HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 7th July, 2022

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 7th July, 2022, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Kay Goldsmith**
Telephone: **03000 416512**

Membership

Conservative (10):	Mr P Bartlett (Chair), Mr P V Barrington-King, Mrs B Bruneau, Mr N J D Chard, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mr D Watkins and Mr A R Hills
Labour (1):	Ms K Constantine
Liberal Democrat (1):	Mr D S Daley
Green and Independent (1):	Mr S R Campkin
District/Borough Representatives (4):	Councillor J Howes, Councillor P Rolfe, Councillor K Tanner, and 1 vacancy

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Membership The Committee is asked to note the change in Borough and District Council membership.	10:00
2.	Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	
4.	Minutes from the meeting held on 11 May 2022 (Pages 1 - 10)	
5.	South East Coast Ambulance Service - provider update (Pages 11 - 26)	10:05
6.	Podiatry Services (Pages 27 - 32)	10:40

7. Kent and Medway Integrated Care Board (Pages 33 - 58) 11:05

8. Learning from the closure of Cygnet Hospital, Godden Green - written item (Pages 59 - 64) 11:25

9. Work Programme (Pages 65 - 70)

10. Date of next programmed meeting – 6 October 2022

EXEMPT ITEMS

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

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

29 June 2022

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 11 May 2022.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Mrs B Bruneau, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mr D Watkins, Mr A R Hills, Mr S R Campkin, Ms K Constantine, Mr R G Streatfeild, MBE and Cllr M Peters

ALSO PRESENT (virtually): Mr R Goatham (Healthwatch Kent)

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny) and Mr M Dentten (Democratic Services Officer)

UNRESTRICTED ITEMS

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

(Item 2)

None.

66. Minutes from the meeting held on 2 March 2022

(Item 3)

RESOLVED that the minutes from the meeting held on 2 March 2022 were a correct record and they be signed by the Chair.

67. Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview - Elective Orthopaedic Services

(Item 4)

In attendance for this item: Dr Andrew Taylor (Consultant Anaesthetist, Maidstone & Tunbridge Wells Trust), Mr James Nicholl (Clinical Director for Trauma and Orthopaedics and Orthopaedic Surgeon), Sarah Davis (Deputy Chief Operating Officer, MTW Trust), Mark Atkinson (Director of Integrated Care Commissioning, Kent & Medway CCG), and Rachel Jones (Director of Strategy, Planning & Partnerships, Kent & Medway CCG)

1. Dr Taylor introduced the report and spoke to the slide deck (included in the agenda pack). The presenters spoke about the operational and procedural benefits of the proposed changes, as well as the communications and engagement strategy in place. The changes were necessary under Get It Right First Time (GIRFT) requirements.

2. A Member asked if letters had been sent as part of the engagement process, as opposed to just digital information, to which Ms Davis confirmed it had.

3. Asked about patient transport, Ms Davis confirmed that was an area under investigation, including the use of public transport. She also confirmed that patients would have the choice to stay with their current surgeon, if that is what they wanted. The barn theatre was providing an additional option. In Mr Nicholl's experience, patients did not mind travelling to a different site if it was in their best interests. The Trust were aware that certain bus contracts in Kent were currently under review.

4. The Trust had been in communication with Healthwatch Kent. Mr Goatham spoke about that engagement and asked whether the Trust would look to the Cardiology review for lessons learnt on what worked well. Ms Davis confirmed the Trust would continue to engage with Healthwatch regarding the changes.

5. A Member asked if the private sector was being utilised to meet demand. Ms Davis confirmed all four acute trusts were using independent providers. The new theatre would provide additional capacity. Dr Taylor spoke of the benefits to junior doctors of more work being carried out in house, in particular they were able to carry out more operations and therefore improve their skills and confidence.

6. Ms Davis confirmed that the new theatre would only be used for elective surgery, not emergency care. Since the pandemic, patient pathways had been streamlined and this meant elective and emergency care would not be mixed.

7. A Member asked what the pathway was for reducing the waiting list. Ms Jones explained that the demand for the new theatre was dependant on the quantity of patients within Kent and Medway making a choice to use the new provision. Part of the engagement work would consider that, along with data collected once the theatre went live. An additional centre in East Kent was also under consideration and that would also impact projections. She offered to return to the Committee after six months with a firmer projection.

8. Responding to a question about staff retention, Mr Nicholl's felt staff would be happier in the new setting, due to the improved environment and the ability to concentrate on the work they enjoyed (orthopaedics) without getting pulled into other areas of work. From experience, Dr Taylor said there was a feeling of safety, knowing there were colleagues nearby should there be a medical emergency.

9. The Chair thanked the guests for attending and all the hard work that had gone into the project. He did not believe the proposals constituted a substantial variation of service.

10. RESOLVED that:

(a) the Committee does not deem the proposed reconfiguration of elective orthopaedic services across Maidstone and Tunbridge Wells NHS Trust to be a substantial variation of service.
(b) the report be noted.

68. Health Inequalities of the local Gypsy, Roma and Traveller Community *(Item 5)*

Rachel Jones (Director of Strategy, Planning & Partnerships, Kent & Medway CCG) and Dr Anjan Ghosh (Director of Public Health, KCC) were in attendance for this item.

1. Ms Jones provided an overview of the paper, recognising that there were health inequalities experienced within the Gypsy, Roma and Traveller (GRT) community including a 10-year mortality gap (the national average). She highlighted that nationally there was a lack of data and information on this community. She recognised that the Kent and Medway CCG had a responsibility to improve the health of the GRT community but reflected that the wider determinants of health were impacted by so much and no one service area could resolve the issues alone.

2. Ms Jones believed the introduction of the Integrated Care Board (ICB) provided an opportunity for joint working between councils, education, health and other public services, to identify what really made an impact and put the necessary changes into effect.

3. An area of concern for Members was the ease of access to primary care services. Ms Jones explained that individuals did not need to provide an address, or ethnic background data, to access GP services. It was their legal right to access healthcare. However, she also recognised that not all primary care settings understood that or failed to accept additional patients. The CCG was working almost weekly on informing surgeries about access criteria, and there was a leaflet available that set out the process. She commented that the CCG often struggled to find out about access issues because very few people from the GRT community reported that there was a problem. She encouraged Members to share such experiences with the CCG so targeted communications could be circulated.

4. Members asked to be sent the information around how individuals, particularly from the Gypsy, Roma and Traveller community, could register with a GP.

5. Recognising that younger generations were more likely to access online information, Ms Jones explained that the CCG website listed sites where care was available, such as Minor Injury Units. Some pathways also had the option for self-referral. Overall, Ms Jones agreed there needed to be more collective action and highlighted the positive relationships built during the targeted engagement for the Vascular Services changes.

6. Mr Goatham said Healthwatch had carried out work in 2017 and 2019 on the GRT community. A key barrier identified had been the use of postal letters by the acute trusts – literacy rates were lower, and members of the community sometimes did not have a fixed address. The Chair asked Ms Jones if there

were any examples of best practice, perhaps utilising phone calls or video conferencing. Ms Jones said she would take it away and see what more could be done, perhaps by involving the voluntary sector. One Member suggested an alternative to the written word might be imagery.

7. Ms Jones confirmed that commissioning teams did not as a matter of course carry out general engagement work with the Gypsy, Roma and Traveller community. However, targeted engagement was carried out when needed, as evidenced by the covid-19 vaccination outreach work, and the Vascular Services review. Also, community services such as midwifery did go into the community. Ms Jones said direct engagement from a commissioning perspective was an area that could be considered further.

8. A Member asked what was being done to ensure Gypsy, Roma and Traveller individuals were not being discriminated against when accessing primary care. Ms Jones accepted that discrimination happened, but felt this usually happened when someone was uninformed, particularly around access criteria – individuals did not need an address to register with a GP. The issue applied to other communities as well. The CCG constantly worked at GP education events and ensured leaflets were readily available on the website, as well as the complaints process.

9. Ms Jones explained there was a joint responsibility between the NHS and Public Health to ensure primary care was available but also to work to improve health overall. The new ICB would be important, and it had named two strategic health and equality priorities in deprivation and mental health - mental health was a real challenge amongst the Gypsy, Roma and Traveller community. There needed to be more work on how meaningful services were provided to a community that chose to travel.

10. Members spoke generally about access to education and literacy levels.

11. One Member voiced their concerns around the poor experiences of the Gypsy, Roma and Traveller community. They spoke about poor health, lower levels of literacy, lower life expectancy, infant mortality rates, suicide rates, and the lack of understanding of their rights. The lack of data available meant it was difficult to make effective plans. The Member questioned whether KCC or the NHS had an Equality Impact Assessment. They felt a Short-Focussed Inquiry (SFI) by KCC was required.

12. The Chair supported the call for an SFI but explained that it was down to the Scrutiny Committee to agree the SFI work programme. A proposal had gone to the Committee before, but another topic had been agreed. A Member reflected that an SFI was not as detailed as a full Select Committee. Asked what an SFI would cover, the Chair proposed to liaise with the Vice-Chair of the Scrutiny Committee (who sat on HOSC also) about the best way forward.

RESOLVED that

i) The report be noted.

ii) The Chair and Vice-Chair of HOSC liaise with the Vice-Chair of Scrutiny to put forward a proposal to the Scrutiny Committee for a Short-Focused Inquiry.

69. Single Pathology Service for Kent and Medway

(Item 6)

Malcolm Nudd, Director of Pathology Transformation was in attendance for this item.

Mr Jordan Meade declared that he was an appointed member of the stakeholder council for the Dartford and Gravesham NHS Trust.

1. Mr Nudd provided a verbal overview of the report, explaining that the work fell under a national programme and one of the aims was to improve the recruitment and retention of staff. Pathology networks would remove the element of competition from the market and instead allow for shared ideas and practice. There would be one IT system as opposed to 7. NHS England and Improvement had issued guidance on what constituted a pathology network.

2. The Chair asked about the physical location of sites and whether staff would have to move. Mr Nudd confirmed that there would continue to be a laboratory at each hospital with some centres specialising in a particular test. Improved IT equipment meant staff did not have to be physically in a laboratory to undertake certain tasks.

3. Considering a question about staffing, Mr Nudd confirmed staff had not been TUPE'd and that they would remain employed by their current Trust but managed as a network. He explained that over the years, pathology had become more factory based than clinical. That meant qualified staff were unable to use the skills they learnt at university and the job became less rewarding. They were working to separate the factory and clinical elements, so that qualified individuals could become experts in their field, whilst those on the more factory side would not need to have qualifications, just the training to follow the processes in place.

4. Mr Nudd explained that Kent's proximity to London meant staff sometimes chose to travel to London Trusts such as Guys and St Thomas' where the pay was better.

5. A Member asked what work was underway to attract young people into pathology. Junior doctors were no longer being taught pathology, but staff under him did have the expertise to fill that gap, so there was work needed to bridge that gap. The pathology profession offered a number of roles, not just clinical ones.

6. A Member asked about digitisation and improving technology. Mr Nudd explained innovation was constantly happening, but at that time, the focus was on the single IT platform and how GPs went about ordering tests.

7. The Chair thanked Mr Nudd for attending and offered his best wishes for discussions with the HMRC around VAT recovery.

   RESOLVED that the report be noted and the Kent and Medway CCG be invited to attend and present an update at the appropriate time.

70. Children and Young People's Mental Health Service - update
(Item 7)

In attendance for this item: Brid Johnson (Director of Operations, Essex and Kent NELFT), Gill Burns (Service Director Children, NELFT), Christy Holden (Head of Strategic Commissioning (Children & Young People), KCC)

In virtual attendance for this item: Jane O'Rourke (Deputy Director, Kent Children's & Maternity Commissioning Team, K&M CCG), Stuart Collins (Director Integrated Services – Early Help and Preventative Services Lead, KCC)

1. Ms O'Rourke introduced the paper, highlighting key areas:

    a. The number of children presenting in crisis continued to increase, rising from an average of 85 children per month before covid-19 to an average of 140 per month. That reflected national trends and there was a system wide steering group that met every two weeks to address the issue.
    b. Key areas of work included improving patient flow through the system, strengthening community support, recruiting an Associate Director of Pathways (Complex and Crisis Care), and an expansion to the NELFT crisis service.
    c. The Tier 4 provider collaborative had invested in increasing their provision.
    d. The number of children experiencing anxiety continued to rise.

2. Mr Collins spoke about the collaborative work underway between the CCG, NELFT and County Council. He explained that the HeadStart Kent contract was coming to an end in June 2022 though several activities would continue until August 2022. The sustainability of that contract was under review, as elements of the work were being carried out elsewhere. A full report would be presented to the Children, Young People and Education Cabinet Committee and would be shared with HOSC members.

3. A question was asked around why there had been such a delay in providing additional inpatient beds at the Kent and Medway Adolescent Hospital (KMAH). Ms Burns responded that it was the result of building material shortages and not related to staffing constraints. It was hoped they would open in the next 2-3 weeks. There were an additional six beds – three would be for short stays and three for longer stays. Clinical work had continued in the meantime including increased work within individual's homes.

4. The Chair asked about the Emerge expansion into Darent Valley Hospital, Maidstone Hospital and Tunbridge Wells Hospital, as referred to in the agenda report. He asked whether such support was already offered in East Kent or whether it would be rolled out in due course. Ms O'Rourke explained the volunteer support offer was being trialled, and once the impact was known it would be rolled out accordingly.

5. There were questions around the use of art, music, gardening and other activities as a form of treatment. Ms Burns confirmed therapies in those areas were in use, though she said their value was perhaps not communicated

enough. A large piece of work on the outside garden area was about to commence.

6. The agenda report (page 51) highlighted that Mental Health Support Teams (MHSTs) would be in 51% of Kent and Medway schools by 2023/24. A Member asked what support would be available to the remaining 49%. Ms O'Rourke explained that different interventions would be commissioned to engage those schools.

7. A member asked whether demand was rising faster than capacity could cope with and if this affected service performance. Ms Johnson explained the service was continuing to look at the most effective way of investing in treatment at home earlier in a patient's pathway. Three of the additional beds at KMAH would be ringfenced to 72-hour stays, but it was recognised that an inpatient bed was not always the right treatment. The service was looking into what more could be done locally for patients with eating disorders as there was no inpatient facility nearby.

8. On patients being placed far from home, Ms Burns reflected that the phrase "local beds for local people" was of course the ideal but was more complex and depended on the individual case. Some patients required specialist or secure provision – for example for some eating disorder treatments there were only a few beds available across the country. Ms O'Rourke explained that Kent and Medway had been proactively working to respond to such issues by speaking to regional and national teams, increasing capacity for the long term and strengthening community teams.

9. A Member had heard from SENCOs that accessing support was all but impossible. Ms Burns advised she had recently met an MP and some local schools to discuss the issues being faced. She offered to take any specific issues up outside of the meeting.

10. A Member reflected on the bleak situation facing young people, from coming out of the pandemic to facing a cost of living crisis, on top of a pre-existing crisis in places such as Thanet. Ms O'Rourke explained that bespoke services were available and there was a huge piece of work underway looking at multidisciplinary roles in primary care including non-clinical ones, expanding the neurodevelopmental pathway pilots, and ensuring individuals knew how to access services.

11. On recruiting and retaining staff, Ms Burns acknowledged there was a challenge with recruitment. She spoke of additional investment in clinical roles and more senior professionals, as well as joint roles with Adult Social Care to improve transition, and the need to bring in trainees for long term sustainability.

12. A Member asked whether it was too early to tell if the increases in young people experiencing anxiety was a short-term concern or a covid-legacy of a cohort of individuals who would always require support. Ms Johnson explained there was no clear trajectory, but they were working to improve early interventions, including considering how the school nurse service could assist. Ms Burns noted it was important not to over-medicalise anxiety as it was also a natural reaction.

13. A Member asked about hidden demand. Ms Burns noted the new Integrated Care Board (ICB) was undertaking a piece of work looking into specific groups. For instance, it was known there was an increase in young men with eating disorders. Communities provided an opportunity for holistic support but how could this be strengthened? Work was underway with the voluntary sector. The ICB had a health inequalities workstream.

14. A Member said that 24 hour coverage from the crisis team was not their experience. This would be taken up outside of the meeting.

15. The Committee were grateful for the comprehensive report.

    RESOLVED that the report on Children & Young People's Emotional Wellbeing & Mental Health Service be noted and the Kent & Medway CCG be invited to provide an update at the appropriate time.

71. GP recruitment attraction package for Medway, Swale and Thanet (pilot)
(Item 8)

RESOLVED that the Committee supports the scheme to recruit GPs in Medway, Swale and Thanet.

72. Roll out of the Spring Covid-19 Booster (written item)
(Item 9)

1. A Member had concerns about the vaccination rollout and the benefits of having the jab. The Chair offered to speak to the Monitoring Officer about whether these concerns would be better addressed by the Health Reform and Public Health Cabinet Committee or HOSC.

   RESOLVED that the Committee consider and note the report.

73. Elective waiting lists in Kent and Medway (written item)
(Item 10)

RESOLVED that the Committee notes the report.

74. East Kent Transformation Programme (written update)
(Item 11)

This item was discussed after item 7 and before item 8 to allow Ms Jones from the CCG to stay on and answer questions.

Present for this item: Rachel Jones, Director of Strategy, Planning & Partnerships, Kent & Medway CCG

1. The scrutiny process involving the Kent and Medway Joint Health Overview and Scrutiny Committee was clarified.

2. Ms Jones confirmed the public consultation would not commence until there was confirmation of funding from the Department of Health and Social Care.

3. Asked whether there had been any impact on staffing, Ms Jones accepted that the level of uncertainty for staff had been difficult. But the project team had been communicating with them often and all were reassured that market testing had commenced. Staff were behind the proposals.

   RESOLVED that the report be noted.

75. Work Programme
(Item 12)

1. Members requested that the provider South East Coast Ambulance Service (SECAmb) provide an update at the next meeting.

RESOLVED that the work programme be agreed.

76. Future meeting dates
(Item 13)

Noted.

77. Date of next programmed meeting – 7 July 2022 at 10am
(Item 14)

(a) **FIELD**
(b) **FIELD_TITLE**

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Item 5: South East Coast Ambulance Service – provider update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 7 July 2022

Subject: South East Coast Ambulance Service – provider update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by South East Coast Ambulance Service.

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1) Introduction

a) At its meeting on 11 May 2022, HOSC requested an update from the South East Coast Ambulance Service (SECAmb). The Trust provides 999 and 111 services to residents in Kent, Surrey and Sussex.

b) The Trust has been asked to provide a general update, but in particular to provide detail around response times and performance against national targets. They have also been asked how they will respond to the new planning framework that will require NHS England to claim an "infrastructure levy" to support expanding the ambulance service in growth areas.

c) An inspection at SECAmb was undertaken in February 2022 after the Care Quality Commission (CQC) received a high number of whistleblowing concerns relating to culture and leadership, including inappropriate sexualised behaviour, bullying and harassment, leaving staff feeling scared to speak out, and a failure by the trust leadership team to address concerns raised.

d) On 22 June 2022, CQC announced they had rated the leadership at SECAmb inadequate. The inspection report can be found online: https://www.cqc.org.uk/provider/RYD. The overall rating for the NHS111 service remains good. The overall rating for the emergency operations centre moved down from good to requires improvement. While CQC carries out further checks on the provider and its registered locations, it has suspended the trust's overall rating.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

None

Item 5: South East Coast Ambulance Service – provider update

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

07 JULY 2022

SOUTH EAST COAST AMBULANCE NHSFT UPDATE

Report from: Emma Williams, Executive Director of Operations
Author: Ray Savage, Strategic Partnerships Manager (SECAmb)

Executive Summary

Since updating the HOSC in September 2021, the NHS has continued to be challenged across all sectors, including NHS Ambulance Services. Regarding ambulance services, these challenges have and are frequently being reported in the media with ambulance response times, workforce, job cycle time (time on spent with a patient) and handover delays making the headlines.

From July 2021 until January 2022, the Trust had been operating at the highest levels of escalation as well as in a Business Continuity Incident (BCI) due to being unable to achieve key response time performance indicators across both its 999 and NHS111 services. It was only in January 2022 that the Trust was able to reduce its Resource Escalatory Action Plan (REAP) from level 4 to level 3 and stand down the BCI after having operated at these levels for many months. REAP is used to manage overall demand and resourcing across all Trust areas and is reviewed on a weekly basis.

The Trust continues to apply its Surge Management Plan and fluctuates dynamically by minute/hour across each 24hr period. This mechanism enables dynamic decision making to mitigate clinical risk, particularly when demand outstrips resources either within a period of time and/or geographical areas. It is reported as between level 1 (lowest) and 4 (highest).

The Trust was not the only service to have faced these unprecedented challenges as all NHS ambulance services, for periods, were operating at REAP level 4, which collectively, had not been experienced by the ambulance sector before. However, and despite these challenges, the Trust has been to achieve some good levels of performance in its 999 service when compared to national data and outperform national outcomes benchmarking for its NHS 111 IUC service.

In April, the Trust set out its 2022-23 priorities. These have been developed in response to the ongoing challenges the ambulance sector is facing, the results of the staff survey, and the high-level feedback given by the Care Quality Commission following their inspection of the Trust's domain 'well led'.

Chairman, David Astley, has recently announced the appointment of Siobhan Melia as the Trust's new Interim Chief Executive, following the resignation of Philip Astle in May. Siobhan, currently the Chief Executive of the Sussex Community NHS Foundation Trust will take up her new role on the 12th July 2022. Dr Fionna Moore, currently the acting Chief Executive will return to her Executive Medical Director role.

1. 999 Performance

1.1. Throughout 2021 and into 2022 so far, the Trust has struggled to achieve its Ambulance Quality Indicators (AQI), for both its emergency operations centre (EOC) call answering times and ambulance response times as set out in the Ambulance Response Programme (ARP) which all NHS ambulance services are benchmarked. This is not isolated to this Trust, but the performance challenges of the past two years have been experienced by all ambulance services across England and the wider UK.

1.2. As indicated in the summary, the Trust had been operating at the highest levels of escalation throughout 2021 and into 2022, often reflecting the escalation status of the health systems that the Trust operates within with these systems declaring Operational Pressures Escalation Levels 4 (OPEL).

1.3. In May 2022, the Trust achieved: Category 1 (C1) 'mean' time of 00:08:29 (England mean 00:08:36) and was positioned 5th out of the 11 Trusts across England. C1 90th percentile was 00:15:32 (England 90th percentile 00:15:15) and was positioned 7th out of the 11 Trusts. Category 2 (C2) 'mean' was 00:28:41 (England 00:39:58) and 90th percentile was 00:57:40 (England 01:25:52). For both the mean and the 90th percentile C2 the Trust was 3rd out of the 11 Trusts. C3 'mean' was 02:04:01 (England 02:09:32) and 90th percentile was 04:42:40 (England 05:22:06). C4 'mean' was 02:53:04 (England 02:47:57) and 90th percentile 06:44:12 (England 06:59:32). Compared with other Trusts this was 7th and 6th respectively. 999 call answering for May was 14 seconds against an England 'mean' of 19. Appendix A

1.4. During past six months (December 2021-May 2022) the Trust, whilst not achieving overall AQIs, has generally performed either in line or slightly better than the 'mean' results for ambulance services across England. This is particularly notable across C2 performance where the Trust has regularly been 2nd or 3rd as a direct comparison between the 11 English ambulance services (including the Isle of Wight) for both the 'mean' and '90th percentile' performance. The Trust's position for C1, C3, and C4 performance (mean), has been more challenging with C1 'mean' being 5th for the past three months (March, April, May).

1.5. Category 2 ambulance responses account for over 60% of all responses for the Trust and are categorised as 'emergencies' with an 18-minute 'mean' response time target. Category 1 responses, account for less than 10% of response activity with a 7 minute 'mean' response time target. These are the most serious and classed as 'life threatening'. C3 responses are circa 30% and are an area of focus for the Trust, along with C4 responses, however C4 activity is a very small percentage of all responses. C3 and C4 responses are categorised as 'urgent' and 'less urgent' respectively.

1.6. 999 call answering has improved over the past six months with May's 999 calls being answered in 14 seconds (mean). This is against a target of 5 seconds (mean) with the Trust achieving a slightly better performance than the England average (mean).

1.7. Despite improvements being noted during March 2022, the Trust, fully recognises that some patients are having to wait too long to receive an ambulance response.

1.8. As highlighted earlier, there are a range of factors which continue to contribute to the poor performance across all metrics.

1.9. One additional area of concern is a change in activity profile and acuity of calls being received. The Ambulance Response Programme (ARP) which was introduced in 2018, was predicated on the more serious of categories, C1 and C2, representing approximately between 55-60% of all ambulance responses. However, since October 2021, this combined activity has exceeded 70%, therefore creating a resourcing gap. This has resulted in the trust requiring a greater level of response per incident than the Trust's business is based on.

1.10. Staff absenteeism either directly or indirectly related to COVID-19, has often seen the Trust operating below its required resourcing levels. March saw over 300 staff absent as a result of COVID-19. In addition, levels of non-Covid sickness have been very high, with the most significant proportion being attributed to stress/anxiety/depression.

1.11. In response to this particular challenge, the Trust, has continued to offer incentivised shifts when responding to either predicted rota shortfalls or unexpected peaks in activity. Staff are paid a one-off amount in addition to overtime payable for a qualifying shift.

1.12. The Trust is running an ongoing recruitment programme for front line staff, including the opportunity for staff to progress towards their paramedic qualification.

1.13. 999 call answering has been on an improvement trajectory and May's 14 seconds (mean) is a significant improvement compared to August 2021 when the 'mean' was 42 seconds.

1.14. Winter monies funding, specifically aimed at recruiting Emergency Medical Advisors (EMA) to answer 999 calls and increasing the support from private Ambulance Providers enabled the Trust to increase its core staffing levels. The Trust received approximately £4.7m of the £55m that the government made available.

1.15. While actual call volumes into 999 have remained consistent, a contributing factor to call performance has been an unintended consequence of 'callers' re dialling 999 for an update on the ambulance arrival time. This has invariably placed an additional strain on the staff answering 999 calls and inflated the number of actual incidents requiring an ambulance.

1.16. Another key focus of the trust is to improve its clinical support to crews on scene who can access specialist paramedics either in the Emergency Operations Centres, NHS 111 Clinical Assessment Service (CAS) or Paramedic Practitioners in the Hub. Hubs are based within the local ambulance depots (Make Ready Centres). This gives the crew an opportunity to clinically discuss the presenting condition of a patient and agree the best course of action. This additional clinical support can also triage lower acuity 999 and 111 calls prior to an ambulance dispatch and where appropriate stand down an ambulance response: 'Hear and Treat' (H&T).

1.17. At this current time, the Trust is in the final stages of negotiation for the 2022-23 contract which will confirm overall staffing numbers for all parts of the 999 service. It is expected that whilst this settlement will increase numbers which will in turn improve performance, sustained delivery of all APR performance targets is not expected to be achieved this financial year.

1.18. Negotiations for the financial envelope for the 111 contract continue.

1.19. Further information regarding the Trust's improvement journey is covered in section 4: Trust Priorities 2022-23

2. NHS111 Integrated Urgent Care Performance

2.1. From the outset of the pandemic, NHS 111 services saw a significant increase in call volumes. For the Trust, this high level of activity in NHS 111 has continued and has presented the service across Kent & Medway and Sussex with ongoing operational challenges in trying to match resourcing to these new higher levels of activity, activity that is higher than was originally forecast or commissioned.

2.2. Ongoing dialogue is taking place between the Trust, Kent & Medway and Sussex commissioners, and NHS England regarding the identified funding gap. The gap between calls offered and commissioned levels of activity are quite stark with a December 2021 through to February 2022 when the level of calls offered was in line with or slightly below commissioned levels. Appendix B

2.3. Despite these challenges, performance for May has shown an improvement over April for both call answering and call abandonment, which are two of the key performance measures and often there is a correlation between call volumes and these measures.

2.4. Calls answered in 60 seconds is up from 32.0% in April to 40.3% in May. The call abandonment rate is down from 17% in April to 14% in May. Other key indicators are the average speed to answer, which is down from 401 seconds to 321 seconds when comparing April to May and the average handling time for calls has also reduced over the past two months with a reduction in of 15 seconds from 630 seconds to 615 seconds.

2.5. NHS 111 First or Direct Access Booking (DAB), continues to see the Trust converting unheralded activity into heralded activity and has continued to achieve the highest numbers of DAB amongst NHS 111 providers. May saw approximately 23,000 direct appointments being made across Kent & Medway and Sussex. Appendix C

2.6. Calls transferred to the Clinical Assessment (CAS) for further clinical input continues to be a strong performance achieving higher than national performance. Clinical contact within the CAS is a key element in ensuring that patients are being signposted to the right service. Appendix D

2.7. The Trust continues to regularly validate up to 95% of all category 3 & 4 ambulance dispositions, maintaining a lower transfer rate than the national average. Appendix E

2.8. NHS 111 is supporting the managing of the pressures being experienced by acute hospitals by signposting patients to alternative services and maintaining a lower percentage of emergency department referrals than the national average. Appendix F

3. Single Virtual Contact Centre (SVCC)

3.1. Currently calls to NHS 111 are directed to the local contact centre, which across England is delivered by a range of providers. The Trust currently provides 111 services for Kent & Medway and Sussex.

3.2. At times when 111 services are facing extreme pressure calls can be answered by another provider under 'national contingency'. This is to alleviate the immediate pressure an individual provider is facing and enable calls to be answered more quickly and reduce the 'abandoned calls rate'.

3.3. In October 2021, the draft 'Integrated Care Commissioning Framework' was published with the aim of ensuring the future sustainability of Integrated Urgent Care and a key part of this framework is the development of the 'Single Virtual Contact Centre', requiring that "call handling is delivered on a regional footprint, and contractual arrangement should reflect that providers need to work together to deliver call handling at this scale. A lead ICS (or lead CCG) must ensure these arrangements are in place."

3.4. The benefits of this are:

- Improved call answering availability across each region
- Alignment of CAS services (Clinical Assessment Service)

3.5. The transition to the SVCC is scheduled to 'go live' during 2022-23 Q2, however it will be dependent on the following:

- Finical package to ensure consistency of call answering capacity across providers
- Alignment of policies and procedures
- Commonality of appointment booking interoperability
- Consistent Directory of Service (DoS) profiling of CAS services to prevent unbalanced clinical demand

3.6. Integrated Urgent Care (UEC) providers are in consultation with NHS England to finalise the deployment timings.

4. Trust Priorities 2022-23

4.1. The results from the 2021 staff survey and the recent publication of the findings from the Care Quality Commission (CQC) inspection on the domain of 'well led' during February 2022, highlighted a number of key areas that the Trust has to immediately focus on.

4.2. Following the inspection and in response to the preliminary high-level feedback given by the CQC, the Trust's Board, Executive, and Senior Management team began working together to provide a clear framework for the Trust's priorities in 2022-23.

4.3. The Trust's Board was updated on these priorities during the Board meeting on the 26th of May and the Executive produced a video for all staff setting out these priorities.

4.4. At the time of writing the CQC report has only just been published but work has already begun on much of what has been highlighted in the report.

4.5. The key themes of the report were spoken about in a video address to all staff on the day of the report's publication.

4.6. This framework is the first seep in the trust's improvement journey and has a focus on 4 key areas. Appendix G

- Culture and People
- Quality Improvement
- Leadership and Engagement
- Responsive Care

4.7. These 4 key areas will provide the Trust with the vehicle for delivering against the CQC deliverables and will give all staff the opportunity to have their say, through different forums.

4.8. In addition to the framework the Trust has developed a focused delivery plan. This will be the mechanism that the Trust will hold itself to account against for the delivery of the core components (4.6).

4.9. Whilst the CQC has identified several areas that require priority attention by the Trust, it is also important to recognise that their findings on patient care was positive with staff were recognised as being kind, compassionate and supportive.

4.10. The Trust's NHS 111 service was also recognised as 'good' and retains this rating.

5. Handover Delays

5.1. Handover delays are a significant concern not only to this Trust but all ambulance services nationally.

5.2. There have been frequent references in the media to ambulances queuing outside accident and emergency departments, with some ambulance crews waiting considerably long times to handover their patients to the departments staff.

5.3. The NHS Long Term Plan sets out as one of its priorities, a reduction in ambulance handover delays. The aim is to have a 'zero' tolerance towards any greater than 60-minute handover delays and a focus on returning to the national standard of all patient handover within 15 minutes.

5.4. Each month, at the National Ambulance Handover meeting – chaired by Anthony Marsh (CEO of West Midlands Association of Ambulance Service/Chair of the Association of Ambulance Chief Executives (AACE)), supported by NHS England/Improvement, and commissioners, the areas that have the greatest challenges with patient handovers are discussed. ECIT also give feedback to the hospitals they have visited and supported.

5.5. In November 2021, AACE published a report titled "Delayed hospital handovers: Impact assessment of patient harm", having collated hospital handover data from all 10 ambulance services, including this, Trust.

5.6. While the report focuses on a single day in January 2021 and the overarching conclusion that 8 out of 10 patients who have to wait greater than 60 minutes are at risk of harm and the study highlighting that 53% did experience some level of harm.

5.7. The Trust, as a whole, has lost 31,524 hours due to handover delays from January 2022 to end of May 2022. 12,423 of these are attributable to Kent and Medway.

5.8. Handover delays by increment, highlight the challenge for acute trusts to reach the 'zero' 60 minutes and all handovers completed within 15 minutes. Appendix H for the Trust as a whole and Appendix I for Kent and Medway.

6. Executive Update

6.1. In September 2021, David Ruiz-Celada joined the Trust as its Executive Director of Planning and Business Development. Also, following the resignation of Bethan Eaton-Haskins, Executive Director of Nursing and Quality the Trust appointed Robert Nicholls as her successor with Rob started in February 2022.

6.2. More recently following a period of illness Philip Astle the Trust's Chief Executive Officer (CEO), resigned and Dr Fionna Moore was asked to act as interim CEO. More recently, the Trust has announced the appointment of Siobhan Melia. Siobhan will join the Trust in July as the Interim Chief Executive from her current CEO position at the Sussex Community Trust NHS FT. Dr Fionna Moore will return to her substantive role as executive Medical Director.

7. Community Infrastructure Levy (CIL)

7.2 Regarding the Community Infrastructure Levy (CIL), the Trust's commissioners will work with the Integrated Care Systems and Integrated Care Boards, who will have the responsibility to ensure that 'Population Health Management' is understood, and that appropriate planning and mitigations are made for potentially increases in demand on local services, including the ambulance service and NHS 111.

7.3 The Trust will in turn work with its lead commissioner when it comes to the CIL, to ensure that risks identified are understood and mitigated for.

8. Electric Vehicles

8.1. The Trust has been successful in receiving some funding from NHS england to start a trial of some electric vehicles. The Trust is initially looking at Mercedes eVitos. This is in addition to the work that the Trust is undertaking in developing a range of zero emission double-crewed ambulances prototypes. The work being undertaken is in line with how the NHS is moving to a 'Net Zero' NHS outlined in its published strategy of October 2020.

9. Combined Ambulance Make Ready Centre, 999 Emergency Operations Centre and 111 Operations Centre

9.1. Work is continuing to progress on the building of the new and exciting joint 999 Emergency Operations Centre and 111 Operations Centre in Gillingham. This new unit

will incorporate the Make Ready Centre for ambulance operations in the Medway area and house the relocation of the 111 Operations Centre from Ashford and 999 Emergency Operations Centre (EOC) from Coxheath.

9.2. January 2023 should see the first operational staff working from the new building, followed in February by NHS 111. A date is yet to be finalised for the relocation of the EOC staff currently based in Coxheath.

9.3. This co-location further enhances the integration of and aids the development of synergies between both the 999 and 111 services, which is a key part of the Trust's Strategic Plan to deliver new integrated services over a wider area. In addition, having both of these services housed in the same building will facilitate the sharing of best practice especially as both are using the same computer system, Cleric, and NHS Pathways as the triage tool. This is a key feature for both services as it allows the continued training and development of staff to undertake both 999 and 111 calls.

9.4. This development will have additional capacity to accommodate a higher number of staff servicing both the 999 and the NHS 111 contracts.

9.5. The Trust has also recently opened its new Make Ready Centre at Falmer (Brighton) and completed a complete rebuild of its estate at Banstead. Both these new openings are a key part of the Trust's estate strategy to significantly improve facilities for staff, including training facilities for Clinical Professional Development (CPD) and the efficiencies of having vehicles maintained and stocked by teams of support staff.

10. Recommendations

10.1. The committee is asked to note and comment on the update provided.

Lead Officer Contact

Ray Savage, Strategic Partnerships Manager (SECAmb)

Background papers

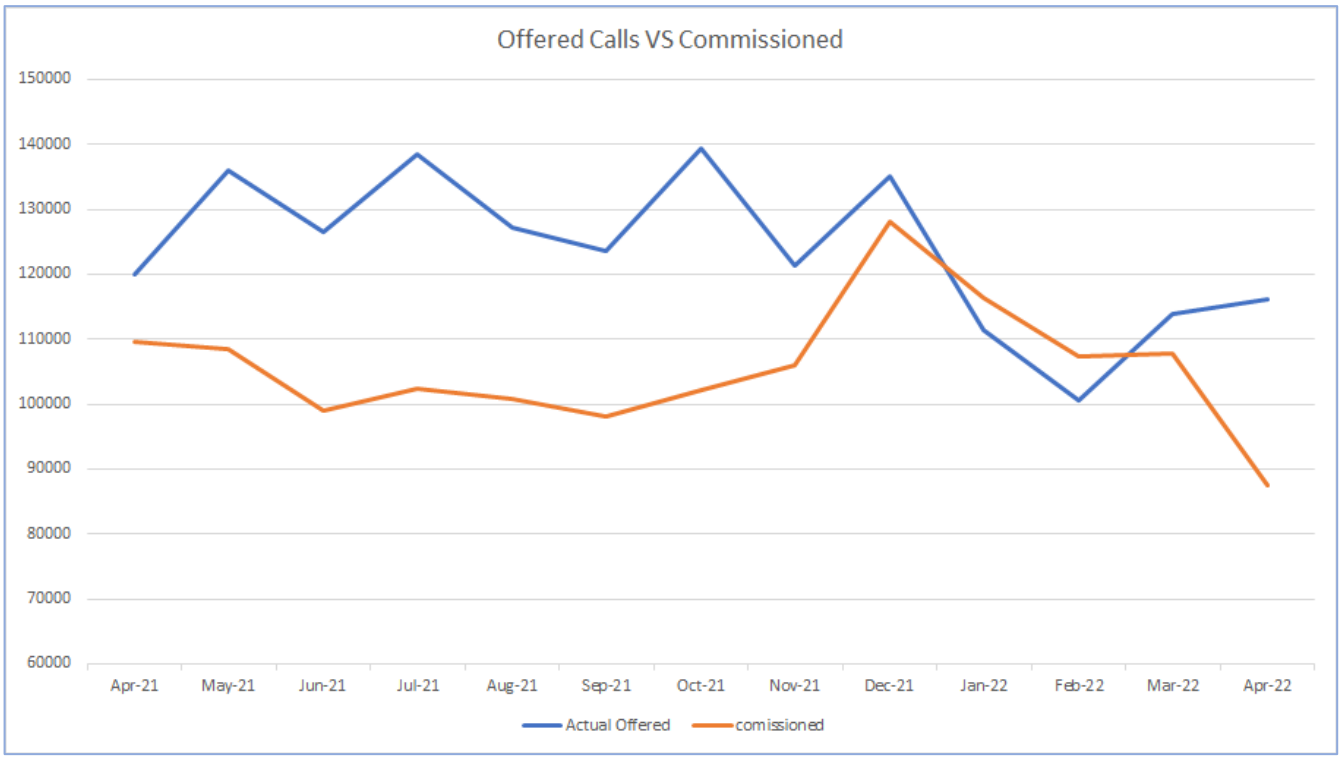
None

Appendices

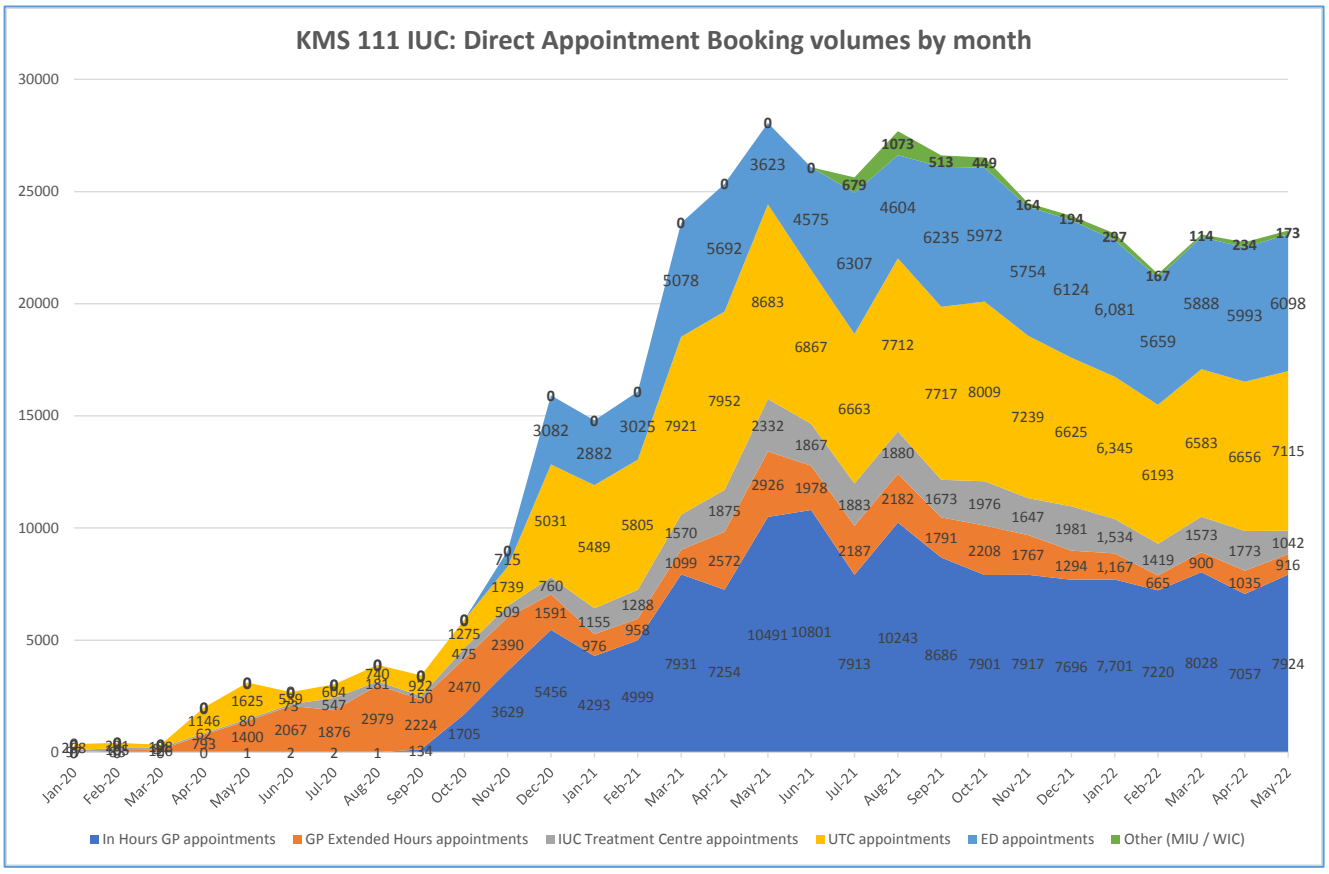
Appendix A – Ambulance Quality Indicators May 2022

Ambulance Quality Indictors												
	Dec-21		Jan-22		Feb-22		Mar-22		Apr-22		May-22	
Category 1	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th
England	00:09:13	00:16:12	00:08:31	00:15:05	00:08:51	00:15:43	00:09:35	00:16:50	00:09:02	00:16:07	00:08:36	00:15:15
SECAmb	00:08:42	00:16:03	00:08:44	00:15:57	00:08:43	00:15:47	00:09:34	00:16:48	00:08:32	00:15:48	00:08:29	00:15:52
Position	4th	5th	8th	8th	6th	6th	5th	5th	5th	5th	5th	7th
Category 2	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th
England	00:53:21	01:59:12	00:38:04	01:23:35	00:42:07	01:31:54	01:01:03	02:17:10	00:51:22	01:56:34	00:39:58	01:25:52
SECAmb	00:34:17	01:10:43	00:28:21	00:56:54	00:32:16	01:06:24	00:39:43	01:22:37	00:33:12	01:08:30	00:28:41	00:57:40
Position	3rd	3rd	3rd	3rd	5th	5th	3rd	3rd	2nd	2nd	3rd	3rd
Category 3	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th
England	02:51:08	07:11:44	01:56:52	04:47:18	02:16:13	05:30:21	03:28:13	08:36:33	02:38:41	06:41:39	02:09:32	05:22:06
SECAmb	02:46:46	06:21:13	02:01:32	04:34:40	02:28:05	05:34:59	03:26:07	08:06:24	02:28:49	05:33:53	02:04:01	04:42:40
Position	5th	5th	6th	6th	8th	7th	6th	6th	6th	5th	5th	5th
Category 4	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th
England	03:27:58	08:05:16	02:34:48	05:52:28	03:01:28	06:52:23	04:07:42	09:56:03	03:08:03	07:41:17	02:47:57	06:59:32
SECAmb	04:01:27	09:42:15	02:46:29	06:21:52	03:23:21	07:49:44	04:23:45	09:48:01	03:33:31	08:22:07	02:53:04	06:44:12
Position	10th	10th	7th	8th	8th	8th	7th	6th	8th	6th	7th	6th
*Call Answer	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th	Mean	90th
England	45	138	19	59	22	68	42	120	28	93	19	65
SECAmb	25	86	12	38	16	61	36	123	19	72	14	49
Position	4th	4th	4th	5th	8th	8th	8th	8th	6th	6th	5th	7th
All times are shown as: HH:MM:SS												
*Call Answering is shown in total seconds												

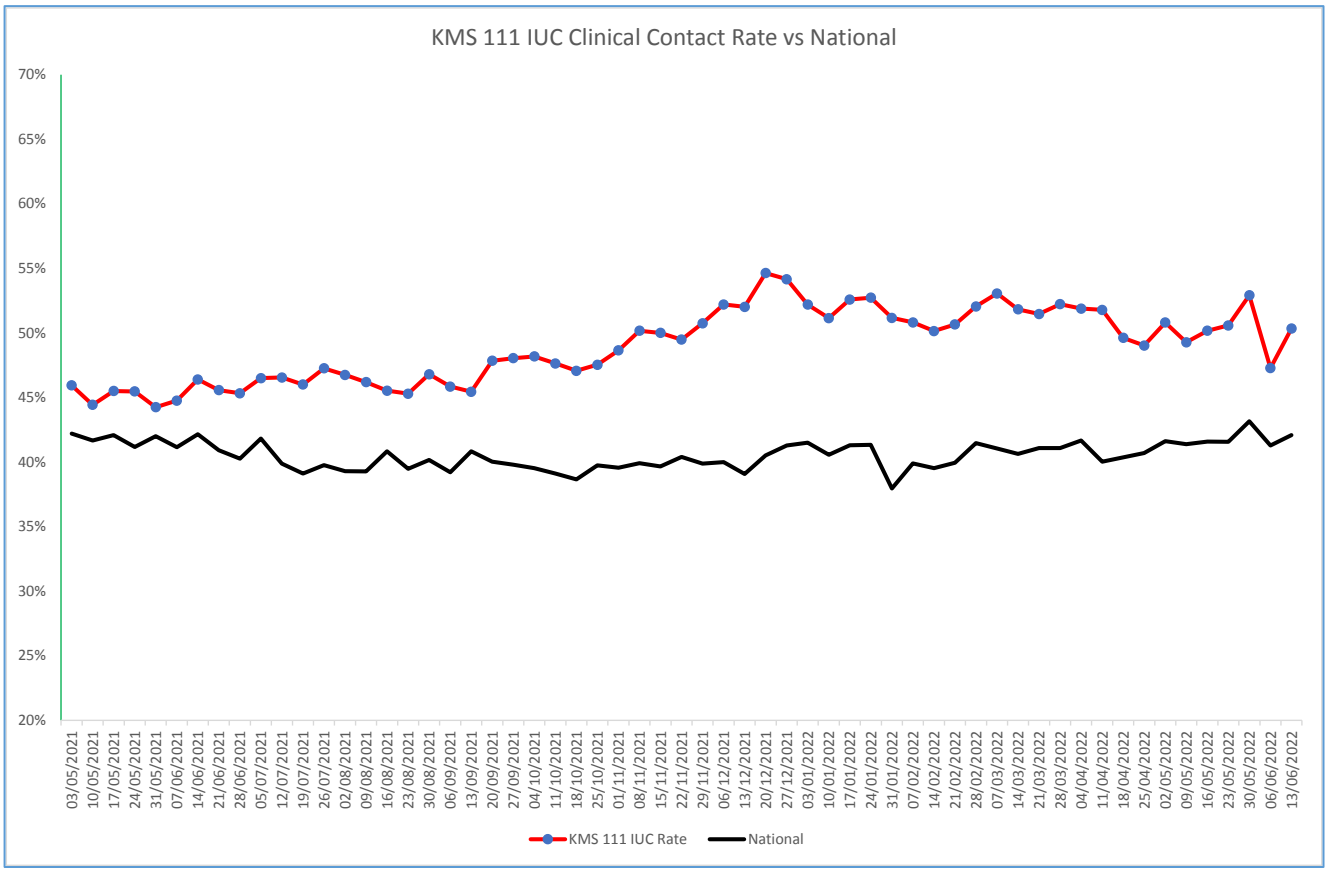
Appendix B – Calls Offered



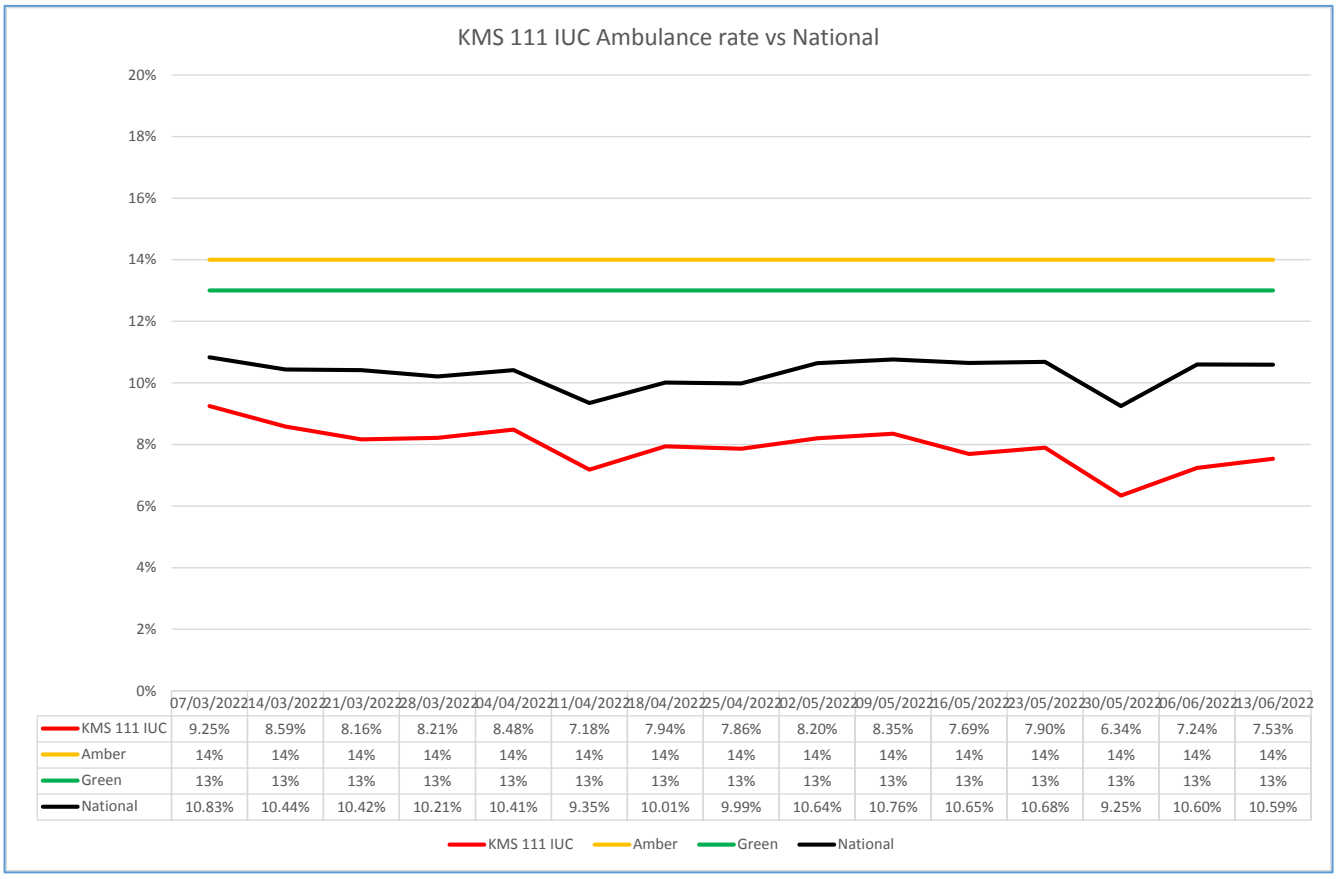
Appendix C – Direct Access Bookings



Appendix D – Clinical Contact Rate

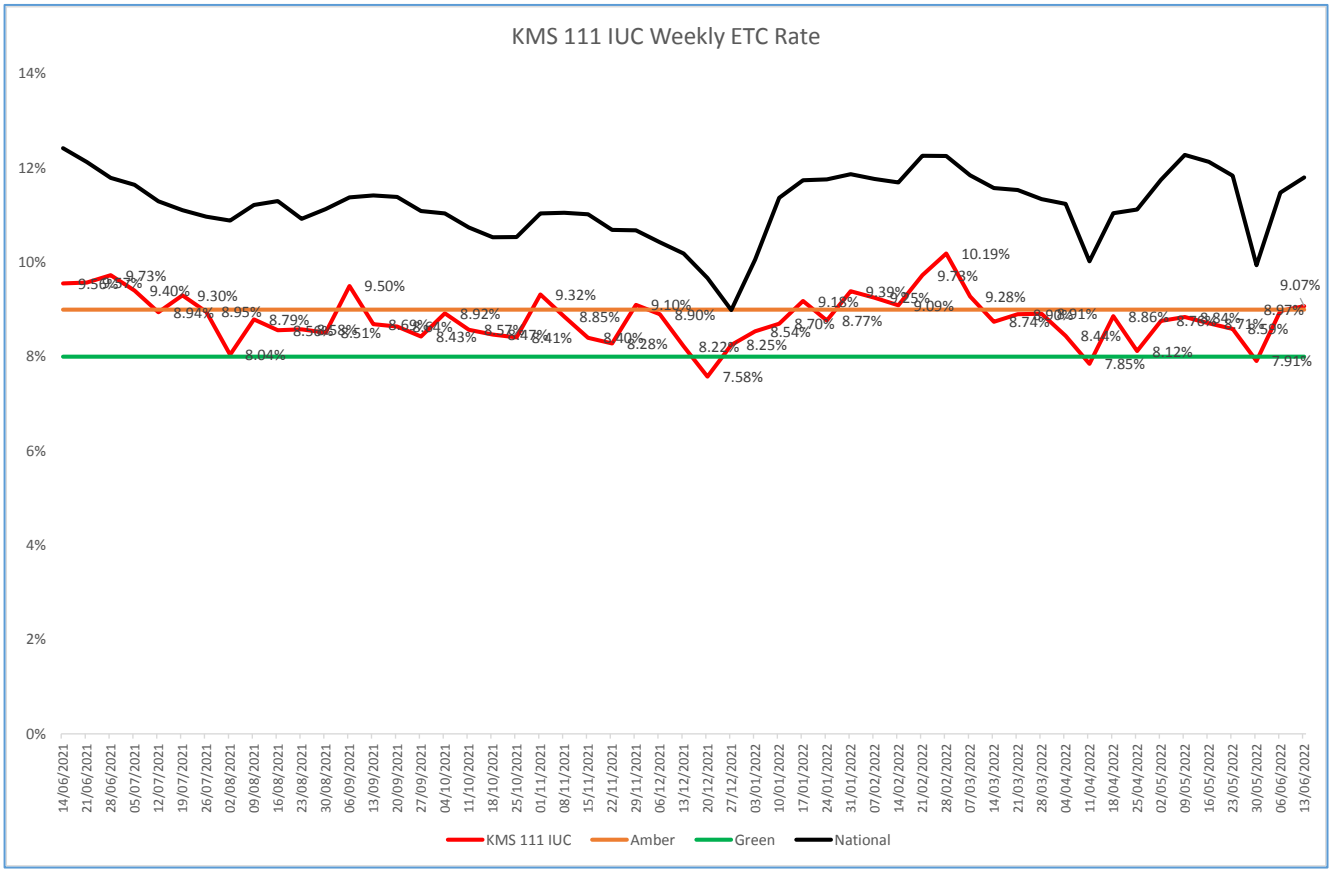


Appendix E – 111 to 999 Ambulance Rate

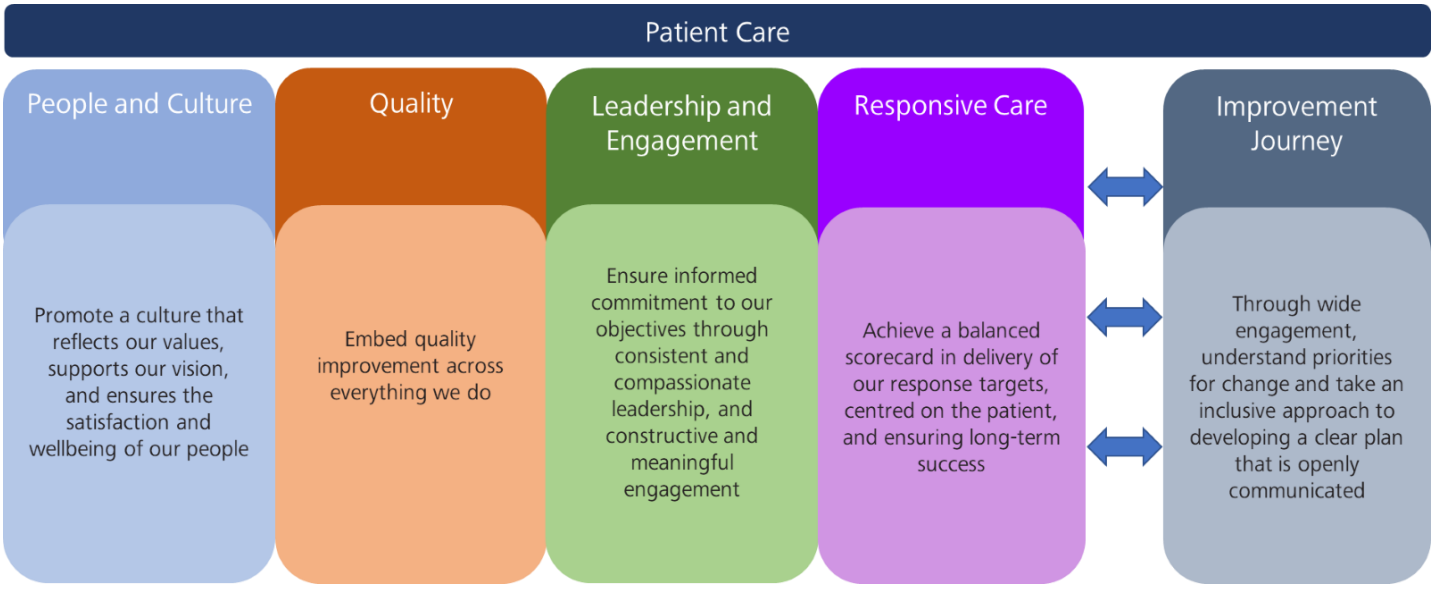


	07/03/2022	14/03/2022	21/03/2022	28/03/2022	04/04/2022	11/04/2022	18/04/2022	25/04/2022	02/05/2022	09/05/2022	16/05/2022	23/05/2022	30/05/2022	06/06/2022	13/06/2022
KMS 111 IUC	9.25%	8.59%	8.16%	8.21%	8.48%	7.18%	7.94%	7.86%	8.20%	8.35%	7.69%	7.90%	6.34%	7.24%	7.53%
Amber	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%
Green	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%
National	10.83%	10.44%	10.42%	10.21%	10.41%	9.35%	10.01%	9.99%	10.64%	10.76%	10.65%	10.68%	9.25%	10.60%	10.59%

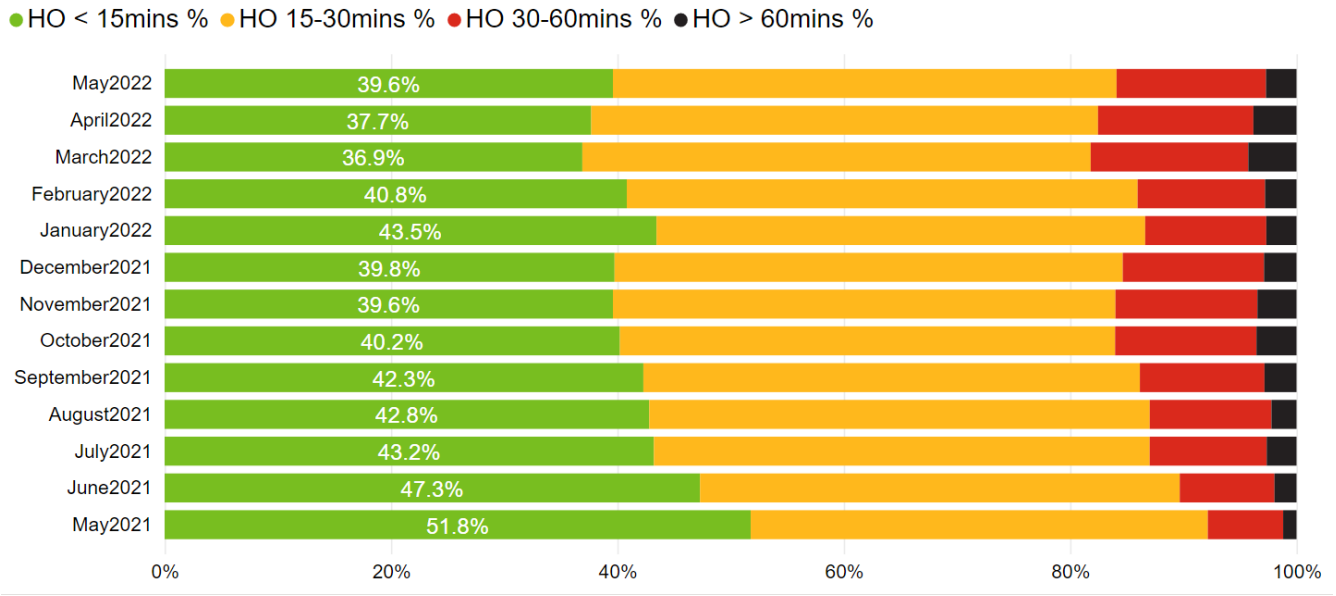
Appendix F – Emergency Treatment Centre Rates



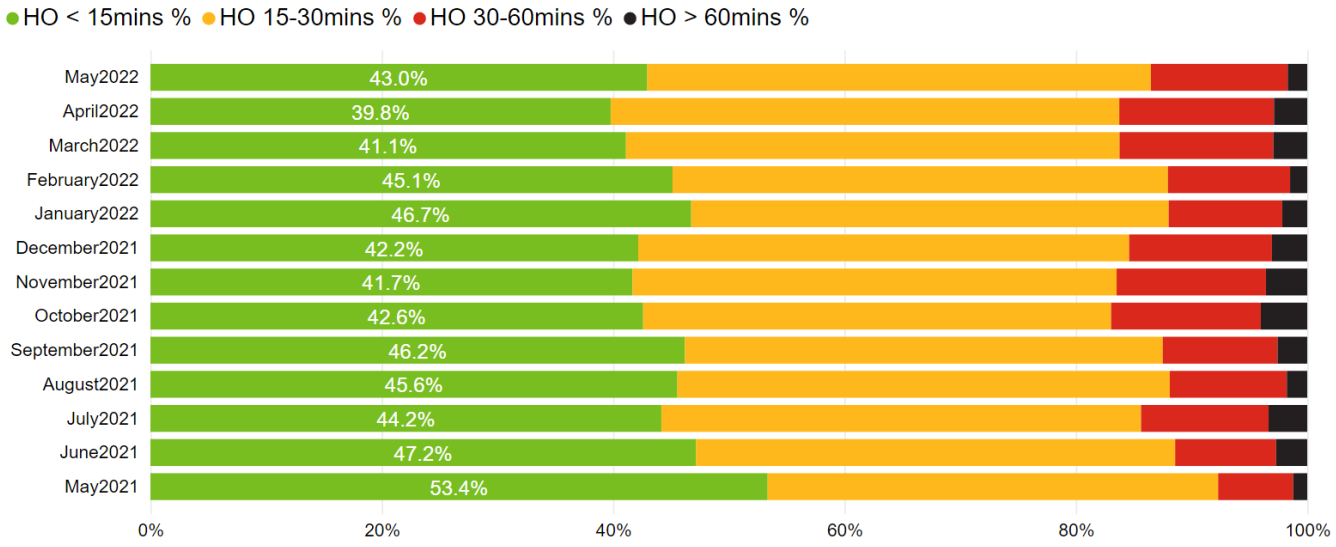
Appendix G – Trust Priorities 2022-23



Appendix H – Trust Handover Delays



Appendix I – Kent and Medway Handover Delays



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Item 6: Podiatry Service (Foster Street, Maidstone) – proposal to change location

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 7 July 2022

Subject: Podiatry Service (Foster Street, Maidstone) – proposal to change location

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent Community Health NHS Foundation Trust (KCHFT).

Members have yet to decide whether this is a substantial variation of service.

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1) Introduction

a) Podiatry is the study, diagnosis and treatment of disorders of the feet and ankles. In Kent, the service is provided by Kent Community Health NHS Foundation Trust (KCHFT). Services are currently located in Foster Street, Maidstone.

b) The provider contacted HOSC's clerk in June 2022 regarding a need to change the location of the service. KCHFT has been invited to attend HOSC today and update them on the background to the project along with future plans.

2) Potential Substantial variation of service

a) The Committee is asked to review whether the relocation of podiatry services constitutes a substantial variation of service. The health scrutiny regulations do not define what a "substantial variation" is, therefore it is for the Committee to make that determination, taking into account the impact and extent of the proposal.

b) Where the Committee deems the proposed changes as not being substantial, this shall not prevent the HOSC from reviewing the proposed changes at its discretion and making reports and recommendations to the NHS.

c) If the Committee deems a proposal a substantial variation of service, KCHFT shall consult with the Committee prior to the final decision being made. The NHS always remains the decision-maker though must take comments of the Committee into account.

d) When KCHFT determines the date it will make a final decision on the relocation, it must let HOSC know. Sufficient time shall be allowed for the Committee to make comments on the proposed decision ahead of this date.

e) Once KCHFT have made a decision, they shall formally presented it at a meeting of the Committee as soon as is practical after it has been taken. The Committee will determine its response to the decision and may support the decision, not support the decision, and/or comment on the decision.

f) Where the Committee does not support the decision, it can refer the matter to the Secretary of State for Health and Social Care under one of the following reasons:

a) The consultation with the Committee on the proposal is deemed to have been inadequate in relation to content or time allowed,
b) The reasons given for not consulting with the Committee on a proposal are inadequate, or
c) The proposal is not considered to be in the interests of the health services of the area.

3. Recommendation

If the proposal to relocate the podiatry service is deemed substantial:

RECOMMENDED that:

(a) the Committee deems that the relocation of podiatry services is a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

If the proposal to relocate the podiatry service is not deemed substantial:

RECOMMENDED that:

(a) the Committee deems that relocation of podiatry services is not a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

Background Documents

None.

Contact Details

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Podiatry Service (Foster Street, Maidstone) – proposal to change location

Presented by: Simon Pendleton and Mark Johnstone

Aim:
To provide accessible Podiatry and Podiatry Surgery Services from an improved location in Kent for both patient care and a working environment for staff.

Background:
The building at Foster Street is owned by KCHFT and located in the middle of Maidstone.

Services from the building include Podiatry and community nursing. Community nursing was moved as part of a project to relocate community services to benefit patient delivery and improved working conditions for teams. This particular service moved to an existing KCHFT property in Hermitage Lane. No patient care was delivered from the building by this team, it was used as a base for the service.

The Podiatry and Podiatric Surgery Service has run clinics at Foster Street for many years and the building is showing its age and does not meet accessibility requirements needed making it easy for everyone to access our services. 11 staff currently work at this site.

There is a lack of parking at the site (limited to 30 minutes only) and the building cannot be made accessible without considerable financial investment. The working conditions for staff are not optimum including heating in the winter, keeping cool in the summer, access and safety. With other services moving from Foster Street, it leaves minimal staff at the site which not only creates risk of lone working but also is not using the building for its full purpose creating additional problems with heating and utilities for one service.

Access to the Podiatry Service at Foster Street is via a steep slope, nearest parking limited to 30 minutes and only one disabled parking space or patient parking on site. The clinic is near a bus route but requires a walk up or down hill on a busy road to get to the nearest bus stop.

KCHFT staff
The move impacts 11 members of staff who have previously voiced their concerns in relation to the Foster Street Clinic including access to the building for their patients and lone working. All 11 staff have been consulted with in relation to the proposed move and are happy with the suggested new premises.

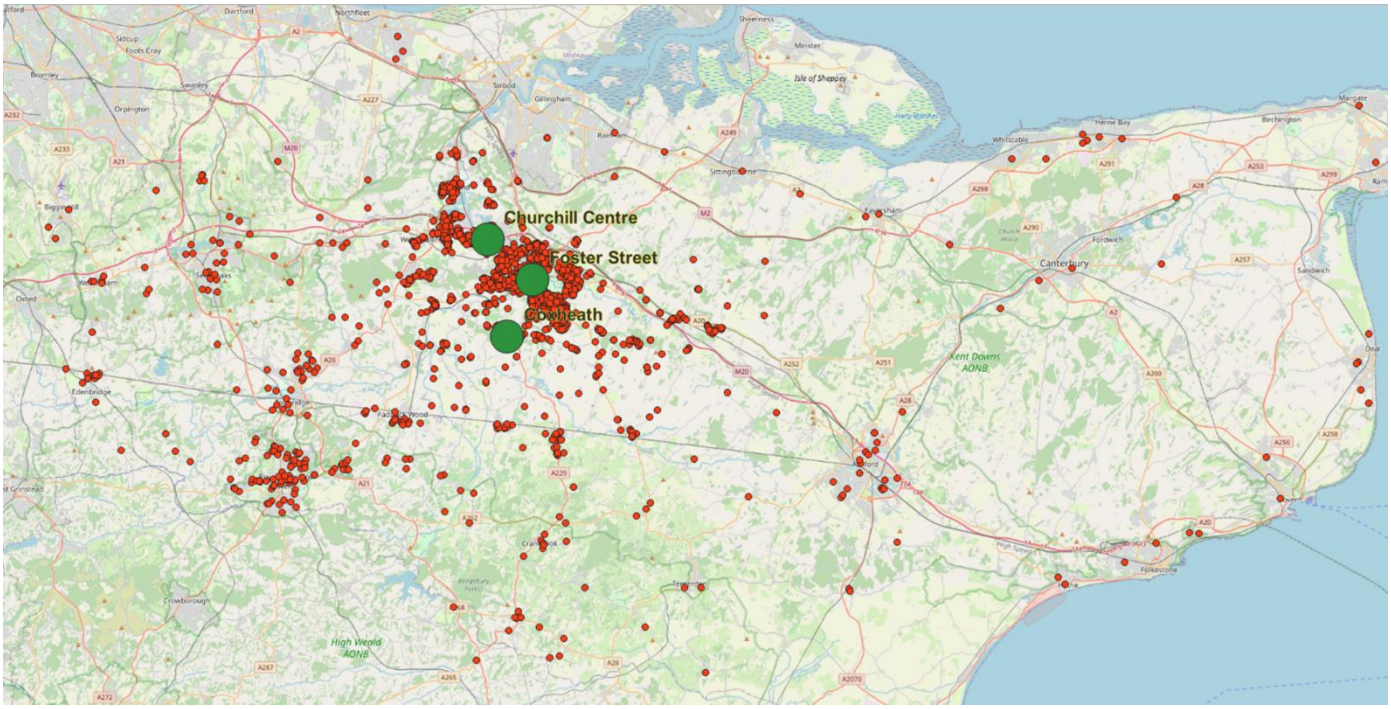
Client demographics
Demographics of those accessing services during 2021/22 was reviewed and showed:

Monthly contacts

	2021									2022			Grand Total
Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Podiatric Surgery	51	43	73	53	37	54	53	47	12	34	42	49	548
Podiatry	317	371	433	382	448	527	431	403	433	345	360	428	4878
Grand Total	**368**	**414**	**506**	**435**	**485**	**581**	**484**	**450**	**445**	**379**	**402**	**477**	**5426**

Current caseloads (as at May 2022)
Podiatric surgery: 548
Podiatry: 1895

The map shows current caseload by geographical area in relation to the current clinic and proposed new sites.



A scoping project was carried out to determine if alternative existing NHS sites, in the Maidstone area, with improved amenities was available.

Two sites were identified as Coxheath Clinic and The Churchill Centre at the Royal British Legion Village, Preston Hall. Both locations remain in the Maidstone area.

Advantages of new sites:

- Reduces the risk of lone working at Foster Street.
- The proposed clinic rooms at Coxheath and Churchill were created in 2021/22 and have been designed and built to HBN guidance.
- The podiatry team will be the first to use these rooms, so will be of a much better quality and condition than those at Foster Street.
- The rooms will be a more comfortable environment to work and provide patient care and will be fully equipped specifically for the service.
- The overall condition of the two buildings that will be used is of a much higher quality than Foster Street and can be more easily adapted should it be required.
- Patients can choose which podiatry clinic they wish to attend.
- Operating from two sites increases the resilience of the service if there was to be an unforeseen issue at a site, compared to all the clinic rooms being in one location.
- The Churchill Centre can be reached via bus from Snodland to Maidstone (No 71/71a) running every 15 minutes which stops at Preston hall and the bus stop is approximately 10 minutes' walk to the clinic.

- The Coxheath Clinic can be reached by a direct bus from Maidstone (No 89), running every 30 minutes and the bus stop is approximately five minutes' walk away. There is more parking for staff and the centre is all on one level with no slopes impacting access. It also includes charging for electric vehicles.
- The Podiatric Surgery Service will be provided at The Churchill Centre with easy access to x-ray facilities at Maidstone Hospital.
- The sites are closer to the current caseloads and reduces the need to travel to the town centre and for many people would reduce travel time and distance.

Disadvantages of sites:

- The Churchill Centre can be reached via bus, however the bus stop is approximately 10 minutes' walk to the clinic.
- Parking at the Churchill Centre has the same capacity as Foster Street. This is mitigated with patients having a choice of clinic to attend.
- Change of location for ongoing clients. Mitigated by engagement programme and continued assistance on site for first visit.

Proposal:

Staff have already expressed their desire to move to the two sites after seeing the benefits of their working environment and the benefits for patient care. The team providing patient care, will not change therefore offer continuity of care to existing clients.
The Podiatric Surgery will move to the Churchill Centre however the Podiatric Service will be available at both the Churchill Centre and the Coxheath Clinic. Patients who require the Podiatry Service will be able to choose which site they wish to attend.

Foster Street will be disposed of in conjunction with DHSC guidance, and KCHFT is working with DHSC regarding the return of Capital monies which could be used to further enhance clinic capacity and capabilities in the Maidstone area.

Recommendation

A six-week engagement period with existing patients and potential patients with an option to contact a dedicated email address with any concerns, to include:

- Information shared with HOSC
- Information shared with all MPs (all areas affected)
- Letter to patients giving them the option of which clinic they would like to attend
- Letter to referrers to advise of the change and list options available
- Letter to all other stakeholders (local authorities, KCC)
- Information shared via CCG bulletins (GPs, community health)
- Information shared via KCHFT bulletins (stakeholders)
- Information on KCHFT website
- Information on CCG website
- Information shared via Healthwatch

A press release (or paid advertising) will also be issued highlighting the changes for our local news outlets.

Any concerns raised during the six-week period will be addressed as appropriate.

A volunteer will be recruited to help guide patients on site for their first visit during the first two months of the transition to help and reassure patients who are cautious about the change.

Summary

Upon approval of the recommendation by HOSC, KCHFT will implement the engagement plan with a proposed move to be planned post 29 August. Any comments or questions will be answered through the engagement period with appropriate mitigations established for concerns raised.

Item 7: Establishment of the Kent and Medway Integrated Care System and the impact on Health Overview Scrutiny Committee (HOSC) Arrangements

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 7 July 2022

Subject: Establishment of the Kent and Medway Integrated Care System and the impact on Health Overview Scrutiny Committee (HOSC) Arrangements

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

---

1) Introduction

a) Clinical Commissioning Groups will be disbanded on 30 June 2022. From 1 July, Integrated Care Boards will be established.

b) The attached report from the Kent and Medway CCG summarises how this will look locally and what it means for the commissioner's relationship with HOSC.

2. Recommendation

RECOMMENDED that the Committee note the report.

Background Documents

None

Contact Details

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NHS
Kent and Medway

13 June 2022

Re: Establishment of the Kent and Medway Integrated Care System and the impact on Health Overview Scrutiny Committee (HOSC) Arrangements

Introduction

1. A report from the Leader of Kent County Council and the Cabinet Member for Adult Social Care and Public Health went to the Council meeting on 26th May 2022, detailing the arrangements for the establishment of new formal statutory arrangements to be implemented from 1 July 2022, following enactment of the Health and Social Care Act. A copy of the Council briefing is attached for information.

2. In essence:

   a. Clinical Commissioning Groups, including Kent and Medway will be disbanded on 30th June 2022.

   b. A new statutory NHS Kent and Medway Integrated Care Board (ICB) will be established at 00:01hours on 1st July 2022. The ICB will take over the functions and duties of the previous CCG, plus a number of new functions from NHS England.

   c. A nationally mandated Integrated Care Partnership (ICP) Joint Committee will also be established between the new statutory NHS organisation and the two upper tier local authorities. The primary role of the ICP will be to oversee the development and delivery of a whole system, all encompassing, integrated care strategy and outcome measures to improve health and well-being and support greater social and economic development of the local population. This will be chaired by the Local Authority Leaders, with Roger Gough holding chairmanship of the Joint Committee in the first instance.

   d. The new ICB will not be the same as the previous CCG. It's Board and committees, plus the ICP, will have membership from various stakeholder groups including the voluntary and community sector, upper and lower tier councils, public health, providers of health and social care and other representatives from sectors such as housing, education, environment, etc. In addition, a People and Communities Forum is also being established, and members of this will be invited to attend the above groups. These arrangements will enable greater influencing and joint decision making, with a greater focus on

improving health and well-being outcomes, alongside delivering improved quality of care.

e. The expectation is that over time, greater levels of decision making will be delegated to local health and care partnerships and collaboratives, made up of similar multi-partner organisations and stakeholders. Between them, they will have an increasing ability to decide local priorities and how best to deliver them based on local need.

3. At the time of reporting, all of the Kent and Medway arrangements for 1 July are on track. Our plans have been separately reviewed by NHS England and our independent auditors and have been given substantial assurance.

4. A verbal update on 1st July establishment will be provided to the HOSC at its meeting in July

Impact of new arrangements with the HOSC

5. The 2022 Health and Care Act does not change any of the arrangements for local authority scrutiny of healthcare services, with the sole exception that the Integrated Care Board replaces the CCG.

6. The 2022 Act does give the Secretary of State for Health and Social Care additional powers to intervene, but this has no impact on the role or authority of local authority scrutiny committees.

7. As such we would expect the existing arrangements to continue and for the NHS Integrated Care Board to continue reporting into the Kent HOSC.

8. The Committee is asked to NOTE this briefing paper.

Mike Gilbert
Executive Director of Corporate Governance
NHS Kent and Medway

Attachment:

1. Health and Care Partnership Working with the Kent and Medway Integrated Care System

From: Roger Gough, Leader of the Council
Clair Bell, Cabinet Member for Adult Social Care & Public Health

To: County Council 26 May 2022

Subject: **Health and Care Partnership Working with the Kent and Medway Integrated Care System**

Classification: Unrestricted

Summary: KCC is committed to work in partnership to improve the health outcomes of our residents through stronger integrated working arrangements that focus on wellbeing and the prevention of ill health.

Achieving the scale of ambition set out in the Health and Care Act requires substantial and long-term commitment not only from Government but from local government and NHS leaders at every level – national, regional, system, place and neighbourhood.

This paper provides the latest in a series of progress reports setting out how KCC will work with the Kent and Medway Integrated Care System and how it intends to act as a partner at both System and Place level. It builds on the extensive partnership working that has taken place to prepare for 1st July 2022, when the Kent and Medway Integrated Care System becomes fully operational.

The paper focuses on strategic arrangements and aims to put in place the correct foundations for joint working, decision making and Governance at a System level. These foundations are captured in the Draft Terms of Reference attached for approval by County Council.

This work will underpin how the Statutory Partners, KCC, NHS and Medway Council will work together moving forward. It creates a framework in which we can come together to fundamentally rethink the way health and social care services are provided and to deliver more preventative, coordinated care to the population we support.

Recommendations:

County Council is asked to note and consider the content of this report

County Council is asked to approve the draft Terms of Reference for the Integrated Care Partnership Committee as found at Appendix 2

1. Background

1.1 The Health and Care Bill is now an Act of Parliament after it received Royal Assent on 28 April. County Council will recall that Integrated Care Systems (ICS) are being established in all areas of the Country as set out in the Act. Integrated Care Systems are partnerships of health and care organisations that plan and deliver joined-up services to improve the health and wellbeing of people in their area. The planned implementation date is 1st July 2022.

1.2 The four core purposes of the Integrated Care System are:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and value for money
- Supporting broader social economic development.

1.3 The structure of the emerging Kent and Medway Integrated Care System is shown in Figure One below. Creating the architecture and governance arrangements for the Integrated Care System continues to be a complex and challenging agenda with a great deal of technical detail involved. KCC is legally required to participate in the Integrated Care System as an equal and significant partner. However, it is also vital for KCC to be fully engaged in the development of its operating framework to influence and shape the priorities, activity and commissioning decisions that will play a major part in the future health and wellbeing of our residents.

1.4 There are two parts to an Integrated Care System. The first part is the integrated care partnership, or ICP: a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. The second part is a statutory body, the integrated care board, or ICB: the ICB will be responsible for the commissioning of healthcare services in that ICS area, bringing the NHS together locally to improve population health and care.

1.5 The roles of the ICP and the ICB are distinct and complementary in supporting the objectives of the ICS. The ICB is an organisation designed to align the planning and operation of NHS care and is accountable for NHS expenditure. The ICP will provide a forum for NHS leaders and local authorities to come together, as equal partners, with important stakeholders from across the system and community. Together, the ICP will generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.

1.6 The Integrated Care Partnership is also expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:

- helping people live more independent, healthier lives for longer
- taking an overview of people's interactions with services across the system and the different pathways within it
- addressing inequalities in health and wellbeing outcomes, experiences and access to health services
- improving the wider social determinants that drive these inequalities, including employment, housing, education, environment, and reducing offending
- improving the life chances and health outcomes of babies, children and young people
- improving people's overall wellbeing and preventing ill-health

2 Latest National Context

2.1 The Health and Care Act is part of the wider set of mutually reinforcing reforms that include the Integration White Paper, *Health and Social Care Integration: joining up care for people, places and populations* and the adult social care reform white paper. A white paper tackling Health Disparities is also expected later this year.

2.2 The Integration White paper is significant as it sets out plans to join up care for:

- patients and service users
- staff looking for ways to better support increasing numbers of people with care needs
- organisations delivering these services to the local population

2.3 The White Paper proposals are summarised in Appendix 1. These proposals give added significance to the role of Places: in Kent and Medway Places equate to our 4 Health and Care Partnership areas.

- Dartford, Gravesham and Swanley
- West Kent
- East Kent
- Medway and Swale

2.4 The Integration White Paper will shape how the Kent and Medway System will operate and it provides both opportunities and challenges for KCC. For example:

i. The focus on a geographical Place as the key delivery mechanism. The expectation set out in the White Paper is that all local areas should aim to manage services and have associated budgets by 2026. In Kent this could provide opportunities for KCC to work in new ways with the 4 Health and Care Partnerships to build local pathways of care and encourage investment in community and preventative services.

ii. To achieve this Places are expected to accelerate the routine pooling and alignment of “a significant and in many cases growing proportion” of NHS and social care budgets. Places will need to develop ambitious plans to increase the scope and proportion of health and care activity and spend to be overseen by and funded through ‘place-based’ arrangements. While the paper states that “eventually” pooled budgets and aligned financial arrangements will cover much health and care funding at place level, the Government says it will not, at this stage mandate how this is achieved.

iii. The hope is for a widespread shift in spending and prioritisation from the treatment of illness towards preventing it in the first place. This provides KCC with opportunities to consider potential innovative joint funding arrangements to drive forward improvement. The White Paper has clear ambitions regarding the future of joint resourcing arrangements at a local level. However, to meet the scale of the ambitions described considerable work needs to be undertaken at a national and local level to determine how this might work. Indeed, it may well need further/additional primary legislation regarding local authority funding arrangements to enable this.

iv. Mechanisms do already exist to support limited pooled funding arrangements and there are plans to make it easier for local systems to enter into such agreements. The Better Care Fund was created in 2013 by Government and requires the NHS and local government to create a local single pooled budget to incentivise closer working around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems. Later this year, the Government will set out a new policy framework for the Better Care Fund from 2023, including how the programme will support the implementation of integration at place level, it will also review regulations underpinning section 75 arrangements and publish revised guidance. Section 75 agreements are made between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s.

v. The government expects all places to have "a single person, accountable for shared outcomes" by Spring 2023. This person will be agreed by the relevant Local Authorities and the integrated care board and could be an individual with a dual role across health and care or an individual lead for a place-based Board. Local authority and NHS accountabilities remain unchanged. In Kent and Medway there would be 4 individuals. The role, responsibility and accountability of these posts will need to be carefully considered to make them meaningful and trusted resources for the System. This may be a particular challenge for the Medway and Swale Health and Care Partnership which is not co-terminous with the Local Authority boundaries of Medway Council and KCC.

vi. The expanding role of CQC will task CQC with considering progress on outcomes agreed at place level as part of its assessment of Integrated Care Systems. KCC will be expected to be a strong and significant partner in delivering against these agreed outcomes

3 Latest Developments in Kent and Medway

Since the last report to County Council the Integrated Care System has been developing its governance arrangements and structures to enable it to fulfil its purposes. Progress includes arrangements for:

3.1 The Integrated Care Partnership Committee (ICP). It has been agreed that

i. It will be chaired by KCC and Medway Council Leaders on a rotational basis of 2 years at a time, with the Leader who is NOT the chair acting as Vice-chair. It has been agreed that KCC's Leader will act as chairman for the first two years with Medway Council's Leader acting as Vice-chair. Along with the ICB Chair Designate they will form a coherent leadership group setting the vision and purpose for the Integrated Care Partnership.

ii. The draft Terms of Reference for the Integrated Care Partnership Committee must be presented to the 3 statutory partners, KCC, Medway Council, and the NHS Integrated Care Board for approval. They are attached at Appendix 2 for approval by Full Council.

iii. There will be a shadow meeting of the Committee in June 2022. The Integrated Care Partnership Committee will then meet monthly until December 2022 to support the development of the Integrated Care Strategy. Government has set a deadline that integrated care strategies should be published by December.

iv. Integrated Care Partnerships are encouraged to form relationships with a range of other stakeholders appropriate to the places they cover, by either inviting them to be members of the ICP committee or engaging with them in other ways. This is because only 10 to 20 percent of good health is considered to come from medical interventions. The other 80 to 90 percent is associated with health-related behaviours, socioeconomic factors, and environmental factors. Therefore, without the involvement of the district, borough, town and parish councils a huge opportunity will be missed to truly improve the health and wellbeing of our population.

v. To take account of this requirement to include the broadest Membership the ICP Committee will also include the Voluntary Sector and Healthwatch. However, there is also a consensus that a subcommittee will be established to inform the development of the integrated care strategy and address the wider determinants of health such as economic and social wellbeing. It is planned that Membership of this subcommittee will include a wide range of partners with expertise including employment, community safety, housing, economic development, environment, leisure and planning.

3.2 The Integrated Care Board (ICB).

The NHS are developing the operationally focussed ICB, taking on the functions of the current CCG with additional responsibilities passed down from NHS England/Improvement. The Corporate Director for ASCH and the Director of Public Health are expected to be members of the ICB. One will be a voting Member and one will be a participant or non-voting member. The ICB will also have a subcommittee focussed on population health outcomes and health inequalities that will work closely with the Integrated Care Partnership and its planned subcommittee on the social and economic causes of inequality.

3.3 Health and Care Partnerships and Provider Collaboratives: In development

i. Partnerships at place level are known in Kent and Medway as Health and Care Partnerships. These are in development and over time will become the engine room for delivering more joined up integrated care and tackling local health inequalities. The details are still in development and will be the subject of further progress reports to County Council. Currently it is expected that the local Area Director for Adult Social Care and Health and a Public Health Consultant will attend these Boards.

ii. Children's services and services for people with learning disabilities, mental health problems or autism may be delivered through county wide arrangements called Provider Collaboratives – this is still very early thinking- as is KCC's involvement and representation. Provider collaboratives are

partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way the health and care system is organised, moving from an emphasis on organisational autonomy and competition to collaboration and partnership working. From July 2022, all NHS trusts providing acute and mental health services will need to join a provider collaborative. NHS community and ambulance trusts and non-NHS providers, such as voluntary, community and social enterprise (VCSE) sector organisations or independent providers, will be offered the opportunity to take part where this will benefit patients and makes sense for the providers. Individual providers may be involved in more than one collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England.

iii. However, how these arrangements develop will vary significantly across the country. They may take different forms and will vary in their scale and scope: some will be 'vertical' collaboratives involving organisations that provide different services (e.g., collaboratives bringing together primary care, community, local acute, mental health and social care providers); others will be 'horizontal' collaboratives that bring together providers that offer similar services (e.g., a chain of acute hospitals or mental health services)

iv. Guidance is clear that it is up to members of the proposed collaborative to decide which arrangement will work best for them in the context of their 'shared purpose and objectives'. This permissive approach recognises that the form and function of the newly mandated provider collaboratives will in many ways be determined locally; influenced by the history of collaboration, the local provider context and the relationships in that area. KCC will need to consider if working through a Provider Collaborative improves care pathways providing new models of care that benefit the people who use those services.

v. The important role of Members is also being developed by Health and Care Partnerships to work out how there will be both KCC and District Member involvement in setting local priorities for tackling health inequalities that will relate to the Integrated Care Partnership and the Integrated Care Strategy.

3.4 Primary Care Networks

42 Primary Care Networks operating at neighbourhood level. Adult Social Care is working jointly at this level through multi-disciplinary teams focusing on identifying and supporting individuals at risk of going into crisis.

4. Local Delivery

4.1 This Paper is focussed on the development of the architecture and governance of the System, the Integrated Care Partnership, and its Sub Committees. However, front line planning and delivery remains firmly in focus. KCC and the NHS continue to strengthen joint working arrangements building on the opportunities provided through the structures of the emerging

Integrated Care System and the challenges that brought us together through the pandemic.

Here are a small number of examples:

i. Adult Social Services is working in collaboration with the NHS to support the flow from hospitals into the community. A joint commissioning management group had been established to agree initiatives with the NHS. Hospital trusts supported by Council staff had been running discharge events. KCC and NHS have also jointly commissioned services to strengthen support to individuals diagnosed with dementia.

ii. Children's Services continue to grow their joint commissioning function which is working to improve access to Speech and Language services and is currently developing a joint preventative project called the nurture programme where mental health teams provide training and support to school staff to identify and understand young people struggling with their mental health and wellbeing.

iii. Public Health continues to develop and focus partnerships on mental health initiatives- for example Kent and Medway Children and Young People Suicide and Self Harm Prevention Network is working across a wide range of partners developing and promoting resources such as the Flux programme which uses the arts and creativity to help young people feel positive about themselves and the Better U app that offers digital self-help tools to support emotional well-being.

iv. Health Overview and Scrutiny Committee have been raising concerns for some time regarding availability of access to GPs. The Chair of HOSC is supporting a project led by NHS to improve GP recruitment in Thanet, Swale and Medway. These areas have a low GP:patient ratio and the pilot aims to improve this and relieve pressures on the local health system. If it is successful, the intention is to roll it out across other areas in Kent.

5. Conclusion

The emerging Integrated Care System is proving to be a complex and technical subject. However, it is vital that Members are aware of the direction of travel and have oversight of the progress being made. At the heart of this work is the ambition to enable health and care organisations to apply their collective strength to tackle the health and care challenges faced by the population we all serve. Agreeing a strong framework for partnership working is the first step in officially setting the tone, purpose and priorities of our Integrated Care System as it matures.

Recommendation:

1. County Council is asked to note and consider the content of this report

2. County Council is asked to approve the draft Terms of Reference for the Integrated Care Partnership Committee as found at Appendix 2.

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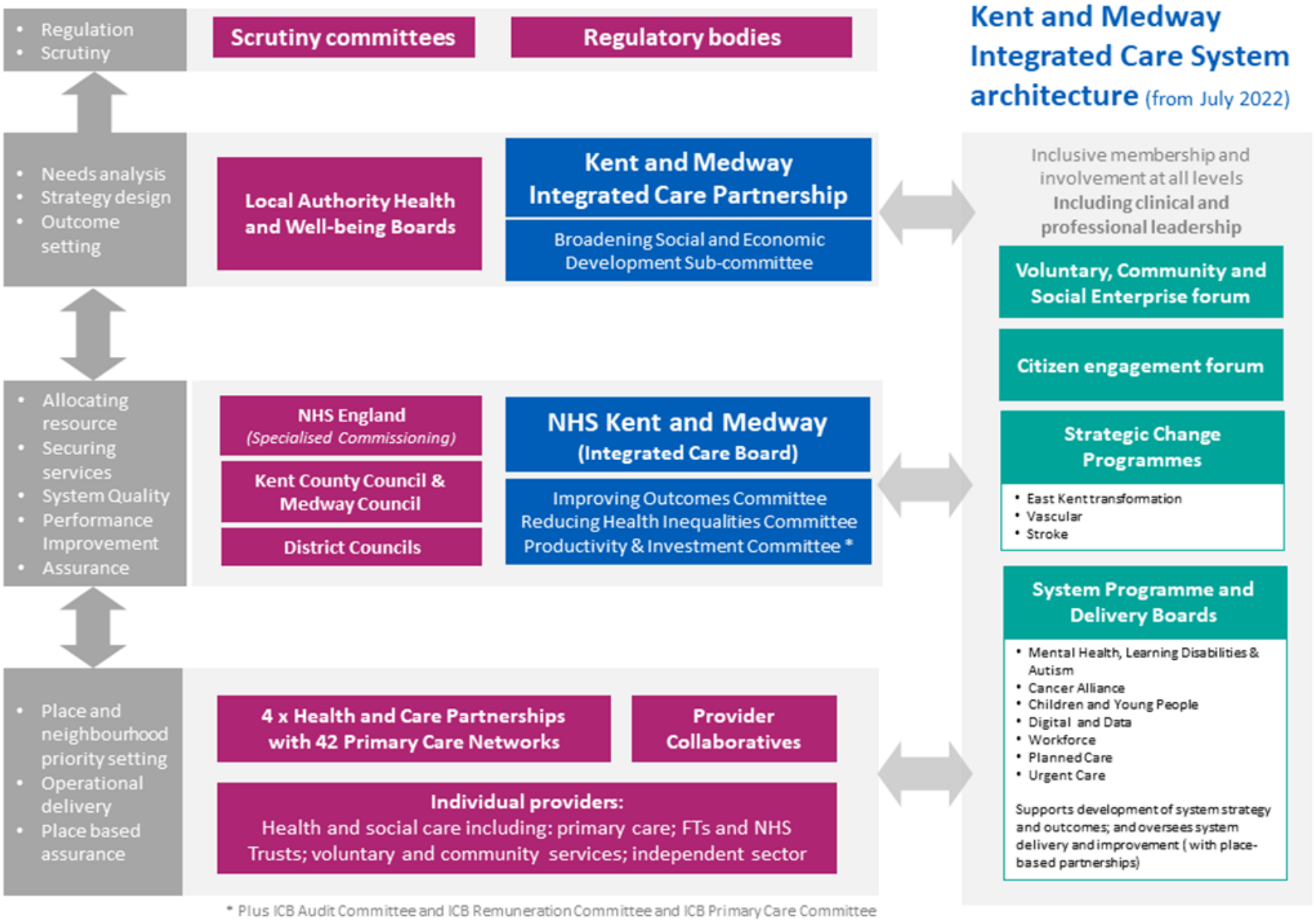
Figure One


Regulation
Scrutiny
Scrutiny committees
Regulatory bodies
Needs analysis
Strategy design
Outcome setting
Local Authority Health and Well-being Boards
Kent and Medway Integrated Care Partnership
Broadening Social and Economic Development Sub-committee
Allocating resource
Securing services
System Quality
Performance Improvement
Assurance
NHS England (Specialised Commissioning)
Kent County Council & Medway Council
District Councils
NHS Kent and Medway (Integrated Care Board)
Improving Outcomes Committee
Reducing Health Inequalities Committee
Productivity & Investment Committee *
Place and neighbourhood priority setting
Operational delivery
Place based assurance
4 x Health and Care Partnerships with 42 Primary Care Networks
Provider Collaboratives
Individual providers:
Health and social care including: primary care; FTs and NHS Trusts; voluntary and community services; independent sector
* Plus ICB Audit Committee and ICB Remuneration Committee and ICB Primary Care Committee
Kent and Medway Integrated Care System architecture (from July 2022)
Inclusive membership and involvement at all levels
Including clinical and professional leadership
Voluntary, Community and Social Enterprise forum
Citizen engagement forum
Strategic Change Programmes
East Kent transformation
Vascular
Stroke
System Programme and Delivery Boards
Mental Health, Learning Disabilities & Autism
Cancer Alliance
Children and Young People
Digital and Data
Workforce
Planned Care
Urgent Care
Supports development of system strategy and outcomes; and oversees system delivery and improvement (with place-based partnerships)

Appendix One: Health and Social Care Integration: joining up care for people, places and populations.

The White Paper defines successful integration as the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives. It emphasises improving outcomes for the population as a whole and states everyone should receive *the right care, in the right place, at the right time.*

It sets out the ambition for better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care. Children's services are not in scope of the White Paper, but it does state that they can be included if all local partners agree.

It focuses on 4 areas:

- Shared outcomes
- Leadership, accountability, and finance
- Digital and data
- Workforce and carers

Integrated Care Systems have the freedom to set up their own local arrangements – so what is reported here as a model is only for guidance and is being developed and agreed locally.

Summary of key proposals that the Government has committed to:

The key proposals of the white paper are summarised below.

The Government will:

- consult stakeholders and set out a framework for shared outcomes with a concise number of national priorities and approach for developing additional local shared outcomes, by Spring 2023
- ensure implementation of shared outcomes will begin from April 2023
- on leadership, accountability, and oversight, set an expectation that by Spring 2023, all places should adopt a model of accountability and provide clear responsibilities for decision making including over how services should be shaped to best meet the needs of people in their local area.
- review section 75 of the 2006 Act which underpins pooled budgets, to simplify and update the regulations
- work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling
- publish guidance on the scope of pooled budgets in Spring 2023

- work with the Care Quality Commission (CQC) and others to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at place
- develop a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review
- publish a final version of the Data Strategy for Health and Care (Winter 2021/22)
- ensure every health and adult social care provider within an ICS reaches a minimum level of digital maturity
- ensure all professionals have access to a functionally single health and adult social care record for each citizen (by 2024) with work underway to put these in the hands of citizens to view and contribute to
- ensure each ICS will implement a population health platform with care coordination functionality, which uses joined up data to support planning, proactive population health management and precision public health (by 2025)
- develop a standards roadmap (2022) and co-designed suite of standards for adult social care (Autumn 2023)
- enable one million people to be supported by digitally enabled care at home (by 2022)
- on workforce, strengthen the role of workforce planning at ICS and place levels
- review barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level
- develop a national delegation framework of appropriate clinical interventions to be used in care settings
- increase the number of clinical practice placements in social care during training for other health professionals
- improve opportunities for cross-sector training and joint roles for adult social care and NHS staff in both regulated and unregulated roles

Key expectations in the White Paper include:

- Consulting with stakeholders to set out a framework with a defined set of national priorities and the approach for developing additional local shared outcomes, by Spring 2023, with expected implementation of shared outcomes from April 2023

- On place based leadership, accountability and oversight, an expectation that by April 2023, all places will adopt a model of accountability and provide clear responsibilities for decision making
- Working with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling of budgets (at system and place level) from spring 2023
- Working with the CQC to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at a place level
- Developing a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships
- Ensuring all professionals have access to a single health and adult social care record for each citizen (by 2024)
- Ensuring each ICS implements a population health platform with care coordination functionality, that uses joined up data to support planning, proactive population health management and precision public health by April 2025 (K&M current plans to have this in place by 2024)
- Developing a standard roadmap during 2022 and co-designed suite of standards for adult social care by autumn 2023
- Reviewing barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level
- Developing a national delegation framework of appropriate clinical interventions to be used in care setting

Appendix Two; *DRAFT – V5 (Final, pre-approval)*

Kent and Medway Integrated Care Partnership
Joint Committee

Terms of Reference

1. Introduction

1.1. In accordance with the powers set out under Section XXXX of the National Health Service Act 2006 (as amended), and the Local Government and Public Involvement in Health Act 2007, the following organisations have established an Integrated Care Partnership (ICP) Joint Committee:

1.1.1 Kent and Medway Integrated Care Board (ICB)

1.1.2 Kent County Council (KCC) and Medway Council, together known for the purposes of this terms of reference as the Local Authorities

1.2. The Integrated Care Partnership is established as a Joint Committee of the above parties, to whom they are accountable. The Joint Committee is authorised to act within these Terms of Reference, which set out the membership, remit, responsibilities, authority and reporting arrangements of the Joint Committee.

2. Principles

2.1. The ICP is founded, first and foremost, on the principle of equal partnership between the NHS and local government to work with and for the communities of Kent and Medway

2.2. The ICP plays a key role in nurturing the culture and behaviours of a system that works together to improve health and well-being for local people. In undertaking its work, the Joint Committee will respect the nine key partnership principles:

2.2.1. Come together under a distributed leadership model and commit to working together equally

2.2.2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate

2.2.3. Operate a collective model of accountability, where partners hold each other mutually accountable for their respective contributions to shared objectives within the remit of the Joint Committee

2.2.4. Agree arrangements for transparency and local accountability, including for example meeting in public with minutes and papers available online

2.2.5. Focus on improving outcomes for people, including improved health and

wellbeing and reduced health inequalities

2.2.6. Ensure co-production and inclusiveness throughout the Integrated Care System (ICS) is championed

2.2.7. Support the triple aim (improved population health, quality of care and cost control), the legal duty on statutory bodies to collaborate and the principle that decision-making should happen at a local level (including provider collaboratives) where that is the most appropriate approach

2.2.8. Draw on the experience and expertise of professional, clinical, political and community leaders

2.2.9. Create a learning system, sharing improvements across the system geography and with other parts of the country, crossing organisational and professional boundaries

2.3. In undertaking its work, the ICP will also ensure it continually champions the four purposes of an integrated care system as defined by NHS England:

2.3.1. To improve outcomes in population health and healthcare

2.3.2. To tackle inequalities in outcomes, experience and access

2.3.3. To enhance productivity and value for money

2.3.4. To help the NHS support broader social and economic development

3. Purpose

3.1. The purpose of the Joint Committee is:

3.1.1. To produce an Integrated Care Strategy, developed with respective system partners and stakeholders, which covers the needs of the whole population of Kent and Medway

3.1.2. To influence improvement in the wider determinants of health and broader social and economic development, in areas such as housing, climate, transport, sport and leisure, etc

3.1.3. In developing the strategy, this should include development of a plan to address the broad health and social care needs of the population within Kent and Medway

3.1.4. Aligned to the Integrated Care Strategy, to develop and agree a suite of corresponding outcome measures - based on robust data, intelligence, research and innovation - to improve the health and well-being of the population at large

3.1.5. To seek on-going assurance in delivery of the strategy and associated outcome measures and, where required, agree actions to secure this assurance

3.1.6. To support the bringing together of health and care partnerships and

coalitions with community partners which are well-situated to act on the wider determinants of health in the local area

3.2. The Joint Committee may from time to time have other responsibilities given to it by the Local Authorities and or the ICB, subject to compatibility with legislation and compliance with the decision making process of the relevant body.

4. Responsibilities:

4.1. The Joint Committee is expected to facilitate coordination on health and well-being issues that no one part of the system can address alone and instead requires action by all partners. These include, but are not limited to:

4.1.1. Helping people live more independent, healthier lives for longer;

4.1.2. Addressing inequalities in health and wellbeing outcomes, experiences and access to health services;

4.1.3. Improving the wider social determinants that drive these inequalities, including employment, housing, education and environment;

4.1.4. Improving the life chances and health outcomes of babies, children, and young people; and

4.1.5. Improving people's overall wellbeing and preventing ill-health

4.2. Members of the Joint Committee will engage with stakeholders at system, place, and community levels in order to achieve the remit of the ICP.

4.3. In achieving its role, the Joint Committee will:

4.3.1. Develop and oversee delivery of an Integrated Care Strategy and a suite of corresponding outcome measures, for improving health and wellbeing across Kent and Medway. The Joint Committee will recommend approval of the Strategy and outcome measures to the ICB and Local Authorities for approval.

4.3.2. Ensure the Integrated Care Strategy:

a. Is built bottom-up from population health management data and local assessments of need (including local authority joint strategic needs assessments), with a specific focus on reducing inequalities and improving population health
b. Considers communities that have or may have specific and or unique characteristics
c. Takes account of any local health and wellbeing strategies, prepared under section 116A of the Local Government and Public Involvement in Health Act 2007

d. Addresses those challenges that the health and care system cannot address alone, especially those that require a longer timeframe to deliver, such as tackling health inequalities and the underlying social determinants that drive poor health outcomes

e. Includes (as part of any mandatory requirements):

- integration strategies, for example, setting of a strategic direction and work plan for organisational, financial, clinical and informational forms of integration
- a joint workforce plan, including the NHS, local government, social care and VSCE workforce
- arrangements for any agreed pooled funding and Section 75 agreements[1]

f. is published and made widely available

g. is reviewed annually

4.3.3. Receive from local authority partners on an agreed basis, updated assessments of need and, on receipt, consider whether the current Integrated Care Strategy should be revised, based on the updated information

4.3.4. Take account of available clinical and social research, innovation, and best practice, drawing on the expertise of appropriate academia and other stakeholders

4.3.5. Align partner ambitions through convening and involving all stakeholders across health, social care and more widely across sectors, in developing strategy and action to improve health and wellbeing and wider socio-economic conditions for the Kent and Medway population

4.3.6. Bolster its understanding of need and expected outcomes, particularly for the most vulnerable and groups with the poorest health and well-being; through insights gained from engagement and collaboration with various sectors, for example the voluntary community and social enterprise (VCSE) sector, Healthwatch, the criminal justice system and service users

4.3.7. Produce, publish and annually review an engagement strategy that emphasises the work of the ICP and the key priorities and expected outcomes in the Integrated Care Strategy

4.3.8. As a Joint Committee between the ICB and Local Authorities, ensure intelligence is shared in a timely manner that enables the evolving needs of the local health and care services to be widely understood and opportunities for at scale collaboration, maximised

4.3.9. Receive information as is required to enable review and on-going assurance

[1] This may also include any other local funding and resourcing arrangements that may be agreed between the parties from time to time.

regarding delivery of the strategy and expected outcomes

4.3.10. Within the agreed levels of any delegated authority of the Joint Committee, agree appropriate action amongst partners to secure the required assurances

4.3.11. Undertake any other responsibilities that may be agreed by the Local Authorities and or the ICB

5. Delegated authority and cooperation

5.1. The Joint Committee is authorised by and accountable to Kent and Medway ICB, Kent County Council and Medway Council.

5.2. All partner members agree to co-operate with any reasonable request made by the Joint Committee to enable it to fulfil its responsibilities, insofar as respective partner member organisational governance arrangements allow..

5.3. In line with the requirements of the Health and Care Act 2022, the Joint Committee shall:

5.3.1. Develop an Integrated Care Strategy, and related outcome measures and assurance arrangements that cover the needs of the whole population. The Strategy and outcome measures will be recommended by the Joint Committee to the ICB and Local Authorities for formal approval through their individual governance arrangements

5.3.2. Request any information necessary from partner members to enable effective review and on-going assurance regarding delivery of the Integrated Care Strategy and associated outcome measures. All information requests between the partner members and with the Joint Committee will be managed in accordance with the relevant legislation and any partner sharing agreements in place

5.3.3. Agree actions amongst ICP partner members to secure the required assurances regarding delivery of the Integrated Care Strategy and outcomes, in so far as partner member schemes of delegation allow this

6. Membership, Chair and Leadership Team

6.1. Membership of the Joint Committee will be made up of elected, non-executive and clinical and professional members as follows:

6.1.1. Leader of KCC

6.1.2. Leader of Medway Council

6.1.3. Chair of the Kent and Medway ICB

6.1.4. Two additional Local Authority elected executive members from KCC, who hold an appropriate portfolio responsibility related to Joint Committee

business

6.1.5. Two additional Local Authority elected executive members from Medway Council, who hold an appropriate portfolio responsibility related to Joint Committee business

6.1.6. One additional ICB Non-Executive Director

6.1.7. An ICB Partner Member who can bring the perspective of primary care

6.1.8. The Chairs of the four Kent and Medway Health and Care Partnerships

6.1.9. An elected District Council representative from within the geographies of each of the four Kent and Medway Health and Care Partnerships

6.2. Members are not permitted to have deputies to represent them.

6.3. The Chair of the Joint Committee shall be either the Leader of Kent County Council or Medway Council and will be elected at the first meeting of the Joint Committee to serve as Chair for a two year period. The Chair will rotate every two years between the Local Authority leaders.

6.4. The Joint Committee shall have the following standing non-voting attendees (these shall be known as Participants):

6.4.1. Medway Council Chief Executive

6.4.2. Kent County Council Head of Paid Service, or nominated representative

6.4.3. Kent and Medway ICB Chief Executive

6.4.4. Kent and Medway Directors of Public Health

6.4.5. Kent and Medway ICB Medical Director

6.4.6. A representative from each of Kent Healthwatch and Medway Heathwatch

6.4.7. A representative from the Kent and Medway Voluntary, Community and Social Enterprise Steering Group

6.4.8. Kent and Medway Local Authority directors of adult and children's social care

6.4.9. A representative from Kent Integrated Care Alliance

6.4.10. A representative from the Kent, Surrey and Sussex Academic Health and Science Network

6.4.11. A representative from the Local Medical Committee

6.5. The Chair may call additional individuals to attend meetings to inform discussion. Attendees may present at Joint Committee meetings and contribute to discussions as invited by the Chair but are not allowed to participate in any vote.

6.6. The Chair may invite or allow individuals to attend meetings held in private as observers. Observers may not present or contribute to any discussion unless invited

by the Chair and may not vote.

6.7. To support the Chair and recognising the collective model of accountability, a Leadership Team comprising the two Local Authority leaders and the Chair of the ICB will be established to agree the forward plan (in discussion with partner members), meeting agendas, and other items of business relating to the Joint Committee.

6.8. In the event that the Joint Committee Chair is not available to chair the meeting (due to absence or a conflict of interest), the other Local Authority leader will preside over the matter(s) to be discussed. Where neither leader is available to preside, the ICB Chair will preside over matters.

7. Meetings and Voting

7.1. Meetings of the Joint Committee will be open to the public. The public and other Observers may be excluded from the meeting, whether for the whole or part of the proceedings, where the Joint Committee determines that discussion in public would be prejudicial to the public interest or the interests of ICB or Local Authorities by reason of:

7.1.1. The confidential nature of the business to be transacted

7.1.2. The matter being commercially sensitive or confidential

7.1.3. The matter being discussed is part of an on-going investigation

7.1.4. The matter to be discussed contains information about individual patients or other individuals which includes sensitive personal data

7.1.5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed

7.1.6. Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time

7.1.7. To allow the meeting to proceed without interruption, disruption and/or general disturbance

7.2. Meetings held in public will be referred to as Part 1 meetings. Meetings or parts of meetings held in private will be referred to as Part 2 meetings.

7.3. When the Chair of the Joint Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify. Where possible this will be agreed by the Leadership Team.

7.4. The aim of the Joint Committee will be to achieve consensus decision-making wherever possible. Where a formal vote is required each member of the Joint Committee shall have one vote. The Joint Committee shall reach decisions by a majority of members' present, subject always to the meeting being quorate. Where a majority vote is not achieved the proposal will not be passed. The Chair shall not

have a second or casting vote, where the vote is tied.

7.5. All Members, Participants and any other individuals involved in the discussions are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the partner member's relevant policy on standards and managing conflict of interests. Where the partner member does not have such a policy or policies, the ICB's policy on business standards and managing conflicts of interest shall apply.

8. Quorum

8.1. A quorum shall be nine voting members:

8.1.1. One of whom shall come from each of the two Local Authorities and one from the ICB

8.1.2. One of whom shall be from the Leadership Team

8.1.3. A minimum of two of the four health and care partnership areas shall be represented by their respective chair or district council representative

8.2. Whilst not part of the quorum, the Joint Committee shall endeavour to always have a public health representative in attendance, unless a conflict of interest precludes this.

8.3. At the discretion of the Chair, members who are not physically present at a Joint Committee meeting but are present through tele-conference or other acceptable media, shall be deemed to be present and count towards the quorum as appropriate.

8.4. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

9. Dispute resolution

9.1. Where a dispute or concern arises, this should be brought to the attention of the Chair. The matter will be discussed by the Leadership Team, who will agree a course of action by consensus, having sought appropriate advice where required and having due regard to the principles of the ICP set out in paragraph 2. Where a consensus cannot be reached, the matter will be referred to the Joint Committee for discussion.

10. Frequency and Notice of Meetings

10.1. The Joint Committee shall meet at least quarterly .

10.2. Notice of any Joint Committee meeting must indicate:

10.2.1. Its proposed date and time, which must be at least five (5) clear working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)

10.2.2. Where it is to take place

10.3. Notice of a Joint Committee meeting must be given to each member of the Joint Committee in writing. Failure to effectively serve notice on all members of the Joint Committee does not affect the validity of the meeting, or of any business conducted at it.

10.4. Where Joint Committee meetings are to be held in public the date, times and location of the meetings will be published in advance on the websites of KCC, Medway Council and the ICB. Other technological and communication media may also be used to maximise public awareness of the work of the ICP.

11. Policy and best practice

11.1. The Joint Committee is authorised by KCC, Medway Council and the ICB to instruct professional advisors and request the attendance of individuals and authorities from outside of the partner members with relevant experience and expertise if it considers this necessary for or expedient to the exercise its responsibilities.

11.2. The Joint Committee is authorised to obtain such information from partner members as is necessary and expedient to the fulfilment of its responsibilities and partner members will cooperate with any such reasonable request.

11.3. The Joint Committee is authorised to establish such sub-committees as the Joint Committee deems appropriate in order to assist the Joint Committee in discharging its responsibilities.

11.4. The Joint Committee will be conducted in accordance with the ICB policy on business standards, specifically:

11.4.1. There must be transparency and clear accountability of the Joint Committee.

11.4.2. The Joint Committee will hold a Register of Members Interests which will be presented to each meeting of the Joint Committee and available on the websites of the ICB and Local Authorities

11.4.3. Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the individual must withdraw from any discussion/voting until the matter(s) is concluded

11.5. The Joint Committee shall undertake a self-assessment of its effectiveness on an annual basis. This may be facilitated by independent advisors if the Joint Committee

considers this appropriate or necessary.

11.6. Members of the Joint Committee should aim to attend all scheduled meetings.

11.7. Joint Committee members, participants and other observers must maintain the highest standards of personal conduct and in this regard must comply with:

11.7.1. The laws of England

11.7.2. The Nolan Principles

11.7.3. Any additional regulations or codes of practice adopted by the Member's appointing body

12. Secretariat

12.1. The Leadership Team will agree the secretariat arrangements to the Joint Committee. The duties of the secretariat include but are not limited to:

12.1.1. Agreement of the agenda with the Chair together with the collation of connected papers;

12.1.2. Taking the minutes and keeping a record of matters arising and issues to be carried forward.

12.2. Before each Joint Committee meeting an agenda and papers will be sent to every Joint Committee member and where appropriate published on the the websites of KCC, Medway Council and the ICB, excluding any confidential information, no less than five (5) clear working days in advance of the meeting.

12.3. If a Joint Committee member wishes to include an item on the agenda, they must notify the Chair via the Joint Committee's Secretary no later than twenty (20) clear working days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to ten (10) clear working days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Chair.

12.4. A copy of the minutes of Joint Committee meetings will be presented to KCC, Medway Council and the ICB. These will be presented in the most appropriate way as determined by these organisations.

13. Confidentiality

13.1. Joint Committee meetings may in whole or in part be held in private as detailed at paragraph 7. Any papers relating to a private meeting will not be available for inspection by the press or the public. For any meeting or any part of a meeting held in private all attendees must treat the contents of the meeting, any discussion and decisions, and any relevant papers as confidential.

13.2. Decisions of the Joint Committee will be published by the Joint Committee except where these have been made in a private meeting. Where decisions have been

made in private a summary of the decision will be made public without any confidential information being disclosed.

14. Review of Terms of Reference

14.1. The terms of reference of the Joint Committee will be approved by the Local Authorities and the ICB and shall be reviewed by the parties annually.

Approved: xxxxx

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment

Item 8: CAMHS Tier 4 provision at Cygnet Hospital, Godden Green

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 7 July 2022

Subject: Learning from the closure of Cygnet Hospital, Godden Green

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

It provides background information which may prove useful to Members.

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

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1) Introduction

a) At its meeting on 24 November 2020, HOSC was notified that Cygnet Hospital, Godden Green, near Sevenoaks had closed following a serious incident which was under investigation by the service commissioner, NHS England.

b) It was agreed that a report on the closure be brought to HOSC once the investigation had concluded.

2) Background

a) Specialist in-patient provision for CAMHS (Tier 4) is commissioned by NHS England. The Chair of HOSC was notified on 26 October 2020 that two CAMHS wards at Cygnet Hospital in Godden Green near Sevenoaks had been closed. A recent Care Quality Commission (CQC) inspection had not provided assurance that the service met the standards expected or that the provider could implement and sustain the improvements required. Cygnet advised NHS England of its intention to close the two wards as a result of that inspection and the closure happened on Monday 26 October.

b) The small number of patients cared for on the CAMHS wards were transferred or discharged. Additional services provided at the Hospital were unaffected.

c) NHS England carried out an investigation into a serious incident that took place at Cygnet Hospital prior to its closure. The investigation has now concluded and HOSC has invited the commissioner to update the committee on its findings.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2020) *'Health Overview and Scrutiny Committee (24/11/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8498&Ver=4

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[Final]

Learning from The Closure of Cygnet Godden Green

Kent Health Overview and Scrutiny Committee

22 June 2022

Purpose:

This report provides a summary of the themes and areas for learning following the closure of the Cygnet Godden Green Child and Adolescent Mental Health Service (CAMHS) providing a General Adolescent Unit (GAU) in 2020. The intention of this report is to inform the Kent Health Overview & Scrutiny Committee (HOSC).

Background Context:

Cygnet Hospital Godden Green in Sevenoaks was an acute CAMHS service for young people aged between 12 and 18 years with mental health conditions and requiring inpatient care, provided over two wards, Knole (15 General Adolescent beds) and Riverhill (5 General Adolescent beds). The service was provided under the national contract standard specification for CAMHS Tier 4 services.

The service permanently closed in Autumn 2020, having worked on embedding continuous quality improvement plans alongside commissioners and system partners. However, following a rise in incidents and quality issues, with formal action from the Care Quality Commission (CQC) following an unannounced visit (Further information can be found here: CQC takes action at Kent mental health service | Care Quality Commission), Cygnet Healthcare took the decision to close this service permanently.
Following the closure, a review meeting was convened between NHSE/I commissioning, quality and contracting leads with Kent & Sussex CAMHS Provider Collaborative (as shadow commissioner at the time) to reflect on the impact of the closure and identify learning for the future.

An independent investigation was also commissioned by NHS England and the Kent & Sussex CAMHS Provider Collaborative, regarding a serious incident which followed the NHS National Serious Incident (SI) Framework. The investigation report published in March 2022, outlined recommendations which enable application for broader application to all CAMHS Tier 4 services alongside Cygnet Healthcare, which continues as a provider of these services for the NHS at locations elsewhere in the country.

The closure of Godden Green reduced the CAMHS T4 regional bed capacity from 204 to 184 beds. Currently there are 186 CAMHS T4 beds in the South East. More inpatient capacity to come on line 2022/23. Expanding Tier 4 capacity to include inpatient, day service, and alternatives to admission (hospital at home) – provider collaborative led, regionally driven. Continued CYP MH community and Tier 4 transformation and improvement programmes in line with NHS Long Term Plan deliverables.

Themes for Learning:

The following areas arising from both the review meeting and independent investigation describe specific areas for learning to improve the quality of specialist CAMHS services, with specific areas for action for Cygnet Healthcare as a continuing provider of these services.

Theme 1: Ensuring that risk assessment / mitigation and observation policies are embedded in daily practice.

The independent investigation highlighted the need to ensure that key policies on individual risk assessment and management, safe and supportive observation, safeguarding children and young people, incident reporting and management (including in particular, learning from incidents) are embedded in day to day practice and care of young people. This process of risk assessment and management is dynamic due to the often rapidly changing needs of young people and clears plans in place to mitigate risk should be both clearly documented and communicated to all staff involved to ensure safety plans are consistently translated into the care of each young person admitted to CAMHS Tier 4 services.

Theme 2: Ensuring that all staff working in CAMHS services are qualified, trained and skilled.

Learning from the independent investigation and the closure of Cygnet Godden Green identified a requirement to demonstrate that any person employed in the care of young people admitted to CAMHS, including locum and agency staff are qualified, trained and appropriately experienced and skilled for the specific role they are fulfilling and that training records are regularly updated and documented.

Theme 3: Service Closures and Repatriation Procedures

During the reflective meeting it was agreed that overall, the repatriation process of young people admitted to Cygnet Godden Green at the time of the service closure, generally went well. Preparatory visits were organised with exceptional packages of care implemented to support the young people transitioning to new placements. The views of young people were considered in their repatriation plans and communicated to stakeholders. Regular check in meetings were held with the provider to review the repatriation process and approach to support the young people impacted and their families.

Learning identified - What could have been better?

On service closure, the main aim and principles were to include the views of the young people impacted and their families in repatriation planning, ensuring they were engaged and supported throughout the process. It was recommended that as a minimum, 28 days would be a more appropriate timeframe for the closure of any CAMHS Tier 4 service. The timeframe for Godden Green was 14 days

As part of the closure procedure, a communications leadership group was implemented to ensure co-ordinated, timely communication with those involved, young people and their families in particular. A single point of contact to liaise with families was helpful to enable consistent messaging and avoid ambiguity at a challenging time. Establishing an accurate stakeholder list from the offset of significant service change or closure is critical, as well as agreed timescales for all forms of formal communications as well as approaches to keep young people and their families fulling informed.

Specific to the timing of the closure of Godden Green, it was found that COVID-19 restrictions in place at that time, hindered the process through the prohibition of face to face meeting and limiting attendance at the site in person to visit with the young people admitted to Knole and Riverhill wards.

Application of Learning identified:

Following engagement with local system partners who were closely involved in the unit's closure, including the provider Cygnet Healthcare, alongside formal consideration of the independent investigation report into a serious incident in accordance with the NHS SI Framework, the following application of learning has now taken place or has already commenced:

1) Robust safety and repatriation planning, with clear and timely communication strategy.

2) A national learning event convened by Cygnet Healthcare to share opportunities for learning across all service lines, including training and policy direction for safety and risk mitigation.

3) Planning for future CAMHS Tier 4 services for the children and young people of Kent.

Sussex Partnership NHS Foundation Trust (SPFT), as lead provider for the Kent & Sussex CAMHS Provider Collaborative have already initiated plans to mobilise a range of services including alternatives to admission and improvements to high dependency care areas in addition to quality improvements within existing services. Additional services include:

- 3 GAU beds at Kent and Medway Adolescent Hospital and 3 short stay beds. The short stay beds will allow for a seamless pathway from crisis to inpatient and discharge back to the home/community setting.
- An eating disorder day service based in Sussex.
- Plans to increase Psychiatric Intensive Care capacity that will be accessible to the population of Kent ICS and other regions from 2023/4.

Since October 2021, when SPFT took over commissioning responsibility for CAMHS Tier 4 service provision in Kent, the following improvements have been demonstrated:

- Reduced numbers of young people who live in Kent admitted to out of area placements (in line with the continued commitment to ensure inpatient mental health care is provided closer to home).

- Reduced rates of admission for children and young people in Kent, in line with the NHS Long-Term Plan ambitions for those with Learning Disabilities and Autism and plans to enable effective alternatives to inpatient admission where possible.

- Reduced average lengths of stay, showing a general improvement in relation to the timely discharge of young people to a home or community setting.

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Item 9: Work Programme 2022

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 7 July 2022

Subject: Work Programme 2022

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee.

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1. Introduction

a) The proposed Work Programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.

b) HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services, as well as the referral of issues by Healthwatch and other third parties.

c) The HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.

d) The HOSC is requested to consider and note the items within the proposed Work Programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2. Recommendation

The Health Overview and Scrutiny Committee is asked to consider and note the report.

Background Documents

None

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

6 October 2022		
Item	**Item background**	**Substantial Variation?**
Nurse recruitment	To receive information about the recruitment of nurses across the county. (This was a member request).	-
East Kent Maternity Services – outcome of the independent enquiry.	Following the discussion on 17 September 2020, Members requested the item return once the Kirkup report has been published (Families have been informed the report will probably be published on 21 September 2022).	-
Hyper Acute Stroke Units - implementation update	Following their discussion on 26 January 2022, Members asked to be kept informed on the implementation of the new stroke services.	No
Sexual Health Referral Centre: Kent	NHS England are looking to relocate the Maidstone site.	TBC

30 November 2022		
Item	**Item background**	**Substantial Variation?**
Stroke rehabilitation services in Maidstone	The Chair has requested a written report on the move of stroke rehabilitation services from Maidstone and Tunbridge Wells NHS Trust to Kent Community Health Foundation Trust (KCHFT)	-
Provision of Ophthalmology Services (Dartford, Gravesham and Swanley)	During their meeting on 21 July 2021, Members asked for an update on the effectiveness of the service changes be received at the appropriate time.	No

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Burns service review	To receive information about a review of burns services by NHS England Specialised Commissioning	TBC
Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview	To receive updates on the Trust's clinical strategy and determine on an individual basis if the workstreams constitute a substantial variation of service. The following items have been to the Committee and not deemed to be substantial: Cardiology Services, Digestive Diseases Unit.	TBC
Maidstone and Tunbridge Wells NHS Trust - Mortuary Security	To receive the Trust's reaction to Sir Jonathan Michael's report following its publication.	No
Transforming mental health and dementia services in Kent and Medway	To receive information about the various workstreams under this strategy.	TBC
Orthotic Services and Neurological Rehabilitation	To receive information on the provision of these services in Kent for adolescents. (This was a member request).	-
Urgent Care Review Programme - Swale	Following the meeting on 2 March 2022, the Chair invited future updates on the transformations and related public communications.	No

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

Kent and Medway Joint Health Overview and Scrutiny Committee NEXT MEETING: TBC		
Item	**Item Background**	**Substantial Variation?**
Transforming Health and Care in East Kent	Re-configuration of acute services in the East Kent area	Yes
Specialist vascular services	A new service for East Kent and Medway residents	Yes

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