KENT COUNTY COUNCIL

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 29 April 2016.

PRESENT: Cllr T Clarke (Chairman), Mr A H T Bowles, Mr R E Brookbank, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Cllr T Murray, Cllr W Purdy, Cllr D Royle, Mr N J D Chard (Substitute) (Substitute for Mr M J Angell), Mr R A Latchford, OBE (Substitute) (Substitute for Mr H Birkby) and Mr S C Manion (Substitute) (Substitute for Mr G Lymer)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Dr J Duke-Macrae, Mr A Scott-Clark, Mrs R Gunstone and Miss L Adam

UNRESTRICTED ITEMS

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

(Item 2)

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

12. Minutes

(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 8 January 2016 are correctly recorded and that they be signed by the Chairman.

13. Kent and Medway Specialist Vascular Services Review

(Item 4)

Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East)) and Dr James Thallon (Medical Director, NHS England South (South East)) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Thallon began by outlining the infomation provided in the report, to address the Committee's recommendations from 8 January 2016 meeting, including travel times, performance indicators and findings from local reviews which were centralising vascular services in accordance with the Vascular Society guidance. He noted that the Vascular Society was exemplary in providing clear best practice guidance to its members and commissioners and the 2012 guidance was being updated in 2016. He reported that the Kent and Medway review was working with the Vascular Society guidance review group and there would be

no significant changes to the guidance. He stated that improving outcomes was driving the review; whilst the two providers in Kent were within the national tolerance levels for mortality, there was a considerable range in performance.

(2) Dr Thallon explained that there were no recommended criteria for travel times in the Vascular Society guidance as the key priority was access to specialist vascular surgery. He quoted Vascular Society guidance which stated that "patient survival after a ruptured aortic aneurysm was between 5-15 percent if they stay in a hospital with no vascular surgeon, compared to 35-65 percent if transferred to an adjacent vascular service. This advantage persists even with up to four hours of hypotension." He noted that the review programme board favoured a network hub and spoke model with a single inpatient centre and one or more spokes; this model would be out to public consultation in the summer subject to NHS England's internal assurance process.

(3) Ms Windibank highlighted the ongoing work including a detailed quality assessment for the affected populations. She reported that a qualitative event with patients and relatives representatives was held in February and considered the recommended option from a patient perspective; key messages included travel times for relatives and a sustainable service remaining in Kent and Medway. She noted that there was a draft public consultation plan and any feedback from the Committee would be reported back to NHS England as part of their internal assurance process.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about co-dependencies with podiatrists and interventional radiologists. Dr Thallon explained that whilst he accepted the importance of podiatry in prevention and noted that there was a shortage of podiatrists; podiatry was not in the scope of the review and was not able to be incorporated into it. He stated that he would be happy to reflect comments made about podiatry to the commissioners. He noted that one group who did have better access to podiatry services were those with diabetic foot problems who were also likely to suffer from vascular conditions. He reported that the review was aiming to create a centre of excellence which would avoid the need for amputation. He explained that interventional radiologists were currently underdeveloped in Kent and Medway and the next generation of vascular surgeons would be hybrid surgeons and interventional radiologists. He noted that whilst a hub and spoke model would create the conditions for interventional radiology to become an attractive speciality, it would take time for this to be developed. He reported that there was agreement from current interventional radiologists to support the new vascular model which was subject to further discussions.

(5) A number of questions were asked about population growth and disease forecast; preventative services; travel times for staff and frail, elderly and low income visitors; and amputations. Ms Windibank reported that population growth and cardiovascular disease forecasts had been included in the modelling. Dr Thallon explained that the abdominal aortic aneurysm screening programme had been key in reducing the number of emergency vascular procedures. He reported that prevention was taken very seriously and highlighted the successful diabetes prevention pilot undertaken by Medway CCG which was being implemented by all Kent and Medway CCGs. Mr Scott-

Clark noted that KCC was responsible for commissioning NHS health checks in Kent which could identify patients at risk of vascular conditions. Ms Windibank explained that detailed work was being carried out to look at travel times for staff and low income families particularly in high prevalence areas. Dr Thallon explained that vascular surgeons in the inpatient hub would be responsible for all vascular surgery including repairs of abdominal aortic aneurysms and amputations if related to a vascular condition. He noted that there were variations in outcomes for amputations and this could be incorporated into the review. Ms Windibank stated that the vascular review had whole system support and was aligned to the wider transformation plan.

(6) In response to specific questions about the operational and financial resilience of the two current providers in Kent and Medway, Dr Thallon explained that in terms of operational resilience, at present, both sites were understaffed and access to 24/7 surgery or interventional radiology was not guaranteed; he warned that the vascular service in Kent and Medway would collapse if the new clinical model was not implemented. He reported that even within challenged trusts such as Medway NHS Foundation Trust there were beacons of excellence such as its neonatal ward and there were signs of overall improvement at the trust under the new leadership. He explained that the creation of a vascular unit would be independent from the rest of a trust and create the conditions to attract staff. He noted that the aim of the review was to establish the clinical model and only the procurement would determine the location of the hub. In terms of financial resilience, Dr Thallon explained that if the clinical model based on Vascular Society guidance was implemented, it would provide an adequate revenue base for the chosen provider. Both of the current providers in Kent and Medway had adequate facilities which could be consolidated at relatively small cost.

(7) The Chairman invited Mr Inett to speak. Mr Inett enquired about the services provided at the spokes. Dr Thallon explained that a network model with a single inpatient centre would increase outcomes for patients but may result in them travelling further. He stated that in mitigation, all other services would be provided locally including diagnostics and outpatients. He noted that in the future some inpatient services could be provided in the spokes including angiology and stenting. Ms Windibank reported that at the qualitative and listening events, the priorities for patients and relatives had been access to specialist vascular services in Kent and Medway. Additional travel times for relatives were a concern but a number of initiatives suggested by attendees such as Skype appointments and support with travel were being looked at by the Clinical Reference Group. She noted the procurement would need to respond to those needs.

(8) A number of comments were made about procurement and public consultation including a consultation event in Medway. Dr Thallon explained that he was limited to the type of information he could provide the Committee in advance of the procurement process due to the risk of prejudice. He stated that he could share the key criteria for procurement including facilities and ease of visiting with the Committee. Ms Windibank reported that NHS England, through procurement, had a duty to market test any provider interested in delivering the clinical model for Kent and Medway. Ms Windibank noted that the procurement process would determine the site of the hub and current vascular performance would not be taken into account. She stated that the purpose of

the public consultation would be to test the model and criteria for procurement; NHS England would return to the Committee after public consultation and before the procurement process began. She explained that the draft public consultation plan included a survey targeting specific patients in Kent and Medway including those patients who travel to London for their care.

(9) RESOLVED that:

(a) NHS England South (South East) be requested to note comments about amputations; the proposed clinical model; podiatry; procurement and public consultation;

(b) NHS England South (South East) be requested to provide the following additional information to the next meeting of the Committee: key criteria for procurement and travel times for staff and frail, elderly and low income visitors;

(c) NHS England South (South East) be requested to present an update to the Committee on their preferred option for procurement for vascular services before NHS England Specialised Commissioning take a final decision on procurement.

14. Kent and Medway Hyper Acute and Acute Stroke Services Review
(Item 5)

Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East)), David Hargroves (Chair, Stroke Clinical Reference Group) and Lorraine Denoris (Public Affairs and Strategic Communications Adviser, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Windibank began by updating the Committee on the option appraisal process. She explained that detailed appraisals had been undertaken for a five, four and three site model and had been reviewed against a set of red flag criteria. The red flag criteria were agreed by the Review Programme Board and aligned to recommendations within the national stroke configuration guidance. She noted that workforce was the key limiting factor to providing seven day cover. She reported that a five site model was most challenging in terms of workforce and there were concerns about the capacity and sustainability of a three site model; more detailed work was being undertaken including the review of alternative clinical models. She stated that a five, four and three site model had been reviewed against the financial envelope determined by the standard tariff for stroke; if best practice guidance was met an enhancement would also be paid.

(2) Members of the Committee then proceeded to ask a series of questions. In response to a specific question about the consultants' letter, Dr Hargroves explained that the process embarked upon had been transparent and engaging; all clinicians had been invited to participate with variable levels of involvement. He stated that the letter had been received at a late stage. The Clinical Reference Group had responded and addressed each of the concerns

raised in the letter including frail and elderly patients, alternative models of delivery and the use of technology; the Group had also reflected on the information it provided to the Review Programme Board and had concluded that it was robust and adequate. Ms Windibank noted that the consultants had been invited to raise any outstanding concerns before the next Review Programme Board.

(3) A number of comments were made about the public perception of travel times and the provision of rehabilitation facilities. Ms Windibank explained that safe travel times would be included as part of the public consultation; she noted that the review was not yet at the stage to go out for public consultation. She explained that the focus of the review was the acute pathway for patients but acknowledged the importance of rehabilitation. She stated that as the model was developed, pathways for rehabilitation were also being identified and the CCGs were being made aware of areas which worked well and where there were gaps. She noted that the new acute model would only work if sustained investment was made by the CCGs into rehabilitation services and the Review Programme Board would be making recommendations to the CCGs about rehabilitation. She reported that she would feedback concerns about rehabilitation facilities for patients with brain injury to the CCGs.

(4) A number of questions were asked about the aim of the review, engagement with highways and weighting of journey times in the decision making. Dr Hargroves explained that the aim of the review was to improve clinical outcomes, care and quality for patients. He reported that the provision of services was variable across Kent and Medway. He noted that the review was not looking to establish a single centre of excellence in Kent and Medway, as the centre would be inefficient for the expected volume of patients. Ms Windibank explained that the review had used ambulance travel times provided by SECAmb and bed usage by CCGs for journey times. She stated that KCC Highways had been approached for data but a response had not been received. She noted that the Review Programme Board was proposing to put forward a request to KCC Highways to prioritise access for medical staff during Operation Stack. She reported that mapping was underway to assess private travel time by car and public transport. She explained that in terms of weighting, priority would be given to a 24/7 specialist service with adequate staffing levels. She noted that the review was working with providers to mitigate costs and travel times for visitors using public transport.

(5) RESOLVED that:

(a) the Kent and Medway Stroke Review Programme Board be requested to take note of the Committee's comments and take them into account during the detailed options appraisal;

(b) the Committee note the three options for a five, four or three site model and make no further comment at this stage;

(c) Kent and Medway CCGs be requested to present an update to the Committee including the final options for public consultation.