Draft meeting minutes

Meeting	**Joint Committee of Clinical Commissioning Groups for the Review of Urgent Stroke Services in Kent and Medway**
Date and time	14th February 2019
Location	Hilton Hotel, Bearsted
Chair	Dr Mike Gill – Independent Chair of the JC CCG

Discussion points and key decisions

This meeting was held in public to consider the Decision-Making Business Case for establishing hyper acute stroke units (HASUs) at Darent Valley, Maidstone and William Harvey hospitals, each with an acute stroke unit (ASU) alongside the HASU

Papers for the meeting can be found on the stroke webpages at www.kentandmedway.nhs.uk/stroke/dmbc

Welcome and introductions

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

The members of the committee introduced themselves.

The process so far

RJ then talked through the slides in the Joint Committee of Clinical Commissioning Groups (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 (five), to a recommended preferred option. She then described the updates and refinements 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 eliminating options from the five that were shortlisted (as per the public consultation), where there was

consensus among attendees exclude two options, then consensus to exclude a further option and then, finally, consensus on 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 minority ethnic groups to ensure representation from these groups in the feedback.

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 fourth 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 there be 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 gave more detail on each of those key themes, including the number of responses in which each theme 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 four councils (East Sussex, Kent County, Medway and Bexley) who are members of the Joint Health Overview and Scrutiny Committee (HOSC), and the responses submitted by the Stroke Programme to the Joint HOSC January 2019 meeting.

Questions and comments submitted to the meeting

MG confirmed that all JCCCG members had received a comprehensive pack including all of questions submitted by the public, the Joint HOSC 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, CHEK 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

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- Travel times from Thanet/Dover/Deal in relation to patient outcomes
- Hospitals that lose HASUs will also be at more risk of losing other services
- Four not three HASUs
- Transport for family and friends
- Keeping the stroke services open in Thanet
- Provision of rehabilitation services.

RJ also summarised the feedback from the Joint HOSC 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 Decision-Making Business Case (DMBC) and changes in each chapter from the Pre-Consultation Business Case (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 Joint HOSC around the recommended phased approach and the resulting changes 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 from deprived communities 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 HASUs 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 and refinements have been made at every evaluation

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stage and that this is a required part of the process. The most important thing is that any amendments are evidenced and transparent. JB asked if evidence from urban areas is being applied 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 from arrival to thrombolysis.

DH responded around the guidance from the South East Coast (SEC) 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, the chair is 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 there are 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 live audio available via a teleconference number. The recording of the meeting has subsequently been uploaded to the stroke web pages.

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 longer travel times will more than be mitigated by the provision of HASUs. It is getting patients to a 24/7 well-staffed unit where rapid diagnostics and early treatment that deliver improved outcomes.

SD asked how the committee could be reassured that the HASUs can be adequately staffed. RN responded that the Stroke Programme is aware of the workforce gap and that a number of things were already planned enhance recruitment including recruitment workshops, defining new roles, work with existing staff, the assurance that there would be additional roles to ensure the services will truly be seven days per week. He confirmed that reconfiguration offers both challenge and opportunity and that the Stroke Programme would be following a competency-based approach. He also confirmed that the Stroke Programme 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

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reflected that strong governance will be in place to monitor all aspects of workforce development. SD 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 the NHS in Kent and Medway cope with the geographical challenges. The Stroke Programme will certainly make sure it learns from the pilots and are already undertaking an ambulance telemedicine pilot in east Kent. He confirmed the Stroke Programme will embrace all new development/technologies as they emerge now and in the future.

MD raised a question as to the viability of four HASUs. DH responded that there are currently two stroke units in east Kent (Thanet and Ashford) and, despite everyone's best efforts they are poorly performing units (Sentinel Stroke National Audit Programme (SSNAP) rated 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 deliver 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 fourth HASU in the same way it will embrace future technologies.

FA asked about how isolated communities (e.g. Swale, Romney Marsh etc) have been considered and asked what ideas are coming from the Travel Advisory Group (TAG).

RJ confirmed that the initial feedback suggested that two TAGs would be needed and that has already been actioned with initial meetings of both having taken place. She confirmed that local populations will input into local solutions and examples already suggested include:

- Fuel vouchers
- Thorough review of currently available public transport
- Review of voluntary transport opportunities
- Subsidised taxis
- Free skype/face time with relatives from GPs or local care hubs

RJ confirmed that the TAGs 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 South East Coast Ambulance Service (SECAmb) on ambulance response times. RS confirmed that the significant investment recently agreed, and the further investment set out in in the DMBC would help ensure that emergency response times meet the required standard.

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

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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 seven days a week.

JM asked about the appropriateness of a two phase implementation plan given the experience in Manchester. RJ confirmed she would ask DH to comment on Manchester however she described the three possible options and reasons why the clinicians were strongly supporting a two phase approach of Darent Valley and Maidstone Hospitals going live together in March 2020 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 two phase approach. Finally, RJ confirmed that there would be a wider stakeholder conversation to finalise the approach, following concern raised by the Joint HOSC, 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 eight to ten years and that the NHS in Kent and Medway 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 required 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 help 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 Joint HOSC had applauded the consultation as good practice.

PG asked for assurance that the bed capacity was sufficient. RJ described the no 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 the NHS 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 the Stroke Programme has confirmed a three-day

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reduction in length of stay by 2024/25. These mitigations will support the network to meet the predicted 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 Moore, 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 when 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 TAGs would look at both patient discharge and relatives/carers travel and referenced her earlier detailed response.

SH confirmed that the discussion had covered most of the areas where questions had been raised and there two issues outstanding which were: CCG duties on health inequalities and FAST/prevention.

SM asked enough is being done 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 there are 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.

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

Resolutions

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

1. To agree and adopt the acute stroke services model with three HASU/ASUs as described in section 3 – **Unanimously AGREED. No abstention.**
2. To agree the establishment of these joint HASU/ASUs at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital as described in section 6.4 - **Unanimously AGREED. No abstention.**

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3. To agree that when HASU/ASUs are developed that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth the Queen Mother Hospital and Kent & Canterbury Hospital - **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 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:

1. To agree that a prevention business case will be presented to the JCCCG as soon as possible - **Unanimously AGREED. No abstention.**

MG closed the meeting.

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

Attendance and apologies

Attendees

Title	First name	Surname	Job title	Organisation	Initials
Independent chair					

Dr	Mike	Gill	Chair	JCCCG	MG
Voting members					
Dr	Jonathan	Bryant	GP and Clinical Chair	South Kent Coast CCG	JB
Dr	Bob	Bowes	GP and Clinical Chair	West Kent CCG	BB
Dr	Peter	Green	GP and Clinical Chair	Medway CCG	PG
Dr	Ethan	Harris-Faulkner	GP/CCG clinical representative	Bexley CCG	EHF
Dr	Simon	Dunn	GP and Clinical Chair	Canterbury Coastal CCG	SD
Dr	Fiona	Armstrong	GP and Clinical Chair	Swale CCG	FA
Dr	Mark	Davies	GP/CCG clinical representative	Ashford CCG	MD
Dr	Siddharth	Deshmukh	GP and Clinical Chair	Bexley CCG	SD
Dr	Navin	Kumpta	GP and Clinical Chair	Ashford CCG	NK
Dr	Sarah	MacDermott	GP and Clinical Chair	Dartford Gravesham and Swanley CCG	SD
Dr	Jihad	Malasi	GP and Clinical Chair	Thanet CCG	JM
Dr	John	Neden	GP/CCG clinical representative	Thanet CCG	JN
Dr	David	Roche	GP and Clinical Chair	High Weald Lewis Havens CCG	DR
Dr	Andrew	Roxburgh	GP/CCG clinical representative	West Kent CCG	RA
Non-voting members					
Mr	Ian	Ayres	Managing Director	North and West Kent and Medway CCGs	IA
Mr	Glenn	Douglas	CCG Accountable Officer	All Kent and Medway CCGs	GD
Ms	Steph	Hood	Comms and Engagement Advisor	Kent and Medway STP	SH
Mr	Steve	Innett	Chief Executive	Healthwatch	SI
Ms	Rachel	Jones	Acute Strategy Programme Director	Kent and Medway STP	RJ
Mr	Ashely	Scarff	Deputy Accountable Officer	High Weald Lewis Havens CCG	AS

Ms	Caroline	Selkirk	Managing Director	East Kent CCGs	CS
Ms	Nicola	Smith	Stroke Programme Lead	Kent and Medway STP	NS
Ms	Paula	Wilkins	Chief Nurse	North and West Kent and Medway CCGs	PW
Expert advisors to the committee					
Dr	David	Hargroves	Stroke consultant and Chair of the Kent and Medway Stroke Clinical Reference Group	East Kent Hospitals University Foundation Trust	DH
Mr	Rob	Nicholls	Programme Director for Clinical Workforce	Kent and Medway STP	RN
Mr	Ray	Savage	Strategy and Partnerships Manager	South East Coast Ambulance Service	RS
Dr	Chris	Thom	Stroke Consultant	Maidstone and Tunbridge Wells NHS Trust	CT

Not in attendance

Title	First name	Surname	Job title	Organisation	Initials
Dr	Mike	Beckett	Independent Governing Body Member	Dartford Gravesham and Swanley CCG	MB
Dr	Mick	Cantour	GP/CCG clinical representative	Swale CCG	MC
Dr	Chris	Healy	GP/CCG clinical representative	Canterbury and Coastal CCG	CH
Dr	Satvinder	Lall	GP/CCG clinical representative	Medway CCG	SL
Dr	Qasim	Mahmood	GP/CCG clinical representative	South Kent Coast CCG	QM