBC to progress to NHS E assurance process*

Clinical Senate (CS)

- 26/10 Submit stroke materials to CS
- 16/11 CS panel review
- 30/11 1st draft report from CS
- 22/12 Final report due from CS

NHS England

Scenario 1: Single meeting of NHS E Investment Committee

~23/01 (TBC) JHOSC

- 09/01 OGSCR
- 17/01 Investment committee
- 31/01 (date TBC) Formal meeting of JC *Sign off full PCBC and agree to launch consultation pending approval from NHS E IC*
- 01/02 (date TBC) Launch consul-tation

Scenario 2: Two meetings of NHS E Investment Committee

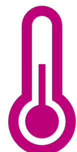
- 28/02 Investment committee
- 06/03 Formal meeting of JC *Decision meeting: agree to launch consultation*
- 08/03 (date TBC) Launch consul-tation

Timeline to implementation

- Six to eight weeks to review consultation responses and prepare the decision making business case (DMBC)
- Approval of final option Oct/Nov 18
- Go-live 12 to 24 months post-end of consultation (dependent on degree of estates development that is required)
- Potential for phased implementation to be considered

Winter planning

- Detail later on HOSC agenda.
- Extensive **joint work between partners** - CCGs, providers and local authorities to tackle winter pressures
- Work includes
  - Temporary **staffing** plans
  - **Local care support** to prevent unnecessary hospital visits
  - **Patient information** on which services to use
  - **'Stay well this winter'** public campaign
  - Encouraging **flu jabs,** including for social care and health staff
  - Careful scheduling of **planned operations**



The provider productivity opportunity is significant in Kent & Medway

£ Millions, Kent and Medway health system

-294
-139
TBC
-434
50
51
102
190
12
122
-122
-29

Provider challenge
CCG challenge
Social care challenge
Total system challenge
QIPP
Spec Comm QIPP
Care Trans-formation
Productivity incl. CIP
Enablers
System Leadership
STF funding
STF investment
Financial challenge, 2020/21, post-intervention

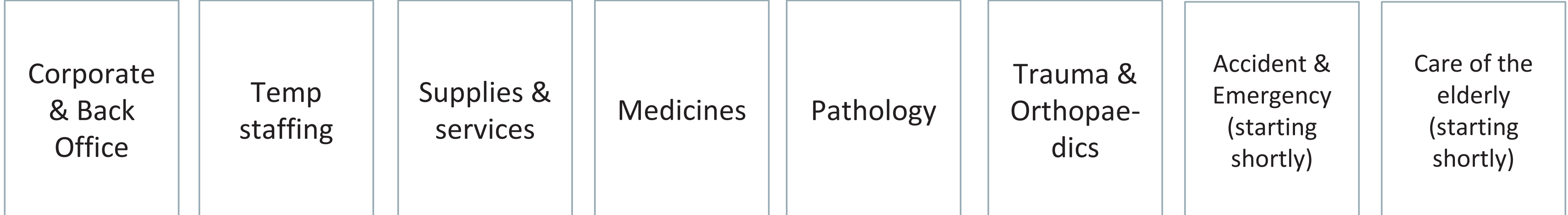
As validated by Model Hospital benchmarking – Acute only

- **£190m** is the productivity opportunity we should expect to deliver, validated by Model Hospital benchmarking (15/16 data).
- We have established a Productivity programme made up of 6 working groups to quantify their own 20/21 targets within the £190m productivity – further groups will be required to close the gap

SOURCE: October 2016 STP financial template submission

Productivity

Eight working groups



Corporate & Back Office

- Consolidate back office functions e.g. Finance, HR, Payroll, etc.

Temp staffing

- Reduce temp staffing spend and usage
- Harmonise agency and bank rates
- Set up collaborative regional bank
- Introduce single STP break glass policy

Supplies & services

- Capitalise on collective buying power
- Deliver category level savings, driving down unit cost
- Use national benchmarking tool

Medicines

- Reduce drug spend e.g. through Biosimilars
- Deliver efficiencies in wider pharmacy/ medicines management

Pathology

- Deliver efficiencies and economies of scale through networked pathology
- Repatriate tests across the region.

Deliver quick win savings and improvements and reduce unwarranted variation. Consistent approach adopted: Pathway, People, Process, Procurement, Performance.

Trauma & Orthopaedics – Focus areas:

- Length of Stay / Occupied Bed Days
- Theater utilisation
- Ortho products
- Workforce variation

Accident & Emergency – Focus areas:

- Delayed transfers of care
- Reduce clinical duplication
- Workforce variation

Care of the elderly – Focus areas:

- Length of Stay / Occupied Bed Days
- Workforce variation
- Mobility (Pyjama paralysis)

20/21 target savings opportunity:

SOURCE: 20/21 opportunities based on Model Hospital benchmarking; NHS Improvement, 15/16 data

Forward plan – emerging productivity priorities for FY 18/19

November – December 2017

- Continue to track and **monitor delivery** in non-clinical groups
- Mobilise **A&E** group and **Care of the Elderly** group – alignment with Clinical Strategy via Clinical Board
- Implement **'quick wins' in trauma & orthopaedics** action plan
- **Board/Exec team** meeting presentations
- Positive **communications to staff,** evidencing STP collaboration benefit
- Prepare for **shared bank** and agree preferred provider
- Work with NHS I to develop **Pathology network strategy**

Q4 2017/2018

- Refresh **Model Hospital opportunity analysis** and benchmarking (after refresh of national data)
- Co-located and shared **medical bank**
- **Harmonise bank and agency rates**
- Submit a **Pathology Outline Business Case** (NHS I timeframe of Jan 18)
- Develop **clinical productivity action plans** and sharing of best practice
- Mobilise **two additional Clinical Productivity groups**:
  - Obstetrics and Gynaecology
  - Community Paediatrics

FY 2018/2019 →

- Recruit a **fixed-term Productivity team** by Spring 2018 (10 WTE)
- Begin to see benefits attributed to the enabling initiatives put in place this year, e.g.:
  - **Category-level savings** from procurement benchmarking
  - **Biosimilars** benefits sharing agreement
  - Efficiencies and reduced duplication from **clinical product trials**

System transformation: A straw man system model ("cementing" the joint working)

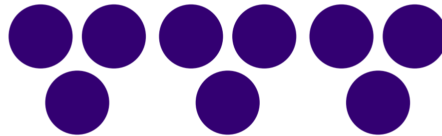
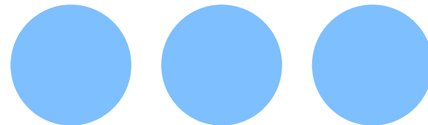
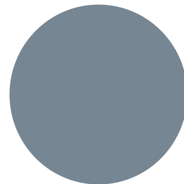
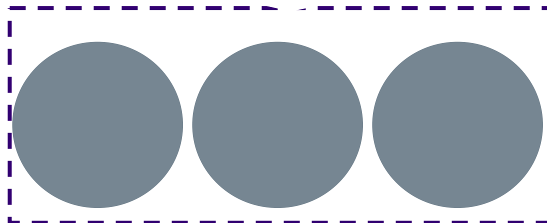
Accountable Care Organisations / Systems

- ACOs big enough to take on responsibility and accountability for whole populations; small enough to reflect differences in place/geography
- Positive and full engagement with front-line in design – therefore ensuring appropriate change in behaviours
- Voices of care professionals and patients central to decisions
- Responsible for the delivery of local (out-of-hospital) care in a way which meets local needs
- Commissions 80% of care for it's population on a more granular basis
- Embedded in local communities, working with local stakeholders

Strategic commissioner

- Strategic direction and planning
- A single organisation responsible for resource allocation (e.g. establishing capitation or alternative payment mechanism)
- Accountable upwards – should seek to take some function from regulators (NHSE / I) and holds ability to intervene
- Improves focused and prioritised clinical outcomes and other constitutional objectives
- Commissions more specialised low volume / high cost care
- Address health inequalities
- Facilitates and accelerates development of ACOs / ACS

System transformation

Local Care infrastructure		Comment	Population served
GP practices		• Individual GP practices providing limited range of services • Many working well at scale, others struggling with small scale and related issues incl. workforce	• Various
Tier 1 Extended Practices with community and social care wrapped around		• Larger scale general practices or informal federations • Providing enhanced in-hours primary care and enable more evening and weekend appointments.	• 20 – 60k?
Tier 2 Multi-specialty community providers / community hubs		• Multi-disciplinary teams delivering physical and mental health services locally at greater scale • Seven day integrated health and social care	• 50 – 200k?
Accountable care organisations / systems		A healthcare organisation characterised by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients"	• 400 to 800k?

To note

- Responds to public requests for more joined-up working
- CCG Transition Arrangements recommendations to establish Strategic Commissioner with the potential to bring together some CCG management functions under consideration
- East Kent Accountable Care Partnership (ACP) at Memorandum of Understanding (MoU) stage. Paul Bentley leading.
- Medway, North, West Kent ACP – work programme to confirm footprint under development. Lead being finalised. Two further workshops over next four weeks
- System Transformation oversight group (chaired by Glenn Douglas) to be mobilised and used to govern and direct sub-streams of work. First meeting end November

Contact information

- **Website:** www.kentandmedway.nhs.uk
- **Email:** km.stp@nhs.net

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Item 6: East Kent Out of Hours GP Services and NHS 111

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: East Kent Out of Hours GP Services and NHS 111

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

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

---

1. Introduction

(a) On 3 June 2016 the Committee received a report from the East Kent CCGs which provided an update about the outcome of the East Kent integrated urgent care service procurement combining NHS 111, GP Out-of-Hours and new care navigation service.

(b) On 25 November 2016 the Committee considered an update about the implementation of the new East Kent integrated urgent care service contract provided by Nestor Primecare Limited.

(c) On 20 September 2017 the Committee was provided with an update following Primecare being rated as Inadequate and being placed into Special Measures by the Care Quality Commission (CQC) on 3 August 2017. It was confirmed at the meeting that Primecare would be leaving the contract early on 7 July 2018. The Committee agreed the following recommendation:

- *RESOLVED that:*

(a) the report be noted;

(b) the East Kent CCGs be requested to provide a written update to the Committee in November and a verbal update in January;

(c) the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.

(d) On 24 October the Committee was notified that Primecare had opted to exercise its right to serve an accelerated notice period of three months on Friday 29 September 2017. On 14 November the Committee was formally notified that Integrated Care 24 (IC24) would take over the contract from the beginning of December.

(e) The East Kent CCGs have subsequently been requested to provide a verbal update to the Committee on 24 November 2017.

2. Recommendation

RECOMMENDED that:

(a) the report be noted;

(b) East Kent CCGs be requested to provide an update regarding the mobilisation of IC24 to the Committee in January;

(c) the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.

Background Documents

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 (25/11/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6263&Ver=4

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/2017)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4

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Health Overview and Scrutiny Committee Briefing

East Kent NHS 111 and GP out of hours services

November 2017

Author: Sue Luff, Head of Contracts

Sponsor: Simon Perks, Accountable Officer

Background

Primecare was commissioned in 2016 to provider an integrated NHS 111 and GP out of hours (GP OOH) service across the four east Kent Clinical Commissioning Groups (CCGs) following a competitive procurement process. The aim of the service was to provide a seamless transition for patients between NHS 111 and GP out of hours services. The lead CCG for the contract is NHS Canterbury and Coastal CCG.

Following a planned mobilisation phase, the GP OOH service went live on 28 September 2016 with NHS 111 following shortly afterwards in a phased approach starting from November 2016.

The contract has been closely performance managed on a monthly basis since the service went live. A key part of this process is to monitor the arrangements to ensure that patients are provided with a safe, effective service and that patient experience is reviewed regularly and lessons embedded into the service.

Regular contract management identified some concerns in relation to quality of care. The CCG has been working with Primecare to oversee improvements and support Primecare to make the necessary changes.

Care Quality Commission inspection

The CQC carried out an inspection in May 2017 and the report was published on 3 August. The CQC report identified a number of concerns and the overall rating was inadequate. The provider was placed in special measures. The concerns identified by the CQC replicated concerns that the CCG had already raised with Primecare.

Following the inspection, the CQC took enforcement action against the provider, namely the issuing of three warning notices.

The warning notices covered:

- **Safe care and treatment** (care and treatment must be provided in a safe way for service users). Primecare had failed to ensure that the risks to the health and care of service users were properly assessed, particularly in respect of reporting, recording and learning from significant events.
- **Good governance** (systems or processes must be established and operated effectively). Primecare demonstrated a lack of key senior staff, used interim staff, staff were not fully

aware of their roles and responsibilities, the disaster /recovery plan was unclear, and there was an absence of patient feedback.

- **Staffing** (sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed). Primecare did not have enough staff to meet the needs of patients and there was a lack of induction and mandatory training.

Primecare ratings for each area inspected

Are services safe? Inadequate

Are services effective? Inadequate

Are services caring? Requires improvement

Are services responsive to people's needs? Requires improvement

Are services well-led? Inadequate

The full inspection report can be viewed on the CQC website.

Progress since previous report to the HOSC

The NHS England Quality Oversight Group for Primecare continues to meet regularly to both provide support, hold Primecare to account and to ensure timely action to addresses the concerns raised during the CQC inspection.

Primecare exercised its right to serve an accelerated notice period of three months on 29 September 2017, in accordance with a joint agreement signed by both parties on 30 August 2017. This followed several weeks of intensive support from the CCG to enable the provider to deliver the required service.

The notice period was due to expire on 31 December 2017. However, the CCG took the view that to implement a new service during the holiday period would not be sensible and therefore took the decision to implement a new service on 1 December.

The CCGs have signed an agreement with Integrated Care 24 (IC24), a not for profit social enterprise, to take over the running of the NHS 111 and GP OOH service from 1 December. IC24 has more than 25 years' experience providing healthcare services, including GP OOH care and NHS 111 services across the east and south of England.

IC24 is completely committed to providing patients with a safe and efficient service and will be working closely with the CCGs and all other healthcare providers across east Kent to ensure they receive a good and safe service.

Current situation

Primecare is facing challenges with the delivery of the services, particularly in relation to the staffing for the GP out of hours bases. Primecare submitted a proposal to the east Kent CCGs to close some of the bases due to the low utilisation rate. This supports Primecare to consolidate staff across the main sites and deliver home visits.

The following bases temporarily closed on 31 October 2017.

Site	Current Utilisation rate
Romney Marsh	21 per cent
Herne Bay	44 per cent
Deal	24 per cent

This arrangement is an emergency measure due to the urgency of the situation and the need to ensure that the service is safe. This will be reviewed in the New Year.

Mobilisation of new contract

The project team is working closely with IC24 to ensure that the GP OOH service is delivered to the specification and within the required timescales. While the timescales are tight, the CCG is confident that IC24 will provide a safe service.

The IC24 GP OOH service will initially not re-open the above bases. However, this will be fully reviewed post-Christmas and will involve representation from patient groups and Healthwatch.

IC24 is an experienced provider of NHS 111 and GP out of hours services. IC24 operates the integrated urgent care service in both Norfolk and South Essex. It also operates the NHS 111 service in North Essex and the out of hours GP led service in West and North Kent, Surrey, Sussex and Northampton. The organisation also provides the nurse-led healthcare at the Sheppey Cluster of prisons. These services cover 6.4million people. In October, 70,322 patients used the 111 service and 49,144 used OOH.

In the last year IC24 has implemented a clinical assessment service in Norfolk and Waveney, has moved to a locality model and has reduced corporate services to move resources to the ‘front line’. IC24 has also introduced a raft of ‘people focused’ initiatives such as a staff forum and a reward and recognition scheme to ensure that staff are consulted on decisions and change within the organisation, and are recognised for their contributions.

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Item 7: NHS preparations for winter in Kent 2017/18

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: NHS preparations for winter in Kent 2017/18

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

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

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1. Introduction

(a) NHS England – South (South East) has been asked to provide a review of 2016/17 winter and an overview of preparations for 2017/18 winter. Representatives from the East, North & West Kent health economies have been invited to update the Committee on their local plans.

2. Recommendation

RECOMMENDED 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.

Background Documents

None

Contact Details

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NHS England

NHS preparations for and response to winter in Kent 2017/18

To: Kent Health Overview and Scrutiny Committee

From: Ivor Duffy, Director of Assurance and Delivery, NHS England South (South East)

Author: Zara Beattie, Winter Resilience Lead, NHS England South (South East)

Date: 14 November 2017

1.0 Purpose

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

2.0 Background

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

The key vehicle for winter Preparedness and Response activities are the Local A&E Delivery Boards that were established in 2016. Kent has four Local A&E Delivery Boards covering the Dartford Gravesham and Swanley; East Kent, West Kent and Medway and Swale. Kent County Council is a core member of each of these groups and is represented on them by an Executive Director.

3.0 Winter 2016/17 Debrief

During Winter 2016/17 weekly teleconferences were held with Local A&E Delivery Board leads to share good practice and assist with any immediate issues requiring escalation. An interim stocktake was held on 2 February 2017 to learn lessons from the management of and performance over the Christmas and New Year Bank holidays to implement any necessary improvements ready for the Easter 2017 Bank Holiday. A full Winter 2016/17 debrief was held with system leads on 9 May 2017. Key successes that have been continued for 2017/18 winter planning include:

1. Training for on-call teams particularly in effective teleconference management
2. GP Service provision within A&E
3. Flexibility of implementation of escalation beds and discharge to assess systems

Key lessons that have been incorporated into Winter 2017/18 plans include:

1. Demand and Capacity forecasting and planning process started earlier in the year, including early engagement with workforce
2. Implementing management systems for non-urgent prescribing
3. Automated real-time data collection available in some form across all Local A&E Delivery Boards.

4.0 Local A&E Delivery Board Assurance ahead of winter

NHS England set a clear expectation that all Local A&E Delivery Boards in Kent would have in place robust plans to deliver the urgent care standards and to ensure that plans are in place to effectively manage winter pressures. Therefore ahead of winter 2017/18 NHS England South (South East) and NHS Improvement facilitated a dual assurance process, via self-assessment and peer review, which required Local A&E Delivery Boards to provide assurance that they have put in place preparations for the winter period. This included a review of the key actions being taken to improve on last year's plan, delivery of the national ten high impact interventions, the flu programme for staff and patients and work on Delayed Transfers of Care.

LAEDB Winter Plans have been assessed through a two part bipartite process and have been assured as Amber: "Assurance that the plans reflect some of the relevant criteria but not comprehensively". 'Check and Challenge' face to face meetings and LAEDB exercises provided an update on progress and informed the assurance return to NHS England South sent 18 October 2017. Whilst the overall assessment of the plans remains Amber, as all systems have aspects where they are continuing to strengthen, the progress is good and LAEDB continue to refine and test their plans with support from NHSE/NHSI as required. NHSE are working with all LAEDBS to produce a Kent and Medway surge management plan in the coming weeks, looking in particular to strengthen mutual aid agreements.

5.0 Surge Management Plans and Exercises

All Local A&E Delivery Boards have prepared Surge Management Plans that are aligned to the NHS England South Region Surge Management Framework which was agreed by the South Region Bipartite of NHS England and NHS Improvement. Plans have been updated to incorporate lessons from Winter 2016/17 and Easter Bank Holiday 2017. NHS England and NHS Improvement have also sent a Bipartite Gateway letter (Reference 06969) confirming the four national priorities for winter 2017/18 which have been incorporated into the Local A&E Delivery Boards Surge Management Plans.

NHS England South (South East) will ensure that each Local A&E Delivery Boards conduct a Surge Capacity exercise ahead of winter 2017-18. The Local A&E Delivery Boards' Surge Management plans will then be updated to ensure that these lessons are addressed.

6.0 Winter Communications

All Local A&E Delivery Boards are promoting the nationally led 'Stay Well This Winter' campaign, which is a joint initiative between NHS England and Public Health England. http://www.nhs.uk/staywell/

This campaign drives home key messages to the public which will take the pressure off frontline services. The messages ask the public to protect themselves as the cold weather sets in by staying warm, stocking up on prescription medicines or checking in on friends and neighbours to make sure they are keeping well and taking up the offer of a seasonal flu vaccination where eligible.

7.0 Seasonal Flu Vaccination

Outbreaks of flu can occur in health and social care settings, and, because flu is so contagious, staff, patents and residents are at risk of infection. The 2014 - 5 vaccination pilot showed reduced GP consultations for influenza-like illness in children by 94% & adults by 59%, children A&E respiratory attendances by 74%, hospital admissions for confirmed influenza by 93%. As a result front-line healthcare workers are offered a flu vaccination. Local A&E Delivery Boards have put in place measures to maximise and monitor updates by eligible Health and Social Care staff.

Flu immunisation provision has now been extended to health and social care staff, employed by a registered residential care/nursing home or registered domiciliary care provider, who are directly involved in the care of vulnerable patients/clients who are at increased risk from exposure to influenza, meaning those patients/clients in a clinical risk group or aged 65 years and over.

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

8.0 Winter Response

NHS England South (South East) is operating a virtual winter resilience room between 24 October 2017 and 30 April 2018. The winter resilience room provides a focal point for winter briefings, escalation discussions and communications through the winter. From here NHS England will provide oversight of the Local A&E Delivery Boards response to winter, monitor daily situation reports prepared by hospitals and community services organisations, prepare daily situation reports and briefings and facilitate system-wide requests for support where required.

9.0 Health and Wellbeing Boards and Better Care Fund Plans

The Health and Wellbeing Boards will be contributing to winter planning through the Better Care Fund Plans and the Eight High Impact Change Model self-assessments on Managing Transfers of Care. NHS England will also be monitoring and reporting to the Health and Wellbeing Board level Delayed Transfers of Care figures for NHS, Social Care and joint delays in the run up to November 2017, and by implication the impact of the BCF and IBCF funds. The November 2017 review of performance will link to 10% of the IBCF allocation for 18/19. The reduction in delayed transfer of care is key in providing capacity in the acute sector to enable delivery of safe services over the winter period. It is paramount that health and social care partners deliver the required reductions in DTOCs and commit all additional or hypothecated resources to achieve this.

10.0 Summary

- Local A&E Delivery Boards, of which KCC is an integral part, have taken steps to prepare the health and social care system to manage winter pressures.
- Individual Health and Social Care organisations and Local A&E Delivery Boards have Surge Management plans.
- These Surge Management plans will be tested by exercise and amended to take account of lessons identified ahead of the winter period.

- A strong national communications campaign is being supported and delivered locally. The NHS recognises and welcomes KCC's ongoing support to successfully deliver these important messages to the population of Kent.
- KCC and other partners' support in encouraging the uptake of seasonal flu vaccination is also welcomed.
- DTOC reduction must be a key focus for health and social care partners
- A robust system of winter reporting has been put in place to identify and respond to any challenges as they arise via the Winter Resilience Room
- In addition to the Surge Management Plans, all the members of Local A&E Delivery Boards have robust, well-rehearsed plans in place to manage the impact of emergencies that can result from severe weather, infectious disease outbreaks or industrial action.
- The Surge Management Plans are support by the Urgent and Emergency Care work stream, Health and Wellbeing Boards and the Better Care Fund Plans.

Zara Beattie
Winter Resilience Lead
NHS England South (South East)

Item 8: West Kent CCG: Over The Counter (OTC) Medicines

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: West Kent CCG: Over The Counter (OTC) Medicines

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

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

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1. Introduction

(a) On 2 November 2017 the Committee was notified by West Kent CCG that its Governing Body had approved an amendment to its prescribing policy so that over-the counter medicines would no longer be prescribed for minor ailments.

(b) The Chair requested an item on the prescribing policy for over-the-counter medicine for minor ailments be brought to the Committee on 24 November.

2. Recommendation

RECOMMENDED that the Committee consider and note the content of the report.

Background Documents

None

Contact Details

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NHS
West Kent
Clinical Commissioning Group

Over The Counter (OTC) medicines.

HOSC: November 2017

Patient focused,
providing quality,
improving outcomes

Introduction

Each year 57 million people in the UK visit their GP and 3.7 million people visit the accident and emergency department of their local hospital for symptoms that could be treated with self-care and over the counter (OTC) products widely available in community pharmacies and supermarkets. The NHS in England spends approximately £645million p.a. on such medicines (NHS England, 2017). A significant proportion of GP appointments and GP practice time is taken up in processing prescriptions for minor ailments. Currently around 20 per cent of a GP's time and 40 per cent of their total consultations are used for minor ailments and common conditions at a cost of an average £2 billion per year to the NHS.

It is recognised that referring patients to their community pharmacist for over the counter medicines aligns with the Five Year Forward View, utilising the skills and competencies of this profession, as well as promoting self-care. Community Pharmacists are well placed to give patients advice on minor ailments and this fits with self-care as well as NHS England's proposals to enhance the offering from community pharmacists as part of the wider health and social care economy.

The proposal to amend the prescribing of over the counter (OTC) medicines was drafted by the medicines optimisation team (MOT), alongside the medicines optimisation group (MOG) in response to the national consultation regarding the prescribing of over the counter medicines

What are 'Over the Counter' medicines?

These include products that:

- Can be purchased over the counter, and sometimes at a lower cost than that that would be incurred by the NHS;
- Treat a condition that is considered to be self-limiting as it will heal/be cured of its own accord; and/or
- Treat a condition which lends itself to self-care, i.e. that the person suffering does not normally need to seek medical care and/or treatment for the condition.
- Over the counter products can be classified as general sales list (GSL) or pharmacy only (P). Pharmacy only products need to be purchased under the supervision of a pharmacist (General Pharmaceutical Council, 2013). Paracetamol and other painkillers in reduced pack sizes are widely available in supermarkets and at local chemists and cost around 1p per tablet, compared to 3p per tablet on the NHS. However a point to note is that not all pack sizes and doses are available 'over the counter'. For example paracetamol pack size 100 is a prescription only medicine and paracetamol pack size 16 is a GSL.

These conditions commonly treated with OTC medicines include but are not limited to the following, which in most cases are minor and/or self-limiting conditions:

Diarrhoea	Cold sores
Constipation	Teething
Acute Pain	Nappy rash
Athlete's foot	Mouth ulcers
Fever	Haemorrhoids
Oral and vaginal thrush	Ear wax
Head lice	Warts and verrucae
Insect bites and stings	Soft tissue injury/musculoskeletal joint injury
Conjunctivitis	Viral upper respiratory tract infections
Contact dermatitis	Scabies
Sore throat	Ring worm
Headache	Mild acne
Indigestion and heartburn (Dyspepsia)	Minor burns and scalds

NHS England and NHS Clinical Commissioners have identified two separate categories of product which are available over the counter and may be considered appropriate for restriction, such that the product is not routinely prescribed in primary care. These categories are:

- Medicines which are used to treat generally time-limited/short term conditions that are suitable for self-care (this will include many conditions which are self-limiting). Medicines within this category account for approx. £50m - £100m p.a. of NHS spend in England. In this category, we mean conditions which are episodic and which do not require ongoing or long term treatment. By self-limiting, we mean conditions which without treatment to alleviate symptoms, would normally heal of their own accord, for example the common cold; and
- Medicines which are used for longer term, chronic conditions but which are being prescribed at an estimated cost of approx. £545m p.a. For example, some but not all of the £70m spent annually on paracetamol might fall into this category, as may antihistamines on which the NHS spends £14m p.a. (NHS England, 2017)

Finance

For the 16-17 financial year, west Kent spent ~£1.8million on the prescribing of all self-care products. Compare that to the year to date extrapolated for 17-18 financial year, west Kent is predicted to spend ~£2.1 million (based on spend from April – May 2017) on the prescribing of all self-care products.

Based on the restricted list agreed by the Medicines Optimisation Group (below), the maximum potential full year savings for 2017/18 would be £1,706,022*. Please note that implementing from December 2017 to March 2018 would produce a maximum potential saving of £568,674. (See Appendix 1 for complete figures). These figures are based on a complete 100% cessation of prescribing of OTC products included in the restricted list, without consideration of the clinical exclusions outlined in the restricted list. .

*Figures obtained from ePact searches and PrescQIPP data

Survey Feedback

Engage Kent reported that 274 people contributed their views (See Appendix 2 for the full report). They found;

- 85% of people currently receiving free prescriptions would buy items from pharmacy if their GP asked them.
- 15% of people said that if one or more of the medicines listed, were no longer available on prescription, it would be a problem for them.
- 45% of people felt that the NHS should provide only the most effective drugs and treatment, regardless of what they cost.
- 68% of people felt that none of the listed medicines discussed with them needed to remain on prescription.
- Some GPs have already reduced what medicines they are prescribing and encouraging patients to buy over the counter. GPs require a CCG wide decision with guidance about a wider range of medicines, as most are currently focused on paracetamol products. (Engage Kent, 2017)

What are other CCGs doing to tackle OTC prescribing?

The MOG debated the approach from other CCGs as part of the review and looked at what other areas were doing to tackle the matter raised.

1. Encouraging and directing patients to buy these medicines over the counter through promotional materials by;
   - Cascading relevant messages to GPs and other healthcare professionals through the distribution of posters which aim to suggest prescribers think twice about prescribing OTC medicines.
   - Distributing posters and other correspondence to prescribers and displaying them within GP practices and community pharmacies.
   - Ensuring GPs can still comply with the GMC contract by not restricting prescribing and encouraging GPs if a prescription is required, to prescribe a small quantity, not on repeat and encourage the patient to purchase any further supplies.
   - Encouraging community pharmacists not to refer patients to a GP when an over the counter product would be suitable.
2. Changing the prescribing policy for only specific groups of OTC medicines;
   - Bath and north Somerset CCG chose to limit the prescribing of painkillers and hayfever medicines.
   - They highlighted the need to avoid a blanket policy and to create some exemptions for certain groups, i.e. those taking painkillers for long-term conditions, for those on low incomes and for young children.

- They stated that in certain exceptional cases GPs may deem it medically necessary to prescribe these treatments because the patient is highly unlikely to source the medicines and self-care independently.

3. Awaiting the results of the national consultation from NHS England. Once that is confirmed, take action according to the result.

4. Completely restrict prescribing of all OTC products

Other points to consider

Pharmacy first

West Kent CCG currently commissions a minor ailment service, Pharmacy first common ailments scheme, across west Kent to reduce the burden on GPs and support the self-care agenda. Pharmacy First Common Ailments Scheme is a well-established service allowing patients to have access to free of charge over the counter medicines to treat minor ailments via a consultation with a community pharmacist.

So far 37 pharmacies out of a total of 69 across west Kent are actively participating in this service. The service has led to an average of 170 saved GP appointments per month.

Pharmacy first and other similar services are integrated into the NHS 5-year forward view. The 5-year forward view highlights the role that pharmacies can play; emphasising there is a need to build the public's understanding that pharmacies can really help patients to deal with minor ailments.

West Kent is the only CCG across Kent and Medway to have pharmacy first. It is therefore an important safety net which other CCGs don't have, which allows patients to still have access to these medicines free of charge if required.

Local Medical Committee (LMC)

The LMC are in agreement to the beneficial impact of promoting self-care and appropriate use of NHS resources. They recognise that prescribing items for self-limiting, short-term, minor conditions has an impact on workload for NHS staff as well as prescribing costs.

The LMC have highlighted that GPs have a contractual obligation to prescribe medication on an FP10 that the GP feels is clinically necessary whether the medication is available over the counter or not.

Other CCG's have sought professional legal advice on this matter, and this has been passed onto the MOT. The CCG who procured the advice is happy for this to be shared with CCG colleagues. However, they have stated it does not constitute NHS England or NHSCC legal advice, and should not preclude CCGs obtaining their own legal advice. The following is an excerpt from the legal advisor addressing the contractual regulations within the GMS contract, specifically relating to the duty of physician to prescribe when a need has been identified

"A prescriber is obliged, where drugs/medicines are "needed for treatment", to offer those to patients on prescription. That is not to say that a GP cannot inform patients (and there is nothing in the GMS Regulations or the standard GMS/PMS contracts to prevent a GP from doing so) that the drug/medicine which is clinically required is available over the counter as an alternative to a prescription. Where, despite that information being conveyed, the patient still requests the

drug/medicine on prescription, however, the prescriber must (ie: is contractually obliged) provide that prescription and a failure to do so would result in breach of contract. It is therefore likely that, whether the drug/medicine is requested on prescription will turn on an assessment of its cost to the patient i.e. whether the patient pays for prescriptions and if the patient does, whether the cost of the prescription is cheaper than the over the counter cost of the item.

It may also be that whilst a drug/medicine could relieve symptoms, it is not "needed for treatment" within the meaning of the regulations and, as such, the prescriber could direct the patient to an over the counter remedy in lieu of prescribing."

Risks

Restricting the prescribing of certain over the counter medicines could result in the following risks;

- Reputational risk to the CCG
- Some groups of patients may be disproportionally effected
- Patients who have purchased pre-payment certificates may be negatively affected

On a counterbalance there are risks associated with not restricting the prescribing of OTC medicines which could include waste of NHS resources. This has an impact on other priority services that the residents of west Kent need across all age groups, geographic and social groups.

What has happened so far?

1/3/17-20/3/17 – Pre-consultation carried out by Engage Kent to reach targeted communities within west Kent to seek their views and thoughts regarding possible changes to the prescribing of Over the Counter (OTC) Medicines, 274 people contributed their views.

28/3/17 - NHS England announced that it would be undertaking a review to consider the prescribing of medicines which are of relatively low clinical value or priority or are readily available 'over the counter' and in some instances, at far lower cost. It is anticipated that this review will cover medicines included in this report such as treatment for coughs and colds, antihistamines and sun cream.

10/8/17 – OTC medicines paper outlining what other CCGs are doing to tackle OTC prescribing was taken to the medicines optimisation group (MOG). The MOG consists of GPs from various areas of different levels of deprivation in west Kent, members of the medicines optimisation team, a community pharmacist representative and a patient representative. The MOG recommendation was for the medicines optimisation team to formulate a restricted OTC medication list and to provide educational materials to patients and GPs prior to this change. This was supported by all members of the MOG.

22/8/17 – MOG recommendations were taken to the governing body. The Governing Body were asked to consider the MOG proposals which were;

- To agree on the principal to promote self-care and encourage patients to buy OTC medicines where available

- Authorise the MOG to create a definitive restricted list.

The governing body agreed but also asked for an equality impact analysis to be carried out. Furthermore, the governing body asked for the paper to be brought back with more detailed analysis of the pre-consultation in terms of a breakdown of the demographics that were represented in the pre-consultation. This is available in appendix 3 of the pre-consultation paper (below).

Target Areas

Target areas	Postcode		No of people
Maidstone 28%	ME14	Maidstone, Bearsted, Grove Green	5
	ME15	Bearsted (Madginford), Downswood, Shepway, Senacre, Maidstone Town Centre, Loose, Mangravet, Park Wood, Tovil, East Farleigh, West Farleigh	60
	ME17	Hollingbourne, Hucking, Harrietsham, Lenham, Boughton Monchelsea, Linton, Coxheath, Chart Sutton, East Sutton, Langley, Kingswood, Sutton Valence	11
Sevenoaks 28%	TN 13	Riverhead, Dunton Green	65
	TN14	Cudham, Otford	7
	TN15	Kemsing, Ightham, Plaxtol, Wrotham, Sevenoaks Weald	4
Rural Tunbridge Wells 30%	TN1	Royal Tunbridge Wells (town centre)	2
	TN2	Pembury	78
	TN3	Langton Green, Groombridge, Frant, Speldhurst, Lamberhurst	2
Unknown 6%			19
Out of target areas 8%	ME1	Rochester, Burham, Wouldham	2
	ME16	Barming, Allington and west Maidstone	1
	ME19	West Malling, Kings Hill, Leybourne	1
	TN4	Rusthall, Southborough	2
	TN9	Tonbridge	1
	TN16	Westerham, Biggin Hill, Tatsfield	3
	TN17	Cranbrook, Goudhurst, Benenden, Frittenden	1
	TN11	Penshurst, Hildenborough, Hadlow	6
	TN12	Paddock Wood, Staplehurst, Brenchley, Horsmonden	4

14/9/17 – OTC restricted list was agreed at the MOG. Analgesia medication as removed from the restricted list due to concerns raised by the MOG and the governing body.

29/9/17 – Equality analysis carried out and ratified by north east London commissioning support unit (NELCSU) equality team.

Summary of equality analysis.

The proposal was ratified by the medicines optimisation group, which contains GPs, members of the medicines optimisation team, a community pharmacist representative and a patient representative. The GPs are members of different practices across west Kent, each with varying levels of deprivation. The community pharmacist representative is a member of the local pharmaceutical committee (LPC) and feeds back the thoughts from the LPC and the patient representative gives the MOG a lay person's opinion on potential new policies.

An equality analysis was carried out retrospectively on 29/9/17 with the help of NELCSU quality team and WKCCG communications team. Following an independent pre-consultation carried out by Engage Kent, all negative impacts to the protected characteristics included in the equality act have been considered. Those protected characteristics identified to have potential negative outcomes include;

1) Age: Patients who currently receive free prescriptions because of age will no longer be able to receive over the counter medicines free of charge on prescription. These groups would therefore have to pay for any over the counter medications for conditions that can be managed by self-care, which could negatively impact their income or their management of self-limiting conditions.

2) Disability: Patients with a disability (e.g. physical or learning disabilities) or those patients who are housebound may have difficulties in purchasing products over the counter and this change may make it less safe for these patients than receiving these items on prescription. Those housebound patients or those with disabilities may not be able to purchase products safely and independently over the counter and thus may be negatively affected by this change.

3) Care home residents: Care home residents, who are currently prescribed over the counter medicines, may be negatively affected by this change. Currently care homes can give patients over the counter medicines via a homely remedy policy, but this only covers for up to 72 hours. Thereafter, carers cannot administer these medicines and patients may be negatively affected.

Mitigating actions have been identified for these negative outcomes and can be found in the full equality analysis in Appendix 3. We plan to monitor for any unintended consequences during the first 6 months from implementation to see if any negative effects have been missed and take action to mitigate these.

Restricting the prescribing of over the counter medicines

NHS West Kent Clinical Commissioning Group supports GPs to reduce their prescribing of over the counter products for patients with short-term, minor, self-limiting conditions.
These medicines can be purchased from pharmacies and supermarkets which are open late and at weekends. A pharmacist is a fully trained healthcare professional and expert on medicines whose broad knowledge and advice is available without an appointment.
Some clinical exclusions to buying these products over the counter are provided below, e.g. pregnancy, breastfeeding and age, these can be applied at the discretion of the prescriber.
Prescribers are also asked to take into account accessibility issues to purchasing these medicines over the counter e.g. disabilities, housebound patients, care home residents etc
Prescribers are reminded that west Kent has a ‘safety net’ in Pharmacy First, where a prescriber can refer patients who normally get free prescriptions, to Pharmacy first, so that these patients can still have access to medicines.

The below list is not exhaustive (See Doris for complete list)

Medicine group	Common examples (not exhaustive)	OTC indications	Common OTC exclusions	OTC age restriction
Antifungals	Clotrimazole cream, miconazole cream, amorolfine/Loceryl®/tioconazole/Trosyl® nail lacquer, Canesten®, Daktarin®	Skin infections due to dermatophyte, yeasts, moulds and other fungi	• Pregnancy and breastfeeding • Diabetes • Nail lacquer – Maximum 2 nails	• >10 years for Canesten HC • 16-60 years for genital thrush treatment • >18 years for nail lacquer
Antihistamines (drowsy)	Chlorphenamine, Piriton®	Hayfever, rhinitis, urticaria, allergies and insect bites.	• Pregnancy and breastfeeding	• >1 years
Antihistamines (non-drowsy)	Cetirizine, loratadine, Clarityn®	Allergic rhinitis and urticaria	• Pregnancy and breastfeeding	• >2 years for hayfever • >6 years for urticaria
Cold-sore treatments	Aciclovir cream, Zovirax® cream	Cold sores	• Immunocompromised • Pregnancy and breast feeding • Only for use on face and lips	• N/A
Cough and cold remedies	Simple linctus, Tixylix®, pholcodine, codeine phosphate linctus, Sudafed®, Dequadine®, Tyrozete®	Acute cough and cold symptoms	• Present for > 3 weeks • Pregnancy and breast feeding • Decongestants – Hypertensive patients	• >6 years for cough mixtures • >18 years for decongestants
Diarrhoea/Constipation	Rehydration sachets, Dioralyte®, loperamide, Immodium®, lactulose, Senna®, Movicol®, Fybogel®, Buscopan®	Acute diarrhoea/constipation symptoms	• Other bowel conditions e.g. IBD • Pregnancy and breast feeding • Non-acute causes • Rehydration salts – Liver/kidney disease, low sodium/potassium diets, diabetes	• >6 years for Fybogel® • >2 years for Movicol® • >12 years for loperamide • >12 years for Senna®
Eye drops (infective)	Chloramphenicol 0.5% drops/1% ointment	Treatment of acute bacterial conjunctivitis	• Non-bacterial causes • Pregnancy and breastfeeding	• >2 years
Eye drops (allergic)	Sodium cromoglicate 2% drops, Opticrom®	Relief and treatment of hayfever symptoms	• Pregnancy and breastfeeding	• >6 years
Emollients	Oilatum®, Epaderm®, Zerobase®, Cetraben®, E45®, Aqueous cream, etc.	Contact dermatitis, atopic eczema, senile pruritus, ichthyosis and related dry skin conditions.	• N/A	• N/A
Hayfever nasal sprays	Beclometasone 50mcg, Triamcinalone 55mcg, Sterimar®, Fluticasone 50mcg, Pirinase®	Prevention and treatment of allergic rhinitis	• Pregnancy and breastfeeding	• >18 years
Haemorrhoid preparations	Preparation H®, Germoloids®, Anusol®, Anusol Plus HC®	Internal and external haemorrhoids, pruritus ani, proctitis and fissures	• Pregnancy and breastfeeding • Bleeding/blood in stool	• Not recommended for use in children
Heartburn/Indigestion	Gaviscon®, Peptac®, magnesium, triscilicate	Acute indigestion/heartburn	• Pregnancy and breastfeeding • Over 55 years	• >12 years for Gavison® • >1 years for Gaviscon® infant
Head lice treatment	Dimeticone 4%, Hedrin®, Lyclear®	Visible head lice	• Pregnancy and breastfeeding	• >6 months
Shampoos and skin rashes	Alphosyl®, Capasal®, calamine lotion/cream	Shampoos; Seborrhoeic dermatitis, itchy, oily scalp, dandruff. Calamine; Mild sunburn and other minor skin conditions	• N/A	• >12 years for shampoos
Steroid creams/ointments	Hydrocortisone, Eurax®, Eurax HC®	Allergic contact dermatitis, irritant dermatitis, insect bite reactions and mild to moderate eczema	• Use on the face, anogenital region or broken skin • Pregnancy and breast feeding • Duration of use > 1 week • Infected skin	• >10 years

CCG Decision

The MOG were supportive of the decision to promote self-care and have agreed the restricted list. The Governing Body approved the MOGs proposal of the restricted list, and approved cascading of the list alongside relevant communications, including posters, leaflets etc. to GP practices, pharmacies and patients.

Following the governing body's approval, the Medicines Optimisation Team will attempt to quantify clinical exclusions and devise a more accurate potential saving opportunity for NHS West Kent CCG.

References

Engage Kent, March 2017. Report on public engagement regarding Over the Counter medicines in west Kent.

General Pharmaceutical Council, November 2013. Developing guidance to support the safe and effective supply of 'Pharmacy (P)' medicines.

NHS England, July 2017. Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs.

PrescQIPP, July 2017 – accessed August 2017.

Appendix 1: West Kent CCG OTC prescribing figures (PrescQIPP, 2017)

	Total Spend YTD (April 17-July 17)	**Forecast total spend financial year 17-18**
Diarrhoea/Constipation	£196,760	£590,280
Antihistamines (OTC)	£46,925	£140,775
Conjunctivitis	£28,352	£85,056
Fungal infection	£18,727	£56,181
Cough and cold remedies	£1,388	£4,164
Heartburn and indigestion	£41,016	£123,048
Nasal Sprays (OTC)	£6,626	£19,878
Eczema	£12,058	£36,174
Head lice and scabies	£3,718	£11,154
Haemorrhoid treatment	£2,817	£8,451
Cold Sore	£1,115	£3,345
Threadworm	£567	£1,701
Emollients (OTC)	£204,784	£614,352
Skin rash	£3,821	£11,463
Total	£568,674	£1,706,022

Appendix 2: Pre-consultation document

Report on public engagement regarding Over the Counter medicines in West Kent.

Engage Kent
March 2017

Executive summary

This report has been prepared for the Medicine Optimisation Group who, via the Clinical Group and the Governing Body, oversaw the public engagement project.

From 1st to 20th March 2017, Engage Kent undertook engagement activities to reach targeted communities within West Kent to seek their views and thoughts regarding possible changes to the prescribing of Over the Counter Medicines, as part of West Kent CCG's wider work to address the financial and operational pressures faced by the CCG and wider NHS. 274 people contributed their views.

We found;

- 85% of people currently receiving free prescriptions would buy items from pharmacy if their GP asked them.

- 15% of people said that if one or more of the medicines listed, were no longer available on prescription, it would be a problem for them.

- 45% of people felt that the NHS should provide only the most effective drugs and treatment, regardless of what they cost.

- 68% of people felt that none of the listed medicines discussed with them needed to remain on prescription.

- GPs have already reduced what medicines that are prescribing and encouraging patients to buy over the counter and would welcome a CCG wide decision with guidance about a wider range of medicines, as most are currently focused on paracetamol products.

- Pharmacists support reducing the range of medicines available on prescription. However, they have concerns about monitoring and support of high risk client groups and the potential for people to be frustrated when Pharmacists are not able to sell something over the counter without the patient having previously seen a GPs.

On 28th March, NHS England announced that it would be undertaking a review to Consider the prescribing of medicines which are of relatively low clinical value or priority or are readily available 'over the counter' and in some instances, at far lower cost. It is anticipated this this review will cover medicines included in

this report such as treatment for coughs and colds, antihistamines and sun cream.

In addition, to inform future thinking and planning, Engage also spoke to people about what they felt were most effective methods of getting information from the NHS/CCG, to help inform future promotional activities.

What are ‘Over the Counter’ medicines?

‘Over the Counter’ medicines refer to those medicines which can be bought from pharmacies, supermarkets and other retail outlets without the supervision of a pharmacist. They include medicines that treat minor self-limiting complaints people may feel are not serious enough to see their GP or pharmacist about. The list of medicines that was discussed with the public can be found in Appendix 1

Project design and methodology

The project was designed around an impact and inequalities assessment that ensured that the engagement activities were tailored to target those that the proposals will most impact, for example people on low incomes, in receipt of free NHS prescriptions or with chronic or long term conditions such as arthritis pain, allergies and minor joint and muscle pain.

A desk top review of the deprivation indices and health inequalities across the West Kent CCG area, plus urban and rural geographical factors, highlighted three target areas;

- Park Wood and Shepway South wards in Maidstone.
- Sevenoaks
- Rural Tunbridge Wells

In order to gain a full 360 perspective, the project was designed to work with public, GP surgeries and Pharmacies within the same target geographical area.

These pairings of GPs and Pharmacies were:

- Wallis Avenue Surgery and Lloyds Pharmacy in Maidstone
- Town Medical Centre and Paydens in Sevenoaks
- Waterfield House Surgery and Pembury Pharmacy in rural Tunbridge Wells

Engaging GPs and pharmacists

Practice Managers were sent a set of questions that they discussed with GPs in their practice and then relayed in a phone interview.

Pharmacists were interviewed using the public questionnaire as a semi structured interview.

Engaging patients and public

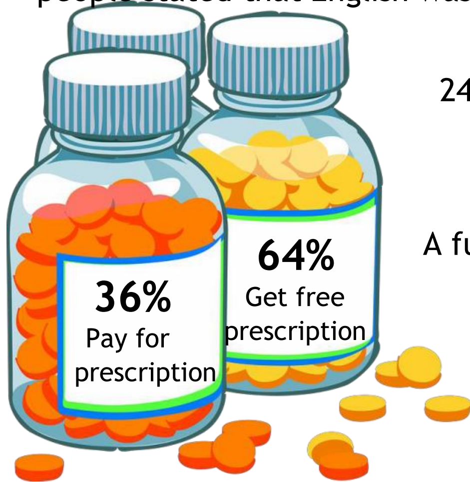
The main methods used to engage the public were;

- Fliers were distributed at participating GP surgeries (Appendix 2)
- Face to face interviews were undertaken with people waiting to collect prescriptions in participating pharmacies (Appendix 3)
- Fliers were handed to morning commuters (7am-8.30am) at three mainline stations within target areas, Maidstone East, Tunbridge Wells and Sevenoaks station.

Who we spoke to

274 members of the public contributed their views, of whom 30% of respondents came from the target area in rural Tunbridge Wells, 28% from Sevenoaks and 28% from the target area in Maidstone.

The majority of respondents were white English/ Welsh or Scottish (90%) and 94% of people stated that English was their first language.



24% identified themselves as carers and 13% identified themselves as disabled. 66% of those engaged were female.

A full profile of the public can be found in Appendix 4

What we found

People were shown a list of medicines and asked to say if they had had this on prescription in the last 6 months, bought it over the counter, or had it on repeat prescription.

The levels of people reporting to buy the listed medicines over the counter were consistently high with an average of 91%. They ranged from items such as hair removal cream and sun creams being exclusively bought over the counter, to the lowest reported over the counter purchased item of soya and infant thickened formulas, with a majority of people saying that they had bought this item.

The levels of people reporting that they had received some of the listed medicines on prescription was significantly lower with an average of 11%. Of the list, the most frequently reported items gained on prescription were soya and infant thickened formula and fungal nail infections for minor conditions, with 20% of people indicating they had this on prescription.

The level of people reporting that they had received some of the listed medicines on repeat prescription was very low, with an average of 0.5%. The most frequent items on repeat were painkillers (3%) Antihistamines (2%), bath additives moisturisers (2%) and nasal sprays (2%). Full breakdown for each listed medicine can be found in Appendix 5

People were also asked what items they thought should remain available on prescription. 68% of people felt that none of the listed items needed to remain on prescription.

It is worth highlighting that 32% of people considered what they perceived the needs of others to be, as well as their own needs in answering this question. There were some common clusters of thinking;

- Painkillers, in terms of frequency and volumes currently gained under prescription.
- Infant formula milk, for families on lower incomes.
- Fungal nail treatments, as they are expensive to buy over the counter.
- Everything should remain available, as NHS should provide everything.

Detailed breakdown can be found in Appendix 6.

To get a sense of the public's expectations of the NHS, people were asked to identify with one of three statements. We found that of the total number of people we spoke to;

45% of people felt that the NHS should provide only the most effective drugs and treatment, regardless of what they cost.

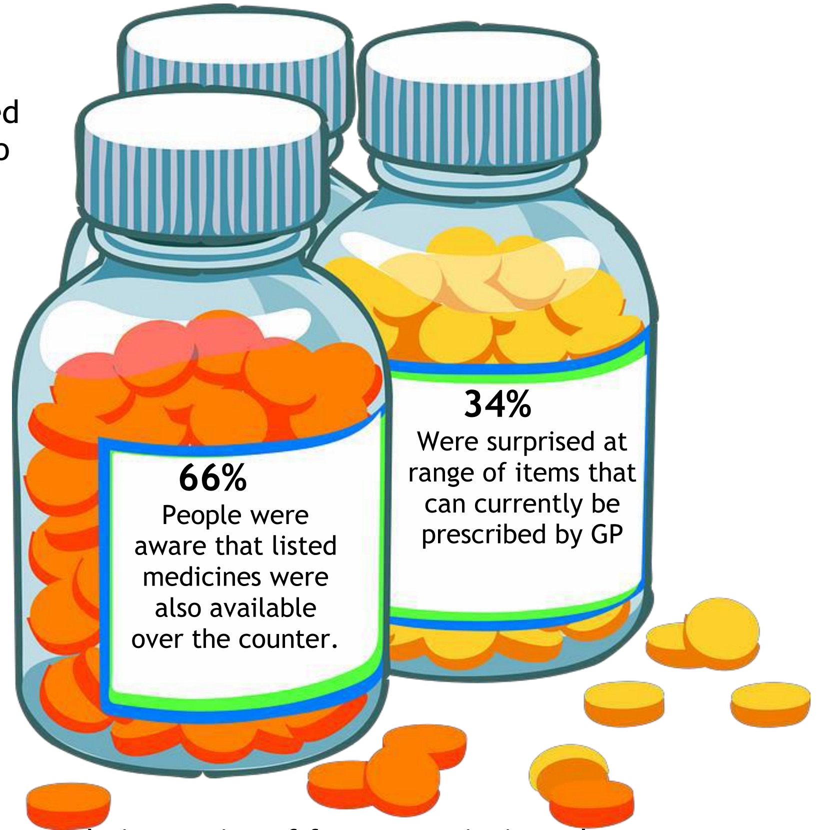
38% of people felt that the NHS should provide the most effective drugs and treatments only if they represent good value for money.

17% of people felt that the NHS should provide all drugs and treatments no matter what they cost.

What we heard from the public

Whilst there was support for reducing the amount of medicines available on prescriptions, there were areas of consideration raised by the public;

- The need to see a GP to determine the seriousness of a condition or to confirm its diagnosis. This included issues such as;
  - Fungal nail infections
  - Nasal congestion
- A greater move to return unused medicines and greater ability to re-enter them into stock.
- Discretionary power for GPs to offer items on prescription for low income families.
- Vitamins to remain on prescription for clinically diagnosed conditions
- Infant formula milks, should come from social services budgets rather than NHS budgets.



64% of the people we spoke to were currently in receipt of free prescriptions, but only 15% said that buying medicines over the counter would be difficult for them.

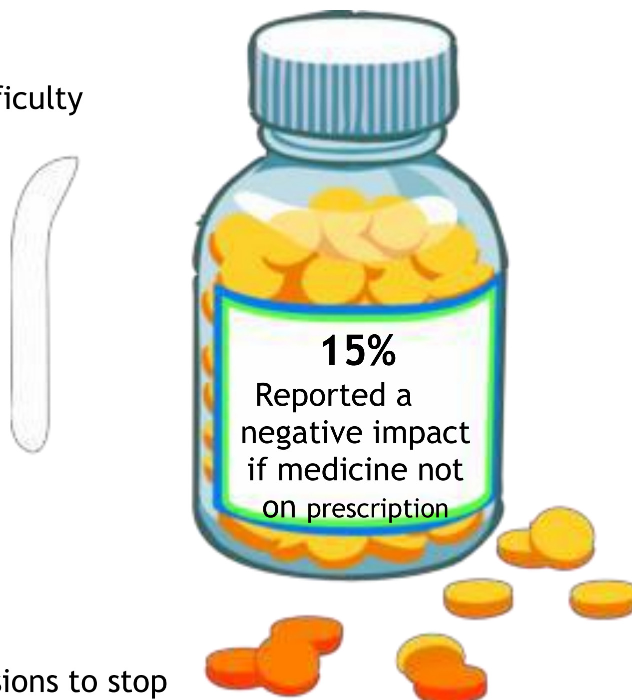
The single biggest area of concern about buying medicine over the counter was the financial impact. Many people were supportive, in principle, of buying relatively cheap items over the counter but expressed a concern about agreeing to buy something without knowing the actual cost.

One 25yr old female explained that it would cost her £14.50 for a tub of food for her baby and that her child benefit wouldn't cover the cost.

Four people raised concerns about being able to buy the volume of painkillers that they needed on a regular basis.

One person highlighted that they would have difficulty accessing a pharmacy to buy medicines on a regular basis.

Whilst surveying the public in Pharmacies the project looked at shelf prices for the medicines listed and noted the average price. For detail see Appendix 7



What we heard from GPs

Each practice reported that they had made decisions to stop prescribing some medicines on the list, such as paracetamol, tablets and suspension for all patients, Ibuprofen and one had stopped freezing verrucae.

One practice explained that when the pharmacy scheme came on line they had made proactive moves to encourage people to get medicines via this scheme.

Example data from one surgery showed that as of end of February 2017, 50% of their patients were in receipt of repeat prescriptions. Not surprisingly the greater numbers of those receiving repeats prescriptions are aged 60-79yrs, with 16% of this group having 5 or more medicines on regular repeat.

The reported reducing of prescribing the listed medicines would seem to be supported by our findings. Given the illustration from one surgery regarding the number of medicines being prescribed to people within age bracket 60-79yrs, we found very small numbers of people in this age bracket reporting being in receipt of the listed medicines via prescription and even fewer in receipt via a repeat prescription.

One GP practice manager explained that they are taking time to talk to frustrated patients who are being advised that the GP is not now prescribing items that they have previously had for free on prescription. They reported that the time invested in these conversations, explaining the reasoning behind the decision is making a difference to how patients feels about buying their medicines over the counter. Patients who raise particular concerns are ‘flagged’ so that GPs are alerted to discuss direct with the patient during the consultation.

The participating GP surgeries would welcome the possibility of a CCG/ NHS wide decision and guidance on medicines beyond paracetamol. Surgeries felt it would support local decisions made within the practice and enable them to frame the issue better when explaining the personal impacts on patients.

The GP surgeries that we talked to are all promoting the common ailments scheme and are actively promoting more 'self-care' among their patients.

The surgeries we spoke to would like the CCG to consider;

- Needs of care homes to still get items on prescription to enable them to work within medicine management frameworks. One surgery went further to ask about possibility of a bulk prescribing policy to recognise the number of residents that have multiple repeat prescriptions.
- Continuation and promotion of Pharmacy Scheme to support patients on limited income.

What we heard from Pharmacists

The number of pharmacists we spoke to was limited to the participating Pharmacies and the Chair of the LPC. However, the single greatest issue they raised was regarding Paracetamol and other painkillers.

Pharmacists noted that they were seeing a growing number of people with prescribed Vitamin D and Iron supplements.

Pharmacists gave examples of how items such as Ensure had made significant contributions to wellbeing of elderly people and the terminally ill. Although not named in the list of medicines we talked to the public about, it could be included under food supplements. Pharmacist asked the CCG to consider the merit of maintaining this on prescription.

Pharmacies feel that they are the face to face contact point with the public and that it may fall to them to manage people's potential frustrations about having to pay for medicine which they currently get free on prescription.

Finally, Pharmacists raised the question of how the CCG sees the future use of the common ailment scheme, which enables patients to see a pharmacist and reduce the demand for GP appointment time.

Pharmacists asked the CCG to further consider;

- Issues around monitoring and building relationships with high risk groups

such as older people and maintaining an oversight of possible additional sources of paracetamol within medicines, i.e. cough and cold products

- The ability for people who take paracetamol for chronic conditions such as arthritis to purchase the volumes that they require over the counter
- The ability of those whose mobility is reduced due to a chronic condition, such as arthritis to access a pharmacy to buy medicines on a regular basis, especially as funding for home delivery services operated by some local pharmacies is now being reduced.

- Ongoing monitoring of people with high blood pressure and diabetes to ensure that pharmacists are not having to refer people back to a GP before being able to sell a medicine over the counter.
- Existing limits to Pharmacists ability to sell fungal nail infection treatments over the counter.

The Local Pharmacy Committee also made the following comments about the design and findings of the engagement activities;

- 4 of the postcode areas surveyed within this engagement (ME17, TN14, TN15, TN3) have dispensing doctors. Dispensing doctors cannot sell OTC products so if they stopped being available through prescriptions then those patients will have to make a special journey to the pharmacy. 24 people from these postcode areas were engaged.

- The area targeted in terms of levels of deprivation, (ME15) also contains Bearsted, Loose and East & West Farleigh which are recognized as more affluent areas. All the other target areas are reasonably affluent, therefore the responses may not reflect areas where people may find the additional cost of purchasing medicines prohibitive and therefore decide to go without (e.g. treatments for fungal nail infections, some of which can be quite expensive). Has the CCG any comparative data with other CCGs areas such as Thanet.

- It appears that few of the patients spoken receive these medications already on a repeat prescription. This suggest that there will be few savings to be made as this is where the scheme such as this could be most effective.
-

Future communication with the public

The public were asked how they found out about changes to the NHS in West Kent and what ideas they had to help ensure that the local NHS (CCG) communicate as effectively as possible with them.

Most people felt that the best way for them to hear about changes would be at their GP surgery, directly from the GP during the consultation when talking about possible treatments. This was closely followed by getting information from the Pharmacy at the point of collecting their prescription. People reported looking at posters and leaflets as they waited.

However, there was mixed feedback about the use of leaflets, many saying that they didn't bother to pick them up, preferring now to get information from social media or from websites direct.

It was noted that the pharmacies that participated had very limited space for display of posters and storage of leaflets and in fact stated a preference for not having them.

Lots of people suggested advertising the changes on packaging for medicines, or on prescription slips or prescription bags. This also included suggestions to include costs of medicines to help raise public awareness of real costs to the NHS.

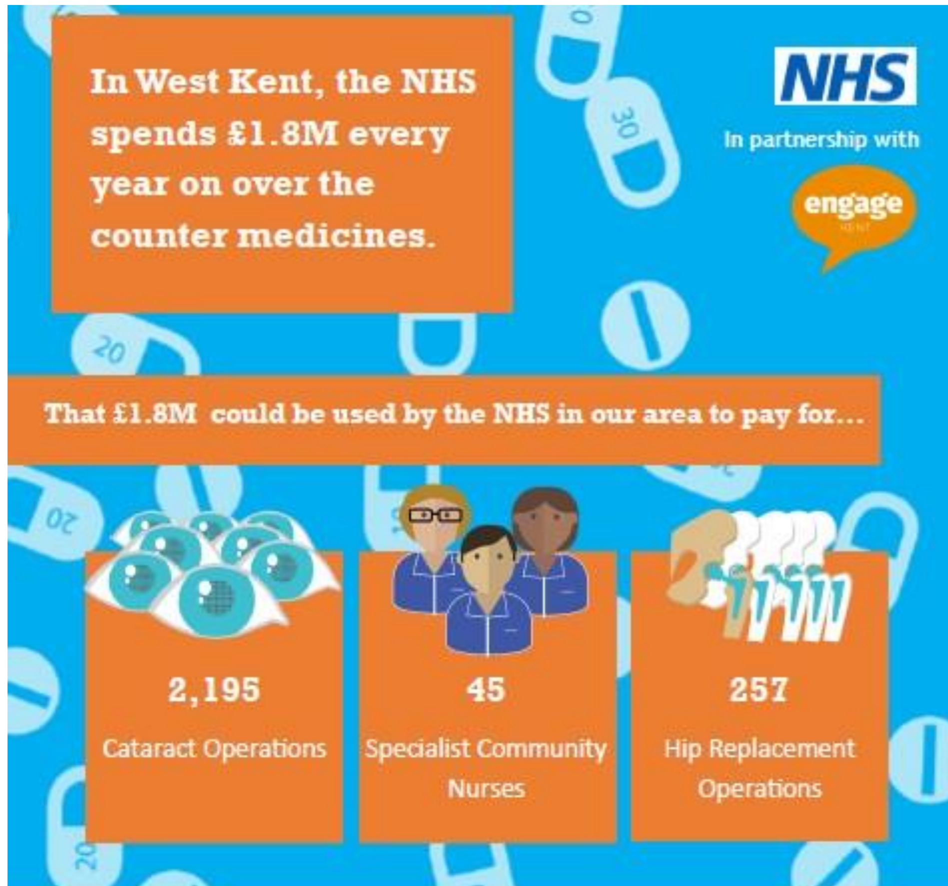
The most frequently mentioned ways of reaching the wider public was the use of advertising media, such as local radio, national day time TV and local press. Ideas included adverts on local buses, at bus stops and billboards.

Pharmacists suggested that it would be useful to have a FAQ that Pharmacy staff could use to answer any questions from the public.

Appendix 1
List of medicines discussed with the public

Painkillers for minor aches and pains ie paracetamol, ibuprofen, asprin
Vitamins
Moisturisers and bath additives for dry skin (not diagnosed eczema conditions)
Antihistamines - bites and stings, hayfever, itching
Ear wax removers
Hair removal cream
Creams for minor scars
Lozenges, throat sprays mouthwashes, gargles and toothpastes
Cough and cold remedies
Nasal sprays for acute nasal congestion
Sun creams (not diagnosed photo sensitivity)
Food and food supplements
Soya and thickened infant formulas
Infant formula for lactose intolerance
Hemorrhoid treatments
Fungal nail infections for minor conditions

Appendix 2
Flier



Appendix 3
Questionnaire

Do you know how much your medicines cost the NHS?
It's a lot more than you think.

Did you know that many medicines are cheaper to buy at a pharmacist than get on prescription?

In West Kent, the NHS spends **£1.8 million** every year on medicines that could be bought cheaper in a pharmacy.

That £1.8 million could be used by the NHS in our area to pay for other essential services such as;

- **2,195** cataract operations or
- **45** specialist community nurses or
- **257** hip replacement operations

How would you feel about buying some of your prescriptions directly from your pharmacy rather than receiving them on prescription?

The NHS in West Kent wants to hear what you think to help them make decisions on how best to spend their limited budget.

Please could you spare 10 minutes to complete a short questionnaire so that we can tell the NHS in West Kent your thoughts.

Q1 Do you currently pay for your prescriptions?

Yes No Don't know

Q2 Below is a list of medicines that can currently be bought over the counter and do not require a prescription.

In the last 6 months have you…?

Appendix 3

	Had this on prescription	Bought this over the counter	Had this on repeat prescription
Painkillers for minor aches and pains ie paracetamol, ibuprofen, asprin			
Vitamins			
Moisturisers and bath additives for dry skin (not diagnosed eczema conditions)			
Antihistamines - bites and stings, hayfever, itching			
Ear wax removers			
Hair removal cream			
Creams for minor scars			
Lozenges, throat sprays mouthwashes, gargles and			

	Had this on prescription	Bought this over the counter	Had this on repeat prescription
toothpastes			
Cough and cold remedies			
Nasal sprays for acute nasal congestion			
Sun creams (not diagnosed photo sensitivity)			
Food and food supplements			
Soya and thickened infant formulas			
Infant formula for lactose intolerance			
Hemorrhoid treatments			
Fungal nail infections for minor conditions			

Q3 Did you realise that so many medicines, currently prescribed in West Kent, were available over the counter?

Yes No

Q4 If anything from the previous list was no longer available on prescription and you had to buy it from a pharmacy, would it affect you?

Yes No

How would this affect you?

Q5 Please tick which item, if any, you think should remain available on prescription

Q6 Which statement do you agree with most

- The NHS should provide the most effective drugs and treatments only if they represent good value for money

- The NHS should provide only the most effective drugs and treatment, regardless of what they cost

- The NHS should provide all drugs and treatments no matter what they cost

Q7 If you do not pay for your prescriptions, would you be prepared to buy those that are cheaper at a pharmacy rather than on an NHS prescription?

Yes No

Q8 The NHS in West Kent would like to make people more aware of the costs of medicine on prescription. What do you think would be the best way to tell as many people as possible?

Appendix 4
Profile of public engaged

Age

Under 25 yrs	4%
25 to 39yrs	20%
40 to 49yrs	14%
50 to 59yrs	20%
60 to 69yrs	15%
70 to 79yrs	16%
80yrs of older	11%

Gender

Male	34%
Female	66%

Carer	-Yes	24%
	-No	76%

Disabled	-Yes	13%
	-No	87%

Appendix 4

First Language

English	94%
Other	6%

Ethnicity

English / Welsh / Scottish	90%
Other white background	5%
Irish	1%
Other ethnic background	1%
Other Asian background	1%
White and Black African	1%
Pakistani	0.5%
Chinese	0.5%

Target Areas

Target areas	Postcode		No of people
Maidstone **28%**	ME14	Maidstone, Bearsted, Grove Green	5
	ME15	Bearsted (Madginford), Downswood, Shepway, Senacre, Maidstone Town Centre, Loose, Mangravet, Park Wood, Tovil, East Farleigh, West Farleigh	60
	ME17	Hollingbourne, Hucking, Harrietsham, Lenham, Boughton Monchelsea, Linton, Coxheath, Chart Sutton, East Sutton, Langley, Kingswood, Sutton Valence	11
Sevenoaks **28%**	TN 13	Riverhead, Dunton Green	65
	TN14	Cudham, Otford	7
	TN15	Kemsing, Ightham, Plaxtol, Wrotham, Sevenoaks Weald	4
Rural Tunbridge Wells **30%**	TN1	Royal Tunbridge Wells (town centre)	2
	TN2	Pembury	78
	TN3	Langton Green, Groombridge, Frant, Speldhurst, Lamberhurst	2
Unknown **6%**			19
Out of target areas **8%**	ME1	Rochester, Burham, Wouldham	2
	ME16	Barming, Allington and west Maidstone	1
	ME19	West Malling, Kings Hill, Leybourne	1
	TN4	Rusthall, Southborough	2
	TN9	Tonbridge	1
	TN16	Westerham, Biggin Hill, Tatsfield	3
	TN17	Cranbrook, Goudhurst, Benenden, Frittenden	1
	TN11	Penshurst, Hildenborough, Hadlow	6
	TN12	Paddock Wood, Staplehurst, Brenchley, Horsmonden	4

Appendix 5
Prescription, purchase and repeat data

	Had on prescription	Bought over the counter	Had on repeat prescription
Painkillers for minor aches and pains ie paracetamol, ibuprofen, asprin	14%	88%	3%
Vitamins	15%	89%	1%
Moisturisers and bath additives for dry skin (not diagnosed eczema conditions)	13.%	89%	2%
Antihistamines - bites and stings, hayfever, itching	16%	86%	2%
Ear wax removers	8%	94%	0%
Hair removal cream	0%	100%	0%
Creams for minor scars	8%	92%	0%
Lozenges, throat sprays mouthwashes, gargles and toothpastes	4%	96%	0.5%
Cough and cold remedies	3%	97%	0%
Nasal sprays for acute nasal congestion	15%	86%	2%
Sun creams (not diagnosed photo sensitivity)	0%	100%	0%
Food and food supplements	11%	91%	1.5%
Soya and thickened infant formulas	20%	80%	0%
Infant formula for lactose intolerance	16%	84%	0%
Hemorrhoid treatments	9%	97%	0%
Fungal nail infections for minor conditions	20%	83%	0%

Appendix 7
What medicines should remain on prescription.

	Number of people who thought item should remain on prescription
Infant formula for lactose intolerance	87
Soya and thickened infant formulas	71
Antihistamines - bites and stings, hayfever, itching	60
Painkillers for minor aches and pains ie paracetamol, ibuprofen, asprin	59
Nasal sprays for acute nasal congestion	49
Hemorrhoid treatments	47
Food and food supplements	41
Fungal nail infections for minor conditions	35
Moisturisers and bath additives for dry skin (not diagnosed eczema conditions)	32
Vitamins	29
Cough and cold remedies	29
Creams for minor scars	20
Ear wax removers	20
Creams for minor scars	20
Lozenges, throat sprays mouthwashes, gargles and toothpastes	17
Sun creams (not diagnosed photo sensitivity)	10
Hair removal cream	9

Appendix 7
Indicative medicine costs as of March 2017

Data taken from three participating pharmacies, with pharmacists highlighting products most frequently referred to on prescription

	Price range
Painkillers for minor aches and pains ie paracetamol, ibuprofen, asprin	Junior Paracetamol liquid from £2.50 16 paracetemol tablets from 25p
Vitamins	From £2 - £5
Moisturisers and bath additives for dry skin (not diagnosed eczema conditions)	£12
Antihistamines - bites and stings, hayfever, itching	£5 - £6
Ear wax removers	£5 - £6
Hair removal cream	£4 - £7
Creams for minor scars	£5 - £15
Lozenges, throat sprays mouthwashes, gargles and toothpastes	£4 - £6
Cough and cold remedies	£2 - £5
Nasal sprays for acute nasal congestion	£5 - £8
Sun creams (not diagnosed photo sensitivity)	£7 - £12
Food and food supplements	Ensure £30 for 12
Soya and thickened infant formulas	£11 - £13
Infant formula for lactose intolerance	£11 - £13
Hemorrhoid treatments	£4
Fungal nail infections for minor conditions	£20 - £22

Equality Analysis Template

This document should be completed in conjunction with the Equality Analysis Guidance document. Should you have any queries, please contact your designated SECSU Equality & Diversity Lead who will be pleased to help (alternatively please contact the Equality & Diversity Team at SECSU.Equality@nhs.net).

Section 1: Policy, Function or Service Development Details and Authorisation	
Name of Organisation:	NHS West Kent Clinical Commissioning Group
Name of the policy, function or service development being assessed:	Medicines Optimisation – Restricting the prescribing of over the counter medicines for minor, short-term, self-limiting conditions
Is this a new/existing/revised policy, function or service development?	New policy for implementation
Briefly describe its aims and objectives	NHS England are undertaking a review to consider the prescribing of medicines which are of relatively low clinical value or priority or are readily available 'over the counter' and in some instances, at far lower cost. It is anticipated that this review will cover medicines such as treatment for coughs and colds, antihistamines and sun cream. West Kent CCG has taken the decision to action this work prior to national guidance. The aim of this policy is to reduce the

	prescribing of medicines that are available to purchase over the counter from pharmacies and supermarkets. This will be implemented by drawing up a restricted list of medicines not to be prescribed, which are readily available over the counter, and allows a GP to advise patients who present with minor, self-limiting conditions that they can purchase products to manage those symptoms over the counter. This policy will help promote patients to self-care as in line with the NHS 5 year forward view, and also free up GP time for more serious, complex conditions. An independent pre-engagement was carried out by health watch to target specifically identified areas to capture a broad range of responses. This policy will have some exceptions to allow GPs to continue prescribing over the counter medicines in certain at risk groups and to ensure that it complies with the 3 aims of the equality duty; 1. Eliminate unlawful discrimination, harassment, and victimisation and any other conduct that is prohibited by the Act. 2. Advance equality of opportunity between people who share a protected characteristic and those who do not. 3. Foster good relations between people who share a protected characteristic and those who do not.
Analysis Start Date:	Aug - 17
Lead Author of Equality Analysis:	Mohammed Soomro/Nigel Gumbleton
Equality & Diversity Lead Approved? Yes/No (please indicate)	Yasmin Mahmood

Equality & Diversity Lead Name: Date of approval:	
Have any financial or resource implications been identified?	No
Date of Governing Body Meeting where the Equality Analysis was ratified:	TBC

Section 2 : Equality Analysis Checklist
For each of the nine protected characteristics in the table below, consider whether the policy/function/service development could have a positive or negative outcome on each of these groups. Involve service users where possible to obtain their opinion, use demographic/census data (available from public health and other sources), surveys (previous surveys or perhaps conduct one), ask PALS and Complaints for reports/data, obtain subject specific reports from providers and other published data. Ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Age Think about different age groups and the policy/function/service development and the way the user would access it, is it user friendly for that age group? What is the age breakdown in the community/workforce? Will the change/decision have significant impact on certain age groups?	In the 16/17 financial year, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets. NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally Pre-consultation was carried out from1st-20th March 2017 by engage Kent. The profile of the ages of patients engaged is; Under 25 yrs - 4% 25 to 39yrs - 20% 40 to 49yrs - 14% 50 to 59yrs - 20% 60 to 69yrs - 15% 70 to 79yrs - 16% 80yrs of older - 11%	In March 2017, there was an independent pre-engagement carried out by health watch. The areas, GP practices and pharmacies targeted in the pre-engagement, were chosen by the MOT, to identify areas where it was thought health inequalities may be present. The urgent care team have also previously carried out scoping work with regards to deprivation levels in west Kent prior to rolling out the Pharmacy first scheme. This information was used to influence areas targeted in the pre-consultation. The medicines optimisation group (MOG) consists of GPs, members of the	Negative - Patients will generally not receive prescriptions for medicines available over the counter for short term self-limiting conditions and will be directed to a pharmacy for advice and to purchase the product if required. Currently, patients can get free NHS prescriptions if, at the time the prescription is dispensed, they are: •60 or over •under 16 •16-18 and in full-time education These groups would therefore have to pay for any over the counter medications for conditions that can be managed by self-care, which could impact income or their management of self-limiting conditions	CCG staff will work with communications team and primary care staff to ensure appropriate education of self-care via posters and leaflets. Have communication with patient participation groups and their chairs to ensure the correct message is given to these patients and is understood Ensure patients in this group who are eligible for free prescriptions are aware of the pharmacy first scheme, which may minimise any negative impact on these patients by providing a route to obtain over the counter medicines free of charge from a pharmacy.	Mohammed Soomro/Nigel Gumbleton, OTC restricted list to be developed for MOG September 2017 Restricted list and policy document to be presented by October 2017 Governing body Communications team, Leaflets and posters to be distributed following go ahead from governing body – October to December 2017 Restricted list to be implemented January 2018 Monitor fall-out from the first 6 months since implementation.

	Feedback from the pre-consultation by engage Kent suggests 85% of people currently receiving free prescriptions would buy items from the pharmacy if their GP asked them while 15% of people said that if one or more of the medicines listed, were no longer available on prescription, it would be a problem for them. 64% of those asked get free prescriptions. 42% of those who currently receive free prescriptions are over 60 years of age. West Kent Population Health and Wellbeing Profile published in 2015 states over the next five years it is estimated that the population aged over 85 years will increase by 22.4% (2,848 individuals). Over the next twenty years, there will be a population increase of 19%. The largest increase is expected in the over 65 age band, with an	medicines optimisation team, community pharmacy representative, and a patient representative. Each of the GPs represents a GP practice within a different area of west Kent and with varying levels of deprivation. The patient representative brings feedback from herself but also from her friends and family, which offers a direct patients view of proposals brought to the MOG.	School aged children who require OTC medicines to be given at school may be negatively affected. Care home residents who cannot purchase these items themselves may also be negatively affected.		

	increase of 59.4%				
Disability Think outside the box – you may not be able to see the disability. It could be physical (for instance hearing or visual impairment), unseen (for instance mental health) or a learning disability (for instance Autism). Consider for example: Accessibility – venue, location, signage, furniture and getting around Disability awareness training for staff Actively involve the service user and talk it through with them Mental Health – does this affect significant communities in the local population?	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets. NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally Feedback from the Pre-consultation by engage Kent suggests 85% of people currently receiving free prescriptions would buy items from the pharmacy if their GP asked them and 15% of people said that if one or more of the medicines listed, were no longer available on prescription, it would be a problem for them. . 13% of those spoken to	As above	Negative - Patients will generally not receive prescriptions for medicines available over the counter for short term self-limiting conditions and will be directed to a pharmacy for advice and to purchase the product if required. Some patients with disabilities may currently receive prescriptions free on the NHS, of which some of these items may include over the counter medicines. Following this change, some individuals in this group may have to pay for those medicines over the counter rather than on prescription. Patients with disabilities may not be able to purchase products safely and independently over the counter and thus may be negatively affected.	As above Work with charities which support groups of patients who are disabled, housebound etc to help communicate this policy. Ensure patients and prescribers are aware to consider accessibility issues when confronted with a decision to prescribe over the counter medicines or not.	As above

	identified themselves as disabled From 2011 census, West Kent CCG Households with one person with long term disability is 22.75% and Of whom 4.18% have dependents		One other group of patients who may be negatively affected would be housebound patients or those with accessibility issues		

Gender Reassignment Think about creating an environment within the policy/function/service development that is user friendly and non-judgemental. Does the organisation need to raise awareness / offer training? If the policy/function/service development is specifically targeting this protected characteristic, think carefully about confidentiality, training, and communication skills	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communication campaigns, with the use of posters, leaflets etc. NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally	As above	No outcomes – The policy or products chosen do not discriminate against gender reassignment patients	As above	As above

Marriage and Civil Partnership Think about access and confidentiality, the partner may not be aware of involvement or access to the service Staff training to raise awareness of ensuring equal status to spouses and civil partners in all HR policies, terms and conditions and services.	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communicati on campaigns, with the use of posters, leaflets etc NHS England are consulting on some principles for this type of product to inform national policy which	As above	No outcomes - The policy or products chosen do not discriminate against marriage and civil partnership	As above	As above

	will then be implemented locally.				
Pregnancy & Maternity The policy/function/service development must be accessible for all e.g. opening hours Are the chairs appropriate for breast feeding? Is there a private area? Are there baby changing facilities and is there space for buggies? What are the future projections for birth rates, neo natal statistics? Will the service/decision have a significant impact on this protected characteristic?	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communication campaigns, with the use of posters, leaflets etc. NHS England are	As above	Positive outcomes – Patients under this protected characteristic will not be negatively affected by this proposal. Medicines available over the counter generally do not have a license for use in pregnancy or breastfeeding, and therefore cannot be bought over the counter for these patients. In these cases, the GP would need to prescribe if they feel clinically appropriate rather than refer the patient to self-care or pharmacy first.	As above	As above

	consulting on some principles for this type of product to inform national policy which will then be implemented locally Preconsultation by engage Kent - 85% of people currently receiving free prescriptions would buy items from the Pharmacy if their GP asked them. 15% of people said that if one or more of the medicines listed, were no longer available on prescription, it would be a problem for them. 66% of those spoken to were female				

Race You need to think carefully about the local demographics of the population who will be accessing the policy/function/service development. Talk to public health. Consider for example: Cultural issues (gender, clothing etc.) Languages Support to access Staff training on cultural awareness, interpreting etc.	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communication campaigns, with the use of posters, leaflets etc. NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally. From WK CCG Annual Equality Report 2013; WK CCG Strategic Commissioning Plan, The proportion of the West Kent population	As above	No outcomes The policy or products chosen do not discriminate against race	As above There needs to be a provision to ensure that the promotional material distributed to patients and displayed within GP practices would be available in other key languages. These will be available upon request and the policy will be communicated through community centres and places of worship	As above

	who are from a non-white British background is 9%, this includes 0.4% from a gypsy and traveller community and 3.6% from a 'white other' background which would include eastern European populations and 5% from a Black or Asian background (BME). The percentage of the BME population is higher in the 0 to 15 age group compared to over 16.				
Religion or Belief Again, think about the local population and what religion or beliefs they may have. Consider for example: Staff training on respecting differences and religious beliefs Are you trying to implement a change/activity at an inconvenient time e.g. during a time of religious holiday such as Ramadan? Is there an area for prayer times, religious rituals e.g. washing area?	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communicati	As above	No outcomes The policy or products chosen do not discriminate against religion or belief	As above Ensure all future communication and engagement work on this includes ethnic minority communities who, like the majority are likely to be affected by this policy. We could also consider cascading the information (leaflets etc.) through places of worship.	As above

	on campaigns, with the use of posters, leaflets etc. NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally From the 2011 census, the proportion of West Kent CCG that has a religion is 66% No religion 26.58% and Religion not stated 7.42%. Of those reported to have a religion, Christian 63.49% Buddhist 0.44% Hindu 0.59% Jewish 0.14% Muslim 0.87% Sikh 0.10% Other religion 0.37%				

Sex This is the impact on males and females. For example same sex accommodation - are there areas for privacy? Is it accessible for both taking into account working service users? Would it be a venue they would go to? What does research show regarding the incidence of for example, mental health, cancers, early or late diagnoses for males or females?	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communication campaigns, with the use of posters, leaflets etc. NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally. Pre-consultation engagement carried out by engage Kent had over 60% of the respondents as female – who may be more likely to be negatively	As above	No outcomes The policy or products chosen do not discriminate against sex	As above	As above

	affected by this change.				
Sexual Orientation Don't make assumptions as this protected characteristic may not be visibly obvious. Providing an environment that is welcoming - for example visual aids, posters, leaflets. Using language that respects LGB&T people. Staff training on how to ask LGB&T people to disclose their sexual orientation without fear or prejudice.	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communication campaigns, with the use of posters, leaflets etc. NHS England are consulting on some principles for this type of product to inform	As above	No outcomes The policy or products chosen do not discriminate against sexual orientation	As above	As above

	national policy which will then be implemented locally				
Carers Does your policy/function/service development impact on carers? Ask them. Do you need to think about venue, timing? What support will you be offering?	In financial year 16-17, WKCCG spent £1.8million on prescribing medicines that could be bought over the counter from pharmacies and supermarkets Other CCGs have begun empowering GPs to restrict their prescribing of over the counter products. This has been done by producing a list of over the counter medicines not to prescribe and extensive education/communication campaigns, with the use of posters, leaflets etc.	As above	No outcomes The policy or products chosen do not discriminate against carers	As above Need to promote this change of policy through carer support networks to ensure there is adequate education among carers who are usually involved in the discussion related to the care and medication of the patient.	As above

	NHS England are consulting on some principles for this type of product to inform national policy which will then be implemented locally. From 2011 census, There were approximately 42,937 carers.				

Other Does your policy/function/service development impact on for example, those on low incomes, who are homeless etc.?	As above	As above	Negative outcomes – Care home residents who are currently prescribed over the counter medicines, may be negatively affected by this change. Care homes can give patients over the counter medicines via a homely remedy policy, but this only covers for up to 72 hours. Thereafter, carers cannot administer these medicines and patients may be negatively affected by this.	As above	As above

Section 3 : Action Plan
For any negative outcomes identified in Section 2, it is important to identify the steps you will take to mitigate consequences on the nine protected characteristics. Complete the Action Plan below to identify and record how you will address these.

Equality Group	Negative Outcome	Mitigating Action (Identify any resource/other implications)	Named Lead and Timeframe
Age	Patients will generally not receive prescriptions for medicines available over the counter for short term self-limiting conditions and will be directed to a pharmacy for advice and to purchase the product if required. Currently, patients can get free NHS prescriptions if, at the time the prescription is dispensed, they are: •60 or over •under 16 •16-18 and in full-time education These groups would therefore have to pay for any over the counter medications for conditions that can be managed by self-care, which could impact income or their management of self-limiting conditions School aged children who require	The policy will aim to reduce health inequalities in the following ways; Over the counter medicines are widely available from supermarkets and pharmacies, which are open late in the evenings and at weekends and the majority are available at lower cost than to patients who would normally pay £8.60 per item for their NHS prescription. For patients who normally receive their prescription free of charge, west Kent has a Pharmacy first service, which can act as a safety net, whereby these patients could still access these over the counter medicines free of charge, if they are unable to purchase them.	Mohammed Soomro/Nigel Gumbleton

	OTC medicines to be given at school may be negatively affected. Care home residents who cannot purchase these items themselves may also be negatively affected	Monitoring any fallout from the first 6 months since implementation to see if any negative effects have been missed and take action to mitigate these. The policy aims to tackle the prescribing of OTC products for minor self-limiting complaints. It includes an exemption for when a treatment is needed for a long-term chronic condition or there are legal restrictions on the amount of medicine that can be purchased over the counter, then the patient's regular clinician will still be able to prescribe. The care of the individual patient must remain a prescribers first concern as described in the GMC 'duties of a doctor' Therefore the prescriber should recommend treatment based on clinical need but if there are concerns about an individual patient's ability to source a medicine themselves the GP may prescribe, e.g. school children, patients in care/nursing homes. •Entail asking patients if they will buy products, recognising that the answer can be 'yes' or 'no' •No 'official ban' on any medicine or product from being prescribed	(From January 2018) All prescribers – January 2018

		•Do not require prescribers to ask patients about their financial circumstances •Enable every patient with an indication for a medicine or listed product to access it Produce and implement a comprehensive marketing and communications plan – This to include: • Support for GPs and other prescribing health professionals • Information for the public on the rationale of the changes • Self-care information for patients • Facts and myths on the changes • Ensure key messages on what is NOT changing, i.e. prescriptions for people with long term conditions • Fact sheets on the medications including alternatives, where over the counter medications can be purchased with appropriate costs and differences, if any, between brands names and shops own brands to reduce cost • Communications to be supported by national campaigns The implementation of a policy will reduce variation between practices' prescribing approaches, providing consistency for patients across west	West Kent communications team and Mohammed Soomro/Nigel Gumbleton (From October 2017)

		Kent.	
Disability	Patients will generally not receive prescriptions for medicines available over the counter for short term self-limiting conditions and will be directed to a pharmacy for advice and to purchase the product if required. Some patients with disabilities may currently receive prescriptions free on the NHS, of which some of these items may include over the counter medicines. Following this change, some individuals in this group may have to pay for those medicines over the counter rather than on prescription Patients with disabilities may not be able to purchase products safely and independently over the counter and thus may be negatively affected. One other group of patients who may be negatively affected would be housebound patients or those with accessibility issues	As above Patients with a disability (learning or physical) that the prescriber deems them not suitable to be able to purchase medicines over the counter themselves safely, are still able to receive these items on prescription. There will be an exemption within this policy for GPs to use for patients they feel would have issues with physically accessing community pharmacies and shops to purchase these medicines and safely able to self-care independently. In cases such as this, the GP is encouraged to continue prescribing. We will visit disability forums organised by health watch to communicate this and answer questions.	All prescribers – January 2018

Gender Reassignment	**N**		
Marriage & Civil Partnership	**N**		
Pregnancy & Maternity	**N**		
Race	**N**		
Religion or Belief	**N**		
Sex	**N**		
Sexual Orientation	**N**		
Carers	**N**		
Other	Care home residents who are currently prescribed over the counter medicines, may be negatively affected by this change. Care homes can give patients over the counter medicines via a homely remedy policy, but this only covers for up to 72 hours. Thereafter, carers cannot administer these medicines and patients may be negatively affected if they are not available on prescription and carers cannot administer them.	As above There will be an exemption to this policy to allow GPs to prescribe over the counter medicines if they feel this is appropriate and the GP believes there may be accessibility issues for the patient to obtain over the counter medicines safely and self-care independently. Care home residents may fall under this category of patients, and thus will still be able to obtain over the counter medicines on prescription.	All prescribers – From January 2018

Section 4 : Submission
On completion of all sections of the Equality Analysis Form, submit your draft along with the policy, function, or service document to your Equality & Diversity Lead. Once reviewed, you will be provided with feedback and any recommended amendments. Having made any necessary changes, the final version should then be submitted to the CCG Equality and Diversity Working Group for quality assurance. The policy can then proceed to ratification at the required Board meeting. The completed EA Template should be appended to the policy, function or service development documentation. The completion of Equality Analysis Forms will be monitored by the Company Secretary.

Item 9: Assistive Reproductive Technologies Policy Review

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: Assistive Reproductive Technologies (ART) Policy Review

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

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

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1. Introduction

(a) NHS Medway CCG, as the lead commissioner for Assistive Reproductive Technologies (ART) services in Kent and Medway, has asked for the attached report to be presented to the Committee.

2. Recommendation

RECOMMENDED that the Committee:

(a) notes that a review of the Assistive Reproductive Technologies (ART) policy is being undertaken by the Kent & Medway CCGs;

(b) requests that the proposed revised policy is presented to the Committee in January in order for it to make a determination about the proposals constituting a substantial health service development or variation.

Background Documents

None

Contact Details

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

24TH NOVEMBER 2017

ASSISTIVE REPRODUCTIVE TECHNOLOGIES – POLICY REVIEW

Summary

This report advises the Committee of proposals under consideration by Kent and Medway Clinical Commissioning Groups (CCGs) in respect of proposed policy changes to Assistive Reproductive Therapies (ART) and funding of assistive conception treatments.

In line with many health economies across England, Kent and Medway CCGs are considering a range of difficult decisions to ensure that overall financial risks are minimized. CCGs have agreed to review the policies relating to Assistive Reproductive Therapies.

The review will focus on two aspects:

- Ensuring that the number of funded cycles is both affordable and reasonable. This may result in a reduction to the number of IVF cycles that are funded for eligible patients.
- Considering the funding of assisted conception treatments using donated genetic materials for all patient groups. A complainant highlighted that the current policy effectively excludes same sex couples access to NHS funded fertility treatment due to their requirement for donated materials.

This report outlines the national and local context with regard to ART policy development and proposes an approach to reviewing the current Kent and Medway CCGs' ART policies.

1. Budget and Policy Framework

1.1 Assistive Reproductive Technologies (ART) are funded by Clinical Commissioning Groups.

1.2 NHS Medway CCG is the lead commissioner for ART services for the eight CCGs across Kent and Medway.

1.3 Under Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Kent. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it.

2. Background

2.1 Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers ("responsible persons") to consult a local authority about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment. Where more than one local authority has to be consulted under these provisions those local authorities must convene a Joint Overview and Scrutiny Committee for the purposes of the consultation and only that Committee may comment.

2.2 If this Committee and Medway Council's Children and Young People's Overview and Scrutiny Committee were to both determine that the proposals constitute a substantial health service development or variation the responsible persons will have to consult the Kent and Medway Joint Health Scrutiny Committee and only that Committee may make comments and require information on the matter.

3 National context

3.1 Although the National Institute for Health and Care Excellence (NICE) Clinical Guideline 156 (CG156) Fertility (2013) recommends the NHS fund up to three full IVF cycles for eligible couples where the woman is aged under 40 years[i], it is widely acknowledged that this level of provision is unaffordable to the NHS in most areas. A spokesperson for NHS England has been quoted as saying that NHS funding of IVF provision is legally a decision for CCGs "who are under an obligation to balance the various competing demands on the NHS locally while living within the budget parliament has allocated".

3.2 Fertility Fairness[ii] audits the number of NHS funded IVF cycles provided by English CCGs. In May 2017 they reported:

- Five CCGs (2.4%) have decommissioned NHS funded IVF and provide 0 cycles[iii];
- 61% of CCGs offer 1 NHS funded IVF cycle[iv] for eligible patients;
- 23% of CCGs offer up to 2 NHS funded IVF cycles for eligible patients; and
- 13% of CCGs offer up to 3 NHS-funded IVF cycles for eligible patients.

3.3 In recent years there has been a marked reduction in access to NHS funded IVF in England. Fertility Network UK[v] reports the number of CCGs offering three cycles of IVF has reduced by 46%, from 50 in 2013 to 27 in 2017. Thirteen CCGs have made reductions to provision of fertility treatment since the beginning of 2017. Across England, there are potential further cuts ahead; eight CCGs are currently consulting on reducing or stopping their NHS funded fertility treatment.

3.4 The Human Fertilisation and Embryology Authority (HEFA) publish success the following information on their website[vi], relating to success rates for IVF:

"The below percentages show the average chance of a birth after one, two, three and four cycles of IVF depending on your age. After four cycles, there are very small increases in the average chance of a birth across all ages. 85% of people have one or two cycles of IVF. Only 5% of people have more than three cycles.

Chances of a live birth – women under 40

One cycle – 32%

Two cycles – 49%

Three cycles – 58%

Four cycles – 63%"

4 Local context: Development of current ART policies in Kent and Medway

4.1 In response to the publication of NICE CG156 and other national policy and guidance in 2013, the Health Policy Support Unit (HPSU) was tasked by Kent and Medway CCGs to review the existing suite of ART policies. An expert group was convened to support this work. Work to support the review included: reviewing current guidance and legislation; identifying and assessing equality issues; establishing the local epidemiology, activity and availability of treatments; assembling and assessing the evidence base; conferring with local stakeholders including clinicians, patients and their representatives; and assessing the impact of potential new policies on the local health economy. The Kent and Medway Policy Recommendation and Guidance Committee (PRGC) considered this work and agreed seven policy recommendations[vii] with associated eligibility criteria. These were ratified by all Kent and Medway CCGs and adopted in April 2014.

4.2 Current Kent and Medway CCGs' ART policies

Currently Kent and Medway CCGs offer eligible couples a maximum of four embryo transfers including no more than two transfers from fresh IVF cycles (others would be frozen embryo transfers). This may be considered locally as two 'full' IVF cycles, though it does not comply with the NICE definition of 'full' cycles which does not put a limit on the number of frozen embryo transfers undertaken[viii].

4.3 Kent and Medway CCGs also fund[ix]:

- Up to six cycles of intrauterine insemination (IUI) using partner sperm for patients who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem;

- Sperm washing (and subsequent IUI or IVF) for eligible couples where the man is HIV positive and his female partner is HIV negative; and
- Fertility preservation (egg, sperm or embryo cryopreservation and subsequent IVF) for people due to undergo treatments likely to make them infertile.

4.4 In order to access NHS funded fertility treatment, Kent and Medway patients must fulfil a number of eligibility criteria addressing: duration of subfertility; the woman's age; previous IVF cycles undertaken; the BMI of the woman; smoking status of the couple; ovarian reserve of the woman; previous children and previous sterilisation.

4.5 Assisted conception treatments (IUI or IVF) using donated genetic materials (eggs, sperm or embryos) and involving surrogates are currently not funded for any patient groups in Kent and Medway.

5. Proposed service development or variation

5.1 The review will focus on two aspects:

- Ensuring that the number of funded cycles is both affordable and reasonable. This may result in a reduction to the number of IVF cycles that are funded for eligible patients.

- Considering the funding of assisted conception treatments using donated genetic materials for all patient groups. A complainant highlighted that the current policy effectively excludes same sex couples access to NHS funded fertility treatment due to their requirement for donated materials.

6. Advice and analysis

6.1 The eight CCGs in Kent and Medway have now considered the potential impacts of a review of ART policies, and have agreed that a review should be undertaken. The proposed process for the review of policies relating to the number of cycles and use of donated genetic material is outlined below.

6.2 Review timeline

1. November and December 2017: presentation of papers to Kent and Medway Health Overview and Scrutiny Boards summarising the CCGs plans to review the policy (this paper).

2. December / January: Proposed revised policy is produced. Pre-consultation engagement commences. Revised policy to Kent and Medway Health Overview and Scrutiny Boards for comment, consideration of significant variation and process.

3. February – April 2018: formal public consultation for three months. Further detail relating to the consultation is provided below.

4. May / June 2018 – outcome of the public consultation is analysed and presented to the Health Policy Reference Group (HPRG) alongside a

further report from the Health Policy Support Unit for decision. The report from the Health Policy Support Unit would provide further detail on financial impacts of potential changes and evidence reviews into areas that CCGs have requested further information on – such as the impact on success rates of a reduction to one NHS funded cycle of IVF. Feedback on public consultation to Kent and Medway Health Overview and Scrutiny Boards.

5. July / August 2018: the decision of the HPRG is presented to each of the individual CCGs for ratification via their individual governance procedures, alongside the revised schedule of policies (if applicable). If agreement is reached relating to policy changes, a new Kent and Medway schedule of policies for Assisted Reproductive Technologies will be published and implemented across Kent and Medway.

6.3 The public consultation process

6.3.1 When considering significant changes to public services, CCGs have a legal duty to involve the public.

6.3.2 In order to ensure that a region-wide policy is maintained, CCG Chief Operating Officers (COOs) will oversee this policy review and discuss progress at regular region-wide meetings.

6.3.3 The North and East London Commissioning Support Unit (NEL CSU) will lead on the public consultation process, with support from individual CCGs.

6.3.4 The process of consulting with the public will be carried out through online questionnaires which would be hosted on each CCG’s website and promoted via social media channels, and public meetings in each CCG area.

6.3.5 A full consultation plan will be developed by NEL CSU in the coming weeks. In addition, the report that is presented to the Health Policy Reference Group will include equality and diversity impact assessments for consideration by the group.

7. Risk management

7.1 Risks associated with reviewing the schedule of ART policies include:

Risk	Description	Action to avoid or mitigate risk	Risk rating
Poor response to consultation	Should there be a poor response to the consultation, CCGs may be required to amend the approach to the review, thus causing increased costs and a delay to the proposed timeline	Clear communication and consultation plan to be developed and implemented. Individual CCGs must support the consultation process	
Lack of input from one or more CCGs	CCGs are under pressure in a number of areas and it is possible that this work is not prioritised by all eight CCGs in Kent and Medway. This would cause a delay to the process and could potentially destabilise the review and consultation phase.	All CCGs are actively involved with this process at present, via Chief Operating Officers. All CCGs are represented on the HPRG and will take decisions via their own governance routes.	
CCGs are unable to agree the outcome of the policy review	At the conclusion of the review, there is the chance that consensus is not reached across the eight Kent and Medway CCGs. This could lead to the implementation of different policies in CCG areas and give rise to allegations of a “postcode lottery” for health services	Agreement exists relating to the need to undertake the review, however this risk must be tolerated to respect the sovereignty of individual CCGs.	
Challenge from patient groups/ reports in local media	ART services are highly emotive and proposed changes could lead to reputational damage for CCGs	Clear communication and consultation plan to be developed and implemented to help mitigate this risk.	

8 Implications for Looked After Children

8.1 At this juncture, there are no implications for Looked After Children associated with the proposed review of ART services.

9 Financial implications

9.1 The Health policy Support Unit estimate that should Kent and Medway CCGs reduce to one cycle of NHS funded IVF per eligible couple, this would have a cost saving of approximately £666k p.a. across Kent and Medway CCGs.

9.2 Depending on the outcome of the consultation and review relating to the use of donated genetic materials, there may be a cost pressure for Kent and Medway CCGs. This cost pressure is being calculated, and further work relating to the cost of the proposed review will be undertaken by the Health Policy Support Unit throughout the consultation phase.

10 Recommendations

10.1 The Committee is asked to note the review of Assistive Reproductive Technologies (ART) policies, set out in the report, in light of the financial challenges faced by Clinical Commissioning Groups (CCGs), and note the review process set out in section six of the report, in particular the public consultation element.

Lead officer contact

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Michael.griffiths@medway.gov.uk

Appendices

None

Background papers

None

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[i] NICE define a full cycle of IVF as one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryos i.e. a fresh cycle and an undefined number of subsequent frozen cycles. NICE also recommend one cycle of IVF for some women aged between 40 and 42.

[ii] Fertility Fairness is a multidisciplinary umbrella organisation representing patient and professional bodies working in the field of fertility. It campaigns for fair and equitable access to NHS-funded fertility services in accordance with NICE recommendations.

[iii] Most of these CCGs now only fund fertility treatment for: (i) patients requiring fertility preservation as they are undergoing treatment that is likely to make them infertile e.g. chemotherapy and (ii) patients requiring sperm washing because the male is HIV positive and the woman is HIV negative.

[iv] IVF 'cycle' is not defined but it is likely to refer to the number of fresh cycles available to eligible patients

[v] Fertility Network UK is a patient-focused fertility charity that provides free and impartial support, advice, information and understanding for people affected by fertility issues

[vi] https://www.hfea.gov.uk/treatments/explore-all-treatments/in-vitro-fertilisation-ivf/

[vii] Policy recommendations addressed: IVF (with or without intracytoplasmic sperm injection [ICSI]), intra-uterine insemination (IUI) using partner sperm, surgical sperm retrieval, sperm washing, fertility preservation for patients receiving gonadotoxic treatments, assisted conception treatments (ACT; IVF or IUI) using donated genetic materials, ACT involving surrogates

[viii] NICE define a full cycle of IVF as one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryos i.e. a fresh cycle and an undefined number of subsequent frozen cycles.

[ix] Surgical sperm retrieval is now the commissioning responsibility of NHS England, however CCGs are responsible for commissioning subsequent storage and IVF with ICSI

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Item 10: Healthwatch Kent: Annual Report

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 24 November 2017

Subject: Healthwatch Kent: Annual Report

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

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

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1. Introduction

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

Healthwatch Kent 2016/17 Presentation pages 145 - 164
Healthwatch Kent 2016/17 Annual Report pages 165 - 182

2. Recommendation

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

Background Documents

None

Contact Details

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03000 412775

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Healthwatch Kent

HOSC November 2017

Healthwatch Kent

Healthwatch Kent : Who are we?

- We are the consumer champion for health & social care
- Our aim is to improve services by ensuring local people's voices are heard
- FREE Information & Signposting service

0808 801 0102
info@healthwatchkent.co.uk

healthwatch Kent

Our Reach

- We have had direct contact with over 7500 people via our Freephone line, community engagement, hospital information stalls and projects
- We gave out nearly 6000 pieces of promotional material
- Thousands of Kent residents will have seen us on our Big Red Bus tour, on ITV & BBC news, our press releases in local papers and news websites, and heard us on Radio Kent throughout the year.

healthwatch Kent

Outcomes

- We spoke to over 300 people about the Children & Adolescent Mental Health service. Our recommendations are part of the new service which recently commenced

healthwatch Kent

Outcomes

- We spoke to over 100 people about their experience of being discharged from hospital in North Kent. We have worked on a new patient leaflet explaining the discharge process which is currently being piloted with 20,000 patients

healthwatch Kent

Outcomes

- Our report on changes to repeat prescriptions is being used to inform all 7 Clinical Commissioning Groups as they work to reduce the amount of money wasted on unwanted medicines

healthwatch Kent

Outcomes

- Our findings about people’s experience of autism services has been used as part of a national report highlighting the challenges that parents and young people with autism are facing

healthwatch Kent

Outcomes

- We have escalated 11 cases of concern for patient safety to the Care Quality Commission and Kent County Council this year. All of our escalations have been investigated and in one instance the care home was prevented from accepting new residents until measures were put in place.

healthwatch Kent

Outcomes

- We have established a new Kent wide Physical Disability Forum which is now a platform from which people with a physical disability can effectively raise their voice and be heard by the right people. Organisations and commissioners of services are working with the Forum around any changes or developments to services

healthwatch Kent

People's Panel

- We are piloting a 'People's Panel' with KCC to give an informed view from the public to encourage co-production at the early planning and design stages.
- A paper is being produced for discussion on how it might fit into governance arrangements going forward.

healthwatch Kent

Volunteers

We achieved the National Investing in Volunteers Award

healthwatch Kent

Sustainability & Transformation Partnership - Support

- Recruited and supported members of the public to join the Kent & Medway Patient & Public Advisory Group and manage their expenses

- Have acted as interim chair since it started meeting

- Represented the group at the STP Programme Board, the development of the Integrated Impact Assessment and other working groups

- Supported it with use of our video conferencing facilities to ensure accessibility

healthwatch Kent

Sustainability & Transformation Partnership - Scrutiny

•Volunteers in Healthwatch Kent steering Group are using our Consultation and Engagement Best Practice guides to scrutinise aspects of the STP

•Currently looking at Stroke

•Feedback on listening events

•Regular meetings with STP Project Management Team and Consultants

healthwatch Kent

Sustainability & Transformation Partnership - Providing

•Commissioned engagement being carried out with seldom heard groups

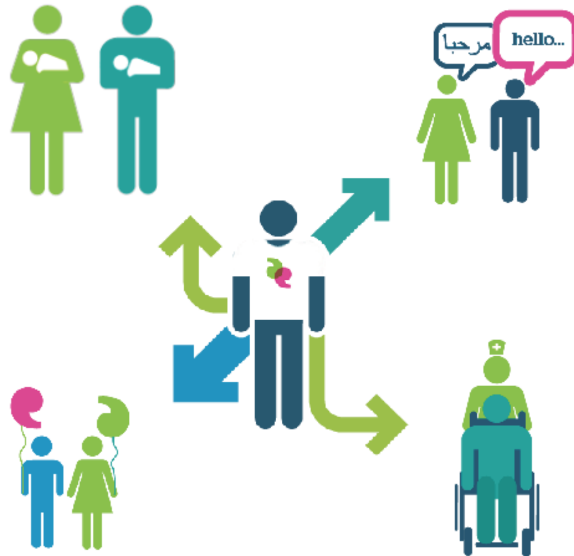
•Undertaken by Trading Arm – Engage

•Materials such as ebriefing and discussion aids being shared with Patient & Public Advisory Group

•More detail about how these roles are delineated in Steve's Blog at www.healthwatchkent.co.uk

healthwatch Kent

Gypsy & Traveller



Healthwatch Kent
Engaging with Communities
Experiences of Gypsy & Traveller Communities in Kent
June 2017

We worked with the KCC Gypsy & Traveller Team to visit all the sites in Kent
We produced a report on our findings: http://www.healthwatchkent.co.uk/sites/default/files/healthwatch_kent_traveller_report.pdf
And developed the Healthwatch Kent Help Cards (next pages)

healthwatch Kent

Help Cards

Help Cards

- ☐ I need help filling in forms
- ☐ I need help reading and understanding
- ☐ I would like a doctor who is the same gender as me
- ☐ I would like to speak to someone confidentially

healthwatch Kent

Help Cards

- We are asking organisations to:
- Pledge that your organisation will support patients who present these cards at your service.

- If you wish to pledge your support, we can send you the following:
- A supply of the cards to distribute to your own patients
- Information to brief your staff
- A pledge poster for you to complete and use to publicise your support in your communications and social media

healthwatch Kent

THANK YOU

ANY QUESTIONS?

Steve@healthwatchkent.co.uk

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healthwatch
Kent

Healthwatch Kent Annual Report 2016/17

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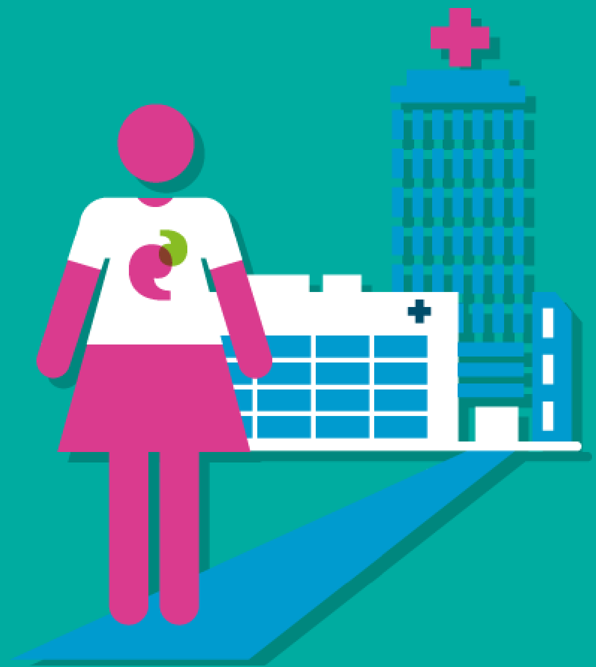
Our vision, mission and values



Our vision

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

Our mission

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

Our values

- Open and transparent
- Volunteer led
- Objective and balanced

We achieve this by

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

- Working in partnership with organisations – no surprises
- Critical friend
- Balancing positive and negative, loud and quiet, many and few
- Truly represent residents of Kent

Foreward from our Chief Executive

This year has been a time of great change.

Both the NHS and social care are under huge strain. Numbers of people needing services continue to increase every month; the money available for services continues to be reduced and we continue to face a critical lack of staff to meet the needs of patients and service users. All of these factors together mean that services must change and the health and social care system in Kent must work differently to ensure that this change can happen.

The role of Healthwatch Kent in this sea of change is to ensure patients and service users have a voice. You should not only be informed of potential changes but also be given the opportunity to get involved in constructive discussions about what those changes could or should look like.

Much of our year has been spent working to ensure you have a voice and a place to get involved with these changes. This journey will continue over the coming year and we would encourage you all to get involved if you can. This is the time to make your views heard.

In addition to this we have continued to focus on specific services and issues that we have heard about from the you including;

- We spoke to over 300 people about the Children & Adolescent Mental Health service. Our recommendations are part of the new service which will be rolled out in 2017
- We spoke to over 100 people about their experience of being discharged from hospital in North Kent. We have worked on a new patient leaflet explaining the discharge process which is currently being piloted with 20,000 patients
- Our report on changes to repeat prescriptions is being used to inform all 7 Clinical Commissiong Groups as they work to reduce the amount of money wasted on unwanted medicines
- Our findings about people's experience of autism services has been used as part of a national report highlighting the challenges that parents and young people with autism are facing

None of this would have been possible without the tireless enthusiasm and determination of our volunteers. We are very lucky to work with some incredible people who are involved in all aspects of our work from invaluable administrative support through to making decisions about our priorities.

This report gives you an insight into our work, but it you are interested in finding out more do please get in touch. We are always looking for people to get involved in any way they can so take a read and give us a call if you want more information.

You can reach us anytime on 0808 801 0102 or email info@healthwatchkent.co.uk

Steve Inett
Chief Executive, Healthwatch Kent

The year at a glance

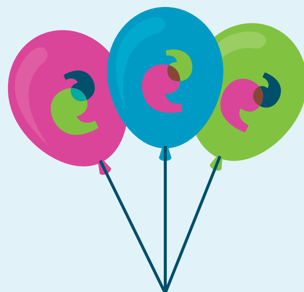
This year we've spoken to 2,467 people through our Helpline

We've spent hundreds of hours visiting community groups and proactively working with groups which are traditionally harder to reach such as Gypsy & Travellers

Our volunteers help us with everything from booking meetings to making decisions about our priorities and resources

We've visited 16 of our local services

We've met hundreds of local people through our work in communities



Our reports have tackled issues ranging from getting a GP appointment through to mental health patients being placed outside of Kent

What we do for you?

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work. We believe that asking people more about their experiences can identify issues that, if addressed, will make services better.

What do we do for you?

- Give you information about health and social care services.
- Signpost you to the correct place.
- Inform you about your rights as a patient and service user.
- Help you to understand how to make a complaint and what support is available.
- Record your experiences of services.
- Regularly analyse the themes and trends from what people have told us.
- Escalate serious concerns to the right people and follow up on the outcome.
- Respond to enquiries on our Freephone line within two working days.
- Meet as many people face to face as possible, in particular contacting groups who do not contact us by other means. To do this we will visit a different district council area each month and visits priority groups in that district.
- Be open and transparent in how we work.

What do we do for commissioners and providers?

- Work in a spirit of partnership, sharing information, informing you about work we are undertaking and supporting work that improves patient/service user experiences.
- Meet with you quarterly to discuss shared areas of concern and monitor an action plan made up of agreed issues, Healthwatch report recommendations and CQC findings.
- Act as a critical friend for consultations you undertake.

What do we offer our volunteers?

- Be clear about the requirements and expectations of you and be open with you if there are any concerns about how you carry out your role.
- Give you clear roles so you can understand your commitment and what you will achieve.
- Give you training and experience in working in health and social care at a strategic level.
- Reimburse your out of pocket expenses.
- Be appreciative of your time and efforts.

For the voluntary sector we offer:

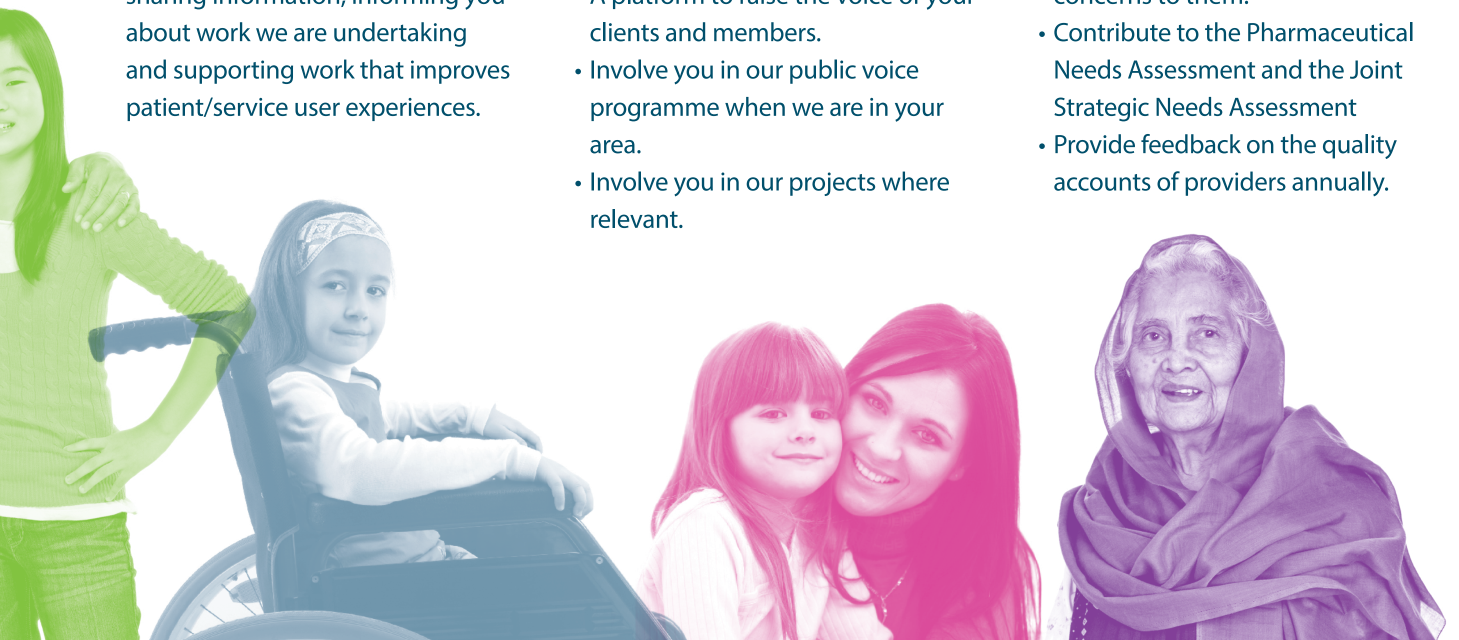
- Regular monthly information shared with your key contact person, known as a Community Champion.
- Regular encouragement to share the experiences of your clients or members with us.
- A platform to raise the voice of your clients and members.
- Involve you in our public voice programme when we are in your area.
- Involve you in our projects where relevant.

District Councils

- Inform you when we are working in your area.
- Support councillors to share experiences of local residents.
- Keep you updated of the outcomes of our work.

To fulfil our other statutory roles we will:

- Use the outcome of escalations, projects and Enter & View visits to make recommendations to Healthwatch England / Care Quality Commission to conduct special reviews or investigations.
- Use the database designed for the Local Healthwatch network to provide Healthwatch England with the intelligence and insight it needs to enable it to perform effectively at a national level.
- Work with CQC and NHS improvements where there are significant concerns about an organisation.
- Continue to be effective participants of the Kent and local Health & Wellbeing Boards.
- Continue to be effective participants of the Kent Health Overview & Scrutiny Committee and escalate concerns to them.
- Contribute to the Pharmaceutical Needs Assessment and the Joint Strategic Needs Assessment
- Provide feedback on the quality accounts of providers annually.



How do we bring about change?

The answer is simple… By listening

We listen to people through a number of different ways:

- When people contact our Helpline directly
- By proactively visiting communities and groups especially those who are classed as seldom heard and may not share their feedback
- Through our regular Information stands at public places including libraries and hospital foyers
- By using our statutory powers to Enter & View any adult health or social care service and talk to patients and users about their experience
- On board our Healthwatch Big Bus which visited every Kent district in 2016

Through this work we have been able to listen to people from all ages from young to old. We've also heard from people who would be classed as 'seldom heard or vulnerable plus people who may not live within Kent but who use Kent's services.

Here's just a few examples of where we have been this year:

- Mental Health support groups
- Eastern European family liaison group
- Several Travellers sites
- Older People's Groups
- Pensioners Advice & Information Fair
- Rural Libraries
- Kent Physical Disability Forum
- Disability Groups
- BME Ladies' Coffee morning
- Young People's Transition Information Day
- Carers Forums
- Kent Mental Health Festival
- East Mencap Fun Day

What we've learnt from visiting services:

We've learnt so much from talking to people but here are a few snapshots

- Services do not currently work as efficiently or as joined up as they could be
- It's extremely confusing for people about how to complain about services
- If people cannot get an appointment from their GP, they are twice as likely to go to A&E
- Translation services within GP surgeries continues to be an issue
- People who require a complex level of care often stay in hospital much longer than they need to
- People are confused and fearful of changes to services. They want to understand what services will look like in the future
- People don't feel they are being engaged and involved in changes to services
- Autistic patients struggle to get the support they need
- The Children & Adolescent Mental health services continues to be an issue for patients and families

What difference have we made?

In our hospitals: Our trained volunteers have visited hospitals in North and West Kent talking to patients about being discharged. As a result, we have worked with Darent Valley Hospital to develop a new patient leaflet explaining the discharge process. This is currently being piloted with 20,000 patients. We have returned to visit Outpatient departments in East Kent and have seen improvements in waiting times and the way appointments are being handled. All our recommendations have been implemented. We've also visited Outpatients in West & North Kent and heard largely positive feedback. Improvements have been made to signage and the information included in appointment letters as a result of our visits.

In our Care Homes: We have escalated 11 cases of concern for patient safety to the Care Quality Commission and Kent County Council this year. All of our escalations have been investigated and in one instance the care home was prevented from accepting new residents until measures were put in place.

For mental health patients and carers: We've worked closely with our mental health trust to follow up on concerns we heard from patients being placed in beds outside of Kent. We're pleased to report that currently the numbers of patients has dropped significantly. There are currently 5 mental health patients in beds outside of Kent.

The recommendations from our report on the Children & Adolescent Mental Health service have all been included in the new specification for the contract. Our findings from Autistic patients was used as part of a national report by Healthwatch England.

Changes to our services: We monitor and where relevant scrutinise consultations that involve changes to our social care or health services in Kent. Through this work we have identified that organisations often don't engage with patients and service users enough prior to any public consultation. To address this we have created our Best Practice Guide to Pre-consultations to ensure all organisations are fully aware of their responsibilities. We are also setting up two new patient groups to support better engagement around the Sustainability & Transformation Plan (STP) and for Kent County Council.

GP services: We visited 3 GP surgeries in South Kent Coast and highlighted that patients aren't aware of online booking or extended opening times. We have written to all South Kent Coast GP practices to ask them how they plan to promote these services to patients.

Dentists: Following our detailed report into NHS dental services we have made a number of recommendations. We will be working on these with NHS England and the Local Dental Practitioners Network to make the changes. We have also created two new leaflets for the public clarifying issues around dental charges and how to find an NHS dentist.

Information & signposting service

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

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

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

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

Call us for FREE on

0808 801 0102

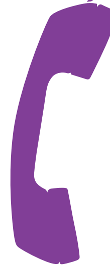
Calls answered from
10am – 4pm every weekday

Messages welcome anytime and responded to within two working days.
Email us at info@healthwatchkent.co.uk or text 07525 861 639. Text 'Need BSL' for our British Sign Language Interpreter to contact you.

5%
Access to services

9%
Appointments / Referrals

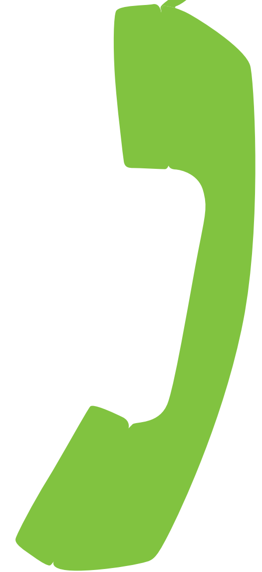
7%
Staff attitude



9%
Waiting times

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

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



43%
of people who got in touch with us did it through email

15%
Quality of treatment

Our Volunteers

Our volunteers are central to everything that we do. They are involved in every level from administration through to decision making.

Here's just a few examples of what our volunteers do for us:

- Hold regular sessions in Kent hospitals talking to patients about their experiences
- Represent Healthwatch at key meetings including all seven local Health & Well Being Boards ensuring that patient voice remains on the agenda
- Work with us to shape the workplan for the Kent Health & Well Being Board
- Visiting services as part of our Enter & View remit to talk to patients about their experiences
- Visiting community and seldom heard groups to understand their experiences of services
- Read, distil and analyse reports and information

Our Steering Group is made up of volunteers

They identify themes and trends for our future work

Together they agree our priorities and projects

They define and shape our project work and allocate resources

Our local Area Teams discuss and examine local issues

They work with local organisations and commissioners

They determine our local activity within each Clinical Commissioning Group area

They are made up entirely of volunteers

The year ahead?

Together with our volunteers, we have identified the following priorities based on what we have heard from the public.

This list is not exhaustive and we will continue to respond to issues brought to our attention during the year.

The Sustainability & Transformation Plan

We will continue to be actively involved in this. We have created and will Chair the new Patient & Public Advisory Group to drive forward better engagement and involvement with the public. We will also exercise our statutory responsibility to act as a critical friend to this process.

Health & Social Care Complaints

This continues to be an issue for people who contact our Helpline. We have recently reviewed organisations' websites in relation to complaints and we are planning a focus group of patients who will work directly with organisations to help them improve their service.

Hospital Discharge

We will be publishing a further report on patients who have a delayed discharge in North Kent.
Our report on Hospital Discharge in West Kent will also be published this year and we will embark on a new project to talk to patients in East Kent about their experiences.

Children & Young Peoples Services

We are a founding member of the new NHS Youth Forum. The forum will ensure that organisations effectively engage with young people but in a co-ordinated and integrated way.

Finances

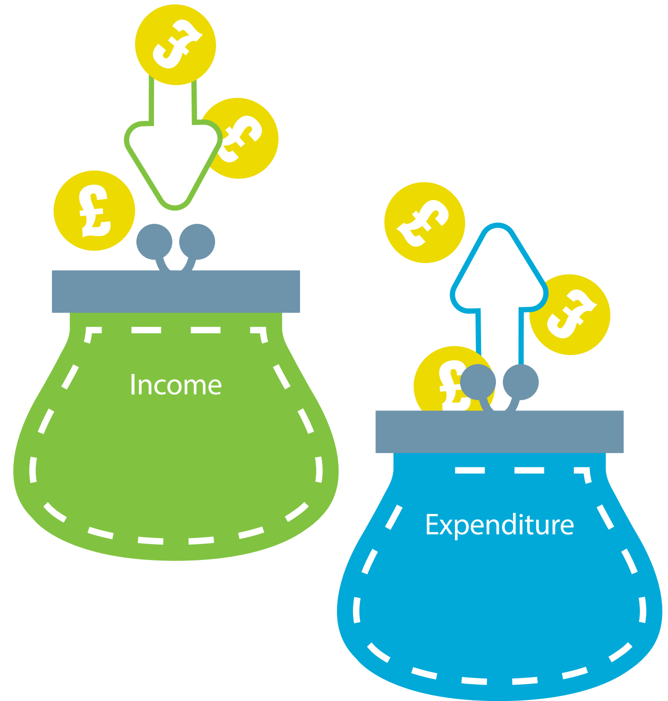


Table heading showing statement of activities for the year ending 31 March 2017

Income	
Funding recieved through local authority to deliver Healthwatch statutory activities	£666,270
Additional Income	£0
Total income	£666,270

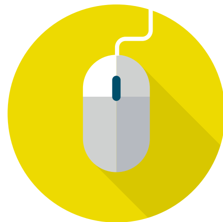
Expenditure	
Operational costs	£240,789
Staffing costs	£327,760
Office costs	£23,805
Volunteer costs, expenses & training	£22,545
Total expenditure	£614,899
Balance brought forward	£51,371

Your comment counts
We want to hear from you

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

By Telephone:
Healthwatch Kent
Freephone 0808 801 01 02

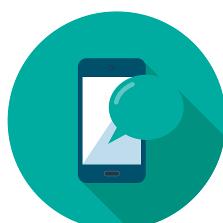
By Email:
Info@healthwatchkent.co.uk



Online:
www.healthwatchkent.co.uk

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

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



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

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healthwatch
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