

**Medway Council**  
**Meeting of Health and Adult Social Care Overview and**  
**Scrutiny Committee**

**Thursday, 15 December 2016**

**6.35pm to 9.00pm**

**Record of the meeting**

**Subject to approval as an accurate record at the next meeting of this committee**

**Present:** Councillors: Wildey (Chairman), Purdy (Vice-Chairman), Aldous, Franklin, Freshwater, Howard, Iles, Joy, McDonald, Murray, Osborne and Shaw

**Co-opted members without voting rights**

Paddy Powell (Healthwatch Medway CIC Representative)

**Substitutes:** Councillors: Osborne for Khan and Joy for Fearn.  
Mr Paddy Powell for Mr Dan Hill.

**In Attendance:** Ian Sutherland, Interim Director, Children and Adults Services  
Linda Jackson, Interim Assistant Director, Adult Care Services  
Ian Ayres, Accountable/Chief Officer, NHS West Kent Clinical Commissioning Group  
John Britt, Head of Adults' (25+) Partnership Commissioning and the Better Care Fund  
Michael Ridgwell, Programme Director for Kent and Medway Sustainability and Transformation Plan  
Phil Watts, Chief Finance Officer  
Kate Ako, Principal Lawyer – People  
Jon Pitt, Democratic Services Officer

**550 Apologies for absence**

Apologies were received from Councillor Naushabah Khan, with Councillor Tristan Osborne attending as substitute and from Councillor Matt Fearn, with Councillor Mark Joy attending as substitute. Apologies had also been received from Dan Hill of Healthwatch, with Paddy Powell attending as substitute and from Christine Baker of the Medway Pensioner's Forum. Councillor Aldous had advised that she would be late to the meeting.

**551 Record of meeting**

The record of the meeting held on 15 November 2016 was agreed and signed by the Chairman as correct.

**552 Urgent matters by reason of special circumstances**

There were none.

**553 Declarations of interests and whipping**

Disclosable pecuniary interests

There were none.

Other interests

There were none.

**554 Kent and Medway Patient Transport Services**

**Discussion**

The Accountable / Chief Officer for NHS West Kent Clinical Commissioning Group introduced the report. The new transport provider, G4S, had taken over the contract from NSL. The new contract commenced on 1 July 2016 and had followed a robust procurement process, which had considered lessons learned from the previous contract. Mobilisation on the first day of the new contract had gone well, with the call centre being able to meet the demand. The service required further improvement, but it was considered that the service at launch was already better than that provided by the previous contractor.

The target for patient pick up from hospital under the new contract was one hour, compared to three hours under the old contract. Performance standards were not yet being met but the quality of the service was improving each month. There had been initial difficulties in relation to the transport of renal patients. This had been addressed within the last month. There were still patients who were not being collected on time and some delays in discharge from hospital. Hospitals had more confidence in the service provided, with some starting to stand down their own ambulances as a result.

The relationships between hospital trusts and G4S were generally much better than they had been under the previous provider and complaint numbers had dropped month on month. No complaints from MPs had yet been received in relation to the new provider. Review of performance data had been built into the contract, with no significant issues having been identified during the review undertaken after three months of the new contract.

The Committee raised a number of points and questions as follows:

**Transport to London Hospitals:** In response to a Member question, the Accountable Officer advised that patient transport services had previously been commissioned by the London hospital trusts to collect patients from within Kent and Medway and take them to London hospitals. This was due to change so

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that the Kent and Medway transport provision would collect patients travelling to London hospitals. This was because the previous provision had been poor.

**Performance data and complaints:** A Member asked whether there was any performance data in relation to the new contract available for the Committee to review and what the nature was of complaints received so far. Complaints tended to focus on delays in being picked up or taken home. Three months of performance data was available but it would not be made publically available at this stage as it was considered that a longer time period was required to make analysis of the data meaningful. It was proposed that data would be released once six months worth was available. The Committee agreed that a written update on the performance data should be provided ahead of a possible update being presented to the Committee.

**Care Quality Commission Inspections** – The Accountable Officer advised that the Care Quality Commission would inspect the patient transport service at some point. It was not known when this would be, but it was likely that it would be at least one year into the new contract.

**Demographic Challenges:** A Member asked how the new contract, which was for a six year period, would be able to cope with the forecast increases in population, particularly amongst those aged over 65 and questioned what size of fleet would be provided under the contract. It was not possible to provide fleet size information at the meeting. The tender had not specified a number of vehicles that had to be provided, but it had accounted for projected population growth.

**Staffing and Joint Working:** In response to a question that asked what the reaction of staff had been to the new contract and whether there were plans to work with patient transport providers in other areas, there had been no concerns raised directly by staff or by trade unions. G4S had brought in a significant number of additional staff as well as staff having transferred from the previous provider. Engagement was due to take place with patient groups in the New Year to ascertain what patients thought of the new service. Engagement would continue throughout the contract. G4S provided other patient transport services but it was not considered that there would be synergies with these or with contracts delivered by other providers given the size of Kent and Medway and because of the geographies of transport routes.

**Contract Termination:** The Accountable Officer advised that the contract contained two ways in which it could be terminated. For a significant contract breach, termination could be immediate. Otherwise, either party could give 12 months notice. Performance metrics within the previous contract with NSL had not been as tightly defined as they needed to be. Due to this and the contract having only been for three years, it would only have been possible to terminate the contract around six months early. Performance management under the G4S contract was more stringent, which would enable, should the need arise, for a decision to be made sooner to terminate the contract.

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**Working relationship with G4S:** The Accountable Officer said that there had been transparency in the working relationship with G4S, with an open book relationship having been adopted. They had been responsive in dealing with issues.

**Bad weather contingency plans:** In response to a Member question about contingency plans, it was confirmed that the patient transport service had some specialist vehicles for bad weather and that contingency plans were linked to the cold weather plans of individual trusts. Use could be made of minicabs if necessary.

### Decision

The Committee considered and commented on the update provided and requested that a written update on the performance of G4S be circulated to the Committee in June 2017, once adequate performance data was available and that a further update may be requested at a Committee meeting following this.

## 555 Sustainability and Transformation Plan - Transforming Health and Social Care in Kent and Medway

### Discussion

The Programme Director for Kent and Medway Sustainability and Transformation Plan (STP) apologised that the Senior Responsible Officer for the STP, who was also the Chief Executive of Maidstone and Tunbridge Wells NHS Foundation Trust, had been unable to attend the meeting. The Programme Director then introduced the report.

Guidance that introduced the concept of Sustainability and Transformation Plans had been provided by NHS England on 22 December 2015. The guidance asked for the plans to do three key things. These were to look at health inequalities and how they could be reduced, to look at the quality and performance of local care organisations and to consider how the finances of health provision could be made sustainable. Partnership working would be key to the future effective delivery of services.

The Kent and Medway STP was proposing significant changes, including in relation to the quality agenda, especially given that a number of local health providers were currently in special measures.

Across Kent and Medway, there had been a £105million deficit in NHS funding at the end of 2015/16, with a deficit of around £125million across organisations providing health and social care. The STP was focused on four themes, which were care transformation, enablers of care, productivity and system leadership. Care transformation was about preventing ill health, intervening earlier and bringing care closer to home. Enablers of care included investing in estates, digital infrastructure and the workforce needed to underpin high-performing systems. Productivity included finding efficiencies in services, procurement and prescribing, while system leadership would see the development of the

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structures to deliver the other elements and would involve organisations coming together to deliver improvement. It was acknowledged that the reduction in costs for non-clinical areas, such as back office functions, were not as effective as they should be.

The Kent and Medway STP had been identified as one of four national pathfinders in relation to productivity. These were looking at how resources available for frontline care could be maximised.

There were four sub-themes within the Care Transformation theme. The most significant of these was local care. This was about the provision of appropriate care in the community, close to the patient's home. There were a number of hospital patients in Kent and Medway who were not best served by being in an acute hospital bed. Work had been undertaken in relation to patients, particularly elderly patients, who did not have a clinical need to be in hospital and investigating alternatives to support patient need.

The ability for investment to be made in local care was limited. The aim was to be able to prioritise money being spent on local care by reducing the reliance on acute provision. Current acute provision was quite thinly spread in some areas. One example was stroke care, with all seven acute hospitals in Kent currently providing this. A more effective and efficient service could be delivered through the provision of specialist services at fewer sites. The same was also true for vascular provision, with it having been identified that focusing service delivery on fewer sites led to reduced mortality. There needed to be a separation of planned and un-planned emergency care as planned care was put at risk by the need to prioritise emergency patients arriving at hospital.

Mental health was a key theme within the STP. The aim was to end the distinction between mental and physical health. The prevention agenda was also key. Refocusing efforts on reducing ill health and promoting prevention would realise benefits to health and social care and to wider society.

A robust programme approach was in place to deliver the STP. Engagement with Medway Council had been positive. The next key step on the critical path was to develop a case for change that would go into detail about why change was necessary. This document would be published at the end of January and it was suggested that this was presented to the Committee.

The Committee raised a number of points and questions as follows:

**Appropriate Care:** In response to a Member question that asked what was meant by appropriate care, the Programme Director advised that individuals with multiple underlying health problems, who were often elderly, were often admitted to acute hospital beds because of a lack of alternative. This could have a detrimental effect on them, resulting in loss of ability to maintain their independence. Appropriate care would be care that did not result in loss of independence. The STP was a high level document which would require the development of workstreams to identify what appropriate care would look like.

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What would be appropriate care varied from person to person. The Member said that there was little mention of care homes within the STP. She considered that more care homes and competition would result in prices falling and questioned whether the personal care provided in a home could be part of the package provided to people in their own home. The Programme Director said that there was a need to ensure that care standards were met regardless of the setting. Providers would be held to account to deliver these standards.

**Engagement:** The Healthwatch Medway representative advised that the organisation had recently been invited to be part of the Communications and Engagement Group and that Healthwatch Medway would be publishing the STP on its website. It was advised that a review of governance of the STP had been undertaken and that engagement would increase. A Partnership Board and a Patient and Participant Advisory Group would be established and a meeting was due to take place with Healthwatch the next week to discuss engagement further.

**Financial Challenge:** A Member highlighted that there was a £486 million financial challenge facing Kent and Medway if no action was taken and that the plan was to close this to £29 million by 2021, a saving of £427 million. She considered that the proposed changes were not driven wholly or partly by the idea that local care was a good thing. They were instead, due to the extremely challenging financial situation facing the NHS, due to underfunding and the failure to face this. The right to increase Council Tax to fund social care that had been announced by the Government was too little and would not address the funding shortfall. Another Member questioned why they should have confidence in the ability of those responsible for the STP being successful when there was already a funding shortfall of £106 million. He also queried apparent discrepancies in some of the figures within the STP documents.

The Programme Director recognised that nationally, resources were limited and there was a need to make the best use possible of what was available. The financial gap of £486 million was a projection of how the existing budget gap would escalate if no action was taken, based upon forecast demand. There was, therefore, no choice but to look at the model of care and to deliver a strategic plan that enabled provision of high quality care and for this to be sustainable. Plan delivery was not, however, all about financial considerations. In particular, ensuring the best care setting was important.

A Member requested that details of the current health and social care budget for Kent and Medway be provided, along with details of the expected 2020/21 budget. The health and care budget for the current financial year was noted to be approximately £3 billion. Adding in expected increases, it would be around £3.4 billion. It was requested that these figures be included in STP documents and that clarification of the budget figures be circulated to the Committee. It was noted that ability to manage demand was restricted by the fact that healthcare was an open access service where it was not possible to precisely predict patient numbers.

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**General Concerns in relation to the STP:** A Member considered that the four key areas within the STP were adequate but that they would not be meaningful to the general public. The STP highlighted the importance of partnership working but the Member questioned what was actually changing in this area. She considered that the changes proposed by the STP would cause a significant clinical shock. One example of these changes included the aim to limit persons over 70 to a maximum of 10 days in hospital. There had previously been attempts to share patient records across Kent and Medway. These had been unsuccessful and costly, so the Member questioned how this would be delivered in the future. The idea of social prescribing was sound but the Member questioned whether services had the capacity for this to be provided. Overall, the Member was extremely concerned and wanted more reassurance and a look at the STP in more detail to give her confidence that changes being proposed could be delivered.

In response, the Programme Director advised that the document presented to the Committee was the summary that had been submitted to NHS England and that consultation would be undertaken. A more accessible summary document had also been published. The aim for there to be zero use of private beds was in relation to mental health patients. The latest available figure showed this had reduced to 23 in Kent and Medway, although another Member was concerned that this reduction could be partly due to people waiting in hospital and leaving again without receiving treatment or being admitted, due to waiting times. There had been a significant decrease in the number of mental health patients in out-of-area beds. The reduction in out-of-county mental health bed placements was a structured programme to bring individuals back on a case by case basis. The reductions experienced were planned reductions attributed to this programme.

The STP would consider how organisations could work collectively in the most effective way. It was recognised that existing infrastructure had not always supported this. The STP was about enshrining new ways of working. The Programme Director was impressed at how organisations were coming together to deal with the challenges that they faced.

**Mental health and engagement:** A Member was concerned that the aims stated in relation to mental health could not be achieved and considered that mental health provision was at crisis point in Medway. Unless there was intensive engagement with mental health providers, there would not be a clear picture of the challenges faced. There were seven layers of engagement within the STP oversight groups, which seemed rather a lot to the Member. On the other hand, there appeared to be a lack of voluntary sector representation and it was disappointing that engagement with Healthwatch Medway appeared to have only recently started. Engagement should also include the Police. The Member was also concerned about the complexity of the wording used in the STP documents, which would make it hard to engage people with the proposals. Several Members were concerned that there was not enough focus on mental health within the STP, especially given that one in four people would suffer some form of mental health issue in any year. A Member noted that the need for local mental health provision was based upon provision being provided within 15 miles of the patient's home. However, there was no acute mental

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health inpatient provision within 15 miles of a significant number of the Medway population. The Member acknowledged that this situation was improving.

The Programme Director said that there would be support from communications and engagement colleagues. Engagement with the Police would take place via the Partnership Board that was due to be established. Engagement also took place via the Kent Chief's meeting, which the Police were members of. There would be a focus on how to engage with the voluntary sector. He acknowledged the concerns around mental health in Medway. There had been a debate about whether mental health should be included within the STP as a separate section, as this could be seen as mental health being something independent of physical conditions. However, the danger of this was that there would not be enough emphasis on mental health. It had, therefore, been included as a separate workstream within the STP. With regards to prevention, individuals would be supported to manage their mental health needs. The definition of what amounted to local provision would need to be considered further. The key to addressing mental health difficulties was in individuals being able to access high quality local provision. Mental health provision needed to be embedded with physical health. A Communications and Engagement Plan was under development.

**Social Prescribing:** Social prescribing was nothing new and a Member welcomed it. However, its success would require GPs to be properly engaged with it. The Programme Director acknowledged that arrangements would need to be put into place that would facilitate social prescribing.

**Demographic Challenges:** The significant forecast increases in the number of over 65's and over 85's during the next five years in Kent and Medway were highlighted by a Member. This would lead to a large increase in demand for health and social care provision. He considered that it was not clear from STP proposals how this increase would be accommodated, especially given the challenges already facing health provision. The increase in the total population would also need to be factored into plans. It was questioned what the current ratio of frontline to back office staff was and how this would need to change to cope with service demand. Another Member asked what use of population data was made in health planning.

The Programme Director advised that a key reason for the focus on local care was the demographic challenge. There were limited resources available so the challenge could not be met simply by spending more. Even if more funding was available, workforce challenges would remain as there were not enough GPs and other health professionals available to be recruited. There also was not the capital available to build new hospitals. System redesign was required to make the best use of the available workforce. The best way of doing this was to focus on the local care model and to create multi-disciplinary care delivery to make provision more robust. In relation to population projections, Office of National Statistics forecasts were utilised. In order to provide a greater degree of accuracy, other sources were utilised, such as public health and local authority figures.



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**Successful Delivery of STP:** A Member said that healthcare was arguably the most important service in the country and felt that the comments previously made by another Member in relation to underfunding of the NHS was somewhat of a political point. Overall, he considered the STP to be a good plan with a lot of points contained within it. The Member asked how confident, on a scale of 1 to 10, the Programme Director was that the STP would be successfully delivered. The Director said that there was no option but to change and was confident that the changes would be delivered.

**STP Priorities:** A Member asked whether there should be emphasis on the Stroke Services and Vascular Services review within the STP as these had already been taking place prior to the commencement of the STP process. The Member also noted that falling GP numbers had been a concern for many years and that this should be made a priority within the STP. The Programme Director said that there would be a need for a joint strategic health plan to be developed even if the STP had not been mandated by national guidance. It was for this reason that the STP included plans and focus areas that had already been under development. GP numbers were an ongoing challenge, with there not being enough new GPs. This would take time to address. The Programme Director suggested that Kent and Medway needed to be made more attractive as a place for doctors to work. The establishment of a medical school in Kent and Medway could help to address these challenges.

**Long Term Planning:** A Member asked how STP planning was being linked to longer term plans for the area. The Committee was informed that although the national STP guidance specified that the Plan should cover a five year period, longer term planning considerations were factored into the STP locally. This had included close working with colleagues at Medway Council.

**Comments by Interim Director of Children and Adult Services:** It was considered that industrialisation of preventative measures was required. While there would be growth in demand due to an increasing number of older adults, there were also growing pressures due to preventable conditions in younger adults, such as the misuse of alcohol. Improvements to integrated working with healthcare were already being made before the start of the STP process. There would be a need to map health and care resources around integrated hubs to enable primary care to utilise the resources more effectively. In relation to mental health, there were growing concerns. A successful workshop had taken place in relation to an Integrated Mental Health Strategy. It was suggested that further information about this work with Kent and Medway NHS and Social Care Partnership Trust and NHS Medway Clinical Commissioning Group (CCG) should be presented to the Committee in the New Year. In relation to the joining together of IT systems for Kent and Medway, there was not enthusiasm for this due to the difficulties previously encountered. The CCG had been allocated some money from the Estates and Technology Investment fund to look at the procurement of software that would enable existing systems to interface with each other.

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The Committee agreed that Medway hospital was important for Medway and that it must be retained and not downgraded.

### **Decision**

The Committee noted the draft Kent and Medway Health and Social Care Sustainability and Transformation Plan, the progress made to date and provided comments on the Plan, with it being agreed that an update would be presented to the Committee at the March 2017 meeting.

### **556 Technology Enabled Care Services (TECS)**

#### **Discussion**

The Head of Adults' (25+) Partnership Commissioning and the Better Care Fund introduced the report. This provided an overview of current work, the activity that would soon commence and some of the longer term plans in relation to Technology Enabled Care Services (TECS).

TECS were an enabler within the Sustainable Transformation Plan. The services were currently being used by around 1,500 private patients, 1,000 of whom were supported through Adult Social Care, as well as a further 1,500 people in other types of accommodation. These services were supporting people to be cared for at home rather than in hospital, which was generally the preference of patients. Telecare enabled health and social care services to engage with people remotely through the provision of real time patient information. Patients were enabled stay in their home longer through the management of long term chronic conditions.

A trial was currently running in Medway, which used a smartphone and other equipment to enable a community nurse to log in and get real time patient information. This could be used to determine whether a visit was necessary, thereby giving the practitioner more time to visit patients who needed this the most. The system also enabled GPs to receive an electronic discharge notification when a patient was discharged from hospital.

There had also been some roll out of preventative services, such as a community Geriatrician initiative. This practitioner, based in a practice in Gillingham, had gone through all the records of frail and elderly people and called them in for an in-depth needs assessment at the surgery. Couples would be seen together. The geriatrician was able to access records, including details of hospital admissions. A further trial was due to take place in the New Year.

Medway NHS Clinical Commissioning Group had invested in software that enabled existing software systems to interact with each other and to facilitate the sharing of information between healthcare professionals working for different organisations.

The Committee raised a number of points and questions as follows:

**Shared software systems and financial savings associated with telecare provision:** In response to a Member who asked why shared information systems were only now being developed when other industries had used such systems for years and how it could be known whether savings would be made through the use of telecare when this had not been accurately tested in Medway, The Head of Adults' (25+) Partnership Commissioning and the Better Care Fund advised that such systems had not been developed sooner due to information governance considerations. Health services had been provided on the basis that information would only be shared with other parties where patients had explicitly given their consent. The sharing of patient information was extremely sensitive, with there still being significant hurdles to overcome. The establishment of systems that could interact with each other and which share only the information that the patient had given permission to be shared would take time. In relation to savings, it was widely accepted that savings could be realised if remote contact with patients was increased and if systems could be linked together to reduce duplication. The Interim Assistant Director of Adult Care Services said that trials across the UK had shown that remote monitoring of patients enabled intervention to take place sooner. This would also reduce costs.

**Telecare costs, patient care and data security:** In response to a Member question about the cost of telecare, whether there was a risk that some patient problems would be missed and data security, The Head of Adults' (25+) Partnership Commissioning and the Better Care Fund stated that a basic telecare package cost a private subscriber £6 per week. The Council was responsible for this provision, which was provided by Medway Commercial Group. Patients receiving telecare as part of a Home First care package had the cost paid by the Council for six weeks. If the patient opted to keep it after an initial six week period, they would generally then pay this cost themselves. Where telecare was provided as part of continuing healthcare, this would be paid on their behalf. A variety of additional options were available, therefore, the cost to the individual could be higher. A balance needed to be achieved between the risk of reducing contact with patients and there being an increased risk of something going wrong due to the number of people involved. The system being created would ensure that each professional involved in a person's care had a complete picture of it. In relation to information security, the NHS had stringent information governance protocols. The security of a closed system had to be balanced with the need for timely information to be available to those delivering the care.

**Risks associated with telecare:** A Member expressed concern that there was the potential for there to be serious failings in care when this was being provided remotely and wanted reassurance that the associated risks were fully understood. Remote provision and reduced personal visits could also increase loneliness. She considered that telecare should be used where it best suited an individual's particular set of circumstances and not just because it was cheaper than other types of care provision. The Member also questioned what sort of training and checks had been made of the frontline staff providing services. The report author advised that telecare was put in as an enabler, rather than as a substitute. It provided assurance that a vulnerable person was being monitored

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24 hours a day. It often was the case that an individual would not require or want a carer to be with them constantly and remote monitoring could help to facilitate this. Medway Commercial Group worked alongside domiciliary care providers, educating them about the operation of telecare. Staff would have received appropriate training and background checks. The officer offered to find out precisely what checks were subject to.

### **Decision**

The Committee noted and commented on the report provided.

## **557 Council Plan Quarter 2 - 2016/17 Performance Monitoring Report**

### **Discussion**

The Interim Assistant Director of Adult Care Services introduced the Council Plan Quarter 2 2016/17 Performance Monitoring Report. Medway was the third best performing local authority in the South East for Delayed Transfers of Care. Work undertaken to support healthy weight was highlighted. The Cabinet Member for Adult Services, Councillor Brake, had chaired the third annual Healthy Weight Summit in September 2016. This had brought together a number of partners and initiatives. Tackling obesity was particularly important because it contributed to a number of long term health conditions.

Activities taking place within Medway had been highlighted within two Local Government Association (LGA) publications in the last 12 months. There were a number of initiatives aimed at reducing social isolation. These initiatives featured joint working with partners, such as Kent Fire and Rescue. One initiative was 'Men in Sheds'. This was contributing significantly to reducing social isolation and supporting the mental health of men participating in the scheme. Public Health was participating in a South East Public Health England Social Isolation Action Learning Set.

An update was due to be provided to the Committee in January in relation to the Adult Social Care Strategy. Work was being undertaken to improve the performance of Adult Social Care and to make required efficiency savings over the next three years.

### **Decision**

The Committee considered quarter 2 2016/17 performance against the Key measures of success used to monitor progress against the Council Plan 2016/17.

## **558 Draft Capital and Revenue Budget 2017/18**

### **Discussion**

The Chief Finance Officer introduced the report on progress towards setting the Council's draft revenue and capital budgets for 2017/18. On 27 September, the

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Council's Medium Term Financial Plan (MTFP) had been approved by Cabinet. The Plan had identified an £11.7 million deficit in the Council's budget for 2017/18. On 22 November, a draft budget had been presented to Cabinet. By this stage, the gap had been reduced to £7.8 million due to work undertaken.

The budget was in the process of being submitted to the Council's four scrutiny committees for comment prior to Cabinet presenting the budget to Council on 23 February 2017. Savings being proposed in Children and Adult Services were through the renegotiation of contracts with service providers, service user pathway redesign, improvement in reablement outcomes and review and recommissioning of a range of services. The Committee was invited to review the draft budget presented to it and to provide any comments.

A Member reiterated concerns raised at the Business Support Overview and Scrutiny Committee on 1 December that the budget proposals presented showed the budgetary gap and outlined proposed savings, but did not provide any detail. It was, therefore, not possible for the Committee to scrutinise the proposals effectively. Details of how the budgetary gap would be closed should have been provided. The Member considered that this omission was unacceptable and noted that it was the fifth year running that concerns had been raised. She advised that the Business Support Overview and Scrutiny Committee had agreed a recommendation to Cabinet that additional information should be provided, in future years, to Overview and Scrutiny Committees to enable them to review proposals.

The Member agreed with the proposal set out in the report that improvement in reablement could result in savings being made, but did not think that further savings could be made in relation to care homes.

In response to a Member question, the Chief Finance Officer advised that a 1% increase in Council Tax equated to £900,000 of revenue.

### **Decision**

The Committee:

- a) Noted that Cabinet had instructed officers to continue to work with Portfolio Holders in formulating robust proposals to balance the budget for 2017/18 and beyond.
- b) Commented on the proposals outlined in the draft capital and revenue budgets in so far as they related to the services within the remit of the Committee and provided comments to be fed back to the Business Support overview and scrutiny committee in January.

**559 Work programme**

**Discussion**

The Democratic Services Officer introduced the Work Programme report, which advised Members of the current work programme in light of the latest priorities, issues and circumstances.

The Committee was advised that the Adult Social Care Improvement item would be considered at its January 2017 meeting and that the Annual Public Health report had been deferred until a future meeting.

At its last meeting, the Committee had agreed two recommendations to Cabinet. One of these related to the impact of falling GP numbers, while the other was in relation to the provision of Street Triage services. These recommendations were due to be presented to Cabinet on 17 January 2017.

The Dementia Task Group had held its final meeting on 8 December 2016. It was anticipated that the Task Group's draft report would be presented to the Committee in March 2017. The report would also be considered by the Health and Wellbeing Board and by the Regeneration, Culture and Environment Overview and Scrutiny Committee ahead of being submitted to Cabinet.

A meeting of The Joint Kent and Medway Health Overview and Scrutiny Committee had taken place on 28 November. This received updates on the Kent and Medway Hyper Acute and Acute Stroke Services Review and the Kent and Medway Specialist Vascular Services Review. Further updates were due to be presented to the Committee in Spring and June 2017 respectively.

A meeting of the South East Regional Health Overview and Scrutiny (HOSC) Network had taken place on 18 November 2016. The meeting received updates on the Kent and Medway Sustainability and Transformation Plan and on the establishment of a sub-group to scrutinise South East Coast Ambulance's (SECAmb) improvement journey. The first meeting of this group was due to take place on 20 December with minutes and actions being reported back to each Council's health scrutiny committee.

**Decision**

The Committee:

- a) Noted the current work programme attached as appendix 1 of the report.
- b) Agreed the suggested additions and changes to the Committee's Work Programme, as set out in paragraph 3 of the report.
- c) Agreed that an update on mental health and the development of a Mental Health Strategy be added to the Work Programme for March 2016.

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2016**

**Chairman**

**Date:**

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