KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber - Sessions House on Friday, 22 March 2019.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Ms K Constantine, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Cllr M Lyons, Mr D Mortimer (Maidstone BC), Mrs R Binks (Substitute), Ida Linfield (Substitute) and Cllr P Todd (Substitute)

IN ATTENDANCE: J Kennedy-Smith (Scrutiny Research Officer), Mr T Godfrey (Scrutiny Research Officer) and Dr A Duggal (Deputy Director of Public Health)

UNRESTRICTED ITEMS

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

(1) Mr Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.

(2) Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of the Canterbury City Council's Planning Committee.

123. Kent and Medway Stroke Review
(Item 3)

Rachel Jones (Acute Strategy Programme Director, Kent and Medway STP), Dr David Hargroves (Stroke Consultant and Chair of the Kent and Medway Stroke Clinical Reference Group), Ray Savage (Strategy and Partnerships Manager, South East Coast Ambulance Service NHS Foundation Trust (SECAmb)) and Steph Hood (Communications and Engagement Advisor, Kent and Medway STP) were in attendance for the item.

(1) The Chair noted that a petition had been received late yesterday from a group called 'Save Our NHS in Kent' (SONiK) which had been forwarded to Democratic Services to be processed in line with County Council procedures. The Chair further acknowledged a new opinion that had been produced by SONiK, as well as the large number of individual representations, sent to Committee Members.

(2) The Chair invited Mr Godfrey to provide an overview of the process for the Committee.

(3) The Chair welcomed the guests to the Committee and requested that a brief overview was provided due to the item not being formally considered by the

Committee since Summer 2015, after which time it had been considered by a Joint Health Overview and Scrutiny Committee (JHOSC) established for the purpose.

(4) Ms Jones informed the Committee about the process that had been undertaken beginning with the production of a case for change. She said that at the first stage there had been 127 options and filter criteria had been applied to reduce the options – moving from 127 to 13 to 5 options. Ms Jones said the remaining 5 options then proceeded to an 11-week public consultation with the output from that leading to the recommended preferred option.

(5) Ms Jones continued that the Decision-Making Business Case (DMBC) was then made and considered by the Joint Committee of Clinical Commissioning Groups (JCCCG), whereby nine resolutions of the JCCCG were agreed.

(6) Ms Jones highlighted that the Case for Change had become more urgent over the 4-5 years this process had taken. She said that despite the hard work and efforts of staff, resources had been spread thinly, the county had the only 'E' rated stroke unit in the country and that it had the only 'D' & 'E' rated units in the South East Coast region. Ms Jones continued that there were performance variations across Kent and Medway.

(7) Ms Jones confirmed that throughout the process feedback had been received from a wide range of organisations and stakeholders, as well as the JHOSC. She stated that all contributions received had led to the refinement of the criteria and that all data used to develop the DMBC was evidence based.

(8) Ms Jones acknowledged that the key themes arising from all engagement activities were a need to change, recognising support for local area hospitals, travel time concerns, deprivation, staffing, rehabilitation, services for Thanet, a general support for Hyper Acute Stroke Units (HASUs) but acknowledging concerns about the number of HASUs in Kent and Medway.

(9) Dr Hargroves gave an overview of his involvement in the Stroke Review and of reviews across the country. He stated that he had not been involved in any other review that had shown such a high quality of engagement as the Kent and Medway Stroke Review had, with the patient firmly at the forefront. Dr Hargroves concluded by saying that the believed that this review would be an exemplar and be followed throughout the country.

(10) Members enquired about staffing, travel times and locations of the HASUs. Dr Hargroves informed the Committee that like other parts of the country, Kent and Medway were experiencing difficulties in recruitment. He continued that retention was also an issue due to unsuitable rotas and unsustainable services. Dr Hargroves said that the current composition of East Kent hospitals meant that junior doctors have said that they would love to work in the area, but the two-site split was not workable. He continued that three locums had left East Kent Hospitals over the last 18 months as they had concluded that there was better working environments elsewhere.

(11) Ms Jones said in relation to travel times that the review had acknowledged that there would be an increase in any travel due to option configurations, and the

question was how the impacts would be managed. She confirmed that the maximum patient journey time was a maximum of 63 minutes and that this was based on East Kent times. Ms Jones said that due to existing centralised services such as trauma services, ambulance journey data gave a current picture of travel times. She stated that the most important aspect was services would be available 7 days a week and the pathway would ensure that definitive decisions and treatment would be processed faster with a dedicated stroke workforce.

(12) Ms Jones explained to the Committee about thrombolysis and said that the national standard for such treatment was 4.5 hours but that the Kent and Medway review was committing to do this within 2 hours.

(13) The Chair enquired specifically about travel times and difficulties in access for relatives and friends. Ms Jones acknowledged that there were serious concerns about difficulties in access and affordability, she understood the need to avoid any further duress. She explained that travel for patients and travel for relatives and friends needed to be tackled separately. She informed the Committee that several travel advisory groups had been established within different communities. Ms Jones said that the groups were devising the best solutions for their local populations and that consideration was being given to fuel vouchers, accommodation, use of technology and working with other organisations on improving bus routes. She confirmed that the groups had a direct link to the JCCCGs to be able to put these suggestions in place.

(14) Ms Jones emphasised that attendance at a HASU is time limited and that rehabilitation was the extended period that would be impacting on patients and family. She said that a commitment had been made to complete a rehabilitation business case by the end of May and that these services would be closer to home.

(15) Dr Hargroves, referring to HASU locations, said that if there was enough staff then all six current units would be kept open but that staffing numbers were not adequate to achieve that.

(16) Ms Jones gave her assurance that every combination of site was considered and that no site had been eliminated at the beginning. Focussing on Canterbury specifically, Ms Jones said that the requirement to implement improved stroke services as soon as possible meant that a clear decision was made that acute stroke services need to be available in sites currently. She continued that more broadly, reconfiguration of services was being explored at Canterbury but that due to the length of time for implementation this would place a significant delay on the delivery of improved stroke services. Ms Jones confirmed that the relocation of stroke services to Canterbury as part of the wider reconfiguration of services could not be ruled out for the future.

(17) Ms Jones said that Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate had been considered but that the hospital saw significantly below the required threshold for patient numbers. She continued that co-adjacent services were available at the William Harvey Hospital which also contributed to decision making.

(18) Dr Hargroves concurred stating that future planning of the ability to deliver thrombectomy was also a factor.

(19) Members enquired about ambulance performance times, HASU resilience including the ability to expand and finances. Mr Savage informed the Committee that the FAST Campaign had raised public awareness and had assisted in early recognition of stroke. He said that the main aim was to have limited time on scene and conveyance of the patient to the right place first time. Mr Savaged acknowledged that SECAmb were challenged in meeting response times but in category 2 performance the service was currently performing better than the England average which was of most relevance to stroke care. He continued that off-peak and peak time analysis had been conducted but recognised that peak times do have an impact but that blue lights saw a 15% reduction in travel times.

(20) Mr Savage said that there were two aspects for traffic navigation – planned and unplanned. He confirmed that SECAmb worked with Highways England and local councils regarding planned traffic disruption and would then plan alternative routes. Mr Savage said that extensive planning for conducted for unplanned events and provided an example of the closure of the Isle of Sheppey bridge and the availability of expert clinicians on the island.

(21) Mr Savage was confident in the travel times provided in the documents and data used for other centralised services.

(22) Mr Savage said that significant investment was being made in SECAmb and that a substantial programme of transformation and improvement was taking place, as a result of the demand and capacity review.

(23) Ms Jones, in reference to unit resilience said that the DMBC gave certainty to 10 years confidence but that it provided a 20-year case. She said that the evidence gathered, and following challenge from the South East Clinical Senate, gave assurance that there was capacity to meet demand. Ms Jones emphasised that the stroke network will recurrently review this to ensure that the units were resilient. She concluded that technological developments will also make a difference.

(24) Referring to finances and to costs arising from the findings of the travel advisory groups Ms Jones said that the JCCCG will look at the work arising from this and can commit additional finances.

(25) A Member enquired if finances invested at the William Harvey Hospital site could be reinvested at another site should the need arise. Ms Jones said that the existing developments being undertaken at the William Harvey Hospital would continue to be utilised by the NHS estate but items such as equipment could be moved and deployed at an alternative site.

(26) A Member raised concerns about frailty and an ageing population. Dr Hargroves informed the Committee that there was a distinction between these and that there was a definition of frailty – the hospital frailty score - universally used in the NHS to attribute frailty relative to other conditions and previous hospital admissions of an individual. Dr Hargroves said that the higher the

frailty score, the more likely the patient is to suffer significantly from stroke, as well as having an impact on their chance of survival. Dr Hargroves highlighted that the greatest frailty levels, as of 17/18 NHS data, were within the Tunbridge Wells and Maidstone areas and that Thanet did not have such a frail population based on those statistics.

(27) The Chair asked about deprivation and low-income impacts. Dr Hargroves said that he had no doubt that deprivation does have an impact on communities when it comes to health and that it was vitally important that everyone worked together to reduce social inequity and deprivation to ensure that everyone could live a long and healthy life. He continued that monitoring was conducted on stroke and deprived wards in Kent and Medway and that the data did not show a direct link.

(28) Ms Jones agreed and said that prevention was the solution and referred to the Sustainability and Transformation Partnership (STP) Prevention workstream. She was encouraged that improving prevention would make the biggest difference.

(29) Ms Duggal was invited to speak by the Chair. Ms Duggal said that the STP Prevention Workstream had been asked to take a clearer look at prevention and that work being undertaken within the County Council would aid this. She continued that deprivation is associated with a slightly higher risk of stroke but that this was not being seen in Kent but that certain ethnicities were more likely to have strokes earlier.

(30) Ms Duggal and Dr Hargroves clarified that the deprivation report findings showed confirmed stroke incidences going through units and not prevalence in the area.

(31) A Member highlighted that the Committee should not forget that some areas of West Kent would also see a significant increase in travel times.

(32) A number of Members agreed with the principle of the plans and acknowledged the amount of work that had been completed but were not convinced by the evidence before them.

(33) A proposal from Mrs Binks was moved and seconded by Ms Constantine:

This Committee considers that, contrary to the new NHS Long Term Plan, the proposal for 3 HASU's will fail to provide healthcare equality to all residents of Kent, particularly those within the proposed East Kent area, and may result in greater inequality of care.

The benefit of HASUs and most particularly the co-ordinated after-care is acknowledged, especially in metropolitan locations. However, all current evidence worldwide concludes that outcomes are still time-sensitive and it is of particular concern that the proposal presents an unacceptable and increased risk of mortality or permanent impairment of health to those at or beyond the extreme limit of internationally recommended "emergency call to needle time" at a HASU: in this case nearly 145,000 residents in Thanet (estimated to rise a further 25,000 by 2041), a densely populated outlying area of East Kent. Thanet

is a holiday destination for thousands of visitors in the summer resulting in severely gridlocked roads. Travel times could be even greater than the current indicated 60 minutes.

Lifestyle is acknowledged as a contributing factor to strokes and Thanet has 78% more people in the most deprived quintile than the national average.

Furthermore, the number of residents over the age of 65 is 23% higher than the national average with a stroke prevalence which is nearly 24% higher than the national average.

Current staffing levels in the QEQM hospital in Thanet do not reflect any recruitment difficulty beyond that which prevails in other non-city hospitals and, unlike some hospitals closer to London, the number of skilled stroke personnel at the QEQM is currently among the highest three for hospital sites in Kent.

Therefore the Committee asks that the NHS consider and respond to these comments and report these back to the Committee ahead of a final determination as to whether or not to refer the decision of the JCCCG to the Secretary of State, on the grounds that the proposal is not considered to be in the best interests of the health service in the area.

(34) Following discussion, Ida Linfield proposed that the motion be amended to include reference to the West Kent area. The amendment was discussed by the Committee. The change was agreed by the original proposer and seconder. This was then put to a vote and, being approved, became the formal recommendation.

(35) RESOLVED that:

This Committee considers that, contrary to the new NHS Long Term Plan, the proposal for 3 HASU's will fail to provide healthcare equality to all residents of Kent, particularly those within the proposed East Kent area, but not forgetting those in West Kent, and may result in greater inequality of care.

The benefit of HASUs and most particularly the co-ordinated after-care is acknowledged, especially in metropolitan locations. However, all current evidence worldwide concludes that outcomes are still time-sensitive and it is of particular concern that the proposal presents an unacceptable and increased risk of mortality or permanent impairment of health to those at or beyond the extreme limit of internationally recommended "emergency call to needle time" at a HASU: in this case nearly 145,000 residents in Thanet (estimated to rise a further 25,000 by 2041), a densely populated outlying area of East Kent. Thanet is a holiday destination for thousands of visitors in the summer resulting in severely gridlocked roads. Travel times could be even greater than the current indicated 60 minutes.

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124. Date of next programmed meeting – Thursday 6 June 2019
(Item 4)