Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Wednesday, 3 October 2018

7.40pm to 8.50pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present: Councillors: Wildey (Chairman), Purdy (Vice-Chairman), Bhutia, Craven, Fearn, Franklin, McDonald, Murray, Opara and Price

Co-opted members without voting rights

Eunice Lyons-Backhouse (Healthwatch Medway CIC) and Shirley Griffiths (Medway Pensioners Forum)

Substitutes: Councillors:
Royle (Substitute for Howard)
Griffin (Substitute for Clarke)

In Attendance:
Sharon Akuma, Legal Services
Maggie Cane, Manager, Medway Healthwatch
Dr Stephen Clark, Chair, Medway NHS Foundation Trust
Patricia Davies, Senior Responsible Officer, Kent and Medway Stroke Review
Glenn Douglas, Accountable Officer for the eight CCGs in Kent and Medway and Chief Executive of the Kent and Medway STP, Accountable Officer - Kent and Medway STP
Lesley Dwyer, Chief Executive, Medway NHS Foundation Trust
Dr Steve Fenlon, Medical Director, Dartford and Gravesham NHS Foundation Trust
Rachel Jones, Senior Responsible Officer, Kent and Medway Stroke Review
Julie Keith, Head of Democratic Services
Stephen Platt, Democratic Services Officer
Dr David Sulch, Medical Director, Medical Director, Medway NHS Foundation Trust
Dr Chris Thom, Maidstone and Tunbridge Wells NHS Foundation Trust
Ian Sutherland, Director of Children and Adults Services
James Williams, Director of Public Health

385 Chairman's Announcement

The Chairman announced that he had called this special meeting of the Committee following the NHS announcement on 17 September of a preferred option for Hyper Acute and Acute Stroke Services which did not include Medway Maritime Hospital.

The preferred option had been selected at an Options Evaluation Workshop of the Joint Committee of Clinical Commissioning Groups (JCCCG) held on 13 September 2018. The Chairman stated that his invitation to that meeting had been as an observer as Chairman of Medway's Health and Adult Social Care Overview and Scrutiny Committee, rather than as Vice-Chairman of the Joint Health Overview and Scrutiny Committee (Joint HOSC). The next stage in the review involved the development of a business case which would be formally presented to the Joint HOSC for comments before a final decision was taken by the Joint Committee of the Clinical Commissioning Groups (JCCCG).

The Chairman advised that the purpose of tonight's was meeting was therefore to provide members of the Health and Adult Social Care Overview and Scrutiny Committee with an opportunity to understand the reasons for the preferred option, and to express views and raise questions which could be taken forward to the Joint HOSC by the four Medway Members of that Committee.

386 Apologies for absence

Apologies for absence were received from Councillors Clarke, Freshwater and Howard.

387 Record of meeting

The record of the meeting held on 21 August 2018 was agreed and signed by the Chairman as a correct record.

388 Urgent matters by reason of special circumstances

There were none.

389 Declarations of Disclosable Pecuniary Interests and Other Significant Interests

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

There were none.

390 Kent and Medway Stroke Review - Identification of Preferred Option

Discussion:

Following on from his comments under 'Chairman's Announcements', the Chairman referred Members to a letter from Councillor Filmer and an email from Councillor Freshwater, Members for Peninsula Ward, copies of which were distributed. These expressed concern and disappointment at the selection of the preferred option for three specialist hyper acute stroke units (HASCs), option B (Darent Valley, Tunbridge Wells, and William Harvey Hospitals), and highlighted the impact of Medway Maritime Hospital not being included on the accessibility and quality of health care for residents on the Peninsula.

Patricia Davies and Rachel Jones, Senior Responsible Officers for the stroke services review, gave a presentation on the background to the review; consultation feedback; post consultation evaluation criteria; the evaluation workshop and the selection of the preferred option.

Patricia Davies said the review had found that specialist stroke services were being spread too thinly and that most hospitals did not meet national standards and best practice ways of working. The vision was to give anybody who had a stroke, day or night, anywhere across Kent and Medway and border areas, the best chances of survival and recovery. It had therefore been concluded that urgent stroke care should be consolidated on three hospital sites with each site to run 24/7 and include a HASU; an acute stroke unit (ASU); and transient ischaemic attack (TIA or 'mini stroke') clinic. Following the development of a clinical model and identification of five reconfiguration options for stroke services, consultation had been conducted through a variety of channels. Engagement with a wide range of stakeholders and with the Joint Health Overview and Scrutiny Committee (JHOSC) was continuing. A set of evaluation criteria had been used to evaluate the five remaining options and a workshop had been held on 13 September to reach consensus on the preferred option for the location of the HASU/ASUs.

Rachel Jones said that, at the workshop, the evaluation matrix was explained and then applied to the five options, with the hospital names being anonymised. After the first evaluation round, two options was excluded and a further option was excluded after the second round. After the third round the preferred option, option B, had been identified.

The following comments and questions were raised by members of the Committee and were responded to by the health representatives present:

Financial evaluation criteria – The Chairman questioned the use of the financial evaluation criteria as, at the evaluation workshop, he had understood that finance would not be a consideration.

Response - Where there was a financial impact, it had been considered; if there was no impact there would be a neutral score. The review process was not about seeking a reduction in cost. Investment of £38m had been secured for the reorganisation of stroke services and none of the options would exceed that amount.

The Chairman asked what the cheapest option would be over a 10 year period as he believed it to be option B. Rachel Jones undertook to provide this information.

Evaluation of Options – The evaluation of option D (Tunbridge Wells, Medway Maritime and William Harvey Hospitals) within the consultation document showed the highest score (very positive) for all three measures under 'Quality of Care'. This did not seem to accord with the rationale given in the presentation for excluding this option. What information at the workshop led to the conclusion that option D 'Did not evaluate well against ability to deliver, (most notably quality of implementation plans), and workforce'? What had changed between the positive assessment of this option in the consultation document and the exclusion of the option at the workshop? Members had supported Medway Maritime Hospital as it had achieved improvements but the evaluation workshop had appeared to conclude that it was not good enough. This was difficult to understand.

The Chairman advised that, at the workshop, participants had been able to identify the hospitals in the anonymised options.

Response – At the pre-consultation assessment stage, deliverability had been by self-assessment and implementation plans had since been examined by an independent deliverability panel. At the workshop, those participating in the selection process had a greater degree of confidence in the deliverability of option B than for the other options.

The process followed at the workshop was for hospitals to be identified at the start so that the evaluation process could be explained to participants. When the process reached a point of determining which evaluated options would be taken forward, hospital names were anonymised. It was acknowledged that it would have been possible for workshop participants to identify hospital names in the options.

Evaluation of the options was in the best interests of Kent and Medway residents. Clinicians at the different hospitals were working together for the benefit of the whole population of Kent and Medway. It was agreed that a more detailed explanation of the evaluation process would be beneficial to Members.

The Clinical Reference Group had reviewed the evaluation criteria that would be used to assess each option, prior to submission of the various options for review by the Joint Committee of CCGs (JCCCGs). Some changes were made to the original evaluation criteria used to develop the pre-consultation business case, for example travel times were refreshed.

Medway Maritime Hospital – The consultation document stated that only one hospital (Medway Maritime) currently saw the originally recommended minimum number (500 per year) of stroke patients for staff to maintain their skills and build expertise. Members of the Committee therefore needed to understand how an option which excluded Medway Maritime Hospital had been chosen. Why had hospitals not been evaluated separately instead of in groups of three?

Response – All hospitals were evaluated separately but the preferred option was for a group of three hospitals. Therefore, the evaluation focused on which combination of three hospitals would deliver the best outcome. This was an art rather than a science.

Lesley Dwyer, Chief Executive of Medway NHS Foundation Trust – Lesley Dwyer stated that representatives of the hospital had been invited to attend a deliverability panel meeting and had been confident that they had developed a good delivery plan. They had been certain about their ability to deliver the new services within a six month period. They were therefore disappointed that an option which included the hospital had not been selected as the preferred option and were seeking greater understanding about the outcome of the evaluation process. She said that it augured well that people were working together and she confirmed that the hospital had looked at its workforce requirement and would continue to develop its stroke services.

In response to a question from the Chairman, Patricia Davies said that the delivery time for option B was 18 months.

Consultation – Under section 8 of the consultation document (Next Steps), it was stated that the JCCCG would meet in public in the autumn to report back on the consultation and make a decision but it was not clear whether or not this had happened. The number of positive scores shown for option D under ‘Quality of Care’ in the consultation document, compared to the corresponding scores for option B, would lead people to conclude that it was the best option. Most respondents had selected option D as their preferred option but their views appeared to have been ignored and discounted at the evaluation workshop.

Response – It was confirmed that the JCCCG would meet in public in either December 2018 or January 2019 to make a decision. With reference to the consultation, it was stated that it was human nature that people would respond to the consultation by selecting the option that included their local hospital. Option D was not the highest scoring option in the consultation. It had been agreed that the consultation responses relating to a preferred option should not be factored into the evaluation process from a statistical point of view.

Documentation used at the workshop of 13 September 2018 – After the media release had been issued, Medway Council had requested a copy of the documentation used at the workshop to enable an analysis of the evaluation

process. The NHS had refused this request and a Freedom of Information request had therefore been submitted.

Response: Glenn Douglas, Accountable Officer of the Kent and Medway CCGs and Chief Executive of the Kent and Medway Sustainability and Transformation Partnership, said that he was happy for all the information available at the workshop to be provided by the end of the week and that he had given the same assurance to the Leader of Medway Council.

Maggie Cane, Manager of Medway Healthwatch – Maggie Cane agreed that HASUs were the way forward. She noted that, during the consultation exercise, most residents in the TN5 postcode had stated a preference for options D or E and that the highest response rate had been from Medway residents. She questioned to what extent public opinion had been taken into account and to what extent the choice of option had been a financial decision. Had the public's views been discarded at the workshop?

Response – There had been an external analysis of the consultation results. This had concluded that there was no overarching public view; option A was a marginally higher preference than the others, followed by option D. Patients had been at the heart of the review over the past 4 years but the consultation had been about seeking views rather than taking a vote. Feedback on the consultation had been given at the workshop. For example, residents had raised concerns about deprivation and it was recognised that this had an impact on people's health. As part of the review incidences of stroke among residents from Medway's most deprived area had been examined and it had been found that this had been lower than for other areas. It was stated that there was no link between deprivation and prevalence of stroke.

James Williams, Director of Public Health at Medway Council, said that there was strong evidence linking socio-economic variation to stroke and poorer outcomes for disadvantaged populations. He also advised that stroke victims tended to be from the older age range and that life expectancy in areas of high deprivation was lower than other areas. Therefore some people in disadvantaged areas with stroke symptoms were more likely to die before being admitted to hospital for treatment. Lesley Dwyer supported this view.

Treatment of stroke victims – How would patients who suffered a stroke while being transferred be treated?

Response – Patients who walked into a non-HASU site or who suffered a stroke as an in-patient would be critically transferred by ambulance to a HASU site.

Staff restructuring - What are the implication for staffing? Why was option B evaluated so strongly against the workforce criteria?

Response – Lesley Dwyer said that she thought staff would vote with their feet and it would increase the challenge for Medway NHS Foundation Trust to maintain its stroke services. The level of workforce shortages was well known

and there would be a risk for all Kent and Medway during the transition process.

Rachel Jones said that the business case would be developed quickly to reduce the level of uncertainty. There was a need to move to the preferred option and give reassurance to staff.

Net present value – The net present value calculation to show the overall financial benefit over the next 10 years was calculated to be £12.1m for option B and £16.1m for option D. Did this reflect a greater level of investment in option B? Did option D score higher against the workforce criteria?

Response – Option B was assessed more favourably as the vacancy factor was not as high and the level of capital investment that would be required was a consideration. The evidence suggested that recruitment would be better now that a preferred option had been identified.

Members expressed concern that this response did not fully explain why option D was the preferred option against net present value criteria. Given that the higher value showed a greater benefit, option D would appear to be better than option B.

Implications of option B for Medway Maritime Hospital – Would option B have a negative impact on Medway Maritime Hospital?

Response - Dr Chris Thom of Maidstone and Tunbridge Wells NHS Trust said that the four hospitals worked together and the clinicians at each hospital met as a stroke team on a monthly basis and would be on call for all four hospitals. The clinicians' role was to support whichever option was chosen.

Dr Steve Fenlon of Dartford and Gravesham NHS Trust supported this view and said that all the clinicians had worked together as part of the process to reach a decision for the benefit of all patients from Kent and Medway.

Scope for challenging the decision – What was the process for challenging the decision once it had been made and would Medway Hospital be ready if the decision was reversed?

Response – The clinicians did not view the process from the perspective of individual hospitals. They worked together as a network of clinicians for the whole of Kent and Medway.

Lesley Dwyer said that the demographic of the local community supported the ambitions for the hospital to be a specialist emergency centre. The management team understood the healthcare needs of the local community and knew the hospital's limitations. She was confident that a HASU could be delivered at Medway Maritime Hospital within the required timescales set out in the review. However, once the decision was made, the hospital would work collegiately to ensure that the residents of Kent and Medway were better served.

Travel times to hospitals – There was concern that travel times had not been taken into account sufficiently. What consideration had been given to residents' ability to travel to hospitals in the preferred option within a reasonable time? 90% of Medway residents were being asked to accept travel times of around 45 minutes.

Response – Patients would only be admitted to a HASU when their condition was in the acute stage. They would then return home or be moved to a rehabilitation unit. It was recognised that transport to the HASU for relatives and carers could be an issue and consideration was being given to how this could be addressed.

Proximity of HASUs – Given that there was a HASU at the Princess Royal University Hospital in Bexley which was 23 minutes from Darent Valley Hospital, was it usual for HASUs to be located so close together?

Response – The two hospitals were not considered to be that close; Bexley residents tended to use Darent Valley Hospital.

Review of the preferred option – In view of the concerns expressed by members of HASC about the process for identifying a preferred option, including the apparent disregard for the results of the public consultation, increased travel times and the link between stroke and deprivation, it was hoped that the review team would reconsider the preferred option before the final decision was taken.

Medway Councillors who were members of the Joint HOSC would expect more detailed answers to the concerns raised by members of HASC when the Joint HOSC met informally on 12 October 2018 to discuss next steps ahead of receiving the business case at a formal meeting of the committee later in the year.

Decision:

The Committee:

i) Noted that Option B has been published by the NHS in Kent and Medway as the preferred option for the location of three hyper acute stroke units across Kent and Medway at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford.

ii) Agreed that comments and questions raised during the meeting as outlined above should be taken into the Joint HOSC process by the four Medway Councillors appointed to the Joint HOSC.

iii) Agreed that a Member briefing be held once the documentation from the evaluation workshop held on 13 September 2018 had been received, for representatives of the review team to give a more detailed explanation of the results of the evaluation process.

Chairman

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