KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 4th August, 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

Thursday, 4th August, 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 Murray, Cllr W Purdy, Cllr D Royle and Cllr D Wildey

UNRESTRICTED ITEMS

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

Item — Timings*

1. Membership

   (1) Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee are asked to note that Cllr Wildey has replaced Cllr Clarke as a member of the Committee.

2. Election of Chairman

3. Election of Vice-Chairman

4. Substitutes

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

6. Minutes (Pages 5 - 10)

7. Kent and Medway Hyper Acute and Acute Stroke Services Review (Pages 11 - 28) 10:10

8. Kent and Medway Specialist Vascular Services Review (Pages 29 - 36) 11:00

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

27 July 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 Darent Room, Sessions House, County Hall, Maidstone on Friday, 29 April 2016.

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

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Dr J Duke-Macrae, Mr A Scott-Clark, Mrs R Gunstone and Miss L Adam

UNRESTRICTED ITEMS

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

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

12. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 8 January 2016 are correctly recorded and that they be signed by the Chairman.

13. Kent and Medway Specialist Vascular Services Review
(Item 4)

Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East)) and Dr James Thallon (Medical Director, NHS England South (South East)) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Thallon began by outlining the infomation provided in the report, to address the Committee's recommendations from 8 January 2016 meeting, including travel times, performance indicators and findings from local reviews which were centralising vascular services in accordance with the Vascular Society guidance. He noted that the Vascular Society was exemplary in providing clear best practice guidance to its members and commissioners and the 2012 guidance was being updated in 2016. He reported that the Kent and Medway review was working with the Vascular Society guidance review group and there would be

no significant changes to the guidance. He stated that improving outcomes was driving the review; whilst the two providers in Kent were within the national tolerance levels for mortality, there was a considerable range in performance.

(2) Dr Thallon explained that there were no recommended criteria for travel times in the Vascular Society guidance as the key priority was access to specialist vascular surgery. He quoted Vascular Society guidance which stated that "patient survival after a ruptured aortic aneurysm was 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." He noted that the review programme board favoured a network hub and spoke model with a single inpatient centre and one or more spokes; this model would be out to public consultation in the summer subject to NHS England's internal assurance process.

(3) Ms Windibank highlighted the ongoing work including a detailed quality assessment for the affected populations. She reported that a qualitative event with patients and relatives representatives was held in February and considered the recommended option from a patient perspective; key messages included travel times for relatives and a sustainable service remaining in Kent and Medway. She noted that there was a draft public consultation plan and any feedback from the Committee would be reported back to NHS England as part of their internal assurance process.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about co-dependencies with podiatrists and interventional radiologists. Dr Thallon explained that whilst he accepted the importance of podiatry in prevention and noted that there was a shortage of podiatrists; podiatry was not in the scope of the review and was not able to be incorporated into it. He stated that he would be happy to reflect comments made about podiatry to the commissioners. He noted that one group who did have better access to podiatry services were those with diabetic foot problems who were also likely to suffer from vascular conditions. He reported that the review was aiming to create a centre of excellence which would avoid the need for amputation. He explained that interventional radiologists were currently underdeveloped in Kent and Medway and the next generation of vascular surgeons would be hybrid surgeons and interventional radiologists. He noted that whilst a hub and spoke model would create the conditions for interventional radiology to become an attractive speciality, it would take time for this to be developed. He reported that there was agreement from current interventional radiologists to support the new vascular model which was subject to further discussions.

(5) A number of questions were asked about population growth and disease forecast; preventative services; travel times for staff and frail, elderly and low income visitors; and amputations. Ms Windibank reported that population growth and cardiovascular disease forecasts had been included in the modelling. Dr Thallon explained that the abdominal aortic aneurysm screening programme had been key in reducing the number of emergency vascular procedures. He reported that prevention was taken very seriously and highlighted the successful diabetes prevention pilot undertaken by Medway CCG which was being implemented by all Kent and Medway CCGs. Mr Scott-

Clark noted that KCC was responsible for commissioning NHS health checks in Kent which could identify patients at risk of vascular conditions. Ms Windibank explained that detailed work was being carried out to look at travel times for staff and low income families particularly in high prevalence areas. Dr Thallon explained that vascular surgeons in the inpatient hub would be responsible for all vascular surgery including repairs of abdominal aortic aneurysms and amputations if related to a vascular condition. He noted that there were variations in outcomes for amputations and this could be incorporated into the review. Ms Windibank stated that the vascular review had whole system support and was aligned to the wider transformation plan.

(6) In response to specific questions about the operational and financial resilience of the two current providers in Kent and Medway, Dr Thallon explained that in terms of operational resilience, at present, both sites were understaffed and access to 24/7 surgery or interventional radiology was not guaranteed; he warned that the vascular service in Kent and Medway would collapse if the new clinical model was not implemented. He reported that even within challenged trusts such as Medway NHS Foundation Trust there were beacons of excellence such as its neonatal ward and there were signs of overall improvement at the trust under the new leadership. He explained that the creation of a vascular unit would be independent from the rest of a trust and create the conditions to attract staff. He noted that the aim of the review was to establish the clinical model and only the procurement would determine the location of the hub. In terms of financial resilience, Dr Thallon explained that if the clinical model based on Vascular Society guidance was implemented, it would provide an adequate revenue base for the chosen provider. Both of the current providers in Kent and Medway had adequate facilities which could be consolidated at relatively small cost.

(7) The Chairman invited Mr Inett to speak. Mr Inett enquired about the services provided at the spokes. Dr Thallon explained that a network model with a single inpatient centre would increase outcomes for patients but may result in them travelling further. He stated that in mitigation, all other services would be provided locally including diagnostics and outpatients. He noted that in the future some inpatient services could be provided in the spokes including angiology and stenting. Ms Windibank reported that at the qualitative and listening events, the priorities for patients and relatives had been access to specialist vascular services in Kent and Medway. Additional travel times for relatives were a concern but a number of initiatives suggested by attendees such as Skype appointments and support with travel were being looked at by the Clinical Reference Group. She noted the procurement would need to respond to those needs.

(8) A number of comments were made about procurement and public consultation including a consultation event in Medway. Dr Thallon explained that he was limited to the type of information he could provide the Committee in advance of the procurement process due to the risk of prejudice. He stated that he could share the key criteria for procurement including facilities and ease of visiting with the Committee. Ms Windibank reported that NHS England, through procurement, had a duty to market test any provider interested in delivering the clinical model for Kent and Medway. Ms Windibank noted that the procurement process would determine the site of the hub and current vascular performance would not be taken into account. She stated that the purpose of

the public consultation would be to test the model and criteria for procurement; NHS England would return to the Committee after public consultation and before the procurement process began. She explained that the draft public consultation plan included a survey targeting specific patients in Kent and Medway including those patients who travel to London for their care.

(9) RESOLVED that:

(a) NHS England South (South East) be requested to note comments about amputations; the proposed clinical model; podiatry; procurement and public consultation;

(b) NHS England South (South East) be requested to provide the following additional information to the next meeting of the Committee: key criteria for procurement and travel times for staff and frail, elderly and low income visitors;

(c) NHS England South (South East) be requested 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.

14. Kent and Medway Hyper Acute and Acute Stroke Services Review
(Item 5)

Oena Windibank (Programme Director, Kent and Medway Vascular Services Review, NHS England South (South East)), David Hargroves (Chair, Stroke Clinical Reference Group) and Lorraine Denoris (Public Affairs and Strategic Communications Adviser, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Windibank began by updating the Committee on the option appraisal process. She explained that detailed appraisals had been undertaken for a five, four and three site model and had been reviewed against a set of red flag criteria. The red flag criteria were agreed by the Review Programme Board and aligned to recommendations within the national stroke configuration guidance. She noted that workforce was the key limiting factor to providing seven day cover. She reported that a five site model was most challenging in terms of workforce and there were concerns about the capacity and sustainability of a three site model; more detailed work was being undertaken including the review of alternative clinical models. She stated that a five, four and three site model had been reviewed against the financial envelope determined by the standard tariff for stroke; if best practice guidance was met an enhancement would also be paid.

(2) Members of the Committee then proceeded to ask a series of questions. In response to a specific question about the consultants' letter, Dr Hargroves explained that the process embarked upon had been transparent and engaging; all clinicians had been invited to participate with variable levels of involvement. He stated that the letter had been received at a late stage. The Clinical Reference Group had responded and addressed each of the concerns

raised in the letter including frail and elderly patients, alternative models of delivery and the use of technology; the Group had also reflected on the information it provided to the Review Programme Board and had concluded that it was robust and adequate. Ms Windibank noted that the consultants had been invited to raise any outstanding concerns before the next Review Programme Board.

(3) A number of comments were made about the public perception of travel times and the provision of rehabilitation facilities. Ms Windibank explained that safe travel times would be included as part of the public consultation; she noted that the review was not yet at the stage to go out for public consultation. She explained that the focus of the review was the acute pathway for patients but acknowledged the importance of rehabilitation. She stated that as the model was developed, pathways for rehabilitation were also being identified and the CCGs were being made aware of areas which worked well and where there were gaps. She noted that the new acute model would only work if sustained investment was made by the CCGs into rehabilitation services and the Review Programme Board would be making recommendations to the CCGs about rehabilitation. She reported that she would feedback concerns about rehabilitation facilities for patients with brain injury to the CCGs.

(4) A number of questions were asked about the aim of the review, engagement with highways and weighting of journey times in the decision making. Dr Hargroves explained that the aim of the review was to improve clinical outcomes, care and quality for patients. He reported that the provision of services was variable across Kent and Medway. He noted that the review was not looking to establish a single centre of excellence in Kent and Medway, as the centre would be inefficient for the expected volume of patients. Ms Windibank explained that the review had used ambulance travel times provided by SECAmb and bed usage by CCGs for journey times. She stated that KCC Highways had been approached for data but a response had not been received. She noted that the Review Programme Board was proposing to put forward a request to KCC Highways to prioritise access for medical staff during Operation Stack. She reported that mapping was underway to assess private travel time by car and public transport. She explained that in terms of weighting, priority would be given to a 24/7 specialist service with adequate staffing levels. She noted that the review was working with providers to mitigate costs and travel times for visitors using public transport.

(5) RESOLVED that:

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

(b) the Committee note the three options for a five, four or three site model and make no further comment at this stage;

(c) Kent and Medway CCGs be requested to present an update to the Committee including the final options for public consultation.

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

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 4 August 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) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) met on 8 January and 29 April 2016 for the purpose of the consultation on the Kent and Medway Hyper Acute and Acute Stroke Services Review. On 29 April 2016 the Committee's deliberations resulted in the following agreement:

- *RESOLVED that:*

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

  (b) the Committee note the three options for a five, four or three site model and make no further comment at this stage;

  (c) Kent and Medway CCGs be requested to present an update to the Committee including the final options for public consultation.

(h) The JHOSC meeting scheduled for 30 June was postponed at the request of the Kent and Medway CCGs and rearranged for 4 August.

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 appraisal process findings to date;

ii) Decide if any further information is require

iii) Refer any relevant comments to the Review Programme Board and request that they be taken into account;

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

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

Kent County Council (2016) '*Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee (29/04/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6357&Ver=4

Contact Details

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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:	4.8.2016
Presented by:	Patricia Davies; Accountable Officer, DGS and Swale CCGs 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

August 2016

Kent and Medway Stroke Services Review.

1.0 Background and Case for Change

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

There was also concern that the stroke service is unable to respond to the need for seven-day services within the current configuration and model of care.
The review has been presented to the joint Kent and Medway Overview and Scrutiny committee on two previous occasions.

A case for change was published and stakeholders invited to engage through a series of sessions that allowed feedback to be obtained. Key issues identified included:

- The need to deliver a sustainable seven-day acute stroke care across Kent and Medway has been made that meet national standards;
- The ability to improve and deliver a seven-day consultant led service is significantly limited by recruitment challenges;
- Ongoing issues associated with the recruitment of nurses that impact on the stroke services;

- Significant concerns around the supply of speech and language therapists
- A mixed picture for therapy services with some areas and hospitals being more successful in certain disciplines. However recruitment for Speech and Language therapists, which are key requirement within quality stroke care is a significant concern.

2.0 Executive summary of progress and current position.

The key outcome of the review is to ensure that there is a specialist consultant led sustainable stroke service for all Kent and Medway residents, which delivers high quality care and improved patient outcomes. This may result in some patients and relatives travelling further in order to receive care that will deliver the required clinical outcomes. These outcomes reduce the number of patients who die and minimise the long-term impacts of a stroke and ability to achieve personal independence. The clinical standards address the needs of all stroke patients including the 20% who may be eligible for thrombolysis through the delivery of a specialist focused 7 day service.

The review has worked through a long to short list of options and in phase two has focused on the 5,4 and 3 site options. This has been supported and underpinned by a range of engagement events.

2.1 A detailed workforce review has confirmed that a 3-site model is the optimum configuration to deliver the national staffing standards required. Previously noted clinical concerns have been discussed and there is now consensus that the current 7-site model is not sustainable.

On the basis of the detailed assessments, the 5-site option was formally removed by the RPB after consideration at its Board meeting in May 2016 and the clinical feedback on the current model was duly noted and accepted.

2.2 High-level financial and activity modeling has been undertaken by the finance and activity sub group of the RPB. This has been built to date using the HES data and the financial costs of the acute EK Stroke service and the available stroke tariff plus ranges of achieving the Best Practice tariff (BPT). Detailed costing analysis is being undertaken with individual providers to ascertain the financial implications for both Trusts and CCGs of the potential options.

2.3 The key messages from this modeling include;

- Assessment to date shows that the 3-site model delivers the optimum option for financial viability and sustainability, this is still being tested clinically.
- Achievement of the BPT creates a cost pressure for the K&M CCGS. Currently the key clinical indicators that deliver the enhanced tariff are not being achieved, this will change with a new quality compliant stroke service.
- The staffing rotas predominantly drive the costs and in particular the Consultant requirements which costs around £1million per site.

- A high level exercise demonstrated that a 3 site model achieving 100% BPT should deliver break even for the provider; this needs confirmation against provider costs.
- Length of stay (LoS) is a key driver of both quality and improved patient outcomes. A key assumption of the activity modeling is that with 7-day services, adequate discharge and rehabilitation flows, the LoS can reduce, improving the patient experience/outcome and maximising the scarce specialist resources.
- The modelling work has shown that there are multiple 3 site models that would ensure that patients are within 51 minutes of their nearest stroke site and would achieve the standard of 95% of stroke patients within 45 mins travel time.
- The bed modelling to date has only used confirmed stroke/ TIA patients and a percentage needs to be added for appropriate stroke mimic patients.

2.4 The 4-site option is considered by the Programme Board to be a risk because it is unlikely to;

- Deliver and sustain a 7-day service and meet the NHS requirements of consultant led services;
- Deliver the key clinical standards/outcomes;
- Support the recruitment of adequate numbers of consultants;
- Provide assurance around the provider costs.

The Board noted and highlighted concerns relating to capacity and resilience of 3 Kent and Medway HASU/ASU's and recognised that this needs to be tested.

2.5 The Stroke Programme Board (RPB) agreed at its May board that the 3 site option should be worked through in more detail. This includes understanding the key site configurations, the provider ability to deliver the activity levels and bed numbers, the likely time line and phasing requirements. The modeling work (including activity and travel times) indicates that a 3-site model is likely to result in a single East Kent site and 2 sites in North and West Kent. This will be further tested through the bed modeling work currently underway.

Detailed understanding and a gap analysis of the rehabilitation pathway is being completed to ensure the sustainability of this model.

It was also agreed that safe and effective implementation would require a phased approach developed in partnership with providers.

East Kent Hospitals Trust are considering the possible impact of implementing a 3-site model as part of its wider clinical strategy.

2.6 K&M CEOs and AOs have advised that a 3 site model is the most likely model to meet the quality and sustainability requirements and noted that the critical clinical co-dependencies will be key. This will require alignment to the

wider Five Year Forward View (FYFV), previously known as STP developments.

2.7 The Programme Board will consider at its August Board meeting the work on activity, finance and clinical delivery and assess the ability of a 3-site model to address the capacity and resilience concerns.

2.8 Further engagement sessions are being planned to engage the public, patients and key stakeholders on the assessment against the options to date and the emerging preferred option(s) and to inform the final recommendations and delivery plans. This will build on engagement activity undertaken earlier in the review process.

2.9 The site configurations are also currently being modeled however these require alignment with the wider STP(FYFV) in order to ensure that critical clinical co-dependencies are embedded into the options.

Work currently underway includes;

- Detailed appraisal of the 3-site model including the phasing required.
- Confirming the actual site bed numbers and activity per option and configuration.
- Confirmation of the detailed travel times per option and configuration
- Provider Trusts to consider/work up impact on their organisation and wider clinical strategies
- Working up and assessing the range of clinical delivery options/considerations and recommend likely risks and timelines, to include wider clinical engagement across K&M
- Confirmation of the rehabilitation and discharge pathways across K&M and ability to meet the requirements of the new model.
- Stroke review emerging recommendations to be considered by K&M CCGs through August/Sept, this will be within the context of the developing STP (FYFV)
- Further engagement events being undertaken over the next few months to test out the 3-site option with the public/key stakeholders. The findings of this will further inform the Quality/Equality Impact assessment (QEIA) work to date
- Aligning the emerging model with the STP/FYFV both in terms of delivery, decision-making and consultation.

3.0 Modelling work; Where are we/key findings to date.

An options appraisal process has considered centralising hyper acute and acute phase of stroke care into fewer acute hospital sites. There is a consensus agreement from clinicians, the public, patients and key stakeholders on the requirement to reduce the number of stroke units.

Key modeling areas have been considered to inform the appraisal process of the options and the final recommendations that include:

3.1 Out of Hospital Pathways:
There is a clear message from clinicians,the public and key stakeholders that without effective out of hospital care the patient flows will not work effectively.

The future hyper acute/acute model will have to consider the whole patient pathway if it is to be successful and sustainable. The review continues to build a picture of the current Early Supportive Discharge and rehabilitation services and pathways. This is informing a gap analysis and is being applied to the emerging model to ensure that delivery of the new model on fewer sites is deliverable and sustainable.
Recommendations on the out of hospital pathway will be incorporated into the recommendations for the Kent and Medway CCGs.

3.2 Stroke related activity;
The review has identified the total volume of stroke activity to determine the ability and impact of reducing hospital sites admitting stroke patients.
This has included confirming the number of;

- Confirmed stroke patients,
- Patients who have a TIA (trans-ischaemic attack),
- Patients with stroke symptoms who present at A&E and who do not have a final diagnosis of a stroke.

The modeling has undertaken a number of audits at each Trust and with SECamb, and has reviewed actual bed usage across the K&M acute hospitals. This has included consideration of all patients who are seen by the stroke team and all stroke patients in a hospital bed even if not on the stroke unit.

3.21 The modeling has confirmed that on average 35% of patients brought to hospital by ambulance with stroke symptoms will not have had a stroke. There are 25% of patients appropriately cared for on stroke units who do not have a stroke (stroke mimics). 10% of patients on the stroke unit are patients who have had a TIA.

The totality of these numbers is being included in appraisal against the site options to understand the impact on both patients and the hospital.
Initially this has been considered on an even share split. The work currently underway is confirming actual patient flows to named sites based on previous activity and patients and understanding the impact of this on the hospital.

The activity split will not be equal, dependent on the site configuration different hospitals will receive greater numbers of both total stroke activity and confirmed stroke numbers. SECAmb will also convey patients to the nearest stroke unit and this assumption is being used as the bed modeling develops.

3.23 The modeling on bed usage has shown that there are a number of patients with a long length of stay and there are outlier stroke patients on medical wards and vice versa. There are opportunities to improve the patient flows and to reduce many of the long length of stays. Adequate and specialist staff including stroke pathway coordinators and Early Supported Discharge

teams can facilitate these improvements. This improvement has been evident in other stroke reconfigurations across the country. Work is currently underway between the finance /activity group and the CRG to review the average length of stay and the long stay patients to inform the bed modeling. Modelling work in Surrey and Sussex has used a 10 – 12 day average length of stay.

3.24 The review has worked with the public health team to consider the future projection of stroke incidence. This has shown that the current number of 2,500 confirmed stroke patients per year is not anticipated to increase significantly. This has included consideration of known population growth and demographics and the current primary care management of prevention and potential stroke cause/ symptoms. This in line with the national picture/expectations and is reflected in the audits and activity modeling undertaken by the review team

3.3 Workforce

The review has undertaken a gap analysis with the local acute Trusts, this demonstrates considerable gaps at consultant and nurse level with a differing picture across therapy services.

3.31 The consultant recommendation is for 6 consultants per unit and the current position is around 30 % of that target. There are also a number of longstanding vacancies and a history of recruitment difficulties across Kent and Medway. This position has a direct impact on the rota requirements of the consultants and therefore the ability to recruit staff. The local clinicians have considered alternative models however this is not easily resolved due to the competency requirements and co-existing medical staff pressures.

3.32 All site options will be difficult to recruit consultants to and the fewer the units the less the gap, there are however concerns that some consultants may choose not to work in the new centralised service. This will be risk assessed and mitigation put in place particularly during the transition phase, this may include the use of neurologists and bespoke consultant job plans.

A centre of excellence with sustainable rotas is more likely to attract both junior and consultant level staff.
The workforce modeling shows that a 3-site option is the most likely to meet the consultant requirements.

3.33 The recommendation for nurse and therapy staffing relates to bed numbers. The qualified nurse gap varies across all sites on average being around 25% below the requirements. Recruitment is generally challenging although it can be easier to recruit specialist nurses or ‘grow’ staff through stroke competency frameworks.

Therapy recruitment is variable with some success evident although there are still gaps and in particular within Speech and Language therapy.

The bed number modeling, based on actual patient usage and an improved length of stay, illustrates that the bed numbers will reduce and therefore the ability to staff the units consistently across 7 days is much improved.

3.4 Access and Travel:

The review has reflected expert clinical advice and best practice to ensure that the future travel times will maximise improved health outcomes for patients. The preferred options will meet the recommended timelines for effective therapeutic interventions.

3.41 There is a considerable focus on ensuring that thrombolysis patients get to a hospital in a timely manner. Recent clinical recommendations both nationally and through the South East Clinical Senate have advised that access and treatment/travel times should be considered across both the out of hospital early phase and the initial in-hospital acute phase.

This working across the pathway will result on a shared standard from 'call to needle' of 120 minutes, (as opposed to the separate 60 minutes for out of and in hospital care)

This also ensures that there is a wider area of access for patients who live further away from the hospital with no negative health impact for them. Thrombolysis accounts for around 20% of all stroke patients and the needs of the remaining 80% of patients must be duly considered and addressed. There is evidence and best practice guidance that the availability of a specialist service 24/7 benefits all patients. Key outcome measures include access to the stroke unit within 4 hours, specialist assessments, and in particular swallow screening within four hours.

3.42 There are a number of options for centralising the hyper acute /acute stroke services onto fewer sites and these have been tested against both achieving a 45 travel time for 95% of patients and being able to deliver the recommended 120 minute call to needle standard.

3.43 Stakeholder engagement has identified some concerns in relation to travel times, the reality of travel times/journeys and in particular for patients residing on the outskirts of the county.

Further detailed work using a number of algorithms has been undertaken assessing the patient travel times from lower super output areas and has identified specific travel times per minute for each possible configuration. (appendix 1)

This data is being used to assess each possible option and the impact on the ability to meet the optimum travel times and the 120 minute call to needle standard.

3.5 Options appraisal for 5, 4 and 3 sites.

The 5,4 and 3 site options have all been tested against the key red flag criteria (appendix 2) and have been discussed and shared with the public, patients and key stakeholders.

3.51 The modeling has shown that workforce is a key limiting factor for all the options, the gap reduces as the site numbers are reduced. There are several configurations in each option that deliver the required access times.
The review is currently identifying the optimum point at which there is a balance between the ability to reduce the sites to meet the workforce required and the ability to have the capacity required to safely meet demand and to retain staff.

In order to deliver the required standards each option needs to be able to deliver a 24/7 consultant led service. The achievement of the standards also provides the financial envelope required to adequately staff the service.

Currently no Trust is able to achieve the standards to the level where they can attract the full tariff. The review is therefore working with the Trusts to ensure that the risks are recognised and managed effectively.

3.52 The review has concluded that a five-site model is highly unlikely to be able to be staffed to a level where a 24/7 consultant led service is deliverable. This option also creates significant financial pressures for the hospital Trusts. **The assessment is therefore that a 5 site model will not deliver the service model required to meet the standards and improve patient outcomes.**

3.53 A 4-site model will also be difficult to staff and deliver across 24/7 and the volumes levels are at the minimum level required. The programme Board has noted concerns that this option may be a risky option, struggling to staff the units and hence meet the standards whilst creating financial risk for some providers who have low volumes.

3.54 A 3-site model is considered the most effective option when taking into account the workforce gap and ability to staff units with specialists, especially the consultant workforce critical to the delivery of required clinical standards.

This model is most likely to deliver financial balance and possibly enable investment into early supported discharge teams.

There have been concerns raised regarding the capacity and resilience of the service if it is reduced to 3 sites for hyper acute/acute stroke care.
This model will take time to implement in order to mitigate against the capacity and resilience issues and needs to be part of the wider strategic discussions.

Key to the reconfiguration is the ability to align the changes to the critical clinical co-dependencies. These have been embedded into the criteria used for the options appraisal. These will however need to be reflected in the developing FYFV that may impact on the core services available at K&M hospital sites. Any stroke service reconfiguration will need to align to the broader FYFV to ensure that clinical co-dependencies are not negatively impacted/lost.

4.0 Impact assessment:

The Quality, Equality and Health Impact Assessment process shows that achievement of the clinical standards produces positive impacts for stroke patients including the protected characteristics groups.
This is based on an even split across the county in terms of travel times and supports the delivery of a reconfiguration for the benefit of stroke patients across Kent and Medway. Mitigation of the negative impacts needs to be part of the delivery plans and provider models including support to relatives and staff.

4.1 The key negative Issues relate to relative travel times and costs, access to rehabilitation in certain areas and concerns re staffing impacts of travel times and costs.

There will be increased travel times for some patients. The appraisal will assess the ability for all patients in Kent and Medway to be treated within the emerging 120 minute standard and meet the four-hour assessment targets.

4.2 The impact on the workforce is unclear and will be initially risk assessed and monitored. It is anticipated that there will be some loss of existing staff but that the new model will be more attractive to new staff. Individual Trusts are working to determine the impact on individual staff and mitigation for them in relation to travel times and costs. Each Trust will identify workforce plans to address these concerns and maximise opportunities for new ways of working for staff.

4.3 Development of the stroke model will impact on the wider health economy particularly flows into A&E departments and medical beds for non-stroke patients. This is being considered at individual Trust level and SECAmb are assessing the impact on their wider operational delivery

4.4 The impact of increased and/or reduced stroke activity on other clinical services will be developed through the wider STP discussions.

5.0 Next steps/ work progressing.

The Stroke Programme Board agreed at its May meeting to remove the 5-site option from the option appraisal process, to understand the risk of delivering a 4 site model and to assess the ability to deliver the hyper acute/acute service across 3 sites.

5.1 The modeling includes alignment to the critical clinical co-dependencies in particular;

- 24/7 A&E departments with full facilities including acute medical rotas
- Rapid access 7 days/ 24hrs to imaging facilities
- Critical care support
- Multi-disciplinary Team access 7 days a week.
- Acute and general medicine, elderly medicine, respiratory medicine,
- Urgent GI endoscopy service,
- Acute cardiology.

The alignment to the critical co-dependencies needs to be aligned to the development and outputs of the K&M STP (ie delivery of the five year forward view)

5.2 The work underway includes consideration of the phasing of the new model over a number of years and alignment to the wider strategic planning decisions.

5.3 This work is underway with the hospital Trusts to fully reflect the capacity and pressures in their system and their ability to deliver the new model. This will include the pathways for A&E, medical beds, discharges home and the patient experience.

5.4 Understanding and managing the workforce risks per option and Trust are being determined and workforce plans developed. This includes consideration of attrition, additional travel times and costs.

5.5 The Early Supported discharge and rehabilitation services are being mapped against the options to ensure that the pathways can work effectively and to identify any gaps or blockages. These will form recommendations to the K&M CCGs, including how to make optimum use of existing effective pathways.

5.6 The Programme Board is commencing further engagement with the public, patients, clinicians and key stakeholders to share and discuss the emerging findings and consider mitigation of transition, travel times.

NHS England South have advised that any formal consultation process around stroke services will need to align to the wider STP/FYFV consultation. This will allow any feedback and decisions made to be informed by the broader strategic issues identified through the STP/FYFV process, specifically in relation to any future locations of emergency and specialised services.

5.7 The process will review and assess the findings to date of the QEIA impact assessment and apply feedback from the engagement events taking place. The review process will work with the providers to identify mitigation against negative impacts of increased travel times for relatives and staff.

5.8 The Clinical Reference Group is developing the clinical delivery model that identifies improved patient flows and maximizes the ability to deliver the clinical outcomes. This will include discharge pathways and out of hospital provision and will be the focus of wider clinical engagement. The focus of this work is to ensure a clinically sustainable delivery of excellent stroke care, improving patient outcomes and experience including length of stay and returning home.
The CRG will shift their emphasis to supporting the commissioners in identifying and ensuring delivery of the implementation plan including the phasing requirements alongside reference to broader STP/FYFV.

7.0 Revised Summary Timeline

Key Action	By who	During and by when
Long list to short list	Review programme board	December 15 Completed
Red Flag criteria appraisal	Programme Board	March 16 Completed
Challenge session to review findings and agree next steps	Programme Board	March 16 Completed
Initial Provider Capacity	Provider CEOs, AOs and Programme Board	June/July 16 Underway
Geographic configurations identified and appraised in relation to bed numbers and travel. Align to the STP developments	Programme Board alongside discussions with provider CEO's STP Board	May/June 16 July/August 16
Clinical delivery model developed through clinical engagement. Bed modeling to be confirmed Wider clinical workshop Key risks identified Possible implementation plan development	CRG with wider clinical engagement CRG and finance/activity group	Through June/July/August August 16 Sept/Oct 16 Sept 16
Public and stakeholder engagement on emerging options	Communication an engagement group	Sept/Oct 16
Recommendation of short list to programme Board. Emerging option to K&M CCGs Presentation and discussion of recommendations to JHOSC	SRO/Programme Director	June/July 16 August/Sept 16 August 16 ? Oct 16
Recommendations for consultation Alignment to wider strategic consultation plans and decision making timelines	CCG governing bodies	Summer 16 Autumn 16

9.0 The Joint Committee is invited to:

i) Consider and comment on the appraisal process findings to date;

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,

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

Appendix 1:

Travel times for 3 site combinations.

Three Site Combinations										
KCH	QEQM	WHH	Maid	TWH	Med	DVH	Max time	Pop outside 45 mins	>75 pop	Strokes Outside 45 mins
							00:40:55	-	-	-
							00:40:55	-	-	-
							00:44:10	-	-	-
							00:44:41	-	-	-
							00:44:41	-	-	-
							00:44:41	-	-	-
							00:44:41	-	-	-
							00:44:41	-	-	-
							00:44:41	-	-	-
							00:44:52	-	-	-
							00:46:59	2,593	211	3
							00:48:42	13,985	1,211	21
							00:50:22	16,695	1,485	27
							00:50:22	14,102	1,274	24
							00:50:22	14,102	1,274	24
							00:51:06	95,063	8,882	289
							00:51:06	95,063	8,882	289
							00:51:06	95,063	8,882	289
							00:51:06	95,063	8,882	289
							00:51:06	95,063	8,882	289
							00:51:06	95,063	8,882	289
							00:51:11	3,320	197	5
							00:51:11	6,342	433	12
							00:51:36	16,146	1,954	70
							00:51:36	16,146	1,954	70
							00:51:36	16,146	1,954	70
							00:52:54	10,720	1,506	46
							00:52:54	10,720	1,506	46
							00:57:35	3,320	197	5
							00:59:52	35,066	4,083	136
							01:01:48	239,702	18,162	401
							01:03:51	272,049	27,872	943
							01:03:51	272,049	27,872	943
							01:03:51	272,049	27,872	943
							01:09:36	337,389	34,563	1,209

Appendix 2

Red Flag Criteria:

- 7 day consultant cover; daily moving to twice daily ward rounds
- 7 day therapy service for Physiotherapy, Occupational therapy and Speech and Language therapy
- 7 day nursing cover
- Nursing and therapy staff to be compliant with the SE integrated stroke services specification
- BASP workforce levels for consultant staff (1:6 rota)
- Min/max activity volumes; >600….<1500 confirmed stroke patients per annum
- 45 min travel times for 95% of patients incorporated into achievement of the 120 minute call to needle standard
- 120 mins call to needle time/standard
- 24 /7 CT imaging provision with timely access
- HASU sited on a HOT ED site.
- Critical co-dependencies in place.

Item 8: 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, 4 August 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) met on 8 January and 29 April 2016 for the purpose of the consultation on the Kent and Medway Specialist Vascular Services Review. On 29 April 2016 the Committee's deliberations resulted in agreeing the following recommendation:

- RESOLVED that:

(a) NHS England South (South East) be requested to note comments about amputations; the proposed clinical model; podiatry; procurement and public consultation;

(b) NHS England South (South East) be requested to provide the following additional information to the next meeting of the Committee: key criteria for procurement and travel times for staff and frail, elderly and low income visitors;

(c) NHS England South (South East) be requested 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.

(g) The JHOSC meeting scheduled for 30 June was postponed at the request of the NHS England South (South East) and rearranged for 4 August.

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 process to date;

ii) Decide if any further information is require

iii) Refer any relevant comments to the Review Programme Board and request that they be taken into account;

iv) Invite NHS England South (South East) to present the final options to the Committee prior to public consultation.

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

Kent County Council (2016) '*Agenda,*
Kent and Medway NHS Joint Overview and Scrutiny Committee (29/04/2016)',
https://democracy.kent.gov.uk/mgAi.aspx?ID=37735

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Paper presented to:	Kent and Medway Joint Health Overview and Scrutiny Committee
Paper subject:	Briefing report; Kent and Medway Vascular services Review.
Date:	04.08.2016
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 brief the JHOSC on the progress of the Vascular review

Kent and Medway Vascular Services Review

1.0 Introduction

This is a briefing paper for the committee to update on the position since the JHOSC meeting in April 2016.

At the April committee the JHOSC supported the review proceeding to consultation on a network model with a single in patient centre in Kent and Medway, the site of this to be determined through the procurement process.

2.0 Procurement update:

The process has tested the market through a Prior Information Notice (PIN) and received interest from the three current providers. Subsequent work has determined that there is one suitable proposal and that is collaboration between East Kent Hospitals Foundation Trust and Medway Foundation Trust.

They have proposed an Integrated Vascular Network. The network solution will be developed on a model with a single arterial centre and a more diverse multi-site model for non-arterial centres..

The model reflects national best practice and a framework that can deliver both the National specification and a sustainable vascular service within Kent and Medway going forward.

Due diligence process will test the model and the ability of the collaboration to deliver the model of care for all Kent ad Medway residents. This will build on the key procurement requirements, the quality assurance standards of the Vascular Service national specification and the feedback of the public/patient and stakeholder feedback.

3.0 Development of the model.

EKHUFT and MFT are working together to identify the delivery model, clearly illustrating the pathways for patients across the network and the key interdependencies.

This includes clear transfer protocols, pathways that maximise the opportunities for local care, new ways of working across a network.

The Quality/Equality Impact Assessment will be used to inform the development of the model and mitigation put in place to address the negative impact areas. These relate to increased travel times and journeys for some communities in K&M.

A joint clinical lead and network manager will drive the collaboration forward.

This model will take into account the concerns raised by the public and patients re travel times, local access to the service and communication with patients and their families.

The model will be developed to reflect the key recommendations of the Clinical Senate report and in particular the critical clinical co-dependencies. The site of the in patient unit requires consideration within the context of the wider Kent and Medway STP.

4.0 Engagement update:

A series of engagement events is being planned through September and October where the collaborative model will be described and reviewed with key stakeholders. This includes vascular patients and their families and will be held across Kent and Medway.

This will build on the previous listening and deliberative events and those previously engaged will be a key part of this engagement work. The review has also identified a number of expert patients who will be actively involved in the due diligence process.

The review team has discussed progress on the Vascular change programme as part of the Strategic Change Stage 1 and 2 Assurance meeting with NHS England. The programme was not assured for Stage 2 on the basis that capital and other developmental costs had not been identified, and that the group did not feel that change of this nature merited specific formal public consultation. In particular the impact of the Kent and Medway STP on critical co-dependencies needs to be fully understood to in order to identify long term site options.

The wider STP public consultation is therefore a key consideration for the vascular Review and the NHS England assurance process recommendation is that consultation on the vascular service needs to be part of the wider STP public consultation. This will ensure that the public are fully sighted and informed of all of the potential changes and their interdependencies.

The September engagement events will provide a focus for pre-consultation engagement for the vascular community.

5.0 Next Steps:

The K&M collaborative network model is being developed and will be tested through the formal procurement due diligence process.

The engagement events will inform both the model and the due diligence process.

The Vascular Review will align to the process of the Kent and Medway STP over the coming months as this detail emerges.

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