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 on Tuesday, 23 July 2019.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr N J D Chard, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton, Mr I Thomas, Mr M J Angell, Mr A M Ridgers and Mr B J Sweetland

ALSO PRESENT: Mr S Inett and Ms C Rickard

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny)

UNRESTRICTED ITEMS

142. Membership
(Item 1)

(1) The Chairman informed the Committee that the district and borough council representation had changed.

(2) Cllr Derek Mortimer, Cllr Michael Lyons and Cllr Marilyn Peters were stepping down from the Committee. The Chairman thanked them for the contribution they had made whilst serving as Members on the Committee.

(3) Cllr Patricia Rolfe, Cllr Mark Rhodes and Cllr Carol Mackonochie had joined the Committee.

143. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 3)

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

(2) Mr Thomas declared an interest as a member of the Canterbury City Council's Planning Committee.

144. Minutes from the meetings 21 May 2019 and 6 June 2019
(Item 4)

(1) RESOLVED that the Committee agreed that the minutes from 21 May and 6 June 2019 were correctly recorded, and that they be signed by the Chairman.

145. Wheelchair Services in Kent
(Item 5)

Ailsa Ogilvie (Director of Partnerships & Membership Engagement, NHS Thanet CCG), Caroline Selkirk (Managing Director, NHS East Kent CCGs), Maria Reynolds

(Head of Nursing, Quality and Safeguarding, NHS Thanet CCG), Cathy Finnis (Governing Body Member, NHS Thanet CCG) and Matthew Inder (Business Process and Continuous Improvement Manager, Millbrook Healthcare) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee and asked them to provide a brief overview of their update paper.

(2) Ms Ogilvie provided the following highlights:

a) Latest data evidenced continued overarching improvement with reductions in the waiting lists for both equipment and repairs.

b) Open episodes of care at the end of May 2019 were ahead of the planned trajectory.

c) The number of children on incomplete episodes of care at the end of May 2019 were slightly behind the planned trajectory.

(3) Nationally set standards highlighted that all children who required a wheelchair would receive one within 18 weeks. There was no such standard for adults, but G4S had set a target of 23 weeks. Ultimately, Millbrook's ambition was for both adults and children to receive a wheelchair within 18 weeks of being referred.

(4) A Member questioned the difference between standard and emergency repairs. Mr Inder explained it was down to the severity of the case and the level of risk presented to the user. Emergency repairs would be dealt with on the same day, whereas standard repairs would be completed within three days. Loan wheelchairs were available where required.

(5) In relation to the service user experience, the CCG acknowledged that the service still needed to improve, and those service users experiencing long waits would not be happy. Ms Finnis explained that increased engagement with users was underway, including (but not limited to):

a) Three service user open meetings which had highlighted areas of concern from over 60 users;

b) The establishment of a Service User Improvement Board, which would meet bi-monthly from 13 August 2019;

c) Workstream meetings in focused areas would involve service users;

d) Recruitment to a full-time post within Millbrook was underway.

(6) The report (page 29 in the agenda) mentioned the upcoming function on the website for service users to upload photos to support their request for repairs. Members were concerned that not all service users would want / be able to use this function. Mr Inder explained that the provider was trialling a number of methods, of which this was just one and did not have to be used by all.

(7) Mr Inett explained that Healthwatch had been liaising with user forums and advocacy groups of wheelchair services. He welcomed the good progress in relation to reduced waiting times but expressed concern that users continued to receive very different experiences. Some of those waiting experienced mental health issues because of their inability to go about their daily lives.

(8) Healthwatch and the CCG also liaised, and Healthwatch had requested a presence on the Service User Improvement Board. Mr Inett expressed that Healthwatch would like to carry out an in-depth piece of work once the changes had bedded in.

(9) A Member questioned the categorisation of formal and informal complaints. Ms Reynolds explained that there had been a historic tendency for "soft concerns" to be classified as formal complaints. These were then unnecessarily processed through the formal complaints process, which delayed a response to what could have been a simple question.

(10) A Member expressed disappointment at the lack of information in the report about staff satisfaction and training. Mr Inder explained that staff surveys were carried out with the results reported to the CCG. Members requested additional information around this area in 12 months time.

(11) Referring to page 35 of the agenda pack, Members asked about the difficultly in recruiting to the post of Rehabilitation Engineer. Mr Inder explained that this was a specialist role, of which there was a national shortage. Technicians, locums and in-house expertise tried to fill the gap in the meantime.

(12) In relation to the phased additional funding from CCGs (page 28 of the report pack), Ms Ogilvie confirmed that this money was to help Millbrook clear the large inherited caseload. The final phase of that funding was under consideration by the CCGs.

(13) Looking at the graphs in appendix 1 to the report, a Member questioned why the planned and actual lines fluctuated each month. Mr Inder explained that the targets had been revised as a result of the additional funding received as part of the demand and capacity modelling.

(14) The Chair informed the Committee that she was aware of a change in ownership for Millbrook Healthcare, and that staff had been notified the day prior to the HOSC's meeting. She did not propose that HOSC discussed the associated detail at that time but requested additional written information for the Committee as soon as practically possible.

(15) Mr Inder confirmed that the company had been acquired by Cairngorms Investment Company after the decision by its Chairman to step away from the business. Members on the Board of Executives at Cairngorms had a healthcare background and were keen to drive their investment through focussing on clinical and service users' needs.

(16) A Member voiced concern that the Committee had not been told the information until the end of the item and requested that in future such information was disclosed earlier. The Chair noted the request.

(17) Another Member requested that the item be referred to the Care Quality Commission (CQC). It was explained that this was not possible because the company was not registered with the CQC.

(18) A Member requested that the item return to the next HOSC meeting for thorough overview and scrutiny. The Chair noted the request and committed to explore outside of the meeting how the item could be considered by HOSC going forward. However, she proposed waiting until the additional written information had been received.

(19) RESOLVED that:

a) the report be noted;

b) Thanet CCG provide a written update as soon as practically possible. The update should include:

i. Assurances that the contractual obligations would remain with the organisation under its new ownership;

ii. Details of the new company;

iii. Arrangements for existing staff;

iv. Any information relating to significant changes in the delivery of services.

c) Thanet CCG return to the Committee at the appropriate time.

146. NHS North Kent CCGs: Urgent Care Review Programme
(Item 6)

Gerrie Adler (Director of Strategic Transformation) and Dr Nigel Sewell (Urgent Care Clinical Lead) from NHS Dartford, Gravesham and Swanley CCG were in attendance for this item.

(a) **NHS North Kent CCGs - Urgent Care Review Programme - Dartford, Gravesham and Swanley CCG**
(Item 6a)

(1) The Chair welcomed the CCG guests and invited them to update Members on progress made since their last attendance in January 2019.

(2) Ms Adler explained that the CCG had been carrying out pre-consultation engagement, with over 4,000 stakeholders participating and briefings for MPs and Councillors. The pre-consultation business case had been completed and scrutinised by Healthwatch.

(3) The Committee had been presented with the Public Consultation Communications and Engagement Plan (published with the agenda) and the next step was for a public consultation which was planned to run for 12 weeks from 29 July – 21 October 2019. The consultation would be on the two site options for the Urgent Treatment Centre.

(4) Ms Adler articulated that the changes around Urgent Care were not proposed in isolation but were part of a wider network of developments such as improved access to primary care, extended access to GPs and the introduction of Primary Care Networks. To support local care (i.e. care received in the home or community), £4.2m was being invested over the next two years.

(5) There were two, very different, proposed options for the location of an Urgent Treatment Centre: Gravesham Community Hospital and Darent Valley Hospital. Each would involve adjusting current services, and these were set out in the agenda paper.

(6) It was noted that the changes proposed affected neighbouring authorities.

(7) A Member asked which MPs had been consulted and what their views were. Ms Adler explained that three Kent MPs had been briefed: Adam Holloway, Michael Fallon and Gareth Johnson. Overall, they agreed with the proposals but did have concerns, mainly around access and parking.

(8) Dr Lauren Sullivan, local member for Gravesham, addressed the Committee with the permission of the Chair. She spoke on behalf of residents that the Labour group had engaged, and one of their main issues was around access to GPs. Concerns raised included:

a) The removal of local Minor Injury Clinics would eventually contribute to the closure of the Gravesham Community Hospital.

b) The need to pay for parking at Darent Valley Hospital, considering current local provision did not charge.

c) The ability to reach Darent Valley Hospital by public transport.

d) The closure in 2020 of the walk-in centre at White Horse Surgery (which had merged with the Forge Surgery and was located on the Fleet Health Campus) would lead to confusion over how residents accessed local care.

(9) With the above in mind, Dr Sullivan sought confirmation from the CCG that there would be no gap in provision of local care. She requested clearer language be used to inform residents about how they could access healthcare. She suggested the CCG consult parents at the school gates, as access to healthcare for their children was so important. She also requested the closed questions in the consultation document be amended to be more open. Ms Adler agreed to take Dr Sullivan's points back to the CCG.

(10) Members discussed the plans and raised a number of concerns around:

a) The impact on transport;

b) The price of paying for parking;

c) The sustainability of Gravesham Community Hospital if the Minor Injuries Unit moved to Darent Valley Hospital.

d) The population served by DGS CCG was forecast to grow and yet the proposals seemed to reduce access to local healthcare services.

e) The shortage of GPs in the workforce.

f) The communication around different categories of healthcare should be reviewed.

(11) In response, the CCG highlighted these points:

a) NHS England supported the development of Urgent Care Centres and the model was already in place in other locations, such as Medway.

b) Transport always presented a challenge but the CCG was undertaking traffic modelling to better understand and mitigate the risks. They were engaging bus operators.

c) Urgent care services treated illnesses and injuries that were not life-threatening but that needed urgent assessment. Residents would still have access to local GPs as well as urgent-care centres.

d) Evidence showed that urgent care centres were being used for primary care needs and this was not sustainable.

e) Gravesham residents currently accessed Darent Valley Hospital for out-of-hours urgent care.

f) There were no plans to reduce further services at Gravesham Community Hospital.

g) An Urgent Treatment Centre may attract those staff wishing to straddle primary and secondary care, and therefore boost the workforce.

(12) Mr Inett explained Healthwatch Kent's role in the process so far. They had scrutinised the Outline Business Case and paid specific attention to the level of engagement and its reach. They were content with the process so far. He recognised the limited role of Healthwatch in the area of transport, and suggested a strategic view was needed, which perhaps may be led by HOSC. The Chair noted his comments.

(13) Summarising the next steps, Ms Adler explained that after the consultation and associated review, a final decision would be presented to the CCG Governing Body in early 2020 with implementation in July 2020.

(14) The Chair noted that Bexley residents could also be impacted by the proposed changes. If the London Borough of Bexley's Overview and Scrutiny Committee deemed the change a substantial variation, there would be a need to form a Joint Health Overview and Scrutiny Committee (JHOSC).

(15) RESOLVED that:

a) The report be noted;

b) The CCG be invited back to HOSC after the consultation had finished but before the final recommendation was taken to the CCG Governing Body;

c) The CCG provide a full transport plan around the site options when they return to the Committee.

(b) **NHS North Kent CCGs - Urgent Care Review Programme - Swale CCG (verbal update)**
(Item 6b)

(1) Ms Adler explained that the CCG were considering the service specification for the Urgent Care Treatment centre in Swale. An initial analysis had finished and included both qualitative and quantitative data. Travel modelling was also being carried out.

(2) Like the DGS proposals, the changes were not being carried out in isolation.

(3) The CCG were committed to meeting the population of Swale's needs as well as national standards.

(4) RESOLVED that the update be noted, and that the CCG return to HOSC with a detailed report in September.

147. Review of St Martin's Hospital, Canterbury
(Item 7)

Caroline Selkirk (Managing Director, NHS East Kent CCGs), Andy Oldfield (Head of East Kent Mental Health Commissioning, NHS East Kent CCGs), Vincent Badu, Executive Director of Partnerships and Strategy, Kent and Medway NHS & Social Care Partnership Trust (KMPT)), and Dr Matthew Debenham (Consultant Psychiatrist and Deputy Medical Director, KMPT) were in attendance for this item.

(1) The Chair welcomed the guests and invited them to outline the proposal for change at St Martin's Hospital, Canterbury.

(2) Mr Oldfield explained that the CCG were proposing changes to the provision of acute adult mental health services across Kent and Medway, with a

particular focus on how that could impact on St Martin's Hospital in Canterbury.

(3) The proposed changes, based on best practice as well as service improvement around treating people outside of hospital unless they had to be there, would see a reduction of 15 acute inpatient beds across the KMPT estate – around 6% of the total bed base.

(4) The Committee referred to the previous HOSC update on 1 March 2019, when the proposal was for a reduction of 9 beds. Since then, a review of patient flow had been undertaken and it was decided additional beds could be closed without impacting the service (as some patients would not be admitted to hospital but be supported within their community).

(5) NHS England/ Improvement has advised that they believe the change constitutes a substantial variation of service.

(6) Members questioned if the CCG were confident that the 15 mental health beds were surplus to requirement. They were unclear why the aim to improve the estate and service delivery justified the reduction in the number of inpatient beds.

(7) Dr Debenham confirmed that the Trust was already not at capacity, and sometimes there were just 77% of beds in use – this represented just a 6% reduction so there would still be flexibility in the system.

(8) Mr Badu explained that the Trust had looked into the patient population that accessed acute beds. The evidence demonstrated there was a significant proportion of patients that were admitted for less than 7 days, which the Trust considered to be clinically inappropriate and that the individual's needs could be met in a different way.

(9) The Committee were advised that in some cases, admitting patients to hospital could actually do more harm than good and that in the drive to do something, perhaps the best support was not always chosen because of a lack of alternative options (e.g. support within the community).

(10) The CCG explained that there were a number of other service developments underway around mental health, and whilst they were just addressing HOSC about specific changes to St Martin's Hospital, the proposal should not be considered in isolation. Examples of other developments included community services, creation of safe havens, and crisis support.

(11) Mr Badu explained three projects that had been developed to improve the effective and more efficient use of inpatient capacity:

a) Reduce the length of stay for older people to be in line with recommendations. KMPT had seen 102 average days compared to the recommended 73.

b) Develop alternative support to inpatient treatment;

c) Extend and improve the Patient Flow Team so that it operates 24/7 and build on appropriate discharge planning.

(12) The Chair understood the need for HOSC to be consulted on the specific St Martin's proposal. However, she felt that should the change go to public consultation, it should not be considered in isolation. The Trust and CCG would have to explain what they were doing, and how patient's treatment would be better because of the changes.

(13) Mr Inett told the Committee that Healthwatch Kent had worked closely with the mental health community and overall the approach was understood. However, the issue was around the complexities of communicating the support options available.

(14) Ms Rickard, from the Local Medical Council (LMC), expressed concern that those patients with moderate mental health needs fall between the cracks. She also questioned if the prolonged length of stay for adults in acute beds reflected that community support services were not in place. Mr Badu explained that the issues varied depending on age, but generally he accepted that primary care support needed to improve, as did the interaction between primary and secondary services.

(15) The Committee felt that the changes discussed represented more than just a site reconfiguration, they were around a reconfiguration of mental health services across Kent and Medway.

(16) Ms Selkirk accepted the points made by HOSC and would take their comments on board.

(17) RESOLVED that

a) the Committee deems the proposed change to St Martin's Hospital (west) to be a substantial variation of service.

b) Kent and Medway NHS and Social Care Partnership Trust (KMPT) and East Kent CCG be invited to attend HOSC and present an update at an appropriate time.

148. Proposed changes to Congenital Heart Disease services in London
(Item 8)

Joanne Murfitt (Regional Director of Specialised Commissioning and Health in Justice) and Claire McDonald (Engagement and Communications Lead, Specialised Commissioning) from NHS England London region were in attendance for this item.

(1) The Chair welcomed the guests and invited questions from Members.

(2) Around 50% of the patients accessing Congenital Heart Disease (CHD) services at the Royal Brompton Hospital were from outside London and the change affected some 70 councils nationwide.

(3) Some London health scrutiny committees have already deemed the proposal substantial. A consultation would run in early 2020.

(4) Overall, HOSC Members did not feel the change was substantial for Kent residents because:

a) The proposed move was to a location 3 miles away, which when travelling from Kent did not represent a significant variation in distance;

b) Patients already had a choice of which hospital location to go to;

c) Patient transport was provided and would continue to be provided to the patient's hospital of choice;

d) The service provided would be the same but just from a different location.

(5) RESOLVED that:

a) the Committee does not deem the proposed changes to CHD Services to be a substantial variation of service.

b) the report be noted, and NHS England/ Improvement keep the Committee advised on progress.

149. South East Coast Ambulance Service NHS Foundation Trust (SECAmb) Update
(Item 9)

Steve Emerton (Director of Strategy & Business Development), Ray Savage (Strategy & Partnerships Manager) and James Pavey (Regional Operations Delivery) from South East Coast Ambulance Services (SECAmb) were in attendance for this item.

(1) The Chair welcomed the guests from SECAmb and asked them to highlight any key points from their paper.

(2) Mr Emerton summarised the progress made in recruitment and updating infrastructure. In addition, he noted:

- over the last quarter response times during the working day had improved but there continued to be challenges in the early to late evening;

- the Trust had experienced high demand with the recent heatwave, similar to the winter period;

- category 1 and 2 calls were almost or already achieving targets, whereas category 3 callers continued to face delays.

(3) A Member asked a question around the training of ambulance staff. Some interventions could only be carried out by a qualified paramedic. Mr Emerton recognised the importance of training and SECAmb were building on that area. The entry routes into becoming a paramedic varied, from a graduate completing additional training lasting less than 12 months to an unqualified recruit that would enter a 3-5 year programme resulting in an academic qualification.

(4) The pressure on staff, and the importance of staff morale and retention were discussed. Mr Pavey agreed that paramedics were a valuable commodity and explained that a key part of SECAmb's strategy was to make the organisation a good place to work.

(5) Referring to the staff survey in appendix 3, a Member asked for a more detailed report into the findings – they had particular concern around health and wellbeing. They also wanted to know the proportion of staff that had regular breaks as well as the number that got home on time each day. Finally, Mr Pavey assured the Committee that appraisals were key and that the organisation had invested significantly in their structure over recent time and that all staff had a named manager.

(6) A Member questioned the impact of heavy town traffic on SECAmb. Whilst traffic did affect an ambulance's ability to get from A to B, this was a national issue. When not answering a call, ambulances would be strategically placed in areas that had a greater chance of receiving a call (based on data modelling). The Trust was a consultee for planning applications.

(7) A Member asked why the response time in the NHS Thanet CCG area was so much quicker than other areas (as shown in Appendix 1 to the agenda paper). Mr Pavey explained that that Thanet population was much more concentrated than in areas such as Swale, which had a lot of rural communities. Rurality presented a challenge as services were more likely to be further away – this could not be reflected under the current targets. Mr Emerton echoed this, but assured HOSC they continued to seek service improvement that would reduce the longer wait times in rural areas.

(8) In order to improve handover delays, Mr Pavey explained how the Trust had regular meetings with the Chief Executives of Hospital Acute Trusts in order to maintain a collective focus on handover delays. Some hospital trusts had capacity issues so the problem could not be solved solely by the ambulance service.

(9) RESOLVED that the Committee note the report and that SECAmb provide an update at an appropriate time.

150. Kent and Medway Non-Emergency Patient Transport Service Performance *(Item 10)*

James Ransom (Programme Lead for Planned Care, NHS West Kent CCGs) and Russell Hobbs (Patient Transport Services Managing Director, G4S) were in attendance for this item.

(1) The Chair welcomed the guests and invited them to highlight any key areas from their report.

(2) Mr Hobbs highlighted that performance had continued to improve over the past 12 months, with a reduction in the number of complaints. Performance against Key Performance Indicators (KPIs) was positive.

(3) Road closures and Operation Brock had caused difficulties but G4S continued to monitor the situation and prepare for Brexit.

(4) It was confirmed that the transport service applied to NHS patients using private providers.

(5) An area of improvement was around collection of patients discharged from hospital. There had been complaints around a lack of communication and prolonged periods of waiting. Mr Hobbs affirmed that every patient matters and they were working with Hospital Trusts to improve this area. One area that could be improved was for Trusts to stagger the discharge of patients, so not everyone wanted to be collected between 3-5pm.

(6) Mr Hobbs stated that G4S had 10 volunteer drivers, and Members felt that perhaps more could be recruited.

(7) The Chair drew the Committee's attention to the recent Care Quality Commission (CQC) report (dated 2 July 2019). Mr Hobbs confirmed that the CQC rating had shown 3 areas as "Good" and 2 as "Requires Improvement", therefore the overall rating was Requires Improvement (RI). There had been 13 good areas, 4 outstanding areas, and 6 RI – 2 of which were isolated, standalone issues. He urged HOSC Members to read the wider report as the summary was not representative of the service.

(8) The Chair thanked Mr Hobbs for his description of the report.

(9) RESOLVED that the Committee note the report.

151. The Maidstone and Tunbridge Wells Stroke Service
(Item 11)

Adam Wickings (Deputy Managing Director, NHS West Kent CCGs) and Sean Briggs (Chief Operating Officer, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee and invited them to provide an overview of the short-term changes to stroke provision services at Tunbridge Wells Hospital (TWH).

(2) Mr Wickings explained that the CCG were committed to commissioning high quality, safe services. For this reason, they supported Maidstone and Tunbridge Wells NHS Trust's (MTW) decision to temporarily move Ward 22 on the TWH site to Chaucer ward on the Maidstone Hospital (MH) site.

(3) The move was not a precursor to the wider stroke review, and would not create a HASU, but was necessary because of a high number of vacancies and difficulty in recruitment. The change was reversible and would be kept under review.

(4) Mr Briggs shared his disappointment with the Committee, and reaffirmed that the move could be reversed and would be considered in light of any wider and ongoing Judicial Review / Referrals to the Secretary of State.

(5) The Chair notified the Committee that they would not be considering the change in light of a substantial variation of service because it was a only temporary.

(6) Overall, the Committee welcomed the upfront and transparent report from the Trust. Comments included:

a) The clinical safety of patients and staff was paramount and therefore the decision was necessary.

b) The move highlighted the degree of specialism required by staff supporting stroke services (particularly thrombolysis nurses).

c) Ward 22 staff at TWH were committed and loyal, but ultimately the impact of upcoming proposed changes were too significant. Reasons for their departure, as highlighted in exit interviews, included retirement and moving to other internal roles.

d) The move would require close partnership working, which included with SECAmb.

e) As to whether lessons could be learnt for other stroke wards, Mr Wickings explained that the Trust do try and mitigate such risks, but that it was difficult when there were staff shortages.

(7) The Chair expressed the Committee's regret that the urgent temporary change was needed but accepted that there was a clinical need. She thanked the Trust and CCG for bringing the item to HOSC's attention and allowing Members to ask questions.

(8) RESOLVED that the report be noted and that the Trust and CCG provide an update to the Committee after September regarding the current situation and how it had been managed.

152. Review of Frank Lloyd Unit, Sittingbourne (written update)
(Item 12)

(1) RESOLVED that the Committee note the briefing received.

153. Items on 6 June 2019 HOSC Agenda: Correspondence Received (Written Update)
(Item 13)

(1) Steve Inett from Healthwatch Kent explained to the Committee that the low number of phone calls and emails to the CCG (page 162 in the agenda pack) did not necessarily provide reassurance that there was not a problem with the Service. Healthwatch continued to receive calls from confused and concerned patients.

(2) Members wanted reassurance that the Service was running as it should.

(3) RESOLVED that the Committee note the briefing received and reaffirm that the CCG return to HOSC before the end of the year with a detailed update on the performance of the contract.

154. Draft Work Programme
(Item 14)

(1) The Chairman invited Members to consider the work programme.

(2) Members voiced concern that the Review of the Frank Lloyd Unit in Sittingbourne had been coming to HOSC for what seemed like a long period of time.

(3) The Chairman informed the Committee that the recently announced CCG ratings would need to come before Members, but the best way of doing this needed to be considered in light of planned CCG changes.

(4) A Member asked when the A&E reconfiguration would return to the Committee. The Chairman said the schedule for this programme would need to be checked, but that it would be added to the next work programme.

(5) RESOLVED that the draft work programme be agreed.

155. Date of next programmed meeting – 19th September 2019 at 10am
(Item 15)