Minutes of the Coventry and Warwickshire Joint Health Overview and Scrutiny Committee held at 10.00 am on Monday 14 October 2019

Present:

Members of the Committee:

Warwickshire County Council (WCC): Councillors Margaret Bell, Clare Golby, John Holland, Wallace Redford and Jerry Roodhouse.

Coventry City Council: Councillors Joe Clifford, Marcus Lapsa and Rachel Lancaster.

Other Elected Members:
Councillors Les Caborn (WCC), Marian Humphreys (North Warwickshire BC), Judy Falp (Warwick DC), Neil Phillips (Nuneaton and Bedworth BC)

Employees:
Warwickshire County Council
Shade Agboola, Rachel Barnes, Becky Hale, Helen King, Nigel Minns, Isabelle Moorhouse, Paul Spencer.

Coventry City Council
Victoria Castree, Gail Quinton

Representatives of Health Organisations:
Dr Sharon Binyon, Jed Francique, Dr Rob Holmes and Claire Quarterman (Coventry and Warwickshire Partnership Trust)
Dr Gavin Farrell (South Warwickshire Foundation Trust)
Prof. Sir Chris Ham and Rachel Danter (Coventry and Warwickshire Health and Care Partnership)
Clinical Commissioning Groups (CCGs): Gill Entwistle and Dr David Spraggett (South Warwickshire), Sarah Raistrick (Coventry and Rugby) and Adrian Stokes & Rose Uwins (representing both Coventry and Rugby and Warwickshire North CCGs)
Chris Bain (Healthwatch Warwickshire)
David Spurgeon (Healthwatch Coventry)

Other Attendees:
David Lawrence (Press)
Prof. Anna Pollert and Dennis McWilliams South Warwickshire Keep our NHS Public

1. General

(1) Appointment of Chair

It was noted that Councillor Wallace Redford would chair this joint meeting in accordance with the terms of reference for the Joint Health Overview and Scrutiny Committee (JHOSC).

(2) Welcome and Introductions

The Chair welcomed everyone to the JHOSC meeting.

(3) Apologies

Apologies for absence had been received from Councillors Ed Ruane and Hazel Sweet (Coventry City Council).

(4) Declarations of Interest

Councillor Jerry Roodhouse declared a non-pecuniary interest as a Director of Healthwatch Warwickshire.

(5) Chair's Announcements

The Chair advised that the stroke services item was a formal consultation on a service reconfiguration, which would be considered after this meeting by the scrutiny committees of both Coventry City and Warwickshire County Councils, before coming back to this body for the determination of the response to the consultation. The other items on this agenda were discretionary items.

(6) Minutes

The Minutes of the JHOSC meeting held on 20 March 2019 were accepted as a true record and signed by the Chair.

2. Public Speaking

Mr Dennis McWilliams and Professor Anna Pollert had given notice of questions to the JHOSC. The questions are attached to the minutes at Appendices A and B respectively. The Chair responded that a written reply would be provided to the questions after the meeting.

3. Coventry and Warwickshire Strategic Five-Year Health and Care Plan 2019/20 – 2023/24

Sir Chris Ham, Independent Chair of Coventry and Warwickshire Health and Care Partnership (HCP) presented the five-year strategic plan for consideration and comment.

Sir Chris summarised the key points of the draft plan and the work undertaken to date. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) were required to create five-year strategic plans, setting out how systems would deliver the commitments in the NHS Long Term Plan.

There was an expectation that STPs/ICSs would bring together member organisations and wider partners as they developed and delivered the plans. A key principle was that the plans should be owned locally.

The draft plan was submitted and feedback was being sought prior to 15 November 2019, when the final plan would be submitted to accord with national timescales. The summary priorities of the draft plan were confirmed.

Sir Chris referred to the process involved in developing the former STP and the different approach undertaken for this document, working with local Healthwatch organisations and building on the work of the two local health and wellbeing boards. The work on prevention and promoting health and wellbeing were referenced particularly and the plan sought to align with these aims. A priority was the aspiration to integrate health and care around patients and populations, with an asset-based approach to health and wellbeing, involving all sectors. There was an aging population who had complex needs that required joined up services.

There was a wish to work differently and to engage more. Sir Chris outlined the three strategic priorities in the plan for the next five-year period being to promote healthy people, build stronger communities and develop effective services. He referred to the four 'places' across Coventry and Warwickshire and approximately 80% of the Plan's ambitions would be delivered in place, rather than across the system. There would be local partnership arrangements for each of the places. For complex services, a system-wide approach would still be required. He highlighted the focus on urgent and emergency care and the pressures these services faced year-round, as well as mental health services, cancer care, stroke and maternity & young people services. Money was a further challenge and whilst additional government funds were being provided to the NHS, there was an increasing and aging population who required more services. The financial constraints for other organisations was a further driver for partnership working. Sir Chris referred to staffing aspects and the shortages in some areas. Investing in the workforce, to recruit, retain and train staff was a further priority. He closed by reiterating the points on prevention and giving young people the best possible start in life. The aim was to have a more resilient urgent and emergency care, strengthened general practice, out of hospital care and social care.

The draft plan was informed by a focused engagement exercise, details of which were provided. The understanding of population needs was drawn directly from the local joint strategic needs' assessments (JSNA). The plan had been developed by the senior responsible officers for each of the workstreams, with involvement from stakeholders across the system. Clinicians had been engaged fully in developing the plan and the supporting clinical planning templates.

Questions and comments were submitted, with responses provided as indicated:

- In the previous STP, it had identified a saving need of £267m. There was a need for increased funding to provide services for the area's aging population. The reference to funding cuts in the STP was really about addressing a gap in funding between identified need and the resources available. There would be a continued growth in funding to the NHS locally, but this would not be sufficient to meet anticipated service demands. The local NHS spent about £1.4bn annually. It was perceived that efficiencies could be achieved to make better use of this money and the other assets available.
- Life expectancy had effectively stalled and it was suggested that the plan make reference to how this would be addressed. This point was broader

than for the UK alone, affecting countries who were not experiencing austerity. It was against the backdrop of the significant improvements made previously. Perhaps the limit on life expectancy had been reached, unless there was further advancement of medical science.

- The place-based approach was welcomed as there were differences between Coventry and Warwickshire and within areas of Warwickshire itself. There would need to be further disaggregation to each local area. Sir Chris agreed that the plan did work at the micro level, being based on JSNA data.
- A view that JSNA boundaries did not align geographically with the boundaries of organisations or elected members' areas.
- Reference to the finance assumptions and the underlying deficit of £101m. The eight finance principles were welcomed with further information being sought on the governance principles.
- Productivity and efficiency were raised. This showed an efficiency requirement of £119.4m and the need for a different approach to achieving savings. This was linked to the previous section on the approach to engagement and co-production. Previous documents had similarly referred to these aspirations, but they hadn't materialised and further information was sought on how work with the voluntary and community sector (VCS) would be approached. Sir Chris acknowledged the financial gap and underlying deficit, whilst reminding of the partnership's status and that financial accountability remained with the CCGs and trusts. NHS bodies were working hard themselves and with partners to address the financial aspects. There were opportunities for efficiency for example in medicine optimisation, collaboration and reducing duplication. In responding to the points on co-production, he made reference to the work with Healthwatch as a body that brought together many smaller groups, but acknowledged that the NHS could do more and learn from local authorities in working with the VCS.
- It was questioned how the system learned from feedback and could become more transparent and accountable. It would be helpful to see this referenced in the document. Some people were fearful of making complaints in case it impacted on the treatment they received. Sir Chris wished to reflect on this point, to provide a more reasoned response.
- Providing additional services at GP surgeries to reduce reliance on accident and emergency (A&E) and outpatient appointments. Coventry's population comprised 33% of people of black and minority ethnicity (BME). It was noted that a higher proportion of the BME population attended A&E. There could be more cohesion. Sir Chris referred to the 18 PCNs being established, which were groupings of GP practices to address workforce challenges and meet the growing needs of the population. These organisations were still developing in the main, although some were better established.
- Reference to the difficulties caused by the 2016 STP document which led to rumours about the closure of maternity services and A&E at the George Eliot Hospital. Clarity was sought that there would be no such closures arising from this review. This also had an impact in recruiting and retaining staff.
- Some of the positives in the report were noted in regard to maternity services, notably the 23% reduction in still births and the 17% of women now having a single midwife throughout their maternity, which was valued

especially for those with difficult pregnancies. Sir Chris Ham confirmed there were no plans to close maternity units. The staffing challenges provided the rationale for working together, rather than in isolation. There was a major piece of work being led by CCGs on how to improve maternity services.

- Reference was made to the key risks and mitigation measures in relation to workforce. There were no plans to increase the workforce numbers, at the same time as reducing agency staff numbers. This implied that existing staff would be asked to do more and could impact on the quality of service provided. The implications of Brexit were raised. The detailed risk register would be welcomed and it was perceived that there was not sufficient funding within the system. Sir Chris agreed with the points on workforce and funding pressures. Staff were working hard to deliver the best services they could, but there was mounting evidence to show the impact this was having on frontline staff. This was why the workforce aspects were referred to extensively in the report. On agency staff there was a need to reduce reliance on them where possible, given the high costs of using agency staff.

Resolved

That the Joint Health OSC:

1) Notes the process for developing and engaging on the draft Plan; and

2) Considers and comments on the draft Plan ahead of final submission by 15 November 2019.

4. Developing Stroke Services in Coventry and Warwickshire - Public Consultation

This item was introduced by Adrian Stokes, Accountable Officer for Warwickshire North and Coventry & Rugby CCGs. The aim of the proposals was to improve stroke services, which were part of both CCG plans and the health and care system improvements identified under the previous item. It had been shown that current local stroke services could achieve better health outcomes for patients and more effective and efficient services. The analysis of current services showed considerable unwarranted variation and inequity. Options for the future delivery of stroke care had been co-produced and appraised through a process involving extensive professional, patient and public engagement.

Adrian Stokes referred to this engagement over the last four years and the current public consultation process underway on the proposed future stroke pathway. Detailed clinical engagement had also taken place and clinicians were in attendance. The report stated that the preferred future stroke pathway would improve the quality of outcomes and clinical care and remove the current variation in access to care. This proposal was for a whole stroke pathway improvement. He also referred to the bed modelling and service delivery in the home. A lot of work had been undertaken on the preventative aspects. Mr Stokes referred to the plans for a hyper acute stroke unit (HASU) and the subsequent rehabilitation support. It was believed this review was the best solution for the whole stroke pathway. He

outlined the learning from the earlier engagement phases and the changes to the proposals, especially for additional ambulance support and workforce aspects.

The Pre-Consultation Business Case (PCBC) was submitted to NHS England and its panel granted provisional assurance, subject to some minor amendments. These amendments had subsequently been completed and the consultation document had been signed off by all local CCGs. The consultation document had been provided as an appendix to the report.

The financial implications were reported. This proposal represented an investment of nearly £3.1 million. He outlined how the public consultation would be undertaken between now and 21 January 2020, with a formal pause over the Christmas holiday period.

Dr Gavin Farrell outlined his involvement in the review as a clinician over the last five years. He referred to the work on early discharge and support in the home, with the excellent outcomes from this initiative in terms of reduced disability for patients and social care cost savings. The proposed review had been clinically led and sought to design the best outcomes from stroke in both the acute and community phases of the pathway.

Questions and comments were submitted, with responses provided as indicated:

- There was recognition of the extensive consultation undertaken to date and the investment being made in stroke services.
- An earlier concern was how the predicted reduction in the number of stroke cases had been modelled and further information was sought about the proposals for community based atrial fibrillation (AF). Early access to the HASU and AF were both stated as ways in which the number of strokes would be reduced.
- There would be some public concerns about transport and accessibility to the HASU at UHCW, especially for relatives wanting to visit a patient. The concerns for relatives and visitors was acknowledged, but it was considered this would be offset by bedded rehabilitation being closer to home.
- It was noted that investment had been made to commission additional services from West Midlands Ambulance Service (WMAS). Members questioned how well WMAS had been engaged in these proposals and they had been involved extensively and would be present at the public consultation events. The additional funding was to ensure WMAS could achieve the required response times.
- Where patients were in hospital with another condition and then suffered a stroke, it was questioned how they would be treated and whether they would be relocated to the HASU. If a patient suffered a stroke whilst in hospital, their treatment would be prioritised on the basis of the dominant condition. There would still be stroke physicians at both Warwick and George Eliot Hospitals, as these would be bedded rehabilitation sites.
- An assurance was sought that ambulance response times and access to the UHCW site could be achieved. Access for WMAS via School Lane was referenced particularly. Adrian Stokes would ask WMAS to provide a formal response to give this assurance to members. He added that there was a streamlined approach at UHCW so when the patient arrived, they were transferred to the HASU as soon as possible. Some patients were already

being transferred to UHCW within four hours for treatment. Access to the site was much better following the introduction of revised parking arrangements.

- The rotation of specialist staff across the sites was discussed. The recruitment and retention challenges were acknowledged especially for acute stroke consultants. The model proposed was an exemplar and it was hoped this would be attractive to staff. Good training and rotation across sites were proposed as part of the vision and this should assist with staff retention.
- If the proposals were approved, there would be implementation of the community services first, to ensure that the modelling, bed numbers and patient flow were correct, before the acute centralisation took place.
- The decision on acute centralisation would be subject to further consultation as part of a staged and monitored process. This clarity was welcomed to avoid any rumours developing that services were being reduced.
- With regard to the report's recommendations, it was not yet possible for the joint committee to provide its formal response. There were some minor aspects to resolve and members would need to see the consultation feedback before submitting their views. It was confirmed that each council's health scrutiny body would review the proposals in detail, before reaching a conclusion at a further JHOSC meeting.
- The WMAS transfer times were a crucial aspect and there were differences between the city of Coventry and a predominantly rural county like Warwickshire, it being questioned if the timescales could be achieved. A meeting with WMAS was required. It was confirmed that WMAS would be involved in the consultation meetings.
- The location and timing of the consultation meetings was raised and these needed to be easily accessible so people could contribute to the review.

Resolved

That the Joint Health OSC:

1. Notes the pre-consultation business case and consultation documentation.

2. Provides its formal response to the consultation following the further discussion of the issues raised above.

5. Coventry and Warwickshire Partnership Trust (CWPT) – Inpatient Bed Review

A report and brief presentation was provided by Dr Rob Holmes with contributions from Dr Sharon Binyon and Jed Francique. This briefed the JHOSC on the programme of inpatient service development and reconfiguration to develop a high performing mental health acute and urgent care pathway in Coventry and Warwickshire.

The programme was one of the workstreams of the Mental Health programme of the Coventry and Warwickshire Health and Care Partnership (HCP). A number of key principles had informed the programme and these were detailed in the report.

A range of projects had been initiated to enhance community-based urgent care to offer triage, assessment and treatment of patients with mental health issues in a responsive and timely manner. CWPT was continuing to review and develop its plans to provide a clearer and more focused set of services across the mental health inpatient sites, being the Caludon Centre in Coventry, St Michael's Hospital in Warwick and the Manor site in Nuneaton. These plans were clinically driven to support the appropriate specialisation and effectiveness of services. It would reduce the need to send some patients out of area to receive their treatment.It was recognised that meaningful stakeholder engagement was essential for the development and finalisation of the plans.

Questions and comments were submitted, with responses provided as indicated:

- The focus on mental health services was welcomed. There were some gaps in provision in the north of the Warwickshire and it was hoped this review would address them.
- Parallels were drawn to the previous item on the review of stroke services, again proposing the centralisation of acute services in Coventry with community services in other locations. There was a need for meaningful consultation with the provider taking on board the feedback received. Furthermore, the community services needed to be established before the acute service changes were implemented.
- Reference was made to the 'Housing First' initiative in Coventry that sought to assist homeless people. A member asked if there were good links to other 'wraparound' support services. CWPT had embedded two specialist nurses in the P3 project in Warwickshire. Meetings were planned with Coventry City Council to explore how those organisations could work together more cohesively. There was a broader aspect in terms of developing housing solutions. Some progress had been made, but more could be done. There were models of support elsewhere in the country where local authorities and mental health service providers were working together on housing projects.
- It was noted that CWPT wanted to work collaboratively, but at the same time it was configuring its services around specific sites. Given the earlier references to place based working and PCNs, it was questioned how this review would align.
- Dr Holmes spoke about the work with PCNs, which were at different stages across the county. Dr Binyon explained how the five year plan referenced mental health services through its work streams and the additional monies allocated to acute liaison and crisis services. There were plans in place to utilise this and anticipated future funding for primary care services. A comparison was drawn to the stroke review and the rationale for short term specialist inpatient care and then more community-based treatment afterwards.

Resolved

That the Joint Health OSC notes the briefing.

6. Merger of the Clinical Commissioning Groups (CCGs)

A report was introduced by Gillian Entwistle, Chief Officer, South Warwickshire CCG, who also provided a brief presentation to the Joint Committee. She clarified that the CCGs were considering options at this stage and hadn't decided to merge.

The local health commissioners were considering how best to support the move to an Integrated Care System (ICS) and how organisations would need to change. An outline was given of the process to date and the current position of the three CCGs. Whilst members in South Warwickshire supported a merger, the governing bodies of the other two CCGs had requested further assurances before reconsidering this matter in November 2019.

Continuing engagement would take place with stakeholders. Should there be a consensus for full merger, the detailed application would be developed for consideration by NHS England with a view to the merger being effective from 1 April 2021. There was a financial requirement for CCGs to reduce internal running costs by 20% in the next year.

Questions and comments were submitted, with responses provided as indicated:

- There were merits in having a single CCG, but may be concerns that localised issues were masked because the reporting was at a broader level. The data needed to be shown at local levels to highlight specific concerns. The same points had been made by local GPs. Local data would still be reported and there would be four places rather than the current three CCG areas. Additionally, data could be compiled at the PCN level.
- Concerns had been raised at the last County Council health scrutiny committee on some aspects of CCG performance, resulting in a further meeting with CCGs to explore this. CCG representatives apologised for their lack of attendance at the recent meeting.
- Reference was made to the anticipated housing growth across Warwickshire from local plan data. It was questioned if services were expanding at the required rate and confirmed that population growth data had been modelled into the five-year plan.

The Chair closed the discussion noting that the further meeting with the CCGs had been arranged. The CCGs would be asked to give a further update as their proposals for review were finalised.

Resolved

That the Joint Health OSC notes the briefing.

6. Any other items of business

There were no additional items of business.

The meeting closed at 12.00 pm

Appendix A

Statement and Question from Dennis McWilliams, Chair SWKONP,
Subject CCG Merger proposals.

Re Item 6
Update on the Future of Health Commissioning Arrangements in Coventry and Warwickshire has a Recommendation

1. **Members are asked to receive the report for information and assurance.**

The report includes the statement:

2.2 We are continuing our engagement with stakeholders throughout this period and beyond, and this meeting provides a further opportunity for our engagement and discussion with you on this matter.

The Briefing Note to Item 6 under **Next Steps** states

6.1. The CCGs continue to provide additional information, including how the new options might look in practice, and to answer questions received from stakeholders and the public, Members, the Local Medical Committees (LMCs), and CCG staff.

There is no mention of local authorities or of HOSCs in these documents. It has been more a question of sidestep than next steps. Reviewing the history reveals:

The proposal Transition Case for Change on CCG merger was published on the 22nd May 2019. There was nothing before the July HOSC on CCG mergers.

The WCC HWBB met on the 1st May (so no mention), sadly did not meet in July, and next met 11th September. It was then reported:

> *A vote of the membership of NHS South Warwickshire CCG in May 2019 identified merger as the option preferred by the majority. NHS Coventry and Rugby CCG and NHS Warwickshire North CCG are continuing to review the options and intend to conduct votes in November 2019, following receipt of a revised case for change.*

The WCC HOSC Agenda paper for 25th September stated

> *The focus for this meeting will include progress towards establishing a single CCG . . .*

But there was no report on merger and no-one from the CCGs attended.

I said at that meeting

> *The scheme for CCG merger is to fit with ICS system requirements, which are to be outlined in the promised STP [plan] update.*

There has been no plan update. Nor is there any "*revised case for change.*"

The WCC HOSC could not mandate delegates to this Committee as it has been ignored by the CCGs on the matter of merger. That is the shape of the "engagement and assurance" in practice.

Yet only the next day NHS England was recommending full local authority membership of ICS Joint Committees[1] and in terms that ICS joint committees "*decisions would also be subject to scrutiny by Local Authority Overview and Scrutiny Committees,*"

Unsurprisingly the WCC HOSC was dissatisfied. One of many expressions minuted was recorded

> **Before the merger of the CCGs was progressed, the Committee needed an assurance that the performance issues raised have been addressed. It would be less easy to monitor performance effectively when it was a monitoring report for a single CCG.**

Chris Bain for Healthwatch is reported to have said in moderate terms

> **it was important that CCGs engaged with the committee effectively, given the future work on primary care networks, integrated care, staffing levels post Brexit and the financial position of the health and care system.**

The Chair sought and gained members approval that

> **The CCG's senior officers would be invited to attend [an additional meeting of the HOSC]** with the minutes reporting **There was also a need to discuss the CCG merger proposals and the associated consultation arrangements.**

Plainly that must take place before any consent to merger by this Committee.

I would suggest that initially, at the least

- The above meeting must take place and its decisions honoured
- The stated "*revised case for change* come before HOSCs and the Joint HOSC
- The CCGs make the arrangements for consultation, as sought above (not, engagement, as proposed by the CCGs.)

My question is: **Does the JOINT HOSC agree to share the concerns and adopt the view of the WCC HOSC and so endorse the three bullet points above as a starting point for continuing scrutiny?**

Dennis McWilliams
Chair SWKONP

[1] Ian Dodge NHS Recommendations to Government and Parliament for an NHS Integrated Care Bill

Appendix B

South Warwickshire, North Warwickshire, Coventry
Keep our NHS Public

Dear Councillor,

Stroke Service Reconfiguration

North Warwickshire, South Warwickshire and Coventry and Rugby CCGs plan to centralised all acute stroke beds at University Hospital Coventry and Warwickshire (UHCW) Hyper-Acute Unite (HASU) and acute unit (ASU). The acute stroke care beds at Warwick Hospital and George Eliot Hospital are to close.

Please consider opposing the planned closure of acute stroke beds at George Eliot and Warwick Hospitals and centralisation of all acute care to the Hyper-Acute Stroke Unit (HASU) at (UHCW). The reasons are set out below.

The concerns.

1) Loss of acute stroke beds.

We need to question the statements in the centralisation plan that acute stroke beds are *moving* to UHCW. They are not. They are being cut. Warwick hospital will lose 12 acute beds. George Eliot Hospital, Nuneaton will lose 19 acute beds. This is a total of 31 acute beds being cut. UHCW is not gaining these 31 beds. In the plans, UHCW gains only 6 hyper-acute beds, going from 6 to a total of 12 beds in the HASU. The ASU gains 1 acute bed, up from 30 to 31. If care were being 'moved' there should be an extra 31 in the UHCW ASU – giving a total of 62.

- It is asserted that less acute care will be needed with greater prevention. This is not proven.
- It is planned that there will be greater throughput with the Early Supported Discharge policy. Again, the true costs and implications for care are not convincingly produced.
- An increase of 19 re-habilitation beds is welcome, but this is a replacement for acute beds, and not an addition overall.

The net loss of 30 acute beds across Coventry and Warwickshire is glossed over by our local policy makers. And this is in the context of a growing hospital bed shortage crisis across all areas of health care.

2) Lack of thorough risk assessment.

The CCG Integrated Impact Assessment (IIA, April 2019) admits that patients in north and south Warwickshire will be disadvantaged:

> **p. 6 ‘’there are likely to be negative travel and access impacts of the proposed changes” (i.e for those patients who would have gone to GEH and to Warwick Hospital)**
>
> **p.8. “Patient who self-present at GEH or Warwick with a stroke, could be seen as disadvantaged as their journey to the hyperacute service is a longer journey”.**

The IIA merely states that these disadvantages will be overcome because these patients will be blue-lighted to the HASU at UHCW. This is unconvincing. ***The HOSC is asked to consider a much more thorough risk assessment, covering ambulance travel time from home to UHCW, road congestion, congestion and capacity at UHCW, skill loss at the other two hospitals where acute wards are due to close, before this centralisation can proceed. In particular, consider that:***

- UHCW is a long distance away for many across Warwickshire and many patients will arrive after the ‘golden hour’ for strokes and outside the maximum four and a half hours since stroke onset for clot busting by thrombolysis to be safely administered. Many will therefore not benefit from what the HASU can offer, and would have been safer going to a nearer ASU.
- UHCW is already over-crowded and the current stroke ward is already over-burdened.
- We fear there will be bottlenecks for ambulances.
- Has extra ambulance distance provision been risk assessed and costed?
- For family and friends, travel from across Warwickshire to UHCW to see their relatives will be very difficult. Some mitigating arrangements are being considered, but these do not mitigate long travel times and major obstacles for visitors across Warwickshire who depend on public transport.

3) Is stroke centralisation appropriate in a large shire county?

Evidence from a nearby shire county, Shropshire, causes concern.

In 2013 Shrewsbury and Telford Hospital Trust closed the acute stroke ward at the Royal Shrewsbury Hospital and centralised all stroke care at the HASU at the Princess Royal Hospital, Telford. Figures indicate a year on year decline in stroke indicators in Shropshire. The HOSC is asked to consider this, and ask whether access to stroke care, because of travel distance, could be among the causes, and if so, call for a pause in Coventry and Warwickshire plans to close ASU wards in Warwick and GEH until a thorough analysis of the Shropshire experience and statistics is completed.

Please could the Joint Coventry and Warwickshire Health and Overview Scrutiny Committee consider the following important points of research as part of its scrutiny activity, for which there is no time for a full address at the 14th October meeting.

a) The argument for centralisation follows an international trend of centralisation of acute stroke care. But most international research takes careful account of travel distance to a central HASU as one of the most significant factors in the centralisation model. It may be cost effective, but does not necessarily improve outcomes compared with improving stroke care at regional hospitals.

In the Netherlands, for example, a 2017 study concludes:

> *Centralising thrombolysis substantially lowers mean annual costs per patient compared to raising stroke care at community hospitals simultaneously.* ***Small, but negative effects on thrombolysis rates may be expected*** *(PMC U.S. National Library of Medicine 2017).*[2]

The Netherlands study also states 'distances to hospitals offering thrombolysis in the Netherlands are relatively short' and also provides detailed modeling of travel times.. Warwickshire is a large county, with a large rural spread.

b) Recent research on the health benefits of stroke centralization in England is based on a study of two metropolitan areas, London and Manchester, where taking patients to a central HASU instead of a local hospital increased travel time minimally, from 14 to 16 minutes (BMJ 2014)[3] . Across Warwickshire and Coventry, centralizing all acute stroke care to UHCW would have a major impact on ambulance travel times. The BMJ 2014 paper (p.5) concludes:

> *The greater travel times in rural areas make centralisation challenging and might necessitate other solutions, such as telemedicine, whereby consultation and triage can be conducted remotely by a stroke physician in a specialist stroke unit.*

The Stroke Association recognises that English evidence of success is based on metropolitan areas, and says:

> *We also know that reorganisation may not work in all areas, such as very rural parts of the country. Reorganisation should only happen where it can be demonstrated that stroke patients will benefit.*[4]

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[2] Centralising and optimising decentralised stroke care systems: a simulation study on short-term costs and effects https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5223548/

[3] Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis
BMJ 2014; 349 doi: https://doi.org/10.1136/bmj.g4757 (Published 05 August 2014) Cite this as: BMJ 2014;349:g4757

[4] What we think about re-organising acute stroke services' https://www.stroke.org.uk/sites/default/files/jn_2640e_-psp_reorganising_acutestrokeservices.pdf

The 'Improving Stoke Outcomes Project' for Coventry and Warwickshire has not demonstrated this. **We have seen no robust travel and distance modelling. The policy merely *asserts* that increased travel time is outweighed by the benefits of centralisation to a HASU.**

c) The limitations of thrombolysis treatment. The main advantage of a HASU, as compared to an acute stroke unit, is that it can provide thrombolysis, the clot busting procedure. Thrombolysis must be administered within a maximum of four and a half hours from onset of stroke. And it can only be done after a scan excludes brain bleeds. Ideally we would want every hospital to have a HASU.

BUT, across the UK, only 11 - 12% of stroke emergencies are eligible to receive thrombolysis, because 'If the time when symptoms started is unknown, or it is more than four and a half hours after symptoms started, the treatment cannot be provided'[5]

The Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit for August-November 2016 Public Report, found that in August/September 2016, hospital reports showed that 32.5 % of emergency stroke patients could not be given thrombolysis because they 'arrived outside the time window for thrombolysis', and 36.8% because 'wake-up time was unknown'. [6]

So in the case of Coventry and Warwickshire, where time and distance are critical factors in reaching the HASU at UHCW, there is no guarantee that patients will arrive in time for thrombolysis. Those who do not will not benefit from the HASU and will arrive at an overcrowded acute ward. It would be quicker and safer to get them to a closer hospital's acute ward for a brain scan and fast stroke treatment.

d) Recent findings on 'standardised' stroke mortality figures. The standardised mortality ratio takes account of severity of stroke, so severity of stroke cannot account for different mortality rates. These are worse at UHCW than at Warwick Hospital and George Eliot Hospital.

The Sentinel Stroke National Audit Programme (2016/17 – the latest available) provides data on the Standardised Mortality Ratio (SMR) **by hospital trust. There is a map[7] of stroke units (with a routinely admitting team – main stroke centre) and their Standardised Mortality Ratio (SMR).**[8]

Units with SMRs of 1.0 and below are marked green, from 1.0-1.25 are yellow, and above 1.25 red. Ratios above 1.0 imply more people have died than would have been expected by the model.

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[5] 'State of the Nation' Stroke Statistics 2017, pp 28-30, https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2017_final_1.pdf.

[6] https://www.strokeaudit.org/Documents/National/Clinical/AugNov2016/AugNov2016-PublicReport.aspx, p.55).

[7] https://fusiontables.google.com/DataSource?docid=1vofH5IefvfFdOjYzp5EbWFKshJjZhCXbW7nFGzAx#map:id=3

[8] **This ratio should be 1.0 when the number of stroke deaths in the unit matches the expected number of deaths based on the mix of case profiles admitted to the unit. The official explanation of the model: "Unlike the Dr Foster data, we have adjusted for case mix including stroke severity. The model used for this has been published in Stroke, and the published paper shows that the model is very reliable when externally validated. Briefly, the model takes account of the age of the patient, whether they are in atrial fibrillation (AF) before stroke, stroke type (haemorrhage or infarction), and the NIHSS score at arrival (where this is not available, the level of consciousness at arrival)."**

Both Warwick (0.92) and George Eliot (0.95) score better than the expected 1.0 on the Standardised Mortality Ratio and are marked as green. UHCW does worse – 1.02 – and is marked as yellow on the map. Yet the CCGS want to close the acute stroke wards at Warwick and George Eliot hospitals, which do better at present, and move everything to UHCW, which shows more people dying than would be expected from the model. The reasons must be complex, but the CCGs should certainly wait until the most recent figures (2018) are available.

e) Is the policy an Improvement or is it a response to Skill Shortage?

We understand from the CE of Warwick Hospital, Glen Burley, that the centralisation policy is primarily a response to specialist staff shortage. He explained to the South Warwickshire Foundation Trust Council of Governors (14 September 2017):

> The main drive for the revised national model is scarce staffing and clinical specialisation. It would not be possible to run a 24/7 thrombolysis service in all 4 local hospitals. Even if the staff were available, they would soon become deskilled due to the low volumes that would come through each door. This argument is also applicable to other specialist roles such as therapy staff. So investment in one high quality 24/7 service makes sense. The movement of our acute beds to University Hospitals Coventry and Warwickshire NHS Trust (UHCW) simply recognises the fact that interventional stroke physicians will ultimately want to work in the hyper acute facility.

So why is the centralisation policy presented as an improvement on stroke care, rather than as a response to skill shortage? Surely, the skill shortage needs to be addressed, and in the meantime, the acute bed wards at Warwick and George Eliot hospitals need to remain, alongside the existing HASU and ASU at UHCW.

In terms of addressing the skill shortage underlying the centralization policy, we would argue that closing acute wards is short-term fire fighting which will only make matters worse in the long run. Closing them means stroke specialists at acute wards in local hospitals become de-skilled. See the discussion by the 'Consultants' Association'. [9]

Conclusions

We hope this letter, and the attachments are useful to you. We urge you, as councillors, to use your powers to scrutinize and challenge the current stroke care plans. Please feel free to phone any of us if you would like to discuss this further.

Yours sincerely,
Anna Pollert, Secretary SWKONP

[9] For a discussion see NHS Consultants Association 2014, p.9, https://www.doctorsforthenhs.org.uk/wp-content/uploads/2015/02/mar2014.pdf