HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

11 AUGUST 2015

PROPOSED DEVELOPMENT OF THE HEALTH SERVICE OR VARIATION IN PROVISION OF HEALTH SERVICE – (REVIEW OF HYPER ACUTE/ACUTE STROKE SERVICES)

Report from: Richard Hicks, Deputy Director, Customer Contact, Leisure, Culture, Democracy and Governance

Author: Julie Keith, Head of Democratic Services

Summary

This report advises the Committee of a proposal under consideration by the Kent and Medway Clinical Commissioning Groups (K&M CCGs) to reconfigure/recommission hyper acute/acute stroke services In the view of the K&M CCGs this is a substantial service reconfiguration.

1. Budget and Policy Framework

1.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Background

2.1 Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers ("responsible persons") to consult a local authority about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment. Where more than one local authority has to be consulted under these provisions those local authorities must convene a Joint Overview and Scrutiny

Committee for the purposes of the consultation and only that Committee may comment. Kent County Council's Health Overview and Scrutiny Committee will consider this matter on the 4 September 2015. If both Kent and Medway determine the change to be substantial it will be necessary to convene the Joint Kent and Medway Health Overview and Scrutiny Committee for the purpose of this consultation.

2.2 The terms "substantial development" and "substantial variation are not defined in the legislation. Guidance on health scrutiny published by the Department of Health in June 2014 suggests it may be helpful for local authority scrutiny bodies and responsible persons who may be subject to the duty to consult to develop joint protocols or memoranda of understanding about how the parties will reach a view as to whether or not a proposal constitutes a "substantial development" or "substantial variation".

2.3 In the previous protocol on health scrutiny agreed between Medway and NHS bodies a range of factors were listed to assist in assessing whether or not a proposed service reconfiguration is substantial. These are still relevant and are set out below

- *Changes in accessibility of the service. For example, both reductions and increases on a particular site or changes in opening times for a particular clinic. There should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location.*

- *Impact of the service on the wider community and other services, including economic impact, transport and regeneration.*

- *Number of patients/service users affected. Changes may affect the whole population (such as changes to accident and emergency) or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial.*

- *Methods of service delivery eg moving a particular service into a community setting from an acute hospital setting.*

2.4 The current DoH guidance suggests local authorities could find a systematic checklist useful in reaching a view on whether or not a proposed service reconfiguration is substantial and that this approach may also be helpful to NHS Commissioners in terms of explaining to providers what is likely to be regarded as substantial. Medway already has a questionnaire for use by responsible bodies wishing to consult Medway Council's Overview and Scrutiny Committees on proposed health service reconfigurations (attached as Appendix A). The questionnaire has recently been updated. It asks for information relating to the factors listed in paragraph 2.3 above, seeks assurance that the proposed change meets the Government's four tests for health service reconfigurations (as introduced in the NHS Operating Framework 2010-2011) and also seeks information the Committee may need to demonstrate it has considered in the event of a decision to exercise the right

to report a contested service reconfiguration to the Secretary of State for Health.

2.5 The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. The circumstances in which a report to the Secretary of State is permitted are where the local authority is not satisfied that consultation on the proposed substantial health service development or variation has been adequate, in relation to content or time allowed, or where the authority considers that the proposal would not be in the interests of the health service in its area or it has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

3. Proposed service development or variation

3.1 To review the provision of Hyper Acute /Acute Stroke services for Kent and Medway residents in order to deliver improvements in care and to ensure a sustainable service across Kent and Medway. This may result in centralising services and or altering patient flows across Kent and Medway.

4. Advice and analysis

4.1 The Committee needs to determine in discussion with the responsible person whether or not the proposed reconfiguration is substantial and therefore subject to the formal requirement for consultation with Overview and Scrutiny.

4.2 If the proposed reconfiguration is substantial the Committee should be advised of the date by which the responsible person intends to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny Committee comments must be submitted.

4.3 If it is agreed that the proposed change is not substantial the Committee may make comments and recommendations to the Commissioning body and or Provider organisation as permitted by the regulations in relation to any matter it has reviewed or scrutinised relating to the planning, provision and operation of the health service in Medway.

5. Risk management

5.1 Risk management is an integral part of good governance. The Council has a responsibility to identify and manage threats and risks to achieve its strategic objectives and enhance the value of services it provides to the community.

Risk	Description	Action to avoid or mitigate risk
Continuing with the current model may see an ongoing trend in deteriorating patient outcomes	The last six months have seen a deterioration in mortality rates across a number of the admitting units above the national average, with a number of units causing concern.	To undertake a review of the key influencing factors within the review. To monitor and support the individual Trusts
An inability to resolve the current workforce issues may result in one or more of the current sites being unsustainable in the short/medium term, this will further impact on pt access and outcomes.	Current providers have significant workforce pressures particularly impacting on weekend cover and medical rotas.	The review aims are to resolve the current service issues. Workforce planning is a key component of the review process;

6. Consultation

6.1 Engagement events are underway with patients and public and will be central to the process, building on feedback at the key decision making points. There will be public consultation on the preferred option(s) and this is likely to be held early 2016.

7. Financial implications

7.1 This will be developed as the options are appraised. The current and projected demand will continue to be met. The main implications may relate to capital costs dependent on the preffered options although there are existing facilities within Kent and Medway.

7.2 Detailed work on travel times may also idenitfy increased ambulance costs and costs to the public of any possible increased travel time/length of journey.

8. Legal implications

8.1 Under Chapter 4 – Rules, paragraph 22.2 (c) terms of reference for Health and Adult Social Care Overview and Scrutiny Committee has powers to review and scrutinise matters relating to the health service in the area including NHS Scrutiny.

8.2 Provision for health scrutiny is made in the Local Authority (Public Health, Health and wellbeing Boards and Health Scrutiny) Regulations 2013 together with a requirement on relevant NHS bodies and health service providers to consult with local authorities about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area.

8.3 There are no additional legal implications for the Council, which have not already been considered within the report.

9. Recommendations

9.1 The Committee is asked to consider the proposed development or variation to the health service as set out in this report and Appendix A and decide whether or not it is substantial, together with the consequential arrangements for providing comments to the relevant NHS body or health service provider either directly from this Committee or via the Joint Health Scrutiny Committee with Kent County Council (should KCC also agree this is a substantial variation).

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Appendices
Appendix A – Substantial Variation Assessment Questionnaire
Appendix B – Case for Change
Appendix C – Decision making process and criteria
Appendix D – Plan on a Page
Appendix E – Communication and Engagement Plan

Background papers
Kent and Medway Stroke Services Review, Case for Change.
Kent and Medway Stroke Review , Decision Making pProcess
Kent and Medway Stroke review Communication and Engagement Plan.
Kent and Medway Stroke Review Plan on a Page

Appendix A

MEDWAY COUNCIL
Gun Wharf
Dock Road
Chatham ME4 4TR

Medway Council
Serving You

Health Overview and Scrutiny

Assessment of whether or not a proposal for the development of the health service or a variation in the provision of the health service in Medway is substantial

A brief outline of the proposal with reasons for the change

Commissioning Body and contact details:
K&M CCG's; SRO leading the review on behalf of K&M CCGs; Patricia Davies Accountable Officer DGS and Swale CCG's.

Current/prospective Provider(s):
Dartford and Gravesham NHS Trust .
Maidstone and Tunbridge Wells NHS Trust.
Medway NHS Foundation Trust.
East Kent Hospitals University NHS Foundation Trust.

Kent Community Health NHS Foundation Trust.
Medway Community Healthcare CIC.
Kent and Medway NHS and Social Care Partnership Trust.

Outline of proposal with reasons:
Why are the Kent and Medway CCG's reviewing hyper acute stroke services?

Commissioners in Kent and Medway are concerned about the performance and outcomes of the seven units currently admitting stroke patients. Performance against both the SEC Clinical and Quality standards and Sentinel Stroke National Audit Programme (SSNAP) measures, varies across the county. Improvement is slow and inconsistent and in a number of sites performance is poor or below average when compared both across the South region and nationally. Where performance is around the national average in a number of areas, this in itself still has considerable room for improvement.

Patient outcomes in the past two quarters have also seen a general deterioration.

The CCGs are committed to making sure that the current performance and outcomes improve for Kent and Medway stroke patients.

These concerns led the CCGs to undertake a review of stroke services. Whilst the whole stroke pathway is important and difficult to separate, there is an urgent need to develop a Kent and Medway wide solution to the delivery of the hyper acute and acute pathway.

(Hyper acute relates to the first 72 hours following a stroke and the package of interventions required to be delivered quickly and a high level of specialist monitoring/intervention. Acute relates to the remaining element of acute care normally up to 10 days post stroke).

Therefore whilst the review will understand and consider care by the GP to prevent strokes, and rehabilitation, it will focus on options for the hyper acute/acute pathway. We expect to identify recommendations for individual CCGs with regard to improving primary prevention and rehabilitation.

The individual hospitals across Kent and Medway are aware of the issues and want to improve the services. All the Trusts have improvement plans in place to address performance issues where possible but a number have recognised that continuation with the existing delivery model is unsustainable.

Stroke is the third biggest killer in the UK and is a major cause of death and disability as well as the main cause for long term disability. Stroke care accounts for about 5% of total spending on healthcare.

The National Stroke Strategy 2007 provides guidance on best practice and although there is no national specification in place there is considerable clinical evidence on the best care.

An important factor is the ability for patients to receive their care in a high quality stroke unit , being seen,assessed and treated quickly by specialists in stroke. The evidence shows us that this reduces the numbers of people who die from strokes and the level of disability following a stroke, meaning that the quality of life is improved. Important features of a successful stroke unit include a specialist workforce, adequate patient volumes and 24 hour access.

The Sentinel Stroke National Audit Programme (SSNAP) audits key clinical components of the stroke pathway and is undertaken by all stroke units. The audit highlights the level of variability across the country and recommends that **doing nothing is not an option going forward.**

The national recommendations are for stroke units to have/be;

- A 7 day dedicated specialist unit with > 600 confirmed stroke admissions and no more than 1500 admissions per annum.

- To achieve rapid assessment and imagery; door to needle times of one hour, imaging within one hour.

- Direct admission onto a specialist stroke unit within 4 hours.

- To stay on the stroke unit for 90% of the in patient episode.

- To be assessed by specialist stroke consultants and stroke trained nurses and therapist within 24 hours.

- 7 day stroke consultant cover

- 7 day stroke trained nurse and therapist cover.

Currently a number of these requirements are difficult for Kent and Medway admitting units to achieve.

This particularly relates to rapid assessment and intervention, 7 day specialist cover and access to the stroke unit within the four hours.

Workforce across all stroke specialisms is a significant issue with numbers around 50% below the recommended levels and 7 day consultant cover only available in one unit.

The aim of the review is to ensure the delivery of clinically sustainable high quality hyper acute/acute stroke services for the next ten to fifteen years, that are accessible to K&M residents 24hours a day, seven days a week.

The review has the following objectives;

- To ensure that the needs of all Kent and Medway residents who experience a stroke or whose family member experiences a stroke are considered within the delivery and configuration of hyper acute/acute stroke care.

- To assess current service provision for stroke patients across Kent and Medway and make recommendations for evidenced based improved outcomes.

- To have an agreed hyper acute/acute stroke service model in Kent and Medway that meets national evidence based best practice.

- To develop a sustainable model of hyper acute/acute stroke care that can meet the needs of residents in Kent and Medway going forward.

As noted the review recognises the importance of effective primary prevention and rehabilitation services. However it is going to focus at this point on reviewing the hyper acute/acute stroke pathway. Resolving key issues in this

area will assist across the pathway in particular in relation to rehabilitation, specialist assessments and the MDT approach.
It is also anticipated that the review will raise issues in relation to primary prevention and rehabilitation that individual CCGs can take forward.

Therefore the priority is to ensure that the hyper acute/acute pathway is delivering according to best practice and is sustainable.

. The Case for Change illustrates that Kent and Medway stroke services are not currently operating within the national clinical guidance or best practice. On this basis there is a need to identify clinically led solutions that can resolve the non-compliance and performance issues. The solutions will be required to ensure a quality and sustainable service that is equally accessible for all Kent and Medway residents and ensures optimum patient outcomes.

. This Case for Change reflects the learning from public listening events, the South East Coast Clinical Senate and the K&M Stroke Review Programme Board members, the Review Clinical Reference Group and national clinical guidance and best practice.

. The next steps will proceed to develop options to address the issues identified within the Case for Change to enable sustainable hyper acute/acute services based on national clinical best practice for Kent and Medway residents.

. These options may range from do nothing to a combination of reconfiguration options that centralise hyper acute services.

The Case for Change makes the following recommendations to the Kent and Medway CCGs.

- To recognise that there is a Case for Change if hyper acute/acute stroke services in Kent and Medway are to:
    - Ensure the optimum outcomes for stroke patients.
    - Deliver 7 day, rapid access to specialist stroke assessments and intervention.
    - Improve performance against the SSNAP measures.
    - Be compliant with the SE Stroke and TIA Service and Quality Standards 2014.
    - To comply with the national best practice guidance for hyper acute/acute stroke services.
    - Consistently meet the needs of all Kent and Medway residents.

- Be sustainable and fit for the future for the next 10-15 years.

- To agree to proceeding with an options appraisal process to identify a consensus agreement on the preferred solution(s) going forward.

- To recognise that there is a Case for Change if services in Kent and Medway are to comply with the national specification and clinical best practice guidance to ensure both quality and service sustainability of vascular services.

- To agree to proceeding with an option appraisal process to identify a consensus agreement on the preferred solution going forward.

Intended decision date and deadline for comments (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require the local authority to be notified of the date when it is intended to make a decision as to whether to proceed with any proposal for a substantial service development or variation and the deadline for Overview and Scrutiny comments to be submitted. These dates should be published.

The Case for Change and Decision Making Process timeline was approved at the RPB in July 2015 and is to be approved across the CCG's through July 2015.

The SEC Clinical Senate report of the Case for Change will be provided mid July for inclusion the Case for Change and review process.

The Options Appraisal will aim to produce a preferred option for the K&M CCG's late Autumn 2015.

If approved any changes are anticipated to begin implementation from April 2016.

Alignment with the Medway Joint Health and Wellbeing Strategy (JHWBS).
Please explain below how the proposal will contribute to delivery of the priority themes and actions set out in Medway's JHWBS and:

- how the proposed reconfiguration will reduce health inequalities and
- promote new or enhanced integrated working between health and social care and/or other health related services

The preferred options will ensure that all K&M residents are equally able to receive quality and sustainable hyper acute/acute stroke services in line with the national guidance and best practice that promotes positive patient outcomes.

Development of a clear pathway for hyper acute/acute and rehabilitation care network model will ensure consistent access through a clear and accessible pathway.

The improvement in outcomes will reduce both mortality and morbidity rates for Kent and Medway residents.

The review will identify the areas of good and poor practice in relation to primary prevention and make recommendations to individual CCGs to improve the management of cardio vascular disease.

Please provide evidence that the proposal meets the Government's four tests for reconfigurations (introduced in the NHS Operating Framework 2010-2011):

Test 1 - Strong public and patient engagement

(i) Have patients and the public been involved in planning and developing the proposal?
(ii) List the groups and stakeholders that have been consulted
(iii) Has there been engagement with Medway Healthwatch?
(iv) What has been the outcome of the consultation?
(v) Weight given to patient, public and stakeholder views

(1) A Communication and Engagement plan is in place and monitored through the Review Programme Board. This plan identifies key public/patient engagement activities along the review pathway.

Key milestones will reflect patient and public involvement.

This includes;

- Developing and understanding the Case for Change
- Reflecting views and feedback into the decision making process development
- Involvement in reviewing potential options and the short list and developing through options appraisal the preferred option.
- A range of engagement events and processes are being undertaken including, listening events, focus groups, involvement at key review meetings, attending stroke interest/support groups and a survey.

(2) Consultation/engagement has/will take place with;

- Local K&M clinicians and the national lead
- The Stroke Association
- Public Health
- H&WBB
- Kent and Medway Healthwatch, South East Regional Healthwatch
- K&M CCG's
- K&M acute and community providers.
- South East Coast Ambulance Service

- NHS England South
- South East Cardiovascular clinical network.
- South East Clinical senate
- Surrey and Sussex Stroke review programme leads.

Feedback from the various consultations have been included into the review, The Case for Change, the Decision Making Process and the options appraisal process.
Key impacts have to been to ensure there is a clear ambition for improvement and delivery of best practice.
To have a detailed understanding of the key interdependencies and impact on both the population and health care.
To clearly understand the impact of travel times and access on possible options.
To ensure the issues of the whole stroke pathway are considered and recommendations made to individual CCGsS.
To ensure that key patient concerns such as communication are highlighted through the review.

(3)Yes.

(4) As above, engagement is currently ongoing and formal consultation will take place once the preferred option(s) are identified.

(5) All engagement feedback from engagement with the public, patients and stakeholders will be taken into account within the context of delivering a safe and sustainable stroke service across Kent and Medway.

Test 2 - Consistency with current and prospective need for patient choice

The review will review the impact of patient choice within the options appraisal and the impact of the options on patient choice.

Currently patients predominantly call 999 if they have stroke symptoms and they are taken to the nearest hospital with an emergency department. The review will ensure that the unit the patient is taken to are able to provide high quality patient care in the future this may not be the nearest hospital.

Currently a small percentage (around 15%) of patients take themselves either to their GP or to an A and E department. If in the future this A&E department doesn't have hyper acute stroke services a clear pathway will be in place to transfer the patient safely.

Test 3 - A clear clinical evidence base

(i) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?
(ii) Will any groups be less well off?
(iii) Will the proposal contribute to achievement of national and local priorities/targets?

I. Yes; The Case for Change illustrates that the current stroke care in K&M is not fully meeting the National Stroke Strategy and that whilst there is some good practice there is room for improvement. Outcomes for stroke across Kent and Medway have in general deteriorated over the past two quarters.

II. The review is seeking to ensure the best care for Kent and Medway and the recommendations will be based on improved outcomes for all patients.

III. The key impact for the public is to consider any possible impact on travel times for patients and their families. A possibility is that some patients will have to travel further than they currently do.

IV. Yes. The preferred outcome will enable the stroke service to meet the national best practice and to improve performance in line with the SSNAP and SEC standards.

Test 4 - Evidence of support for proposals from clinical commissioners – please include commentary specifically on patient safety

Clinical commissioners have instigated the review as this is a Kent and Medway wide priority. The commissioners are committed to improving the care provided and in turn seeing an improvement in outcomes.
The CCGs are key members of the Review Programme Board where the preferred options will be developed and agreed in principle. The individual CCGs have/are currently approving the Case for Change and will formally approve the final option that is taken to consultation.
Patient safety and patient choice have been key to the approval by the clinical commissioners with concerns raised re sustainability of the current services and any consideration that may have an adverse effect on patient safety. The key issue raised in relation to safety relates to adequate workforce and the availability of care over the weekend periods and the ability to get to a specialist unit within the recommended and safe timelines.
A quality review of patient safety is built into the options appraisal process this reflects best practice developed elsewhere and will not only assess the options but the ability of providers to ensure safe care.

Effect on access to services

(a) The number of patients likely to be affected
(b) Will a service be withdrawn from any patients?
(c) Will new services be available to patients?
(d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

(a) Currently 2,500 Kent and Medway patients had a confirmed stroke in 2013/14 * to be updated with 14/15. Around another 30/35% of patients will present with stroke symptoms and the review will need to clearly identify how their care will be managed.
(b) No, the delivery sites may change but the service will remain available for all current and future stroke patients.
(c) We anticipate that there will be an increasing requirement for new techniques and the options will be developed so that they can respond to these new methods.
(d) Depending on the preferred option some patients may have to travel further to a hospital than they currently do.

Demographic assumptions

(a) What demographic projections have been taken into account in formulating the proposals?
(b) What are the implications for future patient flows and catchment areas for the service?

(a) The projected population growth and growth in age groups and clinical risk factors for Kent and Medway has been taken into account in planning activity. Detailed public health assessment is underway to ensure that the modelling is accurate and can meet the needs of Kent and Medway for the future. A literature review is also being undertaken to ensure learning from research and best practice evidence.
Review of planned developments has been considered in relation to increasing population and demographics.
(b) Depending on the preferred options, patient flows may change around Kent and Medway as patients travel to a hyper acute centre.
The review is unlikely to increase the catchment area.

Diversity Impact

Please set out details of your diversity impact assessment for the proposal and any action proposed to mitigate negative impact on any specific groups of people in Medway?

TBC through the options appraisal process and the current public health analysis modelling.

Financial Sustainability

(a) Will the change generate a significant increase or decrease in demand for a service?
(b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)
(c) What would be the impact of 'no change'?

TBC through the option apprisal process.

(a) Depends on the preferred option but will not impact on overall demand
(b) The proposal is not driven by financial reasons. It is anticipated that the recommendations will identify opportunities to maximise the best practice tariff for providers. There are concerns that the current model is not the best use of scarce resources.
(c) The modelling will assess if there are any capital costs if centralising services is proposed.

Wider Infrastructure

(a) What infrastructure will be available to support the redesigned or reconfigured service?
(b) Please comment on transport implications in the context of sustainability and access

(a) This will be fully understood through the option appraisal and understanding of activity numbers into the options but initial analysis would suggest little additional infrastructure is required if any.
(b) Transport implications will depend on the preferred option. The less admitting units there are, the more significant this will be. The Clinical Reference Group is currently working through the travel times and issues across Kent and Medway and detailed work will consider both emergency and non emergency travel times.
The review will consider the ability to move patients closer to home for ongoing acute and rehabilitation care.

Is there any other information you feel the Committee should consider?

This review is set within the context of reviews across the country and also in Surrey and Sussex. Two of the current units also deliever services to West Went and South London residents.

Please state whether or not you consider this proposal to be substantial, thereby generating a statutory requirement to consult with Overview and Scrutiny

The Review Programme Board does consider the proposals and final recommended options will be substantial.

Appendix B

Kent and Medway Stroke Services Review

Case for Change

July 2015

Version	Date	Author	Comments
10.0	**06.07.15**	**Oena Windibank**	**Agreed at Stroke Review Programme Board 13.5.15 To South East Clinical Senate 14.5.15**

Contents:

1.0 Executive summary.

National picture
Stroke is the third biggest killer in the UK and is the main cause of long term disability in the population.

Stroke care accounts for about 5% of total spending on healthcare in England.

Stroke services are commissioned by clinical commissioning groups (CCGs). Although there is no national specification in place for stroke services, the National Stroke Strategy 2007 provides guidance on recommended best practice.

This shows that key to successful outcomes for stroke patients is a high quality stroke unit with rapid access to diagnostics, specialist assessment and intervention. Evidence shows that rapid specialist assessment and intervention in the hyper-acute phase (the first 72 hours after a stroke) reduce mortality and improve long term outcomes for stroke patients. Key features of a successful hyper-acute/ acute stroke unit include a specialist workforce treating adequate volumes of patients (enabling them to sustain and improve their skills), and 24 hour access.

The key features of the National Strategy and the recommendation of the national lead articulate that recovery from a stroke is significantly influenced by the percentage of patients;

- Seeing a stroke consultant within 24 hours;
- Having a brain scan within 24 hours of admission;
- Being seen by a stroke-trained nurse and one therapist within 72 hours of admission;
- Being admitted to a dedicated stroke unit

And that the most significant interventions are:

- A nutritional assessment and swallowing assessment within 72 hours;
- Being given antiplatelet therapy within 72 hours;
- Receiving adequate food and fluids for the first 72 hours.

The Sentinel Stroke National Audit Programme (SSNAP) highlights that there is a high level of variability in the performance of stroke services across the country and recommends that doing nothing is not an option going forward.

The key requirements of a ‘good’ hyper acute/acute stroke service that delivers the best outcomes for patients are:

- **Access 24 hours, seven days a week**
- **Rapid and accurate diagnosis**
  - Clinical expertise
  - Access to imaging and good interpretation
- **Direct admission** to a specialist stroke unit
- **Immediate access** to treatment
- Specialist centres with sufficient **numbers** of patients and expert staff
- High quality **information and support** for patients and carers

- **Inpatient care** through a specialist unit
- The service **measures** what it does, publishes **data** and constantly **looks for improvements.**

The national recommendations are for stroke units to:

- Be a seven-day dedicated specialist unit with more than 600 confirmed stroke admissions and no more than 1500 admissions.
- Achieve rapid assessment and imagery; door to needle times of one hour, imaging within one hour.
- Have patients admitted directly onto a specialist stroke unit within four hours.
- Have patients stay in the stroke unit for 90% of the inpatient episode.
- Assess patients by specialist stroke consultant and stroke trained nurse and therapist within 24 hours.
- Have seven-day stroke consultant cover
- Have seven-day stroke trained nurse and therapist cover.

Currently, a number of these requirements are difficult for Kent and Medway admitting units to achieve or sustain.

Local picture
About 2,500 people in Kent and Medway have a stroke every year. Each of the seven local acute hospitals admits stroke patients who are in the hyper-acute phase. Performance against the South East Coast Clinical and Quality standards and SSNAP standards is variable across the county. The CCGs are committed to improving both the current performance and, in turn, the outcomes for Kent and Medway stroke patients.

The priority is to ensure that patients receive the best possible care, consistently and quickly within the first 72 hours and for the immediate acute rehabilitation element of their care. This hyper-acute/acute pathway must deliver care to patients according to best practice and be sustainable for the Kent and Medway population. This particularly relates to rapid assessment and intervention, seven-day specialist cover and access to the stroke unit within four hours.

Performance against the SSNAP domains by the Kent and Medway admitting units are variable and, in some cases, inconsistent; improvement has been slow. At a number of sites, performance is poor or below average when compared both to other units in the South region and nationally. It should be noted that the national average itself has considerable room for improvement.

Whilst the issue with performance is recognised by all the provider Trusts, key challenges such as a shortage of specialist workforce and the ability to deliver services seven days a week are not easily resolved internally.

This, and the evidence that centres treating larger numbers of people achieve improved outcomes, have triggered this review across Kent and Medway.

There are concerns noted by all in the review in relation to the sustainability of the existing provision.

The Case for Change finds that no change is not an option.

Scope of this review
This review recognises that the acute pathway cannot be considered in isolation. A clear understanding of the management of risk factors across the county, the pattern of referral/access to urgent care, rehabilitation and long term health and social care support will be developed. It is clear that these factors will impact on the range and potential success of any solutions.

It is anticipated that the review will raise issues in relation to primary prevention and rehabilitation that individual CCGs should take forward as part of their local clinical strategies.

However, whilst particularly recognising the importance of effective primary prevention and rehabilitation services, this review is focused on improving treatment and care in the hyper-acute/acute phase. Resolving key issues in this area will assist across the pathway, in particular in relation to rehabilitation.

The aim of the review:
To ensure the delivery of clinically sustainable, high quality, hyper-acute/acute stroke services for the next ten to fifteen years, that are accessible to Kent and Medway residents 24 hours a day, seven days a week.

The review has the following objectives:

- To ensure that the needs of all Kent and Medway residents who experience a stroke or whose family members experience a stroke are considered within the delivery and configuration of hyper-acute / acute stroke care.

- To assess current service provision for stroke patients across Kent and Medway and make recommendations for evidence-based improved outcomes.

- To have an agreed hyper-acute/acute stroke service model in Kent and Medway that meets national evidence-based best practice.

- To develop a sustainable model of hyper-acute/acute stroke care that can meet the needs of residents in Kent and Medway going forward.

As part of this, we are engaging with local people across Kent and Medway, to understand their experience of hyper-acute care and their priorities for an effective hyper-acute/acute stroke service for the future. This review follows and builds on a local review in west Kent, initiated by Maidstone and Tunbridge Wells NHS Trust and supported by NHS West Kent Clinical Commissioning Group. This work asked local people for their views on quality standards, developed by the South East Coast Clinical Network and based on those in the SSNAP.

It found:

- There is public support for new higher standards of care covering the critical first 72 hours of a stroke patient's care and a need for the NHS to develop ways of achieving these
- The NHS needs to improve the whole of the stroke patient's pathway, including the care stroke patients receive out of hospital
- The NHS needs to improve the information and support available to patients and carers following a stroke
- Quality needs to be maintained within a timeframe that provides maximum opportunities of recovery for patients.
- The NHS needs to improve planning about how and when a stroke patient can leave hospital and the next steps in their rehabilitation

Ambition for stroke services in Kent and Medway

The ambition of this review is to ensure that stroke services in Kent and Medway aim towards achieving an 'A' SSNAP, going beyond average and delivering improved outcomes. Kent and Medway stroke services will be recognised as areas of good practice, where staff want to work and develop their practice.

The stroke services will be delivered robustly 24 hours, seven days a week, by an appropriately skilled, multi disciplinary team of professionals . The level of skill and expertise is maintained through an innovative and motivated workforce who delivers excellent outcomes and practice.

The services will be organised and delivered in a manner that maximizes effective use of scarce resources and skills. This will include the skills and support of a wide range of non stroke services.

Central to the review and its findings is for patients to benefit from improved outcomes, communications and support and for consistency of good practice across Kent and Medway.

Benefits for patients are central to the review and will include:

- Improved pathways of care and outcomes, particularly ensuring that patients are given the best possible chance of survival and minimised risk of disability.

- Sustainable stroke services for all Kent and Medway residents.

- Consistent high performance of hyper-acute/acute stroke care against the national best practice, delivering the associated positive patient outcomes.

- Access to 24 hour, seven-day specialist stroke care, including specialist and resilient stroke seven-day workforce comprising specialist consultants, stroke trained nurses and therapists.

- Consistency of hyper-acute/acute stroke care for Kent and Medway residents regardless of where they live.

2.0 Purpose of the Report.

The purpose of this report is to reflect the current position of hyper acute/acute stroke services in Kent and Medway within the context of the best practice standards, national guidance and sustainability going forward. The report will reflect the Kent and Medway issues and context and consider if there is a need to make recommendations that will look to develop solutions to identified issues. The report will consider if Kent and Medway has sustainable hyper acute stroke services that can consistently meet the needs of all its population.

The Case for Change will be reviewed to reflect the public/patient view post public listening events held through late spring early summer 2015 and informed by the feedback from the South East Clinical Senate.

3.0 Recommendations.

- To recognise that there is a Case for Change if hyper acute/acute stroke services in Kent and Medway are to:

Ensure the optimum outcomes for stroke patients.

Deliver 7 day, rapid access to specialist Stroke assessments and intervention.

Improve performance against the SSNAP measures.

Be compliant with the SE Stroke and TIA Service and Quality Standards 2014.

To comply with the national best practice guidance for hyper acute/acute stroke services.

Consistently meet the needs of all Kent and Medway residents.

Be sustainable and fit for the future for the next 10-15 years.

- To agree to proceeding with an option appraisal process to identify a consensus agreement on the preferred solution(s) going forward.

4.0 Background

A stroke is the brain equivalent of a heart attack. The blood supply to part of the brain is interrupted by either a blood clot or a bleed, and surrounding brain tissue is damaged or dies. There are two main types of stroke, ischaemic or haemorrhagic stroke.

Ischaemic strokes most common form of stroke, caused by a clot blocking or narrowing an artery carrying blood to the brain. The likelihood of suffering an ischaemic stroke increases with age.

Some patients may suffer from a Transient Ischaemic Attack (TIA), a temporary stroke that occurs when the blood supply to part of the brain is cut off for a short time only. This results on short term symptoms which normally disappear within 24 hours. This is often a warning that the patient may be at risk of a more serious stroke occurring.

Stroke is a major health problem in the UK. It is a preventable and treatable disease that is the third biggest cause of death in the UK and the largest single cause of severe disability.

Each year in England, approximately 110,000 people (Scarborough et al, 2009) have a first or recurrent stroke which costs the NHS over £2.8 billion. South Asians (Indians, Pakistanis and Bangladeshis) have a higher risk of stroke than the rest of the population.

Stroke mortality rates in the UK have been falling steadily since the late 1960s. The development of stroke units and the further reorganisation of services following the advent of thrombolysis, have resulted in further significant improvements in mortality and morbidity from stroke (National Sentinel Stroke Clinical Audit, 2011).

The burden of stroke is likely to increase in the future as a consequence of the ageing population.

The acute stroke pathway;

Hyper-acute stroke services (72 hours post symptoms) enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams.

Following a stroke, a patient is taken directly to a hyper-acute stroke unit where they will receive expert care, including immediate assessment, access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes of arrival at the hospital.

It is clear that patients presenting with a stroke to hospital should be cared for in a specialist stroke unit, under the care of a multidisciplinary team including specialist nursing staff based in a designated for stroke unit.

The intensity and nature of care required by the patient depends on the time lapsed

after the stroke has occurred and the severity of the stroke.

Patients should receive their care on a specialist Stroke unit. Initially this will be on a hyper acute unit and then post 72 hours it will be on an acute unit, some units have combined units.

Hyper-acute stroke units (HASUs),

For the first 72 hours of care post-stroke, including assessment for, and the administration of, thrombolysis in suitable patients. Key features include: continuous physiological monitoring(Electrocardiography (ECG), oximetry, blood pressure); immediate access to scanning for urgent stroke patients; direct admission from Accident and Emergency (A&E)/front door; senior specialist ward rounds seven days a week; acute stroke protocols/guidelines; nurses trained in swallow screening; and nurses trained in stroke assessment and management.

Acute stroke units (ASUs) for subsequent (72 hrs +) acute hospital care. This includes ongoing specialist care, with 7 day therapies services (physiotherapy, occupational therapy, speech and language therapy, dietetics input), and effective Multi-Disciplinary Team (MDT) working.

4.1 Context to the current Kent and Medway Stroke Services review.

In Kent and Medway hyper acute/acute stroke care is provided across seven admitting hospital sites with a range of rehabilitation provision and Early Supported Discharge services available.

Kent and Medway providers have struggled to meet the standards of the national Stroke Sentinel Audit Programme (SSNAP) with a range of achievement from poor to good across the region. (E to B December Q3 14/15). The majority of scores are below average and although there has been some recent improvements since June 2014, this has been slow and is inconsistent.

Achievement of the SE Stroke and TIA Service and Quality Standards is also variable across the sites as is achievement of the measures within the National Stroke Strategy. This performance has raised concern with the CCGs and reviewing stroke services was identified as a Kent and Medway priority by the Commissioning Assembly in September 2014. A number of the CCGs have raised individual performance issues with providers and the Trusts themselves have recognised the need to address both performance and sustainability issues.

Sustainability is of concern across all providers with a particular focus on the workforce both in terms of numbers and coverage specifically in relation to out of hours.

A gap analysis has been undertaken across all providers with action plans at various stages of development and delivery. Stroke Improvement Processes have been initiated at all provider Trusts; East Kent Hospitals Foundation Trust , Maidstone and Tunbridge Wells Hospitals Trust , Darent Valley Hospital Trust and Medway Foundation Trust.

This review of stroke services was commissioned in December 2014 and is supported by NHS England South (South East) and the South East Cardiovascular Strategic Clinical Network (SE CVD SCN)

Nationally a number of reviews have taken place or are ongoing in order to address the variability and inconsistency of performance highlighted through SSNAP. The reviews in the East Midlands and more recently Birmingham have produced best practice indicators and guidance for subsequent reviews recognising that key principles can be built upon whilst reflecting the differences/needs of local communities. NHS England have commissioned a tool kit to support these reviews and this best practice guidance on configuring stroke services will be published later in 2015.

Currently there are stroke services reviews underway in Surrey and Sussex and a Kent, Surrey Sussex overview group is in place to consider the implications for each locality and cross boundary issues.

4.2 The aim of the Kent and Medway Strokes services review .

The aim of the review is to ensure the delivery of clinically sustainable high quality hyper acute/acute stroke services for the next ten to fifteen years, that are accessible to K&M residents 24hours a day seven days a week

A review of the existing stroke services across Kent and Medway is required to;

- Ensure that Kent and Medway hyper /acute stroke care seeks to meet the needs of all K&M residents.
- Improve and ensure the consistency of the hyper acute /acute Stroke pathway across Kent and Medway.
- Identify and make recommendations for the continued improvement of outcomes for stroke patients.

- Ensure that services across Kent and Medway are high quality, safe, sustainable and fit for the future population in Kent and Medway for the next 10 to 15 years.

- To ensure that hyper acute /acute stroke services are commissioned to be compliant with best practice guidance and work towards Level A in SSNAP.

- To ensure that Kent and Medway stroke services are delivered in accordance with the national evidence based best practice models and specification

- To ensure that the model for hyper acute /acute stroke care is financially and clinically viable

4.3 The review approach.

The review will undertake a phased approach:

- Recognising the national guidance and clinical best practice for Hyper Acute/acute Stroke services
- Scoping and identifying the current Hyper Acute/Acute stroke services provision available for Kent and Medway residents, benchmarking against the national guidance/best practice.
- Identifying gaps and issues in achieving best practice.
- Identifying solutions and options for resolving the gaps/issues.
- Recommending models of delivery that can achieve quality and sustainability going forward.
- Engaging and listening to patients, public and clinicians throughout the process.

The review will be conducted in line with the NHS England guidance on service developments and reconfiguration. There will be a programme of engagement with the public, clinicians both locally and externally and key stakeholders that underpins the review process. The review will be governed through a Review Programme Board with membership from all key stakeholders and regular communication will be undertaken with clinical commissioners. The process will be tested and evaluated at key points including the Case for Change , the development and agreement of the decision making process and the options appraisal process and agreement on final recommendation(s).

This Case for Change has been developed and informed by the review's Clinical Reference Group, national guidance, SE CVD SCN guidance and local discussions with Clinical Commissioning Groups. Evidence and lessons learnt from regional and national reviews have been considered and applied as appropriate.

Public engagement is central to the review its findings and recommendations. A sequence of engagement events is underway to both inform and test the Case for Change, which will be amended accordingly. This will be followed by public events developing solutions and final recommendations with members of the public/patients

involved at both Board level, modeling groups and the Communication and Engagement sub group.

If the Case for Change is recognised and the direction of travel is approved by CCG governing bodies (June/July 2015) further work will be required to develop the range of options and to engage with the public and wider clinical community and key stakeholders. This will include a more in depth analysis of the clinical model, travel times, population growth, preventative strategies, workforce planning, capacity modeling and impacts

4.4 Best Practice and Performance frameworks

The review process has been undertaken within the requirements and recommendations of national and regional best practice for Stroke patients. This includes the;

- National Stroke Strategy 2007
- NHSW Midlands and East, Stroke Specification , 2012
- South East Coast, Integrated Stroke Specification, 2012 (under review)
- SEC CVD SCN Stroke Clinical Advisory Group; service/quality standards.
- Sentinel Stroke National Audit Programme (SSNAP)
- Published body of evidence. (through Literature review)
- NHS England guidance on the Configuration of Stroke Services 2015

4.5 The key elements of best practice for hyper acute/acute Stroke care include;

- Rapid specialist stroke assessment this includes imagery and assessment.
- Expert clinical assessment including 7 day consultant cover.
- 24 hour Stroke trained nurse cover with appropriate senior level skill mix and specialist stroke nurse leadership.
- The delivery of 7 day specialist therapy interventions and rapid access particularly to Speech and Language therapy
- 24 hour availability of rapid imagery and subsequent therapeutic Interventions, including 24/7 thrombolysis.
- MDT assessment, to include specialist physicians, nurses , therapists. A wider group of specialist is increasingly advised including clinical psychology, dietetics.
- Sufficient patient volumes that deliver clinical sustainability, maintain clinical expertise, and produce consistently good clinical outcomes.

5.0 The National Context.

Acute Stroke services are seen within the context of emergency care with the Stroke Strategy for England (2007) specifying that stroke is a medical emergency and that local networks need to plan to ensure that everyone who could benefit from urgent care is transferred to an acute stroke unit that provides ;

24-hour access to scans and specialist stroke care, including thrombolysis.

NHS England is clear that acute services should be delivered to a high standard regardless of the day of the week. Acute trusts are being encouraged to provide 7 days services such as diagnostics and therapies where they have traditionally been a Monday to Friday service or on call for emergency patients. This strategy supports stroke services as the TIA clinics should be accessed 7 days a week and the acute pathway 24 hours a day both of which require appropriate skilled workforce

The national guidance and Stroke National Clinical Director, Professor Tony Rudd, notes that the quality of the stroke unit is the single biggest factor that can improve a person's outcomes following a stroke. Successful stroke units are built around a stroke-skilled multi- disciplinary team that is able to meet the needs of the individuals.

The NHS Five Year Forward View, published in October 2014 by NHS England sets out a positive view for the future based around new models of care. Stroke services were recognised as falling under the new care model of specialised care.
Within this new model there is the recognition that for some services, such as stroke, there is a compelling case for greater concentration of care.

More specifically it highlights the strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. The document references the London service change of consolidating 32 stroke units to 8 specialist ones and highlighted this achieves a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The Manchester review has also identified improvement in outcomes and performance due to centralization, however this took a number of years to achieve and was reviewed regularly until this improvement was achieved.

It is important to note that there are variances with the London and Manchester models that may not be relevant to Kent and Medway.

A review of Stroke services in Midlands and West 2011 resulted in a best practice model and specification.

As the review develops it will ensure that lessons are learned from other national reviews whilst recognizing the issues for Kent and Medway that may require specific/different consideration or a modified approach. For example understanding

travel times and routes available locally.

NHS England commissioned a review of stroke configuration good practice (2015) and have produced a guidance tool for use when undertaking a stroke review and deciding on stroke configuration. (ref)

5.1 Policy context; Standards and guidance.

- The National Stroke Strategy 2007, is a quality framework set to secure improvements across the stroke pathway over a period of ten years.

The strategy outlines 20 quality markers that improve stroke care across the whole stroke pathway. The strategy provided the evidence base for what key elements need to be implemented for high quality stroke care that would result in good clinical outcomes for patients.
The plan has two years left but organisations locally and nationally continue to struggle to deliver a service that meets all the quality markers.

The key features of the National Strategy and the recommendation of the National lead articulate that recovery from a stroke is significantly influenced by the percentage of patients;

- **Seeing a stroke Consultant within 24 hours;**
- **Having a brain scan within 24 hours of admission;**
- **Being seen by a stroke trained nurse & one therapist within 72 hours of admission;**
- **Being admitted to a dedicated stroke unit**

And that the most significant interventions are:

- **A nutritional assessment & swallowing assessment within 72 hours;**
- **Being given antiplatelet therapy within 72 hours;**
- **Receiving adequate food and fluids for the first 72 hour.**

5.2 Patient /User voice.

The K&M Stroke review is undertaking a patient and clinical engagement process which will inform both this Case for Change and the development of options and appraisal process going forward.

This will include Listening Events that discuss the Case for Change , illustrating the current position and the elements of good clinical practice that support good outcomes. The process will develop the engagement to pick up the important issues for patients and to ensure that when considering possible solutions to the issues the public are able to make informed choices. The patient and public will be actively encouraged to tell the review team about the things that are important to them and their families and the review will ensure that feedback informs the process and outcome.

Nationally the collective evidence of the patient voice provides a view of priorities when reviewing/redesigning stroke services. These support;

- Seven day, 24 hour services
- Access to the right people, right time and equipment
- Scans within four hours to give a better chance of rehabilitation
- Quick ambulance response and quick entry into hospital
- Access to the right services in the first 72 hours. (BBCS 2014 Stroke review patient event)

5.3 The Stroke Services Configuration guidance 2015 NHS England. (Draft)

Sandwell and West Birmingham CCG were commissioned by NHS England to provide an overview of the support and guidance available to Clinical Commissioning Groups (CCGs) and stakeholders/partners for reference when considering service change for stroke services.

The aim is to provide these CCGs and their partners with a suite of guidance documents, templates and analytical models based upon the work that has already been undertaken in areas of England where stroke reconfiguration has already progressed.

This guide is designed to be a framework, ensuring a consistent application of principles across England for stroke services.

The guidance is to be considered within the context of local circumstances in how they are applied.

The guidance reflects and builds on the work undertaken in the previous Stroke services reviews in London, Birmingham and the Black Country and more widely in the East of England and Midlands.

The guidance has been supported by the National Clinical Director for Stroke, Professor Tony Rudd and he summarises key issues below;

"The way that stroke services are organised will have a major impact on outcomes after stroke.

We have robust evidence that management on a stroke unit saves lives and reduces disability.

We know that that the most important interventions are maintaining homeostasis and preventing stroke associated complications.

We know that thrombolysis delivered quickly will reduce the chances of surviving with disability.

Effective prevention strategies after stroke and TIA will reduce the risk of recurrence and specialist rehabilitation both in hospital and in the community also have a strong evidence base.

Data from the Sentinel Stroke National Audit Programme (SSNAP) has shown that larger stroke services operate more efficiently than smaller services and it is likely that they are more likely to be financially viable as well.

It has been shown that levels of nurse staffing also has a direct impact on the chance of patients surviving.

To deliver the best outcomes it is therefore vital that patients are managed in a well organised service that can deliver the best quality of care.''

Tony Rudd, Professor of Stroke Medicine National Clinical Director for Stroke, NHS England

The guidance toolkit provides advice on the review process and the recommended characteristics of a quality stroke unit.

These include;

- That the most important care for people with any form of stroke is prompt admission to a specialist stroke unit.
- That a stroke unit undertakes adequate volumes of activity to maintain clinical quality and outcomes.
- That 95 % of patients can access the Hyper acute unit within 45-30 minutes.
- That Hyper-acute stroke services enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams.
- To treat Transient Ischaemic Attack quickly if stokes are to be avoided, and must ne treated as a stroke whilst symptoms persist.
- Ambulance staff to use a validated screening tool and transfer suspected stroke patients to a specialist acute stroke unit within 1 hour.
- For urgent brain imaging within a maximum of 1 hour.
- For direct admission to a specialist stroke unit within 4 hours and receive thrombolysis if clinically indicated, (about 20% of patients)
- Early and intensive physiological and neurological monitoring and evidence based protocols for abnormalities ie bleeding, anaphylaxis, infection, VTE , Malignant MCA syndrome.
- Specialist swallow screening within 4 hours of admission, with assessment and planning for the provision of adequate nutrition
- Assessment and management by stroke trained nursing staff and one member of the specialist team within 24 hours and by all relevant members within 72 hours.
- Documented multi disciplinary goals should be in place.

The guidance recognizes the importance of and builds on the work from the **Sentinel Stroke National Audit Programme** and notes that the findings across the country indicate that there are still considerable variations in the quality of stroke care across England. This evidence demonstrates a clear need to look at the

opportunities to improve the quality of stroke services and therefore ***doing nothing should no longer be an option.***

The impact of Telemedicine on the pathway.
Telemedicine is only able to replace the expert opinion on diagnosis and immediate management. It cannot replace the need for high quality stroke unit facilities, well trained stroke nurses on site and access to on-going specialist medical opinion that will be needed repeatedly during the course of an average stroke admission. A telemedicine consultation does not remove the need to provide specialist bedside assessment of the patient on a daily basis. It is unacceptable to provide an acute assessment using telemedicine on a Friday evening and then not provide a specialist bedside opinion until the Monday. There have been no studies evaluating the effectiveness or feasibility of conducting telemedicine ward rounds. There must always be the option of a bedside assessment of a patient where telemedicine is insufficient to address the patient's needs.

5.4 Literature Review findings.

The Kent and Medway Public Health teams have undertaken a literature review as part of the review. This is an evidence review in relation to Hyper acute stroke units. The review has considered a number or key aspects, these include a summary of standards, evidence of clinical and cost effectiveness. It considers reconfigurations elsewhere, Telemedicine and travel times.

Further analysis of the evidence is underway however early indications are that the findings suggest that Hyperacute Stroke units are both clinically effective and some evidence that these are cost effective. However, there is evidence to suggest that preventing a stroke is cost effective and prevention strategies should be implemented at a population level.

*Once completed the final findings will be considered against this Case for Change and applied as appropriate. The findings will also be utilised through the option appraisal process.

5.5 Sentinel Stroke National Audit Programme. (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks. Building on 15 years of experience delivering the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP), SSNAP is pioneering a new model of healthcare quality improvement through near real time data collection, analysis and reporting on the quality and outcomes of stroke care

SSNAP is the single source of stroke data and has 100% participation of acute hospitals in England, with 95% case ascertainment.

The audit considers 44 Key Indicators representative of high quality stroke care which are grouped into 10 domains covering key aspects of the process of stroke care.

- Domain 1: Scanning
- Domain 2: Stroke unit
- Domain 3: Thrombolysis
- Domain 4: Specialist Assessment.
- Domain 5: Occupational therapy
- Domain 6: Physiotherapy
- Domain 7: Speech & language therapy
- Domain 8: MDT working.
- Domain 9: Standards by discharge processes.
- Domain 10: Discharge

Each domain is given a performance level (level A to E) and a total key indicator score is calculated based on the average of the 10 domain levels for both patient-centred and team- centred domains.

A combined total key indicator score is calculated by averaging the patient-centred and team-centred total key indicator scores. This combined total key indicator score is adjusted for case ascertainment and audit compliance to result in an overall SSNAP level.

Within the NHS England guidance on the configuration of stroke services there are recommendation for reviews/commissioning to focus on key indicators with a view to considering if a unit can deliver against these or can reasonably work towards them before accepting them as a HASU.

- Domain 1) Proportion to pts scanned at 1 hr and 12 hrs and median time between clock start and scan.
- Domain 2) Proportion of pts admitted to Stroke unit within 4 hours and who spend 90% of stay on unit. Median time between clock start and arrival.
- Domain 3) Proportion of thrombolysis for all Stroke pts/eligible pts and within 1 hour.
- Domain 4) Median time for assessment by consultant and nurse. Proportion with a swallow screen and then assessment.

- Domain 8) Applicable pts assessed by OT, Physio, SLT. Pts with rehab goals within 5 days and combination of all of the therapy and nurse assessments.

**** before they can admit: consider these domains and if not in place is there a robust plan for delivery.***

5.6 South East Cardiovascular Strategic Clinical Network;

The network has produced Stroke and TIA Service and Quality Standards for the hyper acute pathway and TIA pathway and is currently localising the recommended East Midlands stroke service specification for use across Kent, Surrey and Sussex. .

The SE CVD SCN Hyper acute Stroke and TIA service and Quality standards are 22 clinical standards used by the Kent and Medway providers to assess their performance against the best practice stroke practice. The standards reflect the SSNAP domains and indicators for the Stroke hyper acute and TIA pathway. These standards currently form the basis of the gap analysis undertaken by the K&M admitting units. (appendix 1)

This will include and reflect workforce requirements and access /travel times that enable achievement of the standards.

5.7 Workforce guidance:

The National Clinical Guidelines for stroke 2012, highlight the importance of ensuring stroke services not only have appropriate organisation structures, but also that physical structures such as staff. Evidence on the appropriate number of the different resources is limited,

Progress over the management of stroke over the last 10-15 years has increased demand for the provision of Consultant based specialist services for people with stroke.

The current SEC Stroke and TIA Service and Quality standards reflect the BASP guidance for staffing levels.

They recommend 24 hour , 7 day specialist cover by Stroke specialists including nursing, 7 day therapy ,7 day consultant ward rounds and 24 hour 7 day thrombolysis rotas

The BASP recommended staffing numbers for a HASU are;

Professional group.	**Recommended levels**	
Specialist Stroke consultants	1.3 per 100,000 pop	22.1. total for K&M
Stroke trained nurses	2.9 wte per bed	Per unit
Therapists; **Physio** **OT**	 1 wte/per 5 beds. .68 wte/ per 5 beds. .68 wte/ per 10	Per unit.

SALT **Dietician.** **Clinical psychologist**	beds .5 wte/per 20 beds 1.0 per 40 beds.	

The National Institute for Health and Care Excellence (NICE) has also published guidance on nursing skill mix required to ensure that acute care is delivered 7 days a week. Evidence has suggested that there is a significant risk of increased mortality if stroke patients are admitted at a weekend .

It is essential that the review understands the workforce required to run a HASU and how this will be delivered. There may not be adequate staff to run two separate HASU and ASU units and consideration needs to be given to how this would be addressed.

5.8 Critical Co-Dependencies

The Sussex CCGs requested the South East Clinical Senate to completed an independent clinical review of the evidence base for the critical co-dependencies of acute patient services, and where in the absence of evidence, to provide a clinical consensus view of service inter-dependencies. The aim was to provide a framework for the commissioners' future discussions with stakeholders on how their hospital infrastructure is configured. The CCGs specified that this work should be generic and not county or region-specific.

A grid of the co-dependencies was produced and for Stroke services it makes the following recommendations for co-location.

HASU/ASU

- A&E/Emergency Medicine
- Acute and general Medicine
- Elderly Medicine
- Respiratory Medicine
- Adult Critical Care
- General Anaesthetics
- Acute Cardiology
- X-Ray and Diagnostic Ultrasound
- CT Scan
- Occupational Therapy and Physiotherapy
- Acute Mental Health Services

HASU or ASU specific:

- Urgent GI Endoscopy(upper and Lower) – HASU only
- MRI scan – HASU only
- Acute Inpatient Rehabilitation – ASU only

Other services are coded as being:

- Red - services coming to the patient i.e. via inreach (physically or via telemedicine) but not in same hospital
- Amber – Ideally on same site but alternatively via robust emergency and elective referrals and transfer protocols
- Green – does not need to be on same site

5.9 Summary of the national guidance and policy:

In summary of the national and regional guidance and requirements the key features of a quality Hyper acute stroke unit would be;

- Unit volumes of > 600 and < 1500 confirmed stroke patients per year.
- Access times that meet the call to door and door to needle times ie 30 to 45 minutes travel time.
- Adequate specialist staffing to meet 7 day specialist Stroke services cover, including consultants, nursing and therapists.
- An acute pathway that meets the following standards;
  - Assessment by ambulance staff using a validated tool, transfer to specialist admitting site……. within 1 hour.
  - Prompt admission to a specialist stroke unit…….within 4 hours.
  - Access to rapid expert Consultant Clinical Assessment …within 1 hour
  - 24 hr Rapid access to brain imagery……within 1 hour
  - Thrombolysis offered to appropriate patients (20%)… within 1 hr (door to needle)
  - Early and intensive physiological and neurological monitoring with immediate recognition and treatment of abnormalities using evidence-based treatment protocols.
  - Specialist swallowing screening…….. within 4 hours of admission.
  - Assessment/ management by stroke nursing staff and at least one member of the specialist rehabilitation team… within 24 hours of admission.
- Assessment by all relevant members of the MDT team.. within 72 hours.
- Documented multidisciplinary goals should be agreed… within 5 days i.e. nutrition, hydration,
- 90 % of patient stay within a specialist stroke unit.

6.0 Current Kent and Medway Provision/Pathways

This review considered the stroke pathway across Kent and Medway, there is no significant out of K&M activity for Stroke patients into neighbouring admitting units or rehabilitation providers.

The admitting units do however also serve out of Kent/Medway population supporting patients from East Sussex and South London. This accounts for approx. 65 patients per year form East Sussex and 70 patients per year from South London.

6.1 Hyper acute/acute pathway.

Across Kent and Medway there are currently seven admitting units for acute stroke care, and they provide both hyper acute (up to 72hours) and acute care. However none of the units deliver within the HASU model.

Suspected Stroke patients are designated and responded to as Red1 and Red2 calls by SECAMB *(here is some CAT3 activity Which has been included but will impact on the door to needle* time)
The patients are then transferred to the nearest admitting unit and assessed within the emergency department whenever possible this is by stroke consultants or specialist nurses.

It is recognized that a small number of patients will choose not to call an ambulance and will self present at hospital and this also needs to be understood form a local perspective in any review of stroke service configuration.

24 hour Thrombolysis rotas are in place across Kent and Medway and patients are accessed within the ED. This is supported by telemedicine out of hours.

Where appropriate rapid imagery is accessed from the ED departments.

Confirmed Stroke patients are admitted wherever possible directly onto the acute Stroke units, stroke mimics are also admitted onto the units.

Generally the stroke unit beds are not protected and therefore when there are acute pressures in the system medical patients may be admitted into the stroke beds. This can lead to outliers where stroke patients are not admitted onto a stroke unit.
All the existing admitting units will strive to keep the Stroke patients on the unit for the duration of their acute phase.

Stroke mimics are admitted onto the Stroke units as their care echoes that of a stroke patient. It is difficult to accurately identify the number of Stroke mimics although an initial mini audit suggests this to be around 30 to 35 % of the total activity.

Rehabilitation care is provided in a combination of on site and local rehabilitation beds.

The admitting/acute care units are under the management of four acute Trusts with additional provision from two community providers for rehabilitation care.

Early Supported discharge (ESD) is offered across the units although this provision is variable.
** Further assessment is needed to confirm the full range of rehabilitation provision and nature/extent of ESD.

Table 1; Current hyper acute/acute Stroke units in Kent and Medway.

Provider	*Location*	*Service*
EKHUFT	WHH, Ashford KCH, Canterbury. QEQM, Margate.	Full acute service on all sites
MTW	Tunbridge Wells Hospital.(TWH) Maidstone Hospital,(MH) .	Full acute services on all sites. Rehabilitation at Tonbridge Cottage Hospital.
Darenth Valley Acute Trust	Darenth Valley Hospital, (DVH) Dartford	Full acute services on site.
Medway Maritime Foundation Trust	Medway Hospital, (MFT) Gillingham.	Full acute service on site.

Stroke Rehabilitation beds are provided in a number of sites across Kent and Medway predominantly by Kent Community Health Foundation Trust , Medway Community Healthcare , MTW and Kent and Medway Partnership Trust.

The referral and care pathways for these beds is variable and not all are dedicated to Stroke patients. The multi disciplinary team approach also differs across the units.

Early Supported Discharge services are also variable across Kent and Medway.

6.2 Stroke incidence.

Current K&M activity;

	DVH	MFT	MH	TWH	WHH	KCH	QEQM	Total K&M
12/13	343 (inc 70 Bexley pts)	368	294	375 (inc 65 E.S pts)	440	292	319	2,431
13/14	324	417	321	325	473	366	346	2,572

**This is coded using;

I61 Intracerebral Haemorrhage, I63 Cerebral Infarction and I64 Stroke not specified as Haemorrhage or Infarction. Also included are I60 Subarachnoid Haemorrhage and I62 Other Nontraumatic Intracranial Haemorrhage as these patients receive the same care as confirmed Stroke pateints.
Generally between 20 to 40 % of suspected stroke patients will not be conformed as strokes however will require the sme treatment pathway and therefore are included in the numbers for capacity planning.

This includes the activity from East Sussex into TWH and Bexley into DVH.

SECAMB will convey all suspected patients who are FAST positive to the nearest Emergency department.
Between April 2014 to September 2014 SECAMB conveyed 3359 patients into the seven admitting units with a designation of a Stroke or neurological condition.
On average around 50% of these patients will not be diagnosed with a Stroke but this activity needs to be verified and modelled into the planning for both stroke units, ED capacity and medical beds. There may also be an impact on repatriation in any further configuration discussions that must be considered in any future modeling.

The activity data shows a marginal increase across Kent and Medway in 13/14 of 141 patients with KCH and MFT seeing the largest increase in confirmed strokes (74 and 49 respectively).
Early analysis of the first three quarters activity for 14/15 shows a similar trend.

This activity data reflects actual numbers per admitting unit, consideration of rate per 100,000 pop shows greater activity in Ashford, Thanet and Swale with a sharp increase in Canterbury and Coastal CCG. This will need to be further analysed when considering possible options. This does not include TIAs although the pattern is similar re trend increases with East Kent showing a sharp increase.

6.3 CCG Stroke profiles (Public Health England, 2014);

CCG Stroke profiles; August 2014

	WK	DGS	Medway	Swale	Ashford	C.Coastal	SKC	Thanet
Stroke prevalence; 2.0 national	1.9	1.9	1.8	2.2	1.9	2.1	2.5	2.7

A.F Prevalence; 1.5 national	1.8	1.5	1,3	1.4	2.1	2.1	2.1	1.9
pop	463,500	249,000	268,000	108,000	120,000	200,500	203,000	135,500
> 65	83,000	41,500	39,000	18,800	21,500	40,000	41,500	29,500
deprivation	2.5%	8.2%	14.8%	22.6%	6.1%	7.8%	20.0%	31.5%
Admitting units	TWH, MH, (MFT)	DVH	MFT	MFT	WHH	KCH, QEQM	WHH, KCH	QEQM

6.4 Public Health Analysis;

The current K&M population is 1,747,000. (2014 CCG profiles)

The Kent and Medway population is currently growing in line with national population growth.

- Population projections for the period 2013 to 2020 show the greatest increase in the older age bands;

  17% within the 65-74 age band

  22% within the 75-84 age band

  29% within the 85 plus age band.

  - There are a couple of key housing developments anticipated. This includes the garden city development at Ebsfleet in the North of the county with a maximum of 10,000 houses planned.
- There is also a planned theme park development due to open in 2020 on the Swanscombe peninsula, expected to bring 27,000 new jobs and families to the area.
- The population projections relating to these developments are currently being worked through however this will be more relevant in the younger age groups ie below 65 years of age.

Initial findings (to be finalised) from the public health analysis identifies that:

Stroke prevalence across the Kent and Medway CCGs are around the national average of 1.9% with higher prevalence in Swale (2.2), SKC(2.5) Canterbury (2.1) and Thanet (2.7)

This picture is reflected in AF prevalence, an understanding of effective AF and hyper tension management is underway to inform potential primary care prevention opportunities.

The Incidence of stroke increases with age, East Kent has the highest population over 65 years of age and therefore sees the highest level of stroke incidence. Across Kent and Medway the West Kent region is projected to have the highest percentage increase in population aged 65 years and over between 2012 and 2020. However East Kent will see the greatest number of individuals within this age group.

East Kent also has the highest prevalence of risk factors, hypertension, Atrial Fibrillation and Diabetes

The research demonstrates a higher incidence of stroke within the black ethnic group. This needs to be considered within the context of the K&M population.

***The complete public health data analysis will be utiilsed to both identify and inform the Options appraisal.*

7.0 K&M performance against Best Practice/Standards.

7.1 Performance against the SEC 22 Clinical and Quality standards.

All Kent and Medway providers have (or are in the process of) completing a gap analysis against the 22 SEC Stroke and TIA Service and Quality Standards.

There are common themes across the providers, these relate to workforce, specialist assessments, thrombolysis and scan within 60 minutes, access to the stroke unit within 4 hours and timely swallow screening and assessments

Key issues table; summary from combined gap analysis against the 22 SEC standards per admitting unit.

	7 day workforce	Thrombolysis within 60 mins (95%)	Scan within 60 mins(50%)	Stroke unit access within 4hrs
DVH	No	33%	48%	50%
MFT	No	11.1%	33.7%	45%
MH	No	66.7%	43%	59.5%
TWH	Only cons	20%	50%	31.4%
WWH	No	16.7%	55.2%	59%

KCH	No	50%	71%	25%
QEQM	No	33.3%	65.4%	59%

7.2 Performance against SSNAP.

All Kent and Medway providers actively participate in the SSNAP and where there have been historic gaps, investment in data /administrative support has improved compliance and subsequently results.

Performance is variable across Kent and Medway with SSNAP levels ranging form E to B.

The table below shows the SSNAP performance for K&M admitting units as of Dec 2014 (Q3 2014/15) and the previous two Quarters

	DVH Q3/Q2/Q1	MFT	MH	TWH	WWH	KCH	QEQM
SSNAP level	**D/D /D**	**E/ E /D**	**C/D /D**	**D/D/ D**	**B/ A/ C**	**D/D/E**	**D/C/C**
Combined score	**C/D/D**	**D/E/D**	**C/B/D**	**D/D/D**	**B/A/C**	**D/D/D**	**B/C/C**

7.3 Performance against the key acute domains (SSNAP)

The following table identifies performance by the K&M admitting units against the key Domains relating to HASU/ASU performance (as noted in the Configuration guidance**)**

The review needs to understand the high levels of compliance with specialist assessments where there is no 7 day working,

Current admitting Units performance against key domains. This table reflects the 2014/15 Q 2 and 3 performance.

	Domain 1 Scanning. <I hour 44.1% < 12 hrs 87.7%	Domain 2 Stroke unit 4 hrs;59.8% 90% stay; 84.3%	Domain 3 Thrombolysis 1 hr: 50% Eligible pts; 79.4% All pts; 11.7%	Domain 4 Specialist Assessment. Cons; 76.4%. Nurse 87.8% Swallow screen 79.2% Swallow assessment; 83.6%	Domain 8. MDT
DVH	Just above average. Improvement Q3	? below, 4 hr access. Improvement Q3	Just below, 1 hr thrombolysis. Improvement Q3	Average, therapy assessment,4hr swallow. No Change	Average. Slight deterioration Q3
DVH Performance in key indicators Q2/Q3	1 hour target; 47.5% /58.1% 12 hour; 96.7%/ 98.6%	4 hour access; 50% /66.7% 90% stay; 88.9% /86.2%	All pts; 9.8% / 13.5% Eligible pts; 100%/ 90% 1 hour target 33.3%/	24hr Stroke con/assessment; 70.5% /70.3% 24hr Nurse ass; ??/86.5% 4 hr Swallow screen ; 66.7% /70.4% 72 hr Swallow ass; 78.6% /81.3%	
MFT	Below ave;1 hr screening. Improvement Q3	Below average 4 hr access. Marked deterioration Q3	Below ave,no within 1 hour poor. Improvement Q3	Below average, esp consultant assessment, swallow screening. No Change, Q3	Below ave. No Change Q3
MFT Performance in key indicators Q2/Q3	1 hour target; 32.9% /42.9% 12 hour; 92.7% /97.6%	4 hour access; 44.3% /25.6% 90% stay ; 83.3% /74.3%	All pts; 11% /14.3% Eligible pts; 90% /100% 1 hour target;	24hr stroke cons assessment; 61% /54.8% 24hr nurse ass;	

			11.1% /16.7%	80.5% /83.3% 4 hr Swallow screening; 62.7% /61.4% 72hr Swallow ass; 65.5% /67.4%	
MH	Variable. Below average, deterioration Q3	Average. Deterioration Q3	Average with some improvements. Deterioration Q3	Just below, consultant assessments and 4hr swallow indicators. No Change Q3	Below average. Slight improvement Q3
MH Performance in key indicators Q2/Q3	1 hour target; 43% /30.7% 12 hour access; 87.3% /89.7%	4 hour access; 59.5% /56.8% 90% stay; 90.6% /85.1%	All pts; 3.8%/5.7% Eligible pts; 100%/80% 1 hour target; 66.7%/20%	24hr stroke con assessment; 67.1% /62.5% 24hr nurse ass; ?? /94.3% 4 hr swallow screen; 70.6 /79.7% 72 hr swallow assessment; 78.8??/90.6% check these	
TWH	just above average. Deterioration Q3	Below average Deterioration Q3	Below average. Improvement Q3	Average. Improvement in Q3	Below average. Improvement in Q3
TWH Performance in key indicators Q2/Q3	1 hour target; 50% %/43.2 12 hour access; 94.3/87.7	4 hour access; 31.4% /31.3% 90% stay; 82.8% /71.2%	All pts; 5.7% /9.9% Eligible pts; 100%/ 88.9% 1 hour target; 20% /37.5%	24hr stroke con assessment; 84.1% /81.5% 24hr nurse ass; 85.2% /91.4% 4 hr swallow	

				screen; 82.4%/ 76.6% 72 hr swallow assessment; 72% /80.8%	
WHH	Above average. Slight deterioration in Q3	Just above average Deterioration in Q3	Above average. Deterioration In Q3	Above average. No change in Q3	Below average. Slight deterioration in Q3
WHH Performance in key indicators Q2/Q3	1 hour target; 71.6% /55.2% 12 hour access; /95.2%	4 hour access; 76.4% /59% 90% stay; 90.8% /86.4%	All pts; 17.4% /11.4% Eligible pts; 81.3% / 69.2% 1 hour target; 50.1% /16.7%	24hr stroke con assessment; 89% /79% 24hr nurse ass; //93.3% 4 hr swallow screen; 89.5% /83.3% 72 hr swallow assessment; 89.2% / 96.6%	
KCH	Just above average. Slight deterioration in Q3	Just above average, below on 4 hr access. Deterioration in Q3	Just above average; just below re eligibility indicators. Deterioration in Q3	Just above, struggles with nurse and therapy indicators. Deterioration in Q3	Below Average. Deterioration in Q3
KCH Performance in key indicators Q2/Q3	1 hour target; 76.3% /71% 12 hour access; 98.7% /93.1%	4 hour access; 56.6% /25% 90% stay; 84.3%/94.6%	All pts; 15.85 /11.6% Eligible pts; 76.3% /87.5% 1 hour target; 58.3% /50%	24hr stroke con assessment; ??100% /85.5% 24hr nurse ass; /93.3% 4 hr swallow screen; 80.4% /65.4% 72 hr swallow assessment 100% / 96.6%	

QEQM	Just above average. Slight deterioration in Q3	Just above average. Deterioration in Q3	Average, below on eligibility. Deterioration in Q3	Slightly above, average. Nurse and swallow 4hr indicator below. Improvement in Q3	Below average. Deterioration in Q3
QEQM Performance in key indicators Q2/Q3	1 hour target; 64.4% /65.4% 12 hour access; 92.2%/ 89.7%	4 hour access; 64.4% /59% 90% stay; 83.7% /83.8%	All pts; 13.3% /19.2% Eligible pts; 66.7% /60% 1 hour target; 66.7% /33.3%	24hr stroke con assessment; 80% / 88.5% 24hr nurse ass; 81.1% / 82.1% 4 hr swallow screen; 61.9% /86.7% 72 hr swallow assessment; 94% /94.6%	

Quarter 3 (2014/15) shows variable performance across Kent and Medway with DVH seeing general improvement, WHH has a general deterioration on its previous good performance, other providers showing a mixed picture.

In relation to Domains;/ Domain 2, Stroke Unit shows a consistent deterioration across the admitting units and this relates to Access to the stroke unit within 4 hours.
The performance shows average performance in relation to specialist assessments which needs to be validated within the context of no 7 day cover.

7.4 Performance against Outcome measures.

Quarter 3 (2014/15) shows a general increase across Kent and Medway in mortality at 7 day and 30 day inpatient stay and 90 day and one year post discharge.
A number of units are experiencing an increase in readmission rates (30 day target) in particular TWH, DVH, MFT and MH. There is a reduction in the East Kent hospitals however against a backdrop of an increasing tend at WHH.

All providers are either close to or above the national averages.

There is a variable picture relating to length of stay, all units are around the national average, except WHH which is below.

The table below illustrates Q3 (2014/15) performance against the key outcome measures and the national average.

	DVH	MFT	MH	TWH	WHH	KCH	QEQM	national
In pt Mortality; 30 days	14%	17%	15%	18%	15%	15%	19%	14%
In pt Mortality 7 days	7%	12%	9%	15%	9%	9%	9%	9%
Mortality; 90 days	19%	21%	18%	22%	18%	18%	22%	18%
Mortality; One year.	22%	22%	21%	26%	20%	18%	23%	21%
Readmissions (30 days)	15%	12%	16%	17%	14%	14%	12%	13%
LoS (days)	12.3	10.9	14.2	16	9.7	12.3	12.7	13

7.5 Performance against workforce requirements/recommendations.

The following table reflects the workforce currently in place per Trust.

	K&M	DVH	MFT	EK	MTW
Current consultant numbers	12.1	1.5	1.5	6.3	2.8
Rec per CCG pop		3.25	4.84	8.45	5.85
pop		(249)	(376)	(658)	(463)
gap	10.29	1.75	3.34	2.15	3.05
Nursing 24/7	No	No	No	?no	No
Therapists 7 days	No	No	No	No	No
Consultants 7 days	No	No	No	No	Only tunbridge wells site
Meeting workforce requirements within SEC	No	No	No	No	No

quality standards					

The options appraisal will require clear agreement re the interpretation and delivery of the BASP recommendations.

7.6 Summary table of key indicators against current sites.

	DVH	MFT	MH	TWH	WHH	KCH	QEQM
SSNAP level Dec 14	D	E	C	D	B	D	D
Combined SSNAP KI Dec 14	C	D	C	D	B	D	B
7 day consultant cover	no	no	no	yes	no	no	no
30 min travel time for CCG pop	yes	yes	yes	yes	yes	yes	yes
Volumes (600 – 1500)	no	no	no	no	no	no	no
Volumes plus mimics	No ?	no	no	no	yes	no	No.
7 day spec/senior Nurse cover	no	no	no	no	no	no	no
7 day therapy	no	no	no	no	no	no	no

8.0 Summary of key findings across Kent and Medway admitting units:

8.1 Best practice/Stroke Standards:

Assessment against best practice illustrates that across Kent and Medway achievement of the standards and best practice is variable. All providers recognize that they are currently struggling to meet best practice, they particularly raise concerns re the ability to further improve, to sustain improvements and quality

measures that they have achieved and to deliver 7 day working across all the specialists.

The CRG have recognized that 7 day cover for consultants, adequate senior trained nurses and therapists are a key priority. A number of the units also highlight the lack of ring fenced beds and bed capacity results in poor achievement of the access targets.

Performance against SSNAP is variable across Kent and Medway, however most units struggle to deliver the key clinical indicators required for a Hyper acute unit. In some cases this may be in line with the national average such as 4 hour access and one hour thrombolysis however there is room for improvement for Kent and Medway patients. There has been minimal improvement across the county in the past twelve months despite improvement plans being in place in most units.
Currently a number of Kent and Medway units are within the lowest quartile of performance and compare poorly with the rest of South East Coast units.

Assessment against the key hyper acute/acute elements of both the SEC Stroke and TIA Service and Quality standards and the SSNAP framework identifies issues meeting;

- The four hour access target.
- One hour thrombolysis target.
- One hour scanning target.
- 24 hour specialist assessments.
- 7 day cover; consultants, nurses and therapists

Only a small number of outcomes are identified across stroke units however the recent picture of deterioration in mortality and readmission rates needs to be monitored to ensure these are not indicative of trends.

8.2 Activity:

Activity data shows that none of the current 7 admitting units meet the recommended minimum volume of 600 confirmed stroke patients. The closest unit sees around 475 stroke patients per annum with other units being around 300 to 400.

Reviewing 2012/13 and 2013/14 activity shows a small increase, * currently determining the likely impact on activity.

It is recognized that Stroke units need to manage stroke mimics in the same way as confirmed stroke patients and this activity needs to be modelled into any discussions re bed modeling. Currently this is estimated at around 30 - 35% of activity but will need detailed analysis as part of the capacity modeling phase.

This activity is currently managed on the stroke units across Kent and Medway.
It is also important to note that SECAMB will convey a number of patients to admitting sites who present as FAST positive but who do not subsequently require care on a stroke unit. This currently equates to similar numbers as those who do

require stroke unit care. Any subsequent modelling will need to understand the impact of any reconfiguration of HASU on ED's and/or repatriation of non stroke patients brought to the HASU by ambulance.

Whilst some HASUs achieve good results and outcomes with fewer than the nationally recommended minimum stroke activity of 600 cases per year, the *aim* of review is to use this as a benchmark. Any designated HASU in Kent and Medway should achieve this minimum activity, based on the wide range of clinical benefits seen in larger units unless there is clear evidence that sustainable care and best patient outcomes can be achieved by the HASU

8.3 Workforce:

The review has identified that both current and future workforce are key issues across all the Kent and Medway providers. The numbers are almost 50% lower than the recommendations across the county and are worse in MFT and MTW. With the exception of a weekend rota at Tunbridge Wells hospital no unit provides 7 day consultant cover which is a key recommendation.

It is difficult to ascertain if this is having an adverse effect currently as there is no evidence of this however the national best practice is clear that this is a key requirement.

There is no specific recommendation relating to specialist nurses however senior stroke trained nurses' being available 24 hours a day 7 days a week is identified as significant for good patient outcomes. No current Kent and Medway admitting unit has this provision available. All the units are heavily reliable on one or two individuals to both provide this role and to train the nursing workforce.

Therapists are central to the stroke pathway and no K&M unit is currently providing 7 day cover, it is particularly difficult in relation to speech and language therapists who play a key role in the hyper acute /acute phase.

The gap analysis also shows that no current unit is meeting the BASP recommendation for a HASU .

It is generally difficult to recruit to stroke specialist roles, there are no workforce plans evident across the Kent and Medway providers that will make a significant difference to this picture.

8.4 Travel/Access:

Currently all the admitting units are accessible within the recommended 30 minutes travel time by ambulance. This also results in a number of residents from East Sussex and South London (Bexley) being conveyed to Kent units.

SECAMB currently meets the national indicator of one hour call to door time. Potential options will consider the travel times and impact on call to door times, including the impact of peak travel times.

The Options appraisal process will model the access times against the possible solutions and identify key negative impacts.

8.5 Summary.

This Case for Change illustrates that there are both current and future concerns re the delivery of hyper acute/acute Stroke services across Kent and Medway.

Do nothing is not an option if improvements are to be made and services are to be sustainable.

Improved performance against SSNAP and delivery of best practice recommendations is required by all K&M CCGs.
The ability to improve against the indicators is likely to be limited by the workforce issues.

An added value of larger units include the ability to drive quality improvements and the benefits of economies of scale to a larger number of people.
The low volume levels across the admitting units do not meet the national recommendation for adequate volumes to deliver good outcomes. It is likely that this may also be impacting on the financial positions of the providers as they struggle to staff low volume centres.

The current staffing levels also makes 7 day working impossible to achieve across the existing sites.

Development of possible options must consider the intended and unintended consequences/impacts across both the patient pathway and the Kent and Medway Strategic planning of clinical commissioners and individual Trusts.

Whilst the review is focusing on the hyper acute/acute stroke pathway the options will need to consider the impact of current and planned Primary Care preventative strategies.

The review Programme Board notes that the key measures for success will be a Kent and Medway hyper acute/acute model that delivers ;

Evidence of consistently good outcomes for patients reducing both mortality and morbidity rates.

Improved performance in relation to SSNAP across Kent and Medway with all admitting sites aiming for level A.
Compliance against the SEC Clinical and Quality standards.

Achievement of the key clinical targets;
Call to door (one hour) and door to needle (one hour) times.
Rapid imagery (one hour)
Four hour access to the stroke unit.

90% stay on a stroke unit.
Timely specialist assessments.
Seven day cover by specialist stroke consultants/nurses and therapists.

Consistency of performance across Kent and Medway to ensure all patients receive high quality hyper acute stroke care regardless of where they live in the county.

Sustainable hyper acute/acute stroke services, that can meet demand and has a workforce that is fit for the future. (10 to 15 years).

Evidence of good recruitment and retention with motivated high caliber professional choosing to work in K&M.

Development of innovative clinical practice.

Conclusion;

The K&M CCGs aspire to deliver excellent stroke care for the residents of Kent and Medway.

The Case for Change illustrates that the current performance across K&M Medway is not at an acceptable level. Whilst this is recognised by the provider Trusts, key issues such as the workforce and ability to deliver across 7 days are not easily resolved within single organisations.
Best practice also recommends that higher volumes of activity benefit patients with regards to improved outcomes.
The current configuration of admitting units needs to be reviewed and options for delivering improved patient outcomes developed. There are concerns noted by all in the review in relation to the sustainability of the existing provision.

The aspiration of the review is to deliver high quality best practice for Kent and Medway residents and to have ambitions beyond average.

9.0 Recommendations:

- The Case for Change to be agreed by the Review Programme Board and ratified by the Kent and Medway CCGs (once public engagement feedback considered/ incorporated)

- To proceed to identify options that can deliver the requirements noted and meet best practice and deliver a sustainable hyper acute/acute model.

The benefits we expect for patients include;

- **Improved pathways of care and outcomes, particularly ensuring that patients are given the best possible chance of survival and minimisation of disability.**

- **Access to 24 hour, 7 day specialist stroke care regardless of where in Kent and Medway the patient resides.**

- **Sustainable Stroke services for all Kent and Medway residents**

- **Consistent high performance of hyper acute/acute stroke care against the national best practice.**

- **A specialist and resilient Stroke 7 day workforce including specialist consultants, stroke trained nurses and therapists.**

- **Consistency of hyper acute /acute Stroke care for Kent and Medway residents regardless of where they live.**

10.0 Next Steps:

The Case for Change will be reviewed to reflect the public/patient view post public listening events.

The Review Programme Board will;
Develop and agree the decision making process and criteria; to reflect national best practice, sustainability, financial modeling, health impact assessment and the clinical and public voice

Build on the current travel times modelling work to assess impact of options of achieving call to door to times, including the possible changes to the current time lines.

Profile activity models and impact on emergency departments and medical wards, to include non stroke patients and stroke mimics.

Assess the impact of possible configurations on treatment rates and disabilities.

Review options against the SEC Clinical Senate Critical Co-dependencies framework and K&M Trust strategic plans.

Undertake a cost benefit analysis of possible options including financial modelling exercises.

The options development to fully consider and describe how the HASU and ASU relationship will work, if separate units, including the impacts of this model on travel times, workforce and repatriation.

Kent and Medway Stroke Services Review.

Decision making process
and
Decision tree/criteria.

1.0 Introduction:

This document is a key component of the current Kent and Medway review of Stroke services and needs to be read within the background of the review process as a whole.
This includes the ;
Case for Change,
Communication and Engagement plan,
Project Initiation Document and
Process Assurance document.

The aim of the paper is to illustrate the process that will be undertaken to ensure a systematic and transparent decision making process.

2.0 The decision making process.

The following decision making process will be undertaken in a systematic approach and will be clinically led.
Central to the decision making process will be regular and robust public engagement.
The decision making process will reflect the involvement and feedback from patients and the public , in particular ensuring that the outcome of the review is improved outcomes for patients.
The process will reflect national best practice and guidance.

The decision making process will be implemented at key decision points in the process. This will include:

- Approving the Case for Change
- Agreeing the Long List of Options
- Agreeing the Short List of Options
- The preferred option(s)
- Additional information
- Provider response
- The decision making tree –

2.1 Case for Change:

The Case for Change was developed to reflect the national context, regional influences and local variables. The key focus will relate to the delivery of the best practice guidance, the National Stroke Strategy 2007 and the (soon to be published) Stroke Configuration Guidance 2015 (NHSE).

The Case for Change has been developed with the Programme Advisory Board (PAB) members and the Clinical Reference Group and informed through the CCG clinical forums.

Listening events with the public will raise awareness and assess understanding of the need for change and the publics key issues/concerns. These will inform the Case for Change and in particular to ensure that it is easily understood and recognisable.

The wider clinical community for Stroke will be involved through local provider Trusts and engagement from the review programme director with workshops planned as the review process develops.

The SEC Clinical Senate are providing a 'critical friend' role in reviewing the Case for Change and the PAB will embrace recommendations made. Independent patient and public engagement is also a part of the clinical senate process.

The draft Case for Change will be shared with the CCG clinical forums, ensuring that it is transparent and clinical leadership can challenge and support the process. The final Case for Change will be ratified at the CCG Governing Bodies.

This document was approved in principle at the Review Programme Board (RPB) on 13th May 2015. Additional information will be added as indicated within the document.

3.0 Options Decision making process.

A systematic process will be in place to enable transparency on the identification of the possible options and assessment of the option range.
Central to the decision making process will be the need to ensure that the future delivery of hyper acute/acute stroke delivers real benefits for patients.
The review will listen to the public and patients through out and adapt and amend the process and findings accordingly.

This will be undertaken within a staged process;

Stage 1 – The Long List

The first stage will Identify and register all possible pathway and service configurations for hyper acute Stroke services for the population of Kent and Medway.

The Clinical Reference group will scope and consider the possible options and feedback from the public listening events and engagement events.

Stage 2 – The Long List Revised to the Short List

The second stage will reduce the long list to a shorter list of options. This will be achieved by applying the key indicators within a decision making tree. These will be identified and informed by:

- National guidance
- Best practice (Midlands Specification/Birmingham review)

- NHSEngland guidance on Stroke Services configuration
- Local and external clinical guidance
- Patient/public views
- Achieving the ambition of the review programme board of sustainable quality improvement , benefits for patients and a sustainable workforce plan.

The possible options will be assessed against the decision making tree and the process will remove options that are not able to deliver these key indicators . This will be undertaken through a prioritisation process, however consideration will be applied to borderline results and will be evaluated in the context of its impact.

The short list will be informed by:

- The public and patients through public engagement feedback.(listening events, focus groups, stakeholder groups, national voice)
- The clinical reference group to the Board (appendix 1).
- Board members and their constituency (for example Kent and Medway CCGs, NHS England, SEC Clinical network, Public Health and the Local Authorities,).

Stage 3 _ Options Appraisal.

Once a short list is identified further detailed assessment will be undertaken to determine the feasibility and impact of the options.
This will include ;
A quality review,
Capacity modeling,
Cost benefit analysis including financial modeling
Health needs impact assessment.
The appraisal process will develop to include public, clinical and external feedback re key issues.

Engagement will be undertaken with the public throughout the detailed assessment to identify key priorities and concerns of the public and to test the findings of the assessments.

Clinical engagement will be ongoing to test the clinical validity of the developing options. This includes at CCG clinical lead level.

The Quality review will assess the provider capability both within the context of the Stroke service and within the Trusts wider Quality priorities.
The capacity and financial modeling will consider the ability of both the options and the providers to respond to the demand in a sustainable and financially viable way.

The review will consider the impact of possible options and enable a risk assessment of the balancing factors by the CCG's. This will include;

- considering the impact of longer travel times either due to length of journey or traffic issues on effective thrombolysis.

- Understanding the benefits of the hyper acute principle of centralisation for patients in rural areas.
- The impact on repatriation rates, ED activity and pressures.
- The possible solutions within the context of wider K&M and Trust's strategic plans.

The initial work undertaken by Public Health on projected growth, prevalence and incidence and the impact of primary prevention for key risk factors on stroke prevalence will be considered in greater detail at this stage. This will inform the options appraisal and subsequent recommendation(s)

The Programme Advisory Board will evaluate the options and identify the final recommendation(s). The Board will be advised by the Clinical reference group and discussions with the wider clinical stroke community.

The Communication and Engagement sub group of the Programme Board will ensure active public participation at all stages of the process including membership of modeling groups.

The findings of the options appraisal will seek to identify an agreed preferred option or options that achieve;

- **Improved patient outcomes and experience.**
- **Clinical viability.**
- **Long term sustainability .**
- **Recommended best practice.**
- **Workforce planning supporting effective recruitment and retention.**

The short list will also be considered within the context of strategic planning and interdependencies across Kent and Medway.

There will be a stakeholder challenge session undertaken following identification of the preferred option/recommendation(s).
This stakeholder session will include:
Public and patients.
Clinical leads from stroke services, medical services and ambulance/ transport services.
CCG clinical leads.
External clinical leads.
SEC CVD network.
SEC Clinical Senate.
Key stakeholders ie Stroke Association.
HWB representation.
K&M councillors and MPs.
K&M CCG leads.

This event will reflect the review process and talk through the decision making process enabling debate and challenge to the findings. The session will proceed with the CCG's and RPB to consider the feedback from the challenge session and advice from the SEC Clinical Senate to confirm and/or amend the final option/recommendation(s).

Stage 4; Preferred option approval.

The option/recommendation(s) will be reviewed through the Kent and Medway Commissioning Assembly to consider a K&M solution and to ensure strategic fit.

The preferred option/recommendation(s) will be presented for approval to the Kent and Medway CCG governing bodies via individual Clinical/business forums.

Public and Clinical engagement will be reflected in the final recommendation(s). Consultation on the preferred option(s) will be undertaken as advised by the Kent HOSC and Medway HASC, who will also advise on the need for a joint HOSC

The clinical reference group will consider models of care based on clinical best practice identifying issues and barriers for consideration.

Appendix 1: Decision Making Tree

This criteria is based on/and reflects the national recommendations for hyper acute/acute stroke services. It is comparable to the DMT used by Birmingham in their review.

The criteria has been discussed and developed in the Clinical reference group and will be further developed with the learning from the public engagement and feedback from the SEC Clinical Senate.

Stage one process:

- Access < 30 mins (95%) ; this relates to travel time of 30 mins allowing the ambulance Trust 30 minutes for the call to patient transfer and therefore meeting the one hour call to door target.
  (The access time will contribute to ensuring the total 120 call to needle time)
- 7 day stroke consultant cover, 7 day Stroke trained nurses with adequate senior staff skill mix and therapists.
- Workforce configuration that meets the HASU requirements (noted in the SEC quality standards);
- Volume >600 < 1500 confirmed stroke admissions (K&M Clinicians keen not to exclude a high performing option that may be slightly below the volumes noted)
- Clinically safe HASU options as assessed through the SEC Quality standards.
- HASU options configurations moderated by EIA
- Negative cost benefit.
- .

[1] Stage two process:

- Detailed appraisal of provider configuration/capacity/feasibility/quality
- Detailed assessment of ability to meet the 120 minutes call to needle time and impact analysis of options on travel times balanced with the benefits of centralisation.
- Cost analysis.*
- Benefit analysis
- Impact assessment.
- Detailed access/travel times review.
- Application of SEC senate Co-dependencies guidance to ensure no negative impact
- Workforce.

(This will consider the workforce requirements to deliver sustainable high quality Stroke services into the future)

- Review of the demographics and projected population growth to determine the impact on delivering a sustainable Hyper acute/acute stroke service.
- This will include consideration of key risk factors and population groups.

Appendix 2:

Recommendations from the Clinical Senate.

These will be reviewed and considered through the Stage two process., in particular reflecting these consideration in the final preferred options.

- Plans for a proposed HASU demonstrate it will be configured, staffed and of sufficient size to deliver its potential for optimal care and outcomes, with a clear aim of achieving >600 cases per annum in a defined period.

- There should be a clear aim, backed by robust demographic modelling, to treat at least 600 confirmed stroke patients per annum, within a defined period. The model should ensure provision is made for compliance with the recommended staffing levels of the full multi-disciplinary team, and will provide the bed capacity to deliver the planned activity (allowing for peaks in demand).

1

- There should be a clear and detailed description of how the proposed HASU would network with surrounding acute trusts and their ASUs to provide coordinated care for acute stroke patients.

- There should be a clear statement of ambition as to the quality of service and outcomes that will be delivered by the stroke units, and the entire stroke network.

- SSNAP level A across the board should be the aim, with stated time scales as to when these could be delivered (accepting that this could not be immediate).

- There should be explicit, realistic and acceptable patient pathways describing how patients with stroke mimic symptoms will be managed after transfer to the HASU and diagnosis of alternative pathology.

- There should be demonstrated an understanding of the key clinical co-dependencies of HASUs and ASUs, and how they will be addressed. Reference should be made to the SECS co-dependencies report (Dec 2014), and summarised for stroke units in Appendix C of this review.

- Proposed HASUs should be able to demonstrate how they will deliver a clinically appropriate 'call to needle' time for patients in their proposed catchment area, taking account of accurate ambulance travel times, and responsiveness on arrival at the HASU.

- This review proposes a call to needle time of 120 minutes as an appropriate standard to meet.

- There should be convincing proposals for how the multidisciplinary workforce (medical, nursing and therapies as required) will be delivered in the HASU, in order to deliver the required 24/7 and/or 7 day services.

- Robust and detailed workforce plans, including the multi-professional education and training needs, should be provided.

- There should be a description of how the overall stroke network in which the proposed HASU would be centred would look, including pre-hospital care, palliative care, and inpatient rehabilitation and community care post-stroke.

- Stroke care needs to be coordinated and integrated across the pathway between the various providers, and an outline model should be provided, demonstrating the network leadership role that HASUs can serve.

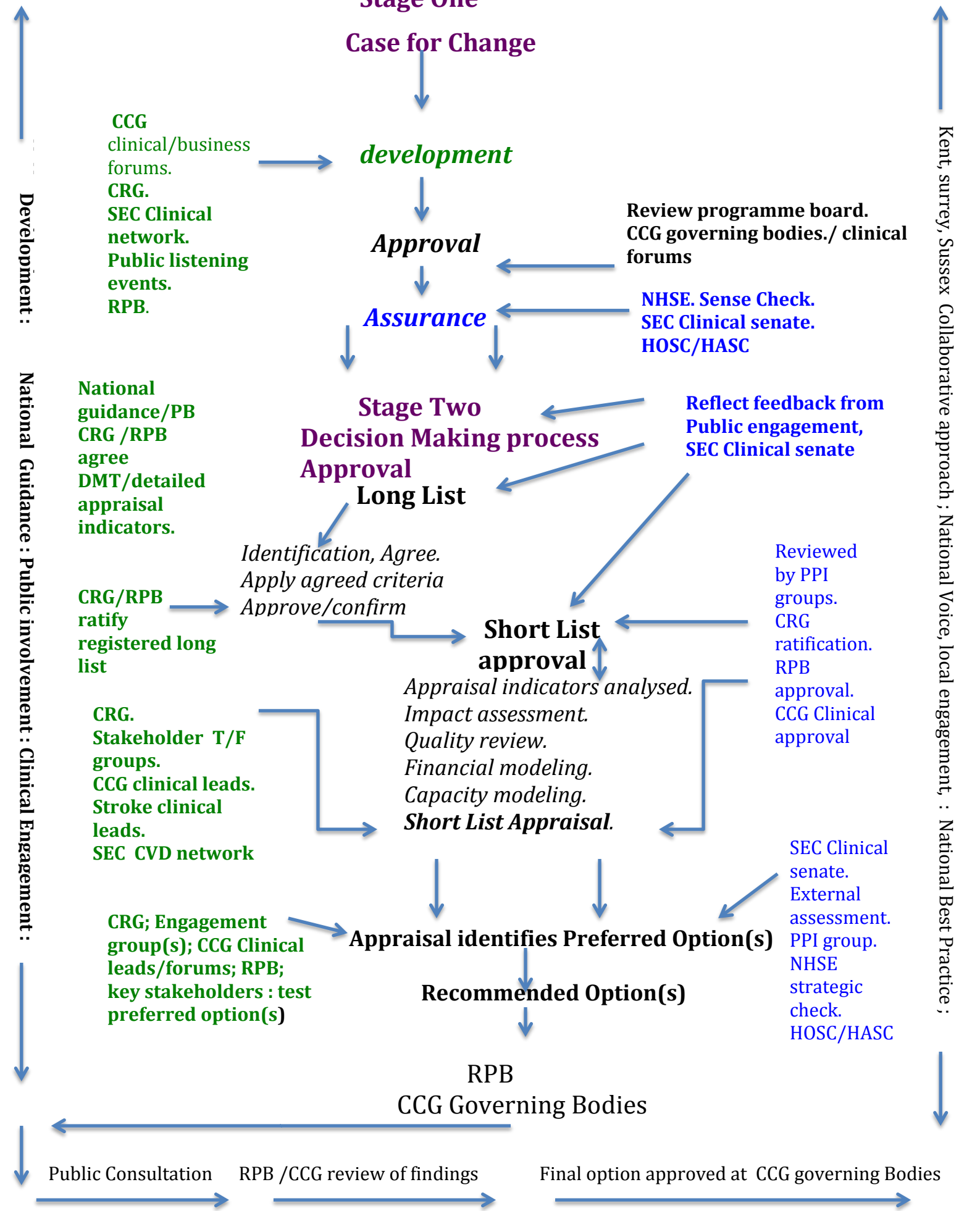
- The TIA pathways for the proposed stroke networks should be outlined, to demonstrate that the required rapidly responsive service would be delivered.

- There should be an articulation of the research role that the HASU would have, and a commitment to support staff (through job planning and other enablers) in participating in clinical trials and other forms of stroke research, in partnership where appropriate with universities, medical schools, the CLRN and KSS's AHS

Appendix 3 :Key Governance/decision points.

	Development	Approval
Case for Change	**Developed through the RPB, CRG, Public listening events, CCG clinical feedback, SEC Clinical network .**	**Approved in principle by RPB, Formal approval by CCG Governing bodies/Clinical Committees.** **HOSC/HASC discussions** **NHSE Sense check**
	Up to June 15	***June/July 15*** ***July/August 15***
Decision Making process	**Developed through the CRG, Public listening events, national guidance, SEC Clinical network.**	**Approved through the RPB and the CCG Governing bodies/Clinical committees.**
	Up to July 15	***June/July 15***
Long list	**Developed through**	**Discussed at RPB**

	CRG, **Informed through public feedback.**	
	July/August 15	***August 15***
Short List	**Assessed through CRG. (DMT applied)** **Discussed and developed through Listening events/focus groups and Engagement group.** **Developed with and discussed at CCG clinical/business groups.**	**Agreed at RPB.**
	August/Sept 15	***Sept/Oct 15***
Options Appraisal	**Informed through public and clinical engagement.** **Assessed through CRG,** **Informed by the CCG clinical leads/forums.** **Stakeholder discussion inc Stroke association, HWB.**	**Approved in principle through the RPB, formally by the CCG governing bodies.** **JOSC late Oct 15**
	Sept 15	***Oct/Nov 15***
Preferred option(s)	**CRG recommendation.** **Public and engagement groups feedback.** **Stakeholder Challenge session**	**NHSE Strategic check.** **Approved in principle through the RPB.** **Formally through the CCG governing bodies.** **JOSC**
	Oct 15	***Nov 15***


Development : National Guidance : Public involvement : Clinical Engagement :
Kent, surrey, Sussex Collaborative approach ; National Voice, local engagement, : National Best Practice ;
Stage One
Case for Change
CCG clinical/business forums.
CRG.
SEC Clinical network.
Public listening events.
RPB.
development
Approval
Review programme board.
CCG governing bodies./ clinical forums
Assurance
NHSE. Sense Check.
SEC Clinical senate.
HOSC/HASC
National guidance/PB
CRG /RPB agree
DMT/detailed appraisal indicators.
Stage Two
Decision Making process
Approval
Long List
Reflect feedback from Public engagement, SEC Clinical senate
Identification, Agree.
Apply agreed criteria
Approve/confirm
CRG/RPB ratify registered long list
Short List approval
Reviewed by PPI groups.
CRG ratification.
RPB approval.
CCG Clinical approval
Appraisal indicators analysed.
Impact assessment.
Quality review.
Financial modeling.
Capacity modeling.
Short List Appraisal.
CRG.
Stakeholder T/F groups.
CCG clinical leads.
Stroke clinical leads.
SEC CVD network
SEC Clinical senate.
External assessment.
PPI group.
NHSE strategic check.
HOSC/HASC
CRG; Engagement group(s); CCG Clinical leads/forums; RPB; key stakeholders : test preferred option(s)
Appraisal identifies Preferred Option(s)
Recommended Option(s)
RPB
CCG Governing Bodies
Public Consultation
RPB /CCG review of findings
Final option approved at CCG governing Bodies

K&M Stroke Review; Plan on a Page. Appendix D

Stroke 3rd biggest Killer in the UK; Largest cause of disability; Accounts for 5% of health spending; Long term care/support costs not clear. Variation of performance across the country, Rapid specialist assessment and treatment improves mortality and morbidity following a stroke.

Key recommendations; rapid skilled assessment and intervention, (120 minutes call to needle time) specialist multi disciplinary workforce, 7 day access to stroke consultants, nurses and therapists, adequate volumes to ensure clinical expertise, rapid access and ongoing care on specialist unit

Kent and Medway picture:

Variable performance; good to poor. Concerns re sustainability and need to improve. Significant workforce gaps; 7 day cover not available (exception at TWH) Recent mortality deterioration.

Review Aim: the delivery of clinically sustainable high quality hyper acute/acute stroke services for the next ten to fifteen years, that are accessible to K&M residents 24hours a day seven days a week

Review process

Scope provision; ***December 14 to April 15***	**Develop/Present Case for Change;** ***March to July 15***	**Develop options;** ***June 15 to August 15***	**Options appraisal** ***August to October 15***
7 admitting units. E to B (SSNAP) Poor to Good. 50% low on consultant numbers. Issues re timely access, assessment,	Current position not sustainable. CCGs require improvements and sustainability. Benefits for patients to be evident.	Systematic process to identify and assess options using national best practice. Identify and agree possible options to deliver improvements, bets practice (aiming for level A), skilled motivated staff	Assess options against clear criteria that deliver best practice and meet the needs of the K&M public safely and sustainably.
Patient and public engagement; Listening events, focus groups, individual representation. Stakeholder engagement; user groups, local communities, CCGs, public health, local authorities.			
Clinical engagement; CRG, local and regional leads, local clinicians, clinical commissioners			

Approval through Programme Board, CCG Clinical leads/committees and governing bodies,

April 15: Scoping and benchmarking hyper acute/acute care.
June 15: Draft Case for Change to RPB
June 15: Commence Public Listening Events
July 15: Finalise /approval Case for Change, develop/agree decision making process.
July/August 15: clinical and public development of options, public focus groups, modeling groups re access, patient profile , capacity planning, public health/demographics.
August/September: Short list options appraisal and final recommended options.
September/October: stakeholder challenge session, Final recommendations .

Assurance through NHSEngland, HOSC/HASC, SE Clinical Senate

Success measures	**Benefits for patients**
High performing admitting stroke units; aiming for level A SSNAP. Evidence of innovative practice.	More patients survive and have less disability with better long term quality of life.
Patients receive hyper acute care within recommended clinical targets.	All patients receive the highest level of care consistently 7 days a week
Sustainable admitting units; effective recruitment/retention	K&M Stroke services are secured to a high standard for 10/15 years

Appendix E

Kent and Medway

Communication and Engagement Plan

Stroke Care Review and Redesign Programme

Version 2.0

July 2015

Prepared by

Sharon Knight – Engagement Manager, North Kent CCGs

1.0 Introduction

Stroke remains a major cause of death and disability across Kent and Medway, with around 2,500 people having a stroke each year across the county. Nationally, three in four people affected by a stroke are over 65 years old. These patients need swift access to high quality, specialist hospital care to give them every opportunity to make a full and speedy recovery.

The NHS in Kent and Medway is committed to reducing health inequalities and improving clinical outcomes for people living in the area. To improve the experience of stroke patients, increase safety and deliver clinically-effective treatments, the local NHS is looking at how it can make sure the right care is provided at the right time and in the right place.

The eight clinical commissioning groups in Kent and Medway are undertaking a review of **hyper acute** stroke services which provide care in the first 72 hours after a stroke. All seven acute hospitals in Kent and Medway currently admit hyper-acute stroke patients. However, performance is inconsistent and variable, with a significant proportion being below average or just meeting average.

This review follows and builds on a local review in west Kent, initiated by Maidstone and Tunbridge Wells NHS Trust and supported by NHS West Kent Clinical Commissioning Group and Healthwatch Kent. This work asked local people for their views on quality standards, developed by the South East Coast Clinical Network and based on those in the SSNAP.

It found:

- There is public support for new higher standards of care covering the critical first 72 hours of a stroke patient's care and a need for the NHS to develop ways of achieving these
- The NHS needs to improve the whole of the stroke patient's pathway, including the care stroke patients receive out of hospital
- The NHS needs to improve the information and support available to patients and carers following a stroke
- Quality needs to be maintained within a timeframe that provides maximum opportunities of recovery for patients
- The NHS needs to improve planning about how and when a stroke patient can leave hospital and the next steps in their rehabilitation

Work is also underway in east Kent, reviewing how services provided by East Kent Hospitals University NHS Foundation Trust can best be delivered for the future. This is part of developing the trust's clinical strategy. Stroke is one of the services covered by their clinical strategy development work. We will take account of this in communications and engagement about stroke for east Kent.

1.1.1 Background to Stroke Services

1.1.1 Drivers of this project

The NHS wants to transform services so that people receive high quality, financially-sustainable services that meet their needs. Hospitals in Kent and Medway do not currently meet the recommendations on best practice identified by the National Stroke Strategy 2007. Kent and Medway are not alone in this. Nationally, there is significant variance in how acute trusts are delivering the strategy and implementing the recommendations.

The national standards for stroke services (SSNAP) are measured through a set of clinical measures and targets for clinical staff under 10 domains of care; these are the main way in which a stroke service can be assessed as high quality by NHS England and local commissioners. The commissioners are committed to improving the quality and consistency of care for all patients in Kent and Medway. Across the stroke services in Kent and Medway, achievement against the standards is variable and performance across some key areas remains low and of concern. CCGs are working with the Clinical Reference Group of stroke consultants to investigate what can and should be done to address this.

Currently people in Kent and Medway with stroke symptoms could be taken to any of the seven acute hospitals which are:-

- Medway Maritime Hospital
- Darent Valley Hospital
- William Harvey Hospital
- Kent and Canterbury Hospital
- Queen Elizabeth the Queen Mother Hospital
- Maidstone Hospital
- Tunbridge Wells Hospital

1.2 Clinical Rationale and Governance

The National Stroke Strategy 2007 specified that stroke is a medical emergency and that local networks need to plan to ensure that everyone who could benefit from urgent care is transferred to an acute stroke unit that provides 24 hour access to scans and specialist stroke care, including thrombolysis.

The key features of the National Stroke Strategy 2007 and the recommendation of the National Stroke Lead, Professor Tony Rudd articulate that recovery from a stroke is significantly influenced by the percentage of patients who:

- Seeing a stroke consultant within 24 hours
- Having a brain scan within 24 hours of admission
- Are seen by a stroke trained nurse and one therapist within 72 hours of admission

- Are admitted to a dedicated stroke unit

And that the most significant interventions are:

- A nutritional assessment and swallowing assessment within 72 hours
- Being given antiplatelet therapy within 72 hours
- Receiving adequate food and fluids for the first 72 hours

For every local acute trust, it is challenging to provide the full range of expertise including dedicated stroke consultants, stroke specialist nurses and therapists, 24 hours a day, seven days a week. Nationally, hospitals are reporting the challenges of recruiting and retaining staff on complex medical rotas such as stroke services.

The National Stroke Strategy 2007 recommended the provision of a hospital based specialist unit - **hyper-acute stroke service** (HASU) serving a population of between 500,000 and two million - is best placed to deliver the stroke pathway, 24 hours per day for 365 days per year. Patients would be conveyed by ambulance to the HASU rather than the nearest hospital.

The CCGs have also taken the evidence to the regional clinical senate to seek their expert review and rigorous assurance of the process and evidence.

Key Messages

1. Stroke is the third biggest killer in the UK and a major cause of long term disability.
2. People who experience a stroke need rapid access to a specialist medical team 24/7 – doctors, nurses and therapists – to maximise their chances of survival and enable the best possible recovery.
3. Stroke services vary across Kent and Medway, as they do across the country. Currently none of the hospitals treating stroke in Kent and Medway fully meets the national strategy recommendations and some people get care that is rated poor by SSNAP
4. The commissioners are working hard with our hospital, ambulance and social care partners on this clinically-led review of hyper-acute stroke services to ensure the people of Kent and Medway receive the best possible care.
5. Working together is critical to our success: our services are inter-dependent and the challenges we face cross organisational boundaries. We need to get services right for everyone who lives or uses hospitals in Kent and Medway so we must work together to find the right Kent and Medway solution.
6. We need to review and change the way we deliver services to ensure they meet the current and changing needs of the local population.
7. Our ambition is to ensure people using stroke services in Kent and Medway get high quality best practice care, that achieves A ratings on SSNAP and improved outcomes for patients. No change is not an option.
8. We are at the start of our process and listening hard to patients and the public to learn from their experience and listen to their views on how we can improve the quality of care across Kent and Medway.

9. We will use a fair, open and transparent process, which takes account of what people say is important to them.
10. We want to hear from you. Your views and experiences are critical in shaping how we move to delivering the best possible care for people who have a stroke, particularly during the crucial first 72-hours known as the hyper-acute phase.
11. No decision has been made as yet and the CCGs will continue to listen to the public to ensure their views are reflected.

1.3 Scope of the Review

The review of hyper-acute stroke services will primarily affect people living in Kent and Medway, residents of Bexley (NHS Bexley CCG) who are admitted to Darent Valley hospital and residents from East Sussex (NHS High Weald Lewes Havens CCG) who are admitted to Tunbridge Wells Hospital. The communications and engagement teams for Kent and Medway will liaise with communications and engagement colleagues in the adjacent areas so that their views and their patients and public can be considered in our planning; as MTW and Healthwatch have done in the preliminary work which they have undertaken in west Kent and east Sussex.

2.0 Governance

The North Kent Communications and Engagement team will work in partnership with partners in the Kent and Medway healthcare system, NHS England South region, and service providers to ensure effective communications planning and implementation, including a rapid response to media issues throughout the duration of the engagement and evaluation period.

Materials, feedback and general approaches to communication and engagement will be shared and developed with communications leads in partner and provider organisations as well as neighbouring CCGs.

The Kent and Medway Stroke Review Communication and Engagement Sub-Group of the Stroke Review Programme Board has been established to oversee all communication and engagement activities including:

- Development of the communications and engagement plan, which includes:
    - Stakeholder communication and engagement
    - Media engagement
    - Development of information and supporting material
- Provide programme update reports and monitor the progress of communications and engagement plan
- Report to the Stroke Review Programme Board progress on the plan and escalate key risks to the project and the associated issues

- Provide assurance on the delivery of all aspects of the communications and engagement plan
- Identify and manage the resources needed to deliver the communications and engagement plan
- Healthwatch Kent are to join the sub group and the Stroke Review Programme Board, as are the Stroke Association.

The group will meet on a monthly basis for the duration of the review, and will report to the Stroke Review Programme Board.

3.0 Objectives of the Communication and Engagement Activities

The objectives of the communications and engagement aspects of the review are:

Informing:

- To identify and engage with relevant audiences in a timely fashion, with clear information via effective channels for discussion and feedback
- Inform patients, the public and stakeholders on the challenges facing stroke services, and the national guidance on standards
- Inspire people to ask challenging questions about the future direction of stroke services

Engaging:

- To manage a robust process of 'listening' that meets national guidance and is regarded by the people it involves as open, reasonable fair and meaningful. This includes involving the relevant Health Overview and Scrutiny Committees.
- To promote dialogue and actively listen to the public views, concerns and insights.

Collaborating:

- Work in partnership with the public to provide answers to their questions raised.
- To ensure that the patient perspective and local views are a component part of all work throughout the review influencing all aspects of the work.
- To support any project groups in ensuring that all internal partners are kept informed and engaged with the project.

3.1 Purpose of Communication and Engagement Plan

The purpose of this plan is to:-

- Ensure the eight CCGs as part of this review of stroke services across Kent and Medway work with and are influenced by patients and clinicians from the outset, to improve the quality, consistency and sustainability of hyper-acute stroke services for everyone in Kent and Medway.
- Inform people on the case for change for hyper-acute stroke care and explore their experiences and views of care during the first 72 hours after a stroke
- Ensure effective and productive two-way communications between those service users who can contribute to the thinking/development on this and those responsible for the decision-making process.
- Prepare a robust plan for the ongoing involvement and communication of patients, staff and the public throughout the review and any potential changes to the model of care which require formal consultation.

4.1 Principles of Communication and Engagement Approach

The following principles will form the basis of all communication and engagement activity:

- Our approach will be open and transparent, and we will be clear about accountability, both internally and externally
- We will seek independent scrutiny of our communication and engagement plans and activities
- Our activities will be clear, timely, accurate and targeted appropriately to the differing needs of our stakeholders
- Our approach will be compliant with legislative frameworks and national policy guidance

3.2 Principles for Communication - Media

The case for change document will be going to each CCG and into the public domain via the Governing Body for transparency. Management of this first access to the public is crucial. Therefore,

- Communications activity will be led by the North Kent CCGs Communications and Engagement Team (nkm.communications@nhs.net) in partnership with communications colleagues throughout Kent to ensure tailored local delivery of the agreed plan.
- The Communications and Engagement sub-group will agree a series of proactive communications to maximise opportunities for public engagement and transparency throughout the review process, including media, social media and online activity.
- The Communications sub-group will coordinate any media interest, with response delivered at a local level, unless substantial interest necessitates a central response.

- A media spokesperson will be identified.

4.0 Audiences and Key Stakeholders

The proposed dialogue and its ultimate outcomes will affect all residents of Kent and Medway.
The priority audiences are:

Public, patients, carers and other people who may have had experience of stroke/ TIA ('mini stroke') services. This includes patient groups where existing conditions are indicative of stroke risk:

- Warfarin users
- People with diabetes
- People being managed for obesity
- People with other cardiovascular conditions
- People over 65
- Individual stroke patient groups in each area
- Age UK
- Residents of care homes

CCG patient reference group(s):

- HRG, PPG chairs, CPRG, APPG, SPLG and Health Networks and Community Networks

Voluntary and community associations:

- Stroke Association
- Diabetes UK
- Other VCS organisations

Protected groups:

- Representatives of minority groups, such as Ethnic groups most at risk of a stroke South Asian , black Africa and black Caribbean
- Groups representing people with disabilities
- Groups representing children and younger people

NHS and social care staff:

- Hospital staff, particularly those working in stroke services and older people's services
- SECAmb staff
- Patient transport service providers (NSL in Kent and Medway)
- GPs and practice staff
- Out of hours GP services
- Community providers
- Mental health providers
- Social care staff
- PALS and FOI teams
- CCG staff

Stakeholders:

- Kent and Medway CCGs – Boards and Execs

- Neighbouring CCGs
- NHS England (South region)
- Trust boards
- South East Coast Clinical Network and Senate
- Kent Health Overview and Scrutiny Committee(HOSC)
- Medway Health and Adult Social Care Overview and Scrutiny Committee(HASC)
- Kent Health and Wellbeing Board
- Medway Health and Wellbeing Board
- Local Health and Wellbeing Boards
- Healthwatch Kent, Health Medway
- MPs
- Members of Kent County Council, Medway Council, district councils

5.0 Equality and Diversity

The North Kent and Medway Communications and Engagement team will ensure that people who find it hard to access health services and provision, and its associated communications and engagement activity, are accommodated within the involvement strategy across Kent and Medway in line with the Equality Impact Assessment. This will include making sure all consultation materials are distributed to these groups in appropriate formats and languages. Where necessary a translator shall be identified and used at these meetings. These groups will also receive invitations to discussion meetings and we will meet with groups at their request. We will ensure that people with aphasia are able to contribute to the review. This work will be informed by an Equality OImpact Assessment carried out as part of the review.

6.0 Communication and Engagement Activities

The communication and engagement activities will be carried out within the following programme phases:

Phase	Dates	Outline of activities	Channels and Tools
Scoping	Jun/Jul 2015	Initial stakeholder events, agreement of design principles, , programme planning and identification of stakeholders	Stakeholder listening events, Outreach to seldom heard groups, listen to regular patient groups, survey in east and north Kent
Development of possible model of care	Aug/Sept - October	Detailed sifting of evidence and working groups to look at: transport, population, workforce, engagement clinical reference group and patients working groups CCG review of final/preferred options	Feedback on early engagement and continue to reach wider audience: Engagement with Patient Reference Group- Local promotions/ face-face engagement - Local promotions Presentations- local promotions
Potential public consultation	Nov– Jan 2016	Public consultation in the eight CCG areas	Media work - Press Road show events- Local promotions/printed literature Deliberation events – Local promotions/printed literature Consultation collateral- Local promotions/printed literature). GP meetings etc Evaluation by independent organisation of responses.-
Post consultation and final business case	Jan 2016 – XXX 2016	Review of consultation responses and preparation of final business case and service specification for agreement by CCGs	Publish response paper- Online/ printed literature

6.1 Engagement Activity

The engagement team will work in partnership with stakeholders to:-

- Ensure that the patient and public views shape the future service specification
- Utilise the public voice to proactively involve them in the direction of travel of the project
- Ensure the engagement process takes account of any Equality and Diversity issues which may come to light.

The range of approaches to engagement outlined in this strategy aim to give stakeholders the opportunity to be communicated with or involved in a way which suits them. Some activities will be targeted, including direct letters and e-bulletins to individuals and groups and out-reach meetings to seldom heard groups, and some will be open, including publishing information on our website, working with the local media.

In particular, we will make sure that people with aphasia can contribute their views and experience to this review.

The engagement team aims to have in-depth discussions and engagement in the work of the pathway working groups about the challenges facing the Kent and Medway CCGs and some of the emerging solutions via deliberation, with a focus on listening to concerns and responding as the review develops.

We are also committed to building on existing knowledge from previous engagement feedback and patient experience data.

When tailoring our engagement activity for each group we will think about:

- Their barriers to engagement
- What's in it for them?
- What do we want them to do?

Communication and engagement effort will then be appropriately focussed.

6.2 Communications Activity

The communications teams will work in partnership to:-

- Provide communications support for stakeholder engagement activities e.g. promoting listening events and/or other external stakeholder events as appropriate, across communication channels such as CCG websites and social media platforms.
- Develop reactive media plan e.g. develop lines to take, Q&A and identify spokespeople in the event of media enquiries.
- Assist with shaping key messages and materials to support engagement activities as required.
- Assist with development of a communications plan for external promotion of any potential public consultation, if appropriate, subject to the outcome of the review.

6.3 Local Briefing

Commissioners and communications leads ensure that all relevant contacts in the locality are briefed as necessary, including, for example:

- Executive team
- Board
- Commissioning team
- Provider services and staff
- GPs and primary care teams
- PPE forums

- Local voluntary organisations and user groups
- Local MPs and other community representatives
- Health and Wellbeing Boards
- HOSC/HASC - JHOSC

7.0 Phase-by-phase plan

A review of events will be provided at the end of each activity. At this time this plan will be refreshed to reflect the next phase(s) of engagement along with the timeline.

8.0 Evaluation

Success of the communications and engagement strategy will be evaluated on:

- Number of people participating in the consultation
- Quantity and quality of feedback from participants
- Comments from participants about the quality of communications and engagement for the consultation
- Tone and quantity of media coverage
- Tone and quantity of social media conversation

8.1 Risks

- Reputation: change is likely to be seen as a loss. Mitigation: carefully build internal and external support, including from service users and support groups. Draw on support from national stroke lead. Brief clinical and political leaders early to build acceptance for need to change and trust in plans. Well developed Equality Impact Assessment and Quality Impact Assessment to identify issues and mitigation. Have clear and consistent information and communication that builds understanding of the situation and the proposed plans.

- Carers and service users may have differing views. Mitigation: be sure to provide adequate means for both to comment.

- Legal challenge if process is not thorough and does not fulfil Secretary of State's four tests (detailed in Appendix A below) – particularly on strong patient and public engagement. Mitigation: clinical review (by South East Coast Clinical Senate), regular briefings and information to HOSC/ HASC, constructive scrutiny of process, plans and decision, early engagement with clinicians and stakeholders, leading to comprehensive consultation process delivered within local communities working with local support groups.

- General risks identified by the Independent Reconfiguration Panel as common reasons why proposals are referred:

- inadequate community and stakeholder engagement in the early stages of planning change
- the clinical case has not been convincingly described or promoted

- clinical integration across sites and a broader vision of integration into the whole community has been weak
- proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services
- important content missing from the reconfiguration plans and limited methods of conveying them
- health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care
- inadequate attention given to responses during and after the consultation

Appendix A: The four tests and assurance questions

(from: *Planning and Delivering Service Changes for Patients, NHS England, 20.12.13)*

The 4 Tests:

- *strong public and patient engagement*
- *consistency with current and prospective need for patient choice*
- *a clear clinical evidence base*
- *support for proposals from clinical commissioners)*

Preparing for an assessment against the four tests – key questions

In preparing proposals for assessment against the four tests, commissioners and other bodies involved in the process may find it helpful to consider the following questions. It may not be necessary to have definitive answers to all questions during the early planning stages, if it is expected will be clarified as proposals are developed further. The application of the four tests should provide a helpful mechanism for assuring the robustness of plans throughout the process.

1. Can I demonstrate these proposals will deliver real benefits to patients?

2. Do I have strong and clear evidence that the proposals improve outcomes, will deliver higher quality care and are clinically sustainable within available resources?

3. Can I quantify with statistically robust evidence the nature and scale of any shortcomings with the current configuration, and can I quantify the extent of the improvement and efficiencies that would be expected from reconfiguration?

4. Are there viable solutions other than reconfiguration? Could I achieve the same outcomes through revising pathways or rotas within the current configuration?

5. How will performance of current services be sustained throughout the lifecycle of the reconfiguration programme?

6. What alternative options are there in the market? Could the services be provided by the other NHS providers, the independent or third sectors, and through new and more innovative methods of delivery?

7. Do the proposals reflect national and international best clinical practice? Have I sought the advice of my local clinical networks and clinical senate?

8. What plans have I put in place to engage relevant health and wellbeing board(s), and to consult relevant local authorities in their health scrutiny capacity? Do proposals align with local joint strategic needs assessments and joint health and wellbeing strategies? Have I considered the impact on neighbouring or related services and organisations?

9. Is there a clear business case that demonstrates clinical viability, affordability and financial sustainability, and how options would be staffed? Have I fully considered the likely activity and capacity implications of the proposed reconfiguration, and can I demonstrate that assumptions relating to future

capacity (and capital) requirements are reasonable? Does the modelling including sensitivity analysis (e.g. does it account for uncertainty in any of the variables)?
10. Have I undertaken a thorough risk analysis of the proposals, and have developed an appropriate to mitigate identified risks, which could cover clinical, engagement, operational, financial and legal risks?
11. Do the proposals demonstrate good alignment with the development of other health and care services, and I have considered whether the proposals support better integration of services?
12. Have I considered issues of patient access and transport, particularly if the location where services are provided may change? Is a potential increase in travel times for any groups of patients outweighed by the clinical benefits?
13. Have I considered the potential equalities impact of the proposals on different groups of users, including those with protected characteristics, and whether the proposals will help to reduce health inequalities?
14. Have I considered how the development of proposals complies with my organisations legal duties and how I have considered and mitigated material legal risks (see Box 1 on page 18 for a summary of duties for NHS England and clinical commissioning groups)?
15. Can I communicate the proposals to staff, patients and the public in a way that is compelling and persuasive? What communication and media handling plans are in place and/or have I identified where I will secure any external communications support?
16. Have I identified local champions who are trusted and respected by the community and can be strong advocates for the proposals?
17. Have I engaged any Members of Parliament who may be interested in the proposals?