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 Monday, 28 November 2016.

PRESENT: Mr M J Angell, Mr H Birkby, Mr D L Brazier, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Mr G Lymer, Cllr T Murray, Cllr W Purdy, Cllr D Royle and Cllr D Wildey

IN ATTENDANCE: Dr A Duggal (Deputy Director of Public Health), Ms L Adam (Scrutiny Research Officer), Dr A Burnett and Mr J Pitt

UNRESTRICTED ITEMS

21. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 4 August are correctly recorded and that they be signed by the Chairman.

22. Kent and Medway Specialist Vascular Services Review
(Item 4)

Oena Windibank (Programme Director, Kent & Medway Vascular and Stroke Services Reviews), James Thallon (Medical Director, NHS England South and Senior Responsible Officer, Kent & Medway Vascular Review), Rachel Jones (Director of Strategy, East Kent Hospitals University Foundation NHS Trust), Noel Wilson (Vascular Services Clinical Lead and Consultant Surgeon, East Kent Hospitals University Foundation NHS Trust and Clinical Lead for the Kent & Medway Vascular Network), Ben Stevens (Director of Clinical Operations, Co-ordinated Surgical Directorate, Medway Foundation Trust) and Anil Madhven (Interventional Radiologist Consultant, Medway Foundation Trust and Deputy Clinical Lead, Kent & Medway Vascular Network) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Thallon began providing an update to the Committee about the Vascular Services Review; he explained that East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Group (MFT) had established a Network to deliver vascular services jointly in East and Mid Kent. He noted that the Committee had requested NHS England to present an update on the engagement events; he explained that these had been delayed until the early next year.

(2) Following a change of membership at the previous meeting, the Chairman asked for a description of vascular services. Dr Wilson explained that vascular diseases related to disorders of the arteries and veins but excluded the heart and cardiothoracic diseases. He stated that vascular services included

interventions to remove interruptions to arterial blood supply in the limbs, neck and abdomen to prevent stroke and repair aneurisms. He noted that aneurisms particularly affected men and common vein conditions included varicose veins and ulceration.

(3) Dr Wilson stated that he was the Vascular Services Clinical Lead and Consultant Surgeon at EKHUFT and was the lead for the Kent & Medway Vascular Screening Programme which screened 11,000 – 12,000 men a year for Abdominal Aortic Aneurysm. He also worked with Public Health England to peer review vascular services across the country and was currently working with NICE to review the vascular guidelines. He explained that resulting from the vascular services review in Kent and Medway, a collaboration between EKHUFT and MFT had developed the Kent & Medway Vascular Network. He noted that the pathway to London for specialist tertiary treatment would continue. He reported that a Network Board had been established, by the Chief Executives of the two Trusts, to move the service forward; Dr Wilson had been appointed as the Clinical Lead and Dr Madhven had been appointed as the Deputy Clinical Lead. He explained that the Network Board was working to develop and build the best service for patients and their families and was very optimistic about its future. He stated that he attended a patient and family engagement event which had given him a greater understanding of patients and their families' priorities for vascular services.

(4) Dr Madhven explained that he was an Interventional Radiologist Consultant at MFT and provided minimally invasive specialist procedures for vascular patients. He highlighted that, although he was not a vascular surgeon, he provided specialist treatment to compliment the work of vascular surgeons. He noted that both Trusts recognised the importance of different specialities working together to provide vascular services. He reported that he been appointed to the role of Deputy Clinical Lead to the Network Board last month and had attended one Board meeting. He stated that he was responsible for identifying and implementing the clinical governance structure for the Network. He stated that he was keen for the Network Board to move forward and develop an improved and safe service.

(5) Dr Thallon introduced Ms Jones and Mr Stevens as the executive leads from both Trusts. Ms Jones stated that alongside the clinical model, the clinically-led business case was being developed which incorporated finance, activity and demand; the impact on patients and their family would also be included following the planned engagement events. Mr Stevens added that the primary purpose of the Network was to provide effective and sustainable vascular services.

(6) The Chairman enquired about the impact of the Sustainability and Transformation Plan (STP) on the review. Dr Thallon explained that the review was started before the STP process with the aim of creating excellent outcomes for patients and sustainability of the service following Vascular Society guidance. He stated that the both Trusts recognised that actions were required to improve the service. He reported that although the review could exist independently outside of the STP process, it was fully integrated into the process and did not need to adapt itself to support the STP. He stated that there was an argument for joint public consultation on the Vascular Review

and elements of the STP to enable those elements to be fully articulated and not cloaked by other high profile choices.

(7) Members of the Committee then proceeded to ask a series of questions and make a number of comments. In response to a specific question about the impact of South East Coast Ambulance NHS Foundation Trust (SECAmb) being placed into quality special measures, Dr Thallon acknowledged that SECAmb was facing temporary operational difficulties but stated that by the time the proposed services were operationalised, it was hoped that SECAmb would have resolved these. He stated that the review had a good working relationship with SECAmb and was working closely with them as pathways and models of care were being developed.

(8) A number of comments were made about workforce. Dr Thallon explained that in order to be competitive, integrated fit for purpose facilities were required to attract staff. Dr Wilson noted that vascular services had been radically changed following the General Medical Council's decision to make it a specialist service. He stated that the majority of vascular services across the country had been centralised and Kent and Medway was lagging behind. He stated that he was optimistic that the model with all care being provided locally, with complex cases being provided as part of a single centralised hub, would attract and strengthen the vascular workforce. He explained that the workforce model and skills required with being reviewed; it was proposed that allied and non-medical staffing, such as nurse practitioners, would help to support consultant-delivered care. He stressed the importance of junior doctors being trained rather than be responsible for the delivery of care.

(9) In response to a question about finance, Dr Thallon stated that the aim of the review was about reducing the amount of vascular activity. He acknowledged that there would be a capital cost attached to modernising the service and it was recognised by NHS England that capital was in short supply. He noted that the STP was looking at capital requirements for the whole system and the vascular services review was looking at an element of that. He stated that the next step was for the development of business case which would include the cost of the collaborative service. He suggested that the next update to the Committee should include the presentation of the business case and the feedback from the engagement events with the timing dependent on purdah. Ms Windibank noted that the engagement events were scheduled to be held at the end of February and the feedback would be incorporated into the business case.

(10) Members enquired about the sustainability of the proposed model of care and centralisation. Dr Wilson explained that he had been appointed as a vascular surgeon in 1995 and his passion had been to develop better care and services since then. He acknowledged that previous reviews had not got the model right and this review provided the opportunity to implement the best model of care which had been successfully implemented and delivered across the country. He stated that the greatest success of the review had been the development of the collaborative Network to implement and deliver the new model of care. In regards to centralisation, Dr Thallon explained that care would be localised as much as possible and only complex care would be centralised. He stated that there was a good evidence base which showed that centralisation improved the outcomes for patients but this needed to be

balanced against the patients' access to their families. Mr Stevens stated that the engagement events would focus on the families to ensure that their needs and concerns were included as part of the business case.

(11) RESOLVED that NHS England South (South East) and the Kent & Medway Vascular Clinical Network Board be requested:

(a) to note the comments about workforce, finance and sustainability;

(b) to present an update to the Committee following the engagement events and the development of the business case.

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

Oena Windibank (Programme Director, Kent & Medway Vascular and Stroke Services Reviews), Patricia Davies (Accountable Officer, NHS Dartford Gravesham and Swanley CCG and NHS Swale CCG and Senior Responsible Officer, Kent & Medway Stroke Review) and Lorraine Denoris (Public Affairs and Strategic Communications Adviser, NHS Dartford, Gravesham and Swanley CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Davies began by outlining the review. She stated that the review began 18 months ago with the formation of the Stroke Review Programme Board to develop a new model of care which would meet the national standards; the Board was made up of representatives from the eight Kent & Medway CCGs, the Stroke Association, clinical experts and patient representatives. She noted that the process was overseen by Professor Tony Rudd, the National Clinical Lead for Stroke. She explained that since the last JHOSC, the clinical data had been reviewed again and a series of engagement events were held which JHOSC members were invited too; the feedback from patients at these events was that patients felt cared for but recognised that the current model was not meeting national standards. She noted at the last Stroke Review Programme Board on 24 November, a three site option was agreed to be the optimum model for stroke services as detailed in the supplementary paper. She stressed that the locations of the three sites had not been determined and would depend on the output from the Kent & Medway Sustainability and Transformation Plan (STP) as a number of other services needed to be collocated on the site including a major A&E and trauma units. She stated that the original 27 configurations had been reduced to nine and each of those configurations met the 45 minute travel time and 120 minute call to needle standard.

(2) Ms Windibank stated that the feedback from the recent engagement events, about workforce, travel time and rehabilitation, was similar to previous events and would be used to inform and influence detailed modelling. She noted that an initial gap analysis on the out of hospital pathway had been undertaken and services were variable across the county; a more detailed analysis would be carried out. She explained that a wider clinical and stakeholder engagement event was planned for early 2017 which would be used to test and validate a three site option. Ms Denoris highlighted that the recent engagement events

brought together patients, carers, stroke survivors alongside clinicians to look at the emerging options, challenges and solutions.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A number of comments were made about rehabilitation services. Ms Davies acknowledged that community rehabilitation services were variable in Kent & Medway and there was no definitive specialist rehabilitation service for stroke which was recognised by clinicians at the recent Review Programme Board. She highlighted that a specialist stroke rehabilitation pathway was being developed as part of the modelling for a three site option and would include consideration about how those stroke services would link to general rehabilitation as part of a patient's recovery. She noted that there were good general rehabilitation services across Kent & Medway and it was for the STP and CCGs to develop rehabilitation services as part of their plans for local care. Ms Windibank noted that robust early supported discharge enabled patients to recover more quickly at home but also improved the quality of care provided to stroke patients who required a longer length of stay; there elements of early supported discharge in the county but it depended on workforce availability. Ms Davies reported that rehabilitation would become an integral part of the next phase of the review by the Stroke Review Programme Board. She noted that there was not a blueprint for stroke rehabilitation services and as part of the next phase there would be consideration of the workforce requirements to provide community and home based rehabilitation services. She also noted that there had been resounding feedback from stroke survivors and their carers about the provision of psychological services throughout a patient's recovery, to enable stroke survivors to become independent and adapt to a change of lifestyle. She stated that psychological services would be included in the next phase of the review. She highlighted the experiences of a student who survived a stroke at the age of 19 and had initially struggled to move forward with her life post stroke. Ms Windibank reported that Dr Hargroves was leading on a piece of work with the cardiovascular network to look at best practice for rehabilitation which included the establishment of multidisciplinary teams. She noted that national recommendations on good stroke rehabilitation services were expected and would feed into the second phase of the review.

(4) In response to a specific question about financial optimisation, Ms Windibank highlighted that in addition to the tariff received by the Trust for the provision of stroke services to a patient, additional remuneration was available through a best practice tariff if patients were assessed quickly by a specialist team in a specialist unit. She noted that across Kent and Medway Trusts were struggling to achieve the best practice tariff and the remodelling of stroke services would put the Trusts in a better position to achieve the tariff.

(5) A Member enquired about collaboration with social services and the capital funding required for modernising the service. Ms Davies noted that social services were an important part of the discharge process and recognised that they were under enormous pressure. She stated there were also constraints on the health budget but there were opportunities through the STP for stroke service providers to utilise resources more efficiently by working collaboratively and reducing waste as recommended by the Carter Review and achieving the best practice tariff. She reported that there was phenomenal demographic growth in Kent and Medway and that the funding allocations did

not take this into account. She explained that CCGs' allocations were based on patients registering with GP practices which took two – three years to flow into the system. She stated that although this would not prevent the redesign of services to meet the needs of the local populations, this created a huge challenge for the health service coupled with the extreme pressures on social care. She stated that central funding for Kent and Medway needed to be reconsidered.

(6) A Member asked about the provision of local care and the workforce gap with a three site option. Ms Davies stated that there was a balance between specialist treatment and care close to home. She highlighted that travel times for patients and careers had been raised as an issue as part of the engagement events and the aim was to keep travel to a minimum. However she recognised the importance of a patient being seen quickly in a centre of excellence which provided high quality treatment would reduce the incidences of death and the impact of disability. She also stated that centre of excellences would provide better training, mentoring and development opportunities which would attract workforce; the current demand on workforce was unprecedented. She noted Kent and Medway lacked well recognised health and social care training facilities and it was the only county which did not have its own medical school, which had been proposed as part of the STP. She stated that there were opportunities to create links with the London Teaching Hospitals. She explained that reduction from seven to three sites would be phased to ensure the workforce was in place.

(7) A number of Members gave positive feedback about the engagement events which they had attended as observers. A comment was made about the number of attendees at the events and a question was asked about engagement with vulnerable groups, Ms Denoris explained that 200 invitations were sent out the recent engagement events and 69 people attended. There had been a deliberate decision to only invite people who had been engaged in the process so far so as not to repeat the previous engagement work. As part of the formal public consultation, an expanded invitation would be used alongside a range of tools and techniques to engage with the public. Ms Windibank stated that she had gone and met with vulnerable groups as part of the engagement process and at risk groups were considered as part of the equality impact assessment. Clinical evidence had found that the proposed consolidation would lead to improved outcomes for everyone including at risk groups but economics and travel times must be a key factor when considering the location of sites.

(8) Members enquired about the impact of PFI in determining site location and learning from best practice. Ms Davies noted that there was no pressure to locate a stroke unit at a PFI hospital site; the locations would be determined on the availability of co-dependent services at the site, travel times and the areas which had the highest prevalence of stroke now and in the future. She stressed that no decisions had been made about the location of the three sites. Ms Windibank explained that learning from best practice in the acute setting and rehabilitation was being undertaken by clinicians including visits to a range of site. It was recognised from these visits that there were areas of good practice being undertaken in Kent and Medway but it was not consistent.

(9) A Member asked about the maximisation of staff time and engagement with staff. Ms Windibank reported that the volume of patients would increase with a reduction in to three sites therefore maximising specialist staffing time. She noted that rotas would reflect quieter periods. She stated that as part of the engagement with staff, there had been conversations with staff about who did and did not want to move; it was hoped that the clinical event, planned for early 2017, would help to better understand staff's concerns and how they can be supported to move. She noted that the feedback from the majority of staff is that they did not feel like they were doing a good job or delivering a good service; there is recognition amongst staff that reducing the number of sites would improve that position.

(10) A Member commented about a stroke group they had attended in Medway and found the stroke survivors were more concerned about the provision of the services to meet their needs, particularly group rehabilitation, than the number of sites.

(11) The Chairman invited Public Health representatives from Kent County Council and Medway Council to comment. Dr Duggal stated that as part of the STP discussions, prevention needed to be at the start of the pathway for stroke and cardiovascular diseases; initiatives such as smoke free hospitals would assist with the prevention agenda. Dr Burnett added that prevention did make a difference and gave the example of Sweden which had the lowest smoking rates in Europe. In achieving low smoking rates, it had significantly reduced the number of abdominal aortic aneurysm and the country's screening programme now only screened smokers. He stated the industrialisation of prevention was an important component in reducing the demand for services and helping patients from deteriorating further.

(12) RESOLVED that the Kent and Medway Stroke Review Programme Board be requested:

(a) to note the comments about rehabilitation services, workforce and finance;

(b) to present the final recommendations for consultation to the Committee, as agreed by the Kent and Medway CCGs, prior to the start of public consultation.