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Date: Friday 29 June 2018

Dear Member

KENT AND MEDWAY STROKE REVIEW JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - THURSDAY, 5 JULY 2018

I am now able to enclose, for consideration at next Thursday, 5 July 2018 meeting of the Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee, the following report(s) that were unavailable when the agenda was published.

Agenda Item 6d Stroke Review Post-Consultation Update (Pages 3 - 182)

- Stroke Consultation Analysis Report (Pages 3 - 142)
- Stroke Consultation Activity Report (Pages 143 - 182)

These reports have been added to the agenda, because it is anticipated that the Chair of the Committee, once appointed, will agree that they should be considered at this meeting as a matter of urgency, as permitted under section 100B of the Local Government Act 1972. This is to enable the Committee to consider the reports and to avoid any possible delay in this. The reports were not available for despatch as part of the main agenda on 27 June 2018 as they required consideration at an NHS Committee which took place on 28 June 2018.

The appendices referred to in the Consultation Activity Report can be viewed here - https://kentandmedway.nhs.uk/stroke/reports/activity-report/

Yours sincerely

Benjamin Watts
General Counsel

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Transforming health and social care in Kent and Medway

djs research

Public consultation on proposed changes to urgent stroke services

Research analysis report

Summer 2018

Structure

1. **Executive summary**
2. **Introduction**
3. **Quantitative research results**
   - Telephone survey
   - Online survey & paper questionnaires
4. **Public consultation: Thematic analysis**

Appendix

Participant profile

Executive summary

Page 5

Executive summary (1)

Background

- Kent and Medway acute stroke services do not always meet the latest national standards and best practice recommendations. New ways of delivering stroke services have been introduced across other parts of the country through the creation of Hyper Acute Stroke Units (HASUs).
- NHS Kent and Medway first began to review stroke services in late 2014. After a long and detailed process, a proposal has been put forward to set up 3 Hyper Acute Stroke Units in the Kent and Medway area. These changes will affect every hospital in the area, and care for residents in both Kent and Medway and in some surrounding areas in East Sussex and south east London.
- Feedback has been gathered from a wide range of audiences including stroke patients and their families, members of the public and stakeholders on the proposed options both for creating HASUs and for the potential locations of the HASUs.
- Five proposed options regarding potential locations of the units were put forward during the public consultation:
  - **Option A:** Darent Valley, Medway Maritime and William Harvey Hospitals
  - **Option B:** Darent Valley, Maidstone and William Harvey Hospitals
  - **Option C:** Maidstone, Medway Maritime and William Harvey Hospitals
  - **Option D:** Tunbridge Wells, Medway Maritime and William Harvey Hospitals
  - **Option E:** Darent Valley, Tunbridge Wells and William Harvey Hospitals
- For more information on the proposal, the consultation and the decision making process, please visit: https://kentandmedway.nhs.uk/stroke/

Executive summary (2)

The public consultation

- In order to encourage and enable as many residents as possible to take part in the consultation, within the available budget, and to get a broad and representative range of views, a variety of different methods of collecting views were used:
  - Telephone surveys
  - Postal and online surveys
  - Listening Events and public meetings
  - Outreach engagement (amongst 'seldom heard' groups)
  - Focus groups (amongst those not engaging in other consultation activities)
  - Social media activity – Twitter and Facebook
  - Letters/emails via dedicated Freepost address and email address
- The public consultation ran from 2 February– 20 April 2018 and generated high levels of interest and response.
- **A detailed report outlining the approach and activity undertaken during the consultation has been developed and may be read in conjunction with this report to give context. This report can be found at: INSERT DETAILS**

Key questions under review:

Opinions have been gathered with a focus on four key areas:

- Should there be hyper acute stroke units (HASUs) in Kent and Medway?
- Is 3 the right number of HASUs for Kent and Medway?
- Which is preferred of the five proposed options?
- Whether there are any other options or any additional information the review team need to consider?

The results of the public consultation activities:

DJS Research, an independent research consultancy, analysed all the information collated and this report provides a summary of the **themes** emerging from the public consultation.

Executive summary (3)

How was the feedback collected?

Telephone surveys:
DJS Research conducted telephone surveys with residents from all ten Clinical Commissioning Group areas. Quotas were set to ensure that the people who took part in the survey were broadly representative of the population of the area. In total, 701 telephone interviews took place between 5-20th April 2018.

Online surveys:
An online questionnaire was made available on the Kent and Medway STP website, and the survey was open from 2nd February–20th April 2018. In total 2,240 surveys were completed.

Paper questionnaires:
Paper questionnaires were made available from a variety of sources. 334 surveys were returned, although some were only partially completed. DJS Research entered the data into an electronic format and analysed this data along with the online survey data.

Listening events:
Listening events took place in locations across Kent and Medway during February-April 2018. These events generally followed the structure of a short presentation followed by an open Q&A session and structured table discussions. The consultation team also attended various community group and public meetings hosted by others.

Other public consultation activities:

- Focus groups were held with 'seldom heard' groups, with members of the public who had not engaged in any other consultation activities and with members of staff involved in delivering stroke care.
- Emails/letters sent in to the consultation team from individuals/those representing individuals.
- Social media comments (Facebook and Twitter).

Executive summary (4)

Telephone survey: Key findings

- Overall, awareness of the review is fairly low, with two-thirds of respondents stating they knew nothing about the review. Awareness is highest amongst residents of Thanet, and lowest amongst Bexley residents.
- Respondents generally support the proposals and understand the reasons for creating HASUs, with over three-quarters agreeing that it makes sense to create these units and that HASUs would improve access to specialist treatment and improve the quality of urgent care for stroke patients.
- The key area of concern is the longer journey times needed to travel to a specialist unit, with two-thirds of those surveyed agreeing this is a concern.
  - This concern is highest amongst residents of Thanet.
- Three-quarters agree that it makes sense to locate acute stroke units and mini stroke clinics on the same sites as hyper acute stroke units.
- Thanet residents are the least likely to agree that:
  - The units would provide quality of urgent care for stroke patients
  - It makes sense to create HASUs to care for all stroke patients across Kent and Medway
  - It is a good idea to concentrate staff and resources within 3 locations across Kent and Medway
  - It makes sense to locate acute stroke units and mini stroke units on the same sites as HASUs
- With regards to the proposals, residents feel the key questions to ask are whether the proposals improve quality of care and access to specialists; they are less concerned about the logistics and whether the proposals are good value for money.

Executive summary (5)

Online / postal survey: Key findings

- Almost 9 in 10 (87%) agree that there are convincing reasons to establish HASUs in Kent and Medway, and over three-quarters agree that HASUs would improve access to specialist care and improve quality of care for stroke patients.
- Choosing the options that would improve access to specialist care and that would improve the quality of care for stroke patients are considered the two most important questions to ask (from the prompted list of questions) when considering the locations of the units.
- The key concerns are longer travel times and the potential locations of the units.
- Respondents were asked to rank the five proposed options.
- Whilst there was no clear 'winner' the most preferred option from the surveys is Option A (Darent Valley, Medway Maritime and William Harvey Hospitals), closely followed by Option B (Darent Valley, Maidstone and William Harvey Hospitals).
  - Key reasons for preferring these options are that they have potentially the greatest reach and accessibility.
- In the free text boxes, comments centred around the desire for an option closer to Thanet, that travelling times should be as fair as possible and that follow up and that rehabilitation services are essential.

Executive summary (6)

Key findings from all other activities (qualitative, or non-numerical data)**:**

Do people agree with the proposal to establish HASUs?

- Overall, people agree with the proposal to establish HASUs in Kent and Medway, and there is a high level of agreement and understanding of the arguments put forward regarding the benefits of having HASUs in Kent and Medway:
  - They understand that current services are not good enough, and are not on a par with other areas of the country.
  - Residents generally agree it is better to be treated by specialists and that HASUs would improve access to specialist care.
- Some members of the public are unsure whether there is a clear case for changing the way stroke services are delivered, either because they feel they do not have sufficient information or knowledge to judge whether the reasons for change are justified, they feel that the investment may be better focussed across the whole pathway, or they are concerned over the potential impact on other local services of introducing HASUs.
- There is a particular concern over whether after care, including rehabilitation services and care in the community is being considered as part of the review, and the impact that HASUs will have on these services.
- A minority of people questioned the existing evidence that shows HASUs provide better outcomes.
- The key questions and concerns are not generally around whether HASUs should be established, but where they should be located.

Executive summary (7)

Key findings from all other activities (qualitative, or non-numerical data)**:**

Is three the right number?

- Whilst many people understand the reasoning behind having three units in the area, and specifically the argument that it would be difficult to staff more than three units in the area, some feel that staffing should not drive such decisions, and that more should be done instead to improve recruitment and retention of staff.
- Many feel that the geography of the area means that four units would be better in order to provide fair and equal access to all residents.

What are the views on the five proposed options?

- Of those expressing a preference for a particular option, many acknowledge that they would choose the option with their preferred hospital, usually the one closest to where they live.
- Many people did not feel any option is suitable, and expressed a desire for Kent and Canterbury Hospital or Queen Elizabeth the Queen Mother (QEQM) Hospital to be re-considered as one of the options.
  - All options are perceived to leave East Kent (particularly Thanet) at a disadvantage with little or no choice.
- Residents often stated that the other NHS reviews and the potential new hospital in Canterbury should feed into the decision on the locations of the units. (continued.)

Executive summary (8)

Key findings from all other activities (qualitative, or non-numerical data)**:**

What are the views on the five proposed options? (continued)

Many questions were raised over the decision making process of the proposed locations. Key areas of concern regarding the decision making process include:

- The inequality of care for East Kent residents
- The reality of the stated travel times
- The implications of increased travel times, in particular on the time from 'call to needle', the impact on the ambulance service, and the impact on friends and relatives
- Whether decisions have been based on population size, density or demographics
- Whether geography or need have been taken into account
- The reasons for omitting the Kent & Canterbury Hospital and the QEQM Hospital from the shortlist
- The influence of bordering areas
- The influence of finance

Other topics discussed included the current political situation and questions around the public consultation.

Introduction

Introduction

In order to **improve hospital-based urgent stroke services** for people in Kent, Medway and the surrounding areas, the NHS in Kent and Medway propose to establish **three hyper acute stroke units (HASUs)** operating 24 hours a day, 7 days a week, to care for stroke patients across Kent and Medway.

The NHS in Kent and Medway, Bexley and the High Weald held a public consultation on the proposal, speaking to a variety of audiences, including:

The consultation ran between 2nd February and 20th April 2018. A detailed report outlining the consultation approach and activity has been developed and will provide helpful context when reviewing the analysis of consultation responses. This report can be found at (INSERT DETAILS). The main areas for consideration included:

- The proposal to establish hyper acute stroke units
- Whether three is the right number
- Five potential options for location
- Whether there are any other options or additional information that should be considered

The consultation process

Members of the public were able to participate in the consultation through a variety of ways:

Attending a Listening Event

Telephone survey

Completing an online survey

Returning a paper survey via Freepost

Focus groups

Street surveys

Feedback via social media, dedicated email address and phone number

Outreach work

Transforming health and social care in Kent and Medway

This report provides feedback on the following strands of feedback from the consultation:

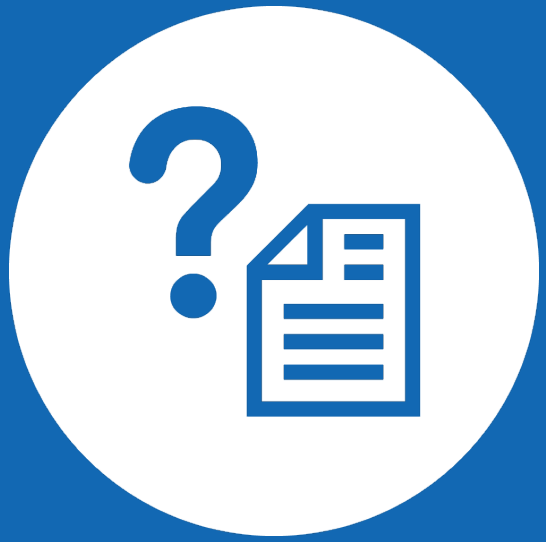
Telephone survey

Online / postal survey

Feedback from a variety of additional sources including:

- Listening Events
- Public meetings
- Social media
- Emails
- Outreach work
- Targeted focus groups with seldom heard groups
- Focus groups held with staff currently working in Stroke Services

Quantitative research
Telephone survey



Methodology

Requirement

- Telephone survey with a representative sample of the consultation population (from all ten Clinical Commissioning Group areas)
- Gather views on the proposals outlined in the consultation document
- Interpretation of the results

Telephone survey

701

- 701 telephone interviews
- Quotas set to be broadly representative of the population
- Data collected in real time
- Average interview length of 15 minutes

To provide a balanced approach, the questionnaire included a mix of open and closed questions. Respondents were asked to comment on both the advantages and disadvantages of the proposals and to mention any concerns that they had.

Fieldwork took place between **5th & 20th April 2018**

At the outset a target of approximately 700 interviews was set and this was achieved within the fieldwork period

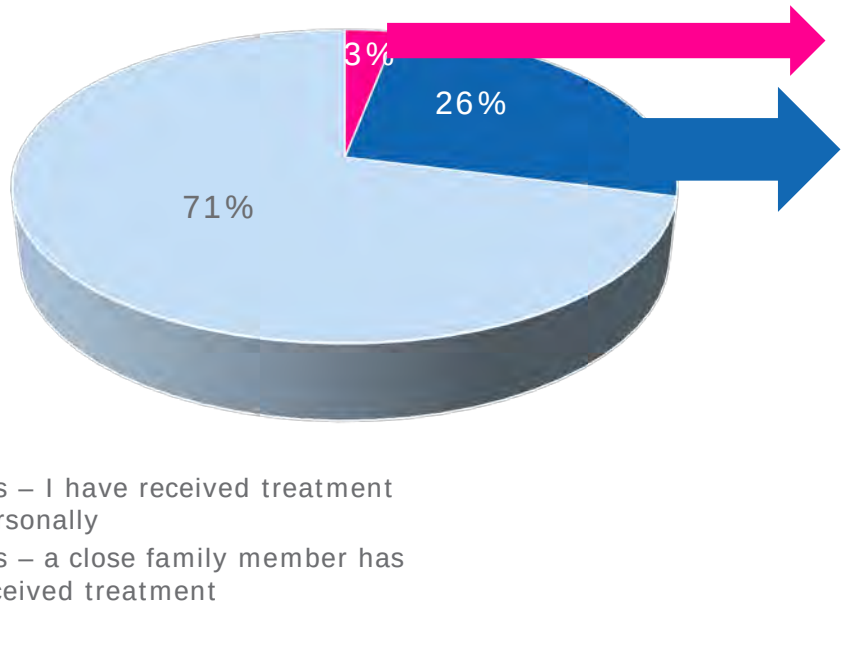
Key findings from the telephone survey

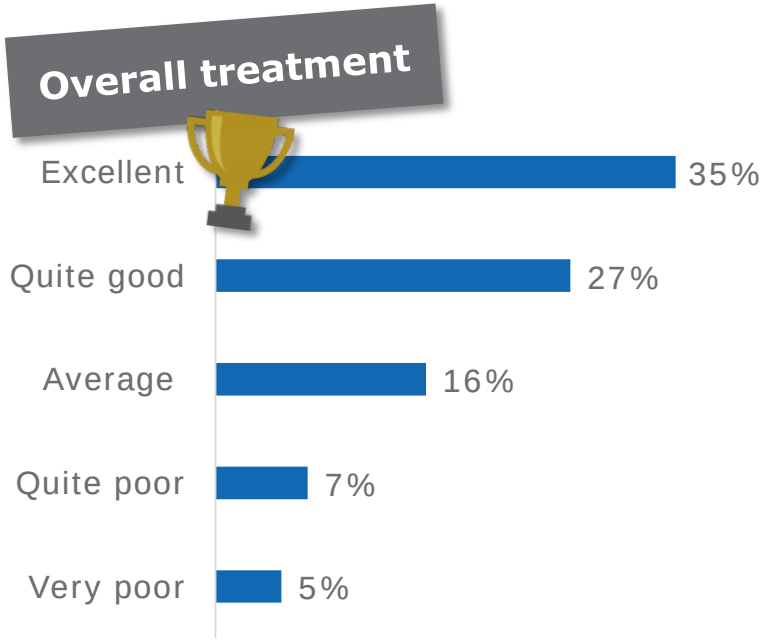
- **Overall awareness of the review is quite low**
- **However respondents generally understand and support the premises underlying the proposals**
- **Three quarters or more agree that creating the Units: will improve access to diagnosis and treatment in the 72 hours following a stroke; improve the quality of care for patients and that it makes sense**
- **For some the potential advantages are marred by one main and repeatedly noted concern – travel times to the HASUs**
- **This was especially relevant to residents living in Thanet, and perhaps goes some way to explaining why this cohort is less likely to see the advantages of creating the Units than residents from other areas**
- **Awareness of the review is also higher in Thanet than in any other area and this may be due to word of mouth** (which may be quite negative)

Hospital treatment

Respondents who had experienced treatment at hospital following a stroke or mini stroke (either personally or through a family member) were generally pleased with the quality of the treatment received with 62% citing the treatment as quite good or excellent.

Q01: Have you or a member of your close family received hospital treatment following a stroke or a mini stroke?





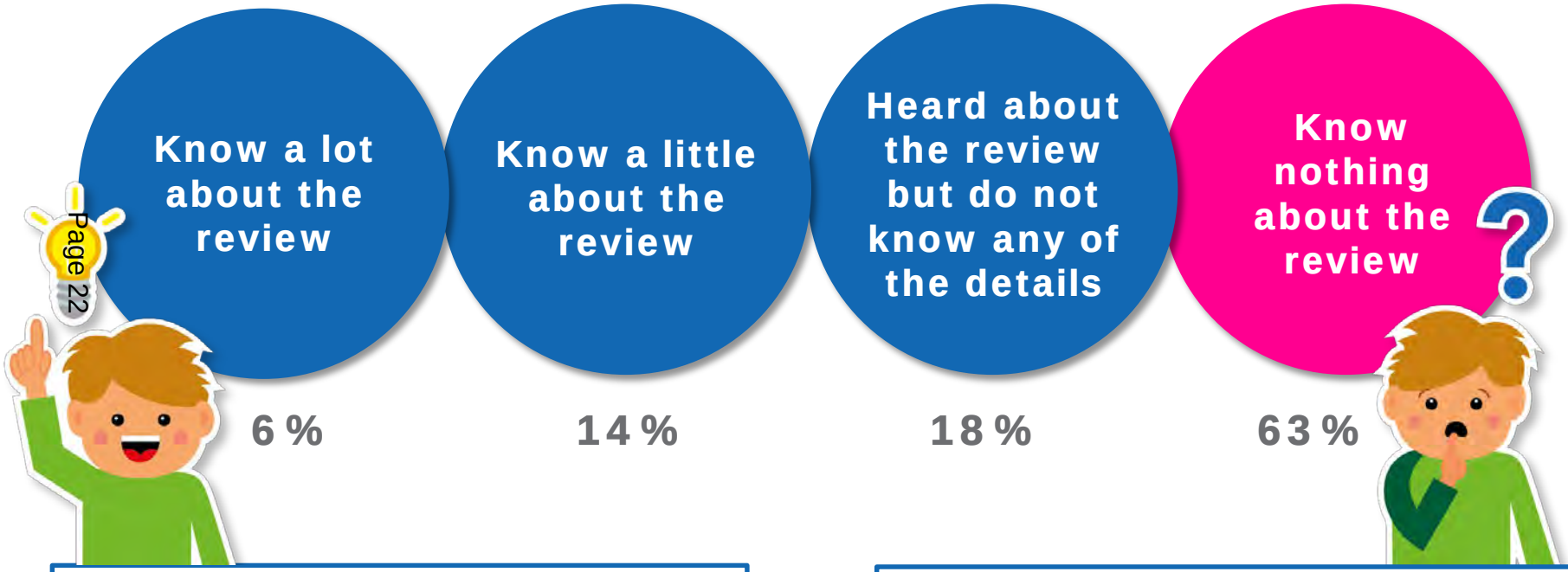
Q02: How would you rate the quality of the overall treatment that you/your family member received?

Q01: Base: All respondents = 701. Q02: Base: Respondents who have either received hospital treatment or have a close family member who has received hospital treatment = 199

Awareness of the review

Despite significant levels of public and patient engagement, two thirds of respondents did not know that the review was going on.

Q03: Before today, how much did you know about the review of stroke services in Kent and Medway?



Regional differences: Awareness of the review was relatively high in Thanet where 38% knew either a lot or a little of the review, whilst in Bexley just 2% had the same level of awareness of the review

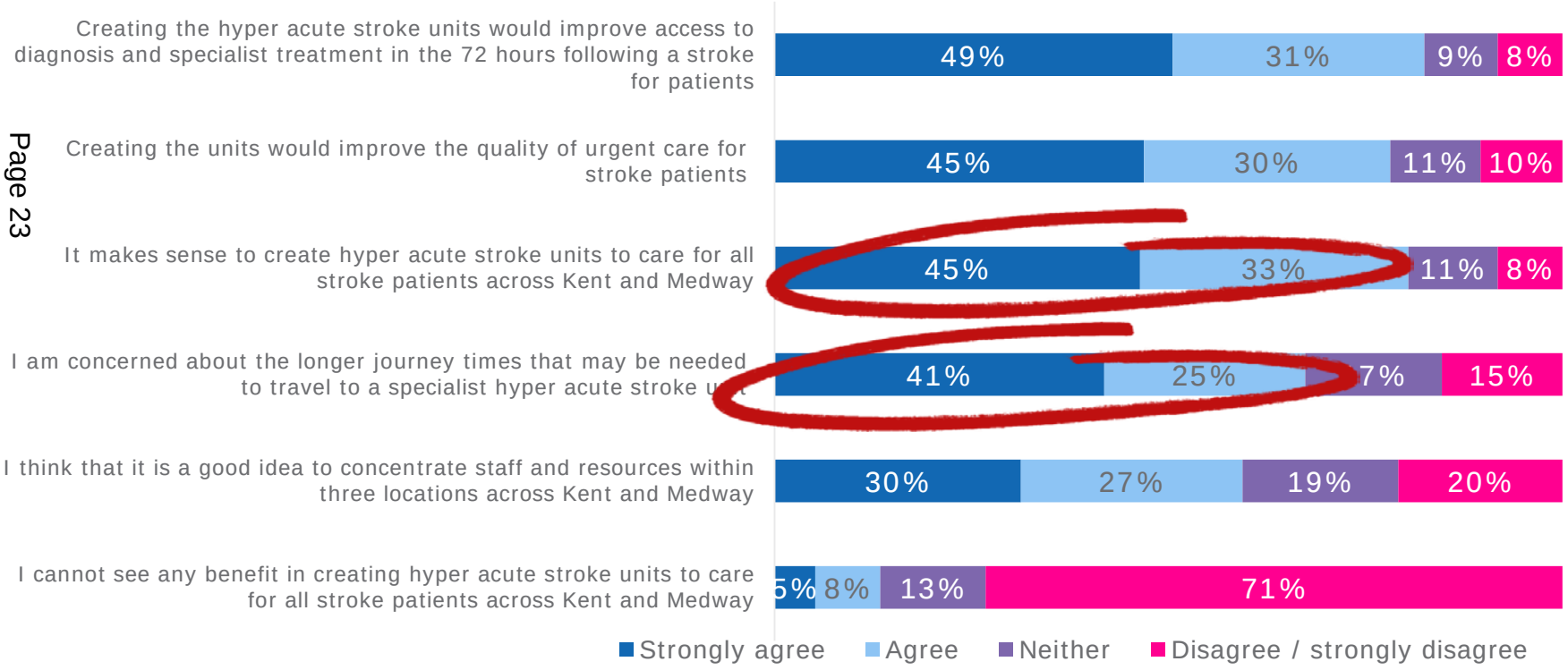
Differences by age: Awareness of the consultation was lower amongst respondents aged either 18-34 or 35-59 with 82% and 68% respectively knowing nothing about the review compared with 55% of those over the age of 59

 Q03: Base: All respondents = 701.

Overall opinions on the Units

Residents were generally in favour of the model with 78% able to see the **sense behind establishing the Units;** however two thirds had **concerns over longer journey times**

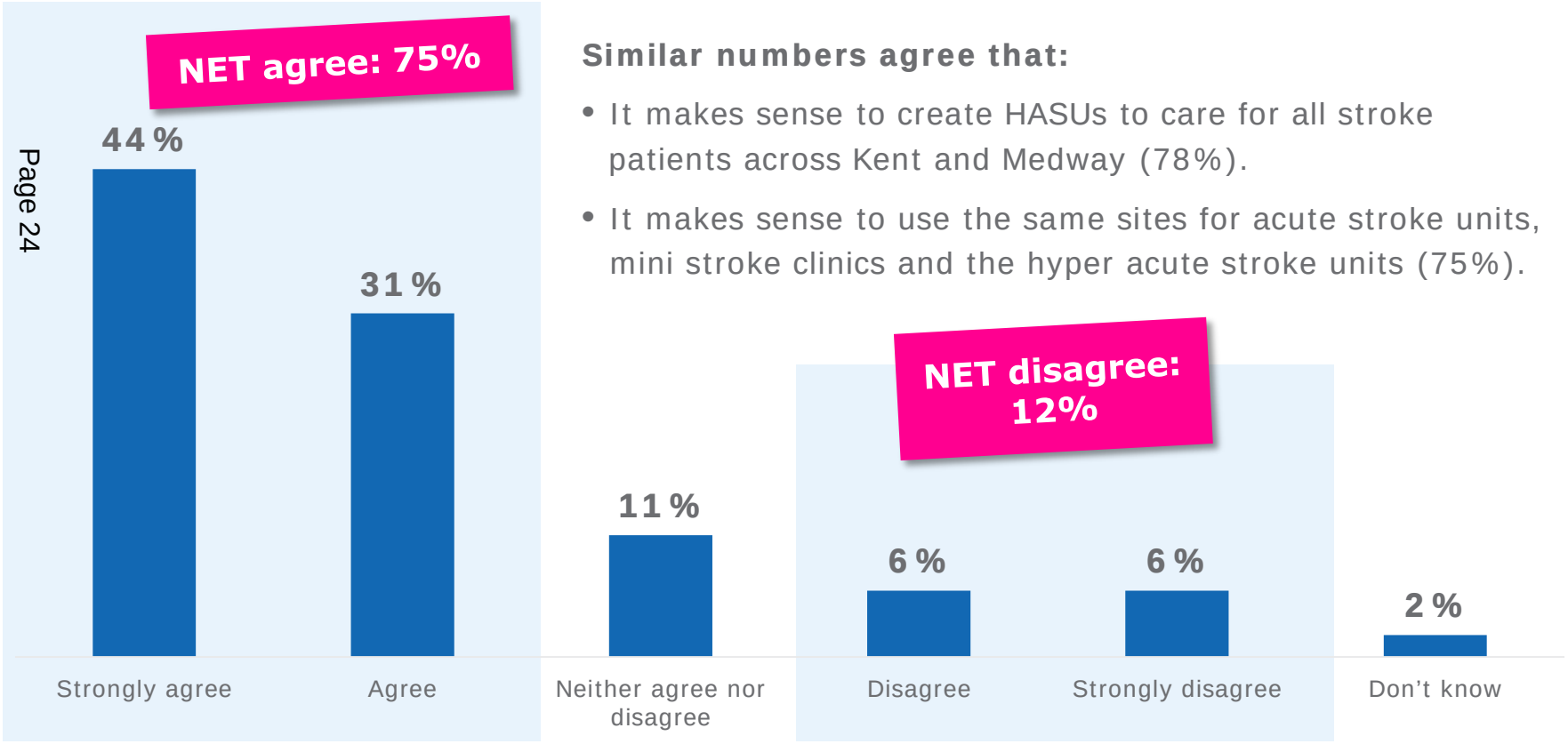
Q04: How strongly do you agree or disagree with the following statements about the proposal?



 Q04: Base: All respondents = 701.

Combining acute stroke units & mini stroke clinics on the same site as the Hyper Acute Stroke Units (HASUs)

Q05: How strongly do you agree or disagree that it makes sense to locate acute stroke units and mini stroke clinics on the same sites as hyper acute stroke units?



Similar numbers agree that:

- It makes sense to create HASUs to care for all stroke patients across Kent and Medway (78%).
- It makes sense to use the same sites for acute stroke units, mini stroke clinics and the hyper acute stroke units (75%).

 Q5: Base: All respondents = 701.

To help with the analysis two statements have been used to separate respondents into distinct groups:

Those who agreed or strongly agreed that *It makes sense to create Hyper Acute Stroke Units (HASUs) to care for all stroke patients across Kent and Medway* may be regarded as **open** to the concept.

Those who agreed or strongly agreed that *There are no benefits in creating HASUs to care for all stroke patients across Kent and Medway* may be regarded as **less open**.

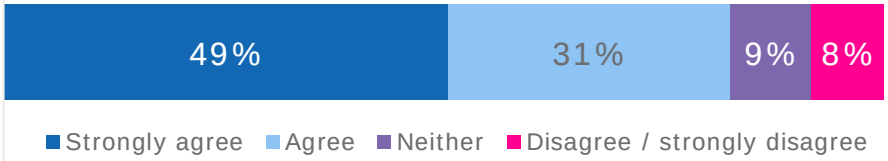
The following slides show the responses given to the five statements by whether the respondent was open and or less open to the overall concept and also provide details on the geographical areas where the lowest and highest levels of agreement were provided. The key points to note are that:

- Respondents less open to the concept were most concerned about the journey times and relatively sceptical that it is a good idea to concentrate staff and resources within three locations.
- Residents of Medway had a greater tendency to agree with the statements that noted the potential benefits of the proposal whilst residents of Thanet were less likely to agree.
- Those living in Thanet were also the most concerned about journey times.

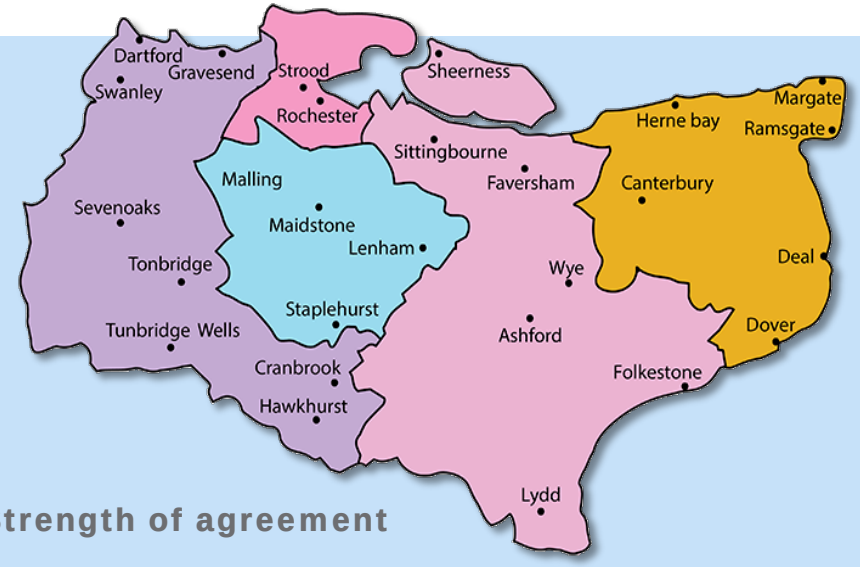
NET agreement: improved access

Q04: How strongly do you agree or disagree with the following statements about the proposal?

Creating the hyper acute stroke units would improve access to diagnosis and specialist treatment in the 72 hours following a stroke for patients



	Open to the concept	Less open to the concept
NET agree	89%	57%
NET disagree	2%	29%



Strength of agreement

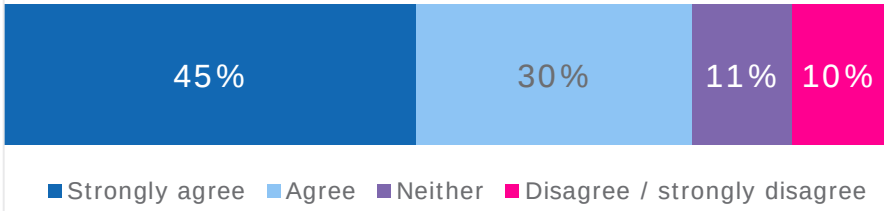
- Highest in Dartford, Gravesham & Swanley (92% NET)
- Lowest in High Weald Lewes Haven (65% NET)

25 Q04: Base: All respondents = 701.

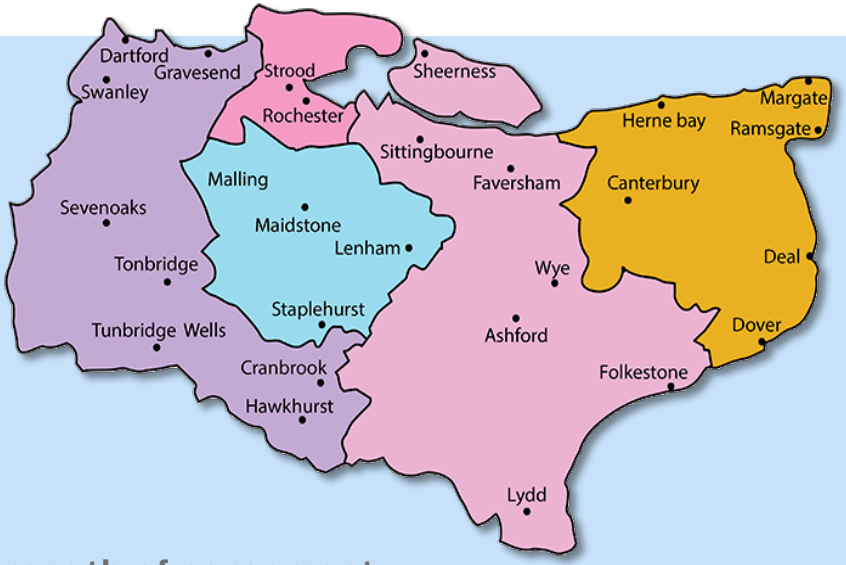
NET agreement: better quality care

Q04: How strongly do you agree or disagree with the following statements about the proposal?

Creating the units would improve the quality of urgent care for stroke patients



	Open to the concept	Less open to the concept
NET agree	86%	49%
NET disagree	4%	33%



Strength of agreement

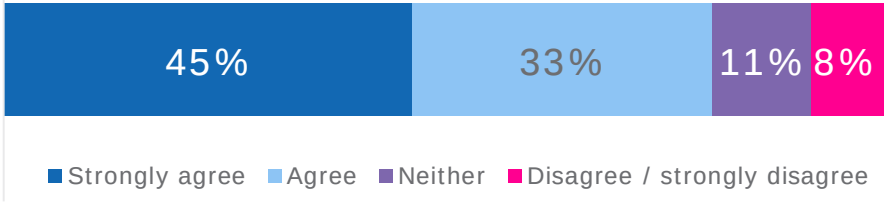
- Highest in Medway (90% NET)
- Lowest in Thanet (62% NET)

 Q04: Base: All respondents = 701.

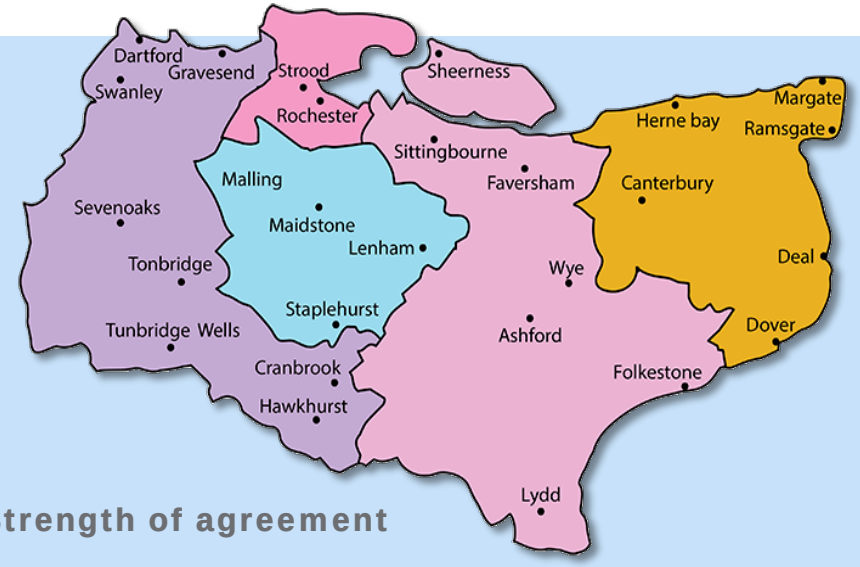
NET agreement: it makes sense

Q04: How strongly do you agree or disagree with the following statements about the proposal?

It makes sense to create hyper acute stroke units to care for all stroke patients across Kent and Medway



	Open to the concept	Less open to the concept
NET agree	100%	52%
NET disagree	0%	29%



Strength of agreement

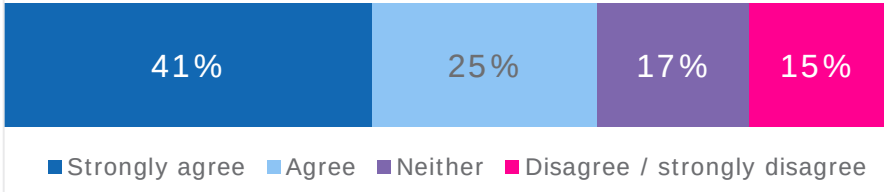
- Highest in Medway (90%)
- Lowest in Thanet and High Weald Lewes Havens (both 63%)

 Q04: Base: All respondents = 701.

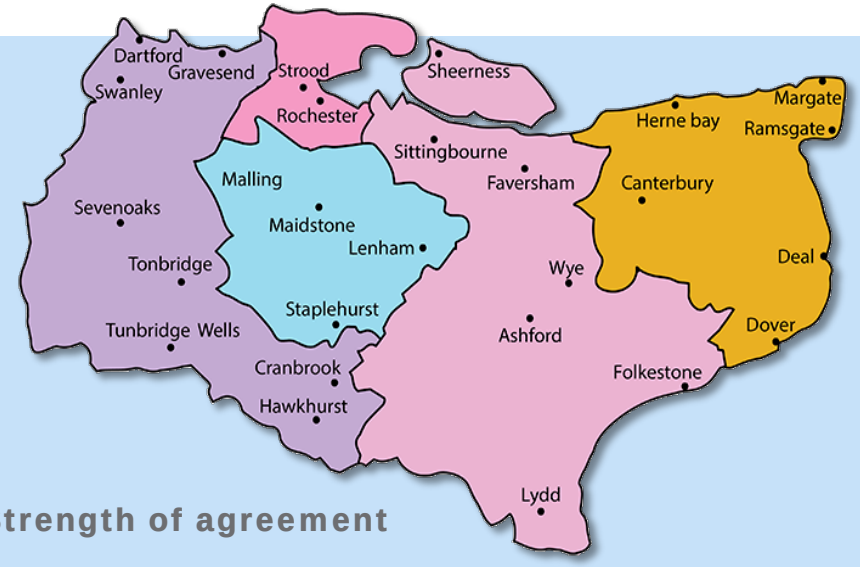
NET agreement: longer journey times

Q04: How strongly do you agree or disagree with the following statements about the proposal?

I am concerned about the longer journey times that may be needed to travel to a specialist hyper acute stroke unit



	Open to the concept	Less open to the concept
NET agree	64%	81%
NET disagree	17%	9%



Strength of agreement

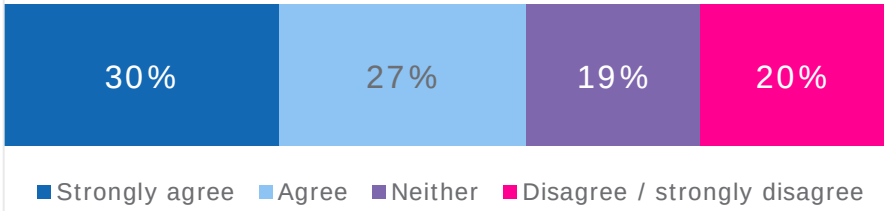
- Highest in Thanet (78%)
- Lowest in Dartford, Gravesham & Swanley (58%)

 Q04: Base: All respondents = 701.

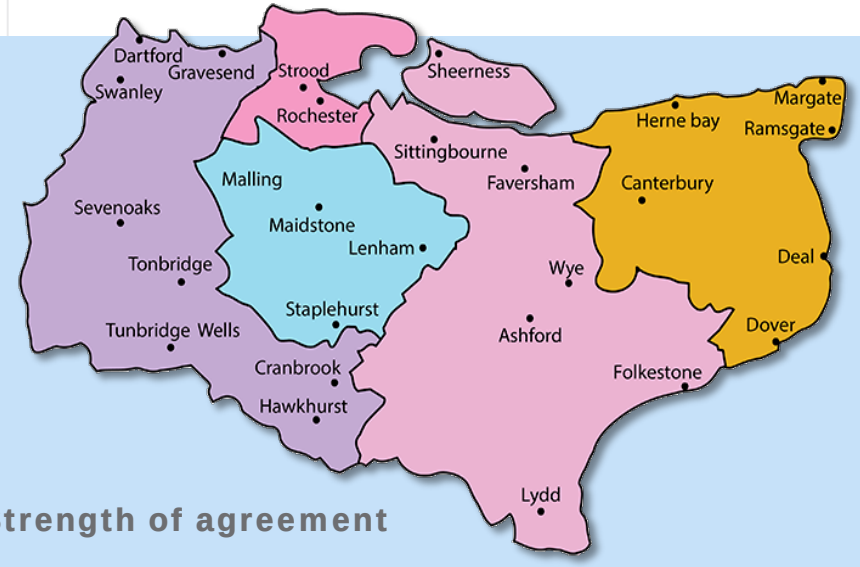
NET agreement: concentrate staff

Q04: How strongly do you agree or disagree with the following statements about the proposal?

I think that it is a good idea to concentrate staff and resources within three locations across Kent and Medway



	Open to the concept	Less open to the concept
NET agree	70%	35%
NET disagree	11%	50%



Strength of agreement

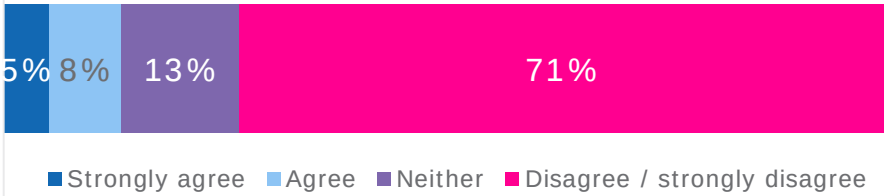
- Highest in Medway (72%)
- Lowest in Thanet (45%)

 Q04: Base: All respondents = 701.

NET agreement: there are no benefits

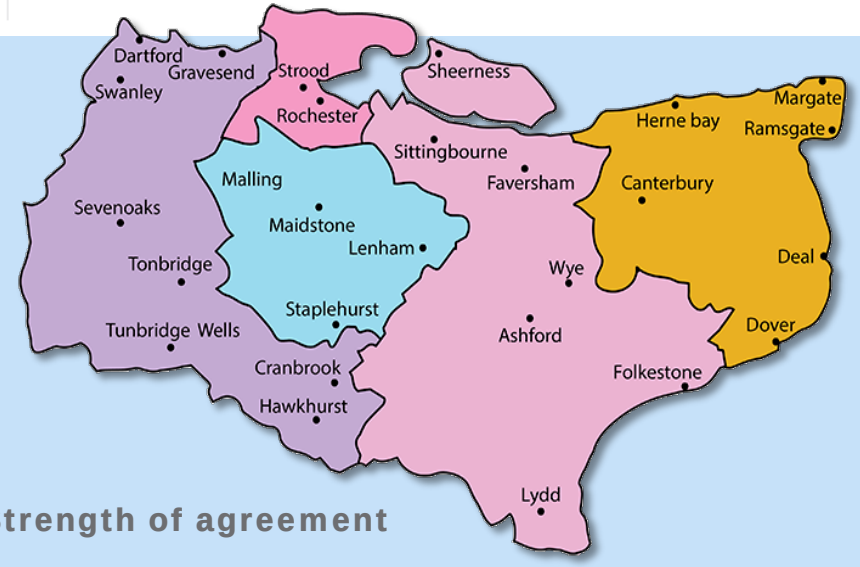
Q04: How strongly do you agree or disagree with the following statements about the proposal?

I cannot see any benefit in creating hyper acute stroke units to care for all stroke patients across Kent and Medway



Highest amongst those aged 65-74 (24%)

	Open to the concept	Less open to the concept
NET agree	9%	100%
NET disagree	81%	0%



Strength of agreement

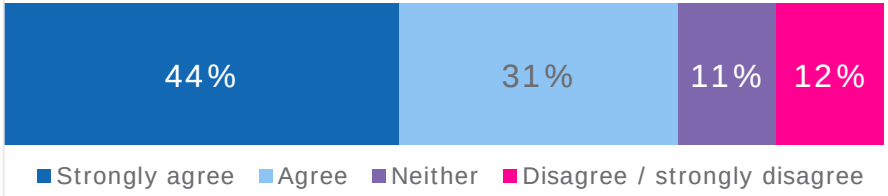
- Highest in Rother Valley (25%)
- Lowest in Hastings (6%)

30 Q04: Base: All respondents = 701.

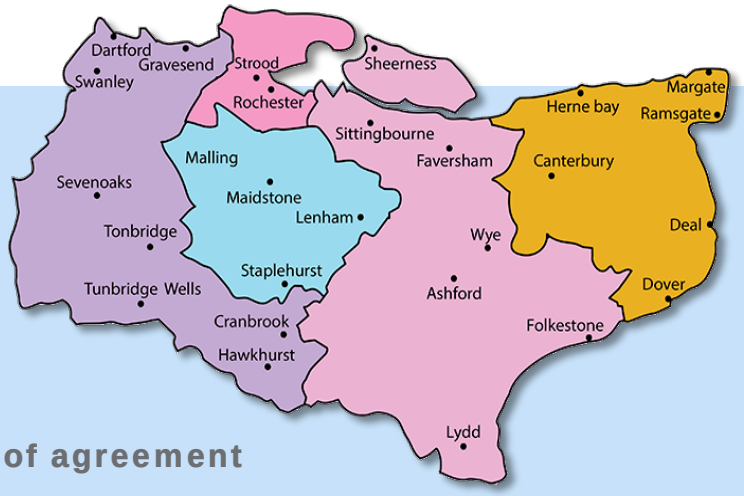
NET agreement: locating acute units, mini stroke clinics and HASUs together

Q05: How strongly do you agree or disagree that it makes sense to locate acute stroke units and mini stroke clinics on the same sites as hyper acute stroke units?

It makes sense to locate acute stroke units and mini stroke clinics on the same sites as hyper acute stroke units



	Open to the concept	Less open to the concept
NET agree	83%	54%
NET disagree	6%	29%



Strength of agreement

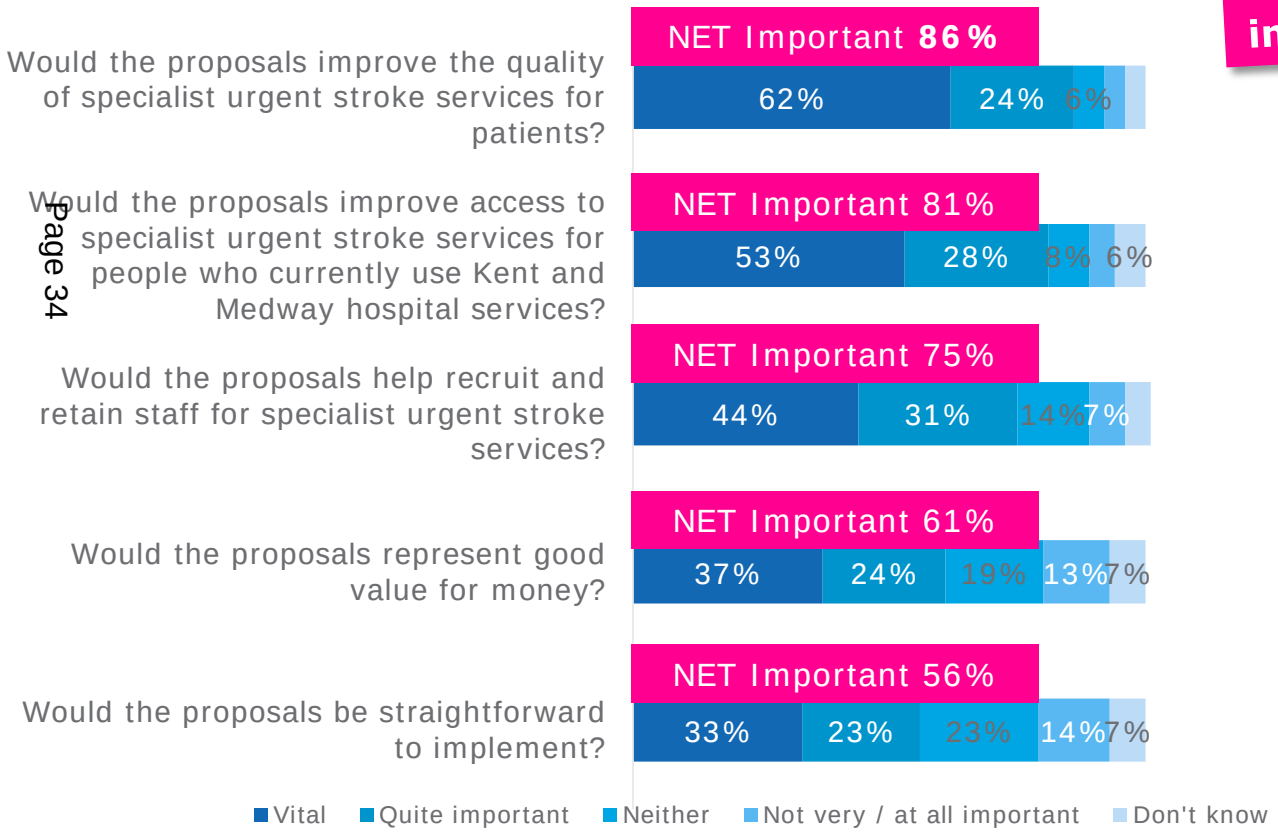
- Highest in Swale (88%)
- Lowest in Thanet (57%)

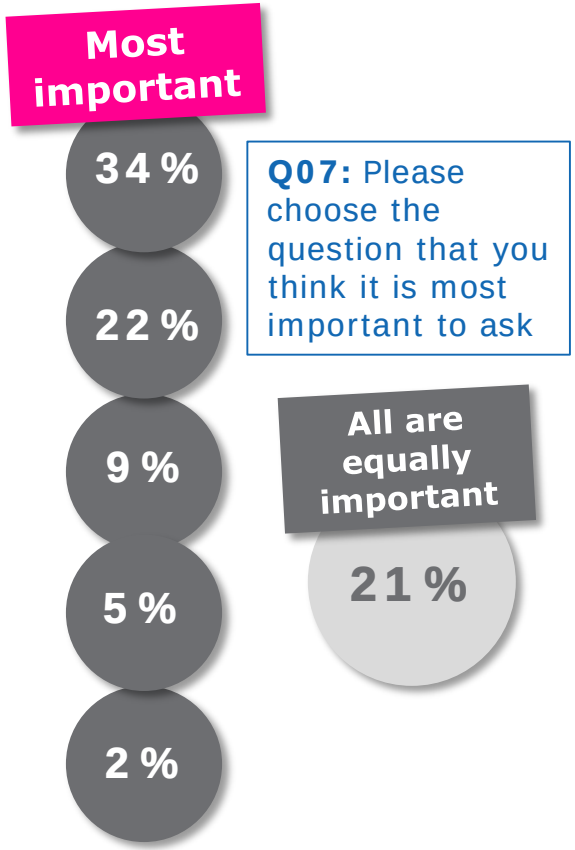
 Q05: Base: All respondents = 701.

Important factors

For respondents, the key question to ask in order to assess the proposals is whether they will improve the quality of services. They are less concerned about the logistics.

Q06: Please can you say how important you think it is to ask each of the following questions?



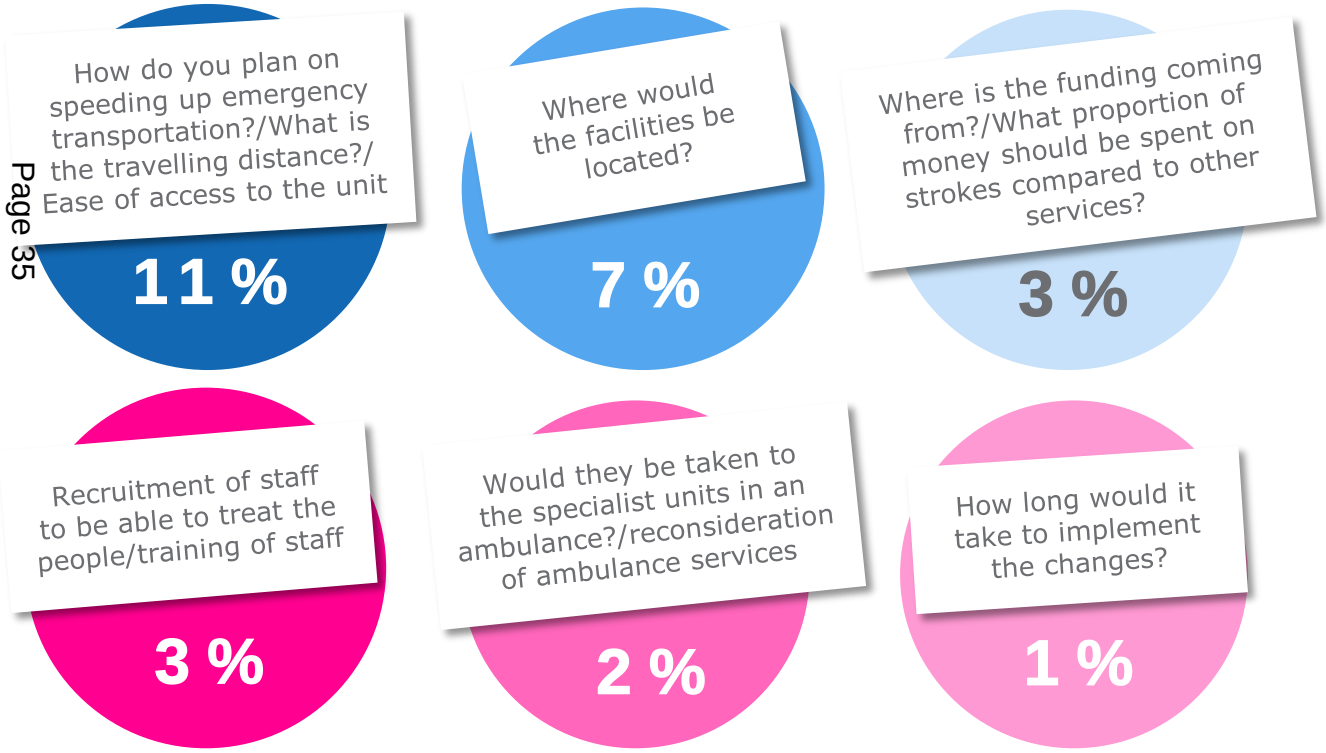


32 For clarity figures of =<5% are not shown on the chart. Q6: Base: All respondents = 701. Q7: Base: All respondents = 70).

Nearly two thirds were unable to suggest extra questions to include in the review

However, issues around getting and accessing the HASU's were suggested by around one in ten.

Q08: Are there any other questions you think should be included?
Open response coded into themes



Other **14%**

No/can't think of any/no comment **65%**

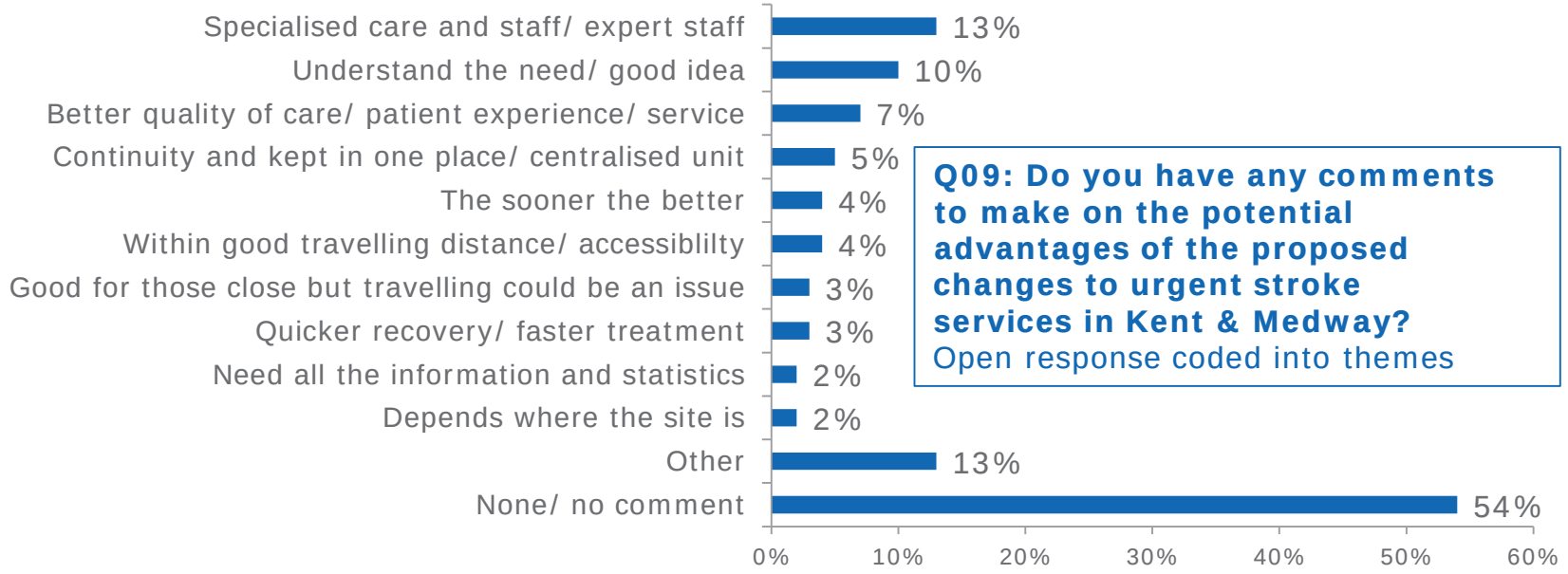
Where the hospitals are going to be. Location wise. It's a huge area to cover.

Accessibility of the 3 centres is the most important aspect.

Have we got the infrastructure to transfer people from A to B. If there is a shortage of ambulances, there is no point setting this service up for people who can't get there.

33 Q08: Base: All respondents = 701.

The potential advantages include…



Q09: Do you have any comments to make on the potential advantages of the proposed changes to urgent stroke services in Kent & Medway?
Open response coded into themes

It's always good to have lots of specialists so you can get the best treatment.

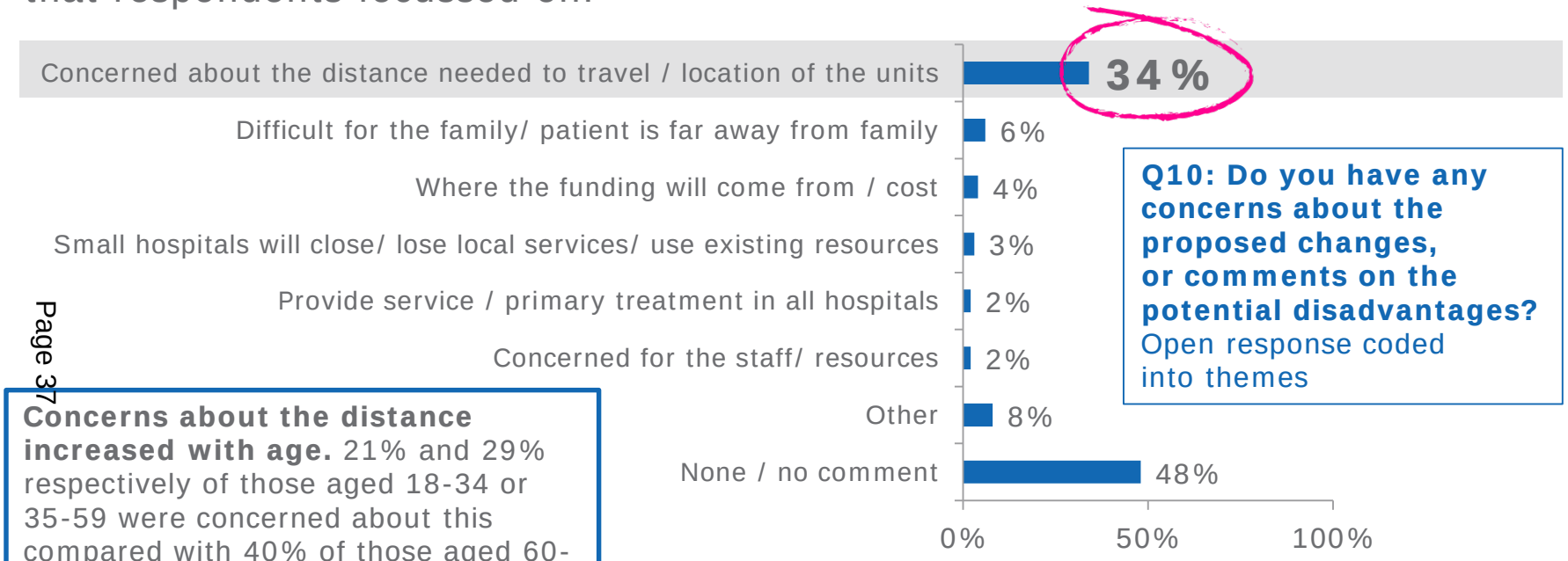
Sounds like a good idea. You need a specialist unit who know what they are looking out for.

I can see that it has benefits, if they split it off from main hospitals it may free up other staff at the main hospitals.

34 Q9: Base: All respondents = 701.

One main concern is apparent

While just under half did not raise any concerns, travel was again the issue that respondents focussed on.



Q10: Do you have any concerns about the proposed changes, or comments on the potential disadvantages?
Open response coded into themes

Concerns about the distance increased with age. 21% and 29% respectively of those aged 18-34 or 35-59 were concerned about this compared with 40% of those aged 60-64 or 42% of those aged 65-74

Only having 3 places is going to create a lot of problems on journey times

It's difficult for family especially for people who are in hospital long term, and people who struggle to afford the costs of travel for example.

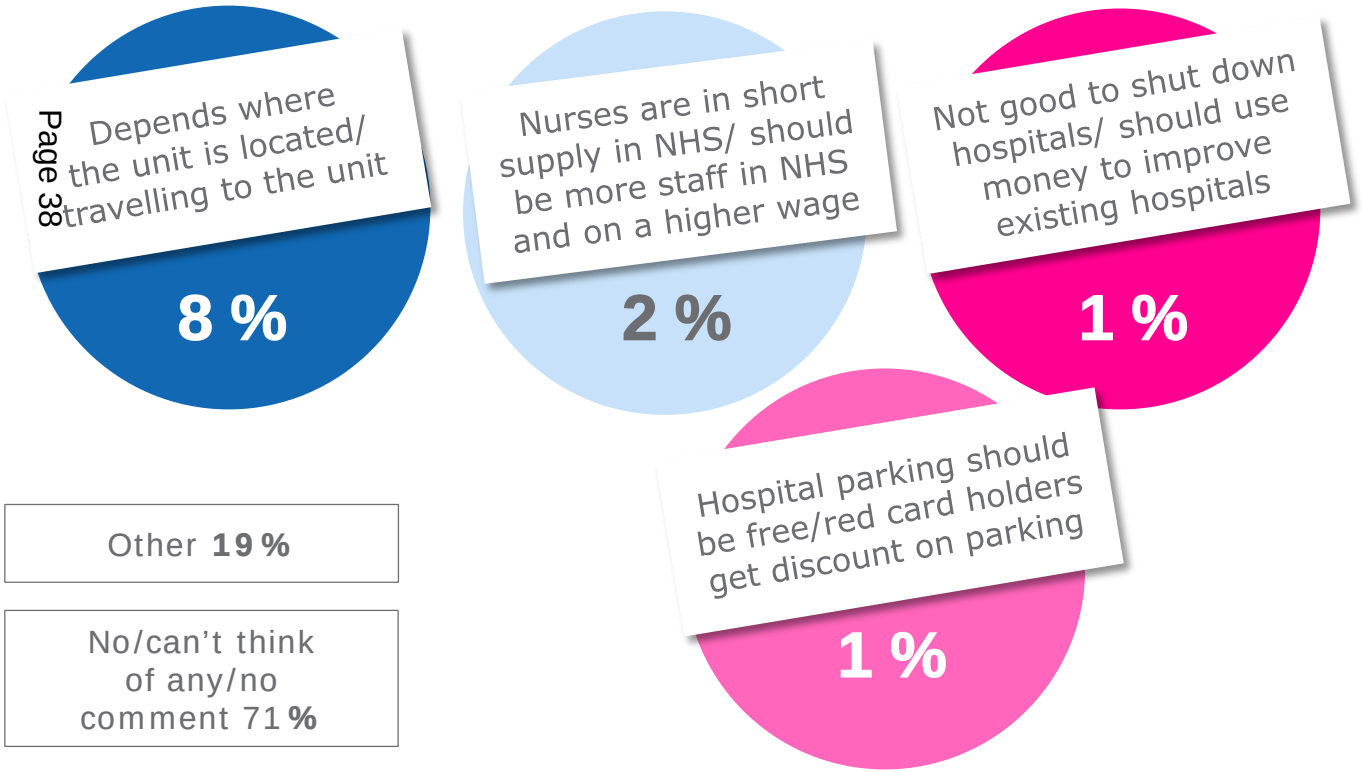
Can the local population access it and is there enough staffing?

Q10: Base: All respondents = 701

When asked to make a final comment...

Location and travelling to the Unit received the final word

Q11: Is there anything else that you think should be taken into consideration, or any other comments or suggestions that you would like to make? Open response coded into themes



Other **19 %**

No/can't think of any/no comment 71 **%**

The locations need to be really accessible to people and safe.

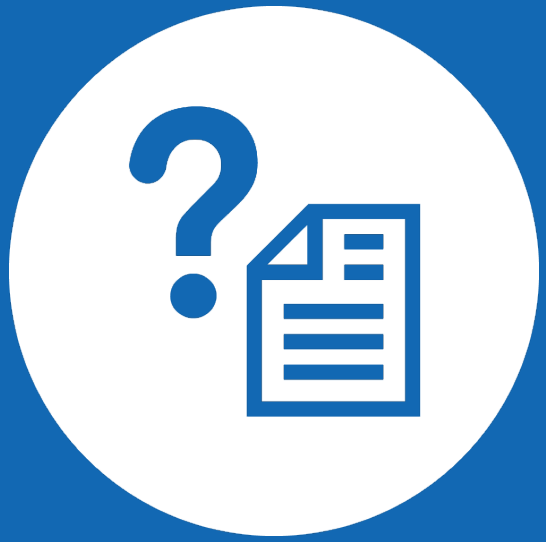
Immediate treatment is vital in most cases. That's what it all depends on.

Just the transport that bothers me. Need to assure people can get there as fast as possible.

36 Q11: Base: All respondents = 701.

Quantitative research

- Online survey
- Paper questionnaires



Methodology

Online survey

2,240

- Hosted on Survey Monkey
- Accessed via a link on the stroke services consultation page of the Kent and Medway STP website
- 2,240 completed surveys
- Average duration 10m:42s
- Survey open between 2nd February and 20th April 2018

Paper questionnaires

334

- Consultation document pull-outs
- Available from a variety of sources
- 334 returned surveys
- Some partially complete
- Data entered by DJS Research

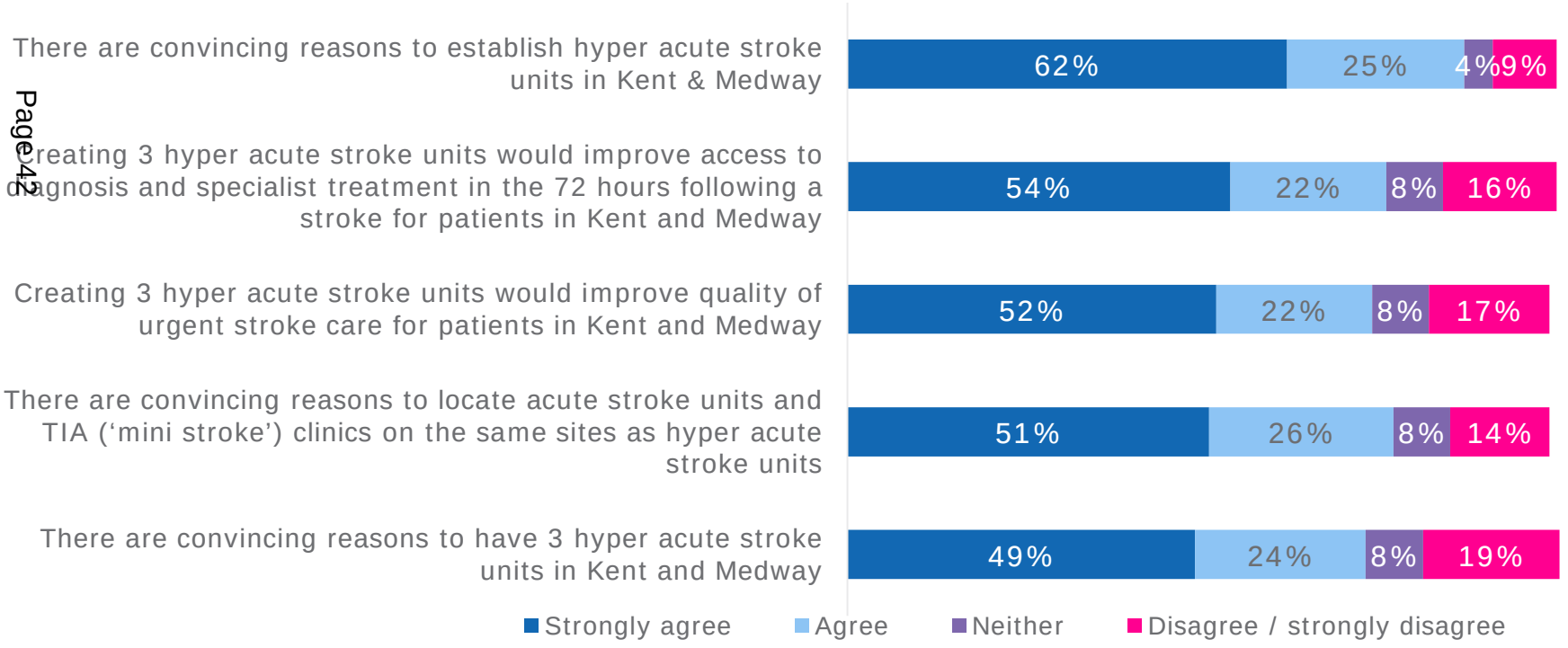
Key findings from the online survey & paper questionnaires

- The results align with the findings from the telephone survey with respondents again in agreement that there are convincing reasons to establish HASUs as it will improve the quality of urgent care and access to treatment, but concerned over travel times
- In terms of location, respondents preferred option A provided in the consultation document: Darent Valley, Medway Maritime and William Harvey
- Reach and accessibility were important to participants when making their choice
- The final words given by respondents in the survey again alluded to the importance of travel times

Overall opinions on the Units

In accordance with the telephone survey, participants who completed the online survey or a paper questionnaire generally **understood the logic behind the proposal** with the majority (87%) agreeing that there are convincing reasons to establish HASUs, and most (73% or over) agreeing with each remaining statement.

Q01: How strongly do you agree or disagree with the following five statements?

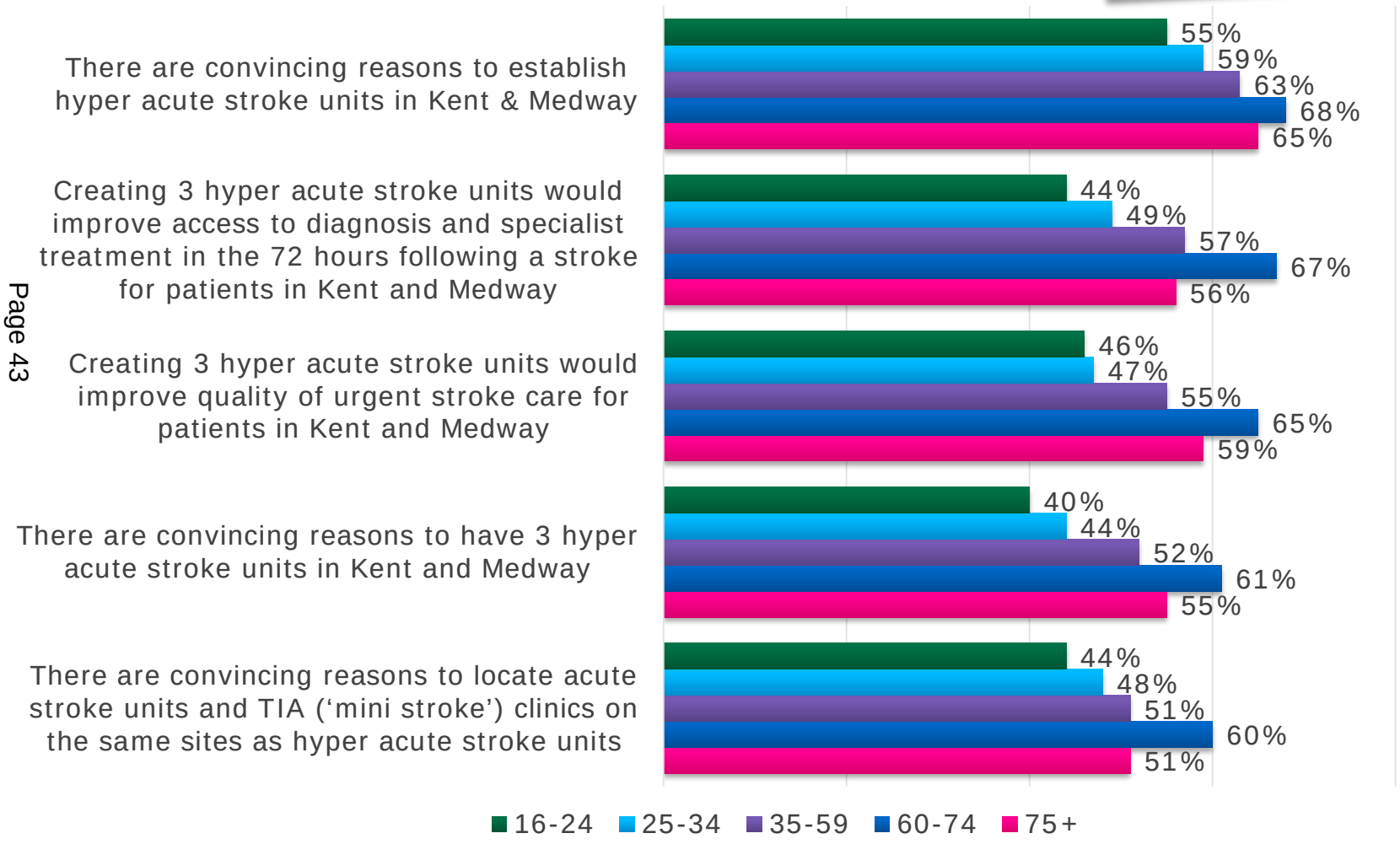


 Q01: Base: All respondents answering = varies between 2,484 and 2,501.

Age: strength of agreement generally increased with age

Q01: How strongly do you agree or disagree with the following statements?

Strongly agree

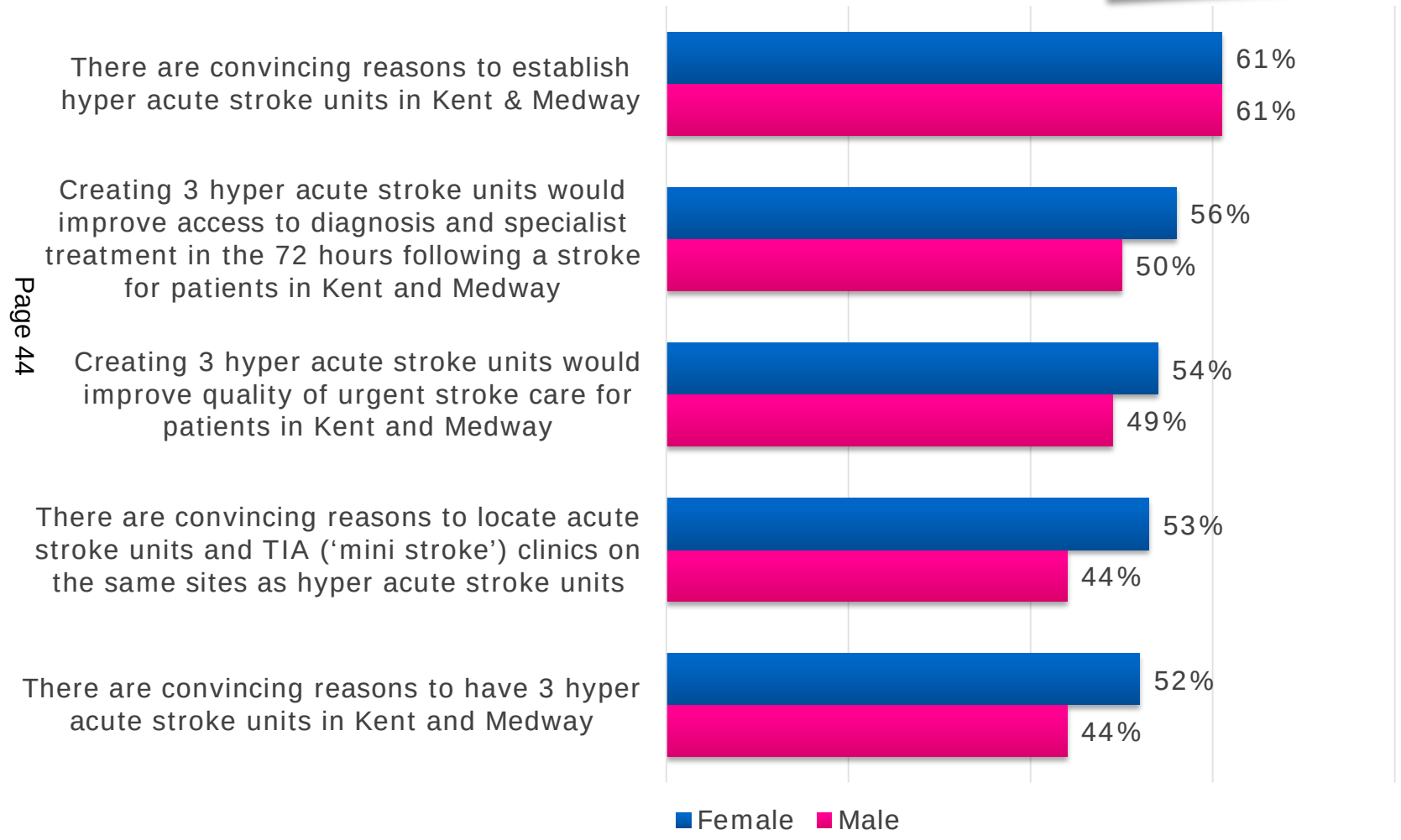


 Q01: Base: All online respondents = 2,240.

Gender: differences in opinion

Q01: How strongly do you agree or disagree with the following statements?

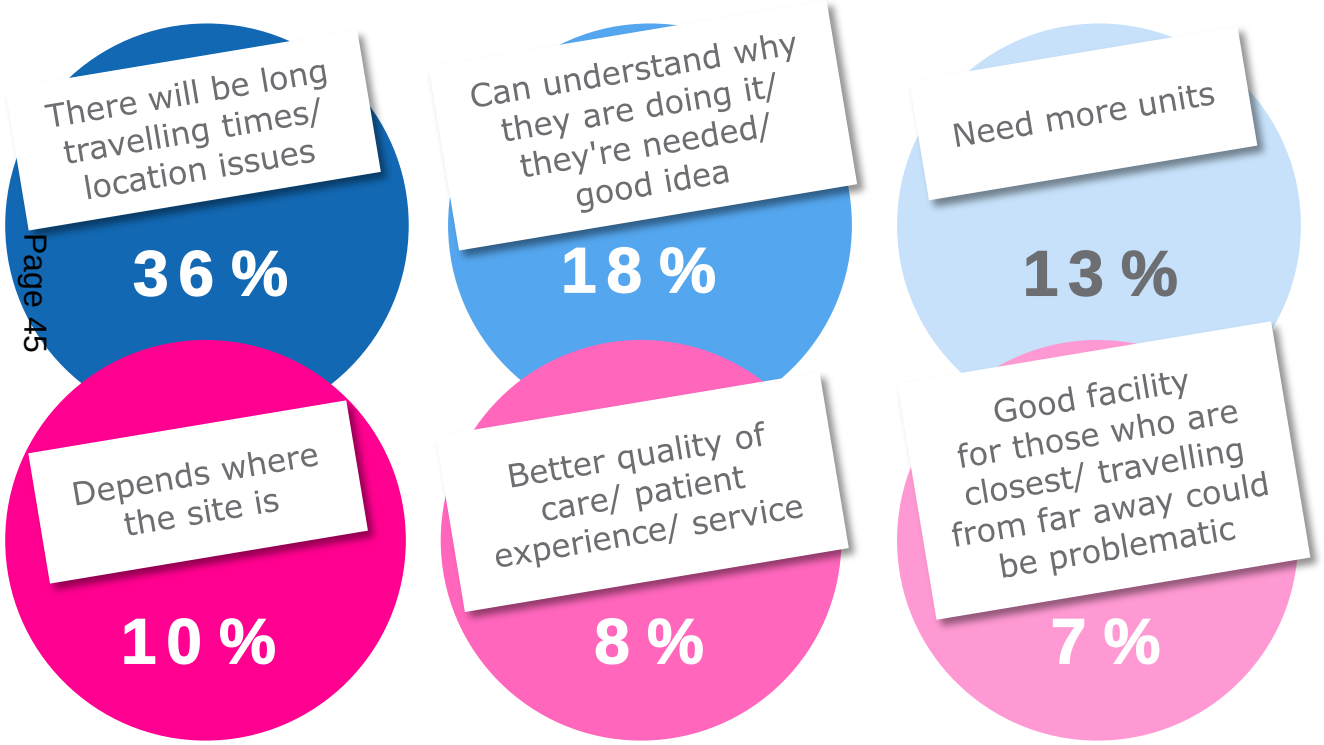
Strongly agree



 Q01: Base: All online respondents = 2,240.

Concerns over longer travelling times were apparent from early in the survey

Q02: Do you have any comments to make on the potential advantages or disadvantages of the proposed changes to urgent stroke services in Kent and Medway? Open response coded into themes



Those who live further away have further to travel, with the time between stroke and treatment being critical this could put people at risk.

I can clearly see the benefits of having all the specialist together in one specialist unit.

Other **13%**

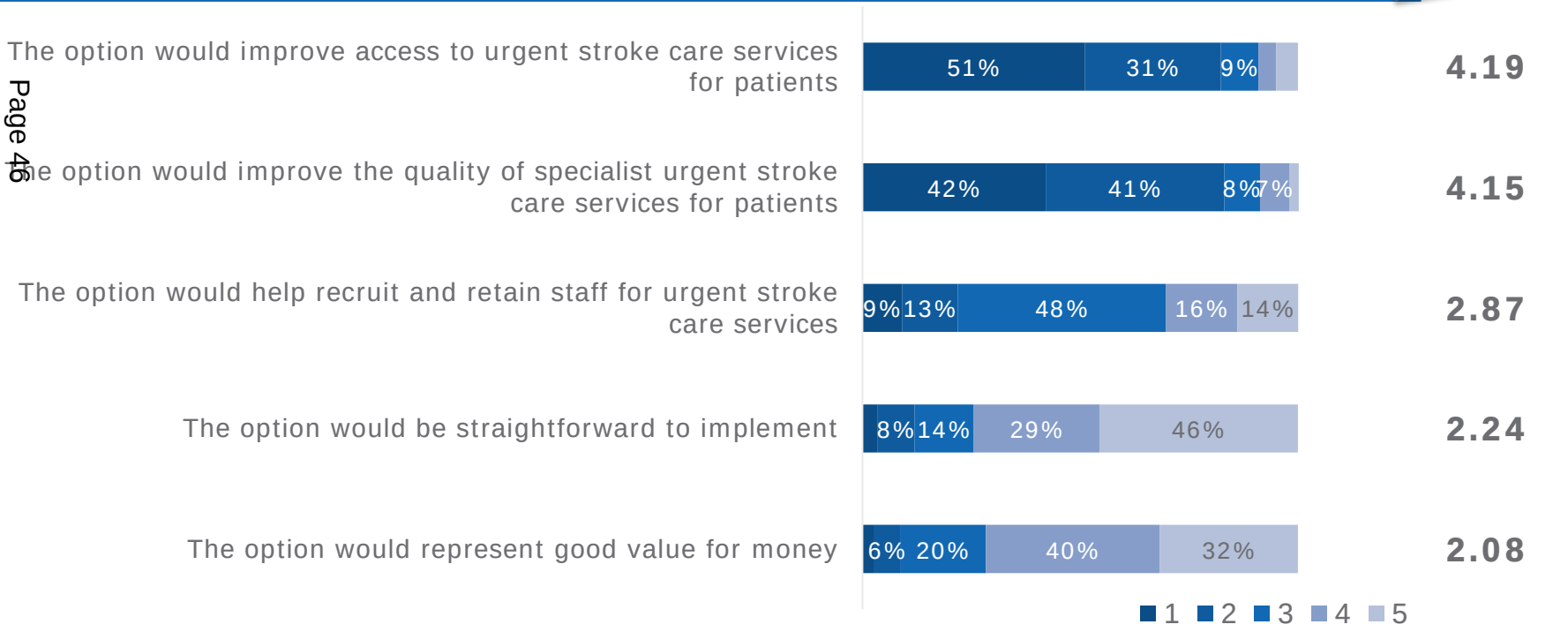
Quicker recovery/ faster treatment; Specialised care and staff/expert staff and Would be better to develop the current unit rather than build a new unit **all 6%**

 Q02: Base: All respondents answering = 1,515

What matters in the decision making?

In the opinion of respondents, the most important questions to ask when deciding on the location of the units are whether it will improve access to services and whether it will improve the quality of the care that will be provided.

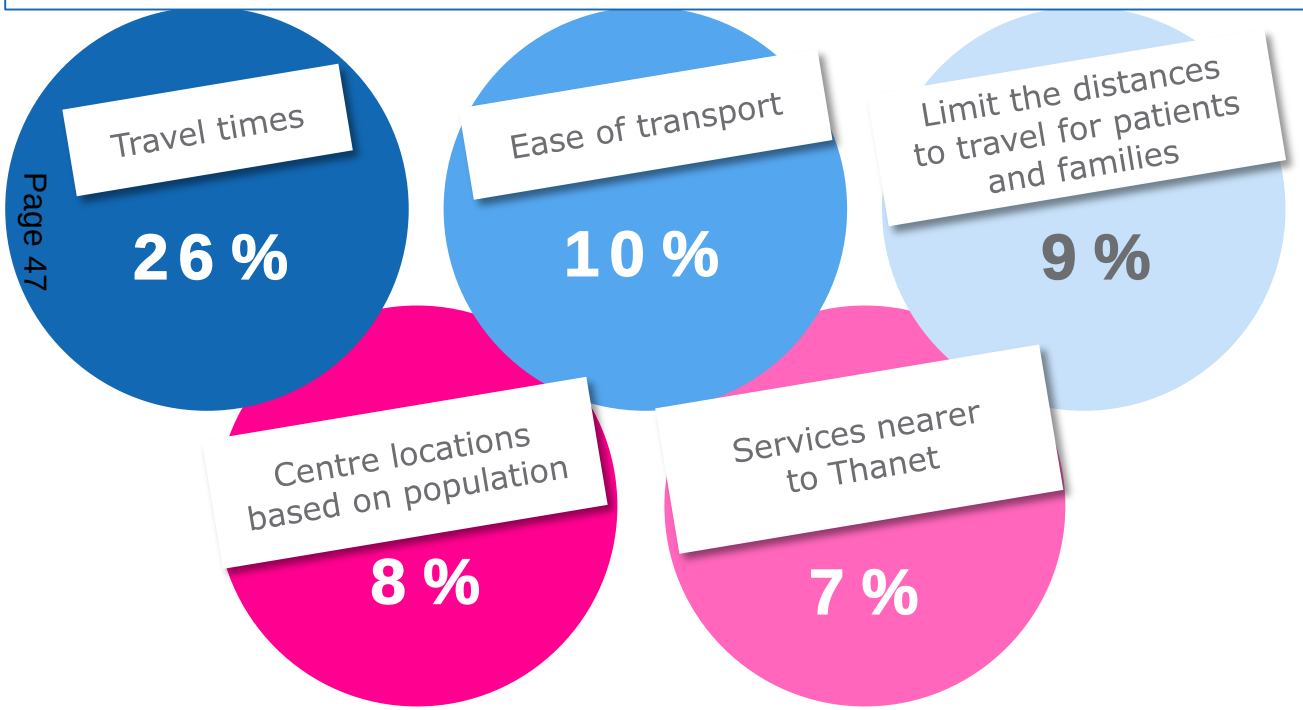
Q03: We have used 5 criteria to help weigh up the pros and cons of potential locations for hyper acute stroke units. Please rank the criteria in your order of importance, with one being the most important and five the least.



 For clarity figures of =<5% are not shown on the chart. Q3. Base: All respondents answering = varies between 2,117 and 2,284

When asked what should be involved in the decision making process, travel times were mentioned again

Q04: Are there any other criteria you think we should consider in our decision making? Open response coded into themes



The time to reach hospitals must not be too long and be detrimental to the patient.

Greatest need and easiest access. It's of no benefit having a unit geared up to respond quickly if people cannot get to it easily.

Other **33%**

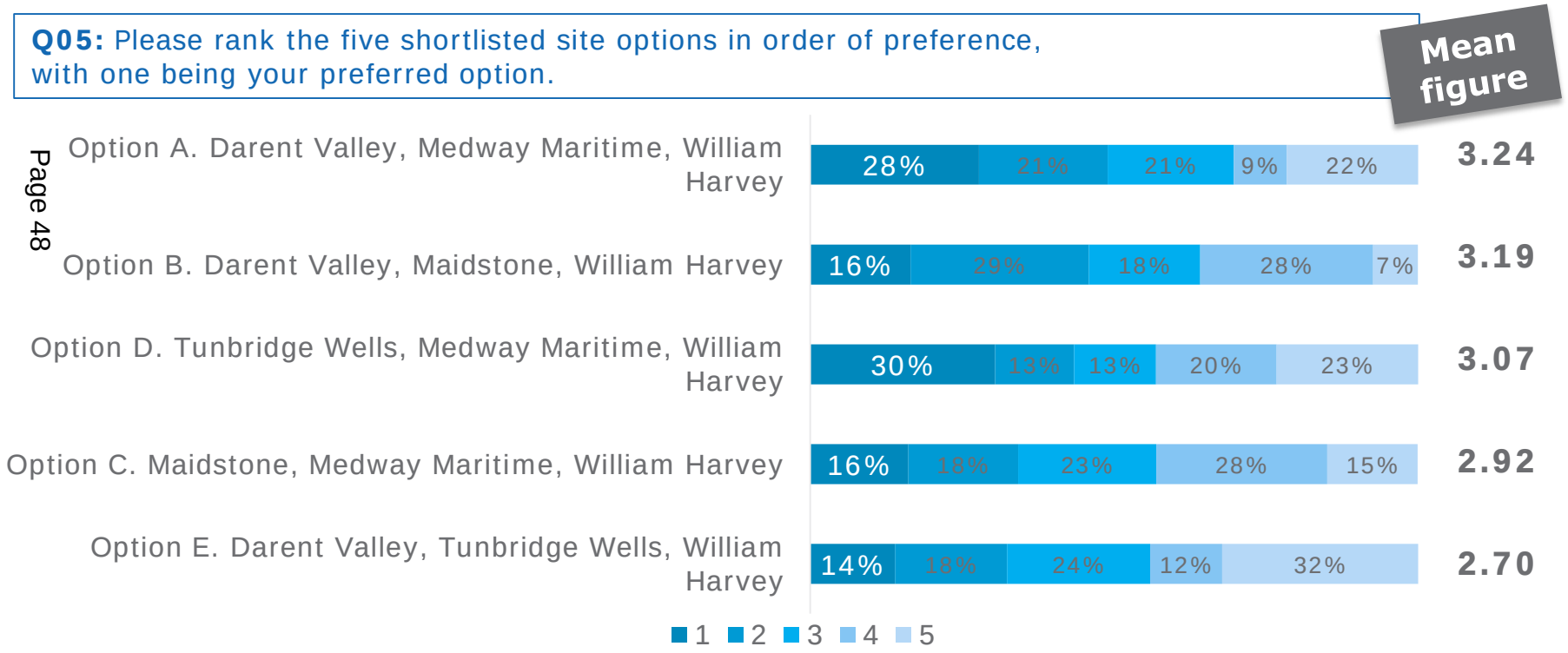
Ease of access to treatment and Have more centres in Kent **both 6%**

45 Q04: Base: All respondents answering = 1,163.

Preferred location – all respondents

The consultation document provided information on five possible site options and respondents were able to make an informed choice on where they would prefer the Units to be located. Whilst option A was the most popular choice there was no strong preference and participants' decisions are likely to have been influenced by where they live.

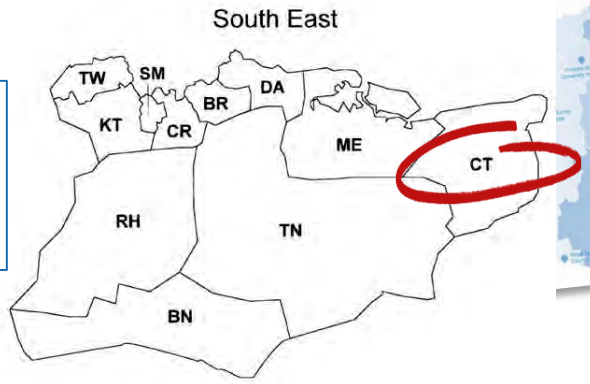
Q05: Please rank the five shortlisted site options in order of preference, with one being your preferred option.

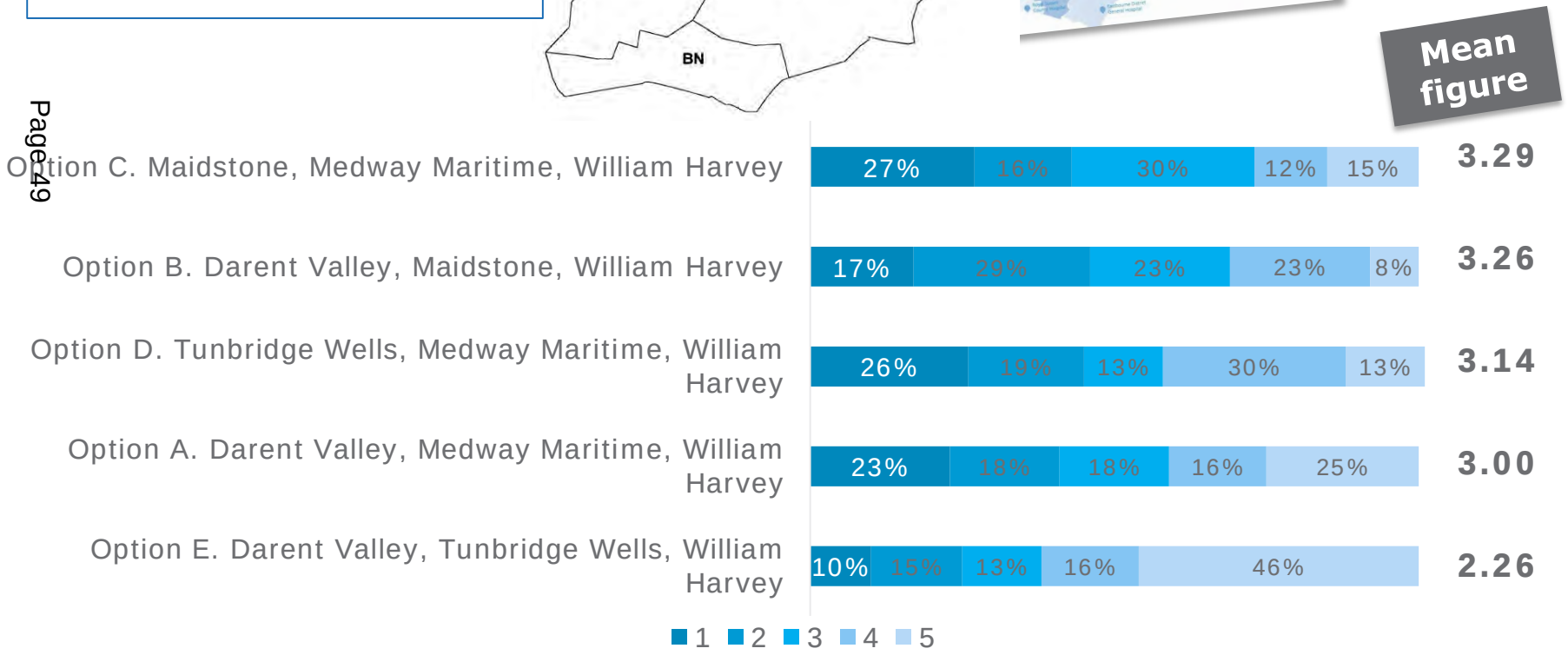


For clarity figures of =<5% are not shown on the chart. Q5. Base: All respondents answering = varies between 1,989 and 2,030.

Option C - Preferred by those living in the CT postcode area

Q05: Please rank the five shortlisted site options in order of preference, with one being your preferred option.

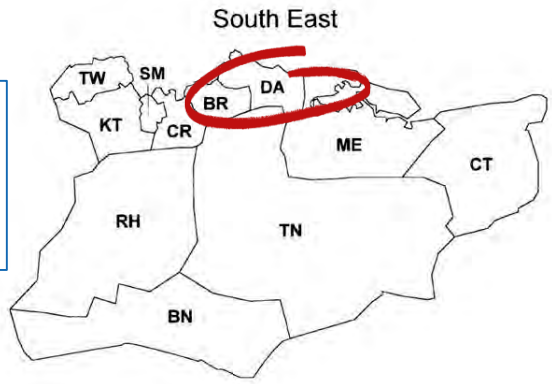


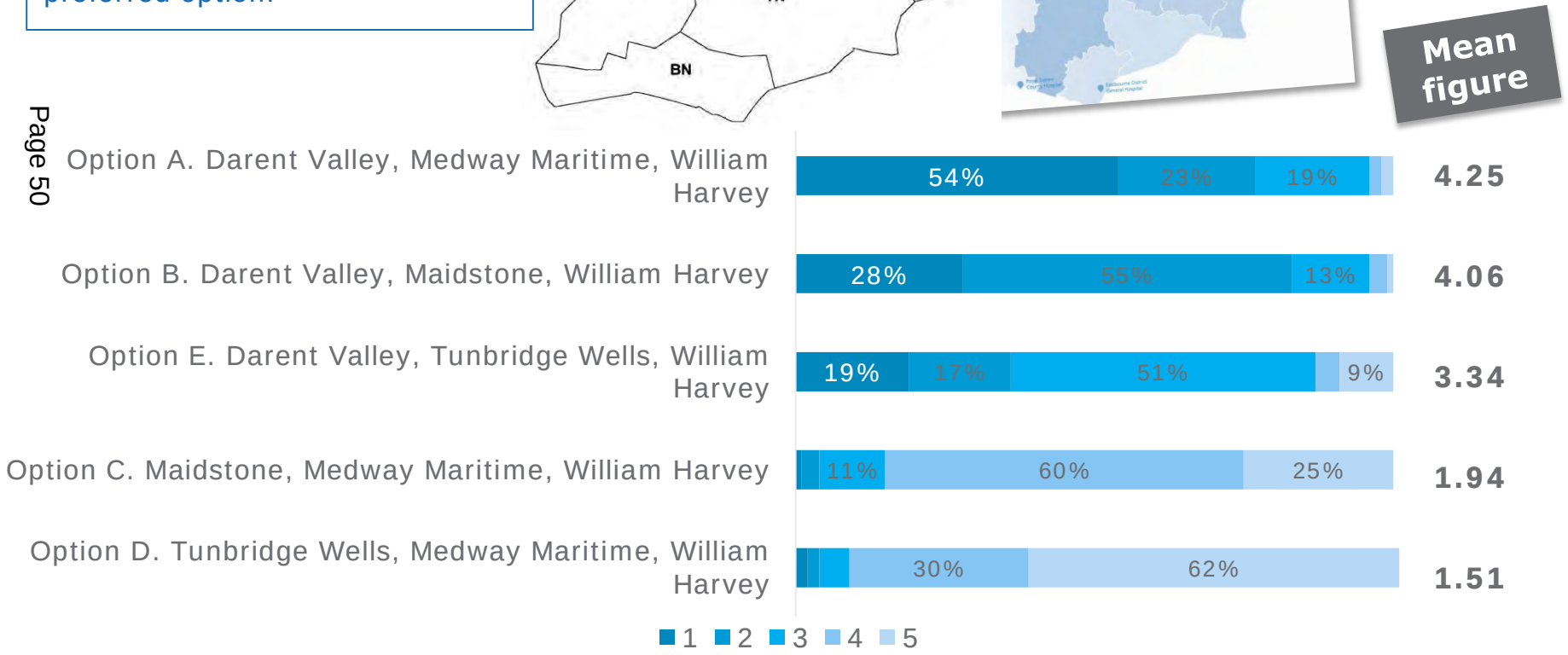


Q5. Base: Respondents in the CT postcode area answering = 310

Option A - Preferred by those living in the DA postcode area

Q05: Please rank the five shortlisted site options in order of preference, with one being your preferred option.

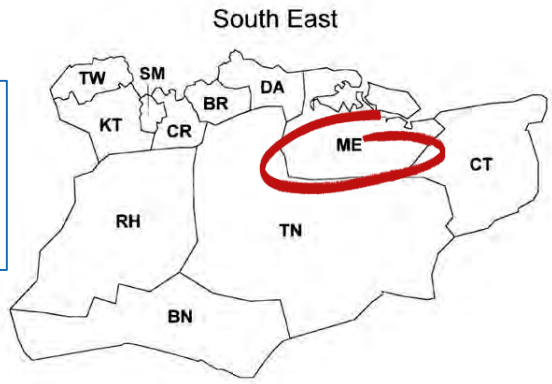


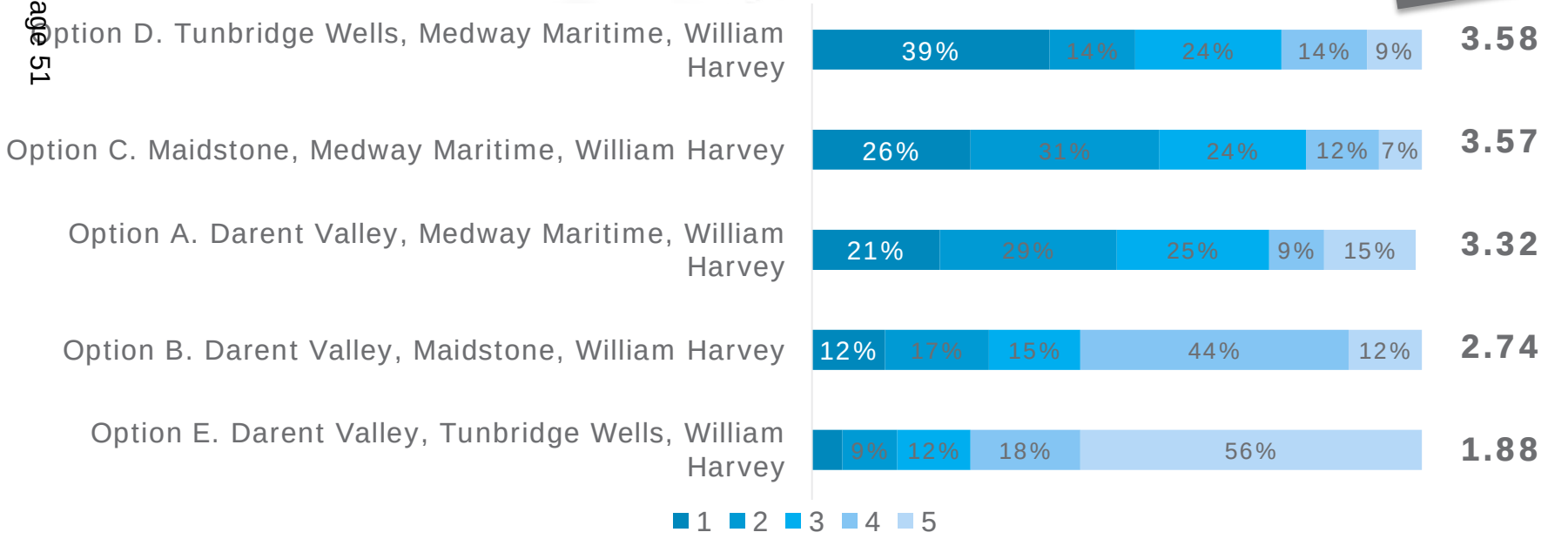


Q5. Base: Respondents in the DA postcode area answering = 492. For clarity figures of =<5% are not shown on the chart.

Option D - Preferred by those living in the ME postcode area

Q05: Please rank the five shortlisted site options in order of preference, with one being your preferred option.

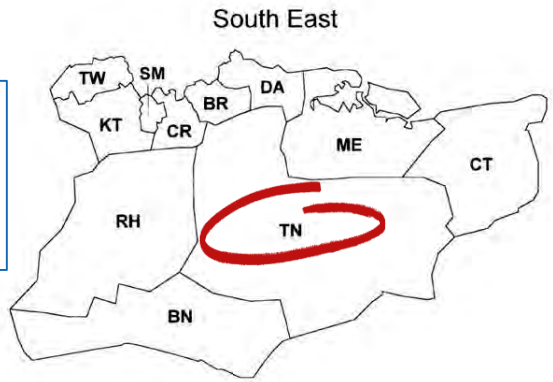


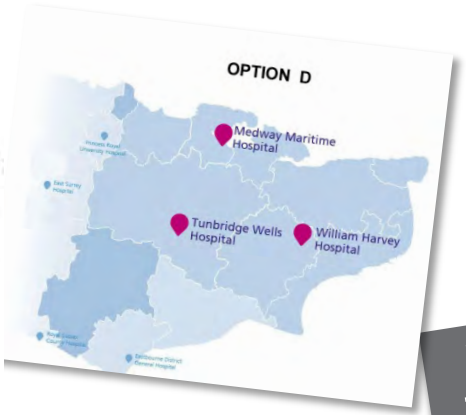


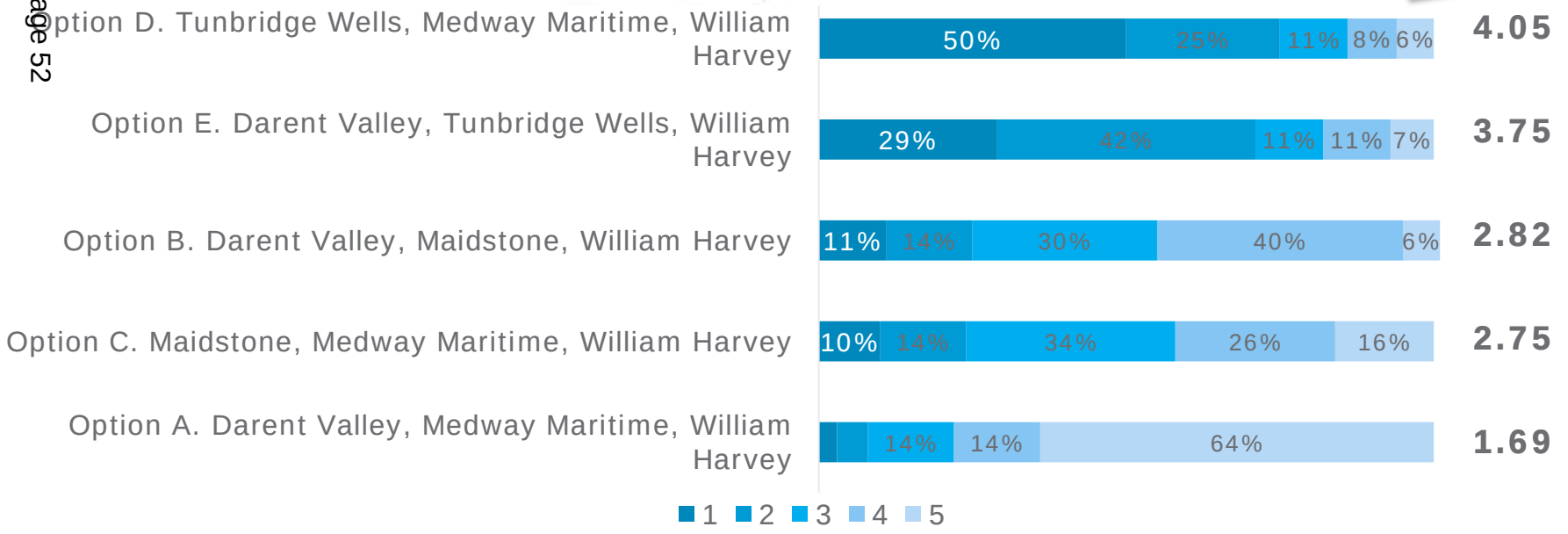
Q5. Base: Respondents in the ME postcode area answering = 643. For clarity figures of =<5% are not shown on the chart.

Option D - Preferred by those living in the TN postcode area

Q05: Please rank the five shortlisted site options in order of preference, with one being your preferred option.



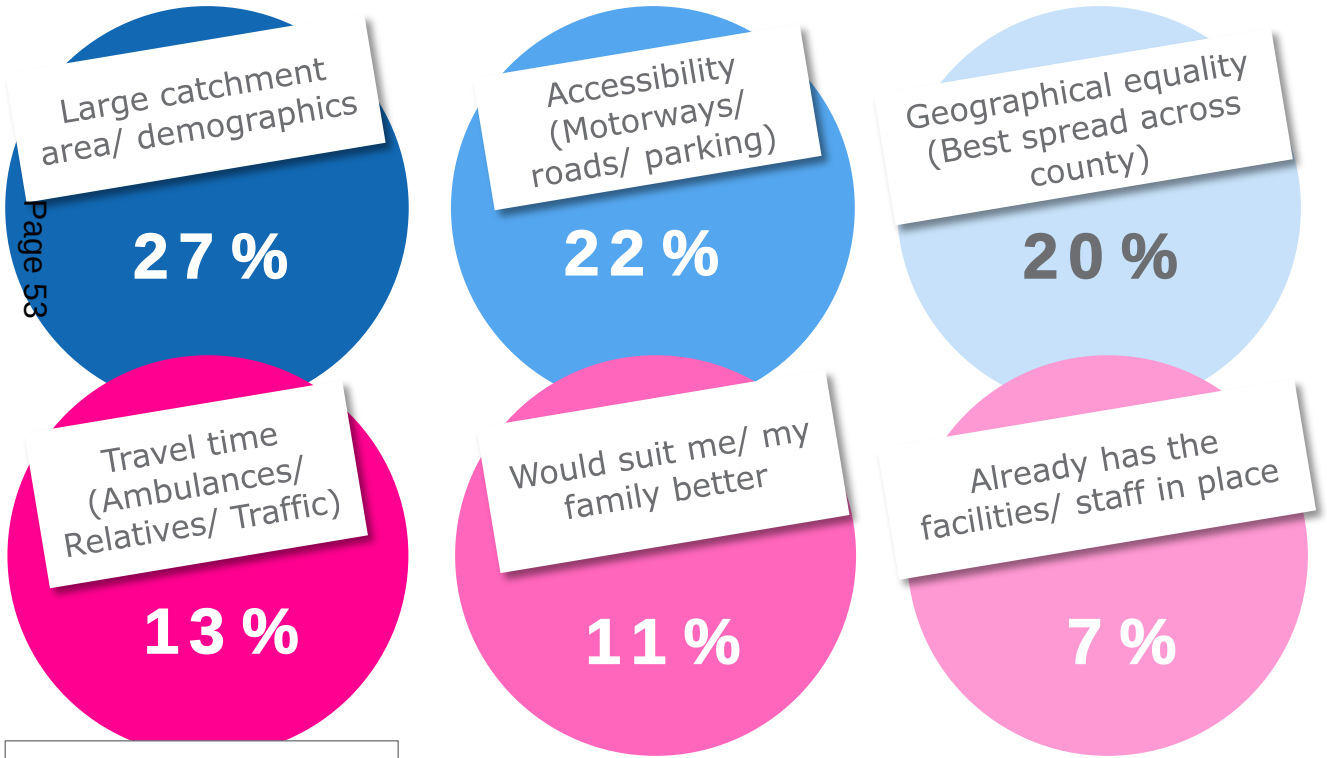




Q5. Base: Respondents in the TN postcode area answering = 315. For clarity figures of =<5% are not shown on the chart.

Reach and accessibility were important to respondents when ranking the five options

Q05a: Please tell us a bit more about why you have given this ranking.
Open response coded into themes



Other **5 %**

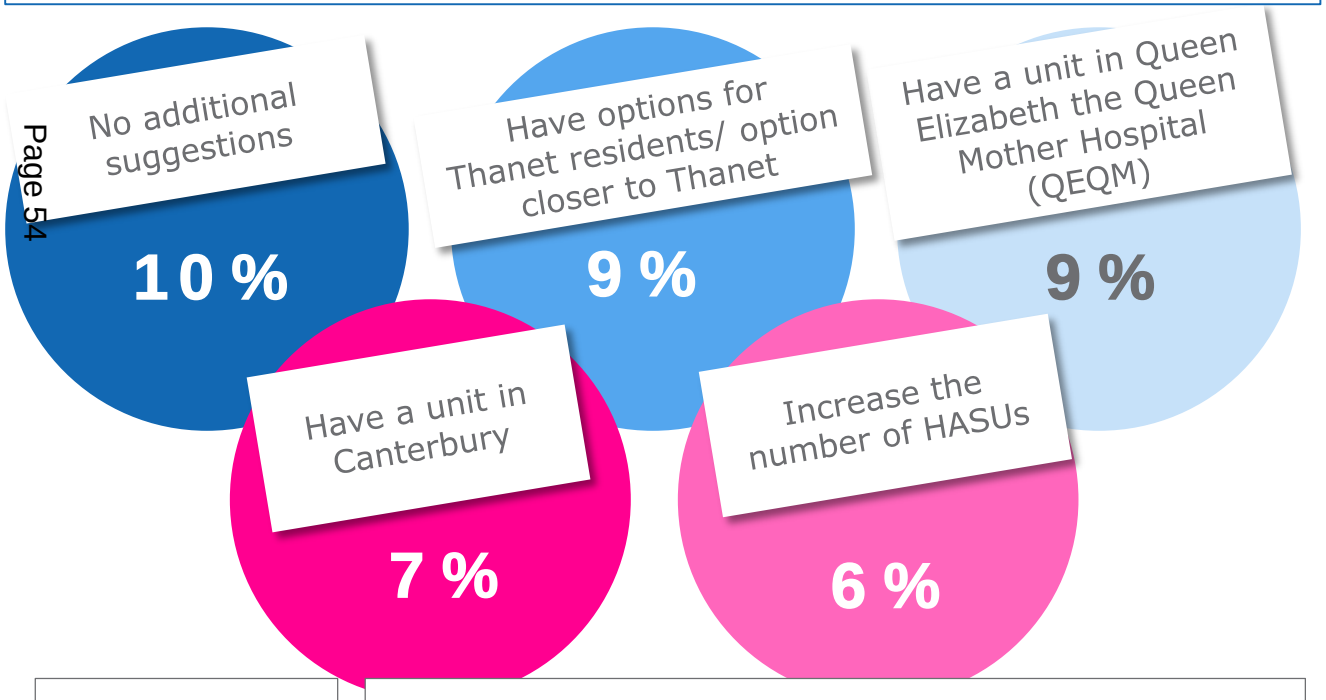
There is a very large population in Medway and it is set to grow if all the new developments go ahead.

Maidstone is an ideal location with good motorway access to most of Kent. Medway Maritime also has good access to the M2 for North Kent.

51 Q05a: Base: All respondents answering = 1,988

Respondents suggested additional sites for the Units, probably close to where they lived

Q06: Should we consider any other ways for how we organise specialist urgent stroke services in Kent and Medway, and/or where those services are located? Open response coded into themes



Other 35 %

Develop what already exists, Have good transport links for the units and Equally spread out the Units **all 5 %**

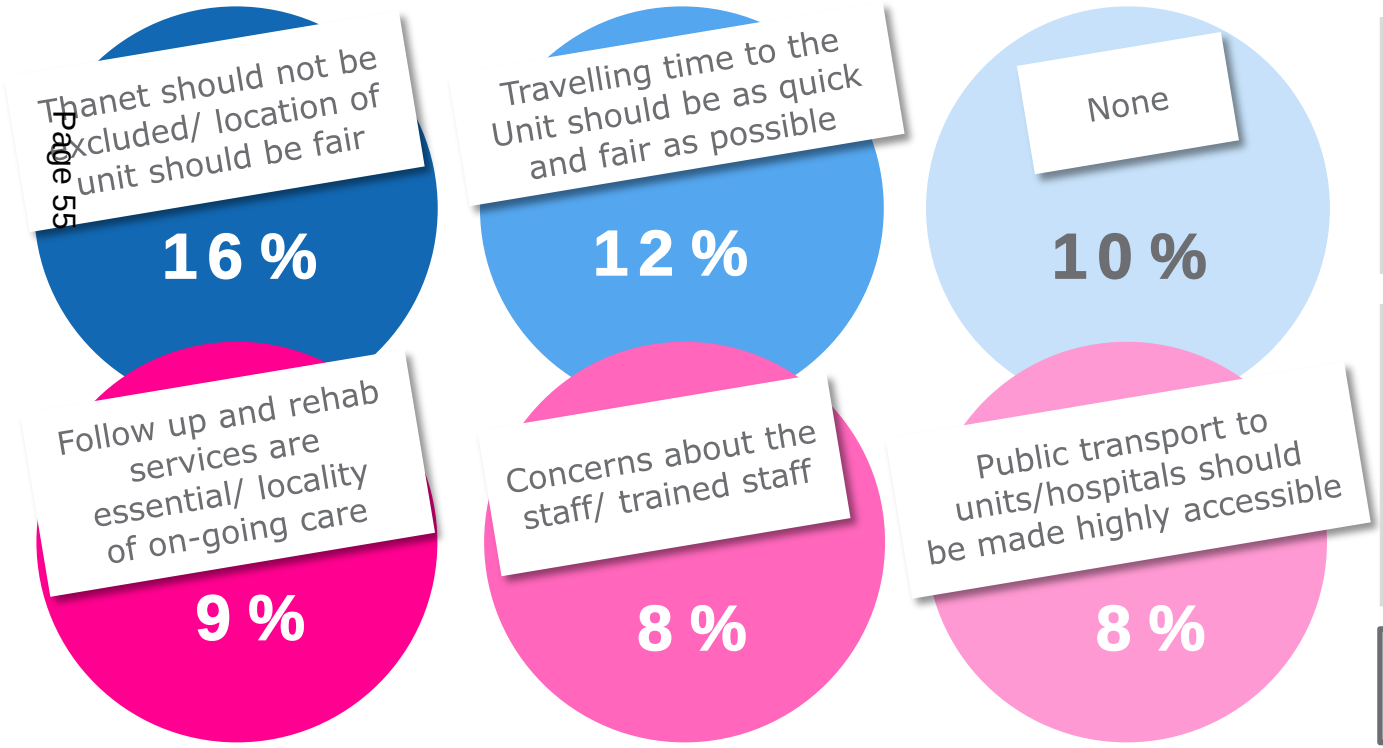
An option much closer to Thanet must be seriously considered, given the deprivation in the area and physical inability of residents to travel long and expensive journey distances for medical care.

Since there is nothing in the consultation for the residents of Thanet, there needs to be four HASUs in Kent, one of which at QEQM, Margate.

Q06 Base: All respondents answering = 1,296

Respondents' final comments again suggest that location and travel times are top of mind

Q07: When thinking about these proposals for stroke services in Kent and Medway, is there anything else you would like us to take into consideration, or any other comments that you would like to make? Open response coded into themes



Put QEQM on the list and save lives. Don't sell Thanet short

Journey times out of areas such as Margate in the Summer months, even on blue lights will be long.

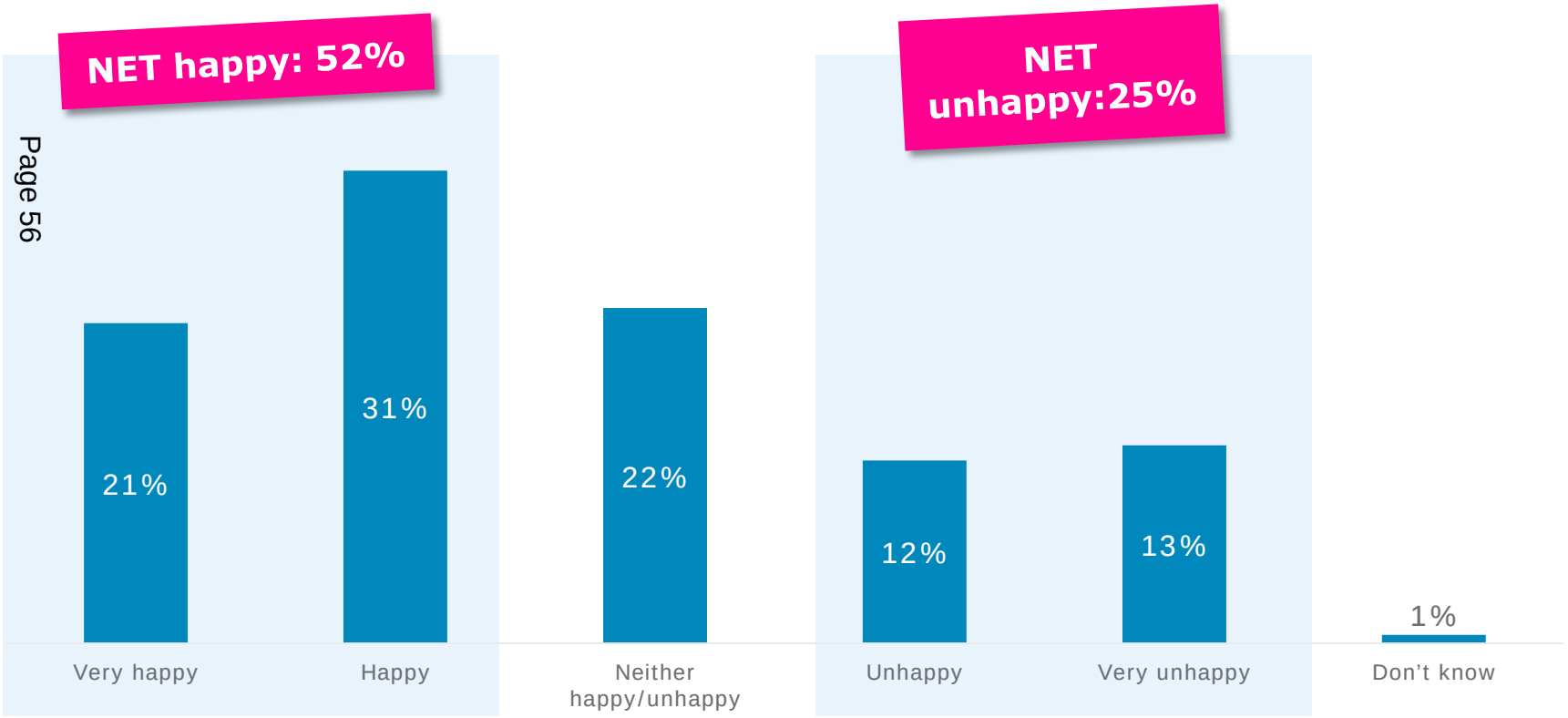
Other **19 %**

Q07: Base: All respondents answering = 1,168

Satisfaction with the consultation

Over half are happy with the way they have been consulted about the proposals, and around a quarter have no opinion either way.

Q08: Please indicate how happy you are with the way you have been consulted with about these proposals



 Q8. Base: All respondents answering = 2,468.

Public consultation: Thematic analysis

Listening Events: locations

28 listening events took place in many locations across the consultation area:

- Ashford
- Bexley Heath
- Broadstairs
- Canterbury
- Crowborough
- Deal
- Faversham
- Folkestone
- Gillingham
- Gravesend
- Heathfield
- Herne Bay
- Maidstone
- Margate
- Minster
- Minster on Sea
- New Romney
- Robertsbridge
- Rochester
- Romney Marsh
- Rye
- Swanley
- Thanet
- Tonbridge
- Whitstable

The analysis also includes questions and comments made at the following meetings:

- CHEK AGM
- Faversham Health Matters, Hawkhurst PPG
- Maidstone Older People Forum
- Tunbridge Over 50s Forum
- GP monthly meeting

Full details of dates and locations of the Listening Events can be found at: https://kentandmedway.nhs.uk/stroke-consultation-listening-events/

Listening events: structure

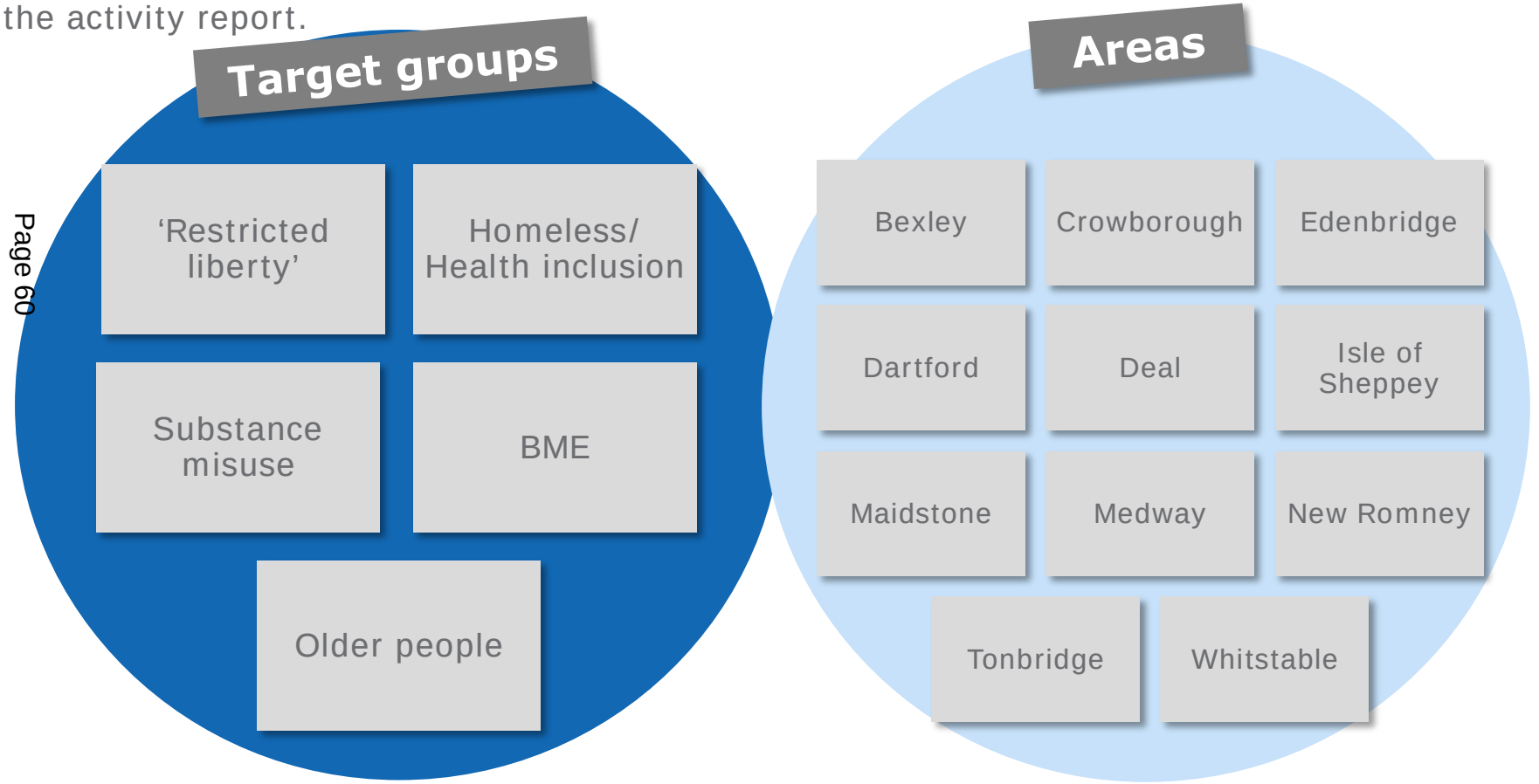
The listening events followed a broad structure which is outlined below. The format was tailored at some events either because there were only a small number of attendees, or because campaigners requested the whole time was dedicated to a Q&A format, without table discussions. NHS organisations that are consulting with the public have a statutory duty to ensure that the public have information on the proposals thy are consulting on. To meet this requirement, each listening event began with a short **presentation** covering key points from the consultation document and supporting information: https://kentandmedway.nhs.uk/stroke-consultation-documents/

- A **Question & Answer** (plenary) session
  - Although detailed notes were taken during these sessions, some of the quotes included in this report for reference or illustration purposes may not be completely accurate
  - Written question cards were available and have been included in the analysis

- **Table discussions** centred around several key questions. Responses to these questions were captured by facilitators and fed into this analysis:
  - Q1: Do you think there is a clear case for changing the way we deliver stroke services?
  - Q2: Do you think there should be hyper acute stroke units in Kent and Medway?
  - Q3: Do you think that three would be the right number for Kent and Medway?
  - Q4: Do you have a preference for any of the five options?
  - Q5: Are there any other options that we should be considering that we haven't already discussed?
  - Q6: Is there anything else we should consider?

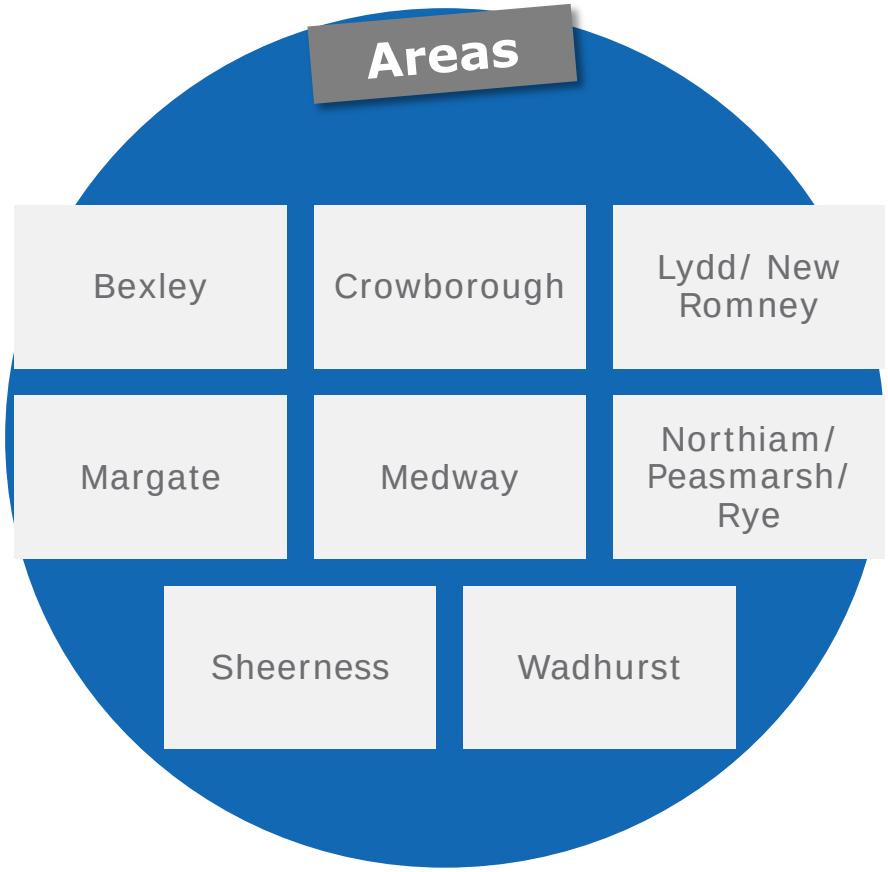
Outreach engagement

Engage Kent were commissioned to undertake engagement activities with community groups who experience barriers to accessing services or are under-represented in healthcare decision making, to ensure their voices are included in the consultation. 171 people were engaged in these outreach visits. More detail about this work can be found in the activity report.



Public focussed conversations

Engage Kent were commissioned to undertake engagement activities with working and older aged residents who had not already been engaged in the other public consultation events. Participation in these groups was weighted by age and other health conditions that could increase the risk of stroke. A total of 94 people attended these groups.



Outreach Engagement, Focused Conversations & Street Surveys

Engage Kent undertook face to face engagement activities with **442** members of the public.

Outreach engagement – 171 people

Talking to targeted community groups who experience barriers to accessing services or who are under-represented in healthcare decision making.

Street surveys – 116 people

Took place in targeted geographic areas to engage with rural communities.

Public focused conversations – 94 people

To explore the consultation proposal in more depth with mixed groups of working and older age groups

Street surveys in Margate – 61 people

Talking to a random sample of shoppers in Margate over a 2 hour period to gather a sample of views and thoughts on the consultation.

81 of the people spoken to had previously heard about the consultation through other routes including local news and six people had participated in another public event, with five people having already completed the online consultation response.

Key themes from the Public Consultation

Part 1

This section summarises the key themes from the following public consultation activities:

- Q&A sessions of the Listening Events
- Question cards filled in at Listening Events
- Table discussions at the Listening Events
- Public meetings
- Outreach engagement and public focus groups
- Letters and email correspondence from individuals

Examples of questions asked and answers given are also included for reference.

Please note that this report analyses the volume of opinions held at a **personal** level from members of the public, campaign groups and staff currently working in Stroke Services. Formal responses from **organisations, campaign groups or professional bodies on behalf of their membership** have not been included in the analysis but have been considered as part of the wider consultation exercise. A summary of these formal responses can be found at the end of the report for reference purposes.

Qualitative feedback: a quick summary

Do people agree with the proposal to establish HASUs?

- Overall, **people tend to agree** with the proposal to establish HASUs in Kent and Medway:
  - Current services are not good enough, and not on a par with other areas
  - Agree it is better to be treated by specialists
- Concerns are not generally **whether** HASUs should be established, but **where**
- Some questioned the existing evidence that shows HASUs provide better outcomes, and expressed a desire for further clarification of this

Is 3 the right number?

- **Many people understand** the argument that it would be **difficult to staff more than 3 units**, however some feel that staffing should not drive decisions, and that instead **more should be done to improve recruitment and retention**.
- Questions and concerns raised were generally around **where the proposed units would be located, the impact of these locations on residents** if there are three HASUs and whether the geography of the area means that **4 units would be better** in order to provide fair and equal care to all residents.

Opinions on the 5 options

- **Questions** were raised on the **decision making process** of the proposed locations.
- Of those expressing a preference for a particular option, many acknowledge that they **choose the option with their preferred hospital,** usually the one closest to where they live.
- **Many did not feel any option is suitable**, either because they feel there should be four units or because they think other hospitals should have been included.
- Many expressed a desire for **Kent & Canterbury Hospital** or the Queen Elizabeth the Queen Mother (**QEQM)** Hospital to be **re-considered** as one of the proposed sites.
- Residents often stated that the **other NHS reviews** and **the potential new hospital in Canterbury** should feed into the decision.

HASUs are a good idea in principle

Across all of the Public Engagement activities, many people are in favour of introducing HASUs in principle:

- Current services not performing well enough
- Better to be treated by specialists
- Stroke care in the area should be on par with other areas in the UK

Overall, there is a high level of agreement and understanding of the arguments put forward regarding the benefits of having hyper acute stroke units to Kent & Medway, in particular:

- 24-7 service
- Dedicated scanners
- Centralisation of specialist staff
- Less queuing in A&E – increase chances of receiving clot busting drug in time
- Better outcomes
- Easier to attract staff to specialist units

Good idea in principle

Example comments

What you are not saying clearly enough is that we don't have a 24-7 service now. You can go to QE but you won't necessarily get the treatment you need. With the new unit, 100% will get the right treatment. At QE, the CT you end up in a queue for the scanner with all the other patients.
Minster Listening Event (Q&A)

I am a stroke survivor. It is important to go straight to the right team and not the emergency department.
Ashford Listening Event (Table discussion)

I'm a stroke registrar and the difficulties we face on a daily basis – not having anywhere in A&E to see your patient, not being able to get your patient in a scanner because of other emergencies… I don't have anything to say on locations but I do have something to say on HASUs – they are brilliant.
Ramsgate Listening Event (Q&A)

It's a good idea to consolidate things in one place rather than spread them too thinly.
Outreach Engagement

A medic needs practice, they need patients coming through. If you spread it too thinly, they don't get the practice and they leave. We will only attract the best doctors and nurses if we have specialist units.
Canterbury Listening Event (Table discussion)

There is a case for change. We are not disputing that. We are questioning the rationale for the choice of locations.
Canterbury Listening Event (Table discussion)

However, for some the case for change is not completely clear

Some members of the public were unsure whether the there is a clear case for changing the way stroke services are delivered, and whether there should be HASUs in Kent & Medway:

- Some individuals did not feel they had **sufficient information or knowledge** to know whether the reasons for change are justified
- Some feel that investment may be better spent focussing across **the whole pathway,** and in particular on **prevention** and **after care**
- Concern over the potential **impact on other local services** of introducing HASUs

Specific groups and individuals **challenged the evidence** that HASUs improve outcomes and feel that the existing evidence is not necessarily applicable to the Kent & Medway area:

- Save our NHS Kent:
  - Disagree that evidence shows that centralisation of stroke services in HASUs improves death and disability outcomes
- Evidence from urban areas (such as London) potentially not applicable
- Evidence not based on those that do not get to a HASU on time, or who have to travel comparable distances to reach a HASU

Focus should be on the bigger picture

Several individuals are unsure that such a focus or investment should be made into one particular service, and rather that the NHS should instead be looking at the whole pathway from prevention to care in the community. Questions were also raised around how these plans fit into the other NHS reviews taking place, and why stroke services are being considered separately.

Example questions/comments

Why aren't you doing this as part of the wider review of the pathway? You'll spend all the money on this, but you need to do the follow up too, need to plan for discharge, look at all the bed-blocking. This isn't going to fix the problem.

Crowborough Listening Event (Q&A)

Investment needs to encompass the whole pathway, including rehabilitation.

Gillingham Listening Event (Table discussions)

You need to be thinking about every part of the process from prevention to discharge.

Crowborough Listening Event (Table discussions)

Summary of answers given

We are doing a lot of work at the moment redesigning primary care. The STP is a partnership and the STP is consulting on stroke at the moment. A second component of that will be the local East Kent acute plans and the local care plans. And another parallel piece of work is to look at improving the ongoing local rehab.

Prevention: example questions/comments

Invest in prevention

Wouldn't it be better if you could screen before for signs of stroke? By the time the patient gets to the front door, it's almost too late.
Ashford Listening Event (Q&A)

Is there a programme of prevention that is going alongside this?
Robertsbridge Listening Event (Q&A)

What is the cost of this vs the cost of prevention – how successful are we at prevention?
Canterbury Listening Event (Table discussion)

Prevention should be included in this.
Swanley Listening Event (Table discussion)

More should be done on advertising to help people know how to take care of themselves.
Gillingham Listening Event (Table discussion)

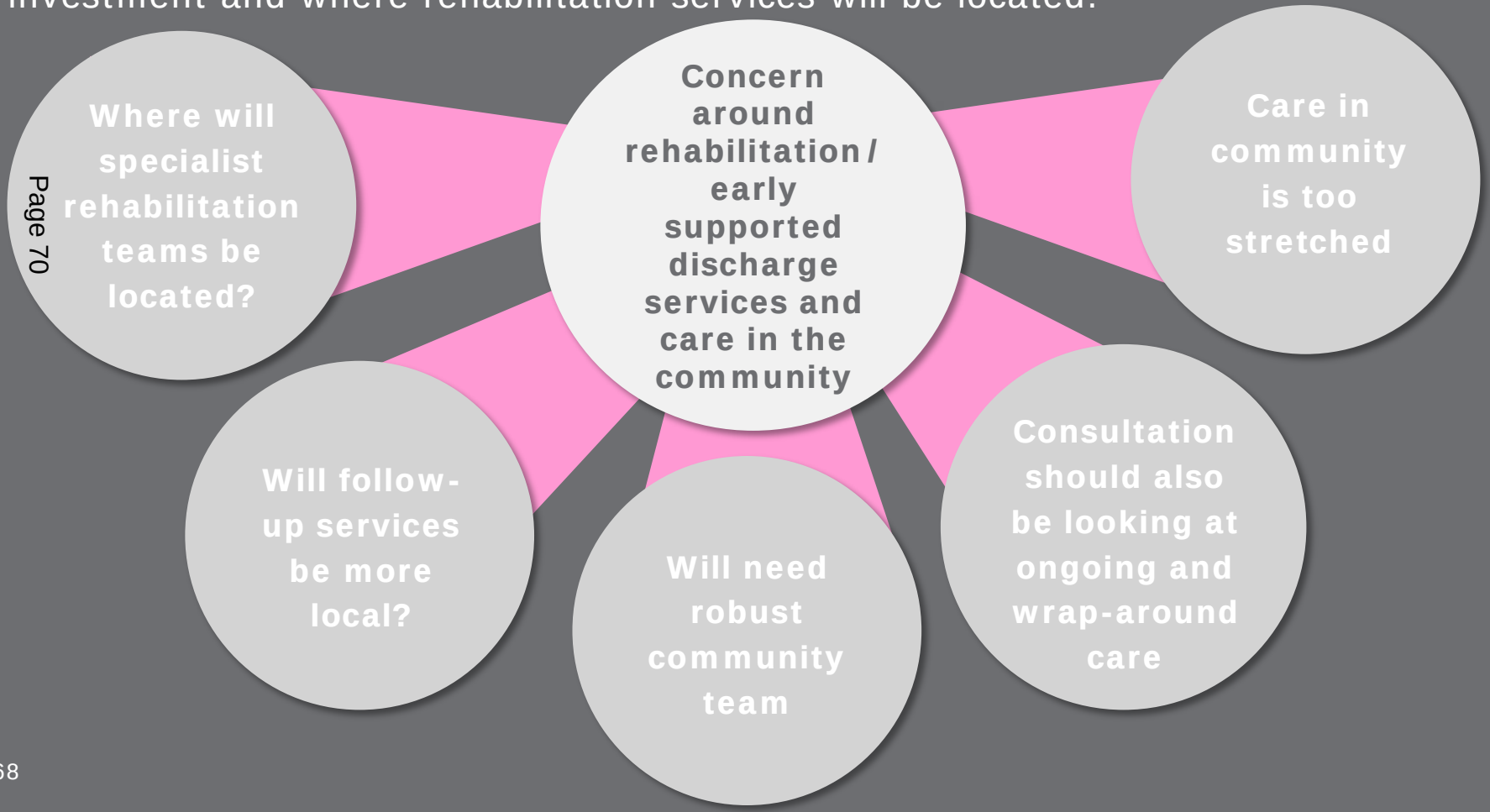
Summary of answers given

The things we can screen for are the risk factors, such as high blood pressure and atrial fibrillation, and we do have beneficial treatments for these. But there are some, around a third, that do not know the cause of strokes. Even with the best screening, people will still have strokes and in significant numbers.

There are primary care prevention programmes plus awareness raising, such as the 'One You' campaign.

There are particular concerns over after care

Although the consultation was about urgent stroke services, concerns were raised over whether rehabilitation services and care in the community will also receive investment and where rehabilitation services will be located.



After care: example questions/comments

Rehabilitation services

The core concept is good, but everything around it needs to be thought about as well, such as rehab.
Outreach Engagement

There is no indication where speech or physio facilities will be provided. *Email Listening Event (Q&A)*

We want rehab and social care to be part of the decision. We must make sure these services are in place otherwise beds will be blocked.
Minster Listening Event (Table discussion)

Care in the community

No good having a great specialist unit if patients get stuck there and have nowhere to be discharged to.
Public focus groups

The drive is to get people back into the community, but the lack of staff in the community is key and will hold up people getting out of hospital.
Tonbridge Listening Event (Q&A)

Summary of answers given

We understand that the consultation is not about the totality of stroke care. There is other work happening on prevention and rehabilitation.

If you provide the initial care in a HASU properly, people come out with less disability and need less community care

We are absolutely committed, with our commissioners, to ensuring our rehab is as good as the hyper acute service. We had to start somewhere. Once we've made the decision about HASUs, we will plan the rehab to meet people's needs.

Impact on other services

Some residents feel it would be better to **invest in existing services**, and there is some concern on the potential **impact** on both **non-HASU hospitals** and **other services in HASU hospitals.**

Better to invest in existing local services

- Stroke care is only a small % of what hospitals do
- Some feel priority should be improving other poorly performing services in the local area, in particular:
  - Ambulance service
  - Primary care
  - All services at local hospitals

Risk of having negative impact on other hospitals

- Evidence suggests that removing particular services can have a detrimental effect on remaining services
- Concern over situations where people with stroke symptoms present at A&E in hospitals without HASUs
- Concern this will lead to removing services from other hospitals

Impact on other services within chosen hospitals

Some individuals expressed concern over whether the HASU will have a negative impact on the other services offered at that hospital

Other services: example questions/comments

Invest in other services

Degradation of our hospitals. 5% of what hospitals do is stroke care…There is a very real risk of destabilising on-call rotas in non-HASU hospitals…If you take people to a HASU past their local degraded hospital, you should hang your heads in shame.
Broadstairs Listening Event (Q&A)

Impact on other services

This could impact on hospitals more widely and other services provided in the HASU hospitals and the ones that lose out. *Rochester Listening Event (Q&A)*

What will happen to the hospitals that get chosen – will capacity be reduced for other services?
Minster On Sea Listening Event (Q&A)

My worry is the wider changes. You've moved cardio to WHH, you'll move stroke to WHH – you've already made that decision. What does that mean for services elsewhere, Thanet, Folkestone etc.?
Whitstable Listening Event (Q&A)

Summary of answers given

This is not a cost saving exercise. This consultation is very much about saving lives and reducing disability. We wouldn't be standing here if we felt this was taking services away from Kent & Medway. This is about improving lives.

Stroke services under these proposals will improve. Other local services absolutely need to improve and wider reviews are looking to improve these. We are making improvements in primary care.

With stroke, there is no evidence that creating HASUs impacts negatively on other services.

Save our NHS in Kent

The campaign group Save our NHS in Kent (SONIK) were against all the options presented and wanted stroke services to stay at the QEQM hospital. They ran a Save Our Stroke Services campaign which received support from communities in Thanet and other parts of East Kent.

SONIK created postcards that were distributed in the Kent area, and the 1595 completed postcards were submitted by the consultation deadline.

These postcards offered the following options to those completing the cards:

SAVE Stroke Services at QEQM: I support the call for a fourth stroke unit (HASU) in the Kent & Medway area, based at QEQM. Re-open the stroke service at K&C Canterbury.

OR

CLOSE Stroke Services at QEQM: And keep the recently closed service at K&C Canterbury shut.

Save Our NHS in Kent: example questions/comments

SONiK

Are the funds from NHSE (up to £40m) entirely contingent upon the adoption of the national plan for centralised HASUs?

Why were the general public not notified about the pre-consultation?

We want to know how many CCG areas in England are currently under consultation for HASUs. And we want to see research that shows an improvement in terms of death and disability outcomes for an area similar to Kent in geographical size, where travel times of one hour apply to a densely populated area.

Summary of answers given

The £40million investment from NHS England is based on the HASU model of care and short-listed proposals put forward in our pre-consultation business case.

With stroke, there is no evidence that creating HASUs impacts negatively on other services.

Extensive engagement work was undertaken throughout the pre-consultation period with stroke survivors, carers, patient and public representative groups, elected representatives, staff and other stakeholders.

Existing evidence

Questions were raised around whether the existing evidence is applicable to the area of Kent and Medway, and some questioned whether evidence actually supports the argument that HASUs improve outcomes. Campaign group 'Save Our NHS in Kent' (SONIK) voiced significant concerns about this during the consultation.

SONiK: no evidence provided that shows centralisation of stroke services improves death and disability outcomes

Evidence from urban areas, such as London, is not applicable to rural/coastal area

Research is on morbidity [sic], not the difference to people's long-term health

Is there evidence based on areas with comparable distances to HASUs?

Evidence: example questions/comments

Evidence

The good outcomes referred to in studies, e.g. in BMJ, do not include people who do not make it to units on time. *Broadstairs Listening Event (Q&A)*

Of examples given about where HASUs have been implemented, are there examples of where people have to travel the same distances as expected by Kent?
Ashford Listening Event (Q&A)

There isn't any research on how these work in a non-metropolitan area.
Maidstone Listening Event (Table discussions)

Has any work been done on outcomes in an area similar to Kent such as Northumberland, which is able to check whether the patients furthest away who travel further have worse outcomes than those who live closer?
Ashford Listening Event (Q&A)

Summary of answers given

The whole country is going through reorganisation. There are 122 units across the country. Northumbria as wider geographical distances, up to 60 miles travel. In the first six months, they have seen significant improvement in care, and improvements in time from door to needle.

There is a lot of additional information available and published on the consultation website.

It is not travel time alone that is important, but call to needle time. The standard we are aspiring to for this is 120 minutes.

Is three the right number?

Whilst many members of the public could understand the argument around not being able to recruit enough staff to run more than three units, many expressed the opinion that four units would be better, with the fourth being based in either the Queen Elizabeth the Queen Mother (QEQM) Hospital or Kent & Canterbury Hospital.

Yes...

- Understand reasoning behind having three units
- Understand it will be difficult to staff more than three units

..but four would be better

- Would better serve East Kent residents, and take pressure off road network
- Shouldn't be based on staff – instead more should be done to encourage staff to move

Number of units: example questions/comments

Agree with three

You can't got to four or five on the basis of recruitment. Three looks sensible.

Tonbridge Listening Event (Table discussion)

Want four

It needs to be four, with one more for East Kent. The William Harvey is not a good option for those living on the coast.

Romney Marsh Listening Event (Table discussion)

I don't think you have made a good enough case for three. Everyone has recruitment problems. Four would be better as it would shorten journey times.

Gravesend Listening Event (Table discussion)

Unsure

We are not in a position to answer – we are persuaded by your data, but we are not qualified to comment.

Crowborough Listening Event (Table discussion)

Summary of answers given

This is a consultation. We would say there is a lot of good evidence for three, but this is part of the debate.

We looked at having one or two, and felt that although the numbers work for the number of patients seen, there are reasons to have more (size of the geography, resilience) but four or more would be hard to staff.

Concerns: staffing

Whilst residents understand the argument about a lack of staff, concerns were raised over **how the shortage of staff can be overcome** and what **more could be done to improve recruitment.**

Will there be enough specialist staff?

- Questions were raised over how the shortage of specialist nurses and doctors would be overcome, particularly if there are national shortages of stroke specialists.
- Concerned that some options indicate staff would be needed from outside of Kent & Medway.
- Will staff just move from other local services and leave these short-staffed?

Why can't more be done to attract staff?

Questions/suggestions around what more could be done to attract staff:

- Make rotas more manageable
- Offer bursaries
- Offer inducements such as Grade C posts
- Staff accommodation

Is it a good enough 'excuse'?

Whilst many accept that staffing is a key reason for having a maximum of 4 HASUs, for some, staff shortages is not seen as a good enough 'excuse' for not providing more HASUs.

Staffing: example questions/comments

What more can be done?

Why can't rotas be more manageable for staff? Why can't you attract more staff?
Broadstairs Listening Event (Q&A)

If you are having problems recruiting staff now, how will you make it better when you need 8 consultants for each unit?
Faversham Listening Event (Q&A)

Impact on other services

Won't it take staff from other areas or hospitals?
Tunbridge Wells Public Meeting

Is it a good enough 'excuse'?

The Stroke Association say that you should never close stroke units because of staffing numbers/shortages of staff?
Minster Listening Event (Q&A)

Summary of answers given

It's not national budgets that are stopping recruitment, it's the availability of staff to employ.

We are a challenging area for recruitment but HASUs are more attractive and exciting places to work.

Acute trusts have looked at flexible working, different shift hours etc. It is not about the money, it's about trying to create the conditions for people to come. We hope the medical school will help as people tend to stay where they train.

Option preference

Opinions were given on which of the five options people preferred (and this was specifically addressed during table discussions at the Listening Events). Of those choosing a preferred option, it was often acknowledged that this was **the option that suited themselves best personally**, and one that included their preferred hospital.

Best option for where I live

Option D is generally seen as offering the best balance geographically

Option D is the only option for the people of North Kent and Medway.
Rochester Listening Event (Q&A)

D&E look marginally better based on travel times.
Ashford Listening Event (Table discussion)

Geographical spread of Option D makes the most sense for Kent & Medway population. Other options benefit populations over the borders who already have access to HASU/ASU sites.
Gillingham Listening Event (Table discussion)

Specific arguments put forward for & against individual hospitals in shortlist

Tunbridge Wells

✓
- Geographically in the centre of Kent
- New hospital
- Has a trauma unit
- Impact on East Sussex if not chosen

✗
- Difficult to get through the town

Darent Valley

✓
- Needs investment
- Good motorway access
- Impact on PRUH and SE London if not chosen

✗
- Adjacent to Princess Royal University Hospital's HASU
- Complex to add on to a PFI

Medway Maritime

✓
- Only site that currently sees more than 500 strokes
- Most populous urban area with high levels of deprivation
- Growing population

✗
- Lack of space in old building
- Poor road network and parking
- Hard to staff

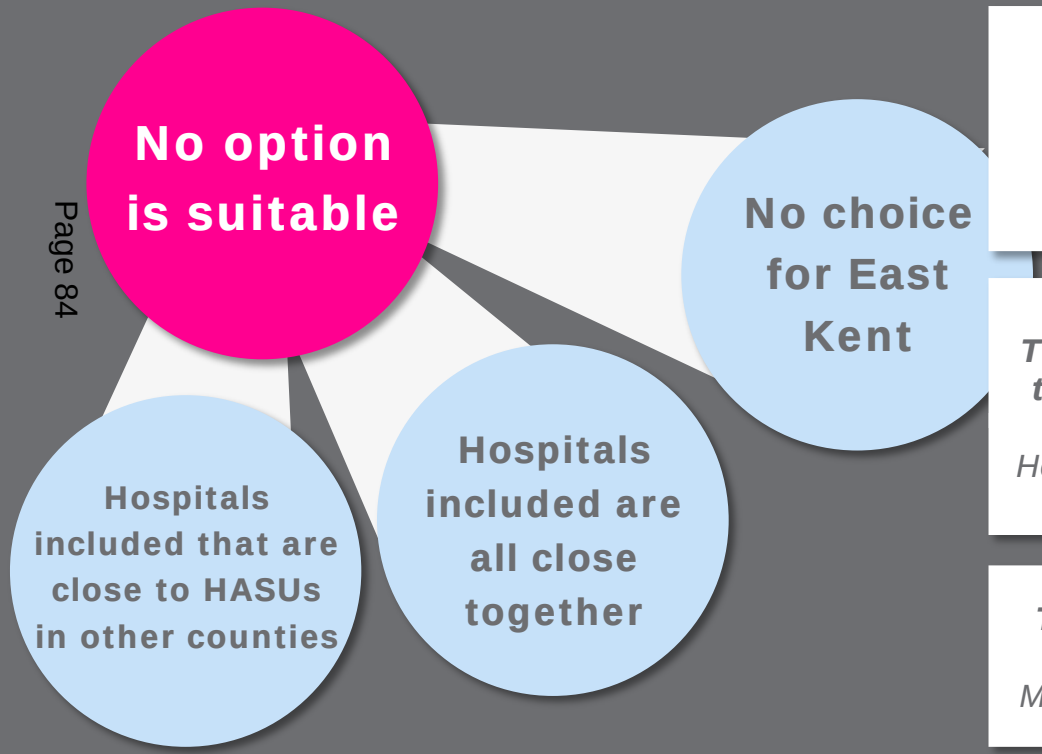
William Harvey

✓
- Number of stroke patients high

✗
- No direct public transport
- Hospital access difficult

Many feel that no option is considered suitable

The lack of a choice for East Kent residents is the key reason that many people expressed the opinion that no option is suitable.



Take out Tunbridge Wells and replace with Thanet. TW is on the border of London.
Minster Listening Event (Table discussions)

Thanet should have an option. Ashford is the only option for East Kent, and many would agree it is South Kent, not East.
Herne Bay Listening Event (Table discussions)

The key thing seems to be that EKHUFT doesn't want two? Why?
Maidstone Listening Event (Table discussions)

Key area of concern: East Kent

Although each proposed option would leave some areas of Kent & Medway less well served than others, all options are perceived to leave East Kent at a disadvantage, and with little or no choice.

All options seen as leaving East Kent at a disadvantage

One of the key areas of concern is that no options under consideration include an East Kent hospital, and in particular that Thanet is a long way from any hospitals under consideration.

Proposed options seen as offering an inequality of care to residents of East Kent, and of Thanet in particular

Residents in East Kent, and Thanet in particular are seen as having no choice of care due to the distances to the nearest proposed HASU.

It is really important that people outside of Thanet understand what this means for Thanet. We need to think about everybody in Kent, not ignore what it means for one community.

Maidstone Listening Event (Q&A)

How can you justify excluding the whole of Margate, Ramsgate, Broadstairs etc, when you know you can't reach WHH from anywhere within 30 minutes?

Thanet Listening Event (Q&A)

However you cut the map, East Kent gets the poor deal.

Ashford Listening Event (Q&A)

Please recognise that no-one here wants these options.

Broadstairs Listening Event (Q&A)

Inequality of care: example questions/comments

Inequality of care based on travel times

In Sussex, everyone gets there in 45 minutes. In Thanet everyone is one hour. 141,000 people in Thanet, that's a lot of people not within 45 minutes. Most areas in the rest of the country are within 45 minutes and London's critical time is 30 minutes. Why is it OK for 10% of the population to be outside of 45 minutes?

Ramsgate Listening Event (Q&A)

For all Options A to E, everyone in Thanet would be outside the 45 minute zone, whereas nearly everyone else in the rest of Kent and Medway would be inside the zone. This is an unacceptable inequality that discriminates against an entire district. *Letter/Email correspondence*

East Kent has no choice

There is no consultation for [Thanet]. There is a choice for others but no options for us.

Thanet Listening Event (Q&A)

Summary of answers given

Capital cities have shorter travel times than rural areas. The Stroke Association supports this three site model and the national limit of 180 minutes from call to needle – in Kent we have determined it to be 120 minutes from call to 999 to needle. If we could deliver a service within 30 minutes to everyone we would do.

Distances are key but an overriding factor is taking the patient to the right place. As we have already experienced with heart attacks and trauma, this may mean driving past the local A&E. It might take longer for some patients, but the whole structure of the care you receive in HASU is the most important part of the care you get.

East Kent further concern:
What if WHH is full?

Residents are concerned that if so many stroke patients are being sent to the HASU at WHH, and if the unit reaches full capacity, then residents from East Kent (and Thanet in particular) will have a potentially long journey to the nearest HASU.

Example questions/comments

What if nearest HASU is full?

If the option nearest to you is full, would you be diverted to another unit?
Minster on Sea Listening Event (Q&A)

Say it takes 40 minutes to arrive in Margate, 20 minutes to decide what is happening, an hour to get to WHH, and then WHH isn't available. Would you ever have to go to Tunbridge Wells?
Maidstone Listening Event (Q&A)

Summary of answers given

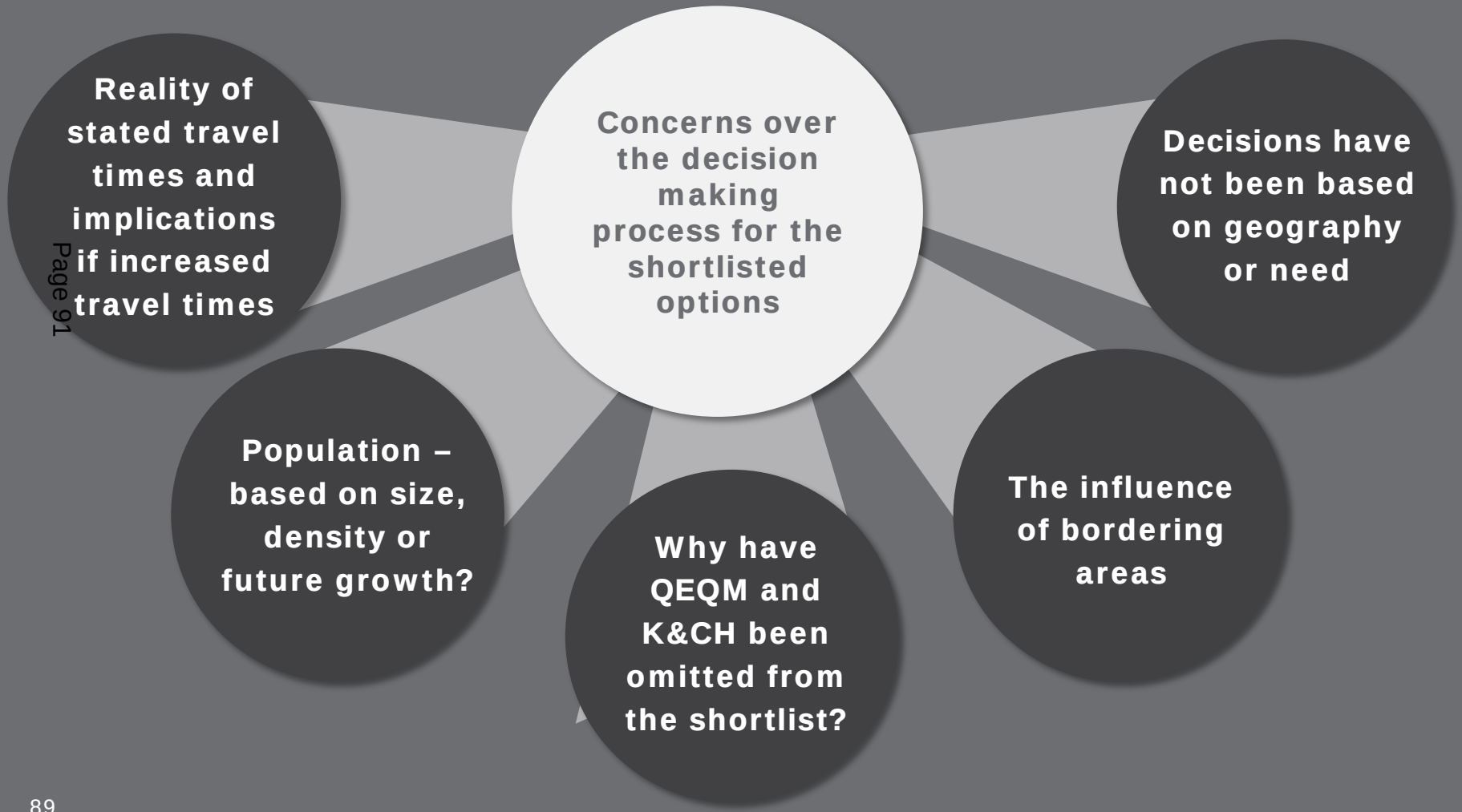
The way HASUs work is that you would be taken to the nearest HASU unless it is on fire. They don't have a "full" protocol, they don't work like that.

All the modelling has been done on 85% bed occupancy. We have a lot of general medical patients currently on stroke units because they are not ring fenced beds as they would be in a HASU model.

Key area of questions/concern: decision making process of shortlist

Residents raised questions around the basis on which the five potential locations of the units is based, in particular on the reality and impact of the travel times, whether population is based on size, density or demographics, the reasons for not including particular hospitals, the impact of bordering areas and the influence of finances.

Concerns over decision making process



Key area of concern: Basis of decision: travel times

Residents are not confident that the travel times on which decisions have been based are realistic. In addition, a key concern, and not just for residents of East Kent, is the impact of increased travel times, in particular on the time from ‘call to needle’, the impact on the ambulance service, and the impact on friends and relatives.

Travel times as stated in consultation documents

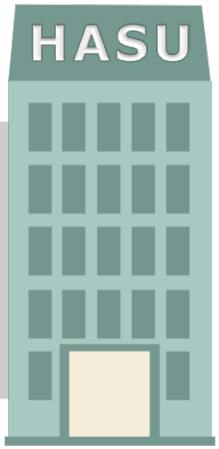
Ideal: within 2 hours from call to needle

Maximum acceptable journey time by ambulance: **60 minutes**

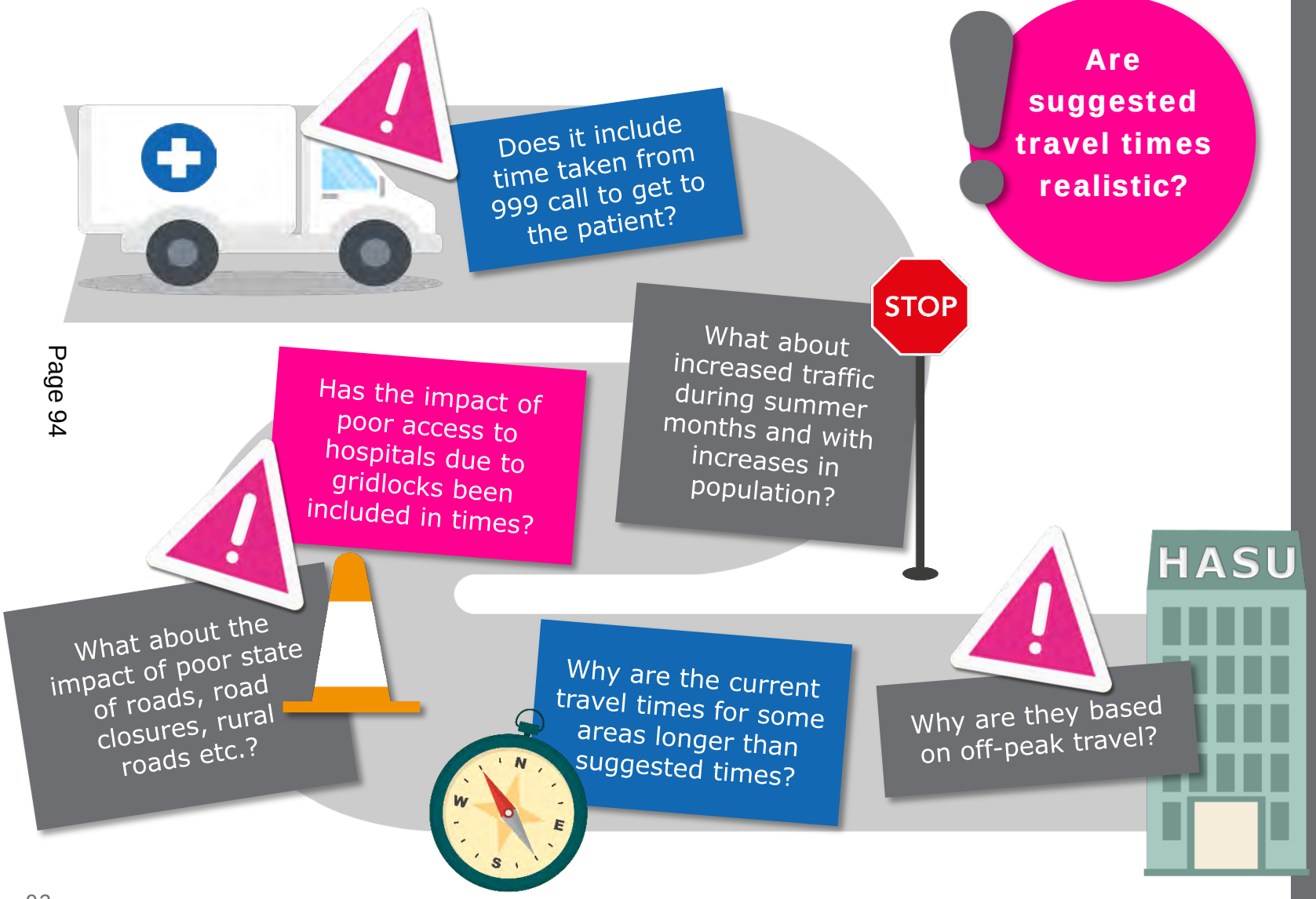
98% of people can reach a hyper acute stroke unit (HASU) within one hour

Over **90%** can reach a HASU within 45 minutes

Around **75%** of people can reach a HASU within 30 minutes



More clarity wanted over the reality of stated travel times



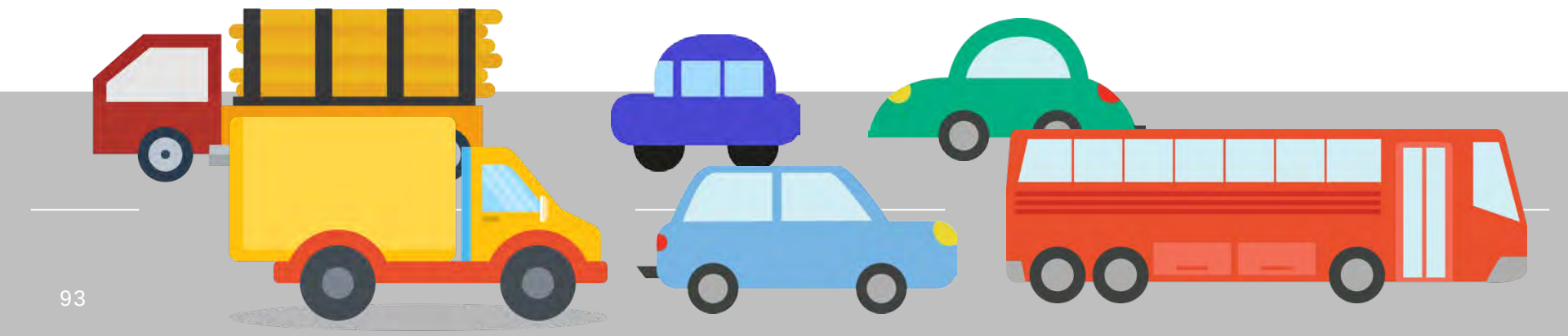
Concerns: travel times

Road & transport networks

With increased travel times necessary for both ambulances and visitors, residents raised questions around whether the infrastructure would be improved alongside the opening of the HASUs, in particular:

- The state of the road networks
- Public transport links
- Access to hospitals
- Parking near hospitals

There was also some concern about the planned lorry park in the area and the potential impact this will have on traffic and roads.



Travel times: example questions/comments

Time to get to patient

Do you factor in travel time to get to the patient and to get them into the ambulance as well as the journey time?

Broadstairs Listening Event (Q&A)

Reality of travel time

Majority of patients are transported by ambulance, are we sure they can make it to the William Harvey from somewhere like Lydd?

Romney Marsh Listening Event (Table discussion)

Travel times are not always easy to predict. How have they managed to say that people can get there in time?

Outreach Engagement

Gridlocked roads

Roads to Ashford are often gridlocked. Likewise for Medway Maritime – always gridlocked. The best ambulance drivers in the world can't overcome this.

Faversham Listening Event (Q&A)

Summary of answers given

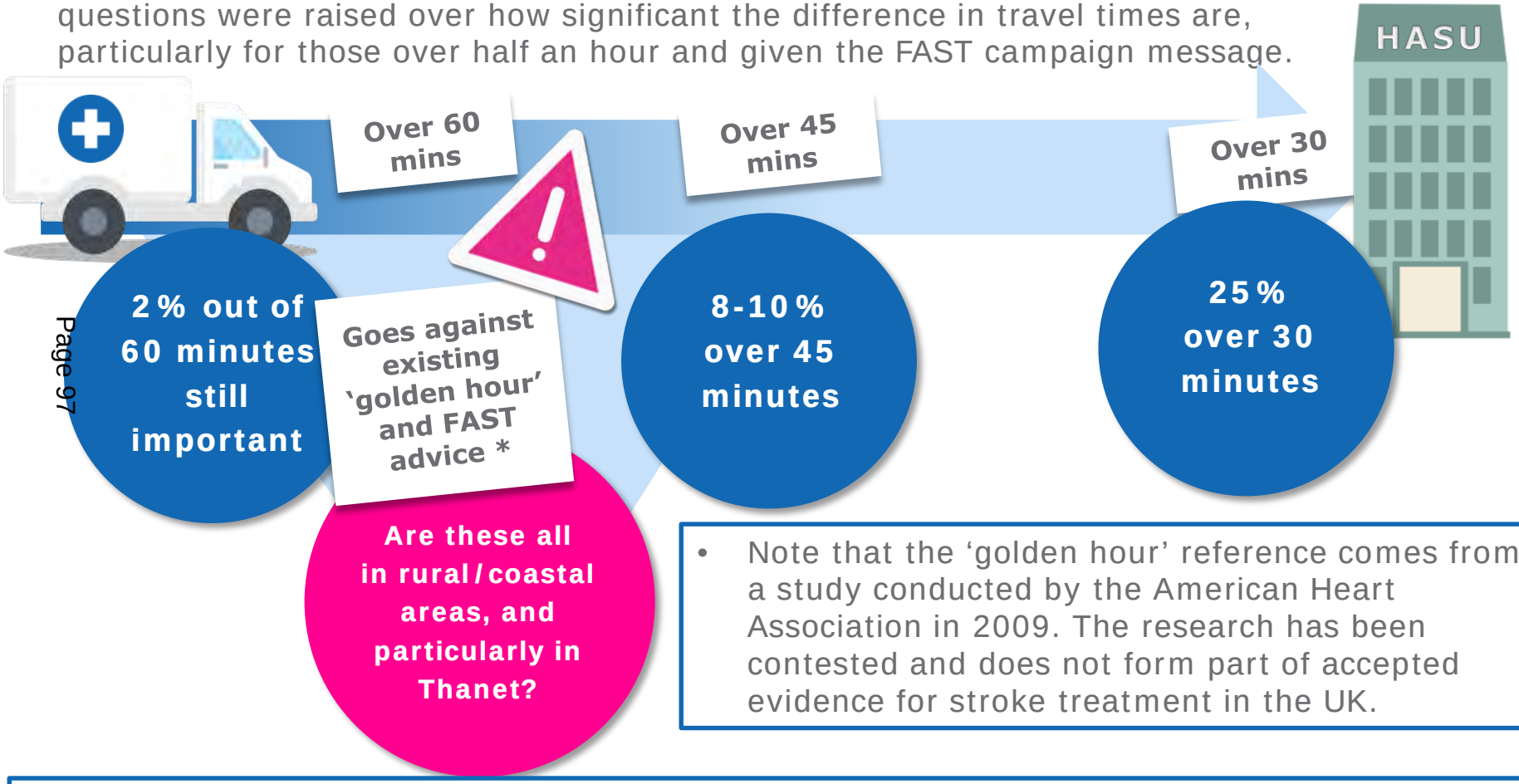
There is a designated 'window' of time, 'call to needle' of 120 minutes. We can get to you quickly enough. Strokes now fall into category 2 calls. Blue lights and sirens knock 10% of normal travel times.

We have mapped using live incident data, time on scene and time to hospital. We have done extensive modelling using Google maps to assess journey times.

The important thing is to get you to the right place. We are already doing this for heart attacks and trauma. Travel times are less important than where you go. It is better to travel further and get expert care.

Road & transport networks

With 2% potentially over the preferred hour travel time, and 8-10% over 45 minutes, questions were raised over how significant the difference in travel times are, particularly for those over half an hour and given the FAST campaign message.



- Note that the 'golden hour' reference comes from a study conducted by the American Heart Association in 2009. The research has been contested and does not form part of accepted evidence for stroke treatment in the UK.

- In addition The K&M stroke proposals complement the advice given in the FAST campaign. When dealing with stroke the most important thing is to get the person to the right place as quickly as possible. The proposals supported and endorsed the FAST advice which is to 'call 999 as soon as people spot the symptoms of stroke.'

Impact of travel: Example questions/comments

Longer travel time goes against current guidance

To the patient how significant is the 45 or 60 minute travel time? SECAmb tell us that the most important factor is getting to the right place first time, and doctors tell us that getting to the stroke unit fast is the biggest influence.

Folkestone Listening Event (Q&A)

Significance of travel time

In the pre-consultation business case, it states that "travel times affecting needle to door time may affect rural areas". This emphasises time is essential.

Deal Listening Event (Q&A)

My concern is transport to hospital within 2 hours. If MFT (Medway Maritime) isn't chosen, how will SECAmb get patients to hospital off the Isle of Sheppey – it won't happen.

Minster on Sea Listening Event (Q&A)

Summary of answers given

Our proposals complement the FAST advice. When dealing with stroke the most important thing is to call 999 as soon as people spot the symptoms of stroke and get the person to the right place as quickly as possible.

There will always be some exceptions, but we are confident we can capture everyone within 120 minutes.

In other parts of the country, ambulances are driving past A&Es to get to HASUs. It's not just about the speed of getting to the unit. It's the first 72 hours of care that makes the difference…. The sooner you get to specialist treatment, the sooner you can get home and the better your outcomes.

Impact on the ambulance service

Residents are concerned that the ambulance service struggles to cope to meet current demands, and that the increased travel times needed to take stroke patients to HASUs will put further pressure on the already stretched service.

Issues with current service

Residents expressed concerns over the current service, in particular **poor response times** caused by:

- Not enough ambulances
- Not enough staff
- Gridlocks at hospital

A concern was also raised around the reliance on **999 call handlers** to be trained to recognise stroke symptoms

Concern that proposed changes will increase pressure further

With increased travel times in cases of suspected stroke patients, residents are concerned that the ambulance service will not be able to cope with this increased pressure

Will there be more ambulances?

Can paramedics be trained to do more for stroke patients?

Could the air ambulance be used more?

Will ambulances be able to get there and then to unit in time?

Ambulance service: example questions/comments

Issues with current service

This assumes that there will be ambulances but they don't function well know. I work in Medway and we have people who have to wait for an ambulance to come from Sheppey – it is desperate, particularly in bad snowy weather.

Public Meeting: CHEK AGM

Impact of changes

My only reservation is ambulance response times – getting patients from site of event to hospital in time. Can SECAmb cope with the demand?

Folkestone Listening Event (Q&A)

Can paramedics do more?

Will the ambulance service, first responder, other clinicians be able to make decisions about whether we need clot busting drugs or not? Do we need to wait until we get to hospital for this decision?

Public focus groups

Summary of answers given

The ambulance service has already done a lot of training to identify strokes and this is something that they will continue. The call receivers, who pick up the phone when you ring 999, also have a series of questions that they run through, which help to identify whether it is a stroke.

This review is not about saving money, it is about recognising that the service offered for stroke in Kent and Medway is not good enough and we appreciate that the costs for running the new service are likely to increase and there will be investment, some of which will go into the ambulance service.

Impact on family and friends

Residents are concerned that longer distances will mean family and friends will find it very difficult to visit, particularly for the elderly and those on low incomes.

Longer distances may make it **too expensive** for visitors

Support from family & friends aids recovery

Longer distances will make it **harder** for friends/relatives to visit

Long distances on public transport will make visiting difficult, particularly for elderly people

Lack of direct public transport links and **poor parking** will make visiting difficult

Impact on relatives: example questions/comments

Impact on visitors

The travel time for relatives to visit someone in a stroke unit, for perhaps 10 days must be thought of. How does a relative even get to Ashford? Would they go to the train station then get a bus? People want to be there to support their relative.

Minster Listening Event (Q&A)

Families are so important in helping someone to recover from a stroke. If families can't travel long distances to visit people, this support will reduce. Has anyone thought about what long term impact of this might be for the patient's recovery?

Outreach Engagement

I know how important it is for survivors to have connection with their families. In this area where there are high levels of deprivation, there are a number of elderly people who do not have their own transport and rely on public transport. It will be arduous for them to visit their relatives.

Whitstable Listening Event (Q&A)

Summary of answers given

We explored the travel issue with stroke survivors and carers, who felt it was more important to get to a specialist centre for the acute phase than being able to be visited by family members. The mitigation is how we can reduce the burden on families, either through financial or voluntary support, to enable patients ,,. to see carers and relatives.

We recognise the difficulties concentrating services on three sites might pose for families and carers, but at the moment we have inconsistent standards of care meaning people spend longer in hospital at an average of 18 days. Our proposals would mean better care available 24/7 which should mean less disability and better recovery with a shorter stay in hospital.

Key areas of concern: Other aspects of decision process

Other questions were raised over how decisions on the shortlisted options have been made, in particular what the population statistics are based on, why particular hospitals are not included, the impact of bordering areas and the influence of finance on the decision.

Has population growth & need been taken into account?

Questions were raised around whether the population figures, and therefore the decisions over which hospitals are included in a recommended option, take into account expected **population growth, density or need?**

Population increases during summer months

New housing developments increasing population

Elderly populations & deprivation in specific areas

Should unit location be based on population density?

Population: example questions/comments

How is the population calculated?

If I were you, then I would be thinking 'Why would I offer the service to a few thousand people who are badly located?', whereas you could make sure you get a HASU in a much more heavily populated bit of Kent. Why wouldn't choice be made by population dispersal?

Crowborough Listening Event (Q&A)

What's the demand? What's the future demand? Show how the demand works out and show how we have fair and equal access times. Think about the increase in population with the new housing, and also in the summer.

Minster Listening Event (Q&A)

500 patients per year now, but need to take account of population grown and younger people having strokes.

Sittingbourne Listening Event (Table discussion)

Summary of answers given

When formulating the options, we factored in projected population growth for the next 15-20 years and identified where communities will grow and where there will be populations of older people. For example, we are anticipating the big growth at Ebbsfleet but the whole population of Kent and Medway is expecting to increase.

Kent is an area with expected population growth. We have looked at the projections of future stroke and population. We have looked at congestions and roads with local authority planners and SECAmb & factored that in.

Need: areas of deprivation and elderly populations will be least well served

Residents are particularly concerned that East Kent has no HASU option yet has both higher proportions of elderly residents and some of the most deprived areas in the country – both of which are linked to higher incidences of stroke.

Have areas of most need been factored into decisions?

Thanet is one of the most deprived areas of the country	Increased likelihood of stroke
East Kent has a high proportion of elderly residents	Less likely to drive, and less likely to be able to afford the increased travel

Demographics: example questions/comments

Deprivation

You talk about causes of stroke and those most at risk. Thanet is one of the most deprived areas in the South East and in the UK. These people are more likely to be suffering strokes, and are also furthest away.

Herne Bay Listening Event (Q&A)

There isn't anyone here who doesn't want to see HASUs set up, it is about where you are doing it. We have a very disadvantaged and a very elderly population, factors that make you more likely to have a stroke.

Broadstairs Listening Event (Q&A)

Elderly populations

Why is Margate not included when there is an increasingly older population?

Ramsgate Listening Event (Q&A)

Thanet is a deprived population. What is the proportion of people over the age of 50? Around 50%?

Minster Listening Event (Q&A)

Summary of answers given

Some areas of Thanet are very deprived, but it is not necessarily true that the most deprived areas have the highest incidences of stroke. Getting you to the unit is important but the team that you see there is also very important.

Deprivation and co-morbidity is a major issue for a number of populations across Kent & Medway, and there are pockets of deprivation in all areas. It is a struggle but we have to do the best by the whole population.

Prevention work is very important in terms of delivering services in deprived areas. This includes tackling smoking, obesity and high blood pressure.

Residents expressed a desire for more clarity on **why particular hospitals have been excluded** from the proposed options...

Queen Elizabeth the Queen Mother Hospital (QEQM)

- Questions were raised over **why QEQM has not been prioritised** and included in the options given:
  - Levels of deprivation in Thanet
  - Distance that residents of Thanet would need to travel to any of the hospitals included in the options
- Some attendees questioned the **validity of the arguments** put forward for excluding QEQM
  - Could ensure all in Kent could be reached within 60 minutes
  - Currently has an A&E and stroke service in place

Several feel **as a minimum**, some **core stroke services** need to be based at QEQM (particularly if new Canterbury hospital doesn't go ahead)

Kent & Canterbury

There was some confusion around whether the stroke service would be moved from WHH to KC&H under Option 2 and why the changes are not being **delayed** until the decision is made on a **new hospital** in Canterbury.

Some residents felt **K&CH should be included** in the options/final decision:

- To better serve East Kent residents than WHH
- Canterbury considered more central with better network than other options
- The medical school will be part based in Canterbury (although is for whole of Kent and Medway)
- Should be easier to recruit to Canterbury than other areas

QEQM: example questions/comments

QEQM

In some parts of Thanet, there are areas of real deprivation and poverty and lifestyle are proven to be big risk factors for stroke, so WHY wasn't the QEQM hospital prioritised to have the Stroke Unit to serve the residents and summer visitors in Thanet? *Broadstairs Listening Event (Q&A)*

Why can't we be asked about whether QEQM and K&C should have a unit. They have already made that decision.
Outreach Engagement

A certain time ago the older units in Kent were assessed and QEQM came up as top. We have the basis of the service there, so why not put the rest of the service there?
Whitstable Listening Event (Q&A)

QEQM isn't included in any of the options. Would you consider bringing the QEQM back into the option configuration?
Maidstone Listening Event (Q&A)

Summary of answers given

QEQM was part of the assessment, and on the 13 options list. Through the process of assessment and evaluation it came off the table – people didn't know which hospital they were evaluating in this process.

QEQM was assessed and evaluated using the agreed criteria. EKHUFT have said they would struggle to fully staff two units, so any option with both QEQM and WHH scored lower than options with just one of these sites.

QEQM doesn't have as many co-adjacent and desirable services so it didn't evaluate as well as options with WHH in the medium list of options.

See p26,36,37,38 of the stroke consultation document for a full explanation: https://kentandmedway.nhs.uk/wp-content/uploads/2018/02/KMStrokeConsultationDocument_final_02022018.pdf

K&CH: example questions/comments

Kent & Canterbury Hospital

Isn't it a complete waste of money to invest in the WHH and potentially make a very different decision in favour of Kent & Canterbury a few months later?
Public Meeting: CHEK AGM

Is there any change or difference now that the medical school for Kent and Medway has been approved?
Broadstairs Listening Event (Q&A)

All roads in East Kent lead to Canterbury, but roads to Ashford and Medway Maritime are always gridlocked. Canterbury is the centre of a spider web of roads.
Faversham Listening Event (Q&A)

Why can't resources from WHH be transferred to K&C site and the HASU project be implemented there – recruitment to Cathedral City of Canterbury likely to be easier, supported by the med school, it is geographically central and has the road network.
Broadstairs Listening Event (Q&A)

Summary of answers given

K&C doesn't currently provide A&E services or urgent stroke services – it doesn't have the necessary co-dependent or co-adjacent services.

K&C wasn't included because it does not currently provide a stroke service or other emergency & urgent care needed to support a HASU. If following the review of emergency care services in east Kent, the William Harvey was no longer a long-term option for emergency & specialist services and these moved elsewhere – then we would anticipate any HASU would move also, subject to public consultation.

Impact of bordering areas

Residents questioned why **East Sussex** have been included in the consultation, and what the **impact of HASUs in neighbouring areas** has on the decision.

Bexley & East Sussex

- Kent and Medway residents raised questions over why numbers from Bexley and East Sussex have been included
- East Sussex residents involved in the consultation mentioned the poor quality roads in East Sussex
- Bexley residents mentioned that due to road networks, DVH is actually the closest hospital for many residents (not PRUH)

Influence of neighbouring areas

- Some feel the bigger picture should be considered, and that other areas, such as East Sussex and London, should be working together on this
- Some questions over whether populations outside of Kent and Medway have influenced locations of HASUs

Finance & influence of finance on decisions

Questions were raised around the financial investment involved in the proposed new HASUs – in particular whether the money is guaranteed, where it is coming from and to what extent it influences decisions.

Where is the **money coming from?**

Is it all **just about money** in reality?

What does the £40 million include?

Is the funding **guaranteed**?

What will happen to any **long-term savings?**

Is the money **enough** – amount is meaningless to us?

Finance: example questions/comments

Finance

Will the money be protected and ring-fenced?
Canterbury Listening Event (Table discussion)

Do you feel all the ways of funding the HASU project have been properly explained to the public?
Broadstairs Listening Event (Q&A)

The amount of investment doesn't mean anything – we don't know how much money is needed.
Rye Listening Event (Q&A)

Can you guarantee that you will get the money you will need?
Bexley Heath Listening Event (Q&A)

The NHS doesn't have the money. It is so important that we understand where the money is coming from and what it is going to cost us with the loans and repayments etc.
Broadstairs Listening Event (Q&A)

Summary of answers given

This has been looked at centrally by NHS England and would be 'new money' (i.e. not from existing funds) as far as is possible.

It is not about saving money, it is about an investment in stroke.

What we are planning has been agreed by NHS England and has been through the national Capital Investment Committee. It is a one-off capital payment and the revenue costs, the costs of running the units, will come from the CCG's budgets.

Other areas of questions/concern:

Other areas of questions/concern.

Please note that whilst these are still important, they were not as widely mentioned as the key areas that have already been provided.

The political situation

A notable number of residents expressed views on the under-funding of the NHS and the impact this has on the proposed plans. There were also questions around whether the proposal is really a cost-cutting exercise.

Example questions / comments

What worries me about this is for all the best intentions people are being ill-served by the national government who are cutting back on the NHS. We have to do something about this, we are just papering up the cracks all over.
Whitstable Listening Event (Q&A)

What if the government changes, could it all change?
Minster on Sea Listening Event (Q&A)

How can this not be about saving money?
Gravesend Listening Event (Q&A)

Summary of answers given

The evidence is clear that this needs to happen – it will not be affected by political policy because the clinical evidence is so strong.

We would all like more money for the NHS, but this is not about trying to save money, it is about trying to improve care, and would actually mean a c£40m investment in services.

Regardless of political viewpoint, the reality is nothing to do with money, it is about the clear evidence that patients do better cared for in 7 day specialist units.

Questions & comments around the consultation itself

Not considered a consultation

- Too many decisions already made
- Residents don't have a vote
- Some feel that the decision on the best option has already been made
- East Kent residents do not feel there is anything for them to consult on

Low awareness of consultation

- Low numbers attending some events
- Perceived lack of advertising of consultation
- Although an event was held wherever this was requested there were some areas who said they had to lobby to get an event in their area

Involvement of specific groups

- More community outreach needed: hard to reach groups, minority groups, sheltered accommodation residents etc.
- Consultation accessibility: online questionnaire and/or physically having to come to an event

Other

- Some would have liked information to have been circulated prior to events
- Some question the validity of the information in the presentation
- Online questionnaire, and the misunderstanding that an option had to be chosen before participants could move to the next question
- Using neutral scores seen as misleading

Residents made suggestions on other possible solutions to improve stroke care…

Scan then transfer

Have dedicated scanners in each hospital, deliver thrombolysis if appropriate *then* transfer to HASU

Mobile scanners

Have mobile scanners in ambulances and train paramedics to diagnose and deliver thrombolysis

999 and paramedics

- Improve diagnostic skills of 999 call handlers and paramedics
- Have specialist ambulances who can start treatment on the journey

Use technology more

- Use telemedicine more
- Video links to specialist stroke teams

Key themes from the Public Consultation

Part 2

The following section summarises the key themes arising from engagement through social media.

Social media engagement

The consultation was publicised through Twitter (reach >500,000) and Facebook (reach >50,000; 4,000 page engagements).

Both platforms were used to provide updates on the consultation and encourage people to get involved.

Posts were liked, retweeted and shared.

Comments made on the posts have been reviewed and (where sufficient) grouped into themes.

Main themes

Across the two platforms three strong themes emerged:

MAIN THEME:

Concerns over the consultation process

Mentioned more often on Twitter

THEME:

General opposition to the proposal

THEME:

Lack of fairness in the suggested locations for the HASUs

Concerns over the consultation process: example questions / comments

A consultation has no validity if the consultees do not have full information on what they are commenting on BEFORE the consultation ends. It's just not sufficient to say that precise arrangements will be revealed only after the consultation has ended.

Facebook comment

The questionnaire is extremely skewed to elicit the answers you want. The data from the main questions will be collated into measurable data. What exactly will you do with the answers from the free text boxes?

Taken from a Twitter thread

What about the consultations held midweek, daytimes and far from urban centres giving few the chance to attend?

Taken from a Twitter thread

Answers given

An independent research company will look at all the consultation feedback and produce a report for the commissioners. Free text comments are an important part of this analysis.

We have run meetings in different locations, on different days of the week and times of day to try to offer a variety of options. We know not everyone will be able to get to a meeting but they're only one part of the consultation plan and there are other ways to get involved.

General opposition to the proposal: example questions/comments

Absolutely ridiculous idea closing Stroke units for just one or two serving the whole of Kent, stroke = FAST. FAST does not happen when it takes up to 45+ minutes to the nearest hospital Stroke Unit from your house That's when the roads are clear. Not to mention the units having to cope with several Big towns worth of potential patients. *Facebook comment*

This is little more than window dressing for cuts in health services. / This is part of an 'efficiency drive' aka cuts. If this wasn't the case you would not be closing existing units. / Proposal for 3 HASUs because of staffing levels is a long way removed from providing the best service.
Taken from a Twitter thread

Yes, seen that before. It's just an empty statement, it's not evidence. It's also contradictory. It says we assess on the basis of co-dependencies but also losing a key service doesn't matter. Co-deps and co-adjacencies DO matter
Taken from a Twitter thread

Answers given

The proposals represent a potential investment of £40 million to improve stroke services across the whole of Kent and Medway. We believe establishing HASUs would improve care for everyone wherever they live.

Yes co-dependencies can matter. But different services have different co-dependencies. An A&E does not need to have a HASU for example. There is no reason for other services being removed from a hospital because it no longer has stroke services.

Lack of fairness in the suggested locations: example questions/comments

According to your maps the ISLE OF SHEPPEY doesn't even exist! There is a high proportion of elderly on the island and much socio-economic poverty. To remove stroke services from Medway Maritime would be giving us (another) death sentence.

Facebook comment

Why are the people of Thanet not worthy of adequate stroke services? What happened to #FAST? / Please fight the cuts and privatisation of OUR health service.

Taken from a Twitter thread

Shutting stroke services in the most deprived area of Kent is scandalous. Haven't you heard of telemedicine or stroke nurse specialists?

Taken from a Twitter thread

Answers given

We are proposing changes to stroke services because we want to provide a consistently high quality stroke service that meets national standards for everyone across Kent & Medway including Thanet residents. The proposals are not about cuts and there are no privatisation plans for stroke.

Thanks for your comments. Please do read more about the reasons behind the proposals for stroke at http://www.kentandmedway.nhs.uk/stroke and fill out the consultation questionnaire to share your views in more detail

Social media: other key themes

Across all strands of the consultation, the desire to maintain services at QEQM and consider the needs of the residents of Thanet have been made clear, and this has been reflected in the comments made on social media. However it should be noted that on Twitter in particular a good proportion of the comments came from a small number of individuals repeating the same message.

- Concern over the costs of making the changes
- Ambulance journeys will take too long when speed is vital
- There should be more Units / hospitals providing stroke services
- Keep services at QEQM
- No option for Thanet
- Lack of supporting evidence / evidence has been mis-used

Consultation with staff currently working in Stroke Services

The following section summarises the key findings from the focus groups held with staff currently working in Stroke Services

Focus groups with staff currently working in Stroke Services (Engage Kent)

Engage Kent was commissioned to undertake 7 focus groups, engaging 60 staff members currently working in Stroke Services to gather views, thoughts and responses to the stroke proposals. This work complemented ongoing staff engagement about the proposals during the consultation period.

Workplaces consulted

- QEQM Stroke Ward (Nurses, OTs Speech and Language Therapists)
- K&CH Stroke Ward (Physios and OTs; Nurses)
- WHH Stroke Ward
- KCC Senior Practitioner OTs meeting
- Darent Valley Dietetic Team
- Operational and 111 call handlers

Questions asked

What information people recalled from the consultation documents…

Instant reactions to the proposal…

Advantages and disadvantages of the proposal…

Whether the proposal was considered sound…

Key messages from the proposal

Staff currently working in Stroke Services were asked what key information they recalled about the proposal, and what this would mean to them. Whilst they generally feel the proposals are trying to improve the service, there are concerns about impact on jobs as well as excitement about being part of a specialist team.

Key messages

- *Several had not read the proposal*
- Trying to improve stroke services
- Consolidation of services
    - Bigger team
- Unit at Ashford, and not at QEQM or K&CH
- Proposal based on misleading information

It's misleading to say it is better to have an acute unit than wait in A&E. This doesn't happen unless they have misleading symptoms. QEQM Stroke Ward

They are looking at the stroke units and it is a way to improve the service. K&C Stroke Ward

What does this mean for you?

- Better service for patients
- Instability of employment (job losses and confusion over possible new roles)
- Sadness – current team is great
- Medical model not a holistic approach: affects family
- Bigger teams if people move

Quite keen on being part of a super specialist team – could offer more opportunities for development. K&C Stroke Ward

My role won't be continued. QEQM Stroke Ward

Reactions to proposals

Staff currently working in Stroke Services were asked for their instant reactions to the proposals. Key mentions are concerns over the increased travel times and staffing of the units.

Instant reactions

- Concerns over longer distances to **travel**
  - For staff members
  - For patients
  - For relatives
  - East Kent not well served
- Concerns over how the units would be **staffed**:
  - Many staff members said they would not move to be part of new team
- Several feel changes are **demotivating** and the staff are not feeling supported; do not feel they 'have a say'
- Concerned existing services will be affected if staff move.
- Shocked at statistics around **current service**
- Some staff members feel a bigger team of specialists will be better and is **exciting**

It affects older patients. Travel and distance are obstacles, as well as the cost of £15 a day public transport. K&C Stroke Ward

I would have to leave at 5am and get back at 10pm, that is not reasonable. QEQM Stroke Ward

From our nursing team, there is only one person who would consider moving to another site. QEQM Stroke Ward

The current service is dangerous. IC24

Perceptions of underlying issues

Staff currently working in Stroke Services were asked what they saw as the underlying issues. Again, travel and staffing are the most often mentioned.

Underlying issues

Travel is seen as a key issue:

- Longer and more expensive commutes (seen as prohibitive for some)
- Impact of therapists covering wider areas during home visits

Staffing:

- Current services already stretched; difficulties in recruiting

Other issues mentioned include:

- Bed shortages
- Impact on ambulance service
- Impact on aftercare

Extra travelling could mean I am off the ward for more time, this will impact on patient care.
K&C Stroke Ward

Technically, it is a pay cut; travel costs, wear and tear on the car etc.
QEQM Stroke Ward

We haven't been able to recruit a Band 6 Speech and Language Therapist at Medway for several years. A new HASU won't change that.
Darent Valley Dietetic Team

The impact on the ambulance service will be huge. They will be on the road for longer and not available to other patients.
IC24

Potential impact on their work

Key perceived advantages of the proposed changes are the potential to recruit and retain staff more easily and the positive outcomes for patients. The impact on current teams, the increased travel, a lack of local therapy and social care are the main perceived disadvantages.

Advantages

- Developing staff
- Able to use specialist skills more
- Positive for patients
- Could be more attractive to staff and therefore improve recruitment

Retention and development of staff will improve, especially nursing staff. Darent Valley Dietetic Team

Full seven day service for all disciplines. WHH Stroke Ward

Disadvantages

- Impact on current team – staff will move, jobs will be lost
- Lack of community therapy
- Increased travel, especially for community OTs
- Early discharge but no improvements in social care
- Thanet at a disadvantage

Staff are already looking for jobs in London as they are concerned about the future of the DVH stroke unit and don't want to move to Medway. Darent Valley Dietetic Team

There are not enough local therapy hubs. WHH Stroke Ward

Questions raised

Staff currently working in Stroke Services were asked whether they had any new questions, and whether they feel it will be easy or difficult to adapt. Most questions centre around after care and staffing. In general, staff feel it would be difficult to adapt.

Questions

- Clarification on after care
- Numbers of staff needed
- How impact on visitors will be addressed
- Timescale for change
- Potential impact on services at other hospitals

How much thought has gone into considering staffing and how hard it will be to recruit to certain areas? Darent Valley Dietetic Team

Could there be accommodation at HASU for relatives? K&CH Stroke Ward

Ease of adaptation

Difficult:

- If community situation doesn't improve
- To adapt to new ways of working and new roles
- A lot of staff will be unwilling to relocate
- To follow up people when discharged home

I don't feel staff would be willing to relocate to keep working in stroke, especially senior staff with families and children at school. Darent Valley Dietetic Team

Decisional questions

Staff currently working in Stroke Services were asked what they would like to see happen next and whether they feel the proposal is sound. In particular, staff would like to be more involved in the next stages, and would like more support through this period of change.

Next steps

- Involve staff in planning
- Provide more information and support
- Re-look at QEQM and K&CH
- Reassurances about after care

Would like to see detailed plans about community and rehab for patients. Darent Valley Dietetic Team

It is important to be clear what support there will be for staff otherwise people will leave. K&CH Stroke Ward

Sound proposal?

Yes
Understand need for HASU in theory

Unsure:
Consultation document inaccurate

No:
Proposed locations do not offer equality of care (East Kent)

The consultation document isn't accurate; the staffing levels, the travel times, the portrayal of current services here at QEQM etc. QEQM Stroke Ward

Brief summary of stakeholder responses to the consultation

For reference purposes, formal responses to the consultation received from stakeholders such as professional groups or organisations, public bodies or campaign groups are included here, indicating whether they are largely in favour or not of the stroke consultation proposals. As many of these responses are detailed or technical in nature, their individual consideration will be required alongside the wider thematic analysis included in this report. All stakeholder responses will be published.

Professional & campaign groups supporting the proposal

These groups formally stated that they are largely in support of the proposals, although many put forward particular reservations and/or requested reassurances about current and future services. Where a particular option was stated as being preferred, this is shown.

- British Medical Association
- Concern for Health in East Kent
- East Kent Hospitals University NHS Foundation Trust
- East Sussex Health Overview and Scrutiny Committee (Option D)
- East Sussex Healthcare NHS Trust (Option D)
- The Grosvenor and St James PPG (Option E)
- Healthwatch Medway CIC
- Kent Community Health NHS Foundation Trust
- King's College NHS Foundation Trust (Options B and E)
- Maidstone Borough Council (Options including Maidstone Hospital)
- Medway NHS Foundation Trust (Option D)
- Our Healthier South East London STP
- The Neurology Department at Dartford & Gravesham NHS Trust (Option E)
- South Park Medical Practice Sevenoaks PPG (Option D)
- The Stroke Association
- Swale Borough Council

In favour of the proposal

Professional and campaign groups with significant reservations

These groups are either largely against the current proposals and would like further consideration to be made or are unable to comment.

Against current proposal

- Save our NHS in Kent, for the following reasons:
    - Failure to identify alternatives
    - Failure to publicise adequately
    - Failure to consult
    - Absence of information
- Deal Town Council: closure of Stroke Unit at QEQM

Unable to comment

- Royal College of Nursing (South East)

Appendix

Telephone survey respondents

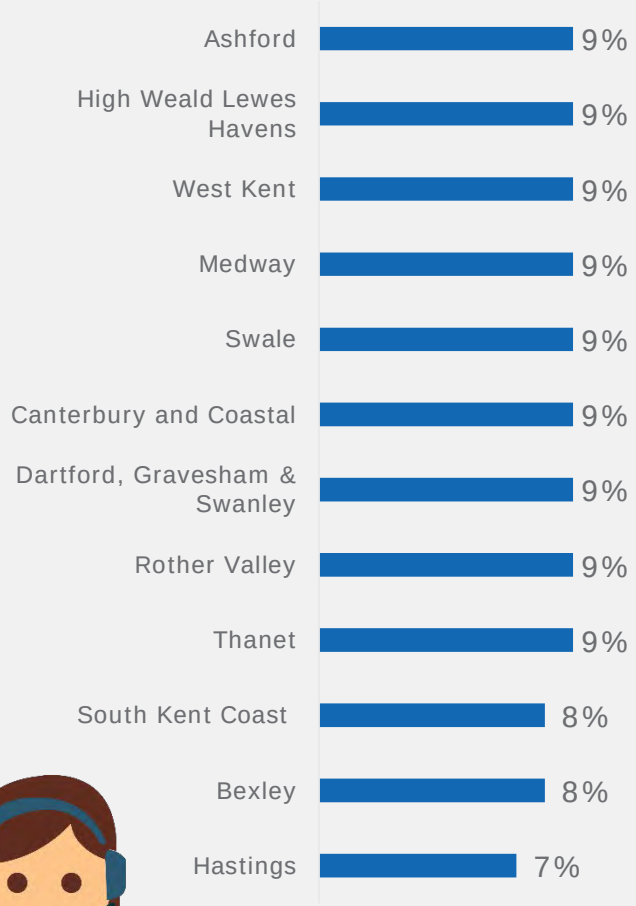
Gender

Male	Female
42%	58%

Age

18-64	65+
72%	28%

Location



Ethnicity

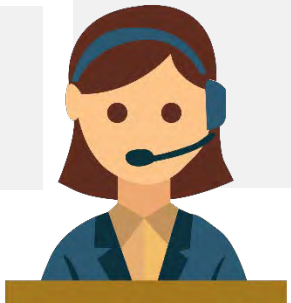
White	96%
Non White	4%

Long term health condition

Yes	3%
No	97%

Caring role

Yes	21%
No	79%



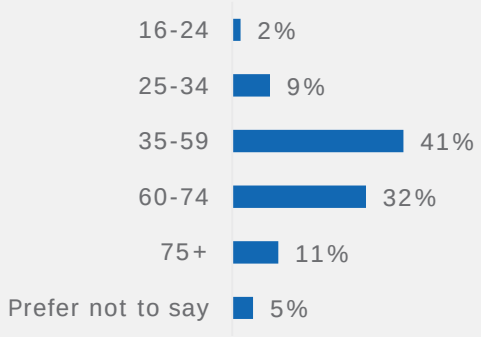
Online survey / paper survey respondents

Gender

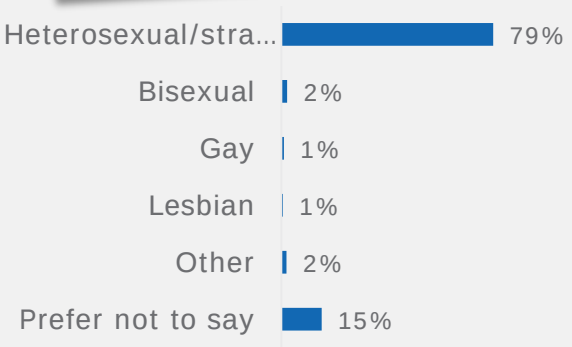
Male **30%**

Female **66%**

Age



Sexual orientation



Ethnicity

White **86%**

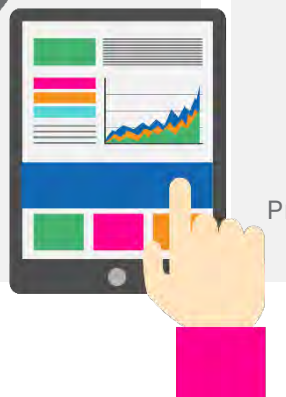
Non White **5%**

Unstated **9%**

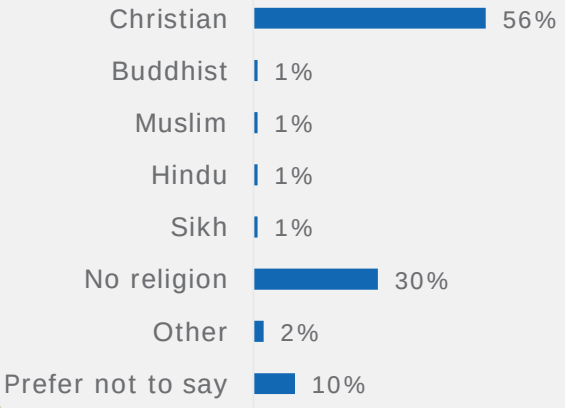
Currently pregnant, or gave birth in the last 12 months

Yes **2%**

No **92%**

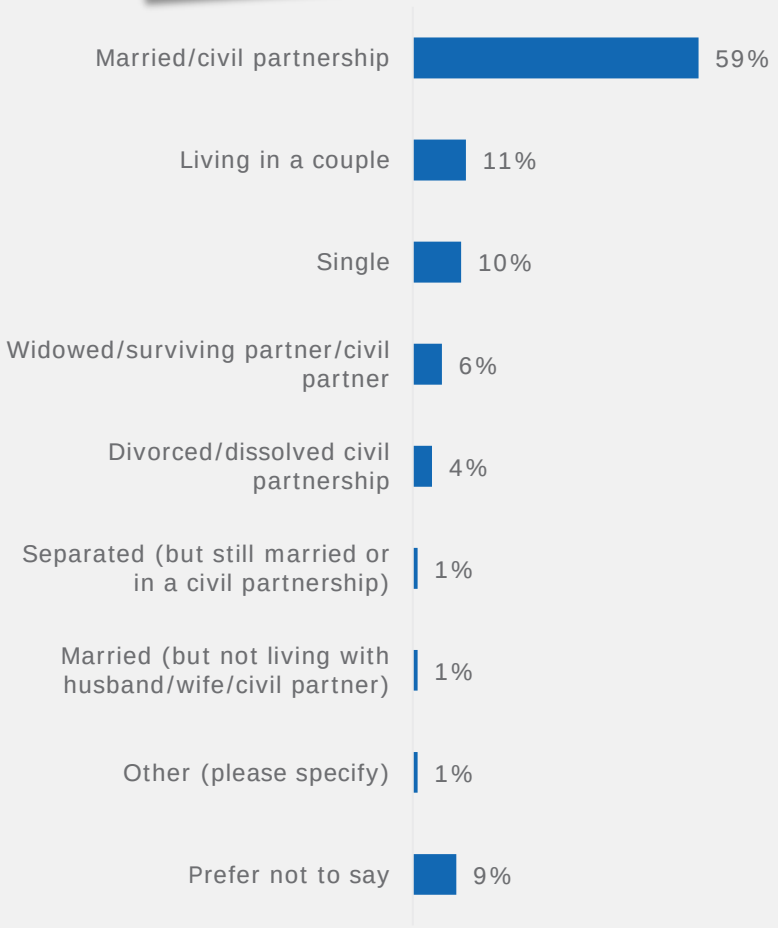


Religion

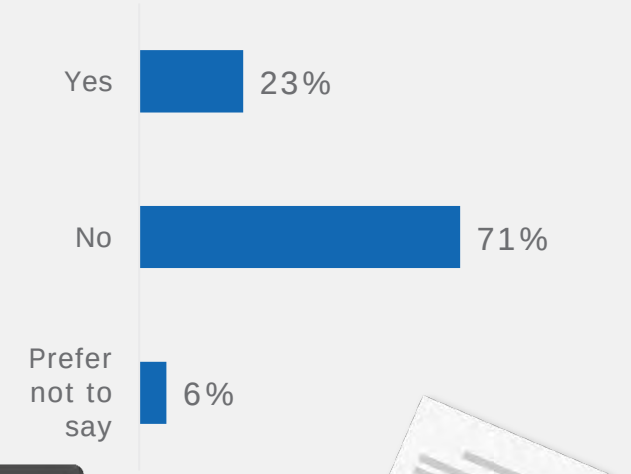


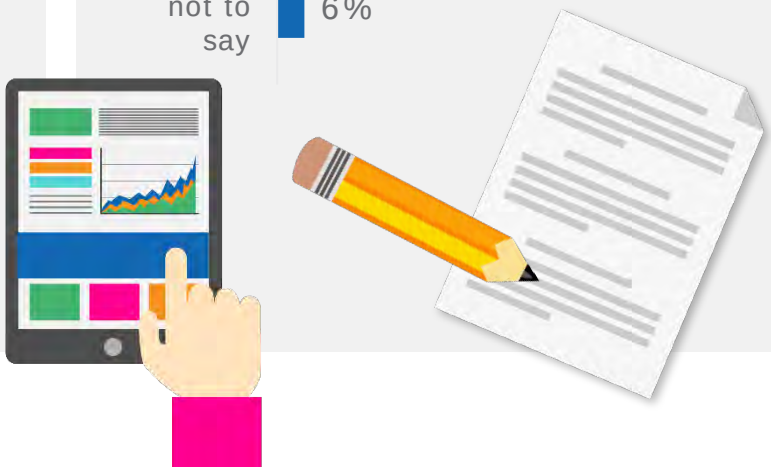
Online survey / paper survey respondents

Living arrangements

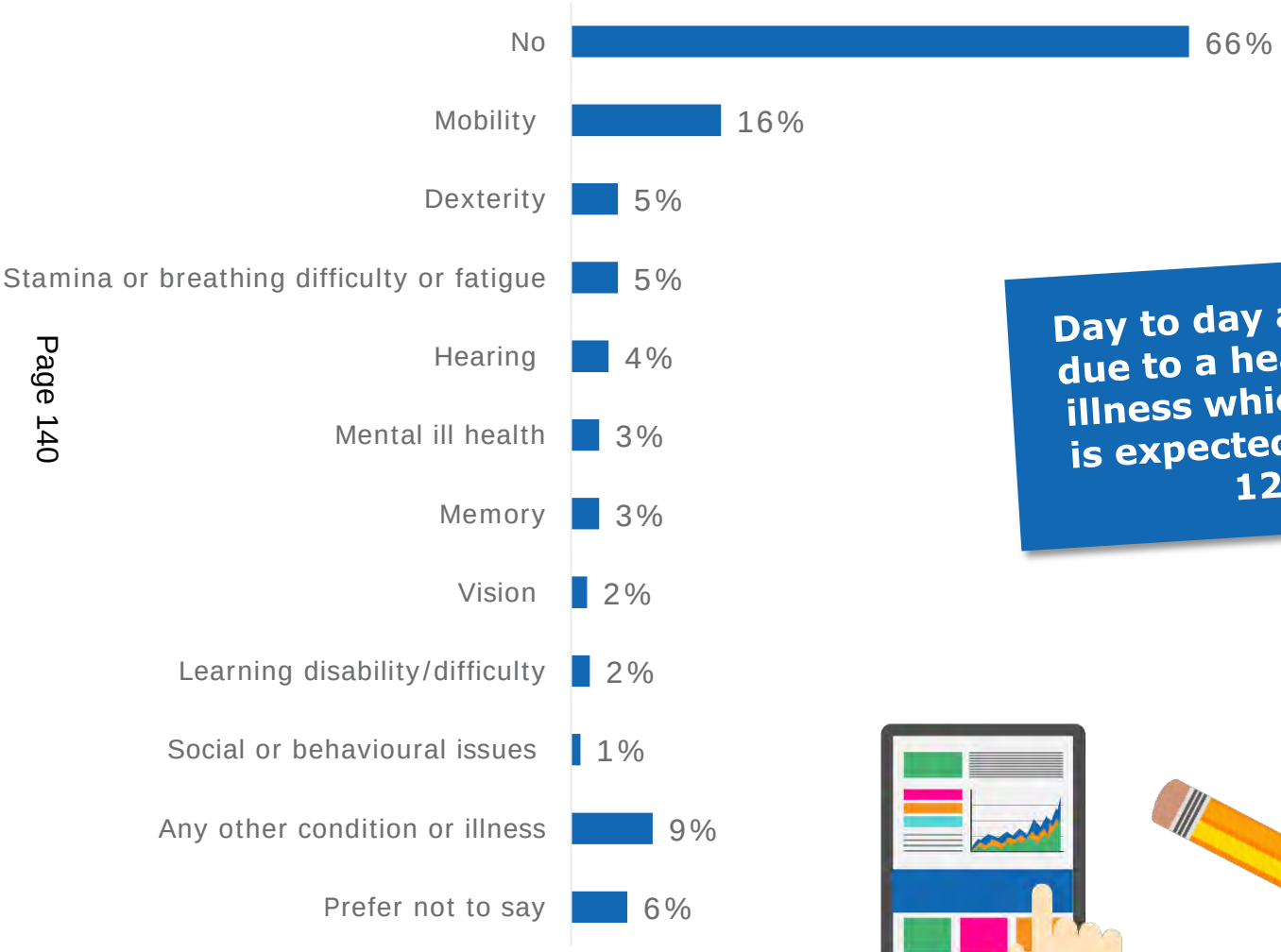


Looking after a relative, neighbour or friend who is ill, disabled, frail or in need of emotional support





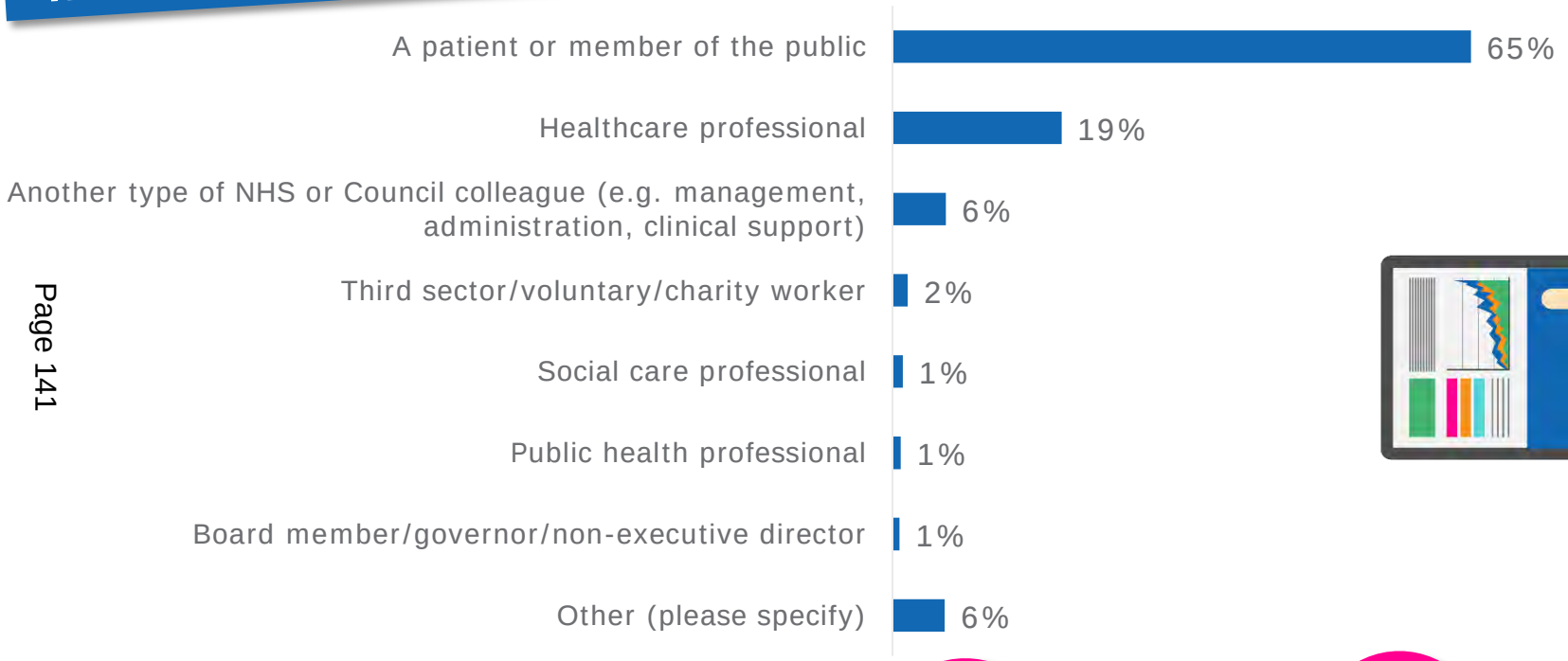
Online survey / paper survey respondents



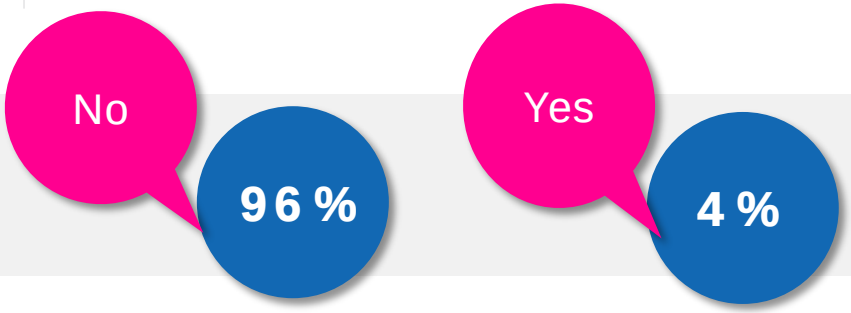
Day to day activities limited due to a health condition or illness which has lasted, or is expected to last, at least 12 months

Online survey / paper survey respondents

Role in relation to completing the survey



"Are you responding on behalf of an organisation?"



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Transforming health and social care in Kent and Medway

NHS

Review of urgent stroke services in Kent and Medway

Our consultation activity report

Report for the Joint Committee of Clinical Commissioning Groups on public consultation activity

29 June 2018

Contents

1 Introduction

Over the last 18 months the NHS, social care and public health teams in Kent and Medway have been working together to plan how we could transform health and social care services to meet the changing needs of local people; improve health and wellbeing; improve the quality of services; and deliver sustainable services for the long-term within our available resources. This work is being progressed through the Sustainability and Transformation Partnership (STP) for Kent and Medway and its driving force is to set out and deliver changes to services to achieve the right, best quality care for people for decades to come.

A major part of this programme of work is to continue to progress the review of hospital-based urgent stroke services across Kent and Medway. The eight GP-led clinical commissioning groups (CCGs) in Kent and Medway (responsible for planning and buying healthcare for local people) have been working together on this review since late 2014. Their work has been in response to national and local evidence, and national requirements and recommendations specifically for hospital-based urgent stroke care, meaning the care people receive in hospital immediately after having a stroke. Partners across our county border in London (Bexley CCG and Bromley CCG) and East Sussex (High Weald Lewes and Havens CCG and Hastings and Rother CCG) have also been involved in our work. Bexley CCG and High Weald Lewes and Havens CCG have opted to be part of the Joint Committee of CCGs consulting on this service change, as they recognise that services in Kent and Medway are used by their residents living close to the Kent and Medway borders and therefore there could be a material impact from this review on their future commissioning of stroke services.

Around 3,000 people who have a stroke each year live closest to a Kent and Medway hospital. National evidence[1] shows people having a stroke do best when they are treated in a specialist stroke unit, staffed by specialist doctors, nurses and therapists - with a specialist team available 24 hours a day, seven days a week. Over recent years, a number of areas[2] across the country have reorganised their stroke services to provide such units and have seen significant improvements[3] in patient outcomes (fewer deaths, and less disability) as a result.

Stroke services are currently offered at six of our seven acute hospitals in Kent and Medway, but these are not 24 hours a day, seven days a week, specialist stroke units. Although hospital staff in Kent and Medway provide the best service they can, the way stroke services are set up currently, along with specialist staff shortages, means our local hospitals do not consistently meet the national standards for clinical quality[4]. Evidence shows that to best maintain their skills, specialist stroke staff should treat at least 500 strokes every year[1]. Only one of the seven hospitals in Kent and Medway regularly treats more than 500 stroke patients a year[4].

Following detailed engagement with stroke survivors, their families, the public, stroke doctors and nurses and other key stakeholders since 2014[5], we began a formal public consultation in February 2018 on proposals to implement 'hyper acute stroke units' (HASUs) in Kent and Medway.

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[1] National Clinical Guideline for Stroke, Royal College of Physicians: 2016; www.strokeaudit.org/Guideline

[2] https://kentandmedway.nhs.uk/latest-news/where-else-are-stroke-services-changing/

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

[4] https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx

[5] https://kentandmedway.nhs.uk/workstreams/hospitalcare/stroke-care-review/

We proposed to establish three hyper acute stroke units and to locate acute stroke units and 7-day transient ischemic attack (TIA or mini-stroke) clinics alongside the hyper acute stroke units. We consulted on five possible three-site options for hyper acute and acute stroke units.

The consultation comprised the following key questions:

1. Do you think there is a clear case for changing the way we deliver stroke services?
2. Do you think there should be hyper acute stroke units in Kent and Medway?
    a. Should acute stroke units and transient ischemic attack (TIA or mini-stroke) clinics be located alongside these units?
3. Do you think that three hyper acute stroke units would be the right number for Kent and Medway?
4. Do you have a preference for any of the five options?
5. Are there any other options or any other factors that we should consider?

The public consultation ran for 11 weeks from 2 February to 20 April 2018.

1.1 About this report

This report sets out how we delivered the formal consultation on urgent stroke services across Kent and Medway and with our neighbouring areas in Bexley and High Weald Lewes and Havens.

It describes the range of activity we undertook but does not describe the responses we received. This is set out in a separate report, developed for the Joint Committee of CCGs by an independent market research company, DJS Research.

This document is essentially a report on how we delivered against our consultation plan. The consultation plan formed part of the pre consultation business case (PCBC) that was co-designed locally with a range of stakeholders, assured by NHS England, approved by the Joint Committee of CCGs and informed their decision to begin the formal stroke consultation. The consultation plan was informed by discussions with colleagues from commissioner and provider organisations across Kent and Medway and CCGs in Bexley, Bromley and East Sussex, the Stroke Association, and our Patient and Public Advisory Group (PPAG). It was also informed by best practice principles from NHS England and NHS Improvement, Cabinet Office guidelines on consultation and from The Consultation Institute, as well as examples of good practice found across healthcare and other organisations in England.

1.2 Governance

Development of this consultation report has been overseen by the communications and engagement workstream of the Kent and Medway STP programme on behalf of the Joint Committee of Clinical Commissioning Groups, reporting in to the Stroke Programme Board via the Stroke Communications Lead (LR) and the STP Programme Board via the STP Communications and Engagement Lead (SH), and to the Joint Committee of the CCGs via the STP Communications and Engagement Lead (SH). Representatives from Bexley and High Weald, Lewes and Havens CCGs are part of the governance structure of the stroke review via the Joint Committee of the CCGs.

The STP Programme Director (MR) is the Senior Responsible Officer for communications and engagement, and the Director of Acute Strategy for the Kent and Medway STP (PD) is the Senior Responsible Officer for the review of Kent and Medway urgent stroke services.

This report will be formally approved and signed-off by the Stroke Review Programme Board, by the Kent and Medway STP Programme Board, and by the Joint Committee of the CCGs. It will be reviewed by a number of other groups, who will be given the opportunity to provide feedback, such as communications leads across the consultation geography, including in Bexley and High Weald

Lewes Havens and the Kent and Medway STP Patient and Public Advisory Group. The report will also be reviewed by the Kent and Medway Joint Health Overview and Scrutiny Committee.

2 Scope

In **geographical** terms, the consultation covered the eight CCG areas in Kent and Medway (Medway; Dartford, Gravesham and Swanley; Swale; West Kent; Ashford; Canterbury and Coastal; Thanet; South Kent Coast), plus two adjacent CCG areas – High Weald, Lewes Havens in East Sussex and Bexley, in south east London.

Whilst we consulted on proposals to change acute stroke services within Kent and Medway, there are neighbouring communities whose residents may be impacted by our proposals. During the development of our consultation plans we engaged with the Health Overview and Scrutiny Committees across our county borders in East Sussex and in Bexley, south east London, as our modelling showed a potential impact for residents in these areas in terms of future access to hyper acute stroke unit services. Both these scrutiny committees confirmed that our proposals constitute significant variation to current service provision for their residents, and therefore they decided to form a Joint Health Overview and Scrutiny Committee with colleagues in Kent and in Medway. We will continue our engagement with members and will continue to formally engage and consult with this new Joint HOSC, in accordance with our statutory duties.

We also engaged with neighbouring clinical commissioning group colleagues in Bexley, Bromley, East Surrey, Hastings and Rother, and High Weald Lewes Havens. Bexley and High Weald Lewes Havens CCGs agreed to join the Joint Committee of CCGs (with the eight Kent and Medway CCGs) and become formal consultors, in recognition of the impact the proposals could have on their commissioning decisions about stroke services for people in their areas. Bromley CCG decided not to be part of the Joint Committee of CCGs in recognition of the potential impact on activity and patient flows at the Princess Royal University Hospital within its CCG area, preferring instead to be a consultee and to respond to the consultation with this in mind.

Our consultation activity therefore stretched across ten CCG geographies, reaching out to residents in Kent, Medway, High Weald Lewes and Haven and Bexley. We also ensured information was available for statutory health and care organisations and key stakeholders, and residents, in neighbouring Bromley in south east London and in the Hastings and Rother area of East Sussex.

To support our consultation work, we worked with communications and engagement colleagues in Bexley, Bromley, High Weald Lewes Havens and Hastings and Rother CCGs to: identify stakeholders and networks – particularly to reach our targeted audiences; cascade and distribute information both physically and digitally; signpost and encourage responses to our consultation questionnaire; attend key meetings and fora; and, in Bexley and High Weald Lewes Havens areas, to hold open listening/ discussion events with the public. We included these areas in our work to gather views from a representative section of our consultation population, for example through focus groups and telephone polling, and in our outreach activity to consult with seldom heard and protected characteristic groups.

In service terms, the consultation proposals focus on changes to hospital-based urgent stroke services in Kent and Medway. We were aware that people would want to know, and consideration has been given to, how these services will align with care given outside of a hospital setting (areas such as rehabilitation and local care and support at home or in a community setting) but rehabilitation services and local care services per se were outside of the scope of this consultation.

3 Pre-consultation engagement

Since the review of stroke services began in late 2014, a significant amount of pre-consultation engagement has been carried out with local people, communities, staff and stakeholders across Kent and Medway. In south east London and East Sussex, engagement work proportionately reflects the impact that these proposals would have on the respective populations. The border CCG areas affected (Bexley, Bromley and High Weald, Lewes Havens and Hasting and Rother) have all been involved as consulting partners or interested stakeholders in the stroke review to date.

Prior to formal public consultation, pre-engagement activity with partner organisations (hospital and ambulance trust and clinical commissioning group clinical and leadership teams), frontline staff, stakeholders such as MPs and local government representatives, and patients, public, stroke survivors, carers and their representatives such as the Stroke Association and Healthwatch, has been done to ensure that the proposals have been clinically led, co-designed and developed with significant input from a wide range of people.

This work is detailed in the pre-consultation business case and a full break down of activity can be found here www.kentandmedway.nhs.uk/stroke.

3.1 Statutory duties and legislation

As NHS organisations we are required to show how the proposals we consulted on met the four tests for service change laid down by the Secretary of State for Health. These are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base to support the proposals
- Support for the proposals from clinical commissioners.

The Chief Executive of NHS England has introduced a ‘fifth test’ that requires NHS organisations to show that significant hospital bed closures, subject to the current formal public consultation tests, can meet one of three conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

There is also a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- Section 242, of the NHS Act 2006, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.
- Section 244 requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees).

- The NHS Act 2012, Section 14Z2 updated for Clinical Commissioning Groups, places a duty on CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
    - in the planning of the commissioning arrangements by the group
    - in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
    - in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Current guidance on involvement is called 'Transforming Participation in Health and Care' and is available here - http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

We needed to make sure that our consultation activities meet the requirements of The Equality Act 2010, which requires us to demonstrate how we are meeting our Public Sector Equality Duty and how we take account of the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

We also needed to consider other relevant legislation and show:

- How we have learnt from the views and requirements of those who may use our services and their carers, families and advocates and responded to their feedback
- How the proposals will bring significant clinical benefits and improve outcomes and accessibility
- How the proposals consider people's diverse and individual needs and preferences including people with protected characteristics.

The activity outlined in this document contributes to the work of the Stroke Review programme in meeting those obligations.

4 Consultation principles

Our consultation activity was underpinned by the following fundamental principles, as stated in our consultation plan.

4.1 Consulting with people who may be impacted by our proposals

- We will reach out to people where they are, in their local neighbourhoods and in local networks.
- We will make sure that there are 'no surprises' for staff whose jobs may be affected by the review and that they will hear from us first about the proposals and have an opportunity to respond. We will ensure that they are aware of the process, understand how their roles may be impacted and will ensure they understand how they can give their views on the consultation.
- We will cover the geography, demography and diversity of Kent and Medway and our boundary populations, including the working population, silent majority, seldom heard, people who are mostly well, and people who aren't, and those with protected characteristics, to gather a fair representation of views and feedback.

4.2 Consulting in an accessible way

- We will provide detailed information on websites to ensure transparency. We will also produce targeted public-facing documents (some printed as we know not everybody wants to access information digitally), summaries, case studies and social media content.
- We will make sure our public information is consistent and clear; written and spoken in 'plain English' avoiding jargon and technical information; accessible to everyone and available on request in a range of languages and formats.
- We will make clinical information and agreements available to the public.
- We will provide a range of opportunities for involvement and engagement with our consultation; reaching out to people where they are, in their local neighbourhoods and in local networks, physically and digitally.

4.3 Consulting well through a robust process

- We will make sure that local people and the staff working in organisations affected by the proposals across Kent and Medway and within the boundaries of London and East Sussex CCG areas have confidence in our consultation process, ensuring it is open, transparent and accessible.
- We will be clear and up front about how all views can influence decision-making, explaining it will not be possible to do everything everyone wants and why difficult decisions have to be made.
- We will make sure people are aware of our consultation even if they choose not to participate.
- The consultation will run for a sufficient length of time to allow people to give their views and we will provide regular reminders about progress and the closing date.
- We will strive to ensure we are acknowledged locally and nationally to have undertaken a meaningful and effective consultation process.

4.4 Consulting collaboratively

- We will work collaboratively with individuals, stakeholders and partner organisations to deliver the agreed consultation principles and make the most of the opportunities of partnership working to reach out to as many people as we can in a meaningful way across Kent and Medway and our boundary populations in London and East Sussex.
- Our information will be relevant to local groups, being clear about what the proposals mean for each geographical area and for each group of people taking account of their interests, diverse needs and preferences.

4.5 Consulting cost-effectively

- We will strive to ensure our consultation budget is spent wisely and used effectively in terms of reach and response, delivering good value for money throughout.

4.6 Consulting for feedback

- We will monitor and evaluate our consultation process consistently and in a systematic way, including capturing feedback and comments from events, meetings, surveys, discussions and individual responses
- We will commission several 'mid-term' reports in terms of consultation response analysis, to assess progress on where, how and from whom we are receiving feedback and responses, so we can target our activity to address gaps in feedback geographically or demographically
- The analysis of feedback will be done independently, and the independent report shared publicly
- The results of our consultation and the feedback received will be thoroughly and conscientiously considered and used to inform decision-making.

4.7 Our commitment to an accessible and inclusive approach

In addition to the general principles above, we also made a commitment to ensuring we targeted, and cater for, the needs of seldom heard groups and others with special requirements. These groups include, for Kent and Medway and in our neighbouring CCG areas, for example: the young, the working well, those in deprived communities, those in more rural communities, migrants, those with learning disabilities and those from BAME groups. We also committed to seeking views on the proposals from those representing the nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation. The integrated impact assessment highlighted the following groups who may have a disproportionate need for stroke services.

- Age (older people aged 65 and over)
- Deprived communities
- Disabled
- Pregnancy and maternity
- Race and ethnicity: Black, Asian and minority ethnic (BAME) communities
- Sex: Male

This commitment to engage specific groups is underpinned by legislation to ensure that all public services make every effort to engage specific groups in consultation to improve and redesign services. The 2010 Equalities Act (updated to Equality Duty 2011) makes clear the responsibility of public services to make additional effort to engage specific groups as a means of improving decision-making.

To best meet needs of people with additional requirements we committed to:

- Producing an ‘Easy Read’ summary consultation document and response form
- Produce materials in different print formats on request – for example large print, braille or audio; and ensure translation services are in place and easily accessible if needed
- Produce material in plain English – in consultation with our Patient and Public Advisory Group, colleagues at The Stroke Association, and an independent research company.

4.8 Our objectives

Throughout the consultation we worked to deliver a best practice consultation within the timeframe and budget allocated and worked with independent providers to deliver key consultation activity and to analyse the results to ensure an objective outcome. We used, and will continue to use in our ongoing evaluation, a mix of qualitative and quantitative methodologies to allow for both volume and richness of response.

To help us achieve our aims, we set the following objectives:

- Make people aware of the public consultation and how they can get involved
- Comply with the duty to inform people about how the proposals have been developed and describe and explain the proposals and what they will mean in practice for the provision of local services so that people can make an informed response
- Seek people’s views on the proposals, including the range and location of services as set out in the proposals
- Ensure that a diverse range of voices are heard and that the engagement activities target specific community groups to ensure the local population is represented
- Consider the responses made as part of the consultation and take them into account in decision-making, with sufficient time allocated to give them thorough consideration

- Ensure that the consultation process uses a range of methods to reach different audiences and maximises opportunities for engagement with the local community and key partners
- Deliver a public consultation in line with best practice that complies with our legal requirements and duties.

5 Stakeholder mapping

We aimed to engage as many people and groups as possible from the local area as the timeframe and budget for our consultation permitted. We worked with our colleagues in health and local authority organisations across the county and in boundary CCG areas to enable this. Our stakeholder map below illustrates the broad range of stakeholders we aimed to target during the consultation.

Patients and public	• Residents of Kent, Medway, Bexley, Bromley, High Weald, Lewes and Havens, Hasting and Rother • Stroke patients, carers and their families, and their representative groups such as The Stroke Association • Those previously involved in pre-consultation engagement activities • Seldom heard groups • Groups with protected characteristics • Relevant Healthwatch groups • Local patient groups (GP Patient Participation Groups, Health Reference Groups etc) • Carers groups • Kent and Medway STP Patient and Public Advisory Group members, and the equivalent in South East London and East Sussex STP areas • Kent and Medway STP Partnership Board members, and South East London and East Sussex equivalent groups • Campaign groups • Voluntary and community sector groups including faith groups
Clinicians and staff	• Trades unions, staffside groups and professional organisations • Acute hospital staff • Ambulance trust staff • Community services provider staff • Social care teams • Mental health trust staff • CCG Governing Body members • CCG GP members • GP practice staff, dentists, opticians, pharmacists and their local council bodies • Royal Colleges • Universities and medical schools • Health education bodies • Academic Health Science Networks
Local and national government and regulators	• NHS England (national and regional) • NHS Improvement (national and regional) • South East Coast Clinical Senate • London Clinical Senate • Professional bodies • Councils (top-tier and district)
Political	• Local MPs • Joint Health Overview and Scrutiny Committee members • Health and Wellbeing Boards • Councillors

Partners and providers	• Acute hospital, ambulance and community services providers – boards and frontline staff • Boards and staff in neighbouring areas • Boards and mental health trust staff in neighbouring areas • GP Governing Body members • CCG GP members • GP practice staff, dentists, opticians, pharmacists • Voluntary and community groups • Local business organisations and chamber of commerce
Media	• Local print and broadcast channels • Specialised press and media including stroke support group newsletters, bulletins and online publications • National print and broadcast (while we will not proactively seek national media coverage, we should be prepared to handle enquiries from these outlets) • Trade press (professional media outlets such as nursing or medical journals and publications, as well as online and social media counterparts, are often useful channels for raising awareness of proposals to staff and professional groups) • Partner organisation news channels such as council papers, local directories, parish bulletins and leaflets and voluntary sector organisation newsletters

6 Consultation approach

Our approach to the consultation was to use a range of techniques and channels to ensure as many stakeholders shown in the table above were aware of, and able to engage and respond to the consultation, should they wish to do so. We wanted to reach a broad range of people, beyond those in statutory organisations, partner organisations and those with a vested interest, or those already highly engaged who usually respond to consultations.

It was our intention, before the consultation began, to have two clear levels of consultation activity: at STP level and at CCG level – as set out below.

1. **Activity at Joint Committee/STP level**: briefings and meetings with groups and stakeholders at county level (eg JHOSC, MPs, some patient and voluntary groups, regulators, partners, royal colleges, clinical senate etc), generation and clearance of core content, production and distribution of consultation materials, planning and delivery of the consultation launch, responses to correspondence, FOI, media requests and proactive media activity, digital engagement etc
2. **Activity at CCG level**: CCGs were asked to develop dedicated plans tailored to their areas allowing them to take into account the specific opportunities, networks, channels and mechanisms that would present themselves across CCG areas, supported by the core consultation team and consistent core consultation materials as appropriate.

However, the day-to-day demands on the time and resources of colleagues in CCGs and provider organisations made it understandably difficult for them to dedicate significant time to organising consultation activities. As a result, whilst some significant and valuable activity was led and delivered by local CCG teams, the majority of consultation activity was planned and delivered by the STP communications and engagement team, working in partnership with local organisations. It is important to recognise that CCGs and provider organisation colleagues gave a huge amount of support to the consultation, despite this time pressure and we thank them extensively for that. Communications and engagement teams and leadership teams from across the NHS in Kent, Medway, East Sussex and South East London played a vital role in the delivery of listening events, staff briefings and sharing information among stakeholders and local communities.

6.1 Digital communications

Digital communication does not replace engaging with people face-to-face, but is a way of raising awareness, providing information and accessing more people; including some people like the working well, mothers of young children or carers, and some older people who find it harder to leave the house and attend meetings.

For a large and growing section of the population digital communication is now their preferred means of communication. Cabinet Office Guidance advises that "digital is the default method for consultation". 'Digital First' is the preferred mass method as it reduces waste, money and time – web and social media activity should be the starting point. The guidance states that paper surveys must be reduced as their evidence suggests people do not like them and few fill them in. It does emphasise that tailored, evidence-led inclusion of target groups must use additional appropriate tools to suit the needs of these groups i.e. face to face road shows and focus groups; which we built into our consultation plan. However, we were aware, through feedback from our own patient and public groups, representatives and networks that there is still a requirement for paper-based copies of documents and we made sure that we supplies of paper-based materials were targeted and distributed appropriately.

Given the above, our approach used the full range of different channels of communication: face to face activities, digital, wide-scale distribution of printed information, paid for advertising and news media.

6.2 Mechanisms for response

We provide the following mechanisms for response:

- Freepost address – for returning paper responses to the consultation questions
- Dedicated consultation email address
- Online – including a web form and via social media e.g. Twitter and Facebook
- Free phone line/voicemail
- Face to face.

All feedback, whether verbal or written, was collected and sent on, as part of the formal response, to DJS Research, the independent research organisation commissioned to collate, monitor, analyse and report on the responses received.

7 Our target for reach and responses

Based on our consultation principles, stakeholder map and consultation approach, the Joint Committee of CCGs agreed a target to reach a minimum of one percent of the impacted population, with a stretch target of five percent. We wanted to reach a representative sample of the population to ensure that there was awareness of the proposals, sufficient opportunity to comment and a rich source of feedback and insight for us to make sure that future decisions on the shape of urgent stroke services are ones that reflect the needs of the local population. The total registered population of Kent and Medway, Bexley and High Weald Lewes and Haven is c2.2million, so one percent is 22,000 and five percent is 110,000.

We were clear that if we set our targets for reach too high we would need to use a lot more paid-for advertising, which may not have resulted in a very different outcome on feedback. Indeed, there was a consistency to the themes and feedback received which may not have altered significantly with any greater volume of response. We were clear that the consultation was not a vote or referendum, but an opportunity to gain rich and deep insights into people's views and feedback on the proposals put forward. The important target was that the feedback was representative of people

and communities across the consultation geography, and that it would deliver some rich insights into people's views. The quality of feedback to our consultation was important alongside the quantity.

Our target for responses was 3000 separate responses. As well as responses to the formal questionnaire, this target included emails, social media interactions, phone calls, letters and comments made at events.

The targets for reach and responses were a key measure of our evaluation for the success of the consultation. The table below show our reach broken down by different channels, which significantly exceeded our stretch 5% target.

7.1 Reach

Channel	Reach
Newspaper advertising	296,842
Radio advertising	341,269
Digital alerts	52,503
Leaflet drop	98,200
Social media promoted posts/tweets	550,000+
Media coverage	Various, including: • TV reports on BBC South East: 900,000+ • Radio reports on Heart Kent FM: 300,000+
Newsletter and bulletin articles	25,000+
Direct dissemination of consultation materials to NHS staff	43,500
Dissemination of consultation materials to NHS organisations (including GP practices)	35,000 summary leaflets and 15,000 full consultation documents were sent to all GP practices, all provider organisations, pharmacies and all public libraries across the consultation geography. See section 8.3 for a more detailed breakdown of the dissemination.
Dissemination to libraries	

7.2 Responses

We significantly exceeded our response target, receiving over 2500 consultation questionnaire responses and attracting over 850 people to public meetings. In addition, our independent telephone research, focus groups and outreach work gathered views from over 1000 people. Further details on the response we gathered are shown below:

- 2240 responses to the online questionnaire
- 299 hard copy questionnaires submitted
- Notes from 28 public listening events attended by 850 people
- Notes and feedback from 12 meetings and forums hosted by others where we discussed the proposals
- Notes from consultation events with staff in NHS trusts
- 701 telephone interview responses
- 442 face-to-face discussions through focus groups, street surveys and outreach engagement
- Over 500 comments and queries received by email, post and phone

- Over 500 comments and queries received via social media channels (primarily Twitter and Facebook)
- 1521 postcard responses and a petition with ~3500 signatures received from a group in Thanet

8 Consultation activity: giving information and promoting the consultation

This section of the report describes in more detail how we provided information on the consultation and what we did to promote it to our target audiences.

8.1 The consultation document and supporting materials

At the core of our consultation was the consultation document and consultation summary leaflet which set out the basis on which we were consulting, the background to the consultation, a summary of the data upon which options have been developed and what the proposals/options were. Both these signposted to more detailed technical information if needed. The consultation document also included a copy of the consultation questionnaire and set out the various other methods by which people could engage in the consultation.

During the drafting of the consultation materials they were circulated widely among the Stroke Programme Board members, Stroke Clinical Reference Group members and Joint Committee of CCGs members to seek input and feedback. We worked very closely with the pre-consultation business case team to ensure the consultation documents fairly and accurately reflected the PCBC, which had been seen and approved by Kent and Medway provider organisations and the ten clinical commissioning group governing bodies across the consultation geography and the NHS England assurance team before publication. We also tested the draft documents and other consultation materials with our Patient and Public Advisory Group, taking on board feedback to ensure they were clear and well-understood. The consultation documents were approved and signed off for publication by the Stroke Review's clinical lead, the Stroke Review's Senior Responsible Officer and the Kent and Medway Sustainability and Transformation Partnership's Programme Director.

The core public documents to explain the proposals were:

- **Main consultation document** (48page A4) including a copy of the questionnaire included as tear out pages and a freepost address for returns. Electronic copies of the designed version, a plain large print copy and a standalone questionnaire were available on the consultation website. 15,000 copies of the designed version were printed (see below for distribution details).
- **Summary leaflet** (8page A5) giving an overview of the proposals and the case for change. Providing links to our website and email/telephone/social media contact details. An electronic copy was published on the consultation website. 35,000 copies were printed (see below for distribution details).
- **Easy read leaflet and questionnaire** - versions of the summary leaflet and response questionnaire were developed by a specialist easy read production company and published on the consultation website. Social media and email cascades were used to inform people that they were available. The easy read material was published on 12 February 2018.

Copies of these materials are available in Appendix A to C.

Additional printed material

- **Poster** (A4) highlighting the key consultation proposals, consultation dates, a 'call to action', signposting to the website for further detailed information and contact details. 1,000 copies were printed and distributed across the consultation geography.

- **Flyer** (double sided A5) This was produced in addition to the original consultation plan following a specific request by a campaign group in Thanet. The flier highlighted 14 specific engagement events, the consultation options and dates, website and contact details. 99,000 copies were printed (see below for distribution details).

Figure 1: Promotional poster

Figure 2: Listening events flyer

8.1.1 Background documents

The full pre-consultation business case and appendices were published online at the start of the consultation at https://kentandmedway.nhs.uk/stroke. Links to these documents were included in social media, email and other correspondence with people asking questions about the detail behind

the consultation. Graphics and slides from the detailed background documents were used on social media to explain background to the evaluation process, travel modelling and a range of other queries that were raised.

A small number of requests were received for printed copies of the background material. These were responded to via the consultation programme management office.

8.2 Distribution of main consultation materials

The electronic copies of the main document and summary leaflet were distributed to all partners for circulation through their internal and external channels; either as attachments or linking to the copies on the Kent and Medway website.

The table below shows where printed materials were distributed and the timings. It was agreed that, in line with the Cabinet Office 'digital by default' principle, the consultation would launch with electronic copies of the main document, summary leaflet, pre-consultation business case and supporting documents. As explained above, we recognised that for this consultation geography and target audiences that printed materials were also important and printing and distribution began following approval to consult being given by the Joint Committee of CCGs on 31 January and final amends to and sign off of the materials following that meeting.

Printed materials and timings	**Locations and quantities** (based on requested numbers informing print, distribution and planning) **NB: These documents were available online and distributed widely electronically at the launch of the consultation**
Main consultation document (distributed between 06 and 19 February)	**Hospital, Community and Mental Health providers:** Sent to 8 providers to make available across all sites for public and staff. Quantities varied from 3,000 copies to East Kent University Hospitals to 15 copies at Princess Royal University Hospital.
	GP surgeries: 5 copies sent to each of 243 GP practices in the consultation area
	Libraries: 10 copies sent to each of 135 libraries in the consultation area
	CCG offices: 10 copies sent to each of 10 sites for display and staff
	Commissioning Support Unit: 250 copies for onward distribution and use at local engagement events.
	Ambulance Trust: 5 copies sent to each of the 8 ambulance stations in the area.
	Healthwatch: Between 10 and 30 copies sent to each of the 4 Healthwatch offices in consultation area for display and use at events.
	Listening events: Copies available at 28 public events
Summary consultation leaflet (distributed between 06 and 19 February)	**Hospital, Community and Mental Health providers:** Sent to 8 providers to make available across all sites for public and staff. Quantities varied from 3,000 copies to East Kent University Hospitals to 75 copies at Princess Royal University Hospital.
	GP surgeries: 25 copies sent to each of 243 GP practices in the consultation area

	Pharmacies: 15 copies sent to each of 354 pharmacies in the consultation area
	Libraries: 25 copies sent to each of 135 libraries in the consultation area
	CCG offices: 200 copies sent to each of 10 sites for display, circulation to staff and use at local events
	Commissioning Support Unit: 2500 copies for onward distribution and use at local engagement events.
	Ambulance Trust: 25 copies sent to each of the 8 ambulance stations in the area.
	Healthwatch: Between 100 and 50 copies sent to the 4 Healthwatch offices in consultation area for display and use at events.
	Public listening events: Copies available at 28 public events
Poster (distributed between 06 and 19 February)	**Hospital, Community and Mental Health providers:** Sent to 8 providers to make available across all sites for public and staff. Quantities ranged from 40 to single copies.
	GP surgeries: 1 copy sent to each of 243 GP practices in the consultation area
	Pharmacies: 1 copy sent to each of 354 pharmacies in the consultation area
	Libraries: 1 copy sent to each of 135 libraries in the consultation area
	CCG offices: 5 copies sent to each of 10 sites for display
	Ambulance Trust: 1 copy sent to each of the 8 ambulance stations in the area.
	Healthwatch: 5 copies sent to the 4 Healthwatch offices in consultation area for display.
Flyer (distributed between 8-23 March)	**Individual households** in areas most affected by extended travel times. Door-to-door distribution of one copy per household to 98,222 homes in the post code areas: CT7, CT8, CT9, CT10, CT11, and CT12 plus CT13 0, CT13 9, CT 14 0, CT14 6, CT14 7, CT14 9 & ME12 4. The distribution company guaranteed a 95% coverage allowing for some human error/lack of access to individual properties.

8.3 Consultation website

The stroke consultation had a dedicated section on the Kent and Medway Sustainability and Transformation Partnership website: www.kentandmedway.nhs/stroke. The stroke section was clearly linked to – using a large banner - from the site's home page, as well as from several of the main navigation menus to ensure it was easy to find regardless of which section of the website visitors arrived at. The website address was promoted in all the main consultation materials and in all publicity across all formats and channels.

From the launch of the consultation, core information was available including all the main consultation documents and background documents, plus a link to the online consultation

questionnaire. Various sections of the site were developed and regularly updated through the consultation period, including:

- Public meeting details were added to the site as the full programme of events and additional asked for meetings were confirmed.
- A 'frequently asked questions' section was initially available as a downloadable document available from the start of the consultation and then developed into 'on-page' content from 19 March 2018.
- A page called 'consultation challenges' was added on 13 March 2018 with answers to some of the comments/challenges being raised about the proposals and the consultation process.
- A page of videos was updated as new material was filmed through the consultation.
- A page highlighting stroke prevention information was added on 5 March 2018 (Note: stroke prevention information was included on the first page of the consultation document and in all public consultation meetings).
- News pages on the main site were used to promote updates during the consultation such as the publication of new videos or blogs and rescheduling public meetings affected by the snow in early March.

The table below shows the top 10 pages (by page views) within the stroke section during the consultation period.

Page / document (published 2 Feb unless stated otherwise)	Page views (2 Feb – 20 Apr 2018)
Stroke consultation home page	13,968
Consultation questionnaire	5,984
Consultation documents	3,916
Public listening events	2,915
Dedicated contact details page (published 20 Feb – contact details were available in the consultation document from 2 February)	1,029
Pre-consultation business case and appendices	513
Supporting documents summary page	500
Consultation challenges (published 13 March)	245
Stroke prevention (published 5 March)	154
Written questions from listening events (published 19 March)	134

It was not possible to track the number of downloads of specific consultation documents, although this is learning we have taken on board and added new functionality to the STP website for future consultations.

8.4 Consultation briefings, updates and frequently asked questions

As described briefly above, in addition to the consultation document, we published regularly frequently asked questions during the consultation period to help answer some of the most common queries. These are available on our website at https://kentandmedway.nhs.uk/stroke-questions-and-challenges/

We also developed a set of frequently asked question slides to support the public listening events. See section 9.2 for more information on the listening events.

8.5 Display

To capitalise on the high footfall in acute trusts, we produced banner stands for each acute site in Kent and Medway which promoted the opportunity to respond to the consultation. These were displayed in prominent positions within the organisations, often alongside consultation materials.

Figure 3: Banner stand graphic

In addition, some hospital sites and GP practices displayed information about the consultation on their public information screens.

8.6 Media approach

Our media approach throughout the consultation was proactive (as well as reacting, of course, to any enquiries or issues that arose), reflecting that, in the consultation catchment area, the local media continues to be important in influencing public perception and reaction to changes to health services.

The media audiences we targeted with information about the consultation included:

- All local newspapers
- Professional journals such as Health Service Journal, Pulse, Nursing Times, Nursing Standard and GP
- Council newsletters and websites
- Local NHS Trust newsletters and websites
- Local community newsletters and websites
- Online media via our social media activity
- Identified and targeted key NHS and health policy commentators and bloggers, as appropriate

Throughout the consultation we took the following approach to working with and engaging the media:

- Provided regular proactive updates on the stroke consultation
- Responded to media enquires in a timely and helpful manner
- Offered the opportunity to speak with clinical spokespeople to explain the reasons for change and our proposals, and supported them appropriately in this role
- Worked closely with local journalists and ensured they were briefed on the reasons for the stroke services consultation and why local clinicians believe the proposals will improve services and save lives
- Worked with our colleagues in media teams at all partner organisations to ensure messages were consistent
- Quickly and robustly rebutted inaccurate or misleading information included in media reports
- Evaluated media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.

Appendix D provides a detailed breakdown of press release, media enquiries and print and broadcast coverage from the consultation period. The table below gives a summary.

Area	Number
Press releases issued	28
Media enquires	18
Print coverage	44 articles
Online coverage	48 articles
Broadcast coverage	79 broadcasts across TV and radio

8.7 Paid for advertising in traditional media

From the outset the stroke consultation plan recognised the need for paid advertising using a variety of channels to raise public awareness of, and responses to, the proposals being put forward.

Pro-active advertising was carried out using:

- Newspaper advertising
- Radio advertising
- Paid promotions on social media (see section 8.8 for more detail on both paid for and organic social media activity)
- Direct mail (see section 8.2 above for details of the flyer dissemination).

8.7.1 Newspaper advertising

Over the period of the consultation we ran 63 newspaper ads in total across 12 publications across the consultation geography, with a total reach of 296,842 readers. The nine weeks of advertising included one extra week than originally planned to account for the consultation being extended by a week.

A series of quarter page, full-colour newspaper ads running over nine weeks targeted the following papers and their readerships:

Canterbury Extra, Dartford & Gravesend Messenger/Extra, Sheerness Times Guardian, Kent Messenger Series, Kentish Gazette Group, Medway Messenger, Sittingbourne News Extra (Wed), Sheerness Times Guardian, Thanet Extra, Kentish Express Series, East Kent Mercury, Folkestone & Hythe Express.

The area of coverage is shown below.

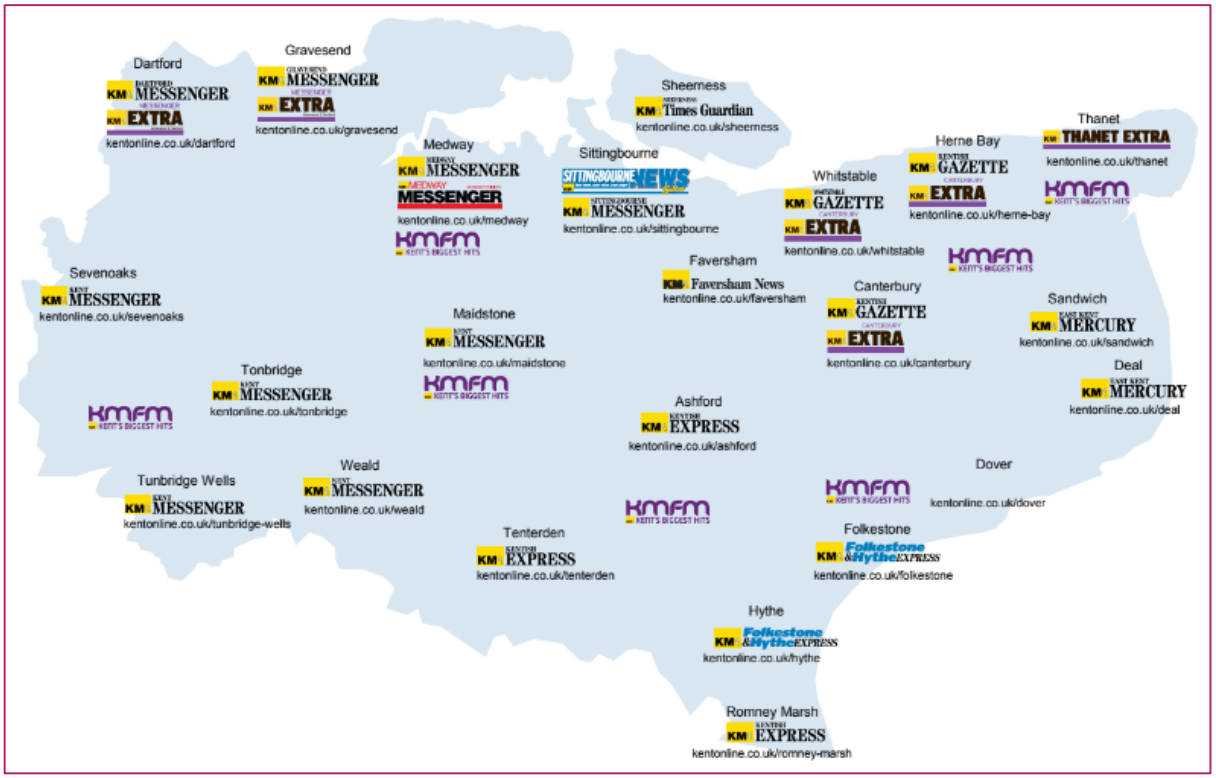

Figure 4: Newspaper & radio ad coverage

Figure 5: Example of newspaper adverts

8.7.2 Radio advertising

We ran a 30 second radio ad over nine weeks across all KMFM stations. In total we ran 4,308 ad spots daily between the hours of 0600 – 2200 across seven FM stations and DAB, reaching 341,269 people over nine weeks. A full transmission report is available in Appendix E.

The stations we used were;

- Ashford - 107.6fm
- Canterbury - 106fm
- Folkestone and Dover - 96.4fm/106.8fm

- Medway - 100.4fm/107.9fm
- Maidstone - 105.6fm
- Thanet - 107.2fm
- West Kent - 96.2fm/101.6fm
- DAB / kmfm.co.uk

The same advertisement ran for the majority of the consultation, with an amended version reminding people of the deadline for responses, running for the final week or so of consultation.

The scripts for both advertisements are available in the post-campaign analysis report in Appendix F.

8.7.3 Digital alerts

In order to boost awareness of the extra week of the consultation, we also commissioned digital adverts to appear in the KM Group's mobile news app for tablets, smartphones and mobile sites. The rolling banner advertisements gained 52,503 page impressions across 11 KM group websites.

Figure 6: Digital mobile banner ad & impact

8.7.4 Impact analysis

Over the course of the consultation our paid advertising:

- Reached 296, 842 newspaper readers across Kent and Medway and in border communities in Bexley and High Weald Lewes Havens over the course of nine weeks
- Achieved 52,503 mobile digital impressions
- Reached 341,269 radio listeners via 4,308 ad spots

A more detailed analysis of the press and radio advertising, is available in Appendix F.

8.8 Social media

In line with our digital by default approach, we used Twitter, Facebook and YouTube to keep online stakeholders informed, and to signpost and facilitate discussion during the consultation period. Our aim was to build on existing relationships with online stakeholders and to engage new audiences.

In addition, we made use of video via our website and YouTube channel, to try to bring the consultation to life for people using Vox pops and longer interviews with key spokespeople, to help engage our target audiences, disseminate key information, share understanding and encourage responses to the consultation.

We had planned to hold online discussions using Twitter – 'tweet chats' – and publish a regular blog, both led by key clinicians involved in the stroke review. However, we found that the demands

placed on these individuals by the increased number of listening events meant this was not possible.

We also made use of paid for promoted posts and adverts on both Facebook and Twitter to help target our key audiences. Targeting parameters, on both Facebook and Twitter, work in tandem in terms of setting geographic area, and interests. Using Facebook targeting as an example, shows how these parameters work in combination:

- **Layer 1, geographic area**. Because people do not need to give their address/postcodes when they sign up for a Facebook account, Facebook works out where people live from their most-often-used IP address, or if on mobile, from their location data. However, geo-targeting alone is not 100% accurate if someone mainly or solely uses Facebook via a smartphone which is moving around all the time. As the map in Figure 7 below shows, as well as targeting Kent and Medway, we also included Bexley and the radius of the geographical parameters included boarder communities in East Sussex.
- **Layer 2, age ranges.** We only wanted to target adults aged 18 or over. Because children are able to use Facebook from the age of 13 onwards we excluded 13-18 year olds from our target audiences.
- **Layer 3, interests.** We used 'inclusive' interests targeting for Layer 3 to target people who had shown an interest in at least one of the following areas: Community issues, Stroke Association, Caregiver, Medway, Health and Social Care, Home care, Healthcare, NHS, NHS foundation trust, Health & wellness, National Health Service (England), Kent, Stroke Awareness, Industry: Healthcare and medical service.

By combining these three layers, anyone who has ever shown any interest (by way of a like, share, or Facebook comment) in for example: 'community issues', 'Kent', 'Medway', 'health & wellness', 'stroke', etc as above, would be more likely to see our promoted Facebook ads.

Facebook cited the potential reach of our targeted advertising as 910,000 people. This is classified as 'broad' and within their recommended green zone - to maximise both reach and targeting.

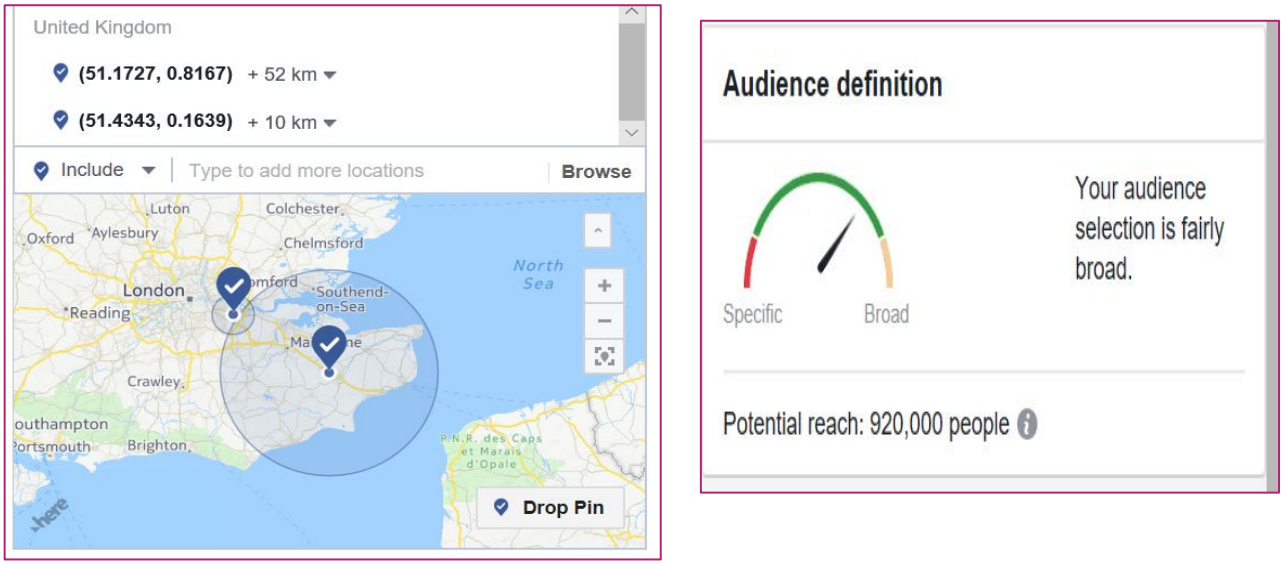

Figure 7: Facebook audience targeting

8.8.1 Twitter

The Kent and Medway Sustainability and Transformation Partnership had already built up some traction on Twitter during last year's summer listening events, although our follower numbers are still relatively small. For both organic and paid promotions Twitter proved a very effective channel to pro-actively inform people about the stroke consultation. In addition to targeting existing followers,

we planned for and worked with our STP member and partner organisations to like, retweet and comment on our posts, thereby creating a ripple effect that broadened our reach to their followers too. We also used @ mentions and tagged posts to encourage them to help us spread the word.

Taking their follower numbers into account our posts on Twitter achieved significant exposure, especially when retweeted by STP partners who have already built up significant follower numbers through being long-established local organisations. The table below shows the followers for key partner and stakeholder organisations.

Organisation	Number of followers
CCGs	
Dartford Gravesham & Swanley	2.3k
Ashford	2.5k
West Kent	6.7k
South Kent Coast	2.8k
Swale	2.5k
Thanet	3.1k
Medway	4.4k
Canterbury	3k
Bexley	3.7k
High Weald Lewes Havens	1k
Councils (county, unitary authorities, district and borough)	
Kent County Council	70.2k
Medway Council	18.2k
East Sussex County Council	16.1k
Sevenoaks	3.6k
Maidstone	12.4k
Tunbridge Wells	9.1k
Dover	8.4k
Tonbridge and Malling	4k
Swale	6.4k
Canterbury	6k
Ashford	7.5k
Thanet	7.2k
Gravesham	3.4k
London Borough of Bexley	6.7k
Lewes	6.5k

Wealden	6.8k
Rother	5.9k
Hastings	4.7k
NHS Trusts	
Medway Foundation trust	3.8k
Maidstone and Tunbridge Wells	2.5k
East Kent Hospitals University NHS Foundation Trust	3.8k
Dartford and Gravesham NHS Trust	2.6k
Kent and Medway NHS and Social Care Partnership Trust	3.4k
Others	
Healthwatch Kent	1.4k
Healthwatch Medway	1.9k
Healthwatch Bexley	1.7k
Healthwatch East Sussex	1.8k
Stroke Association South	1.3k

In total, their followers add up to over 200,000 people and many of our STP partner organisations also put out their own Tweets and Facebook posts encouraging people to respond to the stroke consultation.

We boosted our organic post reach by a limited number of targeted paid for boosted posts. These advertisements were used to both raise awareness of the consultation more generally, raise awareness of consultation events taking place over the course of the consultation, and in the final weeks, remind people to respond to the consultation by the closing deadline.

In total, the organic and paid stroke consultation related Tweets on our feed gathered 461,751 impressions (number of times Tweets were seen) and generated 4,851 engagements (number of times people interacted with a Tweet), including 909 retweets, 244 replies, 587likes and 799 link clicks.

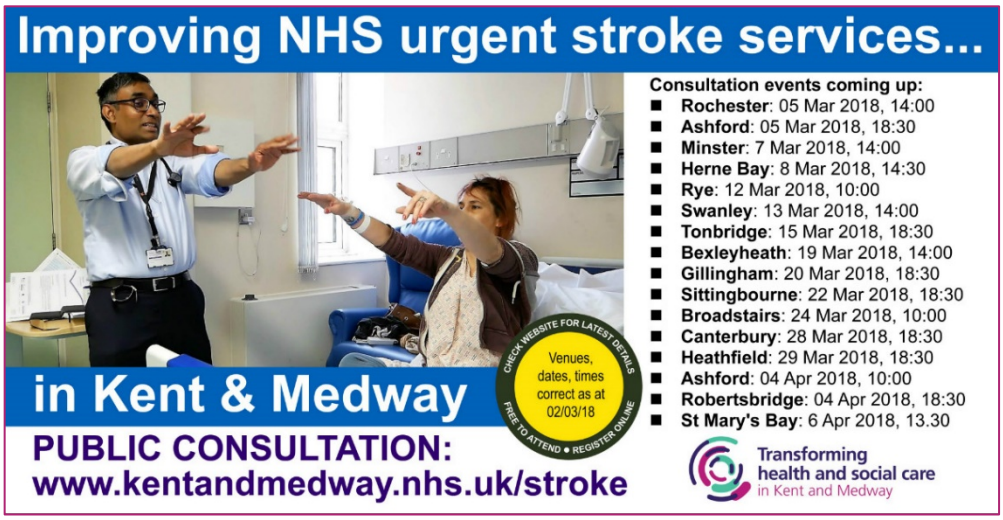

Figure 8: Example of Twitter card used during the consultation to promote events coming up

Figure 9: Example of promoted tweet

8.8.2 Facebook

Our follower numbers on Facebook are much smaller than on Twitter, as the STP's Facebook page has only been running for less than a year. Despite this, by tracking clicks on links we know that paid Facebook advertising proved highly effective in raising awareness and encouraging responses to the consultation – both on Facebook and by driving traffic to the STP website or encouraging people to turn up to a consultation event near them.

In total, all Kent and Medway stroke consultation-related posts on Facebook achieved 292,515 impressions, reaching 169,496 unique users; generating 11,340 engagements (an engagement is classified as either a like, share, comment or link-click).

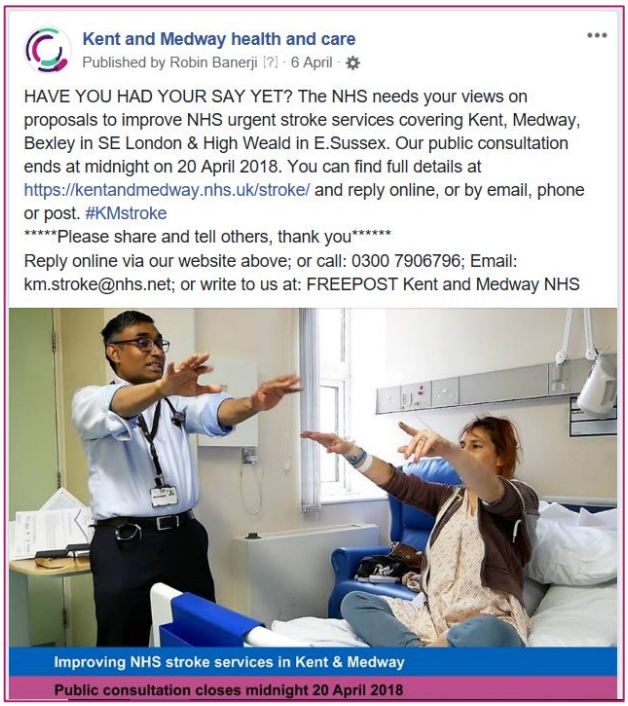

Figure 10: Example of awareness raising post on Facebook

We also used Facebook to directly engage people on the four key questions being asked by the stroke consultation. Some people responded in the comments section, others simply clicked the 'like' button for the picture showing the option they preferred. In total the 4 Key Questions post (promoted and organic) generated 158,033 impressions, reaching 88,733 unique users, and engaged 8,174 engagements.

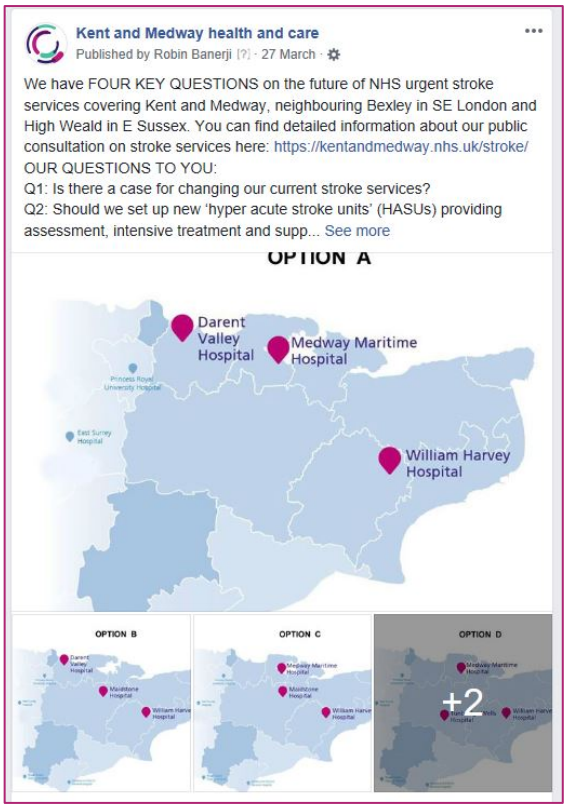

Figure 11: Example of promoted post

8.8.3 Social media impact

Through our use of both organic and paid for promotions on social media we:

- Reached over 200,000 people via our own and member/partner STP organisations' followers on Twitter, achieving 461,751 impressions
- Reached 169,496 people on Facebook, generating 292,515 impressions.

8.9 Measuring the success of paid for advertising

We have to measure the success of our advertising across these channels within the parameters of our objectives for the stroke consultation:

1. Raise public awareness of the stroke consultation
2. Encourage people to respond and give us their views

In terms of measuring the impact of this, we significantly exceeded our targets for both reach and awareness-raising of the consultation, and for responses to the consultation. Many more people were reached with awareness-raising information than responded, but we are satisfied that our response figures were good and the range and depth of insight and feedback generated was comprehensive, i.e. consistent themes came through in the consultation responses received that may not have significantly changed with a higher response rate.

8.10 Animation

In line with the aims set out in the Consultation Plan and to augment our digital and online campaign presence, we developed a short animation for use during the consultation period. Running at 4.54 minutes long, the animation outlined the proposals in an engaging and easy to understand way and as a 'call to action', encouraging feedback on the options that were presented to the public during the consultation period.

Featuring simple messages and a strong, design-led visual approach, the animation followed standard Equality Act 2010 (EQA) accessibility guidelines with English subtitles and graphics that were suitable for sight-impaired viewers. It was used during meetings and events, and was available on the stroke consultation section of the Kent and Medway STP website https://kentandmedway.nhs.uk/the-importance-in-getting-involved-in-the-stroke-consultation and on our YouTube channel https://www.youtube.com/watch?v=56mrtQ_pMF4

8.11 Video

Eleven videos were produced to promote the key issues under consideration in the stroke consultation.

In addition to the specially commissioned animation (above), a number of senior clinicians were interviewed to explain how the proposed changes would benefit both patients and staff:

- Dr David Hargroves, Consultant Physician and Clinical Lead for Stroke Medicine at the East Kent Hospitals University NHS Foundation Trust (EKHUFT)
- Dr David Sulch, Deputy Medical Director and Consultant Physician at the Medway NHS Foundation Trust
- Dr Steve Fenlon, Medical Director of the Dartford and Gravesham NHS Trust
- Dr Peter Maskell, Consultant Physician in Stroke Medicine and Medical Director, Maidstone and Tunbridge Wells NHS Trust
- James Pavey, Paramedic and Regional Operations Manager, South East Coast Ambulance Service (SECAmb)

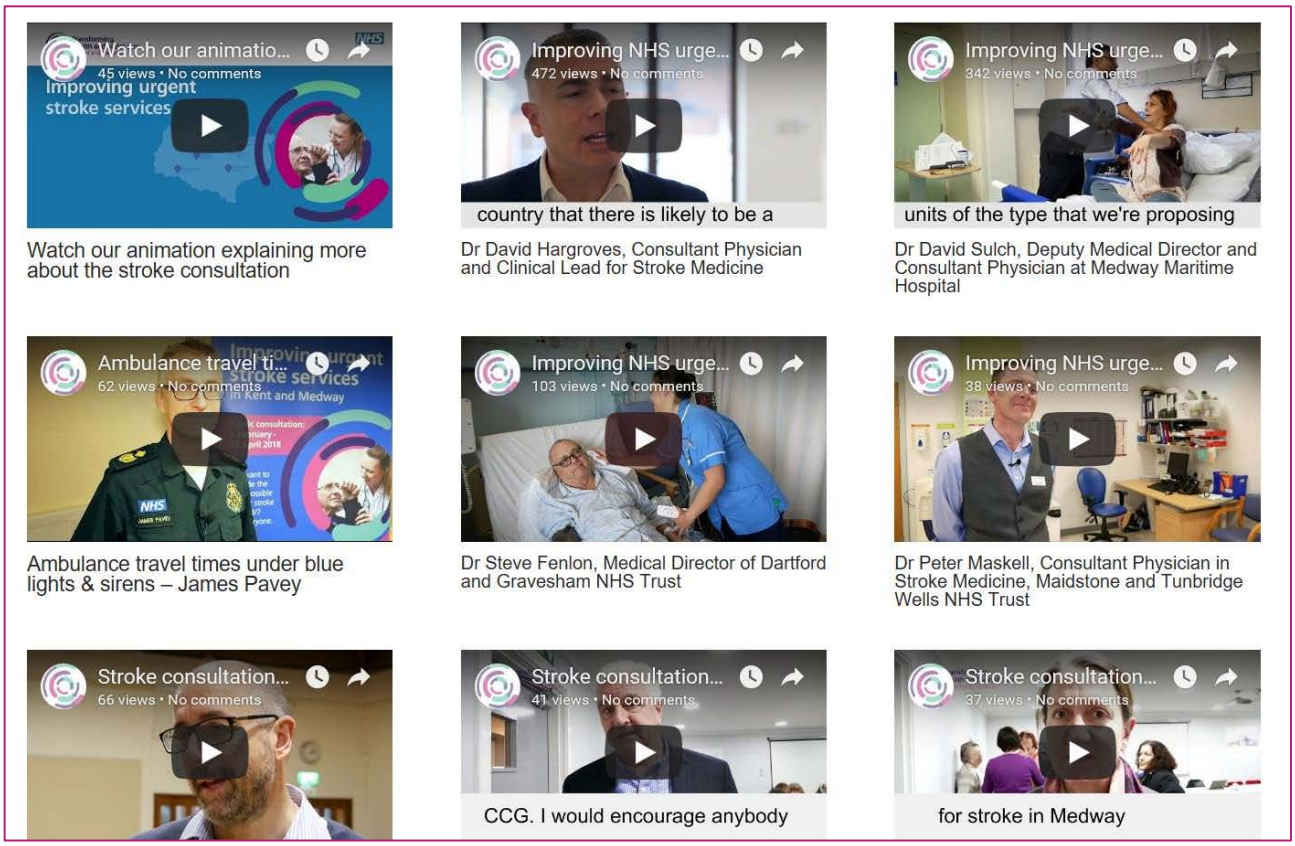

Figure 12: Videos from our YouTube channel

In addition to hosting the videos on the K&M STP's YouTube channel at https://www.youtube.com/channel/UCwhn95yX5P0ceMRCjqpmF3g the videos were also embedded on a page within the stroke consultation pages on the K&M STP website at https://kentandmedway.nhs.uk/the-importance-in-getting-involved-in-the-stroke-consultation/

There were also five short videos featuring members of our Patient and Public Advisory Group (PPAG) encouraging members of the public to respond to the consultation.

Collectively the videos received 1,550 views, helping – along with other content supporting the case for change for reorganising stroke services – to communicate the messages around the stroke consultation from senior clinicians. For those who were unable to attend one of the stroke consultation events, they would have been able to hear these senior clinicians outline some of the key issues at stake for themselves via this channel.

9 Consultation activity: gathering views

This section describes how we engaged with (as opposed to simply gave information or promoted) local communities on the future of stroke services in Kent and Medway.

9.1 Consultation questionnaire

The consultation questionnaire was our primary way of gathering views on the proposals. The questionnaire was developed in line with the key consultation questions, as set out in the consultation document.

In developing the consultation questionnaire, we sought expert advice from an independent research organisation, DJS Research, to help us design non-leading questions that met the highest standards of research design for this sort of exercise.

The questionnaire was available in hard copy and also online, via the SurveyMonkey platform. It was linked to from the stroke consultation web pages and regularly promoted via a wide range of communications channels.

There was a criticism received from a correspondent during the consultation period that the online version of the questionnaire 'forced' people to choose an option from the five proposed options for HASU locations before allowing completion of the next sections of the questionnaire, meaning respondents had to pick one of the five, even they disagreed with all the proposals. The consultation team were concerned to hear this and re-tested the functionality of the questionnaire on a range of different PCs, laptops, tablets and phones, and a range of different web browsers, but did not encounter the same problem. In this testing, all of the questions were optional and it was possible to leave any section of the questionnaire blank and still move through to the end.

The questionnaire *was* seeking views on the five proposed options, but also gave free text boxes for people to write other responses and specifically invited people to suggest any alternative ways that specialist urgent stroke services could be organised and/or where they could be located. The consultation materials also made clear that there were a range of ways to give views and feedback in addition to the online questionnaire – for example by telephoning or emailing directly, or by attending a meeting, or by sending views by freepost, either by letter or hard copy completion of the questionnaire from the printed consultation documents.

We also produced an 'easy read' version of the questionnaire to support the easy read version of the consultation document.

The questionnaire is available in Appendix G.

9.2 Listening events

The purpose of the public listening events was to give an overview of the stroke consultation proposals, the process followed to reach them and to give local communities the opportunity to ask questions and share their views. Ahead of the consultation, our intention was to hold a minimum of two public listening events in each of the ten CCG localities – adding more events where there was demand. We planned for one listening event during the day and one in the evening, to allow for different work, caring and other commitments people have and to give as many people as possible the opportunity to get involved. We were clear from the outset that we would be very happy to respond to requests for additional meetings and added an additional 8 meetings hosted by the stroke team, as well as attending meetings hosted by others where we were invited to do so.

We held 28 public listening events, attended by around 850 people, during the consultation period, including adding events in the Hastings and Rother CCG area to reflect the potential impact of the proposals on that community. The graphic below shows the locations of the listening events. The distribution of the events reflects the high levels of interest in the consultation in the Thanet, Medway and Dartford, Gravesham and Swanley CCG areas.

Ashford	Minster in Thanet
Bexleyheath	Minster on Sea
Canterbury	Rainham
Crowborough	Ramsgate
Deal	Robertsbridge
Erith	Rochester
Faversham	Rye
Folkestone	Singleton, Ashford
Gillingham	Sittingbourne
Gravesend	St Mary's Bay
Heathfield	St Peter's, Broadstairs
Herne Bay	Swanley
Maidstone	Tonbridge
Margate	Whitstable

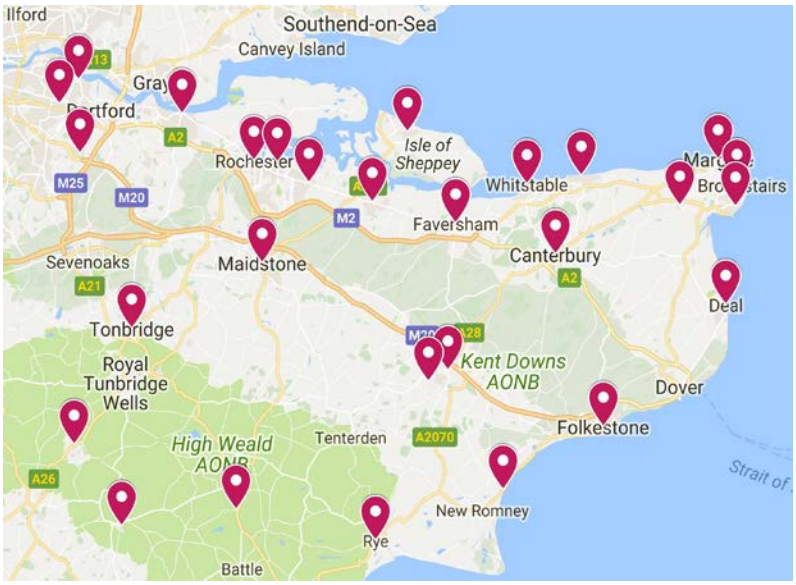

Figure 13: Map of locations of public listening events

The listening events were publicised through a wide range of channels, including advertising in local press and radio, on the Kent and Medway STP website, through our own and others social media channels, and by NHS, local government and stakeholder organisations (see Section 8 above).

A full list of when and where each event was held, and the panel members at each meeting is available in Appendix H.

The content of the listening events was based around a core slide pack which was further developed and refined over the course of the meetings to address the most commonly asked questions. The slide pack is available in Appendix I.

Each event followed a similar format with a presentation from a panel of Clinical Commissioning Group and NHS Trust leaders, including clinicians such as GPs, paramedics and stroke consultant specialists, followed by opportunity for questions and answers with the panel, and then facilitated table discussions where smaller groups were asked to give their responses to the following questions:

- Do you think there is a clear case for changing the way we deliver stroke services?
- Do you think there should be hyper acute stroke units in Kent and Medway?
- Do you think that three would be the right number for Kent and Medway?
- Do you have a preference for any of the five options?
- Are there any other options that we should be considering that we haven't already discussed?
- Is there anything else we should consider?

At some listening events, where many attendees indicated they would prefer to use the time allocated solely for questions and answers, we did not hold round table discussions in the same way. In these meetings we kept a plenary question and answer session and offered anyone who wanted to join a smaller discussion group the opportunity to do so in a different room with NHS staff trained in facilitating such conversations.

9.3 Correspondence and enquiries

Email, postal and telephone queries were managed through a central office with all queries logged and distributed to relevant people to draft responses.

Over 500 separate queries and comments were logged. Wherever possible our aim was to provide a detailed response to comments and queries, including setting out our position on areas of challenge and providing additional information where we could. Where correspondents were clearly expressing an opinion on the proposals rather than raising specific questions or challenges these were logged and added to the feedback to be analysed by the independent research organisation.

Our aim was to respond to questions as quickly as possible, however, given the wide range of questions and varying degrees of complexity we did not set a specific deadline for replies. Our average response time across all queries was 8 days.

Around half a dozen requests for detailed information beyond what was available in the consultation material and background documents and other readily available, held information were treated as Freedom of Information requests.

10 Consultation activity: commissioned research and outreach

As part of the consultation activity, Engage Kent was commissioned to undertake research and engagement activities with members of the public and staff to complement other planned consultation activity. Engage Kent are specialists in engaging and reaching communities. They work with their sister organisation Healthwatch Kent and parent company, social enabler Engaging Kent. They were appointed following a tender process that followed NHS procurement guidelines.

In the last three years Engage Kent have built a significant track record in reaching into communities across Kent and have a good network of relationships and contacts, along with innovative approaches to reach seldom heard groups using sensitive and appropriate methods to deliver meaningful engagement. They have been involved in the Kent and Medway stroke review before, having been commissioned to design and deliver public engagement events in West Kent at the start of the review in 2015. They also undertook seldom heard outreach engagement for the Kent and Medway STP during August to October 2017 http://kentandmedway.nhs.uk/wp-content/uploads/2017/11/Final-report-STP-Seldom-Heard-v1.pdf

10.1 Public-facing research and engagement

Engage Kent apply the best practice principles of The Consultation Institute and Healthwatch Kent to ensure they meet the needs of all public engagement and consultations. This best practice ensures not only better quality public engagement and consultation but also more reliable outcomes (i.e. we can be confident the findings are likely to be a fair reflection of people's views).

Between 15th March and 16th April 2018, Engage Kent undertook outreach engagement and focus group activities across CCGs in Kent, Medway and the neighbouring CCG areas of Bexley, High Weald Lewes Havens and Hastings and Rother, as part of the public consultation. The purpose of these activities was to gather the public's views, thoughts and responses on the stroke services proposals to ensure that commissioners have a broad spectrum of responses and insights from across the consultation catchment area.

Highlighted within the Consultation Plan as a means of reaching people who might not typically engage in public consultations or have an interest in local health services, these activities were in addition to other forms of engagement activity such as public listening events, a telephone survey, an online survey and hard copies of the consultation document which were being facilitated separately.

Each method of engagement was differently targeted and weighted.

Five key methods of engagement were used to reach as many people as possible within the timeframe:

1. **Talking to targeted community groups** who experience barriers to accessing services or who are underrepresented in healthcare decision making, to ensure their voices were heard and included. This was targeted to engage health inclusion groups, restricted liberty groups, substance misuse groups and older people.
2. **Street surveys** – these took place in targeted geographical areas to engage with rural communities, to gather public feedback on the proposals.
3. **Public focused conversations** - to explore the consultation proposal in more depth with mixed groups of working and older age adults.
4. **Street survey in Margate** - talking to a random sample of shoppers in Margate over a two-hour period, to gather a sample of views and thoughts about the consultation.
5. **Digital cascade** - to ensure that community groups within Kent, Medway, East Sussex and Bexley received email alerts about the consultation with links to the online consultation. In addition, Engage targeted expectant and new mothers and the lesbian, gay, bisexual and transgender (LGBT) community.

A total of 442 members of the public were engaged, face to face, through these activities. 81 of the people spoken to had previously heard about the stroke consultation through other routes including local news and six people had participated in another public event, with five people having already completed the online consultation response.

Method	Number of people engaged
Outreach engagement	171
Street surveys	116
Public focused conversations	94
Street survey in Margate	61

This research was a mix of qualitative and quantitative analysis that was developed to add richness and diversity to the consultation responses. As well as identifying some key themes from participants in the research, the intention was to allow for a more in-depth understanding and personal responses to the proposals and to elicit genuine and honest feedback from a variety of different demographics across a range of geographical locations.

The full report on this activity is attached as Appendix J.

10.2 Outreach engagement

These activities were designed to reach seldom heard groups within the communities of Kent and Medway, East Sussex and Bexley who experience barriers to accessing services or who are underrepresented in healthcare decision making.

The questionnaire focused on the areas outlined in the consultation document and gathered additional comments or insights pertaining to stroke services including rehabilitation, support services and advice. It also gave people a chance to discuss their preferred option for the configuration of the proposed three Hyper Acute Stroke Units (HASU).

A copy of the questionnaire is attached in Appendix J.

Engage focussed on reaching the following targeted groups, whose voices were under represented in earlier engagement activities:

- Those living with substance misuse problems

- Those living with restricted liberty
- Those currently homeless or living in areas with statistical variations in health
- Older people
- People from BME communities

Target Group	Date(s)	Postcode	Group details	No. of people
Restricted liberty	26.03.2018	ME12 Isle of Sheppey	HMP Elmley – prisoner health group	6
Substance misuse	11.04.2018 13.04.2018	ME4 Medway DA8 Bexley	Addiction support groups	11 9
Homeless / health inclusion	29.03.2018 19.03.2018 21.03.2018	ME4 Medway TN9 Tonbridge CT5 Whitstable	Street soup kitchen Healthy living group Soup kitchen/foodbank	32 8 8
BME	05.04.2018	DA1 Dartford	The Gurdwara	10
Older People	26.03.2018 29.03.2018 11.04.2018 12.04.2018 16.04.2018	TN6 Crowborough TN28 New Romney TN8 Edenbridge CT14 Deal ME15 Maidstone	Dementia activity group Day centre Community centre Community centre/ stroke group Stroke community support group	15 17 7 23 25

A total of 171 people were engaged in these seldom heard outreach visits. A demographic profile of respondents can be found in Appendix J.

26 people had heard on local media (radio and TV) about the proposals to change stroke services, 4 of the 171 participants had been to an event or participated in the consultation online.

10.3 Street surveys

These activities were designed to reach communities living in villages, market towns and communities along the Kent, East Sussex and Rother borders. The decision to focus on these border areas reflects the fact that the review of stroke services began as a Kent and Medway-wide initiative but it became apparent in 2017 that a small number of residents of south east London (predominantly Bexley) and East Sussex could also be affected by the proposals and the consultation was the right time to step-up engagement with communities in these areas.

Surveyors walked around villages and towns, approaching people and undertaking a short questionnaire designed to capture their reaction to the proposal and an indication of its impact in these geographical areas.

A copy of the survey can be found as Appendix J.

Over the 15th to the 19th March 2018 surveyors visited:

- Darwell (TN32)
- Burwash (TN19)
- Robertsbridge (TN19)
- Brightling (TN32)
- Rye (TN31)
- Peasmarsh (TN31)
- Wadhurst (TN5)
- Ticehurst (TN19)
- Etchingham (TN19)
- Brede (TN31)

Some of the locations were very small hamlets with no public facilities and dog walkers or hikers were the only foot traffic observed, whilst others were small market towns with more people using the shops and facilities.

At each location surveyors walked around public areas including libraries, cafes, bus stops, high streets or village main streets, village halls approaching people and working through a short survey. The aim of this survey was to gather a snap shot of public feeling about the proposals from these border areas, and enable people to register their preferred option. Surveyors proactively approached all members of the public they met as they walked around the target locations and, as such, participants were randomly selected by virtue of being present.

A total of 116 random members of the public completed the surveys. A demographic profile of respondents can be found in Appendix J.

10.4 Public focused conversations

These activities were designed to reach working and older aged people living in areas across Kent, Medway and East Sussex and Rother borders, who had not already been engaged in the other public events.

The focus groups were undertaken as a focused conversation (developed by the Institute of Cultural Affairs (ICA)) to create a structured discussion exploring things on a rational and an emotional level. The group discussions were aiming for small groups of 6-8 people but in some instances the groups were as large as 21 people. The same approach was used regardless of group size. Discussions were facilitated around a set of pre-designed question prompts.

A copy of focused conversation template can be found in Appendix J.

The questions explored:

- What information people recalled from the consultation documents (Objective questions)
- The instant reactions to the proposal (Reflective questions)
- The advantages and disadvantages of the proposal (Interpretive questions)
- Whether the proposal was considered sound (Decisional questions)

It also gave each group a chance to nominate their preferred option for the configuration of the proposed three HASUs.

Membership of these groups was weighted by health indicators, such as age and other health conditions that could increase risk of stroke.

Date	Location	Number of participants
28.03.2018	Wadhurst	16
28.03.2018	Sheerness	6
03.04.2018	Northiam/Peasmarsh/Rye	15
05.04.2018	Lydd/New Romney	21
05.04.2018	Medway	6
09.04.2018	Crowborough	4
11.04.2018	Bexley	12
13.04.2018	Margate	14

A total of 94 people were engaged in these public focus groups.

8 people had heard on local media (radio and TV) about the proposals to change stroke services, none of the 94 participants had been to an event or participated in the consultation in any other way.

10.5 Street survey – Margate

This activity was designed to reach people living in Margate, who might not be attending the organised listening events. A short survey was undertaken outside a national food retailer for 2 hours in the morning. The aim was to talk to a random sample of shoppers, to gather a sample of views and thoughts about the consultation.

A copy of the survey can be found in Appendix J.

A total of 61 people took part in the survey. A full demographical breakdown of these respondents can be found Appendix J.

Of these respondents:

- 34 had heard about the proposed changes
- 2 people had been to a protest event but not an organised listening event.
- 5 people had responded to the consultation online.

10.6 Digital cascade

Engage worked with the four local Healthwatches of Kent, Medway, Bexley and East Sussex, who cover the areas impacted by the stroke service consultation.

Through their local networks of communities and communication groups, a digital cascade was created to promote the online consultation with the opportunity for people to register a preferred option. For example, Healthwatch Kent shared the information about the consultation with their database but also ensured that all the Kent Older Peoples Forums, Mental Health Action Groups and mental health service user forums were sent information about the consultation and how to give their views.

In addition, expectant and new mothers were targeted via the National Childbirth Trust local network groups:

- Maidstone Branch NCT
- Canterbury Branch NCT
- Ashford Branch NCT
- Sevenoaks and Tonbridge NCT

- Medway NCT
- Tunbridge Wells NCT
- East Grinstead NCT
- National NCT

Finally, Engage worked with a national LGBT Charity to promote the consultation to its members in Kent, Medway, Bexley and East Sussex.

10.7 Staff-facing research and engagement

Engage were also commissioned to undertake research and engagement with staff across Kent and Medway during the consultation. This activity was in addition to other forms of staff engagement taking place within organisations.

A total of 60 employees were engaged, face to face, through these activities.

Date	Workplace	Number of participants
27.03.2018	Queen Elizabeth Queen Mother Hospital Stroke Ward	13
27.03.2018	Kent and Canterbury Hospital Stroke Ward	5
28.03.2018	William Harvey Hospital Stroke Ward	11
28.03.2018	Kent County Council Senior Practitioner Occupational Therapy	15
05.04.2018	Kent and Canterbury Hospital Stroke Ward	5
10.04.2018	Dietic team	5
11.04.2018	IC24 (a provider of out of hours care, NHS 111 service and home visits etc)	6

The focus groups were undertaken as a focused conversation (developed by the Institute of Cultural Affairs (ICA)) to create a structured discussion exploring things on a rational and an emotional level. The group discussions were aiming for small groups of 6-8 people but in some instances the groups were as large as 15 people. The same approach was used regardless of group size. Discussions were facilitated around a set of pre-designed question prompts. A copy of the focused conversation template can be found in Appendix K.

The questions explored:

- what information people recalled from the consultation documents (Objective questions)
- the instant reactions to the proposal (Reflective questions)
- the advantages and disadvantages of the proposal (Interpretive questions)
- whether the proposal was considered sound (Decisional questions)

It also gave each group a chance to nominate their preferred option for the configuration of the proposed three HASUs.

10.8 Telephone survey

An independent research agency, DJS Research, was commissioned to conduct a telephone survey across the consultation catchment area during the consultation period. The appointment was made adhering to NHS procurement guidelines.

Throughout the process, DJS adhered to all its relevant duties prescribed by the Data Protection Act (DPA) and Market Research Society Code of Conduct.

Computer aided telephone (CATI) methodology was used to conduct the research which has the following benefits:

- It can be programmed to control the number of interviews achieved in each CCG using information from the sample and/or screener questions.
- Have routed questions (closed and open ended) which direct respondents depending on their responses.
- Have checks and instructions to ensure all questions are filled in properly.
- Collects data in real-time so that results can be reviewed on an ongoing basis.
- Provides management data allowing review of activity for efficiency, strike rates and questionnaire length.

Running from 4th April until the 20th April, the research involved a survey questionnaire that explores views on the proposals as per the consultation document. The questionnaire was developed to take approximately 15 minutes to complete. A copy of the questionnaire is available in Appendix L.

A total of 600 interviews was proposed as a target with more if time allowed. By the end of the polling period 701 interviews were carried out. These interviews were spread equally across each of the ten CCGs (Ashford, Canterbury, Dartford, Gravesham & Swanley, Medway, South East Kent Coast, Swale, Thanet, West Kent, Bexley and High Weald Lewes Havens) providing 60 interviews in each CCG.

Quotas were not set within individual CCG areas but the research company aimed to ensure that the sample was broadly representative at an overall level as set out in the table below.

Demographic details	Total no of proposed interviews*
Age	
18 – 64	450
65+	150
Gender	
Male	294
Female	306
Disability	
Daily activities limited a lot	50
Ethnicity	
White	558
Mixed	12
Asian / Asian British	24
Black / African / Caribbean / Black British	6

*Actual numbers varied as more interviews were carried out than the initial target

The survey was piloted with approximately 30 respondents in order to check that the questions were clear before the main fieldwork began on 4th April.

Once the fieldwork was complete, verification checks were conducted by the research agency before producing data tabulations to an agreed specification.

The table below shows the number of telephone interviews that were conducted during the fieldwork period across the consultation catchment area. In total, 701 interviews were conducted against the initial target of 600.

Location	Number interviewed
Ashford	60
Bexley	57
Canterbury and Coastal	60
Dartford, Gravesham & Swanley	60
Hastings	49
High Weald Lewes Havens	60
Medway	60
Rother Valley	60
South Kent Coast	55
Swale	60
Thanet	60
West Kent	60

11 Consultation costs

Understandably, resources were needed to deliver the stroke consultation, particularly to ensure that we met statutory requirements and, in the event of a legal challenge, that the correct process has been followed.

It is important to note that consultations tend to be challenged on process – and this could lead to long delays, potential re-consultation and increased costs, and of course too the opportunity costs for patients in delays to making improvements to services. In summary, although the investment required to deliver the consultation was significant, it enabled us to deliver a thorough and inclusive consultation, run properly, effectively and robustly.

The table in Appendix M gives a breakdown of the non-pay cost of the consultation.

12 Conclusion

In conclusion, we believe this activity report shows that we delivered a comprehensive, and wide reaching consultation that fully met its objectives as set out in our Consultation Plan. We significantly exceeded our reach target and our response target and have gathered a rich depth and breadth of feedback, perspectives and views on the proposals. These have been collated and independently analysed and show the themes that have emerged.

Not unexpectedly, there was a lot of feedback, media and social media coverage, and local community activity from a couple of campaign groups. Their views and feedback have been heard and described in the analysis of all feedback. We thank them for their engagement in the consultation process. But it was important that we heard too from the ‘silent majority’ of people across Kent and Medway and in our border communities in Bexley and East Sussex. We believe we have, through using a wide range of consultation mediums and activity, raised awareness amongst a significant proportion of the local population and given people the opportunity to have their say. We are confident we have received a wide range of views from a representative group of

people across Kent and Medway, East Sussex and south east London. We hope the information gathered, as presented in the independent report by DJS Research, gives helpful information and data to inform Joint Committee of CCGs members in their decision-making role on this important issue over the coming months.