KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 7 March 2014.

PRESENT: Mr R E Brookbank (Chairman), Mrs A D Allen, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr C R Pearman, Cllr P Beresford, Cllr M Lyons, Mr J N Wedgbury (Substitute) (Substitute for Mr M J Angell), Mrs M Elenor (Substitute) (Substitute for Mr R A Latchford, OBE) and Cllr R Davison (Substitute) (Substitute for Ms S Spence)

ALSO PRESENT: Mr S Inett (Healthwatch Kent) and Cllr Mrs A Blackmore

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Ms D Fitch (Democratic Services Manager (Council))

UNRESTRICTED ITEMS

21. Declarations of Interest

(1) Mr Nick Chard declared a Disclosable Pecuniary Interest as a Non-Executive Director of Healthwatch Kent.

(2) Councillor Michael Lyons declared an other significant interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

(3) Mr Adrian Crowther declared an interest as a Governor of Medway NHS Foundation Trust.

22. Minutes

(Item 3)

(1) Mr Nick Chard requested that the Minutes be amended to reflect the fact he declared a personal interest in the Agenda as a Non-Executive Director of Healthwatch Kent at the meeting.

(2) Dr Mike Eddy requested that the Minutes be amended to reflect the fact that Mr Angell declared a personal interest, rather than a personnel interest, at the meeting.

(3) RESOLVED that, subject to these changes being made, the Minutes of the Meeting held on 31 January 2014 are correctly recorded and that they be signed by the Chairman.

23. Membership

(Item 4)

(1) The Committee noted that Mr Crowther had replaced Mr Burgess as a UKIP representative and group spokesperson on this Committee.

24. Musculoskeletal and Orthopaedic Care Pathways

(Item 5)

Sean Crilley (Head of Planned Care Commissioning, NHS Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs) and Karen Benbow (Chief Operating Officer, NHS South Kent Coast CCG) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The guests explained that they had been invited to update the Committee on the work of Musculoskeletal Services in East Kent. They had provided a paper which responded to questions raised by Members at January's meeting.

(2) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A number of Members enquired about alternative therapies. It was explained that osteopathy and chiropractics were not commissioned as part of the service in East Kent. The treatment criteria were based on clinical effectiveness which excluded many alternative therapies. The commissioning of alternative therapies may be considered by the CCG in the future.

(3) Acupuncture was only available through Community Orthopaedics which was permitted under NICE guidance. The review into Community Orthopaedics has been completed; the redesigned service will be implemented from 1 May 2014. The new service will enable direct GP referral rather than an assessment by the Community Orthopaedics team.

(4) Mr Crilley apologised for the data error in the previous report regarding the number of primary care referrals. The service was reviewing and developing corrective action for the next financial year.

(5) RESOLVED that the guests be thanked for their attendance and contributions today, and they be requested to take on board the comments made by Members during the meeting particularly with regards to alternative therapies and the Committee looks forward to receiving further updates in the future at the appropriate time within the next twelve months.

25. Medway NHS Foundation Trust: Update

(Item 6)

Dr Phil Barnes (Medical Director, Medway NHS Foundation Trust) and Mark Morgan (Interim Director of Operations, Medway NHS Foundation Trust) Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale

CCG), Dr Fiona Armstrong (Clinical Chair, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The representatives from Medway NHS Foundation Trust began by updating the Committee on the four main issues at the Trust: Quality Improvement Plan, Transforming Medway Programme, CQC regulatory action and Governance.

(2) The Quality Improvement Plan was produced to deliver the six recommendations arising from the Keogh Review in July 2013. Under the six recommendations 50 targets were produced; 90% of these had been completed or on track to be finished by the end of March. There was an emerging view that whilst the Trust would deliver the Quality Improvement Plan, the plan may not deliver a high quality acute hospital. There was a need for strategic focus to examine and deliver the Keogh, Francis and Berwick Reports; Urgent & Emergency Care Review and operational pressures.

(3) A new strategy, Transforming Medway, had been developed by the new executive team, following the decision not to proceed with the merger with Darent Valley Hospital. The strategy had the broad support of stakeholders and regulators. The strategy focused on seven high priority and high impact projects. The absolute priorities for the strategy were to improve the Emergency Care Pathway and to provide an excellent patient experience.

(4) To improve the Emergency Care Pathway, the Trust planned to create a single acute admissions area. Hospitals nationally had found that emergency care delivered in one area had improved the flow of patients, reduced length of stay, improved quality and mortality rates. At present, the acute medical unit in the Emergency Department had only sixteen bed spaces rather than the 65 – 75 beds required; other areas of the hospital were frequently opened up for acute admissions. The Trust was also piloting seven day services, recruiting staff and re-designing medical rotas to ensure senior doctors were at the front end of the patient pathway.

(5) To improve the patient experience, customer service issues such as car parking, appointment letters and the physical environment were being investigated to ensure a good healing experience for the patient; in addition to the concerns regarding quality and mortality rates.

(6) In regards to CQC regulatory action, Maternity Services provided by the Trust were inspected unannounced in August 2013. A number of significant issues were raised in the CQC report; the most pressing being staffing levels. A compliance notice was issued by the CQC which was met by the December deadline; the Trust now met the best practice levels of staffing. Maternity Services had not been revisited by the CQC but will be the focus, alongside the emergency department, of a forthcoming major inspection by the Chief Inspector of Hospitals.

(7) An unannounced inspection of the Trust's emergency department was carried out by the CQC on 31 December 2013. New Year's Eve had been one of the busiest nights for A&E in recent years and the Trust had requested a divert, as

the department had been so busy, but this had not been possible to be put in place. The inspection found significant breaches in infection control and cleanliness. The Trust accepted the findings in full and agreed an action plan with the CQC which were implemented by 28 February 2014.

(8) The emergency department was treating upwards of 90,000 patients a year in a building designed for 50,000 patients. The A&E department at Queen's Hospital in Romford was facing a similar challenge. Local media reported that Medway NHS Foundation Trust was the most challenged and worst performing in regards to length of A&E wait in January. An Executive Director of the Trust was physically on-site seven days a week; a significant amount of work had been undertaken to support the A&E department. For the last four weeks, the Trust had been running in internal incident mode with a tactical command team to improve emergency patient flow. By the end of March, the Trust was hoping to meet the 95% target of patients seen within four hours; last week's performance was 93.7%. Performance targets relating to infection control and elective surgery in non-emergency departments had been met.

(9) Increasing staff levels had come at a significant cost. The Trust had initially forecasted a small deficit (£1.2 million) for the year 2013/14; the cost of additional staffing has increased the projected deficit to £7.9 million by the end of the financial year. Improvements in quality and the use of new pathways could reduce future costs.

(10) The governance of the Trust had recently changed with the appointments of interim Chief Executive, Nigel Beverley and interim Chairman, Christopher Langley. Nigel Beverley was an experienced Chief Executive who was previously interim Chief Executive at Ipswich Hospital NHS Trust. Christopher Langley was an experienced Chairman who had helped turnaround two Foundation Trusts: Heatherwood and Wrexham Park Hospitals NHS Foundation Trust and Rotherham NHS Foundation Trust. Apologies were given on behalf of the interim Chairman and interim Chief Executive who were unable to attend this item on the Committee's agenda.

(11) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about the sudden escalation of A&E attendances. Trust representatives explained that a significant increase had taken place in the last 10 -11 years across all Trusts. One of the issues for the Trust was that the emergency department was seen, both by users and members of staff in the hospital, as the place people should go. Improvements need to be made internally to ensure patients who require medical assessment, go to a medical assessment unit rather than the emergency department. For the public, the emergency department was a place known to provide 24/7 care.

(12) The Trust was looking at the whole of the urgent care pathway with Swale and Medway CCGs. There had been early discussions about an urgent care centre – a new build which would provide additional capacity. Patients would initially be seen by a specialist nurse or GP who would direct the patient to the most appropriate service. The Trust recognises that it was not in the best interest of the patient to be hospitalised; better joined up working would enable the delivery of services at home.

(13) In response to a specific question about seven day services; it was explained that Medway NHS Foundation Trust was selected to be one of thirteen Trusts to gain pilot status for seven day services. The Trust was developing plans and staff models to deliver seven day services focused on quality. Members expressed concerns that seven day services could place additional stress on the system.

(14) A Member expressed concern about the exclusion of finance as a key theme in the Quality Improvement Plan (QIP). It was explained that the QIP was developed with the regulator before the new management structure was in place; finance was not chosen to be one of the key themes of the plan. The additional transitional and on-going costs (£6 million) resulting from the Keogh Review correlated to the increased projected deficit from £1.2 million to £7.9 million. Following the Keogh Review, there was now an understanding across Trusts nationally that staffing levels should not be reduced to balance the budget; other efficiencies needed to be identified. Different forms of reorganisation were being investigated including vertically integrating community and social care services to deliver healthcare savings. There was also a national challenge to deliver and share services across larger areas to make them more sustainable.

(15) A further question on the provision of shared services was asked. The Trust has been in discussion with the CCGs about developing shared services; building on the cancer and vascular services provided in Medway to patients from Maidstone and Tunbridge Wells and parts of Dartford and Gravesham.

(16) A series of questions were asked about the leadership of the Trust. The new Chairman and Chief Executive had introduced a new management structure. Senior doctors were now responsible for the four business units focusing on three main areas: planned care, unscheduled care and cancer services. One of the immediate changes in the last month was that senior leaders had been requested to work across the whole organisation. An example was given; the Division Director for Surgery traditionally focused on planned care but was now additionally looking at the provision and delivery of unplanned care.

(17) A new team had been set up with the CCG, the Integrated Discharge Team, which had brought together health and social care teams to support the discharge of patients over the winter period. 20% of patients required additional support at home after being discharged. Different services had been working much more cohesively to deliver a better patient experience.

(18) A number of questions were asked about complaints, morale and winter pressure. It was explained that there were two key areas for complaints in Medway: communications and clinical care. There was a peak of complaints in January, when the hospital was at its busiest, many relating to the emergency department. The change of leadership had not been the only issue to affect morale. Scrutiny of the Trust has affected morale on the floor and in the boardroom. The absolute number of patients in A&E has not been as great as in previous years. However it has still been a busy winter with the acuity of patients being greater than normal.

(19) A series of further questions were asked about the upgrade to the Medway Emergency Village and triage. It was explained that the plan for the implementing the Medway Emergency Village was complex. Areas of the emergency department were being cleared, refurbished and put back into use as part of a sequence of moves. The Vanguard Unit, the temporary outbuilding was providing additional capacity during the upgrade. At present A&E could only triage patient to services within the hospital. The proposed Urgent Care Centre would be able to extend the hospital's ability to signpost to services such as social services, community wound management services and community diabetes services.

(20) Representatives from NHS Swale CCG were asked for their comments. Dr Armstrong explained that the quality of care and safety of patients in Swale was a key aim of the NHS Swale CCG; the CCG would like Medway NHS Foundation Trust to become a beacon of excellence and the hospital of choice. The issues at Medway could not be solved by the Trust alone. The CCG were working with the Trust, GPs and the public to develop a wider integrated primary care team enabling care in the community to work alongside hospital care. Ms Davies explained that it was important that quality improved at Medway; providing good basic care to the community. Trust finances were a concern for the CCG; the CCG were working closely with Monitor on this. There is a risk that if CCG finances need to be utilised to improve the financial position of the Trust, it would reduce the CCGs ability to invest in community care.

(21) RESOLVED that the guests be thanked for their attendance and contributions today, they be requested to take on board the comments made by Members during the meeting and that the Committee looks forward to the interim Chairman and interim Chief Executive attending the meeting of the Committee on 5 September 2014.

26. Accident and Emergency: North Kent

(Item 7)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG), Dr Fiona Armstrong (Clinical Chair, NHS Swale CCG and Clinical Representative for NHS Dartford, Gravesham and Swanley CCG), Dr Philip Barnes (Medical Director, Medway NHS Foundation Trust), Mark Morgan (Interim Director of Operations, Medway NHS Foundation Trust) and Elliot Howard-Jones (Director of Operations and Delivery, NHS England Kent & Medway)were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. Ms Davies began by explaining that an additional £10 million winter funding had been made available in North Kent: Darent Valley Hospital (£4 million) and Medway Maritime Hospital (£6 million). Both hospitals had introduced a system governance structure to utilise the funding with clinicians designing and developing the winter plans.

(2) Darent Valley Hospital had a challenging winter with wet but mild weather. The Dartford and Gravesham NHS Trust had developed good clinical relationships with the community team, mental health team and ambulance service to ensure the whole system worked well. The Integrated Discharge Team (IDT) was introduced as part of the winter funding in September to reduce inappropriate admission to hospital. The IDT were working with patients who initially required diagnostics and treatment in an acute setting but were quickly discharged to receive further care and support in the community. The IDT leadership team was hosted by Darent Valley Hospital; the CQC noted that the IDT was an area of excellence in their inspection report.

(3) The winter funds had also been used to develop telehealth and formulate the Better Care Fund application. Telehealth and telemedicine had been utilised in care homes enabling consultants to remotely monitor patients. The Better Care Fund application was proposing to expand the integrated discharge team and integrated primary care team. As part of the proposed collaborative model for primary care, district nurses would be moving back into GP practices. Changes in community services had moved district nurses out of surgeries; this had caused dissatisfaction amongst nurses who were not working with the same cohort of patients and did not have direct support and back up of specific GPs. Demand for primary care was phenomenal with a large proportion of GPs coming up for retirement. An integrated primary care team would generate a different type of workforce and utilise skills to provide care outside of hospital.

(4) Ms Acott noted that the IDT was created to respond to patients with more complex needs, such as dementia, who are not best served by coming into hospital. There had been an increasing number of patients presenting with dementia; half of all medically stable patients in the hospital had dementia. The introduction of telemedicine had supported home care; it had enabled patients with dementia who would have been previously admitted to hospital, when their nursing or residential home could not cope, to stay in a familiar environment and give confidence to nursing staff to support them.

(5) Mr Howard-Jones added that the current emergency system has been working at or near capacity for a large amount of time; redesign was required in response to the Keogh Urgent and Emergency Care Review. CCGs were redesigning services with their local populations and Urgent Care Groups were working to create system coherence with health and social care services. One of the key roles of the Urgent Care Groups was to monitor performance; these groups were looking more widely at the quality of care and management of acuity, rather than focusing on the 95% target of patients seen within four hours. Emergency management had been significant due to flooding; the response has been exceptional. The Sheppey Bridge incident was cited as another good example with the ambulance service, Darent Valley Hospital and Medway Maritime Hospital providing an excellent response.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member shared his personal experiences of visits to a Minor Injury Unit (MIU) and A&E. He expressed concerns about the difficulty in getting a GP appointment resulting in unnecessary A&E

attendances; limited services available at a MIU and a lack of connectivity between MIU and A&E with regards to triage.

(7) The Member also referred to a piece of work being carried out by Healthwatch Kent about A&E attendances. Mr Inett was asked to comment, he reported that a joint 'Enter and View' exercise was recently carried out by Healthwatch Kent and Healthwatch Bexley at Darent Valley Hospital's A&E department. Healthwatch found that patients were quite satisfied with the care and patient experience at the A&E department. Healthwatch Bexley were currently writing the report, once published, Healthwatch was planning a return visit as the department was quite quiet during the first visit. The report could be brought to HOSC at a later stage.

(8) Further, Healthwatch England recently published the results of a survey; 1 in 5 people who attend A&E know that it is not the most appropriate place for their care needs. Culturally, A&E had become the point of least resistance for immediate care. GPs, CCGs and NHS England had developed an urgent care pathway agreement to offer emergency GP appointments; GPs were being asked to sign up to this. Healthwatch Kent had found that people did not access the Faversham MIU as they are not aware of what services it provided and did not understand the difference between treating illness and injury.

(9) Clarification was sought regarding the increase in A&E attendance. Ms Davies explained that there had been demographic growth since the 1960s; however A&E attendance had significantly increased nationally in the last 10 – 12 years. A&E attendance at both Trusts has been fairly flat over the last two – three years. The Trusts were now looking to the future; NHS Dartford, Gravesham and Swanley CCG were anticipating additional pressure on their services as there had been a change of activity in South London with the London Ambulance Service diverting to Darent Valley Hospital. There was also projected demographic growth in Gravesham with the Ebbsfleet development over the next five years. NHS Swale CCG was looking to tackle health inequalities now, such as clinical obesity in 33% of children, to mitigate the impact on acute providers in the future. Both CCGs are working with the King's Fund to model future acute bed capacity.

(10) One of the Members enquired if the Sheppey Bridge incident affected Medway's A&E performance. Dr Barnes explained that A&E performance was better during the immediate period following the Sheppey Bridge incident. Accidents, minor and major injuries were included within the 95% target of patients being seen within four hours. Medway dealt well with accidents and minor injuries. It has been difficult to deal with major incidents due to increased ambulance conveyances and bed occupancy.

(11) A Member questioned why the changes to A&E had not happened before. Ms Davies explained that the reorganisation of the NHS from Primary Care Trusts to Clinical Commissioning Groups has enabled lead clinicians to design services and make decisions; bureaucracy had previously prevented clinicians getting involved. The winter funds had enabled clinicians to make key changes to improve A&E performance.

(12) The issue of inappropriate A&E attendance was raised. Ms Davies explained that the King's Fund had looked at the type of patients who attend A&E and admissions in NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG. Their research found that 20 – 25% of patient could have been better looked after in the community.

(13) A timeline for the Medway Emergency Village was requested. Dr Barnes explained that the Medway Emergency Village should be completed by Christmas this year. It was a very ambitious change programme. In the interim, the hospital was using existing ward stock to achieve different ways of working.

(14) A question about the major incident planning and practices was asked. Mr Morgan explained that emergency practices were tested regularly in all hospitals. From next year, emergency planning and testing would be built into the contracts with the CCGs which would be set out in the essential services plans. The Sheppey Bridge incident was a major incident test in real life. Medway NHS Foundation Trust had a formal committee for emergency planning which employed emergency planning officers who ensured key services take forward emergency plans and programme tests. Mr Howard-Jones added that in Kent there was a local health resilience conference which meets on a two-monthly basis to test resilience and review emergency plans. After a major incident, a formal debrief was held to evaluate and review the emergency plans. It is chaired by Mr Howard-Jones and the Director for Public Health at Kent County Council.

(15) A series of questions were asked about signposting to the most appropriate service. Mr Morgan explained that many patients did not know where they should go for urgent and emergency care. At the proposed urgent care centre in Medway, patients would be seen by a primary care clinician who would be able to signpost the patient to the most appropriate place for care. The urgent care centre would also be able book GP appointments and register patients for GP surgeries. Evidence had shown that if people were turned away, they would return at a later point. Dr Armstrong highlighted examples of signposting being piloted in North Kent such as the Health Now app. CCGs were working with NHS England, who commission primary care, to free up GPs to enable them to carry out greater numbers of same-day appointments. The future of the walk-in centre in Swale was being reviewed and would be consulted on; at present it enabled unregistered patients to directly access primary care. Ms Davies accepted that more education, training and signposting was required; walk-in centres and minor injury units needed to be more clearly defined to avoid confusion. A suggestion was made for the CCGs to advertise on borough and district websites.

(16) Questions were asked about GP retirement and recruitment and the use of decision-making tools. Ms Davies acknowledged that there was an issue with GP retirement: 33% of GPs in Swale and 20% of GPs in Dartford are due to retire in five years. An educational research hub was being developed in North Kent to attract new GPs. With regards to decision-making, Ms Davies explained that the guests represented different organisations, which had different governance structures. Decisions were taken through a board of

directors who had access to decision-making tools. When joint boards were convened, prioritising tools were used to help with commissioning intentions.

(17) Mr Inett enquired about the urgent care delivery group. Ms Davies explained that the group was convened by the CCGs within each health economy boundary. The patient representatives on the delivery groups were mainly from the voluntary sector. Ms Davies stated that she would be happy to involve Healthwatch in future meetings of the delivery group.

(18) A Member made a comment about the use of acronyms in the NHS reports. The Scrutiny Research Officer was asked to update the letter sent to the NHS to include a note about the use of acronyms.

(19) RESOLVED that:

(a) the guests be thanked for their attendance and be requested to take on board the comments made by Members during the meeting and a report be presented by the representatives to the Committee in nine months' time.

(b) a meeting be arranged between with Healthwatch Kent and Members of the Committee to consider how the work of Healthwatch Kent, in areas such as urgent and emergency care, could support the work of the Committee.

27. CQC Inspection Report - Darent Valley Hospital

(Item 8)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) was in attendance for this item.

(1) The Chairman welcomed Ms Acott and asked her to introduce the item. Ms Acott began by setting out the new CQC inspection process which was being overseen by Professor Sir Mike Richards. Dartford and Gravesham NHS Trust was selected as one of 18 Trusts to pilot the new inspection regime. The Trust was also selected to be one of three Trusts to pilot of the new rating system; Royal Surrey County Hospital NHS Foundation Trust and Heart of England NHS Foundation Trust were also included in this pilot.

(2) The inspection was preceded by an Intelligence Monitoring report and a very detailed data pack produced by the CQC which listed the Trust's achievements, outcomes, mortality statistics and demographic information on the population it serves. The inspection involved 40 inspectors who met with the public and held focus groups with junior and senior staff.

(3) Ms Acott was very pleased, on the whole, with inspection: staff were found to be engaged and loyal, the organisation was caring, effective, safe and efficient. The following areas for improvement were also identified: A&E, qualifications of staff and a focus on the symptoms of very high occupancy. Pilot status enabled the Trust to shape and feedback to the CQC and

Professor Sir Mike Richards directly. Ms Acott reported that there was lots of goodwill towards the inspection and that confidence in the CQC inspection regime was returning.

(4) Members then proceeded to ask a series of questions and made a number of comments. An area identified for improvement by the CQC was the cascading of learning from a serious incident in a timely manner. The CQC found that it could take up to a year for learning from a serious incident to be implemented and staff often did not hear the outcome. A Member enquired about the steps that had been taken to address this. It was also suggested that the Committee look into key lines of enquiry used by the CQC.

(5) Ms Acott explained that the key lines of enquiry were drawn from the data pack produced before the inspection which was published on the CQC website for transparency. When a serious incident takes place, the Trust had to go through a specific investigatory process involving NHS England and the CCG. The investigation process was led by clinicians who carried out Root Cause Analysis. Following the CQC inspection, the Trust had introduced end dates to investigations, begun electronically reporting incidents and changed the Terms of Reference for its governance meeting to enable it to feedback outcomes and learning from incidents to staff.

(6) A series of questions were asked about the cost of a CQC inspection and serious incident inspection. Ms Acott explained that a serious incident inspection did not have a financial cost, only an opportunity cost to the Trust. The cost of a CQC inspection is unknown.

(7) The progress of single sex wards was raised. It was explained if there was a clinical need to mix the sexes, which mainly occurs at night, patients were moved to single sex wards as soon as possible. Incidents of mixed sex wards were reported to Ms Acott and resolved as soon as possible. Clinical need overrides the requirement for single sex wards.

(8) A question was asked about the Trust's response to the CQC inspection. Ms Acott explained that within 21 days of the CQC inspection, the Trust had to submit a compliance plan to the CQC with details of how it would resolve issues. Once the Trust informed the CQC that they had completed the compliance actions, the CQC would come back on an unannounced visit to check. The Trust also had to submit an Improvement Plan which was a developmental piece. The improvement plan had to be agreed with the CCG, NHS England, ambulance and mental health services and sent to the CQC. It is expected that the CQC would return in the summer or autumn to ensure any issues were concluded.

(9) A comment was made about the inclusion of older people's care in the medical care section of the inspection findings. Ms Acott explained that the CQC had chosen not to distinguish these types of care; she was surprised that they had not been separated. However inspectors distinctively looked at frail and elderly patients during their inspection.

(10) RESOLVED that Ms Acott be thanked for her attendance and that an update be submitted to the Committee at an appropriate time.

28. Forward Work Programme

(Item 9)

(1) Members considered the work programme as set out in the report and made a number of suggestions for additions to the work programme.

(2) It was suggested that a working group be established to consider the financial situation of the four acute hospital trusts' in Kent and Medway.

(3) RESOLVED that:

(a) the work programme as set out in the report be noted and that the following be added to the work programme:

- CQC Inspection Regime
- Integration
- Future Leadership of the NHS
- Profile of GPs in Kent

(b) A working group be established to consider the financial position the four acute hospital trusts' in Kent and Medway and report back to this Committee.

29. Date of next programmed meeting – Friday 11 April 2014 @ 10:00 am

(Item 10)