KENT COUNTY COUNCIL

KENT AND MEDWAY STROKE REVIEW JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee held in the Council Chamber - Sessions House on Wednesday, 5 September 2018.

PRESENT: Mrs S Chandler (Chair), Cllr D Wildey (Vice-Chairman), Mr P Bartlett, Ida Linfield, Cllr T Murray, Cllr W Purdy, Cllr D Royle, Cllr C Belsey, Cllr R Diment and Cllr A Downing

ALSO PRESENT:

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer), Mr J Pitt (Democratic Services Officer, Medway Council) and Claire Lee

UNRESTRICTED ITEMS

6. Substitutes
(Item 1)

(1) Apologies were received from Mr Pugh and Cllr Howell.

7. Declarations of Interests by Members in items on the Agenda for this meeting
(Item 2)

(1) There were no declarations of interest.

8. Minutes
(Item 3)

(1) The Chair explained that the minutes would be brought back to the next meeting of the Committee for approval, to enable a query to be resolved.

9. Kent and Medway Stroke Review: Update
(Item 4)

*Patricia Davies (Senior Responsible Officer, Kent & Medway Stroke Review), Rachel Jones (*Acute Strategy Programme Director, Kent & Medway STP*), Alice Caines (Principal, Carnall Farrar), Ellie Davies (Senior Analyst, Carnall Farrrar) and Steph Hood (STP Communications and Engagement Lead, Kent & Medway STP) were in attendance for this item.*

(1) The Chair stated that an updated report had 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 updated report which was not available for despatch as part of the main agenda on 28 August 2018 as it required the approval of an NHS Committee taking place on the same day. She noted the updated document replaced the NHS report in the original Agenda pack.

(2) The Chair welcomed the guests to the Committee. Ms Davies began by giving an overview of the review process to date including the development of the case for change and model of care; engagement with stakeholders; the development of the five three-site options and pre-consultation business case (PCBC) and the delivery of the public consultation; she advised that the Joint Committee of Clinical Commissioning Groups (JCCCGs) had reviewed and considered the outputs from the public consultation and was now working towards the application of the evaluation criteria to identify the preferred option and the development of the decision making business case (DMBC).

(3) The Chair advised that the item would be taken in three parts: travel times, evaluation criteria and model for community rehabilitation.

Travel Times

(4) Ms E Davies introduced the additional information on travel times, as requested by the Committee at its previous meeting, and proceeded to give a presentation (attached as a supplement to the Agenda pack, pp. 6 – 15) which covered the data source used; the approach to travel time modelling; validation exercises; evaluation criteria and a deep dive into travel times for Thanet. She highlighted the following key points:

- the data had been refreshed using 2017/18 average travel times;
- the use of car off-peak travel data as the blue light proxy had been agreed as the most appropriate measure with SECAmb;
- the maximum travel time from any location was 63 minutes.

(5) Members enquired about thrombolysis eligibility and benefits of stroke centralisation. Ms P Davies explained that there were two main types of stroke: clot and bleed. 70 – 80% of patients experienced a stroke as a result of a clot; of those patients, only 15 – 20% were eligible for thrombolysis. She noted that thrombolysis was not appropriate for a bleed stroke. She confirmed that a target of 120-minute call to needle time for patients had been set on the advice of the South East Coast Clinical Senate. Ms P Davies highlighted a UCL study, which reviewed reconfigured stroke services in London and Greater Manchester; it had found that the centralisation of stroke services reduced death and disability for the whole population.

(6) A Member expressed concerns about population growth and the impact on travel times from additional cars on the road. Ms P Davies explained that throughout the review, extensive work had been undertaken with local authorities with regards to population growth and this had been factored into the total resource required. Ms E Davies noted that work had been undertaken with the public health teams in Kent & Medway to look at increased car activity in relation to new housing developments and the mitigations put in place; there was no evidence for additional time to be added to the travel time from growth areas. Ms Jones stated as part of the methodology, baseline data from consecutive years had been used;

for ambulances, additional cars on the road, did not make a difference as they were able to use blue lights. She highlighted that despite population growth, the number of strokes were flatlining due to prevention measures. The Chair enquired about the involvement of SECAmb in the development of travel times. Ms P Davies explained that SECAmb had been involved in the process and their isochrone data had been cross-referenced with the Basemap data. She recognised that whilst there may occasionally be delays due to traffic, the creation of HASUs would enable paramedics to carry out an initial assessment and ring ahead to the HASU to prepare them and admit the patient directly, rather than attending A&E which would create a significant time saving.

(7) A Member asked about engagement with the London Ambulance Service (LAS) and the impact of HASUs in London if Darent Valley Hospital was not chosen as a HASU site. Ms Caines confirmed that there had been engagement with LAS who supported the use of car off-peak travel times as the blue light proxy; it was recognised that the closer to London, the slower the travel time. Ms P Davies stated that South East London patients could access a London HASU within 45 minutes and if Darent Valley was not chosen, it would not have a detrimental affect on South East London patients. She explained that there had been extensive discussions with the Princess Royal University Hospital (PRUH). She reported that PRUH was able to provide stroke services to the South East London patients but was concerned about additional patients from Kent if Darent Valley was not chosen as an option. She noted that 54 patients from South East London a year were taken to Darent Valley Hospital; they had been assessed by paramedics as not requiring a London HASU.

(8) Members enquired about the use of periphery hospitals such as Basildon Hospital in the data set, traffic flow being faster in peak periods and the percentages of population accessing sites within 30 and 45 minutes by private car. Ms E Davies explained that the data set had initially been over procured and had therefore included periphery sites. She confirmed that Basildon Hospital was not the first, second or third closest hospital for patients in the Kent & Medway catchment area. Ms E Davies reported that in a few cases, the data showed that traffic flow was faster in peak periods. She explained that Basemap data showed flows both ways, so it was unable to differentiate the flow each way; she gave the example of faster traffic flow coming out of London than going into London. Ms E Davies stated that private peak travel times had been run following the publication of the paper and had not been included. She confirmed that the percentages for 45-minute travel time by private car were similar to the blue light proxy; the percentages were lower for the 30-minute travel time, fewer patients would be access a site within 30 minutes by private car. Ms Davies stated it was safest for patients to be conveyed by ambulance if a stroke was suspected and public messaging supported this.

(9) In response to a specific question about accuracy of the data following an increase in the percentage of the population accessing sites within a 45-minute travel time by blue light proxy in Option E from 91.9% in the consultation document to 98.9% in the updated report; and the use of revised data, Ms E Davies explained that there had been a consultation commitment to refresh the data to ensure accuracy prior to option evaluation. She committed to rechecking all the travel times and sending the revised travel times for blue light proxy and private car to the Committee prior to the JCCCG Options Evaluation on 13 September 2018.

(10) A Member asked about stroke diagnosis. Ms P Davies explained that the 999-triage process was able to identify potential strokes however diagnosis was not definitive until a CT scan had been undertaken. She noted that stroke mimics had been built into the model of care in terms of beds and attendances. She reported that centralisation of services into HASUs in London had demonstrated that those units were effective in identifying those who had experienced a stroke and screened out patients who had had a mimic.

(11) A Member commented about the length of the process and the importance of a decision being made by the JCCCG. The Chair read a statement from Ms Constantine, KCC Member for Ramsgate, regarding travel times; a petition in Thanet, signed by 5000 people, stated that a 120-minute door to needle time was too long and did not have the confidence of the public. Ms P Davies highlighted that the 120-minute target for thrombolysis was for call to needle time and had been set by the South East Coast Clinical Senate. She noted only 15% of stroke patients were eligible for thrombolysis and the first 72 hours in a HASU was the most important aspect of care. She stated that whilst thrombolysis was licenced for 4 hours, it could be administered beyond this time if appropriate.

Evaluation Criteria

(12) Ms Jones gave a presentation on the evaluation criteria being used to identify the preferred option on 13 September by the JCCCG (attached as a supplement to the Agenda pack, pp. 16 – 36) which covered the original and additional evaluation principles; the development and agreement of the quality, access, workforce, ability to deliver, affordability and value for money criteria.

(13) She highlighted the following key points:

- The evaluation criteria used within the PCBC would be applied to maintain consistency; additional criteria had only been added as a result of the consultation or a change to national policy.
- The options would be evaluated rather than scored; the preferred option would not be identified by a mathematical score.
- Mechanical thrombectomy was not currently provided in Kent & Medway; new national stroke guidance about the provision of this procedure was anticipated.
- The national recommendation for patient volume at a HASU was expected to rise from 500 – 1500 to 600 – 1500 patients; the revised stroke guidance had been delayed.
- The Deliverability Panel met on 4 September 2018. The panel included Regional Director (South East) for NHS England & NHS Improvement, NHS England Medical Director (Kent, Surrey & Sussex), an external stroke consultant and a patient representative.

(14) Members enquired about the national shortage of interventional radiologists, the impact of health inequalities on stroke incidences and workforce gaps. Ms P Davies noted that workforce was a national issue particularly for technical staff. She stated that Kent & Medway would benefit from the opening of the new medical school. She reported that evidence showed that areas which had implemented centres of excellence providing specialist services had improved their ability to recruit and retain staff. She noted that a piece of work, looking at how to retain staff, was being undertaking by the HR directors, chief nurses and medical directors of the acute trusts. Ms Caines explained that the level of deprivation for each Lower Layer Super Output Area (LSOA), based on Lower

Index of Multiple Deprivation (IMD), combined with the over 75 population was used as an accurate indicator of future stroke incidences. Ms P Davies noted that a Prevention Strategy Group, which included the Directors of Public Health from Kent County Council and Medway Council, were looking at stroke risk factors such as hypertension and stroke prevention strategies such as reducing diabetes and obesity. Ms Jones confirmed that the workforce gap was calculated by comparing best practice requirements to staff in post.

(15) Members asked about the application of the same rating if two sites were within 5% of each other with regards to travel time percentages; ranking feedback from public consultation; and outcome of deliverability panel. Ms E Davies explained that the same rating would be applied if two values, rather than percentages, were within 5% of each other; the example of a 5% difference in capital costs was given. Ms P Davies stated that respondents to the public consultation were asked to rank the five options in preference order; whilst option D was the highest ranked in this process, there was a very small percentage difference between the five options, so respondents' ranked feedback had not been included as an evaluation criteria. Ms Jones confirmed that each evaluation criteria had equal weighting. Ms P Davies applauded the time and effort put in by all providers who presented at the Deliverability Panel. Providing verbal feedback to each provider was underway and Ms P Davies stated that she was unable to provide further feedback at this time; she highlighted that this was one aspect of the evaluation process. She noted that the Deliverability Panel had been independently chaired by Anne Eden (Regional Director (South East), NHS England & NHS Improvement).

(16) In response to specific questions about capital investment, Ms P Davies explained that as part of the PCBC development, a need for a £38 million investment had been identified which had subsequently been agreed by NHS England Investment Committee as the maximum envelope. She noted that if additional capital was identified through the DMBC, it would require the JCCCG to go back to the Investment Committee for approval. Ms Caines stated that all sources of capital were being explored. She noted that whilst NHS Trusts did have access to small provisions of capital, each Trust would need to complete a business case to demonstrate that it was a priority area and complied with Treasury guidance. Ms P Davies explained that the methodology to use £38 million as a midpoint for the evaluation criteria was on the advice of the Chief Finance Officer Group; whilst the capital envelope was recognised, it was considered important not to retrofit services to capital size.

(17) Members enquired about the three evaluation scores for travel times and the use of a 10-year Net Present Value (NPV). Ms Caines explained that the three evaluation scores had been identified as part of the PCBC. However, since the development of the paper, there had been a proposal to change the double negative score to a neutral score so that there was not such an extreme differentiation between the options. Ms P Davies stated that a 10-year NPV was used as it gave a greater indication of the economic and patient benefit in terms of reduced mortality and disability which impacted on health and social care costs. Ms Caines noted that the NPV was normally calculated over 20 years; NPV had been calculated for both 10 & 20 years but a 10-year measure had been chosen on the advice of the Finance Group as it was easier to differentiate between options over 10 years in terms of patient and economic benefit.

Model for Community Rehabilitation

(18) Ms P Davies began by noting that rehabilitation was highlighted as an area of focus by the Committee at its previous meeting. She reported that this view was shared by the Stroke Programme Board and Clinical Reference Group; a clear pathway for rehabilitation which runs in parallel to the stroke service and introduced at the same time was required. She stated that the rehabilitation sub-group was chaired by Fiona Lloyd Davies, the wife of a stroke survivor who had produced a BBC documentary detailing her husband's recovery. The proposed pathway, based on the South East Coast Clinical Network Model, was due to be signed off by the Clinical Reference Group on 7 September.

(19) A Member requested greater member input into the proposed model for rehabilitation pathway in Kent & Medway. Ms P Davies stated that she would welcome member input; once the model of care had been agreed by the Clinical Reference Group it would be subject to appropriate consultation with a range of stakeholder including the Kent HOSC and Medway HASC.

(20) Members enquired about rehabilitation services for patients who lived alone and in over-the-border areas. For patients who lived alone, Ms Davies highlighted the important of multifaceted services including the provision of health and social care. For patients in over-the-border areas, Ms P Davies confirmed that there were no plans to change rehabilitation services in East Sussex and Bexley.

(21) The Chair enquired about the ability of members of the public to input the process prior to the final decision being made in January 2019. She also read a statement from Ms Constantine, KCC Member for Ramsgate, regarding meaningful and ongoing communication and consultation with Thanet residents. Ms Hood explained that there was an ongoing communication and engagement programme which would communicate information at key points such as the identification of the preferred option. She stated that there would be good patient and public engagement in design of the rehabilitation pathway.

(22) RESOLVED that:

(a) the updated report be noted

(b) the following comments be referred to the JCCCG:

(i) the Stroke JHOSC requests that the travel times are checked for accuracy prior to their application at the Options Evaluation on 13 September 2018;

(ii) the Stroke JHOSC requests that the JCCCG takes into account population growth and the impact of additional cars on travel times;

(iii) the Stroke JHOSC requests that there be further stakeholder engagement with regards to the proposed model for community rehabilitation.