KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th January, 2016

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th January, 2016, 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

Kent County Council	Mr M J Angell, Mr H Birkby, Mr A H T Bowles, Mr R E Brookbank, Mr A H D Crowther, Mr D S Daley, Ms A Harrison and Mr G Lymer
Medway Council	Cllr T Clarke, Cllr T Murray, Cllr W Purdy and Cllr D Royle

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Membership	
	(1) Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee are asked to note the membership listed above.	
2.	Substitutes	
3.	Election of Chairman	
4.	Election of Vice-Chairman	
5.	Declarations of Interests by Members in items on the Agenda for this meeting	
6.	Kent and Medway Specialist Vascular Services Review (Pages 5 - 24)	10:10

7. Kent and Medway Hyper Acute and Acute Stroke Services Review 11:00 (Pages 25 - 42)

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

30 December 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.

Item 6: Kent and Medway Specialist Vascular Services Review

By: Lizzy Adam, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 8 January 2016

Subject: Kent and Medway Specialist Vascular Services Review

Summary: This report invites the Kent and Medway NHS Joint Overview and Scrutiny Committee to consider the information provided by NHS England South (South East).

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

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1. Introduction

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

(b) On 11 August 2015 the Medway Health and Adult Social Care Overview and Scrutiny Committee considered the Kent and Medway Specialist Vascular Services Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *The Committee agreed that the reconfiguration of vascular services constituted a substantial variation and noted the arrangements in place for Kent Health Scrutiny Committee to be consulted which may necessitate the need for a Joint Health Scrutiny Committee to be established.*

(c) On 17 July and 9 October 2015 the Kent Health Overview and Scrutiny Committee considered the Kent and Medway Specialist Vascular Services Review. The Committee's deliberations on 9 October resulted in agreeing the following recommendation:

- *RESOLVED that:*

  (a) the Committee deems the proposals to be a substantial variation of service.

  (b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

(d) Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 states that where relevant NHS bodies and health service consults more than one local authority on any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation and only the JHOSC may:

- make comments on the proposal;
- require the provision of information about the proposal;
- require the relevant NHS bodies and health service providers to attend before it to answer questions in connection with the consultation.

(e) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) has therefore been convened for the purpose of the consultation on the Kent and Medway Specialist Vascular Services Review.

(f) The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. A decision on whether to make a report to the Secretary of State would be a matter for the Kent County Council Health Overview and Scrutiny Committees and/or the Medway Council Health and Adult Social Care Overview and Scrutiny Committee to make rather than the JHOSC.

2. Legal Implications

(a) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the local authority health scrutiny function. The provisions in the regulations relating to proposals for substantial health service developments or variations are set out in the body of this report.

3. Financial Implications

(a) There are no direct financial implications arising from this report.

4. Recommendation

The Joint Committee is invited to:

i. Consider and comment on the proposed clinical model of a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway

ii. Decide if any further information is required

iii. Refer any relevant comments to NHS England (South East) and request they be taken into account during the development of the clinical model and further stakeholder engagement as applicable.

iv. Invite NHS England South (South East) to present an update to the JHOSC Committee on 26 February 2016.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (17/07/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5841&Ver=4

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (09/10/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5843&Ver=4

Medway Council (2015) '*Agenda, Health and Adult Social Care Overview and Scrutiny Committee*', http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

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Kent and Medway Vascular Services Review

Kent and Medway Vascular Services Review

Kent and Medway JHOSC report: 8 January 2016

Version number: 2

First published: 8th January 2016

Prepared by: Oena Windibank, Programme Director;
Diana Cargill, Service Specialist, Specialised Commissioning NHS England South (South East)

Classification: OFFICIAL

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

1 Introduction:

1.1 What Are Specialist Vascular Services?

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.

NHS England South (South East) commission specialised treatment in Kent and Medway, Surrey and Sussex under the national specification for specialised Vascular Services.

Specialised vascular services are types of treatment for:

- 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.

The types of treatment that might be required include:

- 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.

All these treatments are highly specialised and need a skilled team available 24 hours a day, every day of the year, to provide this service and support patients.

This review has looked at both emergencies and planned specialist vascular treatment. It includes both patients treated in Kent and Medway hospitals and people living in Kent and Medway who go to London for their treatment.

This review has not looked at varicose vein surgery, heart disease, heart surgery or the management of the common types of stroke.

The national service specification was published in 2013 following concerns about the outcomes for patients in England and Wales receiving vascular services. The standards within the specification were developed through a national specialised Clinical Reference Group (CRG) and reflect the best practice guidance of the National Vascular Society 2012

The key aim of the specification and guidance is to improve outcomes, so that patients with vascular disease benefit from the lowest possible disability and mortality rates, for both elective and emergency care. The clinical evidence underpinning the specification and guidance recognises the relationship between treating adequate numbers of patients and improved patient outcomes.

As a result of the implementation of the national specification there have been marked improvements in outcomes for vascular patients across the country.

1.2 What Does the National Specification Say?

It sets out that specialist vascular services need:

- To work within a hub and spoke clinical network where one hospital (the hub) provides all the inpatient surgery and the other hospitals (spokes) provide outpatient and diagnostic services in collaboration with the hub and, where appropriate, some day case surgery
- To serve a minimum population (800,000) to ensure staff see enough different types of cases
- 24 hour access to specialist care, including six vascular surgeons, six interventional radiologists and specialist nurses, with sustainable on call rotas.
- To provide access to cutting-edge technology, including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures and a dedicated ward for vascular patients
- To have the right mix of highly skilled, specialist staff who each carry out enough specific procedures (known as core index procedures) to maintain and improve their skills, ensuring consistent safe quality care.

Our review has assessed vascular services for people in Kent and Medway against the best practice standards set out in the national service specification.

1.3 What is the Current Position Across Kent and Medway?

About 900 people a year in Kent and Medway need specialist vascular services. In Kent and Medway, it is provided by Medway NHS Foundation Trust (MFT) in Gillingham and East Kent Hospitals University NHS Foundation Trust (EKHUFT) in Canterbury. Most people from the west and far north of the county - Tonbridge, Tunbridge Wells, Sevenoaks, Dartford, Gravesham and Swanley - receive their care in London, predominantly at St Thomas' Hospital. This arrangement has developed, over the past 5/6 years as a result of links between doctors at different hospitals, and clinical and patient choice.

2 Kent and Medway Case for Change

2.1 How Do the Current Inpatient Centres Do Against the National Standards?

- The service provided by St Thomas' Hospital in London is fully compliant with the national clinical guidance and best practice specification.
- The services across Kent and Medway, while delivering on a number of the key standards, are not fully compliant with the national clinical guidance or best practice specification.

- The main issues are that they are not treating a large enough population, are carrying out too few or borderline numbers of core index procedures and have too few staff, particularly consultants.

2.2 The Main Areas of Non-compliance Are:

- The lack of a vascular network across Kent and Medway. Although the different stages of patients' care locally (before, during and after their hospital stay) seem to work well, there is little evidence of the two units in Kent and Medway formally collaborating. It is less clearly understood across East Kent and Medway how things work for those patients who go to London.
- The number of people served by both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) is below the 800,000 minimum which is recommended by the Vascular Society.
- At both trusts, the total number of some of the core index procedures is either borderline or below the recommended numbers.
- The number of consultants is currently lower than required so there is concern about being able to staff the vascular surgical and interventional radiology rotas 24/7 at both sites
- The outcomes for the Kent and Medway centres are within the current acceptable levels but in some cases are outside of the recommended targets and they vary across the county.

NHS England South (South East) have been granted "a derogation" meaning that services in Kent and Medway can continue, even though they do not fully meet the national specification, while we work with the clinical specialists, patients and carers to find a solution that can fully meet the specification and provide sustainable service going forward.

3 The Review Process

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

The review has considered and scoped the current provision of specialised vascular services for Kent and Medway residents and is identifying solutions that can deliver the national specification, the Vascular Society guidance and improve outcomes for patients.

The review process is overseen by a Vascular Review Programme Advisory Board, which is clinically led and includes both external and local clinical experts in vascular care.

The Review Board is supported by a clinical reference group (CRG) providing clinical advice and expertise, both from the current providers and also from the vascular society.

3.1 The CRG Has Developed a Vision for Vascular Services for Kent and Medway Residents

Vascular services are a specialised area of healthcare which, evidence has shown, will benefit from organisation into larger centres covering a population that will facilitate significant volumes of activity in all areas of service, with a robustly staffed workforce able to deliver services 24 /7, 365 days of the year.

There is an opportunity to ensure that excellence in patient care and outcomes can be provided and that resource is always available for the vascular service to continue to improve on the type and standards of care provided. In Kent and Medway, the opportunity exists to develop this.

Establishing a vascular service of excellence will offer the opportunity for a much improved and comprehensive service to patients. In particular, the right model of care could deliver the opportunity to provide more local care to Kent and Medway residents and the type of care could include more complex procedures.

Such a centre(s) will be better able to embrace new technology and innovation in practice. A regional centre(s) of excellence is most likely to facilitate a change in patient flows. Such a centre (s) is most likely to be able to attract the highest calibre workforce and offer sustainability.

The training boards will look to centres of excellence to be involved in training the future generation of vascular clinicians. This not only benefits the service but invests in the future provision of excellence in patient care. A suitably sized centre (s) with the appropriate population could offer opportunity for quality audit and research.

The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that offers all of these benefits.

3.2 External Clinical Scrutiny

This is in place via the South East Clinical senate that has reviewed the Case for Change and will review the findings of the programme board and its subsequent recommendations.

3.3 Alignment to the national/local Emergency and Urgent Care strategy

The Vascular review has been cognisant of the emerging Kent and Medway strategy on the Urgent and Emergency care landscape in line with the national picture.

** Appended to this report is a summary of this work to date. The vascular review will ensure that the key recommendations of the national work are reflected in the options for specialist vascular services.

3.4 Communication and Engagement

The review is also supported by a communications and engagement plan, which sets out how the review will ensure effective engagement and communications throughout the process. This has included Listening Events held between July and August 2015 the findings of which have been used to shape the Case for Change and the options appraisal process.

The review will continue to engage both the public and patients as the process develops in particular to influence and shape the patient pathway.

4 Progress to Date

Both the Kent and Medway Overview and Scrutiny Committees were notified of the Case Change and agreed to the establishment of a JHOSC.

The participants at the Listening events reported a **positive experience of vascular services both in Kent and Medway and in London.**

There were 64 attendees at the Listening events, 12 individuals were Medway residents and the remainder were Kent residents

The attendees recognised the Case for Change and noted that having access to a specialist vascular team or centre was most important and reassuring in a life threatening situation. Having good access to such a service in Kent and Medway was vital.

The key priorities noted by the public include:

- The ability to make choices
- Adequate Information and communication, both to make choices and throughout the patient journey
- The need for high calibre staff with the specialist skills, and capacity to deliver the service 24/7
- The best treatment possible as quickly as possible, particularly in an emergency and smooth access to elective care
- The need for support particularly following amputations, when people return home
- Joined up working between services and disciplines, working within a clinical network, including improving the ability to recognise vascular disease.

5 Option Development and Appraisal.

The detailed option appraisal has to date considered a number of key areas. These will be built upon through development of the clinical model and include:

- **Travel/Access:** considering ambulance travel times across Kent and Medway and into London based on 60 minute travel times and impact on the ambulance trust. Reviewing public transport facilities/times.
- **Patient demand:** assessing the numbers of patients requiring specialist inpatient and day patient vascular care, noting the numbers of patients attending London units.
- **Co-dependencies:** assessing the impact on other clinical areas and the need for co-located services.
- **Vascular interventional radiology (minimally invasive interventions performed endoscopically by radiologists):** ensuring that this service is co-located and viable and assessing the impact on non-vascular interventional radiology work.
- **Workforce:** confirming the workforce requirements, including on call rotas for specialist 24-hour vascular care. Assessing the current gaps and options for delivering seven-day services. Reviewing workforce training and supply and possible workforce options. Assessing competencies across the vascular pathway.
- **Public health:** assessing population growth and demand, Identifying key demographic influences and impacts on service configuration.
- **Financial planning:** assessing current financial envelope/flows for Kent and Medway. Identifying cost implications of options including increased transfers, additional facilities, workforce implications, implementation costs.

Agreement has been unanimously reached by the Programme Board members that specialised vascular services should remain in Kent and Medway.

Early assessment notes that continuing with the status quo will **not** address the current gaps against the national specification or address the sustainability issues.

The CRG has considered a long list register of options in line with the specification and agreed that there were two options that needed further clinical development/review to establish if these could address the key issues.

The clinical leads were tasked to develop the clinical models and then the CRG determined if these could address the case for change and therefore require detailed appraisal**.**

These options included;

Option 1 a two centre arterial hub with spokes model working within a network.

Option 2 a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway.

The findings of the CRG are:

- **Option 1:** will not deliver the required volumes without significant repatriation and will struggle to meet the required consultant numbers. The CRG could not support this model going forward.
- **Option two:** this reflects the national best practice model and will meet the requirements of the national specification.

The CRG have recommended to the programme board that a single Kent and Medway hub and spoke model working in a network is the only model that should been taken forward.

The Programme board (PAB) has accepted the findings of the clinical reference group, this reflects the priorities noted in the Listening Events. The PAB and is keen to hear the views of the JHOSC.

The CRG is currently developing the clinical model further building on the clinical requirements, best practice and the public's priorities taken from the listening events.

The public /patient feedback to date highlighted the importance of:

- Workforce and the possibility of attracting the best specialists to Kent
- Speed of access to and availability of specialist care
- Considering the specifics of local populations when planning and designing options for vascular services as the review goes forward
- Recognising that patient/clinical choice is important
- The population growth in Kent and Medway, particularly in Dartford.

A clinical/public/patient workshop is planned early February to consider and test the pathway.

The programme board is keen that the JHOSC is involved in shaping this model/pathway and members will be invited to attend this event.

6 Next Steps and timeline

6.1 Development of the Clinical Model

The Clinical Reference Group will develop the clinical model illustrating the patient pathway. This will include assessment of the key indicators and impact areas and inclusion of the public priorities.

The model will be tested against national best practice models and reviewed by the South East Clinical Senate.

Feedback from the JHOSC will inform and influence the clinical model recommended to NHS England south specialised commissioning.

6.2 Approval of the Programme Board Recommended Option and Clinical Model.

The programme board will make its final recommendations to NHS England Specialised Commissioning in March 2016.

Procurement advice is being sought to clarify the appropriate procurement route to commence early April 2016.

Implementation will depend upon the mobilisation plan required and may take on an incremental process with a target of the end of the 16/17 financial year (March 2017).

7 Proposed Timeline

Key actions	By who	By when
Development of the clinical model	CRG Supported by patient and public and JHOSC engagement	Approval by PAB; March 2016
Development of Clinical model	Stakeholder event to test and develop the clinical model and describe the patient pathway K&M JHOSC meetings	February 2016 Jan and Feb 2016
Detailed Appraisal of the option (inc EA)	Led by Programme director; business case to PAB	March 2016
Recommendation of option and clinical model	Programme board	Approval by NHS England south March/April 2016
Procurement process	Confirm requirements and commence process	End March 2016

8 Recommendations to the JHOSC

- To consider and comment on the proposed clinical model of a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway
- To decide if any further information is required.
- To refer any relevant comments to NHS England (South East) and request they be taken into account during the development of the clinical model and further stakeholder engagement as applicable.

9 Appendices

9.1 Appendix 1: Briefing on the development of the Kent and Medway Emergency and Urgent care strategy.

1. CCGs in North Kent, West Kent and Medway are working together to develop strategic commissioning intentions for acute care. Similar work is also progressing in East Kent between the CCGs and East Kent University Hospitals Foundation Trust. as part of a wider strategic 'whole system review' programme that is also looking at the future pattern of community, mental health and primary care services, together with the interface with social care services, across east Kent. Whilst the regulation of the healthcare market remains the responsibility of Monitor and the Trust Development Agency, CCGs have a responsibility to ensure the reasonable healthcare needs of their population can be met. This CCG responsibility can only be achieved if there are viable healthcare providers in place who are able to deliver the commissioning requirements of the CCGs. As such, CCGs have a strategic responsibility to ensure the viability of healthcare providers.
2. The objectives of this work in North Kent, West Kent and Medway are to develop a set of strategic commissioning intentions that outline the changes required by CCGs in acute hospital providers. The aim of these changes will be to:
    - Address documented quality concerns (e.g. identified by Monitor, Trust Development Agency, Care Quality Commission…)
    - Ensure delivery of key performance targets as specified in the national prevailing NHS contract
    - Support ongoing workforce and financial stability
3. Changes in the demographics of the local population mean that the model of care needs to develop to meet the associated changing demand placed upon services. . Demand for healthcare is expected to be greater in terms of future predicted volumes of people but also different according to changing needs. There are a number of factors that need to be considered when looking at how the Kent and Medway population is going to change. In 2011 the base population for Kent and Medway was calculated as 1,731,400. By 2031 this is projected to increase to 2,024,700, an increase of 293,300 that is equivalent to a 17% rise (circa 42,000

for Medway / 251,000 for Kent).

4. In particular, the percentage of old people, who are living longer with multiple co-morbidities, is changing and by 2021 it is projected there will be a:

   - 25.5% increase in number aged 65 years +
   - 34.1 % increase in the number aged 85 years +

5. The projected 17% increase in the local population also includes population increases as a result of a planned 158,500 additional dwellings that are expected between 2011 and 2031. These developments will have a skewed impact on different areas. In particular, there are significant developments planned in Dartford, Ebbsfleet and Ashford (as well as significant housing development in Bexley, South-East London, which are not factored into the housing numbers referenced above but whose residents would look to Darent Valley Hospital as their local acute provider).

6. The current acute healthcare arrangements, when considered against the projected changes in the population, are not sustainable either from a financial or workforce perspective. which in turn could affect quality This points to a need to move to a model of care that sees more people empowered to manage their own healthcare , and to receive more care in out-of-hospital settings, and places less reliance on hospital based care. With regard to workforce there are already significant challenges recruiting to certain key clinical and specialist posts and the impact of this is already being felt. This adds to quality concerns, which are a further issue driving change, and result in a number of key performance targets not being delivered.

7. Issues in primary care, including the lack of sustainability of some practices predicted rates of GP retirement, and issues around business viability, can also not be ignored. These point to the need for a clear, coherent and mutually compatible strategic direction across providers within the wider Kent and Medway health and social care systems.

8. In setting out to determine the strategy for acute hospital based care the delivery of acute emergency care is a key consideration and a starting point. The NHS England Emergency and Urgent Care Review identified that hospitals with emergency centres are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs. These hospitals include:

   - an emergency department, under the continuous supervision of a team of consultants in emergency medicine (not necessarily continuously present, but are available to attend within 30 minutes); and
   - some facilities and beds to admit and investigate patients' illnesses and injuries as well a range of outpatient and supporting services.

9. When the NHS England review is considered against the current configuration of acute hospitals in Kent and Medway, which is considered later in this document, it is suggested that three types of emergency defined in the national review centre can be identified:

   - Emergency centres with an emergency medical take only (such as that provided at the Kent and Canterbury Hospital and Maidstone Hospital)

- Emergency centres with emergency surgical and medical takes
- Emergency centres with emergency surgical and medical takes, with some more specialist services

10. An emergency centre with specialist services has all the features of an emergency centre, but also includes twenty-four hour-a-day, seven-days-a-week access to some more specialist services (all supported on-site by level three critical care (the highest level for the most seriously ill patients) and interventional radiology). Such facilities should include a grouping of identifiable specialist services that support a network, current examples include:
    - major trauma management including neurosciences, plastic surgery, burns;
    - primary percutaneous angiography for ST-segment elevation myocardial infarction (Primary Percutaneous Coronary Intervention (pPCI)) ie very specialist cardiology services;
    - stroke thrombolysis;
    - emergency vascular surgery; and
    - specialist paediatric services.
11. Kent and Medway CCGs are reviewing the above list to see if there are additional specialist services that clinicians and clinical commissioners believe should only be provided once or twice across Kent and Medway.
12. In North Kent, West Kent and Medway, CCGs are progressing work on acute strategic commissioning intentions on the basis that where current accident and emergency departments exist at the main hospitals, there will continue to be some form of emergency department clinicians and clinical commissioners believe as described in Point 9. It is envisaged that the main changes that might be required are around the consolidation of the more specialist services and moving to a model of care that places a greater emphasis on care being delivered outside of acute hospital settings.
13. In east Kent the East Kent Strategy Board has been newly established by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of east Kent. This programme of work is wide-ranging as it involves all health and care organisations within east Kent and will take a ‘whole system’ approach to transforming the local health and care economy.

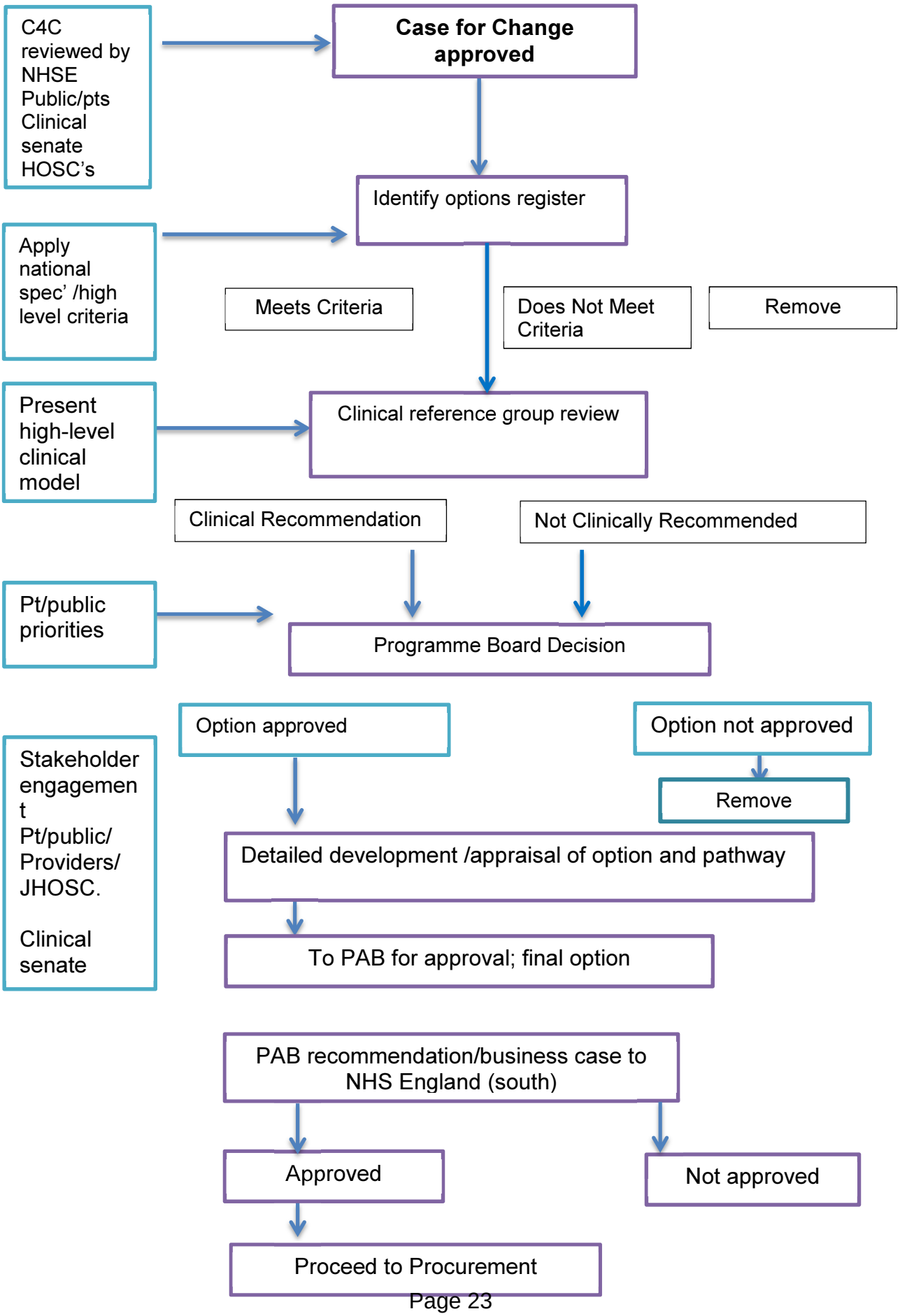
    Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent’s NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

14. The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Hearing the views of clinicians and support staff, patients, their families and carers and the wider public is integral to this transformation programme and the

Board has pledged to engage widely before any decisions are made about the future pattern of services.

15. CCGs hope to meet in the near future with the Kent Health and Social Care Overview and Scrutiny Committee and the Medway Health and Social Care Overview and Scrutiny Committee. to update them further and to listen to and understand their views and perspective on this work.

9.1 High level decision making process:



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

By: Lizzy Adam, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 8 January 2016

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

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Summary: This report invites the Kent and Medway NHS Joint Overview and Scrutiny Committee to consider the information provided by the Kent and Medway Clinical Commissioning Groups (CCGs).

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

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1. Introduction

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

(b) On 11 August 2015 the Medway Health and Adult Social Care Overview and Scrutiny Committee considered the Kent and Medway Hyper Acute and Acute Stroke Services Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *The Committee agreed that the reconfiguration of hyper acute/acute stroke services constituted a substantial variation and noted the arrangements in place for Kent Health Scrutiny Committee to be consulted which may necessitate the need for a Joint Health Scrutiny Committee to be established.*

(c) On 17 July and 4 September 2015 the Kent Health Overview and Scrutiny Committee considered the Kent and Medway Hyper Acute and Acute Stroke Services Review. The Committee's deliberations on 4 September 2015 resulted in agreeing the following recommendation:

- *RESOLVED that:*

  (a) the Committee deems the stroke proposals to be a substantial variation of service.

  (b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

(d) NHS England has held three separate People's Panels (deliberative events) for this review: Cllr Royle attended as an observer on 19 November 2015; Mr Birkby attended as an observer on 20 November 2015; and Cllr Clarke & Miss Harrison attended as observers on 11 December 2015.

(e) Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 states that where relevant NHS bodies and health service providers consults more than one local authority on any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation and only the JHOSC may:

- make comments on the proposal;
- require the provision of information about the proposal;
- require the relevant NHS bodies and health service providers to attend before it to answer questions in connection with the consultation.

(f) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) has therefore been convened for the purpose of the consultation on the Kent and Medway Hyper Acute and Acute Stroke Services Review.

(g) The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. A decision on whether to make a report to the Secretary of State would be a matter for the Kent County Council Health Overview and Scrutiny Committees and/or the Medway Council Health and Adult Social Care Overview and Scrutiny Committee to make rather than the JHOSC.

2. Legal Implications

(a) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the local authority health scrutiny function. The provisions in the regulations relating to proposals for substantial health service developments or variations are set out in the body of this report.

3. Financial Implications

(a) There are no direct financial implications arising from this report.

4. Recommendation

The Joint Committee is invited to:

i) Consider and comment on the options development and appraisal process.

ii) Decide if any further information is required.

iii) Refer any relevant comments to the Review Programme Board and request that they be taken into account during the detailed options appraisal.

iv) Consider the final options for consultation.

v) Invite Kent and Medway CCGs to present an update to the JHOSC Committee on 26 February 2016.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (17/07/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5841&Ver=4

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (04/09/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=32939

Medway Council (2015) '*Agenda, Health and Adult Social Care Overview and Scrutiny Committee*', http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

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Paper presented to:	Kent and Medway Joint Health Overview and Scrutiny Committee
Paper subject:	Kent and Medway Hyper Acute/Acute Stroke Services Review.
Date:	8 January 2016
Presented by:	Oena Windibank; Programme Director, K&M Stroke Review.
Senior Responsible Officer:	Patricia Davies; Accountable Officer, DGS and Swale CCGs
Purpose of Paper:	To update the JHOSC on the progress of the Kent and Medway Stroke Hyper Acute/Acute Review; to consult on the emerging options and next steps.

Kent and Medway NHS Joint Health Overview and Scrutiny Committee Briefing

January 2016

Kent and Medway Stroke Services Review

1.0 Introduction

Stroke is a preventable and treatable disease. Yet it is the third biggest killer and the main cause of long term disability in the UK. Stroke care costs the NHS in England £2.8billion a year.

A stroke is a serious, life-threatening medical condition: the brain equivalent of a heart attack. It occurs when the blood supply to part of the brain is cut off by a blood clot or a bleed. Surrounding brain tissue is damaged or dies.

The purpose of treatment is to re-establish the blood supply to the affected part of the brain as quickly as possible.

Around 2,500 people are treated in Kent and Medway for a stroke every year.

2.0 The Review process

The Kent and Medway Stroke Review commenced in December 2014 following concerns about performance and sustainability across the seven hospitals currently treating stroke patients.

2.1 The aim of the review is

To ensure the delivery of clinically sustainable, high quality, hyper-acute and acute stroke services for the next 10 to 15 years that is accessible to all Kent and Medway residents 24 hours a day, seven days a week.

The review is overseen by a Review Programme Board (RPB) with membership from all eight Kent and Medway CCG's, NHS England (South), Public Health, the SE Cardio Vascular Network, the Clinical Reference Group (CRG), SECAmb, NHS communications teams, Healthwatch Kent, Healthwatch Medway, the Stroke Association and a patient representative.

The CRG supports and advises the RPB, providing clinical advice, expertise and assessment of the case for change and the options appraisal process. The group is currently leading on detailed modeling to understand some of the challenges, which will inform the options development process.
The options appraisal will have input from a range of stakeholders.

The review is also supported by a Communications and Engagement sub group, responsible for ensuring effective engagement and communications through the process.

The review is proactively working with the acute and community providers for stroke care to ensure consideration of all aspects of stroke care.

The Stroke review has been cognisant of a number of key clinical strategy developments in Kent and Medway. This particularly relates to the emerging Kent and Medway strategy on the Urgent and Emergency care landscape in line with the national picture.
** Appended to this report is a summary of this work to date. The stroke review will ensure that the key recommendations of the national work are reflected in the options for hyper acute stroke services.

2.2 Vision for the future
The ambition of this review is to ensure that stroke services in Kent and Medway aim towards achieving an 'A' in SSNAP, going beyond average and delivering improved outcomes for local people. 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 a day, seven days a week, by an appropriately skilled, multi-disciplinary team of professionals. The level of skill and expertise will be maintained through an innovative and motivated workforce who delivers excellent outcomes and practice.

The services will be organised and delivered in a manner that maximises 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.

3.0 The Case for Change

The Case for Change sets out the national perspective and guidance, and the Kent and Medway position. It establishes that there is a need to review and remodel hyper acute/acute stroke care across Kent and Medway. There is a clear recognition of the importance of effective primary prevention and robust rehabilitation services. The review will make recommendations to individual CCGs where these areas require further exploration.

3.1 What does good hyper acute/acute stroke care look like?

The best practice guidance notes that death rates are reduced and long term outcomes are improved if stroke patients are treated in a high quality stroke unit where they get **rapid access to diagnostics, specialist assessment and intervention.**

Such a unit needs to have a **specialist workforce treating the right number of patients** (enabling them to sustain and improve their skills), and to be available **24 hours a day, every day.**

The national strategy, and guidance led by Professor Tony Rudd, the National Clinical Director for Stroke, highlights that recovery from a stroke is significantly influenced by the percentage of patients:

- Seeing a stroke consultant within 24 hours
- Having a brain scan, ideally within an hour of admission and at least 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 within four hours of arriving at A&E
- Having clot-busting drugs (if appropriate) ideally within one hour of arriving at A&E and at least within six hours
- Having a specialist swallow screening within four hours
- Having adequately skilled staff to ensure key interventions are undertaken including:
- Receiving adequate food and fluids during the first 72 hours
- A nutritional assessment and swallowing assessment within 72 hours

Together, the national and regional guidance and requirements recommend that a quality hyper-acute stroke unit:

- Treats between 600 and 1500 confirmed stroke patients a year
- Meets target times for access – 30 to 45 minutes travel time from patients' homes to A&E; clot-busting treatment within two hours of the 999 call
- Has enough specialist staff to provide 24-hour, seven-day specialist stroke services cover
- Meets the following standards:
    - Patients are assessed by ambulance staff using a recognised screening tool and transferred to the hyper-acute unit within **60 minutes**

- Patients are admitted directly onto a specialist stroke unit within **four hours**
- Patients have a clinical assessment by a consultant within **one hour** of arrival at A&E
- 24-hour brain scanning service: patients scanned within **one hour** of arrival at A&E
- Appropriate patients (20 per cent) are offered thrombolysis (clot busting treatment) within **one hour** of arrival at A&E
- Staff monitor patients early and intensively, using evidence-based protocols. Abnormalities are immediately spotted and treated
- Patients get a specialist swallowing screening within **four hours** of admission

3.2 What is the current position across Kent and Medway?

Each of the seven local acute hospitals provides hyper-acute/acute care for people in Kent and Medway having a stroke. In addition, Tunbridge Wells Hospital treats some patients from East Sussex (the Crowborough area) and Darent Valley Hospital treats some patients from London (Bexley). In total, the hospitals treat around 2500 patients every year.

The hospital trusts in Kent and Medway have struggled to consistently meet the standards of the national Stroke Sentinel Audit Programme (SSNAP). This monitors performance against key clinical indicators (such as the proportion of patients getting clot-busting treatment within the recommended time).

One unit provides seven-day consultant cover and another has seven-day specialist nursing cover but generally none of the stroke units has full seven-day cover by stroke consultants, senior trained nurses and therapists. Another issue for a number of units is pressure on beds within the hospital, with stroke patients not always being cared for in stroke unit beds.

There is a national shortage of specialist stroke staff which impacts on the ability of local units to recruit. Both the hospital trusts and clinical commissioning groups are concerned about long-term sustainability of existing services.

None of the stroke units in Kent and Medway treats the numbers of patients recommended as a minimum in the best practice guidance.

The Commissioners and hospital trusts in Kent and Medway all recognise that improvements are needed and that the workforce pressures impact on the ability to deliver consistent high quality care across seven days.

4.0 Progress to date

4.1 The Case for Change

The Case for Change has been approved by the eight CCGs and agreement made on the direction of travel; to develop options for resolving the current performance and sustainability issues.

The Case for Change has been shared with the Kent Health and Overview Scrutiny Committee (HOSC) and the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC).
The Case for Change is publicly available on the CCG websites.

4.2 Communication and Engagement

Ten 'Listening Events' have been held across Kent and Medway to share the Case for Change and raise awareness with the public. A further number of focus groups have been held in partnership with the Stroke Association and protected characteristics groups. An online survey has also been completed with responses from 285 individuals.

Three deliberative events have been held throughout November and early December, testing out the criteria used in the options appraisal process and the emerging options. These events included representation from members of the public, patients, carers, the Stroke Association, stroke champions, Public and Patient Involvement leads and JHOSC members.

Communications on the review and progress have been shared across the provider organisations and a clinical event was held for staff in November attended by the National Clinical Director, Professor Rudd.

Feedback from these events has been used in the option development and decision making process.

4.3 Options development

Eight headline options have been identified. Models range from one to seven sites (raised to meet standards), plus the status quo.

Early assessment suggests that to 'do nothing' i.e. the status quo of the current seven sites with no change is unlikely to deliver sustainable services or consistently good performance.

The appraisal process has reviewed the possible options against the high level decision making tree, as agreed by the CRG and the RPB, which reflects the national guidance/best practice recommendations.

This has focused on the key areas of workforce, travel times and patient numbers/need, and has reduced the long list to a recommended short list for approval by the RPB.

Moving to detailed options appraisal, the process will look in detail at the recommended short list building on the modeling work to date. This has and will include:

- **Travel/Access:** considering ambulance travel times across Kent and Medway based on 30 and 45 minute isochrones. Qualitative review of travel pressure points/times. Reviewing public transport facilities/times.
- **Patient Profiles/Capacity:** assessing the numbers of patients requiring specialist stroke care, the number of patients suffering from transient ischaemic attacks, and the numbers of patients attending Accident and Emergency departments. The requirements for transferring patients between hospitals.
- **Workforce:** confirming the workforce requirements for specialist stroke care. Assessing the current gaps and options for delivering 7 day services. Reviewing workforce training and supply and possible workforce options. Assessing competencies across the stroke pathway.
- **Public Health:** assessing population growth and demand, incidence of stroke and atrial fibrillation. Identifying key demographic influences and impacts on service configuration.
- **Financial planning:** confirming the current financial envelope across Kent and Medway. Identifying cost implications of options including increased transfers, additional facilities, workforce implications and implementation costs.

5.0 General Findings

5.1 The key priorities noted by the public and patients note the following emerging themes:

- **Workforce** – the need to address staff shortages and attract high quality staff was seen as a key priority.
- **Travel time** – participants recognised the need to balance travel time with the provision of efficient specialist care and good quality outcomes.
- **24/7 working** – concerns were raised in relation to a lack of 24/7 and poor out of hours service. There was a perception that poor outcomes were linked to out of hours presentation.
- **GP appointments** – participants reported that GP appointments were often hard to make.
- **Communication** – the need to provide tailored, clear and concise information for both patients and their carers was recognised.

5.2 Workforce

Workforce is the biggest limiting factor for delivering high quality services 24 hours a day, seven days a week.There are significant gaps in the stroke consultant workforce that will be difficult to recruit to. The national shortage of nursing staff is reflected in stroke care and there are very small numbers of specialist nurses available. Across therapies the hospital trusts have

slightly different pictures with regards to recruitment and retention. However, no unit provides a seven day therapy service and six days is difficult to achieve.

5.3 Travel Times

Whilst travel times are important, access to units with skilled staff available 24/7 is more important. Travel journeys across Kent and Medway allow a number of options and a reduction of sites whilst still achieving the required time frames.

The key geographical areas that need consideration in relation to travel times are the Isle of Sheppey, Dymchurch, the Romney Marsh and the borders with Sussex and south London.

5.4 Patient Demand/Need

The patient demand/need has been reviewed to understand the levels of activity that will move with any relocation of services. This shows that around 35-40% of people who attend A&E with stroke symptoms do not have a stroke diagnosis. These individuals will either require admission to a medical ward or will be discharged home.

The public health review has illustrated that the incidence of stroke has plateaued and there is only a marginal increase anticipated over the next ten years, including allowing for the demographic changes.

6.0 Summary feedback from the deliberative events

Three deliberative events were held during November and early December in Maidstone and Ashford, involving 55 patients, carers, clinicians and members of the public.

The following describes the attendance at the events;

- 17 people took part in the Deliberative Event, held on 19 November 2015 Of these, 6 were stroke survivors or families/friends of someone who had a stroke, 5 were people with a civic interest (for example, voluntary organisations e.g Headway; PPGs) and 6 were independently recruited members of the public with no personal or close experience of stroke. 10 participants were male, 7 female and came from the following CCG localities: Medway, West Kent, Thanet, South Kent Coast, Canterbury and Coastal, Ashford and Swale. 16 were white/English, 1 was B/A/C. Participants ages were within the following groups: 2 were 21-30; 1 was 31-40, 1 was 41-50, 6 were 51-60, 2 were 61-70, 4 were 71-81 and 1 was 80+. 4 people had a disability.

- 16 people took part in the Deliberative Event, held on 20 November 2015. Of these, 4 were stroke survivors or families/friends of someone who had a stroke, 5 were people with a civic interest (for example, voluntary organisations; PPGs and Healthwatch) and 7 were independently recruited members of the public with no personal or close experience of stroke. 7 participants were male, 9 female and came from

the following CCG localities: Ashford, Canterbury and Coastal, South Kent Coast, Dartford Gravesham and Swanley, West Kent and Thanet. 15 were white/English, 1 was B/A/C. Participants ages were within the following groups: 3 were 21-30, 1 was 31-40, 4 were 41-50, 4 were 51-60, 2 were 61-70, 1 was 71-80 and 1 was 80+. 1 person had a disability.

- 22 people took part in the Deliberative Event, held on 11 December 2015. Of these, eight were stroke survivors or families/friends of someone who had a stroke. Eight were people with civic interest e.g. voluntary organisations, PPGs and Healthwatch and six were independently recruited members of the public with no personal or close experience of stroke. 13 male and nine female participants came from the following CCG localities: Ashford, Canterbury and Coastal, Dartford, Gravesham and Swanley, Medway, Swale, West Kent, West Sussex, and Hastings and Rother. 20 were white/English, one was B/A/C and one was other. Participants ages were within the following groups: one was 21-30, two were 31-40, one was 41-50, five were 51-60, six were 61-70, seven were 71-80. Three people had a disability.

Feedback from participants reaffirmed the Case for Change, with attendees expressing confidence in the review process to date and the opportunity to participate in the decision making throughout.

The event attendees welcomed the opportunity to consider the modeling work and initial findings indicated that:

- The need for a skilled, specialist workforce was viewed as a priority for participants, as was the availability of services across seven days. Attendees would be prepared to travel further for specialist care, however this should be as near to their community as possible. Effective rehabilitation close to home is also very important. Prevention and rehabilitation services are important and must be understood as part of the pathway. The needs of staff, in particular at lower bands, are important and must be factored into the assessment for the options.

The final report will be considered by the RPB in December and will feed into the options appraisal.

7.0 Summary assessment of the findings

The modeling work confirms that while doing nothing may show some continued improvement, it is unlikely to be sustainable or deliver seven day provision.

As previously reported, a single or two site Kent and Medway specialist hyper acute units model would be extremely challenging, due to the patient volumes, geography/travel, the impact on accident and emergency units, medical beds and the number of stroke beds required. Therefore these configurations are unlikely to be viable.

Neither the attendees at the deliberative events nor the CRG support the status quo, a single or two site model.

The modeling work, the summary of the deliberative events and the CRG recommendations will be discussed at the December RPB.

8.0 Next Steps:

- The RPB will consider the findings of the CRG and the deliberative events on 22.12.15. (JHOSC to receive an update briefing post the RPB meeting).
- To identify, against the criteria, the short list for detailed review.
- Undertake detailed analysis, including financial review, workforce risk assessment, equality assessment and provider plans against options.
- The RPB will establish the best options for consideration at the CCG clinical forums and governing bodies.
- To review the findings alongside the emerging urgent and emergency care landscape. Final recommendations will be considered by CCG governing bodies and urgent and emergency care programme board in February 2016.
- The review will proceed to public consultation on preferred options during March/April 2016.

8.1 Summary Timeline

Key Action	**By who**	**By when**
Long list to short list	**Review programme board**	**December 15**
Short list appraisal	**Stakeholders inc JHOSC, Clinical senate, CCG clinical forums. Urgent and emergency care board.**	**Late February 16**
Final short list for consultation	**CCG governing bodies**	**End of Feb/March 16**

9.0 Recommendations for the JHOSC

- To consider and comment on the options development and appraisal process.
- To decide if any further information is required.
- To refer any relevant comments to the Review programme board and request that they be taken into account during the detailed options appraisal.
- To consider the final options for consultation.

Appendix 1 - Briefing on the development of the Kent and Medway Emergency and Urgent care strategy.

1. CCGs in North Kent, West Kent and Medway are working together to develop strategic commissioning intentions for acute care. Similar work is also progressing in East Kent between the CCGs and East Kent University Hospitals Foundation Trust. as part of a wider strategic 'whole system review' programme that is also looking at the future pattern of community, mental health and primary care services, together with the interface with social care services, across east Kent. Whilst the regulation of the healthcare market remains the responsibility of Monitor and the Trust Development Agency, CCGs have a responsibility to ensure the reasonable healthcare needs of their population can be met. This CCG responsibility can only be achieved if there are viable healthcare providers in place who are able to deliver the commissioning requirements of the CCGs. As such, CCGs have a strategic responsibility to ensure the viability of healthcare providers.
2. The objectives of this work in North Kent, West Kent and Medway are to develop a set of strategic commissioning intentions that outline the changes required by CCGs in acute hospital providers. The aim of these changes will be to:
    - Address documented quality concerns (e.g. identified by Monitor, Trust Development Agency, Care Quality Commission)
    - Ensure delivery of key performance targets as specified in the national prevailing NHS contract
    - Support ongoing workforce and financial stability
3. Changes in the demographics of the local population mean that the model of care needs to develop to meet the associated changing demand placed upon services. . Demand for healthcare is expected to be greater in terms of future predicted volumes of people but also different according to changing needs. There are a number of factors that need to be considered when looking at how the Kent and Medway population is going to change. In 2011 the base population for Kent and Medway was calculated as 1,731,400. By 2031 this is projected to increase to 2,024,700, an increase of 293,300 that is equivalent to a 17% rise (circa 42,000 for Medway / 251,000 for Kent).
4. In particular, the percentage of old people, who are living longer with multiple co-morbidities, is changing and by 2021 it is projected there will be a:
    - 25.5% increase in number aged 65 years +
    - 34.1 % increase in the number aged 85 years +
5. The projected 17% increase in the local population also includes population increases as a result of a planned 158,500 additional dwellings that are expected between 2011 and 2031. These developments will have a skewed impact on different areas. In particular, there are significant developments planned in Dartford, Ebbsfleet and

Ashford (as well as significant housing development in Bexley, South-East London, which are not factored into the housing numbers referenced above but whose residents would look to Darent Valley Hospital as their local acute provider).

6. The current acute healthcare arrangements, when considered against the projected changes in the population, are not sustainable either from a financial or workforce perspective. which in turn could affect quality This points to a need to move to a model of care that sees more people empowered to manage their own healthcare , and to receive more care in out-of-hospital settings, and places less reliance on hospital based care. With regard to workforce there are already significant challenges recruiting to certain key clinical and specialist posts and the impact of this is already being felt. This adds to quality concerns, which are a further issue driving change, and result in a number of key performance targets not being delivered.

7. Issues in primary care, including the lack of sustainability of some practices predicted rates of GP retirement, and issues around business viability, can also not be ignored. These point to the need for a clear, coherent and mutually compatible strategic direction across providers within the wider Kent and Medway health and social care systems.

8. In setting out to determine the strategy for acute hospital based care the delivery of acute emergency care is a key consideration and a starting point. The NHS England Emergency and Urgent Care Review identified that hospitals with emergency centres are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs. These hospitals include:

    - an emergency department, under the continuous supervision of a team of consultants in emergency medicine (not necessarily continuously present, but are available to attend within 30 minutes); and
    - some facilities and beds to admit and investigate patients' illnesses and injuries as well a range of outpatient and supporting services.

9. When the NHS England review is considered against the current configuration of acute hospitals in Kent and Medway, which is considered later in this document, it is suggested that three types of emergency defined in the national review centre can be identified:

    - Emergency centres with an emergency medical take only (such as that provided at the Kent and Canterbury Hospital and Maidstone Hospital)
    - Emergency centres with emergency surgical and medical takes
    - Emergency centres with emergency surgical and medical takes, with some more specialist services

10. An emergency centre with specialist services has all the features of an emergency centre, but also includes twenty-four hour-a-day, seven-days-a-week access to some more specialist services (all supported on-

site by level three critical care (the highest level for the most seriously ill patients) and interventional radiology). Such facilities should include a grouping of identifiable specialist services that support a network, current examples include:

- major trauma management including neurosciences, plastic surgery, burns;
- primary percutaneous angiography for ST-segment elevation myocardial infarction (Primary Percutaneous Coronary Intervention (pPCI)) ie very specialist cardiology services;
- stroke thrombolysis;
- emergency vascular surgery; and
- specialist paediatric services.

11. Kent and Medway CCGs are reviewing the above list to see if there are additional specialist services that clinicians and clinical commissioners believe should only be provided once or twice across Kent and Medway.

12. In North Kent, West Kent and Medway, CCGs are progressing work on acute strategic commissioning intentions on the basis that where current accident and emergency departments exist at the main hospitals, there will continue to be some form of emergency department clinicians and clinical commissioners believe as described in Point 9. It is envisaged that the main changes that might be required are around the consolidation of the more specialist services and moving to a model of care that places a greater emphasis on care being delivered outside of acute hospital settings.

13. In east Kent the East Kent Strategy Board has been newly established by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of east Kent. This programme of work is wide-ranging as it involves all health and care organisations within east Kent and will take a 'whole system' approach to transforming the local health and care economy.

    Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

    The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Hearing the views of clinicians and support staff, patients, their families and carers and the wider public is integral to this transformation programme and the Board has pledged to engage widely before any decisions are made about the future pattern of services.

14. CCGs hope to meet in the near future with the Kent Health and Social Care Overview and Scrutiny Committee and the Medway Health and Social Care Overview and Scrutiny Committee. to update them further and to listen to and understand their views and perspective on this work.

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