KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Friday, 29th April, 2016

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Friday, 29th April, 2016, at 10.00 am
Darent Room, 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.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting	
3.	Minutes (Pages 5 - 12)	
4.	Kent and Medway Specialist Vascular Services Review (Pages 13 - 30)	10:05
5.	Kent and Medway Hyper Acute and Acute Stroke Services Review (Pages 31 - 56)	10:45

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

21 April 2016

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.

KENT COUNTY COUNCIL

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 8 January 2016.

PRESENT: Mr H Birkby, Mr A H T Bowles, Mr R E Brookbank, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Mr G Lymer, Cllr T Clarke, Cllr T Murray, Cllr W Purdy, Cllr D Royle and Mr N J D Chard (Substitute) (Substitute for Mr M J Angell)

ALSO PRESENT: Mr S Inett and Dr Saloni Zaveri

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mrs R Gunstone

UNRESTRICTED ITEMS

5. Membership
(Item 1)

(1) Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee noted the membership as set out above.

6. Election of Chairman
(Item 3)

(1) RESOLVED that Councillor T Clarke be elected Chairman.

7. Election of Vice-Chairman
(Item 4)

(1) RESOLVED that Mr M Angell be elected Vice-Chairman.

8. Declarations of Interests by Members in items on the Agenda for this meeting
(Item 5)

(1) Mr Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.

9. Kent and Medway Specialist Vascular Services Review
(Item 6)

Dr James Thallon (Medical Director, NHS England South (South East), Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East) and Michael Ridgwell (Programme Manager, Emergency and Urgent Care Strategy, North Kent CCGs) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Thallon began by outlining the background to the review; he explained that NHS England South (South East) commissioned specialised treatment in Kent, Medway, Surrey and Sussex under the national specification for specialised vascular services. The standards within the specification were developed through a national specialised Clinical Reference Group and reflected the best practice guidance of the Vascular Society. He stated that it was rare for best practice guidance by a professional society to be implemented by NHS England as a national service specification which demonstrated the importance and power of the guidance. As part of the review, current providers were asked to carry out a self-assessment of their services in Kent and Medway; services were found not to be fully compliant with the national critical guidance or best practice specification. NHS England South (South East) was granted a derogation which allowed services in Kent and Medway to continue, although they did not fully meet the national specification, until a solution to meet the specification and provide sustainable services was found.

(2) Dr Thallon explained that a sustainable specialist vascular services needed to work within a hub and spoke clinical network; serve a minimum population of 800,000; have 24 hour access to specialist care and staffing with sustainable on call rotas; provide access to cutting-edge technology including a hybrid operating theatre and interventional radiology. He noted that 900 people a year in Kent and Medway required specialist vascular services: two-thirds of these patients received their care from Medway NHS Foundation Trust and East Kent Hospitals University NHS Foundation Trust and one-third of these patients from West and North Kent received their care in London predominantly at St Thomas' Hospital. Patients reported positive experiences of vascular services in Kent and Medway and in London. Services provided in London was an arrangement developed over the past five – six years as a result of links between doctors at Maidstone and Tunbridge Wells NHS Trust, Dartford and Gravesend NHS Trust and trusts in London, clinical choice and patient choice. The service provided by St Thomas' Hospital in London was fully compliant with the national clinical guidance and best practice specification.

(3) Dr Thallon reported that services provided in Kent and Medway were not fully compliant with the national clinical guidance and best practice specification; both providers were not treating a large enough population and were carrying out too few or borderline numbers of core procedures. He noted that whilst both providers in Kent and Medway had been placed in special measures by the Care Quality Commission; the specialist vascular services were isolated services within their trusts and their clinical quality was closely monitored. A national 6% mortality rate for elective vascular repair had been set as an achievable standard: Medway had a 4.6% mortality rate, East Kent Hospitals University NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust both had a 1% mortality rate. The Vascular Society aimed for a 4% mortality rate through the national clinical specification; reconfigurations of specialised vascular services across the country using the national specification had shown improved quality and outcomes.

(4) Dr Thallon stated that the review process had been overseen by a Vascular Review Programme Advisory Board which had been meeting for 18 months. The Board was looking at travel and access, patient demand, co-

dependencies, vascular interventional radiology and workforce. The Review Board was also supported by a Clinical Reference Group (CRG) who provided clinical advice and expertise from the current providers and the Vascular Society. The CRG had considered a long list of options in line with the specification and had agreed that two options needed future development and review to establish if they could address the key issues: a two centre arterial hub with spokes model working within a network and a single Kent and Medway arterial hub with spokes working in a network. The CRG had recommended to the Review Board that a single hub model was the only model to be taken forward and the Review Board had accepted this finding. He stated that the new clinical model would have to meet the current financial envelope. He reported that the current providers had been invited to work collaboratively to provide the hub and spokes; if they were not able to reach agreement a formal procurement would be required.

(5) Ms Windibank gave an overview of the engagement to date. She noted that the Case for Change had been presented to Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee. 64 participants attended listening events in July and August 2015; participants reported a positive experience of vascular services both in Kent and Medway and in London. She reported that the participants recognised the Case for Change and noted that having access to a specialist vascular team or centre was the most important and reassuring in a life threatening situation. Key priorities by the public also included the ability to make a choice, adequate information and communication to make choices, the need for support particularly following amputations when people return home and joined up working between services and disciplines. She explained that rehabilitation services were not part of the review but the Review Board would be making recommendations to the CCGs as part of the clinical model. She stated that a People's Panel had been provisionally scheduled for Tuesday 23 February 2016 and she would provide verbal feedback to the next meeting of the Committee on 26 February 2016. She noted that a financial model and an equality impact assessment were being developed.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about initial assessment of vascular conditions in the ambulance. Dr Thallon explained that it was more difficult for Community First Responders and Paramedics to diagnose vascular conditions than stroke. Patients presenting with stroke symptoms were often transferred directly to a hyper acute unit whilst vascular patients tended to be conveyed to a standard A&E before being transferred to a specialist centre. Ms Windibank stated that the new model would establish a vascular network and clearer patient pathways; it would include a pathway for patients who did not enter the service through the hub or spoke.

(7) A number of comments were made about workforce. Dr Thallon explained that there were enough specialist vascular surgeons in Kent and Medway to staff a single arterial hub; if two hubs were established there would not be enough surgeons to provide safe staffing levels. A single hub with six vascular surgeons within a network would create conditions for a centre of excellence and provide a high end offer for both patients and surgeons. Ms Windibank noted that a one in six rota for vascular surgeons was recommended as a minimum by the Vascular Society and it was difficult to recruit to a more

frequent rota. Dr Thallon reported that there was a shortage of interventional radiologists; skill consolidation was required to ensure a sustainable service and patient choice. He noted at present patients did not have the choice between endovascular and open surgery. The professional body for interventional radiologists had stated they would support whatever configuration was chosen. Dr Thallon stated that if procurement was required, providers would have to demonstrate how they would recruit and retain staff. Ms Windibank stated that there would also be opportunities for nursing staff such as specialist nurse-led clinics and diagnostics within the spokes and higher pay which would assist recruitment. Dr Thallon noted that the implementation of vascular reconfigurations in different parts of the country had not been affected by staffing.

(8) In response to a specific question about the podiatry service, Dr Thallon explained that rehabilitation services such as podiatry were not part of the review. He noted that vascular patients with diabetic foot problems were not affected by the new access restrictions to podiatry services as they were considered high risk. Ms Windibank stated that she had been engaging with the Diabetic Network as part of the review.

(9) A number of comments were made about visitor access, timeline and engagement. Dr Thallon acknowledged that there was a balance between specialist care and other factors such as visitors, the environment and quality of nursing in improving outcomes for patients. Dr Thallon stated that the timeline would most likely slip; the review would take as long as required in order to achieve a sustainable service. Dr Thallon reported that 8-9% of patients who experienced vascular services had attended the listening events. Ms Windibank stated that the participants at the next People's Panel would include those currently in the pathway and those at risk of entering the pathway (who would be identified through GPs and the NHS Abdominal Aortic Aneurysm Screening Programme). She reported that if the engagement was not adequate, NHS England South (South East) would repeat the process.

(10) A Member requested assurance that the new model and pathway would be sustainable. Dr Thallon explained the previous model and pathway had failed as patients in West Kent had continued to be referred to London which had not been accounted for in the old clinical model. He noted that under the new clinical model referral to London would be allowed to continue; if an excellent clinical offer for a specialist vascular service was established in Kent and Medway, commissioners in North and West Kent may no longer chose to refer their patients to London in the future. He stated that the new model and pathway was based on best practice and the national specification; it was realistic to look at a five-ten year timeframe. He noted that there was clinical and executive support for a single hub. He reported that there had been a successful Kent and Medway wide consolidation of angioplasty and stent procedures at the East Kent Cardiac Catheter Suite, William Harvey Hospital, Ashford which had implemented best practice, improved outcomes and reduced length of inpatient stay. Ms Windibank explained that there had been detailed and challenging conversations with clinicians regarding consolidation of vascular services; clinicians acknowledged that the current position was not sustainable due to the recruitment issues. She also noted that an excellent clinical offer for specialist vascular service in Kent and Medway was required to improve recruitment.

(11) Members enquired about the collaborative working between providers and the Urgent & Emergency Care Network. Dr Thallon explained that the providers would initially be invited to work collaboratively to fulfil the best practice guidance and national specification; if they were unable to reach agreement, a formal procurement process would be required. He stated that the providers were not able to compromise on best practice. Dr Thallon reported that he was responsible for establishing the Kent, Surrey and Sussex Urgent and Emergency Care Network; he stated that the outcome of the Vascular Review would be in a position to support any future reconfiguration of the Urgent and Emergency Care Network.

(12) Mr Ridgwell was invited to comment: he explained that he was working with CCGs in North Kent, West Kent and Medway on their joint commissioning intentions for acute care which were linked to the Stroke and Vascular Reviews. He noted that NHS England's Urgent and Emergency Care Review Programme had identified different types of emergency centres and emergency centres with specialist services. The specialised services included cardiology, paediatric, stroke, trauma and vascular. He stated that Kent and Medway CCGs were reviewing all of the specialist services above; in North Kent, West Kent and Medway, CCGs were basing their commissioning intentions on the basis that current accident and emergency departments would continue to have some sort of emergency department but were looking to consolidate specialist services. He stated that there was no additional funding to develop or consolidate emergency services. He reported that he would be bringing a paper to the Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee to update them on the work on the Kent and Medway Emergency and Urgent Care Strategy. The Chairman requested that maps with travel distances be included in the paper to the Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee.

(13) RESOLVED that:

(a) NHS England South (South East) be requested to note comments about the proposed clinical model of a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway, the development of the clinical model and further stakeholder engagement.

(b) NHS England South (South East) be requested to provide the following additional information at the next meeting of the Committee: population maps; performance indicators of the current service; findings and learning from other reconfigurations nationally and regionally; and the services to be provided in the spokes.

(c) NHS England South (South East) be requested to present an update to the JHOSC Committee on 26 February 2016.

(14) The meeting was adjourned at 11.33 and reconvened at 11.43.

10. Kent and Medway Hyper Acute and Acute Stroke Services Review
(Item 7)

Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East)) and Julie Van Ruyckevelt (Principal Associate, South East CSU)) were in attendance for this item.

(1) The Chairman welcomed the guests. Ms Windibank began by outlining the case for change which established the need to review and remodel hyper acute (first 72 hours) and acute (remaining acute stay) across Kent and Medway. She explained that primary prevention and rehabilitation services were not part of the review; the review would make recommendations to the individual CCGs where those areas required further exploration. She stated that there were a number of concerns about the performance and sustainability across the seven hospitals currently treating stroke patients including access to diagnostics, specialist assessment and intervention; specialist workforce treating the minimum number of patients; and 24 hours, seven day specialist stroke services cover. She reported that none of the current services met the national strategy and guidance.

(2) Ms Windibank stated that eight clinical options had been identified; models ranged from one to seven sites plus the status quo. She explained that the Stroke Review Programme Board had identified that the single, two site model and status quo were not sustainable. On 22 December 2015 the Stroke Review Programme Board considered the feedback from the People's Panel; and the Review's Clinical Reference Group and agreed that a detailed appraisal, workforce risk assessment, travel heat maps, public health incidence growth and equalities impact assessment for a five, four and three site model should be undertaken. She reported that the number of strokes was levelling out nationally and the number of strokes in Kent and Medway were expected to increase by 650 annually. She noted that following the successful FAST campaign, the number of patients transferred to hospital with stroke like symptoms had increased; 30 – 40% of patients who attended their local Accident and Emergency department were not admitted with a stroke or transient ischaemic attack (TIA) which needed to be considered as part of any reconfiguration. She stated that the recommended options for public consultation would be presented to the Committee on 26 February 2016.

(3) Ms Van Ruyckevelt gave an overview of the communication and engagement activity. She stated that ten Listening Events were held across Kent and Medway to share the Case for Change and raise awareness with the public; 110 participants attended including stroke survivors, families and carers of stroke survivors, voluntary sector and residential care providers. 220 participants attended 15 Focus Groups which were held in partnership with the Stroke Association and 285 participants completed the online survey. Three deliberative events were also held in November and December which tested out the criteria used in the options appraisal process and the emerging options. The events included representation from members of the public, patients, carers, the Stroke Association, stroke champions, Public and Patient Involvement leads and JHOSC members. She reported that feedback included support for the Case for Change, a recognition that the required standards were not being met and an understanding of the pressures regarding workforce; the Public Panels voted for either a four or five site option. She

noted that the Review was built upon and superseded the work of Maidstone and Tunbridge Wells NHS Trust, Healthwatch Kent and East Sussex carried out in December 2014. She stated that Healthwatch Kent, Healthwatch Medway, Healthwatch Bromley and Healthwatch East Sussex were part of the Communications Sub Group.

(4) The Chairman invited Mr Inett to speak. Mr Inett began by endorsing the engagement work carried out as part of the Review. He stated that deliberative events had built participants' knowledge and confidence and involved them in the decision making. He noted that he was a member of the Stroke Review Programme Board which he had found to be open and transparent.

(5) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member expressed disappointment that a deliberative event had not been held in Medway. Ms Van Ruyckevelt stated that a range of engagement activities had been arranged to involve as many participants as possible. She noted that a Focus Group was held in Medway and 34 people from Medway had responded to the online survey. She explained that the three deliberative events had been held in central locations with a range of 21 participants at each event. Another Member stated that out of the two main road networks in Kent and Medway the A2/M2 and A20/M20 both events had been held on the A20/M20 route. Ms Windibank stated that there would be further focus groups and events as part of the next phase of the review. Attendees who had attended the Public Panels and requested additional information were being provided with this. She also noted that the Equalities Impact Assessment would identify population groups to specifically target.

(6) Members enquired about rehabilitation, attracting workforce, current performance by providers and involvement with social care services in Kent and Medway. Ms Windibank stated the variability of rehabilitation services was not consistent; the Review had taken this on board and would be making recommendations to the CCGs. She noted that the acute model would only work if a successful pathway was in place. Ms Windibank explained that there were different models for Hype Acute and Acute Stroke services; in London patients were admitted to one of 8 hyper acute sites for the first 72 hours before being transferred to a local acute site for the remainder of their acute stay. She reported that combined hyper acute and acute sites in Kent would be much more attractive for specialist workforce including nurses and therapists. Ms Windibank stated that the decision making would not be based on current performance; providers would be judged on how they would deliver the service going forward. Ms Windibank explained that Public Health were part of the Stroke Programme Review Board and fed back to Social Care and CCGs; she noted that they would be more actively involved in the next phases and once the final recommendation had been made, the Programme Review Board would morph into a mobilisation group.

(7) RESOLVED that:

(a) the Kent and Medway Stroke Review Programme Board be requested to note the Committee's comments and take them into account during the detailed options development and appraisal.

(b) Kent and Medway CCGs be requested provide details of travel infomation at the next meeting of the Committee.

(c) Kent and Medway CCGs be requested to present an update including options for public consultation to the JHOSC Committee on 26 February 2016.

Item 4: 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, 29 April 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 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.

(f) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was therefore convened on 8 January 2016 for the purpose of the consultation on the Kent and Medway Specialist Vascular Services Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that:*

  (a) NHS England South (South East) be requested to note comments about the proposed clinical model of a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway, the development of the clinical model and further stakeholder engagement.

  (b) NHS England South (South East) be requested to provide the following additional information at the next meeting of the Committee: population maps; performance indicators of the current service; findings and learning from other reconfigurations nationally and regionally; and the services to be provided in the spokes.

  (c) NHS England South (South East) be requested to present an update to the JHOSC Committee on 26 February 2016.

(g) The JHOSC meeting scheduled for 26 February 2016 was postponed at the request of the Kent and Medway CCGs and rearranged for 29 April 2016.

(h) NHS England South (South East) held a Patient Feedback Event on 23 February 2016; Mr Angell attended as an observer.

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 clinical delivery model;

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, particularly in relation to the recommended model of one inpatient centre and a number of spokes;

iv) Invite the Review Programme Board to present an update to the Committee on their preferred option for procurement for vascular services before NHS England Specialised Commissioning take a final decision on procurement.

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 (11/08/2015)*',

http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

Kent County Council (2016) '*Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee (08/01/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6314&Ver=4

Contact Details

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Paper presented to:	Kent and Medway Joint Health Overview and Scrutiny Committee
Paper subject:	Update report; Kent and Medway Vascular services Review.
Date:	29.04.2016
Prepared by:	Oena Windibank; Programme Director, K&M Stroke Review.
Senior Responsible Officer:	James Thallon; Medical Director NHS England South East
Purpose of Paper:	To update the JHOSC on the Vascular review process.

Kent and Medway Vascular Services Review

Introduction

This paper updates on progress of the current Vascular service review

1. Review context

The Kent and Medway review of specialist Vascular services commenced in December 2014 in response to non compliance by the two local providers against the national specification. This resulted in a commissioner led derogation; services allowed to continue with delivery whilst solutions are identified to ensure compliance.

2. The Case for Change

This has previously been shared with the JHOSC members and is publicly available on the NHS England website
https://www.england.nhs.uk/south/2016/02/19/vascular-service-review-2/

The Case for Change demonstrates the key components of the national specification and the national clinical recommended practice from the Vascular Society. These have both been clinically led following the Aortic Abdominal Aneurysm Quality Improvement Programme and make a clear evidence based case for improving outcomes for patients. The delivery of the specification criteria and the guidance has seen a considerable improvement in patient outcomes and in particular in improving the mortality rates for abdominal aneurysm repair.

Following the delivery of the specification in 2013 these have improved dramatically from 8% to 1.5%, with a requirement for units to move to below 3%.

The clinical evidence shows that where there are high volumes of the vascular procedures being undertaken the better the outcomes for patients. This also shows that this care must be available 24/7 and delivered by skilled specialists. Other key features include improving the assessment to surgery time which improves when working in a network model with adequate staffing levels.

2.1 Current K&M position/performance

Kent and Medway residents receive their Vascular care from three main providers; East Kent Hospitals University Foundation Trust (EKHUFT), Medway Foundation Trust (MFT) and Guys and St. Thomas' Hospitals Trust (GSTTH)
Neither EKHUFT nor MFT meet the national specification.
The key areas of non-compliance are:

1. Inadequate population volumes to generate adequate levels of activity
2. Inadequate or borderline numbers of the main procedures being undertaken
3. Inadequate numbers of specialist staff in particular consultant surgeons and Interventional radiologists.
4. There are concerns relating to the specialist facilities available.

There are also concerns across the services re sustainability due in particular to the low workforce numbers.

Whilst the outcome measures at EKHUFT and MFT are within the agreed acceptable levels there is a considerable range across the providers ie from 1.1 to 4.6 for mortality rates for Abdominal Aneurysm repairs.
GSTTH meets the national specification.

Risk adjusted Mortality rates; AAA/CE (NVR data September 15)	MFT 4.6%/ 4.0%	EKHUFT 1.1%/ 1.0%	GSTTH 0.6%/ 3.5%	All within national tolerance

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The K&M Vascular Review case for change made the following recommendations

- 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.

- To undertake an option appraisal process to address the case for change.

- To develop and agreed preferred solution that addresses the case for change.

3. Options Appraisal

The criteria used in the options appraisal are set within the National specification and the Vascular Society Provision of Vascular Services. This includes;

- Minimum population volumes
- Minimum procedures numbers undertaken
- Minimum staffing numbers for consultant surgeons and Interventional radiologists.
- Specialist facilities including dedicated hybrid theatres and wards.
- Targets for key outcomes measures.
- To work within a network, using a Hub (in patent unit) and Spoke (outpatient and diagnostic units) delivery model.

The options appraisal process identified a register of options that were then assessed against the national criteria.

The Clinical Reference Group (CRG), which is constituted by local clinicians and external experts developed a clinical vision that supported their appraisal. This was supported by the review programme board

'Vascular services are a specialised area of healthcare, which evidence has shown, will benefit from organisation into larger centres. These centres should cover a population big enough to facilitate significant volumes of activity in all areas of service. There must be 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 outcome can be provided and the 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 repatriation of patient flows. Such centres are 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. Suitably sized

centres 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 could offer all of these benefits.**

The CRG identified through the initial appraisal two possible options that were then worked through in detail.

The two options are for;

1. A network model with two inpatient centers and a number of spokes.
2. A network model with one inpatient centre and a number of spokes.

The appraisal considered the ability to meet the aforementioned criteria and the quality and safety issues of each option.
This included consideration of;

- delivering a safe sustainable staffing rota and availability
- travel times
- essential co-dependencies
- current activity and possible impact of future population growth.

3.1 Travel and activity analysis.

There is no recommended criteria for travel times for vascular patients and the review has followed the guidance from the Vascular Society.

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. Other patients note the need to get to specialist care quickly and recognise this may require travelling further.

The Vascular Society (VS) guidance notes that 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. There is recognition that whilst most hospitals are within an hour from their neighbor, the key priority is to transfer the patient to a vascular unit, even if the travel time is beyond the hour, as evidence shows that this dramatically improves patient outcomes.

" Patient survival after a ruptured aortic aneurysm is between 5-15 percent if they stay in a hospital with no vascular surgeon, compared to 35-65 percent if transferred to an adjacent vascular service. This advantage persists even with up to four hours of hypotension, although patients who suffer a cardiac arrest are unlikely to survive transfer."

The VS guidance recommends that vascular services should be arranged to minimise transfer times.

A mapping of emergency travel times shows that all Kent and Medway residents are able to access the two current providers within 60 minutes. London hospitals are able to receive patients within an hour if they live in the north and north west of the county.

Travel time mapping was undertaken by the Geographic Information System unit at SW CSU. Travel times were calculated both for ambulance and for private transport.. The work also considered the emergency admission rates across Kent and Medway for circulatory disease.

Emergency admission rates were calculated on hospital episode statistics for the period April 2013 to March 2014. Rates of emergency admissions were mapped at the Middle Super-Output Area level (MSOA). MSOAs are geographic areas created by groupings of postcodes to create areas of similar population.

The key findings of the mapping show that:

- Medway Maritime and Kent & Canterbury hospitals are equally accessible within 45 minutes
- London hospitals are accessible within 60 minutes by ambulance only to areas in the north and western quarter of Kent.
- A service centred on Medway Maritime hospital would be over 60 minutes by ambulance from the east coast around Thanet which has a high number of admissions of circulatory disease (n = 1699). A service centred on Kent & Canterbury would over 60 minutes by ambulance from Tunbridge Wells, but this area has lower number of admissions than around Thanet (n = 796).

Medway Maritime hospital is accessible to 39% of the population within 30 minutes by ambulance, 72% within 45 minutes and 92% within 60 minutes. This falls to 28%, 53% and 80%, respectively, for private transport. The areas not well served are in the east and south coasts of Kent.

In comparison, Kent & Canterbury covers 28% of the population within 30 minutes by ambulance, 71% within 45 minutes and 95% within 60 minutes. This falls to 18%, 49% and 80%, respectively, for private transport. The areas not well served are in the West and South of Kent.

Therefore, Medway Maritime covers a greater proportion of the population within 30 minutes, but as travel time increases to 45 minutes there is little difference in terms of the proportion of the population covered, just the geographic area covered.

From Medway Maritime the most inaccessible area is the east coast around Thanet, and for Kent & Canterbury it is south-west Kent around Tunbridge Wells.

In terms of absolute numbers of emergency admissions for circulatory conditions there are more in the west of Kent compared to the east, reflecting the larger overall population.
However when considering admission rates of admission analysis shows that rates are generally higher in the south and east of Kent, and this probably reflects difference in epidemiological risk-factors, with a higher proportion of older people living in the east of Kent.

Table one; shows emergency travel times for cardiovascular disease across Kent and Medway

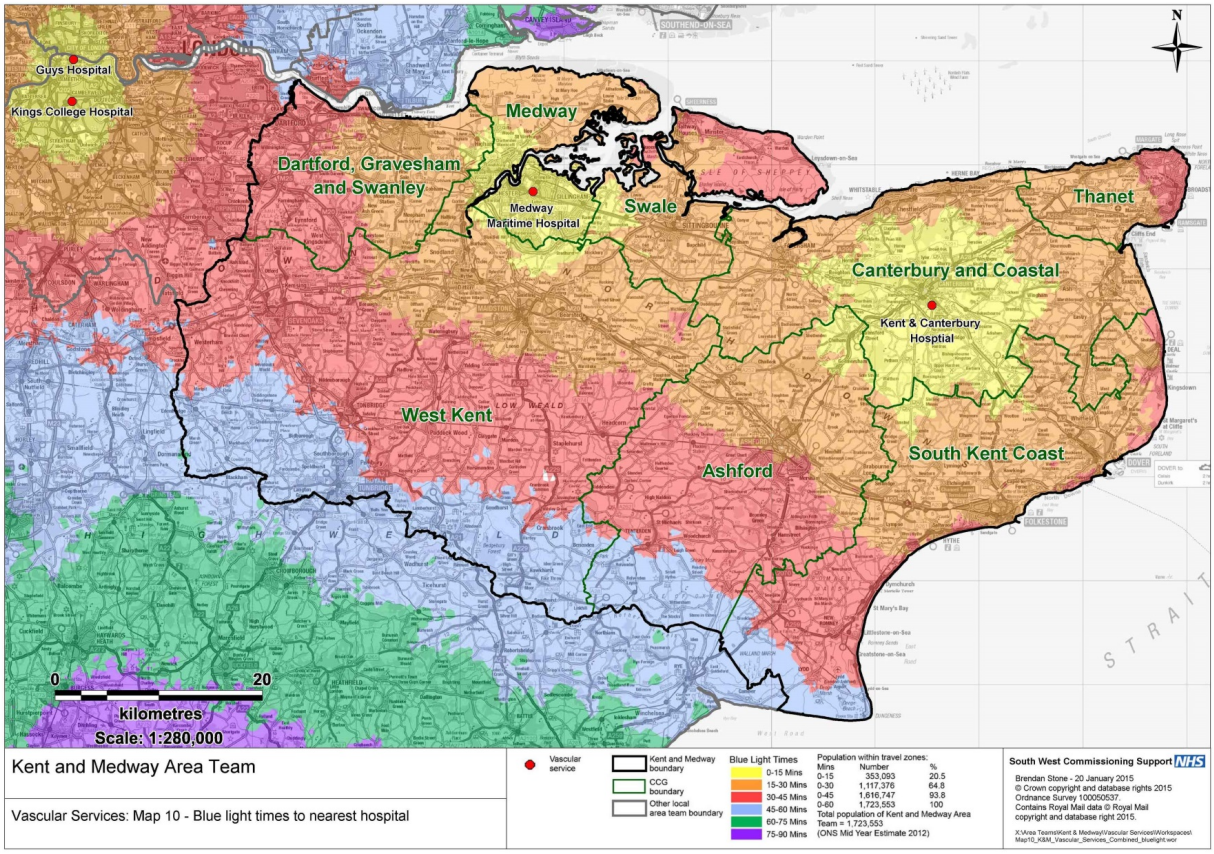
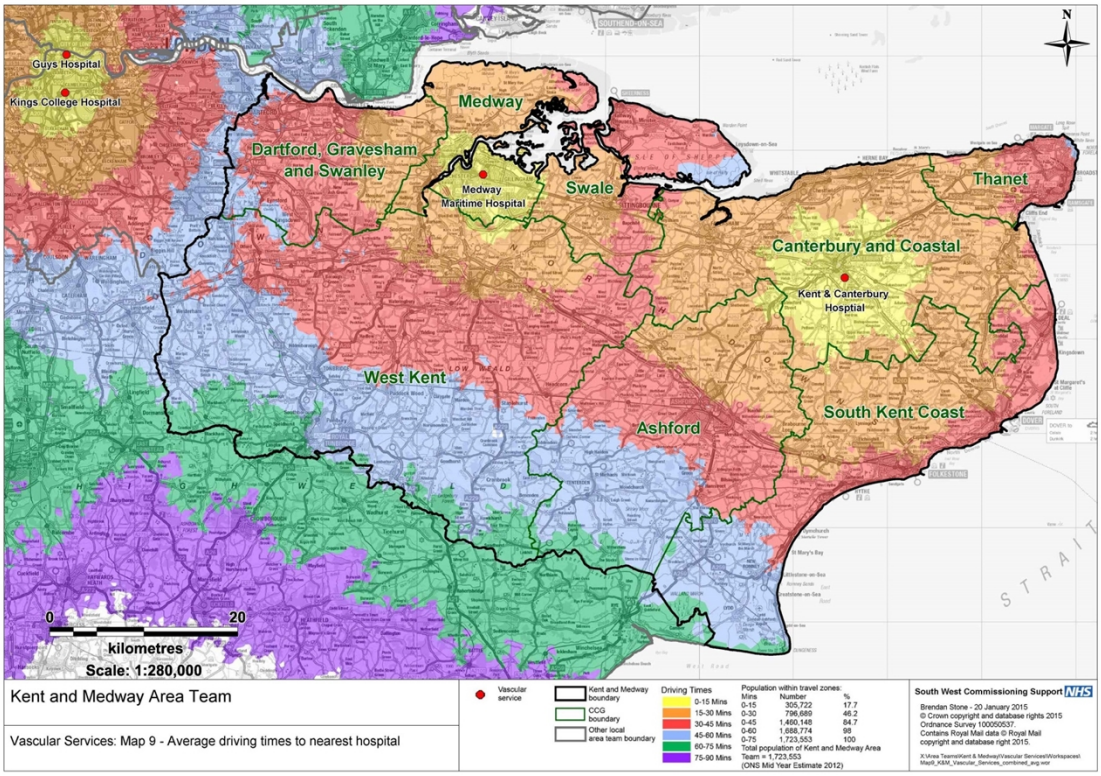


Table two; shows private travel times across Kent and Medway.



SECAmb also undertook a review of transfer times for vascular patients which shows that the majority of emergency transfers (ave 75%) are across East Kent to Kent and Canterbury Hospital.

The key variable for travel times relates to the patient's condition rather than the time of day or distance to be travelled.

Secamb achieve an emergency travel time within 60 minutes to both KCH and MMH and for a single in patient centre in the future the main areas affected would be the far West Tonbridge area and the far south east parts of Thanet, dependent on the site.

The options appraisal process has reviewed the core activity for 2013/14 and most recently 2014/15, this has specifically focused on the inpatient flows and usage in EKHUFT and MFT. The review has analysed data from the hospital episodic statistics (HES), the Trusts data and from the National Vascular registry (NVR) to ensure the most accurate activity numbers and patient flows are considered.

Patients will still be able to use the pathway from Tunbridge Wells and Darent Valley hospitals into St.Thomas' hospital in London.

Patients will continue to be able to have local care through their nearest general hospital for all out patient care including monitoring, interventions and management, pre and post surgical care, diagnostics, and day surgery

(where appropriate).
The number of patients affected by this change will be around 600 and of that figure it is likely to be circa 300 who will have further to travel for their inpatient care.

MFT serves the Maidstone, Medway and Swale populations and undertakes around 260 vascular in patient procedures. EK serves the total EK population and also treats patients who have been identified through the Abdominal Aneurysm screening programme. (These patients travel from across Kent and Medway for their elective repair of their aneurysm as in patients.) EK performs around 330 vascular in patient procedures.

CCG locality profiles show a high level of cardio vascular need in both Medway and Thanet

The findings demonstrate that there are inadequate population levels to generate the required minimum activity levels to meet the minimum standards set when delivered over two inpatient sites The ability to recruit to two units is currently difficult and would remain so. Running a shared rota may leave patients unsupported in one of the units at certain periods creating an unacceptable clinical risk.

The CRG recommended to the Progarmme Board that option two was the only clinically acceptable option.

4 Option development and clinical delivery model

Option two is a network model that works across a number of spoke sites with a single inpatient centre. This reflects the national recommendation for best practice.

This network model will mean that clear pathways will be place across the vascular network to ensure patients receive a seamless and timely service. The network will be responsible for co-ordinating vascular care across the region, ensuring good communications and maximising the delivery of care in the spoke sites.

The network will also ensure that there are improved and clear pathways with other clinical specialties, in particular Diabetes care especially foot care/clinics. The amputation rates for Kent and Medway residents are high and the development of a clear pathway between Vascular and Diabetes services will enhance the pathway and facilitate earlier intervention in peripheral vascular disease.

All vascular in patient care will take place in the single hub/centre, this will include recovery from surgery as the specialist vascular skills are required until the patient is fit to either return home or to be transferred to rehabilitation care. This is mainly the case for patients needing amputations.

The spoke sites will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospital's building on the current provision at these sites.
This will include the hub site, which will be a spoke for its local population.
The spoke sites will deliver a range of services that seek to keep care as close to home as possible for patients.
This will include:

- Out patients clinics; ie multi-disciplinary clinics, condition specific clinics, one stop shops clinics, nurse led and consultant clinics.
- Pre and postoperative care
- Monitoring and management of vascular conditions ie Peripheral vascular disease,
- Diagnostics and tests
- Day surgery where appropriate.

The specialist vascular team including the consultants and nurses will staff the spoke sites.

As previously reported to the JHOSC, the review programme board has agreed to assess and develop the network model with a single inpatient hub supported by local spokes as the recommended option

4.1 Financial modeling

The review has and is completing identification of the financial envelope relating to the affected activity. This has included the triangulation of Trust and National Vascular register data alongside commissioning data (HES) to ensure that both the capacity and financial planning is robust.
Currently both Trusts report a negative position in relation to the cost of delivering the vascular service due to the low volume numbers and high staff costs.

EKHUFT and MFT are reviewing the impact of any reduction or increase in either activity or finances on their organisation.

4.2 Quality and Equality Impact Assessment

The health impact assessment shows that delivering the key criteria will improve outcomes for K&M Vascular patients.
A detailed quality and equality impact assessment is underway but the equality screening does not show a negative impact on any of the protected characteristic groups.

The key inequality concerns relate to the impact of visiting relatives in particular elderly people who may have difficulty with travel arrangements and low income families who may struggle with additional travel costs.
The travel mapping is currently scoping the range and impact of the in patient travel times between the two current hospital sites. The isochrones show that

both sites are within a one hour travel time in private transport, the detail on the public travel times for relatives is not yet completed.

The review recognises the importance of relatives to be able to visit whilst their relatives are in hospital and the benefits for the patient themselves. The key issue for vascular patients is to have a specialist safe 24/7 day vascular service that optimises their outcome. Considerations on minimising the impact on relatives of a longer travel time will need to be given through the procurement process.

4.3 Co-dependencies

The review has considered the South East Clinical senate report on the Clinical Co-dependencies. These are met through the recommended option. Further consideration of these will be embedded into the procurement due diligence.
Work is currently underway by the CRG to identify the potential impact on other clinical areas, this is mainly relates to access to the vascular service by other clinical teams. Referral pathways already exist for supporting areas such as general medicine, trauma and obstetrics and the future position will build on these.
Interventional Radiology is a key component of the Vascular Service and the clinical delivery model describes how this will operate and considers the impact and mitigation for non-vascular IR work.

The Vascular review has reported into the Kent and Medway Urgent and Emergency care Board and is part of the Strategic Transformation Plan development.

The vascular network model will align to the emerging urgent and emergency care plan and there are no anticipated changes to these sites that would prevent this being delivered at either Trust

5. Patient Priorities

The national clinical reference group that developed the service specification that guides the proposed developments was comprised of patient and carer representatives as well as clinical and commissioning experts from across England and representative of the Vascular Society of Great Britain throughout its development. Following this a national programme of public and patient engagement informed the production of the final service specification that specialised commissioning teams have now been asked to implement across England. NHS England's response to the public consultation can be located at:

http://www.england.nhs.uk/wp-content/uploads/2013/07/consult-ssscp-13-14-sum.pdf

The Kent and Medway review has built on the national engagement and consultation work to reflect and consider local needs and priorities. This commenced with a number of Listening Events where key priorities were identified. These included the ability to make choices, to have good information and communication available. To have the right staff available 24/7, with speedy access in an emergency and smooth access to elective care. Early recognition of vascular disease was important and a network that could improve this was seen as positive**.**

Having access to a specialist vascular team or centre was most important and reassuring in a life threatening situation, and having good access to such a service in Kent and Medway was vital.

A subsequent qualitative deliberative event in February brought together patients, relatives, clinicians and some public representatives. The event considered the recommended option from a patient perspective and considered in detail the patient journey.

The event was attended by the Progarme Board, and a vascular society representative who was able to describe the findings form other review and describe his own organisations experience.

The event also considered the priorities for the patients to be considered in the procurement process.

Detailed discussions were had and people were able to express their views openly and to challenge both the clinicians and the review leads.

The event identified a number of people expressing an interest in being part of the procurement process as expert patients.

The clinical delivery model and the procurement process have/will be adapted to reflect the feedback.

The attendees supported the findings of the review and the recommended option.

Key messages were;

- A specialist 24/7 service is vitally important and must remain in K&M
- The ability to keep out patient care close to home is important and needs to ensure that the out of hospital support is timely especially after surgery.
- A recognition that some patients would have to travel further for inpatient care but this was acceptable in order to get safe and high quality care and the best outcomes.
- Additional travel times for relatives were a concern and the attendees suggested a number of initiatives that could reduce the impact of this. This included SKYPE and support with travel.
- Providing adequate support to relatives and carers is key particularly pre and post surgery.

The clinical delivery model has been updated to reflect this feedback and the programme board is considering the draft model on the 28 April 2016.

6. Public Consultation

A draft Consultation plan has been developed and this will be considered at the April Programme Board. This describes the formal public consultation process which is planned for June 2016, dependent on sign off by NHS England assurance process and timelines required by Purdah.

This includes a number of engagement activities including;

- a survey for both existing patients and members of the public
- direct discussions with patients and carers in local clinics
- events/focus groups with protected characteristics groups
- a minimum of 2 public events.

The outcome of the consultation will inform the procurement process which will commence formally shortly afterwards. The key priorities noted in the previous events will also inform the procurement process.

7. Learning from elsewhere

The Vascular Society believes that the better outcomes for patients stem from a number of initiatives that aim to improve the quality of surgery. This includes the reorganisation of vascular units into larger specialised regional centres that are better placed to offer the full range of surgical services, 7-days a week.

Increasing numbers of patients with AAA are also undergoing minimally invasive endovascular repair in the UK instead of more complex open surgery. New models of care need to support endovascular developments going forward.

There are a number of reviews across the country that are centralising vascular services in accordance with this best practice guidance. Implementation of this has seen an improvement of in patient mortality following repair of abdominal aortic aneurysms from around 8 to 1.5 % average.
Other key improvements are a reduction in length of stay and improved waiting times form assessment to surgery.

The Kent and Medway review has a member of the Vascular society on the programme board who provides feedback from reviews elsewhere. The review has also discussed the learning and challenges from the review in Bristol in particular the patient feedback, the recent Sussex review and the Wessex review currently underway.

The key lessons learned have included the importance of**:**

- Considering phasing in any changes, such as prioritising high risk clinical areas, developing new practice and innovations over time.
- Investing in network leadership and co-ordination to support the process and embed the changes
- Developing locally agreed clinical delivery and agreement on the model/option. This requires time and support to design across local clinicians the clinical delivery model, to share concerns and experiences.
- Ensuring the engagement of the Interventional radiologists in the review.
- Building adequate time into the mobilisation process.
- To recognize that some staff may chose to leave the service.
- Recognising that there may be a small number of patients and relatives who have to travel further but this is considerably outweighed by the improved outcomes. Being open and clear about the communities/ areas affected is important.
- commissioners to ensure that vascular providers provide information about available community support, particularly transport and in patient information packs are provided as standard,
- Create a shared and equal network where there is a real focus on ensuring spoke services are maximized.

8. Next Steps

The Programme board to agree and approve the clinical delivery model, the formal consultation process and recommended procurement process.

This will include continued discussions with local and external clinical leads to describe the clinical delivery that aligns to the national specification and ensures a sustainable K&M service.

To ensure that the key impacts identified, (through quality, equality and inequality impact assessment) are mitigated through the procurement process and due diligence testing.

To ensure that there is a robust consultation process that informs the procurement process.

This will include key activities such as:

- Completion of detailed work on public transport times and journeys to inform impact assessment and identify mitigating actions
- Completion of the quality and equality Impact assessment
- Completion and agreement of financial modeling to inform the procurement process
- Completion of the draft procurement plan.
- Sign off by the NHS England Assurance process

The April Programme Board will consider the following recommendations to go to NHS England Specialised commissioning.

1. Approval of a Kent and Medway Network model with a single in patient unit alongside local spokes, building on the existing spoke sites.
2. Approval of the consultation plan
3. Agreement of the procurement process including agreement that this will determine the in patient site that can deliver the key specification requirements.

9. The JHOSC is asked to consider the following recommendations:

1. To consider and comment on the options development and clinical delivery model
2. To decide if any further information is required.
3. To refer any relevant comments to the Review Programme Board and request that they be taken into account, particularly in relation to the recommended model of one inpatient centre and a number of spokes;
4. To invite the Review Programme Board to present an update to the Committee on their preferred option for procurement for vascular services before NHS England Specialised Commissioning take a final decision on procurement.

Item 5: 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, 29 April 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) The Kent and Medway CCGS 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 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.

(g) On 8 January 2016 the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was therefore convened for the purpose of the consultation on the Kent and Medway Hyper Acute and Acute Stroke Services Review. The Committee's deliberations resulted in the following agreement:

- *RESOLVED that:*

  (a) *the Kent and Medway Stroke Review Programme Board be requested to note the Committee's comments and take them into account during the detailed options development and appraisal.*

  (b) Kent and Medway CCGs be requested to provide details of travel infomation at the next meeting of the Committee.

  (c) Kent and Medway CCGs be requested to present an update including options for public consultation to the JHOSC Committee on 26 February 2016.

(h) The JHOSC meeting scheduled for 26 February 2016 was postponed at the request of the Kent and Medway CCGs and rearranged for 29 April 2016.

(i) The Kent and Medway Stroke Review Programme Board held a Challenge Session on 23 March 2016. Cllr Royle and Mr Brookbank attended as witnesses and provided feedback about the Review's engagement with 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, particularly in relation to decisions on the options of a 5,4 or 3 site model;

iv) Invite Kent and Medway CCGs to present the final options for public consultation to the Committee.

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 (11/08/2015)*', http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

Kent County Council (2016) '*Agenda,*
Kent and Medway NHS Joint Overview and Scrutiny Committee (08/01/2016)',
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6314&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:	29.4.2016
Presented by:	Oena Windibank; Programme Director, K&M Stroke Review. Lorraine Denoris Public Affairs and Strategic Communications Adviser, DGS CCG
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 Joint Health Overview and Scrutiny Committee briefing

April 2016

Kent and Medway Stroke Services Review.

1.0 Introduction

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

This review reflects a series of reviews across the country including regionals reviews in Surrey and Sussex. In most cases these reviews are either complete or near completion.

The aim of the stroke reviews are to ensure the delivery of clinically sustainable, high quality stroke services. For Kent and Medway there is a

clear need to ensure that the solution meets the needs of the population for the next 10 to 15 years, and to ensure accessible high quality hyper acute/acute stroke care to all Kent and Medway residents, 24 hours a day, seven days a week.

This does not currently exist across the county and the acute stroke units in Kent and Medway do not comply with the national best practice.

The new Kent and Medway model will support the achievement of the key clinical measures recorded through the Stroke Sentinel National Audit and in particular those indicators within the acute domain. These clinical measures support the delivery of positive patient outcomes.

Central to the review and the final recommendations is for a positive health impact for patients including improved outcomes, communications and support, and for consistent good practice across Kent and Medway.

Currently there has been some improvement in performance across the pathway, in some units however this is not consistently evident particularly in the key acute indicators.

Workforce poses a significant challenge reflecting the national and regional picture, in particular stroke consultants and nurses
Currently across Kent and Medway there is a shortfall of 29.5 consultants against the recommended 42 required for 7 units. This reflects the British Association of Stroke Physicians (BASP) recommendation of 6 consultants per unit. This allows the consultants to safely cover the rotas, working one in every 6 weeks out of hours.

The Case for Change was approved by the eight CCGs in 2015 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) and is publicly available on the K&M CCG websites.

2.0 Review Options appraisal process.
The review moved into an options appraisal process following agreement of the Case for Change.
The review has built on national recommendations and best practice with the aim of delivering the key components of good quality stroke acute care. This includes;

- Rapid access to diagnostics, specialist assessment and intervention.

- A specialist workforce treating the right number of patients available 24 hours a day, every day.

A clear decision making tree has been developed reflecting the national guidance on reconfiguration of Stroke services and agreed through the Clinical Reference group and the Programme Board.

As previously reported to the JHOSC, phase one appraisal considered eight possible options focusing on the key areas of workforce, travel times and patient numbers/need, and reduced the long list to a recommended short list

Detailed appraisal of 3 options (3,4 and 5 sites) has been taken forward. Modelling the geographic configurations is underway however only those that can meet the agreed criteria and in particular cover the whole K&M geography within the required travel times will be considered.

Phase two reviewed the 3 options against a set of red flag criteria, further building on the phase one criteria, reflecting the achievement of positive health impacts and nationally recommended best practice.
The red flag criteria were agreed through the Programme Board and aligns to the recommendations within the national stroke configuration guidance. They were also agreed by the CRG, with the exception of the activity volumes

Red Flag criteria;

- 7 day consultant cover
- 7 day therapy services (physiotherapy/OT/SLT)
- 7 day stroke trained nursing staff with adequate senior staff in skill mix
- BASP and SE Integrated Stroke specification workforce levels
- Min/max activity; volumes; >600….<1500 confirmed stroke patinets.
- 45 min travel times *(95% of pts)*
- Meet 120 mins call to needle time for 100% of eligible pts.
- HASU sited on a HOT ED site; *(A HOT medical take to be in place at the units ED)*
- 24 /7 CT imaging provision *(timely access to 24/7 imaging)*
- Critical co-dependencies as noted within the SE Clinical Senate report
- Financial indicators re viability

Alongside the red flag assessment, work has continued on bed modeling, activity/patient flows and quality and equality impact assessment.

3.0 Programme Board Challenge session; March 2016
The initial findings of the red flag assessment were considered at a Programme Board Challenge session in March 2016.

The challenge session operated as a panel with ‘evidence’ provided from a number of sources. This included the findings of the red flag criteria and the strengths, weaknesses and opportunities and threats of each option.

The clinical reference group presented their feedback on the options including their key areas of concern/challenge.

There was feedback from the patient public engagement work including an individual stroke champion identified through the Stroke Association, who provided a personal perspective as well as feedback on her experience on the engagement activity itself
JHOSC representatives also attended to observe and provided their perspective of the review to date.

The Programme Board agreed at the end of the Challenge session that the five site model appeared extremely challenging from both a workforce and finance perspective.

Whilst the Programme Board recognised that each option posed workforce challenges, the gap and the history of recruitment make the 5 site model an unlikely option going forward. There a understandable public concerns in relation to travel and some local clinical concerns re keeping stroke services local. In recognition of this, the programme board is currently reviewing the workforce and financial evidence to balance the 5 site option with the ability to deliver the required health outcomes. This includes inviting workforce options from local clinicians and consideration of existing rehabilitation pathways.

The three site model provides the best financial and workforce option however there were concerns regarding the capacity required at the sites and resilience within the system, including impacts of winter pressures. The three site option may also create difficulties for existing staff in relation to travel times and possible increased attrition.

The Board agreed to review the workforce issues for the 5 site model including asking the clinicians to detail possible options to deliver a 7 day service. There are also discussions underway with each hospital trust to look at workforce plans and the capacity and resilience issues.
The review has moved to consider the geographic options and impact on travel costs/journeys for relatives and staff and the impact for non stroke patients. The impact of increased/reduced activity on Trusts and in particular Emergency departments and medical beds is being reviewed.
Modeling to develop the optimum length of stay and rehabilitation pathways required is also underway.

3.1 Headline findings to date.

- All options meet the 45-minute travel time for 95% of patients, indicator

- The ability to deliver 7 day consultant led services in any of the options is driven by the available workforce. This is a key limiting factor and consultants in particular are a significant workforce gap.
- All options will have gaps in consultant numbers and will need development of workforce models to address the gap particularly in the short term.
- The new model of delivery should attract the enhanced tariff for the providers (Stroke best practice tariff) helping to address the impact of the cost of the service. However each option has a cost pressure (as does the existing model), this reduces as the number of sites and therefore the number of consultants required reduces.
- There are longstanding consultant vacancies, which further increase the gap.
- Nurse and therapy numbers relate to bed numbers so do not alter with the number of sites however the ability to cover sites over 24 hours may be impacted with greater site numbers

5 site model;
Popular with some of the public and clinicians
Does not meet minimum recommended activity volumes
Biggest consultant gap
Largest financial gap

4 site model;
Popular with some of the public and clinicians
Just meets minimum volumes
Improved financial position

3 site model;
Lowest workforce gap
Meets the recommended min/max volumes
Least popular with public and some clinicians
Concerns re. capacity in bed numbers and ED activity
Concerns re. resilience across the total health care system.
Whilst this meets the clinical travel times indicator this will increase relatives and staff travel times.
May be the best financial position but only if the number of consultants (6) can manage the bed numbers effectively.

Public/patient feedback.
There has been extensive engagement through a programme of Listening Events, a survey, focus and deliberative vents. There has also been work with the Stroke Association and stroke champions and this has illustrated a clear recognition of the need to change.
Healthwatch have observed and supported the process and reflected that this has been a robust and open process.

The feedback shows support from patients and the public, reflecting that 'no change is not an option.'
There is a recognition and acceptance that this may mean longer travel distances in order to get the right care and outcomes. A key priority is to have access to specialist stroke care over 7 days, as close to home as possible.
There are concerns for travel times for relatives and good local rehabilitation services are a key requirement.
The patient representatives at the challenge session clearly articulated that the current position is not acceptable and that the priority must be to ensure we can deliver good acute care particularly in the first 24 hours to ensure the best possible outcomes as soon as possible.

Clinical reference group feedback.
The CRG have considered and agreed the Red Flag criteria with the exception of the recommended minimum and maximum activity volume numbers.

A key concern of the members is the ability to recruit staff and the risk of staff leaving the service if their local unit closes. This will increase the workforce gap.

The need to ensure effective rehabilitation pathways is clearly articulated by the CRG members.

The group highlights the need to develop the clinical pathway to address the issue of stroke mimics who do not need admission to a stroke unit, ensuring that they are safely cared for. This may result in increased transfer journeys back to local hospitals for these patients and an impact on medical beds in the receiving hospital. Clear transfer and treatment protocols will need to be in place for non-stroke patients.

Additional Clinical concerns

The Programme Board received a letter from a number of consultants immediately prior to the Challenge session. This was also sent to CCG Accountable Officers and the JHOSC Chair and Vice Chair. In later discussion, the Programme Director was advised that the views expressed in the letter did not represent any Trusts' formal position but were the views of individual clinicians

The letter raised concerns that the process has not duly considered the possibility of continuing to deliver acute stroke services from the existing 7 sites.
It noted that the needs of and impact on non-stroke patients needed to be duly considered. There were a number of areas of misunderstanding/inaccuracy, these related to:

- Understanding the impact of the current Surrey and Sussex reviews,

- The impact of the K&M review on the Sussex and Bexley patients using Kent facilities
- Consideration of future technology of Kent and Medway services.
- Alignment to the current strategic plans and in particular the Urgent and Emergency care programme.

The Programme Board has responded to the consultants concerned, reflecting the process and agreed criteria used to consider options and reassuring them that many of the points they have raised either have been or are under consideration.

Reassurance has been given on the points above, in particular.

- There is a Kent Surrey Sussex working group bringing together all three stroke reviews and this demonstrates no impact for Kent and Medway on the neighboring reconfigurations. The border patient numbers have been included in the K&M modeling.
- The pathway for non-stroke patients and impact on ED/medical beds is being worked through the activity modeling and will be part of the clinical delivery model and provider capacity assessment.
- The future development of a thrombectomy unit in Kent and Medway has been recognised and the co-dependencies will ensure that at least one hyper acute unit will be co-located with the appropriate services. The Chair of the CRG is working closely with the national leads and NHS England South (south-east) cardiovascular network to develop this service model.
- The plans for urgent and emergency care are being considered within the Stroke review as they emerge. The stroke review has and will continue to be discussed at both the STP and Urgent and Emergency care Boards and cited in the forthcoming STP submission.

The Programme Board has repeated the invitations to attend the clinical reference group and in particular for them and the CRG to consider the possible workforce solutions.
The Chair of the CRG has subsequently spoken to a number of the signatories to get a greater understanding of concerns and provide reassurance.

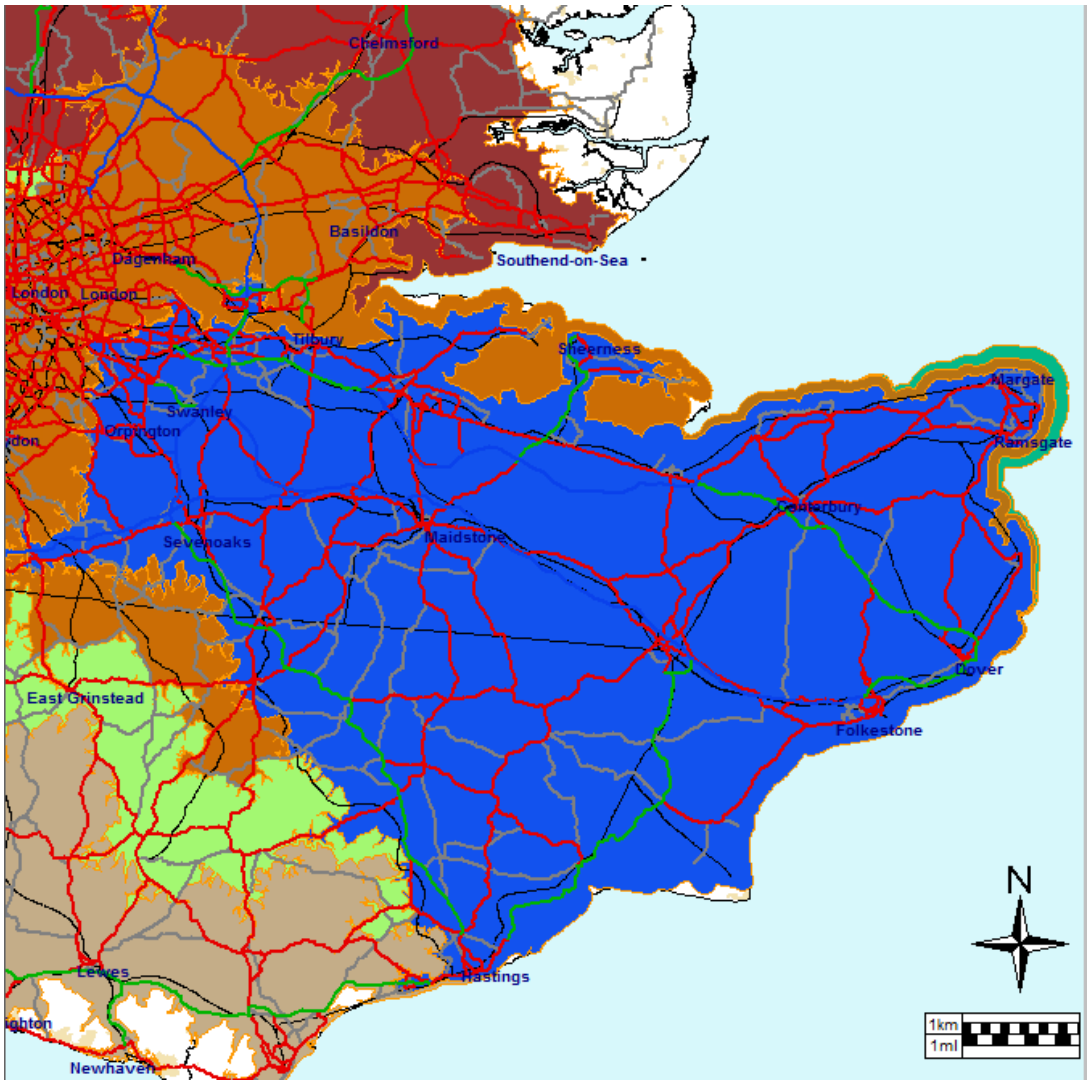
5.0 Key Modeling Areas

- **Travel/Access:**

The SECAmb isochrones (appendix 1) illustrate that all of the options (5,4 and 3 sites) can meet the 45 minute travel time indicator. There are a number of geographic configurations within each site option all of which meet the travel criteria.
The isochrones used measure standard travel times across the county including speed limits. Stroke patients are transferred to hospital via blue light ambulance.

The qualitative considerations show that the city centres create the main delays. There are clear protocols in place to manage Operation Stack from an ambulance perspective, although this does not include hospital staff.
The key areas impacted through travel changes are the Isle of Sheppey particularly the south of the Island, the Hythe, Romney Marsh and Dymchurch area and the Isle of Thanet.
With the exception of Thanet these areas have sparse population and low incidence levels.

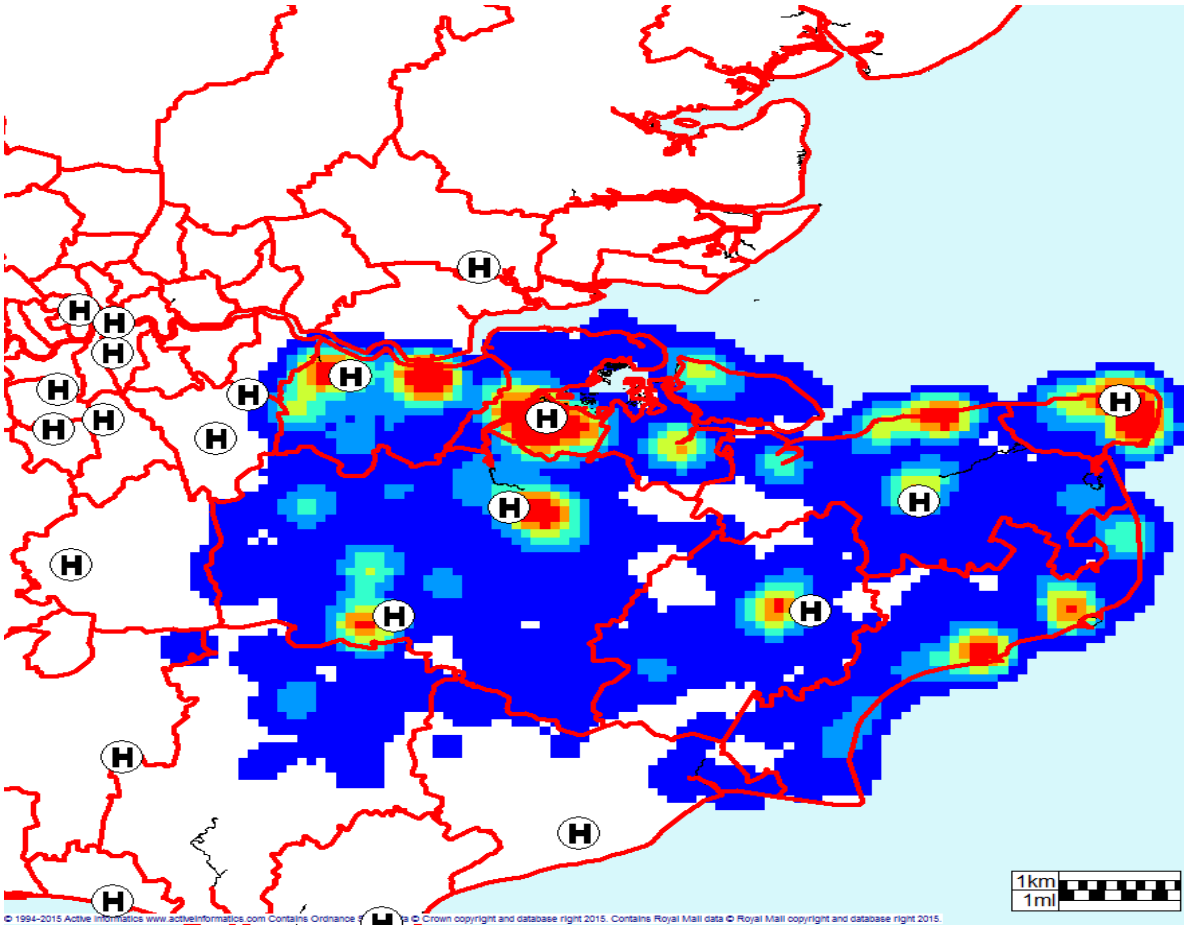
The diagram below shows an overview of the 45 minute travel time (isochrones) from the Kent and Medway hospitals. (appendix one shows the travel times from each K&M hospital; the blue areas show coverage over 45 minutes)



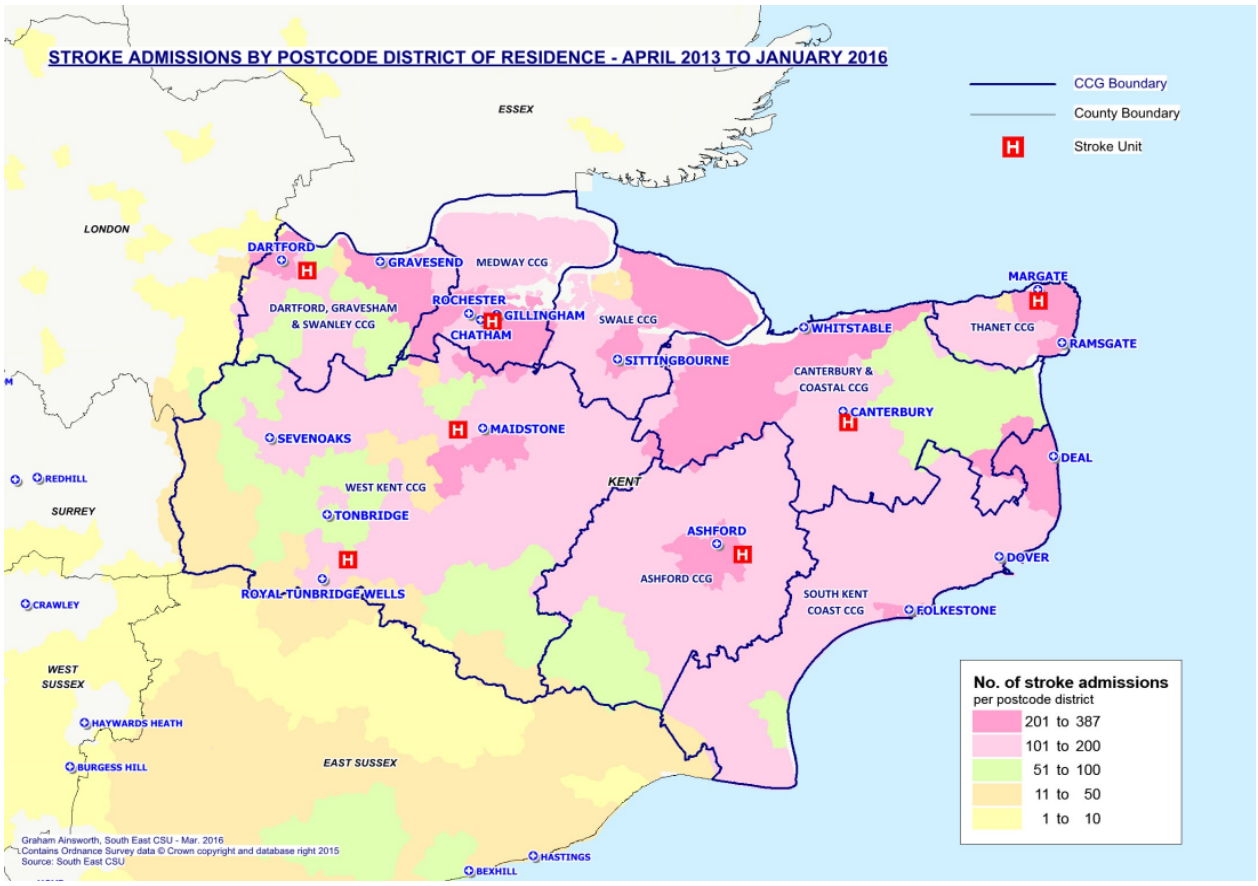
Private travel times by car reflect the isochrones however as the review considers the potential geographic sites, mapping is underway of the impact in relation to public transport and cost for relatives and staff.

The appraisal process has considered the patient flows alongside the travel times. This information is also being used when mapping the options and geographic configurations. This includes mapping the number of ED attendances both stroke and non stroke and the possible number of medical patients requiring either admission or repatriation. To date this has been averaged across the site options, moving forward SECAmb are mapping the likely transfers/admitting sites to get an accurate picture of both capacity and travel times.
The heat maps demonstrate the highest areas of activity for stroke admissions by post code and by ambulance transfers. These show that the main areas of activity surround Medway, Gravesend, Thanet and Ashford. This data will be used alongside the normal ED activity to determine impact on individual units.

The diagram below is the SECAmb map illustrating the hot spots where SECAmb have transferred stroke patients from and shows the K&M hospital sites. (April 14 to September 14.)



The diagram below illustrates the stroke admissions by post code for the period April 2013 to January 2015.



- **Patient Activity:**

The review has identified that there are circa 2,500 patients admitted to Kent and Medway hospitals per annum. Around 140 patients come from the borders of Sussex and Bexley. Activity has generally plateaued over the past few years, reflecting the national and regional picture of reducing stroke incidence. Projections show little change is anticipated in the next 10 years, even with the population /demographic increases anticipated in some areas of Kent and Medway.

The number of confirmed strokes is almost equal between East (1211) and West/North Kent (1289) despite considerably higher populations number in W/N Kent. (1,088 vs 658)

When determining the bed numbers required the number of TIAs and stroke mimics who appropriately require admission to the stroke unit have been included, this equates to around 35% of all admissions.

The Ambulance Trust data shows that around 35% of all transfers to hospital with stroke symptoms are not stroke patients.

As the geographic configurations are modeled this activity is included in the modeling and clear pathways will be identified to effectively and safely care for these patients.
As noted further work is underway to establish the average numbers and needs of non stroke patients

The review has undertaken 3 activity audits completed by each admitting unit and SECAmb to triangulate the data sets.

The Finance/activity modelling group has reviewed actual patient spells and bed usage and identified referral source by postcode.
The activity heat maps demonstrating the activity/referral hot spots are being reviewed to determine the financial and activity impact on receiving Trusts.

- **Workforce:**

The review has used the BASP guidance, and the South East Coast Integrated Specification and agreed SE standards.
These include;
A 1:6 consultant rota and minimum of daily ward rounds, consideration of twice daily ward rounds.

Profession	Per HASU bed	Per ASU bed
Nurses	2.9 (80/20 trained untrained spilt)	1.35 (65.35 trained/untrained spilt)
Physiotherapy	0.146	0.168
SLT	0.068	0.081
OT	0.136	0.162
Dietitian	0.025	0.025
Clinical psychologist	0.025	0.030

Ability to deliver 7 day services across all MDT professions has been considered and will form part of the provider capacity assessment.

A gap analysis has been undertaken in each Trust for each profession and is updated regularly, although there has been little change.
Average cost has been identified for each profession to inform the financial planning and assessment of both the current and future financial position.
Qualitative feedback has been given re current vacancy rate and recruitment history. This has been considered by profession at each Trust.

General feedback shows consistent difficulty recruiting to stroke consultants for a number of years with long standing vacancies.
All K&M Trusts have difficulty recruiting generally to nurses particularly at band 5 with international recruitment underway in most hospitals.

Senior and specialist nurses are trained from within and vacancies are easier to fill.

All hospitals have a stroke competency framework in place and have a level of specialist nurse or therapy support at senior level coordinating the service as part of their role.

Recruitment to therapy posts varies across the county and varies for different professions. There is a sense that lessons can be shared and recruitment to this staff group may be easier but will/may be impacted by centralisation.

Risk assessment shows that the current stroke medical workforce supports general and geriatric medicine and the impact of this is included in the provider capacity appraisal.
Experience from other stroke units is being used to develop the consultant job plans.

There are also concerns re the level of attrition across all professions in particular stroke consultants and nurses.
The gaps in general and geriatric medicine may mean that some stroke consultants who do want to move can take on full time roles on these areas. This can result in stroke only consultant posts being available this may aid recruitment.

- **Financial planning:**
  The financial and activity modeling group have considered the cost of each option and reviewed against the financial envelope determined by the stroke tariff. The costs are predominantly driven by the workforce and primarily the consultant costs.
  Analysis shows that the five site model is the most financially challenging, this will cost approximately 1 million pounds more than the 4 site model due to the additional consultants required for the same total number of beds
  Analysis shows that there are a number of patients staying in hospital for long periods and analysis of the available rehabilitation services is underway to ascertain the gaps and opportunities to more effectively support patients.

  Currently the group is considering the potential geographic options to confirm the activity levels and the individual financial envelopes.
  The group is working with the individual Trusts to determine the impact of any changes either in increasing or removing stroke activity both on finances but on the Trust and the co-dependencies)

The financial modeling illustrates that there are cost pressures currently and whilst centralisation can improve this up to a point, there will still be pressures for both commissioners and providers

- **Quality and Equality Impact Assessment**
  The criteria used to assess the options are based on national best practice for delivering positive patient outcomes.
  Each area considered is tested against the health impact for stroke patients.

  The Equality screening has shown that the improvements planned will improve health for all patient groups including the protected characteristic groups.
  The geographic configurations are being tested from a quality, equality and inequality impact perspective.
  The emerging issues relate mainly to the ability for non English speaking patients and members of the public to get emergency medical attention
  Another key issue is the impact on elderly patients, relatives and carers of longer travel times for visiting
  A key consideration is the impact on low-income members of the public, including relatives and staff on longer, more costly journeys. This will be detailed in the geographic options and trusts asked to develop possible mitigating actions.

  The issue of increased travel times/costs for staff and relatives is a key concern that needs to be balanced with the ability to deliver a sustainable quality hyper acute/acute service across Kent and Medway. Where this is an issue mitigation will be considered and developed with each of the providers.

6.0 Next Steps:

- To determine provider capacity and consider delivery models. This will commence with meeting the provider CEOs and CCG Accountable Officers. This will also support alignment with the strategic transformation plans
- Ensure ongoing alignment to urgent and emergency care programme and K&M Strategic Transformation Plan.
- Complete detailed impact assessment of geographic options
- Development of clinical pathways/delivery model with the CRG, local clinicians and support from other stroke services providers and national experts.
- The RPB to consider and establish the best options for consideration and present to the CCG clinical forums and governing bodies. Final recommendations will be considered by CCG governing bodies and urgent and emergency care programme board in the summer 2016.

- Agree consultation timeline in alignment with considerations of Urgent and Emergency careand the strategic Transformation Plan.

7.0 Summary Timeline

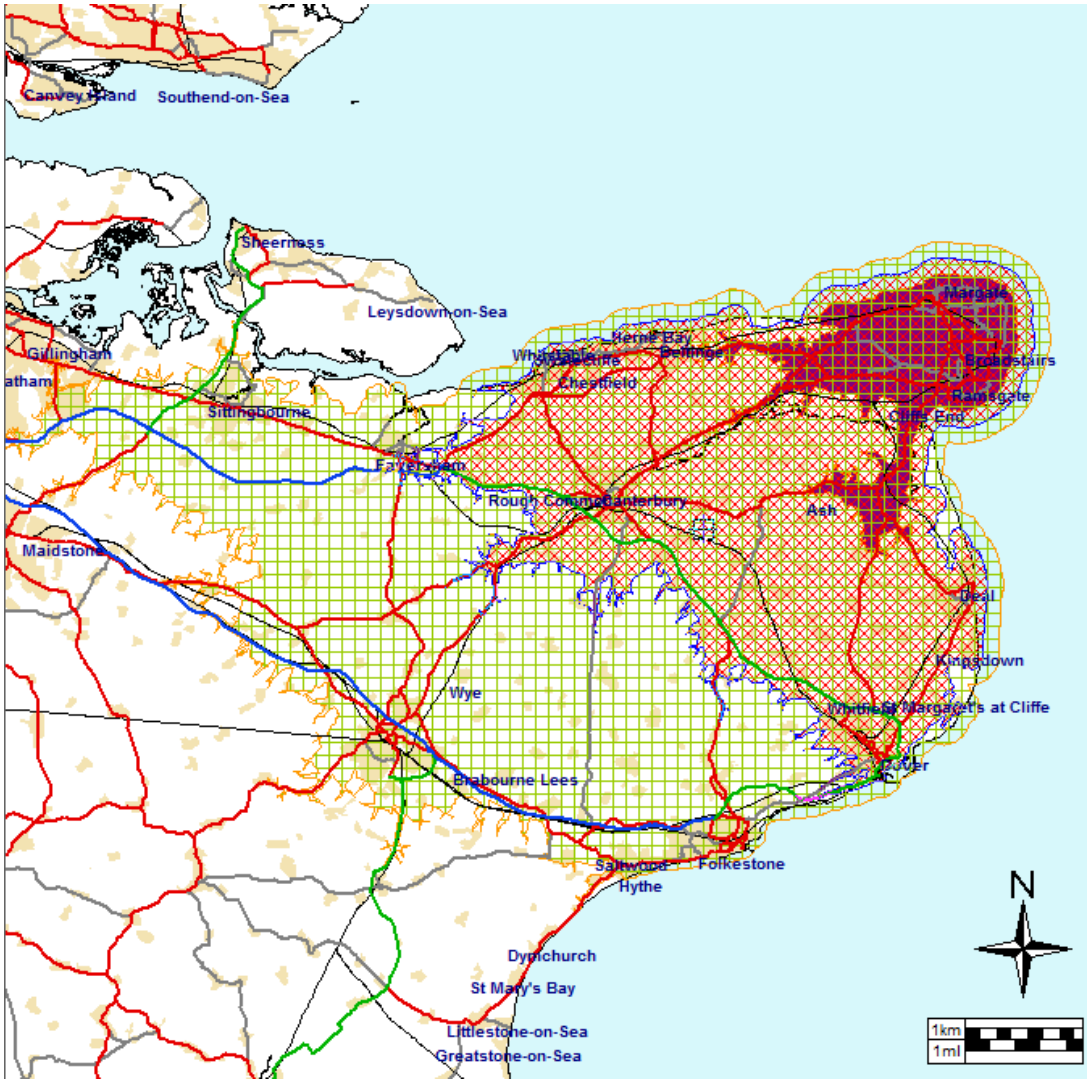
Key Action	By who	By when
Long list to short list	**Review programme board**	**December 15**
Red Flag criteria appraisal	**Programme Board**	**March 16**
Challenge session to review findings and agree next steps	**Programme Board**	**March 16**
Provider Capacity	**Provider CEOs, AOs and Programme Board**	**April /May 16**
Geographic configurations agreed and appraised	**Programme Board alongside discussions with provider CEO's**	**May/June 16**
Recommendation of short list to programme Board Presentation and discussion of recommendations to JHOSC	**SRO/Programme Director**	**June/July 16**
Final short list for consultation	**CCG governing bodies**	**July (summer)16**

8.0 Recommendations for the JHOSC

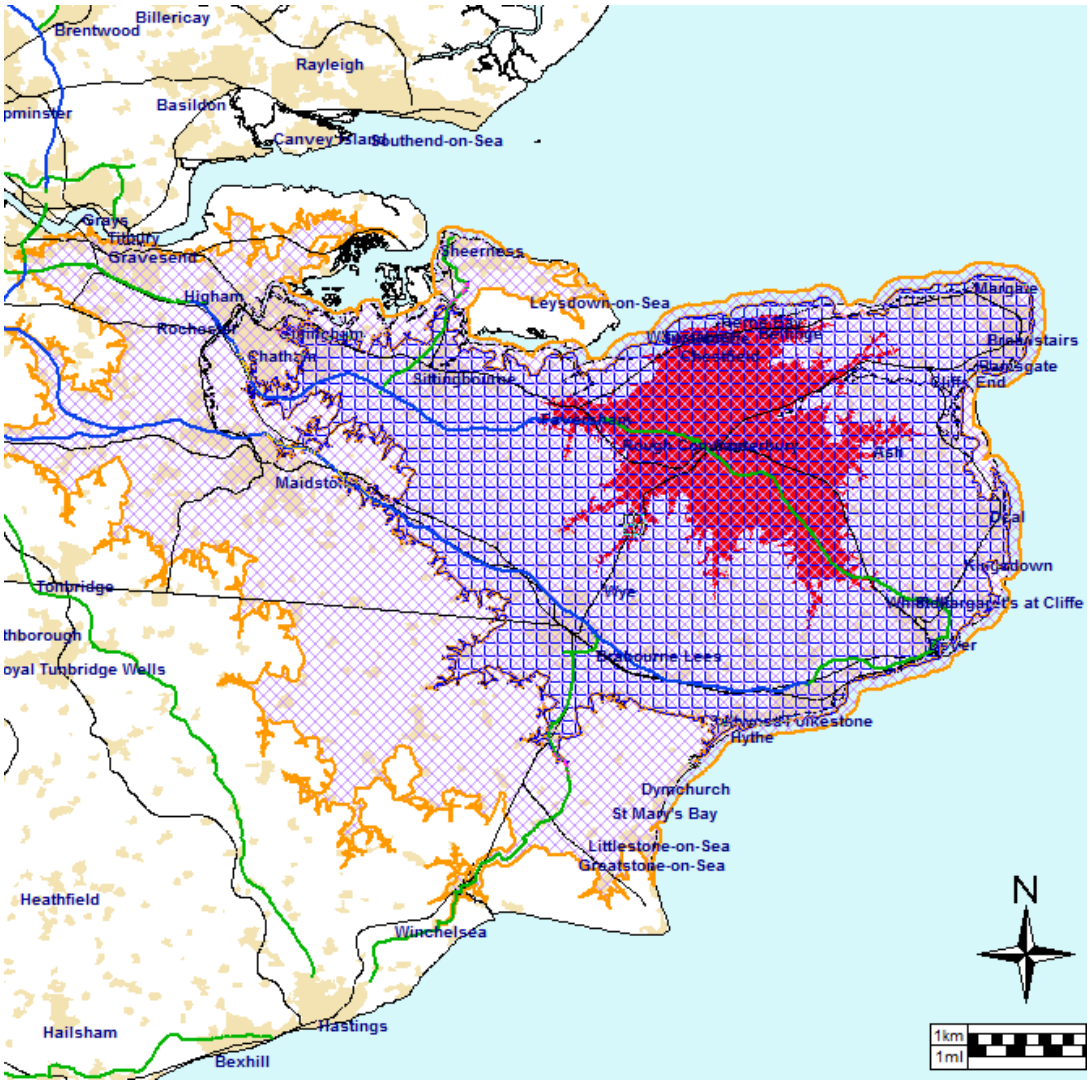
- To consider and comment on the options development and appraisal process.
- To decide if any further information is required.
- To refer any relevant comments to the Review Programme Board and request that they be taken into account, particularly in relation to decisions on the options of a 5,4 or 3 site model.
- Invite Kent and Medway CCGs to present the final options for public consultation to the Committee

Appendix One;
Kent and Medway standard road travel times form each acute hospital site (SECAmb Isochrones). The darker colours show 15 minutes travel time form the hospital, medium colour is 30 mins and the lightest colour is within 45 minutes.

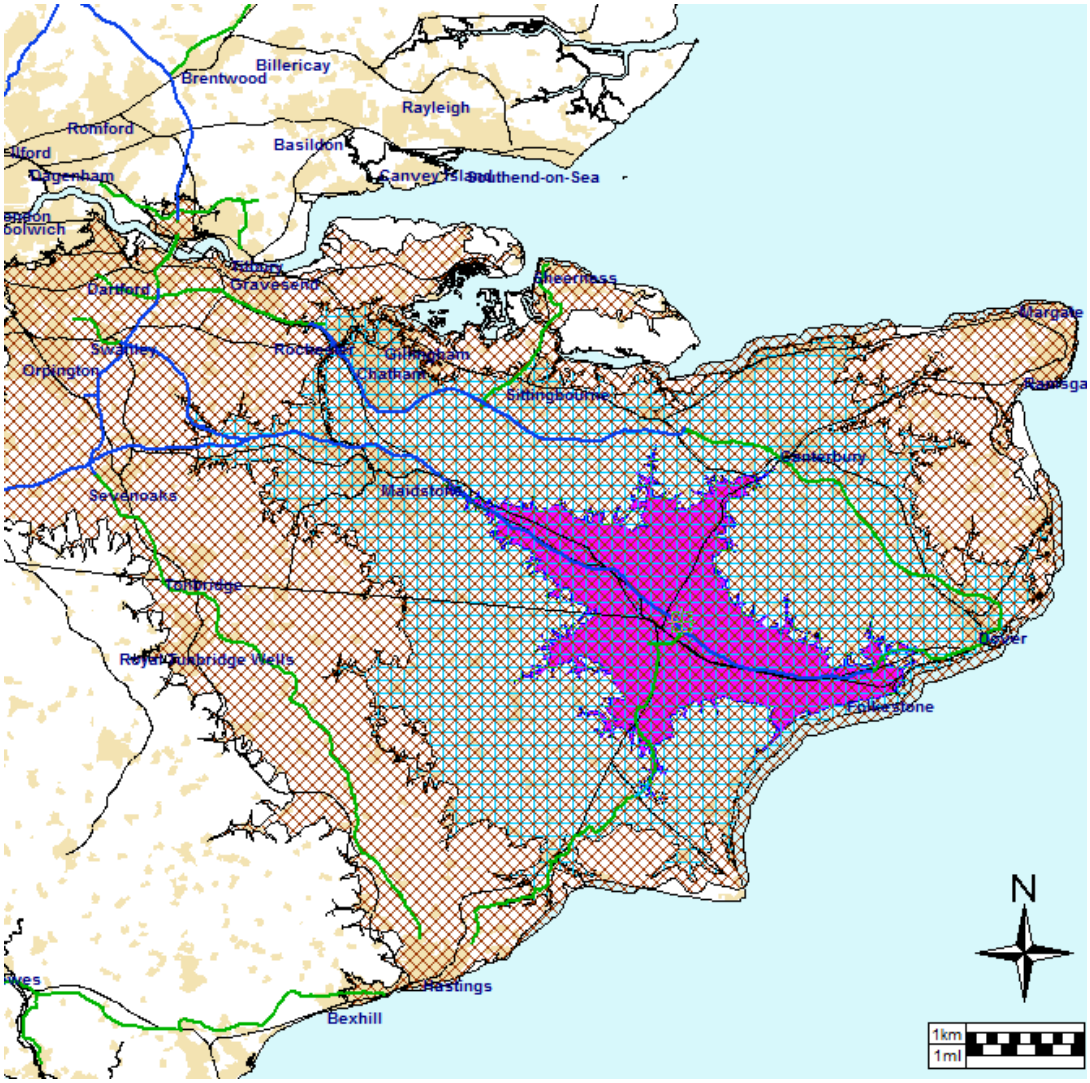
1) QEQM hospital, Margate



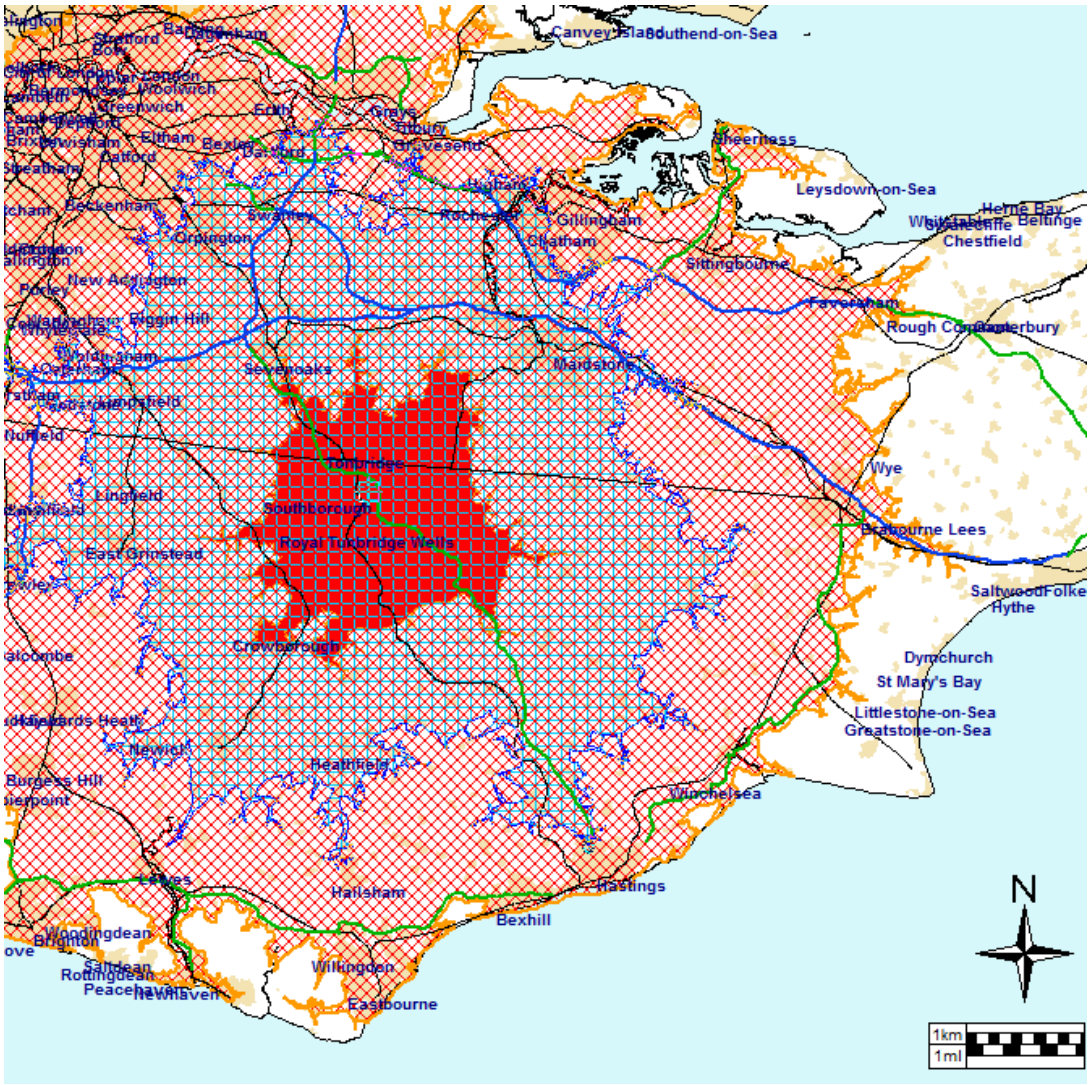
2) Kent and Canterbury hospital, Canterbury.



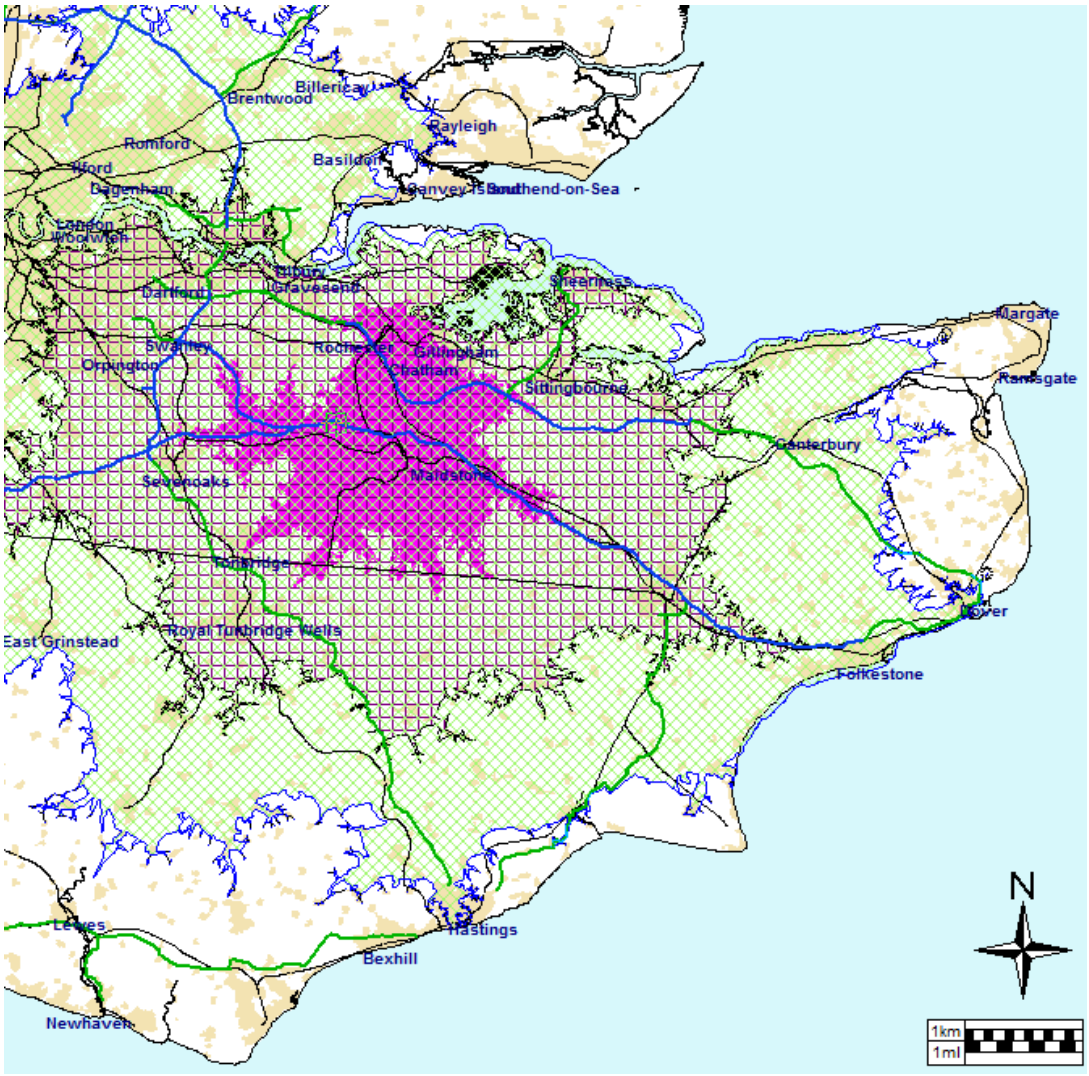
3) William Harvey hospital, Ashford



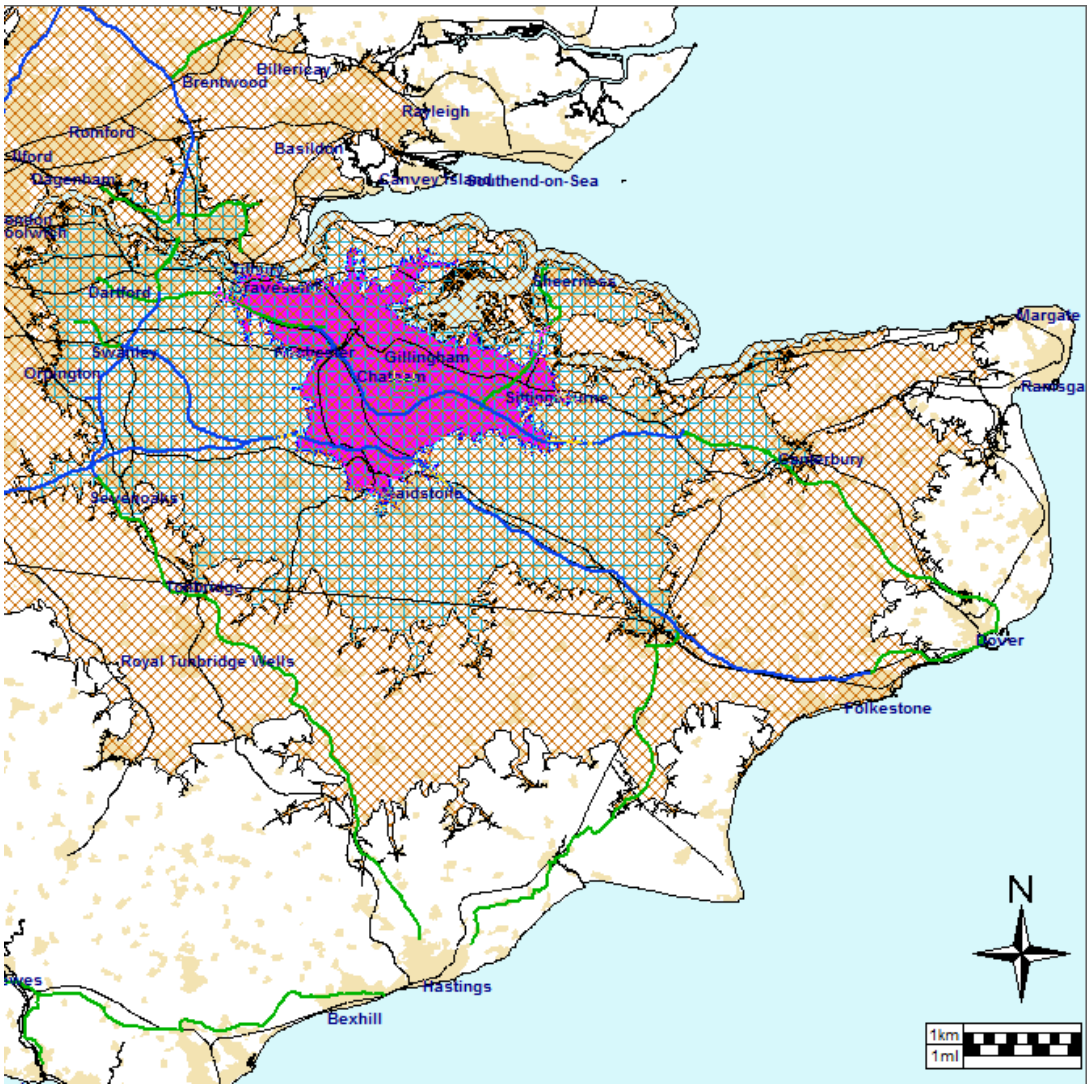
4) Tunbridge Wells hospital, Pembury



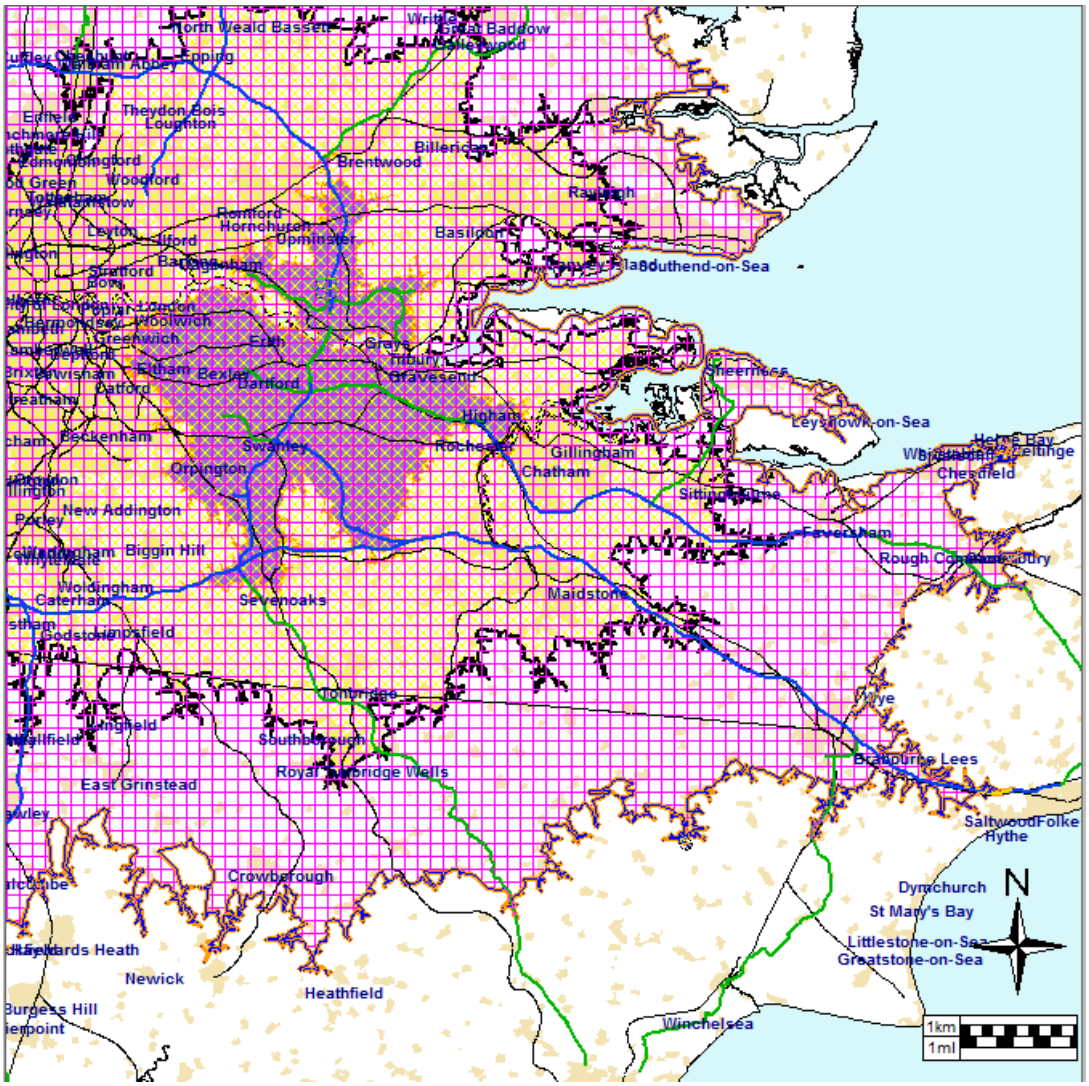
5) Maidstone hospital, Maidstone



6) Medway Maritime hospital, Medway



7) Darent Valley hospital, Gravesend.



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