Transforming health and social care in Kent and Medway

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.

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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;

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- 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

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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

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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

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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

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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.

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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

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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