Paper presented to:	Kent and Medway Joint 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 JHOSC on the outcome of the K&M stroke review progarmme Board 24.11.16

Kent and Medway Joint Health Overview and Scrutiny Committee post review Programme Board briefing

November 2016

Kent and Medway Stroke Services Review

1. Introduction

The following paper should be read in conjunction with the submitted and tabled November JHOSC report.

This paper outlines the discussion and recommendation of the Stroke Programme Board held on the 24th November 2016.

In making its final recommendations, the Programme Board considered all of the evidence including recommendations from the clinical reference group. This was reviewed in line with the national standards, requirements and the criteria set (and approved by the national team) at the beginning of this process. It also reviewed information from the patient and stakeholder

engagement events including the most recent Autumn events carried out across the county.
On the basis of this iterative process of evidence, review, testing and engagement, the Programme Board support and recommend a three-site model for combined hyper-acute/acute stroke care. This model provides the best option against the agreed criteria and, therefore, the best opportunity for delivering best care, outcomes and value for money to patients and residents in Kent and Medway.

2. Review of progress

The Kent and Medway Stroke Review progarmme Board on the 24th November 2016 reviewed the progress of the review to date including the findings of the modelling work

The Board reviewed the Case for Change and the options appraisal process and considered a number of recommendations going forward.

The Case for Change identifies that there is a need to reconfigure hyper acute/acute stroke services in order to ensure sustainable quality 24 hour /7 day specialist stroke care for the residents in Kent and Medway.

The options appraisal identifies a decision making process and criteria that enables robust assessment of options. The criteria have been developed to ensure positive outcomes for patients and reflect national and regional best practice. The process and criteria have been developed with the Clinical Reference Group and supported by the South East Clinical Senate and the national Clinical Director for Stroke Care

A robust patient engagement process has been undertaken throughout the review, testing and validating the Case for Change and the options appraisal. The most recent events considered the emerging preferred options and the feedback from these events informs the findings and next steps.

The review process has undertaken a detailed modelling process to inform the options appraisal in phased approach.

Phase one reviewed;

- Access times
- Workforce
- High-level financial appraisal
- Activity.

Phase two looked at these in more detail and applied a Red Flag(essential) criteria:

- Seven day consultant cover; daily moving to twice daily ward rounds in line with national requirements

- Seven day therapy service for Physiotherapy, Occupational therapy and Speech and Language therapy
- Seven day nursing cover with adequate skill mix to ensure stroke competencies on all shifts.
- Nursing and therapy staff to be compliant with the SE integrated stroke services specification
- BASP (British Association of Stroke Physicians) workforce levels for consultant staff (1:6 rota)
- Minimum and maximum activity volumes; between 600 and 1500 confirmed stroke patients a year
- 45 minimum travel times for 95% of patients incorporated into achievement of the 120 minute ‘call to needle standard’
- 120 mins call to needle time/standard
- Timely access to 24 hour /7 day CT imaging provision
- HASU sited on a HOT ED (24 hour full ED service) site.
- Critical co-dependencies in place.

Phase three has considered the three and four site models in detail, specifically reviewing the red flag criteria and the bed modelling.

Qualitative engagement events in September and October 2016 also reviewed and considered the emerging three or four site options. (please see attached report)

3. Modelling Work

3.1 Workforce modelling

The workforce modeling has been developed using the national and regional recommendations . This includes the;

- Requirements of the South East Cardio Vascular Disease Clinical Network Stroke Specification (2015)
- Strategic Clinical Network (SEC CVD SCN Stroke Clinical Advisory Group); service/quality standards
- British Association of Stroke Physicians recommendations (BASP)
- NHS England guidance on the Configuration of Stroke Services 2015
- Learning and experiences from other reviews and stroke services

A gap analysis has been undertaken to assess the challenge and the national, local recruitment and retention informs the options appraisal.

The workforce gap is the key limiting factor for delivering a sustainable quality Stroke service. And this is a local and national issue. Future providers will be required to develop workforce plans illustrating new and innovative roles and support for existing staff. The analysis demonstrates that a four-site model has a considerable gap that will be very difficult to address even with new roles and a focus on recruitment and retention.

The three-site option is the optimum option in relation to the workforce.

3.2 Access/Travel times

The access and travel times have used two separate travel times software and the SECAMb travel times and this has been applied to the options to appraise against the national recommendation of a 45 minute travel time criteria, from the patients home to the nearest stroke unit.
The Clinical Senate recommended that the review works towards a 120 minute call to needle standard across the pathway This recognises an improved response within the acute setting and an ability to therefore keep patients at the geographic periphery within the best practice standards by better managing patient flows.
Best practice and clinical evidence shows that working towards achieving thrombolysis within four hours of symptom onset will optimise therapeutic benefits.

This data modelling has considered both peak and interpeak travel times by car across the county and work has also been undertaken on public transport travel as this has been raised as a key concern through the engagement events.

The maximum travel time for patients in the emerging 3 site options using standard travel times (ie not blue light ambulance times) is 60 minutes.
SECAmb can reduce when using blue light transfers and achieve a 45 minute travel time in several three site options providing full coverage across the county.

Travel times for relatives and staff is a key concern for the public and stakeholders and this will need to be mitigated against in the provider delivery plans. The travel time analysis for public transport has shown that between 97 and 99% of the population will be able to reach the emerging 3 site hospital configurations within a 2 hour timeframe and the maximum time by car is 70 minutes.

3.3 Activity and financial modelling

The activity modelling has been developed as a ‘bottom up’ design, working with the individual patient level data for all stroke patients across Kent and Medway in the past year. A series of audits has also been undertaken on each site to ensure that there is an accurate understanding of the stroke pathway and the number of stroke mimic and Transient Ischaemic Attack (TIA) patients.
The modelling team has worked alongside the CRG and Trust staff to develop an agreed modelling process, ensuring that the numbers of patients, the level of activity and the staffing requirements have been robustly assessed. The activity levels have been applied to each of the options to inform the workforce numbers required and the financial viability of each option.

The modelling demonstrates that the three site option is the optimum model for activity and value for money. This option enables the providers to achieve the Best Practice tariff for stroke care, which is available when the key clinical standards are achieved.

4 . Key findings to date:

- Workforce is a key driver for delivering a sustainable 24/7 stroke service
- While the review initially focused on the hyper acute/acute phase and will make recommendations on the acute services going forward, rehabilitation and out of hospital services are a key concern. There is a requirement for a more detailed consideration of the early supported discharge model and rehabilitation pathways against each possible site configuration. This needs to align to the current local care work underway as part of the STP.
- Alignment with the Kent and Medway Health and Social care Sustainability Transformation Plan (STP) is required to ensure that critical clinical co-dependencies are reflected in the new model and the future site configurations.
- The modelling indicates that a three-site option provides the optimum solution when assessing against the appraisal criteria.
- The three-site option also provides the optimum financial position for providers; this includes the ability to deliver the best practice tariff, which creates a cost pressure for commissioners.
- A three-site option still has a workforce gap in relation to the existing workforce, however this is likely to be realistic to recruit to or cover with new roles.
- Travel time modelling illustrates that there are a number of viable three-site options that meet the travel time standard and have full access across the county.
- Moving from the current seven sites to a reduced site model will require a phased implementation process and this needs to be fully detailed.
- Work is required from each provider based on the activity, length of stay, workforce and finance to assess their ability to deliver the new model. This includes alignment to the out of hospital pathways in their locality.

5. Recommendations from the Stroke Review Programme Board.(RPB)

- The RPB considered the modelling work to date and agreed that the three site option is the optimum option.
- Further work is required with providers to assess the possible geographic three site options before recommendations on options for consultation can be made to the Kent and Medway Clinical Commissioning Groups (CCG's.) This includes work to identify a robust transition plan.

- The Board also identified that a wider clinical and stakeholder engagement event would be valuable to test and validate the preferred three site option and this will be planned for early 2017.
- The detailed options appraisal on the geographic sites needs to align to the current Kent and Medway Sustainability and Transformation Plan to ensure that the key clinical interdependencies are in place and informed consultation is undertaken.
- Detailed work on out of hospital care including development of a Kent and Medway approach to early supported discharge and rehabilitation should be taken forward.
- Recommendations to the Kent and Medway CCGs to be delayed until spring 2017 to enable the clinical and stakeholder event to take place and for providers to assess the impact of the new model and the rehabilitation requirements.
- The JHOSC to receive a further update in early spring 2017