Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Tuesday, 12 March 2019

6.40pm to 8.45pm

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), Aldous, Bhutia, McDonald, Murray, Opara and Price

Co-opted members without voting rights

Margaret Cane (Healthwatch Medway CIC Representative) and Shirley Griffiths (Medway Pensioners Forum)

Substitutes: None.

In Attendance: Laura Caiels, Legal Advisor
Steph Hood, STP Communications and Engagement
Rachel Jones, Senior Responsible Officer, Kent and Medway Stroke Review, Kent and Medway STP, Kent and Medway STP
Julie Keith, Head of Democratic Services
Chris McKenzie, Assistant Director - Adult Social Care
James Pavey, Regional Operations Manager, South East Coast Ambulance Service
Jon Pitt, Democratic Services Officer
Ray Savage, South East Coast Ambulance Service
Dr David Sulch, Medical Director, Medway NHS Foundation Trust
Dr David Whiting, Consultant in Public Health
James Williams, Director of Public Health

872 Apologies for absence

Apologies for absence were received from Councillors Clarke and Fearn.

873 Urgent matters by reason of special circumstances

There were none.

874 Disclosable Pecuniary Interests or Other Significant Interests and Whipping

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

There were none.

875 Outcome of NHS Consultation on Acute and Hyper-Acute Stroke Services in Kent and Medway

Discussion

The Director of Public Health introduced the report, summarising Medway's concerns in relation to the NHS chosen option for the Kent and Medway Stroke Review.

The report set out the outcome of the Kent and Medway Stroke Review Joint HOSC (JHOSC) meeting on 26 February 2019 that had considered the outcome of the review. This had followed the meeting of the Joint Committee of Clinical Commissioning Groups for Stroke (JCCCGs) on 14 February. This had selected Option B, which would locate Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital in Dartford, Maidstone Hospital and the William Harvey Hospital in Ashford.

Medway Members of the JHOSC did not consider that Option B was in the best interests of the population of Kent and Medway. A motion was put to the JHOSC requesting that it recommend that the individual health scrutiny committees of Medway, Kent, Bexley and East Sussex consider referring the decision to the Secretary of State for Health. This motion was not agreed. The JHOSC then recommended that the individual committees do not make a referral. The Medway Health and Adult Social Care Overview and Scrutiny Committee needed to determine whether the decision to select Option B warranted referral to Secretary of State for Health in view of the issues identified in relation to it.

Medway had relatively high levels of deprivation with some of the population living in areas amongst the most disadvantaged communities in England. Medway Maritime Hospital served a population of approximately 500,000 from Medway, Swale and elsewhere in Kent. Evidence from the Sentinel National Stroke Audit programme that monitors outcomes for people who have had a stroke showed that people from more disadvantaged communities had worse outcomes if they had a stroke.

The proposed HASUs set out in Option B were located in some of the more affluent CCG areas in Kent and Medway. The JCCCG had been told that Option B would reduce health inequalities but Medway Council had seen no evidence that this would be the case and none had been presented to the CCGs. Furthermore, Option B would increase the likelihood of health inequalities persisting in Medway and disadvantaged parts of Kent.

Mitigation work had been undertaken by the NHS to ensure that Option B would provide sufficient bed capacity. However, under Option B, bed capacity would be insufficient by 2023 without further action as the proposed mitigations were based on the assumption that patient length of stay could be reduced in order to free-up beds.

The Council had commissioned an independent review of the Stroke Review decision making process. This had identified that the weighting of additional factors, not considered at the consultation stage, had resulted in Option D not being identified as the preferred option. Had these factors not changed, it was considered likely that Option D would have been selected.

A range of issues had been identified by the NHS that needed to be resolved in order to make the stroke system work effectively post HASU implementation. The JCCCGs had said that a transport advisory group should be established to consider how people would travel to and from the HASUs. The financial sustainability of Option B also needed to be further reviewed and work was required to mitigate against the impact of health inequalities. Work was also needed to ensure that the prevention workstream reduced the likelihood of first strokes or repeat events.

The Senior Responsible Officer for the Kent and Medway Stroke Review responded to the concerns highlighted. Work had taken place during the previous two months to address these concerns. In relation to health inequalities, HASUs would result in all Kent and Medway stroke patients having improved outcomes, regardless of where they lived. The existing stroke units in Medway and Thanet were amongst the worst rated in the country, with there being too many units for the number of staff available in Kent and Medway. The Joint Committee of CCGs (JCCCGs) had recognised that improvements delivered by HASUs would not address the gap in health inequalities and had, therefore, made a commitment to focus on this with the development of a prevention Business Case having been requested. Prevention of stroke would help to address health inequalities.

Significant work had been undertaken in relation to bed capacity although it was difficult to mitigate this challenge. A commitment had been made to reducing the average length of hospital stay for stroke patients by three days over a five-year period. This would make length of stay at the Kent HASUs similar to that of existing HASUs and Acute Stroke Units (ASUs) elsewhere in the UK. Should this reduction not be achieved, 22 additional beds would be provided to ensure sufficient capacity was available. This would include 14

beds at Darent Valley Hospital, four at Maidstone and four at William Harvey Hospital.

In relation to the evaluation criteria for identifying the preferred option, the criteria had not been weighted, with each criterion having been considered equally. The Deliverability Panel had scrutinised the process following advice received that external scrutiny was required. This had included consideration of ability to deliver and go-live plans. Work would continue in relation to transport for patients and their families.

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

Rating of Medway Maritime Hospital Stroke Unit – In response to a question asking how much the Stroke unit at Medway Hospital would improve from its current E rating, on an A to E scale with A being the best, in the event that it became a HASU, it was confirmed that all HASUs would be expected to achieve an A rating within six months of go-live.

Health inequalities – The NHS had previously stated that people from more deprived areas would benefit disproportionately from the establishment of HASUs but this claim was no longer being made with frailty now being presented as an important factor in the siting of HASUs. It was questioned what specific evidence was available in relation to the impact of the development of HASUs on health inequalities as improving outcomes for all was not the same as reducing inequalities and the renewed focus on prevention was also not relevant to this. The concept of disproportionate benefit had not been included in the public consultation. Consideration of inequalities and their impact on the consultation options should have been included. It was the NHS that had first made the assertion that the preferred option would reduce health inequalities.

The Senior Responsible Officer (SRO) said there was clear evidence that the development of HASU / ASUs would result in improved outcomes for all patients. It was reiterated that some Kent and Medway residents were currently served by stroke units that were among the worst performing in the country. The development of HASUs would result in all stroke patients receiving an improved service. In terms of health inequalities, prevention made the most significant difference, which was why the JCCCGs had asked for a business case to be developed. Inequalities had not been included in the original business case as outcomes would improve for everyone. The SRO said that, latterly, consideration had been given to inequalities as this had been raised by the Stroke Review Joint Health Overview and Scrutiny Committee.

Scoring of options – In response to a question asking how consultation option B had scored higher than the other options, the SRO confirmed that five options, A to E, had been consulted upon. These options were further evaluated in order to identify a preferred option. This had included assessment against deliverability and implementation. Option D had evaluated less favourably than Option B at this stage.

Inclusion of the PRUH and consultation evaluation – A Committee Member commented that the Princess Royal University Hospital (PRUH) in Orpington had not been included in the public consultation, while another Member said that the results of the consultation had been completely disregarded at the September 2018 meeting that had identified the preferred option. The STP Communications and Engagement representative said that the impact of the PRUH on neighbouring hospitals had been considered but that it had not been part of Option D. Some Committee Members said they disagreed with this.

Data to be provided to the Committee – In the event that Option B was implemented, there would be an expectation that the Committee would be provided with quarterly reports from the Sentinel Stroke National Audit Programme (SSNAP) showing outcomes for Medway patients. The data to be provided would also include mortality reports, broken down by quintile of deprivation across Kent and Medway, for before and after the establishment of HASUs as well as data on hospital length of stay. The SRO confirmed that this data would be provided.

Impact of the consultation on decision making – The STP Communications and Engagement Lead said that the consultation had been undertaken across 10 clinical commissioning groups, including Medway. This covered a population of 2.2 million across Kent and Medway and the boundary areas of East Sussex and South East London. The consultation had gathered insights, views and concerns and provided an understanding of support for the consultation options. The JHOSC had agreed that the consultation was robust. The results of the consultation had been given in-depth consideration by the JCCCGs as had other considerations, such as workforce and finance. The JCCCGs had considered the raw consultation data as well as the consultation feedback report. A significant period of time had been spent analysing the feedback and compiling the Decision Making Business Case. In response to a further Committee Member question, it was confirmed that the consultation had followed the same format at all public meetings. Any data that had been anonymised for events held in Medway would have been anonymised elsewhere.

Confidence in process – A Member said that people in Medway lacked confidence in the consultation process and did not feel that their views had been properly considered. It was questioned whether the Stroke Review team felt the process to have been flawed given that Medway Maritime Hospital had been included in three of the consultation options but was not in the final chosen option. The Communications and Engagement Lead said that Medway and all other areas had been listened to. Common themes had been identified, such as concern about travel arrangements for relatives of stroke patients.

Bed Capacity – Independent analysis had identified risks in relation to the bed capacity of Option B and that Option D could have better capacity. A Member asked whether additional work would be undertaken to consider whether risks attributed to Option B could be better mitigated by Option D, whether detailed risk modelling had been undertaken for the other options, besides Option B and

whether work on the Decision Making Business Case (DMBC) had intended to make Option B appear stronger.

The SRO said that work had been undertaken in relation to potential increases in demand. She noted that the DMBC had forecast that demand would not increase significantly. However, the South East Clinical Senate had referred the Stroke Review team to evidence suggesting that demand could increase due to an aging population. The Senate had, therefore, requested that modelling work be undertaken in relation to bed capacity. Significant work had been undertaken with Medway Public Health to look at capacity needs over the next 20 years. Robust mitigations had been put in place relating to length of stay and bed capacity. Mitigation work had only considered Option B. There was no expectation that similar work would be completed for the other options. This work had not been undertaken to strengthen Option B but rather to answer the questions and concerns raised about Option B.

Acuity of patients – A Committee Member said that there was evidence that patients in Medway tended to be sicker than patients elsewhere before they would be admitted to hospital. Another Member highlighted that people from deprived backgrounds tended to have lower recognition of the importance of symptoms and were therefore more poorly when an ambulance was called.

The Regional Operational Manager of South East Coast Ambulance Service said that ambulance responses were driven by an assessment of the condition of the patient with geographic location having no bearing on the response. His experience did not indicate that people from deprived backgrounds called ambulances later and ambulances actually attended patients in deprived areas more frequently. There had been a successful campaign to help the public recognise stroke symptoms which had led to an increase in calls.

The Director of Public Health advised that a national stroke survey had found that people in deprived areas were less likely to recognise symptoms and therefore likely to be in a worse state when they called ambulance. This same review, using data from the national Stroke Sentinel Survey, found people living in areas of deprivation were also more likely to have a stroke, than those living in more affluent areas.

Transport Advisory Group – A Member asked when the decision had been made to establish a Transport Advisory Group, how it would help Medway and what representation Medway residents would have.

The SRO said that three groups had been established across Kent and Medway, including one for Medway and Swale. Initial meetings had taken place, with the Medway and Swale Group having agreed to focus on patient discharge from hospital and associated transport and access arrangements. Suggestions made by each group would be submitted directly to the JCCCGs for consideration. Membership of the groups included a number of volunteers with the roles having been advertised. A list of those who had attended the Medway and Swale Group would be provided to the Committee. A Member said that they had not seen adverts for public participation in the Group.

It was requested that details of the membership of the existing Patient and Public Advisory Group be provided to the Committee. This group was part of existing NHS infrastructure and had been established three to four years ago. The Group had considered the stroke review proposals and consultation activity and it was confirmed that there was Medway representation on this Group. The Public Health Consultant highlighted that the Stroke Programme Board meeting on 30 January had talked about the establishment of a Patient Advisory Group, which suggested that the Group was being newly established. The SRO suggested that this was an error and that the reference should have been to the Transport Advisory Group. She undertook to clarify this point.

Consultation Process – A Member asked, whether, in view of inconsistencies in the consultation process, the decision to select Option B would be reconsidered and alternatives to the current model, that would better meet the needs of Medway, be considered. The SRO said that the decision would not be reconsidered as Option B had been the preferred option identified from full analysis of the consultation findings and all other relevant information.

Importance of Rehabilitation – A Committee Member said that rehabilitation would become even more important for Medway if it did not host a HASU. No clear information had yet been provided about rehabilitation, such as the locations of these services or the structure of these services. The SRO advised that rehabilitation services would be close to patient homes and aligned with community hubs. Medway and Swale already had strong community facilities that some other parts of Kent did not. An audit had been undertaken to provide an understanding of existing provision. A draft business case would be completed in early April with the expectation being that this would be finalised by the end of May. The Business Case would not be put forward to the JCCCGs until there was confidence of local support.

Outcomes in relation to journey times – In response to a Member statement that longer journey times to a HASU would lead to worse patient outcomes, the Regional Operations Manager accepted that this would be the case if everyone could be taken to a specialist centre as close as possible to their location. However, there was exceptionally strong evidence that taking patients to a HASU would result in a better outcome than a shorter journey to a non-HASU site.

Stroke rehabilitation Pathway – In response to a Member question about how the rehabilitation pathway would work and why rehabilitation had not been considered earlier in the Stroke Review, the SRO said that there would be several different pathways. Some patients would be well enough to go home directly from a HASU, with rehabilitation taking place in their home or in an outpatient facility close to their home. Medway had two good community hospitals with it being envisioned that these could be used. The focus of the stroke review had initially been on acute provision as this was the key to saving lives and reducing disability. However, outcomes would be better if acute provision and rehabilitation were integrated. It had not originally been intended that new rehabilitation provision would go live at the same time as acute provision but there had been feedback that the provision of acute stroke care

would be compromised without there being appropriate rehabilitation provision in place. (It was later clarified that Medway Community Health Care currently provided stroke rehabilitation which was not currently delivered via a community hospital model in Medway). Details of the planned rehabilitation facilities in Medway would be provided to the Committee. In Thanet, consideration was being given as to whether to provide rehabilitation services within the acute hospital. This was something that could be considered in Medway if there was a local appetite.

Workforce requirements – A Committee Member asked whether the workforce needs of each HASU had been finalised, how many staff would be needed, where they would be based and what action would be taken if it was not possible to obtain sufficient staff. The SRO said that the provision of HASUs would result in there being full specialist cover at all sites 24/7, which was not the case for existing non-HASU stroke units. It was anticipated that the equivalent of 7.1 consultants would be provided at Maidstone Hospital, 7.1 at Darent Valley Hospital and 9.6 at the William Harvey Hospital. Staffing levels would be over and above those specified in national guidance. Staff would move between the three HASUs when required but would have a base hospital. It was anticipated that staffing requirements would be met and it was noted that simply meeting, rather than exceeding, the national standard would enable three HASUs to operate.

Workforce evaluation – A Committee Member said that the evaluation of the workforce at each of the potential HASUs had been inconsistent. At the start of the consultation, workforce factors at each hospital site had been considered to be similar and would therefore not have had a significant impact on the option chosen. However, following the consultation, Medway had been evaluated less strongly than other sites and it was difficult to identify what had changed. This appeared to have then changed again, with the papers considered by the JCCCGs on 14 February suggesting that workforce considerations had not had a significant impact on the option selected. The consultation had been in relation to stroke services and not about wider workforce considerations at each hospital but the Member felt that these wider issues had been considered subsequently in order to support the decision made to select Option B.

The SRO said that the way in which workforce requirements had been evaluated had not changed during the process. Factors considered had included the gap between the current workforce and the workforce required to provide a HASU and levels of staff vacancies and turnover. Implementation of a HASU would be a boost to the host hospital in terms of wider recruitment. Consequently, these factors were considered in the evaluation. The three hospitals in Option B had evaluated more strongly against these metrics.

Staff morale – In response to a Member question, the Committee was advised that decisions were communicated to staff immediately in order not to unnecessarily harm morale. There had been a number of meetings with staff at the existing stroke units. All staff had been assured that they would have a job following the implementation of HASUs. Morale would be boosted by

implementation of the HASUs as soon as possible. Any delay also risked staff being lost to neighbouring areas that already had HASUs.

Rollout of HASUs – It was confirmed that the existing stroke units would remain open until after the HASUs had become operational. The HASUs at Maidstone and Darent Valley would be ready to open earlier than the unit at the William Harvey Hospital. The preference of the Clinical Reference Group was for Maidstone and Darent Valley to open first, followed by William Harvey, rather than waiting until all three units could open simultaneously. Concerns had been raised at a meeting of the JHOSC about the inequality of the William Harvey HASU opening later than Darent Valley and Maidstone. A workshop event would be arranged to give further consideration to the phasing of the implementation. A Committee Member suggested that the phasing of HASUs would not be fair on patients who would not be taken to a HASU while patients elsewhere in Kent and Medway would. The Stroke Review team noted that there was currently an inequitable service for all of Kent and Medway as there were already HASUs in East Sussex and London but it was acknowledged that the phasing decision was a difficult one.

Changing the decision – A Committee Member asked if anything would make the JCCCGs reconsider its decision. The SRO said that this would not happen unless there was intervention by the Secretary of State for Health.

Closing comments – A Member said that this challenge was being made to save lives rather than because there was any desire to hold up the process. It was considered that there were inconsistences in the consultation and review process.

The SRO said that the review had tried to listen to concerns raised and answer questions as best as it was able in order to select the best option for the population of Kent and Medway as a whole.

A Member said that there had not been a preconceived idea that a HASU would be located in Medway and asked what evidence there was to support the claim that HASUs would save a life a fortnight in Kent and Medway. The SRO advised that this was based upon expected improvement to the service once HASUs had been implemented and upon the current number of strokes treated and patient outcomes. This had been evidenced by work with researchers at University College London. The supporting methodology would be shared with the Committee.

Another Committee Member said they were not only considering the needs of Medway as they considered that Option D was in the overall best interests of the health service in the whole of Kent and Medway.

Decision

The Committee agreed:

i) To exercise the power to report to the Secretary of State for Health about the proposed establishment of Hyper Acute Stroke Units (HASUs) at Darent Valley Hospital, Dartford, Maidstone Hospital and William Harvey Hospital Ashford (consultation Option B) and resulting removal of acute stroke services from other hospitals in Kent and Medway, including Medway Maritime, for the reasons set out in paragraph 6.2 and on the basis that the requirement to take practical steps to reach agreement with the NHS on this matter have been taken, as set out in paragraph 10.4.

ii) To Delegate authority to the Director of Public Health and Head of Democratic Services (who is the Council's Designated Scrutiny Officer) to take the necessary steps to produce and submit the report to the Secretary of State for Health, based on the rationale set out in paragraph 6.2, in consultation with the Chairman, Vice-Chairman and Opposition Spokesperson of this Committee.

iii) To formally notify the Joint Committee of Clinical Commissioning Groups for Stroke Services of the decision to report to the Secretary of State.

Chairman

Date:

Jon Pitt, Democratic Services Officer

Telephone: 01634 332715
Email: democratic.services@medway.gov.uk