KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 12th December, 2017

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 12th December, 2017, at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

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

Tea/Coffee will be available from 1:45 pm

Membership

Kent County Council	Mr M Angell, Mr A Bowles, Mrs S Chandler, Mr D Daley, Mr K Pugh, Mr M Whiting and Vacancy (Conservative) x 2
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 Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee are asked to note the membership listed above.	
2.	Election of Chair	
3.	Election of Vice-Chair	
4.	Minutes (Pages 5 - 12)	
5.	Kent and Medway Hyper Acute and Acute Stroke Services Review (Pages 13 - 42)	14:05
6.	Kent and Medway Specialist Vascular Services Review (Pages 43 - 56)	14:45

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*

John Lynch
Head of Democratic Services
03000 410466

4 December 2017

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 Monday, 28 November 2016.

PRESENT: Mr M J Angell, Mr H Birkby, Mr D L Brazier, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Mr G Lymer, Cllr T Murray, Cllr W Purdy, Cllr D Royle and Cllr D Wildey

IN ATTENDANCE: Dr A Duggal (Deputy Director of Public Health), Ms L Adam (Scrutiny Research Officer), Dr A Burnett and Mr J Pitt

UNRESTRICTED ITEMS

21. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 4 August are correctly recorded and that they be signed by the Chairman.

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

Oena Windibank (Programme Director, Kent & Medway Vascular and Stroke Services Reviews), James Thallon (Medical Director, NHS England South and Senior Responsible Officer, Kent & Medway Vascular Review), Rachel Jones (Director of Strategy, East Kent Hospitals University Foundation NHS Trust), Noel Wilson (Vascular Services Clinical Lead and Consultant Surgeon, East Kent Hospitals University Foundation NHS Trust and Clinical Lead for the Kent & Medway Vascular Network), Ben Stevens (Director of Clinical Operations, Co-ordinated Surgical Directorate, Medway Foundation Trust) and Anil Madhven (Interventional Radiologist Consultant, Medway Foundation Trust and Deputy Clinical Lead, Kent & Medway Vascular Network) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Thallon began providing an update to the Committee about the Vascular Services Review; he explained that East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Group (MFT) had established a Network to deliver vascular services jointly in East and Mid Kent. He noted that the Committee had requested NHS England to present an update on the engagement events; he explained that these had been delayed until the early next year.

(2) Following a change of membership at the previous meeting, the Chairman asked for a description of vascular services. Dr Wilson explained that vascular diseases related to disorders of the arteries and veins but excluded the heart and cardiothoracic diseases. He stated that vascular services included

interventions to remove interruptions to arterial blood supply in the limbs, neck and abdomen to prevent stroke and repair aneurisms. He noted that aneurisms particularly affected men and common vein conditions included varicose veins and ulceration.

(3) Dr Wilson stated that he was the Vascular Services Clinical Lead and Consultant Surgeon at EKHUFT and was the lead for the Kent & Medway Vascular Screening Programme which screened 11,000 – 12,000 men a year for Abdominal Aortic Aneurysm. He also worked with Public Health England to peer review vascular services across the country and was currently working with NICE to review the vascular guidelines. He explained that resulting from the vascular services review in Kent and Medway, a collaboration between EKHUFT and MFT had developed the Kent & Medway Vascular Network. He noted that the pathway to London for specialist tertiary treatment would continue. He reported that a Network Board had been established, by the Chief Executives of the two Trusts, to move the service forward; Dr Wilson had been appointed as the Clinical Lead and Dr Madhven had been appointed as the Deputy Clinical Lead. He explained that the Network Board was working to develop and build the best service for patients and their families and was very optimistic about its future. He stated that he attended a patient and family engagement event which had given him a greater understanding of patients and their families' priorities for vascular services.

(4) Dr Madhven explained that he was an Interventional Radiologist Consultant at MFT and provided minimally invasive specialist procedures for vascular patients. He highlighted that, although he was not a vascular surgeon, he provided specialist treatment to compliment the work of vascular surgeons. He noted that both Trusts recognised the importance of different specialities working together to provide vascular services. He reported that he been appointed to the role of Deputy Clinical Lead to the Network Board last month and had attended one Board meeting. He stated that he was responsible for identifying and implementing the clinical governance structure for the Network. He stated that he was keen for the Network Board to move forward and develop an improved and safe service.

(5) Dr Thallon introduced Ms Jones and Mr Stevens as the executive leads from both Trusts. Ms Jones stated that alongside the clinical model, the clinically-led business case was being developed which incorporated finance, activity and demand; the impact on patients and their family would also be included following the planned engagement events. Mr Stevens added that the primary purpose of the Network was to provide effective and sustainable vascular services.

(6) The Chairman enquired about the impact of the Sustainability and Transformation Plan (STP) on the review. Dr Thallon explained that the review was started before the STP process with the aim of creating excellent outcomes for patients and sustainability of the service following Vascular Society guidance. He stated that the both Trusts recognised that actions were required to improve the service. He reported that although the review could exist independently outside of the STP process, it was fully integrated into the process and did not need to adapt itself to support the STP. He stated that there was an argument for joint public consultation on the Vascular Review

and elements of the STP to enable those elements to be fully articulated and not cloaked by other high profile choices.

(7) Members of the Committee then proceeded to ask a series of questions and make a number of comments. In response to a specific question about the impact of South East Coast Ambulance NHS Foundation Trust (SECAmb) being placed into quality special measures, Dr Thallon acknowledged that SECAmb was facing temporary operational difficulties but stated that by the time the proposed services were operationalised, it was hoped that SECAmb would have resolved these. He stated that the review had a good working relationship with SECAmb and was working closely with them as pathways and models of care were being developed.

(8) A number of comments were made about workforce. Dr Thallon explained that in order to be competitive, integrated fit for purpose facilities were required to attract staff. Dr Wilson noted that vascular services had been radically changed following the General Medical Council's decision to make it a specialist service. He stated that the majority of vascular services across the country had been centralised and Kent and Medway was lagging behind. He stated that he was optimistic that the model with all care being provided locally, with complex cases being provided as part of a single centralised hub, would attract and strengthen the vascular workforce. He explained that the workforce model and skills required with being reviewed; it was proposed that allied and non-medical staffing, such as nurse practitioners, would help to support consultant-delivered care. He stressed the importance of junior doctors being trained rather than be responsible for the delivery of care.

(9) In response to a question about finance, Dr Thallon stated that the aim of the review was about reducing the amount of vascular activity. He acknowledged that there would be a capital cost attached to modernising the service and it was recognised by NHS England that capital was in short supply. He noted that the STP was looking at capital requirements for the whole system and the vascular services review was looking at an element of that. He stated that the next step was for the development of business case which would include the cost of the collaborative service. He suggested that the next update to the Committee should include the presentation of the business case and the feedback from the engagement events with the timing dependent on purdah. Ms Windibank noted that the engagement events were scheduled to be held at the end of February and the feedback would be incorporated into the business case.

(10) Members enquired about the sustainability of the proposed model of care and centralisation. Dr Wilson explained that he had been appointed as a vascular surgeon in 1995 and his passion had been to develop better care and services since then. He acknowledged that previous reviews had not got the model right and this review provided the opportunity to implement the best model of care which had been successfully implemented and delivered across the country. He stated that the greatest success of the review had been the development of the collaborative Network to implement and deliver the new model of care. In regards to centralisation, Dr Thallon explained that care would be localised as much as possible and only complex care would be centralised. He stated that there was a good evidence base which showed that centralisation improved the outcomes for patients but this needed to be

balanced against the patients' access to their families. Mr Stevens stated that the engagement events would focus on the families to ensure that their needs and concerns were included as part of the business case.

(11) RESOLVED that NHS England South (South East) and the Kent & Medway Vascular Clinical Network Board be requested:

(a) to note the comments about workforce, finance and sustainability;

(b) to present an update to the Committee following the engagement events and the development of the business case.

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

Oena Windibank (Programme Director, Kent & Medway Vascular and Stroke Services Reviews), Patricia Davies (Accountable Officer, NHS Dartford Gravesham and Swanley CCG and NHS Swale CCG and Senior Responsible Officer, Kent & Medway Stroke Review) and Lorraine Denoris (Public Affairs and Strategic Communications Adviser, NHS Dartford, Gravesham and Swanley CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Davies began by outlining the review. She stated that the review began 18 months ago with the formation of the Stroke Review Programme Board to develop a new model of care which would meet the national standards; the Board was made up of representatives from the eight Kent & Medway CCGs, the Stroke Association, clinical experts and patient representatives. She noted that the process was overseen by Professor Tony Rudd, the National Clinical Lead for Stroke. She explained that since the last JHOSC, the clinical data had been reviewed again and a series of engagement events were held which JHOSC members were invited too; the feedback from patients at these events was that patients felt cared for but recognised that the current model was not meeting national standards. She noted at the last Stroke Review Programme Board on 24 November, a three site option was agreed to be the optimum model for stroke services as detailed in the supplementary paper. She stressed that the locations of the three sites had not been determined and would depend on the output from the Kent & Medway Sustainability and Transformation Plan (STP) as a number of other services needed to be collocated on the site including a major A&E and trauma units. She stated that the original 27 configurations had been reduced to nine and each of those configurations met the 45 minute travel time and 120 minute call to needle standard.

(2) Ms Windibank stated that the feedback from the recent engagement events, about workforce, travel time and rehabilitation, was similar to previous events and would be used to inform and influence detailed modelling. She noted that an initial gap analysis on the out of hospital pathway had been undertaken and services were variable across the county; a more detailed analysis would be carried out. She explained that a wider clinical and stakeholder engagement event was planned for early 2017 which would be used to test and validate a three site option. Ms Denoris highlighted that the recent engagement events

brought together patients, carers, stroke survivors alongside clinicians to look at the emerging options, challenges and solutions.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A number of comments were made about rehabilitation services. Ms Davies acknowledged that community rehabilitation services were variable in Kent & Medway and there was no definitive specialist rehabilitation service for stroke which was recognised by clinicians at the recent Review Programme Board. She highlighted that a specialist stroke rehabilitation pathway was being developed as part of the modelling for a three site option and would include consideration about how those stroke services would link to general rehabilitation as part of a patient's recovery. She noted that there were good general rehabilitation services across Kent & Medway and it was for the STP and CCGs to develop rehabilitation services as part of their plans for local care. Ms Windibank noted that robust early supported discharge enabled patients to recover more quickly at home but also improved the quality of care provided to stroke patients who required a longer length of stay; there elements of early supported discharge in the county but it depended on workforce availability. Ms Davies reported that rehabilitation would become an integral part of the next phase of the review by the Stroke Review Programme Board. She noted that there was not a blueprint for stroke rehabilitation services and as part of the next phase there would be consideration of the workforce requirements to provide community and home based rehabilitation services. She also noted that there had been resounding feedback from stroke survivors and their carers about the provision of psychological services throughout a patient's recovery, to enable stroke survivors to become independent and adapt to a change of lifestyle. She stated that psychological services would be included in the next phase of the review. She highlighted the experiences of a student who survived a stroke at the age of 19 and had initially struggled to move forward with her life post stroke. Ms Windibank reported that Dr Hargroves was leading on a piece of work with the cardiovascular network to look at best practice for rehabilitation which included the establishment of multidisciplinary teams. She noted that national recommendations on good stroke rehabilitation services were expected and would feed into the second phase of the review.

(4) In response to a specific question about financial optimisation, Ms Windibank highlighted that in addition to the tariff received by the Trust for the provision of stroke services to a patient, additional remuneration was available through a best practice tariff if patients were assessed quickly by a specialist team in a specialist unit. She noted that across Kent and Medway Trusts were struggling to achieve the best practice tariff and the remodelling of stroke services would put the Trusts in a better position to achieve the tariff.

(5) A Member enquired about collaboration with social services and the capital funding required for modernising the service. Ms Davies noted that social services were an important part of the discharge process and recognised that they were under enormous pressure. She stated there were also constraints on the health budget but there were opportunities through the STP for stroke service providers to utilise resources more efficiently by working collaboratively and reducing waste as recommended by the Carter Review and achieving the best practice tariff. She reported that there was phenomenal demographic growth in Kent and Medway and that the funding allocations did

not take this into account. She explained that CCGs' allocations were based on patients registering with GP practices which took two – three years to flow into the system. She stated that although this would not prevent the redesign of services to meet the needs of the local populations, this created a huge challenge for the health service coupled with the extreme pressures on social care. She stated that central funding for Kent and Medway needed to be reconsidered.

(6) A Member asked about the provision of local care and the workforce gap with a three site option. Ms Davies stated that there was a balance between specialist treatment and care close to home. She highlighted that travel times for patients and careers had been raised as an issue as part of the engagement events and the aim was to keep travel to a minimum. However she recognised the importance of a patient being seen quickly in a centre of excellence which provided high quality treatment would reduce the incidences of death and the impact of disability. She also stated that centre of excellences would provide better training, mentoring and development opportunities which would attract workforce; the current demand on workforce was unprecedented. She noted Kent and Medway lacked well recognised health and social care training facilities and it was the only county which did not have its own medical school, which had been proposed as part of the STP. She stated that there were opportunities to create links with the London Teaching Hospitals. She explained that reduction from seven to three sites would be phased to ensure the workforce was in place.

(7) A number of Members gave positive feedback about the engagement events which they had attended as observers. A comment was made about the number of attendees at the events and a question was asked about engagement with vulnerable groups, Ms Denoris explained that 200 invitations were sent out the recent engagement events and 69 people attended. There had been a deliberate decision to only invite people who had been engaged in the process so far so as not to repeat the previous engagement work. As part of the formal public consultation, an expanded invitation would be used alongside a range of tools and techniques to engage with the public. Ms Windibank stated that she had gone and met with vulnerable groups as part of the engagement process and at risk groups were considered as part of the equality impact assessment. Clinical evidence had found that the proposed consolidation would lead to improved outcomes for everyone including at risk groups but economics and travel times must be a key factor when considering the location of sites.

(8) Members enquired about the impact of PFI in determining site location and learning from best practice. Ms Davies noted that there was no pressure to locate a stroke unit at a PFI hospital site; the locations would be determined on the availability of co-dependent services at the site, travel times and the areas which had the highest prevalence of stroke now and in the future. She stressed that no decisions had been made about the location of the three sites. Ms Windibank explained that learning from best practice in the acute setting and rehabilitation was being undertaken by clinicians including visits to a range of site. It was recognised from these visits that there were areas of good practice being undertaken in Kent and Medway but it was not consistent.

(9) A Member asked about the maximisation of staff time and engagement with staff. Ms Windibank reported that the volume of patients would increase with a reduction in to three sites therefore maximising specialist staffing time. She noted that rotas would reflect quieter periods. She stated that as part of the engagement with staff, there had been conversations with staff about who did and did not want to move; it was hoped that the clinical event, planned for early 2017, would help to better understand staff's concerns and how they can be supported to move. She noted that the feedback from the majority of staff is that they did not feel like they were doing a good job or delivering a good service; there is recognition amongst staff that reducing the number of sites would improve that position.

(10) A Member commented about a stroke group they had attended in Medway and found the stroke survivors were more concerned about the provision of the services to meet their needs, particularly group rehabilitation, than the number of sites.

(11) The Chairman invited Public Health representatives from Kent County Council and Medway Council to comment. Dr Duggal stated that as part of the STP discussions, prevention needed to be at the start of the pathway for stroke and cardiovascular diseases; initiatives such as smoke free hospitals would assist with the prevention agenda. Dr Burnett added that prevention did make a difference and gave the example of Sweden which had the lowest smoking rates in Europe. In achieving low smoking rates, it had significantly reduced the number of abdominal aortic aneurysm and the country's screening programme now only screened smokers. He stated the industrialisation of prevention was an important component in reducing the demand for services and helping patients from deteriorating further.

(12) RESOLVED that the Kent and Medway Stroke Review Programme Board be requested:

(a) to note the comments about rehabilitation services, workforce and finance;

(b) to present the final recommendations for consultation to the Committee, as agreed by the Kent and Medway CCGs, prior to the start of public consultation.

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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, 12 December 2017

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

(1) 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.

(2) 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.*

(3) 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.

(4) 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.

(5) 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 Committee and/or the Medway Council Health and Adult Social Care Overview and Scrutiny Committee to make rather than the JHOSC.

(6) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was therefore convened and has met on 8 January, 29 April, 4 August and 28 November 2016 for the purpose of the consultation on the Kent and Medway Hyper Acute and Acute Stroke Services Review. On 28 November 2016 the Committee's deliberations resulted in the following agreement:

- *RESOLVED that the Kent and Medway Stroke Review Programme Board be requested:*

  (a) to note the comments about rehabilitation services, workforce and finance;

  (b) to present the final recommendations for consultation to the Committee, as agreed by the Kent and Medway CCGs, prior to the start of public consultation.

(7) A meeting to update the Chair and Vice-Chair was held on 31 August 2017 followed by an informal JHOSC briefing on 3 November 2017. The Chair attended the Stroke Evaluation Workshops on 30 August and 20 September as an observer.

(8) On 29 November and 30 November 2017 Bexley Council's People Overview and Scrutiny Committee and East Sussex County Council's Health Overview and Scrutiny Committee considered the Kent and Medway Hyper Acute and Acute Stroke Services Review as a number

of their residents access stroke services in Kent and Medway. Both Committees determined that the proposals were likely to be a substantial variation for their areas and requested that arrangements were made to establish a new JHOSC comprising of members from Kent County Council, Medway Council, East Sussex County Council and Bexley Council. The Terms of Reference and membership of the new JHOSC will be subject to agreement by the full councils of Kent County Council and Medway Council.

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 progress to date;

ii) Refer any relevant comments to the Joint CCG Committee and request that they be taken into account;

iii) Invite Joint CCG Committee to present the final options and consultation plan to the Committee prior to the start of public consultation.

Background Documents

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

Medway Council (2015) '*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) '*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) '*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

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (04/08/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=7405&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (28/11/2016)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=42592

Contact Details

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Transforming health and social care in Kent and Medway

Kent and Medway Sustainability and Transformation Partnership

Kent and Medway Joint Health Overview and Scrutiny Committee

12 December 2017

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Agenda
JHOSC presentation 12 December 2017

- Welcome and introductions
- Overview of the Stroke Review
- Governance
- Progress to date
- Independent Impact Assessment (IIA)
- Communication and engagement
- Implementation
- Vascular services
- AOB

Objectives

The Kent and Medway JHOSC is asked to:

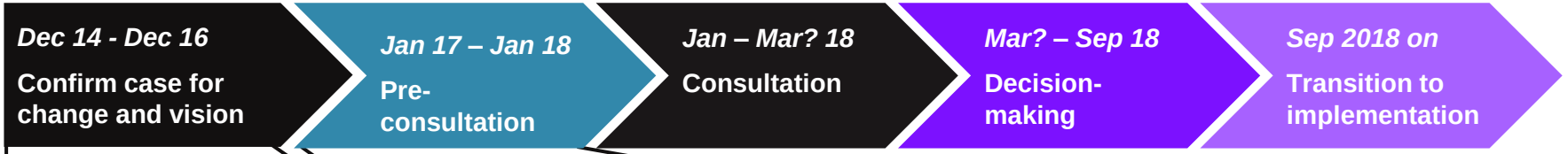
Stroke:

1. Provide support to the public consultation;
2. Advise on duration of the public consultation;
3. Discuss and agree how the members and colleagues can support the consultation process.

Background context

- The eight clinical commissioning groups (CCGs) in Kent and Medway (plus CCGs outside Kent & Medway whose populations use stroke services in Kent & Medway) have been working together on the stroke review since late 2014
- The review is being led by a Stroke Programme Board comprised of commissioners, providers and patient representatives from across Kent and Medway and a representative of the Stroke Association
- It is supported by a Clinical Reference Group which provides clinical leadership and input to the Stroke Review, a Public and Patient Advisory Group (PPAG) which provides a patient perspective and a Finance Group which provides financial leadership and strategic advice
- The review has developed a set of proposals covering the case for change for stroke services, the model of care and options for service deliver
- through a series of major stakeholder events, meetings, focus groups, online surveys, newsletters and other channels, the thinking has been tested with clinicians, patient groups, the public, provider organisations, local authorities, and MPs, to gather feedback and act on it as proposals have been developed
- Although hospital staff in Kent and Medway provide the best service they can, the way stroke services are set up currently, along with staff shortages, mean local hospitals do not consistently meet the national standards for clinical quality
- The ambition of the stroke review is to deliver clinically sustainable, high quality stroke services that are accessible to Kent and Medway residents 24 hours a day, seven days a week
- To deliver this ambition, and following detailed engagement with stroke survivors, their families, the public, stroke doctors and nurses and other key stakeholders since 2014, CCGs are proposing the creation of specialist hyper acute and acute stroke units in Kent and Medway

Overview of work to date and high level timeline



During this phase, the Stroke Review:

- ✓ Established governance
- ✓ Published case for change (July 2015)
- ✓ Agreed vision for stroke care in Kent and Medway
- ✓ Developed the benefits framework
- ✓ Undertook pre-consultation stakeholder engagement with clinicians, commissioners, providers, patients and other local stakeholders
- ✓ Developed a draft business case proposing a 3 site HASU configuration

During this phase, the Stroke Review:

- ✓ Further developed the acute stroke clinical model
- ✓ Developed and assessed options against agreed hurdle criteria to create a medium list of site specific options
- ✓ Developed and evaluated the medium list of options against agreed evaluation criteria
- ✓ Conducted sensitivity analysis to support identification of a shortlist of options
- ✓ Developed the Pre-Consultation Business Case (PCBC)
- ✓ Continued engagement with the full range of stakeholders, including numerous stakeholder events to inform the work of the programme
- ✓ Carried out an equalities impact assessment
- ✓ Planned the public consultation and developed consultation documents

Overview of the Stroke Review

In Kent and Medway there are four acute trusts providing stroke services. Six hospital sites currently provide stroke care following the temporary cessation of services at Kent and Canterbury

Currently no sites have a hyper acute stroke unit (HASU)

Source: Kent & Medway Case for Change (2017)

Overview of the Stroke Review

The Case for Change identified the key issues with the current service provision for stroke across Kent and Medway.

- **No hospitals** provide 7 day (twice daily) consultant ward rounds
- Recommended patient volumes should fall between 500 and 1,500 confirmed stroke admissions per year but patient volumes in all but one acute hospital are **below the 500 patient threshold**
- In two Kent and Medway hospitals, **fewer than 50% of patients receive thrombolysis within 60 mins** and overall all Kent and Medway hospitals are below the national average
- Generally **< 50% of all patients are being admitted within 4 hours** and performance is below national average
- Improvements in acute stroke service provision have been difficult to sustain

Source: Kent & Medway Case for Change (2017)

Overview of the Stroke Review

To improve the quality of stroke service provision, a future delivery model for stroke has been designed based on best practice and with strong clinical support

This includes:

- Seven day specialist consultant-led stroke service;
- Three combined Hyper Acute Stroke Units (HASUs) and Acute Stroke Units (ASUs) to leverage workforce consolidation;
- Early Supported Discharge available for min 50% of patients;
- Improved rehabilitation services;
- Potential development of a mechanical thrombectomy centre;
- Co-location of services with desirable co-adjacencies to improve patient outcomes and support staff.

SOURCE: Kent & Medway Review of Stroke Services (2015 /2016); The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014]; Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

Overview of the Stroke Review

This acute delivery model will be supplemented by additional work on the rest of the stroke pathway, including rehab.

The Kent and Medway stroke review has focussed on the **acute** part of the stroke pathway.

It is recognise that rehabilitation (including ESD) is a crucial part of the overall model.

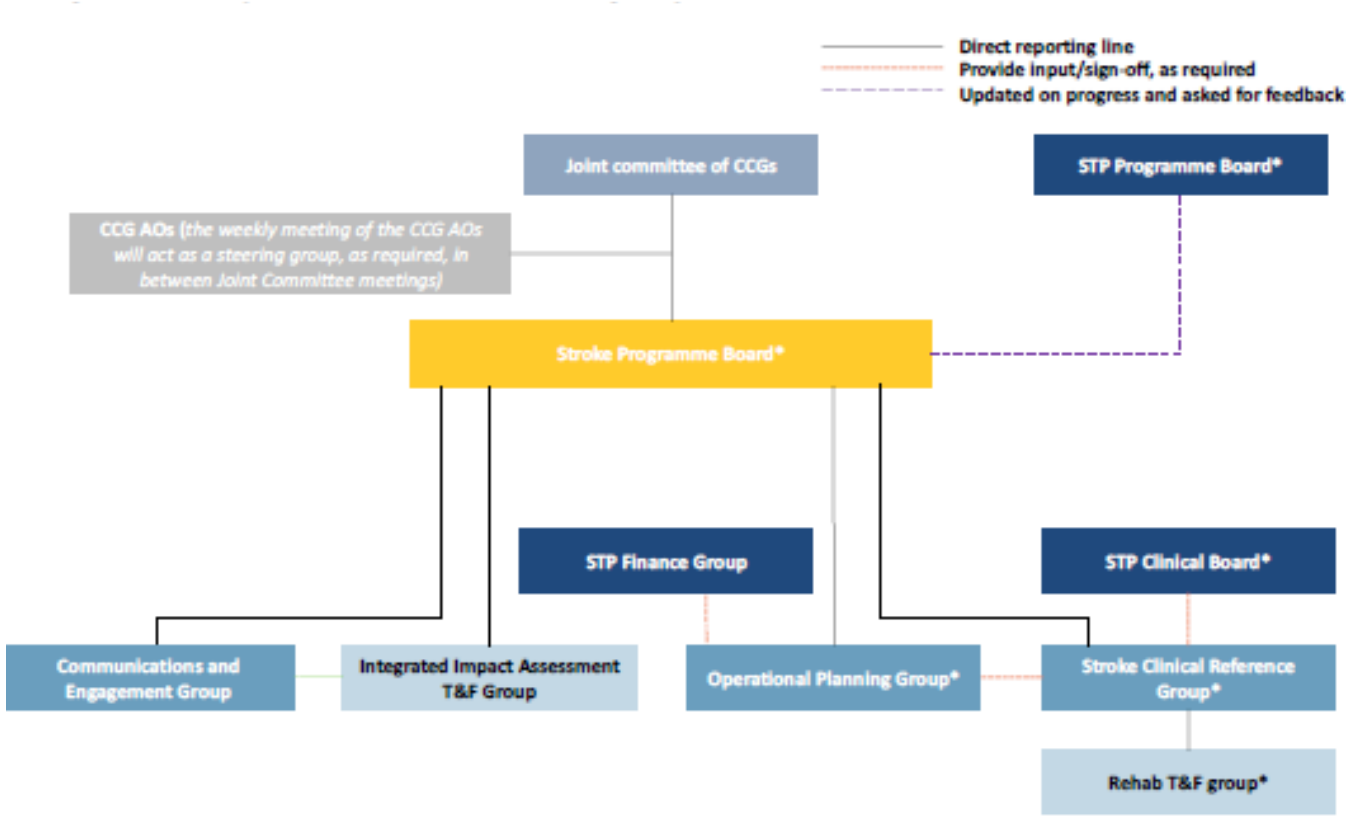
Work to develop proposed service models has been undertaken by the Clinical Reference Group:

This includes:

- Rehabilitation;
- Pathway for TIAs;
- Pathway for stroke mimics;
- Thrombectomy pathway;
- Pathway for inpatients who have a stroke in a hospital without a stroke unit.

SOURCE: Kent & Medway Review of Stroke Services (2015 /2016); The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014]; Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

New Stroke Review governance structure



*Membership includes clinical and provider representatives

1

Key points:

- Stroke Programme Board will oversee the Stroke Review and make recommendations directly to the Joint Committee of CCGs.
- There will be four streams of work reporting into the Stroke Programme Board; operational, clinical, communications and integrated impact assessment.
- The STP Finance Group and STP Clinical Board will continue to advise
- The Stroke Programme Board will share material with the STP Programme Board

The Joint Committee enables CCG members to work effectively together, collaborate and take joint decisions about stroke

The role of the Joint Committee is to:

- Consider and approve a collective strategy and associated commissioning intentions for hyper-acute and acute services across Kent and Medway, enabling the delivery of high-quality, sustainable and financially viable clinical services. This will include determining the service delivery model and locations from which services will be provided
- Ensure effective public and stakeholder engagement and involvement, including formal consultation as required, has taken place to enable informed and legally compliant decision making
- Oversee the implementation of the approved service delivery model and any associated reconfiguration of services
- Ensure representation and contribution to national, regional or other relevant Alliances and Networks, including clinical networks, as appropriate
- Work with the Kent and Medway STP Board to ensure any decisions made by the JC are informed by the complement wider strategic planning

Joint Committee terms of reference

Current membership (1/2)

Name	Organisation	Role	Voting member?
Mike Gill	Independent Joint Committee Chair		No
Dr Mark Davies	NHS Ashford CCG	Clinical Lead (GP)	Yes
Dr Navin Kumta	NHS Ashford CCG	CCG Clinical Chair (GP)	Yes
Simon Perks	NHS Ashford CCG	AO	No
Dr Sid Deshmukh	NHS Bexley CCG	Clinical Chair (GP)	Yes
Dr Ethan Harris-Faulkner	NHS Bexley CCG	GP	Yes
Dr Nikita Kanani	NHS Bexley CCG	Clinical AO	No
Dr Chris Healy	NHS Canterbury and Coastal CCG	Governing Body member (GP)	Yes
Dr Simon Dunn	NHS Canterbury and Coastal CCG	Clinical Chair	Yes
Dr Sarah Macdermott	NHS Dartford, Garvesham and Swanley CCG	Deputy Clinical Chair (GP)	Yes
Dr Mike Beckett	NHS Dartford, Garvesham and Swanley CCG	Secondary Care Ind Member	Yes
Patricia Davies	NHS Dartford, Garvesham and Swanley CCG	AO and Stroke Review SRO	No
Ian Ayres	NHS West Kent CCG	AO	No
Michael Ridegwell	Kent and Medway STP	Programme Director	No
Glenn Douglas	Kent and Medway STP	Chief Executive	No
Steph Hood	Hood and Wolf	STP communications and engagement lead	No
Julia Nason	Kent and Medway STP	PMO	No

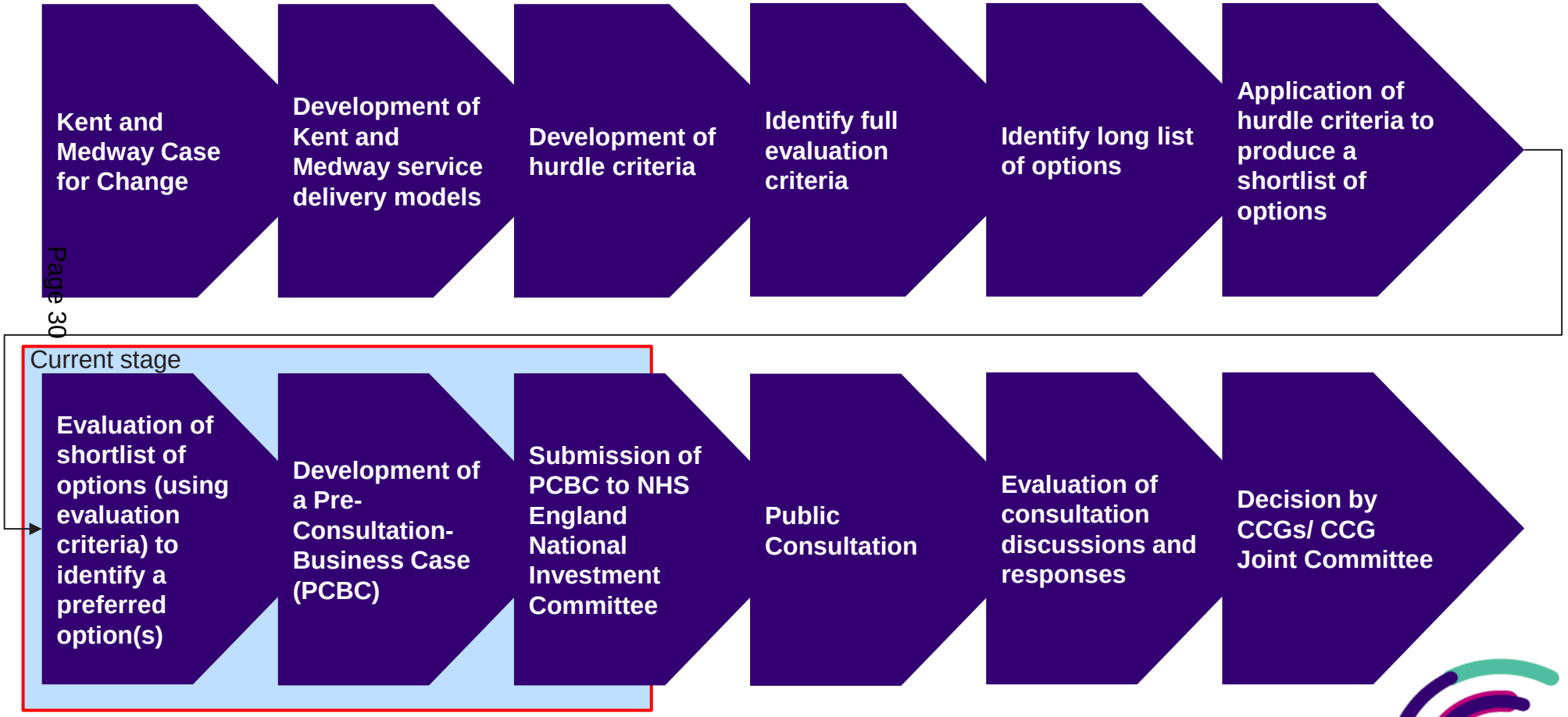
Joint Committee terms of reference

Current membership (2/2)

Name	Organisation	Role	Voting?
Dr Peter Birtles	NHS High Wealds, Lewes, Havens CCG	GP	Yes
David Roche	NHS High Wealds, Lewes, Havens CCG	GP	Yes
Ashley Scarff	NHS High Wealds, Lewes, Havens CCG	COO	No
Dr Peter Green	NHS Medway CCG	Clinical Chair	Yes
Dr Satvinder Lall	NHS Medway CCG	GP	Yes
Caroline Selkirk	NHS Medway CCG	AO	No
Dr Jonathan Bryant	NHS South Kent Coast CCG	Clinical Chair	Yes
Dr Qasim Mahmood	NHS South Kent Coast CCG	Governing Body member (GP)	Yes
Hazel Smith	NHS South Kent Coast CCG	AO	No
Dr Fiona Armstrong	NHS Swale Clinical CCG	Clinical Chair	Yes
Dr Mick Cantor	NHS Swale Clinical CCG	Governing Body member (GP)	Yes
Dr Tony Martin	NHS Thanet CCG	Clinical Chair	Yes
Dr John Neden	NHS Thanet CCG	Governing Body member (GP)	Yes
Dr Bob Bowes	NHS West Kent CCG	Clinical Chair	Yes
Dr Andrew Roxburgh	NHS West Kent CCG	GP	Yes
James Thallon	NHS England	Medical Director	No
Ivor Duffy	NHS England	Director of Performance	No
Jackie Huddleston	NHS England	Associate Director South East Clinical Networks	No
Oena Windibank	NHS Thanet CCG	Programme Director	No
Steve Inett	Kent and Medway Healthwatch	Chief Executive	No

Public consultation

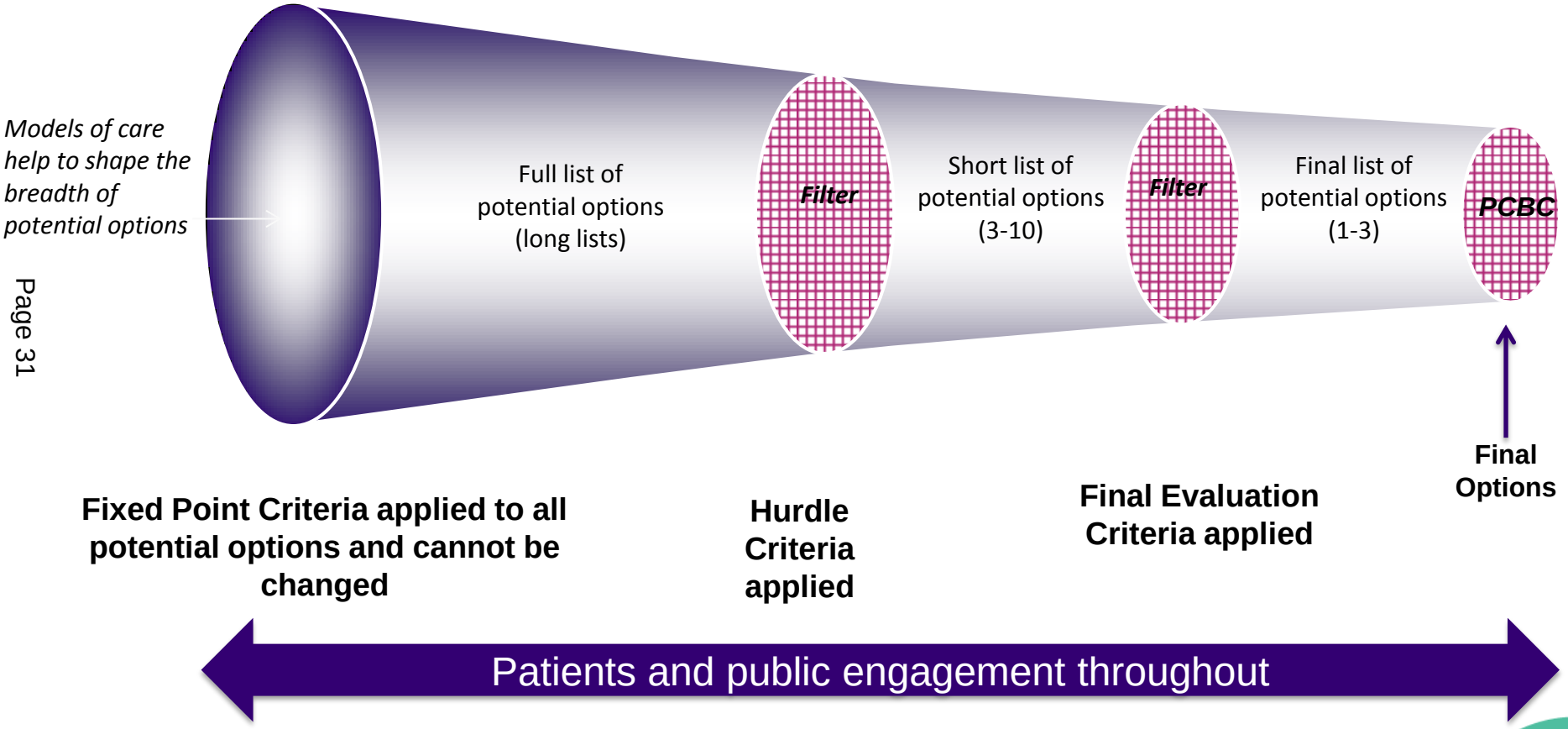
In moving to public consultation, we are following a process that covers a number of stages



NB - This stage involves multiple stakeholder reviews as part of the agreed evaluation process

How a decision is made

We have been through an extensive evaluation process, with engagement along the way, to narrow down the list of options for service change.



Progress to date

The medium list of options have been evaluated against the following five criteria: Quality, Access, Ability to deliver and Affordability

Criteria		Sub-criteria
1	Quality of care for all	• Clinical effectiveness and responsiveness • Safety • Patient experience
2	Access to care for all	• Distance and time to access services • Service operating hours
3	Workforce	• Scale of impact • Sustainability • Impact on local workforce
4	Ability to deliver	• Expected time to deliver • Co-dependencies with other strategies • Trust ability to deliver
5	Affordability and value for money	• Revenue costs • Capital costs • Transition costs • Net present value

Review of draft Independent Impact Assessment (IIA)

The aim of an integrated impact assessment (IIA) is to explore the potential positive and negative consequences of Kent and Medway STP proposals to transform healthcare in Kent and Medway

The proposals were assessed against their impact (both positive and negative) on Health, Travel and Access, Equality and Sustainability.

The key **positive** impacts identified were:

- Improvement to patient outcomes and removal of the variation currently experienced
- The ability to achieve recommended workforce standards
- Patients identified as having a disproportionate need for stroke services are likely to use these services more and, therefore, experience the benefits of improved health outcomes to a greater extent.
- Improvement in rehabilitation services for stroke patients, supporting patients to regain their independence and overall quality of life

The key **negative** impacts identified were:

- A risk that capacity could become constrained within these units due the consolidation of stroke services
- Longer ambulance journeys for some patients required to be conveyed to a HASU will negatively impact the capacity of the ambulance service
- The reconfiguration of stroke services is considered to bring logistical challenges for some staff, which could result in increased staff turnover and the loss of current expertise
- Across all of the proposed shortlisted options there is a reduction in accessibility within 30 minutes by blue light ambulance for patients currently accessing stroke service
- Increased journey times or the need to make different and/or unfamiliar journeys to access care, is likely to affect some equality groups more than the general population.

A detailed list of potential ways in which to enhance opportunities and to mitigate or reduce the effect of the potential negative impacts identified in the equality impact assessment ***has been developed against the key impacts identified.***

Kent and Medway STP engagement

- Case for Change published March 2017
- Listening events and engagement activity has taken place across the county throughout the Stroke Review
- In spring and summer 2017 we engaged around the case for change and evaluation criteria
- Feedback from the summer listening events, stroke and vascular focus groups and online surveys independently analysed
- Feedback from stroke focus groups fed back to board
- The latest STP engagement/research report brings together feedback from all engagement activity this summer, published on STP website www.kentandmedway.nhs.uk

Overview of pre-2017 stroke engagement

- 1000s of people have engaged in stroke review since late 2014 including: stroke survivors/ their families and carers/ members of the public/ clinicians/ key stakeholders including CCGs, providers from Kent, Medway, and across the borders in Sussex, Surrey and south London.
  They have provided a valuable challenge throughout the review.
  Views have been fed into the decision-making process.

- Variety of engagement channels have been used including surveys, focus groups, listening events, roadshows, face to face meetings

- We have used a variety of channels to communicate including e newsletters, printed magazines, emails, media, social media, websites

- All engagement work has been logged and evidenced and is detailed as an appendix to the Stroke Review Pre Consultation Business Case.

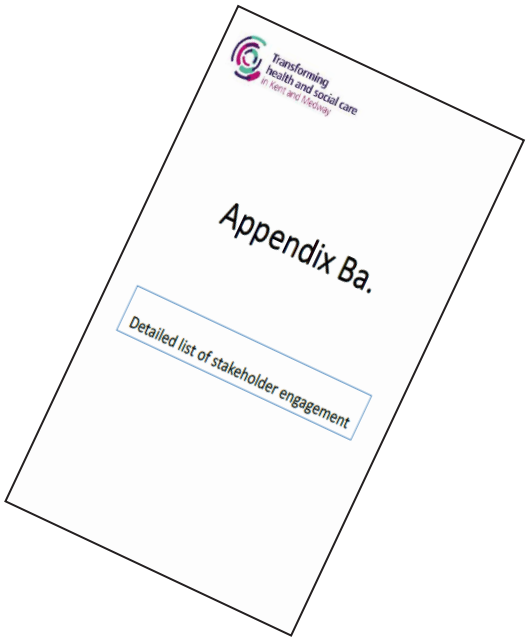
2017 STP engagement activity

1	**Feb - August**	**East and West Kent**: 12 listening events with approx. 70 people at each
2	**Feb -August**	**East, West Kent, Dartford, Gravesham and Swanley, and Swale:** Summer roadshow across area at supermarkets, health centres, Gateways – talking about STP, urgent care, evaluation criteria and stroke
3	**July - August**	**Swale and Medway**: 3 events on urgent care and local care
4	**July - August**	**Evaluation criteria**: online survey and face to face engagement with public and staff
5	**August**	**Vascular:** 2 focus groups held in Ashford and Medway to test the evaluation criteria
6	**August-Sept**	**Stroke:** 8 focus groups (K&M), online survey and stakeholder event to test the evaluation criteria
7	**August-Sept**	**Seldom heard voices**: 15 outreach groups with hard to reach and protected characteristic groups
8	**August-Sept**	**Integrated Impact Assessment:** 10 focus groups in Kent and Medway
9	**Sept-October**	**Dartford, Gravesham and Swanley**: 2 events on urgent care and local care

PCBC: stakeholder engagement in detail

- Appendix to Pre-Consultation Business Case details engagement to date
- 43 pages listing details of audience, the engagement, date, feedback

- Documented under:
  - case for change
  - hurdle criteria
  - evaluation criteria
  - options appraisal



Stroke communications and engagement: next steps

- More and ongoing engagement with clinicians
- Proactive communications about STP and stroke review – to audiences we've already engaged with, and beyond - staff/key stakeholders/public and informing them a consultation is planned for early in 2018
- Consultation plan – in development
- Launch of consultation – anticipated early 2018
- Consultation activities – to include publication and distribution of information, digital and hard copy questionnaire, public meetings and events, attendance at existing meetings and fora, discussions with staff, media and social media, outreach work with seldom heard and other targeted audiences
- Consultation analysis – independent

Consultation plan

- Overview and approach to our consultation activity including:
  - Consultation principles
  - Target reach: 1% of Kent and Medway population
  - Stakeholder map informing key audiences and distribution plans for consultation documents (digital and hard copy)
  - Accessible formats: summary and Easy Read/access to translation/Braille and audio copies on request
  - Supporting collateral eg: frequently asked questions, posters, adverts, newsletter content, website content, animation etc
  - Media and social media plan
  - Programme of face-to-face meetings and events activity
  - Programme of publicity to raise awareness and encourage responses.

Timeline to implementation

- Six to eight weeks to review consultation responses and prepare the decision making business case (DMBC)
- Approval of final option June/July 18
- Go-live 12 to 24 months post-end of consultation (dependent on degree of estates development that is required)
- Potential for phased implementation to be considered

See separate paper

Any Other Business

Item 6: Kent and Medway Specialist Vascular Services Review

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 12 December 2017

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

(1) 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.

(2) 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.*

(3) 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.

(4) 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.

(5) 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 Committee and/or the Medway Council Health and Adult Social Care Overview and Scrutiny Committee to make rather than the JHOSC.

(6) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was therefore convened and has met on 8 January, 29 April, 4 August and 28 November 2016 for the purpose of the consultation on the Kent and Medway Specialist Vascular Services Review. On 28 November 2016 the Committee's deliberations resulted in the following agreement:

- *RESOLVED that NHS England South (South East) and the Kent & Medway Vascular Clinical Network Board be requested:*

  (a) to note the comments about workforce, finance and sustainability;

  (b) to present an update to the Committee following the engagement events and the development of the business case.

(7) Engagement and listening events were held in February and August 2017 for this review; a number of JHOSC members attended these events as observers. A meeting to update the Chair and Vice-Chair was held on 31 August 2017.

2. Legal Implications

(1) 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

(1) 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) Refer any relevant comments to the Vascular Programme Board and request that they be taken into account.

Background Documents

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

Medway Council (2015) '*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) '*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) '*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

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (04/08/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=7405&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (28/11/2016)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=42591

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Paper presented to:	Kent and Medway Joint Health Overview and Scrutiny Committee meeting
Paper subject:	Update report on the Kent and Medway Vascular services Review
Date:	12th December 2017
Prepared by:	Oena Windibank, Programme Director, K&M Stroke Review, supported by the K&M Vascular network Board
Presented by;	Michael Ridgwell, K&M STP Programme Director
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 and executive summary

This paper updates the committee on progress of the current specialist Vascular services review. The scope of the review covers the range of services and standards within the national specification.

Specialist Vascular services are currently delivered on two acute sites, Kent and Canterbury Hospital (EKHUFT) in Canterbury and Medway Maritime Hospital in Gillingham. Neither unit is complaint with the national specification due to low consultant numbers, low total population served numbers and borderline levels of activity.

The non-compliance resulted in a commissioner led derogation; services allowed to continue with delivery whilst solutions are identified to ensure compliance with the specification. The Vascular review was established to determine the options available and recommendations for the future delivery of specialist Vascular services

The review process has worked with clinicians, the national Vascular Society and through public engagement to work up and identify the Case for Change, the Clinical model and the possible options.

A JHOSC was formed in September 2015 following presentation to the Kent HOSC and Medway HASC. Each Committee determined that the proposals amounted to a substantial development of or variation in the provision of health services in the local authority's area. JHOSC has received previous reports advising on the Case of Change, the options appraisal process and the public engagement undertaken.

The JHOSC has received previous reports advising on the Case of Change, the options appraisal process, the clinical model identified and the public engagement undertaken. There has been a lengthy period while the K&M Vascular network has developed the business case. During this time feedback to committee members has

been limited as the network has formed and the detail of the model has been worked through. An informal JOHSC committee meeting was held in August 2017 to advise the JOHSC of progress.

The Case for Change clearly demonstrates that the Do Nothing option is not sustainable. The options approval process considered a number of options and excluded Do nothing/status quo and an option of no in patient unit in Kent and Medway.

The review process has worked with clinicians, the national Vascular Society and members of the public (through extensive public engagement) to identify the case for change, define the clinical model and work up the possible options for the future of vascular surgery across Kent and Medway.

The findings of the review have concluded that in order to maintain a clinically sustainable specialist Vascular service in Kent and Medway a network approach is required, in line with best practice.

The network will deliver in patient vascular services through a single unit (Arterial centre) supported with diagnostics and outpatient services in spoke hospitals (non arterial centres) This model has been shared and developed with Vascular patients and carers including discussion on the site options.

A K&M Vascular network has been established between East Kent Hospital University Foundation Trust (EKHUFT) and Medway Maritime Foundation Trust (MMFT).

The K&M Vascular Network Board is finalising a business case for approval at the Vascular Programme Board and NHSE specialised commissioning. This will detail the final preferred site options for the Arterial and Non arterial centres and the transitional arrangements required.

Extensive engagement has taken place throughout the review with the public and specifically vascular patients and their families. This has informed the development of the Case for Change, the options appraisal process and the clinical model. A video is planned to describe the review process and the findings to the wider public once the final decision is reached

1.0 Summary of the Case for Change

The case for change has previously been shared with the JHOSC members and is publicly available on the NHS England website.

In summary, the case for change demonstrates the key components of the national specification and the national clinical recommended practice from the Vascular Society of Great Britain and Ireland. These make a clear evidence-based case for improving outcomes for patients. Delivery of the service specification criteria and the guidance

has demonstrated considerable improvement in patient outcomes and in particular in improving the mortality rates for abdominal aneurysm repair across the country.

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

Kent and Medway residents currently 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). GSTTH meets the national specification for vascular surgery, however neither EKHUFT nor MFT currently meet this.

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; and

4. Concerns relating to the specialist facilities available.

There are also sustainability concerns across the services due, in particular, to workforce (for example, the number of consultants required to run services on more than one site, throughput of acute cases and the ability to maintain surgeons' skills).

Whilst the outcome measures at EKHUFT and MFT are within the agreed acceptable levels, there is a considerable range of clinical outcomes across the two service providers i.e. from 1.6 to 4.0 for mortality rates for Abdominal Aneurysm repairs. GSTTH has an outcome score of 1.2 for mortality rates for AAA repair and meets all the national specification requirements

The Kent and Medway Vascular Review Case for Change made the following recommendations:

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

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

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

2.0 Options Appraisal for the clinical model

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.

"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 the benefits of a vascular centre of excellence as laid out by the national Association of Vascular Services".

The criteria used in the options appraisal are set within the National specification and the Vascular Society Provision of Vascular Services and 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; and
- 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 CRG undertook the initial appraisal of a long list of options and short-listed two possible clinical model options for further detailed analysis. The two options were;

Option 1 A network model with two inpatient centers and a number of spokes.

Option 2 A network model with one inpatient / emergency 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; and
- current activity and possible impact of future population growth.

The review considered travel times as part of the options appraisal, these together with travel distances / difficulties were an understandable concern for patients. Some perceived that travelling further for surgery would put patients at greater risk. Other patients noted the need to get to specialist care quickly and recognised that this may require the need to travel further.

There is no recommended criteria for travel times for vascular patients. This is an area of concern for the public and the review has followed the guidance from the Vascular Society;
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 neighbour, 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.

The key findings of the mapping showed that:

- 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 be over 60 minutes by ambulance from Tunbridge Wells, but this area has lower number of admissions than those around Thanet (n = 796).
- Re absolute numbers there are more emergency admissions for cardiovascular disease in the west of Kent reflecting the larger overall population. However the rate of admission is greater in the south and southeast probably reflecting the difference in epidemiological risk-factors, with a higher proportion of older people living in the east of Kent.
- A review of ambulance transfer times for vascular patients 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.

The options appraisal process also reviewed the core activity for 2013/14 and 2014/15. The appraisal is specifically focused on the inpatient flows and usage in EKHUFT and MFT. The review 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 were considered. The activity modeling demonstrated that there are insufficient population levels to generate the required minimum activity to meet the minimum standards set when delivered over two inpatient sites.

The review of workforce demonstrated that the two units currently find it very difficult to recruit staff and without significant changes this would remain so. Also, running a shared rota across two sites may leave patients unsupported in one of the units at certain periods thus creating an unacceptable clinical risk.

The CRG advised that option one was not viable and would not deliver the national clinical standards. They recommended to the Programme Board that option two was the only clinically acceptable option that should be considered further.

This model was tested with the public / vascular community through a deliberative event and two subsequent workshops.

Under option two, patients would still be able to use the pathway from Tunbridge Wells and Darent Valley hospitals into St.Thomas' hospital in London, supporting the requirement for patient choice. Patients would also continue to be able to have local care through their nearest general hospital for all outpatient 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 would be around 600 and of that figure around 300 are likely to have to travel further for their inpatient care.

The Abdominal Aneurysm screening programme would not be affected by the proposed changes.

3.0 Option Development and Clinical Delivery Model

Option two requires the delivery of a network model across a number of sites, but with a single inpatient centre. This reflects the national recommendation for best practice.

As previously reported to the JHOSC, the review programme board agreed to assess and develop the network model with a single inpatient hub supported by a single enhanced arterial centre and a number of local non arterial centres as the recommended option.

Following this decision the two hospital Trusts (EKHUFT and MFT), formed the Kent and Medway Vascular Network, with a formal Vascular Network Board supported by a number of work streams. The network is responsible for developing the model of care and for completing a business case for approval by the Vascular Programme Board, and NHSE specialist commissioning, individual Trust Boards and oversight by the K&M JHOSC.

The agreed model of care would see the delivery of:

- A single Arterial Centre delivering all emergency care and in patient care. It will also provide out patients, diagnostics and same day surgery for its local population.
- A single Enhanced Non-Arterial Centre; delivering day surgery and in particular looking at new and innovative procedures being developed for K&M residents, alongside out patients and diagnostics for its local population
- A number of Non-Arterial Centres, providing outpatient and some diagnostic services for the local community.

This reflects the national model of best practice and aligns with the national direction of travel that most areas have or are adopting. The difference in K&M is the development of one of the non-arterial centres as an enhanced centre building skills and expertise particularly in day surgery.

The network is also required to ensure that there are clear and improved 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.

4.0 The K&M Vascular Network Board

The Vascular Network Board has been established and there is a formal Memorandum of Understanding in place between the two Trusts. This commits the two organisations to working together to develop the model of care, produce the business case and to provide clear clinical pathways to support patients through the period of change.

The Board has a clinical chair and vice chair representing the two organisations. Reporting into this Board is a number of work streams which include clinical pathway modeling, finance and activity modeling, governance and human resources.

The Vascular Network Board identified that there are two possible site options for delivering the clinical model. The two options are:

Option A — The single arterial centre in East Kent with the enhanced non arterial centre in Medway and the other non-arterial centres remain as they are currently across K&M

Option B — The single arterial centre is in Medway (MFT) with the enhanced non arterial centre in East Kent and the other non-arterial centres remain as they are currently across K&M.

The options were evaluated against a set of criteria which were tested and developed with the vascular community. The key areas/domains of this include:

- ***Quality***: - will it improve patient care?
- ***Access***: - are patients and relatives able to get to the unit?
- ***Affordability***: - Is it affordable and value for money?
- ***Workforce***: - do we have the right number and level of staff?
- ***Deliverability***: - can it be implemented in the timeframe?
- ***Research and Education***: - will it support research and education/development?

The business case for the proposal has been produced and approved by the Vascular Network Board. It has been presented to the EKHUFT's Strategic Investment Group and MFT's Management and Executive Board. Both Committees requested that further work be undertaken to close the projected financial deficit of the business case.

Members of the Vascular Network Board are meeting with the NHS Specialist Commissioning Team to discuss the financial challenges that the business case presents.

The initial findings of the K&M network options appraisal indicate that the Arterial centre would be best placed in EK with an enhanced non-arterial centre in Medway. The review programme Board has yet to review these findings and recommendations and this will be undertaken in January 2018. The final recommendation will be shared with the JHOSC early 2018.

This proposal will be detailed in the business case presented to the K&M Vascular Review programme Board for consideration before making recommendations to NHSE specialist commissioning on the option(s). This will include the preferred site option the Arterial and Non-arterial centre, for assessment by the Vascular Review programme Board before the final decision by NHSE specialist Commissioning.

5.0 Patient Engagement and feedback on priorities

The review was presented to stage 1 of the NHSE assurance process in June 2016. The model was supported and the review was advised on the key features required for the business case. As previously advised to the JHOSC, it was not NHSE assurance team expectation that this change required formal consultation on the proviso that the review satisfied adequate engagement through the process.

Over the past two and a half years, a series of patient engagement events has been undertaken to support the review:

- **July 2015:** Listening events across Kent and Medway discussing and developing the Case for Change
- **February 2016:** A deliberative all day workshop reviewing and developing the clinical model with clinicians and public having detailed discussions
- **February 2017:** two workshop events at the two hospital sites developing the clinical model and reviewing the range of possible sites
- **August 2017:** two workshops to test and review the evaluation criteria

The key findings of the engagement to date have included:

- Access to a specialist vascular team or centre was most important and reassuring in a life threatening situation
- Having good access to such a service in Kent and Medway was vital.
- Support for the findings of the review and the recommended clinical model.

- 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.
- Recognising that additional travel times for relatives were a concern suggestions that 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 feedback has been used to inform the review process including the case for change, the options appraisal process and the clinical model.

NHS England believes that there has been sufficient public and patient engagement over the past two and a half years and that formally consulting on the proposals would not have any additional value to the process. The final decision will be determined when the final business case is discussed at the Review programme Board and at the Specialist Commissioning decision making meeting.

6.0 Next Steps.

The Vascular Programme Board is keen to secure wide agreement on the proposed model for vascular services in Kent and Medway. The business case will now be presented to the Programme Board for formal discussion and approval in early 2018. The final recommendations are then presented to NHSE specialist commissioning for approval.

NHS England Specialist Commissioning will work with the two NHS Trusts and the Clinical Commissioning Groups to determine and address any financial issues related to implementing the approved model of care.
The business case and recommendations will be presented to the K&M JHOSC following discussion at the Programme Board and prior to implementation

The final solution for vascular services will be delivered through the Kent and Medway STP therefore it is critical that the two Trusts work formally as a Network to ensure vascular services are delivered as safely and sustainably as possible. Focused work is now underway to ensure that robust networking arrangements are established and that the two vascular teams are working collaboratively for the benefit of patients across Kent and Medway. This work is currently underway and will the network continue to ensure sustained service provision through the period of transition.

The JHOSC is asked to note the contents of the report.

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