Transforming health and social care in Kent and Medway

Kent and Medway Sustainability and Transformation Partnership

Stroke Joint Health Overview and Scrutiny Committee

Discussion Document

14th December 2018

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.

NHS

Agenda

Item
Welcome, introductions and objectives
Responses to questions from JHOSC
Overview of draft DMBC
Key changes since informal JHOSC in November
Integrated Impact Assessment and planned mitigations
Sign off process and next steps

Objectives

The Joint Health Overview and Scrutiny Committee is asked to:

a) **NOTE and DISCUSS** responses to the supplementary questions from JHOSC members

b) **NOTE** the content of the Decision Making Business Case

c) **NOTE** the changes made to the DMBC since the November JHOSC

d) **NOTE** the findings of the Integrated Impact Assessment and planned mitigations

e) **NOTE** the sign off process for the DMBC

Agenda

Item
Welcome, introductions and objectives
Responses to questions from JHOSC
Overview of draft DMBC
Key changes since informal JHOSC in November
Integrated Impact Assessment and planned mitigations
Sign off process and next steps

Agenda

Item
Welcome, introductions and objectives
Responses to questions from JHOSC
Overview of draft DMBC
Key changes since informal JHOSC in November
Integrated Impact Assessment and planned mitigations
Sign off process and next steps

Overview of draft DMBC

Chapter 1: Introduction	•This chapter describes the work that has been done in Kent and Medway on stroke services through the Stroke Review and within the STP
Chapter 2: Case for change	•This chapter introduces the context for stroke services in Kent and Medway and describes why change is necessary and why it must start now.
Chapter 3: Clinical vision for the future	•This chapter describes how patients will be treated in the future to ensure they receive the highest standards of care for stroke in prevention, urgent care and rehabilitation.
Chapter 4: Shortlisting options for consultation	•This chapter details the process that was undertaken in order to arrive at a shortlist of options for consultation and the feedback from consultation on this process
Chapter 5: Public consultation	•This section describes the public consultation on the five shortlisted options that took place between 2 February and 20 April 2018 (11 weeks).
Chapter 6: Identifying the preferred option	•This chapter describes the process undertaken to identify a preferred option for service change.

Overview of draft DMBC

Chapter 7: Assuring the preferred option	•This chapter describes the external assurance and scrutiny that the Stroke Review has undergone to ensure that the proposals are robust.
Chapter 8: Assessing the implications of the preferred option	•This chapter details the implications of the recommended preferred option on quality, activity, travel and access, equalities, workforce and finance.
Chapter 9: Implementation plan	•This chapter details the implementation plan for the recommended preferred option.
Chapter 10: Benefits of the proposed changes	•This chapter describes the benefits that are expected to be achieved as a result of implementing the recommendations.
Chapter 11: Conclusion and recommendations	•This chapter outlines the decisions that need to be taken by the JCCCG to determine the final configuration of stroke services and the expected timeline for decision making.

Agenda

Item
Welcome, introductions and objectives
Responses to questions from JHOSC
Overview of draft DMBC
Key changes since informal JHOSC in November
Integrated Impact Assessment and planned mitigations
Sign off process and next steps

Key developments and changes

The following slides detail the key changes made to the DMBC since the informal JHOSC in November.

Recommendation	Action taken
Provide a clearer overview and summary of the preferred option	A summary of the preferred option has been added to the Executive Summary and in more detail in Section 6.4.
Explicitly state the ambition and timescales for every Trust to achieve SSNAP grade A	The JCCCG agreed that the ambition should be to achieve SSNAP Grade A. The CRG recommended that this could be done within 6 months of go-live for the new model of care (+3 months for reporting). This was agreed by the SPB on 28 November 2018 and has been added to the DMBC in the benefits section (see Section 10.4).
To make clearer the intention to comply with the Royal College of Physicians' recommendations for stroke care	This has always been the intention and has now been clarified in Section 3.3.3.
To provide a statement of the STP prevention targets around the risk factors for stroke (obesity, physical inactivity, diabetes, atrial fibrillation and hypertension)	Details of the STP prevention targets can be found at Appendix CC.
Make clear how the risks to worsening inequalities might be mitigated by the better patient outcomes that will result from the improved stroke care	This is further detailed in Section 8.4. They include; • A focus on health promotion and prevention particularly for deprived populations as a way of reducing the number of people having a stroke and therefore requiring treatment. • Close monitoring of activity and outcome information during implementation and beyond to ensure that quality standards are being met and the benefits of the changes are being realised, especially for deprived populations. • Engagement with stroke care staff to support them through the changes and encourage them to remain in Kent and Medway. • Continued engagement and clear communication with the public to ensure they understand the changes and where to access services. • Work with voluntary transport services to ensure remote and deprived populations can access services and visit patients. • Review of the cost/availability of car parking spaces for patients and carers as part of the implementation of the plans.

Key developments and changes

Recommendation	Action taken
To take note of the longer term predicted trend in the incidence of strokes and explore what the implications of this could be.	*The Clinical Senate report notes on p12 that* "The bed modelling based on the current stroke incidence rates, and length of stay of stroke, TIA and stroke mimic patients is considered appropriate". Various things have previously been done to take account of activity growth that is different to predictions: - *Sensitivity analysis* - *Risk identification and management* The Programme Team commissioned Public Health to undertake further analysis around stroke incidence. The outcome of this work will be considered and any mitigations put in place.
To re-examine the data for the under 75s especially in relation to health inequalities and areas of deprivation	The impact on people from deprived areas will be further examined during implementation, and appropriate mitigations put in place.
To clarify the catchment populations for each HASU and of the neighbouring HASUs outside of K&M so that capacity is aligned with demand.	This work has already been completed and is shown in Appendix X.
To demonstrate the ability to deliver the additional beds for the HASUs and ASUs on time and with sufficient capital needs careful review once plans are presented	This work has been completed and is shown in Section 9.4.
To emphasise that longer travel times can be mitigated by slicker processes on arrival at the HASU hospital, helping to address the concerns of those faced with longer ambulance travel times to get to their nearest HASU hospital	This is further detailed in Section 8.4. It has been made clearer that while the changes will result in more patients having to travel further to access fully functioning hyper acute stroke units, it is considered that this is offset by the quality benefits of having access to a streamlined and fully resourced hyper acute stroke unit on arrival
To review actual SECAmb data for pPCI as it is expected that this would be less than that estimated by Basemap.	SECAmb have reviewed the blue light for pPCI and trauma and the travel times are slightly shorter than the ones used for stroke from base map, and all within the 60 mins. See Appendix BB for further information.
Provide greater transparency about the travel times for residents living furthest from HASUs.	Travel times have been a key part of the work to date and have been part of the evaluation process at all stages. Travel times for people in Thanet have been reviewed extensively and further details are shown in Section 8.3.3. The travel time map from the Integrated Impact Assessment has been included in the DMBC in Section 8.3.2.

Key developments and changes

Recommendation	Action taken
Clarify additional funding to SECAmb to enable the consistent achievement of the Category 2 response time target	This will be detailed in the financial section of the DMBC.
Clarify that all HASUs will have at least two functioning CT scanners, and that they prioritise new stroke patients accordingly	This has been confirmed by EKHUFT and DGT. One scanner at MGH is outside the ED but MTW have confirmed that it is quickly accessible and will be staffed to allow 24/7 imaging for HASU.
To provide more detail on future plans around the provision of Mechanical Thrombectomy	Thrombectomy is not currently part of this DMBC and activity analysis would be considered as part of any separate business case. However, EKHUFT are developing this business case in anticipation of proposing to undertake a thrombectomy service in the future, and details of this are shown at Appendix AA.
To confirm that all three HASUs will be able to provide 24/7 CT angiography, as this is required to select patients urgently for thrombectomy	This has been confirmed by all trusts.
Explicitly confirm that all three HASUs will meet the recommendations in the South East Clinical Senate's report 'The clinical co-dependencies of acute hospital services' and to state the co-adjacent services	All the HASUs in the preferred option meet this guidance as one of the hurdle criteria for site options was that sites must have these co-located services. This is shown in Section 4.2.2. e major emergency centre requirements are set out in Appendix M and are: • Acute cardiac ppci • A&E • Emergency surgery • Full obstetrics The CRG recommend that, although a required service for a major emergency centre, a level 3 NICU has marginal clinical relevance to a HASU so its availability was not considered in the evaluation.

Key developments and changes

Recommendation	Action taken
To clarify the clinical pathway for stroke mimics	A pathway for stroke mimic patients has been developed and is detailed in the DMBC. This has been agreed by the CRG and the SPB. More detail is shown in Section 3.3.3.
To reflect the ongoing pathway for stroke mimic patients after admission to a HASU, and to demonstrate the impact of stroke mimics in the bed modelling assumptions	Further work will be done as part of the implementation phase. The impact on the bed base was considered by the CRG who agreed that the impact is likely to be 2-3 beds per site. This has not been included in the HASU/ASU bed base but was included in provider presentations to the deliverability panel and in the provider business cases (see Appendix Q and Appendix V).
To ensure that Inpatient rehabilitation capacity is considered alongside ASU bed requirements	Inpatient rehabilitation capacity that sits alongside current acute stroke beds (e.g. at MTW) has already been included in the modelling (as ring-fenced beds). Inpatient rehabilitation capacity will be further reviewed as part of the rehab business case that is currently being prepared (see Section 3.4).
To define the social work input required around rehabilitation and ensure Local Authority ASC input to the development of plans for rehabilitation	Agreed. This is being discussed as part of the work on the rehabilitation business case, as detailed in Section 3.4. There is representation from local authority adult social care on the rehabilitation working group (RWG).
To recognise and demonstrate the risks and timescales around the development of the rehabilitation business case	This has been added to the programme risk register (see Section 9.4).
Confirm the commitment of the K&M commissioners to the rehabilitation commissioning principles	The JCCCG has discussed rehabilitation on a number of occasions. There is a firm commitment to developing a business case for rehabilitation.
To reflect the palliative care pathway in the model for rehabilitation	All providers currently have palliative care pathways for stroke and CRG agreed that these will continue to be used.
To further detail the risks around the delivery of the workforce implementation plan	The risks have been more explicit and are shown in Section 9.4.

Key developments and changes

Recommendation	Action taken
To provide more assurance around the ability to address the workforce gaps in the timescales being proposed, and detail the creative interim solutions planned	It is essential that there is an agreed, robust monitoring process of the workforce gap and a collective focus on driving and delivering the recruitment and retention plan. Providers will consider how to better utilise their temporary workforce (bank and agency staff) and how staff are redeployed from other areas within the Trust. This work will be done as part of implementation, following a decision. A Kent and Medway network recruitment campaign is being developed, supported by the STP.
Consider the upskilling of other medical specialties in stroke competencies to support stroke units and on call rotas	Agreed. Work has started on considering a range of roles, as set out in Section 3.5.1. Further work will be done as part of implementation, following a decision.
Detail the steps that will be taken to ensure sustainability of services at Medway hospital during transition	Work has been done to support Medway and the immediate workforce issues have been resolved. Phasing was considered as part of the work on implementation. It was agreed that the disadvantages of transferring patients earlier to Maidstone outweighed the advantages (see Section 9.1). However, capacity could be available at Maidstone, if required.
To qualify the assumptions about transferring staff from hospitals losing their stroke units qualified and consider alternative ways of staffing the HASU/ASUs	Providers are developing plans to transfer staff between hospitals. It is expected that providers will continue to engage and involve staff in this work. Providers may initiate a staff consultation aligned to their HR policy. This work will be done as part of implementation, following a decision.
Consider rotational posts for stroke nursing and therapies staff. This would develop broad skills, and may enhance recruitment and retention.	Plans for rotational posts are being developed including a Kent and Medway Education and Training Competency Framework. There is also an opportunity to work with the deanery and the new Medical School regarding trainee doctors' rotation to stroke services across Kent and Medway. In the first instance, work will be undertaken with Health Education England on the steps required to achieve this goal. Further work will be completed as part of implementation, following a decision.
To consider the SEC guidance for stroke networks on hospitals without acute stroke units and define pathways for stroke patients at non HASU hospitals	This document was considered by the CRG at their meeting of 13/11 and formed the basis for proposals for pathways for non-HASU patient transfer (see Section 3.3.4). These were considered and agreed by SPB on 28/11.

Key developments and changes

Recommendation	Action taken
To clarify how detailed discussions with stroke care staff is taking place to explain the transition, and to understand the opportunities for and plans of such staff	Detailed on-going engagement is taking place with stoke care staff. This is planned to continue throughout implementation, as outlined in Section 9.5.
The many benefits of centralising stroke services to patient outcomes following a stroke must be clearly communicated to the public	This message has been a key part of communications throughout the Stroke Review and this will continue during implementation. Further details of the communications and engagement plan for implementation is shown in Section 9.5.
To further detail the steps that could be taken to mitigate the impact on relatives and carers who may have to travel longer distances to visit the patient whilst in the HASU or ASU	A Transport Advisory Group including stroke patients, carers and patient representatives is being set up. This group is part of the programme governance structure (see Section 9.3) and will continue to meet and make recommendations throughout implementation.
The implementation period should be minimised.	Agreed. This was discussed as part of the work on implementation planning and phasing. The local ambition is to implement the new services as quickly as possible whilst ensuring that quality and patient safety are not compromised. Further details are in Section 9.1.
To detail any impact of the future configuration of acute hospitals in East Kent, with an alternative major emergency hospital located in Canterbury being considered.	Work is underway to review services and develop options for a clinically and financially sustainable model for East Kent University Hospitals NHS Foundation Trust. The outputs of this work will in time be subject to public consultation. It is noted this will need to be kept under review, but given Kent and Canterbury Hospital cannot currently provide a HASU and a model for improved care is urgent, it is recommended that Kent and Canterbury Hospital should not be considered as a potential hyper acute and acute stroke unit at this time. This reference is already included in the DMBC and was in the PCBC. See, for example, Section 4.3.2. It was clearly communicated during consultation.
To define the strong and effective clinical leadership and programme management that will be in place to support the implementation of HASU/ASUs within Kent and Medway	A clinical director lead across Kent and Medway will be appointed across Kent and Medway. In addition, each provider has appointed strong clinical leadership for the individual HASU/ASUs. See Section 9.3 for more details.

Agenda

Item
Welcome, introductions and objectives
Responses to questions from JHOSC
Overview of draft DMBC
Key changes since informal JHOSC in November
Integrated Impact Assessment and planned mitigations
Sign off process and next steps

Consideration of Integrated Impact Assessment

The aim of an integrated impact assessment (IIA) is to explore the potential positive and negative consequences of implementing the preferred option.

The objectives of the IIA are to;

- Understand the overall demography and the protected characteristic groups (as defined by the Equality Act 2010) of the different CCG populations affected.
- **Undertake a HIA:** Identify the impact on patient outcomes, safety, effectiveness of care and patient experience.
- **Undertake an EqIA,** critical in supporting the CCGs in meeting their obligations under the Equality Act 2010. Understand the impacts on protected characteristic groups across the CCG populations through a programme of stakeholder engagement.
- Undertake a **travel and access impact assessment:** Consider increases and decreases in journey times and changes in journey patterns for the overall impacts and consider travel and access impacts for protected characteristic groups.
- Undertake a **sustainability impact assessment:** Identify any sustainability impacts by reporting on the carbon footprint change.

Consideration of Integrated Impact Assessment

Summary of the positive impacts identified;

Health

- The proposed changes will improve patient outcomes and remove the variation currently experienced.
- The consolidation of workforce resources will enable the three stroke units to achieve recommended workforce standards, creating a more sustainable workforce.
- Rehabilitation services for stroke patients will be improved, supporting patients to regain their independence and overall quality of life.

Equality

- 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. These groups are:
  - Age (older people aged 65 and over)
  - Disabled people
  - Pregnancy and maternity
  - Race and ethnicity
  - People from deprived communities

Consideration of Integrated Impact Assessment

Summary of the potential negative impacts identified and planned mitigations;

Potential negative impact	Planned Mitigation
Patients who experience a stroke at a non-HASU site will require transfer to a HASU. This could potentially have a negative impact on patient outcomes	• Pathway for patients suffering a stroke at a non-HASU site has been developed.
Activity is consolidated into fewer hospital sites so capacity could be constrained	• Activity and bed modelling has applied necessary sensitivities
If links to co-dependent services are not managed this could have implications on the safety of care	• Need to maintain a strong STP focus and plan across wider acute strategy including East Kent and Vascular reviews
Reconfiguration could result in logistical difficulties for staff therefore increased turnover and loss of expertise	• Recruitment and workforce plans in place including support for existing staff and developing a multi-faceted recruitment campaign across K&M

Consideration of Integrated Impact Assessment

Summary of the potential negative impacts identified and planned mitigations;

Potential negative impact	Planned Mitigation
Some patients will have to travel further to access stroke services	• We continue to reinforce that our criteria is that 95% of people should be within 60 minutes and thrombolysis within 120 minutes of calling for an ambulance. Also it is being cared for on a specialist unit for the first 72 hours that improves patient outcomes, not the journey time to hospital
Longer journey times may impact on the capacity of the ambulance service	• Additional resource agreed with SECAmb to mitigate this.
The changes will result in higher transport costs for some people; may result in them not choosing not to use cars	• Travel Advisory Group will meet to consider impacts on different population groups and ensure solutions are developed to mitigate any adverse impacts.
The preferred option will mean people from deprived areas have disproportionately longer journey times	• Journey times will be longer for some areas, whether they are deprived or not • Travel Advisory Group will meet to consider impacts on different population groups and ensure solutions are developed to mitigate any adverse impacts.

Agenda

Item
Welcome, introductions and objectives
Responses to questions from JHOSC
Overview of draft DMBC
Key changes since informal JHOSC in November
Integrated Impact Assessment and planned mitigations
Sign off process and next steps

Sign off process and next steps