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, 5 February 2010.

PRESENT: Mr B R Cope (Vice-Chairman, in the Chair), Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle, Mr A Willicombe, Cllr Ms A Blackmore, Cllr C Kirby (Substitute for Cllr Mrs J Perkins), Cllr M Lyons, Mr M J Fittock and Mr R Kendall

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Minutes - 27 November 2009
(Item 3)

(1) Mr Wickenden informed the Committee that some Members of the Task and Finish Group looking at the reconfiguration of Women's and Children's services by Maidstone and Tunbridge Wells NHS Trust had visited the new Pembury Hospital. He was aware that other Members of the Committee would also to visit the Hospital and he would contact Mr Douglas to arrange this.

(2) RESOLVED that the minutes of the meeting held on 27 November 2009 are correctly recorded and that they be signed by the Chairman.

2. Dover Healthcare
(Item 4)

Mr Dawson (Head of Development and Public Protection, Dover District Council), Ms Donovan (Planning and Communications Manager, Environment Agency), Ms Harrison (Director of Assurance and Strategic Development, NHS Eastern and Coastal Kent), Mr Ingleton (Head of Regeneration, Dover District Council), Mr Morley (Associate Director of Estates, East Kent Hospitals University NHS Foundation Trust (EKHUFT), Caren Swift, Director of Strategic Development, (EKHUF),and Mr Tutton (LINk) were present for this item.

(1) The Chairman invited Ms Harrison to give the Committee a brief update on progress since this matter was considered at the meeting on 30 October 2009.

(2) Ms Harrison referred to papers circulated with the agenda which showed the outcomes of stakeholder events. These outcomes had been considered by the Primary Care Trust (PCT) Board in November 2009. At this meeting the PCT Board had considered the three original sites, Buckland, Whitfield and mid town and also two further sites, Buckland Hospital and Charlton Green. The Board considered all of

these sites and resolved at this stage to rule out the mid town site, because of flood risk, and the two newer sites as they did not have any significant advantages. The PCT Board requested the business case from East Kent Hospitals University NHS Foundation Trust (EKHUFT) for these two sites before making a decision. Ms Harrison confirmed that the PCT's priority was to deliver the most affordable and rapidly deliverable option. The business case from the EKHUFT was considered at the PCT Board on 27 January 2010 where it was decided to develop a full business case for the Buckland hospital site.

(2) Mr Tolputt asked whether the Buckland Hospital site had adequate land available for expansion, and what impact there would be on services at Buckland Hospital whilst the site was being developed. Mr Morley replied that there was extensive land available at the Buckland Hospital site and that none had been sold to a third party. He explained that the new Hospital would be built on the existing car park and therefore at no point would the development of the site adversely affect services.

(3) Mr G Prosser, MP was invited to speak. He explained that his consistent position was that what Dover wanted was a local community hospital that was deliverable, affordable and which could be developed quickly. He expressed his respect for those in Dover who supported and campaigned for their favourite site option and acknowledged that many of those, including Mr Hansell, had been critical of the mid town site which had been supported by many including Dover District Council and himself. However, the flood issue prevented the use of the mid town site - in time it might have been possible to ameliorate the effects of flooding but not within the timescale necessary for the development of the hospital. He stated that the Buckland Hospital site was in the ownership of the Hospital Trust, there was additional land available on the site, and it did not have an issue with flooding. The issue of using the monies available was still the priority and any further time slippage would put the scheme in jeopardy. Mr Prosser expressed his support, without reservation, to site Dover's new Community Hospital on the Buckland Hospital site.

(4) Mr Hansell was invited to speak. He set out the reasons why he believed that Whitfield was the most suitable site and why he believed that the Buckland Hospital site was unsuitable. These included lack of room for expansion on the Buckland site and inadequate parking. He also stated that the Whitfield site was closer to more areas of deprivation than Buckland Hospital. In conclusion he stated that Dover had been promised a £20m hospital and what was on offer was a £11m clinic.

(5) Councillor Heath (Dover District Council) expressed concern about the access problem for the Buckland Hospital site. He referred to a visit 3 years ago by the Dover District Councils Scrutiny Committee to Buckland Hospital where Councillors had been told that Buckland Hospital was not fit for purpose and that the Mid Town site was preferable. He asked what had changed the Hospital Trusts mind and whether this was this based on financial considerations.

(6) Councillor Lyons stated that the Environment Agency had made it clear that the only place that would not flood was the Buckland site and it was in the ownership of the NHS, whereas the Whitfield would have to be purchased. He expressed concern at the length of time that it had taken to get to this stage.

(7) Ms Harrison explained that the PCT and EKHUFT had been in dialogue about this issue for a long time and she reminded the Committee that it had been decided some time ago to build on the Buckland site. However, at a meeting of this Committee they were asked to reconsider using the mid town site, which had delayed the process. However, the issue of flooding had ruled out the mid town site and therefore the opportunity had been taken to consider all site options again. The most important consideration was ensuring that any site met the health needs of the people of Dover. Therefore, the development of new build on Buckland Hospital car park was the best option. At this meeting health colleagues were looking for an understanding from the Committee so that they could go forward in a timely way as any delay would put the funding for this scheme at risk.

(8) Mr Daley stated that the Committee had listened to the arguments for and against these sites on a number of occasions and had listened to all interested parties, including Mr Hansell and elected representatives at all levels. The key factor for any site was that it must be capable of being delivered now. All sites had issues but the Buckland site was deliverable within the timeframe. There were planning issues in relation to the Whitfield site which could cause delay and lead to the funding being reallocated.

(9) Mr Tutton (Kent LINk) gave details of discussion on the Whitfield site with Planning Officers from Dover District Council that he had attended with Mr Hansell. He expressed the view that public engagement on this issue had been haphazard. The operation of the proposed Community Hospital by the EKHUFT rather than the PCT was confusing for the public. He disputed the statement that the majority of the pubic in Dover were in favour of the mid town site as an on line survey had shown that only 14% of those who responded thought that mid town was the best site. It was important to ensure that the new Hospital would serve the community not only in Dover but also in Deal, Sandwich etc. He also highlighted the difficulty faced by Dover residents in accessing some services such as blood tests.

(10) Mr Dawson set out Dover District Councils' current planning position which was that in terms of planning policy there was no identified site for the new Hospital. In an earlier version of their Core Strategy there was reference to a Community Hospital on the mid town site but this had been removed as it had not been possible to resolve flooding problems at that point. In an attempt to help EKHUFT to resolve this issue Dover District Council had made available all their site information. In a couple of years time the mid town site may be the best site but not within the timescale for this development.

(11) Councillor Kirby acknowledged that the mid town site was not available due to circumstances beyond Dover District Council's control. Therefore, it was necessary to move forward. He asked the PCT to confirm that using the Buckland site would involve a new build and not a refurbishment of the existing building and that there would be adequate parking on site. Also he sought confirmation that the Deal Hospital would be retained to provide facilities to Sandwich, Deal and the rural area to relieve pressure on Buckland.

(12) Ms Donovan explained that the Environment Agency had provided information to the PCT Board to help it to understand the environmental issues for the various sites. She stated that both Buckland and Whitfield had the lowest level of flooding. The Environment Agency believed that the environmental issues for both sites could

be managed and they wanted to assist Dover get its hospital as soon as possible. She referred to a meeting that was due to take place at County Hall later in the day to look at how surface water risk in Dover could be managed

(13) Mr Ferrin stated that he was happy to support the suggestion to use the Buckland site as long as there was adequate parking. He also asked if parking on the Buckland site was going to be free of charge.

(14) In relation to the parking issue, Mr Dawson stated that Dover District Council, as the Planning Authority would require a travel plan and County Council highways staff would get involved at that time.

(15) Mr Morley confirmed that the business case considered at the EKHUFT Board recommended £19m as an outline cost of the scheme for the Buckland site. He confirmed that the Trusts' landholding at Buckland was extensive and the scheme would consolidate development into a single facility on a smaller footprint which would provide the opportunity for adequate parking. A desk top study had been carried out and the risk of contamination on the Buckland had been identified as low.

(16) RESOLVED that the Committee unanimously supports the NHS Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals University NHS Foundation Trust with moving forward with an affordable and rapidly deliverable facility in Dover.

3. Emergency Care Pathways (Cardiac, Stroke, and Trauma)
(Item 5)

Mr Roche, Medical Director (South East Coast Strategic Health Authority). Ms Evans, Head of Business Planning and Strategy, and Mr Reynolds, Head of Business Development,(South East Coast Ambulance Trust were present for this item.

(1) The Chairman welcomed health colleagues to the meeting and invited them to introduce each of the care pathway areas and to answer questions from Members.

<u>Cardiac</u>

Dr Mishra, Clinical Lead Cardiology and Ms Andrews CBE, Director of Nurses and Director of Infection Prevention and Control, Ms Hiscox - Lead Commissioner Cardiovascular (NHS Eastern and Coastal Kent), Mr Wheat, Director of the Cardiac Network, Ms Stewart, Senior Service Improvement Project Manager (Kent Cardiovascular Network) and Mr Lawson, Patient Representative were present.

(2) Mr Wheat set out the current treatment pathway for a suspected heart attack following a 999 call. He referred to the new treatment which was being rolled out nationally which would reduce admission time for patients.

(3) Dr Mishra stated that the way that heart attacks were treated was changing, nationally 47% of people who had heart attacks had primary angioplasty compared to 6% in Kent it had taken time to get this service developed. It was hoped that by April

2010 Kent would have 100% of heart attack patients going to the Heart Centre and having balloon angioplasty rather than drug therapy.

(4) Mr Daley commended the upward trend in good outcomes and asked if there were plans for angioplasty to be carried out more locally in east Kent.

(5) Mr Wheat explained that over the past 5 years five cardiac catheter laboratories had been opened at various locations across Kent and Medway so that patients could be treated closer to home. The first was at the William Harvey Hospital, Ashford in 2004 and the latest had opened in Maidstone at the end of 2008.

(6) Dr Mishra stated that the reason it had been decided to concentrate on one Heart Centre was the need to have a certain number of patients coming through to maintain the expertise both for the unit and the operators. It had been decided to base this at Ashford as it was the first cardiac catheter laboratory and therefore had a high volume of patients. In future if it was found that there is a high enough demand consideration would be given to locating a second centre in East Kent.

(7) In response to a question from Mr Smith, Mr Wheat explained that whenever he designed a care pathway he argued that decisions regarding where a patient was taken for treatment was for the clinician from the ambulance service who was with patent.

(8) Mr Tolputt asked whether all ambulance staff were now trained in administering thrombotic drugs. Mr Reynolds explained that the care pathway had moved away from using thrombotic drugs and now a paramedic would attend all 999 calls for heart pain, even if they were not the first to attend, and following an ECG would decide if it was a heart attack and deal with it appropriately.

(9) In response to a question from Councillor Blackmore on the comparative length of stay in hospital following treatment, Doctor Mishra explained that currently if a patient was admitted to hospital with a heart attack they were likely to stay seven days (or longer if it was over a weekend), with the new treatment the patient should be able to go home on the third day and after that have their rehabilitation at a local hospital. This saved 3 to 4 overnight stays in expensive beds. She acknowledged that there was a financial as well as a health benefit to this change in practise. In relation to rehabilitation, as patients were spending less time in hospital there was a danger that they would not recognise the seriousness of what had happened to them, therefore part of the rehabilitation was convincing them of this.

(10) In relation to transfer time, from call to balloon angioplasty, Dr Mishra stated that the national prescribed limit was 150 minutes and the Trust were aiming for 120 minutes and were hoping to get below that.

(11) Mr Ferrin expressed the view that there was too much emphasis placed on travel time and that patients would be prepared to go to the hospital that gave them the best chance of a good outcome. Dr Mishra explained that it was only possible to have cardiac intervention at high volume centres and that all of the Trust's cardiac consultants also worked in London. Therefore it was the doctors that were travelling to and from London rather than the patients.

Stroke

Ms Hunt, Director of Nursing and Quality (NHS West Kent), Mr S Duckworth, Stroke Network Director (Kent Cardiovascular Network) and Ms Hiscox - Lead Commissioner Cardiovascular (NHS Eastern and Coastal Kent) were present.

(12) The Chairman invited health colleagues to introduce this item and to take questions from Members.

(13) Ms Hunt gave some background to the service and stated that a couple of years ago the service was poor in patches compared to the rest of England. Rapid improvements had been made over the last 18 months particularly in relation to hyper acute stroke services. Two years ago there were not any acute stroke services in Kent now there were acute stroke services in all hospitals in Kent and Medway and all could provide acute thrombolysis. They had worked with the ambulance trust in relation to response times and acute strokes were now regarded as a medical emergency. It was not possible for ambulance staff to administer thrombolysis, therefore patients needed to get to hospital as soon as possible so that they could be treating with three hours of the symptoms.

(14) Ms Hunt explained that there were currently different approaches to treatment in East and West Kent. In East Kent patients could be taken to any acute hospital for assessment and treatment remotely by a consultant, this was facilitated by telemedicine equipment. In West Kent there was currently a rota with the service always available at one acute hospital at least, ambulances would take patients to this hospital for initial treatment and when they were stable they would be transferred to their local hospital. The Network had recently received an innovation award from the Strategic Health Authority which would enable them to purchase telemedicine equipment for West Kent and Medway so that patients in those areas could also be taken straight to their local acute hospital and would be able stay in the same hospital throughout.

(15) In response to a question from the Mr Kendall, Ms Hunt confirmed that currently clinical outcomes were equally good in East and West Kent. The introduction of the telemedicine equipment in the summer would just provide a logistically better service.

(16) Mr Daley referred to the increase in public awareness of the importance of acting quickly in the case of a stoke for the best outcomes.

(17) Ms Hunt agreed that the public awareness campaign had been very helpful in enabling the public to recognise a stroke and the importance of getting help as quickly as possible. Also if the patient was within the 3 hour timeframe a stroke team would be waiting at Accident and Emergency to receive them and if appropriate arrange for thrombolysis to be administered by either a consultant or a specialist nurse. In East Kent the time from a patient arriving at hospital to treatment being administered had been reduced to 40 minutes.

(18) Mr Duckworth explained that it was not possible to give thrombolysis to all patients who had a stroke, however, even for those patients who could not have it if they got onto a dedicated stroke pathway they would have better outcomes. Therefore, the thrombolysis service improved processes and outcomes for all stroke patients even those were not able to receive this treatment.

(19) Mr Duckworth confirmed that the time of day the stroke occurred made no difference to the outcome and that the current mortality rate was 12%.

(20) Regarding the care pathway for a transient ischaemic attack (TIA), Mr Duckworth explained that people who were regarded as a high risk were seen within 24 hours and were given treatment if necessary. Anyone of a lower risk would be seen within seven days. Two years ago the average waiting time for a TIA appointment was 4 – 5 weeks. Approximately 50% of patients go on to have stroke following a TIA within the first few weeks, therefore waiting weeks for an appointment not appropriate. He highlighted the great progress that had been made in this area.

(21) Mr Roach emphasised the importance of having a comprehensive package for all stroke patients even those who do not have thrombolysis. He also mentioned the advertising campaign which was a national success story. Real progress had been made in this area by colleagues who were passion about the service provide to these patients.

<u>*Trauma*</u>

Ms Thomas, Director of Service Redesign (NHS West Kent) and Andrew Cole, Head of Commissioning Urgent and Continuing Care (NHS Eastern and Coastal Kent) were also present.

(22) Mr Roche referred to the major trauma report that had today been issued by the National Audit Office. Major trauma was not currently a success story, the UK was just starting to look at major trauma services. In Kent one of the issues was logistics, in 2008 66 people in Kent died in road traffic accidents, and most of these were in the coastal area away from the major road network. Patients with complex trauma need to be rapidly assessed by ambulance crews. Approximately 60% of those with complex trauma had head injuries. Many patients from Kent were taken to King's College Hospital, London. However King's could not accept transfers by air ambulance at night. It was recognised that there was a problem with trauma treatment in Kent and a review had already been commissioned across the Strategic Health Authority area. Trauma Leads had been appointed in Brighton and Kent who would form the basis of a trauma board. The message was that major trauma patients like heart attack patients needed a 24/7 service available with senior staff and urgent access to further services if necessary. He stated that he was determined to come back to the Committee in the future with a success story for trauma.

(23) The Chairman stated that he was encouraged that Mr Roche approached this Committee at this early stage and sought the Committees vies our views as representatives of the layperson.

(24) In relation to a question from Councillor Blackmore seeking clarification on the air ambulance and night flying, Mr Roche explained that only police pilots could fly at night, but another issue was the affect of adverse weather on the air ambulance. Accidents involving major trauma were more likely to occur in poor weather conditions.

(25) Councillor Lyons asked whether there were likely to be a number of dedicated centres in Kent or whether there would be a shared facility with Sussex. Mr Roche

explained that 600 – 700 patients a year were needed to support a fully equipped trauma centre. It was anticipated that Kent would produce less than 100 patients a year and therefore it was very unlikely Kent could host a centre. In Kent the issue was logistics and there was a need to ensure that patients were assessed, any immediate problems resolved and then were able to access good pathways to appropriate care in a timely manner. It was then necessary to repatriate and properly rehabilitate these patients. This needed to be put in place across Kent to ensure the best outcomes for the patient.

(26) In response to a question from Mr Cooke, Mr Roche confirmed that the most significant number of road deaths in Kent occurred outside of the M25 and M20 corridor, along class "A" roads and in the coastal areas. The aim was to provide the best possible service and not disadvantage people because of where they lived or where an accident occurred.

(27) Mr Daley asked whether when Pembury Hospital was open it would be able to deal with aspects of the major trauma services that patients currently had to go to Brighton or London to receive. Mr Roche replied that patients with brain or chest injuries would still need to go to other centres. He stated that Kent was to be congratulated in centralising its heart treatment, which had been done by clinicians working together to provide a service that was best for patients and he was keen that the same principle would drive the reconfiguration of acute trauma.

(28) In response to a question from Mr Lyons, Mr Roache confirmed that the trauma leads would inform him of relevant organisations to seek views from, However, the service would be developed around the benefits to the patients and not any vested interests.

(29) In answer to a question from Mr Kendall, Mr Roache stated that very few cyclists were killed in Kent but that there was evidence from America that the use of helmets reduced injuries for cyclists.

RESOLVED That the Committee supports the developments taking place in emergency care pathways and heath colleagues be thanked for bringing the paper on trauma to this Committee to enable Member to have an input at an early stage.

4. Date of next programmed meeting – Friday 19 February at 9:30
(Item 6)

It was noted that the substantive item for this meeting would be Women's and Children's Services in Maidstone and Tunbridge Wells NHS Trust.