Transforming health and social care in Kent and Medway

# Kent and Medway Sustainability and Transformation Partnership

**Kent and Medway Joint Health Overview Scrutiny Committee**

Discussion Document

22 January 2018

*Transforming health and social care in Kent and Medway* is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

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# Agenda

| Item | | Time |
|---|---|---|
| Overview of the stroke review | PD | 15 mins |
| Governance | PD | 10 mins |
| Evaluation process | PD | 20 mins |
| Proposal | PD | 30 mins |
| Integrated Impact Assessment | MR | 15 mins |
| Consultation | SH | 20 mins |
| Next steps | PD | 10 mins |

## The Kent and Medway JHOSC is asked to:

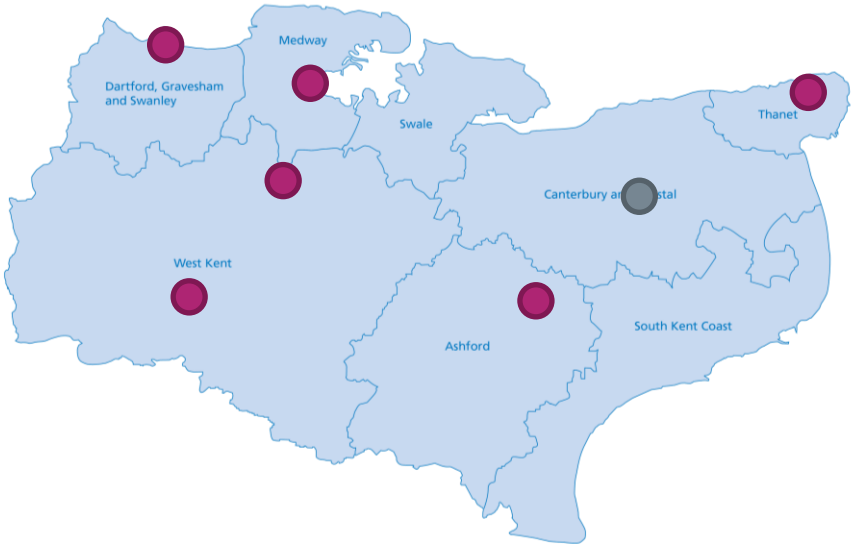
1. NOTE the shortlisted options
2. SUPPORT the proposed public consultation plan on the shortlisted options
3. SUPPORT the proposed duration of the public consultation.

# Overview of the stroke review (Patricia Davies)

Stroke is a serious life-threatening condition caused by a blood clot or bleed in a blood vessel in the brain.

How well people recover is affected by speed and quality of treatment.

- Around 3,000 people a year who have a stroke live nearest to a Kent and Medway hospital
- Around 250 patients currently treated for stroke in Kent and Medway hospitals are from outside of Kent and Medway

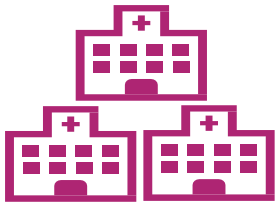



*Services not currently provided at Kent and Canterbury Hospital

**Six of our seven* hospitals currently provide some urgent stroke care** across Kent and Medway.

But we are **not consistently meeting national quality standards** or delivering best practice care.

We want anybody who has a stroke, day or night, anywhere across Kent and Medway, and our border areas, to have the **best chances of survival and recovery**. To do this we must reorganise our stroke services.



## Consolidate urgent stroke care on **three hospital sites**

**Each site to run 24/7 and include:**

- Hyper acute stroke unit
- Acute stroke unit
- Transient ischaemic attack (TIA or ‘mini stroke’) clinic

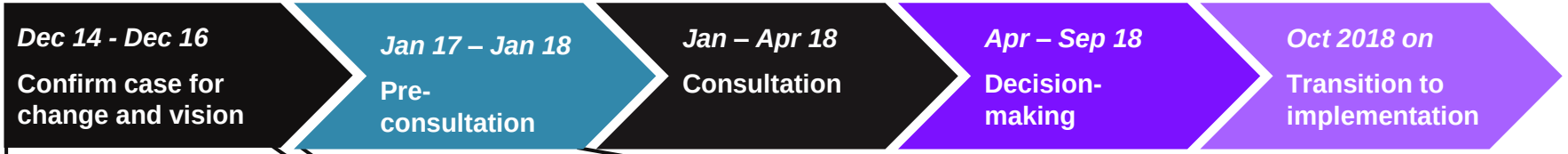
Urgent stroke services would **no longer be available at other hospitals** in Kent and Medway

**Investing up to £40m** in hospitals and recruiting more staff

## Overview of stroke engagement

- Thousands of people have engaged in stroke review since late 2014 including: stroke survivors/ their families and carers/ members of the public/ clinicians/ key stakeholders including CCGs, providers from Kent, Medway, and across the borders in Sussex, Surrey and south London
- They have provided a valuable challenge and helpful insight throughout the review
- Views have been fed into the decision-making process
- Variety of engagement channels have been used including surveys, focus groups, listening events, roadshows, face to face meetings
- We have used a variety of channels to communicate including e newsletters, printed magazines, emails, media, social media, websites
- All engagement work has been logged and evidenced.

# Overview of work to date and high level timeline




During this phase, the Stroke Review:

- ✓ Established governance
- ✓ Published case for change (July 2015)
- ✓ Agreed vision for stroke care in Kent and Medway
- ✓ Developed the benefits framework
- ✓ Undertook pre-consultation stakeholder engagement with clinicians, commissioners, providers, patients and other local stakeholders
- ✓ Developed a draft business case proposing a 3 site HASU configuration

During this phase, the Stroke Review:

- ✓ Further developed the acute stroke clinical model
- ✓ Developed and assessed options against agreed hurdle criteria to create a medium list of site specific options
- ✓ Developed and evaluated the medium list of options against agreed evaluation criteria
- ✓ Conducted sensitivity analysis to support identification of a shortlist of options
- ✓ Developed the Pre-Consultation Business Case (PCBC)
- ✓ Continued engagement with the full range of stakeholders, including numerous stakeholder events to inform the work of the programme
- ✓ Carried out an equalities impact assessment
- ✓ Planned the public consultation and developed consultation documents

# Current challenges – our case for change

**Specialist stroke resources are spread too thinly** and most hospitals do not meet national standards and best practice ways of working.

**24/7 access is not consistently available** for consultants, brain scans and clot busting drugs

Over 1/3 of stroke patients are **not getting brain scans** in recommended time

**We only have 1/3 of the stroke consultants** needed to deliver a best practice service in all hospitals

Half of appropriate patients **not getting clot busting drugs** in recommended time

**Only one unit seeing enough stroke patients** for staff to maintain and develop expertise (recommended minimum of 500 stroke patients per year)

# Hyper acute stroke units in action

- Run 24 hours a day, 7 days a week

- Always have access to a stroke consultant with seven day/week consultant ward rounds

- Able to do brain scans and give clot-busting drugs within 2 hours of calling an ambulance, round the clock

- Staffed by teams of stroke specialist doctors, nurses and therapists

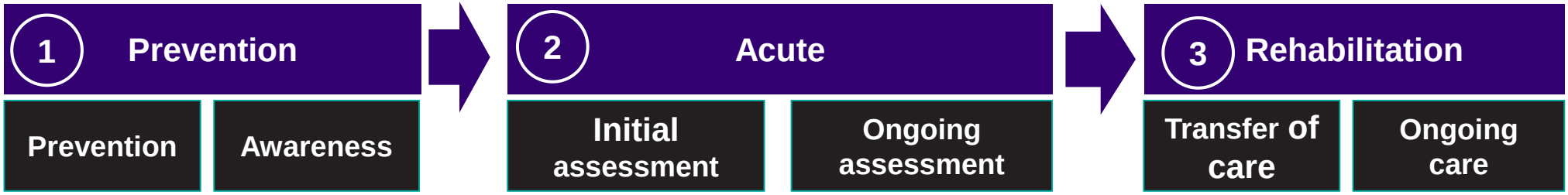
- Inpatient care for first 72 hours is on the hyper acute unit, follow up care is also on specialist acute stroke unit

# Benefits of change

**Consolidating urgent stroke services would help deliver consistently high-quality care regardless of where people live or when a stroke/TIA occurs**

- more patients getting brain scans and, if needed, clot busting drugs within the recommended time
- a reduction in deaths from stroke
- fewer people living with long-term disability following a stroke
- fewer people losing their independence and being admitted to nursing/care homes following a stroke
- shorter stays in hospital
- fewer vacancies within the stroke services and less turnover of staff
- improved experiences for patients and staff through best practice care delivered in specialist units 24 hours a day, seven days a week.

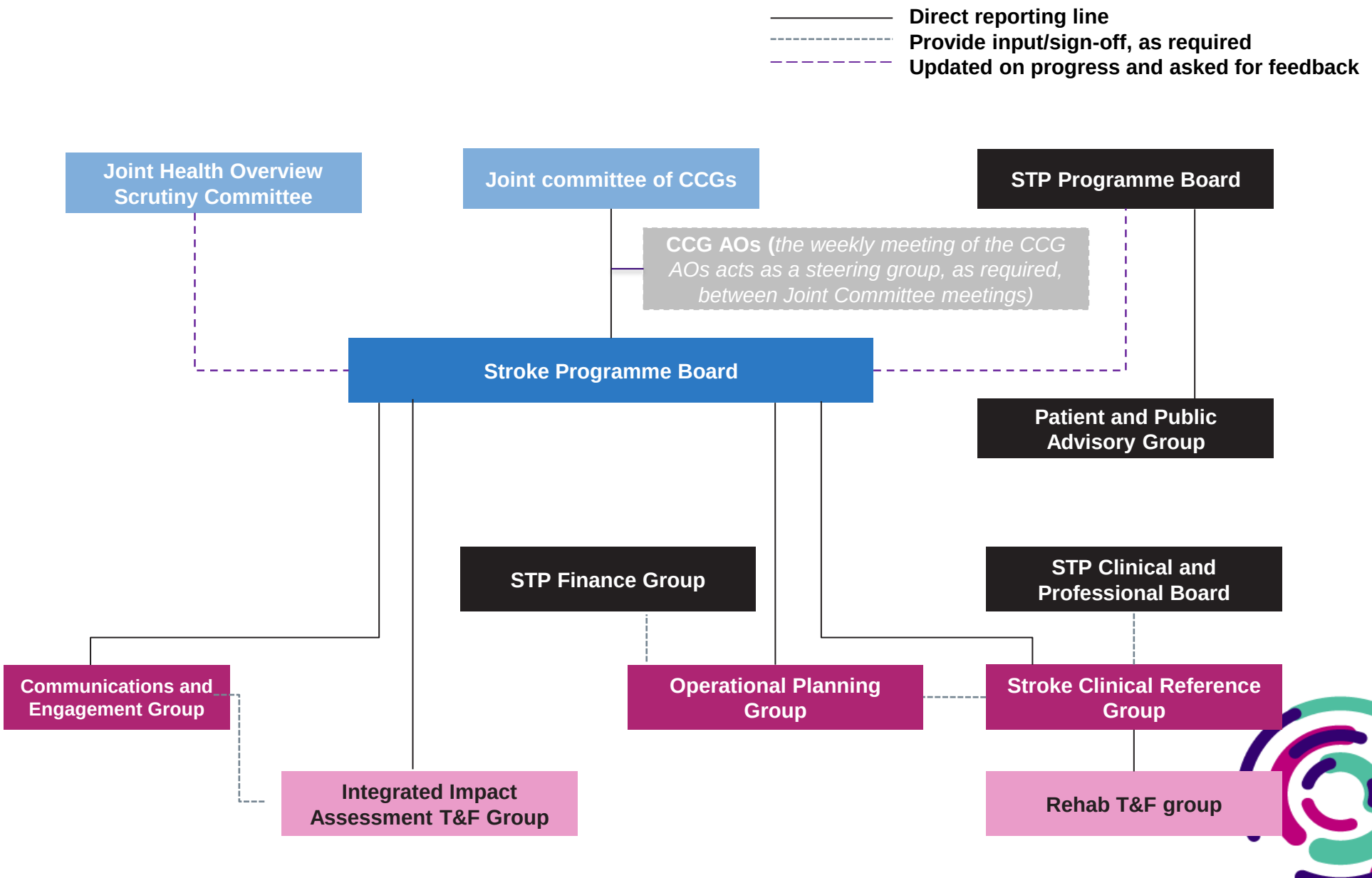
# This acute delivery model will be supplemented by additional work on the rest of the stroke pathway, including rehabilitation




- The Kent and Medway stroke review has focussed on the **acute** part of the stroke pathway
- It is recognised that rehabilitation (including Early Supported Discharge) is a crucial part of the overall model

SOURCE: Kent & Medway Review of Stroke Services (2015 /2016); The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014]; Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

# Governance structure (Patricia Davies)



# A Joint Committee of the ten clinical commissioning groups in Kent, Medway, Bexley and High Weald Lewes and Haven has been established

The JCCG enables CCG members to work effectively together, collaborate and take joint decisions about stroke. Its role is to:

- Consider and approve a collective strategy and associated commissioning intentions for stroke services across Kent and Medway, enabling the delivery of high-quality, sustainable and financially viable clinical services. This will include determining the service delivery model and locations from which services will be provided
- Ensure effective public and stakeholder engagement and involvement, including formal consultation as required, has taken place to enable informed and legally compliant decision making
- Oversee the implementation of the approved service delivery model and any associated reconfiguration of services
- Ensure representation and contribution to national, regional or other relevant Alliances and Networks, including clinical networks, as appropriate
- Work with the Kent and Medway STP Board to ensure any decisions made by the JC are informed by the complement wider strategic planning

# The Kent and Medway Stroke Review Joint Committee of CCGs is meeting in public to discuss the shortlist on 31 January 2018 at County Hall in Maidstone

**Agenda**

1. Welcome, Introductions and apologies
2. Background context
3. Case for Change
4. Proposal
5. Evaluation process
6. Assurance process
7. Questions
8. Close

It is a meeting in public, but places are limited by the venue. Members of the public can book a place and register in advance via: https://strokejcccg.eventbrite.co.uk

Decisions about any future location of stroke services will not be taken at this meeting. Those decisions will be taken after formal public consultation and once all the feedback and evidence has been thoroughly considered, likely in the autumn of 2018.

# Establishing a JHOSC to include Bexley and East Sussex, in addition to Kent and Medway

**A new JHOSC is to be established to include Bexley Council and East Sussex County Council as voting members**

The formal decision to establish a new JHOSC incorporating Bexley Council, East Sussex County Council, Kent County Council and Medway Council will be made by:

Kent County Council on 20 February
Medway Council on 22 February

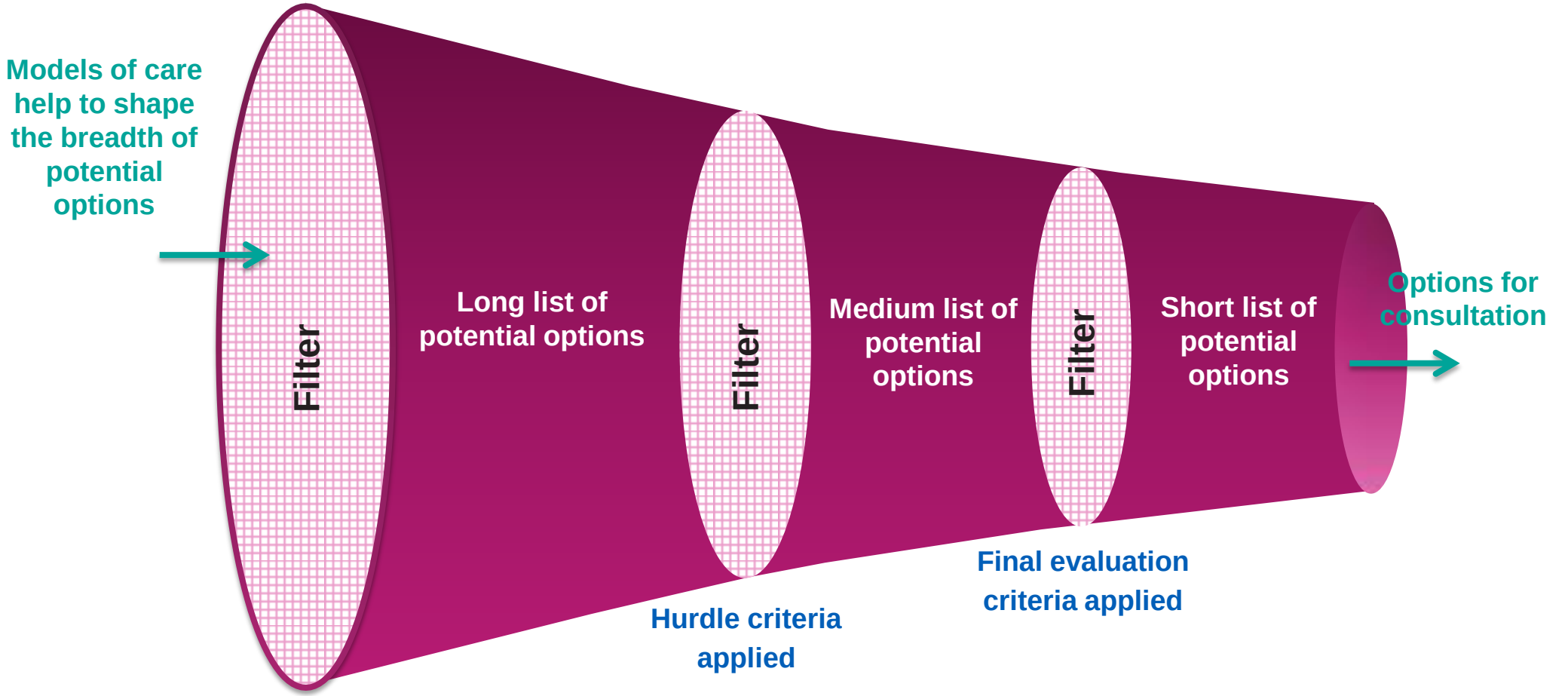
**Bexley and East Sussex have their own arrangements for agreeing the establishment of a new Joint HOSC.**

# Evaluation process (Patricia Davies)

## Significant service change requires consultation with the public on the proposed changes


*NB - This stage involves multiple stakeholder review as part of the agreed evaluation process*

# The evaluation process



# An agreed set of hurdle criteria were applied to the long list of stroke options which resulted in a medium list of 13 remaining options

**Hurdle criteria**

- Is the potential configuration option clinically sustainable?
- Is the potential configuration option implementable?
- Is the potential configuration option accessible?
- Is the potential configuration option a strategic fit?
- Is the potential configuration option financially sustainable?

**Hurdle criteria applied**

**Medium list of options**

1. DVH, WHH, QEQM
2. MGH, MMH, QEQM
3. DVH, MMH, WHH
4. DVH, MMH, QEQM
5. DVH, MGH, WHH
6. DVH, MGH, QEQM
7. DVH, TWH, QEQM
8. MGH, MMH, WHH
9. TWH, MMH, QEQM
10. TWH, MMH, WHH
11. DVH, TWH, WHH
12. DVH, MGH, MMH
13. MGH, WHH, QEQM

Darent Valley Hospital (DVH)
Tunbridge Wells Hospital Pembury (TWH)
Maidstone General Hospital (MGH)
Queen Elizabeth The Queen Mother Hospital (QEQM)
William Harvey Hospital (WHH)
Medway Maritime Hospital (MMH)

# The 13 options were evaluated against the following five domains: Quality, Access, Workforce, Ability to deliver and Affordability

| Criteria | | Sub-criteria |
|---|---|---|
| 1 | Quality of care for all | • Clinical effectiveness and responsiveness |
| 2 | Access to care for all | • Time to access services |
| 3 | Workforce | • Scale of impact<br>• Sustainability |
| 4 | Ability to deliver | • Expected time to deliver<br>• Trust ability to deliver |
| 5 | Affordability and value for money | • Net present value |

# Full evaluation matrix

| | | 1) DVH, WHH, QEQM | 2) MGH, MMH, QEQM | 3) DVH, MMH, WHH | 4) DVH, MMH, QEQM | 5) DVH, MGH, WHH | 6) DVH, MGH, QEQM | 7) DVH, TWH, QEQM | 8) MGH, MMH, WHH | 9) TWH, MMH, QEQM | 10) TWH, MMH, WHH | 11) DVH, TWH, WHH | 12) DVH, MGH MMH, | 13) MGH, WHH, QEQM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Quality | • SEC co-adjacencies | / | / | + | / | + | - | / | + | / | ++ | + | + | / |
| | • Co-adjacencies for mech. thrombectomy | / | / | + | / | + | - | / | + | / | ++ | + | + | / |
| | • Req. for MEC | ++ | / | ++ | + | + | / | + | + | + | ++ | ++ | / | + |
| 2 Access | • Blue light, proxy | ++ | + | + | + | + | + | + | ++ | ++ | ++ | ++ | - - | ++ |
| | • Private car, off peak | ++ | ++ | + | + | + | ++ | + | + | ++ | ++ | ++ | - - | ++ |
| 3 Workforce | • Gap in workforce requirements | - | - | / | / | / | / | - | - | - | - | / | / | - |
| | • Vacancies | ++ | - - | / | - | + | / | ++ | - - | - - | - | ++ | - - | / |
| | • Turnover | - - | + | - - | - - | / | / | - | + | + | + | - | - | + |
| 4 Ability to deliver | • Expected time to deliver | - | - | / | - | / | - | - | + | - | - | - | / | - - |
| | • Trust ability to deliver | - - | ++ | ++ | ++ | ++ | ++ | ++ | ++ | ++ | ++ | ++ | ++ | - - |
| 5 Finance | • Net Present Value (NPV at 10 yrs, £m) | - - | + | + | ++ | + | / | - | + | + | + | + | ++ | - |

# Proposal (Patricia Davies)

Over the course of the review we looked at:

- a long list that considered different numbers of hyper acute stroke units
- a medium list of possible three-site options
- the shortlist of deliverable three-site options now being consulted on.

| Option | Hospitals |
|---|---|
| A | Darent Valley \| Medway Maritime \| William Harvey |
| B | Darent Valley \| Maidstone \| William Harvey |
| C | Maidstone \| Medway Maritime \| William Harvey |
| D | Tunbridge Wells \| Medway Maritime \| William Harvey |
| E | Darent Valley \| Tunbridge Wells \| William Harvey |

Options are not ranked in order of preference.
A preferred option will be developed after consultation.

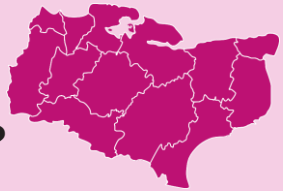
# Comparison of options

| | | A<br>Darent Valley, Medway, William Harvey | B<br>Darent Valley, Maidstone, William Harvey | C<br>Maidstone, Medway, William Harvey | D<br>Tunbridge Wells, Medway, William Harvey | E<br>Darent Valley, Tunbridge Wells, William Harvey |
|---|---|---|---|---|---|---|
| Hospital site locations | |  |  |  |  |  |
| Population within 30 mins by ambulance | | 73.4% | 74.2% | 76.2% | 82.2% | 76.9% |
| Population within 45 mins by ambulance | | 91.0% | 91.3% | 91.3% | 92% | 91.9% |
| Capital investment | | £30.82m | £36.29m | £37.86m | £35.95m | £30.63m |
| More stroke doctors needed | In K&M | 8 | 8 | 8 | 8 | 8 |
| | Outside K&M | 0 | 0 | 2 | 2 | 0 |

# Potential disadvantages and concerns

Since starting the stroke review in 2015 we have been talking to staff, patients, the public and wider stakeholders. Issues already raised include:

## Is three the right number



**Why not have a hyper acute stroke unit at every hospital?**

**Why not centralise everything on one site?**

## Travel times

**Can ambulances get people to a hyper acute stroke unit fast enough?**

**Can relatives and carers visit easily?**

## Recruitment & retention

**Can we recruit enough staff for the proposed changes?**

**Will staff be willing to move to new locations?**

## Impact on other hospitals

**Will sites that lose stroke services suffer?**

**Are hospitals outside Kent and Medway affected?**

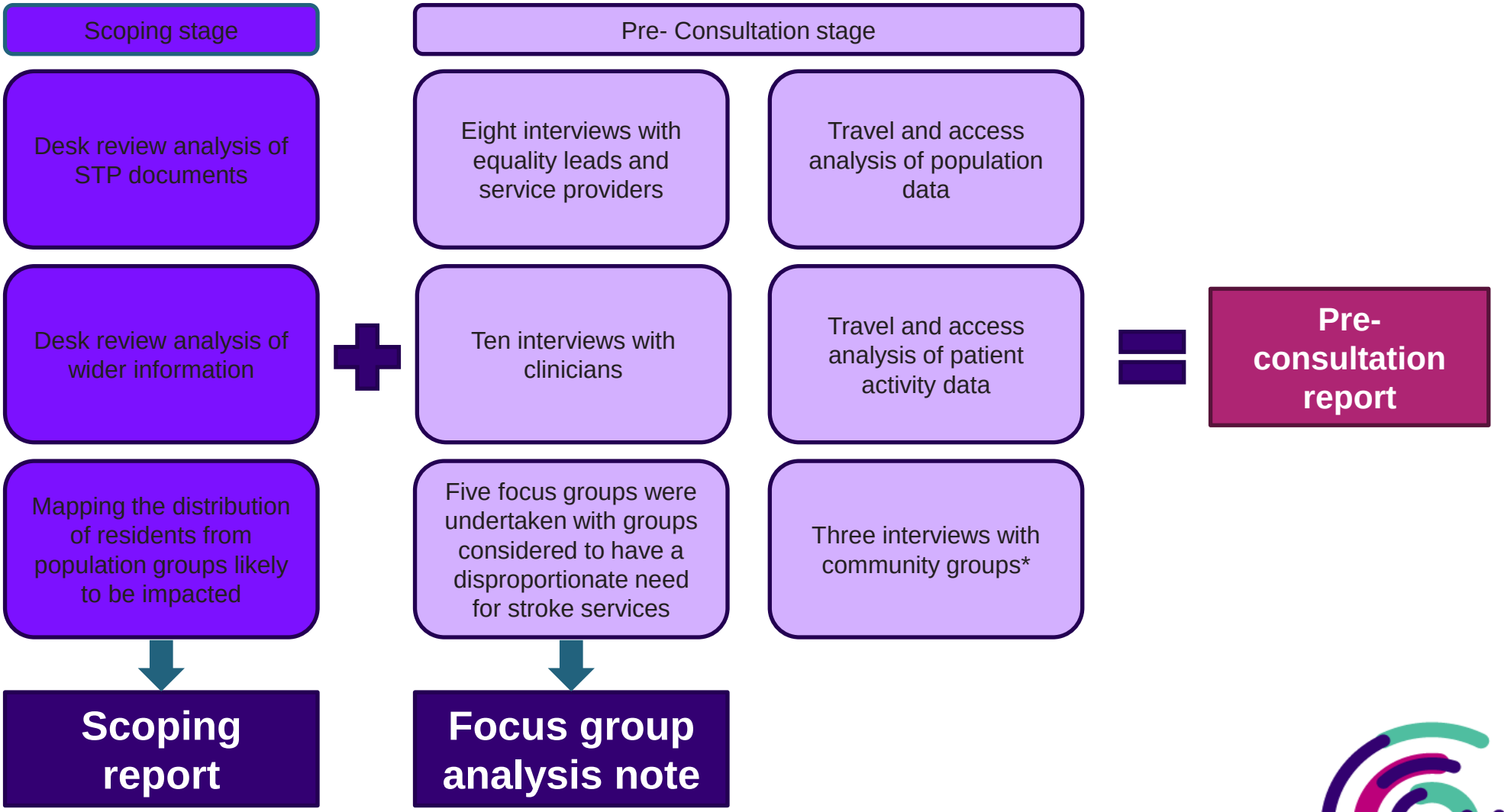
# Integrated impact assessment (IIA)

- In May 2017, the Kent and Medway STP Programme Board commissioned Mott MacDonald to undertake an IIA of stroke services. This is an independent review of the proposals in the PCBC.

- There have been five iterations of the pre-consultation report evaluating the potential impacts of the proposed options for stroke services across Kent and Medway.

- The report has been disseminated and commented upon by the following groups/people:
  - Inequalities steering group for the Kent and Medway STP
  - Integrated Impact Assessment Task & Finish Group
  - Clinical Reference Group
  - Operational Planning Group (by email)
  - Clinical Senate

# Approach to developing the IIA report



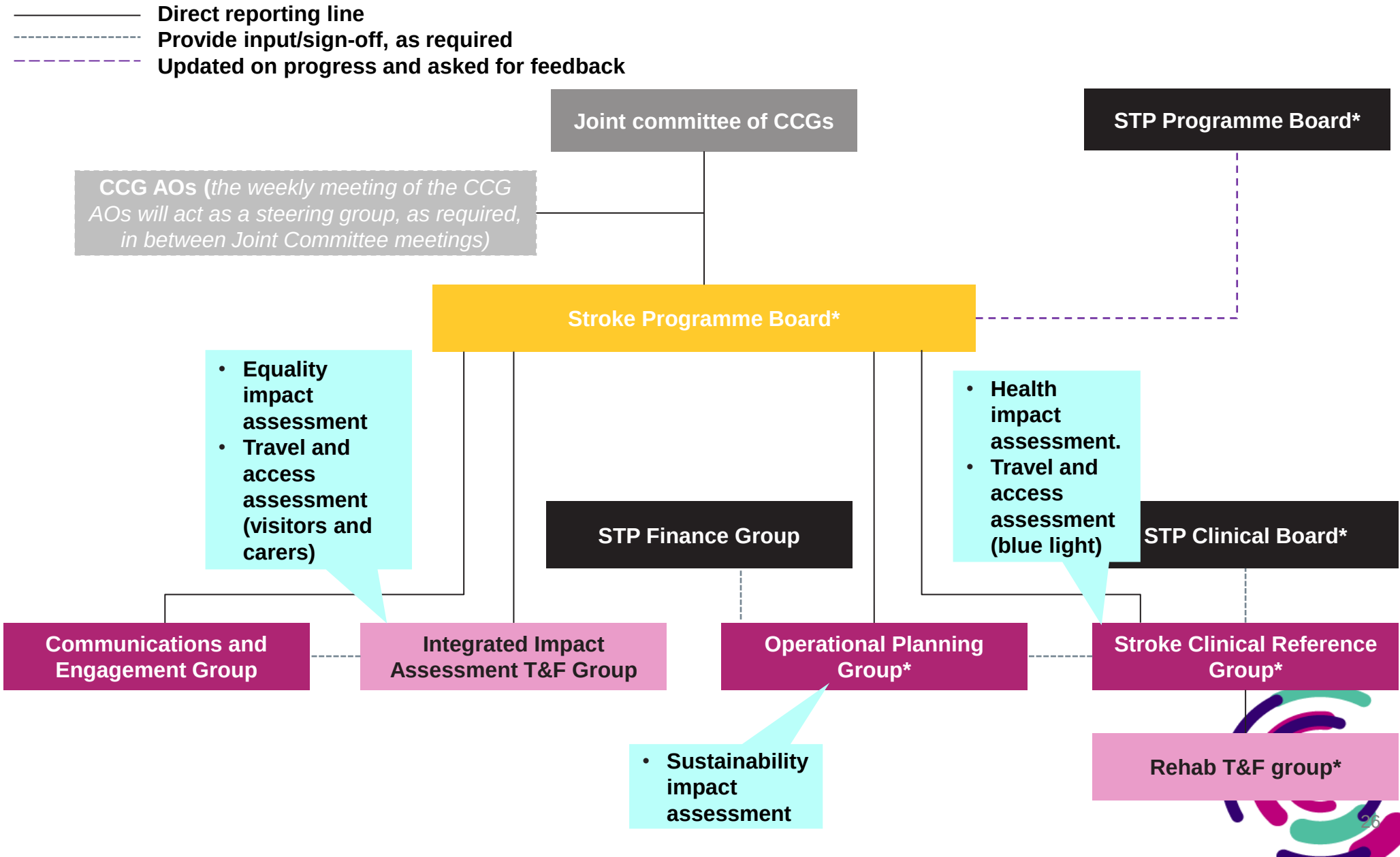

*It should be noted that 68 community groups were invited via email to participate in this report through one-to-one interviews. They were sent two reminder emails to take part in an interview.*

# Scoping phase

In order to assess the impact of the service changes on protected characteristic and deprived groups, the scoping phase involved detailed analysis to understand which groups may have a disproportionate need for stroke services. These groups are as follows:

- Age: Older people (65 and over)
- Disabled people
- Pregnancy and maternity
- Race and ethnicity
- Sex: Male
- People from deprived communities

# Different groups have considered different parts of the IIA



# Integrated Impact Assessment (Michael Ridgwell)

## Key findings from the Integrated Impact Assessment

**Health**

- The proposed changes will improve patient outcomes and remove the variation currently experienced
- The consolidation of workforce resources will enable the three comprehensive stroke units to sustainably achieve recommended workforce standards. This will create a more sustainable workforce for providing stroke care across Kent and Medway
- Rehabilitation services for stroke patients will be improved, supporting patients to regain their independence and overall quality of life
- For patients experiencing a stroke whilst already in hospital at one of the four sites no longer providing stroke services, a transfer will be required to a HASU
- With activity for stroke services being consolidated into fewer hospitals, there is a risk that capacity could become constrained within these units
- If links between clinical inter-dependent services across the wider STP programme are not appropriately maintained, this has the potential to negatively impact on the safety of care
- The reconfiguration of stroke services is considered to bring challenges for some staff, which could result in increased staff turnover and the loss of current expertise

**Sustainability**

- The assessment shows that all proposals are expected to increase emissions. Proposal D would result in the lowest change in GHG emissions. Options A, C and D are similar in terms of GHG emissions. Options B and E have the highest emissions, which are nearly twice that of the other proposals

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, January 2018

## Key findings from the Integrated Impact Assessment

**Travel and access**

- The proposed changes will mean that some patients will have to travel further to access a stroke service
- The proposed changes will result in longer ambulance journeys for some patients required to be conveyed to a HASU, which will negatively impact the capacity of the ambulance service
- Across all shortlisted options there is a reduction in accessibility within 30 minutes by BLA (blue light ambulance)

**Equality**

- There are disproportionately longer journey times for a number of the listed equality groups under most of the options:
  - Option B: those from deprived backgrounds, those with a LLTI
  - Option C: those from deprived backgrounds
  - Option D: those from a BAME background, those from deprived backgrounds, those with a LLTI
  - Option E: those from deprived backgrounds, those with a LLTI

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, January 2018

# Mitigations (health impact assessment) (1/3)

| Proposed mitigations (IIA) | Response | Reviewed by |
|---|---|---|
| Further detail on the care model for rehabilitation is required, responding to the lack of clarity that some stakeholders perceive around this. This is an essential part of the stroke pathway of care. | This additional detail has been developed as part of the task & finish group and will be included in the updated PCBC. | Clinical Reference Group |
| As well as treatment, focus must also be placed on prevention and health promotion activities to counter potential risk factors for stroke. | Agreed. This is covered in the section on prevention in the PCBC. | Clinical Reference Group |
| The stroke clinical group should review estimated ambulance travel times for the shortlisted and preferred options to ensure that they achieve relevant standards. | The shortlisted options have been shown to meet travel times as part of the evaluation of options. | Clinical Reference Group |
| As part of evaluating the impact of these changes, activity and outcome information should be closely monitored to ensure standards and outcomes of care are maintained. | Agreed. This will be part of the benefits realisation process as outlined in the PCBC. | Clinical Reference Group |
| Appropriate protocols should be established for patients already in hospital but requiring urgent transfer to a HASU. | Agreed. These are being discussed within the Clinical Reference Group and detailed protocols will be in place before implementation. | Clinical Reference Group |
| Continue to update STP activity modelling to ensure that sufficient capacity can be provided at selected Kent and Medway hospitals, for the increased volume of stroke related activity, as well as demand for inter-dependent and clinical support services. | Agreed. This will be monitored through the Clinical Board and the Programme Board which sit across the STP. | Clinical Reference Group |

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, 25 October 2017

# Mitigations (health impact assessment) (2/3)

| Proposed mitigations (IIA) | Response | Reviewed by |
|---|---|---|
| The assessment of capacity and resources must have sensitivities applied including:<br>• The capacity of HASU/ASU services at neighbouring hospitals (should this be closer to patients than their nearest HASU in Kent and Medway)<br>• The impact on capacity if other patients choose to self-present at hospitals with a HASU and require other acute services. | This has been done as part of the updated sensitivity analysis and will be included in the updated PCBC. | Clinical Reference Group |
| As the wider STP programme develops, continues to review the co-dependencies matrix to ensure that essential links are maintained. | Agreed. This will be the responsibility of the Clinical Board which sits across the STP. | Clinical Reference Group |
| A programme of engagement with clinical, nursing and wider staff should be undertaken, with clear messages to ensure that staff recognise that they are valued and are proactively encouraged to stay within the Kent and Medway stroke network, despite potential changes to their local service. This engagement should be commenced with all existing services in advance of the announcements of the short list or preferred option. | Agreed. This engagement has already commenced and will continue throughout consultation, decision-making and implementation. | Clinical Reference Group |
| A workforce plan for the stroke network should be established which focuses on both the short term and longer term resource and succession planning of services. This should consider potential recruitment strategies as well as the impact of trends in specialisation to ensure that the new model of care can be delivered. | A detailed workforce plan is being developed and will form part of the DMBC. Further work is being undertaken on non-consultant groups following feedback from the Clinical Senate and will be included in the PCBC. | Clinical Reference Group |

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, 25 October 2017

# Mitigations (health impact assessment) (3/3)

| Proposed mitigations (IIA) | Response | Reviewed by |
|---|---|---|
| Incentives to encourage staff to relocate should be considered. For example, one stakeholder suggested offering training opportunities to nurses who are band 6 or below. | These opportunities are being considered as part of the workforce planning and will be outlined in more detail in the PCBC and DMBC. | Clinical Reference Group |
| Where staff are not able to transition to these new arrangements, alternative approaches should be sought to ensure that they are retained within Kent and Medway. | Agreed. Plans are already in place to offer alternative employment where possible. Detailed plans are being developed and will be included in the DMBC. | Clinical Reference Group |
| Communications with the public should continue to highlight the drivers for change; high quality care and improved outcomes. | Agreed and is included within the consultation plan. | Clinical Reference Group<br>IIA Task & Finish Group |
| This should include clear messages to the public on the new care models and where to go for services to minimise potential negative transitional impacts. | Agreed. This will be an important part of implementation which will be overseen by the Stroke Programme Board. | Clinical Reference Group<br>IIA Task & Finish Group |
| Ensure that the clinical regiment currently established continues as the stroke programme progresses. This includes due process, an independent chair of the clinical reference group and clinical engagement. | Agreed. The governance and ownership of implementation has been outlined in the PCBC and will be amended to clarify the on-going role of the CRG in driving the clinical aspects of implementation. | Clinical Reference Group |
| The South-East Coast Clinical Senate identified that in order for potential benefits to be realised, timescales for implementation need to be realistic, and the feasibility of the models is dependent on effective enabling functions (digital, workforce and estates). Stakeholders have also highlighted these enablers. | Agreed. There are separate workstreams for these enablers and these will become increasingly important as the programme moves towards implementation. | Clinical Reference Group |

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, 25 October 2017

# Mitigations (travel and access assessment)

| Proposed mitigations (IIA) | Response | Reviewed by |
|---|---|---|
| Once a preferred option has been decided, the ambulance service should be involved in assessing the impact of change on their capacity and ascertain the additional resources that may be needed to minimise any impact on the wider ambulance service. | Agreed. Discussions with the ambulance service have already started. Greater detail will be included in the DMBC once a preferred option is identified. | Clinical Reference Group |

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, 25 October 2017

# Mitigations (equalities assessment)

| Proposed mitigations (IIA) | Response | |
|---|---|---|
| Maximise public transport accessibility of specialist centres through engagement with local transport providers. | Agreed. It will be particularly important to engage with voluntary transport services. | IIA Task & Finish Group |
| Ensure the effective communication of the future model of care to the local population, so they understand how to access and use services and the potential increased journey times. | Agreed – this is part of the work of the communications and engagement group. This will include engaging with people with protected characteristics. | IIA Task & Finish Group |
| - | Consideration of the role of voluntary transport services in transporting carers and relatives particularly from rural areas. To be incorporated included in the implementation phase of the work. Funding to be considered as part of the DMBC as not material to the options. | IIA Task & Finish Group |
| - | Review cost/availability of car parking spaces for carers and relatives of longer-term stroke patients. To be incorporated included in the implementation phase of the work. | IIA Task & Finish Group |
| - | Explore options for carers and relatives to stay overnight, especially if they are far from home. To be incorporated included in the implementation phase of the work. Funding to be considered as part of the DMBC as not material to the options. | IIA Task & Finish Group |

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, 25 October 2017

# Mitigations (sustainability assessment)

| Proposed mitigations (Operational planning group) | Response |
|---|---|
| Any “new” buildings should be replacements for existing facilities, where possible. | Agreed. Where possible, the proposed “new” buildings will be replacements or refurbishments of existing buildings. New builds and conversions are subject to the latest NHS building standards, which are more energy efficient than facilities that were built many years ago. |

Source: K&M STP Integrated Impact Assessment: pre-consultation report – stroke services, 25 October 2017

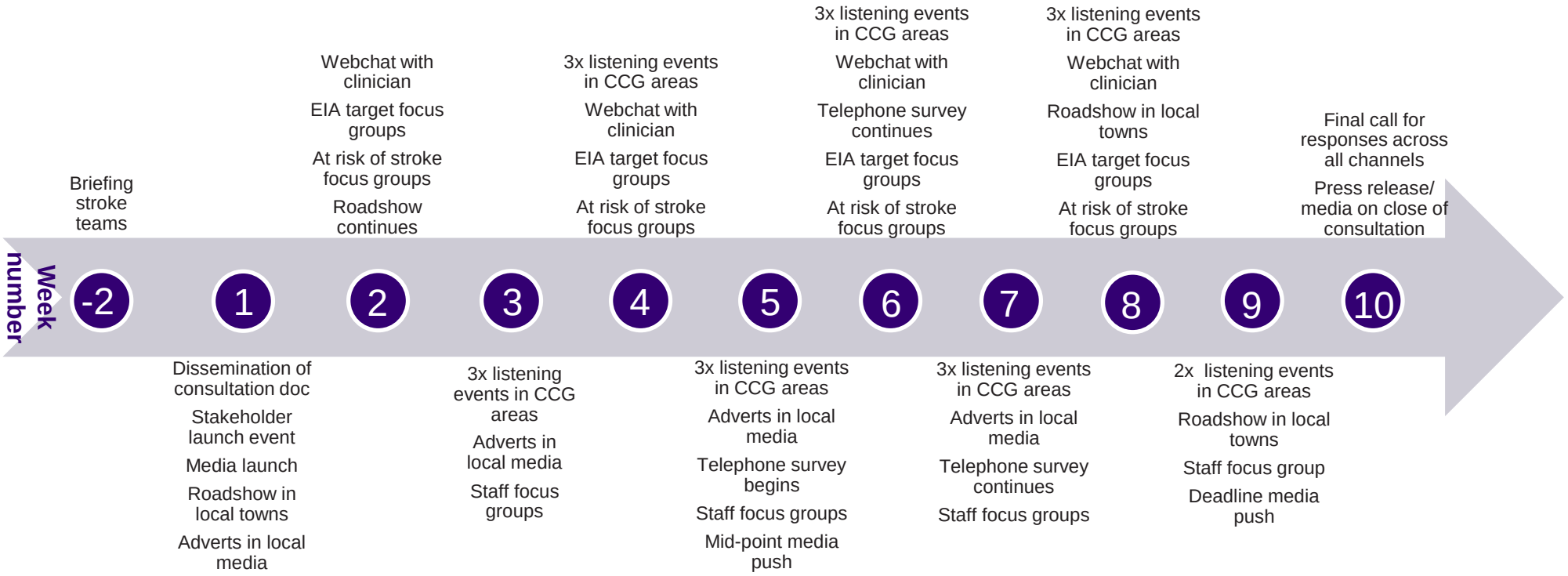
# Consultation activity overview (Steph Hood)

It is proposed to launch the public consultation on **1 February 2018** to run for **ten weeks.**

**During the consultation period we plan:**

- proactive listening events x 10 CCG areas
- existing meetings schedules and opportunities at K&M and CCG level
- responding to meeting requests
- support for meetings run by others (eg animation, consultation documents, FAQs)
- outreach to seldom heard groups (building on pre-consultation engagement)
- targeted focus groups i) IIA ii) likely impacted by stroke changes iii) staff
- representative sample population – telephone survey
- 1-1 stakeholder engagement for targeted responses
- digital and social media campaign
- media campaign

# Consultation activity overview




**Activity taking place throughout consultation period**

- Supporting materials and survey on STP website and signposted from CCG and provider sites
- Weekly topic-specific content shared via STP, CCG and provider communications channels (e.g. website, social media, bulletins/newsletters, staff briefings etc)
- Promotion of consultation to and in 3rd party stakeholder organisations communications channels
- Presentations to/attendance at key stakeholder meetings/groups
- Information displayed in provider organisations (including staff areas), GP practices, libraries, community centres and other public spaces
- Providing support materials for 3rd party meetings (e.g. animation, consultation documents, FAQs)
- Proactive outreach to seldom heard groups
- Targeted1-1 stakeholder engagement to generate responses

# Giving your views

## Once our consultation has launched:

- You will be able to read more about the proposed changes
  Visit www.kentandmedway.nhs.uk/stroke
  for the consultation document and questionnaire (these will also available in printed format), and find more information on our website including:
  - pre-consultation business case
  - travel time modelling
  - options evaluation process
  - integrated impact assessment and more

- And when you are ready to respond

  - Complete the consultation questionnaire online or by post

# Next steps (Patricia Davies)

## Indicative high level timeline