KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 20 September 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, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Mr M Whiting, Cllr L Hills and Cllr T Searles

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

UNRESTRICTED ITEMS

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

(1) Mr Pugh declared an Other Significant Interest as a non-voting member of NHS Swale CCG's Primary Care Committee.

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

(3) Mrs Game declared an interest as the Chair of the QEQM Hospital Cabinet Advisory Group at Thanet District Council.

12. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 14 July 2017 are correctly recorded and that they be signed by the Chairman.

13. Children and Young People's Emotional Wellbeing and Mental Health Service and All Age Eating Disorder Service
(Item 4)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance.

(1) The Chair welcomed the guests to the Committee. Mr Ayres began by stating that the joint reprocurement of the Children and Young People's Emotional Wellbeing and Mental Health Service between the NHS and Kent County Council had been a positive step forward and could be used as a model for future commissioning. The NHS and KCC had worked with young people, parents and carers to develop a single strategy and service model which had

been used to procure the new service; historically KCC and the NHS had commissioned services separately and there had been overlap.

(2) Mr Ayres explained that the new contract for Children and Young People's Mental Health Services commenced on 1 September 2017 with services being delivered by North East London NHS Foundation Trust (NELFT); the primary school public health service element of the contract was being delivered by Kent Community NHS Foundation Trust. He stated that a key aspect of the contract was the commissioning of a single point of access to provide advice, guidance and access to all services under the strategy. He reported that the contract mobilisation had gone well; there had been few complaints and hidden waiting lists, which had been discovered during mobilisation phase, were being dealt with.

(3) A Member thanked Mr Ayres and the stakeholders for all their efforts in procuring the new service and requested an update in six months to provide assurance that the new service was working well. Members asked about capacity, waiting lists, the number of providers who bid for the contract and the use of subcontractors. Mr Ayres stated that the new contract should have sufficient capacity to meet the demand and he would be able to provide an update in six months about how the contract was performing. He reported that the new provider was working rapidly with the previous provider to clear the waiting lists. Mr Ayres noted that there were a limited number of providers who were capable of delivering a Kent wide service and had not been expecting a large number of providers to bid for the contract. The new provider had a track record of delivering high quality and innovative services. Mr Ayres stated that a provider would need permission from the CCG to use a subcontractor and would only be granted after a due diligence process had been undertaken.

(4) With regards to the new all age eating disorder service in Kent and Medway, Mr Ayres reported that the service was also being delivered by NELFT which provided opportunities to integrate services. A Member enquired if both services would be procured together in the future. Mr Ayres explained that the services had been historically been procured separately but if services were integrated and timelines aligned, it may be possible for an integrated service with a broader specification and scope to be reprocured in the future which the Committee would be kept informed about.

(5) In response to specific questions about access to specialist services, Mr Ayres noted that as part of the new service model, services should be delivered as locally as possible but recognised that some treatments were so specialist they may require travel to access them. Mr Ayres committed to providing the Committee with the number of children and young people currently in an out-of-county placement and their distance from home; in addition to the number of all-age patients accessing eating disorder services in a residential unit.

(6) Members commented about staff training, the single point of access and the provider's financial position. Mr Ayres explained that the contract required the provider to train staff and he was confident that the provider would do this; staff training would be monitored through contract management. Mr Ayres confirmed that the single point of access would be based in Kent and there were no concerns about the provider's financial position.

(7) RESOLVED that the reports on Children & Young People's Emotional Wellbeing & Mental Health Service and All Age Eating Disorder Service be noted and the CCG be invited to provide an update in six months.

14. Patient Transport Service
(Item 5)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance.

(1) Mr Ayres began by explaining that there had been problems with the previous provider and the patient transport services contract was reprocured at the earliest possible stage. He noted that patient transport services were mostly provided by commercial organisations and there were few providers of significant scale. He stated that G4S was awarded the new contract and mobilised last year; it was a quality driven procurement and G4S had the highest quality scores.

(2) Mr Ayres stated that the three elements of the contract were mobilised on 1 July 2016: Kent and Medway patient transport excluding the transport of renal patients and transport to and from Dartford and Gravesham Hospital Trust; renal patient transport; and Kent and Medway patient transport to and from DGH sites. Transport into London was not mobilised until February 2017 until a due diligence process with London trusts was carried out. He explained that the mobilisation of the renal service had some initial problems but had stabilised and was operating well; both renal transport and transport to and from Dartford and Gravesham Hospital Trust had moved into business as usual mode.

(3) Mr Ayres reported that the remaining part of the contract was being disrupted by the journeys to and from central London. Journeys to and from London represented 1 – 2 % of all journeys and were being taken out of the contract due to the small volume of journeys with the exception of journeys to and from Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. The CCG had sought independent advice to review activity to ensure that there were sufficient vehicles and staff to deliver the contract. The CCG had issued a performance notice to G4S regarding its complaints process; G4S had made significant progress and it was anticipated that the notice would be removed within a month.

(4) Mr Ayres reported that mobilisation would be completed within three – six months. He stated that it was disappointing that the mobilisation had not been quicker but noted that it had been better than the previous provider. He recognised that there had been significant failures and confirmed that a detailed analysis would be undertaken to review and understand the mobilisation.

(5) The Chair enquired about the provision of qualitative and quantitative performance data including details of the patient experience which the Committee had previously requested. Mr Ayres confirmed that this could be

shared with the Committee once the detailed analysis of data had been completed.

(6) A Member stated that delayed journeys had significantly impacted patients and their families and reported difficulties in them being able to contact G4S. Mr Ayres acknowledged that some patients had been let down very badly and he had a weekly phone call with the G4S Managing Director for Patient Transport Services to review performance. He stated G4S were required to have an onsite presence at every hospital and where the onsite presence worked well, there were fewer complaints; he reported that the onsite presence required improvement at two sites. The CCG was reviewing complaints categorised as unknown as part of it performance notice. He noted that there had been initial complaints about eligibility criteria; G4S had worked with the CCG and hospital trusts to develop a clear schedule which set out eligibility and as a result the number of complaints had been reduced. He stated that he was pleased that G4S was working collaboratively to resolve issues as they occurred.

(7) A Member expressed concerns about the performance of the current provider and its similarities with the performance of the previous provider. Mr Ayres stated that whilst he understood the concerns, he only recognised those in terms of the London activity. He explained that a key learning point from the previous contract was that inaccurate data led to difficulties with the procurement. He reported that the Kent activity in the new contract was mostly accurate; early identification of inaccuracies in the London activity had resulted in the mobilisation being delayed. Options being considered to improve transport to and from London included increasing G4S' capacity and making arrangements with the London trusts for them to provide for patients with transport.

(8) Members enquired about measures to prevent repeated failed journeys and the eligibility criteria. Mr Ayres reported that G4S monitored patients who had been let down during mobilisation to ensure that it did not happen again. He stated that CCGs were reviewing complaints to assure itself that incidents were reducing. Mr Ayres explained that there was a national specification which set out the eligibility criteria for patient transport services to patients who had a medical need that prevented them from using private or public transport. Mr Ayres confirmed that changes to the eligibility criteria had not been reduced in order to meet performance targets. He stated that G4S was able to signpost patients who were not eligible for transport to local voluntary services; it was working with KCC to get an accurate and up-to-date list of services.

(9) Members asked about contractual levers and the flexibility of trusts to see patients if they were delayed. Mr Ayres explained that the CCG was due to receive the reprofiling of the service in the next two – three weeks from G4S which could result in changes to the contract. He stated that there were a range of levers in standard NHS contract such as a removal of a service with one year notice which included a no blame clause. If the provider significantly breached its contract, CCGs can serve notice with immediate effect. There were a number of informal levels including the provision of a reference to the provider if they wish to bid for other services.. He reported that whilst trusts were being flexible and would accommodate delayed patients where possible,

patients were more likely to be delayed on their return, rather than outward, journey.

(10) In response to specific questions about the use of alternative modes of transport and volunteer drivers, Mr Ayres committed to finding out about use of trains for patient transport service journeys. He explained that although G4S did use volunteer drivers, they were mostly used as part of voluntary services. The previous provider had used volunteer drivers and it had not worked effectively. He confirmed that volunteer drivers did not require medical training as they provided care rather than medical interventions.

(11) RESOLVED that:

(a) the report on Patient Transport Services be noted;

(b) NHS West Kent CCG be requested to provide an update in six months with:

(i) qualitative and quantitative data including the details about patient experience and areas of underperformance;

(ii) feedback from the action plan regarding complaints.

15. West Kent CCG: Out of Hours (OOH) GP Relocation
(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance.

(1) Mr Wickings began by explaining the 2013 Keogh Urgent and Emergency Care Review provided opportunities for primary care input into emergency departments. In 2015 the CCG began to co-locate GP Out of Hours (OOH) services within the two Emergency Department at the Maidstone and Tunbridge Wells NHS Trust hospital sites but it was only achieved at the Maidstone site.

(2) Mr Wickings stated that following the securing of capital funding, the CCG was now proposing to relocate GPs from Cranbrook and Tonbridge OOHs bases to be part of co-located primary care service at the Tunbridge Wells site; patients would no longer be able to walk-in to Tonbridge Cottage hospital base. He stated that a roving OOH GP car would be retained to visit patients who were unable to travel. He reported that the move to the Tunbridge Wells site provided a number of advantages including improved GP rota fill, greater clinical input and integration within the emergency department.

(3) A Member enquired about minor injury units. Mr Ayres explained that there was a move to integrate minor injury services as part of primary care. The model was being explored in Edenbridge and Hawkhurst; GPs in Hawkhurst were looking to move into the community hospital site which would enable them to provide minor injury services. Minor injury services were part of the West Kent integrated urgent care proposals which included the creation of Urgent Care Centres and the reprocurement of 111 service supported by an enhanced Integrated Clinical Advice Service.

(4) In response to questions about the use of technology, Mr Wickings stated that the emergency departments were already able to view GP records. The CCG was exploring the use of apps to signpost and provide advice and information.

(5) Members asked about the procurement of the 111 service and the timescale for the integrated urgent care proposals. Mr Wickings confirmed that there would be a Kent & Medway wide procurement of the 111 service and he would be the Senior Responsible Officer. He stated that the CCGs were proposing to implement the changes to the OOH service whilst they continued to engage with patients and public on their wider proposals for integrated urgent care model. He committed to sharing information with the Committee as the proposals were developed.

(6) RESOLVED that:

(a) the Committee agrees with its original decision that the co-location of out-of-hours services within an emergency department is not a substantial variation of service.

(b) West Kent CCG be invited to submit a report to the Committee in six months including an update about the relocation of the Sevenoaks OOH base.

16. West Kent CCG: Gluten Free Services (Written Briefing)
(Item 7)

(1) The Committee considered an update report by NHS West Kent CCG about its Governing Body decision to no longer routinely prescribe gluten-free food from 1 September for people with coeliac disease in West Kent.

(2) A Member commented that the decision would particularly affect low income families on universal credit.

(3) RESOLVED that the CCG's decision to no longer routinely prescribe gluten-free food for people with coeliac disease in West Kent be noted.

17. West Kent CCG: Financial Recovery Plan (Written Briefing)
(Item 8)

(1) The Committee considered an update about NHS West Kent CCG's Financial Recovery Plan which contained details about its 2016/17 outturn and 2017/18 control totals and plans.

(2) RESOLVED that the Committee:

(a) noted the report regarding the Financial Recovery Plan;

(b) is notified, in good time, as any further proposals are developed by the CCG.

18. West Kent CCG: Dermatology Services (Written Briefing)
(Item 9)

(1) The Committee considered an update about the mobilisation and performance of the West Kent Dermatology Service which had commenced in April 2017.

(2) RESOLVED that the report on the mobilisation of the West Kent Dermatology Service be noted.

19. Mental Health Rehabilitation Services in East Kent (Written Briefing)
(Item 14)

(1) The Committee considered a letter from Helen Greatorex, Chief Executive, Kent & Medway NHS and Social Care Partnership Trust regarding the outcomes for patients who had been on the Davidson ward at St Martins Hospital, Canterbury which had closed.

(2) RESOLVED that the letter from KMPT, regarding the outcomes of patients who had been on the Davidson ward, be noted.

20. SECAmb Regional Scrutiny Sub-Group (Written Briefing)
(Item 15)

(1) The Scrutiny Research Officer stated that in September 2016 the Care Quality Commission (CQC) published its inspection report on South East Coast Ambulance Service NHS Foundation Trust (SECAmb) which rated the Trust as 'inadequate' and recommended that it be placed in special measures.

(2) She advised that at the request of the Trust, NHS England and NHS Improvement and in recognition of the logistical difficulties of SECAmb reporting to each of the six health scrutiny committees in the Trust's area, a SECAmb Regional Scrutiny Sub-Group was established to monitor the Trust's development and progress against its improvement plan at a separate joint meeting.

(3) She highlighted that the sub-group had met on three occasions: 20 December 2016, 20 March 2017 and 26 June 2017. The sub-group was comprised of two representatives from each of the six health scrutiny committees. The Kent representatives were Mrs Chandler and Mr Angell.

(4) She confirmed that the Agenda and papers would be shared with the Committee in advance of future meetings to enable Members to have the opportunity to propose questions for the Kent representatives to ask. The notes of the meeting would be shared with the HOSC and it was proposed that they were published as part of a future Agenda.

(5) RESOLVED that:

(a) the establishment of the SECAmb Regional Scrutiny Sub-Group be noted;

(b) the Committee considers the notes of future SECAmb Regional Scrutiny Sub-Group meetings as part of its Agenda;

(c) SECAmb be requested to attend a meeting of the Committee where deemed appropriate by the Kent representatives on the Sub-Group.

(6) The meeting was adjourned at 11:45 and reconvened at 13:15.

21. CCG Annual Rating

(Item 10)

Mike Gilbert (Assistant Accountable Officer, NHS Swale CCG and NHS Dartford, Gravesend and Swanley CCG) was in attendance for this item.

(1) The Chair welcomed Mr Gilbert to the Committee. Mr Gilbert began by explaining that NHS Dartford, Gravesend and Swanley CCG had been invited to present to the Committee following it being rated as inadequate and placed in financial special measures by NHS England in their annual assessment of CCGs. Four areas of concern had been identified by NHS England: the first two areas related to the non-delivery of the NHS constitutional standards on A&E 4 hour and 62 day referral to treatment cancer targets which were not unique to the CCG. The second two areas related to the CCG's deficit of £13.5 million in 2016/17, which was the primary reason for the rating, and the leadership capacity of the CCG which was shared with NHS Swale CCG. Mr Gilbert stated that the CCG accepted the rating and was working with NHS England to make improvements, particularly in relation to its financial performance.

(2) Mr Gilbert outlined the actions being taken by the CCG. He reported that the CCG had a financial recovery plan which had been in place since last year; a review at the start of the financial year had identified further efficiencies and the forecasted deficit was £7.3 million in 2017/18. He stated that there had been a number of appointments to the Governing Body including a Chief Operating Officer, Deputy Chief Nurse and additional GP clinical leads. He noted that a number of efficiency schemes had been introduced including a campaign to reduce medicine waste which was anticipated to make £2 million of savings. He highlighted that the CCG was working with GPs on clinical appropriateness of referrals into secondary care; there had been a 9% growth in activity at Darent Valley Hospital. He stated that the CCG was in contractual management discussions with its providers to review, refine and renegotiate contracts to ensure effectiveness and value for money; in some circumstances the CCG may need to decommission services. He stated that the CCG recognised that it was living beyond its means, he highlighted the impact of growth on the area with the creation of the garden city with 60,000 residents moving into the area in the next 10 – 12 years and the importance of funding allocations to reflect this.

(3) The Chair enquired about the increase in hospital activity and the impact of services being shifted from the acute to community as proposed in the STP. Mr Gilbert explained that there had been a significant increase in activity going to London providers and Darent Valley Hospital; for every patient treated in London, a market forces factor was paid in addition to the national tariff. Whilst the CCG recognised patient choice, it was reviewing with GPs, when offering choice, that routine services provided in London were more expensive. Mr Gilbert reported that the shift of services from the acute to community would

require and enable significant investment and integration of community services through local hubs.

(4) Members asked about the CCG's relationship with NHS England, joint commissioning with social care and the community services contract with Virgin. Mr Gilbert explained that the CCG had a good working relationship with NHS England locally who recognised the impact of growth in the CCG's area; both organisations were working together to identify and address issues faced by the CCG. He confirmed that the CCG had had joint commissioning arrangements, for learning difficulties, mental health and some children services, with Kent County Council for the last 18 months; further joint commissioning of adult social care was required. He stated that the CCG had awarded a seven year block contract for community services to Virgin; the contract was performing at the level it was commissioned and did not cost more than the previous contract.

(5) In response to questions about the joint executive team, over-performance of providers and audit of GP referrals, Mr Gilbert reported that NHS Swale CCG and NHS Dartford, Gravesend and Swanley CCG had a joint executive team which worked for both Governing Bodies; the recently appointed Turnaround Director and Chief Operating Officer worked across both organisations. He explained that providers such as Dartford & Gravesham NHS Trust were paid per patient and the CCG was required to pay for any activity above the planned level which resulted in underfunding. The CCG was working with the Trust to ensure that it met its targets whilst keeping activity within the planned level. He reported that audits were carried out as part of routine contract management checks.

(6) Members enquired about the commissioning of specialist services, budgeting and funding allocations. Mr Gilbert explained that NHS England commissioned specialist services so were not included in the CCGs' baselines. He noted that it was more difficult to budget for non-elective activity as there were a number of factors which influenced activity such as winter pressures. He reported that NHS Swale CCG also had a small deficit for the first time in its history. He stated that NHS England set allocations based on a 1% growth in the CCG area; the CCG asked for this to be reviewed as it was based on historic ONS data which did not reflect growth in its area. He stated that whilst the CCG had made representations to NHS England and its local MPs about its funding, the CCG recognised that it had to operate within its current allocation and demonstrate efficiency; as an example the CCG was exploring the use of technology between GPs and consultants to improve the effectiveness of outpatient appointments.

(7) Members asked about workforce, special measures and the rationalisation of services. Mr Gilbert explained that due to its proximity to London staff were attracted to London's world renowned specialist centres and pay weighting; staff who worked at Darent Valley Hospital received a fringe waiting. He noted that Dartford & Gravesham NHS Trust and Guy's and St Thomas' NHS Foundation Trust were working together as part of a vanguard to rotate staff between their sites. It was hoped that the health developments as part of the Ebbsfleet garden city would attract staff to work, live and train in North Kent. An area of particular concern was GP workforce which had an increasing workload and the CCG was working with them on their sustainability. He

stated that the CCG was determined to turn itself around and get out of special measures this year but recognised that there was a significant amount of work to do. He reported that the CCG would have to make difficult decisions which could include the rationalisation of services; any decision around this would be done in discussion with local people and may require consultation. A Member requested that the CCG present to the Committee at the earliest stage about service change proposals.

(8) RESOLVED that:

(a) the report be noted and the Kent CCGs be requested to provide an update to the Committee annually;

(b) NHS Dartford, Gravesham & Swanley CCG be requested to provide an update on its financial recovery plan at the appropriate time.

Mr Pugh, in accordance with his Other Significant Interest as a non-voting member of NHS Swale CCG's Primary Care Committee, withdrew from the meeting following Mike Gilbert's presentation and took no part in the discussion or decision.

22. East Kent Out of Hours GP Services and NHS 111
(Item 11)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance.

(1) The Chair welcomed Mr Perks to the Committee. Mr Perks began by assuring the Committee that the East Kent CCGs were working closely with the provider Primecare; a robust plan to address the issues identified by the CQC had been developed and was being monitored by the CCGs. The CQC would be reviewing the three warning notices covering safe care and treatment, good governance and staffing during the following week. He stated that there had been some difficulties with contract which the CCGs were seeking to resolve with Primecare. He confirmed that Primecare would be leaving the contract early on 7 July 2018.

(2) In response to a specific question about the CCG's oversight of the provider, Mr Perks stated that he took personal responsibility for overseeing the provider and its improvement plan; he was confident that the plan was achievable. He explained that regular contract management had identified concerns prior to the CQC inspection which had resulted in a performance notice being issued. He noted that a review of the procurement was also being undertaken. The CCGs were one of the first to combine 111 and care navigation services and there had not been a national specification at the time of procurement; the navigation service element of the contract had never been mobilised. He explained that the CCGs had worked closely with Primecare during mobilisation and there had been a phased implementation of the 111 service. He reported that Primecare was committed to addressing the concerns and he was confident that the actions being taken would resolve these; he anticipated that the CQC would confirm this at its next meeting.

(3) Members enquired about financial sanctions and staffing. Mr Perks explained that whilst it was possible to apply financial sanctions, in this instance, it would prevent the provider in making the necessary changes due to resourcing challenges. Mr Perks stated that there had been problems with the management during the mobilisation and Primecare had not engaged with local GPs as the previous provider had done. He reported that Primecare had subsequently appointed a medical director to build relationships with local GPs. The CCGs were monitoring the level of staff cover being provided; if the 111 or out-of-hours service did not work effectively, it could have implications on the wider system such as increased A&E attendance.

(4) A Member asked about the potential of bringing the service in house. Mr Perks stated that consideration was being given to out-of-hours services becoming part of seven day working in primary care but it required significant GP resource which was not currently available. The provider had been contracted to integrate 111, out-of-hours and care navigation services but had not been able to make the partnership arrangement required to do this; partnership working would be a focus of a future contract award. Mr Perks reported that a joint procurement of a Kent & Medway 111 service, to go live in April 2019, had been agreed. The East Kent CCGs were developing interim arrangements between the Primecare contract ending in July 2018 and the start of the new contract.

(5) A number of comments were made about performance. Mr Perks explained that 111 service was subject to local and national performance standards such as the percentage of calls addressed by clinicians. He stated that the contract required doctors to be on call but the provider had struggled with its fill rate; there had been a number of hours at the weekend where out-of-hours doctors had not been in place. He stressed the importance of the provider improving its relationship with local GPs so they could work in partnership to improve the service.

(6) RESOLVED that:

(a) the report be noted;

(b) the East Kent CCGs be requested to provide a written update to the Committee in November and a verbal update in January;

(c) the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.

23. Local care in East Kent
(Item 12)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance for this item.

(1) Mr Parks began by explaining that the paper set out the four different approaches to the local care model in East Kent. As part of the model, CCGs were investing in community services to enable more care to be provided out of hospital; this had been evidenced in the Canterbury & Coastal CCG area where a catheter clinic in the community had lowered acute admission rates.

He reported that the management teams of the East Kent CCGs were working together to share learning.

(2) A Member requested an update about the reinstatement of acute medicine at the Kent & Canterbury Hospital. Mr Perks reported that the Trust was making progress with its recruitment and had asked Health Education England to reassess the situation before Christmas. He stated that the challenges in East Kent were not unique; he had attended a meeting of the 80 trusts with the worst A&E performance, including organisations in Lincolnshire, East Sussex and Dorset, which had a similar geography with a mix of rural and urban areas and faced difficulties in recruiting junior doctors. Mr Perks committed to provide an update about the local care models in Faversham and Sandwich.

(3) Members enquired about public engagement, minor injury services and investment in public transport. Mr Perks explained that a range of engagement methods had been used including public meetings and a survey which had received 1200 responses. He recognised that there were groups of people, such as the young and the working age population, which had not been reached. Mr Perks stated that whilst there was a national design for urgent care. In Canterbury, there were minor injury units (MIU) in Faversham and the recently opened unit in Herne Bay which were well used; in East Kent there were 290 MIU attendances a day, in addition to 550 – 570 A&E attendances. He noted that minor injury and illness services would be developed as part of the community hubs. Mr Perks noted that EKHUFT had invested in additional public transport as part of its outpatients reconfiguration and it was being looked at by the Trust as part of its future plans.

(4) Members asked about forecasting, x-ray facilities at Estuary View Medical Practice and the impact of the GP closure in Folkestone. Mr Perks stated that ONS data did not reflect growth in Ashford which impacted on the CCG's financial allocation. Mr Perks noted that there was an x-ray pipe between the Estuary View Medical Practice and the hospital which enabled images to be sent to and reviewed by a radiographer. Mr Perks noted that whilst he could not specifically comment on the GP closure in Folkestone as it was not in his area, it was important that primary care increased its scale in order to be sustainable. He noted that large practices such as the Estuary View Medical Centre, which served a population of 32,000 and had 30 partners, did not have problems recruiting staff. He stated that whilst some GPs felt the current value of the GMS contact made it difficult to deliver quality services, it was beginning to be demonstrated that primary care was able to provide enhanced community services through mergers and networks.

(5) RESOLVED that the report on Local Care in East Kent be noted and an update be presented to the Committee in six months.

24. Ashford CCG and Canterbury & Coastal CCG: Financial Recovery Plan
(Item 13)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance for this item.

(1) Mr Perks began by explaining that the financial recovery plan was fundamental to enable the delivery of local care model. A memorandum of

understanding regarding the implementation of model was due to be signed by partner organisations including East Kent Hospitals University NHS Foundation Trust (EKHUFT). The focus of the plan was based on ambitious Quality, Innovation, Productivity and Prevention (QUIPP) savings. The recovery actions were all red rated and remedial actions were being implemented to get the plan back on track; if sufficient progress was not made, rationalisation of services may be considered, to maintain the financial balance.

(2) In response to a specific question about reserves and the length of the plan, Mr Perks explained that the CCGs were required to hold a reserve and have a 1% surplus; reserves were being deployed to help manage the risk in the plan. The financial recovery plan was linked to transformation of services which were required to implement to the STP. Mr Perks noted that it was a two-year financial recovery plan which covered the NHS Ashford CCG and NHS Canterbury & Canterbury CCG areas. He reported that NHS Ashford CCG had a small deficit and had not achieved a 1% surplus for three years which had been managed through non-recurrent fixes. Through the plan, the CCG would achieve financial balance by 2019/20.

(3) RESOLVED that the report on financial recovery in Ashford and Canterbury CCGs be noted and an update presented to the Committee in January.