KENT AND MEDWAY STROKE REVIEW JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 26th February, 2019

9.30 am

Council Chamber - Sessions House, Maidstone, Kent, ME14 1XQ

AGENDA

KENT AND MEDWAY STROKE REVIEW JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 26th February, 2019, at 9.30 am
Council Chamber - Sessions House

Ask for: **Jill Kennedy-Smith**
Telephone: **03000 416343**

Tea/coffee will be available 15 minutes before the start of the meeting

Membership

Kent County Council (4)	Mr P Bartlett, Mrs S Chandler, Ida Linfield, Mr K Pugh
Medway Council (4)	Cllr T Murray, Cllr W Purdy, Cllr D Royle, Cllr D Wildey
East Sussex County Council (2)	Cllr C Belsey, Cllr J Howell
Bexley Council (2)	Cllr R Diment, Cllr A Downing

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item

1. Substitutes

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

3. Minutes (Pages 5 - 24)

4. Kent and Medway Stroke Review (Pages 25 - 116)

- Draft JCCCG Minutes – 14 February 2019 (pages 33 – 43)
- JCCCG Meeting Pack – 14 February 2019 (pages 45 – 99)
- Response to JHOSC Feedback (pages 101 – 108)
- Review of Growth Assumptions in the DMBC (pages 109 – 115)

The Decision-Making Business Case was included in the previous agenda pack.

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

18 February 2019

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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 Friday, 1 February 2019.

PRESENT: Mrs S Chandler (Chair), Cllr D Wildey (Vice-Chairman), Mr P Bartlett, Ida Linfield, Mr K Pugh, Cllr T Murray, Cllr W Purdy, Cllr D Royle, Cllr J Howell, Cllr A Davies (Substitute), Cllr R Diment and Cllr A Downing

ALSO PRESENT: Mrs L Game, Ms K Constantine, Mr J Gilbert (Enodatio Consulting Ltd.)

IN ATTENDANCE: Mr T Godfrey (Scrutiny Research Officer), Mrs J Kennedy-Smith (Scrutiny Research Officer), Ms J Keith (Head of Democratic Services, Medway Council), Mr J Williams (Director of Public Health - Medway Council), Mr J Pitt (Democratic Services Officer, Medway Council) and Ms L Peek (Principal Scrutiny Officer, Bexley Council)

UNRESTRICTED ITEMS

15. Substitutes
(Item 1)

(1) Apologies were received from Cllr Belsey, who was substituted by Cllr Davies.

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

(1) There were no declarations of interest.

17. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 14 December 2018 are correctly recorded and that they be signed by the Chair.

18. Kent and Medway Stroke Review
(Item 4)

Rachel Jones (Senior Responsible Officer, Kent and Medway Stroke Review), James Pavey (Regional Operations Manager, South East Coast Ambulance NHS Foundation Trust (SECAmb)), Glenn Douglas (Accountable Officer, Kent and Medway CCGs) Dr David Sulch (Medical Director, Medway NHS Foundation Trust & Stroke Physician) and Dr Stephen Fenlon (Medical Director, Dartford and Gravesham NHS Trust) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. The Chair acknowledged receipt of a letter that had been circulated directly to JHOSC Members from Save Our NHS in Kent (SONIK) and a separate letter from Craig Mackinlay MP. The Chair informed the Committee that a supplementary paper had been circulated that morning, as requested by Medway Council and the meeting was adjourned to allow time to consider the paper.

(2) Following the adjournment, the Chair reminded Members that this meeting would be the last meeting prior to the Joint Committee of Clinical Commissioning Groups (JCCCG) on 14 February 2019. The Chair confirmed that another meeting of the JHOSC would then take place to consider formally the outcome of the JCCCG meeting.

(3) Two Kent County Councillors, Mrs Game and Ms Constantine, had made a formal request to deliver statements to the Committee. The Chair had given her agreement and the statements were delivered.

(4) Mrs Game informed that the Committee that during the consultation period all options being considered were rejected by Thanet and Thanet District Council. She believed that residents of Thanet were being treated unfairly and were not being listened to. Mrs Game raised concerns about population forecasts in Thanet in comparison to Ashford, disproportionate travel distances and peak periods of travel particularly as Thanet was a tourist destination, a factor which she believed had not been taken into consideration. She continued that health service staff recruitment was difficult in the Thanet area and that the introduction of a state-of-the-art centre of excellence would increase levels of staff interest in the area as a result. Mrs Game emphasised that the NHS consultation stated that it had a duty to bring life improvements and increase health expectancy and that Thanet would fall short of these requirements in the preferred option. She said that the preferred option placed two units in west Kent and close to London centres of excellence and that there would be a disparity in service across the County. Mrs Game concluded that the residents of east Kent should be given the same life chances as other areas in the County and that consideration should be given to a fourth Hyper Acute Stroke Unit (HASU) at the Queen Elizabeth The Queen Mother Hospital (QEQM).

(5) Ms Constantine informed the Committee that she concurred with Mrs Game. She emphasised that the call to needle time was of great concern to the people of Thanet, questioned the Decision-Making Business Case's (DMBC) travel data and was concerned that this placed people close to the 'danger zone'. She said that she had met with many residents and the vast

majority, including the local councillors and MP were not behind the proposal. Ms Constantine continued that residents of Thanet were concerned about the NHS generally and emphasised that recent reports had cited Thanet was as one of the worst places in the country with regard to GP access. She stated that Thanet should have been a consideration at the beginning of the process and raised concerns about valuable staff being lost at the QEQM. She concluded with a request that the Committee do not agree with the stroke review proposal and ask that the plans be reconsidered.

(6) Cllr Wildey referred to the supplementary report and requested that Mr Gilbert, an external expert commissioned by Medway Council address the Committee and briefly highlight the key points from the report referred to in (1).

(7) The Chair welcomed Mr Gilbert to the Committee and invited him to speak. Mr Gilbert thanked Ms Jones for addressing some of the concerns raised at a previous meeting within the DMBC but highlighted three significant reasons that he believed Option B, the NHS preferred option, was not in the best interests of the residents of Kent and Medway. He highlighted the following views from his report:

- Bed capacity – due to a predicted increase in stroke admissions up to 2040/41 there would be a requirement for more beds but mitigations in a shorter term of 5/10 years by the rehabilitation business case focused on seeing length of stay reduce. Against a backdrop of demand from South East London residents currently seen at the Princess Royal University Hospital (PRUH), a shift of 8 beds into Darent Valley Hospital, consideration should be given as to whether this was a good use of capacity for the residents of Kent and Medway. All Bexley resident stroke patients currently seen at the PRUH or Darent Valley would be seen at a Kent and Medway hospital.
- Areas of higher deprivation – all options will improve outcomes for all patients regardless of where they live. The NHS 10-Year Plan makes a commitment to reducing inequalities and action on health inequalities will be central to everything that the NHS does. The preferred option achieves the exact opposite. The services should be targeted to those who need it most and that the placement of HASUs, within the preferred option, does not place services in the areas of greatest need. Within the consultation, concerns were expressed about travel times and deprivation. The statement in the DMBC that residents from areas of higher deprivation would disproportionately benefit was questioned as this would necessitate them being given priority upon arrival at a HASU.
- Evaluation Process – the process was flawed, and the evaluation criteria should not have been changed without good reason. In some instances, there was good reason to do this but, in some areas, good reasons were lacking. Priority order was repeatedly stripped away even though quality and access were a key point of concern for

consultation respondents. A key question was whether all options were competing on a level playing field and if not, whether this called into question the preferred option selection.

(8) Mr Gilbert believed that the preferred option, 'Option B' was not in the best interests of the residents of Kent and Medway and 'Option D' would be a better alternative. He said the reasoning behind this was demonstrated in the reports commissioned from him by Medway Council and provided to the Committee.

(9) A Member enquired if Mr Gilbert could answer questions on his report. The Chair highlighted that this would be possible once the NHS had delivered their report.

(10) The Chair invited the NHS to summarise any key points from the DMBC. Ms Jones began by informing the Committee that three things had been changed and amended since their last attendance. She referred to incidence and increase in demand, which were concerns for the Committee and the South East Clinical Senate. Medway Council's Public Health Intelligence Unit supported the review with the now concluded report. She said the report set out the mitigations – a reduction in length of stay which had been evidenced in other parts of the country where this has been implemented and a recognition of the requirement for increased bed capacity that may need to be available. Ms Jones clarified that these went in to the three Trust Business Cases with the beds confirmed by the Trust Boards and should they be required they can be delivered – 14 at Darent Valley Hospital, 4 in Maidstone and 4 in East Kent Hospitals.

(11) Ms Jones referred to concerns raised about inequity of the two-phase implementation and following a review by the Stroke Programme Board this remained the clinical preference for reasons of patient safety. Ms Jones emphasised that they had referenced in the DMBC that this was a clinical preference and that there would be opportunity for a much wider stakeholder engagement that would take place once the next phase is reached. She said she would welcome the Committee being involved in that conversation.

(12) Ms Jones highlighted workforce gaps and said that they had strengthened recruitment planning proposals following previous expressions of concern by the Committee.

(13) Some Members expressed concern at the impact on areas of deprivation and how it would address health inequalities. Members questioned the DMBC's ability to reduce inequalities and did not accept the assertions contained within the document on how to achieve that. A Member did not accept the claim that stroke patients from the most deprived areas would disproportionately benefit compared to patients from less deprived areas and wondered if coming from a deprived area could be taken into account when determining the order of being seen at a HASU.

(14) Ms Jones referred to the profile of the current facilities sited in areas of high levels of deprivation and stated that they have a poor profile of performance. She highlighted that two areas are 'D' and 'E' rated - which is the worst rating in the country - with another area performing at a 'B'. She said that that therefore meant a differential service currently existed in Kent and Medway and emphasised that this played a fundamental part of the Case for Change. Mr Douglas said that they were passionate about the need to provide a service for Kent and Medway and that there was a need for HASUs. He agreed that differentials in service were a bad thing but if the system worked together it would benefit everyone.

(15) Dr Sulch said that the disproportionate benefit was largely related to the current situation where patients in most deprived areas are receiving the worst service in comparison to other parts of Kent and Medway. He highlighted that Medway Maritime Hospital currently had a Sentinel Stroke National Audit Programme (SSNAP) rating of 'E', which meant that according to the Getting it Right First Time (GIRFT) statement that they were the worst performing in the country. He said that more needed to be done to benefit patients and centralisation would help to do that. Dr Sulch also explained that clinical need was how patients were prioritised, not whether they lived in an area of higher deprivation.

(16) Members enquired as to why the siting of the HASU was not focussing on driving up standards in Trust areas where provision did not currently meet expectations and why Medway Maritime Hospital, which had the largest volumes of stroke activity in Kent and Medway, would not benefit from a HASU at the site. Ms Jones said that the process was focussed on the provision for the entire population of Kent and Medway and had never been about driving standards in a particular area or the prioritisation of individual hospital sites.

(17) A Member welcomed the stroke review across Kent, Medway, East Sussex and Bexley and did not subscribe to the postcode lottery notion of where someone came from determining the order of treatment received. They believed that that was against the ethos of the NHS and that patient pathways should be dependent on medical need.

(18) A Member sought clarity from the content of the DMBC that the NHS were making the best effort it could to deliver parity of service across Kent and Medway. Ms Jones confirmed that that was correct.

(19) Some Members commented on travel times and raised the following comments:

- asking why some units in the preferred option were chosen due to their proximity to each other and that implementation of Option D would see a fairer geographic distribution of HASUs
- what process was undertaken by the ambulance service to prioritise patients suspected of having a stroke;

- what training and skills ambulance staff had undertaken to receive patients suspected of having a stroke;
- Medway currently had the most stroke patients in Kent and Medway so it was illogical for Medway not to be a HASU.
- what decision making was undertaken by the ambulance service for patients who were equidistance to each HASU;
- that the most deprived people not only have low health levels but call ambulances later during an emergency;
- what planning was undertaken for peak periods of traffic such as tourist traffic, severe weather incidences, etc.;
- due to the locations of the preferred option of HASUs those in deprived areas would have to travel a lot longer and went against the new NHS 10-year plan of reducing inequalities;
- the Highway Authority (KCC) definition of areas was not consistent with the area references of the NHS – Ashford was classified as East Kent when KCC's definition was Mid Kent;
- a Member welcomed the introduction of Integrated Assessment Workshops and would welcome the feedback from that as well as information on future meetings. They further welcomed that this focus was on a local level as well as on relatives, carers and families as they were an important factor to remember in the implementation phase; and
- a Member queried why these had not been in place before.

(20) Dr Sulch said that when units are consolidated someone somewhere will have to travel longer distances and that it was important to consider the patient pathway, which had three key phases to it – the call, acknowledging the point that patients from deprived areas do present later; the speed of ambulance response and transport to unit; and finally speed of treatment on arrival. He said that the ambition in the DMBC, and fitting with other consolidated areas, states that the door to needle time should be median 30 minutes which would equate to half of people and that the speed of response will outweigh the benefits of the time taken to travel to hospital. Referring to thrombolysis, Dr Sulch said the review was about the entirety of the stroke pathway not just those patients requiring this specific procedure. He said that the stroke national clinical guidelines ambition is for stroke patients to be admitted to a stroke unit within 4 hours. He stated that evidence had shown that treatment in a HASU saves lives and reduces disability significantly.

(21) Mr Pavey informed the Committee that the aspiration of the ambulance service was to deliver the best care to patients and therefore the best outcome. He said that closer was not always better. He emphasised that SECAmb were not a provider of HASUs and that they were a community responding organisation who support what is safe for patients and commented that HASUs save people's lives. Mr Pavey highlighted centralisation of trauma services had been completed across Kent and

Medway and that currently people travel a lot further and receive a better outcome.

(22) Mr Pavey said that travel time issues were always going to be there but that a clinical assessment of need was based on symptoms which would generate a call prioritisation. He said the service was good at identifying stroke cases and have a target to attend patients within 18 minutes on average and in 90% of the time within 40 minutes. He confirmed that this was being achieved. Mr Pavey highlighted the national system which had a vigorous pathway and that the public stroke awareness campaign had demonstrated an improvement in this area.

(23) Mr Pavey said that ambulance staff were trained on the FAST test (Face, Arms, Speech, Time) but that there was not a lot of treatment that can be performed in an ambulance so that conveyance to the right place was key along with as the correct ambulance vehicle dispatch. He referred to the telemedicine pilot which informed decision making.

(24) In relation to equidistance, Mr Pavey said that conveyance would be to the nearest HASU but an important latitude discussion with the patient and family was had.

(25) Ms Jones referring to Integrated Impact Assessment Workshops said that one of the workshops had taken place in Maidstone and another was due in Thanet. She said she was keen to hear the strong views of local people. Ms Jones said that the focus was on travel, access and mitigations that could be put in place. She said there was a strong interest in public health and areas of prevention focus for the future.

(26) Ms Jones said multiple Travel Advisory Groups were needed to focus on local need with Romney March a case in point. Ms Jones emphasised that a key part of this work was to focus on relatives, carers and families who may have difficulty in travelling. She aimed to hold as many of the workshops as possible and confirmed that any feedback collected to date and ahead of 14 February would be fed in to the information submitted to the JCCCG and that she would be happy to circulate details of this to the Committee.

(27) A Member highlighted that the reduction in Public Health funding will have an impact in relation to preventative measures being taken to lessen the numbers of stroke patients presenting.

(28) A Member was concerned about the impacts of the PRUH on capacity at Darent Valley Hospital. Mr Gilbert was invited by the Chair to comment and he said that he believed there was a capacity issue and questioned if the correct strategic decision was being made as the preferred option was propping up the PRUH.

(29) Ms Jones stated that a vigorous process had been undertaken over a period of nearly two years and that it was important that this was robust and that

this process gave the answer to the required criteria which stakeholders had been involved in developing.

(30) Members talked about the planning for the new Kent and Canterbury Hospital and major acute services. Members asked about the associated impacts of this on implementing the William Harvey Hospital option and the potential for the creation of a future HASU in Canterbury and expressed concern about the possible provision of a differential service across Kent and Medway during a phased implementation. A Member referred to recruitment and retention of doctors and enquired as to why investment in this location was not being considered if services were returning to this site in the long term.

(31) Mr Douglas said, hypothetically speaking, that a potential new hospital at Kent and Canterbury could take 7 to 10 years to be up and running and therefore a decision had to be made to put the service in to William Harvey Hospital and achieved as soon as possible. He said that the East Kent reconfiguration would go out to public consultation and stroke services will be part of that process.

(32) Members were concerned that there was very little reference to East Sussex in the papers and were concerned about the process. They sought reassurance that capacity had been considered for East Sussex and Bexley as well as Kent and Medway as they believed that capacity information was lacking in the DMBC.

(33) Members asked if 3 HASUs were enough and if 4 HASUs could be supported. Additionally, Members enquired of the planning undertaken on population expansion and if existing sites could be expanded if the need arose. Ms Jones said that the DMBC was a twenty-year case, bearing in mind that in ten years, the twenty-year outlook could look a little different. She said, with the support of specialist colleagues, including Medway Council's Public Health Unit, that everything had been done to project future growth.

(34) Ms Jones acknowledged that adapting to change will have to occur, exemplified by technological advancement. She said that as a network they would be conducting recurrent reviews across the County.

(35) In reference to strategic capacity, Ms Jones informed the Committee that the guidance recommends that no unit deals with more than 1500 strokes annually – with the current proposal of 3 HASUs equating to 4500 strokes annually. She emphasised that the predictions showed that the system would see 3000 – Darent Valley and Maidstone would receive 800-900 each and that therefore meant that there was capacity in the system before the 1500 guidance figure was reached. Ms Jones said that the demographic of the population would need to be factored in to ongoing reviews.

(36) Ms Jones confirmed that growth infrastructure figures provided by the local authorities were included to project future growth.

(37) Dr Sulch said that reconsidering the 3 HASU plan was not an option and that with a 4 HASU model it was likely that one unit would not receive enough patients to meet standards and would further aggravate staff ratios. Ms Jones confirmed that if the population could support 4 HASUs in the future, to meet the minimum requirements, that would then be reconsidered.

(38) Several Members enquired about bed capacity and if there was ability to increase them if the need arose. A Member referred to the reduction from 2 to 1 wards at Eastbourne Hospital's HASU and queried if there were enough beds to treat people and if a long-term view had been taken of where bed numbers can be increased.

(39) Ms Jones highlighted that resilience had been built into the DMBC with an additional 22 beds across the network which would be available from the start. She said that stroke sits within a much bigger medical specialty and that there was a significant bed base across hospitals around acute medicine. She acknowledged that in future there would be a need for future bed capacity, even with developments in local care and early discharge. Formal yearly reviews will be undertaken. Ms Jones was confident that there was enough resilience in the system until 2030.

(40) Mr Douglas said that this review saw an increase in the bed base and was different to previous reconfigurations undertaken which tended to focus on bed reduction. He said this was the first review that had been developed in a cohesive way and should provide reassurance.

(41) Dr Fenlon agreed that capacity was a good focus of questioning as it demonstrated that the evidence gathered was used to do the best for the most people and that centralisation was the best way of managing stroke. He emphasised that the work was not about the building but about the provision of access. He also commented that a recent update to the evidence base was factored into future planning.

(42) Reassurance was sought regarding the business case for stroke rehabilitation services and that its implementation would take place at the same time as the services set out in the DMBC. Ms Jones gave assurance that that was the case but that there was variable provision across all areas and a live audit was capturing data to assist in forming the rehabilitation business case. She said that she was confident that a business case will be available by May 2019 and the two programmes would go live together.

(43) A Member reminded the Committee that consideration needs to be given to the fact it was a national service and not just a Kent and Medway one. They continued that the report presented facts and figures on which a decision was being made and that the NHS should be thanked for the work undertaken and questions answered at each attendance.

(44) A Member expressed concern that the priority order of the evaluation criteria had been removed and that this and other changes to the evaluation criteria had affected the preferred option selected.

(45) A Member felt that Kent and Medway had sufficient population to support the establishment of a fourth HASU. He reiterated concerns about changes to the evaluation criteria since the consultation which he considered had effectively removed Option D as a viable option. In relation to Option B, the Member also felt that each individual HASU should be implemented as soon possible rather than waiting until both Darent Valley and Maidstone were ready.

(46) A Member questioned the length of the process and was keen to see the services in place as soon as possible.

(47) Members enquired about the phased approach options and the consideration given to this and requested that the process be managed safely.

(48) The meeting was adjourned at 1319 and reconvened at 1331.

(49) A proposal from Councillor Wildey was moved and seconded by Councillor Murray:

(a) Proposed that the Joint HOSC should agree to recommend the following to the Joint Committee of CCGs (JCCCGs) on 14 February 2019:

i) The JCCCGs should delay taking a decision to implement Option B, the NHS preferred option, on the basis that it is not in the interests of the health service across Kent and Medway to pursue an option which locates all three HASU's in CCG areas with relatively low levels of deprivation. This is of significant concern in the context of the new NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. There also remain concerns that:

- there are serious issues in relation to the process used to select the preferred option for Kent and Medway which is open to challenge
- the capacity of the 3 preferred HASU's will be significantly impacted on given the flow of patients from South East London into Darent Valley hospital and

(b) Secondly,

ii) The Joint HOSC should further recommend that the JCCCGs develop a decision making business case for Option D, which would locate the third HASU at Medway Maritime Hospital which serves one of the most deprived CCG areas in Kent and Medway (see Figure 3 on page 16 of

the decision making business case) recognising that there is now a prospect of the HASU which serves the population of East Kent being located at Kent and Canterbury hospital (see page 142 of the final decision making business case for Option B).

(50) The proposed recommendation was NOT AGREED.

(51) A proposal from Mr Bartlett was moved and seconded by Mr Pugh:

(a) The NHS are asked to pass on the comments of the JHOSC to the Joint Committee of Clinical Commissioning Groups (JCCCG) and to report back to the Joint Stroke HOSC and ask that the JCCCG prepare and consider an analysis of how population growth in North Kent, specifically Medway and the Thames Gateway, and East Kent has been taken into account in the proposals, particularly in relation to the number of HASUs being proposed.

(52) The proposal was AGREED and became the formal recommendation.

(53) RESOLVED that:

(a) The NHS are asked to pass on the comments of the JHOSC to the Joint Committee of Clinical Commissioning Groups (JCCCG) and to report back to the Joint Stroke HOSC and ask that the JCCCG prepare and consider an analysis of how population growth in North Kent, specifically Medway and the Thames Gateway, and East Kent has been taken into account in the proposals, particularly in relation to the number of HASUs being proposed.

(54) In line with the Terms of Reference for the Committee, a Member requested that the Members that had not supported the recommendation set out at (51), be allowed to agree a minority response.

(55) Of these Members, one proposed that the proposal set out at (47) be agreed as the formal minority response of the JHOSC. This was seconded and AGREED by these Members.

(56) The formal recommendation of the Committee (51), along with the formal minority response (47), would therefore be submitted by the JHOSC to the JCCCG.

19. Date of next programmed meeting - To be confirmed
(Item 5)

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Please contact: 01634 332715
Your ref:
Our ref: JP – Stroke Review Minority Response
Date: 6 February 2019

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Joint Committee of Clinical Commissioning Groups for Stroke Services

C/O: Glenn Douglas, Accountable Officer for the Kent and Medway CCGs;
Rachel Jones, Senior Responsible Officer for the Kent and Medway Stroke Review
Kent and Medway Sustainability and Transformation Partnership
2nd Floor, Magnitude House,
New Hythe Lane, Aylesford, ME20 6WT

Sent electronically

Dear Mr Douglas and Ms Jones,

Stroke Review – Minority Response from Medway Council representatives on the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee

As you are aware, a meeting of the Kent and Medway Stroke Review – Joint Health Overview and Scrutiny Committee (JHOSC) took place on 1 February 2019. The purpose of this meeting was for the JHOSC to comment both on the final version of the Decision Making Business Case and on NHS preferred option, Option B, ahead of the Joint Committee of Clinical Commissioning Groups for Stroke Services (JCCCG) meeting on 14 February 2019 that is due to make a decision on the NHS preferred option.

At the JHOSC meeting, Councillor Wildey, the Vice-Chairman of the JHOSC and Chairman of the Medway Health and Adult Social Care Overview and Scrutiny Committee, moved a proposal to the JHOSC that it should recommend that the JCCCG delay taking a decision to implement Option B (which would see the development of Hyper Acute Stroke Units and Darent Valley Hospital, Dartford, Maidstone Hospital and William Harvey Hospital, Ashford) and further recommend that the JCCCG develop a decision making business case for Option D (Medway Maritime, Tunbridge Wells and William Harvey hospitals).

Upon being put to the vote, the proposal was not agreed by the JHOSC. An alternative proposal was then moved and upon being put to the vote, was agreed by the Joint HOSC. The four Medway Members abstained from this vote.

The Terms of Reference of the Kent and Medway Stroke Review Joint HOSC (as agreed by Medway Council, Kent County Council, East Sussex County Council and the London Borough of Bexley), allow for the submission of a minority response under the following circumstances:

The formal response of the JHOSC will be reached as far as is reasonably practicable by consensus and decided by a majority vote. If the JHOSC cannot agree a single response to a proposal under consideration then a minority response which is supported by the largest minority, but at least two Members, may be prepared and submitted for consideration by the NHS body or a relevant health service provider with the majority response.

In accordance with the JHOSC Terms of Reference, Councillor Wildey moved that his proposal, supported by the reasons outlined to the JHOSC and by the expert opinion of Jon Gilbert, commissioned by Medway Council and presented to the JHOSC, be submitted for consideration by the JCCCG as the JHOSC Minority Response.

The four Medway Council Committee Members of the JHOSC voted in favour of this proposal. In accordance with the Terms of Reference of the JHOSC, please accept the attached report as the Committee's Minority Response to the JCCCG ahead of its meeting on 14 February 2019.

The full text of the proposal is set out in the enclosed JHOSC Minority Response.

Please confirm that the Minority Response will be provided to the JCCCG members in advance of 14 February to enable it to be fully taken into account during the decision making process.

Please also note that the expert opinion included in the Minority Response has had some footnotes added since the JHOSC meeting in order to address related questions raised at the JHOSC. It is otherwise as provided to the JHOSC.

Yours sincerely,

Jon Pitt

Jon Pitt, Democratic Services Officer, on behalf of the Medway Council Members of the Kent and Medway Stroke Review JHOSC

Enclosures:
Kent and Medway Stroke Review JHOSC Minority Response to the JCCCG

Copy to:
Rehman Chishti, MP;
Tracey Crouch, MP;
Kelly Tolhurst, MP;
Ivor Duffy, NHSE;
Stuart Jeffery, NHS Medway CCG

REPORT TO MEETING OF THE JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS FOR STROKE SERVICES (JCCCG) - 14 FEBRUARY 2019

KENT AND MEDWAY STROKE REVIEW – CONSULTATION WITH THE JHOSC

MINORITY RESPONSE FROM THE MEDWAY COUNCIL REPRESENTATIVES ON THE JHOSC

1. This minority response is submitted for the following reasons:

1.1 We have listened carefully to the NHS's rationale for the proposed configuration of hyper acute services across Kent and Medway and have listened to the answers provided to our questions.

1.2 Whilst we all agree the principle of developing new hyper acute stroke units to deliver high quality stroke services, Medway remains unconvinced that the proposed locations for the three Units is in the interests of the health service across the whole of Kent and Medway.

1.3 Medway has three principal reasons for recommending that the NHS should reconsider the location of the HASUs:

1.4 Firstly, health inequalities – HASUs should be located in more deprived areas. We are not persuaded that the NHS can deliver disproportionate benefit for stroke patients from deprived areas unless stroke patients from these areas are given preferential access to the service on arrival at a HASU over patients from more affluent areas. Clearly this will never happen. Neither can we find evidence to support claims by the NHS that populations in deprived areas have benefitted more than those in more affluent areas from reconfigurations elsewhere.

1.5 Secondly we are concerned about capacity – the NHS is recommending expenditure of £39 million on a HASU model where bed capacity will be quickly outstripped by growth in demand. 100% of Bexley residents currently seen at the PRUH or Darent Valley will now flow to provision in Kent and Medway, immediately absorbing 23% of the capacity at Darent Valley. With significant future growth planned in South East London over the next twenty years, capacity at Darent Valley is likely to be taken up meeting this demand, at the expense of residents from Kent and Medway itself.

1.6 Thirdly, we believe the evaluation process to have been flawed as has been set out by our expert. We remain convinced that had the changes not been made to methodology option B would not have been selected and the NHS may now be considering an option to locate a HASU in Medway. There is also a big question mark over the validity of the business case for Option B if the location of one of the HASUs is to move from Ashford to Canterbury which will affect travel times, patient access across Kent and Medway not to mention workforce and capital costs.

PTO

2. RECOMMENDATION TO THE JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS FOR STROKE SERVICES (JCCCG)

2.1 That the Joint Committee of CCGs (JCCCG) consider the following recommendations as the Minority Response from the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee:

i) The JCCCG should delay taking a decision to implement Option B, the NHS preferred option, on the basis that it is not in the interests of the health service across Kent and Medway to pursue an option which locates all three HASU's in CCG areas with relatively low levels of deprivation. This is of significant concern in the context of the new NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. There also remain concerns that:

- There are serious issues in relation to the process used to select the preferred option for Kent and Medway which is open to challenge.
- The capacity of the 3 preferred HASU's will be significantly impacted on given the flow of patients from South East London into Darent Valley hospital and;

Secondly,

ii) That the JCCCG develop a decision making business case for Option D, which would locate the third HASU at Medway Maritime Hospital which serves one of the most deprived CCG areas in Kent and Medway (see Figure 3 on page 16 of the decision making business case) recognising that there is now a prospect of the HASU which serves the population of East Kent being located at Kent and Canterbury hospital (see page 142 of the final decision making business case for Option B)

PTO

3. EXPERT OPINION FROM JON GILBERT, COMMISSIONED BY MEDWAY COUNCIL IN RELATION TO THE KENT AND MEDWAY STROKE REVIEW

Jon Gilbert - Enodatio Consulting Ltd

Jon is a procurement and contracts expert with over 15 years' experience. He has extensive experience running multi-million pound tenders for the public sector and has provided advice across a range of projects to local authorities, NHS trusts, Public Health England and the private sector. He is a non-practising solicitor.

Opinion

1 I have reviewed Medway Council's concerns regarding the selection of Option B as the Preferred Option and I do not consider that it represents the best option for the residents of Kent and Medway. This is because:

1.1 **bed capacity** will be quickly outstripped by growth in demand, and will be taken up by the population of South East London, at the expense of residents in Kent and Medway:

1.1.1 There is a predicted increase of 43% in stroke admissions up to 2040/41.

1.1.2 To maintain the required capacity thresholds, an additional 4 HASU beds & 12 ASU beds would be required by 2025 (8 HASU & 22 ASU beds by 2030; 15 HASU & 40 ASU beds by 2040). The provision of additional capacity and a reduction in the length of stay can help mitigate this up to 2030. However, capacity will remain an issue.

1.1.3 Under the Preferred Option, 100% of Bexley residents who are currently seen at the PRUH or DVH will now be seen within K&M.[1] As a result, 8 out of 34 HASU/ASU beds at DVH (23.5% of capacity) will immediately start to be taken up by patients currently seen at the PRUH.

1.1.4 This capacity will be further taken up by residents of South East London, with Bexley Council's ambition to deliver 31,500 new homes by 2050 (p14) – 80% of which within the DVH catchment. The impact of these new developments has not been modelled (contrary to p78), as the modelling work was based on ONS predictions (rather than the K&M Growth & Infrastructure Framework) (see p2 of Appx EE).

[1] See p223 of the meeting pack (p143 of DMBC) which states: "it is expected that around 200 strokes (eight beds) of strokes that are currently seen at the Princess Royal University Hospital (which is already a HASU) will be seen at Darent Valley Hospital once it is established as a HASU/ASU". This is further evidenced by Appx D (Changes to the activity and travel time analysis) in the DMBC, where page 8 states "100% of Bexley CGG patients currently seen in DVH and PRUH would be included in the scope for the 'K&M catchment'". Page 15 of this Appx shows that, under Option B, the PRUH will see zero strokes and provide zero beds for the K&M catchment.

1.1.5 The combined effect of an increase in demand and choosing locations closer to the K&M borders will mean that capacity is taken up by increasing number of South East London residents at the expense of residents in Kent and Medway.[2]

1.2 residents from areas of **higher deprivation** (who have greater need for stroke services) will be disproportionately adversely affected – especially regarding travel times:

1.2.1 The NHS 10-year plan makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. The Preferred Option achieves the opposite of this.

1.2.2 The DMBC (p87[3]) suggests residents from more deprived areas will disproportionally benefit. This is at best misleading. The only way people from more deprived areas, such as Medway and Thanet, could benefit more than people from less deprived areas, such as West Kent, is if they were somehow given preferential access on arrival in a HASU. Also on page 76 of the meeting pack the NHS states that "evidence from all other implementations have demonstrated a reduction of health inequalities", but I have been unable to find any such evidence to support this assertion. No peer reviewed, academic evidence appears to have been presented to either the Clinical Reference Group or the Stroke Programme Board in support of this to date.

1.2.3 The service should be targeted on those who need it most. The Preferred Option does not place HASUs in those areas of greatest need. Figure 3 on page 96 of the meeting pack shows that the HASUs will be located in the least deprived CCG areas.

1.2.4 There is also a risk that adopting a two-phased approach will further impact areas of higher deprivation, that would only receive a HASU in phase 2. Recent peer reviewed evidence published in January 2019 into patient outcomes following a two-phased implementation in Manchester, compared to London which was single phase, identified clear negative outcomes for stroke patients in Manchester.

1.3 the **evaluation process** in selecting the Preferred Option was flawed:

1.3.1 The evaluation criteria and process should not have been changed without good reason. The more changes that are made, the greater the risk that the consultation process and shortlisting process are undermined.

1.3.2 However, significant changes were made:

1.3.2.1 the criteria's priority order was removed. (The NHS argues the criteria were never prioritised but p141 sets out how they were created and makes it clear that participants prioritised the criteria that were most important in determining how options should be evaluated. This was

[2] Placing another HASU at DVH, within 15 miles (c.22 minutes' drive) of the PRUH, would help short-term capacity issues at the PRUH but would not be in the long-term best interests of the NHS as a whole. This is because it would provide disproportionate support to South East London and West Kent rather than spreading the HASUs more evenly across the Kent and Medway region.

[3] Page 87 of the meeting pack / Page 15 of the DMBC

repeated at the consultation stage and so the public and stakeholders were led to believe that the criteria were prioritised);

1.3.2.2 additional sub-criteria were included;

1.3.2.3 scoring keys were changed; and

1.3.2.4 the methodology for combining individual site scores into a 'whole option score' was replaced.

1.3.3 Each of these changes improved the scoring of the Preferred Option. Had these unwarranted changes not been made, the Preferred Option is unlikely to have been selected.

1.3.4 Also, the DMBC now envisages that the WHH HASU could, subject to further consultation, be relocated to the Kent and Canterbury Hospital (p222). As this highly significant change was not considered in the evaluation process, it further undermines the selection process.

2 I support Medway Council in its view that 'Option D' (MMH, TWH and WHH) addresses these concerns and represents the best option for the residents of Kent and Medway:

2.1 It focuses service provision on areas of higher deprivation (Medway and Swale) with shorter travel times for those most in need.

2.2 Bed capacity is focused on the residents of Kent & Medway – all of whom can reach a K&M HASU within required Call To Needle times. This focus frees-up capacity in the short term, and HASU sites for Option D can be expanded to provide additional capacity in the longer term.

2.3 In the Consultation feedback, Option D was "generally seen as offering the best balance geographically".

2.4 If no unwarranted changes had been made to the evaluation process, Option D is likely to have been selected as the Preferred Option at the Evaluation Workshop.

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Item 4: Kent and Medway Stroke Review

By: Jill Kennedy-Smith, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee, 26 February 2019

Subject: Kent and Medway Stroke Review

Summary: This report invites the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (Stroke JHOSC) to consider the decision of the JCCCG on 14 February 2019.

It provides additional background information which may prove useful to Members.

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1. Introduction

(1) Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers ("responsible persons") to consult a local authority about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment.

(2) Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 states that where relevant NHS bodies and health service providers consult more than one local authority on any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation and only the JHOSC may:

- make comments on the proposal;
- require the provision of information about the proposal;
- require the relevant NHS bodies and health service providers to attend before it to answer questions in connection with the consultation.

(3) In Summer 2015 Kent County Council's Health Overview and Scrutiny Committee and Medway Council's Health and Adult Social Care Overview and Scrutiny Committee determined that changes being proposed by the NHS to Hyper Acute and Acute Stroke Services in

Kent and Medway amounted to a proposal for a substantial variation to the health service across both areas.

(4) The Kent and Medway NHS Joint Overview and Scrutiny Committee was therefore convened and met during 2016 and 2017 to consider and comment on the review of Hyper Acute and Acute Stroke Services, the emerging case for change and possible options for a new model of care.

(5) On 12 December 2017 the Kent and Medway Joint HOSC was formally notified that the Joint Committee of Clinical Commissioning Groups overseeing the Stroke Review (initially comprising of the eight Kent and Medway CCGs) had been expanded to include Bexley CCG and High Weald Lewes Havens CCG as activity modelling had highlighted the extent of external flows of stroke patients to Kent and Medway from Bexley and East Sussex.

(6) As a consequence of this further analysis the relevant Committees in East Sussex and Bexley were advised of the review and both determined that the emerging proposals to reconfigure stroke services in Kent and Medway constituted a substantial variation to these services for their areas. This generated a statutory requirement to set up a new Joint Health Overview and Scrutiny Committee involving Kent County Council, East Sussex County Council, Medway Council and Bexley Council for the purpose of consultation by the NHS with Overview and Scrutiny on the Stroke Review.

(7) Prior to the establishment of the new JHOSC and to enable the public consultation to proceed as planned, representatives of Bexley Council's People Overview and Scrutiny Committee and East Sussex County Council's Health Overview and Scrutiny Committee were invited to attend and speak at the Kent and Medway NHS Joint Overview and Scrutiny Committee on 22 January as non-voting guests. The Committee met to consider the proposed options and consultation plan for the Kent & Medway Stroke Review.

(8) The Terms of Reference and membership of the new Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (Stroke JHOSC) were agreed by Bexley Council's People Overview and Scrutiny Committee; East Sussex County Council's Health Overview and Scrutiny Committee; and the full councils of Kent County Council and Medway Council in February and March 2018.

(9) The Kent & Medway Stroke Review's public consultation ran from 2 February – 20 April 2018.

(10) The inaugural meeting of the Stroke JHOSC was held on 5 July 2018. The Committee met to consider a post-consultation update which included NHS consultation activity and feedback reports. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the consultation analysis and activity reports be noted;

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

    (i) the Stroke JHOSC requests that the rehabilitation pathway be implemented at the same time as the HASUs and the JHOSC be presented with the draft pathway at its next meeting;

    (ii) the Stroke JHOSC requests that the JCCCG gives further consideration to, and assurance about, travel times particularly in the Thanet area;

    (iii) the Stroke JHOSC notes that the public consultation was comprehensive and well managed.

(11) The Committee met on 5 September 2018 to receive an update on the review with the meeting taken in three parts: travel times, evaluation criteria and model for community rehabilitation. The Committee agreed the following recommendation:

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.

(12) The Committee Members met informally on 22 November 2018 to receive an update from the NHS.

(13) The Committee met on 14 December 2018 to receive the Draft Decision Making Business Case and following discussion the NHS requested that the Final Decision Making Business Case be presented to the Committee prior to the JCCCG Meeting. The Committee agreed the following recommendation:

RESOLVED that the Stroke JHOSC:

(a) Considered and commented on the report:

(b) Referred for consideration any relevant comments or representations relating to the information provided by the NHS on the Stroke Review to the Joint Committee of Clinical Commissioning Groups.

(14) The Committee met on 1 February 2019 to receive the Final Decision-Making Business Case and agreed the following recommendation:

RESOLVED that:

(a) The NHS are asked to pass on the comments of the JHOSC to the Joint Committee of Clinical Commissioning Groups (JCCCG) and to report back to the Joint Stroke HOSC and ask that the JCCCG prepare and consider an analysis of how population growth in North Kent, specifically Medway and the Thames Gateway, and East Kent has been taken into account in the proposals, particularly in relation to the number of HASUs being proposed.

(15) In line with the Terms of Reference for the Committee, a Member requested that the Members that had not supported the recommendation be allowed to agree a minority response.

(16) A proposal from Councillor Wildey was moved and seconded by Councillor Murray:

(a) Proposed that the Joint HOSC should agree to recommend the following to the Joint Committee of CCGs (JCCCGs) on 14 February 2019:

i) The JCCCGs should delay taking a decision to implement Option B, the NHS preferred option, on the basis that it is not in the interests of the health service across Kent and Medway to pursue an option which locates all three HASU's in CCG areas with relatively low levels of deprivation. This is of significant concern in the context of the new NHS Long Term Plan which makes a commitment to a concerted and systematic approach to reducing inequalities with a promise that action on health inequalities will be central to everything the NHS does. There also remain concerns that:

- *there are serious issues in relation to the process used to select the preferred option for Kent and Medway which is open to challenge*

- *the capacity of the 3 preferred HASU's will be significantly impacted on given the flow of patients from South East London into Darent Valley hospital and*

(b) Secondly,

ii) The Joint HOSC should further recommend that the JCCCGs develop a decision making business case for Option D, which would locate the third HASU at Medway Maritime Hospital which serves one of the most deprived CCG areas in Kent and Medway (see Figure 3 on page 16 of the decision making business case) recognising that there is now a prospect of the HASU which serves the population of East Kent being located at Kent and Canterbury hospital (see page 142 of the final decision making business case for Option B).

2. Further information

(1) The NHS stroke consultation website is at: https://kentandmedway.nhs.uk/stroke/; and

The Decision Making Business Case with appendices is at: https://kentandmedway.nhs.uk/stroke/dmbc/.

(2) The decision of the JCCCG taken on 14 February 2019 is set out in the papers provided by the NHS for this item.

(3) The Terms of Reference for the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee are appended to this covering report for Members' information.

3. Legal Implications

(1) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the local authority health scrutiny function. The provisions in the regulations relating to proposals for substantial health service developments or variations are set out in the body of this report.

(2) Regulation 23 (9) makes provision for Local Authorities to refer proposals for substantial developments or variations to the Secretary of State in certain circumstances where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation.

(3) The circumstances in which a Local Authority may report to the Secretary of State are where

a. the authority is not satisfied that consultation on the proposal has been adequate in relation to content or time allowed, or

b. the authority considers that the proposal would not be in the interests of the health service in the area.

(4) There is also provision to report to the Secretary of State where a decision to implement a substantial health service change or variation has been taken without allowing time for consultation because of a risk to safety or welfare of patients or staff and the local authority is not satisfied the reason given are adequate. This provision would not apply in relation to the proposed changes to hyper acute stroke services in Kent and Medway.

(5) The four Councils participating in this Joint Committee have not delegated the power to make a referral to the Secretary of State to the Joint Committee. This remains a matter for independent determination by each of the four Councils. However, the Terms of Reference of the Joint Committee require it to consider whether the proposal for a substantial change to stroke services should be referred to the Secretary of State and if deemed appropriate to recommend this course of action to the four participating local authorities who may each agree to make a referral in line with their respective Constitutions.

(6) Current Local Authority health scrutiny guidance issued by The Department of Health states that when exercising the power to make a referral to the Secretary of State Local Authorities should ensure they are in a position to satisfy the relevant requirements under Regulation 23 to include certain explanations and evidence with the referral and in particular a requirement to ensure that practicable steps have been taken to reach agreement if there is disagreement between the health scrutiny body and the NHS where the health scrutiny comments include a recommendation. This would be a matter for each Council to demonstrate prior to making a referral.

(7) In determining whether or not to recommend that the four participating Councils consider referral of the proposed changes to hyper acute stroke services to the Secretary of State, the Joint HOSC should take into account the requirement to provide an explanation of the reasons for recommending the referral and the evidence in support of those reasons.

4. Financial Implications

(1) There are no direct financial implications arising from this report.

5. Recommendation

The Committee is asked to consider the decision of the JCCCG on 14 February 2019 and recommend that the relevant Committees of the four local authorities take one of the following actions:

(a) Consider supporting the decision of the JCCCG;

(b) Consider referring the decision of the JCCCG to the Secretary of State; or

(c) Consider and note the work of the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee.

Background Documents

Kent County Council (2015) *'Health Overview and Scrutiny Committee (17/07/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5841&Ver=4

Kent County Council (2015) *'Health Overview and Scrutiny Committee (04/09/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=32939

Medway Council (2015) '*Health and Adult Social Care Overview and Scrutiny Committee (11/08/2015)*', http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (08/01/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6314&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (29/04/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6357&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (04/08/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=7405&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (28/11/2016)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=42592

Bexley Council (2017) *'People Overview and Scrutiny Committee (29/11/2017)'*, http://democracy.bexley.gov.uk/mgAi.aspx?ID=31671

Kent County Council (2017) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (12/12/2017)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=46699

Kent County Council (2018) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (22/01/2018)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=7997&Ver=4

Medway Council (2018) *'Council (22/02/2018)'* https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=122&MId=3775

Kent County Council (2018) *'Council (15/03/2018)'* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=113&MId=7573&Ver=4

East Sussex County Council (2018) *'Health Overview and Scrutiny Committee (29/03/2018)',* https://democracy.eastsussex.gov.uk/ieListDocuments.aspx?CId=154&MId=3156&Ver=4

Kent County Council (2018) *'Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (05/07/18)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=909&MId=8095&Ver=4

Kent County Council (2018) *'Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (05/09/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=909&MId=8117&Ver=4

Kent County Council (2018) '*Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (14/12/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=909&MId=8299&Ver=4

Kent County Council (2019) 'Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee (01/02/2019)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=909&MId=8356&Ver=4

Contact Details

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DRAFT MINUTES

Meeting	**Joint Committee of Clinical Commissioning Groups**
Date and time	14th February 2019
Location	Hilton Hotel, Bearsted
Chair	Rachel Jones - Stroke Review SRO

Discussion points and key decisions

This meeting was held in public to consider the Decision Making Business Case.
Papers for the meeting can be found on the stroke website.

Mike Gill welcomed all committee members and the public to the meeting. He drew attention to the meeting etiquette which has also been circulated to all members of the public registered to attend.

The process so far
RJ then talked through the slides in the JCCCG slide pack that had been circulated for the meeting describing at a high level, the process to date, a summary of the case for change and the proposed new model of care. She went on to describe the process of applying evaluation criteria, which were refined at each stage, from all possible options, to a long list (127), to a medium list (13), to a short list (5), to a recommended preferred option. She then described the updates to the evaluation criteria between the short list and the selection of recommended preferred option. There were interruptions from protesters in the public audience which made it difficult to continue.

RJ confirmed to the audience that all questions that had been submitted, alongside other forms of feedback that had been received, would be discussed in the committee discussion section of the agenda.

RJ then went on to describe the format of the workshop which has resulted in the recommendation of the preferred option. She explained the process of unanimous option elimination to go from 5 options (as per the public consultation) to 3 options, to 2 options and then, finally, to a recommended preferred option.

The Public Consultation
SH described the public consultation process including promotion, engagement, the breadth of the responses, receiving and agreeing the consultation reports. She confirmed further work had been undertaken with Black, Asian and ethnic minority groups to ensure we had representation of these groups in the feedback.

Discussion points and key decisions

Questions comments and feedback throughout the process

RJ described the key themes from the feedback throughout the process were:

- General agreement that stroke services need to change
- General support for having hyper acute stroke units
- Concerns about travel times and people want journeys to be as short as possible
- Many people said they would want a 4th HASU or a HASU in Thanet
- People felt levels of deprivation and population size in specific areas should be taken into account
- Concerns about staffing; will we have enough and has enough been done to attract staff
- People want to know that good a quality rehabilitation services will be in place.

RJ then described each of those points including the feedback, the volume of responses in which it was referenced and also the JCCCG response as outlined in slides 18 to 25.

During this section there was a significant level of interruption from some of the protesters in the audience. RJ had to stop several times until the calling out diminished in order that the committee members could hear the information.

RJ then went on to detail the areas of feedback provided from the 4 councils (East Sussex, Kent County, Medway and Bexley) who are members of the Joint Health Overview and Scrutiny Committee and the responses submitted to the January 2019 meeting.

Questions and comments submitted for today's meeting

MG confirmed that all JCCCG members had received a comprehensive pack including all of the submitted public questions, the JHOSC feedback from the January 2019 meeting, the Medway Council Minority Report and the significant amounts of other correspondence. This included, but was not limited to, SONIK correspondence including their report, a paper on mechanical thrombectomy, CHECK letters, Medway MP letters, Thanet MP letters and acute Trust provider letters.

SH outlined the questions that had been submitted from members of the public as:

- Concern of distances and consideration of mobile stroke units;
- Mechanical thrombectomy paper and how it would be considered;
- BMA report on medical recruitment;
- Travel times from Thanet/Dover/Deal in relation to patient outcomes;
- Hospitals that lose HASU's will also be at more risk of losing other services;
- 4 not 3 HASU's;
- Transport for family and friends;

Discussion points and key decisions

- Keeping the stroke services open in Thanet; and
- Provision of rehabilitation services.

RJ also summarised the feedback from the JHOSC including the Medway Council minority report for the committee members and confirmed that all of those areas of concern and feedback would be considered in the Committee discussion section of the agenda.

Developing the Decision Making Business Case

RJ described the final DMBC and changes in each chapter from the PCBC, reflecting where feedback had been incorporated. She talked through the assurance of the recommended preferred option to date, the implications of the recommended preferred option and consideration of the Integrated Impact Assessment.

She went on to describe the Implementation plan including the concerns raised by the JHOSC around the phased approach and the change therefore to the DMBC and, finally, the proposed benefits of the change.

Committee Discussion

The minutes do not represent every comment made but are a summary of the discussion. The full audio recording of the discussion is available on the stroke website

: https://kentandmedway.nhs.uk/stp-workstreams/stroke/audio-recordings-of-stroke-joint-committee-meeting/

PG commenced the discussion by raising concerns around deprivation, recognising that people are often ill earlier and for longer. He referenced the importance of prevention to support the reduction of health inequalities. He asked would it make any difference to patient outcomes if HASU's were in areas of deprivation?

DH responded that relationship is between deprivation and prevalence rather than incidence and that the most important factor is frailty which is not correlated with deprivation. CT confirmed that the most important factors with regard to deprivation is prevention, rehabilitation and longer term care.

There was significant disruption from protesters in the audience.

BB asked RJ to describe in detail the amendments to the evaluation criteria. She used slide 9 to describe the updates and rationale from the PCBC evaluation criteria. BB then asked if these changes had influenced the preferred option. PG clarified that he understood that the most up to date data had been used. RJ confirmed it had. SD asked if there had been good reason (evidence) to make the updates and RJ explained the detail for each amendment. She also clarified that amendments have been made at every evaluation stage and that this is a required part of the process. The most important thing is that any amendments are evidenced and transparent. JB

Discussion points and key decisions
asked if we were applying evidence from urban areas to rural areas? RJ confirmed there was also evidence from areas with rural populations such as Greater Manchester and Northumbria. DH confirmed Northumbria had seen an improvement of 26 minutes in the time to thrombolysis. DH responded around the guidance from the South East Coast Clinical Senate and confirmed to the committee, in response to a comment shouted from the audience, that he was not the chair of SEC Clinical Senate, which was Dr Lawrence Goldberg. During the discussion there was significant disruption from the audience and MG asked if members of the committee could hear the discussion. They confirmed they could. MG asked for quiet from the audience but this was met with a verbal refusal. JM asked about the impact of increased travel times from Thanet. DH responded that despite hard working staff, the unit is one of the worst in the country and across K&M we have a number of very poorly performing units. The disruption from the audience reached a point where MG asked the committee if they could hear and they confirmed they could not. He asked several times for some members of the audience who were disrupting the meeting to sit down and be quiet in order that the meeting could continue. His repeated requests were ignored and rejected by a number of protesters in the audience. He confirmed that he would adjourn the meeting if the committee were going to be continued to be prevented from undertaking their meeting and gave several reminders that this was a meeting in public, not a public meeting. MG adjourned the meeting and the committee members left the room. The meeting reconvened with members of the media present and a full audio recording uploaded to the stroke website. MG reopened the meeting and asked DH to continue with his response in regard to the impact of travel times on patient outcomes. DH further explained that getting patients to a 24/7 well-staffed unit where rapid diagnostics and early treatment deliver improved outcomes and longer travel times will more than be mitigated by the provision of HASU's. SD asked how we could be reassured that we can adequately staff the HASU's. RN responded that we were aware of the workforce gap and that a number of things were already underway to begin recruitment including recruitment workshops, defining new roles, work with existing staff, the assurance that we have added additional roles to ensure the services will truly be 7 days per week. He confirmed that reconfiguration offers both challenge and opportunity and that we would be following a competency based approach. He also confirmed that we would be running a national and international campaign in line with the Global Learners Programme. Education and training will also be provided across the stroke network. He reflected that strong governance will be in place to monitor all aspects of workforce development. SD

Discussion points and key decisions

asked for assurance that this would link with other workforce programmes across the STP? RN confirmed it already was linked in. NK asked about the impact on the current stroke workforce. RN confirmed, once a decision was made, further engagement with the current workforce would take place. RJ added that all staff have already been told that they have a job either in stroke or another specialty. SD asked about the impact of the proposed medical school. CT responded that there was good evidence that the medical school is likely to attract new people to K&M and that is was very positive that it was not just focussed on doctors.

A question was raised about the use of mobile stroke units and DH responded that the current evidence to support these is poor and it is not likely to help us cope with our geographical challenges. We will certainly make sure we learn from the pilots and are already undertaking an ambulance telemedicine pilot in east Kent. He confirmed we will embrace all new development/technologies as they emerge now and in the future.

MD raised a question as to the viability of 4 HASU's. DH responded that they have 2 now in east Kent (Thanet and Ashford) and, despite everyone's best efforts they are poorly performing units (D and C respectively). He also reflected that not all sites have the ideal co-adjacent services and that is particularly relevant if looking to mechanical thrombectomy for the future. RJ confirmed that if future demand increases beyond that currently predicted or guidance/best practice changes then the network would reconsider a 4th HASU in the same way it will embrace future technologies.

FA about how we have considered our isolated communities (e.g. Swale, Romney Marsh etc) and asked what ideas are coming from the Travel Advisory Group?
RJ confirmed that the initial feedback suggested at 2 TAG's would be needed and that has already been actioned. She confirmed that local populations must input into local solutions and examples already are:

- Fuel vouchers
- Thorough review of currently available public transport
- Review of voluntary transport opporutniteis
- Subsidised taxi's
- Free skype/face time with relatives from GP's or local care hubs

RJ confirmed that the TAG's would make recommendations to the Joint Committee and it may well be that different mitigations are required in different geographies.

DR asked for assurance from SECAmb on ambulance response times. RS confirmed that the significant investment recently agreed and the further investment in the DMBC would ensure that emergency response times meet the required standard.

JN asked about the provision of rehabilitation. RJ confirmed that the provision of

Discussion points and key decisions

rehab is fundamental to ensuring the HASU/ASU units can function to their full potential. She described the public feedback that it should be as close to home as possible and must be in place at the go-live of the HASU/ASU model. She also confirmed the business case would ensure services were available 7 days per week.

JM asked about the appropriateness of a 2 phased implementation plan given the experience in Manchester. RJ confirmed she would ask DH to comment on Manchester however she described the 3 possible options and reasons why the clinicians were strongly supporting a 2 phase approach which is Darent Valley and Maidstone Hospitals going live together in March 2021 and Ashford going live as soon as the unit was built in spring 2021. DH described the phasing in Manchester which was around stroke type rather than geography. He also explained further the clinical rationale for a 2 phase approach. Finally, RJ confirmed that there would be a wider stake holder conversation to finalise the approach, following concern raised by the JHOSC, once the decision was made.

JH asked for confirmation that Ashford could not go-live earlier with more money. GD responded that this was not the case and that Ashford go-live was determined by the time to build.

SD asked what would happen to stroke services in east Kent if the east Kent reconfiguration resulted in a major emergency centre in Canterbury. GD responded that a public consultation will be required for any significant service change in east Kent and stroke would be part of that. He also confirmed that the likely timeline for a new hospital in Canterbury would be 8-10 years and that we needed to improve stroke services much sooner than that.

NK asked how the SECAmb investment will be used? RS responded by outlining the extensive work on demand and capacity undertaken by SECAmb that has informed the investment. He confirmed that stroke is a category 2 response (18 minutes) and the additional money in the DMBC was a reflection of the increased journey times and mitigation to provide resource to ensure there is not a negative impact on ambulance availability.

MG asked if there was a risk that HASU hospitals might undermine the future of non HASU hospitals? IA responded that the consolidation of stroke services would do nothing to destabilise hospitals that will no longer provide stroke services.

FA wanted assurance of how she can be sure the consultation was robust and the feedback has been taken into account? SI responded that Healthwatch advised that his organisation had worked closely with the stroke programme throughout and he confirmed they believed it had been a very robust consultation. He also reflected that the JHOSC had applauded the consultation as good practice.

PG asked for assurance that the bed capacity was sufficient. RJ described the no

Discussion points and key decisions

growth assumptions in the PCBC and the challenge by the SEC Clinical Senate based on a recent European study on stroke and the ageing population. She talked through the additional work undertaken by Medway Public Health Intelligence Unit which indicated we may need to plan for a growth in stroke admissions. To this end a further 22 beds have been confirmed available across the network and we have confirmed a 3 day reduction in length of stay by 2024/25. These mitigations will support the network to meet the predicated increases in capacity until at least 2030. RJ also confirmed further work has been done on population growth related to new housing and that is has already been included and has no further impact. A review of actual activity from Ebbsfleet has also been undertaken to confirm this.

NK asked about the impact of Brexit. The SECAmb medical director, Fionna, confirmed that they were planning for the impact of Brexit specifically around ambulance journeys. She also confirmed that, given the timeline for go-live, the impact of Brexit will have been managed by then. GD confirmed that was his understanding.

JM asked about thrombectomy could start and DH responded that the appropriate staff would need to have the right competencies for the service to commence safely. He confirmed that they are hoping to commence a pilot and working with the national team but that it was vital to have a HASU model in place.

DR asked about relatives and carers travel times/arrangements. RJ confirmed the TAG's would look at both patient discharge and relatives/carers travel and referenced her earlier detailed response.

SH confirmed that we had covered most of the areas where questions had been raised and there 2 issues outstanding which were CCG duties on health inequalities and FAST/prevention.
SM asked if we were doing enough around prevention as this was the most important area of focus to reduce health inequalities recognising that many of health determinants for stroke are also factors in other diseases such as heart disease and cancer. RJ described the prevention input into the programme and the atrial fibrillation identification scheme which has already started. All agreed prevention must be targeted at specific populations, such as deprived areas, to be most effective.

PG asked about inequalities and it was confirmed that we have inequalities in the provision of care now and standardising the acute response to the best care for all patients would result in a better outcome for all.

Discussion points and key decisions

Resolutions

MG asked all committee members if their questions had been answered and they confirmed they had no further questions. He then moved to the resolutions taking each one in turn

Taking into account all of the evidence that has been made available to JCCCG members, the JCCCG is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality acute stroke care for the patients in and the residents of Kent and Medway.

1. To agree and adopt the acute stroke services model with 3 HASU/ASU's as described in section 3 – **Unanimously AGREED. No abstention.**
2. To agree the establishment of these joint HASU/ASU's at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital as described in section 6.4 - **Unanimously AGREED. No abstention.**
3. To agree that when HASU/ASU's are developed that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth the Queen Mother Hospital and Kent & Canterbury Hospital - **Unanimously AGREED. No abstention. There was a recommended word change with the word 'developed' changed to 'operational'.**
4. To note the Integrated Impact Assessment of the preferred option as set out in section 8.4 and agree the establishment of a Transport Advisory Group to make recommendations on travel issues as part of implementing the plans - **Unanimously AGREED. No abstention.**
5. Agree the current financial impact and confirm a review of long term financial sustainability will be undertaken as part of implementation - **Unanimously AGREED. No abstention.**
6. To agree the key performance benefits as set out in section 10.4 and agree to set up the benefits monitoring system outlined in section 10.5 - **Unanimously AGREED. No abstention.**
7. To agree that a business case for stroke rehabilitation is needed as a matter of urgency and will be presented to the JCCCG no later than spring 2019 - **Unanimously AGREED. No abstention. The committee wished to add that improved rehabilitation will be in place when the HASU/ASU model goes live.**
8. To agree the adoption of the governance model and resourcing plan set out in

Discussion points and key decisions
section 9.3 - **Unanimously AGREED. No abstention.** The committee then proposed an additional resolution around the important of prevention specifically in regard to reducing health inequalities. It was proposed the additional resolution was: 9. To agree that a prevention business case will be presented to the JCCCG as soon as possible - **Unanimously AGREED. No abstention.**

ACTIONS – to be reviewed at the next meeting

Action	Owner	Deadline
Meeting notes to be circulated	RJ	22nd February 2019
DMBC resolutions to be amended	RJ	22nd February 2019
Written response to all questions submitted	RJ	22nd February 2019

ATTENDEES

Name	Role	Organisation	Initials
Dr David Hargroves	Expert and chair of CRG	EKHUFT	DH
Dr Chris Thom	Expert	MTW	CT
Ray Savage	Expert	SECAmb	RS
Rob Nicholls	Expert	K&M STP	RN
Nicola Smith	Stroke Programme Lead	K& M STP	NS

Name	Role	Organisation	Initials
Steph Hood	Comms and engagement	K& M STP	SH
Rachel Jones	Acute Strategy Programme Director	Kent and Medway STP	RJ
Dr Mike Gill	Chair	JCCCG	MG
Dr Navin Kumpta	GP	Ashford CCG	NK
Dr Mark Davies	GP	Ashford CCG	MD
Dr Simon Dunn	GP	Canterbury Coastal CCG	SD
Dr Jihad Milasi	GP	Thanet CCG	JM
Dr John Neden	GP	Thanet CCG	JN
Dr Jonathan Bryant	GP	South Kent Coast CCG	JB
Caroline Selkirk	Managing Director	East Kent CCG's	CS
Paula Wilkins	Chief Nurse	NWKM CCG's	PW
Dr Bob Bowes	GP	West Kent CCG	BB
Dr Andrew Roxburgh	GP	West Kent CCG	RA
Dr Fiona Armstrong	GP	Swale CCG	FA
Dr Peter Green	GP	Medway CCG	PG
Dr Sarah MacDermott	GP	Dartford Gravesham and Swanley CCG	SD
Ian Ayres	Managing Director	NWKM CCG's	IA
Glenn Douglas	CCG Accountable Officer	All K&M CCG's	GD
Dr David Roche	GP	High Weald Lewis Havens CCG	DR
Ashely Scarff	Deputy Accountable Officer	High Weald Lewis Havens CCG	AS

Name	Role	Organisation	Initials
Dr Siddharth Deshmukh	GP	Bexley CCG	SD
Dr Ethan Harris Faulkner	GP	Bexley CCG	EHF
Steve Innett	CEO	Healthwatch	SI

NOT IN ATTENDANCE

Name	Role	Organisation	Initials
Dr Mike Beckett	Independent Member	Dartford Gravesham and Swanley CCG	MB
Dr Mick Cantour	GP	Swale CCG	MC
Dr Chris Healy	GP	Canterbury and Coastal CCG	CH
Dr Satvinder Lall	GP	Medway CCG	SL
Dr Quasim Mahmood	GP	South Kent Coast CCG	QM

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Transforming health and social care in Kent and Medway

NHS

Joint Committee of CCGs for the review of urgent stroke services in Kent and Medway

Decision making meeting: Thursday 14 February 2019

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Agenda

Welcome and introductions	**Mike Gill**
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

Meeting etiquette and housekeeping

- This is a **meeting in public,** members of the public can attend to observe but are not permitted to join in the discussion
- There is an expectation that the committee will be able to conduct its business without undue interruption: please switch phones to silent and avoid talking during the discussions
- We will ask all members of the committee to introduce themselves in a moment, and to say who they are before they speak for the first time
- This meeting is being audio recorded, not filmed. Others may be filming, if you do not wish to be filmed please raise your hand.
- There is no fire drill expected, so if the alarm does ring we will need to leave via the signed exits
- Toilets are located outside the meeting room to the left
- We will need to finish this meeting by 4:30

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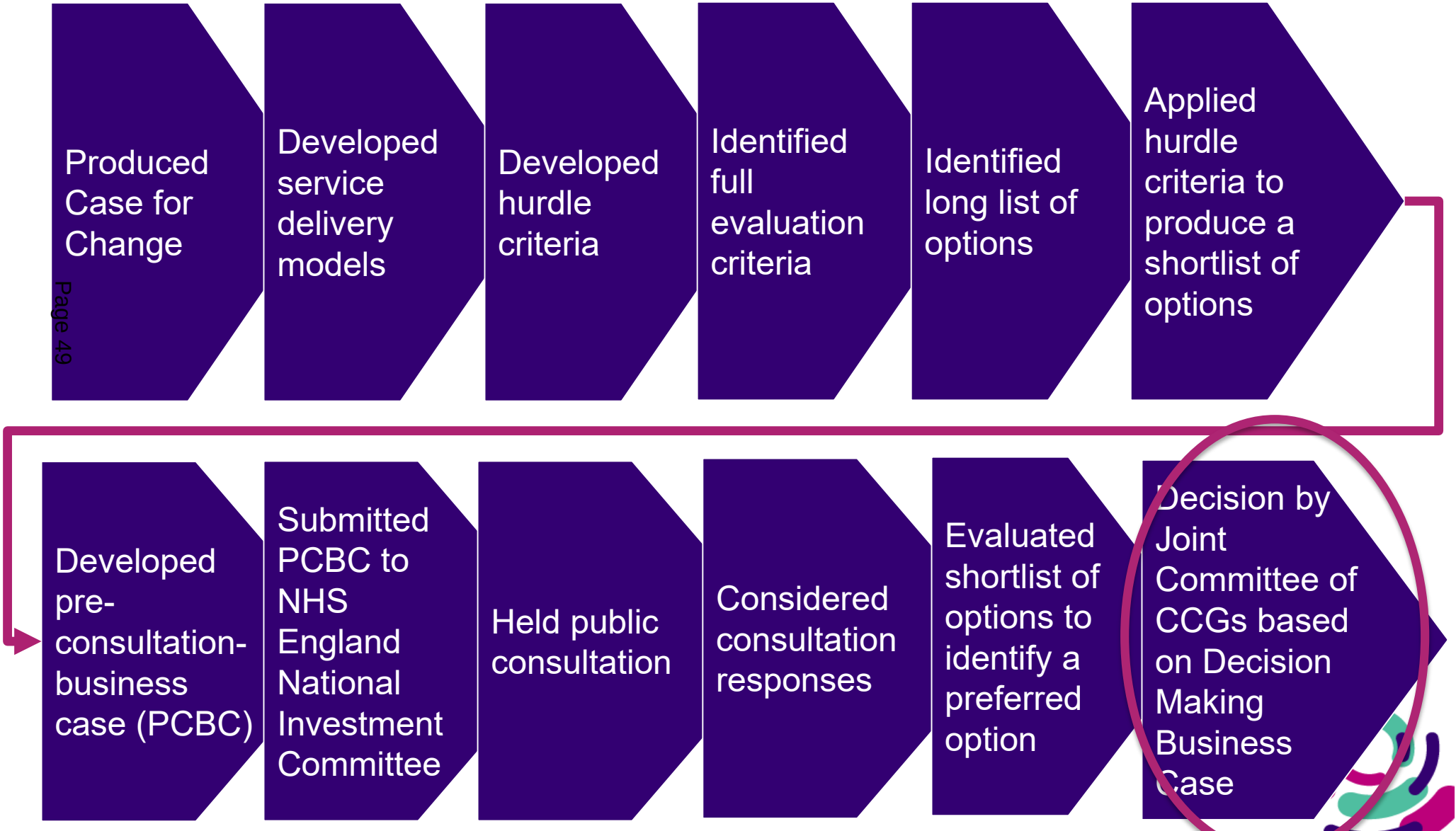
Overview of the process



Current challenges – our case for change

Specialist stroke resources are spread too thinly and most hospitals do not meet national standards and best practice ways of working

- Latest SSNAP data shows all D and E rated units in the South East are in Kent and Medway
- We have the only E rated unit in the country

Consultants, brain scans and clot busting drugs **aren't consistently available 24/7**

One in three stroke patients are **not getting brain scans in the recommended time**

We have **only 1/3 of the stroke consultants needed** to deliver best practice in all our hospitals

Half of appropriate patients **are not getting clot busting drugs** in the recommended time

Only one unit sees enough stroke patients for staff to maintain their skills (recommended minimum is 500 patients per year)

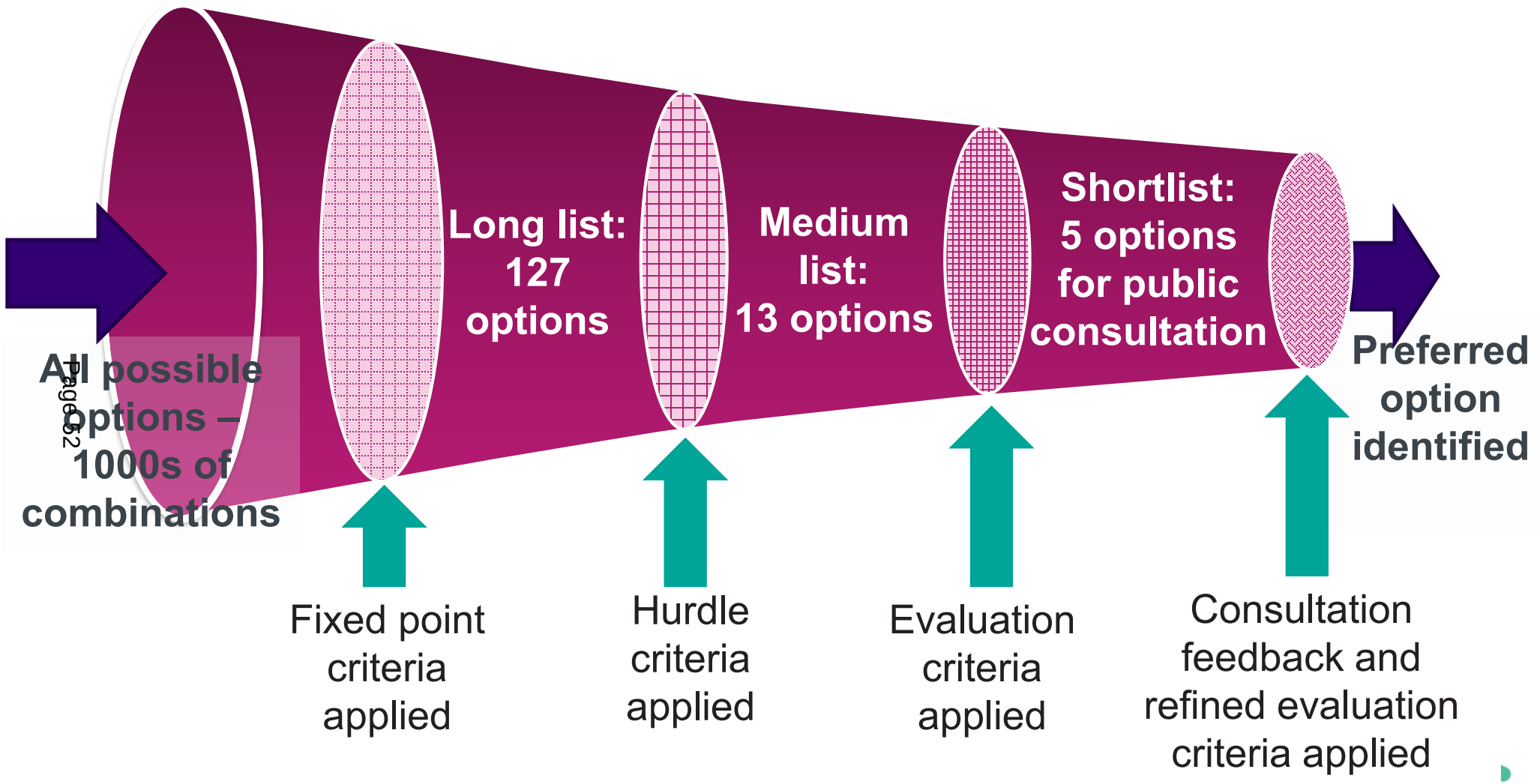
A new model of care

- Services run 24 hours a day, 7 days a week
- Staffed by teams of stroke specialist doctors, nurses and therapists 24/7
- Daily consultant ward rounds, including at weekends
- Able to do brain scans and give clot-busting drugs within 2 hours of calling an ambulance, round the clock
- Care for first 72 hours is on a hyper acute unit, follow up care is also on specialist acute stroke unit
- Rehabilitation services based in local communities, close to where people live

Expected benefits

- ✓ A reduction in deaths from stroke
- ✓ Fewer people living with long-term disability following a stroke
- ✓ Fewer people losing their independence and being admitted to nursing/care homes
- ✓ Fewer vacancies and lower staff turnover
- ✓ Shorter stays in hospital
- ✓ Better patient and staff experience as a result of excellent working practices
- ✓ Follow up care closer to home

Reaching the preferred option



Updates to the evaluation criteria

Criteria		Sub-criteria
1	Quality of care for all	• Stroke co-adjacencies • Co-adjacencies for mechanical thrombectomy • Requirements for major emergency centre • **Activity volumes**
2	Access to care for all	• Blue light proxy • Private car, peak
3	Workforce	• Gap in workforce requirements • Vacancies • Turnover
4	Ability to deliver	• **Go-live date** • **Confidence in go-live date** • **Quality of implementation plan**
5	Affordability and value for money	• Net present value, 10 years • **Capital requirement**

Assessment of options against minimum/maximum activity levels

Update of activity flows using 2017/18 activity and travel time data
Applied standardised whole option evaluation

Update of workforce baseline to March 2018
Applied standardised whole option evaluation

Detailed work with Trusts to update:
• Time to implement
Panel assessment of:
• Flexibility of proposals
• Readiness to go live

• Capital cost criteria now included
• Update of NPV using 2017/18 data

The following groups reviewed the refinements to the criteria:
- Evaluation criteria working group
- Stroke Programme Board
- Stroke Clinical Reference Group
- Finance Group

Each option was evaluated against each criteria and given either a double positive, positive, neutral, negative or double negative (++, +, /, -, --)

Workshop format

The primary objective of the workshop was to reach consensus on the future potential location of HASU/ASUs for the K&M population and it had two key parts:

1. Reviewing and discussing evaluations for each of the five shortlisted three-site options against the criteria
2. Discussing the anonymised evaluation matrix, to come to a collective view on any of the options that could be excluded until a preferred option was agreed.

How and why each option was excluded

Identifying any options to be excluded

- Consensus to exclude two options
  - Option C (Maidstone, Medway Maritime, William Harvey)
  - Option D (Tunbridge Wells, Medway, William Harvey)

Rationale for excluding Option C and D

- Did not evaluate well against ability to deliver, (most notably quality of implementation plans), and workforce
- Option D also did not evaluate as strongly as others against net present value which considers the overall cost effectiveness and financial benefit of the option.

Consideration of remaining three options

- Consensus to exclude Option E (Darent Valley, Tunbridge Wells, William Harvey)

Rationale for excluding option E

- Did not evaluate as well against ability to deliver compared to Options A and B
- Evaluated less strongly for confidence in go live date and quality of implementation plan
- No better for access or quality but was more expensive and therefore lower overall value

Consideration of remaining two options

- Consensus that Option B (Darent Valley, Maidstone, William Harvey) was the preferred option

Rationale for selecting Option B as preferred option

- Option evaluates strongest against workforce criteria
- Good confidence in ability to deliver: evaluated stronger against both confidence in go live date and quality of implementation plan
- Agreement that a networked solution for major emergency centre co-adjacencies was clinically robust

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What we did: promotion

Over the 11 week consultation we:

- Distributed **15,000 consultation documents** and **35,000 summary documents**, and **posters**, to **c850 locations** across Kent, Medway and border areas in south east London and East Sussex (hospital waiting areas, GP surgeries, pharmacies, libraries etc)
- Cascaded information to **43,500 health and social care staff** across Kent and Medway and borders – they are also residents, patients and carers
- Cascaded information through **patient groups and networks linked to NHS organisations, local authorities, voluntary sector partners, GP practice groups** etc
- Ran paid-for **advertising on local radio and in local newspapers**
- Distributed **leaflets to 98,200 individual households**
- Used both **paid for advertising** and non paid for activity on **social media** (Twitter, Facebook, YouTube)
- Issued media releases to raise awareness with **coverage in broadcast and print media**
- Ran regular articles in **council, NHS, Healthwatch and other partners' newsletters, e-bulletins, magazines and websites**
- **Promoted the consultation through our own website**

What we did: engagement

Over the 11 weeks we:

- Held **28 listening events** across the 10 CCG areas, as well as in Hastings and Rother
- Attended **meetings run by third parties** – e.g. Dartford Elders Forum, Thanet Over 50s Forum, CHEK AGM, to discuss our proposals
- Carried out **telephone research interviews** covering all 10 CCG areas
- Had face to face discussions through **focus groups, street surveys** and **roadshows**
- Held NHS trust **staff engagement events and discussions**
- Engaged through outreach to **seldom heard groups** included discussions with homeless people, prisoners, ex-servicemen and substance mis-use groups
- Engaged with people representing those with **protected characteristics** eg older people, LGBTQ groups, mother and baby groups
- Actively engaged through **social media channels**, asking questions and responding to queries
- Responded to **questions, queries and comments** via email, letter and phone
- Continued engagement with **stakeholders** eg: elected representatives, provider organisations, health and care partners, unions, patient groups

Consultation responses

- 2240 responses to the online questionnaire
- 299 hard copy questionnaires
- Notes from 28 public listening events attended by 850 people
- Notes from meetings and forums hosted by others where we discussed the proposals
- Notes from consultation events with staff in NHS trusts
- 701 telephone interview responses
- Notes from 442 face to face discussions through focus groups, street surveys and outreach engagement
- 500+ email / postal / phone comments and questions
- 500+ comments and questions through social media
- 1521 postcard responses and a petition with ~3500 signatures received from a group in Thanet
- >14,000 website and >50,000 page views over the course of the consultation
- Twitter reach >500,000; Facebook reach >50,000; >4,000 page engagements on Facebook; YouTube >1,000 views of our videos

Receiving and agreeing the consultation reports

- At a meeting on 28 August 2019 the Joint Committee were asked to consider the following
  - Did the consultation secure the involvement of key stakeholders?
  - Was everyone given a reasonable opportunity to state their views?
  - Was it possible to engage with a diverse set of views?
  - Did anyone with a significant viewpoint fail to participate?
  - Are the Joint Committee satisfied the consultation has been delivered to a reasonable standard?
- The JCCCG agreed the above
- However, they asked for some further research to be carried out with Black, Asian and minority ethnic groups to ensure representation of these groups in the consultation feedback
- This work was undertaken and the responses aligned with the key themes from the consultation

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The key themes from feedback throughout

General agreement that stroke services need to change (although people support and are loyal to their local hospital)

Concerns about travel times and people want journeys to be as short as possible

People felt levels of deprivation and population size in specific areas should be taken in to account

People want to know that good quality rehabilitation services will be in place locally

General support for the idea of having hyper acute stroke units

Many people said they would like there to be four HASUs… …or a HASU in Thanet

Concerns about staffing: will we have enough staff and has enough had been done to attract staff

Agreement that stroke services need to change

- Most people agreed there is a ‘case for change’ and that we need to work differently to improve stroke services in Kent and Medway
- But people were typically very supportive of the quality of care at their local hospital

Response

- General agreement with the case for change and the idea of hyper acute stroke units told us that people understood our reasons for wanting to organise stroke services differently
- As a result we decided that **our general proposals** for implementing HASUs in Kent and Medway **did not need to change**

87% of people who responded to the questionnaire agreed there are convincing reasons to create hyper acute stroke units in Kent and Medway

Support for the idea of hyper acute stroke units

Most people agreed that:

- Creating hyper acute stroke units would improve access to diagnosis and specialist treatment in the 72 hours following a stroke for patients
- Creating hyper acute stroke units would improve quality of urgent stroke care for patients

Response

- General support for creating hyper acute stroke services and agreement that they would improve quality and access to specialist treatment told us that people understood the benefits of specialist care in dedicated units
- As a result we decided that **our general proposals** for implementing HASUs in Kent and Medway **did not need to change**

Around 75% of questionnaire responses and telephone survey participants agreed hyper acute stroke units would improve access to specialist treatment and quality of care

Concern about travel times and keeping journeys as short as possible

- Lots of people were worried that consolidating stroke services into three specialist centres would mean journey times to hospital would not be safe
- People said travel times to proposed HASUs needed to be as short as possible
- Some people were not confident about the accuracy of the travel time data we used to help plan the locations of proposed HASUs

Response

- Reviewed national and local standards to ensure proposals are safe and would allow us to treat people in the required timeframes
- Checked latest travel time data against original proposals to see if anything had changed
  - The data confirmed that 99.9% of people would be within a 60 minute journey time to a HASU, and 100% within 63 minutes
  - The data we used comes from a nationally and internationally recognised source and is taken from real journey times from satellite navigation systems
- As a result we decided that our proposal for **the locations of proposed HASUs did not need to change**

Around 35% of both questionnaire responses and telephone participants said they were concerned about the travel times to the proposed HASUs

People would like there to be four HASUs…

- Many people said that they would like there to be four HASUs to allow shorter journey times
- People particularly felt there should be a fourth HASU in Thanet

Response

- Looked again at the data that had informed recommendation for three HASUs:
  - The number of confirmed stroke patients that each unit would see (a minimum of 500 a year)
  - The number of staff needed to run four units
- Four units would mean some would not see the required minimum number of confirmed stroke patients per year for safety and quality
- We would be very unlikely to recruit enough consultants to run four units safely
- As a result we decided that our proposal for having **three HASUs** in Kent and Medway **did not need to change**

13% of questionnaire responses said there should be more units. Around 10% said there should be a unit closer to Thanet and another 10% that the unit should be at QEQM specifically.

….and a HASU in Thanet

People said that if there couldn't be four HASUs, one of the three proposed sites should be in Thanet because:

- travel times to Ashford are too long
- there are higher levels of deprivation in some areas that could lead to greater need for stroke services
- deprivation could also impact on peoples' ability to visit relatives and friends in hospitals that are further away

Response

- Looked again at the rationale for excluding QEQM:
  - QEQM has fewer of the desirable 'co-adjacent' services
  - EKHUFT said they would find it difficult to staff two HASUs
  - Therefore Ashford was the more favourable site for a HASU based on the desirable services
- Reviewed the data on the numbers of stroke in areas of deprivation
  - The numbers of confirmed strokes in deprived areas is no higher than anywhere else in Kent
  - The key way to improve health in deprived areas is through prevention
- Established a travel group to ensure mitigations are put in place during implementation to reduce the impact of increased travel times
- As a result we decided that there was **no new evidence for QEQM** to be considered as a location for a HASU

16% of questionnaire responses specifically mentioned that there should be a HASU in Thanet in the free text responses. A petition with 3500 signatures and1521 postcards and were received calling for a HASU at QEQM.

Deprivation and population size should be taken in to account

People said they were concerned that people living in deprived areas should be closer to a HASU because they were more likely to have a stroke. They also said that HASUs should be located in the most densely populated areas.

Response

- Looked again to see if there is a connection between numbers of strokes and areas of deprivation across the whole of Kent and Medway
  - The data does not show that areas of high deprivation have higher numbers of stroke
- Clinically, there are two criteria that influence the location of a HASU:
  - Can 95% of people reach it within an hour?
  - Are there enough people in the 'catchment' area to ensure the HASU treats at least 500 strokes a year?
- All the proposed sites for HASUs in Kent and Medway meet this criteria
- As a result we decided that **no one option was any better placed to deliver stroke care** on the basis of population size or deprivation than another

27% of people said they ranked the five options on the basis of the size or demographic of the population (i.e. levels of deprivation, number of elderly people) around the sites

Concerns about staffing challenges

- There were concerns that we would not be able to recruit enough staff to run the proposed HASUs
- Some people also felt that staffing challenges should not be a reason to limit the number of HASUs in Kent and Medway

Response

- Looked again at the current staffing levels, vacancy rates and staff turnover rates:
  - We need at least three more full time stroke consultants to run three HASUs
  - There are recruitment challenges with some hospitals having as many as 20% of their nursing posts vacant (across all departments, not just stroke)
- We are developing a detailed workforce plan that will address how we help existing staff to stay working in stroke services and how we attract new staff
- We reviewed the way each site was evaluated to see if staffing influenced any of our decisions about the number or location of proposed HASUs
  - The main influence on the number of HASUs was ensuring each unit would see enough patients (a minimum of 500)
  - The main influence on location was the other desirable services at each site
- While we recognise there is significant work to do around staffing as part of our implementation plans, we decided that **our general proposals did not need to change because of staffing issues**

In the telephone survey 57% of people said they thought it was a good idea to concentrate staff on fewer sites. 8% of questionnaire responses mentioned concerns about staffing

The need for good quality rehabilitation services

- Lots of people said we need to make sure as much rehabilitation as possible happens close to, or in, peoples' homes to minimise the amount of time some patients would need to be away from relatives and friends
- Staff also made clear that HASUs will only be successful if they are supported by good quality rehabilitation that is in place at the time the HASUs are implemented

Response

- Originally intended to review stroke rehabilitation services across Kent and Medway once the decision on implementing HASUs had been made
- As a result of the feedback from consultation **we decided to speed up work on stroke rehabilitation** services
  - This work is being bought in line with the timeline for the implementation of the proposed HASUs
  - We are working with the Stroke Association and stroke rehab specialists to develop a clear plan for new services
  - We have committed to ensuring that sufficient rehab is in place, across Kent and Medway, not just alongside the proposed HASUs
  - We have committed to ensuring sufficient rehab will be in place at the same time as HASUs, if they are implemented

9% of questionnaire responses mentioned the importance of rehabilitation services. Rehab was one of the most commonly mentioned additional areas for consideration in focus groups and at public listening events

East Sussex Council

East Sussex Feedback	Response
There must be support for access by families and carers e.g. provision of travel information, flexible visiting arrangements, provision of telephone contact with HASU and patients, with full discharge information for carers.	Agreed. The HASU/ASUs will operate as a single network as described in the DMBC. Communication and information will be reviewed with patients, relatives and carers. This will be developed and formalised during implementation. Measures such as flexible visiting and phone contact will be agreed as part of implementation.
The HASUs must be able to demonstrate how they will maximise the speed of treatment of patients on arrival at hospital to offset additional travel time for patients.	Agreed. This is demonstrated in the commitment to deliver the acute pathway at pace (section 3.3) including to deliver call to needle in 2 hours (section 3.2). SSNAP data will demonstrate this is achieved.
Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that the East Sussex Healthcare NHS Trust (ESHT) Hyper Acute Stroke Unit (at Eastbourne District General Hospital) is able to accommodate and treat patients who would otherwise have gone to Tunbridge Wells Hospital.	Agreed. ESHT have been involved throughout the process and have confirmed their support. The preferred option has a minimal impact on patients attending ESHT as demonstrated in Appendix L.

East Sussex Council continued

East Sussex Feedback	Response
Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that: • A full community neurological rehabilitation team is in place in the High Weald Lewes Havens CCG area of East Sussex. • The proposed discharge pathways to these community services have been considered, tested and agreed with the relevant community provider, Sussex Community NHS Foundation Trust	Agreed. This has been discussed with the Responsible Executive Officer for High Weald Lewes Havens CCG who has confirmed that the review and development of rehabilitation should include representatives from the community provider.
Residents in the affected area of East Sussex should receive improved preventative services including appropriate public health campaigns and awareness campaigns that highlight the need to treat stroke as a '999' emergency – e.g. running a FAST awareness campaign.	Agreed. The FAST campaign is a national initiative and will continue to be promoted. The prevention plans will be shared across all CCG's as described in section 3.

Kent County Council Feedback

Kent Feedback	Response
With only one HASU based in East Kent, we have concerns about the travel times for the deprived communities in Romney Marsh and Thanet and would like to see further detail on how this will be mitigated.	Agreed. This has been highlighted by feedback from the public consultation and through the preferred option IIA specifically (Appendix SS). Additional detail has been added in section 8.4.3. A second IIA workshop is being arranged in east Kent and will be taken forward in implementation.
Across the whole of East Kent, we have concerns about what mitigations will be put in place in this part of the County as a result of the introduction of the HASU coming later than the HASUs in West Kent. While we understand the practical challenges, this will potentially lead to Kent residents experiencing an unequal level of service in different parts of the County during any transition period.	The concern is understood. The DMBC (section 9) has been amended to reflect the clinical proposal for implementation is a 2 phase approach. This will be tested, following a decision, with a wide stake holder group review.

Kent County Council continued

Kent Feedback	Response
As a basic principle, we would like to be assured that local rehabilitation services were established and ready to run on the same day that any HASU becomes operational.	Agreed. This is described in section 3.4. The rehabilitation pathways will be in place to coincide with the go-live of the HASU/ASUs. A rehabilitation business case is under development with a county wide audit currently taking place. The business case is due for completion in spring 2019.
As raised at JHOSC meetings, some financial information was changed at a late stage in the consultation process and we have concerns about the revised information being fed into it at a late stage.	The DMBC was updated with the most recent information in all applicable areas as outlined in section 6 and the detailed provider presentations are available at Appendix K. The letter from NHS E setting the investment expectations is available in Appendix T.

Medway Council Feedback

Medway Feedback	Response
Medway council do not consider Option B represents the best option and are concerned the process for selection had flaws in it.	The process has been clearly laid out in the DMBC in sections 4 and 6. At each the process and information were rigorously tested with sub groups of the stroke programme governance and with attendees of decision making meetings.
Medway are concerned about the phased approach for implementation having a detrimental impact on east Kent patients.	The concern is understood. The DMBC (section 9) has been amended to reflect the clinical proposal for implementation is a 2 phase approach. This will be tested, following a decision, with a wide stake holder group review.
Medway are concerned about how and where patients will be cared for if they are unable to return home after the acute hospital stay.	Agreed. The pathway for transfer of care from hospital to the community is described in section 3.4.1. The rehabilitation and early supported discharge pathways will be in place for go live.
No response has yet been received to the Medway Council letter dated 8th November to Ivor Duffy from NHS England.	The response has now been provided from Rachel Jones, SRO for Stroke.

Medway Council continued

Medway Feedback	Response
Medway are concerned that the public consultation is not being re-run particularly with regard to the inclusion of the PRUH.	The flows to hospitals outside of K&M were included in public consultation document. The impact in both Bexley and East Sussex was visible and both areas were formally included in the public consultation and both council's joined the JHOSC.
From the externally commissioned report: Option B may not be able to meet expected increases in demand.	Following these concerns and a recommendation to review the stroke admission projection from the SEC Clinical Senate a further piece of work was commissioned. Details of this can be found in section 7.2.3 (6 P11). The mitigations for any increased demand have been approved by the CRG, SPB and JCCCG.
Option B carries the significant risk that bed capacity will be taken up by South East London residents at the expense of K&M residents.	London have already reconfigured stroke services and patients have access to a number of units within 30 minutes. SEL commissioners and London Ambulance Service have confirmed they do not wish to change their commissioning or current transfer protocols. Bexley CCG have confirmed patients will flow as they do now.

Medway Council continued

Medway Feedback	Response
Option B unnecessarily and disproportionately affects areas of higher deprivation.	The full range of impacts are identified in the Integrated Impact Assessment (Appendix SS) and the IIA workshops will develop specific mitigations. Travel and access has been highlighted and the Travel Advisory Group will make recommendations to the JCCCG to ensure all mitigations to support local communities are put into place.
Medway Council is concerned about changes to the evaluation criteria and methodology: • Criteria priority order was removed • Additional sub criteria were added • Scoring keys were changed • Composite methodology was changed • The impact of the PRUH were not appropriately considered	Detailed responses to these concerns and questions have been responded to separately. The detail of the selection of the preferred option is detailed in section and this has been expanded to detail the amendments (section 6.1) and a log of changes has also been included in Appendix QQ.
Medway are concerned that the location of HASUs outside of Medway will increase health inequalities.	The evidence from all other implementations have demonstrated a reduction of health inequalities and an improvement in all patients outcomes. This is also supported in the IIA report at Appendix SS.

Medway Council continued

Medway Feedback	Response
The changes appear to have been made to provide assistance to areas outside of K&M.	The purpose of stroke review has always been to improve services for all patients who have a stroke or suspected stroke and would attend a hospital in Kent and Medway.
The PRUH failed to deliver an implementation plan.	The PRUH did deliver a plan and attended the Delivery Panel held on 4th September. The plan they submitted can be found at Appendix W.

Bexley Council Feedback

Bexley Feedback	Response
We consider that the decision-making business case could be strengthened even further if it were clearer on the significance of the impacts of the stroke review on the PRUH. Given that the hospital is outside the Kent and Medway STP area, the link between the ability of the PRUH to cope with any increased activity and the deliverability of the options may not be immediately clear, but this is a key issue.	Agreed. The PRUH response to the Deliverability Panel process has been included in Appendix W. The impact of that information is demonstrated in section 6.2.
We think the impacts of future population growth should be carefully considered as part of the decision making process and that the Bexley aspect needs further narrative within the documentation being used as part of the final decision making process.	Agreed. We have undertaken further work on future population growth, specifically in relation to the ageing population and potential impact on stroke admissions to K&M HASU/ASUs. This additional work can be found at Appendix EE and in section 7.2 (6 P11)

Bexley Council continued

Bexley Feedback	Response
We hope that both the SEL STP and LAS will be collaboratively engaged in discussions to agree the postcodes for the DVH catchment and to agree protocols for conveying Bexley patients to DVH and any ambulance transfers that may subsequently be required.	Agreed. The SEL STP and LAS have engaged with the programme and have considered the travel time modelling. Bexley CCG and LAS have confirmed they would expect their patients to flow as they do now. They LAS and London commissioners will continue to be involved during implementation to ensure detailed plans, including catchment postcodes are agreed.
We note that there is a work stream to consider the rehabilitation model across Kent and Medway and would hope that LB Bexley's Director of Adult Social Care will be engaged as these discussions continue as clearly there will need to be some understanding or alignment of processes across Kent, Medway and SE London.	Agreed. The rehabilitation work stream will include representatives from Bexley. It is worth noting that London has already delivered HASU and ASU and K&M are working with them on lessons learned, including the development of rehabilitation as referenced in section 7.2.

Questions and comments submitted for today's meeting

Please see attached documents;

1) "Questions for JCCCG" – public
2) JHOSC feedback and Medway Minority Report

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Final DMBC and key changes from PCBC

Chapter	Overview	Key changes from the PCBC
Chapter 1: Introduction	Describes the background, progress and key stakeholders in the Stroke Review	None
Chapter 2: Case for change	This chapter introduces the context for stroke services in Kent and Medway and describes why change is necessary and why it must start now	None
Chapter 3: Clinical vision for the future	Describes the clinical model for stroke, from prevention through to Rehabilitation	• Pathways for Stroke Mimics and transfers from Non HASU hospitals • More detail around the Prevention Plan • More detail provided around the plan to deliver a rehabilitation business case by Spring 2019
Chapter 4: Shortlisting options for consultation	This chapter details the process that was undertaken in order to arrive at a shortlist of options for consultation and the feedback from consultation	None
Chapter 5: Public consultation	This section describes the public consultation on the five shortlisted options, details key themes arising from the consultation and our responses	In reflection of issues raised from consultation, more detail has been provided around how the projected increase in stroke incidence will be managed

Final DMBC and key changes from PCBC

Chapter	Overview	Key changes from PCBC
Chapter 6: Identifying the preferred option	This chapter describes the process undertaken to identify a preferred recommended option for service change	Some further detail provided around the de-anonymised nature of the evaluation data
Chapter 7: Assuring the preferred option	This chapter describes the external assurance and scrutiny that the Stroke Review has undergone to ensure that the proposals are robust	Following from Clinical Senate recommendations, more detail and assurance have been provided around: • SECAmb ability to deliver • Rationale behind 3 day length of stay reduction and ability to deliver
Chapter 8: Assessing the implications of the recommended preferred option	This chapter details the implications of the recommended preferred option on quality, activity, travel and access, equalities, workforce and finance	More detail has been provided around: • Workforce assumptions that underpin the preferred option including more detail on the initiatives planned and in place • The financial assumptions section has been re-worded and simplified

Final DMBC and key changes from PCBC

Chapter	Overview	Key changes from PCBC
Chapter 9: Implementation plan	This chapter details the implementation plan for the recommended preferred option and proposes a 2 phase approach to implementation	Following feedback, it has been emphasised that the 2 phase approach will be subject to further analysis, discussion and agreement
Chapter 10: Benefits of the proposed changes	This chapter describes the benefits that are expected to be achieved as a result of implementing the recommendations	None
Chapter 11: Conclusion and recommendations	This chapter outlines the decisions that need to be taken by the JCCCG to determine the final configuration of stroke services across Kent and Medway and the expected timeline for decision making	None

Assuring the preferred option

- The Stroke Review has sought to exceed its obligations in meeting the statutory requirements and assurance that accompany any major change to NHS services
- Clinical proposals have been reviewed at three stages by the South East Coast Clinical Senate
  - Recommendations of these reviews have been incorporated into the proposals.
- The evaluation process and pre-consultation engagement was assured by NHS England and approval to undergo consultation was dependent on this assurance
  - This included a review of the proposals by the National Investment Committee in January 2018
- We have formally consulted with the Joint Health Overview and Scrutiny Committee and engaged with individual Health Overview and Scrutiny Committees across the four relevant local authorities
  - We have used their feedback and challenge to refine our proposals at every stage of the process
- The Stroke Review has met the four tests and three conditions for reconfiguration set out by the Secretary of State and CCGs have complied with their duties under the Equalities Act 2010

Assessing the implications of the preferred option (1)

We have looked at the impact of the preferred option on quality, activity, travel and access, equalities, workforce and finance

- There would be higher quality, more consistent care in hospital for urgent stroke services with the development of hyper acute and acute stroke units
- There would be greater access to specialist staff and equipment and quicker treatment times
- Some patients would have to travel further for the urgent aspects of their stroke care, with the maximum journey time being 63 minutes however, consolidating hospital stroke services will save lives and reduce disability

Assessing the implications of the preferred option (2)

- There would be a combined HASU/ASU unit at Darent Valley Hospital (34 beds), Maidstone General Hospital (38 beds) and William Harvey Hospital (52 beds), with a small outflow to Eastbourne General Hospital (2 beds)
  - Robust protocols have been developed and would be put in place to transfer any patient at a hospital without a HASU/ASU who is suspected of having a stroke
- There would be an increase in specialist stroke staff including additional consultant, nurses and Allied Health Professionals
- Financial sustainability would be improved with a reduction in the K&M deficit however, the service remains loss making. Following feedback from providers and to ensure sustainability, the JCCCG has committed to a further financial review as part of implementation

Consideration of Integrated Impact Assessment

Potential negative impact	Planned mitigation
Patients who experience a stroke at a non-HASU site will require transfer to a HASU. This could potentially have a negative impact on patient outcomes	• Protocol for patients suffering a stroke at non-HASU site has been developed
Activity is consolidated into fewer hospital sites so capacity could be constrained	• Activity and bed modelling has applied necessary sensitivities
If links to co-dependent services are not managed this could have implications on the safety of care	• Need to ensure a strong STP focus and plan in place across wider acute strategy including East Kent and Vascular reviews
Reconfiguration could result in logistical difficulties for staff therefore increased turnover and loss of expertise	• Recruitment and workforce plans in place including support for existing staff and developing a multi-faceted recruitment campaign across K&M

Consideration of Integrated Impact Assessment

Potential negative impact	Planned mitigation
Some patients will have to travel further to access stroke services	• We continue to reinforce that our criteria is that 95% of people should be within 60 minutes of a HASU and for thrombolysis to be given within 120 minutes of calling an ambulance. Also it is being cared for on a specialist unit for the first 72 hours that improves patient outcomes, not the journey time to hospital
Longer journey times may impact on the capacity of the ambulance service	• Additional resource agreed with SECAmb to mitigate this
The changes will result in higher transport costs for some people; may result in them not choosing not to use cars	• Form a Travel Advisory Group to better understand any transport strategies which can help to mitigate any travel impacts
The preferred option will mean people from deprived areas have disproportionately longer journey times	• Journey times will be longer for some areas, whether they are deprived or not • We will form a Travel Advisory Group to better understand any transport strategies which can help to mitigate any travel impacts

Implementation plan

- If a decision is made today to progress with our preferred option, ambition is to implement the new services as quickly as possible whilst ensuring that quality and patient safety are not compromised
- Local clinical leaders have initially proposed that a two-step approach to implementation would be the most effective
  - HASU/ASUs at Maidstone and Darent Valley Hospitals would go live in March 2020
  - William Harvey Hospital would go live in spring 2021
- The proposed two-step approach will be rigorously tested as part of implementation preparation
- We will establish a Stroke Review Implementation Board, a clinical lead will be appointed across Kent and Medway and a senior clinician will oversee the changes at each site.
- Key implementation activities have been agreed in principle and a proposed programme plan has been developed
- Maintaining quality and workforce have been identified as the highest risk areas and mitigations have been agreed
- A communications and engagement plan has also been developed

Benefits of the proposed change

- The main areas of benefit expected to be delivered by the reconfiguration of stroke services are:
  - Improved clinical outcomes for patients
  - Improved experiences of care for patients and their carers
  - Improved experiences for staff, due not only to improvements in patient care, but also improved team and multi-disciplinary working and increased opportunities to maintain and enhance skills
  - Supporting the delivery of clinically and financially sustainable services
- Plans have been made to monitor progress against the benefits from the outset using an agreed set of measures
- We have an ambition to achieve a SSNAP A rating at all three units within 6 months of launching the HASU/ASUs

Resolutions

Taking into account all of the evidence that has been made available to JCCCG members, the JCCCG is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality acute stroke care for patients in, and residents of, Kent and Medway

1. To agree and adopt the acute stroke service models with 3 HASU/ASUs as described in Section 3
2. To agree the establishment of these joint HASU/ASUs at Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital as described in section 6.4
3. To agree that when the HASU/ASUs are developed that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth, the Queen Mother Hospital and Kent & Canterbury Hospital

Resolutions

5. To note the integrated impact assessment of the preferred option as set out in Section 8.4 and agree the establishment of a Transport Advisory Group to make recommendations on travel issues as part of implementing the plans
6. Agree the current financial impact and confirm a review of long term financial sustainability will be undertaken as part of implementation
7. To agree the key performance benefits set out in Section 10.4 and agree to set up the benefits monitoring system outlined in Section 10.5
8. To agree that a business case for stroke rehabilitation services is needed as a matter of urgency and will be presented to the JCCCG not later than spring 2019
9. To agree the adoption of the governance model and resourcing plan set out in Section 9.3

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Transforming health and social care in Kent and Medway

NHS

Response to JHOSC feedback from 1st February 2019

26th February 2019

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

JHOSC Feedback

Feedback	Response
Concern about the stroke review impact on health inequalities.	Currently the services provided by the hospitals in some of the highest areas of deprivation are delivering, despite the best efforts of staff, some of worst performances (SSNAP) in the country. Moving to the model of HASU/ASU's as described in the DMBC will improve outcomes for all. The JCCCG have also agreed an additional resolution for prevention which is recognised to reduce health inequalities in deprived communities and is an addition to the modelling in the business case.
We should drive up standards in all stroke units now	Agreed. We will continue to work with all the existing stroke services to focus on safe services and improving standards during implementation.

JHOSC feedback continued

JHOSC Feedback	Response
The DMBC is aiming to drive parity of care across K&M.	Agreed. This is a fundamental principle of the stroke review and DMBC.
The impact of the PRUH on capacity at DVH	This has been understood and DVH have confirmed that they have up to 14 additional beds that can be made available for stroke. The stroke programme will closely monitor actual activity with the HASU/ASU providers to ensure flows are as expected.
Concerns around SECAmb triage, staff training and travel delays.	These have been understood. SECAmb confirm they use a national system to triage patients who may be suffering from a stroke. These are category B responses which should be responded to with an ambulance within 18 minutes. All staff receive full training to recognise conditions such as stroke. FAST campaigns have been successful with the public to support an early call for help. SECAmb will always take to the closest HASU/ASU and this is considered in terms of journey time not just distance.

JHOSC Feedback

JHOSC Feedback	Response
Concerns about public transport for relatives and carers	Agreed. Travel Advisory Groups have been established to both focus on patient discharge and access for relatives and carers. There will be at least 2 groups considering mitigations for different communities. They will report into the JCCCG.
Feedback from Integrated Assessment Workshops	Two workshops have now taken place. One in Swale and one in Thanet. We have had good engagement and a range of ideas which are being written up for consideration. Many ideas related to relative travel and access which will be fed into the Travel Advisory Groups. An example is the provision of free skype/facetime from GP/local care hubs for relatives and carers as well as ideas such as subsidised taxi's and fuel vouchers.

JHOSC Feedback

JHOSC Feedback	Response
Concerns about the possible development of the Kent and Canterbury Hospital and the impact of the investment in WHH (Ashford).	Understood. Any new hospital is at least 8-10 years away and we just can't wait that long to improve stroke care. Should a new hospital be consulted on then the provision of stroke in east Kent would be part of that consultation process.
Concerns around bed capacity.	Understood. We have undertaken further work on future population growth, specifically in relation to the ageing population and potential impact on stroke admissions to K&M HASU/ASU's. This additional work can be found at Appendix EE and in section 7.) In addition we have done more detailed work on population growth specifically in relation to new housing and it is attached as a separate presentation.
The timeline for the rehabilitation business case.	Agreed. The business case will be ready in the spring of 2019 and the JCCCG have made an amendment to the resolutions to be specific that improved rehabilitation will be in place for the go-live of HASU/ASU's.

JHOSC Feedback

JHOSC Feedback	Response
Could 4 HASU's be supported in K&M	The activity review has concluded that current and future demand is best met with 3 HASU's. Currently a 4th unit would not meet the minimum volumes required to sustain a HASU (500 cases). Population growth has been reconsidered and it does not currently support a 4th unit. Should the position change in the future the provision of a 4th unit would be reconsidered.

Medway Council Minority Report

Feedback	Response
Medway council believe that HASU/ASU's would be best located in areas of high deprivation.	The full range of impacts are identified in the Integrated Impact Assessment (Appendix SS). The clinical evidence does not support that the siting of units (other than the service must meet the minimum activity volumes) has any impact on the outcomes for patients. What is clearly evidenced is the improvement to the whole population outcomes by having access to HASU/ASU's 24/7. Improving prevention is also proven to have the most positive impact on reducing health inequalities and the JCCCG have added an additional resolution to ensure this happens.
Medway council are concerned that bed capacity will be taken up by South East London residents moving from the PRUH	Understood. The activity modelling has included all the patients (regardless of postcode) that will flow the DVH. In addition we have agreed a 3 day LOS over a 4 year period and DVH have confirmed up to an additional 14 beds can be available for stroke, We believe this fully mitigates any risk.

Medway Council Minority Report

Medway Feedback	Response
Medway Council is concerned about changes to the evaluation criteria and methodology: • Criteria priority order was removed • Additional sub criteria were added • Scoring keys were changed • Composite methodology was changed • The impact of the PRUH were not appropriately considered.	Detailed responses to these concerns and questions have been responded to separately. The detail of the selection of the preferred option is detailed in section and this has been expanded to detail the amendments (section 6.1) and a log of changes has also been included in Appendix QQ.
Medway Council have requested the NHS work up a business case for Option D	The NHS are unable to comply with this request because Option D was not recommended as the preferred option and there is no rationale, from the process undertaken, to do so. Option D was eliminated as a recommended preferred option in the first round of workshop discussion, as described in the DMBC.

Review of Growth Assumptions in the DMBC

February 2019

DMBC Population Growth review

- The DMBC contains demographic growth taken from the Kent and Medway Growth Infrastructure Framework (GIF). The framework draws together information and data from a range of sources, including district local plans, Infrastructure Delivery Plans (IDPs) and infrastructure and service providers.

- The growth in this framework is higher than ONS as it includes all major housing developments.

- For non demographic growth, figures have been derived from monthly activity returns from primary care. Figures for the past 9 years have been analysed and a compound annual growth rate (CAGR) included.

- Both of these growth assumptions have been planned for in the DMBC.

- NB Its important to note that stroke incidence fell by almost 30% 1.48 per 1000 to in 1999 to 1.04 per 1000 in 2008 *(UK stroke incidence, mortality and cardio vascular risk management 1999 – 2008: time trend analysis from the GP Research Database. Sally Lee, Anna Schafe, Martin Cowie.)*

DMBC Population Growth review

- Activity modelling has been undertaken using the catchment for the respective stroke units and therefore includes the population (not just K&M residents) that would access each unit.

- Stroke activity has been built up from LSOA data, using stroke diagnosis codes and the Index of Multiple Deprivation (IMD) to ensure that factors such as deprivation have also been included in the predicted activity modelling.

- It is important to note that catchments for the HASU's is based predominantly on travel time to the nearest unit but has also been cross checked against current flows of patient activity where they exist.

DMBC Age related incidence review

Most recently we have further reviewed the likely impact that an ageing population might have, including modelling for multiple strokes:

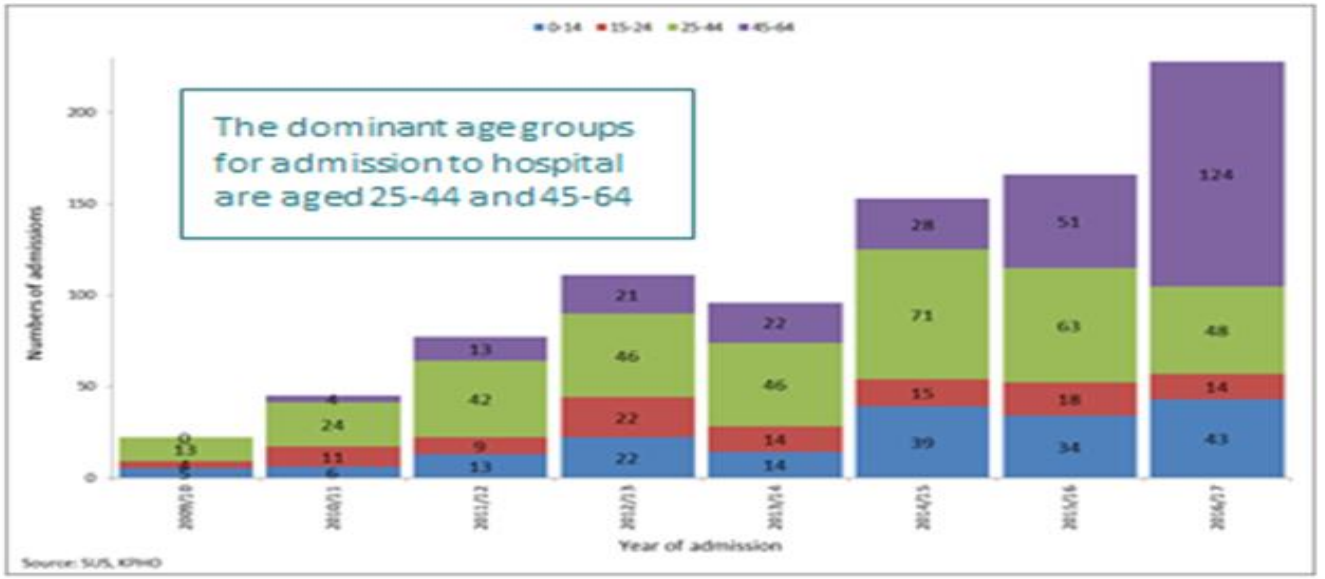
- This is also based on the K&M catchment, not limited to K&M CCG's.
- It focussed on the population aged 65 and over (stroke is predominantly an age related disease) and included multiple strokes.
- The study suggests the stroke activity could climb to 4,370 by 2040/41. This would continue to be accommodated by three Hyper Acute and Acute Stroke Units across Kent and Medway as the suggested maximum volume for a successful unit is 1,500 patients.
- This study has assumed no further impact of prevention or developments in modern technology which are likely to reduce this figure.

Housing Growth Impact – an example

- We have specifically reviewed the actual admissions from the largest new development (Ebbsfleet) which will bring around 15,000 new homes by 2035.
- We sought completed postcodes from the Ebbsfleet Development Corporation and searched for all hospital activity coming from those postcodes (Castle Hill and Springhead Park).

Hospital admissions for residents of Ebbsfleet Garden City, 2009/10 - 2016/17, by age band

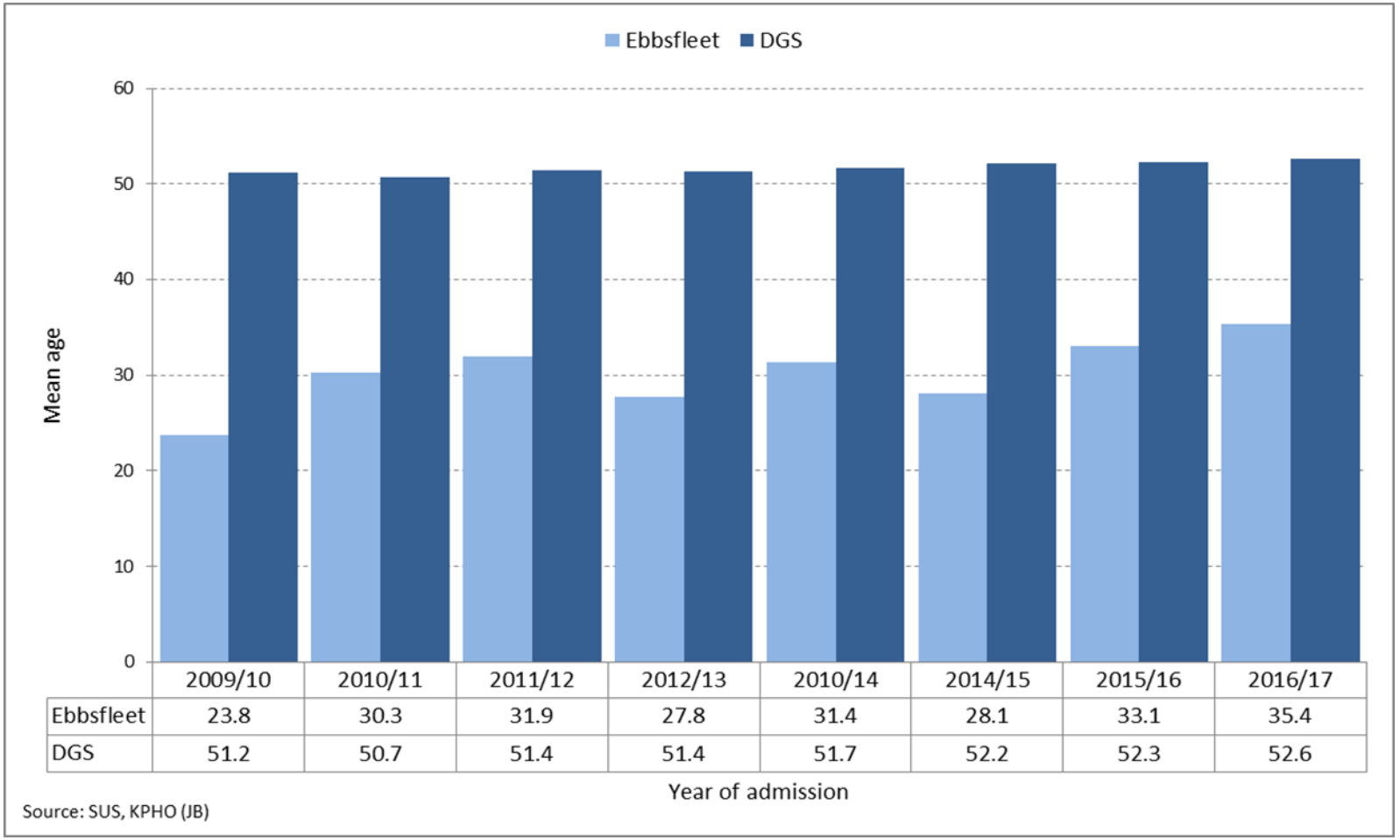
KENT PUBLIC HEALTH OBSERVATORY



Ebbsfleet hospital activity, 2016

21

- The profile of admissions is strongly weighted to the younger population with no admissions aged 75 and over in 2016/17 and only a handful aged 65 and over.



	2009/10	2010/11	2011/12	2012/13	2010/14	2014/15	2015/16	2016/17
Ebbsfleet	23.8	30.3	31.9	27.8	31.4	28.1	33.1	35.4
DGS	51.2	50.7	51.4	51.4	51.7	52.2	52.3	52.6

Summary

- The DMBC has modelled predicted activity on the a broad range of data and in line with other county level planning tools (GIF, ONS, actual activity over time).
- The modelling includes those areas outside of K&M that will use stroke services.
- It has also included the potential impact of growth of the ageing population for the K&M catchment. The findings were in line with a European study and have been built into the DMBC.
- A review of substantial new housing has demonstrated that this is not having an impact on the numbers of strokes as the demographic in those communities tends to be the younger population.

Overall the DMBC reflects a robust and up to date review of current and future demand which will be served by 3 HASU's.

The Stroke Network will monitor all aspects of operation of the units and report yearly to enable future changes to be managed.

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