AGENDA

KENT HEALTH AND WELLBEING BOARD

Wednesday, 26th February, 2020, at 2.00 pm Ask for: **Ann Hunter**

Darent Room, Sessions House, County Hall, Maidstone Telephone **03000 416287**

Refreshments will be available 15 minutes before the start of the meeting

Membership

Mrs C Bell (Chairman), Dr B Bowes (Vice-Chairman), Dr F Armstrong, Mr I Ayres, Mr P B Carter, CBE, Mrs S Chandler, Dr S Chaudhuri, Mr M Dunkley CBE, Dr S Dunn, Cllr F Gooch, Mr R W Gough, Cllr Mrs A Harrison, Cllr Mrs J Hollingsbee, Mr S Inett, Dr N Kumta, Dr S MacDermott, Dr J Malasi, Mr A Scott-Clark, Ms C Selkirk, Ms P Southern and Dr R Stewart

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UNRESTRICTED ITEMS

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

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes

3 Election of Chairman

4	Election of Vice-Chairman
5	Declarations of Interest by Members in items on the agenda for this meeting To receive any declarations of Interest by Members in items on the agenda for the meeting
6	Minutes of the Meeting held on 7 February 2019 (Pages 1 - 4) To receive and agree the minutes of the last meeting
7	Neuro Developmental Disorders Deep Dive - Verbal Update
8	Future Arrangements for the Kent and Medway Joint Health and Wellbeing Board (Pages 5 - 18)
9	Briefing on Analytics for the Kent & Medway ICS (Pages 19 - 38)
10	Pharmaceutical Needs Assessment Updates and Supplementary Statements (Pages 39 - 74)
11	Amendment to the Terms of Reference of the Kent Health and Wellbeing Board (Pages 75 - 78)
12	Date of Next Meeting - 2 February 2021

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)

Benjamin Watts
General Counsel
03000 416814

Tuesday, 18 February 2020

KENT COUNTY COUNCIL

KENT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent Health and Wellbeing Board held in the Darent Room - Sessions House on Thursday, 7 February 2019.

PRESENT: Mr P J Oakford (Chairman), Dr B Bowes (Vice-Chairman), Cllr S Aldridge, Mr G K Gibbens, Cllr F Gooch, Mr R W Gough, Mr S Inett, Dr S MacDermott, Mr A Scott-Clark, Ms P Southern and Mr S Collins (Substitute for Mr M Dunkley CBE)

ALSO PRESENT: Mr G Douglas

IN ATTENDANCE: Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

332. Chairman's Welcome
(Item 1)

333. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr Armstrong, Mr Carter, Dr Chaudhuri, Ms Cox, Mr Dunkley, Dr Kumta and Ms Selkirk. Mr Collins attended as substitute for Mr Dunkley.

334. Declarations of Interest by Members in items on the agenda for this meeting
(Item 3)

There were no declarations of interest.

335. Minutes of the Meeting held on 21 March 2018
(Item 4)

Resolved that the minutes of the last meeting are correctly recorded and that they be signed by the Chairman.

336. Integrated Adult Learning Disability Commissioning - Section 75 Agreement
(Item 5)

Xanten Brooker and Emma Hanson (Senior Commissioners) were in attendance for this item

(1) Xanten Brooker and Emma Hanson introduced the report which provided an update on the Learning Disability Section 75 Agreement that had been established to host integrated commissioning arrangements between Kent County

Council and the seven clinical commissioning groups. They also gave a short presentation which had been circulated with the agenda papers.

(2) Penny Southern said that the Learning Disability Alliance had, on the whole, been successful and that it was important to ensure services for people with learning disabilities were not lost as a result of changes to Integrated Care Partnerships and to consider how they could be further developed.

(3) In response to questions and comments, Xanten Brooker and Emma Hanson provided further information about responsibility for patient referral within the Learning Disability Alliance, the provision of annual health checks; and assessments made under the Care Act. Mr Gough and Mr Collins answered questions about the register of elective home-schooled children.

(4) Resolved that the report be noted.

337. Kent Better Care Fund Annual Report
(Item 6)

Jo Frazer, STP Lead, Adult Social Care and Health was in attendance for this item

(1) Jo Frazer introduced the report which provided an annual update on the progress of the Kent Better Care Fund.

(2) Resolved that the report be noted and, if any further submission is required for the extension of the BCF plan, that the sign off be delegated to the Chairman.

338. Kent Joint Strategic Needs Assessment (JSNA) Exceptions Report 2018/19
(Item 7)

Dr Abraham George (Consultant in Public Health) was in attendance for this item

(1) Andy Scott-Clark introduced the report by saying that in 2018 the Kent and Medway STP had published an updated Case for Change and that this drove the work for transforming health and care services in Kent and Medway. He said the findings of the needs' assessment highlighted in the paper would be reflected in the refreshed STP Case for Change which would be aligned with the NHS Long Term Plan.

(2) Abraham George said this report was the sixth Kent Joint Strategic Needs Assessment Exceptions Report to be presented to the Health and Wellbeing Board. He drew the Board's attention to the principal issues raised in the report.

(3) Members of the Board expressed disappointment that health inequalities appeared to be widening across Kent. Members also said it was important to hold the whole system to account and that consideration be given to making high-level strategic objectives relevant and meaningful to health practitioners, particularly those in deprived areas. The importance of a whole system approach to reducing liver disease, excessive alcohol consumption and obesity was acknowledged.

(4) Mr Douglas said it was important to identify the approaches to tackling strategic issues which worked best and to re-use those approaches in other areas.

(5) Resolved that:

(a) a system-wide focus on prevention, especially the continued whole-system focus on the reduction of smoking prevalence, particularly for women who smoke during pregnancy be endorsed;

(b) the continued focus on local populations with the lowest life expectancy be endorsed;

(c) work be undertaken to ensure whole systems are communicating systematically and effectively in order to gain the best outcomes, particularly to address multiple long-term conditions and both physical and mental health, across the life course;

(d) the focus on improving Stroke and Cancer pathways from prevention through diagnosis, treatment, rehabilitation and palliative care be continued;

(e) key highlights and emerging issues be embedded into the reiterated Kent and Medway Case for Change;

(f) a report on addressing health inequalities be considered at the Health Reform Public Health Cabinet Committee in June 2019 and at a meeting of the STP Board.

339. 0-25 HWB Update and Forward Pan
(Item 8)

(1) Stuart Collins introduced the report which provided an annual update on the progress of the 0-25 Health and Wellbeing Board.

(2) In response to questions from the Board, Mr Collins said that health visitors were co-located in Children's Centres in Ashford and would soon be co-located in Children's Centres in Dartford. He also said that 98% of early years services had been assessed as good or better.

(3) Members of the Board broadly welcomed the report.

(4) Resolved that:

(a) the report, the progress to date and the proposed direction of travel set out in the Forward Plan be endorsed;

(b) the 0-25 HWB's plans for the identification of further opportunities to strengthen partnership working be supported.

340. Kent and Medway Health Crisis Care Concordat 2017/18 Annual Report
(Item 9)

Dave Holman (Head of Mental Health Commissioning, NHS West Kent CCG) and Adam Wickings (Deputy Managing Director West Kent CCG and MNWK CCGs) were in attendance for this item

(1) Dave Holman introduced the report which provided an update on the commitments made in the Mental Health Crisis Care Concordat across Kent and Medway. The report included information about progress to date and drew attention to the increase in the number of admissions under Section 136 of the Mental Health Act which remained high despite a range of initiatives. Adam Wickings spoke about the work underway to reduce the number of admissions and the deep dive undertaken earlier in the year.

(2) Resolved that the progress be noted and that planned work across agencies be supported.

341. Pharmaceutical Needs Assessment Updates and Supplementary Statements
(Item 10)

Allison Duggal (Deputy Director of Public/ Public Health Consultant) was in attendance for this item

(1) Allison Duggal introduced the report which described the current process for updating the Pharmaceutical Needs Assessment, asked the Board to agree to formalise the process and delegate responsibility to the Pharmaceutical Needs Assessment Steering Group.

(2) Resolved that the Pharmaceutical Needs Assessment Steering Group be given delegated responsibility to consult, collate and respond to all written requests from NHS England in relation to the PNA and the provision of pharmaceutical services on behalf of the Health and Wellbeing Board.

342. Date of Next Meeting - 26 February 2020
(Item 11)

Resolved that the next meeting of the Kent Health and Wellbeing Board be held on 26 February 2020.

HEALTH AND WELLBEING BOARD

26 FEBRUARY 2020

FUTURE ARRANGEMENTS FOR THE KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

Report from: David Whittle, Director of Strategy, Policy, Relationships and Corporate Assurance Kent County Council

Julie Keith, Head of Democratic Services Medway Council

Author: Jade Milnes, Democratic Services Officer, Medway Council

Karen Cook, Policy and Relationships Adviser (Health), Kent County Council

Summary

This report reviews the achievements of the Kent and Medway Joint Health and Wellbeing Board (Joint Board) since it was established in 2018 and provides feedback from the development session held on 17 September 2019. The report reviews arrangements for the Joint Board and recommends that the Health and Wellbeing Boards of Kent County Council and Medway Council approve the continuation of the Joint Board.

1. Budget and Policy Framework

1.1 The Kent and Medway Joint Health and Wellbeing Board (Joint Board) has been established as an advisory Joint Sub Committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012.

1.2 The Joint Board was established for a time limited period of two years commencing from 1 April 2018. It is for the respective Health and Wellbeing Boards of Kent County Council and Medway Council to consider and determine the role and continuation of the Joint Board.

2. Background

2.1 Upper tier Councils in England were each required to establish a Health and Wellbeing Board, as a Committee of the Council, under Section 194 of the Health and Social Care Act 2012. The Board must include at least one Councillor (nominated by the Leader in authorities operating executive arrangements), the Directors of Adult and Children's Services for the area, the Director of Public Health, a local Healthwatch representative and a representative of each local clinical commissioning group. There is discretion to include other people or organisations, as each local authority thinks appropriate.

2.2 The purpose of Health and Wellbeing Boards is to provide collective leadership to improve health and wellbeing across the local authority area. The principal functions of HWBs are set out in the Health and Social Care Act 2012 and

include preparation of a Joint Strategic Needs assessment, a Pharmaceutical Needs Assessment and a Joint Health and Wellbeing Strategy which should underpin and inform commissioning decisions across health, social care and public health.

2.3 Section 198 of the Health and Social Care Act 2012 states that two or more Health and Wellbeing Boards may decide for:
(a) any of their functions to be exercisable jointly.
(b) any of their functions to be exercisable by a joint sub-committee of the Boards.
(c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.

2.4 A proposal to establish a Joint Board was put forward to consider fundamental issues relating to future arrangements for the financing, commissioning and delivery of services across the Kent and Medway health and social care system. This proposal emerged after the Kent and Medway Sustainability and Transformation Partnership (STP) began operating across a Kent and Medway geographic footprint. It was intended that, given the complexity of the STP, the formation of the Joint Board would play an important role in providing a strong democratic voice and local authority engagement in the STP discussions.

2.5 On 20 February 2018 and 21 March 2018 respectively, the Health and Wellbeing Boards of Medway Council and Kent County Council (KCC) agreed to establish the Joint Board as an advisory Joint Sub Committee of the respective Health and Wellbeing Boards under Section 198(c) of the Health and Social Care Act 2012. Both the KCC and Medway Council's Health and Wellbeing Boards continue to discharge their respective statutory functions.

2.6 The Joint Board operates principally to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the STP plans for Kent and Medway.

2.8 With respect to membership, the existing Terms of Reference (TOR) provide that the Joint Board may appoint other persons to be non-voting members as it considers appropriate. Furthermore, with the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may also be included.

2.9 In line with these provisions, on 28 June 2018, the Joint Board agreed to appoint Dr Robert Stewart as a non-voting member of Joint Board in his capacity as the Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation. In addition, on 14 December 2018 the Joint Board agreed to appoint Dr Bob Bowes as a voting member of the Joint Board, in his capacity as Chairman of the Strategic Commissioner Steering Group.

3. Achievements of the Joint Board to date

3.1 The Joint Board has undertaken a number of 'deep dives' into priority areas within the Kent and Medway STP Prevention Action Plan, including reducing smoking prevalence, obesity and alcohol consumption and increasing physical activity. In doing so, the Joint Board has taken an evidence based approach to identifying opportunities for added value across the system.

3.2 The Joint Board has also considered the transformation of health structures and new ways of working, including the development of the Integrated Care System, including the System Commissioner, Integrated Care Partnerships and Primary Care Networks and implementation of local care with wider partners across Kent and Medway.

3.3 It has taken account of system wide risks, such as winter planning arrangements between health and social care, preparations for leaving the European Union and the Kent and Medway Workforce strategy which provides a focus on a key challenge for our area in managing workforce shortages and how staff are recruited and retained.

3.4 The work of the Joint Board has been recognised by the Local Government Association and has been featured in a series of case studies on social care, health and integration.

4. Development Session

4.1 A development session for Members of the Joint Board was held in September 2019 in place of the scheduled Joint Board meeting.

4.2 At this development session, members present considered the findings from the Joint Strategic Needs Assessment (JSNA) Case for Change and the key health and wellbeing challenges facing the Kent and Medway population.

4.3 Members also received presentations on the personal experience of both a local resident and the Head Teacher of a nursery and infant school.

4.4 Members expressed a view that there was merit in continuing with the Joint Board arrangements on the understanding that both Local Authorities retain their current arrangements for their own Health and Wellbeing Boards.

4.5 It was suggested that should each respective Health and Wellbeing Board agree that the Joint Board should continue, it should increase its focus on children and young people and the wider determinants of health, such as housing. In addition, the Joint Board should look at the outcomes it wants the system to target which would impact on the health and wellbeing of the population with particular attention on activity and commissioning plans that will help to narrow the gap in life expectancy and increase years lived in good health based on the evidence of the JSNA Case for Change.

5. Future arrangements for the Joint Board

5.1 National and local Health policy context has developed since the Joint Board's inception in 2018. The NHS national Long term Plan, published in January 2019 set out a framework for NHS activity for the next 5-10 years, including a focus on joining-up care, a 21st century approach to prevention, tackling long-term unmet needs (children's health, young people with mental health needs, autism and learning disabilities) and inequalities, and dealing with the biggest killers and disablers. It also set down an expectation that each STP will become an Integrated Care System (ICS) and that every system would produce a local five year plan (in Kent and Medway this is called the Strategic Delivery Plan). This plan was considered by Medway's Health and Wellbeing Board on 16 January 2020 and Kent's Health and Wellbeing Board on 8 January 2020.

5.2 In October 2019, NHS England approved a proposal to establish a single Kent and Medway CCG from 1 April 2020. As the Integrated Care System across Kent and Medway continues to take shape, it is anticipated that the next few years will be transitional. From 2021 four Integrated Care Partnerships (ICPs) across the Kent and Medway footprint will be mobilised, namely: Medway and Swale; East Kent; West Kent; and Dartford, Gravesham and Swanley. A 2020 shadow operating model has been designed to transition the system to ICP full mobilisation.

5.3 The Long Term Plan talks about each system having a Partnership Board and also refers to working with Health and Wellbeing Boards. Health and Wellbeing Boards are increasingly being cited as the place for whole system working to come together so that all stakeholders can be held to account for meeting the health needs of the local population. Therefore, the Joint Board continues to have value and grow in significance. It can fulfil both a national and local challenge about where system wide leadership comes from and the Joint Board may wish to develop further into this space, with approval from both Kent and Medway's Health and Wellbeing Boards.

5.4 To align with the planning timeframe of the Kent and Medway Strategic Delivery Plan (five year plan) which runs from 2019/20 to 2023/24, it is proposed that the Kent and Medway Health and Wellbeing Boards agree to the continuation of the Joint Board as an advisory Joint Sub Committee of these Boards for a further four year period commencing 1 April 2020 (with an opportunity to review this annually at the request of either Kent's or Medway's Health and Wellbeing Board. In Kent, where the Board meets less often it is proposed that the Director of Public Health can trigger a review in consultation with the Chairman of the Health and Wellbeing Board.)

5.5 The existing governance arrangements for the Joint Board are set out at Appendix 1 to this report. No changes are proposed to the terms of reference, membership formula or rules of procedure. The proposal suggested in paragraph 5.4 of the report is tracked in for ease of reference.

5.6 In line with the establishment of the single K&M CCG, CCG representation on the Joint Board may be revised. It is anticipated that the Accountable Officer of the single CCG will be nominated to this position. This will be subject to further discussion and confirmation in due course.

5.7 With the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may be appointed to the Joint Board. In accordance with this clause, subject to agreement of the Joint Board at its meeting on 17 March, Members are asked to agree the appointment of:

- the Clinical Chair of single Kent and Medway CCG as a voting member of the Joint Board;

- the Senior Responsible Officer of each of the four ICPs as non-voting members of the Joint Board (with a view to review whether they should be appointed as voting members when the ICPs are fully mobilised).

5.8 Under transitional arrangements, members are also asked, subject to the agreement of the Joint Board, to agree the re-appointment of the Chairman of the System Commissioner Steering Group for a further year.

5.9 The re-appointment of the Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation as a non-voting member of the Joint Board is a matter for the Joint Board. The Joint Board will consider this in addition to a proposal to appoint a representative of the Kent Association of Local Councils as a non-voting member of the Joint Board to represent the views of member parishes in Kent and Medway at their meeting on 17 March 2020.

5.10 Appendix B to the report shows how the current membership of the Joint Board compares to the proposed membership outlined in paragraphs 5.6 to 5.9 of the report.

6. Financial, legal and risk management implications

6.1 There will be a cost associated with continuing the Joint Board in terms of support for the Board and meeting arrangements. This cost will be shared, with each local authority supporting the Board for one year in turn within existing resources. The Joint Board itself will not have a budget. Any executive decisions or the determination of any matter relating to the discharge of the statutory functions of the Kent and Medway HWBs will remain a matter for each Council.

6.2 The scope for two or more Health and Wellbeing Boards to establish arrangements to work jointly is provided in section 198 of the Health and Social Care Act 2012. Section 198 allows for the joint exercise of functions by a Joint HWB or by a Joint Sub Committee or for the establishment of a Joint Sub Committee to advise the participating HWB's on any matter related to the exercise of their functions.

6.3 When the Medway Health and Wellbeing Board was established in 2013 the Council permitted the Board itself to set up Advisory Sub Committees. Any proposal to delegate the functions of the Board to a Sub Committee or an Officer (or from a Sub Committee to an Officer) is subject to approval by full Council. The proposal in this report can be agreed by the Medway Health and Wellbeing Board without referral to full Council.

6.4 There are no risks arising from the proposal to set up joint arrangements between the Kent and Medway Health and Wellbeing Boards.

7. Recommendations

7.1 The Health and Wellbeing Boards of Kent County Council and Medway Council are asked to each agree:

(i) to the continuation of the Kent and Medway Joint Health and Wellbeing Board constituted as an Advisory Sub Committee, with Terms of Reference and procedure rules as set out in Appendix 1 to this report;

(ii) that the role and continuation of the Joint Board should be reviewed after four years unless triggered earlier at the request of either Kent's or Medway's Health and Wellbeing Board and that this decision is delegated in Kent to the Director of Public Health in consultation with the Chairman of the Health and Wellbeing Board; and

(iii) subject to the agreement of the Joint Board on 17 March 2020 and as summarised in Appendix 2 to this report:

- to appoint the Clinical Chair of single Kent and Medway CCG as a voting member of the Joint Board;
- to appoint the Senior Responsible Officer of each of the four Integrated Care Partnerships (ICPs) as non-voting members of the Joint Board noting that this will be reviewed when the ICPs are fully mobilised;
- to re-appoint the Chairman of the System Commissioner Steering Group for a further year.

Lead officer contact:

Karen Cook, Policy and Relationship Adviser (Health). Strategy, Policy, Relationships and Corporate Assurance: karen.cook@kent.gov.uk Tel: 03000 415281

Appendices

Appendix 1 – Governance arrangements for the Joint Board
Appendix 2- Position on Membership

Background papers

None.

Appendix 1 Governance Arrangements for the Kent and Medway Joint Health and Wellbeing Board

1. The Medway Health and Wellbeing Board and the Kent Health and Wellbeing Board are each separately responsible for discharging the following statutory powers and duties for their own areas:

(a) Preparation and publication of a Joint Strategic Needs Assessment (JSNA) – Section 196 of the Health and Social Care Act 2012.

(b) Preparation and publication of a Joint Health and Wellbeing Strategy to meet the needs identified in the JSNA – Section 196 of the Health and Social Care Act 2012

(c) Assessment of need, preparation and publication of a Pharmaceutical Needs Assessment – Section 128A of the National Health Service Act 2006

(d) For the purpose of advancing the health and wellbeing of the people in either Kent or Medway, to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner – Section 195 of the Health and Social Care Act 2012

(e) Encouragement to persons who arrange for the provision of any health related services in Kent and Medway to work closely with the Board – Section 195 of the Health and Social Care Act 2012

(f) Encouragement to persons who arrange for the provision of any health or social care services in Kent and Medway and to persons who arrange for the provision of any health-related services in the area to work closely together – Section 195 of the Health and Social Care Act 2012

(g) Provision of such advice, assistance or other support as thought appropriate by the respective HWBs for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services – Section 195 of the Health and Social Care Act 2012

(h) Involvement in preparation or revision of CCG Commissioning Plans – Section 26 of the Health and Social Care Act 2012

(i) Review of draft CCG Commissioning Plans before the beginning of each financial year (and any in - year revisions to plans) and provision of an opinion to the CCG as to whether or not the draft, or any revisions ,take proper account of the Joint HWB Strategy (with an option to provide an opinion to NHS England) -Section 26 of the Health and Social Care Act 2012

(j) Provision of advice to the local authority that established the HWB of its views on whether the local authority is discharging its duty to have regard to the JSNA and Joint Health and Wellbeing Strategy – Section 196 of the Health and Social Care Act 2012

(k) Provision of a view to NHS England when the annual performance assessment of CCGs is conducted, on the contribution of the CCG to the delivery of the Joint HWB Strategy – Section 26 of the Health and Social Care Act 2012

2. Establishment of an advisory joint sub-committee to be known as the Kent and Medway Joint Health and Wellbeing Board

(a) In exercise of their powers under Section 198 of the Health and Social Care Act 2012 which permits two or more Health and Wellbeing Boards to make arrangements for any of their functions to be exercised jointly, Kent County Council and Medway Council have agreed to establish an advisory joint sub-committee to be called the Kent and Medway Joint Health and Wellbeing Board KAMJHWB) for a time limited period of four years to start from 1st April 2020. On an annual basis, by agreement of the respective Health and Wellbeing Boards of Kent and Medway this may be reviewed.

3. Operating principles

(a) The KAMJHWB is an advisory sub-committee which operates to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the Sustainability and Transformation Partnership (STP) Plans for Kent and Medway.

(b) It will seek to:

i. Ensure collective leadership to improve health and well-being outcomes across both local authority areas, to enable shared discussion and consensus about the STP across the Kent and Medway footprint in an open and transparent way;

ii. Help to ensure the STP has democratic legitimacy and accountability, to seek assurance that health care services paid for by public monies are provided in a cost-effective manner.

iii. Consider the work of the STP and encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner

iv. Take account of and advise on the wider statutory duties of Health and Social Care Partners

4. Key Functions

(a) To consider and influence the work of the STP focussing on prevention, Local Care and wellbeing across Kent and Medway.

(b) To consider and shape the development of Local Care within the STP which will impact on adult social care delivery in both authorities, advising the Kent and Medway Health and Wellbeing Boards accordingly.

(c) To give advice to the STP in developing clear plans and business cases to assist commissioners in making best use of their combined resources to improve local health and well-being outcomes, particularly relating to the Local Care and Prevention work streams, making recommendations to the Kent and Medway Health and Wellbeing Boards on support that could be provided.

(d) To keep NHS commissioning plans under review, insofar as they relate to STP Plans to ensure they are taking into account the Kent and Medway JSNAs and local HWB Strategies, referring back to the STP Programme Board and respective Kent and Medway Health and Wellbeing Boards where they do not.

(e) To champion integration in local care delivery, including working with the STP to establish a Kent and Medway Local Care Board

(f) To support the development of the Clinical Strategy

(g) To ensure alignment of the Kent and Medway JSNAs with population health needs to inform the STP Case for Change and the associated Clinical Strategy

(h) To consider and advise on the development of the STP Preventative work-stream given it is heavily focussed on Public Health functions within both upper-tier authorities

(i) To consider and advise on the development of options for the local authorities' role in a Strategic Commissioner arrangement with Health – the engagement in which remains a matter for each of the local authorities.

(j) To consider options for the Local Authority role in the development of Integrated Care Systems (previously known as Accountable Care Partnerships), the engagement in which remains a matter for each of the local authorities.

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5. Membership

(a) The Chairman of the KAMJHWB will be appointed at the first meeting of the Board and thereafter at the first meeting of the Board after the annual meetings of Kent County Council and Medway Council. It is expected that the position of Chairman will be rotated between the chairmen of the constituent authorities' Health and Wellbeing Boards on an annual basis.

(b) The Vice-Chairman of the Joint Board will also be appointed at the first meeting of the Board and thereafter at the first meeting of the Joint Board after each Kent and Medway Annual Council meetings. It is expected that the position of vice-chairman will also be rotated on an annual basis and will be the chairman of the authority's Health and Wellbeing Board who is not the chairman of the KAMJHWB.

(c) Voting members of the KAMJHWB are as follows:

- The Leader of each Council and up to three other members of each council nominated by the respective leaders (or their substitutes)
- The Director of Adult Social Services for Kent and the Assistant Director Adult Care Services for Medway
- The Director of Children's Services for Kent and the Director of Children and Adults for Medway
- The Director of Public Health for each local authority
- Representatives of the Local Healthwatch organisations for Kent and Medway who must not be a Member of a Health Overview and Scrutiny Committee for either authority and who may each have a named substitute
- A representative of each Clinical Commissioning Group (noting that section 197 (7) of the Health and Social Care Act 2012 provides for one person to represent more than one CCG on a HWB subject to the agreement of the Board). Each CCG representative may have a named substitute.

(d) Non Voting Members of the KAMJHWB are as follows:

- The Police and Crime Commissioner
- A representative of the Kent and Medway Local Medical Committee (who may also have a named substitute)

(e) The KAMJHWB may appoint other persons to be non-voting members as it considers appropriate. If at any time after the establishment of the Joint Board either of the authorities' Health and Wellbeing Boards wish to appoint additional non-voting members of the Board this may only be done after consultation with the KAMJHWB. In addition there should be observer representatives from two District Councils in Kent (aligned with the footprint of the Integrated Care Systems)

(f) With the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may also be included.

6. Procedure Rules

(a) **Conduct**. Members of the KAMJHWB must comply with the relevant Council's Code of Conduct.

(b) **Registration and Declaration of Interests**. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the KAMJHWB. A register of interests is held by Kent County Council and Medway Council. Members of the KAMJHWB must register interests as required by the relevant Council's code of conduct. A Member of the Board or any substitute may not participate in a discussion of or vote on any matter in which he or she has a DPI or other significant interest (both those already registered and those disclosed at the meeting) and must withdraw from the room during such discussion.

(c) **Frequency of Meetings**. The KAMJHWB will usually meet quarterly. The date, time and venue of meetings are fixed in advance by the JKAMHWB. At the end of the time limited period the Board may agree to continue its arrangements with approval through the relevant Council governance for each authority.

(d) **Meeting Administration**. Administration for the KAMJHWB will be rotated annually between Kent County Council and Medway Council.

- The Joint Board will give at least five clear working days' notice in writing to each member of every ordinary meeting of the KAMJHWB, to include any agenda of the business to be transacted at the meeting.
- Papers for each KAMJHWB meeting are published at least five clear working days in advance.
- Late papers may be added to the agenda at less than five days' notice only where the Chairman is satisfied that the business is urgent by way of special circumstances which must be specified in the minutes.
- Meetings will take place in public with provision for exclusion of the press and public where confidential or exempt information is likely to be disclosed as defined in the Local Government Act 1972.

(e) **Special Meetings**. The Chairman or Vice-Chairman may convene special meetings of the KAMJHWB in addition to scheduled meetings as considered necessary

(f) **Minutes.** Minutes of all of KAMJHWB meetings are prepared recording:

- the names of members of the KAMJHWB (and any substitutes) who are present at a meeting and any apologies for absence
- details of all proceedings and resolutions of the meeting
- Minutes are normally published and circulated before the next meeting of the KAMJHWB, when they are submitted for approval by the KAMJHWB and are signed by the Chairman.

(g) **Agenda.** The agenda for each meeting normally includes:

- Apologies for absence
- Declarations of interest
- Minutes of the previous meeting for approval and signing
- Reports to the KAMJHWB
- Any item which a member of KAMJHWB wishes included on the agenda provided it is relevant to the Terms of Reference of the Board must be notified to the Chairman and relevant Democratic Services Officer at least one calendar month before the meeting however any decision to include an item on any agenda rests with the Chairman and Vice-Chairman following advice from the relevant officers.

(h) **Absence of Members and of the Chairman**. If a member is unable to attend a meeting, they may provide an appropriate substitute to attend in his/her place (noting that CCG, LMC and Healthwatch representatives must have named substitutes). The Democratic Services Officer for the meeting should

be notified of any absence and/or substitution prior to the meeting. Any substitute member must register his/her interests, in accordance with either the Medway or Kent Councillor Code of Conduct and these must be published before participation as a formal member of the Joint Board is permitted.

(i) The Chairman presides at KAMJHWB meetings if he/she is present. In their absence the Vice-Chairman presides. If both are absent, the KAMJHWB appoints from amongst its members an Acting Chairman for the meeting in question.

(j) All matters coming before the KAMJHWB shall be decided by a majority of the members of the Board present and voting thereon at the meeting. In the case of an equality of votes the person presiding at the meeting shall have a second or casting vote.

(k) **Quorum.** A third of the total number of voting members of the Board, and at least one representative from each of the two councils, form a quorum for the KAMJHWB meetings. No business shall be transacted at any meeting of the KAMJHWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman must either suspend business until a quorum is re-established or declares the meeting at an end.

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

(m) **Order at Meetings**. At all meetings of the KAMJHWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. The Chairman decides all questions of order that may arise.

(n) **Overview and scrutiny**. Overview and scrutiny (within the meaning of the Local Government Act 2000 and The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) will be the responsibility of each constituent Authority and the appropriate scrutiny arrangements of each Authority will apply. No member of a Health Overview and Scrutiny Committee from either Kent County Council or Medway Council may also be a member (or substitute member) of the KAMJHWB.

Appendix 2 - Position on Membership

Voting Members				
No.	Current Membership	No.	Proposed Membership	Comments
1	Medway Council, Leader	1	Medway Council, Leader	No Change
2	Medway Council Elected Representative	2	Medway Council Elected Representative	No Change
3	Medway Council Elected Representative	3	Medway Council Elected Representative	No Change
4	Medway Council Elected Representative	4	Medway Council Elected Representative	No Change
5	KCC Leader	5	KCC Leader	No Change
6	KCC Elected Representative	6	KCC Elected Representative	No Change
7	KCC Elected Representative	7	KCC Elected Representative	No Change
8	KCC Elected Representative	8	KCC Elected Representative	No Change
9	Medway Council, Assistant Director Adult Social Care	9	Medway Council, Assistant Director Adult Social Care	No Change
10	Kent County Council, Corporate Director Adult Social Care and Health	10	Kent County Council, Corporate Director Adult Social Care and Health	No Change
11	Medway Council, Director of Children and Adults	11	Medway Council, Director of Children and Adults	No Change
12	Kent County Council, Corporate Director Children, Young People and Education	12	Kent County Council, Corporate Director Children, Young People and Education	No Change
13	Medway Council, Director of Public Health	13	Medway Council, Director of Public Health	No Change
14	Kent County Council, Director of Public Health	14	Kent County Council, Director of Public Health	No Change
15	Local Healthwatch Representative Kent	15	Local Healthwatch Representative	No Change
16	Local Healthwatch Representative Medway	16	Local Healthwatch Representative	No Change
17	CCG Representative – Glenn Douglas	17	CCG Representative For Nomination by NHS	The membership formula allows for a representative of each CCG. It is anticipated that the AO of the new single K&M CCG will be nominated to this position.
18	CCG Representative – Caroline Selkirk (East Kent)			
19	CCG Representative – Ian Ayres (West Kent)			
20	Chairman of Strategic Commissioner Steering Group - Dr Bob Bowes	18	Chairman of the Strategic Commissioner Steering Group - Dr Bob Bowes	The forum is formally called the System Transformation Executive Board (STEB). This is time limited.
		19	Clinical Chair of new K&M CCG - Navin Kumta	Newly created post in the single CCG.

Non - Voting Members				
No.	Current Membership	No.	Proposed Membership	Comments
21	Kent Police and Crime Commissioner	20	Kent Police and Crime Commissioner	No Change
22	Kent Local Medical Committee	21	Kent Local Medical Committee	No Change
23	District Council Representative Nominated by Kent Chiefs	22	District Council Representative	No Change
24	District Council Representative Nominated by Kent Chiefs	23	District Council Representative	No Change
25	Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation – Dr Robert Stewart	24	Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation – Dr Robert Stewart	Re-appointment to be considered at the Joint Board on 17 March 2020.
		25	KALC (parish and town council representation) Chairman of the KALC Health & Well-Being Advisory Committee, which is currently Cllr John Rivers.	Appointment to be considered at the Joint Board on 17 March 2020.
		26	Medway and Swale ICP Senior Responsible Officer (SRO)	The ICPs will operate in shadow form until April 2021, therefore it is recommended that each ICP lead be appointed as a non-voting member at this stage to be reviewed at a later date.
		27	East Kent ICP SRO	
		28	West Kent ICP SRO	
		29	Dartford, Gravesham and Swanley ICP SRO	

From: Claire Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

26 February 2020

Subject: Briefing on Analytics for the Kent & Medway ICS

Classification: Unrestricted

Summary:
This briefing describes a short update on the current position of analytics for the new and emerging Kent & Medway Integrated Care System (ICS). It describes latest position of linked datasets development in our system, the Analytics strategy and work around some of the critical enablers, led by the Kent & Medway Shared Health & Care Analytics Board (SHcAB).

Recommendation:
The Kent Health and Wellbeing Board are asked to **COMMENT** on the paper and **ENDORSE** the following recommendations:

- Endorse the Kent and Medway Health and Care Analytics Strategy.
- Work with local partner organisations, where appropriate, in moving towards a consistent approach in the production and use of applied analytics for population health management.
- Relevant member organisations, including KCC, to sign up to Joint Controller arrangements via the SHcAB at their earliest possible convenience.

1. Background

1.1 A significant amount of collaborative work has been undertaken by KCC and NHS senior officers in enabling applied analytics for the Kent health economy. It builds on work that has been undertaken over many years to build the Kent Integrated Dataset or KID and its application for population health and other applied analytics supporting the Kent & Medway STP. These developments are related in part to ongoing workstreams led by the Kent & Medway STP Shared Health & Care Analytics Board and input provided, among others by the Kent Public Health Observatory (KPHO).

2 OPTUM KID

2.1.1 After a lengthy procurement process, the Kent & Medway CCGs awarded the commissioning support / business intelligence contract to OPTUM in autumn 2017. Among other things the ambition was to look for a better supplier for business analytics using the NHS England Lead Provider Framework

developing a robust commissioning tool for NHS commissioners using one single linked dataset from local and national NHS data sources and suitable dashboard / management information system to interrogate it.

2.2 After several years of development, OPTUM KID / Mede-analytics platform is currently accessible and being used by CCGs. While good progress has been made in data linkage across a wide variety of NHS provider and GP datasets for commissioning intelligence purposes, there has been mixed feedback in terms of the quality and delivery of some of its services. Discussions are under way by CCGs to consider the future of OPTUM's role in the Kent & Medway ICS and contract renewal.

2.3 Kent Public Health Observatory (KPHO) have been working with the KCC Data Protection team to develop the necessary governance arrangements for access to the OPTUM KID / Mede Analytics platform. This includes obtaining a legal opinion to understand and assess the risks to KCC around data sharing and contractual relationships with OPTUM. Access authorization is likely to be finalised by March 2020.

3 HISbi KID

3.1 Kent County Council Public Health has led the creation of the HISbi KID. It currently comprises the main dataset used by the KPHO team for core public health intelligence work supporting the Kent JSNA, wider public health intelligence needs and the derivation of evidence to support KCC Strategic Commissioning activities.

3.2 The CCG contract award for OPTUM KID has resulted in the withdrawal of CCG support and governance arrangements to HISBi KID and was subsequently earmarked for deletion by 31st March 2019.

3.3 However, due to the delays in setting up formal arrangements mentioned above for KCC access to OPTUM KID dashboard, an extension of the MOU has been agreed to utilise the existing HISbi KID for another 2 years (until 31st March 2021), as the KPHO team gradually transitions towards using OPTUM KID. This contingency was devised and established by KPHO to act as a safeguard to preserve the strategic analytic capability for the Council.

3.4 As a result of this extension, work is under way to refresh the existing governance arrangements of the KID, which involves transitioning data controller arrangements from KCC to the SHcAB, which has recently taken on the Joint Data Controller responsibilities for the new and emerging ICS.

3.5 These changes are expected to improve existing processes and procedures for a safe and secure 'controlled environment' for the KID. It will also facilitate authorization of new data access requests from other organisations for applied research and applied analytics e.g. University of Kent and Kent Surrey Sussex Applied Research Collaboration (ARC) programme.

4 SHcAB Activities – Analytics Strategy

4.1 With support from NHS England and the Kent Surrey Sussex AHSN, an analytics strategy was completed in October 2019 and presented to our STP oversight groups – STP Partnership Board, Clinical & Professional Board, Finance Directors and NEDS.

4.2 The strategy described our vision and ambition to become an exemplar in production and use of applied analytics to improve population health. It highlights and builds on local examples of best practice and, more importantly, key enablers such as data management, information governance and workforce development that require targeted resourcing and capacity to create an efficient 'supply chain' of good analytics supporting our system.

5 SHcAB activities – Joint control

5.1 In January 2019, the SHcAB agreed to develop appropriate governance arrangements and seamless processes and procedures (for commissioner AND provider organisations) in the use of data for the STP/Integrated Care System. This is underpinned by a Joint Data Control arrangement which has been acknowledged and recommended in latest national IG guidance from NHS England. Such arrangements will have a number of benefits, most notably: the ease and flexibility of linking other NHS and non NHS datasets that are not of direct interest to commissioners, but still relevant for population health analytics supporting the STP/ICS going forward.

5.2 Based on good feedback and engagement over the last year, documentation was sent out in December 2019 to local NHS organisations to sign up / be onboarded to Joint Control.

5.3 As January 2020, East Kent University Hospitals NHS Trust and Maidstone & Tunbridge Wells NHS Trust have signed up to Joint Controller arrangements via the SHcAB. Other organisations, including KCC and the Kent & Medway CCG, when it is formalised, are expected to follow suit.

6 SHcAB activities – KERNEL database

6.1 Previous SHcAB meetings have discussed the intent to build a database to be known as KERNEL, utilising and starting with existing datasets such as HISBi KID and local NHS Trust provider clinical and operational data currently warehoused by the HISBi team. The purpose of KERNEL will be to prioritise population health analytics including research and operational business intelligence work that local NHS providers require

6.2 As per the Analytics Strategy agreed last year, the vision, project timeline and funding requirements for the KERNEL was formally launched and discussed at the SHcAB in January 2020. A working group has been set up involving key SHcAB members including the HISBi data warehouse team, who will be responsible in developing it.

6.3 Development of the KERNEL was also discussed at the System Commissioner group in February 2020, particularly how it compared with the other similar datasets – OPTUM & HISBI KID – and what are the short and long term implications for linked dataset development supporting population health management function of the Kent & Medway ICS going forward.

6.4 This will affect the future decision making processes as to how the ICS will commission outside agencies for strategic consultancy work requiring complex analyses and, as mentioned in analytics strategy, to what extent the ICS wishes to adopt a local partnership approach and encourage greater ownership in the 'complex supply chain' of data curation and data quality assurance leading to the production and delivery of applied analytics.

7 Outcomes Based approach to Commissioning

7.1 A paper was presented and agreed by the Clinical & Professional Board in December 2019 around the opportunities to reposition the role of the strategic commissioner, from an activity and finance based relationship to a place based and outcomes based model, underpinned by a strong population health approach and an outcomes framework and dashboard.

7.2 A presentation was delivered at the January 2020 System Commissioner group by Outcomes Based Healthcare, a private company commissioned by NHS England to develop a national population segmentation approach and outcomes metrics tool for local health economies under the Bridges to Health programme. Agreement was reached by the Kent & Medway System Commissioner to take part in a one year national pilot in order for our ICS to become an early adopter.

7.3 A working group has been set up involving local stakeholders, including Kent and Medway public health teams to assist in data curation and analysis, using the HISbi KID and KERNEL (when operational). Further discussions have also taken place to explore the synergies between this project and ongoing modelling and simulation work in the North and West Kent CCGs that have supported the 5 year Long Term Plan submissions. Workshops are being planned in March and September 2020 to present early results and engage with local stakeholders for further development.

7.4 This project represents one of many examples of strategically important analytic projects spanning across Kent & Medway that requires robust local governance and technical capacity and support in terms of linked data access and analyses.

7.5 The outputs of the work are expected to significantly benefit the Kent JSNA development process and improve on existing population segmentation and

outcomes surveillance outputs that are regularly described in JSNA related reports.

8 Conclusions

8.1 HISBi KID will be extended for another year (till March 2021) and its governance arrangements move over to SHcAB joint control to ensure business continuity arrangement KPHO work on behalf of KCC Public Health and wider ICS. Role based access to other internal and external teams can be suitably assessed and sanctioned for business continuity purposes, while OPTUM and KERNEL mature from varying stages of their development and functionality. A further discussion by the SHcAB may be had later in the year to assess its future options e.g. development into a 'synthetic' dataset for research purposes.

8.2 Use of Optum KID / Mede platform as a commissioning dataset will carry on as planned until current contract expires in 2022. Decision for renewal will be up for future discussion based on changing analytical requirements for the ICS including population health management.

8.3 There appears to be growing interest for KERNEL as a locally owned and developed solution for analytics. Going forward, it needs to be brought under clear ICS leadership (under a formal analytics workstream) and commensurate funding so that it can support population health management work including the national pilot mentioned above.

9 Recommendations

The Kent Health and Wellbeing Board are asked to **COMMENT** on the paper and **ENDORSE** the following recommendations:

- Endorse the Kent and Medway Health and Care Analytics Strategy
- Work with local partner organisations, where appropriate, in moving towards a consistent approach in the production and use of applied analytics for population health management
- Relevant member organisations, including KCC, to sign up to Joint Controller arrangements via the SHcAB at their earliest possible convenience

10. Contact Details:

Report Author:

Abraham George
Consultant in Public Health Medicine
abraham@george@kent.gov.uk

Appendix 1 :

Kent & Medway Analytics Strategy

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Kent and Medway Health and Care Analytics Strategy

Quality of life, quality of care

Transforming health and social care in Kent and Medway

Transforming
health and social care
in Kent and Medway

Kent & Medway Clinical Vision

Quality of life, quality of care

What this means:

A holistic view of individuals
Prevention is at the heart of our approach

Apply interventions that address the interactions between mental and physical health, social and general wellbeing, and wider determinants of health

We enable people to access care and support in the right place to manage their conditions and recovery better, at the right time based on need

We strive to achieve the best outcomes and the highest standards of care by adopting evidence based practice, applying best practice guidelines and embracing research and development.

We continually assess our performance, are always learning, including from our mistakes, and make changes to improve.

Jane Ollis,
Non-Executive Director
Kent Surrey Sussex Academic Health Science Network

Unmet health and wellbeing needs: A call to use data to save lives

The next few decades will see enormous opportunities for data to be used to understand patterns of ill health and wellbeing, and to plan how services can be proactive to meet the needs of the population in the most effective and efficient way possible.

The number of people living in Kent and Medway is predicted to rise by almost a quarter by 2031, a higher rate of increase than the average across England. Local people are living longer and older people tend to have additional health needs.

Many people (including children) in Kent and Medway have poor physical and/or mental health with over 528,000 local people – that's almost one in three of those living in Kent overall – living with one or more significant long-term health conditions. Many long-term conditions such as Diabetes, high blood pressure or breathing problems (for instance COPD – Chronic Obstructive Pulmonary Disease) can be better managed and improved if people can get the right support easily and quickly.

Too many of these conditions are largely attributable to living unhealthy lifestyles are preventable with the right lifestyle interventions and changes.

There are also unacceptable differences in health across the region. For example, women in the most deprived areas of Thanet live on average 22 years less than those in the least deprived. With the right help it can be possible to prevent the main causes of death, which are often linked to issues, such as obesity, smoking and childhood poverty.

The scale of this local challenge means that if we don't change how we work and spend our money for the greatest benefit, we will be overspent by £486m by 2020/21.

Kent and Medway are one of the most advanced areas in the country for linking longitudinal patient data across a number of health and care settings – this has the significant advantage of being able to understand the whole picture of people's health and care. It is critical that we make the most of this advantage by ensuring our analytical capabilities can use this data to optimise health and care across Kent and Medway.

Glenn Douglas
Chief Executive, Kent and Medway STP

Dr Fiona Armstrong
Chair, Kent and Medway Clinical and Professional Board

Transforming
health and social care
in Kent and Medway

Current state

Transforming health and social care in Kent and Medway

Our vision

for Analytics

Through the existence of leading integrated datasets and a mature analytical and research capability, Kent and Medway is well placed to use data to transform the prevention, early detection and treatment of ill health by 2030.

We will ensure our communities are enabled to have the best quality of life and quality of care through leading-edge, actionable analytics and innovation.

We will:

- Develop shared health and care analytics, which will enable us to understand the health needs of the population and to estimate how we can make the biggest improvements in improving health outcomes, patient experience, cost efficiency, workforce wellbeing and reducing health inequalities.
- Examine the bigger picture of the drivers of good health and provide an understanding of the relationship and variation between care received throughout different points in an integrated care system.
- Design how to move from reactive care to preventative care, through the use of prescriptive rather than descriptive analytics to provide a more holistic view of a patient's requirements and care.
- Develop the new and collaborative ways of working across organisational health and care boundaries needed to deliver the changes that our patients and communities need.

Transforming health and social care in Kent and Medway

The strategic goals

Population Health Intelligence
We will develop intelligence to plan and commission services based on what will offer the most value for individuals, considering every aspect of their health and wellbeing, proactively preventing poor health and being ready to best manage it when it happens.

Intelligence for citizens
We will enable citizens to take control of their health and wellbeing through informed decision making, optimised self-care and opportunities to influence their health and care services.

Driving innovation by working with research and industry partners
We will drive world class research and collaboration at scale that is translated to patient communities so that Kent and Medway can increase the pace of innovation in how technology is adopted.

Whole-system demand and capacity intelligence for integrated care management
We will develop a system-wide view of the flow of people and service performance, to optimise the efficiency in how our services are developed and delivered.

Intelligent decision support for clinicians and care teams
We will enable clinicians and care teams to identify people who are at risk of poor health and wellbeing, match them to the most appropriate interventions, and view personalised information on likely risks or benefits to inform shared decision making.

The new integrated care system will work collaboratively to achieve these goals, supported by robust foundations in:

- Information governance
- Data management
- Analytical workforce and processes
- Procurement and partnerships
- Skills and environment to turn intelligence into action

Transforming health and social care in Kent and Medway

Goal: Population Health Intelligence

We will develop intelligence to plan and commission services based on what will offer the most value for individuals, considering every aspect of their health and wellbeing, proactively preventing poor health and being ready to best manage it when it happens.

We will:

- Describe the whole picture of individuals' health and wellbeing, how this is likely to change in the future, and what interventions would have the most value.
- Identify where we can make the most impactful improvements by addressing prevention, vulnerable groups, gaps in care, inequalities and poor outcomes.
- Review which interventions work well to address similar problems elsewhere, as well as where local or service specific adaptations may be needed.
- Assess the holistic impact of different options before implementation.
- Evaluate continuously which care pathways do and do not work well, for whom, and why.

We will begin by developing a population health intelligence solution that:

- Is co-designed with clinicians, managers and commissioners from across the system, developed iteratively and reviewed annually.
- Can be viewed at Integrated Care System, Integrated Care Partnership and Primary Care Network level, with the option to drill.
- down to organisation or other appropriate levels of interest.
- Considers whole health pathways from prevention to end of life, including, for example, risk factors, social determinants, mental health, quality of life and health outcomes.
- Allows users to extract data and to build reports themselves.
- Incorporates and aligns with pre-existing national intelligence sources.

By 2024 we will be:

- Maximising the potential and safety of artificial intelligence to identify patterns that allow us to predict and target poor health before it happens.
- Using accurate patient-level predictions of future health and care need to support value based planning and commissioning within and across organisations.

Transforming health and social care in Kent and Medway

Goal: Intelligence for citizens

We will enable citizens to take control of their health and well-being through informed decision making, optimised self-care to influence their health and care services.

We will do this by:

- Engaging with citizens to see how they would want to see their data used for public benefit.
- Involving citizens from the beginning in the design and implementation of applications that are populated with their data.
- Empowering citizens to manage their own health and influence their own care.

We will begin by:

- Scoping a programme to engage directly with citizens around co-design, data-sharing and trust.
- Ensure all uses of health and care data are transparent and for public benefit.
- Build on successes in maternity and cancer care to develop pathway guidance apps in all major health and care pathways.

By 2024 we will have:

- A mature, system-wide, service user-driven design capability across Kent and Medway.
- Delivered user-friendly, real time information on personal health data, empowering patients to take responsibility for their own health and access appropriate support.
- Care that is increasingly personalised, from prevention to screening and diagnosis to treatment and decision support, enabled by data-driven technologies.
- Citizens who are confident in using data-driven technologies where appropriate, and alternative solutions where they are not.
- A workforce that is confident in their decisions about when and how human interaction must take priority over interactions between humans and artificial intelligence.

Transforming health and social care in Kent and Medway

Goal: Driving innovation by working with research and industry partners

We will drive world class research and collaboration at scale that is translated to patient communities so that Kent and Medway can increase the pace of innovation in how technology is adopted.

We will do this by:

- Ensuring research will be integrated with health and care analytics in Kent & Medway, with aligned priorities, and a number of research partners who will work together and integrate into the health and care system.
- Providing access to Kent and Medway's linked datasets for researchers, to enable population-level research and feasibility studies.
- Ensuring that the results of research undertaken within and beyond Kent & Medway will be included in the Kent & Medway Knowledge Management System.

We will begin by:

- Setting up a research subgroup for the Shared Health and Care Analytics Board to establish partnerships with academia and industry, and set research priorities.
- Writing a Kent and Medway Research Strategy that aligns with Integrated Care System priorities.
- Setting up a knowledge management system that can be accessed and intuitively used by the whole system.

By 2024 we will have:

- Established a self-funding and internationally recognised 'Data Research Laboratory'. This will provide a real-world simulation and synthetic data that academics and SMEs can use to test their hypotheses before service changes are made.
- Set up a placed based real-world research service supporting retrospective and prospective public health and clinical studies with established links with national agencies such as NICE, MHRA, NIHR to inform local, national and international clinical policy.
- Created more efficient links with the quality improvement and operational teams, so that there remains an emphasis on actionable research.
- Registered at least 30,000 citizens to participate in research.

Transforming health and social care in Kent and Medway

Goal: Whole-system demand and capacity intelligence for integrated care management

We will develop a system-wide view of the flow of people and service performance to optimise efficiency in how our services are developed and delivered.

We will do this by:

- Modelling the flow of people across the Integrated Care System, Integrated Care Partnerships and Primary Care Networks in real time, from primary care to community care.
- Mapping capacity in real-time across the system, and balancing this against demand.
- Directing people to the right part of the system, to receive the right care in the most efficient way for both the patient and the health and care system.
- Tracking performance targets in real-time and alerting to any issues before they happen.
- By monitoring the drivers of performance to understand and predict issues.

We will begin by:

- Harmonising current solutions, through standardised definitions, processing and methods, to enable an agreed set of data upon which to plan by.
- Developing a whole-system view of real-time demand and capacity.
- Developing consistent standards for demand and capacity modelling, building on those already working well and using the latest simulation technologies.

By 2024 we will be:

- Using data-driven algorithms in real-time to support a virtual command and control centre, and associated live dashboards.
- Using data collected through electronic tracking devices to map demand and capacity in real-time.
- Using accurate predictions of demand and capacity issues consistently across all services, with directives to management as to the best courses of action.

Alan Day,
Technology Commissioning and Strategy,
Kent County Council

If we are transparent and open in our use of data, people will reward us with their trust

Goal: Intelligent decision support for clinicians and care teams

We will enable clinicians and care teams to identify citizens who are at risk of poor health and wellbeing, match them to the most appropriate interventions, and view personalised information on likely risks or benefits to inform shared decision-making.

We will do this by:

- Developing risk stratification models with acceptable levels of sensitivity and specificity, that have been validated by local clinicians.
- Developing models to identify not only citizens with the highest risks, but also those who are likely to have increasing risk, and those who are likely to be most impacted by available interventions.
- Routinely identifying missed elements of pathways of care for individuals and ensuring that those gaps are filled.
- Providing clinicians and care teams with personalised intelligence for each citizen, so that they can inform them of likely impacts of different care options.

We will begin by:

- Creating and implementing a framework to evaluate current decision support tools, enabling recommendations for using existing tools in a consistent way, and identifying gaps for further development.
- Exploring initial uses of artificial intelligence and machine learing.
- Ensuring that we have a workforce that is confident in their decisions about when and how human interaction must take priority over artificial intelligence-human interaction.

By 2024 we will have:

- Consistent risk and impactability algorithms for that consider the whole picture of an individual's health and wellbeing, and can be easily applied directly at the point of care by clinicians and care teams for all individuals in the population.
- Decision support algorithms that alert clinicians and care teams of personalised matches to intervention options based on predicted risks and benefits.
- Reduced unwarranted variation by providing clinicians with tools to compare their outcomes with peers.

Enablers: What do we need to make this happen?

Enabler 1: Governance and Leadership
To achieve our ambition of whole person population-based care, we need understandable analytics that can be used to make decisions in a complex and inter-related healthcare system.

Enabler 2: Information Governance
We will optimise the data sharing process with joint data control so that we can utilise data for designing improvement as well as direct patient care. We will ensure transparency and public trust in the secure, robust and beneficial use of data.

Enabler 3: Data Management
We will optimise the data infrastructure and management of our data to ensure seamless connectivity between different sources, agreed recording conventions and a single view of data from live through to research. We will take account of system agreed priorities and reduce duplication in the movement and storage of data.

Enabler 4: Analytical Workforce
We aim to develop the best analytical workforce in the UK, we will adopt national standards and work towards professional accreditation for all staff. We will develop analysts that can work alongside decision makers so that the right questions are designed and rigorous evaluation conducted.

Enabler 5: Communication and Engagement
We will develop a range of presentation methods that span clinicians, managers and patients so that there is greater understanding of data and a greater readiness to make decisions based on rigorous evidence.

Enabler 6: Population health intelligence
We will develop intelligence and statistical modelling tools so that services can be planned and commissioned to provide the best value for money, considering every aspect of a citizen's health and well-being, pro-actively managing poor health and being ready to best manage it when it deteriorates.

Enabler 7: Integrated Care Management
We will develop a system-wide view of the flow of people and services performance, and to optimise efficiency in how our services are developed and delivered.

Enabler 8: Clinical Engagement
We will enable clinicians and care teams to identify people who are at risk of poor health and wellbeing, match them to the most appropriate intervents, and view personalised information on likely risks or benefits to inform shared decision making.

Transforming
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Enabler 9: Research and Innovation
We will drive world class research and collaboration at scale that is translated to patient communities so that Kent and Medway can increase the pace of innovation in how technology is adopted.

Enabler 10: Citizen Engagement
We will enable citizens to take control of their health and wellbeing through informed decision making, optimised self-care and opportunities to influence their health and care services.

Abraham George,
Consultant in Public Health, Kent County Council

"To become a Learning Health System, data has to be everybody's business, so that we can align science, informatics, incentives and culture for continuous improvement
and innovation."

Transforming health and social care in Kent and Medway

Dr Marc Farr
Chief Analytical Officer
East Kent Hospitals University Foundation Trust

"There is an incredible coincidence of individuals with an interest and expertise in the use of data in Kent.

The opening of a Medical School and a Data Research Laboratory in Kent, the support of national funding bodies and a concentration of a superb analyst community means we are perfectly placed to exploit the opportunities for patients to benefit from leading edge use of data #datasaveslives"

Next Steps

- Establish governance to support the delivery of the strategy including oversight for the delivery of the supporting plans
- Identify individuals to lead on supporting plans ensuring they have capacity to progress high priority actions quickly
- Agree prioritisation process for work carried out under this strategy
- Determine the scale of financial commitment to deliver the agreed high priority items
- Establish joint data controller arrangements

Supporting Plans

Workstream	Purpose
Population Health Intelligence	Agree what pop health management means in K&M and what analytics are required for it
Demand and Capacity Intelligence	Scaling demand and capacity intelligence to whole system, with consistency across all elements
Intelligence to support clinicians and care teams	Identifying what is currently in use and what future requirements are
Citizen Intelligence	Identifying ways to engage citizens and scoping citizen-facing tools
Research	Health and care research strategy
Evaluation	Health and care evaluation strategy
Data architecture plan	Determine number and type of data warehouses

Workstream	Purpose
Data quality plan	Improve data quality across Kent & Medway with a particular focus on primary care
Information governance plan	Setting up a joint controller for all health and care data and updating IG documentation and notices
Review of current contracts and suppliers	Determine best ways to invest to deliver the strategy and set framework for future procurement
Analytical capacity plan	Identify work that could be stopped or optimised, and identifying most efficient ways of working
Turning intelligence into action	Giving people across the system the skills they need to ask the right questions, interpret intelligence and turn it into action

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Methodology and approach to producing this strategy

Kent and Medway is proud home to some of the country's best linked health and care data assets, as well as exemplary work in health and care analytics, which is featured in NHS England's library of best practice. As the STP makes the transition to integrated system working, there is an urgent need to develop early system capability and capacity around a number of core business functions, including business intelligence, building on excellence already established in the region.

Responding to this need, Kent and Medway Shared Health and Care Analytics Board (SHcAB) commissioned this strategy in January 2019, with an aim of providing strategic direction for health and care analytics development, to ensure that it:

- Is cohesive across all of Kent and Medway
- Maximises the potential benefits of health and care analytics
- Ensures investment of resource is optimised and futureproofed

Development of the strategy was facilitated by NHS England and Kent Surrey Sussex Academic Health Science Network, with generous support from the STP Digital Strategy Group.

The strategy was developed by a dedicated task and finish group consisting of subject matter experts and system information leaders from over 15 organisations across Kent and Medway.

The working group advised on scope and underpinning principles for the strategy, and also supported the team in conducting:

- A stock-take of health analytics currently in use across Kent and Medway, conducted via interviews and information assets across NHS and non NHS (wider public Sector).
- A 'discovery' phase, aimed at understanding 'what good looks like', what other areas are doing and what national analytical products are available, conducted via a workshop.
- A needs assessment to support understanding intelligence user requirements.
- Reviews and detailed comments on multiple drafts of this report prior to submission to STP programme Boards and reviewers.
- Designate leader and key milestones for each supporting plan workstream.

Input from the working group was augmented by detailed interviews with a number of individuals from across Kent and Medway. The strategy could not have been completed without the dedication of countless individuals and organisations across the STP, as detailed in the following acknowledgements pages.

About the Kent and Medway Shared Health and Care Analytics Board

The SHcAB will be the delivery vehicle for the regional analytics strategy. The Shared Health and Care Analytics Board was established in 2017 and currently reports into the STP Clinical and Professional Board. The SHcAB brings together enthusiastic and dedicated health and care professionals and data analysts as a professional community and network. The board's aims are to ensure that sustainable change Methodology and approach to producing this strategy is cost-effective and delivers real benefits to citizens, provide professional development opportunities, and nurture the skills needed for careers in data science and analytics.

Highlights of recent work led by the SHcAB include:

- The SHcAB Research Strategy;
- NHS England Health System Led Investment funding application to modernise the local data warehouse infrastructure (known as HISBi);
- A proposal for a Strategic Intelligence Unit; and
- Plans for a Joint Data Controller arrangement on behalf of the Kent and Medway.

The SHcAB is proud to commission this business intelligence strategy, which will be key to supporting the use of data to improve the lives of Kent and Medway residents, while at the same time generating a national reputation for excellence in analytics.

Martin Griffin,
Patient, East Kent

"I hear a lot about people linking data together to understand more about patterns of care and to plan where our services should be. This makes perfect sense and I would think that the NHS should already be doing it as long as the data is all secure."

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Acknowledgements

Advisory board

The SHAcB is particularly grateful to the Kent and Medway STP boards who supported the authors on this project and provided feedback on the drafts of this paper: the STP Programme Board, the Clinical and Professional Board, The Integrated Care System Steering Group, the Digital Strategy Group, Kent and Medway Health and Wellbeing Board, Kent County Council Public Health Consultants and the STP Finance Group.

Reviewers:
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- Ian Ayres, West Kent CCG
- Bob Bowes, Chairman of Governing Body, West Kent CCG
- Vincent Godfrey, Strategic Commissioner, Kent County Council
- Caroline Selkirk, Managing Director, East Kent CCGs
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- Iain Anderson

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- Simon Barnes
- Richard Ewins
- Lindsay Forbes
- Sue Luff
- Representatives from Transforming Systems
- Representatives from Optum
- Simon Burrell, Involve

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From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

26 February 2020

Subject: Pharmaceutical Needs Assessment Updates and Supplementary Statements

Summary:
The Pharmaceutical Needs Assessment (PNA) describes the current pharmaceutical service in Kent, systematically identifying any gaps or unmet needs in services, and makes recommendations on future development, in consultation with stakeholders.

The current PNA covers the period up to April 2021 and we have commenced the initial steps towards the development of the 2021-24 PNA.

Recommendations
The Kent Health and Wellbeing Board are asked to **AGREE** the proposed timeline for the delivery of the next Pharmaceutical Needs Assessment for Kent covering the period 2021 to 2024

---

1. Introduction

1.1 The Pharmaceutical Needs Assessment (PNA) describes the current pharmaceutical service in Kent, systematically identifying any gaps or unmet needs in services, and makes recommendations on future development, in consultation with stakeholders.

1.2 The PNA is a key document used by the local area Pharmaceutical Services Regulations Committee (PSRC) to make decisions on new applications for pharmacy contracts and change of services or relocations by current community pharmacies. It is also used by commissioners reviewing the health needs for services within their particular area, to identify if any of their services can be commissioned though pharmacies.

1.3 The Health and Social Care Act 2012 transferred responsibility for the Pharmaceutical Needs Assessment (PNA) from Primary Care Trusts to the Health and Wellbeing Boards on 1 April 2013. A PNA must be published every 3 years. In addition, the NHS Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 sets out the legislative basis for developing and updating Pharmaceutical Needs Assessments.

1.4 A revised assessment should be made as soon as is reasonably practicable after identifying significant changes since the previous assessment such as significant changes to the number of people in the area that require pharmaceutical services, the demography of the area and the risks to health or well-being in the area.

1.5 Pending publication of a revised assessment, a Health and Wellbeing Board may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of the last PNA. These supplementary statements become part of the PNA when the changes are relevant to granting of applications, where the changes are needed to prevent significant detriment to the provision of pharmaceutical services in its area.

1.6 The Health and Wellbeing Board is consulted on applications for pharmaceutical services such as consolidation of service (i.e. where a community pharmacy is giving up a contract, but this does not affect the access to pharmaceutical services in the area) or applications for new pharmaceutical service contracts.

2.0 Pharmaceutical Needs Assessment Steering Group

2.1 The PNA Steering Group is chaired by a Consultant in Public Health (currently the Deputy Director of Public Health) and includes representatives from Kent HealthWatch, Kent Local Medical Committee, Kent Local Pharmaceutical Committee, NHS England, a pharmacist from the Clinical Commissioning Group, the Kent Public Health Observatory and the Kent Public Health team.

2.2 The Steering Group meets regularly when the PNA needs to be refreshed and queries and consultations are shared with members of the committee for comment.

2.3 Kent County Council Public Health will be entering into discussions with Medway Council to consider whether it would be advantageous to combine Kent County's and Medway's PNA in the future, especially in light of the formation of the Integrated Care System.

3.0 Proposed Process for Delivery of the 2021-2024 PNA

3.1 The process for the delivery of the 2021-24 Kent County PNA has already commenced.

3.2 From October 2019 a small team has been clarifying any changes that might need to be made to the contents of the PNA. A format is being developed using this information and comparing to other examples of PNAs, such as Dorset and Manchester.

3.3 The Public Health Observatory has commenced collating data for the report.

3.4 The constituency of the PNA Steering Group is currently being considered, to take into account any changes to organisations (e.g. the merging of NHSE and NHSI and the creation of one CCG for Kent and Medway) and any changes to personnel in the last 2-3 years.

3.5 The PNA Steering group should be constituted by April 2020 to allow sufficient time to collate the data on population health needs, housing etc. and the collation of data on pharmaceutical services in Kent.

3.6 The document will be written and ready for consultation, which should take place November – January 2021. Following consideration of the consultation results, the report will be edited and brought to the Health and Wellbeing Board meeting in March 2021 for Members' agreement prior to publication.

4 Recommendation

The Kent Health and Wellbeing Board are asked to AGREE the proposed timeline for the delivery of the next Pharmaceutical Needs Assessment for Kent covering the period 2021 to 2024

5 Contact Details

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6 Appendices

Appendix 1: PNA Guidance

Appendix 2: PNA Steering Group Terms of Reference

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Department of Health

Pharmaceutical needs assessments

Information Pack for local authority Health and Wellbeing Boards

May 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Pharmaceutical Needs Assessment

Information Pack for local authority Health and Wellbeing Boards

Prepared by Medicines, Pharmacy and Industry – Pharmacy Team with the assistance of the Local Government Association and members of the National Learning Network for HWBs

Contents

Preface

This information pack has no statutory standing, nor does it constitute non-statutory guidance, but it aims to support local authorities to interpret and implement their duty with regard to pharmaceutical needs assessments (PNAs)

Summary

- The Health and Social Care Act 2012 transfers responsibility for the developing and updating of PNAs to health and wellbeing boards (HWBs). Under the Act, the Department of Health has powers to make Regulations.

- The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/.

- This information pack is intended to support local authority HWBs in a practical way in understanding and implementing these requirements. The pack is set out as follows:

  - chapter 1 gives an introduction and legislative background;

  - chapter 2 outlines what the term “pharmaceutical services” includes in relation to PNAs;

  - chapter 3 outlines the minimum information that must be in PNAs;

  - chapter 4 expands on what the legislation says about the publication and updating of PNAs;

  - chapter 5 explains the consultation requirements; and

  - chapter 6 outlines matters to consider when making assessments.

- There are two appendices:

  - appendix 1 contains a glossary of terms and phrases used in regulation 2 of the 2013 Regulations; and

  - appendix 2 sets out some frequently asked questions and answers.

Chapter 1 – introduction and legislative background

Introduction

1. If a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, GPs) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by the NHS Commissioning Board, now known as NHS England. This is commonly known as the NHS "market entry" system.

2. Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis. The first PNAs were published by NHS primary care trusts (PCTs) and were required to be published by 1 February 2011.

3. From April 2013, Health and Well-being Boards (HWBs) will be developing PNAs for the first time. We therefore have limited examples of practice involving HWBs. However, we have included some examples of the ways in which PCTs developed their first PNAs. The examples are illustrative and provide HWBs with an indication of how they may wish to approach their work.

Legislative background

4. The Health and Social Care Act 2012 established HWBs. The Act also transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

5. The NHS Act (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make Regulations.

128A Pharmaceutical needs assessments

(1) Each Health and Well-being Board must in accordance with regulations--

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision--

(a) as to information which must be contained in a statement;

(b) as to the extent to which an assessment must take account of likely future needs;

(c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;

(d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision--

(a) as to the pharmaceutical services to which an assessment must relate;

(b) requiring a Health and Well-being Board to consult specified persons about

specified matters when making an assessment;

(c) as to the manner in which an assessment is to be made;

(d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

Wider context

6. The Health and Social Care Act 2012 also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation to Joint Strategic Health Assessments (JSNAs). The aim of JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment for the health and wellbeing needs of the local population. They will be used to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to improve health outcomes and address health inequalities.

7. The preparation and consultation on the PNA should take account of the JSNA and other relevant strategies, such as children and young people's plan, the local housing plan and the crime and disorder strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of PNAs is a separate duty to that of developing JSNAs as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs). HWBs may therefore wish to note that PNAs, as a separate statutory requirement, cannot be subsumed as part of these other documents but can be annexed to them.

Chapter 2: Pharmaceutical needs assessments

What the legislation says

1. Regulations 3-9 and Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for PNAs.

Pharmaceutical services

2. Section 126 of the 2006 Act places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section also makes provision for the types of healthcare professional who are authorised to order drugs, medicines and listed appliances on an NHS prescription.

3. "Pharmaceutical services" in relation to PNAs include:

- *"essential services"* which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service[1] – the dispensing of medicines, promotion of healthy lifestyles and support for self-care;
- *"advanced services"* - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary – these are Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use Reviews and the Stoma Customisation Service for dispensing appliance contractors; and
- *locally commissioned services* (known as enhanced services) commissioned by NHS England.

4. The following are included in a pharmaceutical list. They are:

- *pharmacy contractors* (healthcare professionals working for themselves or as employees who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use); and
- *dispensing appliance contractors* (appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc). They cannot supply medicines.

[1] The precise contractual requirements for providing NHS pharmaceutical services are set out in Schedules 4-6 of the Regulations.

5. In addition, there are two other types of pharmaceutical contractor - d*ispensing doctors,* who are medical practitioners authorised to provide drugs and appliances in designated rural areas known as “controlled localities” (see Appendix 1) and *local pharmaceutical services (LPS) contractors* who provide a level of pharmaceutical services in some HWB areas.

6. A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

7. The definition of “pharmaceutical services” in relation to PNAs is set out in the following table:

Regulation	Explanation
Regulation 3(2) *– the pharmaceutical services to which each pharmaceutical needs assessment must relate are all the pharmaceutical services that may be provided under arrangements made by the NHS CB for:* *(a) the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list.*	There are three types of pharmaceutical service provided by pharmacy and dispensing appliance contractors as outlined in paragraph (3) above. Directed services are those services set out in Secretary of State Directions to NHS England, for example, medicines use reviews and NHS England commissioned enhanced pharmaceutical services, such as services to care homes, language access and patient group directions.
(b) the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services).	A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. “LP services” is a legal term. NHS England has powers to include in LPS contracts other NHS services or other wider services, such as services relating to the provision of education and training. However, including those other services in an LPS contract turns those services into “LP services” but it does not turn them into “local pharmaceutical services”.
(c) the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the NHS CB with a dispensing doctor).	For dispensing doctors, only the provision of those services set out in their pharmaceutical services terms of service (set out in the Schedules to the 2013 Regulations) is included within the definition of pharmaceutical services. Services such as GP enhanced services – either directed, such as childhood immunisation programmes or local, such as phlebotomy are not “pharmaceutical services”.

3: Information to be contained in PNAs

What the legislation says

1. Regulation 4 and Schedule 1 of the 2013 Regulations outline the minimum requirements for PNAs.

Pharmaceutical needs

2. When assessing local need for pharmaceutical services, HWBs may wish to note that general health need is not the same as the need for pharmaceutical services. There will be differences within HWB areas between:

- those health needs that may be met using pharmaceutical services commissioned by NHS England. For example, NHS England wishes to commission pharmaceutical services that help reduce the number of people in the HWB area who are being unnecessarily readmitted to hospital due to non-compliance with their medication. NHS England might therefore commission local community pharmacies to carry out medication use review services;
- public health services commissioned by local authorities; and
- those that cannot be met by pharmaceutical contractors, for example, minor surgery clinics.

3. Schedule 1 sets out the minimum information to be contained in pharmaceutical needs assessments. The following table provides the text of the Schedule as well as an explanation:

Regulation	Explanation
Schedule 1, paragraph 1 – necessary services: current provision *1. A statement of the pharmaceutical services that the HWB has identified as services that are provided:* *(a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and* *(b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).*	In order to assess the adequacy of provision of pharmaceutical services, current provision by all providers of such services needs to be mapped. This can be done, for example, by using NHS England's list of pharmaceutical services providers for the relevant area. This will need to include providers and premises within the HWB area, and also those that may lie outside in a neighbouring HWB area but who provide the services to the population within the HWB area. Examples of this type of service provider are pharmacies, distance-selling pharmacies (those who provide pharmaceutical services but not face to face on the premises, dispensing appliance contractors and dispensing doctors). Data from the Information Services Portal at the NHS Business Services Authority (NHS BSA)[2] can be used to assess the use of distance-selling pharmacies and dispensing appliance contractors by people residing within the HWB's area. The PNA includes a statement outlining this provision.

[2] The Information Services Portal provides access to a variety of information reports on key prescribing areas. It is anticipated that all NHS Prescription Services reporting will be accessed via the Portal in the future. For more information, see: http://www.nhsbsa.nhs.uk/PrescriptionServices/3607.aspx.

Schedule 1, paragraph 2 – necessary services: gaps in provision *2. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied-* *(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;* *(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.*	Having assessed local needs and the current provision of services, the PNA needs to identify any gaps that need to be filled. Such needs might comprise a pharmacy providing a minimum of "essential services" in a deprived area, or pharmaceutical services of a specified type. The PNA may also identify a gap in provision that will need to be provided in future circumstances, for example, a new housing development is being planned in the HWB area. Gaps in provision are not just gaps in pharmaceutical health needs but also gaps by service type. For example, a locality may have adequate provision of essential services to meet the needs of the population, but have a need for more specialist services, such as the management of a long-term condition. Examples of gaps that HWB's may identify, include: • inadequate provision of essential services at certain times of day or week leading to patients attending the GP-led health centres being unable to have their prescription dispensed; • opening hours that do not reflect the needs of the local population; • areas with little or no access to pharmaceutical services; and • adequate provision of dispensing services (by those GPs who dispense), but patients unable to access the wider range of essential services. The PNA includes a statement outlining any gaps.

Schedule 1, paragraph 3 – other relevant services: current provision *3. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided-* *(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access to pharmaceutical services in its area;* *(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;* *(c) in or outside the area of the HWB and, whilst not being services of the types described in sub-paragraph (a) or (b), or paragraph 1, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area.*	This is related to the types of application that persons can make to be included on a pharmaceutical list or provide directed services. There are five types of market entry application (known as routine applications): • current need; • future need; • improvements or better access; • future improvements or better access; and • unforeseen benefits (where the applicant provides evidence of a need that was not foreseen when the PNA was published). The HWB will have identified those services that are necessary for the provision of adequate pharmaceutical services (See the section on Schedule 1, paragraph 1 above). There may, however, be pharmaceutical services that provide improvements to the provision or better access for the public whether at the current time or in the future.

Schedule 1, paragraph 4 – improvements and better access: gaps in provision *4. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied-* *(a) would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type, in its area,* *(b) would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services or a specified type, in its area.*	It is important that PNAs identify services that are not currently being provided but which will be needed to secure future improvements to pharmaceutical services – common examples of this are major industrial, communications or housing developments, service redesign as set out in, for example, the Joint Health and Wellbeing Strategy, or re-provision. Provision may also change where significant economic downturn is expected, i.e. a large employer moves their operations to Europe or Asia. HWBs can also identify those services, which are currently not being commissioned by NHS England, local authorities or CCGs but may be services that could be commissioned in the future. It should be noted that if a HWB identifies a need or improvement and better access, NHS England does not have to meet the need – this is because NHS England may have other factors to take into account, i.e. other commissioning decisions. The PNA includes a statement outlining this provision.
Schedule 1, paragraph 5 – other services *5. A statement of any NHS services provided or arranged by the HWB, NHS CB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect-* *(a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its*	There may be services provided or arranged by the HWB, NHS England, a CCG, an NHS trust (including foundation trusts) which could, if they were included in a PNA, be provided by pharmaceutical services contractors. For example, a large health centre providing a stop smoking service or immunisation service at a community hospital. Only those NHS services which affect the need for pharmaceutical services or potential pharmaceutical services need to be included.

area; or *(b) whether further provision of pharmaceutical services in its area would secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type in its area.*	The PNA includes a statement outlining the services identified in the assessment which affect pharmaceutical needs.
Schedule 1, paragraph 6 – how the assessment was carried out *6. An explanation of how the assessment has been carried out, in particular –* *(a) how it has determined what are the localities in its area;* *(b) how it has taken into account (where applicable)-* *(i) the different needs of different localities in its area, and* *(ii) the different needs of people in its area who share a protected characteristic; and* *(c) a report on the consultation that it has undertaken.*	HWBs may wish to divide up their area to reflect different needs in different localities – for example, to identify needs for different segments of their populations. If so, HWBs may wish to designate any PNA localities to mirror JSNA localities. The PNA includes a statement setting out how the HWB has determined the localities; the different needs of different localities in its area including the needs of those people in the area sharing a protected characteristic, for example, a large travellers' site; and a report on the consultation undertaken on the PNA.

Maps

4. Paragraph 7 of Schedule 1 of the 2013 Regulations specifies that HWBs are required to include a map in their PNA identifying the premises at which pharmaceutical services are provided in the area of the HWB.

5. Regulation 4(2) requires HWBs to keep the above map up to date, in so far as is practicable (without the need to republish the whole of the assessment or publish a supplementary statement) – see Chapter 4 below.

Case study

Several PCTs worked with other agencies and organisations to produce pertinent maps. When Greater Manchester PCT wanted to determine the accessibility of their pharmacies by determining the hours they were open, they asked the Greater Manchester Passenger Transport Executive for their help in calculating this using a specific software package.

4: Publication and updating of PNAs

What the legislation says

1. Regulations 5 and 6 cover the date by which the HWB's first PNA must be published and the arrangements for revising the PNA.

Publication of first PNA

2. Regulation 5 states that the HWB's first PNA must be published by 1 April 2015. However, this does not preclude HWBs from publishing their first PNA earlier.

Updating and revising PNAs

Timelines for publication of first and revised assessments

- The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 come into force on 1 April 2013;
- HWBs will be required to produce **the first** assessment **by 1 April 2015**;
- HWBs will be required to publish a revised assessment within **three years** of publication of their first assessment; and
- HWBs will be required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

6. The following box gives some examples of possible changes which may mean a revised assessment or supplementary statement is needed and the factors HWBs may want to consider:

Revised PNA or supplementary statement?

Example: in its first PNA, the HWB identifies that a housing development is anticipated to commence in the second year of its PNA and that there would be a need for the provision of pharmaceutical services to the development at the point of occupation of the hundredth house. Subsequently, they are advised that the development has been delayed for two years.

In this instance, the HWB may need to consider whether it is disproportionate to revise the assessment in year 2. The HWB may consider not issuing a Supplementary Statement as there have been no changes to the availability of pharmaceutical services.

Example: a contractor with several outlets in the HWB area gives notice that it intends to close all or some of these outlets.

The HWB may consider whether the making of a revised assessment is a proportionate response. Will the provision of services be continued for its population, i.e. are there alternative providers of services? Would closure of all or some of the outlets warrant a full-scale revision of the PNA or would that be disproportionate, taking into account all relevant circumstances? If the change in the availability of pharmaceutical services is likely to have an impact on the need for additional pharmaceutical services, the HWB may consider issuing a supplementary statement.

Example: within its PNA, the HWB has identified that a locality has over-provision of essential and advanced services. Subsequently, one pharmacy within that locality gives notice to NHS England that it intends to close.

Following that closure, the HWB may consider issuing a Supplementary Statement that stated pharmacy X had closed. The HWB may also consider issuing a Supplementary Statement if the change is relevant to whether or not there is a gap in the provision of pharmaceutical services.

5: Consultation

What the legislation says

1. Regulation 8 sets out the requirements for consultation on PNAs. The local authority duty to involve was first introduced in the Local Government and Public Involvement in Health Act 2007 and was updated and extended in the Local Democracy, Economic Development and Construction Act 2008.

Those to be consulted

2. The Regulations set out that:

- HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA. Any neighbouring HWBs who are consulted should ensure any LRC in the area which is different from the LRC for the original HWB's area is consulted;
- there is a minimum period of 60 days for consultation responses; and
- those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

6: Matters for consideration when making assessments

What the legislation says

1. Regulation 9 sets out the matters HWBs must have regard to when developing their PNAs as far as is practicable to do so.

Matters for consideration

2. The following are the matters for consideration by HWBs:

- the demography of its area;
- whether there is sufficient choice with regard to obtaining pharmaceutical services; (see box below);

Possible factors to be considered in terms of the benefits of sufficient "choice"

- What is the current level of access within the locality to NHS pharmaceutical services?
- What is the extent to which services in the locality already offer people a choice, which may be improved by the provision of additional facilities?
- What is the extent to which there is sufficient choice of providers in the locality, which may be improved, by additional providers?
- What is the extent to which current service provision in the locality is adequately responding to the changing needs of the community it serves?
- Is there a need for specialist or other services, which would improve the provision of, or access to, services such as for specific populations or vulnerable groups?
- What is the HWB's assessment of the overall impact on the locality in the longer-term?

- any different needs of different localities in its area;
- the pharmaceutical services provided in the area of any neighbouring HWB which affect the need for pharmaceutical services in its area, or whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area;
- any other NHS services provided in or outside the area (not covered above) which affect the need for pharmaceutical services in its area, or whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area; and
- likely future needs (see box below).

Identifying known future needs

Are there:

- known firm plans for the development/expansion of new centres of population i.e. housing estates, or for changes in the pattern of population i.e. urban regeneration, local employers closing or relocating?
- known firm plans in and arising from local joint strategic needs assessments or joint health and wellbeing strategies?
- known firm plans for changes in the number and/or sources of prescriptions i.e. changes in providers of primary medical services, or the appointment of additional providers of primary medical services in the area?
- known firm plans for developments which would change the pattern of local social traffic and therefore access to services, i.e. shopping centres or significant shopping developments whether these are in town, on the edge of town or out of town developments?
- plans for the development of NHS services?
- plans for changing the commissioning of public health services by community pharmacists, for example, weight management clinics, lifechecks?
- introduction of special services commissioned by clinical commissioning groups?
- new strategy by social care/occupational health to provide aids/equipment through pharmacies or dispensing appliance contractors?

Appendix 1 – Glossary of terms and phrases defined in regulation 2 of the 2013 Regulations

Term or phrase	Definition as per regulation 2 of the 2012 Regulations	Explanation
Controlled localities/controlled locality	Means an area that is a controlled locality by virtue of regulation 36(1) or is determined to be so in accordance with regulation 36(2).	A controlled locality is an area which has been determined, either by NHS England, a primary care trust a predecessor organisation or on appeal by the NHS Litigation Authority (whose appeal unit handles appeals for pharmaceutical market entry and performance sanctions matters), to be "rural in character". It should be noted that areas that have not been formally determined as rural in character and therefore *controlled localities*, are not *controlled localities* unless and until NHS England determines them to be. Such areas may be considered as rural because they consist open fields with few houses but they are not a *controlled locality* until they have been subject to a formal determination.

Core opening hours	Is to be construed, as the context requires, in accordance with paragraph 23(2) of Schedule 4 or paragraph 13(2) of Schedule 5, or both.	Pharmacies are required to be open for 40 hours per week, unless they were approved under Regulation 13(1)(b) of the 2005 Regulations in which case they are required to open for 100 hours per week. Dispensing appliance contractors (DACs) are required to be open for not less than 30 hours per week.
Directed services	Means additional pharmaceutical services provided in accordance with directions under section 127 of the 2006 Act.	These are advanced and enhanced services as set out in Directions.
Dispensing doctor(s)	Is to be construed in accordance with regulation 46(1).	These are providers of primary medical services who provide pharmaceutical services from medical practice premises in the area of NHS England; and general practitioners who are not providers of primary medical services but who provide pharmaceutical services from medical practice premises in the area of the HWB.
Distance selling premises	Listed chemist premises, or potential pharmacy premises, at which essential services are or are to be provided but the means of providing those services are such that all persons receiving those services do so otherwise than at those premises.	These premises could have been approved under the 2005 Regulations in which case they could be pharmacies or DACs. Under the 2012 and 2013 Regulations only pharmacy contractors may apply to provide services from distance selling premises. Distance-selling contractors are in the main internet and some mail-order, but they all cannot provide “essential services” to persons face to face at their premises and must provide a service across England to anyone who requests it.

Enhanced services	Means the additional pharmaceutical services that are referred to in direction 4 of the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.	These are pharmaceutical services commissioned by NHS England, such as services to Care Homes, language access and patient group directions.
Essential services	Except in the context of the definition of "distance selling premises", is to be construed in accordance with paragraph 3 of Schedule 4.	These are services which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service – these include the dispensing of medicines, promotion of healthy styles and support for self-care. Distance-selling pharmacy contractors cannot provide essential services face to face at their premises.
Neighbouring HWB	In relation to a HWB (HWB1), means the HWB of an area that borders any part of HWB1.	Used when, for example, an HWB is consulting on their draft PNA and needs to inform the HWBs which border their HWB area.
NHS chemist	Means an NHS appliance contractor or an NHS pharmacist.	

Appendix 2 – Frequently asked questions

Q1: What are "pharmaceutical services"?

The NHS Act 2006[3] sets out a wider definition for pharmaceutical services. Pharmaceutical services are generally provided by virtue of Part 7 of the Act. Under section 126(1) – (3), NHS England is required to secure, on the basis of Regulations made by the Secretary of State, the provision of services to people in their area of medicines and listed appliances and "such other services as may be prescribed" (*section 126(3)(e)*). Prescribed services must be set out in Regulations. Therefore, these prescribed services, and the dispensing services referred to in section 126(3)(a) to (d), constitute the core NHS pharmaceutical services. Section 127 also provides for "additional pharmaceutical services" to be set out in Directions to NHS England. This facility was originally introduced in the late 1990s to enable pharmacies to provide other types of service that did not fall within those core services as defined by Section 126(3). Directed services include advanced and enhanced services for pharmacy contractors and advanced services for dispensing appliance contractors.

Pharmaceutical services do not include any services commissioned directly from the above pharmaceutical contractors by local authorities, clinical commissioning groups etc.

Q2: Wouldn't it have been better if the Board produced and updated Pharmaceutical Needs Assessments as it is commissioning NHS pharmaceutical services?

No. Local authorities worked with PCTs (and are now working with NHS England) to produce Joint Strategic Needs Assessments. It was therefore a logical step for HWBs to take over PNAs from PCTs. These PNAs are designed to be an integral part of that wider strategic approach to commissioning. Alongside identifying strategic health needs through JSNAs, HWB PNAs will inform the commissioning of community pharmacy services by NHS England and local public health commissioning decisions.

[3] http://www.opsi.gov.uk/acts/acts2006/ukpga_20060041_en_1

Q3: Is market entry the responsibility of the local authority since they will be more familiar with local health and wellbeing issues than NHS England?

No. Commissioning and market entry are inter-related and if local authorities took on responsibility for market entry, they would also need to be the commissioners of pharmaceutical services. This would divorce pharmaceutical services from the rest of primary care and would create new burdens and costs for local authorities who would need to acquire specialist knowledge to implement legislation with which they were unfamiliar.

Added to that, if a local authority came to the conclusion that there was, for example, a gap in pharmaceutical services, it would have to bear the consequences in terms of more costs to itself of any increased capacity that the local authority had concluded in its pharmaceutical needs assessment was necessary.

Q4: Will Health and Wellbeing Boards be obliged to consult pharmacists about local PNAs?

Yes. The NHS Act 2006 already requires the Department to set out in Regulations various matters about pharmaceutical needs assessments. The 2013 Regulations stipulate minimum consultation requirements, including a need to consult local contractors.

Q5: If the PNA identifies a need for pharmaceutical services, then shouldn't NHS England be required to address that need?

NHS England will be acting under an annual mandate from Secretary of State. Beyond that, NHS England should therefore be free to decide how best to meet its responsibilities for commissioning services according to the needs of the local population. We expect NHS England to weigh all the evidence carefully – taking account of pharmaceutical needs alongside other relevant factors. Placing an obligation on NHS England to fill a gap would hamper the Board's ability to make such robust commissioning decisions.

Kent Pharmaceutical Needs Assessment Steering Group

Terms of Reference

Aim

To oversee the development and production of a Kent Pharmaceutical Needs Assessment (PNA) covering the geography of Kent, in line with national guidance. The output will be a PNA for Kent.

Objectives

1. To oversee the process for the development of the PNA on behalf of Kent Health and Wellbeing Board.

2. To ensure active engagement from all stakeholders in the development of the PNA.

3. To communicate to a wider audience the development progress and outcomes of the PNAs, and in particular to the Health and Wellbeing Board.

4. To ensure the outputs from the PNA (commissioning intentions) are integrated into the commissioning process of each organisation, particularly NHS England who holds all primary care contracts.

5. To agree how the published Pharmaceutical Needs Assessments are updated and to develop systems and processes that ensure the PNAs are always up to date.

6. To check PNA outcomes and commissioning intentions are consistent with bordering NHS England areas, especially Southeast London and Surrey, Sussex and Medway.

Membership

- NHS England Area Team
- KCC Public Health
- Kent Public Health Observatory (for mapping)
- KCC Engagement representative (for consultation)

- Kent Local Medical Committee (officer and dispensing GP representative)
- Kent Pharmaceutical Committee (officer and community pharmacist)
- Kent Local Pharmacy Network representative
- HealthWatch Kent
- CCG representative(s)

Declaration of Interest

Each meeting will begin with any Declarations of Interest being declared and recorded.

Timetable

National

The national timetable set out in Department of Health guidance published May 2013 is as follows:

- The National Health Service (Pharmaceutical Services and Local Pharmaceutical services) Regulations 2013 came into force on 1st April 2013;
- Health and Wellbeing Boards (HWBs) were required to produce the first assessment by 1st April 2015
- HWBs are required to publish a revised assessment within three years of publication of their first assessment
- HWBs will be required to publish a revised assessment as soon as practical after identifying significant changes to availability of pharmaceutical services since the publication of its PNA unless satisfied that making a revised assessment would be a disproportionate response to those changes

Kent

In producing a PNA the regulations require and number of elements to be completed before publication, not least consultation.

Working this into the timelines suggests the following timeline:

Action	Date
Draw the requirements of the PNA to local Health and Wellbeing Boards	????
Set up Steering Group (this is not a statutory requirement, but is considered good practice for any needs assessment)	???
Agree data sets and time at which we use the data to assess pharmaceutical need.	???
Agree geographical level at which we publish PNAs and undertake analysis producing maps	???

Determine pharmaceutical commissioning intentions	???
H&WBs to sign off Consultation draft	???
Consult as per statutory guidance on those intentions (Regulations set out a minimum of 60 days) Agreement on the exact length of the consultation will need to reflect other legislation that's guides Local Authorities	???
Following consultation produce the final PNA for Publication	???
Final publication to be approved by respective Health and Wellbeing Boards	??
Publication of PNA	March 2021

Reporting
Progress will need to be reported to:

Frequency of Meeting
Meetings schedule to be agreed at the first meeting.

Agenda and papers
Agendas and paperwork will be circulated one week in advance of the meeting.

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By:	**Ben Watts, General Counsel**
To:	**Health and Wellbeing Board**
Date:	**26 February 2020**
Subject:	**Amendment to the Terms of Reference of the Kent Health and Wellbeing Board**
Classification:	**Unrestricted**
Past Pathway of paper	**Not applicable**
Future Pathway of paper	**Not applicable**

Summary: This report invites the Kent Health and Wellbeing Board (KHWB) to consider a change to its Terms of Reference to enable the Leader of the County Council to nominate the Member representatives of Kent County Council on the Kent Health and Wellbeing Board and update the Officer representation in line with the current structure.

Recommendations:

1. The KHWB is asked to agree an amendment to the Terms of Reference of the HWB to:

   a. enable the Leader of Kent County Council to nominate the Council's elected Member representatives; and

   b. update the statutory Kent County Council Officer representation in line with the Council's current structure.

1.1 The Terms of Reference for the Kent Health and Wellbeing Board specifies that the Kent County Council's representation on the Kent Health and Wellbeing Board comprise:

(a) The Leader of Kent County Council and/or their nominee*.
(b) Deputy Leader of Kent County Council.
(c) Corporate Director, Social Care, Health and Wellbeing*.
(d) Director of Public Health*.
(e) Cabinet Member for Adult Social Care and Public Health.
(f) Cabinet Member for Children.

(*denotes statutory member of the KHWWB)

1.2 In accordance with these Terms of Reference there are four elected Members of KCC on the KHWB. To most appropriately align KCC's

executive functions and responsibilities with the functions and role of the KHWB, it is proposed to amend the Board's Terms of Reference to enable the Leader to nominate the most appropriate elected Members to serve on the Board. Accordingly, in place of specifying that the Deputy Leader, the Cabinet Member for Adult Social Care and Public Health and the Cabinet Member for Children are members of the Board, it is proposed that in addition to the Leader and his/her nominee that the Leader be able to nominate three elected Members to serve on the Board.

1.3 In addition, the health and Social Care Act 2012 names the 'director of adult social services' and the 'director of children's services' as a statutory member[1]. At the time of the original Terms of Reference being agreed, these were combined in the single role of Corporate Director, Social Care, Health and Wellbeing. This role no longer exists and there is a separate 'Corporate Director Adult Social Care and Health' and 'Corporate Director Children, Young People and Education.' There is a need to update the Terms of Reference accordingly to ensure the Board continues to conform to the statutory requirements.

1.4 The intention is therefore to amend the section of the Terms of Reference dealing with the KCC Membership (as set out in 1.1 above) to read as follows:

(a) The Leader of Kent County Council and/or their nominee*.
(b) Three elected Members of Kent County Council nominated by the Leader of Kent County Council.
(c) Corporate Director Adult Social Care and Health*.
(d) Corporate Director Children, Young People and Education*.
(e) Director of Public Health*.

(*denotes statutory member of the KHWWB)

2. Financial Implications

2.1 There are no financial implications arising from the update to the membership.

3. Legal Implications

3.1 Section 194 of the Health and Social Care Act 2012 specifies that each upper tier local authority must establish a health and wellbeing board for its area. The legislation and regulations have been drafted with the deliberate intention of allowing flexibility for local authorities and their partners to set up and run health and wellbeing boards that suit local circumstances.

[1] Section 194, http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/2/crossheading/health-and-wellbeing-boards-establishment

3.2 The County Council formally established the Kent HWB with effect from 1 April 2013 at its meeting on 28 March 2013.

3.3 The membership of HWB was agreed as

- The Leader of Kent County Council or his nominee*
- Corporate Director for Families and Social Services*
- Director of Public Health*
- Cabinet Member for Adult Social Care & Public Health
- Cabinet Member for Business Strategy, Performance and Health Reform (now updated to Cabinet Member for Education and Health Reform)
- Cabinet Member for Specialist Children's Services
- Clinical Commissioning Group representation: up to a maximum of two representatives from each consortium (e.g. Chair of CCG Board and Accountable Officer)*
- A representative of the Local HealthWatch*
- A representative of the NHS Commissioning Board Local Area Team*
- Three elected Members representing the District/Borough/City Councils (nominated through the Kent Council Leaders.

(* denotes statutory member of the HWB).

3.4 An amendment to the Terms of Reference was subsequently agreed in November 2013 to enable the co-option of non-voting members to the KHWB.

3.5 As the proposed changes are consequential upon the exercise of the executive function within KCC as it relates to the portfolios of Cabinet and the Management Structure as agreed by Council, and makes no changes to the substantive powers and responsibilities of the Board, the Terms of Reference as amended do not require the approval of full Council and will take effect immediately the Board agrees the recommendation.

4. Equalities Implications

4.1 The are no direct equalities implications arising from the proposed amendment to the Terms of Reference.

5. Recommendation

5.1 The KHWB is asked to agree an amendment to the Terms of Reference of the HWB to:

a. enable the Leader of Kent County Council to nominate the Council's elected Member representatives; and

b. update the statutory Kent County Council Officer representation in line with the Council's current structure.

6. Background Documents

6.1 None.

Report Author	Relevant Director
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