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, 14 December 2018.

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 C Belsey, Cllr J Howell, Cllr R Diment and Cllr A Downing

ALSO PRESENT: Mr J Gilbert (Enodatio Consulting Ltd.)

IN ATTENDANCE: 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), Ms L Peek (Principal Scrutiny Officer, Bexley Council) and Mr T Godfrey (Scrutiny Research Officer)

UNRESTRICTED ITEMS

10. Substitutes
(Item 1)

(1) There were no apologies for the meeting.

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

(1) There were no declarations of interest.

12. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 5 July 2018 and 5 September 2018 are correctly recorded and that they be signed by the Chair.

13. Kent and Medway Stroke Review
(Item 4)

Rachel Jones (Senior Responsible Officer, Kent and Medway Stroke Review), Nicola Smith (Stroke Programme Lead, Kent and Medway Stroke Review), Lucy Readings (Communications and Engagement, Kent and Medway STP), Dr Chris Thom (Consultant

Stroke Physician – Maidstone and Tunbridge Wells NHS Trust), Ray Savage (Strategy and Partnerships Manager, South East Coast Ambulance NHS Foundation Trust) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. The Chair emphasised to the Committee that the draft Decision-Making Business Case document was unvalidated and as such was subject to change. Additionally, the Chair highlighted that information from the group 'Save Our NHS in Kent' (SONiK) had been circulated informally to the Committee prior to the commencement of the meeting.

(2) NHS representatives were invited to update the Committee. Ms Jones began by giving context to the documents provided, accentuating that due diligence had not been completed on the Decision-Making Business Case (DMBC) and that there would be changes to the final version. She said that it was a strong working draft and given its importance, it made sense to provide this to the Committee to give opportunity for comment.

(3) Ms Jones said that she had attended the Kent and Medway Joint Health and Wellbeing Board that morning, at which point comments had been received which would also be duly incorporated. She informed the Committee that the final date for feedback was 21 December 2018 whereupon the final and validated document would be created by 3 January 2019.

(4) Ms Jones emphasised the table within the NHS report which documented feedback received and the associated actions taken. She highlighted that there were three things still of particular focus beyond what had been raised in feedback - workforce, stroke incidence and detailed finance assumptions.

(5) Some Members expressed concern regarding the practices being undertaken that lead to the final decision process. Changes to information that had emerged in respect of Princess Royal University Hospital (PRUH) led some Members to the conclusion that the decision-making process was unclear. Ms Jones clarified that the decision had not been made until the documents had been finalised and that the Joint Committee of Clinical Commissioning Groups (JCCCG) would ultimately make the final decision. She said that the documentation provided enabled the Programme Team to conduct enough work to show understanding of every possible intended and unintended impact and consequence of the option being considered for recommendation and preference. Ms Jones clarified the stages undertaken; highlighting that the PRUH had never been part of the public consultation but that the impacts on the PRUH were documented in all the of the options. She highlighted that two other hospitals on the periphery of Kent and Medway were also included.

(6) Ms Jones informed the Committee that they followed learning and took advice from previous stroke consultation programmes including those in London, Manchester and Northumbria. In addition, formal feedback was received from a regulator and any changes in national clinical guidance since these changes would be incorporated in the decision making.

(7) Ms Jones drew attention to previous Committee presentations which documented criteria that had changed from the Pre-Consultation Business Case to the Evaluation Workshop stage where the preferred option was essentially arrived at. She said that the Programme Team had been working with the most recent data as this was recurrently refreshed throughout the varying stages. She emphasised that this did not change the criteria.

(8) A Member enquired about stroke activity and the minimum size of stroke unit change from 500 to 600. It was commented that Table 2 of page 295 of the business case as included in the Agenda pack required clarity in presentation to ensure that the projected transfer of stroke activity was understood.

(9) Ms Jones said that in relation to minimum activity volumes of five hundred strokes per unit a year, that a ten percent tolerance at pre-consultation was applied but the Clinical Senate had informed the Programme Team that this should not be added and therefore at the Evaluation Workshop the sensitivity was removed as it was a minimum volume. She reminded the Committee that the evaluation criteria used was presented to the Committee and considering any potential increase of minimum size to 600, by a change to national guidance, a neutral evaluation was applied for any unit between 500 and 600 so that there was no disadvantage.

(10) Ms Jones confirmed that clinicians involved in the planning and advice to the Programme Team, as well as involved in work at a national level, felt strongly that the rise in the minimum level would be part of the guidance shortly. She believed that the data therefore reflected both current and potential future guidance.

(11) Ms Jones said that incidences planning was critical due to the amount of stroke activity that the units will have to cope with now and in the future. Ms Jones said that the Clinical Senate had fed back that the Programme Team should consider a recent European publication regarding the impacts of stroke incidences based on age and the increasing elderly population. She said that this meant that the assumptions made throughout, regarding stable activity of past stroke incidences, had to be reconsidered. Ms Jones confirmed that Medway Council's Public Health Department, who produced the initial report on first stroke incidences, had been commissioned to produce a report which will form part of the final DMBC; this was also produced to include impacts of deprivation. She said that this was still in draft but was happy for this to be shared with the Committee.

(12) Ms Jones advised the Committee that the DMBC was a twenty-year case but emphasised that with all types of future planning it becomes less accurate as the years progress.

(13) Ms Jones informed the Committee that an external panel, chaired by the NHS England/Improvement Regional Director, Anne Eden, was convened to assess organisational deliverability. This work was put forward into the Evaluation Workshop. Ms Jones said that the presentations included the PRUH due to associated impacts on that organisation. She highlighted that the PRUH's presentation identified that there would be a disadvantage to the established HASU at the PRUH, serving predominantly the South London population and delivering a significant number of strokes per year. Ms Jones confirmed that this significant challenge and problem was not known at the time of public consultation.

(14) A Member enquired about the Evaluation Workshop process. Ms Jones explained the process, highlighting the independent working of the groups, the clarity around the individual components with the groups, the stages of reducing the options and reaching a consensus following feedback amongst the groups to realise a unanimous consensus on the proposed option.

(15) With reference to the Evaluation Workshop meeting held on 13 September, a Member made clear that any Councillors present had attended as observers.

(16) A Member sought justification for not re-running the consultation based on new information not included in the Pre-Consultation Business Case (PCBC). They felt

that involvement of residents served by the PRUH deserved to be part of the consultation and be made aware of the associated impact as described. Ms Readings said that consultation was undertaken in Bexley with listening events held with consultation materials distributed. She confirmed that consultation materials were also sent to the PRUH for people to access.

(17) Ms Readings said that her understanding of the process was that unless the JCCCG were unable to reach a decision the consultation would not be re-run.

(18) In reference to page 312 – 'stroke patients needing ongoing inpatient rehabilitation' – Members highlighted that the need for full alignment was at this stage not made clear and reassurance was sought for this to be in place at the time of the HASU/ASU going live. Additionally, questions were asked about whether the funding envelope included this.

(19) Ms Jones explained this reference was to the Clinical Senate recommendation – in very simple terms if those pathways, capacity and workforce were not in place at go live then this would lead to extended lengths of stay beyond what was both right for the patient and planned for in the capacity of the units. However, Ms Jones emphasised that the programme has an absolute responsibility that the Hyper-Acute Stroke Units (HASU) and Acute Stroke Unit (ASU) could not go live without rehabilitation pathways in place and that the challenge was not to delay their opening. She confirmed that this was a separate business case and that it was being worked on at the current time with the intention for this to be presented in Spring 2019. Ms Jones said that rehabilitation groups had been established, with all partners involved in the conversation due to the variable provision at present. She highlighted that care needed to be taken to ensure that destabilisation of neuro-rehabilitation provision did not occur.

(20) Ms Jones explained to the Committee that the public consultation identified the need for local rehabilitation, local pre- and post-stroke care and a commitment had been made to deliver this locally.

(21) Dr Thom said that a key consideration was sufficient bed capacity to deal with the inpatient phase of rehabilitation. He said that according to the current model, emphasising that it was not perfect, more rehabilitation in patients' homes should lead to less beds than planned but that sufficient bed numbers were available.

(22) A Member enquired under what circumstances the JCCGs would reject the preferred recommended option and what opportunity had arisen for them to hear more about differing submissions. Ms Jones informed the Committee that the integrity of the process was that a decision would not be made until the JCCCG made it and at any point they can reflect on the feedback and the commentary in the response and ask the programme to consider other factors, look at something differently or accept the DMBC as the most viable and deliverable option. She said that the main job of the programme was not to have any unexpected or unplanned for impacts and to have a way of mitigating any challenges.

(23) Members discussed population growth and queried whether the options could accommodate expansion at a future date if the need arose. Ms Jones confirmed that population growth data had been provided by all Kent and Medway Public Health systems, and that the data supplied, including new housing stock had been included in all sections of planning for the next ten years. She assured the Committee that the system resilience was adequate and had the capacity to cope and that growth presumed that nothing was achieved in terms of positive impacts regarding public health, length of stay or occupancy.

(24) A Member commented that the review team had previously stated that the DMBC required a more substantial level of detail than the PCBC but that the document presented to the Committee did not provide much more detail or fully explain the changes to the process.

(25) A Member probed the increase in capital cost of Tunbridge Wells Hospital as an education centre / car park and the need for this to be rebuilt rather than relocated within an existing building. The Member was also concerned that this had effectively made any option that included Tunbridge Wells unviable. The short timeframe during which this change had occurred – between 5 September and evaluation on 13 September – was also questioned.

(26) Ms Jones said that an initial estates review conducted some time ago on additional capacity came to a view at the time that Tunbridge Wells Hospital would be able to manage the relocation of its education centre without necessarily the need for a new build. She said that Members would be aware of news during the week regarding national and local pressures being experienced by hospitals. With the time that it took to go through the varying stages it was felt that when the estates solutions were looked at there was nowhere for the unit without it being a new build. Ms Jones said that various solutions had been investigated but following architectural costings it was shown to be too expensive. Ms Jones reminded the Committee that there had been significant challenge on the capital costings of the William Harvey Hospital build as the main capital requirement was for one site. She said that a Capital Challenge Session was held with an external adviser from Kent County Council as well as peer challenge of hospital to hospital and all plans were reconsidered.

(27) Dr Thom said that the plan to develop the education centre sites in Tunbridge Wells probably was not realistic and that he thought it was optimistic to retrofit a ward into non-clinical space with stroke services spread over more than one level meaning that it would be clinically difficult to manage.

(28) A Member expressed concern that travel time mistakes, reported to the JHOSC on 5 September, had been disregarded nor reported in the documentation provided. Ms Jones said that she acknowledged that the Committee's feedback was valued about this and following the meeting the data had been checked again, confirmed that it was an error and had been put right.

(29) Referring to page 204 – 'implementation risks' – the level of red scores, mostly relating to staffing issues, was a concern to some Members. They sought reassurance that the delayed opening of stroke services at William Harvey Hospital and the attraction of staff wishing to work within a HASU would not have an impact on staffing in the East Kent area. It was also questioned how Darent Valley and Maidstone would be able to cope with the extra patients that they would need to treat in the period before the William Harvey HASU opened, otherwise there was concern that here would be a differential service across Kent and Medway.

(30) Ms Jones emphasised that the finalisation of plans could not be taken until a decision was made. She said that the conversations that had taken place were based upon three HASUs going live in Kent and Medway; one would be in East Kent, two would be in the North-West Kent and Medway area. Ms Jones said that the decision is then between going live with all three at the same time, or sequentially by patient flows. She highlighted that the aim was improved services for as many people as quickly as possible but without causing confusion in relation to travel arrangements.

(31) Ms Jones underlined that the testing will be assured by the regional teams and the decision on implementation will be made when it is safe to do so. She said that the population mapping had identified a very small population transfer for patients who live on the borders between services in terms of patient flows.

(32) Ms Jones said that due to the significant building lead in time in East Kent, the go live date there would not be until early 2021. The current thinking was that benefits would be delivered to North West Kent and Medway because the HASUs in this area can go live earlier and manage the population in one flow. She confirmed that there would need to be significant work regarding improving the units that are available now as part of the transition, with the Margate and Ashford service remaining until the HASU was ready. She continued that the Clinical Senate and the Regulators have made it clear about the responsibility of the Programme to do that. She noted concerns expressed by a Committee Member that there would therefore be a differential stroke service across Kent and Medway during the implementation period.

(33) Ms Jones said she welcomed feedback on those plans should the Committee have any, including any views on whether the implementation planning proposed was unsupported.

(34) The Chair sought clarity that the work at William Harvey Hospital would commence straight away with no preference to other sites and on estate planning timescales. Ms Jones confirmed that work will start as soon as possible with no preference to any HASU with making the best decision for the safety and outcomes of the population being essential. She said that the Programme was exploring and intending to make use of technology and innovation. She referred to a previous Committee Member's suggestion of exploring telemedicine and confirmed that this had begun in October with a pilot in East Kent.

(35) Dr Thom informed the Committee that the process would be externally reviewed over time with standards having to be met before the HASUs can be operational.

(36) A Member sought assurance that decisions were being made on clinical need and not on financial restrictions. Ms Jones explained the financial criteria process and said that in the PCBC net present value – benefit to the whole system as a population benefit – was applied to identify all the options' maximum financial envelopes. She confirmed that at that point it was agreed with Regulators that this would be £38 million but clarified to the Committee that there was no indication that something more expensive could not be considered. This, however, would need to be presented and justified to the Investment Committee again. Ms Jones said that at the Evaluation Workshop an additional criterion was included regarding benchmarking against the financial envelope.

(37) A Member highlighted that Thanet would benefit from another HASU/Hospital being included in the review. Ms Jones respectfully disagreed and said that Thanet was a constant point of consideration, particularly in view of the East Kent Reconfiguration Programme and that current performance was not achieving best outcomes across Kent and Medway.

(38) A Member sought a guarantee that training in diagnosis would be available in the ambulance services. The Member also sought data on how many stroke-related deaths in ambulances had occurred in the last 1-2 years. Ms Jones referred to the introduction of technology and future opportunities previously presented and highlighted to the Committee that the introduction of HASUs would lead to research

innovation and attract people as part of the workforce commitment. Mr Savage did not have the information available on stroke-related deaths in ambulances and committed to providing it to the Committee.

(39) Thrombolysis treatment timelines were questioned. Assurances were given in the meeting about National Guidance on the interval between the onset of symptoms and thrombolysis for acute ischemic stroke is 4.5 hours, but Members felt this could be clearer in the Business Case.

(40) A Member said that the fact that the review process had already taken four years and that there would now be further delay before all HASUs opened, was unacceptable. They had no confidence in the process or the system. Members has previously been told that the cost was not a key consideration and that original guidelines established at the out set had not been followed.

(41) A Member thanked the Stroke Review Team for the level of work that had been undertaken. They believed that patient care was at the heart of the work and the service needed to be up and running as soon as possible. They highlighted that Bexley had several other hospital specialities used by Kent and Medway residents and that the national context needed to be considered.

(42) Mr Gilbert, an external expert commissioned by Medway Council addressed the Committee. He highlighted the following views:

- There was evidence that option B may be unable to meet demand in the future and that additional beds could be required as early as 2025.
- In order for stroke services to be effective, there needed to be adequate rehabilitation provision and this appeared underdeveloped at this time..
- Darent Valley Hospital was a Private Finance Initiative Hospital and therefore, its ability to expand was questionable and much of the capacity could be taken up by south London residents.
- Option B unnecessarily and disproportionately affected areas of high deprivation.
- There were significant disadvantages to the phased approach being proposed.
- The evaluation criteria were no longer placed in an order of priority in the evaluation for the DMBC. ‘Quality’ and ‘access’ had been identified by the consultation as being key concerns but despite this, the priority had been removed between publication of the PCBC and DMBC. This change had favoured options B and C.
- An additional ‘quality’ sub-criterion had been included in the DMBC. As every option had scored the maximum, the impact of the other ‘quality’ criteria had been diluted.
- The sub-criteria in relation to ‘ability to deliver’ had changed. There had been a positive impact on the option B and a negative impact on option D.
- Capital requirements had been introduced in the DMBC as an extra ‘finance’ sub-criterion. This amounted to duplication as capital costs had already been considered as part of the net present value criterion.
- Scoring keys had been changed in relation to financial criteria. This had increased the importance of financial criteria compared to quality criteria.
- The Clinical Reference Group had only been provided papers a day in advance and some key information had been provided at the meeting. This was insufficient given the importance if the meeting in considering factors relating to ability to deliver and workforce.

(43) Following presentation of the expert opinion from Medway, a Member informed the Committee that this had shown that fundamental changes had taken place since the outset of the consultation and questioned whether this was inherently fair or reasonable. The Member highlighted that the two-phased approach would be significant to a lot of people who would have to go a long way to get treatment, with areas in East Kent and Medway being the most impacted and having amongst the highest levels of deprivation. The Member queried why no HASU was preferred in these deprived areas.

(44) Members of the Committee discussed how to best proceed with consideration of the issues. It was clarified with the NHS representatives present that the meeting of the JCCCG on 10 January was being postponed and the NHS requested the opportunity to bring the final DMBC to the Committee ahead of the JCCCG meeting to discuss it. NHS representatives stated that a new date for the JCCCG had not been agreed, and that it would follow any further meeting with the Committee. It was anticipated that the postponed JCCCG meeting would take place later in January and would only be further delayed if the JHOSC was unable to meet in time to enable this to be facilitated.

(45) It was confirmed that agreement to the recommendation set out in the agenda would enable the statements provided by councils represented on the Joint HOSC, and updated if necessary in response to information arising from the meeting, to be submitted for consideration by the Joint Committee of Clinical Commissioning Groups. This would be in addition to submission of the minutes of the meeting. It was also confirmed that this would not prejudice the capacity of the Committee to agree a final response to the final decision making business case at its next meeting and that this could potentially include the submission of a minority response.

(46) A number of Members felt that Medway's expert had raised a lot of important points and were disappointed that the meeting could not be extended further and that, as a consequence, there was not an opportunity to further explore these points.

(47) The recommendation in the report was then put to the vote.

(48) 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. Date of the next programmed meeting - To be confirmed

(Item 5)