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 St George's Centre - St George's Centre on Tuesday, 10 September 2019.

PRESENT: Mrs S Chandler (Deputy Chair), Cllr D Wildey (Chair), Cllr B Kemp, Cllr T Murray, Cllr W Purdy, Mr D S Daley and Mr K Pugh

IN ATTENDANCE: Mr J Pitt (Democratic Services Officer, Medway Council), Mr T Godfrey (Scrutiny Research Officer), Mrs K Goldsmith (Research Officer - Overview and Scrutiny) and Whiting (Consultant in Public Health, Medway Council)

UNRESTRICTED ITEMS

9. Membership
(Item 1)

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

10. Apologies and Substitutes
(Item 2)

Apologies were received from Mr Bartlett.

11. Election of Chair
(Item 3)

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

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

12. Election of Vice-Chair
(Item 4)

(1) Mr Pugh proposed and Mr Daley seconded that Mrs Chandler be elected as Vice-Chair of the Committee.

(2) RESOLVED that Mrs Chandler be elected as Vice-Chair of the Committee.

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

There were no declarations of interest.

14. Minutes from the meeting held on 12 October 2018
(Item 6)

RESOLVED that the Minutes of the meeting held on 12 October 2018 are correctly recorded and that they be signed by the Chair.

15. Assistive Reproductive Technologies (ART) Policy Review
(Item 8)

Stuart Jeffery (Deputy Managing Director, NHS Medway Clinical Commissioning Group) and Michael Griffiths (Programme Lead, Children and Families, NHS Medway Clinical Commissioning Group) were in attendance for this item.

(1) The Chair explained that as he anticipated that the discussion in relation to this item would be relatively short, he had decided to vary the order of the Agenda and take this as the first substantive item of the Agenda.

(2) NHS representatives explained that the consultation previously discussed with the Committee was on hold. There were several barriers to further progression. However, the need to make certain changes had been flagged up and Kent and Medway was now in line with the law and the rest of the country.

(3) In response to a question it was clarified that the IVF offer across Kent and Medway was the same. It was further explained that the contract was out of date so on behalf of all the Kent and Medway CCGs, NHS Medway was moving ahead with a procurement on the basis of the existing policy. This was not expected to change as the CCGs moved to becoming a single CCG.

(4) In discussion with Members, it was explained that demand for ART had remained steady over recent years, but changes have meant new groups, such as same-sex couples, have become eligible and this may increase demand. It was also established that once the CCGs were ready to progress, the normal consultation and engagement process would be followed.

(5) RESOLVED that the report be noted.

16. Kent and Medway Specialist Vascular Services Review
(Item 7)

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 (EKHUFT)), Fiona Hughes (NHS England and NHS Improvement - Specialised Commissioning), Dr David Sulch, Interim Medical Director, Medway NHS Foundation Trust), Liz Shutler (Deputy CEO for EKHUFT and

Executive Lead for Programme), and Dr Noel Wilson (Consultant Vascular Surgeon, EKHUFT) were in attendance for this item.

(1) The Chair introduced the topic and expressed concerns that there did not seem to have been much detail in the report as to what progress had been made since the last time the Committee met to discuss this topic almost a year ago previously and that information requested at this previous meeting had not been provided.

(2) In providing an introductory overview on behalf of the NHS, Fiona Hughes said that she appreciated that there had not been an update in the interim period and that the focus of NHS Specialised Commissioning was the need to reinvigorate the process.

(3) NHS representatives then proceeded to provide the background. In 2012, the Vascular Society produced service specifications for the UK. These were revised in 2015 and updated in 2018. The core feature was that as a result of the clinical complexity and population demand, there needed to be a centralisation of high-risk care. A single arterial centre (the 'hub') would need to be established with other hospitals in the geographical areas delivering non-arterial services; these hospitals would be the 'spokes' in the proposed vascular networks. The overriding difference between the hub and spokes is that the former would be the only one with inpatient beds so that patients requiring a bed would be directed there. This applied to both planned and unplanned care. Other care would be delivered closer to home with day case and outpatients still being delivered at local hospitals along with diagnostics.

(4) Moving on to the service standards for vascular work, it was explained that these were very clear and covered the volumes of activity, timelines for interventions, and the need for equitable service across the network.

(5) On the geographical spread of the network, it was explained that patients seen at Tunbridge Wells and Darent Valley Hospitals had a patient pathway that directed them to St. Thomas' in London for specialist work.

(6) Clinical representatives explained that vascular surgical work mainly focused on three areas – aortic aneurysms, peripheral vascular disease, and carotid endarterectomy.

(7) Several comments and questions from Members referred to the recent proposals for acute and hyper acute stroke services and the connections and comparisons with vascular services. It was explained that while vascular disease covered a broader range of conditions, including cardiac care and dementia, the total amount of inpatient care and vascular surgery (planned and unplanned) was around a third the number of stroke patients. This meant fewer consultants were needed and a single hub. The only surgical

intervention that was of direct relevance to stroke care was carotid endarterectomy. No more than 1 in 10 stroke patients would require this and it was important to ensure this was a high-quality service with consultants carrying out a sufficient volume of this procedure. Medway Foundation Trust did not see a high enough volume of cases to continue as a standalone vascular centre, whereas Kent and Canterbury Hospital did.

(8) Members asked a range of questions covering changes since the case for change in 2015. Specific concerns were raised about travel times and workforce. Particular reference was made to safety concerns that had been raised by staff at Medway Foundation Trust at the previous meeting. One of the causes for concern was that Kent and Canterbury did not have an accident and emergency (A&E) department.

(9) NHS representatives explained that it was not that unusual for there not to be an A&E department on the same site. There were advantages to not having one on the same site as other disciplines would not squeeze the vascular service by taking up theatre time and beds. There were, however, other concerns relating to support services. Vascular patients often have co-morbidities. Doctors David Sulch and Paul Stevens had carried out a review in January of this year. 8 patients were considered in multi-disciplinary meetings and assurances were produced that good support and medical care was available, with critical care being particularly strong. There were no concerns about the support on site. The number of patients covered by the hub and spoke network would be 800,000 and 6 consultants were needed to cover this population. There were the 8.5 full-time equivalents available.

(10) Interventional radiology was also discussed. This was a complicated area as half of the interventional radiology work at Medway was non-vascular, this service would need to be located and available there still. As there were 7 interventional radiologists in Kent, with 3 in East Kent, there may be a need to restructure. Six were needed for a rota and the local NHS were looking to recruit.

(11) Overall, the views of the team at Medway were deemed as having undergone a ‘sea change’. Where there was once uncertainty about the need for change, there was now a desire to get on with the changes and end the uncertainty, which impacted recruitment. It was explained that the working practices for doctors and nurses needed clarifying and the formal staff consultation needed to be undergone. The view of NHS representatives was that the majority were willing to move.

(12) There was no upper time limit on travel times but as 2/3 of the inpatient work related to residents of East Kent, locating the hub at Canterbury had the least impact on travel times. Depending on commissioning decisions and patient choice, there could be increased patient flow from Tunbridge Wells and Darent

Valley in the future. Evidence from rural areas suggested travelling around an hour did not affect the patient outcomes. Travel times were only an issue in an emergency situation, and these tended to be for haemorrhages, ruptured aneurysms and limb threatening events. Due to screening, ruptured aneurysms were declining. Currently Medway saw one vascular emergency case per day.

(13) Concerns were raised about the financial impact on Medway Hospital and the erosion of facilities and services there, particularly in view of the prevalence of health inequalities in Medway. The suitability of Kent and Canterbury Hospital to host a vascular hub was also questioned. It was explained that vascular services were not profitable and risk sharing would need careful consideration.

(14) NHS representatives went on to explain that rather than an A&E department, the important elements to have on the site of the hub were an intensive care unit, theatre, and renal dialysis. Kent and Canterbury had all three. Inpatient renal dialysis had been centralised at Kent and Canterbury since at least 1995. There was often a clinical need to continue renal and kidney dialysis during vascular inpatient treatment and this was available at Canterbury. A lot of work had been spent on developing the right patient pathways and on arriving at hospital, vascular patients did not go to A&E but went direct to the service. The NHS representatives advised that it was anticipated that a hub at Kent and Canterbury would be operational from spring 2020.

(15) In response to questions from Members, information was provided on the screening programme and NHS representatives undertook to provide a link to the criteria for screening to Officers for circulation to Committee Members. In sum, across the whole of Kent and Medway, all men were invited to an ultrasound during their 65th birthday year. These tests were delivered at 36 venues across the area. Men were 6-7 times more likely to be affected but there were pathways in place to identify high risk women and others who may need to be screened. Around 11,000 were invited each year and Kent and Medway had one of the highest uptakes in the country at 84%. Three outcomes from the screening were possible – a normal aorta; a problem diagnosed to be monitored; and a consultant referral. 30-35 patients a year needed surgery as a result of this screening. Kent and Canterbury treated these patients.

(16) Several comments were made that the word ‘interim’ was misleading when the proposed service change would last 5-10 years, and this was accepted by the NHS. Investment was not affected by use of the word.

(17) The NHS clarified that they were carrying on with a process of engagement, rather than a consultation with several options. Three events were being arranged and 200 letters had been sent to service users, and 117 calls had been made. There was also an online survey.

(18) The NHS also explained that they had learnt from the experience of the stroke review to project population numbers forwards, particularly in the context of an ageing population which would be at higher risk of aneurysms. The Chair asked for a heat map to be able to track patient movements. It was confirmed that this was being produced and the request was made for this to be shared as soon as possible and to be provided as part of the next meeting on this issue.

(19) Several requests were made regarding information to be provided to the Committee for its next meeting: a written report on any engagement/consultation activities, including a geographic breakdown of this activity; more information on renal and interventional radiology services; data on where patients came from as well as where they were treated, and what numbers of patients came from areas of deprivation; more information on the timetable for change; and information on prevention.

(20) RESOLVED that:

(a) the Committee has considered the report and that it be noted, and

(b) that the NHS be invited to return to the Committee at a time to be determined with the information requested.