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 on Friday, 12 October 2018.

PRESENT: Mrs S Chandler (Chair), Cllr D Wildey (Vice-Chairman), Cllr T Murray, Cllr W Purdy, Cllr D Royle, Mr P Bartlett and Mr D S Daley

IN ATTENDANCE: Mr J Williams (Director of Public Health - Medway Council), Ms L Adam (Scrutiny Research Officer) and Mr J Pitt (Democratic Services Officer, Medway Council)

UNRESTRICTED ITEMS

1. Membership

(Item 1)

Members of the Kent & Medway Joint Health Overview and Scrutiny noted the membership listed on the Agenda.

2. Election of Chair

(Item 2)

(1) Cllr Wildey proposed and Mr Bartlett seconded that Mrs Chandler be elected as Chair of the Committee.

(2) RESOLVED that Mrs Chandler be elected as Chair.

3. Election of Vice-Chair

(Item 3)

(1) The Chair proposed and Cllr Purdy seconded that Cllr Wildey be elected as Vice-Chair of the Committee.

(2) RESOLVED that Cllr Wildey be elected as Vice-Chair.

4. Substitutes

(Item)

Apologies were received from Cllr Royle and Mr Pugh who was substituted by Mrs Hamilton

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

(Item 4)

(1) There were no declarations of interest.

6. Minutes

(Item 5)

(1) RESOVLED that the Minutes of the meeting held on 22 January 2018 are correctly recorded and that they be signed by the Chair.

(2) In relation to Item 4, paragraph 16, Cllr Wildey expressed a view that the feedback from the public consultation relating to the Kent & Medway Stroke Review had not been taken into account by the NHS at the Evaluation Workshop.

7. Kent and Medway Specialist Vascular Services Review

(Item 6)

Dr James Thallon (Medical Director NHS England South East), Oena Windibank (Programme Director, Kent & Medway Vascular Review), Michael Ridgwell (Programme Director, Kent & Medway STP), Liz Shutler (Deputy Chief Executive and Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust), Simon Brooks-Sykes (Senior Strategic Development Manager and Programme Manager for the Kent and Medway Vascular Clinical Network, East Kent Hospitals University NHS Foundation Trust) , Dr David Sulch (Interim Medical Director, Medway NHS Foundation Trust) and Dr Anil Madhavan (Consultant Interventional Radiologist at Medway NHS Foundation Trust and Deputy Chair for the Kent and Medway Vascular Network) were in attendance.

(1) The Chair welcomed the guests to the Committee. Dr Thallon began by giving a summary of the review and providing an update. He explained that the review commenced in December 2014 in response to a commissioner led derogation for both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) which identified the inability for both Trusts to deliver against either the national specification for specialist vascular services or the guidelines from the Vascular Society which included the delivery of services in a network model.

(2) Dr Thallon noted that patients from North and West Kent travelled to Guys and St Thomas Hospital Trusts for vascular surgery. It was not proposed that those patients would be directed however, it was acknowledged that this may change in the future if a centre of excellence was established in Kent & Medway. The catchment area for the review was therefore East Kent & Medway which had a population of approximately 800,000.

(3) Dr Thallon stated that the case for change was agreed in 2016 by the Programme Advisory Board (PAB) and the review process had identified a clinical model of a single inpatient centre in Kent & Medway supported by a number of spokes including an enhanced spoke unit. A Get It Right First Time (GIRFT) review in 2018, supported the case for change, and highlighted a number of key issues to be addressed including the introduction of a hub and spoke model, increased patient volumes and better outcomes.

(4) Dr Thallon explained that a clinical network had been established between EKHUFT and MFT and there was broad clinical agreement for the long-term arterial centre to located be in East Kent subject to public consultation.

However, the site of the arterial centre in East Kent would be determined by the outcome of the East Kent Transformation Programme, as it was recommended that vascular services should be co-located on the site of a major emergency centre, which was being modelled on a seven year plus timetable. A need for an interim solution for vascular services had therefore been identified due to the length of time for the long-term option to be implemented.

(5) Dr Thallon noted that the Vascular Network had four primary objectives which included shared multidisciplinary teams/meetings and a single on call rota. He reported that there had been some progress towards collaborative working but no progress on delivering a single on call rota and the future disposition of IR services. The Network had also been unable to reach an agreement on the preferred interim option and requested a commissioning decision. A review of the interim options, including both Trusts' submissions, was considered. A recommendation for the interim option to be located on the Kent & Canterbury Hospital (KCH) site was made due to better patient outcomes; better capacity in terms of bed and intensive care; minimal capital investment being required; and better workforce mitigations. Whilst the KCH site did not have an MEC, which was not in line with clinical best practice for vascular services, it had been agreed that it was not a critical limiting factor for an interim solution.

(6) Dr Thallon reported that MFT had raised safety concerns about non-elective procedures carried out by EKHUFT and the recommendation for the interim option to be located at KCH. Dr Thallon explained that the recommendation will go to NHS England Specialised Commissioning for a decision in principal; if approved, a business case would be developed and would address queries including finance and safety. He noted that formal consultation on the interim model may be required and welcomed the JHOSC's advice on this. The Chair stated that it was not for the Committee to provide advice or determine if public consultation was required. A number of comments were made about the Kent & Medway Stroke Review consultation and the importance of consultation being meaningful. Mr Ridgwell stated that the feedback from the Stroke Review was taken into consideration as part of the preferred option decision-making.

(7) Members enquired about workforce risks. Dr Thallon acknowledged that there were workforce issues and recognised that staff may be unwilling to move to KCH. He noted that the workforce mitigations by EKHUFT indicated that the Trust would be able to deal with workforce difficulties more successfully than MFT. He stated neither Trust met the requirements for a modern vascular service and the uncertainty about future provision both impacted on workforce; a number of surgeons were also coming up to retirement age. Ms Shutler noted that optimal configuration of service was important to recruitment. Dr Sulch highlighted that MFT had some pockets of success particularly in A&E by offering personal and professional development opportunities. Mr Ridgwell concluded by stating that workforce was one of the several key areas considered for the interim option which also included theatre and intensive care unit (ITU) capacity.

(8) Members asked about safety concerns. Dr Thallon explained that further work to understand MFT's concerns about safety was being undertaken. He noted

that both Trusts' submissions would be reviewed, as part of the due diligence process, for the business case. Dr Sulch reported that the two areas of concern for MFT were how the clinical pathways would operate with no consultant-led emergency department at KCH and how a single interventional radiologist (IR) rota that supports both vascular and non-vascular patients would work. Ms Shutler noted that whilst KCH did not have an A&E, it did have 24/7 medical cover and outcomes at KCH, under the existing arrangements, were good. She noted that the East Kent population had similar levels of health inequality and deprivation as Medway.

(9) Members commented about the colocation of vascular services with an MEC, the Clinical Senate's clinical co-adjacencies and the length of the process. Mr Ridgwell explained that the location of vascular services within a MEC was proposed in the long-term solution for Kent & Medway. A range of factors including workforce, theatre capacity and ITU were considered in forming the recommendation that the interim option would be best placed at KCH. He stated that neither EKHUFT or MFT were currently configured to meet the national service specification and achieve the best clinical outcomes. Dr Thallon explained that the Clinical Senate's co-adjacencies identified services that should, rather than must, be on the same site; the colocation of vascular services with an MEC was not an absolute requirement. Ms Shutler highlighted that both IR and ITU, two critical adjacencies which should be provided on the same site as vascular, were provided at KCH. Mr Ridgwell noted that an interim solution had been generated, as it was not appropriate for the current service to continue without recongfigutation, whilst the outcome of the East Kent Transformation Programme was implemented over the next 5 – 7 years. He suggested that the it might be more useful for the interim option to be called Stage 1 and the long-term option to be known as Stage 2.

(10) Members enquired about the GP's perspective and microsurgery for amputation. Dr Allingham explained that GPs understood that in order to achieve the best possible outcomes, a degree of centralisation was required. However centralisation resulted in patients and their families travelling greater distances and often required GPs to carry out follow-up work which created additional pressure on primary care services. Dr Madhavan confirmed that microsurgery was not used for patients who required amputation. He stated that he was in favour of centralisation but had reservations about the interim option recommendation and hoped that these concerns would be addressed. He reported that MFT was achieving the same mortality outcome as EKHUFT and highlighted that MFT had a complete on call vascular service and IR rota with no gaps for the past 12 years; He suggested that another Trust could be found to implement the long-term option within the next two-three years.

(11) In response to Dr Madhavan's suggestion that another Trust be found to implement a long-term option, Dr Thallon explained that the review had been a four-year process which had included a review of all options and the hub and spoke clinical model between EKHUFT and MFT was the only long-term option which would achieve compliance with the national specification and Vascular Service guidance. However, if significant information emerged, during the development of the business case, he committed that it would be reviewed and be brought back to the Committee.

(12) A Member enquired about engagement with clinicians. Dr Thallon explained that the process was supposed to be led by clinicians; as the Trusts were unable to reach agreement, a commissioning decision was requested to move the process forward. He stated that NHS England's preferred model was for the clinicians to work collaboratively on the review and this remained an option. Ms Windibank confirmed that significant time had been invested in setting up the clinical network including the establishment of a forum, with independent support, to accommodate conversation and dialogue between the Trusts and their staff.

(13) RESOLVED that

(a) the update report on the Kent & Medway Vascular Services Review be noted;

(b) the formal consultation plan on the interim model be shared with the Committee;

(c) the Committee receives an update on the business case including workforce, safety issues and the delivery of best practice.

8. Assistive Reproductive Technologies (ART) Policy Review

(Item 7)

Stuart Jeffery (Deputy Managing Director and Chief Operating Officer, NHS Medway CCG) and Michael Griffiths (Partnership Commissioning Programme Lead – Children and Families, Medway Council and NHS Medway CCG) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee and noted that an additional report has been added to the agenda, via a supplement, as she had agreed that it should be considered at this meeting as a matter of urgency, as permitted under section 100B of the Local Government Act 1972; this was to enable the Committee to consider the East Kent CCGs' position statement which was not available for despatch as part of the main agenda on 4 October 2018.

(2) Mr Jeffrey began by providing an update about the progress of the review since presenting to the Kent HOSC and Medway HASC in January 2018; he noted that the initial timetable was running significantly behind schedule. He stated that there was currently a single schedule of policies in Kent & Medway relating to Assistive Reproductive Technologies (ART) services which included two cycles of IVF for eligible patients. He reported that NHS Dartford, Gravesham & Swanley CCG and NHS Swale CCG had started pre-consultation engagement on IVF cycles, NHS West Kent CCG was about to begin, and NHS Medway CCG had concluded this stage of work. He highlighted that the East Kent CCGs had decided not to participate in the review relating to the reduction in IVF cycles as they had other priorities in relation to hospital reconfiguration in East Kent. He noted that whilst NHS Medway CCG was the lead commissioner for ART services, each CCG was independent and there was a risk that different policies could be created across Kent & Medway. In relation to donated genetic material (DGM), all Kent & Medway CCGs were supportive of the review to establish the inclusion of

DGM in the ART schedule of policies. He explained that a meeting had been held earlier in the week and there were still a few issues to resolve before CCG agreement which was expected within the next couple of months.

(3) Members enquired about the use of a new technology to reduce the costs of ART and pre-conception advice. Mr Jeffery stated that he was not aware of the new technology being referred too but would look into it. He reported that comments about pre-conception advice had been highlighted in the pre-consultation engagement phase and would be taken forward with the Commissioning Support Unit. Mr Griffiths added that the STP Prevention Group was considering a study of 1000 women in relation to pre-conception.

(4) Members expressed concerns about the potential for different levels of provision for couples seeking IVF in Kent & Medway and welcomed the inclusion of the use of DGM. In response to a question relating to achieving a unified CCG position, Mr Jeffery noted that there was currently different level of provision across England. As lead commissioner, he stated that his preference would be for a unified decision. He reported that he was continuing to have conversations with East Kent about the policy review and there was the potential for it to be brought back together.

(5) Members asked about NICE full cycles of IVF and success rates of IVF cycles. Mr Griffiths explained that NICE defined a full cycle of IVF as one fresh cycle and an undefined number of subsequent frozen cycles; the current provision in Kent & Medway was not deemed to be a full cycle as patients were only entitled to one fresh IVF and one frozen embryo transfer per cycle. Mr Jeffery committed to providing the Committee with a briefing note about cycles. Mr Jeffery stated that the average rate of a live birth was 32% after one cycle and 49% after two cycles. He confirmed that measures such as pre-conception skills to improve the success rate of the first cycle were being considered.

(6) The Chair enquired if the review of IVF cycles was worth continuing given the creation of different provision across Kent & Medway, the relatively small financial savings and the impact that the change would have on the mental health of couples seeking IVF cycles. Mr Jeffery noted that savings were required across Kent & Medway and the East Kent CCGs' decision would be taken into consideration before moving to the next phase. In response to a specific question about re-consulting the remaining CCGs following the East Kent CCGs' decision, Mr Jeffery confirmed that the CCGs had not been formally notified but would be at their next Governing Body meetings.

(7) The Chair invited Dr Allingham to provide a GP's perspective. Dr Allingham stated that GPs were not supportive of different levels of provision particularly in areas close to boundaries. He noted that whilst GPs would support individual funding requests if it was in the patient's best interest, he noted that they were time consuming and were often not successful.

(8) RESOLVED that:

(a) the report on Assistive Reproductive Technology Services policy review be noted;

(b) the Committee expresses grave concerns about the potential for different levels of provision for IVF cycles across Kent & Medway and requests that NHS Dartford, Gravesham & Swanley CCG, NHS Medway CCG, NHS Swale CCG and NHS West Kent CCG, in light of those concerns, reconsider their decision to continue with the review of IVF cycles.

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