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, 2 September 2016.

PRESENT: Mr M J Angell (Chairman), Mrs A D Allen, MBE, Mrs P Brivio, Mr A H T Bowles, Mr N J D Chard (Vice-Chairman), Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Ms D Marsh, Mr C R Pearman, Cllr J Howes, Cllr M Lyons, Cllr N Heslop, Cllr Chris Woodward, Mr L Burgess (Substitute) (Substitute for Mr A D Crowther) and Mrs Z Wiltshire (Substitute for Mr H Birkby)

ALSO PRESENT: Mr S Inett

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

UNRESTRICTED ITEMS

38. Election of Chairman
(Item 1)

(1) Mr Chard proposed and Mr Bowles seconded that Mr Angell be elected Chairman of the Committee.

(2) RESOLVED that Mr Angell be elected as Chairman.

(3) The Chairman stated that it was with regret that he had to inform Members of the death of Mr Robert Brookbank, Chairman of the Health Overview and Scrutiny Committee.

(4) RESOLVED that the Committee records the sense of loss it feels on the sad passing of Mr Brookbank and extends to his family and friends our heartfelt sympathy to them in their sad bereavement.

39. Election of Vice-Chairman
(Item 2)

(1) The Chairman proposed and Mr Bowles seconded that Mr Chard be elected Vice-Chairman of the Committee.

(2) RESOLVED that Mr Chard be elected as Vice-Chairman.

40. Membership
(Item 3)

(1) Members of the Health Overview and Scrutiny Committee noted the following changes to the membership of the Committee:

(a) Ms Marsh filled the vacancy following the recent death of Robert Brookbank.

(b) Cllr Woodward (Tunbridge Wells Borough Council) replaced Cllr Ring (Maidstone Borough Council) as a borough representative on the Committee in 2016/17.

(c) Cllr Heslop (Tonbridge & Malling Borough Council) replaced Cllr Peters (Dartford Borough Council) as a borough representative on the Committee in 2016/17.

41. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 5)

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

(2) Cllr Lyons declared an Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

42. Minutes
(Item 6)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 3 June 2016:

(a) Minute Number 9 – NHS Swale CCG: Review of Emergency Ambulance Conveyances. At HOSC on 29 January, a Member enquired if the closure of the A249 (Sheppey) had had an adverse impact on SECAmb. On 15 March SECAmb confirmed that there were no adverse incidents with the closure of the A249 to Sheppey and the Trust utilise the lower road bridge crossing in the event of the A249 closure.

At HOSC on 8 April, a Member stated that the query about the closure of the A249 (Sheppey) was regarding the sinkhole and not the closure of the road bridge. Mr Davies, Interim Chief Executive, undertook to clarify if there had been an adverse impact on SECAmb due to the sinkhole. On 3 June SECAmb confirmed that there had been no adverse impact.

(b) Minute Number 30 - Review of winter preparedness and BMA Industrial Action in Kent 2015/16. At HOSC on 3 June, a Member requested NHS England to provide a written briefing about the SAFER bundle which was circulated to Members on 9 June.

(c) Minute Number 31 - Darent Valley Hospital: MRSA. On 3 June the Committee agreed that the Vice-Chairman-in-the-Chair would write a letter to the Secretary of State for Health and Chief Executive of Public Health England requesting a review of the Public Health England guidance on targeted admission screening for MRSA.

Subsequently the Vice-Chairman-in-the-Chair was made aware of Public Health England data which showed that since the introduction of targeted screening in 2014 MRSA infection rates had remained steady nationally. As a result of this infomation, Mr Angell, in consultation with the group representatives, sent a letter to the Trust to say that he would not be writing to the Secretary of State for Health asking for a review of the guidance – it was felt that it was local issue regarding infection control management at the Trust (rather than the guidance).

(2) RESOLVED that the Minutes of the meeting held on 3 June are correctly recorded and that they be signed by the Chairman.

43. Patient Transport Service
(Item 7)

Ian Ayres (Accountable Officer, NHS West Kent CCG) was in attendance for this item.

(1) The Chairman welcomed Mr Ayres to the Committee. Mr Ayres began by explaining that the new contract with G4S went live on 1 July. He reported that overall mobilisation of the contract had gone well and G4S was moving to the 'business as usual' phase. He noted that there had been some teething problems for dialysis patients in West Kent, receiving their treatment from Guy's and St Thomas' NHS Foundation Trust, which was being monitored daily. There had been very few patient complaints and media enquiries in recent weeks and Trusts had reported that G4S were responsive and resolved issues. He stated that sub-contractors who had been brought in to reduce deficits of the previous provider were being stood down and the transporting of Kent and Medway patients to and from London hospitals would begin on 1 November. He explained that the CCG would be carrying out a true-up process with the provider, taking place three and six months into the contract, to look at the actual activity against the data set out in the contract; this process had been implemented following the lessons learnt from the previous contract.

(2) A number of questions were asked about the capture and reporting of performance data. Mr Ayres explained that there were three contracts: one for renal patients, one for Dartford and Gravesham NHS Trust patients and one for the rest of Kent and Medway. He noted that once data became available the CCG would be able to breakdown performance data by acute hospital and be able to identify hotspots. He noted that G4S were undertaking 6000 journeys a week including 50-80 journeys a day for patients requiring dialysis in West Kent. He reported that one or two of the renal journeys a day were disrupted which was too high but stated that this was a significant improvement from the previous provider. Mr Ayres undertook to check whether data was being captured about the number of journeys completed but were found no longer to be required due to cancellations of appointments and clinics on arrival at the place of care.

(3) RESOLVED that the report be noted and NHS West Kent CCG & G4S be requested to attend the Committee in March and provide an update including qualitative and quantitative performance data with details about the patient experience and areas of underperformance.

44. Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures *(Item 8)*

Steve Orpin (Finance Director, Maidstone & Tunbridge Wells NHS Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Orpin began by explaining that Maidstone & Tunbridge Wells NHS Trust was one of five acute providers to be part of the first cohort of financial special measures. The new system of financial special measures was introduced by NHS Improvement in July 2016; providers were considered for financial special measures using a small number of criteria including those who had not agreed a control total and those who had agreed a control total but had a negative variance against the plan. He stated that the Trust was moving at pace to rapidly respond and move forward towards an agreed control total. NHS Improvement had identified support including the appointment of Simon Worthington who was Deputy Chief Executive of Bolton NHS Foundation Trust – a Trust which was in surplus and had been rated 'good' by the Care Quality Commission. He noted that the Trust was developing a high level recovery plan and would be meeting regularly with NHS Improvement who would review whether the Trust would remain or exit financial special measures.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. Members enquired about the pay bill. Mr Orpin explained that NHS Improvement had carried out a review and the Trust's pay bill, in relation to its activity, was growing faster than comparable organisations. He noted that the pay bill (5 – 10%) was growing faster than income activity (4 – 5%). The pay bill accounted for 65% of expenditure and its increase was made up of three key components.

(3) Mr Orpin stated that the first was increasing activity and demand in urgent and emergency care; there had been a 6% increase in A&E attendance in the first four months in comparison to the previous year and in August there had been an unprecedented spike of serious illness in additional to the expected increase in seasonal accidents. The second was that the human resources market was influenced by the Trust's proximity to London with staff commuting or moving to London to progress their careers in teaching hospitals. The third was workforce planning particularly for medical surgical specialities. There were shortages of nursing and medical staff in acute frontline services due to constant growth, increased pressure and organisations with quality issues locally which resulted in greater competition for staff. The Trust was working to reduce its agency and temporary staffing through recruitment and the bank process; there had been a 20% decrease in agency and temporary staffing in the previous year with no deterioration to the quality of service. He noted that the Trust was working in collaboration with the CCG to develop new services and expand provision in acute and community settings to serve patients in West Kent which were effective and efficient and provided high quality care.

(4) A Member asked about the impact of PFI, Mr Orpin explained that within the PFI there was a unitary charge paid for the PFI service. The Trust received £8 million of funding annually to cover this charge; however the actual cost of the unitary charge was £5-10 million greater than the funding received. He noted

that the Trust had to identify all additional savings and efficiencies before being able to ask for additional support for the PFI cost.

(5) In response to a specific question about timescales and exiting special measures, Mr Orpin explained that financial special measures provided the Trust with an opportunity to improve services and reduce cost. He stated that whilst the emerging plan had not been presented to the Trust Board, the Board was committed to financial recovery and delivery of quality services. He noted that the Board and Finance Committee would be holding extraordinary meetings before the planned meeting with NHS Improvement at the end of September to review progress; this would be the first opportunity were the Trust could exit financial special measures.

(6) A number of comments were made about the deficit, the costs attached to financial special measures and planning for population and demographic growth. Mr Orpin explained that the deficit was planned by the Trust and NHS Improvement had not accepted the control total which had resulted in the Trust being placed in financial special measures. Mr Orpin reported that the cost of the Financial Improvement Director and their team was incurred by NHS Improvement; it was not a cost to the Trust at the current time. Mr Orpin noted that all providers were experiencing growth and changes to demography as people were living longer with co-morbidities. He stated that the Trust was working on the current issues which would act as a cornerstone for the future. He highlighted the role of the Sustainability and Transformation Plan in planning for population and demographic growth particularly in Ebbsfleet.

(7) A number of questions were asked about the impact of special measures on staff and efficiencies. Mr Orpin explained that as part of its financial recovery plan, the Trust had actively gone out into the organisation and engaged with frontline staff about improvements to services. He reported that he was impressed with the dedication and ideas provided by the staff including energy saving measures. He noted that work was being done to identify waste at the Trust and by making staff aware of the cost of items when ordering enabled them to make an informed judgement about whether to proceed with the purchase.

(8) The Chairman asked Mr Ayres to comment. Mr Ayres stated that the Trust was in financial special measures solely for financial issues. He commended the Trust's leadership team for not accepting an unrealistic control total and stated that he had full confidence in the Trust to resolve the financial issues. He noted that the money provided to the NHS did not cover an aging and growing population or advances in technologies; year-on-year efficiencies would be required to deliver the same level of service currently provided.

(9) RESOLVED that the report be noted and the Trust be requested to provide an update to the Committee in January.

45. Kent and Medway Sustainability and Transformation Plan
(Item 9)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Michael Ridgwell (Programme Director, Kent & Medway Sustainability and Transformation Plan) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about emergency & elective care provision and patient choice. Mr Ridgwell explained that although emergency and elective services provided different services, they were intransigently linked. He noted that whilst emergency and elective services could be provided on the same or different sites, it was important that medical, rather than surgical services were co-located with emergency care. He reported that the current acute emergency medical pathway was unviable due to workforce pressures. He stated that whilst patients had the right to choose their healthcare including the use of private providers; in emergency provision it was more important to have a sustainable workforce.

(2) A number of comments were made about centralisation of services. Mr Ayres stated that a number of specialist services in Kent had already been successfully centralised including cancer and major trauma. He noted that in West Kent, the CCG was working with district and borough councils to improve primary care estates to enable community services to jointly use the same sites. He stated that it was not sustainable for the seven acute sites in Kent & Medway to continue to provide all services. Through the STP process some services would need to be centralised and some would need to be provided locally. He reported that engagement work for the Kent and Medway STP would begin in the autumn, prior to public consultation to be held after the County Council elections in May 2017. Mr Ridgwell noted that the East Kent system was further advanced and had its own timetable.

(3) In relation to the cost effectiveness of centralisation, Mr Ayres gave an example regarding the centralisation of elective care by the Epsom and St Helier University Hospitals NHS Trust. The Trust previously provided elective care specifically hip and knee replacements across five sites. Following centralisation quality had improved; there was no hospital acquired infection; length of stay had reduced; professionals were working with each other to improve services; and patient satisfaction had increased. Due to its cost effectiveness, the centralisation had also enabled Accident & Emergency centres to be maintained on the other sites. He noted that specialist centres were attractive to workforce and stressed the need to engage with local people.

(4) Members enquired about collaboration, out of hospital care, A&E attendance and population growth & decline. Mr Ayres explained that through the STP the local system was required to balance the budget collectively which may result in commissioners and providers having a surplus or deficit. Mr Ayres stated that out of hospital care and general practice had diminished over the last 20 years which had put pressure on acute providers; both community and primary care services needed to be improved going forward. He noted that there would be a clearer local and national picture regarding the STPs following a further submission to NHS England in October

(5) Mr Ridgwell explained that a large number of patients attending A&E had a primary care need and it was important for that cohort to be diverted to a more appropriate resource. He stated the importance of redesigning provision to include better access to primary care and to promote behaviour change. Mr Ayres noted that the STP was using current population and demographic

growth including 57,000 new residents to the Ebbsfleet development. He noted that there was a likelihood that there will be an overall population decline but not within the next 20 – 30 years. Mr Ridgwell added that Ebbsfleet was a new town, rather than an infill development, which meant that it provided an opportunity for new, rather than existing infrastructure, to be developed.

(6) The Chairman invited Steve Inett and Andrew Scott-Clark to comment. Mr Inett explained that Healthwatch Kent was keen to engage with the public regarding the STP. He stated that the report provided to the Committee did not do the full STP justice. He stated the importance of communicating the positives to the public particularly the reinforcement of community and primary care services. Mr Scott-Clark stressed the importance of embedding prevention into the system in order to maintain services. He noted that there was a good history of collaboration in Kent with the Catheter Centre in Ashford.

(7) RESOLVED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee in November with a detailed plan including finance.

46. East Kent Strategy Board
(Item 10)

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Swale CCG) was in attendance for this item.

(1) The Chairman welcomed Ms Carpenter to the Committee. Ms Carpenter began by explaining that since the last presentation to the Committee in June, the East Kent Strategy Board had been working closely with the Kent & Medway Sustainability and Transformation Plan to determine how best to engage with the wider plan. She noted that the Case for Change had been published on 26 July and the public engagement programme had begun including public focus groups to discuss the new models of care. She reported that the East Kent Clinical Forum had agreed the outputs of the four clinical workshops as the basis for developing future models of care and work was under way to ensure the full utilisation of NHS and local authority estates in East Kent.

(2) Ms Carpenter noted that the evaluation criteria for the long list of options were being developed and public consultation was planned to start at the end of January 2017 and conclude prior to the start of purdah for the local council elections. She highlighted that the options would be tested by the Clinical Senate on 26 October, confirmed by the Clinical Senate on 6 November and presented to the National Investment Committee at the beginning of January. She reported that the Board was exploring the development of out of hospital integrated health and care services being provided across 16 localities in East Kent.

(3) In response to a specific question about local services in Deal, Ms Carpenter explained that she was unable to give specific details but highlighted that GPs in Deal wanted the maximum number of services to be delivered locally. She

stated that the model was most advanced in Thanet with the development of Primary Care Homes; a pilot in Margate was planned for the autumn. Primary Care Homes would be a community focused model with a dedicated integrated team to manage patients with comorbidities and work with primary and secondary care practitioners; if a patient was unable to be managed in the community they would be moved to a hot ambulatory care unit.

(4) A number of comments were made about finance and public consultation. Ms Carpenter explained that the Board would not be able to go out to public consultation until the finance and costings had been completed. She noted that the financial analysis was being undertaken by a collaboration of finance leaders from East Kent Hospitals University NHS Foundation Trust, Kent County Council, Kent Community NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership. The Chairman requested that a draft copy of the public consultation be shared with the Committee before publication. Ms Carpenter undertook to provide the engagement programme and draft consultation document to the Committee.

(5) RESOLVED that the report on the East Kent Strategy Board be noted and an update be presented to the Committee in November with a detailed plan including finance.

47. Chemotherapy Services in East Kent & East Kent Cervical Screening Programme (Written Briefing)
(Item 11)

(1) The Committee received a report from East Kent Hospitals University NHS Foundation Trust which provided an update about the Celia Blakey Centre at the William Harvey Hospital, Ashford and actions taken following the Public Health England Screening Quality Assurance Review of the East Kent Cervical Screening Programme and there was no discussion.

(2) RESOLVED that the report on the Chemotherapy Services in East Kent & East Kent Cervical Screening Programme be noted and the Trust be invited to submit an update to the Committee in January 2017.

48. CCGs Annual Rating (Written Briefing)
(Item 14)

(1) The Committee received a report from the Kent CCGs which provided details of NHS England's assessment of their performance against the 2015/16 CCG assurance framework and a summary of their improvement plans.

(2) RESOLVED that the report be noted and the Kent CCGs be requested to provide an update to the Committee annually.

49. All Age Eating Disorder Service in Kent and Medway (Written Briefing)
(Item 15)

(1) The Committee received a report from NHS West Kent CCG regarding the procurement of an all age eating disorder service for Kent and Medway.

(2) A Member enquired about the difference between waiting time standards between children & young people and adults. The Scrutiny Research Officer undertook to liaise with NHS West Kent CCG to provide a response.

(3) RESOLVED that:

(a) the Committee does not deem the proposals to be a substantial variation of service;

(b) NHS West Kent CCG be invited to submit a report to the Committee at the conclusion of the procurement of an all age eating disorder service for Kent and Medway.

50. Dermatology Services in West Kent (Written Briefing)
(Item 16)

(1) The Committee received a report from NHS West Kent CCG which provided an update about the procurement of dermatology services in West Kent and a written briefing from King's College Hospital NHS Foundation Trust regarding the relocation of dermatology outpatient services from Orpington Hospital to Beckenham Beacon.

(2) RESOLVED that:

(a) the report on the procurement of dermatology services in West Kent be noted and NHS West Kent CCG be requested to provide an update following the mobilisation of the new provider.

(b) the written briefing provided by King's College Hospital NHS Foundation Trust regarding the relocation of dermatology outpatient services from Orpington Hospital to Beckenham Beacon be noted.

(3) The meeting was adjourned at 12:30 and reconvened at 13:50.

51. SECAmb: Update
(Item 12)

Geraint Davies (Acting Chief Executive, South East Coast Ambulance NHS Foundation Trust), Patricia Davies (Accountable Officer, NHS Swale CCG) and Helen Medlock (Associate Director of 999 and NHS 111 Commissioning for Kent and Medway CCGs) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Davies began by explaining that NHS Swale CCG was the lead commissioner for 999 and 111 in Kent and Medway. She noted that the Trust had been through a period of turmoil relating to quality, safety and performance. She stated that the Trust was developing a Unified Recovery Plan which would include clear and realistic targets. She noted that the changes being implemented by the Trust were moving in the right direction.

(2) Mr Davies explained that following a CQC inspection in May 2016, the Trust received a warning notice from the CQC with regards to governance, leadership and operations at the Trust. A two year recovery plan was being

developed to cover eight specific areas where improvement was required such as an improved culture, the roll out of electronic patient records and the move to the new headquarters. He stated that he would be the acting Chief Executive until a new substantive appointment was made; his focus during this interim period would be to take forward the concerns in the warning notice to ensure safe services. Mr Davies committed to bringing back the CQC inspection report once published.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A number of comments were made about staffing. Mr Davies explained that following an enhanced recruitment process the NHS 111 service was now fully staffed. The Trust had undertaken work to find out why staff were leaving and buddied new members of staff with experienced call takers as part of the training programme. A similar piece of work was being carried out in 999 as it was facing similar problems; the management of 111 and 999 were now sharing best practice. He stated that the Trust needed to recruit 200 paramedics and was competing against nine other Trusts; the Trust needed to be seen as an attractive organisation to recruit and retain paramedics including a clear career structure and opportunities to become a paramedic practitioner and rotate into primary and higher acuity care. He reported that there was currently a 14% turnover of paramedics.

(4) Members enquired about the structure of the Trust, the role of the CQC and dispatching multiple ambulance vehicles. Mr Davies explained that the Trust was restructuring its operation system to better engage and support staff; an operations manager would now be responsible for 15 members of staff and would be on the same rota as those staff. There would also be a clinical lead as part of the team. He noted that if the ambulance service was county based, the same operations system would have to be implemented. Mr Davies stated that the CQC played a valuable role; it was important for the organisation to receive external validation and work with commissioners to address concerns raised by the CQC. Mr Davies noted that the Trust sent more vehicles per call than other Trusts; the Trust was working to safely implement Dispatch on Disposition through the Ambulance Response Programme to enable clinicians to have time to triage the call and dispatch the correct resource. He highlighted that 999 performance was lower than performance standards and trajectory which the Trust needed to meet in order to be safe.

(5) A number of comments were made about Hear & Treat and See & Treat, and bullying and harassment at the Trust. Mr Davies explained that Hear and Treat was telephone clinical advice provided by 999 call handlers which currently represented 10 – 12% of calls and was expected to increase. He stated that See and Treat was when a clinical decision was taken at the scene to refer to elsewhere or take to hospital. He noted that there was bullying and harassment at all levels of the organisation; the Trust had a Security Manager to protect staff against the public and had taken forward prosecutions. He reported that the Trust was working with the London Ambulance Service NHS Trust to share best practice and develop policies and procedures regarding values and behaviours. He stated that recruitment was based on values and that the Trust had a whistle-blower and raising concerns process were staff were able to directly email or call senior staff including the Chief Executive.

(6) In response to a specific question about handover delays, Ms Davies explained that from a commissioner's perspective SECAmb could not tackle patient flow into the acute sector alone. She noted that West Midlands Ambulance Service NHS Foundation Trust had a policy where they walked away from a patient after 15 minutes of arrival as set out in the national standards. She noted that SECAmb had imposed a local policy of 45 minutes; NHS Swale CCG had commissioned a piece of work to look at improved flow and handover at Medway Maritime Hospital and Darent Valley Hospital. Mr Davies noted that if the Trust invoked a 15 minute policy, such as the West Midlands Ambulance Service, it could undermine the ability of an Accident & Emergency to treat and admit patients. He reported that through a phased approach by the end of the financial year, the Trust would be implementing a policy to walk away from patients if they were not able to handover patients within 45 minutes on the grounds of wider patient safety.

(7) Members enquired about finance and the use of technology. Mr Davies explained that the Trust had an NHS Improvement risk rating of 3 which meant that they were financially solvent. However in the current financial year, the Trust would need to go into deficit by £7.1 million to deliver the recovery plan which was allowed, under the terms of being a Foundation Trust, as a one-off. He stated that existing technology was already an important part of being a mobile healthcare provider; staff were able to use iPads to record electronic patient data and use videoconferencing to send video information to the burns unit at the Queen Victoria Hospital. Ms Davies noted that whilst technology led to quality and safety improvements, capital funding for technology would be challenging in the next financial year as the Trust was required to breakeven or produce a surplus.

(8) In response to a question about blue light collaboration, Mr Davies reported that there had been collaboration between the Trust and the Surrey Fire Service in providing the fire staff with training to be Community First Responders if they arrived on the scene first. He stated that there was not a strategic fit for the Trust to be co-located with other blue light services as the Trust provided a clinical and NHS service. Ms Davies highlighted the importance of collaboration between the Trust with primary and out of hospital care in creating efficiencies and improving safety and wellbeing; paramedic practitioners had been working in Swale since September 2015 and have reduced the number of ambulances by two a day to Medway Maritime Hospital. In response to a specific question about his biggest concern as acting Chief Executive, Mr Davies stated that it was having sufficient staffing to meet the demand facing the organisation.

(9) RESOLVED that the report be noted and SECAmb be requested to share the findings of the Patient Impact Review and CQC Inspection Report upon publication.

52. Healthwatch Kent: Annual Report and Strategic Priorities
(Item 13)

Steve Inett (Chief Executive, Healthwatch Kent) was in attendance for this item.

Mr Chard referred to his Disclosable Pecuniary Interest as a Director of Engaging Kent and the requirement for him to withdraw from the meeting for this item. At the invitation of the Chairman, Mr Chard remained in the meeting.)

(1) The Chairman welcomed Mr Inett to the Committee. Mr Inett introduced Healthwatch Kent's Annual Report and Strategic Priorities and proceeded to give a presentation (attached as a supplement to the Agenda pack) which covered the following key points:

- Background infomation about Healthwatch Kent
- Review of activity in 2015/16
- Feedback from the public in 2015/16
- Achievements in 2015/16
- Priorities for 2016/17 including Sustainability & Transformation Plan & Discharges

(2) A Member enquired about the expenditure relating to Engaging Kent, grants, projects and research. Mr Inett explained that the £28,000 payment to Engaging Kent went to the Directors for their time in ensuring it met its legal and contractual requirements and providing support to projects; in addition, as part of its contract with KCC at the time, Healthwatch Kent had to submit a business case to KCC when working with an external provider with a proportion of money going to Engaging Kent to fund the cost of the business case. Mr Inett stated that grants included funding to set up the Physical Disability Forum and reimbursement to Porchlight for assisting their clients to fill out a survey.

(3) A Member reminded the Committee of the legal obligations relating to Declarations of Disclosable Pecuniary Interest.

(4) RESOLVED that the report be noted and Healthwatch Kent be requested to provide an update to the Committee annually.

53. Date of next programmed meeting – Friday 7 October 2016 at 10:00
(Item 17)

(1) A Member enquired about the scope of the Sevenoaks Hospital item scheduled for 7 October. The Scrutiny Research Officer undertook to liaise with NHS West Kent CCG to provide a response.

(2) A Member requested information to be provided about the financial implications for any service change brought to the Committee for consideration.