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, 3 June 2016.

PRESENT: Mr M J Angell (Vice-Chairman), Mr H Birkby, Mrs P Brivio, Mr A H T Bowles, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer and Mr C R Pearman

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

UNRESTRICTED ITEMS

27. Vice-Chairman in the Chair

(1) In the absence of the Chairman, the Vice-Chairman, Mr Angell, assumed the chair for the meeting.

(2) The Committee requested the Scrutiny Research Officer pass on their best wishes for a speedy recovery to Mr Brookbank on behalf of Members and Officers.

28. Declarations of Interests by Members in items on the Agenda for this meeting.

(Item 2)

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

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

29. Minutes

(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 8 April 2016:

(a) Minute Number 9 – NHS Swale CCG: Review of Emergency Ambulance Conveyances. At HOSC on 29 January, a Member enquired if the closure of the A249 (Sheppey) had had an adverse impact on SECAmb. On 15 March SECAmb confirmed that there were no adverse incidents with the closure of the A249 to Sheppey and the Trust utilised the lower road bridge crossing in the event of a A249 closure. At HOSC on 8 April, a Member stated that the query about the

closure of the A249 (Sheppey) was regarding the sinkhole and not the closure of the road bridge. Mr Davies, Interim Chief Executive, undertook to clarify if there had been an adverse impact on SECAmb due to the sinkhole. A response was awaited.

(b) Minute Number 23 – Better Care Fund. At HOSC on 8 April Mr Scott-Clark suggested a briefing to the Committee on public health datasets and how they helped to support health and social care commissioning. A Member briefing had been arranged for Tuesday 7 June at 13.00 in the Lecture Theatre.

(c) Minute Number 24 - King's College Hospital NHS Foundation Trust: Outpatient Services at Sevenoaks Hospital. At HOSC on 8 April a Member requested a breakdown of postcodes for patients who used King's College Hospital NHS Foundation Trust clinics at Sevenoaks Hospital. Patient activity was circulated to the Committee on 3 June 2016.

(d) The next meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee was scheduled for Thursday 30 June.

(2) RESOLVED that the Minutes of the meeting held on 8 April are correctly recorded and that they be signed by the Chairman.

30. Review of winter preparedness and BMA Industrial Action in Kent 2015/16 *(Item 4)*

Matthew Drinkwater (Head of Emergency Preparedness Resilience and Response, NHS England - South (South East)), Pennie Ford (Director of Assurance & Delivery, NHS England – South (South East)), David Robinson (Lead Commissioning Manager - Urgent Care, NHS West Kent CCG) and Corrine Stewart (Assistant Director of Commissioning, NHS Dartford, Gravesham and Swanley CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Ford began by providing an overview of the two papers. She explained that preparations for winter in Kent had worked well; although the health and social care system was challenged, none of the systems moved into whole system Black escalation. She noted that the systems worked well together and were able escalate and manage pressures locally which reflected the hard work undertaken behind the scenes. She reported that all systems including social care did escalation exercises in advance of winter to test their plans and further exercises were planned for the summer and autumn in preparation for next winter. She stated that NHS England had run Winter Resilience Rooms to monitor and support systems and manage data reporting. She noted that the spike in winter pressures was in February and March which was later than the spike before Christmas during the previous winter; work was being undertaken to prepare for next year's spike. She explained that she was very grateful to all Trusts' for their effective emergency planning and response during the periods of industrial action; the system had worked well. She noted that NHS England was waiting on the outcome of the BMA national ballot on the new agreement for the Junior Doctor contract.

(2) Mr Drinkwater explained that there had been a national Winter Resilience Room in London, a regional Winter Resilience Room in Reading and a local Winter Resilience Room in Tonbridge. He explained that the local Winter Resilience Room in Tonbridge monitored pressure being experienced across the South East and allowed NHS England to support systems as required particularly in Surrey and Sussex during spikes. Mr Robinson reported that NHS West Kent CCG no longer planned just for winter; they were constantly reviewing services with partners. The CCG and providers had come together to reflect on the previous year and completed exercise scenarios. The CCG had also updated surge plans, membership and risk register of the local Systems Resilience Group. Daily conference calls with providers had taken place and designated leads were assigned which had improved relationships and communication. Ms Stewart explained that in North Kent workshops had been carried out with all providers to ensure the necessary escalation plans were in place prior to winter. Daily telephone calls with providers took place during the winter to enable the CCGs to understand and deal with local pressures. Workshops to refine the plan for the upcoming winter were planned. She noted that there were significant challenges throughout the year and the system was continually under pressure.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about the SAFER bundle. Mr Drinkwater explained that it was an evidence based system to improve patient flow which included senior clinical review. He noted that during the industrial action patient flow was more efficient as consultants were able to use their clinical judgement to discharge admit or patients. Mr Robinson stated that SAFER stood for:

Senior Review

All patients would have an Expected Discharge Date

Flow of patients would commence at the earliest opportunity from assessment units to inpatient wards.

Early discharge

Review of patients with extended lengths of stay (over 14 days)

(4) A Member asked about the impact of the mild winter on NHS services. Mr Scott-Clark explained that the previous winter was the worst in 10 years and excess deaths were caused by the circulating flu virus and not the weather. He stated that the flu virus in 2014/15 particularly affected the elderly and was not covered by that year's flu vaccine. He reported that in 2015/16, the weather was warm until after the Christmas period and the circulating flu virus was H1N1 – Swine Flu which was more prevalent in younger people and did not cause them serious illness. Mr Drinkwater explained that a bad winter was defined by a number of factors including seasonal influenza and respiratory illness, cold weather and snow. He stated that, in the event of bad weather, he had high levels of confidence in the NHS emergency planning and support from organisations in the Winter Resilience Forum such as the Police, Fire Service and Environment in responding to the situation.

(5) In response to a specific question about funding for winter pressures and the industrial action, Mr Drinkwater explained that year round surge money was included in CCG baseline budgets. Ms Stewart noted that in North Kent, the CCGs had invested in an integrated discharge team which was a multi-provider team based at Darent Valley Hospital including KCC care managers, community services and end of life specialists from the Ellenor hospices. She reported that the North Kent CCGs had also implemented an integrated primary care team to provide responsive out of hospital care. The team included colleagues from KCC, mental health and community services reviewed the top 2% of patients at risk of being admitted to hospital or who had comorbidities and put a care plan in place to support them. She highlighted that the North Kent CCGs had also rolled out the Single Health Resilience Early Warning Database (SHREWD) which enabled providers to upload performance data; this provided the CCGs with advanced notice of escalation and enabled them to plan and respond to it. Ms Stewart highlighted that the cost of the industrial action had been absorbed by the providers. Mr Robinson stated that in West Kent CCG four additional GP appointments per GP practice had been made available which had cost £6000.

(6) A Member enquired about the sustainability of domiciliary care. Ms Ford explained that domiciliary care was challenged and needed to be included as part of short and long term planning across the health and social care system. She noted that early discharge was part of the SAFER bundle and it was important for frail and elderly patients to be discharged back home quickly as it reduced the amount of domiciliary care required. She stated that the career path for domiciliary carers into other roles such as Health Care Assistants and nursing was difficult. Mr Drinkwater reported that the availability of domiciliary care was an issue across the South East and innovative thinking was required to make it an attractive care path. He noted home care and integration would be part of the current sustainability and transformation plans to deliver the Five Year Forward View. Mr Robinson noted that West Kent CCG had a discharge to assess model to enable a timely discharge to home or a community setting for patients. Ms Stewart reported that in North Kent elderly and frail patients were assessed, using the primary care screening tool, at the earliest opportunity. The North Kent CCGs were working with voluntary organisations particularly Age UK to support elderly and frail patients to return to their homes.

(7) A number of questions were asked about the dates for the winter resilience room, the review of communication plans, the impact of the industrial action on primary care and areas of improvement for next winter. Mr Drinkwater explained that the dates for the winter resilience room were set nationally; the winter resilience room was extended virtually until May due to pressures in Surrey and Sussex. He reported that there had been a series of reviews of the communication plans. He stated that as part of the post-winter debrief with the System Resilience Groups, A&E clinicians reported a positive impact of the media campaigns. He highlighted a quantitative review by the Department of Health which found that national media campaigns targeted at the over 65s had the greatest impact on over 75s. He noted that there had been a decline in A&E attendance during the industrial action which was attributed to media campaigns. He explained that there was a minimal impact on primary care as junior doctors were not able to work independently; they are shadowed by existing GPs. He highlighted that the unions were balloting ambulance staff for

industrial action. He reported an area for improvement for next winter would be the implementation of criteria for escalation using common language; this winter in Surrey and Sussex, there were occasions where hospitals with the same issues would move to different levels of escalation. He noted that the emergency planning process with cyclical and was constantly being reviewed and improved.

(8) RESOLVED that the report be noted and NHS England be requested to:

(a) provide an overview of the 2016/17 winter plans to the Committee at its October meeting;

(b) provide a written briefing on the SAFER bundle to the Committee.

31. Darent Valley Hospital: MRSA
(Item 5)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Annette Schreiner (Medical Director, Dartford and Gravesham NHS Trust), Patricia Davies (Accountable Officer, NHS Dartford, Gravesham & Swanley CCG and NHS Swale CCG), Richard Miller-Holliday (Interim Deputy Chief Nurse, NHS Dartford, Gravesham & Swanley CCG) and Nicola Jones (Head of Quality & Safety, NHS Dartford, Gravesham & Swanley CCG and NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Acott began by explaining that hospitals were high risk for infections as patients included those who were admitted due to an infection, those who were immunosuppressed or very unwell and those receiving treatment with side effects which made them prone to infections; in addition to infections which were antibiotic resistant. She highlighted the importance of infection prevention and control at the Trust; data relating to a number of infections including MRSA, E.coli, C. difficile and MSSA was publically published and monitored by the Trust's board as a measure of infection prevention and control.

(2) Ms Schreiner explained that the Trust reported monthly to Public Health England on acquisitions of MRSA, E.coli, C. difficile and MSSA. She noted that 3% of the population carried MRSA on their skin and infection occurs if there is a break in colonised skin. She reported that E.coli was often linked to catheter acquired infections and C. difficile affected people recently treated with antibiotics. She stated that up until February 2015 there had been no MRSA acquisitions at the Trust for 12 months. In April 2015 the Trust moved from universal to targeted screening following advice published by Public Health England in 2014. In summer 2015 the infection prevention and control team had been affected by long term sickness and the teaching programme fell behind. She noted that there were 14 MRSA acquisitions at the Trust in 2015/16; five between the introduction of targeted screening in April 2015 and 19 December 2015 and nine between 20 December 2016 and 25 February 2016 which was outside of acceptable and expected levels. She reported that universal screening was reintroduced on 25 January 2016 and there had been no further acquisitions since 26 February 2016; a large number of MRSA

colonised patients were identified following the reinstatement of universal screening which was reducing. She reported that there had been no cases of C. difficile and MSSA since March 2016 and there had been a very low number of cases of E.coli.

(3) Ms Schreiner stated that in March 2016 all of the infection prevention and control team had left the organisation due to retirement, long term sickness and personal reasons; NHS Dartford, Gravesham and Swanley CCG seconded an infection prevention specialist nurse to the Trust to stabilise the interim team whilst permanent staff were appointed. A taskforce met every two weeks to implement the action plan following the TDA inspection visit in March 2016. As part of the action plan, daily MRSA huddles took place every morning to coordinate work streams. The Trust had introduced a communication strategy for all staff and wards focusing on hand hygiene, cleaning and decontamination. The Infection Control Committee was now meeting monthly, instead of quarterly, to address the MRSA issues and a Non-Executive Director now attended this Committee on behalf of the Board. She highlighted that occupancy and infection rates were linked; infection rates rose when occupancy was over 85%. She stated that the Trust had had 100% occupancy since April 2015 and peaked at 107% in February 2016. She explained that the Trust was concerned about the occupancy rates, particularly due to the development of the Thames Gateway and Ebbsfleet Garden City.

(4) Mr Miller-Holliday gave an overview of the CCG's response to the MRSA incidences at the Trust. He explained that the CCG had initially raised concerns about infection prevention in March 2015; a table top exercise in May 2015 was carried out which identified key recommendations. Due to a lack of consistent infection prevention team in 2015, no sustainable improvements were made. The CCG considered issuing a Contract Performance Notice but, as the Trust had gone two months without reporting a further case, it was not implemented. In January 2016 the CCG issued a Contract performance Notice and placed them under a Remedial Action Plan. He stated that the Trust Development Authority visited the Trust in March 2016 and implemented an improvement plan which was monitored weekly in a telephone conference call between the Trust, NHS Improvement (formerly the Trust Development Authority) and the CCG. He noted that monthly verbal updates were given to the North Kent HCAI Assurance panel meetings and bi-monthly quality assurance meetings with the Trust. He noted that the CQC and NHS Improvement would revisit the Trust in late June following their visit in May 2016.

(5) Members of the Committee made a number of comments and asked a series of questions. A number of comments were made about acquisition and reducing occupancy. Ms Schreiner explained that a hospital acquired MRSA infection was an infection which was not present at admission or occurred more than 48 hours after admission. She stated that the Trust had undertaken interventions in three surgical and three medical wards including the implementation of a screening tool. She noted that if an area became MRSA positive, a deep clean of the area and additional screening for neighbouring patients was undertaken. She reported that in May there had only been 4 – 8 acquisitions in two wards. Ms Acott reported that the Trust's had plans to increase its clinical footprint to reduce occupancy and accommodate the new

housing growth. She explained that only 55% of the hospital building currently provided direct medical care; the Trust was looking to move administrative and clerical staff out of the hospital building to enable the installation of additional beds. The Trust was also looking to transfer elective surgery to Queen Mary's Hospital in Sidcup. She noted that the Trust had recently carried out a five year retrospective and had identified a number of factors which had led to delayed discharges and high occupancy rates including population growth with aging population and high fertility rate; increased activity following service changes at St Mary's Hospital; and greater patient acuity.

(6) Members enquired about the Public Health England guidance which recommended targeted screening. Ms Acott stated that the guidance had seemed reasonable as the Trust had not had an MRSA acquisition for a year when implemented. She noted the Trust's intention to write to Public Health England to request a review of the guidance. She explained that the Trust had been caught off guard and it highlighted the need to evaluate the adequacy of its systems and processes. Ms Schreiner noted that the Trust was unlikely to revert to targeted screening if similar guidance was published in the future. Mr Scott-Clark stated that infection control was fundamental for providing quality care and this incidence had highlighted the importance of due diligence. Ms Davies stated that there had been recognition by the Trust of a lack of due diligence and the Trust had made significant improvements under the action plan. She was assured that it was not a wider culture issue.

(7) In response to a specific question about the cost of reinstating universal screening, Ms Schreiner stated that it had cost around £30,000 in consumable materials, such as swabs, for universal screening since January 2016; in addition to staff time and lab costs. Ms Acott noted the costs would be ongoing as the Trust admitted over 200,000 patients per year. She explained that there had also been costs for targeted screening, there had been an individual cost to the 14 patients who had contracted MRSA in 2015/16. The Trust had also incurred additional costs for the antibiotics to treat the infections, increased length of stay for affected patients and deep cleaning services. The Trust had undertaken a review of the cleaning arrangements with its facilities management contractor. She stated that the MRSA incidences did not result in any cancellations.

(8) RESOLVED that:

(a) the reports provided by Dartford and Gravesham NHS Trust and NHS Dartford, Gravesham and Swanley CCG be noted;

(b) Dartford and Gravesham NHS Trust be requested to provide an update to the Committee in six months;

(c) the Chairman write a letter to the Secretary of State for Health and Chief Executive of Public Health England requesting a review of the Department of Health guidance on targeted admission screening for MRSA.

After the meeting, the Vice-Chairman-in-the-Chair received clarification from the Trust regarding the guidance referred to in the meeting. The guidance was not by Public Health England, it was instead the Department of Health expert advisory

committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)'s 'Implementation of modified admission MRSA screening guidance for NHS (2014)'

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf

32. North and West Kent Neurorehabilitation Service
(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Dave Holman (Head of Mental Health and Children's Commissioning, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Holman began by giving an overview of actions taken following the closure of the Knole Centre in Sevenoaks, provided by the Kent and Medway NHS and Social Care Partnership Trust, in December 2015. He explained that the CCGs had worked to develop a new community based model and pathway using external providers. He noted that there had been eight placements since 24 December which was in line with the predicted annual activity and financial envelope; the CCGs were not looking to reprocure the service. He reported that the CCGs were looking to engage with Healthwatch Kent to receive patient feedback. He stated that practitioners were pleased with progress and found the placements were meeting patients' needs; in some cases patients' length of stay had reduced.

(2) A Member enquired about the South East Commissioning Support Unit (SECSU). Mr Holman explained that NHS West Kent CCG commissioned SECSU to deliver their assessment and placement process; the SECSU made recommendations to the CCG about placements which where ratified by panels made up of staff from both organisations. Mr Ayres noted that Commissioning Support Units (CSUs) were governed by NHS England; there had been speculation since the Health & Social Care Act 2012 that CSUs would become autonomous and self-sustaining entities but this had not yet happened.

(3) RESOLVED that the report provided by NHS West Kent CCG be noted.

33. Kent and Medway Sustainability and Transformation Plan
(Item 7)

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

(1) The Chairman welcomed the guests to the Committee. Mr Ayres began by giving apologies for Glenn Douglas, Chief Executive of Maidstone and Tunbridge Wells NHS Trust, who was the nominated lead for the Kent and Medway Sustainability and Transformation Plan (STP). He stated that Mr Ridgwell was working with Glen to support him in his STP role.

(2) Mr Ridgwell began by highlighting that there were significant challenges for health and social care both locally, in Kent & Medway, and nationally due to population demographics, quality, performance and finance. He stated that those challenges were being addressed by a strategic solution, the Five Year Forward View (FYFV), and 44 Sustainability and Transformation Plans were being developed to create system leadership to enable the implementation of the FYFV. He noted that the four main areas of work in Kent and Medway were: self-care and prevention; strengthened primary care and integrated out of hospital care; acute hospital strategy including mental health; and cost reduction measures.

(3) In response to a specific question about the financial position of the NHS in Kent and Medway. Mr Ridgwell explained that currently demand outstripped supply and would get worse due to an increasing elderly population; the forecasted financial outturn for the end of 2015/16 was £-105.9 million in Kent and Medway. He noted that quality of care and finance were linked and workforce was often the common factor. Mr Ayres stated that the deficit would remain in Kent and Medway until a plan of action through the STP process would be implemented to resolve the financial position. He reported that the NHS had not done collaborative planning like this for over twenty years and there was the opportunity to create integrated out of hospital care using primary care, mental health and social care. He stated that there would need to be an IT infrastructure to support integrated care and develop a single clinical record.

(4) Members enquired about social prescribing and the commissioning of voluntary services. Mr Ridgwell explained that medicalised models of care were not always best for patients' health and wellbeing; social prescribing provided alternative models of care such as exercise and feeling part of a community. Mr Ayres stated that due to the ongoing financial positon, the NHS would need to move away from giving grants to the voluntary sector to commissioning them to deliver care. He noted that a fully professionalised service was not sustainable in supporting complex community needs.

(5) RESOLVED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee in September.

34. East Kent Strategy Board
(Item 8)

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

(1) The Chairman welcomed Ms Carpenter to the Committee. Ms Carpenter began by outlining the work in progress as part of the East Kent strategy development. She explained that the Case for Change was being finalised and would be presented to the East Kent Strategy Board in early June prior to publication and stakeholder engagement. An assurance exercise with NHS England had recently been undertaken regarding options appraisal and planned consultation in late October and November. She reported that information for the options appraisal was being drawn from a wide range of

sources including clinical task and finish groups which had been established to look at best practice and set out clinical ambition for mental health, urgent care, frailty and paediatrics; the Clinical Senate report into co-dependencies; the Whitstable Medical Centre MCP Vanguard and the Accountable Care Organisations in Thanet and the South Kent Coast.

(2) Members enquired about the patient pathway and engagement with the South Kent Coast Health and Wellbeing Boards. Ms Carpenter explained that the patient pathway would be developed as part of the options appraisal; technical documents had been developed to inform the Case for Change. Ms Carpenter stated that the CCG was represented on the South Kent Coast Health and Wellbeing Board and the views of the local Health and Wellbeing Boards were being feed back to the East Kent Strategy Board. She noted that both the NHS South Kent Coast CCG and NHS Thanet CCG were looking to integrate commissioning for health and social care.

(3) RESOLVED that the report be noted and the East Kent Strategy Board be requested to present an update to the Committee at its September meeting.

35. East Kent Integrated Urgent Care Service Procurement (Written Briefing)
(Item 10)

(1) The Committee received a report from the East Kent CCGs which provided an update about the outcome of the East Kent integrated urgent care service procurement combining NHS 111, GP Out-of-Hours and new care navigation service.

(2) RESOLVED that the report on the East Kent Integrated Urgent Care Service Procurement be noted and the East Kent CCGs be requested to provide an update on the implementation of the new contract.

36. Date of next programmed meeting – Friday 15 July 2016 at 10.00
(Item 11)

(1) The Scrutiny Research Officer advised the Committee that the two Agenda items scheduled for the next meeting were not time critical and could be postponed until a later date.

(2) RESOLVED that the Health Overview and Scrutiny Committee scheduled for Friday 15 July be cancelled.

(3) The meeting was adjourned at 12.30 and reconvened at 12.45.

37. Kent & Canterbury Hospital: Emergency Care Centre
(Item 9)

Matthew Kershaw (Chief Executive, East Kent Hospitals University NHS Foundation Trust) and Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Shutler began by providing an update about the model of care at Kent & Canterbury Hospital's Emergency Care Centre. The Trust had worked with SECAmb to reinforce the criteria for patients conveyed to hospital who were severely inebriated, had a primary mental health condition and had abdominal pain that may require a general surgical assessment. The revised conveyance criteria was implemented on 9 May 2016 and was expected to affect 9 patients a week; patient flow was monitored on a daily basis.

(2) She reported that the Trust had been working to design a primary care led Urgent Care Centre where all patients who self-presented were triaged by a GP or nurse to the MIU, Urgent Care Centre or Acute Medical Unit; the Urgent Care Centre was due to be introduced on 6 July 2016. She stated that there had been a successful recruitment of GPs to cover during the day but acknowledged that the Trust was looking to use locums to cover the overnight period. She noted that the Trust had communicated changes to stakeholders; there had been less communication with the public as the service provided by the Kent & Canterbury Hospital would remain unchanged for the majority of the public. The Trust and NHS Canterbury & Coastal CCG worked with Healthwatch Kent and the University of Kent on the communication plan.

(3) Mr Kershaw noted that he had met with Health Education Kent, Surrey & Sussex and the GMC. He stated that his understanding was that if the new model of care and GP led Urgent Care Centre was implemented; Health Education Kent, Surrey & Sussex and the GMC would continue to support the provision of medical trainees at the Kent & Canterbury Hospital site.

(4) Members enquired about the sustainability of services and patient choice. Mr Kershaw explained that the changes to the Emergency Care Centre was linked to East Kent Strategy Board and wider Kent and Medway Sustainability and Transformation Plan as part of the Trust's developing clinical strategy. He stated that the Trust needed to take urgent action to ensure it continued to provide safe, sustainable and effective services. He highlighted the Trust's increasing challenge in maintaining the consultant rota with 20 consultant vacancies including 10 emergency consultants. He noted that the Trust may need to make changes outside of the STP process and requested to provide an update to the Committee in July. He stated that patient choice remained but running the same services at multiple sites such as vascular services was not sustainable and did not provide the best service for patients.

(5) RESOLVED that:

(a) the East Kent Hospitals NHS University Foundation Trust report be noted;

(b) East Kent Hospitals NHS University Foundation Trust be requested to organise an informal briefing about their Clinical Strategy for the Committee in July;

(c) East Kent Hospitals NHS University Foundation Trust be requested to present an update to the Committee about its Clinical Strategy at its September meeting.

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