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, 24 November 2017.

PRESENT: Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Ms K Constantine, Mr D S Daley, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Cllr L Hills, Cllr J Howes, Cllr M Lyons, Cllr T Searles and Mrs R Binks (Substitute) (Substitute for Mr M Whiting)

ALSO PRESENT: Mr S Inett

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

UNRESTRICTED ITEMS

25. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

(1) Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.

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

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

26. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 20 September 2017 are correctly recorded and that they be signed by the Chair.

27. EKHUFT Operational Issues
(Item 4)

Liz Shutler (Director of Strategic Development & Capital Planning & Deputy Chief Executive, EKHUFT), Lesley White (Divisional Director, East Kent Hospitals University NHS Foundation Trust), Simon Perks (Accountable Officer, NHS Ashford & NHS Canterbury and Coastal CCGs) and Hazel Smith (Accountable Officer, NHS South Kent CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee.

(2) Members enquired about the appointment of a permanent Chief Executive and Chair and the Trust's Financial Recovery Plan. Ms Shutler explained that Susan Acott and Dr Peter Carter OBE had joined the Trust as interim Chief Executive and Chair of the Trust. It was anticipated that interviews for a permanent Chair would take place in January with interviews for a permanent Chief Executive taking place as early as February. Ms Shutler noted that the Trust had a deficit target of £19m by the end of the financial year. She reported that the Trust was making good progress and had already delivered on over £30m of cost improvement savings. She noted that given the size of the organisation, the Trust's deficit was relatively low in comparison to other Trusts across the system. In response to a comment about saving targets resulting in service cuts, Ms White explained that savings related to efficiencies. She gave an example of the savings made within the Urgent Care and Long Term Conditions division; due to the successful recruitment of permanent middle grade staff in A&E, the division had made significant savings against agency spend. Ms Shutler noted that it was not efficient for the Trust to provide services on all sites; it was important for specialist services and teams to be co-located together.

(3) Members asked about the pay award and staff recruitment particularly consultant recruitment at Queen Elizabeth The Queen Mother (QEQM) Hospital. Ms White explained that the pay award was a national issue. She noted the Trust was looking at new roles, particularly for Band 4 nurses and more senior nursing roles, to enable staff as part of their career development to move into specialist roles. She reported that the Trust was working to recruit medical staff both in the UK and abroad. Vacancies were being advertised in the BMJ and the Trust was looking to attract staff by offering clinical specialisms; flexible working; shared posts in the community; and potential research posts with universities. Ms Shutler noted that the Trust had advertised 74 consultant posts and recruited 55 staff including 22 staff that had joined since June; however the Trust continued to have gaps in medicine and geriatric roles. Ms White stated the Trust had recruited two new consultants to the QEQM Hospital since June; a Respiratory Consultant who had subsequently left and a Geriatrician. She reported that the Trust was continuing to actively recruit to posts across all three sites.

(4) A number of comments were made about sickness absence, the flu vaccine and appraisals. Ms Shutler acknowledged that the sickness absence was above the Trust's 4% target and committed to providing the Committee with a briefing about sickness absence. She stated that the Trust had worked hard to encourage and increase the number of staff choosing to have the flu vaccine; for every staff flu vaccination, the Trust was donating a flu vaccine to Africa. The Trust's target was for 70% of staff to have the flu vaccine; 58% of staff had had the vaccine which was the highest percentage ever achieved by the Trust. Ms Shutler noted the importance of appraisals and the Trust was working to improve the staff appraisal rate; the national staffing survey had identified a high staff appraisal rate by the Trust.

(5) A Member enquired about the declaration of a Code Black at the QEQM Hospital. She explained that a Code Black at QEQM Hospital had not been declared to external partners. Due to a high level of activity at both the William Harvey Hospital and QEQM Hospital, the Trust had internally declared Code

Black the previous night and had implemented additional activities to support A&E and emergency medical admissions which had included increased consultant activity, ward rounds, nursing and management support. It was anticipated that the sites would be downgraded to Code Red by lunchtime. Ms Shutler noted that codes were reviewed and changed throughout the day depending on activity levels. She reported that the actions in the emergency care improvement plan were beginning to make a difference; in the last week the Trust compliance rate for the A&E 4 hour target had improved to 80% in comparison to 70% in September.

(6) In response to a specific question about the establishment of a medical school, Ms Smith explained that there was a national process for creating new medical schools; a key element in the national criteria for the creation of a new medical school was being able to evidence a deficit in local GP workforce. She stated that a bid for a medical school in Kent & Medway had been submitted and an announcement by Higher Education Funding Council for England (HEFCE) and Health Education England (HEE) was expected in March 2018; if the bid was successful, the medical school would open in the 2020/21 academic year. The bid was supported by the University of Kent and Canterbury Christ Church University; in addition to every NHS organisation, local authority and Member of Parliament in Kent & Medway. She noted that the bid focused on primary care and psychiatry and had partnered with an existing medical school, Brighton University, to ensure General Medical Council agreement to the proposed curriculum. Ms Shutler added that the Trust, along with the other Kent & Medway acute trusts, were supportive of the bid and noted that the medical school would be for the whole of Kent and Medway.

(7) The Chair invited Steve Inett, Chief Executive, Healthwatch Kent to comment. Mr Inett stated that he wanted to assure the Committee that Healthwatch undertook regular visits to the Trust's sites to gather patient experience and shared these experiences with the Chief Nurse as part of its regular meetings with the Trust. Healthwatch had been invited to attend an oversight group which had overseen the move of junior doctors from the Kent & Canterbury Hospital site and had been involved in the drafting of letters and press releases to patients about those changes.

(8) The Chair stated that whilst the early indications of improved A&E performance were welcome, it was important that the improvements were sustainable. She recommended that regular written updates on A&E performance should be provided to the Committee to enable them to monitor performance.

(9) RESOLVED that:

(a) the reports be noted;

(b East Kent Hospitals NHS University Foundation Trust be requested to provide an verbal update at the appropriate time;

(c) the Committee receives regular written updates on A&E performance at the Trust.

Cllr Lyons, in accordance with his Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust, withdrew from the meeting for this item and took no part in the discussion or decision.

28. Kent and Medway Sustainability and Transformation Partnership
(Item 5)

Michael Ridgwell (Programme Director, Kent & Medway STP), Simon Perks (Accountable Officer, NHS Ashford & NHS Canterbury and Coastal CCGs), Hazel Smith (Accountable Officer, NHS South Kent Coast and Thanet CCGs), Liz Shutler (Director of Strategic Development & Capital Planning & Deputy Chief Executive, EKHUFT) and Lesley White (Divisional Director, East Kent Hospitals University NHS Foundation Trust), were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. The Chair noted that the Committee had received an additional report regarding reconfiguration of services in East Kent and the focus of the discussion would be on the new information rather than the general STP update which had been printed as part of the agenda. Ms Smith confirmed that the additional report had been published as part of the papers for the East Kent Joint CCG Committee.

(2) Ms Smith began by updating the Committee about the development of local care in East Kent which would not be subject to public consultation; GPs were working together to develop primary and community care to support their local populations of 30,000 – 60,000. She noted that a frailty pathway developed at a Kent & Medway level was being implemented locally with the same model across East Kent. In addition to this, she reported that five specialties, including rheumatology, cardiology, diabetes, and the tiers of care to support those specialities at a primary and secondary care level had been identified. She reported that in Thanet three primary care homes had been developed in Margate, Ramsgate and Quex & Broadstairs to bring together GP practices in those areas; the aim was for the homes to provide services relevant to their populations and strengthen primary care. In Margate the CCG was working with the District Council to relocate relevant services, such as the Margate Task Force, to be part of the home. In South Kent Coast all GP practices had come together to form the Channel Health Alliance which had been contracted to provide three primary care hubs in Dover, Deal, Folkestone; an additional hub to support Hythe and Romney Marsh was being developed. Mr Perks noted, in addition to GPs working together and taking responsibility for their populations as part of the development of local care, there were tangible benefits; the provision of a multidisciplinary team at the Estuary View vanguard had reduced urgent care admissions by 7%.

(3) Mr Ridgwell stated the importance of a local care model across Kent & Medway to meet the rising demand. He noted that the issues raised in the previous item, EKHUFT Operational Issues, had highlighted the case for change to acute services in East Kent.

(4) Ms Shutler began by outlining the engagement with the Committee over the last 18 months including the presentation of the East Kent and Kent & Medway Cases for Change. She reported that urgent and emergency care and orthopaedic services had been identified as priority areas as it was not

feasible for the Trust to continue to provide a large number of services across three hospital sites due to the sustainability of the rota, recruitment and the training of junior doctors. She noted the importance of local care in supporting the Trust; at any one time the Trust had 250-300 patients who did not require hospital care and could be discharged if alternative provision was available.

(5) Ms Shutler stated that the potential options for urgent and emergency care and acute medicine had been developed using the Keogh Review and a commissioned review of clinical adjacencies by the South East Coast Clinical Senate. She noted that the options did not include a major trauma unit because of the large catchment population of two-three million people required to support very specialist services such as neurosurgery and cardiothoracic surgery; patients would continue to travel to access the major trauma centre at King's College Hospital in London.

(6) Ms Shutler explained that hurdle criteria had been applied to a long list of options which included:

- each of the existing hospital sites operating as: a major emergency centre with specialist services; or an emergency centre or medical emergency centre; or an urgent care centre or integrated care hospital.
- a new hospital on a "Greenfield" (i.e. on a new site);
- consolidation of existing hospitals onto one site; and
- consolidation of the existing hospitals on to two sites, by closing an existing hospital.

(7) For the clinical sustainability criteria, Ms Shutler explained the catchment populations required to deliver specialist services were reviewed. The Trust currently provided specialist vascular, renal, trauma and cardiac services to a population over one million which had indicated that the Trust could support one major emergency centre with specialist services. The population in East Kent was 695,000 which indicated that the Trust could also support an emergency centre to assess and initiate treatment for the majority of emergency services. The Keogh guidance stated that emergency departments with over 40,000 attendances were required to be co-located alongside acute medicine and intensive care. There were over 110,000 attendances in East Kent which suggested that East Kent could support two emergency centres including a major emergency centre with specialist services but no more than two emergency centres due to workforce. None of the options were removed at this stage.

(8) For implementable criteria, Ms Shutler reported the Trust had looked at the cost and timescale to build a new hospital or remove services from one site. The estimated cost of a new build was over £700 million and recent examples of new build hospitals of a similar size in Derby and Glasgow took 9 - 11 years to build. She stated that a Greenfield or single site options on a current acute site were removed as options due to the cost and not being implementable by 2021.

(9) For the accessibility criteria, Ms Shutler noted that a travel time of one hour or less by car had been set. Analysis found that the entire East Kent population

was within one hour's car drive of emergency, urgent care and acute medical services and all options remained.

(10) For the strategic fit criteria, Ms Shutler highlighted that two measures were taken into account. The first was the national and regional designations which included the designation of a percutaneous coronary intervention (PCI) service and trauma unit at the William Harvey Hospital. The second was public consultations undertaken in the early 2000s which had resulted in the removal of the Accident & Emergency department at the Kent & Canterbury Hospital. She explained that taking these two measures into account the William Harvey Hospital had been identified as the major emergency centre with specialist services; with the Queen Elizabeth The Queen Mother (QEQM) Hospital becoming the second emergency centre and the Kent & Canterbury Hospital becoming an integrated care hospital or urgent care centre.

(11) For the financially sustainable criteria, Ms Shutler stated that the final option to be tested was whether the QEQM Hospital should be an emergency centre or medical emergency centre. She reported that due to the significant capital costs of making the QEQM Hospital a medical emergency centre, it was concluded that the site would need to be an emergency centre. This resulted in option one as outlined in the additional report with William Harvey Hospital as the major emergency centre with specialist services, QEQM Hospital as second emergency centre and the Kent & Canterbury Hospital becoming an urgent care centre.

(12) Ms Shutler explained that the Trust had received a proposal from a commercial third party, to build the shell of a new hospital on or adjacent to, the current Kent & Canterbury Hospital site. It was proposed that the new hospital would be a single major emergency centre with specialist services in Canterbury and be supported by two peripheral hospitals at the William Harvey and QEQM sites. She noted that whilst the proposal sat outside of the process to date, legal advice stated that it would be unreasonable not to consider the proposal from the developer and it was therefore being considered as an additional option, option two.

(13) With regards to the elective orthopaedic services in East Kent, Ms Shutler reported that the long list of eight options included:

- no inpatient orthopaedics unit on any of the Trust's three acute hospital sites in east Kent but a centralised Kent and Medway unit in west Kent;
- a single east Kent inpatient orthopaedic unit on one of the three hospital sites;
- all combinations of two orthopaedics units on two of the acute hospital sites;
- an inpatient orthopaedics unit on all three hospital sites.

(14) For the clinical sustainability criteria, Ms Shutler highlighted evidence from the South East Clinical Senate that had suggested that elective units undertaking more than 3,000 joint procedures a year would enable the delivery of higher standards of care and improvements for patients and would improve the efficiency of the service. As the Trust undertook more than 3000 joint procedures a year, it demonstrated that East Kent could support its own

elective surgery and therefore the only options going forward would be delivered from one, two or three sites.

(15) For the implementable and accessibility criteria, Ms Shutler stated that only 43 elective inpatient orthopaedic beds would be required in East Kent, it had been concluded that the service could be delivered from any one, two or three of the current EKHUFT sites which were all within the hour travel time.

(16) For the strategic fit and financially sustainable criteria, Ms Shutler noted that previous consultations had reduced the number of sites for inpatient orthopaedic services from three to two in 2004/5 due to workforce pressures; the three site options had therefore been discounted.

(17) Ms Shutler stated that the hurdle criteria had produced a medium list of six options:

- Only Kent and Canterbury Hospital (K&C)
- Only QEQM Hospital (QEQM)
- Only William Harvey Hospital (WHH)
- Both K&C and WHH
- Both K&C and QEQM
- Both WHH and QEQM

(18) Ms Shutler noted that the medium list options for both urgent, emergency and acute medical care and planned inpatient orthopaedic care in east Kent would now be discussed in more detail by the East Kent Joint CCG Committee who would assess which options should go forward to public consultation next year.

(19) The Chair requested that the final options be brought to the Committee prior to the start of the public consultation; Ms Smith confirmed this. Ms Shutler invited the Committee to attend public events which will be held as the options were evaluated further. The Chair enquired about patient flow between East Kent and its neighbouring areas. Mr Ridgwell explained that whilst the initial findings indicated that patient flows between the different areas was limited, which would be further tested as part of the detailed evaluation of the options and the NHS England assurance process, he noted that these proposals sat within the wider Kent and Medway strategic framework.

(20) The Chair invited Paul Carter, Leader of Kent County Council, to speak. Mr Carter expressed concerns about the lack of investment in local care and the focus of reconfiguring acute services in East Kent only. He highlighted that population growth in East Kent may require one major emergency centre and two emergency centres to support this and the need for a new hospital in Canterbury. He suggested that the current proposals were sufficiently concerning to warrant a potential referral to the Secretary of State for Health.

(21) Mr Ridgwell acknowledged that the financial position was difficult but as part of the STP's investment case, spending was being re-profiled to invest in local care. He stated that the challenges faced by the acute sector in East Kent were more pronounced than the rest of Kent and Medway and required urgent action. Ms Shutler commented that analysis of patient flow had shown that

when services were changed in East Kent, patients did not flow to West Kent. She noted that discussions were taking place in West Kent about urgent care services but due to the operational issues in East Kent, urgent change was required and they were unable to wait for the rest of Kent & Medway. She stated the creation of a single emergency centre with specialist services would require 900 - 1000 beds and become the 17th largest A&E in the country; similar new build hospitals in Birmingham & Derby had cost £700 - 900 million. She noted that the proposal from the developer was significant as there would be less capital costs but there was a risk to the timescale.

(22) Members commented about travel times particularly those from deprived areas who may not have access to a car or from rural areas. Ms Shutler explained that the entire East Kent population was within one hour's car drive of the Trust's three sites including Faversham and Swale. This finding had been verified by Basemap, a piece of software which used data from journey at peak and non-peak times via satellite navigations systems. Ms Shutler committed to share the travel data with the Committee. She noted that an Equality Impact Assessment had been commissioned which would look at social demographic factors such as car ownership; Mr Ridgwell committed to sharing the Equality Impact Assessment with the Committee. Ms Shutler stated that if a 30 minute travel time had been applied as a hurdle criteria, it would have indicated that services should be provided on all three sites which was not sustainable. She reported that travel times had previously been discussed at the Committee and public events. She noted as part of the changes to outpatient services, the Trust had paid Stagecoach £400,000 to provide additional bus routes which now paid for themselves.

(23) In response to a specific question about the difference between the current model and option one, Ms Shutler acknowledged that whilst the transfer of acute medicine and junior doctors from the Kent & Canterbury Hospital was an emergency and temporary move due to workforce pressures, until a decision was made following public consultation, emergency services were technically provided from three sites. She noted that the Trust currently provided a range of specialist services across three sites including PCI and trauma at the William Harvey Hospital, renal and vascular at the Kent & Canterbury Hospital and gynaecology at the QEQM Hospital; in option one, these specialist services would be moved to a single major emergency centre. In terms of elective orthopaedic services, she reported that the number of patients had increased by 75% over four years, and pressures from emergency and medicals services had resulted in an increasing number of elective procedures being cancelled. The proposal for orthopaedic services was for it to be delivered from one or two site depending on the urgent care option chosen.

(24) Members enquired about workforce. Mr Ridgwell stated whilst additional money would be welcome, it would not resolve the workforce shortages; the delivery of services was required to change. He stressed the importance of having optimally configured and modern services alongside multidisciplinary teams to attract and retain staff. Ms Smith reported a Kent & Medway framework was being developed to support staff's training and development. She gave the example of a national programme which recruited pharmacists into primary care; pharmacists in Shepway and Dover were working with GPs

to support care homes and their staff with medicine management. She noted that a single bank for staffing was being developed across Kent & Medway.

(25) Members asked about the medical school, joined up working and the STP. Ms Smith confirmed that the medical school was not predicated on a new build site in Canterbury. The focus of the bid for a medical school was to support primary care development as set out in the national criteria. She highlighted that whilst the medical school would be in Canterbury, it would support hospitals across Kent and Medway. Mr Perks acknowledged that the NHS needed to better demonstrate how these proposals were joined up with the STP. He stated that the STP had joined up elements of planning including local care and it was important that the NHS was able to show the Committee successful work being undertaken. Mr Ridgwell noted that there was a significant focus on improving integrated working and efficiency and productivity as part of the STP.

(26) The Chairman invited Steve Inett, Chief Executive, Healthwatch Kent to comment. Mr Inett noted that the impact of social care, particularly in relation to patient flow, as part of hospital reconfigurations. He stated the importance of senior KCC leaders participating in upcoming engagement events.

(27) The Chair concluded the discussion. She stated that the proposed changes were predicated on local care and it was important that the Committee had a clear understanding of the local care model. She stated that Members had challenged some of the assumptions regarding the proposed options and requested that the guests reflect on these. She noted that it had been difficult to consider the additional information and invited the NHS to present to the Committee again in January.

(28) RECOMMENDED that the report on the Kent and Medway Sustainability and Transformation Partnership be noted and a full update on the proposed reconfiguration of services in East Kent be presented to the Committee in January.

Cllr Lyons, in accordance with his Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust, withdrew from the meeting after the presentation and took no part in the discussion or decision.

29. East Kent Out of Hours GP Services and NHS 111
(Item 6)

(1) Due to the amount of time taken to discuss other items on the Agenda, the Chairman determined to postpone consideration of this item until the next meeting.

30. NHS preparations for winter in Kent 2017/18
(Item 7)

Ivor Duffy (Director of Assurance and Delivery, NHS England South (South East)); Rachel Jones (Director of Commissioning and Performance, NHS Dartford, Gravesham & Swanley CCG & NHS Swale CCG); Simon Perks (Accountable

Officer, NHS Ashford & NHS Canterbury and Coastal CCGs) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chair welcomed guests to the Committee. Mr Duffy introduced the Winter Preparedness report, highlighting the fact that planning for winter had begun during the previous year and that two 'wash up' exercises were undertaken. He noted that the 2017 assurance processes had been much more robust, with considerable joint working and information sharing with NHS England and other relevant partners, supported by significant testing of the plans to confirm that they were practical and effective.

(2) Responding to Member questions regarding the seasonal flu vaccination uptake, Mr Duffy advised the Committee there was no authority to require anyone to receive the flu vaccine, NHS England had contributed significant resources to provide for social care staff and partners who wished to receive the vaccination.

(3) Mr Wickings advised the Committee that the previous winter had posed challenges for the West Kent health economy, particularly in relation to patient discharge management involving care home provision and other factors. He advised that work had been undertaken, supported by some additional BCF funding, which had addressed these issues to some extent, reducing the discharge delays. Mr Wickings explained that work was ongoing around the Home First approach, which sought to ensure that those with the most significant frailty could have needs addressed appropriately in a way that minimised any delays to discharge; this involved ensuring processes were in place to manage ongoing care assessments and support plans outside of the hospital setting. Mr Wickings commented that while the planning work had been positive and that progress had been made, winter always presented significant challenges to the NHS and he assured the Committee that these challenges were taken very seriously.

(4) Ms Jones highlighted the challenges in the North Kent health economy related to domiciliary care. She advised that work was ongoing to engage with relevant providers to identify solutions. While this had not yet addressed all issues, Ms Jones advised the Committee that preparations were better in 2017 than they had been in the previous year. Ms Jones also commented on the specific issues relating to Darent Valley Hospital as a key link with London whereby its demand level for care and support resources included patients from outside the CCG area.

(5) Mr Perks highlighted the specific issues affecting the East Kent health economy, including having one of the worst performing A&Es in the country. This meant that there was a risk around capacity to handle surges in demand over the winter period. He noted that in previous winters, East Kent had managed most issues fairly well, with a surplus beds being available. However, the changes to acute care meant that this would not necessarily continue. Mr Perks commented that joint working with key partners was ongoing, which was expected to allow some other parts of the health care sector to take some of the pressure when demand surges occurred. He highlighted the positive impact of the joint working, advising the Committee that the silo working which had been criticised previously had been replaced

by a much more co-operative partnership approach to managing key issues around health and social care.

(6) Mr Duffy commented work was being undertaken by NHS England to ensure best use of the BCF funding to support effective hospital flow, whereby patients could be moved and managed where it was most appropriate, taking into account both the patient's needs and service capacity. This had been presented to the Kent Health and Wellbeing Board. He also explained that work was being done around the mutual aid programme to help support effective sharing of resources around the county to deal with pockets of demand surge.

(7) Responding to Member questions, Mr Duffy explained that NHS England had been supporting effective communication about the availability of primary care services over the Christmas period. This involved ensuring appropriate advertising and information sharing was put in place. Mr Perks commented that the East Kent Hospitals communications team, now under a single director, had developed a more cohesive message around accessing services appropriately. This included making people more aware about the services available from the minor injury units, pharmacists and self-care advice. He advised that it was hoped that this approach would reduce unnecessary demand at A&E. Mr Perks and Mr Duffy confirmed that these communication programmes would include appropriate methods to reach different parts of the community, such as social media, apps, online information and leaflets. Mr Perks highlighted the benefits of the Waitless App, which directed people to the most appropriate service, taking into account waiting times. He noted that the usefulness did depended on patients being able to access transport to get to alternative care sites. Members agreed with the positive use of the Waitless App.

(8) RESOLVED that the report be noted and NHS England be requested to provide an update about the performance of the winter plans to the Committee at its June meeting.

The meeting was adjourned at 12:45 and reconvened at 13:30.

31. West Kent CCG: Over The Counter (OTC) Medicines
(Item 8)

Bob Bowes (Chair, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman invited West Kent CCG representative, Dr Bowes, to update the Committee on the decision of the CCG governing body to amend its prescribing policy so that over-the-counter medicines would no longer be prescribed for minor ailments.

(2) Dr Bowes apologised to the Committee that the process followed in developing the proposals had not been in line with that set out to the Committee at previous meetings. He advised the Committee that it was important to note that the CCGs were not able to enforce changes to what GPs were and were not allowed to prescribe due to GPs' contracts with the General Medical Council. However, Dr Bowes explained that the CCG was of

the view that when made aware of the significant cost implications of prescribing over the counter medications, many patients were happy to purchase their own for short-term use for minor ailments. He confirmed that this proposal would not dictate how GPs prescribed but that by highlighting the issue, it was hoped that it would lead to change in prescribing habits and that this would equate to around £300,000 worth of savings out of the £1.7m budget currently in use. Providing clarification to the Committee, Dr Bowes confirmed that the proposal was a recommendation to GPs, rather than a directive.

(3) Members commented on the importance of encouraging healthier lifestyles to minimise a reliance on regular medication.

(4) Responding to questions from Members, Dr Bowes explained that approximately 80% of patients did not pay for prescriptions and that it was this patient group that may be asked to buy low cost, short term prescriptions over the counter as part of the proposal. He reassured the Committee, that the free prescription patient group did not get this entitlement based on their financial situation in the majority of cases, so it was not expected that there would be any significant negative impact and he reiterated that when given the appropriate advice by GPs regarding purchasing over the counter medication, most patients were agreeable to this approach. Dr Bowes advised the Committee that where patients did still require a prescription, based on medical assessment, appropriate prescriptions would still be issued. He confirmed that the proposal would mean that where many consultations already involved doctors providing information leaflets to help patients self-manage, this could now also include a recommendation to purchase the relevant over-the-counter medication themselves. Dr Bowes also highlighted the Pharmacy First scheme, which provided an alternative method of accessing free prescriptions without additional medical consultation.

(5) In response to comments, Dr Bowes agreed that whilst people were using the Pharmacy First scheme, it still had a greater potential. He recognised that it was important to ensure a balance between appropriate access to primary care for medical consultations and seeking pharmaceutical advice outside these care settings. This helped relieve pressure of GPs and still allowed patients to access the help they needed. Dr Bowes clarified that the Pharmacy First scheme involved pharmacists prescribing medication as appropriate, without the need for the patient to visit a doctor. However, he noted that this would also mean that those who were advised to purchase their own medication but were unable to afford them could still obtain prescriptions via a pharmacist when appropriate.

(6) Dr Bowes also addressed comments from Members regarding returned, unused medications and the provision of infant formula. He advised that where a medical reason necessitated the prescribing of infant formula, this would still happen in line with normal prescribing practice. He noted that many prescription formulas were more than standard formula, which should be taken into account. In terms of returning medication, he explained that safety and the risk of tampering were crucial factors in the approach and it was a national level decision given the wide reaching implications.

(7) Responding to comments, Dr Bowes and Mr Wickings explained that the target areas identified in the reports referred to the sampling undertaken as part of the equality impact assessment and clarified that there was no intention that the proposed scheme was going to be applied differently in different areas within the CCG. The Committee requested that further information was provided regarding the patient sampling and engagement undertaken around the proposals and the CCG representatives agreed to provide this.

(8) In response to a question regarding GP adoption of new practices and policies, Dr Bowes advised the Committee that there was a commitment at all levels within the CCG, including GPs, to identifying appropriate measures to save money to ensure good quality care could continue in the future in the face of significant financial challenges. He also commented that the West Kent CCG health economy had recovered fairly well despite the challenges but this did not change the need to work hard on efficiency. Mr Wickings reassured the committee that the recommendations from the CCG to GPs were developed in collaboration with GPs, so there was engagement and discussion prior to any notification or implementation of any proposals.

(9) The Chairman summarised the discussion, noting that the Committee had requested the item as part of expressing its disappointment in not being consulted more fully as the proposal was developed.

(10) RESOLVED that the Committee:

(a) expressed disappointment about the lack of consultation by the CCG with the Committee about its review of prescribing policy for over-the-counter medicine for minor ailments;

(b) proposed that a joint protocol is developed which sets out how the Committee and its NHS counterparts will jointly reach a view as to whether or not a proposal constitutes a “substantial development” or “substantial variation.

32. Assistive Reproductive Technologies (ART) Policy Review
(Item 9)

Stuart Jeffery (Chief Operating Officer, NHS Medway CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) Mr Jeffery advised the Committee that Medway CCG was the lead CCG for IVF and all assistive reproductive technologies (ART) in Kent. He introduced the report which outlined proposals for a review of the service. Mr Jeffery explained that the review outlined was undertaken as part of the CCG’s standard review cycle but also because it had become evident that the service offer provided by Kent and Medway was different to that offered in rest of the country, notably that Kent and Medway were offering two cycles of therapy when other health areas only offered one or fewer. He also noted that it had recently been identified that the current policy may have discriminated against same sex couples, which was an issue the CCG was keen to address as soon as possible. He advised that the report set out the process, timeline and planned consultation work as part of the review, which would latterly involve

bringing the proposals back to the Committee for further consideration in due course.

(2) Steve Inett, Chief Executive, Healthwatch Kent, extended an offer to support stakeholder engagement to assist the CCG with capturing public views and identifying potential issues. He also queried how the CCGs were planning to align ongoing service changes to ensure effective consultation. Mr Jeffery, explained that consultation planning was ongoing and that stakeholder engagement was planned, with potential for agencies to be employed to support this work. Mr Wicking noted the large scale of the Kent and Medway area and that it contained a significant range of different population and stakeholder groups. He also explained that work was undertaken by the Commissioning Support Unit (CSU) to try to plan and programme in consultation and engagement activity so that the schedule was not overwhelming or confusing for stakeholders. Mr Jeffery reassured the Committee that the planned consultation work would involve using professional organisations to support obtaining a representative sample of views.

(3) Responding to questions regarding the proposed reductions, Mr Jeffery explained that each cycle included one frozen embryo and one fresh embryo. This meant that the current two cycle approach involved four embryos and it was proposed that this drop to two, in line with wider practice nationally.

(4) Responding to a question regarding the planned provision for patients who may require ART in order to conceive as a result of injury or trauma, Mr Jeffery advised the he would confirm the full policy details and provide the information in due course.

(5) Mr Jeffery reassured the Committee that there was no appetite in the CCG to completely remove ART provision but there was a recognition that it was appropriate to review and change the way it was provided. As per the early stage proposals, it had been assessed that a reduction from two cycles to one cycle of treatment was appropriate. Mr Wickings also commented that the CCG was basing the proposals on the best expert advice and that while it would not choose to implement such reductions, there were many difficult decisions to be taken and in light of the financial challenges, not saving money in one area would mean having to save money in other areas of medicine. Responding to further comments, Mr Wickings advised that the CCGs were aware of the sensitivity of the subject but was committed to being honest about the drivers behind the change, notably the requirement to find savings while still maintaining critical care issues.

(6) Mr Jeffery advised the Committee that the information provided represented the plans as far as they had been developed and that the CCG's policy unit was still working to finalise the proposals to be put out to consultation. He assured the Committee that the detailed proposals would be provided in January, when the CCG would also ask the Committee to advise on whether the matter should be considered as a substantial variation of service.

(7) Responding to questions regarding service variations across the county, Mr Wickings explained that CCGs had been striving to operate on a Kent and

Medway wide basis when planning service changes. He clarified that this approach was positive but not always possible as each CCG has authority to make its own decisions. He was hopeful, however, that the majority of Kent and Medway CCGs would make similar decisions around this service, preventing problematic service variations around the county. Mr Jeffery commented that the planning and development of the policies did involve significant engagement and discussion with a range of CCGs and that this often encouraged greater consistency.

(8) RESOLVED that the Committee:

(a) notes that a review of the Assistive Reproductive Technologies (ART) policy is being undertaken by the Kent & Medway CCGs;

(b) requests that the proposed revised policy is presented to the Committee in January in order for it to make a determination about the proposals constituting a substantial health service development or variation.

33. Healthwatch Kent: Annual Report

(Item 10)

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

(1) Steve Inett presented Healthwatch Kent's Annual Report. He highlighted the following points:

- The report sought to present a balance between activities taken by Healthwatch Kent (HWK) and the outcomes that had been achieved. This reflected the collaborative approach Healthwatch endeavoured to take when working with the Council and the NHS.
- HWK's 70 volunteers were reviewing their role to identify how they could offer best value. Mr Inett commented that their commitment was excellent, supported by HWK's recent receipt of the Investors in Volunteers award.
- HWK's budget during the period covered by the Annual Report had been at £666,000 (10% reduction from the year before) and that this budget had since been reduced by a further 20% to £511,000. Mr Inett explained that some of the funding had previously been put aside to support engagement work within their operational budget but that this area had largely had to cease because of the budget cuts.

(2) Responding to questions, Mr Inett explained that work was ongoing to shift the public focus on to the Healthwatch volunteers, as historically the paid staff had been more visible through organisation engagement.

(3) Members commented on the positive work conducted by Healthwatch, noting in particular the progress made with engaging with Gypsy and Traveller communities. Mr Inett confirmed that engaging with seldom heard communities was a key priority for Healthwatch. Part of this work involved working in different districts to enable engagement across the county and across all the protected characteristics. He also noted the support provided by KCC's Gypsy and Traveller service in engaging with the community. Mr Inett

highlighted that the work with the seldom heard communities had led to the development of the Help Card which allowed those in need to discreetly ask for assistance. He noted that that the majority of CCGs and practices have signed up to this programme. Linked with this activity, Mr Inett highlighted Healthwatch's support of the Accessible Information Standard from NHS England. Healthwatch had requested updates from all NHS trusts on how they assess people's additional communication and support needs, as it was now a legal requirement to do so. He advised the Committee that Healthwatch have been visiting Kent hospitals to test staff's knowledge of these processes.

(4) Responding to questions, Mr Inett confirmed that the funding for Healthwatch Kent was from the Department for Health, administered and commissioned via Kent County Council.

(5) In response to a question regarding the new physical disability forum, Mr Inett advised that the forum was very successful and that attendance varied depending on the types of meetings being held. Some sessions were open sessions to gather public views from a wider group and that these were supported by smaller working group sessions aimed at developing plans for progressing the issues raised through the wider forum. He highlighted the positive work already achieved; recommendations had been shared with relevant agencies, including the promoting of research and assessments conducted by other organisations that have struggled to connect with appropriate authorities.

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

Mr Chard, in accordance with his Disclosable Pecuniary Interest as a Director of Engaging Kent, withdrew from the meeting for this item and took no part in the discussion or decision.