HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 5th February, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 5th February, 2010, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **01622 694486**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr K A Ferrin, MBE, Mr J A Kite, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Cllr Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Cllr Mrs M Peters

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item — Timings

1. Substitutes

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

3. Minutes (Pages 1 - 12)

4. Dover Healthcare (Pages 13 - 18)

   (Further Papers to Follow)

5. Emergency Care Pathways (Cardiac, Stroke, and Trauma) (Pages 19 - 46)

   (Further Papers to Follow)

6. Date of next programmed meeting – Friday 19 February at 9:30

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

28 January 2010

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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, 27 November 2009.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr D S Daley, 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 and Cllr M Lyons

UNRESTRICTED ITEMS

21. Minutes
(Item 3)

RESOLVED that the minutes of the meeting held on 30 October 2009 are correctly recorded and that they be signed by the Chairman subject to the following additions and amendments:-

(a) in relation to the proposed mid town site for a Dover Healthcare facility Kent Highways services be asked to provide the Committee with information on the actions they had or were proposing to take to mitigate the risks from serious flooding; and

(b) on page 3 paragraph 7 line 6 insert the words “the call would be diverted” and change paragraph 9 line 1 to reflect that the correct description is "out of hours."

22. Maidstone and Tunbridge Wells NHS Trust Service Redesign
(Item 4)

Mr G Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Ms G Duffey (Head of Midwifery Services, Maidstone and Tunbridge Wells NHS Trust), Dr C Unter (Consultant Paediatrician, Maidstone and Tunbridge Wells NHS Trust), Ms J Thomas (Director of Service Redesign NHS West Kent), and Mr J Ashelford (LINk) were in attendance for this item.

(1) The Committee had before them a background paper prepared by the Research Officer to the Committee on the Maidstone and Tunbridge Wells NHS Trust Service Redesign together with Briefing Papers prepared by the Maidstone and Tunbridge Wells NHS Trust and NHS West Kent. Circulated separately to the Committee was a copy of the Minutes of Maidstone Borough Councils External Scrutiny Committee on 13 October which had reviewed the issue of Maternity Services in Maidstone as a Councillor Call for Action

(2) The Chairman explained to the Committee that this session was intended to be an opportunity for the Committee to look at the whole service redesign for the Trust although he was aware of the specific interest in the maternity service

provision. He intended to look at all other elements of the service redesign first and then concentrate on maternity services.

(3) Mr Douglas took the opportunity to inform the Committee that last week the Care Quality Commission had carried out an unannounced inspection and no issues had been raised. This was a major step forward for the Trust. Mr Douglas added that in relation to the Declaration of Standards for Better Health, the Trust had fully met the health care standards. As a result it was virtually impossible for the Trust to be assessed as "weak" at its next review. This was the result of an enormous amount of work over the past two years.

(4) Mr Douglas then gave an update on progress with the new Pembury Hospital. Building was 4 to 5 months ahead of schedule which provided a buffer for any delays that occurred during the winter months. It also gave more time to embed, equip, and make the hospital ready for occupation. He also informed the Committee that the new Hospital would be the most environmentally friendly hospital when it opened. It had been built with sustainability in mind e.g. it would be partly powered by wood chip burners using locally sourced fuel.

(5) The Trust had been working with colleagues at Kent County Council (KCC) in relation to the transport infrastructure and transport links, especially bus services. It was unfortunate that despite lobbying of the Government by both the Trust and KCC, the work on the Castle Hill bypass was programmed to start at the time when the hospital opened. The Trust had also worked with Tunbridge Wells Borough Council to increase the number of car parking spaces especially for visitors at the new hospital. The Committee noted that the Trust would shortly be publishing its green transport plan.

(6) In relation to the Maidstone Hospital site the roof was now on the new endoscopic training centre. The Committee were advised that the Trust's strategy depended on a number of factors coming together with the moving of some services from the Kent and Sussex Hospital, Tunbridge Wells to Maidstone. This would give the Trust the ability to start to introduce local services for Kent residents who currently have to go to London hospitals for specialist cancer treatment.

(7) Mr Douglas stated that the Strategic Health Authority had approved the Trust's capital plans for the centralisation of pathology. Laboratory services would move from Medway Hospital, Pembury Hospital and Preston Hall in to the centralised unit. This was important for the new cancer centre. Funding had also been approved for the midwifery led unit at a nursing home near Maidstone Hospital. There would also be two state of the art laser therapy machines at Maidstone and Canterbury Hospitals, these were the only ones outside of the bigger London hospitals.

(8) In response to a question on when the public were likely to be able to have up to date information on where services, not located within the new Pembury Hospital, are to be located, Mr Douglas stated that the location of a number of services had already been agreed. He added that the pain management service would be based at Pembury but a service would be provided at Maidstone as well. In relation to the diabetes service, this would be located in the Assura building in the centre of Tunbridge Wells and rheumatology and neurology based in Pembury. Decisions remained to be taken on the location for outpatient physiotherapy and neurology rehabilitation services which were planned to be located in local community hospitals.

The Trust was close to having a cohesive location plan for all services. Mr Douglas undertook to make sure that the future location of services was made known to interested parties, including the Committee.

(9) Regarding the way in which the Trust was assessed by the Care Quality Commission, Mr Douglas explained that they made a self assessment, rather like the Ofsted process. Officers made a declaration and it was peer reviewed. Stakeholders such as the Health Overview and Scrutiny Committee and the LINk were usually invited to contribute to the process. Most health organisations did not receive a visit from the Care Quality Commission. However, the Maidstone and Tunbridge Wells NHS Trust had received more regular visits from the Care Quality Commission (which took over from the Healthcare Commission) than any other organisation.

(10) In relation to the journey time between Maidstone Hospital and Pembury (as opposed to Tunbridge Wells) Mr Douglas stated that he did this journey regularly at different times of the day and he usually did it in less than 30 minutes. He added that an ambulance using its blue light would do the journey in less time. There were occasions when Colts Hill was congested but he believed that a blue light ambulance would probably still make this journey in 30 minutes. Mr Douglas said that Pembury hospital was a superb site for an emergency hospital because its road communications are good. He added once the Castle Hill dualling was completed it would be very good and if there was a Colts Hill bypass it would be excellent. Doubts were expressed by a number of Members that the time quoted for travelling between Maidstone and Pembury hospitals was very optimistic.

(11) Mr Ashelford (a LINk governor and Chief Executive of the Hospice of the Weald) expressed the view that the whole transport issue needed to re-considered.

(12) The restoration of the pain clinic at Maidstone following representations from the public was welcomed. The importance of ensuring reasonable access to clinics for those patients that need to attend a clinic on a regular basis was emphasised.

(13) Mr Douglas stated that the Trust hoped to mount an information campaign in the next few months to dispel the myths around the reconfiguration of services. The majority of people who visited hospitals were outpatients and there would be no change for them. When looking at where services were provided it was necessary to look at the economics. He added that outreach clinics were likely to be based in Community Hospitals.

(14) Mr Douglas invited all Members of the Committee to visit the new Pembury Hospital and Maidstone Hospital to look at the facilities and receive a presentation showing how the services linked together.

(15) Ms Thomas informed the Committee that at a meeting on 26 November 2009 the West Kent Primary Care Trust (PCT) Board had received the PCT Strategic Commissioning Plan and Community Strategy in which the future use of community hospitals was discussed. She added that the PCT Strategy was about having a better profile of services in more local locations. The PCT's analysis showed that there is a large population from the Sevenoaks area, Edenbridge and Crowborough, that use Maidstone and Tunbridge Wells' services. On that basis the PCT have proposed some changes. The PCT have discussed having a larger profile at local hospitals. The PCT would be engaging the public to see where services could be

developed and located. Ms Thomas said that the PCT were aware of the importance of locating clinics locally for people with long term conditions who had transport difficulties.

(16) In response a question on whether there would be consultant led services provided at both Maidstone and Pembury or whether these would be shared, Mr Douglas explained that consultants working across sites tried to plan their work so that they spent the day in either Pembury or Maidstone. There were currently occasions when consultants needed to travel between sites and they could be affected by adverse traffic conditions, this would still be the case with the service redesign.

(17) In response to a question on whether there was reluctance on the part of consultants to work in various community hospital locations, Mr Douglas replied that the Trust had not experienced any major problems getting consultants to run clinics in community hospitals. It was in the Trusts' interests to promote outpatient services in order to bring work into the larger hospitals.

(18) Ms Thomas explained that the NHS in West Kent was waiting for information from the Department of Health on tariff changes. They wanted to ensure that they get the most from their money. As part of the Strategic Commissioning Plan there was an incentive to adopt best practise at a local level. Regarding total care pathways, the PCT were trying to stimulate the local market, by were working with clinicians to move more services closer to the patient.

(19) Dr Eddy (LINk Member) raised a number of issues relating to transport. These were firstly the pubic being able to get to hospitals for outpatients appointments and day care, and secondly, ambulance emergency transport from the patients location to the most appropriate hospital, and finally transfer between hospitals by ambulance if a problem occurred, for example during childbirth. He asked what input the ambulance service has had into the decisions around this. Mr Douglas confirmed that there had been a lot of dialogue with the ambulance service and they were supportive of the Trust's plans. The Trust was working through protocols with the Ambulance service. As part of the design of the new hospital there was provision to turn ambulances around as quickly as possible. Mr Douglas undertook to supply information to the Committee on the work the Trust had undertaken with the Ambulance service

(20) Ms Thomas reminded the Committee that many of these issues, including the transport issues raised by Dr Eddy, were ones that the Independent Reconfiguration Panel had asked to be resolved prior to the implementation of the reconfiguration of orthopaedic services. In July 2008 the Board had considered the issue of transport. The Board had established a group that included members of the Maidstone branch of the BMA, Maidstone Consultants and an invitation had been extended to the HOSC. The PCT Board was satisfied that the issues had been addressed. Therefore there had been a very recent reconfirmation of the adequacy of arrangements. Ms Thomas said she would be happy to make the Board papers available to the Committee.

Redesign of maternity services

(21) Mr Datta, a consultant obstetrician at Maidstone Hospital, emphasised the risks for mothers in having to travel distances in an emergency situation to access services and asked what the trust were doing to minimise the risk

(22) Mr Pentecost (a retired consultant) stated that he had figures provided to him by another consultant at Maidstone Hospital, Jonathan Goodman, which indicated 1 in 3 women being transferred during labour.

(23) Mrs Whittle referred the Committee to her personal experience regarding having to travelling to Maidstone to give birth. Mrs Whittle raised the issue of women who were not assessed as high risk but needed to have emergency caesarean - she assumed would have to be transferred from the Maidstone birthing unit to Pembury and expressed her concern at the risks involved with this transfer. She also asked what consultation had taken place with midwives.

(24) If there was not going to be a full consultant led maternity service at both hospitals then there were serious concerns for expectant mothers which needed to be addressed.

(25) Ms Duffey (Associate Director of Midwifery at both Maidstone and Tunbridge Wells) explained that the birthing centre would not replace the maternity suite. The birthing centre was for mothers who were assessed as low risk and who could also deliver at home. Currently 6% of births took place at home and midwives were well equipped to provide care. Throughout labour, risk continued to be assessed for women who were delivering in the birthing unit which was staffed entirely by midwives. Referring to the transfer rate of 30% which had been quoted, Ms Duffey explained that transfer did not necessarily occur because of an emergency, some transfers occurred because of a delay in labour or lack of progress or because the mother required pain relief that was not available in the birthing unit. The Trust would continue to provide maternity services close to home and make provision for those at high risk to give birth in a facility with a consultant available.

(26) Dr Datta explained that some women who had been classed as low risk may go to a birthing unit but they become a high risk in a matter of minutes. There is therefore a disadvantage to giving birth in a unit that does not have a consultant. Also the Maidstone birthing unit does not have a foetal assessment unit.

(27) Ms Blackmore expressed concern that epidurals cannot be given at birthing units; if this was required there would a journey of at least 30 minutes. She referred to the original decision that had been taken 5 years ago, at the time this looked good on paper but with hindsight it did not seem to work. She asked that the Trust look at the whole reconfiguration again.

(28) Mr Pentecost expressed the view that to move the mother requiring an epidural was dangerous and to make a women to wait any length of time and then to be taken by transport to Pembury was cruel.

(29) A member of MASH (Maidstone Action for Services in Hospitals) gave the example of his daughter who due to complications after giving birth had to have an emergency hysterectomy at Maidstone, expressed the view that had his daughter had to have been transferred to Pembury she would have died. He asked that this

service redesign be looked at again and the people of Maidstone be given the chance to express their views.

(30) Councillor Mrs Wilson (Member of Maidstone Borough Council and Vice Chairman of MASH) stated that she and everyone she represented were concerned about the issue of maternity services. MASH had worked constructively with the Trust on this one issue and MASH were of the view that it need to be reconsidered. Maternity was not an illness, it was a natural function but at times things go wrong. She asked what the implication of ambulance turnaround times was and how long would it take an ambulance to get to the birthing unit if there was not one on standby. She referred to official figures from the Office for National Statistics for 2007 which showed Maidstone as the district with the highest number of live births, Maidstone also had one of the highest under-18 conception rates in the county with a growing population. There were also three areas of multiple-deprivation. She stated that her understanding was that often early conception and deprivation often led to a higher complication rate in births. She stated that there had been changes over the past 5 years and therefore the service redesign should be looked at again.

(31) Mr Douglas acknowledged that the Trust have had a constructive dialogue with MASH and that they had listened and responded to concerns regarding pain management and trauma and orthopaedic services. The Trust had looked at their plans 5 years ago and had taken into account population growth. He reminded the meeting there were midwife led units in Canterbury and Dover. He suggested that Members go and look at these facilities and talk to staff and users. This was not a radical and new service and it existed in other parts of the country. Women had a choice between a midwife led and consultant led unit. One measure of success was to make sure that the mother to be was clear about the risks and the options available. The Health Overview and Scrutiny Committee when it responded to the consultation on Women's and Children's Services five years earlier had recommended that the midwife led unit should be located off the Hospital site so that it was clear to people that they were not going into a hospital but into something else.

(32) Ms Duffey referred to the document "Maternity matters" which talked about what women want. What they want is choice, either home birth or midwife or consultant led service. Ms Duffey said in 2011 women would be offered that choice. The birthing unit at Crowbough had been open 20 years and the local population were supportive of services from that unit. In terms of an epidural, this required an anaesthetist. She pointed out that an epidural was the only form of pain relief not available in a birthing unit. Many women having a first baby want an epidural, so in these circumstances she indicated that she would suggest that this woman goes to one of the consultant led units e.g. at Pembury.

(33) Mr Douglas stated that it was about providing more specialist, better quality, services at Pembury. The aim was to provide the best level of service in Kent, if not in the south east of England.

(34) Ms Thomas stated that the PCT's had brought together a collaborative group to discuss how the PCT and Trust could deliver the choices set out in "Maternity Matters". This Group included all providers including independent midwives. Ms Thomas added that the two Trusts wanted to assure themselves that their projections were up to date. The PCT wanted to commission choice for women – with birth at home, a midwife led unit, or a consultation led unit. She added that in approving the

business case for the new Pembury hospital, the Trust was past the point of no return regarding capacity of 4,500 – 5,000 births.

(35) Dr Unter (Consultant Paediatrician at Maidstone for nearly 20 years and Medical Director at the Trust up until 5 years ago). He felt that Children's services had not been mentioned. He understood the issues and why it had been proposed to move the inpatients unit to Pembury. Due to the change in the service, for example more day care cases and services provided as close to home as possible, the amount of work in the paediatric unit had decreased and the European Working Time Directive had lead to more staff being required. There was a need to have a critical mass to ensure that there was the highest level of service. Another factor was that fewer people were choosing to specialise in paediatrics and therefore there were fewer training posts. It was not practical to try to staff two units which is why it was proposed to centralise services on one site; it was better to have one service that worked than two that were falling apart. There would be outpatients and assessment services for children morning to evening at Maidstone and 24-hour services at Pembury.

(36) A Member asked if the inability to attract paediatricians related to salary, the uncertainty caused by the service reconfiguration, or a national shortage. It was confirmed that there was a shortage of trained paediatricians and that there were currently vacancies at Maidstone and Tunbridge Wells as there were nationally.

(37) Mr Kenworthy (Member of LINk) stated that there was a problem with the road infrastructure in this area of Kent; it was inadequate to meet the current population needs today. He sat on three different health-related committees there had been a lot of discussion regarding transport at each of these. He referred to the Ambulance Trust and the work to centralise services at Paddock Wood. This would save 2,000 hours of paramedic and ambulance crew time. They were working towards approximately 76% of 3 minute response times on Category A calls. Response posts would be set up in certain areas where access was an issue. This and other improvements would solve some of the problems we have been talking about in relation to ambulance travel times to Pembury.

(38) Mr Lyons acknowledged the improvements to services at Maidstone Hospital and understood the wish to centralise services to create a world class hospital but he believed there was a need to look again at the obstetrics unit to take into account the large catchment area.

(39) Mr Daley stated that one of the key issues appeared to be the removal of the consultant service from Maidstone, if this was added to the service at Maidstone the Committee would not be having this discussion. He suggested that consideration could be given to using the staff skills that will be available at Maidstone from 2011, under the remote supervision of a Consultant at Pembury giving advice in real time via the instant link between the operating theatres in Pembury and Maidstone. A decision could then be made as to whether to transport the patient to Pembury or to have a general surgeon deal with the situation at Maidstone, maybe under the supervision of a consultant by real time video link. He gave the example of the complexly new services called laparoscopic service which worked well with operation being directed by a surgeon at another site. He suggested that the Trust be asked to look at the feasibility of this suggestion.

(40) Cllr Mrs Wilson stated that the Trust were making the same points that their previous Chief Executive Ms Gibb had made. She stated that 4000 women wanted consultant led services on both sites and she asked the Committee to refer this matter to the Secretary of State.

(41) The Chairman acknowledged that this issue was a serious one and that the Committee did have the power to refer this matter to the Secretary of State; however this power needed to be exercised responsibly. He asked for advice from Mr Wickenden (Overview, Scrutiny and Localism Manager). Mr Wickenden stated that although the Committee did have the power to refer this matter it was not an action to be taken lightly. He advised the Committee to enter into a dialogue with health colleagues and stakeholders before deciding whether or not to refer this matter to the Secretary of State. If the Committee decided to refer this matter today there was a possibility that it would be dismissed as there had been no attempt to seek a local resolution before making the referral.

(42) Ms Blackmore stated that in Sussex there had been three proposed reconfigurations, two had not taken place. She questioned whether it was possible to have a world class hospital with a second class maternity service. If this service redesign was not financially driven and the public want the obstetrics service, why was it not possible to have an obstetrics service on both sites.

(43) Mr Douglas emphasised what the Trust were trying to achieve at Pembury and that patient safety was driving everything. The new hospital at Pembury would provide the best level of patient safety. He acknowledged that there was an issue regarding patients getting to Pembury from Maidstone. In the Trust's Business case it was accepted that Ashford and Medway would take some of the births from areas adjoining them. However, Pembury would not only be offering a service that was the best in south east and safest but he believed once the hospital is open that it would be the hospital that people would choose to go to, not only from Maidstone but also from East Sussex. There was a need to put the services together to achieve a critical mass at Pembury. He would investigate the feasibility of Mr Daley's suggestion regarding utilising a video link for consultant support.

(44) Ms Duffey stated that there was also the issue of recruiting staff, it was difficult to recruit obstetric staff and they had to use locums on a regular basis. Recruiting midwives had also been an issue, and although they were currently fully staffed there would be a shortage of midwives in future due to the aging population. She stated that as a woman who had had children she supported this service redesign.

(45) Ms Thomas referred to this emotive issue and the strength of feeling in the local population. This had never ever been about finance; it was about the delivery of patient safety and having an open process to ensure choice for women. As a result of this it might not be possible to deliver every single service in every single place. It is worth looking at this issue again if the Committee are considering a referral.

(46) Ms Blackmore suggested delaying the decision until the new road is built and asked whether it was possible to delay the decision and supported investigating Mr Daley's suggestion of using a video link.

(47) The Chairman stated that if the Committee were considering challenging this redesign then they needed to make sure that they had the evidence to put before the Secretary of State. He suggested that a Sub Committee be established to look at this matter in detail and report back to the Committee in February, either at the programmed meeting or at a special meeting. This would put the Trust and the PCT on notice to consider the issues that had been raised.

(48) There was discussion about whether a Sub Committee was the best mechanism to look at this in detail rather than the whole Committee

(49) Mrs Whittle expressed her support for Councillor Wilson's suggestion that this Committee should refer this matter to the Secretary of State.

(50) Mr Daley urged caution as a referral to Secretary of State was a course of last resort. The Committee had been involved with this matter for five years and two years ago had made a referral to the Secretary of State. The Independent Reconfiguration Panel had supported the Trust's proposal and therefore unless there is something new then the likelihood was that any referral would be unsuccessful. He added what we have now is a general acceptance of the majority of the reconfiguration following some concessions. We have the women's and children's service and specifically maternity services to consider. The Trust should now consider the discussion today and the points raised and look at these with the Sub Committee. Mr Daley seconded the motion put forward by the Chairman.

(51) Ms Blackmore agreed that it was important that the Committee have the evidence gathered by the Sub-Committee before making a decision on whether to refer this matter to the Secretary of State for Health and she expressed a wish to be part of this Committee as a District Council representative on the HOSC.

(52) Mr C Smith emphasised the importance of exploring every avenue before the Committee considered whether to take the serious step of referring this matter to the Secretary of State. He also expressed concern about the time factor and the importance of ensuring that the new hospital was up and running in 2011.

(53) Dr Eddy expressed the view that information from the Ambulance Trust would be a key element in the deliberation on this issue

(54) In response to a question of who would be on the Sub-Committee, Mr Wickenden requested delegated authority, in consultation with the Chairman, spokesmen and stakeholders to decide the membership of Sub Committee. Mr Horne reaffirmed his previous comment that there was no reason why the Committee should not have an extra meeting to hear the results.

(55) RESOLVED that:-

a) the Committee thank colleagues from the Maidstone and Tunbridge Wells NHS Trust for the information that they have provided on the provision of services across the Trust and the redesign following the opening of the new Pembury Hospital in 2011;

b) a small Sub Committee be established to explore in greater detail with the heath organisations within the health economy the rationale of the provision of

women's and children's services to establish whether this best meets the needs of patients who look to the Maidstone and Tunbridge Wells NHS Trust for these services and to report back to a meeting of this Committee in February 2010;

c) the Overview, Scrutiny and Localism Manager be given delegated authority in consultation with the Chairman, Spokesmen and stakeholders to determine the membership of the Sub Committee referred to in resolution (2) above; and

d) the Committee accept the Trusts offer to visit the Maidstone and Pembury Hospital sites and the necessary arrangements be made for these visits as soon as possible.

23. Update on Health and Transport
(Item 5)

Mr M Ayre (Senior Policy Manager, Kent County Council), Mr D Hall (Head of Transport and Development, Kent County Council), and Ms Z Fright (Senior Lead Commissioner Urgent Care, NHS Eastern and Coastal Kent) were in attendance for this item.

(1) The Committee have frequently expressed an interest in the issues facing patients in accessing healthcare services outside of their homes, particularly as this is an important non-clinical aspect of service reconfigurations.

(2) The interest also extends to the issues facing family and friends in maintaining contact with those in hospital and people attending healthcare facilities for out patient appointments.

(3) Attached to the report was the report of a multi-agency event held on 18 May 2009 entitled "Commissioning Transport for Health" notes of a Health and Transport multi agency event on 22 September and the Terms of Reference and draft minutes of a recently re-established Transport for Health Group in East Kent for which a similar group would be established for West Kent.

(4) It was agreed that at a future meeting of the Committee it would be useful to have a more detailed report including what the issues might be around the Total Place pilot.

(5) The Committee noted the work which was being conducted on the Integrated Transport Strategy for Kent. The Committee were informed of the very successful hopper bus which operated in Thanet in providing access for the local population to the Queen Elizabeth the Queen Mother Hospital in Margate.

(6) Similar discussions were taking place around the issues which had been considered by the Committee relating to the Maidstone and Pembury Hospitals.

(7) Several Members of the Committee asked questions relating to the Voluntary Transport scheme and the opportunity through Total Place for all the agencies to work together more effectively. There was real concern about the lack of information available to patients, friends and family on the Voluntary Car schemes.

One suggestion was that more information should be made available in doctors' surgeries.

(8) The Committee noted that work was being undertaken to map all the transport services of agencies across Kent to avoid duplication and make better use of the transport available.

(9) **RESOLVED** that the report be noted and more detailed report be made to a future meeting of the Committee

24. Work Programme January 2010 to July 2010
(Item 6)

RESOLVED - that the report be noted.

25. Date of next programmed meeting – Friday 8 January 2010 at 10:00
(Item 7)

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 5 February 2010

Subject: Item 4. Intended Outcomes: Dover Healthcare.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: one for members of the public and the other for the Scrutiny Committee.

2. Outcomes for the Dover Healthcare Agenda Item

(1). Public Question

a) What is happening about a new hospital in Dover?

(2). Scrutiny Questions

a) Can the Committee have an update on what progress has been made in moving forward with an affordable and rapidly deliverable option for a healthcare facility in Dover?
b) What is the future timeline for this project?
c) What are the outstanding issues that require further work?

3. Recommendations

(1) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 5 February 2010

Subject: Item 4: Dover Healthcare

In 2006, the NHS in East Kent carried out stakeholder and public consultations into possible models of health and social care delivery in Dover. The Dover Project, as it was called, was more focused on what services should be provided, rather than where, and so was not specifically concerned with the future of Buckland Hospital. The NHS OSC, as it was then called, received a number of updates on this issue in 2006 and 2007.

Work was then undertaken to develop specific service proposals. Estate issues, including the future of the Buckland Hospital site, formed part of this process.

The issue of healthcare provision in Dover was formally referred to the HOSC by the Eastern and Coastal Kent Patient and Public Involvement Forum (PPIF) in a letter dated 5 February 2008.

The HOSC considered this matter at its meeting of 9 May 2008. According to the Minutes of this meeting:

> "12) Howard Jones, Director of Facilities for East Kent Hospitals Trust, explained that the Trust had come up with two options for the future of the Buckland Hospital site:
>
> - a general upgrade of the site, at a cost of £8 million;
> - the construction of a new building, at a cost of £11 million.
>
> "13) The Trust was currently discussing with Dover District Council other possible estate options in the area. Late July/early August had been set as the deadline by which the options for consideration should be set."[1]

At the end of this item, the Committee passed the following resolution:

> "RESOLVED unanimously, on the motion of Dr Robinson, seconded by Mr Marsh, that:
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> *"The Health Overview & Scrutiny Committee of KCC strongly recommend & support E K Hospitals Trust working closely with the ECK PCT & Dover District Council to locate a central in Dover for the Community Hospital Services for the population of Dover & the surrounding areas.*

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[1] Minutes, Health Overview and Scrutiny Committee, 9 May 2008, http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MID=305

"This proposal to be delivered to the EKHT by the end of August 2008. This third option to be considered & evaluated alongside options 1 & 2 concerning the Buckland Hospital site."[2]

The HOSC returned to this subject at its meeting of 5 September 2008. At this meeting, the Committee was informed by NHS Eastern and Coastal Kent that:

> "12) The selection criteria had been applied to all options and the following three options had been shortlisted:
>
> (a) Mid Town Development;
> (b) Whitfield (White Cliffs); and
> (c) Rebuild on Buckland Hospital site."[3]

At the end of the discussion on this item:

> "(45) Mr R Tolputt moved, and Mr D Daley seconded:-
>
> "that the Kent County Council's Health Overview and Scrutiny Committee strongly recommends, supports and endorses Eastern and Coastal Kent Primary Care Trust working closely with East Kent Hospitals Trust, Kent County Council, Dover District Council and the Consortium of Local General Practitioners (CLGP) to develop a central site for Dover for a modern Community Hospital for the population of Dover and the surrounding area by 2011.
>
> "Carried:- 14 votes for, 0 against, 1 abstention."[4]

The HOSC looked at the subject again at its meeting of 30 October 2009 "as the NHS were reconsidering the site of the proposed healthcare facility due to a flooding objection raised by the Environment Agency."[5]

At the end of this item the Committee:

> "(15) RESOLVED that the Committee support the PCT in moving forward with an affordable and rapidly deliverable option for a healthcare facility in Dover and that they be invited to attend to February meeting of the Committee to update Members on progress."[6]

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[2] Ibid.
[3] Minutes, Health Overview and Scrutiny Committee, 5 September 2008, http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=308
[4] Ibid.
[5] Minutes, Health Overview and Scrutiny Committee, 30 October 2009, http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=1850
[6] Ibid.

Dover Community Hospital - Update from the Kent Local Involvement Network

Introduction

The Kent Local Involvement Network (LINk) has received the following update from LINk Participant, Douglas Tutton, who will be attending the meeting to give evidence on behalf of the LINk.

"Since the 30 0ctober 2009 I have attended two meetings where the subject was on the agenda:

4 November 2009 - Dover District Council (DDC) Scrutiny Committee at which the DDC officers and council members supported the mid town site as their preferred option. They considered the flooding problems to be solvable, but how and in what time scale was not discussed or where the funding would come from. The site at Whitfield was said to have "planning problems" because this area has been designated for job creation.

30 November 2009 - Mr Reg Hansel, the Chair of Dover New Hospital Group [who organised a 32,000 plus petition sent to Downing Street], invited me to attend a meeting with Mr Tim Ingleton and Mr Mike Dawson of DDC Planning Department.

- It was stated that DDC advocated the Mid Town Site as their preferred option.
- They considered the Buckland Hospital Site (although not ideal) to be a better option than Whitfield due to the previously mentioned planning problems. It was pointed out to them that a hospital could create more jobs per square metre than any business that might be attracted to the site. But, we were told that there would be no new jobs at Whitfield as the jobs would be transferred from Buckland Hospital. However, one of the stated aims of the NHS for the new hospital is to increase patient throughput by at least three times and it is difficult to see how this could be achieved without an increase in staff. The planners were unaware of this aim.

We were informed by the planners that the Hospital Trust had an option on Plot 13 at the Business Park (Phase Two), Whitfield, but that any planning application would be a drawn out affair due to change of use. The question was asked why was B&Q, a retail unit, allowed on the development contrary to the original redevelopment plans? The answer given was that this development was the key to opening up the phase two site. It was pointed out to the planners that a new Hospital built on a suitable site for long-term expansion and with adequate car parking is the key to the long term health care for those living in DDC.

We were told that a planning application at Whitfield would most likely be called in by the Government Office of the South East, which could result in considerable delays. When asked if this was likely to happen we were informed that the planners did not know as they had received no application. I reported that I had been told by a Ms Gilks of the Government Office for the South East (GOSE 01483-882255), that because of the flood issues in mid town it was unlikely that the Government Office would put forward any objections to the Hospital being built at Whitfield.

There appeared to have been a lack of communication between the various interested bodies and Mr Hansell asked the DDC planners to arrange a meeting between them, the East Kent Hospitals University NHS Foundation Trust, Primary Care Trust, Environment Agency and GOSE in order to agree a site suitable for the long term health needs of DDC's area including the rural and town populations of Sandwich and Deal as well as the town itself. The planners gave assurances that they would endeavour to arrange such a meeting.

Since these two meetings it is interesting to note that the railway bridge over the main access road to the Buckland site was closed for a considerable time. It was struck by a lorry causing considerable damage, not a unique experience! The low bridge was the reason why several companies rejected or left the industrial site at the top of Coombe Valley Road.

Doug Tutton
2 January 2010"

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 5 February 2010

Subject: Item 5. Intended Outcomes: Emergency Care Pathways.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: one for members of the public and the other for the Scrutiny Committee.

2. Outcomes for the Emergency Care Pathways Agenda Item

(1). Public Question

a) If I suffer from a stroke, or a heart attack, or am involved in a serious accident, how will I be treated and where will I be taken?

(2). Scrutiny Questions

a) The 2008 document Healthier People, Excellent Care, by the South East Coast Strategic Health Authority made the following recommendation: "By 2010 all appropriate heart attack, stroke patients and major trauma patients will receive their care from 24/7 specialist units." What progress has been made in achieving this?
b) Specifically, how successfully is this aim being achieved in Kent?
c) How is the nature and location of cardiac, stroke and major trauma services changing for the people of Kent?

3. Recommendations

(1) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 5 February 2010

Subject: Item 5: Emergency Care Pathways (Cardiac, Stroke, Trauma)

Background

As part of the Next Stage Review, Lord Darzi asked the Strategic Health Authorities (SHAs) to produce a regional vision.[1] *Health People Excellent Care*, *A Vision for the South East Coast* was the report from NHS South East Coast. This was published on 2 June 2008, and made the following pledge:

> "By 2010, strokes, heart attacks and major injuries will always be treated in specialist centres."[2]

On 30 June 2008, the Department of Health published *High Quality Care for All. NHS Next Stage Review Final Report.* This was a response to the Strategic Health Authorities 'visions'. This pledge is picked up within the report:

> "The visions have sent a powerful message that the most effective treatments should be available for all NHS patients. Their plans for transforming treatment for heart attack, stroke and major trauma vividly illustrate this. For stroke – the third largest cause of death and single largest cause of disability in the UK – the clinical evidence clearly demonstrates that the quality of care is greatly improved if stroke is treated in specialist centres. Each region is therefore pushing forward with the development of specialised centres for their populations with access to 24/7 brain imaging and thrombolysis delivered by expert teams. For example, by 2010, NHS South East Coast intends that all strokes, heart attacks and major injuries will be treated in such specialist centres. Once implemented, these plans will save lives. From every corner of the NHS, there was also a strong emphasis on the importance of patient safety. They all aim to make hospitals and health centres clean and as free of infection as possible."[3]

The rest of the briefing note provides background information on each of the three areas separately – cardiac care, stroke, and trauma.

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[1] London had a slightly different process to the other nine SHAs.
[2] NHS South East Coast, *Healthier People, Excellent Care. A Vision for the South East Coast*, June 2008, p.6, http://www.southeastcoast.nhs.uk/hpec/documents/Hpecreport.pdf
[3] Department of Health, *High Quality Care for All. NHS Next Stage Review Final Report*, 30 June 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

Part 1 - Cardiac Care

Coronary Heart Disease (CHD) is the biggest cause of death in the country, killing more than 70,000 people in England each year, with 110,000 having a heart attack.[4]

The National Service Framework (NSF) for Coronary Heart Disease (CHD) was published by the Department of Health in March 2000[5] and set out a strategy to modernise CHD services over a ten year period. Chapter Three dealt specifically with "Heart attacks and other acute coronary syndromes." At the time this document was produced, around 300,000 people suffered a heart attack (or, acute myocardial infarction) each year in the United Kingdom, of whom 140,000 died. Between a third and two-thirds of these deaths occurred outside a hospital, often within the first few minutes of the onset of symptoms.

The NSF set out a number of standards relating to ensuring access to the most appropriate care as soon as possible, including use of a defibrillator by an appropriately trained person within 8 minutes, and thrombolysis within 60 minutes of calling for professional help ('call-to-needle time'; see next page for further key terms)[6]. Thrombolysis is a clot dissolving drug, and at the time the NSF was produced, only a third of A+E departments were able to offer it[7].

The treatment of heart attack patients was monitored and in the Seventh Public Report of the Myocardial Ischaemia National Audit Project (MINAP), published in June 2008, it was reported that 71% of patients were receiving thrombolytic treatment (the national target was 68%)[8]. The report also reported on the increasing use of pre-hospital thrombolytics and primary angioplasty (also referred to as primary percutaneous coronary intervention or PPCI).

> "Coronary angioplasty is a technique for unblocking arteries carrying blood to the heart muscle. A small balloon at the tip of a catheter tube is inserted via an artery in the groin or arm and guided to the blocked heart artery. It is then inflated and removed, leaving in place a 'stent' - a rigid support which squashes the fatty deposit blocking the artery, allowing

[4] Department of Health website, *Coronary Heart Disease*, http://www.dh.gov.uk/en/Healthcare/Coronaryheartdisease/index.htm
[5] Department of Health, National Service Framework for Coronary Heart Disease, March 2000, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094275
[6] Ibid., Chapter Three, p.2.
[7] Ibid., Chapter Three, p.4.
[8] MINAP Steering Group, *MINAP Seventh Public Annual Report*, June 2008, p.ix, http://www.rcplondon.ac.uk/clinical-standards/organisation/partnership/Documents/Minap-2008.pdf

blood to flow more easily. Primary angioplasty uses this technique as the main or first treatment for patients suffering a heart attack."[9]

The Department of Health, in collaboration with the British Cardiovascular Society and British Cardiovascular Intervention Society, set up the National Infarct Angioplasty Project (NIAP) to examine the feasibility of setting up a primary angioplasty service across the country.

This began work in 2005 and the final report was published by the Department of Health in October 2008 as *Treatment of Heart Attack Overall Guidance.* The following are the overall conclusions of this report:

- "National roll-out of PPCI is feasible over the next three years but may be logistically challenging in some parts of the country.
- Times to treatment within 120 minutes are achievable but a PPCI service needs to achieve these reliably regardless of the time of day or day of the week.
- Hybrid services offering daytime PPCI and out-of-hours thrombolysis are not satisfactory.
- A PPCI service needs to be 24/7 and carried out in centres with a sufficiently high overall volume of cases to maintain and develop skills.
- If an acceptable PPCI service cannot be established, pre-hospital thrombolysis is preferable to in-hospital thrombolysis. Forthcoming European guidelines are likely to recommend subsequent referral for coronary angiography for anyone having thrombolysis."[10]

This report also provides the following definitions of some key terms used:

> **"Call-to-balloon (CTB) time:** the time from the patient calling for medical help to the time when an angioplasty balloon is first inflated, or coronary reperfusion is confirmed on angiography."
>
> **"Call-to-needle (CTN) time:** the time from the patient calling for medical help to the time when intravenous thrombolysis is given."
>
> **"Door-to-balloon (DTB) time:** the time from the patient arriving in hospital (whether this be a PPCI centre or a non-PPCI centre) to the time when an angioplasty balloon is first inflated or coronary reperfusion is confirmed on angiography."
>
> **"Door-to-needle (DTN) time:** the time from the patient arriving in hospital to the time when intravenous thrombolysis is given."

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[9] Department of Health website, *Thrombolysis and primary angioplasty*, http://www.dh.gov.uk/en/Healthcare/Coronaryheartdisease/Thrombolysisandprimaryangioplasty/index.htm

[10] Department of Health, *Treatment of Heart Attack Overall Guidance Final Report of the NIAP*, October 2008, p.5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089454.pdf

"Reperfusion: the restoration of blood flow to an organ or tissue, for example after a heart attack. An immediate goal is quickly to open a blocked artery and reperfuse the affected heart muscle. Early reperfusion minimises the extent of heart muscle damage and preserves the pumping function of the heart."[11]

Part 2 - Stroke

Stroke is the third biggest cause of death in the UK, and each year around 110,000 people in England will suffer from a stroke. It is also the largest single cause of severe disability.[12]

In December 2007, the Department of Health launched a new stroke strategy. This document provides the following definitions:

> "Stroke is a 'brain attack' caused by a disturbance to the blood supply to the brain. There are two main types of stroke:
>
> - Ischaemic: the most common form of stroke, caused by a clot narrowing or blocking blood vessels so that blood cannot reach the brain, which leads to the death of brain cells due to lack of oxygen.
> - Haemorrhagic: caused by a bursting of blood vessels producing bleeding into the brain, which causes damage.
>
> Transient ischaemic attacks (TIA), also known as minor strokes, occur when stroke symptoms resolve themselves within 24 hours."[13]

Chapter Two, 'Time is Brain', of the strategy set out the quality markers (QMs) which set out the changes that needed to happen in the emergency management of TIAs and strokes:

> "High-risk TIA patients need to be assessed by experts and, wherever possible, scanned using magnetic resonance imaging (MRI) within 24 hours of experiencing symptoms; lower-risk groups need to be seen within seven days and are given follow-up care (QM5 and QM6). People with suspected stroke should be immediately transferred to a hospital providing hyperacute services throughout the day and night – this includes expert clinical assessment, rapid imaging and the ability to deliver intravenous thrombolysis. They should receive an early multidisciplinary assessment, including swallow screening, and have prompt access to a high-quality stroke unit (QM7, QM8 and QM9)."[14]

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[11] Ibid., pp.31-33.
[12] Department of Health website, *Stroke*, http://www.dh.gov.uk/en/Healthcare/Stroke/index.htm
[13] Department of Health, *National Stroke Strategy*, December 2007, pp.10-11, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_081059.pdf
[14] Ibid., pp.5-6.

These services are to be provided as part of a local stroke network according to the strategy.

National Director for Heart Disease and Stroke

Professor Roger Boyle CBE is the National Director for Heart Disease and Stroke (appointed March 2000). He set out the clinical case for reconfiguration for heart disease and stroke services in *Mending hearts and brains – clinical case for change*, published by the Department of Health in December 2006[15]. This document outlined how a 'hub and spoke' model for both services would work and how there would be an increasing role for the paramedic in deciding whether a patient would be taken direct to a specialist centre (which might be further than the local hospital's A+E department).

Part 3 - Trauma

Selected key facts:

- Trauma means wounding due to physical injury. Major trauma is used to describe multiple injuries involving different tissues and organ systems that are, or have the potential to be, life threatening.
- Globally, it is responsible for around 10% of all deaths.
- There are over 16,000 deaths due to injury in England and Wales each year, and the numbers are increasing.
- About 7% of the total annual NHS budget (approximately £1.6 billion) is spent on treating trauma injuries.
- Major trauma accounts for 15% of all injured patients.
- Major trauma admissions to hospital account for 27-33 patients per 100,000 population per year and represents less than 1 in 1,000 emergency department admissions. [16]

Over the years, there has been a growing body of evidence concerning the need to improve trauma services. In 2007, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a report entitled *Trauma: Who Cares?* This found "Almost 60% of the patients in this study received a standard of care that was less than good practice. Deficiencies in both organisational and clinical aspects of care occurred frequently."[17]

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[15] Department of Health, *Mending hearts and brains – clinical case for change*, December 2006, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072493.pdf

[16] All key facts taken from: The Intercollegiate Group on Trauma Standards, *Regional Trauma Systems. Interim Guidance for Commissioners*, December 2009, p.9, http://www.rcseng.ac.uk/news/docs/Regional_trauma_systems.pdf. The exception is the definition of major trauma, which is taken from The Royal College of Surgeons of England, *Provision of Trauma Care Policy Briefing*, September 2007, p.1, http://www.rcseng.ac.uk/publications/docs/provision-of-trauma-care-1

[17] NCEPOD, *Trauma: Who Cares?*, 2007, p.10, http://www.ncepod.org.uk/2007report2/Downloads/SIP_report.pdf

Among the principal recommendations contained in the NCEPOD report was a call for designated Level 1 trauma centres as part of a regional service.

The Royal College of Surgeons of England provides the following definition:

> "For a unit to be defined as a 'major trauma centre' it must provide, 24-hours a day, a fully staffed emergency department, a consultant-led resuscitative trauma team, dedicated trauma theatres and operating lists, the presence of all major surgical specialties on a single site (orthopaedic trauma, general and vascular surgery, neurosurgery, plastic surgery, cardiothoracic surgery, head and neck surgery, urology), interventional radiology (which uses radiological techniques to place wires, tubes or other instruments inside a patient to diagnose and treat various conditions) and anaesthesia with appropriate intensive care facilities."[18]

Across England, regional plans for trauma systems are being developed. A regional trauma system will aim to reduce death and disability as a result of major trauma. The idea is that resources will be managed in such a way that trauma patients are treated by the right people in the right place. Major trauma patients will go to major trauma centres and trauma units will take other trauma patients.

On 1 April 2009, Professor Keith Willett was appointed as the first National Clinical Director for Trauma Care and his team assists SHAs in developing these trauma networks.

Plans are at different stages around the country. In the early part of 2009, Healthcare for London held a consultation on plans for trauma and stroke services. As regards trauma, the decision was to set up four trauma networks with major trauma centres at:

- The Royal London Hospital, Whitechapel
- King's College Hospital, Denmark Hill
- St. George's Hospital, Tooting
- St. Mary's Hospital, Paddington[19]

In the South East Coast Strategic Health Authority region[20], at its Board Meeting of 17 November 2009, the SHA approved the Outline Business Case for the Brighton and Sussex University Hospitals NHS Teaching, Trauma and Tertiary Care Centre (3Ts). One of the five investment priorities of this plan would be:

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[18] The Royal College of Surgeons of England, *Provision of Trauma Care Policy Briefing*, September 2007, p.2, http://www.rcseng.ac.uk/publications/docs/provision-of-trauma-care-1

[19] Healthcare for London, http://www.healthcareforlondon.nhs.uk/consultation-on-developing-new-high-quality-major-trauma-and-stroke-services-in-london#section1

[20] Brighton and Hove, Kent, Medway, Surrey, East Sussex, and West Sussex.

> "developing the Royal Sussex County Hospital[21] as the Level 1 major trauma centre for South East Coast would enable 360 cases a year of patients with multiple injuries to be treated in Sussex rather than having to be taken out of area, mainly to London. In establishing the Level 1 Trauma Centre, the Trust will work with Queen Victoria Hospital NHS Trust[22] to provide plastic surgery cover."[23]

This does not mean that all, or even most, major trauma patients from Kent and Medway would go to Brighton. It appears likely that hospitals in London will be the destination for most major trauma patients. Further detailed information on this can be found in the Appendix, which contains a letter received by the Chairman of the Committee following a briefing on the 3Ts programme last year.

[21] Located in Brighton.
[22] Located in East Grinstead, West Sussex.
[23] South East Coast Strategic Health Authority, *Unconfirmed Minutes of 17 November 2009 Board Meeting*, http://www.southeastcoast.nhs.uk/aboutus/theboard/papers/documents/79-09.4UNCONFIRMEDMINUTESBoardmeeting17-11-09.pdf

Appendix: Letter Concerning the 3Ts Development

Brighton and Sussex University Hospitals NHS Trust

3Ts Programme Office
The Royal Sussex County Hospital
Top Floor Sussex House
1 Abbey Road
Brighton
BN2 1ES

Tel: 01273 696955

Godfrey Horne MBE
Chairman,
Health Overview and Scrutiny Committee
Kent County Council
County Hall
Maidstone
Kent
ME14 1XQ

29 September 2009

Dear Mr Horne

Brighton & Sussex University Hospitals NHS Trust: 3Ts Development

I am writing further to the very helpful meeting which Darren Grayson and I attended at your offices on 3 July. We discussed the redevelopment of the Royal Sussex County Hospital and our need to develop and expand neurosciences and cancer services for the people of Sussex.

As we discussed, as part of this development, the Trust and its local commissioners has established a Sussex Trauma Network to look at the potential to develop a Level 1 Major Trauma Centre in Brighton. We have worked with South East Coast Ambulance Trust (SECAmb) and the emerging major trauma networks established through the Healthcare for London work.

At the meeting, you asked us to provide an estimate of the likely number of Kent residents who might fall within the trauma centre catchment and which wards these represented.

We have used SECAMb's road ambulance travel times to model the equidistance between the Royal Sussex County Hospital and the next nearest major trauma centres, being the Royal London, St. George's Hospital, King's College Hospital and Southampton University Hospital. We then used population data at individual ward level to identify a logical catchment area. The analysis also includes project population growth to 2014. We estimate our total workload of around 360 cases per annum in major trauma to be drawn from a catchment of 1.49m.

The road travel times show the catchment for the Sussex Trauma Network overlapping slightly with the West Kent and Eastern & Coastal Kent Primary Care Trust boundaries (and therefore with the Kent County Council boundary).

Our modelling suggests that the following wards could fall within the Sussex Trauma Network catchment:

- Tunbridge Wells Borough excluding the northern wards of Paddock Wood, Frittenden & Sissinghurst, Capel, Southborough and Brenchley;

- Ashford Borough, but only including the wards of Oxney and Rolvenden & Tenterden West;

- Shepway Borough, but only including Lydd and part of Romney Marsh wards.

We estimate that, by 2014, there will be a population of around 100,000 in these areas which could translate to around 25 cases per annum – so quite a small proportion of the overall total.

I should like to stress again that these are planning estimates. The decision where to take a particular patient will be clinically driven and will depend upon the acuity of the patient.

I hope that this is the information you were seeking.

Yours sincerely

Duane Passman
Director of 3Ts, Estates & Facilities

cc. Darren Grayson, NHS Brighton & Hove
Tristan Godfrey, Kent County Council
David Meikle, NHS Eastern & Coastal Kent
Paul Wickenden, Kent County Council

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Kent Cardiovascular Network

BRIEFING PAPER FOR
KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
5th February 2010

CARDIAC – 24/7 PRIMARY ANGIOPLASTY

What service changes for heart attack patients are planned to provide a 24/7 specialist unit?

Approximately 275,000 people in the United Kingdom suffer a heart attack each year of which around 2,500 occur in Kent. A person has a heart attack (or acute myocardial infarction) when the flow of blood through the arteries, which supply blood to their heart muscle, is reduced to such an extent that part of the heart muscle dies. Between a third and two thirds of heart attack deaths take place outside hospital, many within the first few minutes of the onset of symptoms. Helping people avoid a heart attack altogether is the prime aim. But for those who do have a heart attack, prompt access to the right treatment can mean the difference between living and dying.

The current primary treatment of heart attack is thrombolysis, or treatment with thrombolytic drugs, and these help dissolve the clot within the artery, which is the cause of the heart attack. Since 2003, the South East Coast Ambulance service has been able to provide this prior to arriving at hospital, when a paramedic has been able to ascertain via ECG that the patient has suffered an ST Elevated Myocardial Infarction (STEMI). If this has not been possible, the patient will be taken to their nearest hospital and given thrombolysis there. These drugs help reverse the effects of a heart attack by opening the blocked coronary artery and returning the blood supply to the affected part of the heart again. Thrombolytic treatment can be given up to twelve hours after the onset of the symptoms of a heart attack but it is most effective when given within the first two hours. This treatment will then, in the majority of cases, be followed up by a diagnostic angiogram, which is an invasive technique to view the arteries, and dependent on the result of this, may lead onto angioplasty or by-pass surgery.

There is now evidence to suggest that primary angioplasty (primary PCI or pPCI), where a small balloon tipped catheter is inserted into the blocked artery, inflated and removed, leaving a stent which improves blood flow, has better outcomes in terms of reduced mortality and better long term outcomes than thrombolysis, when both delivered in a similar timeframe.

The Department of Health and the British Cardiovascular Society[i] undertook a 2 year study and published its final report on the National Infarct Angioplasty (NIAP) project in October 2008. This project was a feasibility study looking at how far primary angioplasty can be rolled out as a main treatment for heart attack in place of clot-busting drugs. The report concludes that it is feasible to roll out 24/7 primary angioplasty for the majority of England within acceptable treatment times and is being published to encourage best practice, with improved outcomes to patients.

Conclusions drawn / recommendations are as follows:

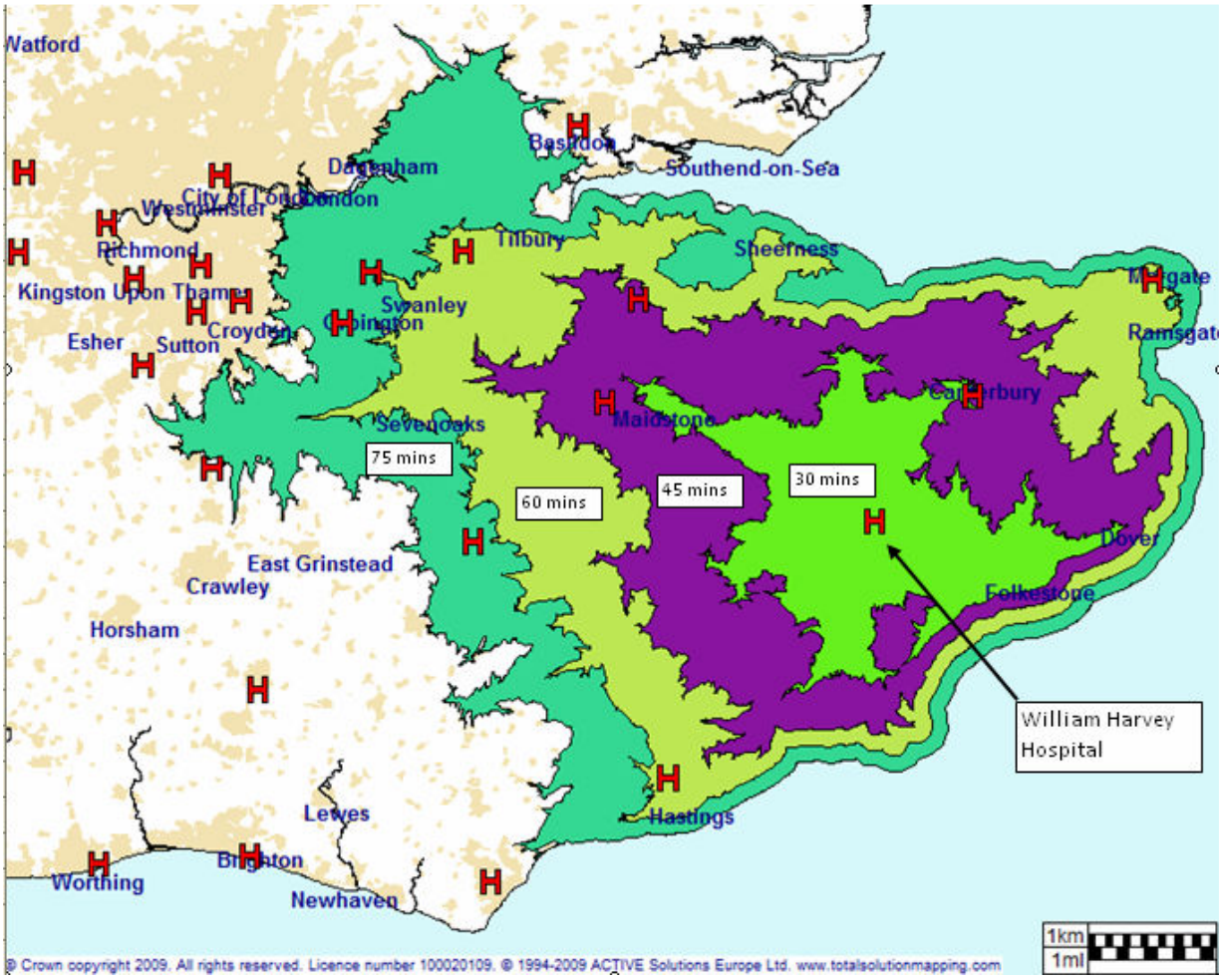
- National roll-out of PPCI is feasible over the next three years, but may be logistically challenging in some parts of the country.
- Times to treatment within 120 minutes are achievable, but a PPCI service needs to achieve these reliably regardless of the time of day or day of the week. **Please note that this time has now been increased to 150 minutes.**
- Hybrid services offering daytime PPCI and out-of-hours thrombolysis are not satisfactory.
- A PPCI service needs to be 24/7 and carried out in centres with a sufficiently high overall volume of cases to maintain and develop skills.
- If an acceptable PPCI service cannot be established, pre-hospital thrombolysis is preferable to in-hospital thrombolysis (usually with subsequent angiography/treatment. Forthcoming European guidelines are likely to recommend subsequent referral for coronary angiography for anyone having thrombolysis.

This NIAP report, as well as clinical evidence suggests that pPCI is a more effective intervention, due to:

- Reduced mortality rates
- Lower rates of re-admission
- Significant reduction in average length of stay
- Faster recovery times
- Better quality of life outcomes for the patient.

A 'Fit for Future' consultation exercise was undertaken in 2007 and completed at the beginning of 2008. Once the NIAP report was published in October 2008, the final decision was that Kent and Medway should look to provide 24/7 primary angioplasty from one central site, that being the William Harvey Hospital in Ashford. This will mean that once the service has been implemented, every patient across Kent and Medway will be taken directly to this specialist centre for treatment.

Map indicating location of service:



Using the Myocardial Infarct National Audit Project (MINAP) data over a 12 month period, it is estimated that approximately 500 people per year across the whole of Kent and Medway will be accessing this service, having suffered an ST Elevated Myocardial Infarction (STEMI) (410 Kent residents, 90 Medway residents).

The new service will be available to every patient who is diagnosed after ECG as having suffered a STEMI, regardless of age, gender or ethnicity. The patients will experience a change in service provision, predominantly the fact that they will now have access to a specialist service 24/7 and receive their intervention within 150 minutes of their time or initial call for help, instead of having to wait for individual diagnostics and then treatment over a longer time period. It is expected that the patient will on average have a length of stay of approximately 3.5 days, whereby the patient will be discharged home, and receive follow-up and rehabilitation from their local hospital.

The current pre-hospital thrombolysis service will cease upon implementation of the new service.

Improved outcomes in terms of mortality rates

The National Infarct Audit Project (NIAP) was a two year study involving data collection on 2,245 patients, during the year April 2005 to March 2006 and then follow-up for a year. Of those patients 65% were admitted directly to a pPCI centre and 35% to a centre not providing pPCI services. Of those 35% who were initially taken to a non-pPCI centre, 58% of these were then transferred to a pPCI centre and underwent pPCI.

The table below shows the mortality rates for those patients who either had pPCI or thrombolysis.

Treatment	30 days	1 year	18 months
pPCI	5.6 %	8.7 %	9.9 %
Thrombolysis	7.9 %	12.4 %	14.8 %

Source: MINAP report October 2008

Time is crucial when delivering this service, but extensive work has been undertaken to ensure that all Kent and Medway residents can receive this service within a timely manner. The maximum transfer time from all postcodes to the William Harvey Hospital will be 75 minutes. It should, however, be noted that this time is for **standard travelling time, not 'blue light emergency travel**', therefore it is expected that the travelling times will actually be shorter. Below is a table showing mortality rates against time pPCI was performed.

Call-to-Balloon time	In-hospital	30 days	1 year
60-120 mins	2.7%	2.9%	5.1%
120-180 mins	4.5%	4.9%	8.7%
180+ mins	11.4%	12.2%	15.9%

Source: MINAP report October 2008

It is not envisaged that any particular groups will be worse off with the new service provision, in fact, more patients will be clinically eligible for primary angioplasty than thrombolysis due to their being no upper age limit.

By performing pPCI as soon as it is needed, it is expected that there will be a reduction in the mortality rates of patients, therefore, assisting with the achievement of the target to reduce the mortality rates of the under 75's for circulatory disease.

What plans are in place to ensure that the general public understand these changes?
The Kent Cardiovascular Network in conjunction with NHS Eastern and Coastal have developed a communications strategy. This outlines the methods of communication which will be tailored to a variety of groups. There will be an awareness campaign through the local media, including newspapers, radio and news articles for television being planned. The ambulance trust will be producing its own leaflets for the patients carers and/or relatives so that they are aware of what is happening, and why the patient is being transferred, as well as giving directions and parking information for the hospital.
How many people in Kent receive emergency treatment for heart attack each year?
Using the MINAP figures from 1 January 2008 to 31 December 2008, there were a total of 1,389 patients who had an ECG determination, and therefore heart attack of either ST Elevation Myocardial Infarction (STEMI), Non-ST Elevation Myocardial Infarction (N-STEMI) or Left Bundle Branch Block (LBBB). Of these, it was predicted that approximately 500 would go on to have primary angioplasty.
How many Kent patients are currently taken outside of Kent to receive treatment in an emergency, where are they sent, and how likely is this to change in the future?
Very few patients are taken out of the Kent area for immediate emergency treatment. There may on occasion be a patient from Dartford who would be taken to Darent Valley Hospital, and then transferred via London Ambulance to a London hospital, but this is a rare occurrence. The arrangements with the South East Coast Ambulance service are that patients should remain within the Kent and Medway boundaries.
What role does the Kent and Medway Cardiovascular Network play?
The Kent Cardiovascular Network plays a key role in the development and project management of this new service provision. It provides the link across all three PCTs and the four acute trust sites, and liaises between all clinical and non-clinical staff. It has established the Primary Angioplasty Steering Group and Workforce Group and feeds into the Cardiac Board on a quarterly basis. It has worked with a wide variety of stakeholders to produce the commissioning strategy, service specification and pathways, as well as the business case to the commissioners, and continues to provide management around the data collections that will be required, as well as contingency planning.

Through the Network's clinical lead, a strong relationship has been built with all of the cardiac interventionalists (consultants) that will be involved in the 24/7 rota. The Network has successfully recruited 9 out of 10 of the consultants, and they have all had involvement in the pathway design and operational protocols that the service will adhere to.

The Network has hosted two events; 1) a pathway planning event, and 2) a contingency planning event. These have both had comprehensive attendance from a wide range of stakeholders, and has ensured that the opinions of all relevant departments contributing towards the running of this service have been taken into consideration.

The Network has been pivotal in ensuring that all relevant stakeholders from across both primary care and the acute care services have been involved within this project, and have been the driving force to ensure the speedy implementation of this service. The Kent area is ahead of its neighbouring networks in Surrey and Sussex, and has been offering support in their own implementations by sharing learning and experiences.

Progress to date

- Equalities Impact Assessment has been undertaken.
- Needs assessment completed.
- Commissioning strategy finalised.
- Service specification agreed and patient pathways agreed with all relevant stakeholders.
- Business plan developed by the Network outlining the financial implications to the PCTs, and the benefits this new service will bring.
- All three Kent and Medway commissioners have agreed to fund this service as of April 2010.
- East Kent Hospitals University Foundation Trust confirmed that it is able to deliver the service as per the service specification.
- The recruitment process has started to ensure that the required increase in staff is secured prior to implementation.
- South East Coast Ambulance service has procured the telemetry system to be installed on each of the ambulances in order that ECGs can be transmitted to the William Harvey Hospital.
- An additional project manager has been appointed by East Kent Hospitals University Foundation Trust to progress the operational tasks, including staffing, bed and capacity planning, operational protocols as well as contingency plans.
- The expected date for implementation will be the 12 April 2010.

Additional Information to note:

It should be noted that:

- the new primary angioplasty service will have an impact in terms of a decrease in mortality rates, therefore assisting with the LAA2 target to reduce circulatory disease mortality rates in the under 75s.
- This service will ensure delivery of the most timely and effective intervention for heart attack patients.
- There has been a high level of patient satisfaction where pPCI is being delivered currently which has been highlighted in the NIAP report.
- This service change has been informed, and is being driven by the Department of Health.
- This service is in line with the key messages within the Darzi review document on developing primary angioplasty.
- The commitment to developing primary angioplasty services is also a key component of the South East Coast Healthier People, Excellent Care Strategy.
- London centres already deliver pPCI as the first line of treatment for heart attack patients.
- An extensive study (NIAP) has demonstrated better outcomes for patients.

[i] Treatment of Heart Attack National Guidance. Final report of the National Infarct Angioplasty Project (NIAP) October 2008, Department of Health and British Cardiovascular Society.

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Health Overview and Scrutiny Committee Meeting – 5 February 2010

Emergency Care Pathways - STROKE

Attendees:

Julie Hunt - Director of Nursing & Quality, NHS West Kent and Chair of the Kent & Medway Stroke Network Board.

Steven Duckworth - Director, Kent & Medway Stroke Network Board.

1. What service changes have taken place across the PCT area, and what changes are planned, in order to provide these 24/7 specialist units?

   Each acute provider now has a dedicated stroke unit that employs specialist staff trained in the management of stroke. These operate on a 24/7 basis. Each PCT has systems for delivering acute thrombolytic therapy (clot-bursting drugs) that have shown to have a beneficial effect on long-term outcomes for people who have suffered a stroke. NHS East Kent has commissioned a 'telemedicine' model from East Kent Hospitals University NHS Foundation Trust that uses the system to undertake investigation and assessment of stroke patients remotely from where the patient presents. NHS West Kent has commissioned a 'rota system' from Dartford & Gravesham NHS Trust and Maidstone & Tunbridge Wells NHS Trust who operate the rota between the 4 hospitals to provide a full 24hr/7 day a week service between them. This rota includes Medway NHS Foundation Trust. The formidable success of the 'telemedicine' system, (it recently won a national award) which has supported the effective treatment of high numbers of patients, has prompted NHS West Kent and NHS Medway to replace the current rota system with a telemedicine solution. A business case is being prepared and funding has been agreed through the SHA Innovation Fund.

   SEC Ambulance Service NHS Trust have provided extensive training for all call centre staff and have adapted their response for stroke calls to ensure an appropriate 'category A with transport' response is deployed in order to transfer patients to the closest operational acute stroke centre as quickly as possible.

   The 2008 National Sentinel Stroke Audit generally showed improvements in care across Kent from the previous audit in 2006.

Darent Valley Hospital went from the middle half to the bottom quartile nationally. A complete pathway service improvement initiative has since led to subsequent improvement in a repeat local audit.

Kent & Canterbury Hospital went from the middle half to the top quartile nationally.

Queen Elizabeth The Queen Mother Hospital went from the lower quartile to the middle half.

William Harvey Hospital went from the lower to upper quartile.

Kent & Sussex Hospital stayed in the lower quartile. A series have improvements have since been initiated. A repeat audit is planned for January 2010.

Maidstone Hospital went from the lower quartile to the middle half.

2. Can the two PCTs provide a map indicating where, across the region, these specialist units are located, or where they are planned to be located in the future?

   Specialist units are situated at:

   Darent Valley Hospital, Dartford. (shared rota)

   Kent & Canterbury Hospital, Canterbury (24hr)

   Queen Elizabeth The Queen Mother Hospital, Margate (24hr)

   William Harvey Hospital, Ashford. (24hr)

   Kent & Sussex Hospital, Tunbridge Wells. (shared rota)

   Maidstone Hospital. (shared rota)

3. For each of these locations can you name the services provided and indicate whether they are available 24/7?

   As mentioned above all the acute providers have a stroke unit that can provide dedicated stroke care from admission onwards. The Acute Stroke Units provide dedicated and specialist stroke care including thrombolysis. They provide rapid, early expert intervention and early rehabilitation for the acute stroke patient through a comprehensive pathway of care. Patients

are looked after by an extensive multi-disciplinary team overseen by a specialist stroke consultant.

4. What plans do the PCTs have to ensure that the general public understand these changes?

   Both PCT's have engaged with the public in order to explain the risks factors associated and what to do in event of them or an acquaintance suffering a stroke. A number of local road shows and events have been organised in order to communicate the stroke services currently available in Kent. This has run concurrently with a large scale public information campaign run by the Department of Health.

   Both PCT's and the Kent Stroke Network have public engagement strategies dedicated to stroke. Links have been made with local stroke clubs and third sector organisations.

5. How many people in Kent receive emergency treatment for heart attacks, stroke, and major trauma each year?

   Stroke:

   East Kent: 1633

   West Kent: 1508

   Total: 3141

6. How many Kent patients are currently taken outside of Kent to receive treatment in an emergency, where are they sent, and how is this likely to change in the future?

   It is not usually necessary for stroke patients to be treated outside of Kent, SEC Ambulance are required to transport patients from within Kent & Medway to the local Kent & Medway acute stroke centre. A very small percentage will need treatment at a tertiary neuro-surgical unit. Up until recently patients would have to be sent outside of Kent for carotid artery surgery (necessary often to prevent further strokes), this can now be provided within Kent although a small number do still go to Kings College Hospital in London for their treatment..

7. What role does the Kent and Medway Cardiovascular Network play?

   The Kent & Medway Stroke Network has brought together key stakeholders and providers to review, organise and improve delivery of stroke services across the care pathway. The Network aims to work with commissioners to ensure that evidence based stroke services are commissioned and can be quality assure using data generated by providers and interpreted by the Network.

   The Network works with providers of stroke care to ensure commissioning agreements are met and employs service improvement techniques to ensure that providers of care maximise the quality and effectiveness of care delivered.

   The governance of these arrangements is via the Stroke Network Board back into the PCTs, to ensure the population of Kent & Medway has fast access to excellent care in the prevention, treatment and support for those at risk of or who have suffered from a stroke.

8. In summary

   Over the past three years the treatment of patients who have suffered a stroke has improved significantly and steadily. A national audit of stroke care carried out in 2006 highlighted that in relation to stroke care, Kent and Medway (K&M) was lagging behind the rest of the country. In 2008 a mean score of the key quality indicators showed K & M had a 70% compliance rate compared with a national rate of 71.9% nationally and 72% across the South East Coast SHA region. In 2006 the compliance score across K&M was 49%. Further strides have been made since the last audit and we are hoping to see improvements in this year's audit.

   Every acute provider in Kent & Medway now has a dedicated stroke unit which ensures patients are able to access quality care near to their place of residence rather than being transferred to a larger 'hub' or tertiary centre. The PCT's in conjunction with the Kent & Medway Stroke Network and local providers are working to ensure that the quality of services offered to all stroke patients across the care pathway, prevention through acute care and rehabilitation to long term-care and end of life care, are constantly being improved and monitored.

Submission from NHS Eastern and Coastal Kent and NHS West Kent

Response to Kent HOSC February meeting – Major Trauma

- By 2010 all appropriate heart attack, stroke patients and major trauma patients will receive their care from 24/7 specialist units. What progress has been made in achieving this?

'Trauma' includes injuries such as a fractured hip or ankle or minor head injury. The term 'major trauma' is used to describe the most severe life-threatening injuries, or multiple injuries. It can include arm or leg amputations, severe knife and gunshot wounds, and major spinal or head injuries.

1. *What service changes have taken place across the PCT area, and what changes are planned, in order to provide these 24/7 specialist units?*

The current ambulance policy is to transfer patients to the nearest appropriate A&E. Patients therefore continue to be taken to the local Kent hospital and assessed locally. If they have major trauma and need specialist care they are then transferred to a major trauma centre. A major trauma centre provides treatment to people with the most serious injuries 24 hours a day, seven days a week. These centres will have the equipment, facilities and teams of trauma experts to ensure effective diagnosis and early treatment of seriously injured patients. Patients in major trauma centres would then be transferred to local hospitals for ongoing care

If the Helicopter Emergency Medical Service (HEMS - Kent Air Ambulance) assesses the patient and find it appropriate to direct to a major trauma centre, they are usually taken to the Royal London Hospital as access for a helicopter is much better than the other Major Trauma Centres. Sometimes patients do go to Kings or other centres, depending on their specialist need and capacity.

All Trusts in Kent are being asked to contribute to the national trauma database 'TARN' to enable outcomes to be audited in future. Completion of this database will also enable more detailed analysis of travel times and transfers for major trauma patients.

South East Coast Ambulance Service NHS Trust (SECAmb) has been developing a higher level of skilled paramedic to be able to assess and support major trauma and other seriously ill patients. Teams are in place in Eastern and Coastal Kent, in West Sussex and with the air ambulance and the role is being evaluated.

Kent Air Ambulance Trust paramedic staff are provided by SECAmb, and the tasking of the helicopter is carried out from the ambulance control room at Coxheath. Work to further refine and formalise protocols has been recently undertaken to help make sure that the HEMS service is used to best effect.

2. *Can the two PCTs provide a map indicating where, across the region, these specialist units are located, or where they are planned to be located in the future?*

The numbers of patients defined as having suffered 'major trauma' is low, being in the region of 300 per year (compared with around 1,600 per year in London). The volume of major trauma cases or potential major trauma cases work does not justify a major trauma centre development in Kent & Medway.

At the Fit for Future 'Galaxy' conference in July 2007 it was agreed that major trauma services for Kent and Medway patients would continue to be provided from the tertiary centres in London - principally Kings College Hospital and the Royal London. NHS London's 'Healthcare for London' consultation sought views on the model of trauma services in 2009 and confirmed these hospitals (with the addition of two other centres) will be the major trauma providers for London.

NHS London and London providers are currently working through the standards and pathways to ensure standards and networks are established.

Brighton & Sussex University Hospital is also undergoing developments to allow it to become a major trauma centre, and this hospital is leading the network currently being developed in Sussex – it is expected to be available as a major trauma centre in 2014.

There are no plans therefore to develop a major trauma centre within Kent. However, a network to support the local services and ensure the appropriate links to the major trauma centres is being developed

3. *For each of these locations can you name the services provided and indicate whether they are available 24/7?*

All major trauma centres, when fully online, will offer 24/7 care. As defined by Healthcare for London, a major trauma centre provides treatment to people with the most serious injuries 24 hours a day, seven days a week. These centres will have the equipment, facilities and teams of trauma experts to ensure effective diagnosis and early treatment of seriously injured patients. Patients in major trauma centres would then be transferred to local hospitals for ongoing care

4. *What plans do the PCTs have to ensure that the general public understand these changes?*

As there are no plans to change the current patient flows, no specific engagement has been planned. As a network develops for Kent & Medway, patient and public engagement will be developed.

5. *How many people in Kent receive emergency treatment for major trauma each year?*

As noted above the number of patients defined as having suffered ‘major trauma’ is in the region of 300 per year across the whole of Kent and Medway

6. *How many Kent patients are currently taken outside of Kent to receive treatment in an emergency, where are they sent, and how is this likely to change in the future?*

As noted above, the number of patients suffering major trauma is considered too low to develop a major trauma centre in Kent, although patients are generally transferred to a local hospital for recovery and rehabilitation.

Further work to review how Kent should develop the pathways and the ‘level 2’ trauma services is starting, to ensure patients have access to the specialise care when needed. It will be included in the Kent Critical Care Network as it develops, as well as with the developing trauma networks in London and Sussex.

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