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)