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, 18 July 2014.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr C P D Hoare, Mr A J King, MBE, Mr G Lymer, Mr C R Pearman, Cllr P Beresford, Cllr J Burden and Cllr M Lyons

ALSO PRESENT: Mr S Inett, Mr M Ridgwell, Dr M Parks, Mr A H T Bowles and Mr T Gates

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

UNRESTRICTED ITEMS

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

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

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

(3) Mr Chris Hoare declared an interest as his son was being assessed for a statement and his wife was pregnant and receiving prenatal care from Maidstone and Tunbridge Wells NHS Trust.

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

52. Minutes - 6 June 2014
(Item 3)

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

(a) Minute Number 43 - Community Care Review: NHS Ashford CCG & NHS Canterbury & Coastal CCG. The CCGs were asked to provide an update on the design of the community hubs. The paper was being drafted and would be circulated to Members informally.

(b) Minute Number 44 - East Kent Outpatients Services: Consultation Update. The draft Minutes for this item had been circulated to EKHUFT

Board and NHS Canterbury & Coastal CCG Governing Body in advance of their decision-making meetings.

(c) Minute Number 48 - Kent Community Health NHS Trust: Community Dental Services (Written Update). KCHT was asked to produce a briefing note to clarify the percentage of local patients who were seen at the Deal Clinic and the commissioner's view on the changes to community dental services. The briefing note was circulated to Members on 9 July 2014.

(d) Minute Number 49 - Child and Adolescent Mental Health Services (Written Update). Michael Ridgwell was asked to co-ordinate a joint response and update on performance across the four CAMHS tiers in Kent. The paper was being drafted and would be circulated to Members informally in the week beginning 21 July 2014.

(e) Minute Number 50 – Date of the next meeting. Following a request by a Member, Mr Gough was asked to include an update on the local Health and Wellbeing Boards' relationship with the Kent Health and Wellbeing Board and the input of local Boards into the Kent Health and Wellbeing Strategy as part of his report to the Committee in July 2014.

(2) The Scrutiny Research Officer requested that Minute 45 be amended to the Queen Elizabeth The Queen Mother Hospital.

(3) RESOLVED that, subject to the amendment in paragraph (2) above, the Minutes of the Meeting held on 6 June 2014 are correctly recorded and that they be signed by the Chairman.

53. Kent Health & Wellbeing Board: Update and Strategy
(Item 4)

(1) The Chairman welcomed the guests to the Committee. Mr Gough introduced the item and proceeded to give a presentation which covered the following key points:

- The 2015 Challenge Declaration - NHS Confederation
- The Initial Health & Wellbeing Strategy
- The Refreshed Health & Wellbeing Strategy
- Communication and Engagement Plan
- Local Health and Wellbeing Boards
- The complexity of the Kent landscape
- Integration Pioneer programme
- Better Care Fund

(2) At the 6 June meeting, a Member of the Committee requested an update on the local Health and Wellbeing Boards' relationship with the Kent Health and Wellbeing Board and the input of local Boards into the Kent Health and Wellbeing Strategy as part of Mr Gough's presentation. Mr Gough gave an overview of the local Health and Wellbeing Boards in Kent. He explained that there was a distinctive set up in Kent with seven CCGs running across 12 local

authority boundaries and three health economies. He highlighted the proposed merger between NHS Ashford CCG and NHS Canterbury & Coastal CCG.

(3) Mr Gough explained that there was a developing relationship between the Kent Health and Wellbeing Board and the local Health and Wellbeing Boards. There was a mandate for local Health and Wellbeing Boards to look at national issues or particular areas such as falls and develop local strategies. The Kent Fire & Rescue Service presented to the Kent Health and Wellbeing Board in July about their contribution to health and wellbeing of Kent which would be taken forward by local boards.

(4) Mr Gough explained that Local Health and Wellbeing Board were key stakeholders in the development of the refreshed strategy. As part of the communication and engagement plan, the local Health and Wellbeing Boards would be engaging with their local populations and reporting back to Kent Health and Wellbeing Board in November 2014. A number of local Health and Wellbeing Boards inputted into the Better Care Fund and reviewed local commissioning plans. Local Health and Wellbeing Boards had mixed economies with Chairs ranging from KCC Cabinet Members, District Council Leaders and CCG Chairs.

(5) The Chairman invited Mr Bowles, a guest of the Committee, to speak. As the Chair of the Swale Health and Wellbeing Board, he raised concerns about financial and staffing pressures on the borough council to facilitate the local Health and Wellbeing Board in particular attendance at additional meetings and leading on public consultation. Mr Gough acknowledged the difficulties Swale faced in covering two CCG areas. He explained that he did not expect borough and districts to lead on consultations. It was for the CCGs to consult on their commissioning plans and the communication and engagement for the refreshed Health and Wellbeing Strategy was being led by KCC.

(6) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A Member raised a concern about the ownership and redesign of NHS estate. Mr Gough explained that NHS estate was owned by NHS Property Services. It would be a significant player in reconfiguration as it could match and mirror changes to services. Mr Ridgwell commented that there was a large amount of NHS estate available to utilise with the redesign of services.

(7) A number of comments were made about ‘hospitals without walls’ and community services. Mr Gough explained that ‘hospital without walls’ was the concept of acute services coming out into the community enabling patients to have a shorter stay in hospital and receiving care in the most appropriate location such as at home or in a community setting. He highlighted Simon Stevens’, Chief Executive of NHS England, support of community hospitals. He noted that the KCC Accommodation Strategy was looking to establish community capacity and ensuring the correct mix of accommodation was available.

(8) A specific question was asked about the Assurance Framework’s fit with the Better Care Fund. Mr Gough explained that the Assurance Framework had been developed over the last year with elements of the Better Care Fund

being anticipated and incorporated. The Assurance Framework fitted well with six Better Care Fund indicators. He noted the Better Care Fund's greater focus on reducing hospital admission.

(9) A Member enquired about devolved budgets. Mr Gough explained that CCGs were responsible for their own budget. Social care budgets would be moving towards the CCG structure and there was a desire to bring the public health funding closer to the local CCG areas. He acknowledged that some public health services would continue to be commissioned county wide. He stated that he would be happy to discuss the issue further with the Member.

(10) A Member highlighted SEN funding and provision. Mr Gough explained that there was a large special school capacity in Kent. There were huge pressures on autism, speech & language and behavioural & emotional services. KCC had invested heavily in reducing out of county placements and had developed six new primary schools with specialised units in areas of need. There would be further integration between KCC as the education authority and the health service with the introduction of the Children and Families Act.

(11) A number of comments were made about CAMHS, statistical variances in the report and the utilisation of libraries and gateways. Mr Gough explained that The Rt Hon Greg Clark MP had suggested the countywide target for improvements to CAMHS. Mr Gough stated that he would need to check the differences in the statistics and would provide additional information on the utilisation of libraries and gateways.

(12) RESOLVED that Mr Gough be thanked for his attendance at the meeting, and that he be requested to take note of the comments made by Members during the meeting and he be invited to attend a meeting of the Committee in nine months' time.

54. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy
(Item 5)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust), Avey Bhatia (Chief Nurse, Maidstone and Tunbridge Wells NHS Trust) and Jayne Black (Director of Strategy & Transformation, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and asked them to introduce the item. Mr Douglas began by giving an overview of the developing five-year strategy.

(2) Mr Douglas stated that the biggest challenge for the clinical strategy was financial viability. The Trust was required to make an annual 5% cost improvement programme consistently over five years which was a quarter of current income. The Trust employed 5,500 staff which accounted for 80% of cost. The Trust was focusing on efficiency and a reduction of in non-elective activity to achieve financial viability. This would enable them to create capacity

and deliver elective or full price non-elective care to a wider population. The Trust only received 30% of the tariff for emergency activity in excess of emergency activity in 2009 which cost the Trust £9 million each year.

(3) He explained that the seven key drivers for change were identified:

1. Quality issues to ensure sustainable clinical services such as the proposed development of the first hyper acute stroke unit in Kent by the Trust;
2. Major financial challenges over the next five years;
3. NHS West Kent CCG's funding gap of £60 million by 2018/19;
4. Predicted increases in demand for emergency non-elective services as the population gets older and lives longer;
5. Changes in technology to improve quality and efficiency;
6. Workforce deficiencies;
7. National recommendations including Sir Bruce Keogh's recommendations to introduce seven day working and two levels of hospital emergency department: Emergency Centres and Major Emergency Centres. The Trust would like to establish one of two/three Major Emergency Centres identified for Kent.

(4) He informed the Committee that a Clinical Strategy Group had been established which identified the four major work streams required to develop the strategy: emergency care; centres of excellence; seven day working; and integration & collaboration.

(5) He |highlighted the key messages from the strategy. The Trust needed to improve efficiency and productivity within the next two years including a reduction in the length of stay to below the national average. The Trust planned to redesign emergency pathways to achieve a reduction in non-elective activity and release 50% of capacity for other services. The Trust was aligning to West Kent's five year commissioning strategy and engaging with local partners.

(6) He stated that engagement with local partners included the Trust's work with the Queen Victoria Hospital NHS Foundation Trust to establish a major hub at Maidstone Hospital. The Trust was working with Brighton and Sussex University Hospitals NHS Trust and High Weald Lewes Havens CCG to look at providing additional services at the Tunbridge Wells Hospital. The Trust was also in discussions with Medway NHS Foundation Trust to move some elective care to the Trust. It had developed strategic links with EKHUFT through the Kent Pathology Partnership.

(7) He confirmed that the Trust was continuing to develop the clinical strategy. Work planned for July – September included the development of implementation plans, a new model of care for stroke services and plans for a paediatric A&E at Tunbridge Wells Hospital.

(8) Members of the Committee then proceeded to ask a series of questions and made a number of comments. Mr Pearman thanked the guests for facilitating a visit to the Tunbridge Wells Hospital in March 2014 with Mr Crowther. He wanted to acknowledge the enthusiasm and professionalism of the staff he had met. He believed that the implementation of the strategy was dependent on front end delivery and was confident that this would be achieved by the

staff. Mr Douglas thanked Mr Pearman for the compliment and highlighted the work of the Trust's staff. The Trust ranked fifth out of 90 Trusts in the NHS Trust Development Authority's Patient Experience Survey which was testament to the staff.

(9) A comment was made about pathway management for patients with multiple long term conditions. Mr Douglas acknowledged the need for the Trust to work closely with GPs and community services to provide pathway management. GPs required additional infrastructure from organisations such as acute trusts to support the co-ordination of patients with multiple long term conditions. Mr Ridgwell reminded the Committee that a paper on the strategic development of GP services would be brought to the September meeting.

(10) In response to a specific question on the PFI initiative at the Tunbridge Wells Hospital and the cost of individual rooms, Mr Douglas explained that PFI was the only option to build a new hospital as the hospital at the old site was unsustainable. An option appraisal had been carried out by the Department of Health and the Treasury, using a Public Sector Comparator, which was supportive of the PFI initiative. It was explained that whilst a single room cost more as there was a larger area to clean with an en suite bathroom, nursing costs had remained the same. All new hospitals had a significant number of single rooms which patients responded well too.

(11) A question was asked about traffic congestion in Tunbridge Wells and its impact on the Hospital. Mr Douglas explained that ambulance timings had not been affected by congestion; they were able to get through the traffic. He noted that staff and patients were impacted by traffic congestion. The old site, the Kent & Sussex Hospital, was located in the centre of Tunbridge Wells which was significantly impacted by congestion. Mr Douglas expressed concerns about the impact on the hospital with the construction of dual lanes on the A21 from Tonbridge to Pembury.

(12) A number of comments were expressed about the CQC inspection at Maidstone and the involvement of the Trust in the Maidstone's Borough Council's Local Plan. Mr Douglas stated that he was disappointed by some of the comments made by the CQC particularly in regards to 24 hour consultant paediatrician cover at Maidstone Hospital. The comment by the CQC was made despite knowing that the paediatric service had moved to Tunbridge Wells and the Trust had closely followed the guidance set out by the Royal College of Paediatricians. Following the CQC inspection, the Trust had reviewed the paediatric pathway and was looking to introduce a paediatric A&E in Tunbridge Wells Hospital. Mr Douglas acknowledged that the Trust needed to take a more active role in the community. He explained that he had responded to the Bluebell Wood planning application as there had been a desire by staff for the wood to remain next to the hospital. He stated that he felt that the Trust was not treated as a partner by the Borough Councils despite being one of the largest local employers which generated economic growth.

(13) RESOLVED that the guests be thanked for their attendance and their contributions, and that there be on-going engagement with HOSC as plans are

developed with a return visit to a meeting of the Committee at the appropriate time.

55. CQC Inspection Report and Royal College of Surgeons Report: Maidstone Hospital
(Item 6)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust), Avey Bhatia (Chief Nurse, Maidstone and Tunbridge Wells NHS Trust) and Jayne Black (Director of Strategy & Transformation, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and asked them to introduce the item. Ms Bhatia began by giving an overview of the three CQC inspections, which had taken place since November 2013. The inspections took place unannounced in November 2013 at the Tunbridge Wells Hospital, in February 2014 at Maidstone Hospital and in April 2014, which looked at safeguarding in North and West Kent. The Trust believed that the Royal College of Surgeons report was the trigger for the CQC inspections.

(2) Ms Bhatia stated that the main theme of the inspections was the provision of paediatric services. A concern highlighted in the Maidstone Hospital inspection was the shortage of paediatric-trained nurses in A&E which was a national issue. The Trust was reviewing the emergency care pathways for children to enable a separate emergency paediatric and adult pathway at both sites. The Trust was exploring the option of a dedicated paediatric A&E department at Tunbridge Wells Hospital.

(3) Ms Bhatia explained that other issues identified in the inspection report, including governance, had been developed into a 20-point action plan with the CQC to deliver improvements. The improvement plan was updated monthly and shared with the CQC. The Trust was expecting a re-inspection towards the end of the year under the new model of inspection to assess compliance with CQC standards.

(4) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A specific question was asked about the recruitment of paediatric-trained A&E nurses. Ms Bhatia explained that paediatric-trained A&E nurses wanted to work in dedicated paediatric emergency department rather than in a mixed model. Ms Bhatia stated that when the model changed to a dedicated emergency paediatric unit, the Trust would be able to recruit. The CQC had become prescriptive about the recruitment of paediatric-trained A&E nurses to all Trusts. Mr Douglas explained that Tunbridge Wells had a fully staffed paediatric unit with paediatricians and paediatric nurses, which received good shortlists when jobs were advertised. A rotation of staffing between the proposed emergency paediatric department and paediatric unit at Tunbridge Wells was being considered.

(5) Mr Angell thanked the guests for facilitating a visit to Maidstone Hospital with Miss Harrison in November 2013. He explained that he had recently met with the Trust's Finance Director who had stated that a high proportion of patients at both sites had dementia and he enquired about dementia training for staff. Ms Bhatia explained that there was lots of training for staff on dementia. Engaging with family members and carers was essential as they knew the needs of the patients. The Trust had introduced the 'This Is Me' booklet, a nationally developed booklet to record key information on memory, mobility and other factors to ensure that the right care was provided for the individual patient. The Trust had a Lead Nurse in Dementia Care. A Dementia Café and Ward had been developed at Tunbridge Wells Hospital and the Activities Co-ordinators at Maidstone Hospital had been key to moving patients out of beds into other areas of the hospital to interact. The Trust had a paper published in the Nursing Times about the Trust's work on dementia. Mr Inett referred to a report on the range of dementia services provided in the community which was presented to the Kent Health and Wellbeing Board in July 2014.

(6) Dr Sigston was invited to provide a brief overview of the Royal College of Surgeons report. The Trust Board was proactive in commissioning the Royal College of Surgeons (RCS) report in response to unexpected deaths following upper gastrointestinal cancer surgery in 2012/13. The Trust commissioned the report in April 2013 and the report was delivered by the RCS in December 2014. In line with the RCS recommendations, the Trust was working with St Thomas' Hospital in London to provide upper gastro intestinal cancer surgery. He stated that only a small minority of patients required this type or surgery.

(7) A Member enquired about the employment status and management of the consultants mention in the RCS report. Dr Sigston confirmed that the three gastro-intestinal surgeons continued to work for the Trust but no longer carried out complex cancer resection surgery. Dr Sigston explained that the document used to manage doctors, 'Maintaining High Professional Standards in the Modern NHS', was not fit for purpose and made it difficult to manage doctors.

(8) In response to a question from a Member, Dr Sigston explained that under guidance, issued by the General Medical Council and the Royal College of Nursing, a competent child was able to give consent and request that information remained confidential regardless of their age.

(9) Mr Douglas confirmed that that, the Trust was not aware of the qualifications and backgrounds of the inspectors carrying out unannounced inspections. The Trust was able to make comments on the draft report. He stressed that the Trust was committed to work with the CQC to make improvements to services and develop a good relationship with them.

(10) RESOLVED that the guests be thanked for their attendance at the meeting, and that they be requested to take note of the comments made by Members during the meeting and that a written update be received by the Committee in December.

56. Patient Transport Services
(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 and asked him to introduce the item. Mr Ayres began by updating the Committee on NSL's performance. He explained that although there had been an improvement in the transport of renal patients, the rest of the service's performance had flat lined for three months.

(2) Mr Ayres explained that the contract with NSL was a standard NHS contract; the contract was for three years with two twelve-month extension periods. There were two clauses for early termination: a no fault termination by either party to terminate the contract early with a twelve month notice period or termination by one of the parties, with immediate effect, if the contract had been breached including the persistent and repetitive breach of a quality requirement. Although the CCG believed that NSL had breached the quality requirement; if this route was pursued by the CCG, it was likely that there would be a legal challenge by NSL to determine a breach.

(3) Mr Ayres confirmed that the CCG was reviewing the contract with procurement experts. As a large and significant contract, it would need to be re-procured with an advert in the European Journal. It would be a full procurement lasting a minimum of 12 – 15 months and a maximum of 18 months. This would mean that the earliest the contract would be re-procured was nine months before the contract expired.

(4) Mr Ayres stated that the CCG would be in a position to talk publically about the future of the contract by September following discussions with NSL and the acute trusts. There were no providers who would be able to deliver the Kent and Medway contract immediately. NSL was now the biggest Patient Transport Services (PTS provider) in the country. It had grown from a small to large company in five years. Mr Ayres raised concerns about the rapid growth of the company and local leadership. Mr Ayres noted that the specification would be revised in advance of procurement at which time the CCG would ask the Committee if it views the changes as a substantial variation of service.

(5) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A Member raised a concern about the quality of the contract. Mr Ayres explained that in the first three – six months there was a range of problems with the quality of the contract; these had been remedied and resolved by December 2013. For the last six months, there was no explanation for NSL's performance; the road networks, geography, staff and vehicles did not hinder performance.

(6) A specific question was asked about the achievability of the contract. Mr Ayres explained that the CCG had looked at targets set, by other CCGs, for PTS providers; the targets for NSL were reasonable and achievable. It was difficult to compare NSL to the service before; targets were not centrally measured as a number of different providers were contracted to provide services.

(7) A number of questions were asked about alternative providers. It was explained that there was a significant range of providers who wanted to bid for the contract. Whilst NSL had a large number of contracts, it was explained it did not have a monopoly over PTS contracts; a number of PTS contracts were held by local ambulance trusts. Mr Ayres stated that nationally PTS commissioners were struggling with ambulance and private sector providers.

(8) A Member enquired about the use of penalty clauses and the logistical movement of patients. Mr Ayres explained that there were one or two penalty clauses in the contract; the CCG was looking to change penalty clauses when PTS was re-procured. Evidence had shown that penalties did not drive performance or change behaviour. A Member made reference to the efficient operation of freight companies to transport goods and produce. Mr Ayres stated that although PTS patients could not be treated as freight he acknowledged that managing logistics to enable the correct utilisation of vehicles and staff was key to provision.

(9) A number of comments were made about a reduction in funding for PTS and the difficulty in accessing patients' properties. Mr Ayres explained that eligibility for PTS was set nationally and had to be provided despite any cost pressures. Patients who were eligible for PTS were not able to use alternative transport; difficulty in accessing properties was part of a PTS provider's role through its talented and committed staff.

(10) RESOLVED that Mr Ayres be thanked for his attendance at the meeting, and that he be requested to take note of the comments made by Members during the meeting and that he be invited to attend a meeting of the Committee in September.

57. Faversham Minor Injuries Unit
(Item 8)

Bill Miller (Chief Operating Officer, NHS Ashford CCG & NHS Canterbury & Coastal CCG), Andrew Bowles (Leader of Swale Borough Council and KCC Member for Swale East) and Tom Gates (KCC Member for Faversham) were in attendance for this item.

(1) The Chairman welcomed Mr Miller to the Committee and asked him to introduce the item. Mr Miller began by outlining the key points in the NHS Canterbury & Coastal CCG paper. Since discussions with HOSC in November 2013, the CCG had worked with the local community through a steering group to explore alternative ways of delivering services at the Minor Injuries Unit (MIU). The recommendations of the steering group were supported by the CCG at its governing body meeting in June. The CCG was in discussions with providers to deliver the new service specification. The specification included direct access x-ray to enable more patients to be seen and treated which was more attractive to providers. The CCG was grateful for the support of the local community and the current provider IC24. The new service would commence in April 2015.

(2) The Chairman invited the local Members, Mr Bowles and Mr Gates, to speak. Mr Bowles explained that the local community was pleased with the outcome. He hoped that a provider would be found to deliver the services. He was grateful to the CCG for listening but expressed concern about how close the MIU had been to shutting. He thanked the Committee for their intervention and sincere support. In addition, he thanked the Cabinet Member for Community Safety and Health at Swale Borough Council and the Mayor of Faversham.

(3) Mr Gates thanked the Committee, Chairman and staff for keeping him informed and updated. He was grateful to the Committee for their hard work in preventing the MIU's closure. He supported the new specification but enquired if the x-ray activity could be increased in the future.

(4) Mr Miller responded to the comments made by local Members. He explained that in Faversham a community network had been developed with local people and the CCG. The network had stimulated discussion and enabled future services to be planned collaboratively with the local community. The CCG was hoping to develop similar networks across the Ashford and Canterbury & Coastal areas. In regards to the extension of x-ray services in the future, it was explained that additional services would be dependent on demand from patients.

(5) A Member highlighted the positive impact the Committee had. The importance of communication with the local community was stressed. A comment was made about contract specification; CCGs were encouraged to ask KCC if they required assistance with contract writing and monitoring.

(6) Mr Inett was invited to speak about the report submitted by Healthwatch Kent. He explained that Healthwatch had powers to conduct 'Enter and View' visits. Healthwatch Kent had attended the steering group meetings and wanted to gain additional insight by visiting the MIU. The visit was conducted on Saturday 31 May during the MIU's busiest time. The staff had been very welcoming and it was a positive experience. Minor recommendations were made and were fed into the steering group's specification in particular raising awareness of the unit and the services it covered. Mr Miller confirmed that greater communication and awareness of the unit was key for the new service specification.

(7) RESOLVED that Mr Miller be thanked for his attendance at the meeting, and that the CCG be requested to take note of the comments made by Members during the meeting and that the Committee is kept informed with progress.

58. Future of Services at Dover Medical Practice

(Item 9)

(1) The Committee received a report from NHS England (Kent and Medway) regarding the future of services at Dover Medical Practice. The paper set out two options available to NHS England to ensure the continued provision of local GP services to patients which requested the Committee to confirm its views on each of the options.

(2) A Member noted that the Committee had been informed that the provider, Concordia Health Limited, had also requested that their contract at The Broadway, Broadstairs be terminated early.

(3) Another Member asked for clarification regarding the status of Dover Medical Practice as one of 13 practices in Dover and Folkestone to pilot extended and more flexible access to GP services as part of the Prime Minister's Challenge Fund.

(4) A number of comments were made about the sustainability of GP services in Kent. Mr Ridgwell explained that sustainability of primary care was a national issue. Dr Parks stated that there were an increasing number of practices that had requested their contract be terminated early. Also General Practice had become unattractive to providers, junior doctors and medical students. Dr Parks was concerned about the capacity for patients to register with an alternative local GP practice.

(5) A Member made a comment about the use of interpreters at GP consultations and asked whether patients should be encouraged to bring someone with them to interpret. Mr Ridgwell explained that it was not always appropriate for a family member to attend and interpret due to the personal nature of the matters to be discussed. He confirmed that interpreting services were available at all GP practices and the cost was funded by NHS England.

(6) RESOLVED that the report be noted, NHS England (Kent and Medway Area Team) take note of the comments made during the meeting and it be noted that there would be a wider discussion on General Practice and the development of services at the next meeting.

59. Date of next programmed meeting – Friday 5 September 2014 at 10:00 am
(Item 10)

(1) The Chairman confirmed that Patient Transport Services would return to the Committee in September 2014.

(2) A Member requested fewer items on the next Agenda to allow time for discussions on General Practice and the development of services.