HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 17th July, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 17th July, 2015, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (2):	Mr H Birkby and Mr A D Crowther
Labour (3):	Mrs P Brivio, Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Howes, Councillor M Lyons, Councillor M Peters and Councillor M Ring

Webcasting Notice

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item — Timings*

1. Substitutes

2. Declarations of Interests by Members in items on the Agenda for this meeting.

3. Minutes (Pages 7 - 16)

4. Membership

   (1) Members of the Health Overview and Scrutiny Committee are asked to note that:

      (a) Cllr Howes (Canterbury City Council) has replaced Cllr Beresford (Dover District Council) as an East Kent borough representative on the Committee in 2015/16.

      (b) Cllr Lyons (Shepway District Council) has been confirmed as an East Kent borough representative on the Committee in 2015/16.

5. NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks (Pages 17 - 24) 10.05

6. Kent and Medway Specialist Vascular Services Review (Pages 25 - 90) 10.45

7. Kent and Medway Hyper Acute and Acute Stroke Services Review (Pages 91 - 166) 11.15

8. NHS England South (South East): General Practice (Pages 167 - 182) 11.45

9. East Kent CCGs: Talking Therapy Services (Written Update) (Pages 183 - 188)

10. Faversham MIU (Written Update) (Pages 189 - 192)

11. SECAmb: Future of Emergency Operation Centres (Written Update) (Pages 193 - 196)

12. Date of next programmed meeting – Friday 4 September 2015 at 10.00

    Proposed items:

    - North Kent: Emergency and Urgent Care Review and Redesign (Long Term)
    - Emotional Wellbeing Strategy for Children, Young People and Young Adults
    - Patient Transport Services
    - West Kent CCG: Diabetes Care

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

**Timings are approximate*

Peter Sass
Head of Democratic Services
03000 416647

9 July 2015

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 5 June 2015.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mrs P Brivio, Mr A D Crowther, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Mr C R Pearman, Cllr Mrs M Peters, Cllr Mrs M Ring, Mr P J Homewood (Substitute) (Substitute for Mr N J D Chard), Mr D L Brazier (Substitute) (Substitute for Mr N J D Chard), Mr S J G Koowaree (Substitute) (Substitute for Mr D S Daley), Mr B Neaves (Substitute) (Substitute for Mr H Birkby) and Cllr M Lyons

ALSO PRESENT: Mr S Inett and Ms C J Cribbon

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

17. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

Mr Adrian Crowther declared an interest as a Governor of Medway NHS Foundation Trust.

Cllr Michael Lyons declared an interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

18. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions which had been taken:

(a) Minute 4 - CQC Inspection Report: Maidstone and Tunbridge Wells NHS Trust. NHS West Kent CCG was asked to provide the cost of translation services. The costs were circulated to the Committee on 3 June 2015.

(b) Minute 6 – Patient Transport Services. NHS West Kent CCG was asked to provide the latest performance data on NSL Kent. The data was circulated to the Committee on 1 June.

(2) RESOLVED that the Minutes of the meeting held on 6 March 2015 are correctly recorded and that they be signed by the Chairman.

19. Membership
(Item 4)

(1) The Scrutiny Research Officer informed the Committee that following the Council's approval of the revised proportionality statement on 21 May 2015, it was agreed that the Labour group would gain a seat on the Health Overview and Scrutiny Committee at the expense of the UKIP group.

(2) Members of the Health Overview and Scrutiny Committee noted that:

(a) Mrs Brivio (Labour) had replaced Mr Hoare (UKIP) as a member of the Committee.

(b) Mr Birkby (UKIP) had replaced Mr Elenor (UKIP) as a member of the Committee and UKIP group spokesperson.

(c) Cllr Peters (Dartford Borough Council) had replaced Cllr Davison (Sevenoaks District Council) as a West Kent borough representative on the Committee in 2015/16.

(d) Cllr Ring (Maidstone Borough Council) had replaced Cllr Burden (Gravesham Borough Council) as a West Kent borough representative on the Committee in 2015/16.

(3) The Scrutiny Research Officer explained that confirmation was awaited of the two borough representatives from East Kent for 2015/16. The Committee noted that Cllr Lyons attended the meeting as an interim East Kent borough representative.

20. North Kent: Adult Community Services
(Item 5)

Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG & NHS Swale CCG) and Julie Hunt (Clinical Programme Lead for Community Services, NHS Dartford, Gravesham and Swanley CCG & NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Hunt began by outlining the review and procurement. She explained that the review was originally considered by the Committee in April 2014 when the CCGs' were looking to remodel Adult Community Services. The scale of the plans had reduced in order for a new contract to be awarded in advance of the Kent Community Health NHS Foundation Trust and Medway Community Health contracts expiring on 31 March 2016. The new contract would provide the same model of care and services as the existing contract. The new contract would be awarded in December 2015 with a three month run-in period prior to the commencement of the new contract on 1 April 2016. The new contract term would be for seven – ten years to encourage a long term developmental partnership. The evaluation criteria for the new provider would be heavily weighted around innovation, flexibility and creativity in service design and development.

(2) A Member enquired about workforce. Ms Hunt explained that the existing workforce would be TUPEd across to the new provider. She noted that the CCGs were not making any assumptions about the incumbent providers being awarded the new contract. She acknowledged that there were some issues

around the recruitment of community staff and that the local health economy was working together to attract staff into the area. Ms Davies noted that the CCGs were working with Health Education Kent, Surrey and Sussex to develop a North Kent Innovation Hub to attract staff into the area. The CCGs would be encouraging bidders to develop their services with the health and social care community. She noted that NHS Dartford, Gravesham and Swanley CCG had success in developing new roles and recruiting staff to its Integrated Discharge Team at the Dartford and Gravesham NHS Trust. She also noted the development of multidisciplinary Integrated Primary Care Teams to support General Practice. Ms Davies acknowledged that the number of nurses entering the health care system had reduced and that the CCGs were linking with Further and Higher Education providers to commission health and social care foundation courses.

(3) A number of comments were made about dentistry services and contract management. Ms Davies explained that dentistry was not included in the Adult Community Services contract. Ms Hunt stated that the CCGs were only letting the contract to a single provider, if the provider sublet the contract to individual providers, the sublet contract management would not be the responsibility of the CCGs.

(4) RESOLVED that:

(a) the Committee does not deem the changes to Adult Community Services to be a substantial variation of service.

(b) North Kent CCGs be invited to submit a report to the Committee in six months.

21. Medway NHS Foundation Trust: Update
(Item 6)

Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG & NHS Swale CCG), Lesley Dwyer (Chief Executive, Medway NHS Foundation Trust), Shena Winning (Chair, Medway NHS Foundation Trust) and Morag Jackson (Chief Operating Officer, Medway NHS Foundation Trust were in attendance for this item.

(1) The Chairman stated that the Trust's report for this item was not published with the papers as the report was not available. He stated that he had decided to take the report as urgent due to the number of substantive items on the agenda for the next meeting in July which would prevent it from being rescheduled.

(2) Ms Winning began by explaining that the Trust had commenced an 18 month recovery plan in November 2014 which aimed to have the Trust in a stable position by April 2016. The Trust was now eight months into the plan and there had been substantial changes including the appointment of a new substantive executive team.

(3) Ms Dwyer stated that it was her third week at the Trust; she had been involved in the decision making at the Trust since her appointment in February 2015. She noted that she had arrived at the Trust at an interesting time and was

pleased to be taking on the challenge. She reported that the recovery plan was solid and would improve the Trust and the quality of care delivered to its community. She stated that the Trust would be reinspected by the CQC in August 2015; the Trust was looking forward to validate progress and improve on the recovery plan.

(4) Ms Jackson reported significant improvement to the Emergency Department. The Trust had moved from being one of the worst performing Emergency Departments to being within the top 50% on the four hour target. The Trust had introduced a new frailty pathway to ensure frail and elderly patients were on the most appropriate pathway. The length of stay for a frail patient had reduced from 17 days to 5-6 days. The Trust had also opened up two wards for patients awaiting discharge which had released inpatient beds and improved patient flow. The Trust had recently appointed Dr Patricia Bain, Chief Quality Officer, who had led safety and quality initiatives for the Department of Health and other NHS Trusts. Dr Bain worked closely with the Chief Nurse and Medical Director to monitor performance daily. The Trust had a large number of Band 5 nursing vacancies who made up a large proportion of the nursing workforce. A Director of Workforce had been appointed and was looking to stabilise retention in order to increase recruitment. The Trust was looking at new models of care including paramedics in the Emergency Department and Anaesthetic Practitioners. She noted that the Trust had made improvements but acknowledged that there was still a significant way to go.

(5) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about the diverting of patients to Maidstone Hospital's Emergency Department and data quality. Ms Davies explained that the CQC issued a Section 31 Warning Notice on Medway's Emergency Department in September 2014. In response to the Notice, commissioners and providers of NHS services in Kent and Medway looked at options to reduce pressure on the Trust including diverting patients to Maidstone Hospital and Darent Valley Hospital. This option was not enacted instead NHS Swale CCG, as the second associate commissioner of the Trust's services, encouraged Swale patients to be seen at Maidstone and Tunbridge Wells NHS Trust for their elective outpatient appointments for cardiology and care of the elderly from November 2014. She noted that referrals to Maidstone and Tunbridge Wells NHS Trust had increased but there had not been much take up of care of the elderly appointments due to transportation issues. NHS Swale CCG was looking into local outpatient clinics provided by the Trust in community hospitals. Ms Davies reported that whilst NHS Swale CCG welcomed the improvements to Accident & Emergency performance, the CCG was concerned with the deterioration of waiting time performance for cancer, upper & lower gastrointestinal and dermatology.

(6) Ms Jackson stated that the Trust had not seen a significant shift of patients move away from the Trust. She explained that a new Patient Administration System was introduced in February 2015. The Trust had employed 20 additional full time staff to transfer patient records onto the new electronic system. In preparation for the transfer to the electronic system, a number of data quality issues were highlighted including the incorrect coding of patients. The Trust had introduced a training programme on data quality to ensure data was correctly entered onto the system. The Trust was in the process of data quality validation and had identified significant pressures on cancer waiting

times in April – May. The Trust was meeting the two week urgent GP referral target; all patients who were waiting for their first cancer appointment had been booked in. The Trust had introduced 30 - 40 additional clinics to achieve this. Ms Jackson acknowledged that improvements were required for 31 and 62 day cancer treatment pathways. She noted that patients arriving into the Emergency Department were routinely seen within 15 minutes of arriving at the hospital by a nurse practitioner; 27% of patients were then referred to the 24/7 Primary Care unscheduled care service through MedOCC at Medway Hospital.

(7) A number of comments were made about workforce including Band 5 Nurses, apprenticeships, morale and language barriers. Ms Jackson explained that Band 5 Nurses were newly qualified with one or two years of experience. The Trust had 15 Band 5 Nurses on each ward. Ms Jackson noted that at her previous Trust in Birmingham, apprentices were used in every area of the hospital. Medway NHS Foundation Trust was looking at every vacant post which did not require a specific qualification to see if it was an appropriate role for an apprentice. She stated that apprenticeships at the Trust would provide opportunities for young people who had previously not thought about a career in health and social care to come into the Trust. The Trust was looking at a number of workforce initiatives including overseas recruitment and improving staffing accommodation.

(8) Ms Dwyer explained that she had spent a significant amount of time speaking with the staff since starting. She noted that despite the negative press coverage, the staff wanted to improve the hospital for their local community. She reported that the Trust had lacked stability and leadership, the recovery plan was binding staff with a common purpose. She stated that negative press coverage and London pay weighting were a challenge for recruitment and retention at the Trust. She explained that she had met with the press to provide a balanced view of the Trust. The Trust needed to understand why people left the organisation and provide flexible opportunities to enable them to return. Ms Jackson stated that the Trust had learnt from previous mistakes and staff recruited must be able to communicate with patients.

(9) A Member thanked Dr Phil Barnes for his contribution as acting Chief Executive. Ms Winning also thanked Dr Barnes for stepping up to a difficult task and providing value and continuity to the Trust. Ms Winning acknowledged that the Committee had heard presentations from the Trust over many years about delivering change but stated that the current executive team would deliver a stable organisation through its recovery plan.

(10) RESOLVED that the reports be noted and Medway NHS Foundation Trust and NHS Swale CCG be invited to submit an update to the Committee once the CQC inspection report is published.

22. East Kent Hospitals University Foundation Trust: Update
(Item 7)

(a) **EKHUFT Clinical Strategy**
(Item 7a)

Liz Shutler (Director of Strategic Development and Capital Planning, EKHUFT), Rachel Jones (Director of Strategy and Business Development), Mary Tunbridge (Divisional Director, Clinical Support Services, EKHUFT), Dr David Hargroves (Chair, Improvement Plan Delivery Board, EKHUFT), Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury and Coastal CCG) and Hazel Carpenter (NHS South Kent Coast CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Shutler introduced the item and proceeded to give a presentation (included within the Agenda pack) which covered the following key points:

- Case for Change
- Integrated Care Strategy
- Staff, Patient and Public Engagement
- Overview of design and development of options for the clinical strategy

(2) Ms Jones reported that the Trust had learnt from the Outpatients Clinical Strategy and was keen to engage with patients and the public on the two – ten year Clinical Strategy. The Trust had been supported by Healthwatch Kent with nine engagement events with community groups, 800 face to face contacts and 180 speak out forms being completed. The Trust would shortly be developing a joint engagement strategy with the East Kent CCGs to agree an East Kent Health Economy wide approach. Ms Shutler noted that the Trust would be holding a formal public consultation in January to March and would be reaching a conclusion at the beginning of the next financial year.

(3) Mr Inett reported that Healthwatch Kent had now spoken to over 1000 people as part of their engagement events. He noted that there had been significant press coverage with regards to service centralisation. He stated that he was satisfied that the Trust was genuinely engaging with the public. He advised that service and site centralisation was different and need to be communicated with the public.

(4) A Member raised concerns about the potential closure of the Emergency Department at the William Harvey Hospital and its impact on the Chilmington Green development in Ashford. Ms Shutler stated that the Trust had begun engaging early with staff, patients and the public in the development of the strategy and options which had led to a lot of speculation in the press. She stated that there would be ongoing engagement and that no decisions about service centralisation had been taken. She acknowledged that there would be major change on all three hospital sites. The Trust was working with the CCGs to develop a coordinated approach. She noted that £1 million had been allocated to address the issues raised in the CQC inspection about the Accident & Emergency department at William Harvey including a paediatric unit. Mr Perks stated that the CCG and NHS England were now involved in the Chilmington Green development; Dr Jim Kelly was leading on the work for NHS Ashford CCG. The CCG had only recently become involved due to a split in the commissioning of primary and secondary care. The CCG was developing ideas for primary and secondary care provision in the development. He noted local innovation with the Whitstable Medical Practice being selected as one of 20 national vanguards.

(5) A Member enquired if the proposed changes would be large scale or a series of smaller proposals for specific services. Ms Shutler explained that there would probably be a combination of large and small scale proposals. Once the model of care was established; implementation would take place in a number of stages. She stated as stages were developed, the Trust would engage with staff, patients and the public. She noted that she would return to the Committee in October prior to formal public consultation to share the proposed options. Ms Carpenter highlighted her presentation to the Committee in January 2015 on the development of an integrated care organisation in NHS South Kent Coast CCG area. She requested that she return to the Committee in October with the Trust to enable the Committee to consider both proposals together.

(6) A number of comments were made about IT integration and the Hospital at Home service. Ms Shutler explained that the Trust was able to view the primary care records of its patients. All four CCGs in East Kent had signed up to the integrated clinical knowledge system with 80 – 90% of GP practices allowing the Trust to view their patients' records. Mr Perks noted that all GP practices in Ashford and Canterbury & Coastal had signed up to read only primary care records being available to the Trust due to the better outcomes it delivered for patients. Ms Shutler explained that some acute services could be shifted closer to patients' homes. The Hospital at Home service was an example of this and had enabled the Trust to reduce its reliance on hospital beds and had extremely good outcomes for patients. Ms Jones noted that the Trust offered the service to all patients in East Kent and had been received very positively.

(7) In response to a specific question about workforce constraints, Ms Shutler explained that the Trust was having difficulty recruiting consultants, junior doctors and nurses. She reported that as consultants were becoming more specialised, they were unwilling to remain on the general medical rota and the Trust was facing difficulty covering rotas with adequate consultants across three sites. She noted that the Trust was using expensive senior doctors to cover junior doctor vacancies and there was a worldwide shortage of nurses.

(8) A Member stated it would be challenging selling service change to the public. Ms Jones acknowledged that as options were developed, it would become more challenging for the Trust to allay concerns. She accepted that there would have to be compromises and the Trust would have to consider the most acceptable compromises to the staff, patients and public. She reported that the Trust had been engaging with Trusts in Leicestershire and Northumbria to learn from their reconfigurations.

(9) A Member requested that the Committee was provided with a draft copy of the public consultation to enable the Committee to make comments to the Trust in advance of its launch. Ms Shutler agreed to this request.

(10) RESOLVED that there be ongoing engagement with HOSC as the EKHUFT's clinical strategy is developed including a draft copy of the public consultation and a return visit to the Committee prior to public consultation to enable the Committee to determine if the options for proposal are a substantial variation of service.

(b) **EKHUFT Outpatient Services**
(Item 7b)

(1) The Committee received a report from East Kent Hospitals University NHS Foundation Trust (EKHUFT) which provided an update on the implementation of the Outpatients Clinical Strategy.

(2) RESOLVED that the report on Outpatient Services be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

(c) **EKHUFT CQC Inspection**
(Item 7c)

(1) The Committee received a report from East Kent Hospitals University NHS Foundation Trust (EKHUFT) which provided an update on the CQC inspection report and improvement plan.

(2) RESOLVED that the report on the CQC Inspection be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

23. Emotional Wellbeing Strategy for Children, Young People and Young Adults
(Item 8)

Dave Holman (Head of Mental Health Programme Area, NHS West Kent CCG) and Karen Sharp (Head of Public Health Commissioning, Kent County Council) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Holman introduced the item and showed a ten minute video which featured service users discussing improvements to emotional wellbeing services.

(2) Mr Holman explained that mental health services for children and young people were of local and national concern. Half of all adults with mental health problems were diagnosed in childhood; if not treated appropriately there were poor outcomes for later life. He noted that only 6% of the national mental health budget was spent on services for children and young people. Following concerns raised by HOSC in January 2014 about the performance of Sussex Partnership NHS Foundation Trust contract, a review was carried out and a whole system approach to children and young people's mental health was agreed. Mr Holman reported that the Trust had been rated outstanding in caring for children and young people's mental health services and good in well-led in the recently published CQC inspection report. Mr Holman noted that in April 2014 a transformation programme was established to ensure whole system commitment and agreement through a range of partners. The Transformation Programme regularly reported to the Children's Health and Wellbeing Board and the Kent Health and Wellbeing Board and strategic summit events.

(3) Ms Sharp explained that the development of the strategy and delivery plan had been driven by a desire to engage with and listen to the views of children, young people, families and professionals via a range of online surveys,

workshops and engagement events. In addition to the engagement activity, the content of both the strategy and delivery plan was also directed by the findings of the refreshed Emotional Wellbeing Needs Assessment.

(4) Mr Holman stated that Part One, the Strategic Framework, had been signed off by the Kent Health and Wellbeing Board. The Strategy had four overarching outcomes: early help, access, whole-family approach & recovery and transition. He reported that there was a golden thread running through each outcome was developing community resilience. He explained that Part Two, the Delivery Plan, was a working conceptual document. He noted that the Young Healthy Minds and Sussex Partnership NHS Foundation Trust contracts had been extended by one year to enable a new model service specification to be developed prior to the formal procurement process which would begin in autumn 2015. A technical group would also be established to look at capacity management and resource allocation.

(5) Ms Sharp noted that the emerging model included the promotion of emotional wellbeing; a single point of access; increased availability of consultations; developing a whole family protocol; multi agency tools and protocol to identify children and young people who have been affected by Child Sexual Exploitation. She highlighted that the development of the Strategy and Delivery Plan had not been at the expense of the current contract. Mr Holman offered to return to the Committee in September with the final version of the strategy.

(6) Members proceeded to make a number of comments and questions. A Member asked about the involvement of the Kent Youth County Council in the development of the Strategy and the delivery of services to children and young people in rural areas. Ms Sharp stated that KCC Youth Health Champions had been engaging with the Kent Youth County Council. She noted that it would be timely to go back to them with an update on the strategy. Mr Holman explained that the commissioners were working with primary care to deliver the same services in rural and urban areas.

(7) In response to a specific question about the cost of the new service model, Mr Holman explained that a financial breakdown would be included in the papers to the Committee in September. He noted that current funding remained static; there could be additional money from NHS England to fund eating disorder and psychosis services and government funding as part of its national review. He reported that there was a growing parity of esteem between adult and children mental health funding within CCGs; NHS West Kent CCG was lobbying hard to improve the provision for children and young people. Ms Sharp stated the importance of building an efficient sustainable service.

(8) A number of questions were asked regarding the involvement of the youth service in early intervention; mental health services for younger children particularly in deprived areas; mental health services for children and young people from minority and hard to reach groups and the provision of counsellors within schools. Clarification was sought in relation to swift access to appropriate Early Help services. Ms Sharp committed to returning to the Committee in September to provide answers to the Members' questions. She noted that the health visiting contract would be transferring from NHS England

to Kent County Council in October 2015 which would include maternal mental health services to support women and their children.

(9) A Member requested the latest Sussex Partnership NHS Foundation Trust performance data by district. Mr Holman agreed to provide this to the Committee. Mrs Allen, Chair of the Corporate Parenting Panel and the Children's Social Care and Health Cabinet Committee, requested that the video be shown to both Committees at their next meeting.

(10) RESOLVED that the report be noted and NHS West Kent CCG and Kent County Council be invited to submit the final version of the strategy and provide answers to questions raised at today's meeting to the Committee in September.

24. Date of next programmed meeting – Friday 17 July 2015 at 10.00
(Item 9)

The Scrutiny Research Office informed the Committee that she had been notified of two items which were to be deferred until October:

- South Kent Coast CCG and Thanet CCG: Integrated Care
- West Kent: Out of Hours Services Re-procurement.

Item 5: NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Ashford CCG and NHS Canterbury and Coastal CCG.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) NHS Ashford CCG and NHS Canterbury and Coastal CCG have asked for the attached report to be presented to the Committee.

(b) On 6 June 2014 the Committee considered the CCGs' Community Care Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that:*

  (a) Mr Perks be thanked for his attendance and contributions to the meeting along with his answers to the Committee's questions.

  (b) NHS Ashford CCG and NHS Canterbury & Coastal CCG be invited back to the Committee in the autumn to provide an update.

  (c) A written update on the design of the community hubs to be produced by the CCGs and circulated to Members informally.

(c) An update paper on the Community Care Review was circulated to Members on 4 November 2014.

2. Recommendation

RECOMMENDED that the report be noted and NHS Ashford CCG & NHS Canterbury and Coastal CCG be requested to provide an update to the Committee in six months.

Item 5: NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks

Background Documents

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (06/06/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27886

Contact Details

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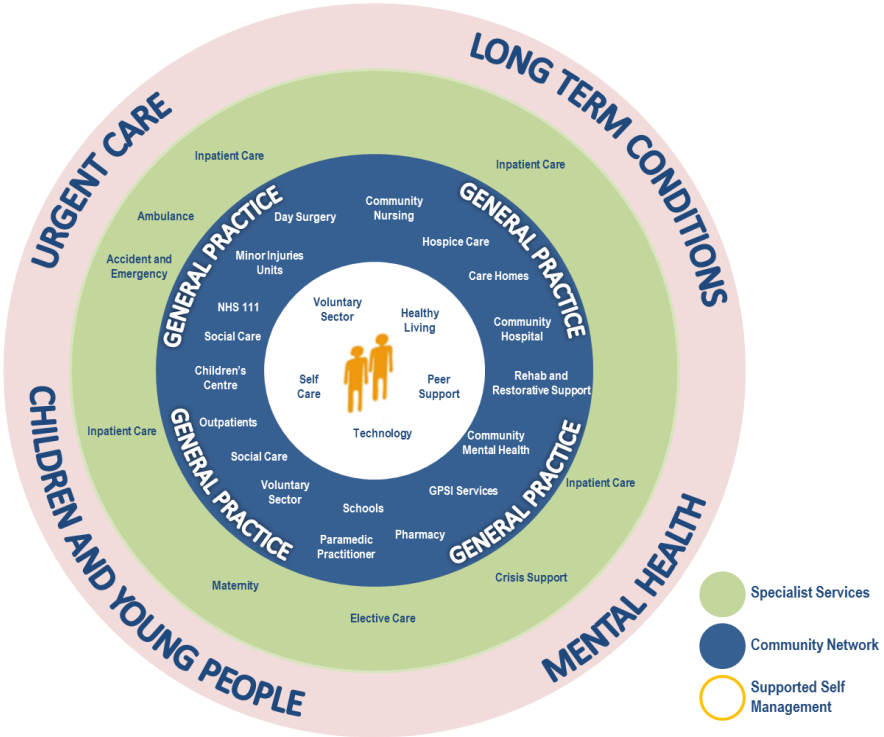
Progress report on NHS Ashford and NHS Canterbury and Coastal CCGs' Community Networks
July 2015

Introduction and background

In September 2013 NHS Ashford Clinical Commissioning Group (CCG) and NHS Canterbury and Coastal CCG initiated a project to review health and social care services provided within a community setting. The objective of the project was to improve how the two CCGs commissioned community-based services with the view to ensuring that these services were high quality, value for money and relevant to the current and future needs of patients and service users. A report on the review was provided to HOSC members in June 2014.

In October 2014 the CCG provided a further update that outlined a new framework for commissioning community-based services, which would build on the earlier review and ensure that health, social care and voluntary services are based around individuals and the communities in which they live and work. The framework is termed Community Networks and is focussed around our clustering of GP practices and the local communities that they serve – see diagram 1 below:

Diagram 1 – Community Network Model



Examples of services that form part of the Community Networks include: some outpatient services, neighbourhood care teams (which provide care to people in their own homes), GP care, consultants who provide care for the elderly, community and voluntary sector support and mental health services.

Location of Networks

In Ashford there are three networks known as North Ashford (including areas in the north of town and Wye, Sellindge and Charing), South Ashford (including areas in the south of town and Kingsnorth) and Rural Ashford (including Tenterden, Hamstreet and Woodchurch).

In the Canterbury and Coastal area there are five networks with Canterbury, Herne Bay, Whitstable, Faversham, Sandwich/ Ash each being a base for one of the networks.

Communications and Engagement Programme

The development of Community Networks is being co-designed with local stakeholder groups which meet regularly to discuss local health priorities. The groups include local GPs, patients, members of the public, Kent County Council (KCC) and providers of health and care services. In September 2014 there were four large public workshops in Ashford and Canterbury which identified the health needs of the local population using the JSNA and the priority areas of care which people attending felt were their local priorities for service improvement or an opportunity to do more with community assets. During winter 2014/15 two rounds of meetings were held to start the process and agree terms of reference. It became clear through these initial meetings that there were some local projects which people felt should be pursued.

In addition the CCGs have adopted a robust approach to evidence based commissioning by utilising detailed information received through the NHS Commissioning for Value work programme which is a partnership between NHS England, Public Health England and NHS Right Care. This approach focuses upon identifying evidence based priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

The process identified circulatory disease (i.e. cardio vascular/stroke) and chronic kidney disease as two areas of care where our population needs and service performance were at variance with other areas very similar to ourselves. We felt that these also needed to be included within the work of the programme too.

Each service area requires significant investigation to provide the detailed information and evidence which will allow the stakeholder groups to have a considered conversation about what could be done better. This means an ongoing programme of work which will allow each stakeholder group to work on these different service priorities and local projects over the next few months.

This work is being reported to the wider community through the CCGs newsletters and via regular updates on the website. We are also giving briefings at other meetings such as Faversham town council, or Ashford meeting of parish councillors where invited.

Each of the localities has now completed the third round of meetings and is gaining momentum through the agreement of several projects. The groups have used the opportunity to review the priorities from the original stakeholder meetings to ensure that the proposed projects meet the needs of the population.

The changing national context and local drivers

With the publication of the NHS Five Year Forward View in October 2014 and the need to address the local health and social care system challenges in east Kent, it has become even more important that our Community Networks contribute to the changes required to deliver sustainable service provision over the coming years.

Working with our partners, we believe the approach we are taking to commissioning integrated, out of hospital care in a primary and community setting aligns with KCC's Social Care Transformation Agenda and Accommodation Strategy. We believe this approach also supports the changes required to East Kent Hospitals University NHS Foundation Trust's (EKHUFT) current model of care which will not be sustainable within the next five years.

New models of care – building on our Community Networks:

An important example of the changes taking place locally is the new model of care being developed within Canterbury and Coastal CCG by the Whitstable, Northgate and Saddleton Road Medical Practices – Multispecialty Community Provider (MCP)

This MCP was announced as one of 29 national vanguard sites in April 2015. This followed a selection process earlier in the year which saw more than 269 sites apply to NHS England's New Models of Care National Team to become vanguards in three different categories.

This is a Multispecialty Community Provider vanguard. Other categories that NHS England sought vanguard applications from include Primary and Acute Care Systems (PACS) and Care Homes Models.

All vanguards received a two day site visit from the National New Models of Care Team, and locally this took place on 5 and 6 May 2015. It was a very well attended event, including KCC Leader Paul Carter, and enabled all partners of the vanguard to share their vision for integrated health and social care.

Positive feedback was received from the National Team and a business case has recently been submitted for a one year transformation fund to enable the MCP's work programme and clinical model to be realised.

Aim of the MCP

The MCP seeks to deliver an integrated health and social care model of care, with primary care at its bedrock, that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home setting.

The objective from this model is to develop community based care and by co-locating most health and social care needs, to improve diagnosis and treatments outside hospital and create a more patient centric model of care. This will include local physical health, mental health and wellbeing services.

Key elements of the new model will include:

- Working towards setting up seven-day a week primary care services, starting with a Saturday service, to cover what is seen as the weekend time of most demand. The effectiveness of this new service can then be evaluated, and the service modified as appropriate. This will maximise access to primary care – this will be inclusive of GP, nursing, mental health and paramedic practitioner services.

- Enabling better use of step up and step down beds, with less delayed transfers of care. This will also enable faster and more successful discharge to a patient's home. It is intended for this to include direct GP referral access to community hospital beds in due course, placing primary care at the very heart of patient care, enabling people to be cared for in the most appropriate setting and reducing the need to access secondary care wherever possible.

- Enhancing the use of IT to facilitate both streamlined communication between patients, clinicians and carers; and to maximise the use of tele care and telemedicine to maintain support of self-care and self-management to promote independence.

- Creating a more cost effective service. By treating patients close to home, reducing the cost of some outpatient procedures and outpatient appointments through expanding the use of GPs with special interest to triage referrals.

- Focusing upon prevention to ensure that as a whole health and social care system we are working seamlessly to support people to stay well and to live independently, with appropriate support where it is necessary.

The MCP has the potential to expand rapidly across the Canterbury and Coastal Community Networks with a number of other GP Practices having recently expressed an interest in joining.

Next Steps

Further updates will be provided to HOSC members as and when required.

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Item 6: Kent and Medway Specialist Vascular Services Review

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: Kent and Medway Specialist Vascular Services Review

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS England.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) NHS England has asked for the attached reports to be presented to the Committee.

NHS England Report	pages 27 - 32
Case for Change	pages 33 - 72
Decision Making Process	pages 73 - 90

2. Recommendation

RECOMMENDED that the report be noted and NHS England be invited to submit an update to the Committee at its September meeting.

Background Documents

None

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Paper presented to:	Kent Health Overview and Scrutiny Committee
Paper subject:	Kent and Medway Specialist Vascular Services Review
Date:	17July 2015
Presented by:	Oena Windibank; Programme Director, K&M Specialist Vascular Services Review. Diana Cargil; Specialised Lead, Specialised Commissioning NHS England South (East)
Senior Responsible Officer:	James Thallon; Medical Director, NHS England South (East)
Purpose of Paper:	To update the HOSC on the Kent and Medway Vascular Services Review, the Case for Change, Decision Making Process and the next steps.

1.0 Background to the Review

1.1 In 2013, the specialist society representing vascular surgeons in England drew up a new specification for vascular services. It sets out what a specialist vascular service needs to provide. It is based on evidence of what achieves best outcomes for patients.

The society did this work because they wanted to see improvements in care given to patients and to ensure that the highest standard of care possible was available. At the time, it was also the case that death rates for aneurysm treatment in England were higher than in most similar countries around the world.

There have been similar initiatives on trauma and heart disease which have successfully reduced death and disability rates for those conditions and improved the care offered to patients.

Vascular disease affects veins and arteries. It may cause blood clots, artery blockages and bleeds which can lead to strokes, amputations of limbs and conditions that might threaten life, if left untreated.

In considering specialist vascular services, we are not discussing heart disease and heart surgery or management of the common types of stroke. These are not part of this review.

When we refer to vascular services as a whole, we consider outpatient care and treatment, day case treatment and inpatient treatment, which we are describing here as specialist treatment.

This review will not make any changes to the outpatient, diagnostic and day case part of the patient experience, other than to improve them and keep them local to patients. What needs to be reviewed is how specialist vascular services are delivered for the complex treatment of vascular disease.

1.2 The types of vascular disease treated are:

- Aortic aneurysms – a bulge in the artery wall that can rupture (treatment may be planned or as an emergency)
- Carotid artery disease, which can lead to stroke
- Arterial blockages, which can put limbs at risk

1.3 The type of treatment that might be required includes:

- Complex and potentially high risk bypass surgery to the neck, abdomen or limbs
- Balloon or stent treatment to narrowed or blocked arteries
- Blood clot dissolving treatments to the limbs
- Stent grafts of varying complexity to treat aneurysms.

The treatments are delivered by both specialist vascular surgeons and specialist vascular interventional radiologists. (These services do not include the management of varicose veins).

1.4 The national specification requires specialist vascular centres to:

- Serve a minimum population of 800,000 to ensure all staff can treat enough different cases to maintain their competency and improve their skills (this figure is expected to rise to 1 to 1.2 million shortly);
- Have the right mix of highly skilled and experienced staff who each carry out enough specific procedures to maintain and improve their skills;
- Have 24/7 on-site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of six vascular surgeons and six interventional radiologists, to ensure consistent high-quality care;
- Provide access to cutting-edge technology, including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures;
- Provide a dedicated vascular ward and nursing staff;
- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine, among other specialties, to provide a comprehensive multi-disciplinary service;
- Be part of a wider clinical network which can provide oversight, governance and opportunities for innovative treatment for patients and development for staff.

2.0 Why is NHS England reviewing Kent and Medway Vascular services?

2.1 Specialist vascular services in Kent and Medway are not fully compliant with the national specification and Vascular Society guidance.

2.2 NHS England is carrying out this review with local people, particularly patients and carers, the clinical commissioners and clinical specialists,

with the aim of delivering a high quality, sustainable vascular service for all Kent and Medway patients which complies with the national specification.

2.3 The review must ensure future specialist vascular services:

- Meet the national standards;
- Have a sustainable specialist workforce;
- Take account of population needs and growth;
- Respect the need for patient and clinical choice.

The review must offer to patients:

- Continued improvement in outcomes for patients
- Development of patients' skills and expertise so they are better able to manage their condition and recovery
- Increased access to outpatient clinics and assessment.

In addition to these we want future vascular services for Kent and Medway residents to be centers of excellence offering the best possible outcomes.

3.0 The Kent and Medway review process

3.1 The review will take a phased approach, starting by understanding what currently happens in Kent and Medway and how that differs with the national specification. It will go onto consider the ways that the service could be delivered to not only meet the specification but also ensure that the service delivers quality care now and into the future.

3.2 Who is involved in the review process?

There is a clinically-led Programme Board working with NHS England to consider what needs to be done.

Public health specialists are taking a detailed look at the needs of the area and its predicted growth to help us plan for the future. Vascular Society members are advising the local Programme Board.

Concerns and evidence about the current services have been shared with the South East Coast Clinical Senate, which maintains an overview of health services across Kent, Surrey and Sussex. The Senate's role is to check that plans for changing inpatient vascular services are clinically sound and will improve outcomes for patients.

The public will be involved in the review through a number of Listening events and focus groups where the gaps in the Kent and Medway services will be discussed and options developed. A public engagement sub group of the programme board will be established to support the review.

4.0 What currently happens for Kent and Medway residents needing specialist Vascular Care?

4.1 In 2013/14 897 people in Kent and Medway needed specialist vascular treatment. Of these, 591 were treated locally - the others mainly travelled to London.

4.2 Kent and Medway patients currently go to three main centres for specialist vascular treatment:

1. Medway Maritime Hospital, Gillingham;
2. Kent and Canterbury Hospital, Canterbury;
3. Guys and St Thomas' Hospital, Westminster, London.

4.3 There is additional day surgery at Darent Valley Hospital, Dartford; Kent and Canterbury Hospital, Canterbury; Medway Maritime Hospital and Tunbridge Wells Hospital, Pembury. Other outpatient clinics are held at: Aylesford Medical Practice; Gravesham Community Hospital; Kent and Canterbury Hospital, Canterbury; Maidstone Hospital; Medway Maritime Hospital; Queen Elizabeth the Queen Mother Hospital (Margate); Sheppey Community Hospital; Tunbridge Wells Hospital (Pembury) and the William Harvey Hospital (Ashford).

5.0 How do the current inpatient centres comply with the national standards?

5.1 The service provided by St Thomas' Hospital in London is fully compliant with the national specification. The services across Kent and Medway are not fully compliant with the national specification. This was identified following a full survey of services and is detailed in our Case for Change document, (this will be available on the NHS England South website.)

5.2 Summary of key K&M issues

- The population volumes are lower than the required 800,000
- The number of cases per year is either borderline or lower than the required numbers.
- The numbers of total Kent and Medway specialist consultants, Interventional radiologists are lower than the required number and there are no specialist nurses working over the weekends.
- There is no vascular network in place across Kent and Medway

6.0 What happens next?

6.1 We have developed a clear process that will be used by patients, carers, clinicians and clinical representatives to recommend a model for future inpatient vascular services in Kent and Medway. This process has been reviewed and agreed by the Programme Board and the South East Coast Clinical Senate. It will be used to evaluate possible options for how vascular inpatient services are provided in the future.

6.2 Case for Change Approval

The Case for Change is currently being reviewed by the South East Clinical Senate. A series of events are underway with the public to explain the issues and understand what is important to them. The

Review Programme Advisory Board is working with its members, including the Kent and Medway units to approve the final case for Change. This will also be approved through the NHS England, Specialised Commissioning delivery group.

6.3 Decision Making and Approval Process

This process will use national best practice guidance, public feedback and local/national clinical recommendations as criteria. The decision making process will work with clinicians and the public, this will include:

- Identifying the range of possible solutions;
- Applying the criteria to develop realistic options for more detailed assessment;
- Detailed analysis of possible solutions particularly focusing on Quality and safety, capacity, access/travel times, key clinical interdependencies, demographic impacts/relationships and workforce;
- Understanding the Impacts and risks of possible options. This will particularly important in relation to the impacts on quality, safety and patient outcomes.

The 'long list' and 'short list' and final preferred options will be considered and tested at each point against the public, stakeholder and clinical feedback.

NHS England South (East) and the South East Clinical Senate will provide an assurance role to the review. Kent HOSC and Medway HASC will be kept informed of the review progress and approached, once the options have been developed, to determine if the proposed options constitute a substantial variation of service. If the Kent HOSC and Medway HASC determines the proposed service change to be substantial, a Joint HOSC will need to be established.

7.0 How will the public be involved in the review?

7.1 It is important to the review that the public and stakeholders are involved in the review. The team will actively seek out people who have experienced vascular services and those who may be at risk as well as the wider public.

7.2 A Communication and Engagement plan has been developed. This sets out how the review will engage with the public and key stakeholders. This will include holding a series of Listening events and focus groups throughout the decision making process and setting up a public engagement sub group.

8.0 When will the review be completed?

8.1 The review is aiming to develop the options over the summer and early Autumn with the preferred option being approved late Autumn/early Winter 2015 with an aim to begin implementation form April 2016. This may need to be a phased implementation.

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Vascular Surgery Review for Kent and Medway

Case for Change

Vascular Surgery Review for Kent and Medway

Subtitle (please add or delete this text)

Version number: 13

First published: 11/03/15

Updated: (only if this is applicable)

Prepared by: Oena Windibank

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

1 Executive Summary

Following concerns re the outcomes for patients in England and Wales receiving vascular services a national service specification was implemented in 2013. The standards within the specification were developed through a specialised Clinical Reference Group (CRG) and reflect the best practice guidance of the National Vascular Society 2013.

The key aim of the specification and guidance is to improve outcomes, providing patients with vascular disease with the lowest possible elective and emergency morbidity and mortality rates. The clinical evidence underpinning the specification and guidance recognises the relationship between adequate volumes and improved patient outcomes.

The Vascular Society guidance identifies best practice, which has been adopted within the national specification standards.

The key features relate to:

- Delivering vascular services through a network where on hospital(the hub) provides all the in-patient surgery and the other hospitals (spokes) work in collaboration with the hub to provide out patient services, diagnostic services and, where appropriate, some day case surg
- Minimum population volumes to deliver adequate vascular interventions.
- 24 hour access to specialist care including vascular surgeons, interventional radiologists and specialist nurses, including sustainable on call rotas.
- Access to hybrid operating facilities.
- Specialist clinicians undertaking adequate volumes of core index procedures to ensure consistent safe quality care.

A vascular services review has been initiated across Kent and Medway by NHS England (South) with regard to determining the current position of vascular services and identifying recommendations, if required, to improve the delivery model. The national specification and best practice guidance have been used as the benchmark measure for the review.

The review process is overseen by a Programme Advisory Board which is clinically led and has both external and local clinical expertise representation.

Throughout the review process there will be active engagement with the public and key stakeholders developing the Case for Change, the decision making process and the final recommendations. This will include Listening events, focus groups and a public/patient sub group of the Programme Advisory Board

Key interdependencies will be identified with a particular emphasis on the central relationship with Interventional radiology.

The aim of the review is to ensure that quality, safe and sustainable vascular services can be delivered now and into the future.

The key recommendations will seek to not only deliver the national specification but also will ensure that;

- Clinical best practice is embedded into the vascular pathway.
- There are additional quality improvements benefits across Kent and Medway including for vascular patients, the health economy, the workforce and other clinical areas/specialities
- The Vascular care model for Kent and Medway attracts, and is delivered by, skilled motivated clinicians across the multi-disciplinary professions; improving both vascular outcomes but also key clinical interdependencies
- Vascular services are sustainable for the future recognising the projected population growth/changes.
- Patients receive an effective pathway from the point of initial symptoms through to their return home.
- The vascular pathway is delivered within a multi disciplinary model effectively utilising the skills of a range of specialised professionals.

The following Case for Change illustrates that Kent and Medway vascular services are not currently operating within the national clinical guidance or service specification.

On this basis there is a need to identify clinically led solutions that can both resolve the non-compliance and ensure sustainable high quality vascular services are equally available for all Kent and Medway residents.

In Kent and Medway arterial surgery is commissioned from two providers, Medway Foundation Trust (MFT) and East Kent Hospitals University Foundation Trust (EKUHFT). Neither of these providers is fully complaint with the specification and a commissioner led derogation is in place for both Trusts. This review addresses that derogation and ensures that the future model can deliver excellence in outcomes.

A significant proportion of Kent and Medway activity (circa 26%) flows into London, mainly to Guys and St.Thomas' Hospitals Foundation Trust. These services are commissioned by NHS England – SE London. This review will describe the detail of the referral pathway both elective and emergency; associated with this activity. It will also consider the patient flow into London within recommendations for the future sustainability and quality of vascular services for Kent and Medway residents.

When referencing the national service specification and the Best Practice Guidance the position in Kent and Medway demonstrates that the key areas of non-compliance relate to:

- The lack of a vascular network across Kent and Medway. Local pathways appear cohesive however there is a lack of clarity in relation to the pathway into the London network and little evidence of collaboration between The Kent and Medway units.
- The populations currently served by East Kent University Hospitals NHS Foundation Trust and Medway Foundation Trust are both below the required level of 800,000. It is anticipated that the minimum population of 800,000 recommended by the vascular society will rise in the next year or two.
- At both trusts the total volume of activity for some of the core index procedures is either borderline or below the recommended numbers.
- The consultant workforce numbers are currently lower than required and the sustainability of the current vascular surgical and interventional radiology rotas is a concern.
- Some vascular care is delivered at other acute trusts in Kent and Medway through visiting specialists; this includes some surgery and outpatient care. This pathway is currently not clearly defined.

The Case for Change seeks to highlight the current position and the requirement to develop a clinical model that can both resolve the non-compliance issues but also deliver quality improvements.

Following endorsement of The Case for Change by the Programme Board, the review will proceed to assess the possible options that can deliver the improvements agreed as required.

The review will develop a preferred option for approval by NHS England South, Specialised Commissioning. This option appraisal process will consider key issues, variables and impacts.

These will include:

- Understanding population growth and changes
- The vascular pathway from symptom to rehabilitation
- Key interdependencies; interventional radiology, emergency departments, diagnostics and other clinical specialities.
- Workforce issues and interdependencies
- Repatriation of patient pathways.
- Understanding the impact on the Vascular Services finances.

And further issues identified through public, clinical and stakeholder engagement

The Kent and Medway review recommends that there should be no justification for any reconfiguration not to deliver the care standards and key service outcomes specified in NSS and VSGBI 2012 and 2014

The key benefits we expect for patients are:

- Continued improvement of clinical outcomes, in particular lower limb amputation

- The development of skills and expertise so that patients are better able to manage their condition and recovery.
- A transparent and effective vascular network, ensuring a smooth pathway across Kent and Medway.
- Increased access to outpatient clinics at spoke units.
- Improve sustainability of the existing vascular services, meeting the needs of both current and future patients and populations.
- Clear lines of accountability and clinical governance across the network that puts clinicians and patients at the heart of performance monitoring and service development.
- A sustainable specialist workforce; consultant surgeons, IR consultants, specialist nurses and the wider multi disciplinary team.
- Standardised methods and promotion of best practice across the clinical teams;
- A more productive and efficient service (minimisation of duplication).
- Improved opportunities for training, research and innovation;
- Reduced length of stay for patients and more effective pathway links with community providers to support timely repatriation of patients following surgery.

Conclusion:

The Case for Change establishes that the current vascular services delivered in Kent and Medway, whilst delivering on most of the key outcome measures do not meet the national specification and best practice (Vascular Society) guidelines. These issues relate to the low population volumes, low level or borderline numbers of core index procedures and sub optimal staffing levels across Kent and Medway.

The review's next step will be to develop a register of options to address the issues identified within the Case for Change.

2 Purpose of the Report

The purpose of this report is to highlight the current position and compliance issues across Kent and Medway's' vascular services and to recommend to the Programme Board, that they endorse proceeding to an options appraisal review.

The options appraisal review will consider and then recommend to the Programme Board how vascular surgery providers in Kent and Medway should work to meet the criteria outlined in the national service specification, that is being implemented across England, in a way that is safe, sustainable and can deliver quality improvements.

3 Recommendations

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

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

4 Background

The scope of specialist vascular services can be briefly summarised as preventing death from aortic aneurysm, preventing stroke from carotid artery disease and preventing lower limb amputation from peripheral arterial disease and diabetes. In 2007 over 65,000 people in the UK had surgery for a problem relating to vascular disease (Vascular Society of Great Britain and Ireland - VSGBI, 2009). The prevalence of vascular disease increases with age meaning that demand for vascular services is likely to increase over time. In addition, there are currently an estimated 3 million people with diabetes in England and this prevalence is increasing; patients with diabetes and vascular disease have a worse outcome, as evidenced by the increasing rate of lower limb amputation in this patient group.

The outcomes from vascular surgery in the United Kingdom have not compared well internationally, with the UK until recently having the highest mortality rates in Western Europe for abdominal aortic aneurysm repair (VASCUNET, 2008). Hence, it is a national priority for the NHS to ensure vascular services are configured in ways that reflect best practice to ensure their safety and quality both now and for years to come.

In 2012 VSGBI published a series of recommendations describing how vascular services should be organised to deliver the best outcomes for patients (Provision of Vascular Services, 2012). VSGBI quality improvement frameworks (QIFs) are also in place for both abdominal aortic aneurysm (AAA) repair and lower limb amputation.

The NHS AAA Screening Programme has made adopting the AAA QIF mandatory for providers treating patients referred from the programme.

In light of these recommendations NHS England, as the commissioners of specialist vascular services, published a national service specification for the provision of vascular services in July 2013. This specification sets out both the essential components of a specialist vascular service and the clinical outcomes that the service should achieve. A clinical reference group, chaired by Professor Matt Thompson, has developed the national service specifications. Reporting outcomes of all vascular surgical procedures to the new National Vascular Registry will be mandatory from April 2015. A copy of the national service specification for vascular services can be found at:

http://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/a04/

The national service specification, the Vascular Society guidance and a range of research papers culminate in the conclusion that an arterial centre needs to provide complex aortic endovascular procedures from a dedicated vascular hybrid theatre. This must be supported by 24/7 vascular surgery and 24/7 interventional radiology, bringing together the expertise and experience of key clinicians in these techniques to provide both elective endovascular procedures and emergency procedures such as endovascular repair for ruptured abdominal aortic aneurysm.

This arrangement has the potential to significantly improve the length of recovery and reduce the risk of surgical complications and the risk of mortality compared to conventional open repairs.

Re-organisation of vascular services into networks enables NHS England to commission more resilient and sustainable vascular services.

Since the publication of the national service specification NHS England – South Coast have been reviewing vascular services across Kent, Surrey and Sussex to determine the work needed to ensure local vascular providers comply with the best practices outlined in the service specification. The key elements of which are that providers of vascular services should:

- Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures.
- Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency.
- Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists (individually undertaking a minimum number of interventions).
- Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures.
- Provide a dedicated vascular ward and nursing staff.

- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service.
- Care of patients will be managed through regular multi-disciplinary team meetings, which will occur at least once a week.
- Provider networks will work towards the aim of all leg amputations being undertaken in arterial centres by 2015

Central to national recommendations is the requirement for arterial surgery to be delivered out of fewer, higher volume specialist arterial surgical centres to improve clinical outcomes (in particular mortality rate) and deliver a range of other benefits to patient

The emphasis on high volume specialist units particularly relates to concerns regarding the risks or poorer outcomes associated with a low numbers of cases each year. Nationally there has been a recognition of the need for reconfiguration proposals to deliver sufficient activity per consultant to maintain standards.

Medway Foundation Trust and East Kent Hospitals University Trust are the two current arterial centres in Kent and Medway.

The tables below show, neither of these trusts fully meets the national service specification.

4.1 Specification Standards

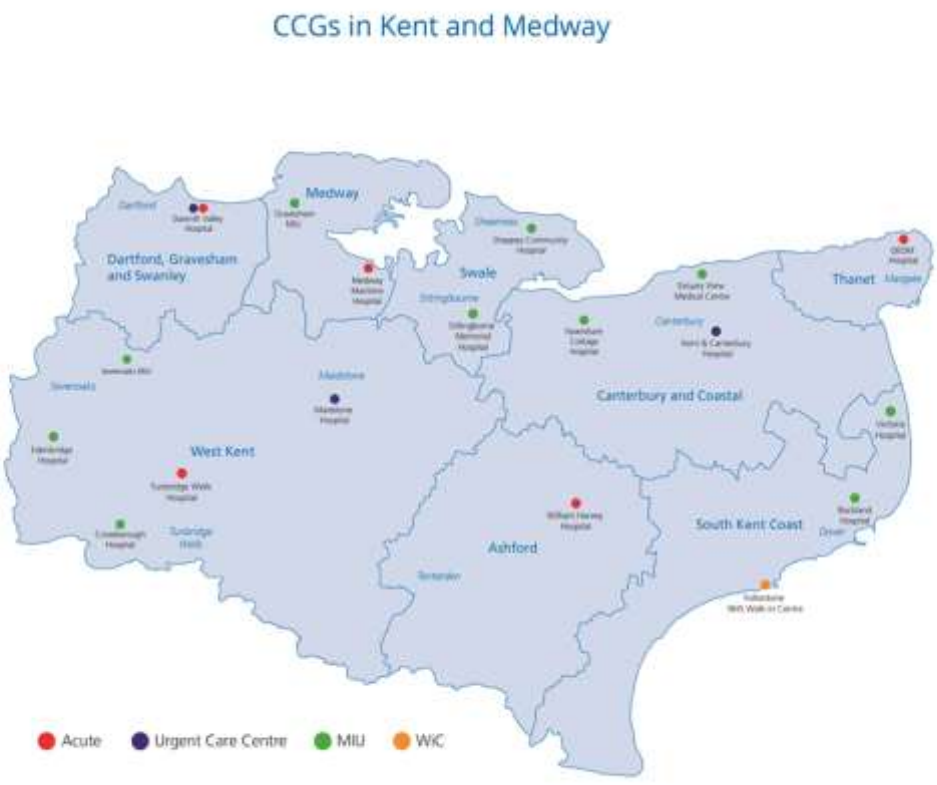
The following table represent the status of the current services measured against the national specification of Medway Foundation Trust, East Kent Hospitals University Foundation Trust and Guys and St.Thomas' Hospitals Trust (the main London provider for K&M).

Required	Medway FT	East Kent Hospitals	St Thomas' Hospital	Comments
24/7 MDT	No	No	Yes	
wte vascular surgeons. **On call rota (1:6)**	No 1:6	No 1:4	Yes 1:6	Recruitment underway in both Trusts (April 2015)

On call Interventional radiology	tbc	tbc	Yes	
AAA screening	Through EK programme	Yes	Yes	The EKHUFT screening programme covers the whole of Kent
Outpatient assessment	Yes	Yes	Yes	
Diagnostics	Yes	Yes	Yes	
In patient non arterial services	Yes	Yes	Yes	
Elective and emergency arterial services	Yes	Yes	Yes	
Day case surgery	Yes	Yes	Yes	
Population currently served; as noted through activity flows	505,569	682,106	450,687 from Kent (plus South London)	Kent Population treated in London: 450,687 Kent population treated outside Kent or London: 86,417
Mortality	Meets the national requirements	Meets the national requirements	Meets the national requirements	Within national tolerance

Table 1

4.2 Map of Kent and Medway with CCGs and Acute Hospital Sites



4.3 Current In Patient Pathway

Vascular Surgery is currently delivered in Kent and Medway at two acute hospital sites:

- East Kent University Hospitals NHS Foundation Trust in Canterbury (EKHUFT)
- Medway NHS Foundation Trust in Medway (MFT)
- Guy's and St Thomas' NHS Foundation Trust - A number of patients travel to London hospitals (most are referred to Guy's and St Thomas NHS Foundation Trust), the majority of the patients are residents in the West and North of Kent; predominantly in the catchment areas of NHS West Kent CCG and NHS Dartford, Gravesham and Swanley CCG.
- A small number of patients across Kent and Medway requiring highly specialised surgical interventions are referred into tertiary providers in London.

East Kent Hospitals Foundation Trust also delivers the AAA screening programme for all Kent and Medway residents.

4.4 Kent and Medway Clinical Commissioning Groups

North Kent CCGs	**Population**
Dartford & Gravesham and Swanley CCG	249,000
Medway CCG	268,000
Swale CCG	108,000
East Kent CCGs	
Ashford CCG	120,000
Canterbury & Coastal CCG	200,500
Thanet CCG	135,500
South Kent Coast CCG	203,000
West Kent CCG	
West Kent CCG	465,500
Total	**1,747,500**
Local Authorities serving Kent and Medway	
Kent County Council	
Medway Council	

4.5 Current Patient Flows

Kent and Medway referral flows for total Core Index Procedures.

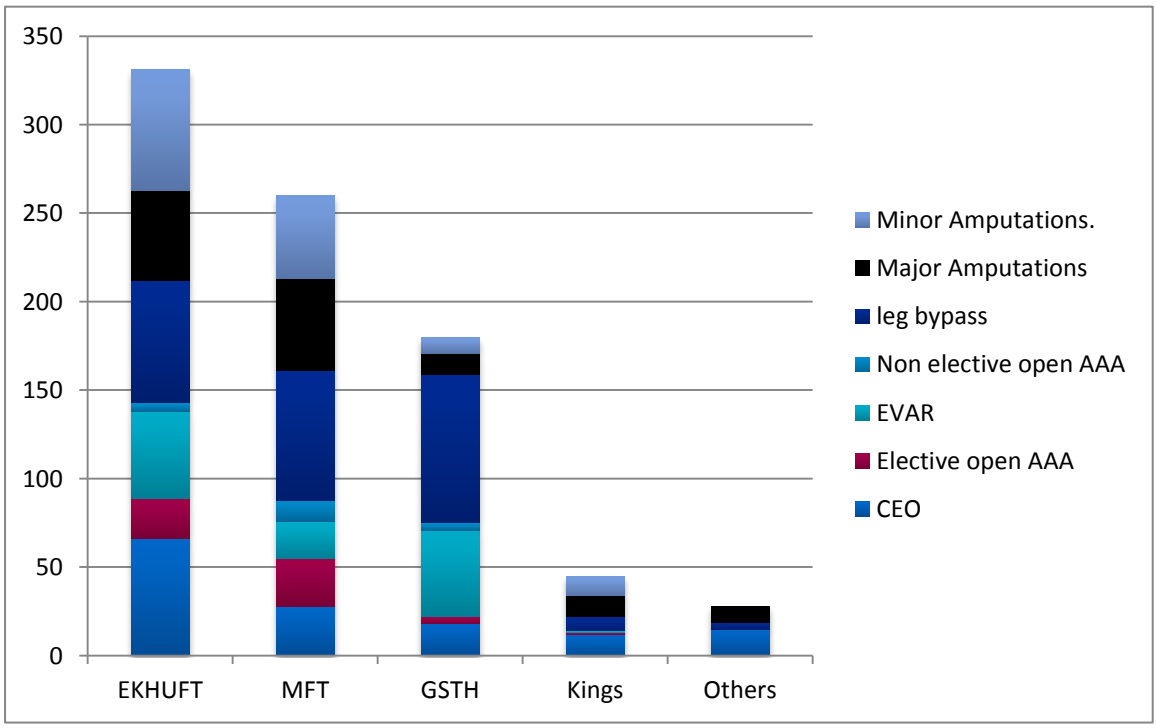


Table 2

4.6 Elective Care Pathway

Patients may enter an elective pathway via a GP referral, a referral from the emergency department, a referral from another secondary care specialty (e.g. diabetes or stroke) or through the AAA screening programme.

If the referral is generated by secondary care (an acute hospital consultant) the patient will either be seen at the same hospital if they provide vascular services or referred to the vascular service used by that consultant. Patients should be given a choice. If the referral is made by a GP or from the AAA screening programme the patient should again be given a choice regarding where they would like to be referred.

For elective patients, the initial referral will normally be for an outpatient appointment. These currently take place at:

- Kent and Canterbury Hospital, Canterbury - (East Kent University Hospitals NHS Foundation Trust)
- Medway Maritime Hospital, Gillingham - (Medway Foundation Trust)
- Pembury Hospital, Pembury - (Maidstone and Tunbridge Wells NHS Trust)
- Maidstone Hospital, Maidstone - (Maidstone and Tunbridge Wells NHS Trust)
- Darent Valley Hospital – (Dartford and Gravesham NHS Trust)
- St. Thomas' Hospital, London –(Guy's & St Thomas' Hospital NHS FT)

Following the outpatient appointment people will undergo diagnostics tests as required at Medway Hospital, Kent and Canterbury Hospital or Tunbridge Wells Hospital and in some cases Guys and St Thomas 'Hospital in London, which will include vascular studies (through vascular laboratories) and radiology.

Following diagnostic test results a discussion is held about each patient at a multidisciplinary team (MDT) meeting. If the decision is made to operate, the patient will be listed either for surgery or an interventional radiological procedure (as either a day case or inpatient procedure). The patient will then be required to attend the hospital where they will be having surgery for a pre-operative assessment. At this stage it may also be determined that a high dependency care bed is required and this will be requested.

Currently surgery performed in Kent and Medway is provided by East Kent University Hospitals NHS Foundation Trust at Canterbury and Medway NHS Foundation Trust at Gillingham. The majority of out of area surgery takes place at St.Thomas' Hospital, London.

Following elective surgery patients recover in the hospital in which they had their surgery. They will then be discharged home or to a community provider (if further rehabilitation is required or if there are further co-morbidities or social issues).

This Table illustrates where outpatient clinics are held and where day surgery and major surgery is undertaken in Kent and Medway.

Hospital Site	Major Surgery	Day Surgery	Out patients	Diagnostics	Comment
EKHUFT - KCH	Yes	Yes	Yes	Yes	
EKHUFT - WHH	No	No	Yes	No	
EKHUFT - QEQM	No	No	Yes	No	
MFT - MMH	Yes	Yes	Yes	Yes	OP also at Maidstone & Sheppey and Gravesend.
MTW - Tunbridge Wells Hospital	No	Yes	Yes	Yes	Surgeon joint appointment with GSTT
MTW - Maidstone Hospital	No	No	Yes	No	
Dartford & Gravesham - DVH	No	? Yes	Yes	Yes	Surgeons joint appointment with GSTT

Table 3

4.7 Emergency Pathway of Care

Patients may present as an emergency either via ambulance or through self-presentation to the emergency department. In general, ambulances will take patients to the closest hospital, which may then require an onward transfer to a hospital providing vascular surgery.

Following emergency surgery patients recover in the hospital in which they had their surgery. They will then be discharged home or to a community provider (if further rehabilitation is required or if there are further co-morbidities or social issues).

Following discharge they will receive ongoing care/monitoring at their most local hospital that provides vascular service (hub or spoke).

Patients in Kent and Medway who call an ambulance in an emergency will generally be transferred to the nearest vascular surgical site that has an available bed. The Ambulance Trust may take the patient to the nearest ED unit for stabilisation and assessment before transferring to the arterial centre depending on local protocols.

For surgical emergencies it is usual practice for East Kent residents to be transferred to Kent and Canterbury Hospital in Canterbury and West and North Kent residents to be transferred to Medway Maritime Hospital in Gillingham.

Patients from some parts of West Kent, in particular Tunbridge Wells, Tonbridge and Sevenoaks and patients from the North Kent area around Dartford and Gravesham will be transferred directly to St. Thomas' Hospital

If a patient is already at The William Harvey Hospital or Queen Elizabeth the Queen Mother Hospital in East Kent they will be transferred to the EKUHFT site for emergency surgery.

Patients already at Maidstone Hospital will be transferred to Medway Hospital.

Patients already at Darent Valley Hospital or Tonbridge Hospital will be transferred to St Thomas' Hospital.

The South East London vascular surgery network is now established and is in the final stages of implementation which will be completed this year (2015). This will result in all referrals being assessed and, if appropriate, undergo surgery through the MDT at St. Thomas' Hospital.

The Kent activity is undertaken through a Service level Agreement (SLA) between Maidstone and Tunbridge Wells NHS Trust and St.Thomas' and Dartford and Gravesham NHS Trust and Guy's and St. Thomas Hospital Foundation Trust. This includes diagnostics, outpatient clinics and day surgery in Kent and London, as required and in patient surgery at St. Thomas' Hospital.

The London providers also undertake fenestrated grafts for complex aneurysms for all Kent and Medway residents and provide clinical advice and support to the Kent and Medway units as required.

Guy's and St Thomas' Hospital Foundation Trust

Guys and St. Thomas' Hospitals Trust are fully compliant with the national specification and Vascular Society guidance.

Currently there is:

- One consultant vascular surgeon joint appointment at MDT with another being actively considered.
- Two consultant vascular surgeon joint appointments at D&G.

This SLA operates under a hub and spoke network model.

For residents in the Tunbridge Wells and Tonbridge area they may not meet the recommended of one hour emergency travel time when travelling to St. Thomas'.

King's College Hospital Foundation Trust

Kings College Hospital Trust currently undertakes a number of core Index procedures for resident of Kent. This is due to historical referral pathways. This will change as the SE London network is fully established and all arterial surgery is undertaken at St Thomas'.

4.8 Referral Pathways

Previous Kent and Medway strategic planning reviews identified the two current vascular surgical sites, MFT and EKUHFT as the centres for the Kent and Medway population. Practice has demonstrated that a proportion of the total Kent and Medway surgical activity has flowed into the London hospitals rather than MFT or EKUHFT since 2011.

It is not possible to definitively determine the reason for the current referral pathways. They will include patient choice, GP referral choice, historical referral patterns, clinical relationships, visiting consultant arrangements and joint appointments.

These patient flows predominantly relate to patients living in and around Tonbridge, Tunbridge Wells, Sevenoaks, Dartford and Gravesham (see map –page 10).

5 Core Information and Standards

5.1 National Service Specification

The National Specification for Vascular services (2013/14) notes that the overarching aim of elective and 24/7 emergency vascular services is to provide evidence-based models of care that improve patient diagnosis and treatment and ultimately improve mortality and morbidity from vascular disease.

Key features of the national specification include:

- All Trusts delivering vascular services must belong to a provider vascular network
- Arterial surgery should be delivered in an arterial centre
- The pathway for vascular services to include; Diagnosis /Assessment /Outpatient activity / In patient activity / Day case activity / Rehabilitation care.
- Non arterial surgery and day care should receive specialist vascular care locally with agreed protocols including emergency transfers to the arterial centre.
- Adequate population volumes; A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required.

- Adequate volumes of core Vascular procedures.(> 60 AAA procedures, > 50 Carotid Endarterectomies and commensurate lower limb procedures)
- 24/7 arterial surgery and vascular interventional
- 24/7 Interventional radiology available
- Acceptable on call rota requirements, ie no less than 1;6.
- A minimum of 6 Arterial surgeons and Interventional radiologists..
- Provision of Vascular surgery by specialist vascular surgeons.
- Provision of Vascular Interventional Radiology by specialist IR consultants.
- Provision of Vascular service by a specialist Multi disciplinary team.

5.2 The Vascular Society

The Vascular Society has published guidance on the Provision of Vascular services (2012). The primary objective of the society guidance is to *"provide all patients of vascular disease with the lowest possible elective and emergency morbidity and mortality rates in the developed world. This will be achieved by modernising services to deliver world class care from a smaller number of high volume hospital sites."*

Key recommendations of the Vascular Society guidance include:

- Recognition that It is no longer acceptable:
    1. For emergency vascular care to be provided by generalists who do not have a specialised elective vascular practice.
    2. To provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.
    3. For the vascular specialist to be providing emergency general surgical cover. In addition, vascular surgeons should not be expected to provide elective general surgical services. (Occasionally some surgeons will undertake specific procedures to maintain competencies directly related to local service needs, but this should be the exception.)
- Networks, involving arterial intervention at more than one site, often result in a reduction in the quality of care and increased mortality for patients in out of hours periods. For this reason, current strategies for the provision of vascular care require that all arterial interventions should be performed on a larger volume hospital site, with intervention provided at these hospitals by vascular surgeons and interventional radiologists from both the central and network hospital sites. This allows for 24/7 patient care and the expeditious treatment of any complications which may occur.

- Services should be organised in a model that allows reasonable elective activity alongside acceptable on call consultant arrangements. This should result in small units creating a modern clinical network where a designated single centre performs all elective and emergency arterial interventions.
- Facilities must be set up for 24/7 provision, supported by 24/7 critical care, dedicated vascular wards and endovascular theatres.
- Minimum procedure volumes are recommended; > 60 AAA procedures per unit with a minimum population of 800,000. Minimum 10 per surgeon.
- Hospitals providing vascular services should know and audit their AAA mortality aiming for elective mortality of 3.5% (end of 2013) and should regularly review the mortality morbidity rates of the Specialists.
- Specialists undertaking aortic interventions should submit their activity to the National Vascular Register
- Specialist nursing care of vascular in-patients , combining aspects of general surgical nursing, critical care, limb and wound assessment, tissue viability, wound care, rehabilitation, care of the disabled and care of the elderly.
- A ward dedicated to the care of vascular patients is essential to ensure an appropriate skill mix of nurses who have been specially trained in the care of vascular patients
- Emergency assessment and treatment should be available within one hour of travel to a recognised vascular unit in most locations in the UK. 95% of patients should be triaged, referred and have arrived at the vascular unit within two hours arrival at the spoke hospital.

The full document can be found at:

http://www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf

5.3 Core Index Procedures

There are many conditions that require the services of a vascular surgeon and/or an interventional radiologist.

A core set of index procedures for vascular surgery have been agreed and are:

- Elective Abdominal Aortic Aneurysm repair (inc EVAR)
- Emergency Abdominal Aortic Aneurysm
- Carotid Endarterectomies
- Leg Arterial Bypass
- Major Amputations
- Minor Amputations

As well as the core index procedures the review is looking at key interdependencies, in particular with emergency departments, renal services, and lower limb ischaemia management. However central to promoting quality and sustainability it is important to understand the number of core procedures being delivered at each surgical site.

Data re the Core Index Procedures is presented from three data sources – 2013/14:

- Data submitted by individual surgeons to the National Vascular Registry (NVAR)
- Secondary Uses Service (SUS); this is the single, comprehensive repository for healthcare data in England and is submitted by each trust
- The Trust's own data.

The data capture was agreed by the lead clinicians at MFT and EKHUFT and the data lead for the programme board and accepted by the Programme Advisory Board. The national specification requires a minimum number of procedures per centre and per consultant for AAA procedures.

- Abdominal Aortic Aneurysms 60 per annum.
- Carotid Endarterectomies 50 per annum.
- Lower limb bypass Commensurate numbers
- Per consultant per year 10 AAA emergency and elective procedures; commensurate lower limb and carotid procedures.

Kent and Medway Activity 2013/14.

Total activity for Kent and Medway 2013/14:

EKHUFT and MFT; 591 Others; 306 Total **Kent and Medway activity; 897**

Index Procedure	East Kent University Hospital FT				Medway FT		
	NVAR	**SUS**	**Trust**		**NVAR**	**SUS**	**Trust**
Carotid Endarterectomy	66	60	61		28	29	28
AAA Electives , open	23	tbc	tbc		27	28	26
EVAR	49	57	57		21	22	22
AAA Non elective, open	5	4	4		12	11	13
Total AAA's	**77**				**60**		
Leg bypass		69	69			73	74
Major amputation		51	53			52	52

Minor amputation		68	68			47	48
Total core index numbers	**331**				**260**		

Table 4

Kent and Medway- Out of Area Activity – 2013/14

Index Procedure	Guys and St Thomas'	King's College Hospital	Brighton and Sussex	Others
Carotid Endartarectomy	18	12		15
AAA Elective open	4	1		
EVAR	49	1	1	
AAA Non elective open	4			
Total AAA's	**57**	**2**	**1**	
Leg bypass	84	8	4	4
Major amputation	12	12		9
Minor amputation	9	11		48
TOTAL	**180**	**45**	**5**	**76**

Table 5

5.4 Reviews and Literature

A number of vascular reviews have been undertaken across England and Wales in recent years.

The key driver behind the reviews have related to the publication of the national specification, the Vascular Society guidance and the increasing evidence of the relationship between high volumes, specialist skills and improved patient outcomes.

These include:

- Yorkshire and Humber NHS 2010.
- NHS England South / NHS Sussex 2011
- NHS Wales, 2012.
- NHS England South/NHS Bath, NE Somerset and NHS Wiltshire 2013

***Key recommendations from the above reviews include**;*

Delivery within a network model with centralised arterial surgery.

- Adequate population volumes.
- Adequate intervention volumes.
- 24/7 access.
- Specialist Surgical and IR consultants.

The drivers of the reviews all relate to improving patient outcomes and delivering quality through delivery of the core standards and the ability to deliver resilient sustainable services for the future.

6 Additional Information

The key for system / service resilience is to actively identify and manage risks that could disrupt normal service (NHS Commissioning Board, 2013). In the context of vascular surgery, there is a need to ensure sufficient capacity (both physical resources as well as human resources) is available and systems are in place to secure the best patient outcomes and experience even in difficult circumstances.

6.1 The Case for Concentrating In-Patient Surgery

The relationship between the volume of cases undertaken and the outcomes achieved has been demonstrated most clearly for elective abdominal aortic aneurysm repair.

A meta-analysis[1] based on over 400,000 elective AAA repairs world-wide concluded in favour of higher volume centres (Holt, Poloniecki, et al., 2007). More recent research by Holt et al. also found an 8.5 per cent mortality rate in lower volume centres compared to 5.9 per cent in higher ones (Holt, Poloniecki, & al., 2010). Holt et al have also found mortality differences between hospitals in the lowest and highest volume quintiles of providing ruptured abdominal aortic aneurysm repair of up to 24% (Holt, Karthikesalingam et al., 2010).

There is also evidence that similar relationships affect the performance of other vascular procedures including lower limb arterial reconstruction and carotid endarterectomy (Karthikesalingham, et al., 2010; Moxey, et al., 2012).

This indicates that the risk of dying decreases when patients receive their surgery from teams that see higher numbers of patients and it is for this reason the service specification sets a requirement that vascular networks must serve a minimum planning population of 800,000.

[1] In statistics, a **meta-analysis** refers to methods focused on contrasting and combining results from different studies, in the hope of identifying patterns among study results, sources of disagreement among those results, or other interesting relationships that may come to light in the context of multiple studies.

6.2 New Technology

A major driver for change has been the introduction of minimally invasive endovascular techniques (i.e. the use of interventional radiology to treat arterial disease thereby avoiding open surgery and reducing recovery time). Such techniques have reduced mortality, morbidity and hospital length of stay (EVAR1 Trial, 2005), but they require specific infra-structure, such as hybrid operating theatres that are equipped with advanced medical imaging devices (CT, MRI), which are dependent on an adequate case volume (higher number of patients) to ensure their safe introduction.

Evidence suggests that high volume centres are more likely to adopt new technologies (Dimick & Upchurch, 2008) and NHS England is keen to foster innovation and constant improvements in how we deliver healthcare.

Hence, an arterial centre needs to provide complex aortic endovascular procedures from a dedicated vascular hybrid theatre supported by 24/7 vascular surgery and 24/7 interventional radiology, bringing together the expertise and experience of key clinicians in these techniques to provide both elective endovascular procedures and emergency ones, such as endovascular repair for ruptured abdominal aortic aneurysm. This arrangement has the potential to significantly improve length of recovery and reduce risk of surgical complications and risk of mortality as compared to conventional open repairs

6.3 Travel - The impact of Travel Distance and Times:

Kent and Medway is centrally well served by three motorways:

- The M2 serving the East and North of the county
- The M20 serving the West and North/West of the county
- Part of the M25 across the North West, serving the road networks.

Public transport routes are generally good with rail services covering most of the region. There are examples of rural road access in particular across the west and south west of the county increasing both ambulance and public transport times.

The VS recommendation is that services should be arranged to minimise transfer times (target less than one hour). 95% of patients should be triaged, referred and have arrived at the vascular unit within two hours of arrival at the spoke hospital.

A mapping of emergency travel times shows that all Kent and Medway residents are able to access the two current providers within the recommended 60 minutes. London hospitals are able to receive patients within the hour if they live in the far north and North West of the county. Travel times and distances are always an understandable concern for patients with some perceptions that travelling further for surgery will put patients at greater risk.

A number of studies have been published reporting no [statistically] significant impact of distance on mortality for vascular surgery.

For example, Cassar et al. studied nearly a decade of records from Raignor hospital in the Scottish highlands and reported no significant difference in the community mortality rate after ruptured aortic aneurysm between patients living within or further than 50 miles from the hospital (Cassar et al., 2001).

Several further studies attempting to determine the impact of distance on mortality have showed similar results.

Butler et al. (1978) studied the impact of regional hubs delivering vascular surgery on mortality outcomes and found no significant difference in operative mortality following ruptured abdominal aortic aneurysm (RAAA) between patients admitted from the local catchment area (58%) and those transferred from other centres for surgery (54%). Similar results were reported in studies by Fielding et al. (1984), D'Sa Barros (Barros, 1990), van Heeckeren (1970), Amundsen et al (1989), Farooq et al. (1996) amongst others, all reporting that centralisation does not prejudice the community mortality outcome for RAAA.

In terms of patients attitudes towards travel for specialist services, an extensive study by Holt et. al (2009) reported that 237 of the 258 patients questioned (92 percent) stated a willingness to travel for at least one hour beyond their nearest hospital. Patients also had a stronger willingness to travel to access services with lower peri-operative mortality, stroke and amputation rates, routine availability of EVAR and an experienced surgical team as opposed to other considerations such as length of stay, seeing the same doctor every time, waiting lists and car parking. The authors of this paper strongly endorsed the idea of concentrating vascular surgery in regional centres to achieve the desired mortality outcomes.

The All Party Parliamentary Group Review of vascular services (March 2014) considered the interrelationship with lower limb amputations and foot care and noted as good practice for vascular centres the need to:

- .Improve use of MDT in vascular networks.
- To establish vascular centers of excellence that can provide 24/7 care.
- To publish amputation rates and outcomes

6.4 Acute Hospital Providers

Across Kent and Medway there are four acute Hospital Trusts with a total of seven sites:

- Dartford and Gravesham NHS Trusts
    - Darent Valley Hospital. (DVH) - Dartford
- East Kent University Hospitals NHS Foundation Trust (EKUHFT)
    - Kent and Canterbury Hospital (KCH) - Canterbury
    - Queen Elizabeth Queen Mother Hospital (QEQM) - Margate
    - William Harvey Hospital. (WHH) - Ashford
- Maidstone and Tonbridge Wells NHS Trust (MTW)

    - Pembury Hospital – Near Tunbridge Wells
    - Maidstone Hospital - Maidstone
- Medway NHS Foundation Trust (MFT)

Two of the sites, MFT and EKUHT provide vascular surgical services (as arterial centres) and Kent and Medway residents also access two central London hospitals (Guys and St. Thomas' Hospital Foundation Trust and King's College Hospital Foundation Trust).

Dartford and Gravesham NHS Trust at Darent Valley Hospital and Maidstone and Tunbridge Wells NHS Trust at Tunbridge Wells Hospital, Pembury are also providing a range of vascular care including small numbers of day surgery through joint appointment specialist vascular consultants.

6.5 Health Needs Assessment.

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

The Kent and Medway population currently grows by 8%, in line with nationally,

- Population projections for the period 2013 to 2020 show the greatest increase in the older age bands;
    - 17% within the 65-74 age band
    - 22% within the 75-84 age band
    - 29% within the 85 plus age band
- There are some key housing developments anticipated. This includes the garden city development at Ebbsfleet in the North of the county with a maximum of 10,000 houses planned.
- There is also a planned theme park development due to open in 2020 on the Swanscombe Peninsula, expected to bring 27,000 new jobs and families to the area.
- The population projections relating to these developments are currently being worked through however this will be more relevant in the younger age groups ie below 65 years of age.
- The recommended population base (National Service Specification and Vascular Society guidance) needed for an adequate number of cases for a viable center is 800,000 and the Vascular Society has indicated that this will increase to between 1 million and 1.2 million within the next few years.
- Allowing for the proposed housing expansions in North Kent are anticipated to see a 26% population growth for the DGS population. This is forecast to the younger age group.
- Currently 26% of the total Kent and Medway activity flows into London.

7 Key Findings

7.1 Self-Assessment of Current Kent and Medway Providers.

EKHUFT and MFT completed an assurance self-assessment in December 2014, theses illustrate compliance across a number of the standards within the specification, including outcome measures.

The key issues noted in the assessments were:

- Mortality and outcomes identified as within the national requirements; The one exception relates to Lower Limb bypass. (Further work could be considered to understand the relationship between the low number of Carotid Endarterectomies and the 30 stroke mortality rates.)
- The numbers of Core Index Procedures were borderline in most cases. Carotid Endarterectomies low in MFT
- The population numbers did not meet the requirement for either unit.
- MDT cover is difficult to achieve over 7 days, particularly in relation to nursing.
- 24/7 consultant cover, Surgeons and Interventional Radiologists.
- Consultant rotas , concerns re sustainability currently; EK 1:4 and MFT 1:6
- There has been no self-assessment undertaken by either MTW or DVH

  As can be seen the key issues for both Trusts relate to low/borderline volumes and across Kent and Medway low workforce numbers and the ability to deliver 7 day specialist services. Neither if these can be resolved internally by the individual Trusts. .

7.2 Activity Data

The data analysis of the index procedures illustrates that the current providers are achieving the total AAA volumes although these are generally borderline.(in some instances only just) but not the Carotid Endarterectomies at MFT.

The Trusts assurance submission in December 2014 show mortality rates at the 3.5% recommended for 2013 and are within the tolerance of the morbidity targets with the exception of lower limb amputations.

In summary:

- The current total Kent and Medway activity is borderline for meeting the minimum requirements for AAA procedures.
- Carotid Endarterectomy levels at MFT are routinely below the minimum requirements

- Carotid Endarterectomies have historically been undertaken at MTW and D&G but now confirmed this has ceased.
- Mortality rates are within the 2013 recommended level of 3.5%, further improvements are likely to be required in the future.

Currently a significant proportion of activity from north and west Kent goes to Guys and St Thomas' hospital with 75 interventions (Carotid endarterectomies / AAA's) as compared with 88 at MFT and 143 at EKHUFT. Repatriation of this activity could give some stability to the existing Kent and Medway providers in particular MFT.

Review of commissioning intentions has advised that there is no imperative to alter patient flows or impact on patient choice.

Patient flows to London may have initially been driven by historic consultant relationships; however there is now a formal pathway in place through a service line agreement between St.Thomas' hospital and D&G and MTW.

7.3 Outcomes

Reported outcomes measures lack validity for making comparisons between Trusts and clinicians. It is noted that the data is not statistically significant and that it is an unreliable source upon which to make recommendations. This is why the Vascular Society has focussed on critical volumes of activity as the key quality measure.

It is also important to note that outcomes are increasingly reported by individual vascular surgeons as well as per Trusts and need to be considered within this context. None of the centres providing care to Kent and Medway residents are outliers and there are examples of good performance.

7.4 Population Data

The population data illustrates that currently neither arterial centre is meeting the minimum 800,000 requirement.

If all of the west and north population was included then the total would exceed the required 1.600,000 across Kent and Medway ie 800,000 per site.

However the referral flows would suggest that it is unlikely that any of this additional activity would flow to East Kent and therefore there would continue to be one site in K&M not achieving the minimum levels. This could only resolved by forcing the distribution of some West Kent activity into East Kent.

Repatriation of this activity would require a commissioner led mandate for referral pathways and could not interfere with patient choice to a recognised, compliant provider. The K&M Vascular review will address this issue within the options appraisal process.

The population flowing into London equates to almost 50% of the West Kent population and 94% of the North Kent population (Dartford and Gravesham).

There are clear indications that the minimum population volumes will increase in the near future, lily to exceed 1,000,000 per arterial centre.

7.5 Pathway Analysis

Currently there is no vascular network in place for Kent and Medway and the best practice model of a front door access to vascular care is not clear or transparent.

The local pathways to the current Kent and Medway arterial centres are well versed and recognised.

The geography of East Kent naturally drives patients in Thanet and parts of South Kent Coast to the East Kent centre whether for elective or emergency care as accessing sites beyond is both difficult and outside of recommended one hour travel times.

Historic relationships and current visiting consultants have contributed to a pathway in west and north Kent that engages with Guys and St.Thomas' in London.

There is an SLA in place re both the elective and emergency pathways for patients in Tonbridge, Tonbridge Wells , Sevenoaks, Dartford and Gravesham. This does not appear to be easily recognised and requires clarification and assurance re quality and sustainability.

Nationally In patient surgery accounts for around twenty per cent of activity within the arterial sites. The current numbers of Kent and Medway residents impacted by any potential reconfiguration of Vascular Inpatient services is around 585.

Out patient access is available at both the in-patient sites across Kent and Medway and in London.

7.6 Workforce

High quality vascular services are delivered through a wide range multi disciplinary team. This includes specialist consultants, Interventional radiologist, nurses, therapists laboratory scientists and anaesthetists. The Case for Change focuses on the requirement for Consultants, nurses and interventional radiologists.

However in developing options the wider MDT will be fully considered.

Given the range of specialist staff required in Arterial Centers, and the relative shortage in many of these professional areas, the future model of vascular networks needs to have a realistic and deliverable overall workforce plan.

High quality vascular units, that are large enough to provide sub-specialisation and high throughput, are more likely to recruit high calibre staff and improve retention.

with robust workforce plans identified.

7.7 Vascular Consultants.

An arterial center (serving a 800,000 population) should have 6WTEs Vascular Consultants, equating to 60-72 PAs of activity.

An individual on the vascular rota, but undertaking little elective work (ie less than 4PA), cannot reasonable be considered a vascular specialist. None of the current

consultants in Kent and Medway undertake less than 4PA. All patients referred to the vascular service at MFT and EKHUFT are seen by vascular specialists.

In Kent and Medway there are specific vascular surgical on call rotas in place in both arterial centres. This meets the guidance of 1:6 at MFT and is 1:4 at EKHUFT, this may raise concerns re sustainability across Kent and Medway.

	EKHUFT	MFT	Comments
Pas per individuals	Cons 1; 11.5 Cons 2; 12 Cons 3; 12 Cons 4; 10	Cons1;12.5 Cons 2; 12.5 Cons 3;11.5 Cons 4; 10.5 Cons 3; 8.0	
Retirements due in next five years	2 posts . 1 in 2 years 1 in 2 to 5 years	None anticipated	
Locum in place	Yes, shared with general surgery.	recruited pt time post, June 15	
Dedicated Vascular rota	Yes. 1:4	Yes 1:6	
Dedicated IR rota	Yes	Yes	To confirm ratio and requirement for non vascular pts.
Dedicated vascular ward	Yes	Yes	
Dedicated specialist nurses	Yes, supporting the wards, Consultant clinics and specialist nurse Out Pt clinics	Yes detail TBC	No Specialist nurses covering the weekends.

Table 6

The specification requires 10 AAA elective and emergency procedures and commensurate other core index procedures to be undertaken by individual consultants per annum. Not all consultants across Kent and Medway are compliant with this recommendation.

No Vascular patients are seen by non Vascular specialist consultants in Kent and Medway.

7.8 Vascular Interventional radiologists.

Vascular Interventional radiologists are a core component of the vascular service, achieving a sustainable vascular rota whilst not impacting on the wider non vascular interventional radiology is difficult. Both Kent and Medway providers have specialist vascular Interventional radiologists, these posts also support non vascular IR.
*A more detailed review of the impact on interventional radiology is underway as part of the review.

7.9 Vascular Nurse Specialists.

Vascular Nurse Specilaists are increasingly important in the delivery of vascular services, especially in Non Arterial Centres. VSGBI 2014 specifies that each NAC should have at least one VNS dedicated to covering the work at each site, in addition to those required at ACs. The role will need to be reviewed and developed to support consultant colleagues in the vascular network, and the VNSs will be the principle point of liaison in an effective network model.

The current Kent and Medway vascular centres both have specialist vascular nurses, they do not provide a service over the weekends.

7.10 Vascular Multi Disciplinary Team.

The wider Vascular team needs to be considered within the context of the review this will include;

- Vascular Multi Disciplinary team Vascular technologists and scientists
- Diabetic and non-diabetic podiatrists and diabetic foot care MDTs (19,20).
- Radiographers
- Physiotherapists
- Occupational Therapists
- Critical Care Paramedics
- Pharmacists

7.11 Travel Times

Travel times mapping for emergency access illustrates that the current two sites are able to meet their existing patient flows within the recommended one hour travel time. Both MFT and EKHUFT are accessible to all K&M residents within 45 minutes by emergency conveyance. The London sites are only accessible within an ambulance travel time of one hour in some parts of north West and far north Kent.

The VS recommendation is that services should be arranged to minimise transfer times (target less than one hour). 95% of patients should be triaged, referred and have arrived at the vascular unit within two hours of arrival at the spoke hospital.

7.12 Critical Co-dependencies

Vascular patients are often critically ill, can have multiple other medical conditions, and need timely access to specialised care from a wide range of other clinical services. It is vital to understand the implications of all these clinical co-dependencies in the safe planning of inpatient care of arterial, and non-arterial centres.

The SEC 'Clinical Co-dependencies of Acute Hospital services '2014 suggest which services should be collocated and/or have close visiting relationships.

Key co-locations for vascular services include;

Interventional Radiology, Accident and Emergency, Critical care, general surgery and acute/ general medicine, hyper acute stroke unit and acute cardiology. The key diagnostics are require to be co-located ie; MRI, CT, X ray and ultra sound. Also advised is colocation with Physiotherapy, general anaesthetics and pathology services.

The Vascular Society guidance advises;

- Co-location with interventional radiology. The impact of any reconfiguration must include IR and an understanding and safe clear pathways for management of non vascular IR
- Interventional radiology (IR) is a critical service for delivering diagnosis and treatments to vascular patients, working in partnership with the vascular surgical service. There are significant issues relating to the centralising of IR and delivering 24/7 IR rotas, including manpower, and the sustainability of non-vascular IR services in non-arterial centres, which need to be recognised and addressed
- The Vascular Society guidance and the SEC Co-dependencies both report advise that it is desirable to locate alongside Accident and Emergency departments and a robust critical care unit. External clinical advice to the review notes that the above is desirable but not essential. However a major trauma unit must have vascular services available on site. Where there is no co-located ED then there must be clear protocols and pathways in place to manage vascular

patients. This must include clinically agreed safe pathways for patient's who present with abdominal pain and collapse covering timely triage and transfer protocols.

- Consideration of the impact on the education and training needs of vascular trainees must be fully considered.
- If a renal unit is present within a site then vascular services should be co-located.
- It is desirable for admitting stroke units to have easy access to vascular services including IR.
- For specialist services such as renal, Stroke and Cardiac close working relationships must be in place and evident.

7.13 Diabetic Care

Current performance for diabetes related amputations shows that four of the eight Kent and Medway CCGs are above the national average.(0.9) ranging from between 1.1 to 1.6.

The establishment of robust multidisciplinary foot care teams, universally across Kent, Surrey & Sussex is becoming an imperative to ensure that changes through, vascular reconfiguration, do not increase the number of amputations across Kent, Surrey & Sussex due to poor service access.

Specialised Commissioning are being asked, by the Strategic Clinical Network Diabetes Clinical Advisory Group to ensure consideration and clear planning is undertaken to ensure that access to vascular services within 24 hours for an emergency foot problem when vascular reconfiguration plans are developed and implemented.

7.14 National Specification – Kent and Medway Position

Summary of findings

Key indicators/measures	Current K&M position	risk
1 hour travel time for emergency AAA/ 2 hour 95% target for triage, transfer and arrive	Current sites meet this across K&M	London hospitals only meet this in some parts of K&M
Population 800,000	Neither Trust meets this currently	Repatriating west and north Kent activity required. This will impact on patient choice and will still leave EKHUFTbelow target.

Total index procedures	AAA's achieved CE's below at MFT	Achievement is generally borderline, increasing the risk of ad hoc practice
24 hr consultant cover	Current sites meet this	Pressure on rotas esp EK. Retirements due in the next 2 to 5 years , concern raised re ability to recruit under current configuration.
Vascular network	Not currently in place	Impact on workforce planning/succession plans. Potential impact on the ability to enhance service provision in relation to innovation
Mortality rates	At 2013 recommended levels 3.5%	Unclear re further improvements required.
Morbidity rates	Generally good , only exception lower limb amputations	Amputation outcomes in K&M poor. Need to understand the impact of low rates of Carotid Endarterectomies on the 30 day stroke mortality rates.
Nursing cover	Not 7 day cover	Potential impact on the ability to develop practice

Table 7

The findings confirm that:

1. The current arterial centres in K&M are not complaint with the national specification and VS best practice guidance.
2. It is apparent that the pathways of care are not clear across Kent and Medway particularly for residents in the west and north of the county.
3. The reported patient outcomes are good/in line with the national average (currently this has not been evaluated at individual consultant level or in relation to interdependent clinical pathways ie diabetes)
4. The current Kent and Medway arterial centres do not fulfil the requirements in relation to population numbers and the volume of core index procedures is not achieved on both sites
5. Access to the two Kent and Medway centres is within the required one hour emergency travel time for the existing patient flows.
6. Access to St.Thomas' hospital in London is outside of the one hour recommended travel time for residents in Tunbridge Wells and Tonbridge.

7. The workforce requirements are not fully met across Kent and Medway with corresponding pressures on on-call rotas and 24/7 nurse cover.
8. There is concern re the current and future sustainability of the workforce rotas, this will be more pressing in the next 2 to 5 years as retirements come into play.
9. There is currently no vascular network in place in Kent and Medway, pathways will not always be clear and transparent, clinical practice may not be consistent or develop effectively.
10. Concerns have been raised re the financial sustainability of the model; the current level of activity cannot sustain the required workforce levels.
11. Current carotid Endarterectomy surgery practice at non arterial sites is non-compliant with the specification and VS guidance; need to confirm this will stop.
12. Maintaining the staffing levels and the cost related to the development of new innovation and technology in all existing vascular providers would require a significant amount of investment from both the providers and NHS England.
13. The risk of occasional practice may increase, with none of the current providers covering the minimum population base of 800,000 people needed to ensure teams treat sufficient numbers of cases to maintain and develop their skills..
14. Re-organisation of vascular services into networks enables NHS England to commission more resilient and sustainable vascular services.
15. Vascular services working together in networks are able to enjoy the benefit of combining existing vascular and other clinical specialists from all the existing providers within the network so that services can be planned across providers.
16. Sharing on-call rotas would address the shortage of appropriately skilled staff.
17. Vascular surgery trainees could be strategically deployed in the vascular centres to ensure they are exposed to the extensive range of vascular conditions to maximise their learning experience.
18. Interventional Radiology is a key component of the service and needs to be fully explored when considering the planning of Vascular services.
19. A detailed workforce plan across all vascular disciplines, including the impact of and on trainees is required.
20. Need to reflect the K&M strategic picture understanding current financial pressures and Quality concerns.

8 Proposal Benefits

The benefits we expect for patients are:

- Continued Improvement of the clinical outcomes, in particular lower limb amputation, working towards achieving the best rather than average performance.;
- Development of skills and expertise so that patients are better able to manage their condition and recovery;
- A transparent and effective vascular network, that benefits from shared clinical expertise and clear effective pathways of care..
- Increased access to outpatient clinics in spoke units.
- Improve sustainability of the existing vascular services
- Clear lines of accountability and clinical governance across the network that puts clinicians and patients at the heart of performance monitoring and service development.
- A sustainable specialist workforce; Consultant surgeons, IR Consultants and specialist nurses and the wider Multi disciplinary team..
- Standardised methods and promotion of best practice across the clinical teams;
- A more productive and efficient service (minimisation of duplication and waste);
- Improved opportunities for training, research and innovation;
- Reduced length of stay for patients and more effective pathway links with community providers to support timely repatriation of patients following surgery.

Conclusion:

- The Case for Change illustrates that the current Kent and Medway provision does not fully meet the national specification or Vascular Society guidelines.
- The review recommends that achieving the national standards and VS guidance should be a minimum requirement.
- There should be an ambition to commission for excellence over and above specification; this includes the delivery of excellent sustainable services that enable all K&M residents to benefit from excellent outcomes. To ensure a high performing workforce attracting motivated and innovative practitioners who aim to deliver outcomes at the highest level.
- The Case for Change recommends developing an options appraisal that can consider fully the possible options to make the required changes for both compliance and improved quality.

- The appraisal process needs to consider all influences and impacts not only to deliver the appropriate recommendations but to ensure sustainability and improvement for both vascular acre and other key clinical specialities.
- Local and external clinical leads will be required to ensure that the solutions are clinically safe, viable and equitable across Kent and Medway.
- The development of a network will be required and needs to ensure that all elements of the pathway are considered and fully understood.
- Public engagement and feedback will be central to the development of the options appraisal.

9 Next Steps

- The Case for Change is reviewed at the Programme Advisory Board for agreement.
- The Case for Change is reviewed by the SEC Clinical Senate and amended accordingly.
- Listening events take place through July and August which will raise the public awareness of the case for change and reflect any concerns/queries going forward.
- Development of solutions will involve public engagement and local Kent and Medway and external clinical leadership in a sequence of listening events and focus groups and through the Clinical sub group of the programme advisory Board. This will include the current vascular leads , the wider Multi disciplinary team, clinical commissioners and expert advisors.
- The review will develop a preferred option for approval by NHS England South, Specialised Commissioning. This appraisal process will consider key issues, variables and impacts.
- These will include;
    - Understanding population growth and changes
    - The Vascular pathway form symptom to rehabilitation
    - Key interdependencies; Interventional radiology, Emergency departments, diagnostics, other clinical specialities.
    - Workforce issues and interdependencies
    - Repatriating patient flows.
    - Issues identified through public, clinical and stakeholder engagement
- The Programme Advisory Board will oversee the development of solutions to the issues within the Case for Change to enable the sustainable delivery of vascular services to Kent and Medway residents in line with national best practice.

10 Glossary

Abdominal aortic aneurysm repair	Abdominal aortic aneurysm (AAA) repair is a procedure used to treat an aneurysm (abnormal enlargement) of the abdominal aorta. Repair of an abdominal aortic aneurysm may be performed surgically through an open incision or in a minimally-invasive procedure called endovascular aneurysm repair (EVAR).
Angioplasty	*Angioplasty* is the technique of mechanically widening narrowed or obstructed arteries.
Arterial surgery	This includes a range of procedures to prevent death from aortic aneurysm, prevent stroke from carotid artery disease, and prevent lower limb amputation from peripheral arterial disease and diabetes.
Carotid endarterectomy	A *carotid endarterectomy* is a surgical procedure to unblock a carotid artery (blood vessels that supply the head and neck).
Clinical Reference Groups	The specialised commissioning function of NHS England is supported by a devolved clinical leadership model. Seventy-five Clinical Reference Groups (CRGs) covering all prescribed specialised services draw membership from each of the 12 geographical areas in England. CRGs bring together clinicians, commissioners, and Public Health experts with the patients and carers who use specialised services. Members are volunteers who have a particular interest, knowledge or experience of a specific area of specialised healthcare and wish to contribute to its development. They are responsible for preparing national specialised service level strategy and developing specialised service contract products such as service specifications and commissioning policies.
Endovascular stent	An endovascular stent graft is a tube composed of grafting fabric supported by a metal mesh called a stent. It can be used for a variety of conditions involving the blood vessels, but most commonly is used to reinforce a weak spot in an artery called an aneurysm. Over time, blood pressure and other factors can cause this weak area to bulge like a balloon and it can eventually enlarge and rupture. The stent graft is designed to seal tightly with your artery above and below the aneurysm. The graft is stronger than the weakened artery and it allows your blood to pass through it without pushing on the bulge.

EVAR	See Abdominal aortic aneurysm repair.
Interventional radiology	Interventional Radiology is a medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. The concept behind interventional radiology is to diagnose and treat patients using the least invasive techniques currently available in order to minimize risk to the patient and improve health outcomes. These procedures have less risk, less pain and less recovery time compared to open surgery.
Peripheral arterial disease	*Peripheral arterial disease* (PAD) is a common condition in which a build-up of fatty deposits in the arteries restricts the blood supply to leg muscles.
Public and patient engagement	'Engagement', 'involvement', 'consultation', 'co-production' and 'participation' are all words that can be used to describe communicating with and listening to patients, carers and members of the public. This ranges from providing information to people about NHS services and commissioning decisions to working with patients and carers at a strategic level so their experiences and insight can be used to shape NHS policy and commissioning decisions.
Service specification	A service specification is a description of what a service should include. For example the number and skills of the staff that provide the service, registration with professional bodies or the environment in which certain procedures and care are carried out (like special thermo-regulated rooms for people being treated for severe burns).
Specialised services	Specialised services generally involve complex procedures that only a few people may have the skills and experience to perform or because they use very specialised, expensive equipment that the NHS simply could not afford to put into every local hospital and/or because the people who need these services are relatively few in numbers, such as very premature babies or people with rare cancers or genetic conditions.
Thoracic aortic disease	Thoracic aortic aneurysms — bulges in the wall of the aorta – are more common than doctors originally thought. If it tears the aorta, the main pipeline for blood from the heart to the body, suddenly bursts, cutting off the supply of life-sustaining blood and flooding the chest or abdomen with blood.

Vascular studies	Vascular studies are a non-invasive (the skin is not pierced) procedure used to assess the blood flow in arteries and veins. A transducer (like a microphone) sends out ultrasonic sound waves at a frequency too high to be heard. When the transducer is placed on the skin at certain locations and angles, the ultrasonic sound waves move through the skin and other body tissues to the blood vessels, where the waves echo off of the blood cells. The transducer picks up the reflected waves and sends them to an amplifier, which makes the ultrasonic sound waves audible.
Vascular surgery	Vascular surgery is a specialty of surgery in which diseases of the arteries and veins are managed by medical therapy, minimally-invasive catheter procedures, and surgical reconstruction. Vascular operations are no longer performed by general surgeons but by specialist vascular multi-disciplinary teams.

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Vascular Surgery Review for Kent and Medway

Decision Making Process and Decision Tree Criteria

Vascular Surgery Review for Kent and Medway

Version number: 9

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Prepared by: Oena Windibank

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Introduction

This document is a key component of the 2015 Kent and Medway review of Vascular services and needs to be read in the context of the review process as a whole. This includes:

- The Case for Change Document
- The Communication and Engagement plan
- The Project Initiation Document
- The Process Assurance Document.

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

1 The Decision Making Process

The decision making process will be undertaken in a systematic way and will be informed by public and clinical engagement.

The process will reflect national best practice and guidance.

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

- Approving the Case for Change
- Agreeing the Long List of Options
- Agreeing the Short List of Options
- The preferred option(s)
- Additional information
- Provider response
- The decision making tree – Parts 1,2 & 3

2 Case for Change

The Case for Change was developed to reflect the national context, regional influences and local variables. The key focus has related to the ability to delivery the national service specification and the Vascular Society's, 'Provision of Vascular Services' (2012).

This document was approved in principle at the Programme Advisory Board (PAB) on 19th May 2015. Additional information will be added as indicated within the document.

Listening events with the public will assess their understanding of the need for change and their key issues and concerns. Learning form these events will inform

the Case for Change. We will also use this opportunity to ensure that the document is readable and understandable.

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

The South East Coast Clinical Senate has been invited to provide a 'critical friend' role in reviewing the Case for Change and the PAB will take into account their recommendations.

The Case for Change will be shared with the Clinical Commissioning Groups (CCGs) clinical forums, and will be presented to the NHS England – South - Specialised Commissioning Delivery Group.

3 Decision Making Process

A systematic process will be in place to enable transparency in the identification and assessment of options.

This will take place within a six stage process:

3.1 Stage 1 – The Long List

The first stage will Identify and register all possible pathway and service configurations for vascular surgery services for the population of Kent and Medway (Section 6 - Registered Options) **to be completed/agreed by the Clinical group on 16th June**.

3.2 Stage 2 – The Long List Revised to the Short List

The second stage will reduce the long list to a shorter list of options. This will be achieved by applying key criteria (as noted within the national specification and Vascular Society Guidance for the Provision of Vascular Services) to each of the long list options to identify viable models.

Development of the short list will be informed by:

- The public through public engagement feedback.
- The clinical sub group to the Board (appendix 1).
- Board members and their constituency (for example Kent and Medway CCGs, NHS England, Vascular Society, external IR representative).
- The Programme of Care Manager – Internal Medicine, NHS England - South

The short list will identify options not providers.

Decision Making Tree Part 1 Long List to Short List

1. Identification of at least the minimum population 800,000. 'A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required' - (National Service Specification 2013).
2. Viability of a surgical consultant rota twenty four hours a day seven days a week (24/7) with an on-call rota of no more than once in every six days (1:6).
3. Viability of an Interventional Radiologist consultant rota 24/7 and 1:6.
4. Emergency Transfer Times – Travel time to the vascular surgical centre by blue light ambulance from a spoke hospital.

Extracts from 'The Provision of Services for Patients with Vascular Disease 2012' The Vascular Society

6.21 Protocols must be developed, particularly by the Accident and Emergency Department and ambulance service, to allow transfer of vascular emergencies to the adjacent vascular unit without delay. Very few hospitals are more than one hour by road from their neighbours, although there is evidence that even with travel time of more than one hour, transfer to a vascular unit improves patient outcomes. Patient survival after a ruptured aortic aneurysm is between 5-15% if they stay in a hospital with no vascular surgeon, compared with 35-65% if transferred to an adjacent vascular service. This advantage persists even with up to 4 hours of hypotension, although patients who suffer a cardiac arrest are unlikely to survive transfer.

6.22 Patients arriving at a non-vascular hospital with a vascular condition requiring emergency intervention should be diagnosed and referred within one hour of arrival. Services should be arranged to minimise transfer times (target less than one hour). 95% of patients should be triaged, referred and have arrived at the vascular unit within two hours of arrival at the spoke hospital. A few remote rural communities may need to agree different transfer target times, but should audit their service provision against locally agreed standards.

The short list will be formally agreed by the Programme Board. The decision making template can be seen at appendix 6.

3.3 Stage 3 – Additional Information – Review of Short List

The short list will be further reviewed using the information from the following work, to identify the preferred option(s).

Decision Making Tree Part 2 – Additional Information

1. Quality Review

   The Quality review will assess key quality indicators within the trusts' wider quality dashboard.

2. Organisational future strategy for clinical services at potential hub sites

   A statement from potential hub sites on their short, medium and longer term strategy for the delivery of clinical services and high level capacity and financial modelling.

3. Health Needs Assessment

   A health needs impact assessment will be developed for each short list option including the impact of new housing developments in Kent and Medway.

4. Essential and Desirable Co-Dependencies

   A list of essential and desirable co-dependences will be listed derived from the national service specification, the Vascular Society Provision of Services for Patients with Vascular Disease (2012) and the South East Coast Clinical Senate Review of The Clinical Co-Dependencies of Acute Hospital Services.

5. Detailed review of Travel Times

   This will include, blue light, private and public transport and highlight risks.

6. Interventional radiology service

   Impact and risks on vascular services and impact and risks on non-vascular services. The potential options must fully consider Interventional Radiology as a central component to the delivery of vascular services.

7. Workforce.

   This will consider the workforce requirements to deliver sustainable high quality Vascular services

8. Review of the demographics and projected population growth to determine the impact on delivering a sustainable Vascular service.

   This will include consideration of key risk factors and population groups.

3.4 Stage 4 – The Preferred Option

The Board will be asked to recommend the preferred option(s). NHS England Specialised Commissioning – South will be asked to endorse the Board's decision. These options will then be worked up through stages five and six.

3.5 Stage 5 – The Provider – Initial Responses

The preferred options will be described to interested hub providers. The providers will be asked to formally acknowledge their organisational commitment to provide the preferred option(s) pathway and model of care as described in the Register of Options.

Interested providers will then be formally asked to develop an outline business case to demonstrate how they would provide the service, meeting the requirement of the national service specification.

3.6 Stage 6 - Provider Business Case

The outline business case will be assessed by NHS England (South) and if deemed viable the interested providers will be asked to develop a full business case setting out how they will deliver the preferred option. The full business case with be scrutinised using the national service specification with particular emphasis on the criteria in the Decision making Tree Part 3 and the information gathered at stages 3 and 5.

Decision Making Tree Part 3 – Business Case (To be completed – work in progress)

- Volume of Core Index Procedures per Trust and per consultant.
- 24 hr access
- 24/7 consultant cover.
- 24/7 IR consultant cover.
- 7 day Specialist nursing cover.
- Co located critical care department.

Co-located Interventional Radiology.

The following recommendations made by the SE Clinical Senate will be reflected and reviewed through the decision making process and in particular in stages 3 and 6 to ensure that the key elements have been duly considered.

SE Clinical Senate Recommendations:

1. Describe in detail how the arterial centres and associated non-arterial centres within the proposed network would inter-relate, and the relevant range of clinical pathways between them. Throughout, there should be evidence of equity of access to the AC, wherever the patient lives or whichever referring hospital they come from.
2. Provide an overview of the whole pathway of care, from pre-hospital emergency care, through to rehabilitation in the community, and how the services and providers would join up and coordinate in delivering high quality outcomes
3. Define the proposed catchment population for the AC, and then model the future activity, based on demographic trends and the impact of preventative measures over the coming 10-15 years. This activity modelling should separately consider elective and urgent work, the impact of endovascular treatment developments, and non-aortic vascular surgery.
4. Demonstrate the feasibility of delivering the capacity required by the AC ((inpatient beds and operating theatre capacity in particular) in the host hospital.
5. Demonstrate how the host hospital will be able to deliver safe and effective general urgent and emergency care services, which high quality care for vascular patients is dependent upon.

6. Proposals assuming repatriation of any patient pathways currently served by south London vascular units should be supported by credible assumptions about the deliverability of such re-direction of work.
7. Detail the full range of clinical co-dependencies (in particular the critical co-located services) required by ACs (and NACs), and how they will be provided by the host hospital (with reference to the national service specification and VSGBI guidance 2012 and 2014, together with the SECS co-dependencies report 2014 (1,4,6)).
8. Explicitly describe the workforce, the skills required and the challenges across the whole pathway, and describe the workforce recruitment, training and education programme plans across the multidisciplinary team to address these challenges. Particular detail on the vascular consultant workforce and the vascular nurse specialist workforce should be provided, taking account of the requirement for care delivery at NACs as well as the ACs.
9. Demonstrate an effective and sustainable interventional radiology service for the AC and its supporting NACs. There needs to be clear plans not only for how a 24/7 IR service is provided at the AC, but also how at least a five day IR service is provided in NACs, how broader non-vascular IR services are provided for all acute hospitals within the network, and how the required radiology rotas in those hospitals are maintained.
10. Describe specifically the aspirations for a high quality service, for the vascular network in general and the AC in particular, and the metrics that would be used to demonstrate achievement of the quality service.
11. Describe how the full range or requirements of the national service specification, and the VSGBI 2012 and 2014 (4,6) recommendations, would be met, and if not, provide a justification, or a timescale by when they would be met.
12. Describe how urgent and elective carotid surgery would be provided for patients with TIAs and strokes for the network.
13. Describe how the renal units serving Kent and Medway would be supporteded in delivering a high quality vascular access service for dialysis patients. This should include the elective and emergency aspects of renal vascular access care, and involve close partnership with the IR service.
14. Present clear travel times within the proposed network that the AC would be centred within. This should be both from home locations across the catchment area, and from the networked NACs. Demonstrate how these travel times would be within safe limits for emergency transfer to the AC to receive the necessary care.
15. Describe the ambition for delivering teaching, specialist training and clinical research at the AC, and the commitment to support staff in providing these activities (through job planning and other enablers), and in partnership where appropriate with universities, medical schools, the CLRN and KSS's AHSN. .

4 Registered Options

4.1 Option 1 – Two Kent and Medway Hubs with Current London Pathway

No Change to the current configuration and patient flows. Kent and Medway surgical services provided at East Kent University Hospitals NHS FT (EKUHFT) and Medway Foundation Trust (MFT) and Guys and St Thomas' Hospital London (GSTH).

4.2 Option 2 – No Kent and Medway Hubs

No arterial surgical centre in Kent and Medway. All arterial surgery takes place in London. All Kent and Medway providers are network spokes.

4.3 Option 3 – Two Kent and Medway Hubs without London

The two vascular surgery centres in Kent and Medway become hub centres and no patients are referred to GSTH, expect for highly specialised procedures.

4.4 Option 4 – One Kent and Medway Hub, no London Pathway

One vascular surgery centre in Kent and Medway becomes the hub centre and no patients are referred to GSTH, expect for highly specialised procedures.

4.5 Option 5 – One Kent and Medway Hub with London Pathway

One vascular surgery centre in Kent and Medway becomes the hub centre. Patients continue to be referred to GSTH.

4.6 Option 6 - Networked Kent and Medway Hubs, no London Pathway

The two current vascular surgery centres provided all arterial surgery for Kent and Medway with no referral to GSTH, except for highly specialised procedures. The two surgical and IR teams network to provide Hub services including surgical cover at both sites 24/7.

4.7 Option 7 - Networked Kent and Medway Hobs with London Pathway

The two current vascular surgery centres provided arterial surgery for Kent and Medway with the current referral pathway to GSTH remaining. The two surgical and IR teams network to provide Hub services including surgical cover at both sites 24/7.

5 Appendices

5.1 Appendix 1 – Member of the Clinical Sub – Group

Name	Position	Organisation
Jonothan Earnshaw	External expert Vascular Consultant/Advisor, Vascular Society representative	Vascular Society
Malcolm Johnston	External expert IR consultant/advisor	BSUH
Waleed Edress	Clinical lead, Vascular Consultant MFT	MFT
Noel Wilson	Clinical lead, vascular Consultant EKHUFT	EKHUFT
Rachel Bell	Clinical lead, Vascular Consultant GSTH	GSTH
Fabian Sebastian.	Clinical lead IR Consultant MFT	MFT
Robert Kaikini	Clinical lead, IR Consultant EKHUFT.	EKHUFT
Paul Sigston	Medical Director, MTW	MTW
Gerard Sammon.	Deputy CEO, Director of Strategic planning, DVH	DVH
Oena Windibank	In attendance, Programme Director (VS review)	NHSE (south)
Diana Cargill	In attendance, Service Specialist, Specialised Commissioning.	NHSE (South)
Brijender Rana.	In attendance, Consultant Public Heath, Specialised Commissioning	NHSE (south)

5.2 Appendix 2 - CCG Populations (2014/15)

Clinical Commissioning Group Name	Population
Dartford and Gravesham and Swanley CCG	249,000
Medway CCG	268,000
Swale CCG	108,000
West Kent CCG	465,500
Ashford CCG	120,000
Canterbury and Coastal.	200,500
Thanet CCG	135,500
South Kent Coastal CCG	203,000
Total Population	**1,749,500**

5.3 Appendix 3 – Core Index Procedures 2013/14

Core Index Procedures

- Elective Abdominal Aortic Aneurysm repair (Including EVAR)
- Emergency Abdominal Aortic Aneurysm repair
- Carotid Endarterectomies
- Leg Arterial Bypass
- Major amputations
- Minor Amputations

Core Index Procedures by Provider 2012/13

- Information from the Case for Change Document
- King's activity will be undertaken at St Thomas' Hospital by the end of 2015/16.
- Dartford and Gravesham Hospital NHS Trust (D&G) and Maidstone and Tunbridge Wells Hospital NHS Trust (MTW) have both ceased to undertake arterial surgery on site.
- The activity (99) under 'other' should be considered as Guys and St Thomas' Hospital, Medway Foundation Trust activity.

Core Index procedure	Medway FT	East Kent University FT	St Thomas Hospital'	Other (Kings, Dartford & Maidstone)
Carotid Endarterectomies	28	66	18	27
Open elective AAA repair	27	23	4	1
EVAR	21	49	49	2
Open non elective AAA repair	12	5	4	0
Leg Bypass	73	69	84	16
Major Amputations	52	51	12	21
Minor Amputations	47	68	9	59
TOTAL	**260**	**331**	**180**	**126**
All activity for Kent and Medway population			**897**	

5.4 Appendix 4 – Activity by Option

Provider Activity; Core index procedures.	Medway FT	East Kent University Hospital FT	St Thomas' Hospital	Total Activity	Explanation
Option 1	283	278	180	**741**	This is the current position; the gap between the total 840 activity and 741 relates to the activity currently identified as 'other' this includes 32 pts who are under the care of GSTH through the SLA
Option 2	0	0	840	**840**	
Option 3	*533	307	0	**840**	* includes all West Kent and Dartford CCG activity.
Option 4	840 0	0 840	0 0	**840**	
Option 5	628 0	0 628	212 212	**840**	This makes an assumption that there is no increase in West Kent CCG activity to GSTH only Dartford activity.
Option 6	533	307	0	**840**	
Option 7	283	278	212	**801**	This gap relates to the 'other' activity with the exception of DGS (32)

5.5 Appendix 5 – Population by Option 1,749,500

1

Population.	MFT	EKUHFT	GTSH	Total Population	Explanation
Option 1	505,569	*682,016	450,687	**1,638,272**	Remaining 111,228 population is accounted for within the 'others' category. *EKHUFT figure includes the AAA screening population
Option 2	0	0	1,749.500	**1,749,500**	Need to understand if any EK activity would flow into BSUH
Option 3	1,090,000	*659,000 ? plus 23,000	0		This assumes West and North Kent CCG activity into MFT and EK CCG activity into EKHUFT. *The EKHUFT figure does not include the AAA screening population, this would need to be factored in, Circa 23,000.
Option 4	1,749,000 0	0 1,749,000	0 0	**1,749,500**	
Option 5	1,187,585 0	0 1,187,585. ? plus 23,000	450,687	**1,638, 272;**	The difference in population relates to the current population/activity flowing into the 'other' category, it is unclear how much of this would stay in K&M or flow into London and would need to be worked through. This predominantly relates to Maidstone activity as this is not under a current SLA. The AAA screening population is not factored in.
Option 6					Further analysis of this option is needed to determine the population flows and therefore numbers.
Option 7	505,569	682,016.	450,687	**1,638,272;**	Remaining population relates to the 'other' category and needs to be worked through re patient flows. Current AAA screening population is factored in.

5.6 Appendix 6 – Option Score Sheet for Long List to Short List

	Population	1: 6 consultant rota viability	1: 6 IR consultant viability	Emergency transfer time	Comment box	Risks	Overall score (see key)
Option 1 ; No change.							
Option 2; No K&M hub (GSTH/BSUH) ** EK activity may flow into BSUH rather than into London.							
Option 3; Two K&M hubs and no London pathway.							
Option 4; One K&M hub with no London Hub.							
Option 5; One K&M hub with London pathway.							
Option 6; Two networked K&M hubs no London pathway							
Option 7; Two networked K&M hubs with London pathway							

Key
Not a viable option – No – Red
Needs more detailed work – Perhaps – Amber
Viable option – Yes – Green

6 Glossary to be completed

Abdominal aortic aneurysm repair	Abdominal aortic aneurysm (AAA) repair is a procedure used to treat an aneurysm (abnormal enlargement) of the abdominal aorta. Repair of an abdominal aortic aneurysm may be performed surgically through an open incision or in a minimally-invasive procedure called endovascular aneurysm repair (EVAR).
Angioplasty	*Angioplasty* is the technique of mechanically widening narrowed or obstructed arteries.
Arterial surgery	This includes a range of procedures to prevent death from aortic aneurysm, prevent stroke from carotid artery disease, and prevent lower limb amputation from peripheral arterial disease and diabetes.
Carotid endarterectomy	A *carotid endarterectomy* is a surgical procedure to unblock a carotid artery (blood vessels that supply the head and neck).
Clinical Reference Groups	The specialised commissioning function of NHS England is supported by a devolved clinical leadership model. Seventy-five Clinical Reference Groups (CRGs) covering all prescribed specialised services draw membership from each of the 12 geographical areas in England. CRGs bring together clinicians, commissioners, and Public Health experts with the patients and carers who use specialised services. Members are volunteers who have a particular interest, knowledge or experience of a specific area of specialised healthcare and wish to contribute to its development. They are responsible for preparing national specialised service level strategy and developing specialised service contract products such as service specifications and commissioning policies.
Endovascular stent	An endovascular stent graft is a tube composed of grafting fabric supported by a metal mesh called a stent. It can be used for a variety of conditions involving the blood vessels, but most commonly is used to reinforce a weak spot in an artery called an aneurysm. Over time, blood pressure and other factors can cause this weak area to bulge like a balloon and it can eventually enlarge and rupture. The stent graft is designed to seal tightly with your artery above and below the aneurysm. The graft is stronger than the weakened artery and it allows your blood to pass through it without pushing on the bulge.

EVAR	See Abdominal aortic aneurysm repair.
Hub Hospital	
Interventional radiology	Interventional Radiology is a medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. The concept behind interventional radiology is to diagnose and treat patients using the least invasive techniques currently available in order to minimize risk to the patient and improve health outcomes. These procedures have less risk, less pain and less recovery time compared to open surgery.
Peripheral arterial disease	*Peripheral arterial disease* (PAD) is a common condition in which a build-up of fatty deposits in the arteries restricts the blood supply to leg muscles.
Public and patient engagement	'Engagement', 'involvement', 'consultation', 'co-production' and 'participation' are all words that can be used to describe communicating with and listening to patients, carers and members of the public. This ranges from providing information to people about NHS services and commissioning decisions to working with patients and carers at a strategic level so their experiences and insight can be used to shape NHS policy and commissioning decisions.
Service specification	A service specification is a description of what a service should include. For example the number and skills of the staff that provide the service, registration with professional bodies or the environment in which certain procedures and care are carried out (like special thermo-regulated rooms for people being treated for severe burns).
Specialised services	Specialised services generally involve complex procedures that only a few people may have the skills and experience to perform or because they use very specialised, expensive equipment that the NHS simply could not afford to put into every local hospital and/or because the people who need these services are relatively few in numbers, such as very premature babies or people with rare cancers or genetic conditions.
Spoke Hospital	
Thoracic aortic disease	Thoracic aortic aneurysms — bulges in the wall of the aorta – are more common than doctors originally thought. If it tears the aorta, the main pipeline for blood

	from the heart to the body, suddenly bursts, cutting off the supply of life-sustaining blood and flooding the chest or abdomen with blood.
Vascular studies	Vascular studies are a non-invasive (the skin is not pierced) procedure used to assess the blood flow in arteries and veins. A transducer (like a microphone) sends out ultrasonic sound waves at a frequency too high to be heard. When the transducer is placed on the skin at certain locations and angles, the ultrasonic sound waves move through the skin and other body tissues to the blood vessels, where the waves echo off of the blood cells. The transducer picks up the reflected waves and sends them to an amplifier, which makes the ultrasonic sound waves audible.
Vascular surgery	Vascular surgery is a specialty of surgery in which diseases of the arteries and veins are managed by medical therapy, minimally-invasive catheter procedures, and surgical reconstruction. Vascular operations are no longer performed by general surgeons but by specialist vascular multi-disciplinary teams.

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Item 7: Kent and Medway Hyper Acute and Acute Stroke Services Review

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: Kent and Medway Hyper Acute and Acute Stroke Services Review

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway CCGs.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) Kent and Medway CCGs have asked for the attached reports to be presented to the Committee:

2. Recommendation

RECOMMENDED that the report be noted and Kent and Medway CCGs be invited to submit an update to the Committee at its September meeting.

Background Documents

None

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Paper presented to:	Kent Health Overview and Scrutiny Committee
Paper subject:	Kent and Medway Hyper Acute/Acute Stroke Services Review
Date:	17July 2015
Presented by:	Oena Windibank; Programme Director, K&M Stroke Review. Mike Gilbert; Assistant Accountable Officer/Company Secretary DGS and Swale CCGs
Senior Responsible Officer:	Patricia Davies; Accountable Officer, DGS and Swale CCGs
Purpose of Paper:	To update the HOSC on the Kent and Medway Hyper acute/acute review, the Case for Change, Decision making Process and the next steps.

1.0 Background to the Review

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

The National Stroke Strategy 2007 provides guidance on best clinical practice and, although there is no national specification in place, there is considerable and accepted clinical evidence on care and treatment. Based on this strong evidence of improved clinical outcomes for patients, this guidance has now been widely implemented nationally. Kent and Medway are one of the few remaining geographical areas not to have implemented the guidance.

An important factor within the 2007 Strategy and guidance, is the ability for patients to receive their care in a high quality stroke unit, being seen, assessed and treated quickly by specialists in stroke. The evidence clearly demonstrates that access to 'specialists' in stroke reduces the numbers of people who die from strokes and the level of disability meaning that the quality of life and return to independent living is much improved.

Important features of a successful stroke unit include a specialist workforce, adequate volumes and 24 hour access.

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

Across England and Wales stroke services are under review with the aim of delivering the National Stroke Strategy and improving outcomes for stroke patients.

NHS England describes a good stroke unit having:

- A 7 day dedicated specialist unit with > 600 confirmed stroke admissions and no more than 1500 admissions.
- Achieve rapid assessment and imagery; door to needle times of one hour, imaging within one hour. Total call to needle time 120 minutes.
- Admit patients directly onto a specialist stroke unit within 4 hours.
- Patients staying on the stroke unit for 90% of their inpatient episode
- Patients assessed by specialist stoke consultants and stroke trained nurses and therapist within 24 hours.
- 7 day stroke consultant cover
- 7 day stroke trained nurse and therapist cover.

2.0 Why are the Kent and Medway CCG's reviewing hyper acute stroke services?

Commissioners in Kent and Medway are concerned about the performance and outcomes of the seven units currently admitting stroke patients.

Performance against the SEC Clinical and Quality standards and SSNAP varies across the county.

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

The Individual hospitals across Kent and Medway are aware of the issues and want to improve the services.

All the Trusts have improvement plans in place to address performance issues where possible, but a number have recognised that continuation with the existing delivery model is unsustainable and will not meet the 2007 Strategy and guidance requirements to have designated specialist units and care

These concerns led the CCGs to undertake a review of stroke services. whilst the whole stroke pathway is important and difficult to separate, there is an urgent need (based on current performance and patient outcome and fact that we are out of kilter with the national average in some domains) to develop a Kent and Medway wide solution to the delivery of the hyper acute and acute pathway.

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

Therefore, whilst the review will understand and consider care by the GP to prevent strokes and rehabilitation, it will focus on options for the hyper acute/acute pathway, which has the greatest impact on mortality reduction and longer term improvements to independent living. We expect to identify recommendations for individual CCGs with regard to improving primary prevention and rehabilitation.

3.0 Kent and Medway Stroke Review

The review will take a phased approach, by continuing to understanding what currently happens in Kent and Medway (this mapping exercise has begun with clinicians and patients) and how that differs with the national best practice and standards. It will go onto consider the ways that the service could be delivered to improve the current care and outcomes and ensure that the service delivers quality care now and into the future.

3.1 Who is involved in the review process?

There is a Programme Board led by clinical commissioning working with key stakeholders to consider what needs to be done. This will include Public Health, patient representation, Quality experts, the Stroke Association and Healthwatch. The programme is also overseen by the national clinical stroke lead, Professor Tony Rudd and NHS England, to ensure that we have the widest level of clinical support and guidance.

The Public health specialists are taking a detailed look at the needs of the area and its predicted growth to help us plan for the future.
Concerns and evidence about the current services have been shared with the South East Cardio vascular network and the SE Clinical Senate, which maintains an overview of health services across Kent, Surrey and Sussex. They will check that plans for changing stroke services are clinically sound and will improve outcomes for patients.

The public will be involved in the review through a number of Listening events and focus groups where the gaps in the Kent and Medway services will be discussed and options developed. A public engagement sub group of the programme board will be established to support the review.

The K&M Stroke review Communication and Engagement plan illustrates this in more detail.

3.2 What is the aim of the review?

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

The review must ensure that**;**

- The needs of all Kent and Medway residents who experience a stroke or whose family member experiences a stroke are considered.
- There is an agreed Hyper Acute/Acute Stroke service model in Kent and Medway that meets national evidence based best practice and goes beyond average.

- There is a sustainable model of hyper acute/acute stroke care that can meet the needs of residents in Kent and Medway going forward.
- Kent and Medway stroke services are aiming for a level A (SSNAP)
- There are clear improvements and benefits for patients, including reduced number of deaths and levels of disability, increased number of patients regaining independence and returning home after their stroke

4.0 What is the current Kent and Medway position?

Hyper acute/acute stroke is delivered in 7 admitting units across Kent and Medway: Darent Valley Hospital (DVH), Medway Foundation Trust, (MFT) Maidstone Hospital, (MH) Tunbridge Wells Hospital (TWH), William Harvey hospital, (WHH) Kent and Canterbury hospital (KCH) and Queen Elizabeth, Queen Mother Hospital (QEQM).

The SSNAP level is variable across Kent and Medway with overall scores varying between E (poor) and B (good). Performance within the 10 SSNAP domains is also variable and inconsistent. There has been some improvement but this is slow and difficult to sustain.

There is evidence of good practice and a number of scores around the national average.

Quarter 3 outcome measures show some deterioration in the mortality and readmission rates.

There are variable rehabilitation pathways in place including a range of Early Supported Discharge.

All K&M Trusts have performance improvement plans in place.

The provider Trusts are all involved in the review with lead clinicians and managers members of the Clinical Reference group.

The following table shows an overview of current K&M performance against the national best practice hyper acute recommendations.

National recommendation	Kent and Medway performance
7 day unit. > 600 confirmed strokes per annum	Only TWH provides a weekend service(1:3 rota) No unit sees 600 confirmed stroke patients (numbers between 321 to 473) Total K&M incidence 14/15 2,572
Rapid assessment and imagery. Call to needle time	This is variable across K&M. Generally scanning within an hour is average. The thrombolysis within one hour is less than average. National average 50% K&M 16.5 to 50%
4 hour access to specialist unit	This is below average (National average,56.9%) K&M 66.7% to 25%
Pt to stay on the stroke unit for 90% of their admission	This is well achieved across K&M
Assessment by specialist consultants, nurses and therapists	This is achieved through the thrombolysis rota but face to face assessment is not undertaken over the weekend
7 day consultant cover	Only at TWH (1:3 rota)
7 day stroke trained nurses and therapists	There is no specialist nurse cover over the weekends, there are nurses with in house training. No routine senior nurse cover 7 days. No therapy cover over the weekends.

4.1 Summary of key K&M issues

The key issues for the hyper acute pathway in Kent and Medway relate to;
The availability of specialist workforce, consultant numbers are around 50% of the recommended levels, nurse and therapist levels are also significantly low.

This impacts on the Trust' ability to deliver consistent care particularly over 24 hours/7 days a week and on their ability to assess and start interventions quickly.

Internal patient flows and pressures impact on meeting clinical targets in the first 72 hours particularly access to the stroke unit within 4 hours and thrombolysis within the one hour requirement.

There are concerns both by the CCGs and clinicians on the ability to improve and to be sustainable with the current model.

The Case for Change details the performance and issues in Kent and Medway in more detail and recommends that to do nothing is not an option.

5.0 Kent and Medway Stroke Review next steps

5.1 Case for Change approval

The Case for Change is currently under critical review by the South East Clinical Senate and is being considered for approval across the Kent and Medway CCGs.
The current series of public listening events underway are testing the understanding and clarity of the Case for Change.

Feedback from these and the HOSC/HASC will inform the final Case for Change.

5.2 Decision making and approval process

This process will use national best practice guidance, public feedback and local/national clinical recommendations as criteria.

The decision making process will work with clinicians and the public, this will include:

- Identifying the range of possible solutions.
- Applying the criteria to develop realistic options for more detailed assessment.
- Detailed analysis of possible solutions particularly focusing on Quality and safety, capacity, access/travel times, key clinical interdependencies, demographic impacts/relationships and workforce.

- Understanding the Impacts and risks of possible options . This will particularly important in relation to the impacts on quality, safety and patient outcomes.

- A number of modeling groups will consider the detail of these issues and possible impacts of options.
- Consideration and alignment with CCG and provider Trusts strategic plans will be considered within the process.

- Public health data will be utilised to project activity, the possible impact on stroke numbers and the impact of proposed developments i.e. Ebbsfleet/Swanley.
- Development of models will include describing the pathway of care and the interrelationship between the Hyper acute Stroke units and the Acute stroke units.
- Impacts of possible options will be clearly explored and understood and any risks identified. This will particularly focus on the impacts on quality, safety and patient outcomes.

The 'long list' and 'short list' and final preferred options will be considered and tested at each point against the public, stakeholder and clinical feedback.

NHS England South (East) and the South East Clinical Senate will provide an assurance role to the review. Kent HOSC and Medway HASC will be kept informed of the review progress and approached, once the options have been developed, to determine if the proposed options constitute a substantial variation of service. If the Kent HOSC and Medway HASC determines the proposed service change to be substantial, a Joint HOSC will need to be established.

The review is overseen by the Stroke Review Programme board which has representation at senior decision making level from all the CCGs, NHS ENGLAND, SE cardio vascular network, public health also representing the local authorities, clinical leadership and a public representative.

An engagement and communication sub group with public representation and a Clinical Reference group support the board.

5.3 How will the review ensure that the public are involved in the process?

It is important to the success of the review that the public and stakeholders are actively involved in the review. We will actively seek out people who have experienced stroke services and those who may be at risk as well as the wider public. We will build on the knowledge and expertise of the Stroke association and feedback provide already to Healthwatch, the CCGs and the individual hospitals.

A Communication and Engagement plan has been developed. This sets out in detail how the review will engage with the public and key stakeholders
Engagement with wider stakeholders will take place with the Stroke association, local community groups, local health and well being boards and CCG patient and public forums.

6.0 When will the review be completed?

The review is aiming to develop the options over the summer and early Autumn with the preferred option being approved late Autumn/early Winter

2015 with an aim to begin implementation form April 2016. This may need to be a phased implementation.

* Appendix 1; K&M Stroke Review Plan on a page.

K&M Stroke Review; Plan on a Page.

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

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

Kent and Medway picture:

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

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

Review process

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

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

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

Assurance through NHSEngland, HOSC/HASC, SE Clinical Senate

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

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Kent and Medway Stroke Services Review

Case for Change

July 2015

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

Contents:

1.0 Executive summary.

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

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

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

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

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

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

And that the most significant interventions are:

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

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

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

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

- High quality **information and support** for patients and carers
- **Inpatient care** through a specialist unit
- The service **measures** what it does, publishes **data** and constantly **looks for improvements.**

The national recommendations are for stroke units to:

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

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

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

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

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

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

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

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

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

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

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

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

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

The review has the following objectives:

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

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

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

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

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

It found:

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

Ambition for stroke services in Kent and Medway

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

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

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

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

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

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

- Sustainable stroke services for all Kent and Medway residents.

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

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

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

2.0 Purpose of the Report.

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

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

3.0 Recommendations.

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

Ensure the optimum outcomes for stroke patients.

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

Improve performance against the SSNAP measures.

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

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

Consistently meet the needs of all Kent and Medway residents.

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

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

4.0 Background

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

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

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

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

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

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

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

The acute stroke pathway;

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

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

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

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

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

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

Hyper-acute stroke units (HASUs),

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3 The review approach.

The review will undertake a phased approach:

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

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

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

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

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

4.4 Best Practice and Performance frameworks

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

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

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

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

5.0 The National Context.

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

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

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

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

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

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

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

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

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

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

NHS England commissioned a review of stroke configuration good practice (2015)

and have produced a guidance tool for use when undertaking a stroke review and deciding on stroke configuration. (ref)

5.1 Policy context; Standards and guidance.

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

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

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

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

And that the most significant interventions are:

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

5.2 Patient /User voice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data from the Sentinel Stroke National Audit Programme (SSNAP) has shown that larger stroke services operate more efficiently than

smaller services and it is likely that they are more likely to be financially viable as well.

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

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

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

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

These include;

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

The guidance recognizes the importance of and builds on the work from the **Sentinel Stroke National Audit Programme** and notes that the findings across the country indicate that there are still considerable variations in the quality of stroke care across England. This evidence demonstrates a clear need to look at the opportunities to improve the quality of stroke services and therefore ***doing nothing should no longer be an option.***

The impact of Telemedicine on the pathway.

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

5.4 Literature Review findings.

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

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

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

5.5 Sentinel Stroke National Audit Programme. (SSNAP)

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

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

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

- Domain 1: Scanning
- Domain 2: Stroke unit

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

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

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

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

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

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

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

5.6 South East Cardiovascular Strategic Clinical Network;

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

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

admitting units. (appendix 1)

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

5.7 Workforce guidance:

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

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

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

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

The BASP recommended staffing numbers for a HASU are;

Professional group.	**Recommended levels**	
Specialist Stroke consultants	1.3 per 100,000 pop	22.1. total for K&M
Stroke trained nurses	2.9 wte per bed	Per unit
Therapists; **Physio** **OT** **SALT** **Dietician.**	 1 wte/per 5 beds. .68 wte/ per 5 beds. .68 wte/ per 10 beds .5 wte/per 20 beds	Per unit.

Clinical psychologist	1.0 per 40 beds.	

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

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

5.8 Critical Co-Dependencies

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

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

HASU/ASU

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

HASU or ASU specific:

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

Other services are coded as being:

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

5.9 Summary of the national guidance and policy:

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

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

6.0 Current Kent and Medway Provision/Pathways

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

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

6.1 Hyper acute/acute pathway.

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

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

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

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

Where appropriate rapid imagery is accessed from the ED departments.

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

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

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

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

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

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

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

Provider	*Location*	*Service*
EKHUFT	WHH, Ashford KCH, Canterbury. QEQM, Margate.	Full acute service on all sites
MTW	Tunbridge Wells Hospital.(TWH)	Full acute services on all sites.

	Maidstone Hospital,(MH) .	Rehabilitation at Tonbridge Cottage Hospital.
Darenth Valley Acute Trust	Darenth Valley Hospital, (DVH) Dartford	Full acute services on site.
Medway Maritime Foundation Trust	Medway Hospital, (MFT) Gillingham.	Full acute service on site.

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

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

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

6.2 Stroke incidence.

Current K&M activity;

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

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

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

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

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

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

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

CCG Stroke profiles; August 2014

	WK	DGS	Medway	Swale	Ashford	C.Coastal	SKC	Thanet
Stroke prevalence; 2.0 national	1.9	1.9	1.8	2.2	1.9	2.1	2.5	2.7
A.F Prevalence; 1.5 national	1.8	1.5	1,3	1.4	2.1	2.1	2.1	1.9
pop	463,500	249,000	268,000	108,000	120,000	200,500	203,000	135,500
> 65	83,000	41,500	39,000	18,800	21,500	40,000	41,500	29,500
deprivation	2.5%	8.2%	14.8%	22.6%	6.1%	7.8%	20.0%	31.5%
Admitting units	TWH, MH, (MFT)	DVH	MFT	MFT	WHH	KCH, QEQM	WHH, KCH	QEQM

6.4 Public Health Analysis;

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

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

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

  17% within the 65-74 age band

  22% within the 75-84 age band

  29% within the 85 plus age band.

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

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

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

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

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

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

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

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

7.0 K&M performance against Best Practice/Standards.

7.1 Performance against the SEC 22 Clinical and Quality standards.

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

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

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

	7 day workforce	Thrombolysis within 60 mins (95%)	Scan within 60 mins(50%)	Stroke unit access within 4hrs
DVH	No	33%	48%	50%
MFT	No	11.1%	33.7%	45%
MH	No	66.7%	43%	59.5%
TWH	Only cons	20%	50%	31.4%
WWH	No	16.7%	55.2%	59%
KCH	No	50%	71%	25%
QEQM	No	33.3%	65.4%	59%

7.2 Performance against SSNAP.

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

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

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

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

7.3 Performance against the key acute domains (SSNAP)

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

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

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

	Domain 1 Scanning. <I hour 44.1% < 12 hrs 87.7%	Domain 2 Stroke unit 4 hrs;59.8% 90% stay; 84.3%	Domain 3 Thrombolysis 1 hr: 50% Eligible pts; 79.4% All pts; 11.7%	Domain 4 Specialist Assessment. Cons; 76.4%. Nurse 87.8% Swallow screen 79.2% Swallow assessment; 83.6%	Domain 8. MDT
DVH	Just above average. Improvement Q3	? below, 4 hr access. Improvement Q3	Just below, 1 hr thrombolysis. Improvement Q3	Average, therapy assessment,4hr swallow. No Change	Average. Slight deterioration Q3
DVH Performance in key indicators Q2/Q3	1 hour target; 47.5% /58.1% 12 hour; 96.7%/ 98.6%	4 hour access; 50% /66.7% 90% stay; 88.9% /86.2%	All pts; 9.8% / 13.5% Eligible pts; 100%/ 90% 1 hour target 33.3%/	24hr Stroke con/assessment; 70.5% /70.3% 24hr Nurse ass; ??/86.5% 4 hr Swallow screen ; 66.7% /70.4% 72 hr Swallow ass;	

				78.6% /81.3%	
MFT	Below ave;1 hr screening. Improvement Q3	Below average 4 hr access. Marked deterioration Q3	Below ave,no within 1 hour poor. Improvement Q3	Below average, esp consultant assessment, swallow screening. No Change, Q3	Below ave. No Change Q3
MFT Performance in key indicators Q2/Q3	1 hour target; 32.9% /42.9% 12 hour; 92.7% /97.6%	4 hour access; 44.3% /25.6% 90% stay ; 83.3% /74.3%	All pts; 11% /14.3% Eligible pts; 90% /100% 1 hour target; 11.1% /16.7%	24hr stroke cons assessment; 61% /54.8% 24hr nurse ass; 80.5% /83.3% 4 hr Swallow screening; 62.7% /61.4% 72hr Swallow ass; 65.5% /67.4%	
MH	Variable. Below average, deterioration Q3	Average. Deterioration Q3	Average with some improvements. Deterioration Q3	Just below, consultant assessments and 4hr swallow indicators. No Change Q3	Below average. Slight improvement Q3
MH Performance in key indicators Q2/Q3	1 hour target; 43% /30.7% 12 hour access; 87.3% /89.7%	4 hour access; 59.5% /56.8% 90% stay; 90.6% /85.1%	All pts; 3.8%/5.7% Eligible pts; 100%/80% 1 hour target; 66.7%/20%	24hr stroke con assessment; 67.1% /62.5% 24hr nurse ass; ?? /94.3% 4 hr swallow screen; 70.6 /79.7% 72 hr swallow assessment; 78.8??/90.6% check these	

TWH	just above average. Deterioration Q3	Below average Deterioration Q3	Below average. Improvement Q3	Average. Improvement in Q3	Below average. Improvement in Q3
TWH Performance in key indicators Q2/Q3	1 hour target; 50% %/43.2 12 hour access; 94.3/87.7	4 hour access; 31.4% /31.3% 90% stay; 82.8% /71.2%	All pts; 5.7% /9.9% Eligible pts; 100%/ 88.9% 1 hour target; 20% /37.5%	24hr stroke con assessment; 84.1% /81.5% 24hr nurse ass; 85.2% /91.4% 4 hr swallow screen; 82.4%/ 76.6% 72 hr swallow assessment; 72% /80.8%	
WHH	Above average. Slight deterioration in Q3	Just above average Deterioration in Q3	Above average. Deterioration In Q3	Above average. No change in Q3	Below average. Slight deterioration in Q3
WHH Performance in key indicators Q2/Q3	1 hour target; 71.6% /55.2% 12 hour access; /95.2%	4 hour access; 76.4% /59% 90% stay; 90.8% /86.4%	All pts; 17.4% /11.4% Eligible pts; 81.3% / 69.2% 1 hour target; 50.1% /16.7%	24hr stroke con assessment; 89% /79% 24hr nurse ass; //93.3% 4 hr swallow screen; 89.5% /83.3% 72 hr swallow assessment; 89.2% / 96.6%	
KCH	Just above average. Slight deterioration in Q3	Just above average, below on 4 hr access. Deterioration in Q3	Just above average; just below re eligibility indicators. Deterioration in Q3	Just above, struggles with nurse and therapy indicators. Deterioration in Q3	Below Average. Deterioration in Q3
KCH Performance in key indicators Q2/Q3	1 hour target; 76.3% /71% 12 hour access; 98.7% /93.1%	4 hour access; 56.6% /25% 90% stay; 84.3%/94.6%	All pts; 15.85 /11.6% Eligible pts; 76.3% /87.5%	24hr stroke con assessment; ??100% /85.5% 24hr nurse ass; /93.3%	

			1 hour target; 58.3% /50%	4 hr swallow screen; 80.4% /65.4% 72 hr swallow assessment 100% / 96.6%	
QEQM	Just above average. Slight deterioration in Q3	Just above average. Deterioration in Q3	Average, below on eligibility. Deterioration in Q3	Slightly above, average. Nurse and swallow 4hr indicator below. Improvement in Q3	Below average. Deterioration in Q3
QEQM Performance in key indicators Q2/Q3	1 hour target; 64.4% /65.4% 12 hour access; 92.2%/ 89.7%	4 hour access; 64.4% /59% 90% stay; 83.7% /83.8%	All pts; 13.3% /19.2% Eligible pts; 66.7% /60% 1 hour target; 66.7% /33.3%	24hr stroke con assessment; 80% / 88.5% 24hr nurse ass; 81.1% / 82.1% 4 hr swallow screen; 61.9% /86.7% 72 hr swallow assessment; 94% /94.6%	

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

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

7.4 Performance against Outcome measures.

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

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

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

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

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

7.5 Performance against workforce requirements/recommendations.

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

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

workforce requirements within SEC quality standards					

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

7.6 Summary table of key indicators against current sites.

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

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

8.1 Best practice/Stroke Standards:

Assessment against best practice illustrates that across Kent and Medway achievement of the standards and best practice is variable. All providers recognize that they are currently struggling to meet best practice, they particularly raise

concerns re the ability to further improve, to sustain improvements and quality measures that they have achieved and to deliver 7 day working across all the specialists.

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

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

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

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

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

8.2 Activity:

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

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

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

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

care on a stroke unit. This currently equates to similar numbers as those who do require stroke unit care. Any subsequent modelling will need to understand the impact of any reconfiguration of HASU on ED's and/or repatriation of non stroke patients brought to the HASU by ambulance.

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

8.3 Workforce:

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

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

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

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

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

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

8.4 Travel/Access:

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

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

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

8.5 Summary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Development of innovative clinical practice.

Conclusion;

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

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

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

9.0 Recommendations:

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

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

The benefits we expect for patients include;

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

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

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

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

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

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

10.0 Next Steps:

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

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

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

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

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

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

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

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

Kent and Medway Stroke Services Review.

Decision making process
and
Decision tree/criteria.

1.0 Introduction:

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

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

2.0 The decision making process.

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

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

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

2.1 Case for Change:

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

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

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

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

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

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

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

3.0 Options Decision making process.

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

This will be undertaken within a staged process;

Stage 1 – The Long List

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

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

Stage 2 – The Long List Revised to the Short List

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

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

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

The short list will be informed by:

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

Stage 3 _ Options Appraisal.

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

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

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

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

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

- considering the impact of longer travel times either due to length of journey or traffic issues on effective thrombolysis.
- Understanding the benefits of the hyper acute principle of centralisation for patients in rural areas.
- The impact on repatriation rates, ED activity and pressures.
- The possible solutions within the context of wider K&M and Trust's strategic plans.

The initial work undertaken by Public Health on projected growth, prevalence and incidence and the impact of primary prevention for key risk factors on stroke

prevalence will be considered in greater detail at this stage. This will inform the options appraisal and subsequent recommendation(s)

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

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

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

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

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

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

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

Stage 4; Preferred option approval.

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

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

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

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

Appendix 1: Decision Making Tree

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

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

Stage one process:

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

Stage two process:

- Detailed appraisal of provider configuration/capacity/feasibility/quality
- Detailed assessment of ability to meet the 120 minutes call to needle time and impact analysis of options on travel times balanced with the benefits of centralisation.
- Cost analysis.*

- Benefit analysis
- Impact assessment.
- Detailed access/travel times review.
- Application of SEC senate Co-dependencies guidance to ensure no negative impact
- Workforce.

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

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

Appendix 2:

Recommendations from the Clinical Senate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

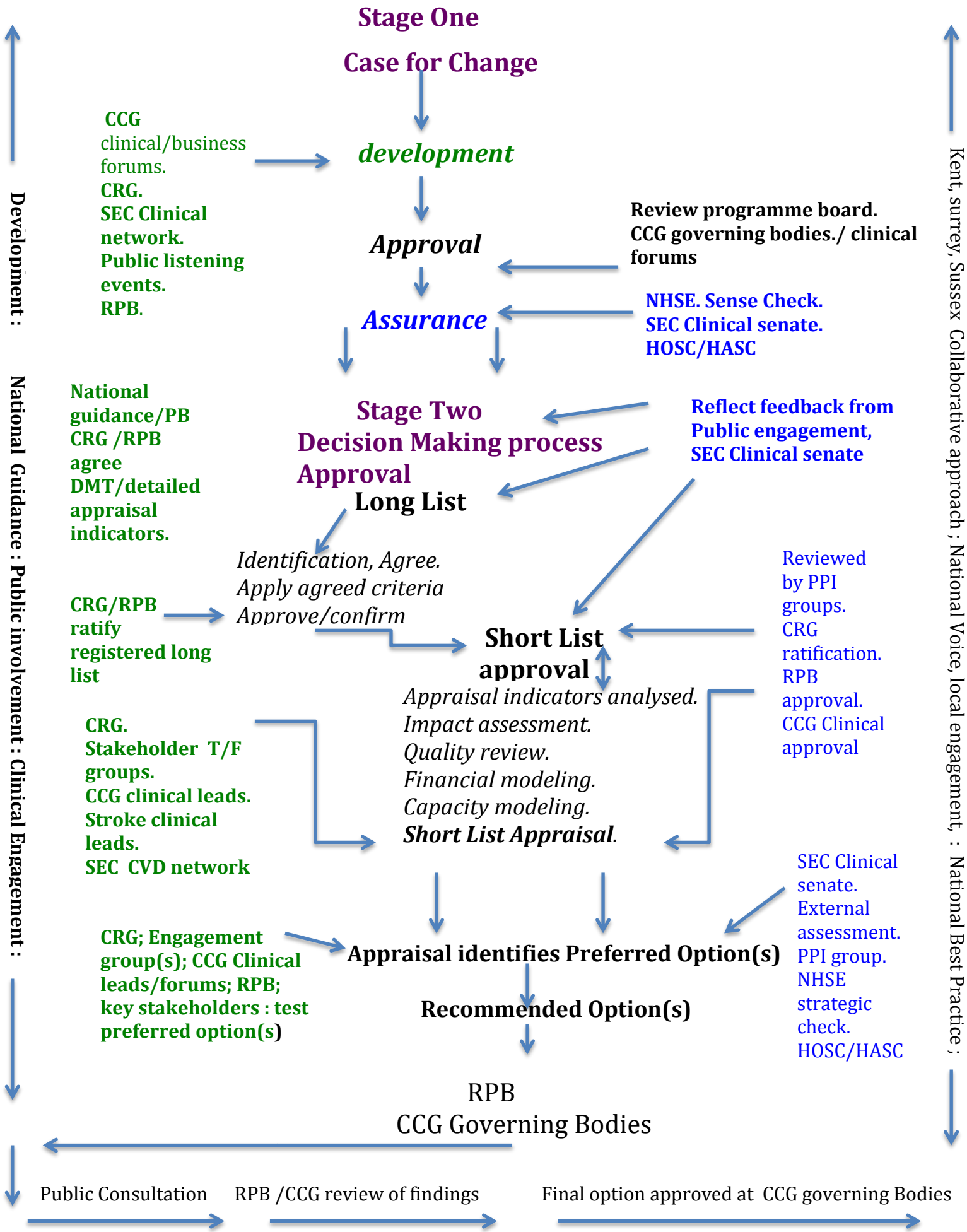
- The TIA pathways for the proposed stroke networks should be outlined, to demonstrate that the required rapidly responsive service would be delivered.

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

Appendix 3: Key Governance/decision points.

	Development	Approval
Case for Change	**Developed through the RPB, CRG, Public listening events, CCG clinical feedback, SEC Clinical network .**	**Approved in principle by RPB, Formal approval by CCG Governing bodies/Clinical Committees.** **HOSC/HASC discussions** **NHSE Sense check**
	Up to June 15	***June/July 15*** ***July/August 15***
Decision Making process	**Developed through the CRG, Public listening events, national guidance, SEC Clinical network.**	**Approved through the RPB and the CCG Governing bodies/Clinical committees.**
	Up to July 15	***June/July 15***
Long list	**Developed through CRG,** **Informed through public feedback.**	**Discussed at RPB**
	July/August 15	***August 15***
Short List	**Assessed through CRG. (DMT applied)** **Discussed and developed through Listening events/focus groups and Engagement group.** **Developed with and**	**Agreed at RPB.**

	discussed at CCG clinical/business groups.	
	August 15	***Sept 15***
Options Appraisal	**Informed through public and clinical engagement.** **Assessed through CRG,** **Informed by the CCG clinical leads/forums.** **Stakeholder discussion inc Stroke association, HWB.**	**Approved in principle through the RPB, formally by the CCG governing bodies.** **?JOSC late Sept 15**
	Aug/Sept 15	***Sept 15***
Preferred option(s)	**CRG recommendation.** **Public and engagement groups feedback.** **Stakeholder Challenge session**	**NHSE Strategic check.** **Approved in principle through the RPB.** **Formally through the CCG governing bodies.** **JOSC**
	Late Sept 15	***Oct 15***


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

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Kent and Medway

Communication and Engagement Plan

Stroke Care Review and Redesign Programme

Version 2.0

July 2015

Prepared by

Sharon Knight – Engagement Manager, North Kent CCGs

1.0 Introduction

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

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

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

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

It found:

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

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

1.1.1 Background to Stroke Services

1.1.1 Drivers of this project

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

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

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

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

1.2 Clinical Rationale and Governance

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

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

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

- Are admitted to a dedicated stroke unit

And that the most significant interventions are:

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

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

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

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

Key Messages

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

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

1.3 Scope of the Review

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

2.0 Governance

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

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

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

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

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

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

3.0 Objectives of the Communication and Engagement Activities

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

Informing:

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

Engaging:

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

Collaborating:

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

3.1 Purpose of Communication and Engagement Plan

The purpose of this plan is to:-

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

4.1 Principles of Communication and Engagement Approach

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

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

3.2 Principles for Communication - Media

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

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

- A media spokesperson will be identified.

4.0 Audiences and Key Stakeholders

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

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

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

CCG patient reference group(s):

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

Voluntary and community associations:

- Stroke Association
- Diabetes UK
- Other VCS organisations

Protected groups:

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

NHS and social care staff:

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

Stakeholders:

- Kent and Medway CCGs – Boards and Execs

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

5.0 Equality and Diversity

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

6.0 Communication and Engagement Activities

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

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

6.1 Engagement Activity

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

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

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

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

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

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

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

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

Communication and engagement effort will then be appropriately focussed.

6.2 Communications Activity

The communications teams will work in partnership to:-

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

6.3 Local Briefing

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

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

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

7.0 Phase-by-phase plan

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

8.0 Evaluation

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

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

8.1 Risks

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

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

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

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

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

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

Appendix A: The four tests and assurance questions

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

The 4 Tests:

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

Preparing for an assessment against the four tests – key questions

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

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

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

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

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

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

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

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

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

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

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

Item 8: NHS England South (South East): General Practice

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: NHS England South (South East): General Practice

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS England.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 5 September 2014 the Committee considered an update on General Practice and the development of services. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted and that NHS England (Kent and Medway Area Team) take note of the comments made by Members during the meeting and be invited to attend a meeting of the Committee in six months.*

2. Recommendation

RECOMMENDED that the report be noted and that NHS England be invited to attend a meeting of the Committee at an appropriate time.

Background Documents

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29238

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An Update on General Practice from NHS England South (South East)

Briefing for a meeting of the Kent Health Overview and Scrutiny Committee for discussion at a meeting on Friday 17 July 2015.

1. Background

At a meeting with Kent County Council Health Overview and Scrutiny Committee (HOSC) on 05 September 2014 a detailed briefing was provided by NHS England (Kent and Medway Area Team) with regards to issues and challenges facing general practice both nationally and across Kent. The Committee requested a further update from NHS England with regards to the actions it was taking both nationally and locally regarding this.

This summary paper and its enclosures seek to update the Committee on:

- The development of national strategy and policy since last autumn,
- How this national strategy is being implemented at a local level
- Changes to general practice provision across Kent

Members are asked to refer back to the Committee papers provided by NHS England (Kent and Medway Area Team) for the 05 September 2014 meeting of the HOSC for information about the issues and challenges currently facing general practice.

In addition to this background context the following additional information may also be useful for Committee members.

- ***Nuffield Institute – "Is General Practice in Crisis" (04 November 2014)***

http://www.nuffieldtrust.org.uk/publications/general-practice-crisis

- ***House of Commons Library – Briefing Paper - Genera Practice in England (22 June 2015)***

http://researchbriefings.files.parliament.uk/documents/CBP-7194/CBP-7194.pdf

2. The development of a national strategy and an agreed budget to support implementation.

A significant number of national strategy and policy developments as well as local implementation actions and issues have occurred since the autumn. These include:

2.1 National Strategy: The Publication of the "Five Year Forward View"

The Five Year Forward View was published on 23 October 2014 by NHS England and sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health

England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

The Five Year Forward View highlights that the traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Increasingly we need to manage systems – networks of care – not just organisations. In particular the NHS of the future needs to be characterised by:

- Out-of-hospital care that is a much larger part of what the NHS does.
- Services which are integrated around the needs of patients. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- Applying rapid learning from the best examples, not just from within the UK but internationally.
- Evaluation of the new care models to establish which produces the best experience for patients and the best value for money.

With specific reference to general practice, the Five Year Forward View sets out the following steps with regards to investment:

- Stabilising core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.
- Giving GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Providing new funding through schemes such as the Prime Minsters Challenge Fund to support new ways of working and improved access to services.

- Expanding as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expanding funding to upgrade primary care infrastructure and scope of services.
- Working with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Building the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or *A&E visit.*

The Five Year Forward View also points towards two new additional models of primary care provision over and above the status quo that NHS England will be promoting over the next 5 years. These are **Multispecialty Community Providers** and **Primary and Acute Care Systems providers**.

Multispecialty Community Providers (MCPs)

Although it is expected that many smaller independent GP practices will continue in their current form it is recognised that primary care is entering the next stage of its evolution.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form - either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.
- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.
- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.
- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.
- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. NHS England will permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.
- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.
- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are more complex in their nature than MCPs. They will take time and technical expertise to implement. As with any new model there are also potential unintended side effects that will need to be managed. The intention therefore is to pilot these in a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

2.2 Agreed Investment Plan for general practice to support Delivery of the Five Year Forward View

NHS England will be investing an extra £1billion into general practice over a four year period commencing 2015/16. This will be in the form of £250M a year, every year over a four year period and is known as the GP Infrastructure Fund.

This funding will deliver on the promise of a new deal for primary care. The first tranche of £250M will improve premises, help practices to harness technology and give practices the space to offer more appointments and improved care for the frail elderly – essential in supporting the reduction of hospital admissions.

GP practices were invited to submit their bids in January 2015, either through making improvements to existing buildings or the creation of new ones. In the first year it is anticipated that the money will predominantly accelerate schemes that were already in the pipeline, bringing benefits to patients more quickly. Practices were asked to set out proposals that would provide them with more capacity to do more; provide value for money; and improve access and services for the frail and elderly.

This new funding will accelerate investment in increasing infrastructure, accelerate better use of technology and in the short term, will be used to address immediate capacity and access issues, as well as lay the foundations for more integrated care to be delivered in community settings.

Across NHS South (South East) a number of the proposals submitted by GP practices will be supported through the GP Infrastructure Fund in 2015/16. The detail underpinning these individual schemes is currently being examined further and confirmation of final support will be issued shortly to the successful practices.

2.3 Other Premises Developments and testing new approaches

In addition to the above investment plan a range of premises developments have also been agreed at a local level through the allocation of improvement grants to practices. In 2014/15 a number of important schemes were supported enabling practices to expand and/or improve the fabric of their existing surgeries.

An example of a scheme supported with Improvement Grant funding is the extensive work undertaken at the Northumberland Court surgery in Maidstone.

2.4 Prime Minsters Challenge Fund (PMCF)

There have been two waves of the PMCF which has tested out new ways of delivering general practice service to local communities.

Across NHS South (South East) the following schemes have been supported.

Wave 1:

Integrated South Kent Coast Pilot delivered by Invicta Health CIC

Extended Primary Integrated Care (EPIC) delivered by Brighton Integrated Care Service (BICS)

Wave 2:

Step Change towards Multispecialty Community Providers delivered by GP Health Partners Ltd in Epsom, Surrey

Worthing & Adur Multispecialty Community Provider pilot delivered by Innovations in Primary Care Limited.

The Integrated South Kent Coast Pilot brings together 17 practices in both Folkestone and Dover to provide extended and more flexible access to services for 110,000 patients by creating a network of primary care with a hub facility based at two local community hospitals. Patients registered at the Folkestone practices have been able to book appointments from 8am to 8pm, seven days a week from 1 October 2014, and the Dover practices have been able to do since March 2015.

This pilot continues to receive positive patient feedback regarding the paramedic practitioner (PP) visiting service. The PPs work with the practices and NHS111 to visit acutely ill patients at home. They have access to GP clinical records and can see and treat patients in collaboration with the patient's GP to avoid admissions or a transfer to A&E. All 17 pilot practices refer patients for urgent visits Monday to Friday.

For patients with urgent mental health needs, this pilot is also introducing a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home, at their GP practice or one of the two community hospital hubs.

2.5 New Care Models - Vanguard Sites

Three GP practices across Whitstable and Canterbury were successful in applying to be one of only 29 sites within the first wave of Vanguard sites to form a Multi-speciality Community Provider service. The Vanguard scheme for Whitstable in Kent is made up of the Whitstable Medical Practice, Northgate Medical Practice and the Saddleton Road & Seasalter Surgeries.

Whitstable's Multispecialty Community Provider will cover a population of 53,382 local people currently registered with these GP practices. They will be working in partnership with local health, care and support organisations including Canterbury & Coastal CCG, Kent County Council, East Kent Hospital University Foundation Trust, Kent Community Health Trust, Kent Partnership Trust and AgeUK.

Patients, such as an elderly person with dementia living in residential care, for example, will see the benefits of the new model of care through better trained care workers looking after them each day. These care workers will have learnt in a new setting, alongside colleagues from other disciplines and with access to new technology. This will result in a team looking after the patient that has better insight into dementia and from specialist input from a geriatrician with expert knowledge of the condition. The patient and their family will feel fully involved in all decisions about their care plan, and will be able to set goals and outcomes for their care and support that are important to them personally.

2.6 "Building the Workforce – The New Deal for General Practice" ("GP Workforce 10 Point Plan")

NHS England, Health Education England (HEE), The Royal College of General Practice, and the British Medical Association GP Committee are all working together to ensure that we have a skilled, trained and motivated workforce in general practice. This is a 10 point action plan across three broad areas of action – recruitment, retention and returners.

All four organisations have jointly developed a new GP workforce action plan which sets out a range of initiatives to expand the general practice workforce:

- **To recruit newly trained doctors into general practice** in areas that are struggling to recruit. We will incentivise them to become GPs by offering a further year of training in a related clinical specialty of interest such as paediatrics, psychiatry, dermatology, emergency medicine and public health. This work will be underpinned by a national marketing campaign aimed at graduate doctors to highlight the opportunities and benefits of a career in general practice. Alongside this pilot training hubs based in GP practices will be established in areas with the greatest workforce needs to encourage doctors to train as GPs in these areas. They will also enable nurses and other primary care staff to gain new skills.
- **To retain GPs** the plan includes establishing a new scheme to encourage GPs who may be considering a career break or retirement, to remain working on a part-time basis. It will enable practices to offer GPs the opportunity to work with a modified workload and will be piloted in areas which have found it more difficult to recruit. There will also be a wider review of existing 'retainee' schemes.
- **To encourage doctors to return to general practice** HEE and NHS England will publish a new induction and returner scheme, recognising the different needs of those returning from work overseas or from a career break. There will also be targeted investment to encourage GPs to return to work in areas of greatest need which will help with the costs of returning and the cost of employing these staff.

NHS England is investing £10million of funding to kick start the initiatives in the plan, which will complement work that is already underway to strengthen the GP workforce. The plan is part of the Five Year Forward View which set out a specific commitment to tackle workforce issues.

Across Kent Surrey and Sussex Community Education Providers Networks (CEPNs) have been established across in each of the 20 CCGs. The purpose of CEPNs is to facilitate educational networks between GP practices with GP and primary care workforce tutors offering support in education, training and workforce planning. The establishment of CEPNs across each of the CCGs provides an important foundation through which to address the workforce challenges facing general practice through a partnership involving HEE, NHS England, CCGs, practices and various professions.

2.7 Clinical Pharmacists in General Practice

NHS England launched a £15 million programme on 07 July 2015 by inviting GP practices to submit their bids for engaging clinical pharmacists in the delivery of GP practice services. This initiative is part of delivering the GP Workforce 10 Point Plan and is about exploring opportunities to support general practice by piloting innovative workforce initiatives.

This pilot builds on the experiences of general practices, which already have clinical pharmacists in patient facing roles, and in some cases this extends to positions as partners. The pilot will be evaluated so that successes and learning are identified and reported.

The intention is to invest at least £15 million over the next three years to test out this new patient-facing role in which clinical pharmacists have extended responsibility over and above many current ways of working. Practices have already suggested that this extended role could include the management of care for people with self-limiting illnesses and those with long term conditions and have asked that the new team members have the ability to independently prescribe.

The pilot will be funded for three years with an expectation that practices will continue with the role into year four and beyond. It is anticipated that in the region of 250 clinical pharmacists will be involved over this period with the ambition of supporting over 1 million patients.

Practices are being strongly encouraged to work together to assemble joint bids involving pharmacists across a number of sites. Applications to participate in the pilot will need to demonstrate a case of need in relation to workforce challenges and clinical demands. It is anticipated that clinical pharmacists will be in post early in 2016.

Details of the pilot can be accessed below:
http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/07/clinical-pharm-gp-pilot.pdf

2.8 Organisational Change and the Development of Co-Commissioning

NHS England's Organisational Alignment and Capability Program was concluded in April 2015. This internal restructure resulted in a shift from 27 Area Teams to 12 Sub Regions with a further reduction in management costs.

The functions of primary care commissioning and contracting are still largely undertaken by NHS England. At a local level the team supporting this is part of NHS South (South East) which covers the Kent Surrey and Sussex area.

Alongside this internal restructuring has been the roll-out and development of co-commissioning. This follows the publication of "Next Steps towards Primary Care Co-Commissioning" by NHs England in November 2014.

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care. Co-commissioning is recognition that CCGs are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now but are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of both primary care. Co-commissioning will be a key enabler in developing integrated out-of-hospital services based around the needs of local communities. It will also drive the development of new models of care such as MCPS and PACS.

Across NHS South (South East) 2 of the 20 CCGs have delegated responsibility for the commissioning of primary medical services. The two CCGs concerned are Eastbourne, Hailsham and Seaford CCG and High Weald, Lewes, Havens CCG. The remaining CCGs have been invited to submit their proposals for either entering into Joint Commissioning arrangements or to take on delegated responsibility by early October 2015. Should their applications be supported then these would take effect from 1st April 2016. CCGs that either do not submit proposals to change their status or whose proposals are not supported will retain their existing advisory role with regards to the commissioning of primary medical services.

2.9 Amendments to the existing national GP contract (General Medical Services contract for 2015/16)

A number of important changes to the GMS contract have been agreed between NHS Employers (acting on behalf of the Department of Health and NHS England) and the General Practitioners Committee (acting on behalf of the BMA) which will take effect from 2015/16. These include the following:

- a named, accountable GP for all patients (including children) who will take lead responsibility for the co-ordination of all appropriate services required under the contract
- the patient participation enhanced service will end and associated funding will be reinvested into global sum. From 1 April 2015, it will be a contractual requirement for all practices to have a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population
- the alcohol enhanced service will end and associated funding will be reinvested into global sum. From 1 April 2015 it will be a contractual requirement for all practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels
- assurance on out of hours provision has been agreed to ensure that all service providers are delivering out of hours care in line with the National Quality Requirements (or any successor quality standards)
- improved maternity/paternity arrangements have been agreed, to cover both external locums and cover provided by existing GPs within the practice who do not already work full time

- further commitment to expand and improve the provision of online services for patients, including extending online access to medical records and the availability of online appointments
- publication of GP net earnings - practices will publish average net earnings (to include contractor and salaried GPs) relating to 2014/15, as well as the number of full and part time GPs associated with the published figure
- assurance on out of hours provision has been agreed to ensure that all service providers are delivering out of hours care in line with the National Quality Requirements (or any successor quality standards)
- improved maternity/paternity arrangements have been agreed, to cover both external locums and cover provided by existing GPs within the practice who do not already work full time
- NHS England and GPC will re-examine the way in which GP practices are funded for their patient lists with the aim of adapting the formula to better reflect deprivation

2.10 Outcome of the General Election and formation of a majority government.

The outcome of the general election should mean that there is consistency in the direction of policy regarding the NHS. The Secretary of State for Health made a speech on 19 June 2015 reaffirming the direction of travel for general practice in policy terms. A copy of the speech, entitled “A New Deal for General Practice” can be accessed below.

https://www.gov.uk/government/speeches/new-deal-for-general-practice

3. Changes to general practice provision across Kent and NHS South (South East) since last autumn

There are a number of changes to the provision of general practice services to update the Committee on. These include:

3.1 Contract Resignations and Practice Closures

The closure of Dover Medical Centre (30 November 2014) following the cessation of the APMS contract formally held by Concordia Health. Patients were supported in finding an alternative practice with which to re-register. Many of these patients chose to re-register with Pencester Health who provide GP services under a permanent GMS contract from within the same building.

The closure of Broadstairs Medical Practice (31 March 2015) following the cessation of the APMS contract formally held by Concordia Health. Patients were supported in finding an alternative practice with which to re-register. Many of these patients chose to re-register with the Albion Road practice who provide GP services under a permanent GMS contract from within the same building.

NHS South (South East) has also recently been served with contract resignation notices by two further GP contractors. The practices concerned are Cecil Square in Margate (where the PMS Agreement will cease on 30 September 2015) and Sterling House in Luton, Medway (where the APMS contract will cease on 30 September 2015). A procurement decision about both patient lists will need to be taken shortly following a period of consultation with patients and stakeholders.

3.2 Termination of two GP contracts in Medway (January 2015) and Hove (June 2015)

NHS England, in the form of the previous Kent and Medway Area Team and as NHS South (South East) served notice to terminate two separate GMS contracts in the interests of patient safety. In both cases temporary APMS contracts have been agreed with neighbouring practices to ensure that patients can continue to access GP services. A procurement decision about the future management of both practices (the Green Suite surgery in Rochester and the former Goodwood Court Surgery in Hove) and patient lists will need to be taken in due course by NHS England South (South East).

3.3 Practice Mergers

A number of practices have recently come together in order to become more resilient and efficient. NHS England is supportive of such changes from GP contractors where this is in the patient and public interest. The following practices across Kent have recently merged:

- Albion Place Medical Practice in Maidstone was created following the merger of Marsham Street and Holland Road practice's on 23 October 2014. The practice will shortly be moving into new premises.
- Faversham Medical Practice – The Cross Lane practice and Dr Logan's practice merged on 1st April 2015.
- Sittingbourne – The Memorial Medical Centre and Dr Venkat's practice at 31 London Road, Sittingbourne merged on 1st July 2015.

3.4 Multiple Contract Holders

There has been a slow but emerging pattern of smaller practices going into partnership with partners and organisations that already hold multiple GP contracts. Sometimes the originating partner(s) remain(s) on the contract and sometimes they simply choose to hand their contract on and leave the practice. The Regulations and Directions that underpin GP contracts allow for these variations to take place so long as they comply with the requirements of the Regulations and Directions.

- **Malling Health and the Directors of Malling Health:** Manage GP contracts at Iwade Health Centre, Staplehurst Health Centre, Ivy Bower Surgery in Greenhithe, West Kingsdown Medical Centre and at Parkwood, Nelson Road & Rainham Healthy Living Centre (Blue Suite) in Medway. Malling Health also manage a large number of contracts for GP services across other parts of England and now form part of the umbrella company Integrated Medical Health (IMH).

- **Minster Medical Group and Directors of Minster Medical Group:** Manage contracts for GP services at Minster Medical Centre on the Isle of Sheppey, at Lakeside in Sittingbourne, and from Parkwood in Rainham.
- **Sydenham House Medical Group:** Manage GP services at Sydenham House Medical Centre, Ashford Kent, Musgrove Park Medical Centre, South Ashford as well as High Glades Medical Centre, St Leonards, East Sussex, Gun Lane Medical Centre, Strood, Rochester and have a share in the partnership at Tunbury Avenue Surgery in Walderslade, Medway.

4. What action is NHS South (South East) taking to ensure high quality GP services are provided and made available to local communities?

NHS England has provided a range of support and leadership to enable the following examples of developmental change to take place over recent months. Examples include:

- Working in close collaboration with our CCGs and LMCs to develop local primary care strategies and implementation plans.
- GP practice workforce baseline undertaken by GP practices for Health Education England in conjunction with NHS England South (South East).
- Providing significant investment to enable numerous GP premises to be improved and expanded.
- Taking tactical opportunities to support existing GP practices to significantly expand their patient lists and develop their infrastructure (e.g.: in Dover, Broadstairs, Hove and Medway)
- Awarding a 10 year APMS contract at Dymchurch Medical Centre (01 April 2015) with the option to extend this for up to a further 7 years following a tender procurement after the previous contract holder had resigned their contract.
- Additional funding allocated to the Wave 1 Prime Minsters Challenge Fund in Folkestone and Dover to enable Invicta Health to extend the pilot to 31 March 2016 (from October 2015).
- Funding to support the North Canterbury Vanguard pilot
- Piloting the role of GP Urgent Care Clinical Fellow with a number of practices in Dartford, Gravesham and Swanley CCG in collaboration with the CCG and HEE.

5. Summary

General practice continues to operate under considerable pressure. Workforce issues, increased demand and expectations on the service, the requirements of regulation, registration and accountability as well as infrastructure constraints pose significant challenges to existing GP contractors and those staff working on the front-line.

These challenges are however recognised and understood. A clear national strategy for the future of the NHS has been set-out and a plan for addressing the principal areas of concern has been and continues to be developed. Action is being taken to address workforce and infrastructure issues. Important changes to the national GP contract have also been made. Implementation of The New Deal for General Practice will require commitment from a

number of parties – the NHS (both NHS England and CCGs), local authorities, from GP contractors and the wider profession as well as from patients and the public.

Most change will be led and shaped locally by GP practices themselves in conjunction with their CCGs and in dialogue with their communities and partners. NHS England will play a key role in shaping and enabling this change to take place but sustainable change will need to be clinical led and locally owned. During this period of change maintaining business continuity is of critical importance such that change is introduced in a planned and managed way such that this minimises inconvenience and anxiety for patients whilst bringing about a system of care that produces good outcomes, high quality care and resilience.

Within Kent a number of changes have taken place as the service evolves and action taken to ensure all patients continue to have access to local GP services. New ways of working are being tested and piloted and new investment is being made into the service both in overall terms as well as being targeted at specific communities, groups of practices and individual contractors where appropriate. However there remains a great deal to do.

We anticipate that the pace and scale of evolution and change of GP services will increase in the coming months and that this will span several years. It is not possible to outline what the final blueprint and disposition of services will look like; however it is almost certain that this will look and feel very different with regards to who provides services, how services are delivered and from which locations. In this respect the place of care through which primary medical care services are provided in the future will not simply be from GP surgery buildings but through a range of ways of engaging and treating patients which harnesses technology, makes full use of new workforce roles and delivers care in a networked way across health and social care. This will mean that the role and function of the GP will also change. What will remain a constant is that the future service will need to deliver safe, high quality care that yields both good outcomes and a positive patient experience.

Stephen Ingram, Head of Primary Care

NHS England – South (South East)
7 July 2015

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Item 9: East Kent CCGs: Talking Therapy Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: East Kent CCGs: Talking Therapy Services

Summary: This invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Ashford CCG, NHS Canterbury and Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG.

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) NHS Ashford CCG, NHS Canterbury and Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG have asked for the attached report to be presented to the Committee.

2. Potential Substantial Variation of Service

a) It is for the Committee to determine if the new service specification constitutes a substantial variation of service.

(b Where the HOSC deems the new service specification as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCGs.

(c) Where the HOSC determines the new service specification to be substantial, a timetable for consideration of the change will need to be agreed between the HOSC and CCG after the meeting. The timetable shall include the proposed date that the CCGs intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

3. Recommendation

If the new service specification is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the new service specification for Talking Therapy Services in East Kent to be a substantial variation of service.

(b) East Kent CCGs be invited to submit a report to the Committee in six months.

3. Recommendation

If the new service specification is *substantial*:

RECOMMENDED that:

(a) the Committee deems the new service specification for Talking Therapy Services in East Kent to be a substantial variation of service.

(b) East Kent CCGs be invited to attend a meeting of the Committee in three months.

Background Documents

None

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Health Overview and Scrutiny Committee

July 2015

Report on the procurement of talking therapy services for East Kent.

1.Background

The Improving Access to Psychological Therapies (IAPT) programme for adults (over 18), launched in 2008, aimed to make evidence-based psychological therapies for depression and anxiety disorders more widely available in the National Health Service, including across Kent and Medway. Talking therapy services commenced in Kent and Medway in 2009 with three providers offering services under area based contracts. After a tendering process in 2012, eleven contracts were offered to providers across Kent and Medway with seven providers offering services to East Kent.

NHS talking therapy services are based on a 'stepped care' model. The least intensive intervention appropriate to a person's needs is provided first and people can readily 'step up or down' the care pathway in accordance with their changing needs and response to treatment. The service is part of an integrated care pathway for people with common mental health disorders and builds on existing multi-agency partnerships with a variety of statutory, voluntary and private providers working collaboratively.

The service offers a range of evidence based psychological interventions which aim to support individuals who are experiencing:

- Depression,
- Generalised anxiety disorder
- Mixed depression and anxiety including peri and post-natal depression
- Panic disorder
- Obsessive-compulsive disorder
- Phobias (including social anxiety disorder (social phobia))
- Post-traumatic stress disorder
- Health anxiety (hypochondriasis)
- Adjustment disorders
- Anger management
- Psycho sexual issues
- Depression or anxiety in adults with a chronic physical health problem or medically unexplained symptoms
- Depression or anxiety in adults with a mild learning disability or cognitive impairment

2. Evaluation of talking therapy services across east Kent

In 2012/13 there were 6,584 completed treatments delivered to people in east Kent at a cost of £4.7 million, representing a significant increase in activity on the previous year. Positive aspects of the service included:

- An increased number of providers delivering talking therapies in Kent and Medway offering more choice to patients and GPs
- Average waiting times from assessment to treatment reduced, with most patients receiving treatment within 28 days
- Increase in numbers of people completing treatment compared to the previous year.
- Cost per referral and cost per completed treatment significantly reduced
- Talking therapy services encourage self-referral and research indicates that this results in increased positive outcomes for patients.
- High quality of therapists with 90 per cent of people reporting confidence in the skills of the staff delivering the interventions.
-

However, while most aspects of the service were positive, there were issues identified that need to be addressed and these included:

- Not all referrals to the service were receiving the 'least intervention first' principle
- The contract type and pricing structure for the service was not clear and user friendly for provider organisations.
- Concerns about equality of access, particularly for people with a long term condition
- Concern regarding the number of treatment sessions being offered, in some cases too few.

National performance targets

NHS talking therapy services are currently measured on a number of key performance indicators (KPIs), the main ones of which are:

- The number of people, as a percentage of need, entering treatment
- The number of people in the service reaching 'recovery'
-

Across east Kent these targets have either been met or exceeded for all current providers.

3. Actions taken

The current contracts for provision of talking therapy services across east Kent end 31 December 2015, therefore a project group was formed at the end of 2014 which included mental health commissioning and clinical representatives from across the four east Kent clinical commissioning groups to look at designing and procuring new talking therapy services moving forward. The work of this group has included revising the current service specification to address the issues highlighted above, identifying the most appropriate contract 'type' in order to ensure patient choice but also financial viability, and also a pricing structure for the service which makes the service 'value for money' but also viable and efficient for patients. The project group have actively engaged with people who use mental health services via Mental Health Action Groups, local network meetings and other forums in order to gain feedback and views on the development of the service, and in addition have worked closely with Local Authority and Public Health colleagues when designing the new service. In addition clinical views have been taken into consideration at all stages of the process and CCG Clinical Committees have been regularly briefed on progress.

In addition to the above performance indicators the project group identified that it will be crucial to be able to identify key 'outcome measures' that would provide a meaningful measure for individuals using NHS talking therapy services to be able to measure the quality of the service they receive and, as a result, some of the proposed outcome measures under consideration are:

- Increased proportion of people with common mental health disorders who are identified, assessed and receive treatment in accordance with appropriate National Institute for Health and Clinical Excellence guidance
- Improved speed of access and response times in the care service pathway
- Increased proportion of people with common mental health disorders who make a clinically significant improvement or recover
- Increased social participation and community integration of service users
- Improved service user choice and experience of services
- Increased number of individuals successfully treated (recovered)

4. Progress

The project group now has an agreed service specification; outcomes and pricing structure for the new service which, whilst not being significantly different to the current service, represents a more user focused approach which is both flexible and value for money.

5. Next steps

Procurement of the new service commenced on 14 July 2015, with contracts due to be awarded in September and the new service to be mobilised by 1 January 2016.

The project group intends to keep the Health Overview and Scrutiny Committee updated on progress and can provide any further information to the committee as required.

End

Report prepared by South East Commissioning Support Unit on behalf of:

NHS Canterbury and Coastal Clinical Commissioning Group, NHS Ashford Clinical Commissioning Group, NHS South Kent Coast Clinical Commissioning Group and NHS Thanet Clinical Commissioning Group.

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Item 10: Faversham Minor Injuries Unit (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: Faversham Minor Injuries Unit (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Canterbury and Coastal CCG.

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The Committee initially considered Faversham Minor Injuries Unit on 29 November 2013. The Committee agreed the following recommendation:

- *AGREED that this Committee asks that the decision to close the service on 31 March 2014 is set aside. This will allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives*.

(b) In addition, the Chairman was asked to write to the Secretary of State for Health setting out the Committee's concerns. The response received from the Secretary of State was included in the Agenda for 31 January 2014.

(c) On 31 January 2014 the Committee considered a written update provided by NHS Canterbury and Coastal CCG. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOVLED that this Committee notes the reports and looks forward to an update at the April meeting.*

(d) On 11 April 2014 the Committee considered an update provided by NHS Canterbury and Coastal CCG. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that its guests be thanked for their attendance and contributions to the meeting along with their answers to the Committee's questions, and that they return to the Committee within three months to give an update on the consultation and final outcome of the steering group review before a final decision is made by the CCG governing body.*

(e) On 18 July 2014 the Committee considered a further update provided by NHS Canterbury and Coastal CCG. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that Mr Miller be thanked for his attendance at the meeting, and that the CCG be requested to take note of the comments made by Members during the meeting and that the Committee is kept informed with progress.*

(f) On 30 January 2015 the Committee considered a further update provided by NHS Canterbury and Coastal CCG. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted and NHS Canterbury and Coastal CCG be requested to keep the Committee informed with progress.*

2. Recommendation

RECOMMENDED that the report be noted and NHS Canterbury and Coastal CCG be requested to keep the Committee informed with progress.

Background Documents

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (29/11/2013)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=26458

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (31/01/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5394&Ver=4

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (11/04/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27879

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (18/07/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29194

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (30/01/2015)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5837&Ver=4

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NHS
Canterbury and Coastal
Clinical Commissioning Group

Faversham Minor Injuries Unit
Briefing Paper
July 2015

Background

1. Members of the Health Overview and Scrutiny Committee will recall that the Faversham Minor Injuries Unit (MIU) service went through a tendering process during 2013 by NHS Canterbury and Coastal Clinical Commissioning Group (CCG).The outcome of the procurement was unsuccessful when only one unacceptable financial bid was received. Without a new service provider the MIU was due to close at the end of the contract with the current provider on 31 March 2014.

2. The matter was discussed at length at the November 2013 Health Overview and Scrutiny Committee (HOSC). Committee members raised concerns about the commissioning process and the impact of changes to the current specification which included 8am to 8pm 7 day a week x-ray making the service difficult to deliver financially. The CCG was asked to set aside the decision to close the service on 31 March 2014 to allow time for a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

3. The CCG accepted the request and arranged to keep the MIU open while a review was carried out to consider a number of aspects of the procurement and potential alternative service models.

4. To help support the review, the CCG established a local Steering Group comprised of representatives from the local community, patients, The Friends of Faversham Cottage Hospital and Community Health Centres, Faversham GPs, Faversham Town Council, Swale Borough Council, Kent County Council, Healthwatch and the CCG.

5. On 4 June 2014 the CCG governing body considered a briefing paper, presented by two members of the public, from the steering group. The governing body supported the recommendation that the CCG should commence a new procurement process for an MIU service in Faversham. The contract would be for an initial three years, extendable to five by agreement, with regular reviews.

6. To maintain continuity of service, the CCG agreed to extend the existing contract to allow time for the procurement process to be completed.

Progress

Since the last update to the HOSC in January 2015 the CCG, supported by members of the stakeholder group, have:

1. Developed a detailed service specification and agreed this with both the stakeholder group and the CCG governing body. The material difference in the specification, to enable the

service to be viable financially, being the reduction of x-ray opening hours from 8-8 7 days a week to 6 hours per day Mon – Fri and the inclusion of Direct Access GP X-Ray.

2. Completed a range of assessments including:

    - an assessment by NHS Property Services indicating that it might be possible to provide a static x-ray service from Faversham Health Centre.
    - an assessment by an independent radiographer, indicating that x-ray could be located on site, recommending the make and model of x-ray, IT infrastructure, personnel model and personnel requirement.
    - an electrical assessment to check that the current power supply to the hospital is sufficient for the x-ray machine and if not, the subsequent actions that would be required and costs.
    - a structural assessment to confirm that the rooms identified as possible locations for the general digital x-ray room on the Faversham Cottage Hospital/Health Centre site are suitable.
    - a detailed financial analysis of the proposed model, with scenario testing to identify a model that is most viable.

3. Agreed a practical procurement approach with the CCG and KCC procurement experts.

4. In January 2015, issued an invitation for expressions of interest from interested providers to deliver the Minor Injuries Unit (MIU) service at Faversham. The CCG received a positive response to the invitation and worked with internal procurement teams to establish the next steps on the procurement timeline.

5. Sent a response to the interested providers with a proposed timeframe for the full procurement process. Held a market day in the first week of February 2015 allowing providers to ask further questions to support their bid. The market day panel included contracts and procurement expertise, finance expertise, steering group representation and CCG representation.

6. Ran a procurement between February and April 2015

Conclusion

1. On 3rd June 2015 the CCG awarded a three-year contract with an option to extend by a further two years to Faversham Medical Practice to deliver the service, starting at the end of August.

2. The Minor Injuries Unit will be equipped to provide x-rays locally and this facility is expected to be available within six months of the August start date. The reason for the delay is to allow time for modifications need to be made to Faversham Cottage Hospital which will enable the x-ray machine to be installed. The x-ray facility will be for both injuries and for GPs to refer patients to, so that local people will not have to travel out of the town to have an x-ray.

Item 11: SECAmb - Future of Emergency Operation Centres (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 17 July 2015

Subject: SECAmb - Future of Emergency Operation Centres (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by SECAmb.

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The South East Coast NHS Ambulance Service NHS Foundation Trust (SECAmb) was formed on 1 July 2006 through the merger of Trusts in Kent, Surrey and Sussex. SECAmb achieved Foundation Trust status on 1 March 2011 - one of the first ambulance service NHS foundation trusts.

(b) SECAmb provides ambulance services to a population of over 4.6 million across 3,600 square miles in Kent, Medway, Surrey, East and West Sussex, Brighton and Hove and North East Hampshire. SECAmb responds to 999 calls and provides the NHS 111 service in Kent, Surrey and Sussex. It also provides non-emergency patient transport services in Surrey and Sussex. In 2013/14 the Trust received 862,466 emergency calls (SECAmb 2014).

(c) On 5 September 2014 the Committee considered the Trust's proposals to reduce the number of Emergency Operation Centres from three to two. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in three months.*

(d) On 30 January 2015 the Committee considered a written update on the Trust's plans to develop two new Emergency Operations Centres in Kent and West Sussex. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted and SECAmb be requested to provide a written update to the Committee in six months.*

2. Recommendation

RECOMMENDED that the report be noted and SECAmb be requested to provide a written update to the Committee in six months.

Background Documents

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29468

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (30/01/2015)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5837&Ver=4

SECAmb (2014) *'Annual Report and Accounts: 1 April 2013 - 31 March 2014 (28/10/2014)',* *http://www.secamb.nhs.uk/about_us/idoc.ashx?docid=22ab8986-3b8e-481b-9de0-46891df5eba7&version=-1*

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SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Up-date to Health Overview and Scrutiny Committee, Kent County Council

1. Introduction

1.1 An up-date was previously to Kent County Council regarding South East Coast Ambulance Service's (SECAmb's) plans to move from three Emergency Operations Centres (EOCs) to two. In addition, a new Trust Headquarters would be provided alongside one of the new EOCs.

1.2 The Committee is reminded that our plan is to move to the following model:

- A new "EOC West" - to be located in the Gatwick/Crawley area, co-located with the new HQ
- A new "EOC East" - to be located in Kent

The drivers for the change, as well as the benefits the new reconfiguration will bring, were also outlined to the Committee in the previous presentation. However, the Committee is also reminded that no definitive locations had been identified at that point.

2. Current position

2.1 Since September 2014, work has been on-going to identify specific locations for both of the new EOCs. However, given the specific pressures affecting the Sussex EOC (located in Lewes), the Trust Board has agreed to prioritise re-locating the EOC West as phase one of the project, to be followed by EOC East.

2.2 As explained in the earlier presentation, our preferred strategic location for the EOC West/new HQ is in the Gatwick/Crawley area.

2.3 A variety of commercial sites have been explored, however an opportunity has arisen during the past twelve months to locate the EOC West/new HQ on a site in Crawley owned by Surrey County Council (the former Thales site). Surrey CC is looking to establish a "campus" site, including other emergency and council services.

2.4 SECAmb's Trust Board gave approval in February 2015 for the "campus" option to be our preferred option for the EOC West/new HQ. If plans progress as hoped, the new site will be ready for occupation in early 2017.

2.5 Whilst phase one is progressed, EOC East will remain at its current location (Coxheath, near Maidstone).

2.6 Further up-dates will be provided to the Committee as required.

Janine Compton, Head of Communications
On behalf of South East Coast Ambulance Service NHS Foundation Trust

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