Kent and Medway

Communication and Engagement Plan

Stroke Care Review and Redesign Programme

Version 2.0

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1.0 Introduction

Stroke remains a major cause of death and disability across Kent and Medway, with around 2,500 people having a stroke each year across the county. Nationally, three in four people affected by a stroke are over 65 years old. These patients need swift access to high quality, specialist hospital care to give them every opportunity to make a full and speedy recovery.

The NHS in Kent and Medway is committed to reducing health inequalities and improving clinical outcomes for people living in the area. To improve the experience of stroke patients, increase safety and deliver clinically-effective treatments, the local NHS is looking at how it can make sure the right care is provided at the right time and in the right place.

The eight clinical commissioning groups in Kent and Medway are undertaking a review of **hyper acute** stroke services which provide care in the first 72 hours after a stroke. All seven acute hospitals in Kent and Medway currently admit hyper-acute stroke patients. However, performance is inconsistent and variable, with a significant proportion being below average or just meeting average.

This review follows and builds on a local review in west Kent, initiated by Maidstone and Tunbridge Wells NHS Trust and supported by NHS West Kent Clinical Commissioning Group and Healthwatch Kent. This work asked local people for their views on quality standards, developed by the South East Coast Clinical Network and based on those in the SSNAP.

It found:

- There is public support for new higher standards of care covering the critical first 72 hours of a stroke patient's care and a need for the NHS to develop ways of achieving these
- The NHS needs to improve the whole of the stroke patient's pathway, including the care stroke patients receive out of hospital
- The NHS needs to improve the information and support available to patients and carers following a stroke
- Quality needs to be maintained within a timeframe that provides maximum opportunities of recovery for patients
- The NHS needs to improve planning about how and when a stroke patient can leave hospital and the next steps in their rehabilitation

Work is also underway in east Kent, reviewing how services provided by East Kent Hospitals University NHS Foundation Trust can best be delivered for the future. This is part of developing the trust's clinical strategy. Stroke is one of the services covered by their clinical strategy development work. We will take account of this in communications and engagement about stroke for east Kent.

1.1.1 Background to Stroke Services

1.1.1 Drivers of this project

The NHS wants to transform services so that people receive high quality, financially-sustainable services that meet their needs. Hospitals in Kent and Medway do not currently meet the recommendations on best practice identified by the National Stroke Strategy 2007. Kent and Medway are not alone in this. Nationally, there is significant variance in how acute trusts are delivering the strategy and implementing the recommendations.

The national standards for stroke services (SSNAP) are measured through a set of clinical measures and targets for clinical staff under 10 domains of care; these are the main way in which a stroke service can be assessed as high quality by NHS England and local commissioners. The commissioners are committed to improving the quality and consistency of care for all patients in Kent and Medway. Across the stroke services in Kent and Medway, achievement against the standards is variable and performance across some key areas remains low and of concern. CCGs are working with the Clinical Reference Group of stroke consultants to investigate what can and should be done to address this.

Currently people in Kent and Medway with stroke symptoms could be taken to any of the seven acute hospitals which are:-

- Medway Maritime Hospital
- Darent Valley Hospital
- William Harvey Hospital
- Kent and Canterbury Hospital
- Queen Elizabeth the Queen Mother Hospital
- Maidstone Hospital
- Tunbridge Wells Hospital

1.2 Clinical Rationale and Governance

The National Stroke Strategy 2007 specified that stroke is a medical emergency and that local networks need to plan to ensure that everyone who could benefit from urgent care is transferred to an acute stroke unit that provides 24 hour access to scans and specialist stroke care, including thrombolysis.

The key features of the National Stroke Strategy 2007 and the recommendation of the National Stroke Lead, Professor Tony Rudd articulate that recovery from a stroke is significantly influenced by the percentage of patients who:

- Seeing a stroke consultant within 24 hours
- Having a brain scan within 24 hours of admission
- Are seen by a stroke trained nurse and one therapist within 72 hours of admission

- Are admitted to a dedicated stroke unit

And that the most significant interventions are:

- A nutritional assessment and swallowing assessment within 72 hours
- Being given antiplatelet therapy within 72 hours
- Receiving adequate food and fluids for the first 72 hours

For every local acute trust, it is challenging to provide the full range of expertise including dedicated stroke consultants, stroke specialist nurses and therapists, 24 hours a day, seven days a week. Nationally, hospitals are reporting the challenges of recruiting and retaining staff on complex medical rotas such as stroke services.

The National Stroke Strategy 2007 recommended the provision of a hospital based specialist unit - **hyper-acute stroke service** (HASU) serving a population of between 500,000 and two million - is best placed to deliver the stroke pathway, 24 hours per day for 365 days per year. Patients would be conveyed by ambulance to the HASU rather than the nearest hospital.

The CCGs have also taken the evidence to the regional clinical senate to seek their expert review and rigorous assurance of the process and evidence.

Key Messages

1. Stroke is the third biggest killer in the UK and a major cause of long term disability.
2. People who experience a stroke need rapid access to a specialist medical team 24/7 – doctors, nurses and therapists – to maximise their chances of survival and enable the best possible recovery.
3. Stroke services vary across Kent and Medway, as they do across the country. Currently none of the hospitals treating stroke in Kent and Medway fully meets the national strategy recommendations and some people get care that is rated poor by SSNAP
4. The commissioners are working hard with our hospital, ambulance and social care partners on this clinically-led review of hyper-acute stroke services to ensure the people of Kent and Medway receive the best possible care.
5. Working together is critical to our success: our services are inter-dependent and the challenges we face cross organisational boundaries. We need to get services right for everyone who lives or uses hospitals in Kent and Medway so we must work together to find the right Kent and Medway solution.
6. We need to review and change the way we deliver services to ensure they meet the current and changing needs of the local population.
7. Our ambition is to ensure people using stroke services in Kent and Medway get high quality best practice care, that achieves A ratings on SSNAP and improved outcomes for patients. No change is not an option.
8. We are at the start of our process and listening hard to patients and the public to learn from their experience and listen to their views on how we can improve the quality of care across Kent and Medway.

9. We will use a fair, open and transparent process, which takes account of what people say is important to them.
10. We want to hear from you. Your views and experiences are critical in shaping how we move to delivering the best possible care for people who have a stroke, particularly during the crucial first 72-hours known as the hyper-acute phase.
11. No decision has been made as yet and the CCGs will continue to listen to the public to ensure their views are reflected.

1.3 Scope of the Review

The review of hyper-acute stroke services will primarily affect people living in Kent and Medway, residents of Bexley (NHS Bexley CCG) who are admitted to Darent Valley hospital and residents from East Sussex (NHS High Weald Lewes Havens CCG) who are admitted to Tunbridge Wells Hospital. The communications and engagement teams for Kent and Medway will liaise with communications and engagement colleagues in the adjacent areas so that their views and their patients and public can be considered in our planning; as MTW and Healthwatch have done in the preliminary work which they have undertaken in west Kent and east Sussex.

2.0 Governance

The North Kent Communications and Engagement team will work in partnership with partners in the Kent and Medway healthcare system, NHS England South region, and service providers to ensure effective communications planning and implementation, including a rapid response to media issues throughout the duration of the engagement and evaluation period.

Materials, feedback and general approaches to communication and engagement will be shared and developed with communications leads in partner and provider organisations as well as neighbouring CCGs.

The Kent and Medway Stroke Review Communication and Engagement Sub-Group of the Stroke Review Programme Board has been established to oversee all communication and engagement activities including:

- Development of the communications and engagement plan, which includes:
    - Stakeholder communication and engagement
    - Media engagement
    - Development of information and supporting material
- Provide programme update reports and monitor the progress of communications and engagement plan
- Report to the Stroke Review Programme Board progress on the plan and escalate key risks to the project and the associated issues

- Provide assurance on the delivery of all aspects of the communications and engagement plan
- Identify and manage the resources needed to deliver the communications and engagement plan
- Healthwatch Kent are to join the sub group and the Stroke Review Programme Board, as are the Stroke Association.

The group will meet on a monthly basis for the duration of the review, and will report to the Stroke Review Programme Board.

3.0 Objectives of the Communication and Engagement Activities

The objectives of the communications and engagement aspects of the review are:

Informing:

- To identify and engage with relevant audiences in a timely fashion, with clear information via effective channels for discussion and feedback
- Inform patients, the public and stakeholders on the challenges facing stroke services, and the national guidance on standards
- Inspire people to ask challenging questions about the future direction of stroke services

Engaging:

- To manage a robust process of 'listening' that meets national guidance and is regarded by the people it involves as open, reasonable fair and meaningful. This includes involving the relevant Health Overview and Scrutiny Committees.
- To promote dialogue and actively listen to the public views, concerns and insights.

Collaborating:

- Work in partnership with the public to provide answers to their questions raised.
- To ensure that the patient perspective and local views are a component part of all work throughout the review influencing all aspects of the work.
- To support any project groups in ensuring that all internal partners are kept informed and engaged with the project.

3.1 Purpose of Communication and Engagement Plan

The purpose of this plan is to:-

- Ensure the eight CCGs as part of this review of stroke services across Kent and Medway work with and are influenced by patients and clinicians from the outset, to improve the quality, consistency and sustainability of hyper-acute stroke services for everyone in Kent and Medway.
- Inform people on the case for change for hyper-acute stroke care and explore their experiences and views of care during the first 72 hours after a stroke
- Ensure effective and productive two-way communications between those service users who can contribute to the thinking/development on this and those responsible for the decision-making process.
- Prepare a robust plan for the ongoing involvement and communication of patients, staff and the public throughout the review and any potential changes to the model of care which require formal consultation.

4.1 Principles of Communication and Engagement Approach

The following principles will form the basis of all communication and engagement activity:

- Our approach will be open and transparent, and we will be clear about accountability, both internally and externally
- We will seek independent scrutiny of our communication and engagement plans and activities
- Our activities will be clear, timely, accurate and targeted appropriately to the differing needs of our stakeholders
- Our approach will be compliant with legislative frameworks and national policy guidance

3.2 Principles for Communication - Media

The case for change document will be going to each CCG and into the public domain via the Governing Body for transparency. Management of this first access to the public is crucial. Therefore,

- Communications activity will be led by the North Kent CCGs Communications and Engagement Team (nkm.communications@nhs.net) in partnership with communications colleagues throughout Kent to ensure tailored local delivery of the agreed plan.
- The Communications and Engagement sub-group will agree a series of proactive communications to maximise opportunities for public engagement and transparency throughout the review process, including media, social media and online activity.
- The Communications sub-group will coordinate any media interest, with response delivered at a local level, unless substantial interest necessitates a central response.

- A media spokesperson will be identified.

4.0 Audiences and Key Stakeholders

The proposed dialogue and its ultimate outcomes will affect all residents of Kent and Medway.
The priority audiences are:

Public, patients, carers and other people who may have had experience of stroke/ TIA ('mini stroke') services. This includes patient groups where existing conditions are indicative of stroke risk:

- Warfarin users
- People with diabetes
- People being managed for obesity
- People with other cardiovascular conditions
- People over 65
- Individual stroke patient groups in each area
- Age UK
- Residents of care homes

CCG patient reference group(s):

- HRG, PPG chairs, CPRG, APPG, SPLG and Health Networks and Community Networks

Voluntary and community associations:

- Stroke Association
- Diabetes UK
- Other VCS organisations

Protected groups:

- Representatives of minority groups, such as Ethnic groups most at risk of a stroke South Asian , black Africa and black Caribbean
- Groups representing people with disabilities
- Groups representing children and younger people

NHS and social care staff:

- Hospital staff, particularly those working in stroke services and older people's services
- SECAmb staff
- Patient transport service providers (NSL in Kent and Medway)
- GPs and practice staff
- Out of hours GP services
- Community providers
- Mental health providers
- Social care staff
- PALS and FOI teams
- CCG staff

Stakeholders:

- Kent and Medway CCGs – Boards and Execs

- Neighbouring CCGs
- NHS England (South region)
- Trust boards
- South East Coast Clinical Network and Senate
- Kent Health Overview and Scrutiny Committee(HOSC)
- Medway Health and Adult Social Care Overview and Scrutiny Committee(HASC)
- Kent Health and Wellbeing Board
- Medway Health and Wellbeing Board
- Local Health and Wellbeing Boards
- Healthwatch Kent, Health Medway
- MPs
- Members of Kent County Council, Medway Council, district councils

5.0 Equality and Diversity

The North Kent and Medway Communications and Engagement team will ensure that people who find it hard to access health services and provision, and its associated communications and engagement activity, are accommodated within the involvement strategy across Kent and Medway in line with the Equality Impact Assessment. This will include making sure all consultation materials are distributed to these groups in appropriate formats and languages. Where necessary a translator shall be identified and used at these meetings. These groups will also receive invitations to discussion meetings and we will meet with groups at their request. We will ensure that people with aphasia are able to contribute to the review. This work will be informed by an Equality OImpact Assessment carried out as part of the review.

6.0 Communication and Engagement Activities

The communication and engagement activities will be carried out within the following programme phases:

Phase	Dates	Outline of activities	Channels and Tools
Scoping	Jun/Jul 2015	Initial stakeholder events, agreement of design principles, , programme planning and identification of stakeholders	Stakeholder listening events, Outreach to seldom heard groups, listen to regular patient groups, survey in east and north Kent
Development of possible model of care	Aug/Sept - October	Detailed sifting of evidence and working groups to look at: transport, population, workforce, engagement clinical reference group and patients working groups CCG review of final/preferred options	Feedback on early engagement and continue to reach wider audience: Engagement with Patient Reference Group- Local promotions/ face-face engagement - Local promotions Presentations- local promotions
Potential public consultation	Nov– Jan 2016	Public consultation in the eight CCG areas	Media work - Press Road show events- Local promotions/printed literature Deliberation events – Local promotions/printed literature Consultation collateral- Local promotions/printed literature). GP meetings etc Evaluation by independent organisation of responses.-
Post consultation and final business case	Jan 2016 – XXX 2016	Review of consultation responses and preparation of final business case and service specification for agreement by CCGs	Publish response paper- Online/ printed literature

6.1 Engagement Activity

The engagement team will work in partnership with stakeholders to:-

- Ensure that the patient and public views shape the future service specification
- Utilise the public voice to proactively involve them in the direction of travel of the project
- Ensure the engagement process takes account of any Equality and Diversity issues which may come to light.

The range of approaches to engagement outlined in this strategy aim to give stakeholders the opportunity to be communicated with or involved in a way which suits them. Some activities will be targeted, including direct letters and e-bulletins to individuals and groups and out-reach meetings to seldom heard groups, and some will be open, including publishing information on our website, working with the local media.

In particular, we will make sure that people with aphasia can contribute their views and experience to this review.

The engagement team aims to have in-depth discussions and engagement in the work of the pathway working groups about the challenges facing the Kent and Medway CCGs and some of the emerging solutions via deliberation, with a focus on listening to concerns and responding as the review develops.

We are also committed to building on existing knowledge from previous engagement feedback and patient experience data.

When tailoring our engagement activity for each group we will think about:

- Their barriers to engagement
- What's in it for them?
- What do we want them to do?

Communication and engagement effort will then be appropriately focussed.

6.2 Communications Activity

The communications teams will work in partnership to:-

- Provide communications support for stakeholder engagement activities e.g. promoting listening events and/or other external stakeholder events as appropriate, across communication channels such as CCG websites and social media platforms.
- Develop reactive media plan e.g. develop lines to take, Q&A and identify spokespeople in the event of media enquiries.
- Assist with shaping key messages and materials to support engagement activities as required.
- Assist with development of a communications plan for external promotion of any potential public consultation, if appropriate, subject to the outcome of the review.

6.3 Local Briefing

Commissioners and communications leads ensure that all relevant contacts in the locality are briefed as necessary, including, for example:

- Executive team
- Board
- Commissioning team
- Provider services and staff
- GPs and primary care teams
- PPE forums

- Local voluntary organisations and user groups
- Local MPs and other community representatives
- Health and Wellbeing Boards
- HOSC/HASC - JHOSC

7.0 Phase-by-phase plan

A review of events will be provided at the end of each activity. At this time this plan will be refreshed to reflect the next phase(s) of engagement along with the timeline.

8.0 Evaluation

Success of the communications and engagement strategy will be evaluated on:

- Number of people participating in the consultation
- Quantity and quality of feedback from participants
- Comments from participants about the quality of communications and engagement for the consultation
- Tone and quantity of media coverage
- Tone and quantity of social media conversation

8.1 Risks

- Reputation: change is likely to be seen as a loss. Mitigation: carefully build internal and external support, including from service users and support groups. Draw on support from national stroke lead. Brief clinical and political leaders early to build acceptance for need to change and trust in plans. Well developed Equality Impact Assessment and Quality Impact Assessment to identify issues and mitigation. Have clear and consistent information and communication that builds understanding of the situation and the proposed plans.

- Carers and service users may have differing views. Mitigation: be sure to provide adequate means for both to comment.

- Legal challenge if process is not thorough and does not fulfil Secretary of State's four tests (detailed in Appendix A below) – particularly on strong patient and public engagement. Mitigation: clinical review (by South East Coast Clinical Senate), regular briefings and information to HOSC/ HASC, constructive scrutiny of process, plans and decision, early engagement with clinicians and stakeholders, leading to comprehensive consultation process delivered within local communities working with local support groups.

- General risks identified by the Independent Reconfiguration Panel as common reasons why proposals are referred:

- inadequate community and stakeholder engagement in the early stages of planning change
- the clinical case has not been convincingly described or promoted

- clinical integration across sites and a broader vision of integration into the whole community has been weak
- proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services
- important content missing from the reconfiguration plans and limited methods of conveying them
- health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care
- inadequate attention given to responses during and after the consultation

Appendix A: The four tests and assurance questions (from: *Planning and Delivering Service Changes for Patients, NHS England, 20.12.13)*

The 4 Tests:

- *strong public and patient engagement*
- *consistency with current and prospective need for patient choice*
- *a clear clinical evidence base*
- *support for proposals from clinical commissioners)*

Preparing for an assessment against the four tests – key questions

In preparing proposals for assessment against the four tests, commissioners and other bodies involved in the process may find it helpful to consider the following questions. It may not be necessary to have definitive answers to all questions during the early planning stages, if it is expected will be clarified as proposals are developed further. The application of the four tests should provide a helpful mechanism for assuring the robustness of plans throughout the process.

1. Can I demonstrate these proposals will deliver real benefits to patients?

2. Do I have strong and clear evidence that the proposals improve outcomes, will deliver higher quality care and are clinically sustainable within available resources?

3. Can I quantify with statistically robust evidence the nature and scale of any shortcomings with the current configuration, and can I quantify the extent of the improvement and efficiencies that would be expected from reconfiguration?

4. Are there viable solutions other than reconfiguration? Could I achieve the same outcomes through revising pathways or rotas within the current configuration?

5. How will performance of current services be sustained throughout the lifecycle of the reconfiguration programme?

6. What alternative options are there in the market? Could the services be provided by the other NHS providers, the independent or third sectors, and through new and more innovative methods of delivery?

7. Do the proposals reflect national and international best clinical practice? Have I sought the advice of my local clinical networks and clinical senate?

8. What plans have I put in place to engage relevant health and wellbeing board(s), and to consult relevant local authorities in their health scrutiny capacity? Do proposals align with local joint strategic needs assessments and joint health and wellbeing strategies? Have I considered the impact on neighbouring or related services and organisations?

9. Is there a clear business case that demonstrates clinical viability, affordability and financial sustainability, and how options would be staffed? Have I fully considered the likely activity and capacity implications of the proposed reconfiguration, and can I demonstrate that assumptions relating to future

capacity (and capital) requirements are reasonable? Does the modelling including sensitivity analysis (e.g. does it account for uncertainty in any of the variables)?
10. Have I undertaken a thorough risk analysis of the proposals, and have developed an appropriate to mitigate identified risks, which could cover clinical, engagement, operational, financial and legal risks?
11. Do the proposals demonstrate good alignment with the development of other health and care services, and I have considered whether the proposals support better integration of services?
12. Have I considered issues of patient access and transport, particularly if the location where services are provided may change? Is a potential increase in travel times for any groups of patients outweighed by the clinical benefits?
13. Have I considered the potential equalities impact of the proposals on different groups of users, including those with protected characteristics, and whether the proposals will help to reduce health inequalities?
14. Have I considered how the development of proposals complies with my organisations legal duties and how I have considered and mitigated material legal risks (see Box 1 on page 18 for a summary of duties for NHS England and clinical commissioning groups)?
15. Can I communicate the proposals to staff, patients and the public in a way that is compelling and persuasive? What communication and media handling plans are in place and/or have I identified where I will secure any external communications support?
16. Have I identified local champions who are trusted and respected by the community and can be strong advocates for the proposals?
17. Have I engaged any Members of Parliament who may be interested in the proposals?