Paper presented to:	Kent Health Overview and Scrutiny Committee
Paper subject:	Kent and Medway Hyper Acute/Acute Stroke Services Review
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Purpose of Paper:	To update the HOSC on the Kent and Medway Hyper acute/acute review, the Case for Change, Decision making Process and the next steps.

1.0 Background to the Review

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

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

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

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

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

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

NHS England describes a good stroke unit having:

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

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

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

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

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

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

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

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

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

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

3.0 Kent and Medway Stroke Review

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

3.1 Who is involved in the review process?

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

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

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

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

3.2 What is the aim of the review?

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

The review must ensure that**;**

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

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

4.0 What is the current Kent and Medway position?

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

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

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

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

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

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

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

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

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

4.1 Summary of key K&M issues

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

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

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

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

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

5.0 Kent and Medway Stroke Review next steps

5.1 Case for Change approval

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

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

5.2 Decision making and approval process

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

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

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

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

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

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

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

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

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

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

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

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

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

6.0 When will the review be completed?

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

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

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