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 Council Chamber, Sessions House, County Hall, Maidstone on Friday, 8 January 2016.

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

ALSO PRESENT: Mr S Inett and Dr Saloni Zaveri

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mrs R Gunstone

UNRESTRICTED ITEMS

5. Membership
(Item 1)

(1) Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee noted the membership as set out above.

6. Election of Chairman
(Item 3)

(1) RESOLVED that Councillor T Clarke be elected Chairman.

7. Election of Vice-Chairman
(Item 4)

(1) RESOLVED that Mr M Angell be elected Vice-Chairman.

8. Declarations of Interests by Members in items on the Agenda for this meeting
(Item 5)

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

9. Kent and Medway Specialist Vascular Services Review
(Item 6)

Dr James Thallon (Medical Director, NHS England South (South East), Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East) and Michael Ridgwell (Programme Manager, Emergency and Urgent Care Strategy, North Kent CCGs) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Thallon began by outlining the background to the review; he explained that NHS England South (South East) commissioned specialised treatment in Kent, Medway, Surrey and Sussex under the national specification for specialised vascular services. The standards within the specification were developed through a national specialised Clinical Reference Group and reflected the best practice guidance of the Vascular Society. He stated that it was rare for best practice guidance by a professional society to be implemented by NHS England as a national service specification which demonstrated the importance and power of the guidance. As part of the review, current providers were asked to carry out a self-assessment of their services in Kent and Medway; services were found not to be fully compliant with the national critical guidance or best practice specification. NHS England South (South East) was granted a derogation which allowed services in Kent and Medway to continue, although they did not fully meet the national specification, until a solution to meet the specification and provide sustainable services was found.

(2) Dr Thallon explained that a sustainable specialist vascular services needed to work within a hub and spoke clinical network; serve a minimum population of 800,000; have 24 hour access to specialist care and staffing with sustainable on call rotas; provide access to cutting-edge technology including a hybrid operating theatre and interventional radiology. He noted that 900 people a year in Kent and Medway required specialist vascular services: two-thirds of these patients received their care from Medway NHS Foundation Trust and East Kent Hospitals University NHS Foundation Trust and one-third of these patients from West and North Kent received their care in London predominantly at St Thomas' Hospital. Patients reported positive experiences of vascular services in Kent and Medway and in London. Services provided in London was an arrangement developed over the past five – six years as a result of links between doctors at Maidstone and Tunbridge Wells NHS Trust, Dartford and Gravesend NHS Trust and trusts in London, clinical choice and patient choice. The service provided by St Thomas' Hospital in London was fully compliant with the national clinical guidance and best practice specification.

(3) Dr Thallon reported that services provided in Kent and Medway were not fully compliant with the national clinical guidance and best practice specification; both providers were not treating a large enough population and were carrying out too few or borderline numbers of core procedures. He noted that whilst both providers in Kent and Medway had been placed in special measures by the Care Quality Commission; the specialist vascular services were isolated services within their trusts and their clinical quality was closely monitored. A national 6% mortality rate for elective vascular repair had been set as an achievable standard: Medway had a 4.6% mortality rate, East Kent Hospitals University NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust both had a 1% mortality rate. The Vascular Society aimed for a 4% mortality rate through the national clinical specification; reconfigurations of specialised vascular services across the country using the national specification had shown improved quality and outcomes.

(4) Dr Thallon stated that the review process had been overseen by a Vascular Review Programme Advisory Board which had been meeting for 18 months. The Board was looking at travel and access, patient demand, co-

dependencies, vascular interventional radiology and workforce. The Review Board was also supported by a Clinical Reference Group (CRG) who provided clinical advice and expertise from the current providers and the Vascular Society. The CRG had considered a long list of options in line with the specification and had agreed that two options needed future development and review to establish if they could address the key issues: a two centre arterial hub with spokes model working within a network and a single Kent and Medway arterial hub with spokes working in a network. The CRG had recommended to the Review Board that a single hub model was the only model to be taken forward and the Review Board had accepted this finding. He stated that the new clinical model would have to meet the current financial envelope. He reported that the current providers had been invited to work collaboratively to provide the hub and spokes; if they were not able to reach agreement a formal procurement would be required.

(5) Ms Windibank gave an overview of the engagement to date. She noted that the Case for Change had been presented to Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee. 64 participants attended listening events in July and August 2015; participants reported a positive experience of vascular services both in Kent and Medway and in London. She reported that the participants recognised the Case for Change and noted that having access to a specialist vascular team or centre was the most important and reassuring in a life threatening situation. Key priorities by the public also included the ability to make a choice, adequate information and communication to make choices, the need for support particularly following amputations when people return home and joined up working between services and disciplines. She explained that rehabilitation services were not part of the review but the Review Board would be making recommendations to the CCGs as part of the clinical model. She stated that a People's Panel had been provisionally scheduled for Tuesday 23 February 2016 and she would provide verbal feedback to the next meeting of the Committee on 26 February 2016. She noted that a financial model and an equality impact assessment were being developed.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about initial assessment of vascular conditions in the ambulance. Dr Thallon explained that it was more difficult for Community First Responders and Paramedics to diagnose vascular conditions than stroke. Patients presenting with stroke symptoms were often transferred directly to a hyper acute unit whilst vascular patients tended to be conveyed to a standard A&E before being transferred to a specialist centre. Ms Windibank stated that the new model would establish a vascular network and clearer patient pathways; it would include a pathway for patients who did not enter the service through the hub or spoke.

(7) A number of comments were made about workforce. Dr Thallon explained that there were enough specialist vascular surgeons in Kent and Medway to staff a single arterial hub; if two hubs were established there would not be enough surgeons to provide safe staffing levels. A single hub with six vascular surgeons within a network would create conditions for a centre of excellence and provide a high end offer for both patients and surgeons. Ms Windibank noted that a one in six rota for vascular surgeons was recommended as a minimum by the Vascular Society and it was difficult to recruit to a more

frequent rota. Dr Thallon reported that there was a shortage of interventional radiologists; skill consolidation was required to ensure a sustainable service and patient choice. He noted at present patients did not have the choice between endovascular and open surgery. The professional body for interventional radiologists had stated they would support whatever configuration was chosen. Dr Thallon stated that if procurement was required, providers would have to demonstrate how they would recruit and retain staff. Ms Windibank stated that there would also be opportunities for nursing staff such as specialist nurse-led clinics and diagnostics within the spokes and higher pay which would assist recruitment. Dr Thallon noted that the implementation of vascular reconfigurations in different parts of the country had not been affected by staffing.

(8) In response to a specific question about the podiatry service, Dr Thallon explained that rehabilitation services such as podiatry were not part of the review. He noted that vascular patients with diabetic foot problems were not affected by the new access restrictions to podiatry services as they were considered high risk. Ms Windibank stated that she had been engaging with the Diabetic Network as part of the review.

(9) A number of comments were made about visitor access, timeline and engagement. Dr Thallon acknowledged that there was a balance between specialist care and other factors such as visitors, the environment and quality of nursing in improving outcomes for patients. Dr Thallon stated that the timeline would most likely slip; the review would take as long as required in order to achieve a sustainable service. Dr Thallon reported that 8-9% of patients who experienced vascular services had attended the listening events. Ms Windibank stated that the participants at the next People's Panel would include those currently in the pathway and those at risk of entering the pathway (who would be identified through GPs and the NHS Abdominal Aortic Aneurysm Screening Programme). She reported that if the engagement was not adequate, NHS England South (South East) would repeat the process.

(10) A Member requested assurance that the new model and pathway would be sustainable. Dr Thallon explained the previous model and pathway had failed as patients in West Kent had continued to be referred to London which had not been accounted for in the old clinical model. He noted that under the new clinical model referral to London would be allowed to continue; if an excellent clinical offer for a specialist vascular service was established in Kent and Medway, commissioners in North and West Kent may no longer chose to refer their patients to London in the future. He stated that the new model and pathway was based on best practice and the national specification; it was realistic to look at a five-ten year timeframe. He noted that there was clinical and executive support for a single hub. He reported that there had been a successful Kent and Medway wide consolidation of angioplasty and stent procedures at the East Kent Cardiac Catheter Suite, William Harvey Hospital, Ashford which had implemented best practice, improved outcomes and reduced length of inpatient stay. Ms Windibank explained that there had been detailed and challenging conversations with clinicians regarding consolidation of vascular services; clinicians acknowledged that the current position was not sustainable due to the recruitment issues. She also noted that an excellent clinical offer for specialist vascular service in Kent and Medway was required to improve recruitment.

(11) Members enquired about the collaborative working between providers and the Urgent & Emergency Care Network. Dr Thallon explained that the providers would initially be invited to work collaboratively to fulfil the best practice guidance and national specification; if they were unable to reach agreement, a formal procurement process would be required. He stated that the providers were not able to compromise on best practice. Dr Thallon reported that he was responsible for establishing the Kent, Surrey and Sussex Urgent and Emergency Care Network; he stated that the outcome of the Vascular Review would be in a position to support any future reconfiguration of the Urgent and Emergency Care Network.

(12) Mr Ridgwell was invited to comment: he explained that he was working with CCGs in North Kent, West Kent and Medway on their joint commissioning intentions for acute care which were linked to the Stroke and Vascular Reviews. He noted that NHS England's Urgent and Emergency Care Review Programme had identified different types of emergency centres and emergency centres with specialist services. The specialised services included cardiology, paediatric, stroke, trauma and vascular. He stated that Kent and Medway CCGs were reviewing all of the specialist services above; in North Kent, West Kent and Medway, CCGs were basing their commissioning intentions on the basis that current accident and emergency departments would continue to have some sort of emergency department but were looking to consolidate specialist services. He stated that there was no additional funding to develop or consolidate emergency services. He reported that he would be bringing a paper to the Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee to update them on the work on the Kent and Medway Emergency and Urgent Care Strategy. The Chairman requested that maps with travel distances be included in the paper to the Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee.

(13) RESOLVED that:

(a) NHS England South (South East) be requested to note comments about the proposed clinical model of a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway, the development of the clinical model and further stakeholder engagement.

(b) NHS England South (South East) be requested to provide the following additional information at the next meeting of the Committee: population maps; performance indicators of the current service; findings and learning from other reconfigurations nationally and regionally; and the services to be provided in the spokes.

(c) NHS England South (South East) be requested to present an update to the JHOSC Committee on 26 February 2016.

(14) The meeting was adjourned at 11.33 and reconvened at 11.43.

10. Kent and Medway Hyper Acute and Acute Stroke Services Review
(Item 7)

Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East)) and Julie Van Ruyckevelt (Principal Associate, South East CSU)) were in attendance for this item.

(1) The Chairman welcomed the guests. Ms Windibank began by outlining the case for change which established the need to review and remodel hyper acute (first 72 hours) and acute (remaining acute stay) across Kent and Medway. She explained that primary prevention and rehabilitation services were not part of the review; the review would make recommendations to the individual CCGs where those areas required further exploration. She stated that there were a number of concerns about the performance and sustainability across the seven hospitals currently treating stroke patients including access to diagnostics, specialist assessment and intervention; specialist workforce treating the minimum number of patients; and 24 hours, seven day specialist stroke services cover. She reported that none of the current services met the national strategy and guidance.

(2) Ms Windibank stated that eight clinical options had been identified; models ranged from one to seven sites plus the status quo. She explained that the Stroke Review Programme Board had identified that the single, two site model and status quo were not sustainable. On 22 December 2015 the Stroke Review Programme Board considered the feedback from the People's Panel; and the Review's Clinical Reference Group and agreed that a detailed appraisal, workforce risk assessment, travel heat maps, public health incidence growth and equalities impact assessment for a five, four and three site model should be undertaken. She reported that the number of strokes was levelling out nationally and the number of strokes in Kent and Medway were expected to increase by 650 annually. She noted that following the successful FAST campaign, the number of patients transferred to hospital with stroke like symptoms had increased; 30 – 40% of patients who attended their local Accident and Emergency department were not admitted with a stroke or transient ischaemic attack (TIA) which needed to be considered as part of any reconfiguration. She stated that the recommended options for public consultation would be presented to the Committee on 26 February 2016.

(3) Ms Van Ruyckevelt gave an overview of the communication and engagement activity. She stated that ten Listening Events were held across Kent and Medway to share the Case for Change and raise awareness with the public; 110 participants attended including stroke survivors, families and carers of stroke survivors, voluntary sector and residential care providers. 220 participants attended 15 Focus Groups which were held in partnership with the Stroke Association and 285 participants completed the online survey. Three deliberative events were also held in November and December which tested out the criteria used in the options appraisal process and the emerging options. The events included representation from members of the public, patients, carers, the Stroke Association, stroke champions, Public and Patient Involvement leads and JHOSC members. She reported that feedback included support for the Case for Change, a recognition that the required standards were not being met and an understanding of the pressures regarding workforce; the Public Panels voted for either a four or five site option. She

noted that the Review was built upon and superseded the work of Maidstone and Tunbridge Wells NHS Trust, Healthwatch Kent and East Sussex carried out in December 2014. She stated that Healthwatch Kent, Healthwatch Medway, Healthwatch Bromley and Healthwatch East Sussex were part of the Communications Sub Group.

(4) The Chairman invited Mr Inett to speak. Mr Inett began by endorsing the engagement work carried out as part of the Review. He stated that deliberative events had built participants' knowledge and confidence and involved them in the decision making. He noted that he was a member of the Stroke Review Programme Board which he had found to be open and transparent.

(5) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member expressed disappointment that a deliberative event had not been held in Medway. Ms Van Ruyckevelt stated that a range of engagement activities had been arranged to involve as many participants as possible. She noted that a Focus Group was held in Medway and 34 people from Medway had responded to the online survey. She explained that the three deliberative events had been held in central locations with a range of 21 participants at each event. Another Member stated that out of the two main road networks in Kent and Medway the A2/M2 and A20/M20 both events had been held on the A20/M20 route. Ms Windibank stated that there would be further focus groups and events as part of the next phase of the review. Attendees who had attended the Public Panels and requested additional information were being provided with this. She also noted that the Equalities Impact Assessment would identify population groups to specifically target.

(6) Members enquired about rehabilitation, attracting workforce, current performance by providers and involvement with social care services in Kent and Medway. Ms Windibank stated the variability of rehabilitation services was not consistent; the Review had taken this on board and would be making recommendations to the CCGs. She noted that the acute model would only work if a successful pathway was in place. Ms Windibank explained that there were different models for Hype Acute and Acute Stroke services; in London patients were admitted to one of 8 hyper acute sites for the first 72 hours before being transferred to a local acute site for the remainder of their acute stay. She reported that combined hyper acute and acute sites in Kent would be much more attractive for specialist workforce including nurses and therapists. Ms Windibank stated that the decision making would not be based on current performance; providers would be judged on how they would deliver the service going forward. Ms Windibank explained that Public Health were part of the Stroke Programme Review Board and fed back to Social Care and CCGs; she noted that they would be more actively involved in the next phases and once the final recommendation had been made, the Programme Review Board would morph into a mobilisation group.

(7) RESOLVED that:

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

(b) Kent and Medway CCGs be requested provide details of travel infomation at the next meeting of the Committee.

(c) Kent and Medway CCGs be requested to present an update including options for public consultation to the JHOSC Committee on 26 February 2016.