Minutes of the meeting of the **OVERVIEW AND SCRUTINY COMMITTEE** held at the Council Offices, Whitfield on Monday, 24 February 2020 at 6.00 pm.

Present:

Chairman: Councillor L A Keen

Councillors: D G Beaney
S H Beer
J Rose
M Rose
C A Vinson
C D Zosseder

Also Present: Caroline Selkirk (Managing Director of Ashford, Canterbury and Coastal, South Kent Coast and Thanet clinical commissioning groups)
Nicky Bentley (Director of Strategy & Business Development, East Kent Hospitals University NHS Foundation Trust)

Officers: Strategic Director (Corporate Resources)
Head of Finance and Housing
Democratic Services Manager
Democratic Services Officer

113 APOLOGIES

Apologies for absence were received from Councillors R S Walkden and P Walker.

114 APPOINTMENT OF SUBSTITUTE MEMBERS

The Democratic Services Manager advised that no notice had been received for the appointment of substitute members.

115 DECLARATIONS OF INTEREST

There were no declarations of interest made by Members.

116 PUBLIC SPEAKING

The Democratic Services Manager advised that no members of the public had registered to speak on items on the agenda to which the public speaking protocol applied.

117 HOUSING MANAGEMENT OPTIONS APPRAISAL – OUTCOME OF FORMAL CONSULTATION

The Strategic Director (Corporate Resources) presented the repot on outcome of the formal consultation over the Council's continued participation in East Kent Housing. The results of the tenant and leaseholder consultation, the cost/benefit analysis and the risk analysis all supported bringing the management of the Council's housing stock back in-house.

Members were advised that this would be a complex task to undertake and that the Council had set-up seven work streams to do this. As part of these work streams

tenant engagement and communication would be examined. However, the immediate priority was to restore stability to the service and ensure compliance was achieved.

There were also a number of risks in the process of bringing the management of the Council's housing stock back in-house such as ensuring that the work needed to ensure compliance with key indicators carried on and retaining key staff during the transition period. In addition, East Kent Housing would remain a sovereign body during the transition process but at this point it only had one senior staff member on a full-time contract.

The Strategic Director (Corporate Resources) advised that the Housing Revenue Account (HRA) remained in good condition and that savings had never been the driving purpose behind the formation of East Kent Housing and examples of where East Kent Housing had been granted extra funding by the Council were cited (such as the development of the single IT system or supporting work in respect of Universal Credit).
The Council was not yet able to quantify the exact costs involved in bringing the service back in-house due to several variables and unknown costs. This included costs around the single IT system, compliance works and TUPE arrangements for staff.

Members expressed support for the decision to bring the housing stock back in-house and dismay at the findings of the Pennington report. In respect of issues around asset management and tackling anti-social behaviour where some Members felt there were failings in East Kent Housing, the Strategic Director (Corporate Resources) advised that these were areas in which Dover District Council was traditionally strong and when the service was brought back in-house it was hoped that these strengths would pass into the housing service.

RESOLVED: That it be recommended to Cabinet:

(a) That a report be made to Cabinet and Overview and Scrutiny Committee at key milestones in the process of bringing housing services in-house.

(b) That the Cabinet be commended for taking control and tackling the issue.

118 LOCAL HEALTH SERVICES

The Chairman welcomed Caroline Selkirk (Managing Director of Ashford, Canterbury and Coastal, South Kent Coast and Thanet clinical commissioning groups) and Nicky Bentley (Director of Strategy & Business Development, East Kent Hospitals University NHS Foundation Trust) who were in attendance to answer the key questions set by the committee.

Buckland Hospital

Q1 What is the current and planned status of the Buckland hospital maternity unit?

There was no Maternity Unit at Buckland. In 2012, east Kent's Clinical Commissioners consulted on closing the two stand-alone midwifery-led birthing units that were provided at Buckland Hospital in Dover (and at Kent and Canterbury

Hospital, Canterbury) in favour of establishing co-located MLUs (Midwifery-Led Units) at the Trust's two acute hospital sites in Ashford and Margate. The consultation document outlined a number of key reasons underpinning the proposed closure of the two stand- alone MLUs, namely:

- There were times when services had to be suspended to ensure safe levels of care in maternity wards on the acute sites;

- They needed to ensure that they had the right staff with the right skills in the right place when they needed them. Sudden and unexpected staff absence and ensuring they had enough midwives where need was highest, meant that they sometimes needed to close the MLUs;

- They were delivering an unfair service where the healthiest mums with lowest risk were likely to receive more one-to-one care than those high-risk mothers giving birth in the consultant-led units. They needed to make sure they provided a fair service for every woman and her baby.

The Trust now provided midwifery-led units that were co-located with full maternity services at both the William Harvey Hospital in Ashford and at Queen Elizabeth The Queen Mother Hospital in Margate. Low-risk mothers who have previously had a non- complicated, natural birth were also offered the option of having a home birth where they were fully supported by an experienced midwife throughout the labour and birth process.

In response to a question from Members it was stated that the standard of care in maternity had not been to the level it should have been. The key to solving this was to make changes quickly and improve the organisational culture. A helpline had been set up to provide information and encourage communication. It was acknowledged that one preventable death was one to many.

Q2 What services are currently available at Buckland hospital – are there plans to increase the range of services here?

Buckland Hospital in Dover had a Minor Injuries Unit (MIU) which was soon to be transformed into an Urgent Treatment Centre (UTC) as part of a recent tender process by the CCG. The site also offered a range of outpatient facilities, renal satellite services, day hospital services, child health and child development services, day surgery for ophthalmology and diagnostic facilities.

Adjacent to the hospital was the new Harmonia (Dementia) facility which was discussed in greater detail in the response to question 7. The Trust would always keep the range and type of services available under review but there was very little empty space at Buckland the services were well used.

An app called 'wait less' was cited as an example of how patients could see the waiting times at the Buckland minor injury unit.

Future Plans

Q3 What does EKHUFT consider its largest challenges in the coming few years?

East Kent Hospitals University NHS Foundation Trust (EKHUFT) was one of the largest hospital trusts in England and ran three acute (major) hospital sites. It had more than 250,000 A&E attendances, about 95,000 hospital stays, and 810,000 outpatient attendances every year.

As well as the services it provided for the people of east Kent, EKHUFT also provided some specialist services for most or all of Kent and Medway, including dialysis for kidney patients in Medway and Maidstone and a specialist cardiac service at the William Harvey Hospital, Ashford for people across Kent and Medway. It has also recently taken on providing AAA (vascular) services for the residents of Medway.

People in east Kent get the overwhelming majority of their healthcare – around 90% - from GP practices and community-based physical and mental health services. Almost all the rest - about 10% - was provided by EKHUFT.

Most of the services the hospital trust delivered were relatively routine care - i.e. outpatient appointments, day surgery, diagnostic services and urgent care for everyday illnesses and injuries. About 1.4% of local people's healthcare was complex, specialist and major emergency care.

At any given time, relatively few of us need highly specialist services but everyone wanted to know these services were available 24/7 in case they need them and for them to offer the highest possible quality of care.

Challenges and drivers for change.

The way services work across east Kent needed to change because:

- **Healthcare needs:** the healthcare needs of the population were changing – health and care services must change too
- **Quality:** the quality of east Kent hospital services would not improve without major change
- **Workforce:** there were significant staffing shortages across the east Kent system and change is needed to ensure east Kent is an attractive place to work
- **Buildings:** East Kent Hospitals University NHS Foundation Trust's hospital estate was in poor condition.

All of these issues, if not responded to appropriately would affect quality of care for patients, patient experience and recruitment within the Trust.

There also needed to be a variety of career options (portfolio careers), particularly as many GPs wanted to be salaried rather than a partner in a practice and had interests in specialising that traditional general practice did not provide. There was also evidence that people tended to settle near where they trained if they liked the area and the medical school would be an asset in this respect.

Q4 What are the future plans for Deal and Dover hospitals?

Members were directed to the response to Q1 above regarding Buckland Hospital, Dover.

Members were advised that there was no intention to downgrade Deal Hospital.

Deal Hospital was managed by Kent Community NHS Trust and provided a 22 bed in- patient unit providing a rehabilitation and intermediate care service. There was a 12-hour (8-8) minor Injuries Service supported by an X-ray service and Phlebotomy (blood tests) service.

Members questioned what impact the shortage of GPs would have on GP led services at Dover and Deal Hospitals and were advised that by providing portfolio careers with a variety of opportunities it would assist in attracting and retaining staff.

Q5 What is happening about 3 East Kent hospitals going down to 2 and have any decisions been made?

The problem is the proposed closure of Canterbury hospital, which all the consultations point to this being in the best position for a major hospital for all of east Kent. The new medical school will be based at Canterbury but there is a limited hospital service provision there at the moment, which does not make sense.

There were no plans to reduce the number of hospitals in east Kent from 3 to 2 or to close any hospitals.

Over a number of years, leading doctors and other health and care professionals in east Kent have led the development of the clinical model to provide the health and care that people in east Kent need. A long list of options was evaluated against a set of hurdle criteria and a medium list of options was identified. The medium list of options (two options) is currently being evaluated, including being tested with the South East Clinical Senate, to establish which options go out to public consultation. Patients and members of the public, the voluntary sector, community representatives, health overview and scrutiny committees and regulators are involved throughout this process.

It is important to note that the “do minimum” scenario is not deliverable or sustainable, but provides a benchmark by giving a realistic cost for reversing temporary changes made in recent years, adding in a number of changes and developments likely to happen in the next 12 years, and taking account of local investment and savings plans.

Both options being evaluated continue to deliver three vibrant, busy hospitals in Margate, Ashford and Canterbury, which work together and with other services, to deliver high quality services to meet the changing needs of the population of east Kent.

Both options propose centralising specialist and major emergency inpatient services onto one hospital site in east Kent and separating low-risk planned surgery from emergency and high-risk surgery. Both options strengthened the provision of intensive care and paediatric surgery by consolidating them on one or two sites (rather than three as now).

Both options also considered the existing hospitals and geography of east Kent.

All three major hospitals will continue to provide the services which must be local because of how often they are used:

- 24/7 urgent treatment for illness and injury
- day surgery – which makes up more than 85% of all planned surgery
- outpatient clinics
- same-day treatment centres for people with breathing problems, deep vein thrombosis
- planned treatment centres for chemotherapy, dialysis and other treatments
- a 48-hour assessment and treatment unit for frail people.

Under both options, they would:

- increase the number of inpatient beds (compared to now) to meet growing demand; and
- increase the number of intensive care beds.

Option 1 proposed:

- **a major emergency centre:** William Harvey Hospital, Ashford will become a major emergency centre with 24/7 A&E, critical care, all specialist services including for hyper acute and acute stroke, inpatient women's health services including consultant-led labour ward and midwife-led birthing unit, inpatient children's care, acute medical services, emergency and high-risk surgery, a 24/7 urgent treatment centre, day surgery, outpatient services

- **an emergency centre:** Queen Elizabeth The Queen Mother Hospital, Margate will remain as an emergency centre with 24/7 A&E and critical care, inpatient women's health services including consultant-led labour ward and midwife-led birthing unit, inpatient children's care, acute medical services, emergency and high-risk surgery, a 24/7 urgent treatment centre, day surgery, outpatient services

- **an integrated care hospital:** Kent and Canterbury Hospital (K&C), Canterbury will become an integrated care hospital with a 24/7 urgent treatment centre, same day emergency care, same day planned care (chemotherapy, endoscopy, dialysis), frailty assessment unit and beds, step-up step-down beds, day surgery, outpatient services, and centre for low-risk elective surgery.

Option 2 proposed:

- **a major emergency centre (MEC):** Kent and Canterbury Hospital will become a major emergency centre with 24/7 A&E, critical care, all specialist services including for hyper acute and acute stroke, all acute inpatient services including emergency and high-risk surgery, acute medicine, inpatient women's health services including consultant-led labour ward, midwife-led birthing unit, inpatient children's care, a 24/7 urgent treatment centre, day surgery, outpatient services

- **two integrated care hospitals:** William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital become integrated care hospitals.

They will each have a 24/7 urgent treatment centre, same day emergency care, same day planned care (chemotherapy, endoscopy, dialysis), frailty assessment units and beds, step-up step-down beds, day surgery, outpatient services and centre for low-risk elective surgery.

- a standalone midwife-led birthing unit at Margate.

In addition to these options, major trauma would still be treated at Kings but it was expected that there would be other services that could be brought back to the area.

Q6 What extra funding will our 3 hospitals get with the new central Government plans, and what will this be spent on?

This response followed on directly from the answers given above. Financing the options was clearly critical to the plans. The source of capital was through additional NHS Capital Funding for Option 1 in its entirety.

For option 2 the source was a combination of NHS Capital Funding and private investment.

Internally generated capital within the Trust would also be used to address any backlog maintenance and equipment replacement programme.

Q7 Please could you provide an update on the progress of the local dementia village near Buckland Hospital

This exciting and innovative facility is now called Harmonia. The development model was designed to allow people living with dementia to live as independently as possible.

In 2015 there were 850,000 people living with the condition in the UK and by 2025 it is estimated that this will have grown to nearly 1,150,000. Dementia now costs the UK economy £26.3 billion a year.

The six semi-detached houses have five bedrooms each to house residents living with dementia. There are also guest house facilities and a village hub/community centre. The construction phase was now complete.

Known officially as Community Areas of Sustainable Care and Dementia Excellence in Europe (CASCADE), Harmonia was part of a wider project that involved partners from the UK, the Netherlands, Belgium and France. Harmonia would provide longer term and short-term respite care which will fully engage with the local community. The wider project will be the basis for passing shared learning and cross-border excellence in dementia care for the future.

All the equipment and furniture had been supplied and installed. The facility was already being used by a range of local community groups.

To provide “healthcare” Harmonia was formally required to have a Care Quality Commission (CQC) certificate. This was granted on 19 February 2020 and the homes were now formally registered as a Nursing Home.

Harmonia had sufficient staff and would begin a phased opening from March 2020. Approximately one house per month (i.e. five residents) will open over the course of 2020.

Staffing and Services

Q8 How many scheduled operations are cancelled?

In answering the question please could you explain the causes for cancellations and how many of these are rescheduled within the national time guidelines?

Planned operations (also called elective surgery) like a hip or knee replacement were too frequently cancelled for “non-clinical” reasons. Some common non-clinical reasons for cancellations included ward beds being unavailable, emergency cases needing theatres, theatre lists over-running or no critical care bed being available. These cancellations could occur on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. 593 such cancellations took place in east Kent, during 2018-19.

Q9 Are there shortages in specialist doctors/consultants provision in East Kent hospitals, and if so what is being done to increase the number? If shortages exist, what is causing these shortages?

Over the last 20 years, the increasing specialisation of medicine and surgery on a national level had increased the staffing needs of hospital services. Where once there was the generalist, there are now a large number of specialist rotas increasing the demand on workforce at both a local and national level. This improved patient care and outcomes but contributed to national staff shortages in key areas.

NHS staff in east Kent are hard-working, dedicated and strive to provide the highest quality of care they can to patients.

In east Kent, there were long standing issues with recruitment, in particular for emergency care services. Nearly half the emergency medicine consultant posts at East Kent Hospitals University NHS Foundation Trust (EKHUFT) were vacant (double the national average) and a quarter of critical care consultants were expected to retire within the next four years.

This meant that health and care services needed to be organised in the way that would best attract and keep staff. Specialist hospital centres and centres of excellence were more attractive places to work, with higher job satisfaction and better opportunities for professional development. In the short term, the Trust was looking at overseas recruitment but in the longer term it was hoped that the medical school would provide local consultants.

Q10 What is the situation in relation to general doctor and support medical (like radiographers etc.) at QEQM, and at Ashford?

This was covered by the responses to Q9 and Q11.

Q11 Are there shortages in nurse provision in the 3 East Kent hospitals, and if so what is being done to increase the number?

It was widely reported that there was a national concern about recruiting and retaining sufficient numbers of nursing staff to meet demand. In the first quarter of

18/19 national nursing vacancy rates stood at 11.8%, which equated to 41,722 vacancies.

EKHUFT's nursing vacancy rates demonstrate that Emergency and Urgent Care and Acute and Speciality Medicine are the areas of greatest concern and are significantly higher than the national average at 24% and 19% respectively.

Q12 **What is causing nurse shortages? What financial support is available for potential students wishing to train as nurses (for example at Christchurch University, Canterbury) given that I believe that such students now have to pay tuition fees (apart from mental health nurse students)?**

Nurses were a critical part of healthcare and made up the largest section of the health profession. Many of the factors also applied to other professions such as Midwives. A shortage of nurses could ultimately significantly affect the quality of patient care, with increased waiting times, potential risks to patient safety and patient experience.

The reasons for the shortage were multiple and were not unique to EKHUFT. Staff were leaving the service due to low job satisfaction whilst recruitment and retention continued to be a growing problem.

Nationally the overall number of nurses employed had increased but this didn't meet the increased demand. There were 36,000 nursing vacancies in England and 33,000 of these were filled by expensive agency or temporary staff. These shortages mean that many NHS nurses "don't feel able to provide the level of care they should be".

Retention was a growing issue with increased pressures on the workforce. Research suggested 70% of nurses leave the NHS within their first year of qualifying. Additionally, 28% of EU nurses have left since the result of the Brexit referendum and overseas have halved. Cuts to nursing bursaries had also led to a 33% drop in university applicants.

The Trust was attempting to provide for more flexible working arrangements as this was one of the draws of agency work. It was acknowledged that this could also bring additional pressures on the workforce if not properly managed.

Q13 What is the latest news on the Stroke unit location

General stroke services were currently provided in many of Kent and Medway's hospitals including at William Harvey Hospital in Ashford and at Queen Elizabeth The Queen Mother Hospital in Margate. There were currently no specialist hyper acute stroke units in Kent and Medway. Hyper acute stroke units (HASUs) in other parts of the country had been shown to significantly improve outcomes for people who have had a stroke.

Although stroke staff do their very best, the way services were currently organised meant that some people did not get the right treatment fast enough, particularly overnight and at weekends. Most hospitals in Kent and Medway struggled to consistently meet national best practice standards of care for stroke patients, for example giving people a brain scan within an hour of getting to hospital. This was mainly because the resources were stretched too thinly across too many hospitals.

The aim was to make sure urgent stroke services in Kent and Medway could meet national best practice standards so that patients received the best possible chance of survival and recovery.

Reorganising urgent stroke services into three hyper acute stroke units in Kent and Medway would mean everyone treated for stroke, would receive consistently high-quality care regardless of where they live or what time of day or night a stroke occurs. These new units would allow people to get the best possible care in the vital first few hours and days immediately after their stroke, saving lives and reducing disability. From national and international evidence and from examples in other parts of the country, hyper acute stroke units help reduce disability and death from stroke. In London, hyper acute stroke units have reduced deaths from stroke by nearly 100 each year.

NHS commissioners had planned carefully to make sure that the travel time to the proposed new hyper acute stroke units was as short as possible. The evidence, from elsewhere in the country where similar changes have already been made, shows that patients who are treated in a hyper acute stroke unit have a much better chance of surviving and making a good recovery, even if they travel further to get there.

Depending on where you live, the ambulance journey to reach one of the proposed hyper acute stroke units may be longer than being taken to your current nearest A&E. However, a shorter journey to a hospital without a hyper acute stroke unit can be worse for stroke patients than a longer journey to a hyper acute stroke unit. The evidence demonstrated that keeping to a minimum the time taken from calling 999 to getting a brain scan and appropriate treatment, gave stroke patients the best outcomes. As hyper acute stroke units had dedicated teams on hand 24-7, they could often respond faster when a patient arrived at hospital than A&E departments without a hyper acute stroke unit. This cut down the overall time between calling 999 and getting treatment, even if the patient had travelled further.

The Joint Committee of Clinical commissioning Groups for the stroke review had agreed to establish three hyper acute stroke units in Kent and Medway with the proposed sites being Darent Valley, Maidstone and William Harvey hospitals.

Hospital Transportation

Q14 What arrangements are there for people who either cannot, or do not, drive, but need to attend hospital - any of the three main hospitals: WH, QEQM, KCH and of course Buckland

Non-emergency patient transport to the hospitals in east Kent was provided by a contractor. The non-emergency patient transport service was for people whose health means they cannot get to or from their NHS appointment in any other way.

Anyone could find out if they were eligible for patient transport by calling the freephone bookings line on 0800 096 0211, 24 hours a day.

Patients (or carers, such as a family member) would be taken through a simple, confidential assessment process to check eligibility. If a patient was not eligible alternative services were possible, including volunteer driver schemes.

The eligibility criteria was set nationally and had not changed. However, a considerable amount of work had been done in Kent and Medway to ensure that the criteria were applied in a completely fair and consistent way.

All patients will go through an eligibility criteria assessment when booking their transport.

Generally patient transport was available for patients who:

- required assistance from skilled ambulance staff e.g. require access to oxygen whilst travelling.
- had a medical condition that would prevent them from travelling to hospital by any other means.
- had a medical condition that might put them at risk from harm if they were to travel independently.
- had treatment with side effects that required support from skilled ambulance staff.

Accident and Emergency

Q15 What are the Emergency ambulance response times to Deal, and comparative journey times to William Harvey, QEQM and Canterbury (if there were an Emergency department there)

Response times and access and travel/transport issues were a key concern for people across east Kent. The Ambulance Trust would be the appropriate body to provide this information to the Committee.

A Travel Advisory Group had been established to support the plans. Additional evaluation sub-criteria were added to the accessibility criteria to ensure that emergency ambulance travel times, car and public transport times, and the overall distance from hospitals were evaluated with a particular focus on deprived communities.

Greater distances to travel had been highlighted as a major concern when ensuring those who are very ill can access acute care as fast as possible. The overall metric under any option was for 95% of the east Kent population to access an A&E department within 60 minutes.

Q16 What are the recent waiting times for patients to be treated in A&E in the East Kent hospitals which serve Dover – Canterbury, Ashford and QEQM? Do these breach the national guidelines?

The NHS saw record numbers of patients in emergency departments across the country in December and like Trusts elsewhere, the hospitals in east Kent were extremely busy. The staff treated more than 4,000 additional patients in December 2019 compared with the same period the previous year and worked tirelessly to provide the best possible care.

Despite the additional pressures, almost three quarters were seen within the national standard and the Trust continued to focus on improving that figure so that no one had to wait longer than the Trust would like.

This issue was one of the major drivers for change and the future design of services which would require whole system change to the provision of A&E services, ways of working within the Trusts workforce and how patients accessed the services.

The focus of the reconfiguration and the forthcoming consultation was to ensure there were high quality and sustainable services across the urgent and emergency care pathway which will lead to improvements in the quality of care in the long term.

Although there was increased demand on A&E services, minor injury units had successfully diverted some people away from A&E. Members welcomed this for those patients who did not need to go to A&E and could receive treatment quicker in minor injury units.

Across the crucial Cancer services, the Trust achieved the 62 day standard for the first time since 2014 in Q3 and was continuing to show improvement against all tumour pathways. Also, there was sustained improvement in the 2 week wait standards, 31 day standards and delivery of the 62 day standard in October and December 2019.

Q17 How many beds are needlessly occupied in our local hospitals by elderly people awaiting suitable social care packages to allow them to leave the hospitals promptly on completion of medical treatment? What is being done locally with KCC Social Services to address this problem and increase suitable social care provision? What information is available about bed-blocking locally? Is there enough care in the community/care homes for people to be discharged when they are ready?

The number of frail people and people with complex needs was growing fast in east Kent. Sometimes people could end up ‘stranded’ in hospital beds, where they could be at risk of catching infections, falls, and muscle wastage.

Reducing delayed transfers of care and length of stay improved hospital flow would have a positive impact on the Emergency Department. Ensuring appropriate length of stay and avoiding delayed transfers of care involved a multi-faceted system wide approach, working with primary care, community care and local authorities.

An internal audit undertaken in November 2016, identified that of 915 occupied beds audited at EKUFT, nearly 36% patients were medically fit to leave their current setting of care, but whose discharge was delayed for a number of reasons.

While it was best for frail people to avoid hospital wherever possible, some people needed to recover from illness or injury with round-the-clock medical supervision. The Trusts vision would provide this care, linking emergency and community services, and improving patients’ chances of regaining their strength and independence.

There were 275 community beds in east Kent providing both health (188 beds) and social care (87 beds). The main providers are Kent Community Health NHS Foundation (KCHT) (99 beds) and Kent County Council (KCC) (87 beds).

In east Kent, there are approximately 7,955 older people in either nursing or residential homes.

The Trust was undertaking work to identify the number of beds it needed based on demographics and care needs.

An integral part of the plans involved a close partnership with KCC to in addition to increasing the number of hospital inpatient beds, build health and care services outside hospital for people who can be cared for elsewhere, which would enable the NHS in east Kent to meet the needs of its population now and for the future.

The Chairman thanked Caroline Selkirk (Managing Director of Ashford, Canterbury and Coastal, South Kent Coast and Thanet clinical commissioning groups) and Nicky Bentley (Director of Strategy & Business Development, East Kent Hospitals University NHS Foundation Trust) for attending the meeting and answering the committee's questions.

The meeting ended at 8.13 pm.