Transforming health and social care in Kent and Medway

NHS

Joint Committee of CCGs for the review of urgent stroke services in Kent and Medway

Decision making meeting: Thursday 14 February 2019

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

Welcome and introductions	**Mike Gill**
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

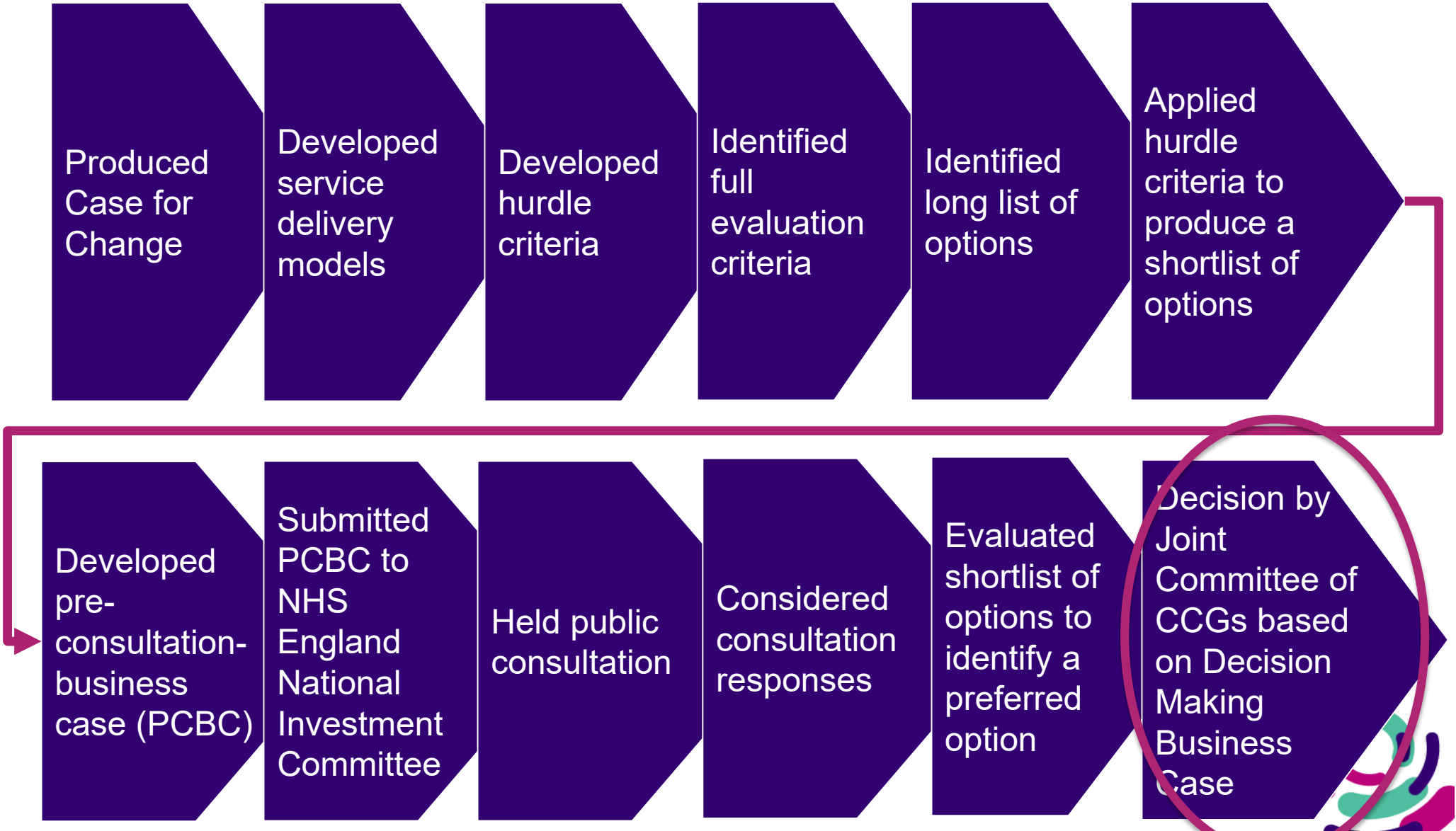
Meeting etiquette and housekeeping

- This is a **meeting in public,** members of the public can attend to observe but are not permitted to join in the discussion
- There is an expectation that the committee will be able to conduct its business without undue interruption: please switch phones to silent and avoid talking during the discussions
- We will ask all members of the committee to introduce themselves in a moment, and to say who they are before they speak for the first time
- This meeting is being audio recorded, not filmed. Others may be filming, if you do not wish to be filmed please raise your hand.
- There is no fire drill expected, so if the alarm does ring we will need to leave via the signed exits
- Toilets are located outside the meeting room to the left
- We will need to finish this meeting by 4:30

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

Overview of the process



Current challenges – our case for change

Specialist stroke resources are spread too thinly and most hospitals do not meet national standards and best practice ways of working

- Latest SSNAP data shows all D and E rated units in the South East are in Kent and Medway
- We have the only E rated unit in the country

Consultants, brain scans and clot busting drugs **aren't consistently available 24/7**

One in three stroke patients are **not getting brain scans in the recommended time**

We have **only 1/3 of the stroke consultants needed** to deliver best practice in all our hospitals

Half of appropriate patients **are not getting clot busting drugs** in the recommended time

Only one unit sees enough stroke patients for staff to maintain their skills (recommended minimum is 500 patients per year)

A new model of care



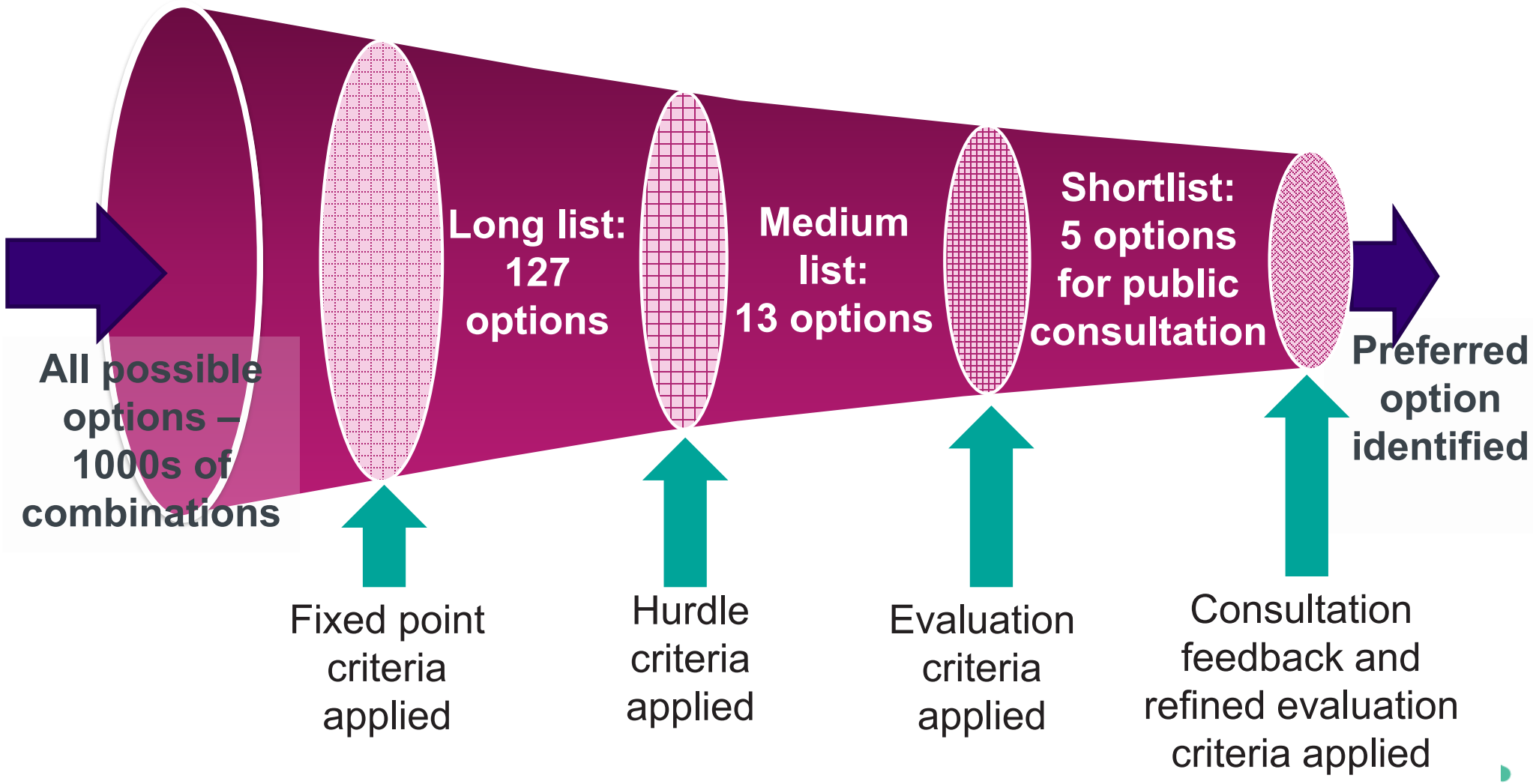



- Services run 24 hours a day, 7 days a week
- Staffed by teams of stroke specialist doctors, nurses and therapists 24/7
- Daily consultant ward rounds, including at weekends
- Able to do brain scans and give clot-busting drugs within 2 hours of calling an ambulance, round the clock
- Care for first 72 hours is on a hyper acute unit, follow up care is also on specialist acute stroke unit
- Rehabilitation services based in local communities, close to where people live

Expected benefits

- ✓ A reduction in deaths from stroke
- ✓ Fewer people living with long-term disability following a stroke
- ✓ Fewer people losing their independence and being admitted to nursing/care homes
- ✓ Fewer vacancies and lower staff turnover
- ✓ Shorter stays in hospital
- ✓ Better patient and staff experience as a result of excellent working practices
- ✓ Follow up care closer to home

Reaching the preferred option



Updates to the evaluation criteria

Criteria		Sub-criteria
1	Quality of care for all	• Stroke co-adjacencies • Co-adjacencies for mechanical thrombectomy • Requirements for major emergency centre • **Activity volumes**
2	Access to care for all	• Blue light proxy • Private car, peak
3	Workforce	• Gap in workforce requirements • Vacancies • Turnover
4	Ability to deliver	• **Go-live date** • **Confidence in go-live date** • **Quality of implementation plan**
5	Affordability and value for money	• Net present value, 10 years • **Capital requirement**

Assessment of options against minimum/maximum activity levels

Update of activity flows using 2017/18 activity and travel time data
Applied standardised whole option evaluation

Update of workforce baseline to March 2018
Applied standardised whole option evaluation

Detailed work with Trusts to update:
• Time to implement
Panel assessment of:
• Flexibility of proposals
• Readiness to go live

• Capital cost criteria now included
• Update of NPV using 2017/18 data

The following groups reviewed the refinements to the criteria:
- Evaluation criteria working group
- Stroke Programme Board
- Stroke Clinical Reference Group
- Finance Group

Each option was evaluated against each criteria and given either a double positive, positive, neutral, negative or double negative (++, +, /, -, --)

Workshop format

The primary objective of the workshop was to reach consensus on the future potential location of HASU/ASUs for the K&M population and it had two key parts:

1. Reviewing and discussing evaluations for each of the five shortlisted three-site options against the criteria
2. Discussing the anonymised evaluation matrix, to come to a collective view on any of the options that could be excluded until a preferred option was agreed.

How and why each option was excluded

Identifying any options to be excluded

- Consensus to exclude two options
  - Option C (Maidstone, Medway Maritime, William Harvey)
  - Option D (Tunbridge Wells, Medway, William Harvey)

Rationale for excluding Option C and D

- Did not evaluate well against ability to deliver, (most notably quality of implementation plans), and workforce
- Option D also did not evaluate as strongly as others against net present value which considers the overall cost effectiveness and financial benefit of the option.

Consideration of remaining three options

- Consensus to exclude Option E (Darent Valley, Tunbridge Wells, William Harvey)

Rationale for excluding option E

- Did not evaluate as well against ability to deliver compared to Options A and B
- Evaluated less strongly for confidence in go live date and quality of implementation plan
- No better for access or quality but was more expensive and therefore lower overall value

Consideration of remaining two options

- Consensus that Option B (Darent Valley, Maidstone, William Harvey) was the preferred option

Rationale for selecting Option B as preferred option

- Option evaluates strongest against workforce criteria
- Good confidence in ability to deliver: evaluated stronger against both confidence in go live date and quality of implementation plan
- Agreement that a networked solution for major emergency centre co-adjacencies was clinically robust

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

What we did: promotion

Over the 11 week consultation we:

- Distributed **15,000 consultation documents** and **35,000 summary documents**, and **posters**, to **c850 locations** across Kent, Medway and border areas in south east London and East Sussex (hospital waiting areas, GP surgeries, pharmacies, libraries etc)
- Cascaded information to **43,500 health and social care staff** across Kent and Medway and borders – they are also residents, patients and carers
- Cascaded information through **patient groups and networks** **linked to NHS organisations, local authorities, voluntary sector partners, GP practice groups** etc
- Ran paid-for **advertising on local radio and in local newspapers**
- Distributed **leaflets to 98,200 individual households**
- Used both **paid for advertising** and non paid for activity on **social media** (Twitter, Facebook, YouTube)
- Issued media releases to raise awareness with **coverage in broadcast and print media**
- Ran regular articles in **council, NHS, Healthwatch and other partners' newsletters, e-bulletins, magazines and websites**
- **Promoted the consultation through our own website**

What we did: engagement

Over the 11 weeks we:

- Held **28 listening events** across the 10 CCG areas, as well as in Hastings and Rother
- Attended **meetings run by third parties** – e.g. Dartford Elders Forum, Thanet Over 50s Forum, CHEK AGM, to discuss our proposals
- Carried out **telephone research interviews** covering all 10 CCG areas
- Had face to face discussions through **focus groups, street surveys** and **roadshows**
- Held NHS trust **staff engagement events and discussions**
- Engaged through outreach to **seldom heard groups** included discussions with homeless people, prisoners, ex-servicemen and substance mis-use groups
- Engaged with people representing those with **protected characteristics** eg older people, LGBTQ groups, mother and baby groups
- Actively engaged through **social media channels**, asking questions and responding to queries
- Responded to **questions, queries and comments** via email, letter and phone
- Continued engagement with **stakeholders** eg: elected representatives, provider organisations, health and care partners, unions, patient groups

Consultation responses

- 2240 responses to the online questionnaire
- 299 hard copy questionnaires
- Notes from 28 public listening events attended by 850 people
- Notes from meetings and forums hosted by others where we discussed the proposals
- Notes from consultation events with staff in NHS trusts
- 701 telephone interview responses
- Notes from 442 face to face discussions through focus groups, street surveys and outreach engagement
- 500+ email / postal / phone comments and questions
- 500+ comments and questions through social media
- 1521 postcard responses and a petition with ~3500 signatures received from a group in Thanet
- >14,000 website and >50,000 page views over the course of the consultation
- Twitter reach >500,000; Facebook reach >50,000; >4,000 page engagements on Facebook; YouTube >1,000 views of our videos

Receiving and agreeing the consultation reports

- At a meeting on 28 August 2019 the Joint Committee were asked to consider the following
  - Did the consultation secure the involvement of key stakeholders?
  - Was everyone given a reasonable opportunity to state their views?
  - Was it possible to engage with a diverse set of views?
  - Did anyone with a significant viewpoint fail to participate?
  - Are the Joint Committee satisfied the consultation has been delivered to a reasonable standard?
- The JCCCG agreed the above
- However, they asked for some further research to be carried out with Black, Asian and minority ethnic groups to ensure representation of these groups in the consultation feedback
- This work was undertaken and the responses aligned with the key themes from the consultation

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

The key themes from feedback throughout

General agreement that stroke services need to change (although people support and are loyal to their local hospital)

Concerns about travel times and people want journeys to be as short as possible

People felt levels of deprivation and population size in specific areas should be taken in to account

People want to know that good quality rehabilitation services will be in place locally

General support for the idea of having hyper acute stroke units

Many people said they would like there to be four HASUs… …or a HASU in Thanet

Concerns about staffing: will we have enough staff and has enough had been done to attract staff

Agreement that stroke services need to change

- Most people agreed there is a ‘case for change’ and that we need to work differently to improve stroke services in Kent and Medway
- But people were typically very supportive of the quality of care at their local hospital

Response

- General agreement with the case for change and the idea of hyper acute stroke units told us that people understood our reasons for wanting to organise stroke services differently
- As a result we decided that **our general proposals** for implementing HASUs in Kent and Medway **did not need to change**

87% of people who responded to the questionnaire agreed there are convincing reasons to create hyper acute stroke units in Kent and Medway

Support for the idea of hyper acute stroke units

Most people agreed that:

- Creating hyper acute stroke units would improve access to diagnosis and specialist treatment in the 72 hours following a stroke for patients
- Creating hyper acute stroke units would improve quality of urgent stroke care for patients

Response

- General support for creating hyper acute stroke services and agreement that they would improve quality and access to specialist treatment told us that people understood the benefits of specialist care in dedicated units
- As a result we decided that **our general proposals** for implementing HASUs in Kent and Medway **did not need to change**

Around 75% of questionnaire responses and telephone survey participants agreed hyper acute stroke units would improve access to specialist treatment and quality of care

Concern about travel times and keeping journeys as short as possible

- Lots of people were worried that consolidating stroke services into three specialist centres would mean journey times to hospital would not be safe
- People said travel times to proposed HASUs needed to be as short as possible
- Some people were not confident about the accuracy of the travel time data we used to help plan the locations of proposed HASUs

Response

- Reviewed national and local standards to ensure proposals are safe and would allow us to treat people in the required timeframes
- Checked latest travel time data against original proposals to see if anything had changed
  - The data confirmed that 99.9% of people would be within a 60 minute journey time to a HASU, and 100% within 63 minutes
  - The data we used comes from a nationally and internationally recognised source and is taken from real journey times from satellite navigation systems
- As a result we decided that our proposal for **the locations of proposed HASUs did not need to change**

Around 35% of both questionnaire responses and telephone participants said they were concerned about the travel times to the proposed HASUs

People would like there to be four HASUs…

- Many people said that they would like there to be four HASUs to allow shorter journey times
- People particularly felt there should be a fourth HASU in Thanet

Response

- Looked again at the data that had informed recommendation for three HASUs:
  - The number of confirmed stroke patients that each unit would see (a minimum of 500 a year)
  - The number of staff needed to run four units
- Four units would mean some would not see the required minimum number of confirmed stroke patients per year for safety and quality
- We would be very unlikely to recruit enough consultants to run four units safely
- As a result we decided that our proposal for having **three HASUs** in Kent and Medway **did not need to change**

13% of questionnaire responses said there should be more units. Around 10% said there should be a unit closer to Thanet and another 10% that the unit should be at QEQM specifically.

….and a HASU in Thanet

People said that if there couldn't be four HASUs, one of the three proposed sites should be in Thanet because:

- travel times to Ashford are too long
- there are higher levels of deprivation in some areas that could lead to greater need for stroke services
- deprivation could also impact on peoples' ability to visit relatives and friends in hospitals that are further away

Response

- Looked again at the rationale for excluding QEQM:
  - QEQM has fewer of the desirable 'co-adjacent' services
  - EKHUFT said they would find it difficult to staff two HASUs
  - Therefore Ashford was the more favourable site for a HASU based on the desirable services
- Reviewed the data on the numbers of stroke in areas of deprivation
  - The numbers of confirmed strokes in deprived areas is no higher than anywhere else in Kent
  - The key way to improve health in deprived areas is through prevention
- Established a travel group to ensure mitigations are put in place during implementation to reduce the impact of increased travel times
- As a result we decided that there was **no new evidence for QEQM** to be considered as a location for a HASU

16% of questionnaire responses specifically mentioned that there should be a HASU in Thanet in the free text responses. A petition with 3500 signatures and1521 postcards and were received calling for a HASU at QEQM.

Deprivation and population size should be taken in to account

People said they were concerned that people living in deprived areas should be closer to a HASU because they were more likely to have a stroke. They also said that HASUs should be located in the most densely populated areas.

Response

- Looked again to see if there is a connection between numbers of strokes and areas of deprivation across the whole of Kent and Medway
  - The data does not show that areas of high deprivation have higher numbers of stroke
- Clinically, there are two criteria that influence the location of a HASU:
  - Can 95% of people reach it within an hour?
  - Are there enough people in the 'catchment' area to ensure the HASU treats at least 500 strokes a year?
- All the proposed sites for HASUs in Kent and Medway meet this criteria
- As a result we decided that **no one option was any better placed to deliver stroke care** on the basis of population size or deprivation than another

27% of people said they ranked the five options on the basis of the size or demographic of the population (i.e. levels of deprivation, number of elderly people) around the sites

Concerns about staffing challenges

- There were concerns that we would not be able to recruit enough staff to run the proposed HASUs
- Some people also felt that staffing challenges should not be a reason to limit the number of HASUs in Kent and Medway

Response

- Looked again at the current staffing levels, vacancy rates and staff turnover rates:
  - We need at least three more full time stroke consultants to run three HASUs
  - There are recruitment challenges with some hospitals having as many as 20% of their nursing posts vacant (across all departments, not just stroke)
- We are developing a detailed workforce plan that will address how we help existing staff to stay working in stroke services and how we attract new staff
- We reviewed the way each site was evaluated to see if staffing influenced any of our decisions about the number or location of proposed HASUs
  - The main influence on the number of HASUs was ensuring each unit would see enough patients (a minimum of 500)
  - The main influence on location was the other desirable services at each site
- While we recognise there is significant work to do around staffing as part of our implementation plans, we decided that **our general proposals did not need to change because of staffing issues**

In the telephone survey 57% of people said they thought it was a good idea to concentrate staff on fewer sites. 8% of questionnaire responses mentioned concerns about staffing

The need for good quality rehabilitation services

- Lots of people said we need to make sure as much rehabilitation as possible happens close to, or in, peoples' homes to minimise the amount of time some patients would need to be away from relatives and friends
- Staff also made clear that HASUs will only be successful if they are supported by good quality rehabilitation that is in place at the time the HASUs are implemented

Response

- Originally intended to review stroke rehabilitation services across Kent and Medway once the decision on implementing HASUs had been made
- As a result of the feedback from consultation **we decided to speed up work on stroke rehabilitation** services
  - This work is being bought in line with the timeline for the implementation of the proposed HASUs
  - We are working with the Stroke Association and stroke rehab specialists to develop a clear plan for new services
  - We have committed to ensuring that sufficient rehab is in place, across Kent and Medway, not just alongside the proposed HASUs
  - We have committed to ensuring sufficient rehab will be in place at the same time as HASUs, if they are implemented

9% of questionnaire responses mentioned the importance of rehabilitation services. Rehab was one of the most commonly mentioned additional areas for consideration in focus groups and at public listening events

East Sussex Council

East Sussex Feedback	Response
There must be support for access by families and carers e.g. provision of travel information, flexible visiting arrangements, provision of telephone contact with HASU and patients, with full discharge information for carers.	Agreed. The HASU/ASUs will operate as a single network as described in the DMBC. Communication and information will be reviewed with patients, relatives and carers. This will be developed and formalised during implementation. Measures such as flexible visiting and phone contact will be agreed as part of implementation.
The HASUs must be able to demonstrate how they will maximise the speed of treatment of patients on arrival at hospital to offset additional travel time for patients.	Agreed. This is demonstrated in the commitment to deliver the acute pathway at pace (section 3.3) including to deliver call to needle in 2 hours (section 3.2). SSNAP data will demonstrate this is achieved.
Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that the East Sussex Healthcare NHS Trust (ESHT) Hyper Acute Stroke Unit (at Eastbourne District General Hospital) is able to accommodate and treat patients who would otherwise have gone to Tunbridge Wells Hospital.	Agreed. ESHT have been involved throughout the process and have confirmed their support. The preferred option has a minimal impact on patients attending ESHT as demonstrated in Appendix L.

East Sussex Council continued

East Sussex Feedback	Response
Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that: • A full community neurological rehabilitation team is in place in the High Weald Lewes Havens CCG area of East Sussex. • The proposed discharge pathways to these community services have been considered, tested and agreed with the relevant community provider, Sussex Community NHS Foundation Trust	Agreed. This has been discussed with the Responsible Executive Officer for High Weald Lewes Havens CCG who has confirmed that the review and development of rehabilitation should include representatives from the community provider.
Residents in the affected area of East Sussex should receive improved preventative services including appropriate public health campaigns and awareness campaigns that highlight the need to treat stroke as a '999' emergency – e.g. running a FAST awareness campaign.	Agreed. The FAST campaign is a national initiative and will continue to be promoted. The prevention plans will be shared across all CCG's as described in section 3.

Kent County Council Feedback

Kent Feedback	Response
With only one HASU based in East Kent, we have concerns about the travel times for the deprived communities in Romney Marsh and Thanet and would like to see further detail on how this will be mitigated.	Agreed. This has been highlighted by feedback from the public consultation and through the preferred option IIA specifically (Appendix SS). Additional detail has been added in section 8.4.3. A second IIA workshop is being arranged in east Kent and will be taken forward in implementation.
Across the whole of East Kent, we have concerns about what mitigations will be put in place in this part of the County as a result of the introduction of the HASU coming later than the HASUs in West Kent. While we understand the practical challenges, this will potentially lead to Kent residents experiencing an unequal level of service in different parts of the County during any transition period.	The concern is understood. The DMBC (section 9) has been amended to reflect the clinical proposal for implementation is a 2 phase approach. This will be tested, following a decision, with a wide stake holder group review.

Kent County Council continued

Kent Feedback	Response
As a basic principle, we would like to be assured that local rehabilitation services were established and ready to run on the same day that any HASU becomes operational.	Agreed. This is described in section 3.4. The rehabilitation pathways will be in place to coincide with the go-live of the HASU/ASUs. A rehabilitation business case is under development with a county wide audit currently taking place. The business case is due for completion in spring 2019.
As raised at JHOSC meetings, some financial information was changed at a late stage in the consultation process and we have concerns about the revised information being fed into it at a late stage.	The DMBC was updated with the most recent information in all applicable areas as outlined in section 6 and the detailed provider presentations are available at Appendix K. The letter from NHS E setting the investment expectations is available in Appendix T.

Medway Council Feedback

Medway Feedback	Response
Medway council do not consider Option B represents the best option and are concerned the process for selection had flaws in it.	The process has been clearly laid out in the DMBC in sections 4 and 6. At each the process and information were rigorously tested with sub groups of the stroke programme governance and with attendees of decision making meetings.
Medway are concerned about the phased approach for implementation having a detrimental impact on east Kent patients.	The concern is understood. The DMBC (section 9) has been amended to reflect the clinical proposal for implementation is a 2 phase approach. This will be tested, following a decision, with a wide stake holder group review.
Medway are concerned about how and where patients will be cared for if they are unable to return home after the acute hospital stay.	Agreed. The pathway for transfer of care from hospital to the community is described in section 3.4.1. The rehabilitation and early supported discharge pathways will be in place for go live.
No response has yet been received to the Medway Council letter dated 8th November to Ivor Duffy from NHS England.	The response has now been provided from Rachel Jones, SRO for Stroke.

Medway Council continued

Medway Feedback	Response
Medway are concerned that the public consultation is not being re-run particularly with regard to the inclusion of the PRUH.	The flows to hospitals outside of K&M were included in public consultation document. The impact in both Bexley and East Sussex was visible and both areas were formally included in the public consultation and both council's joined the JHOSC.
From the externally commissioned report: Option B may not be able to meet expected increases in demand.	Following these concerns and a recommendation to review the stroke admission projection from the SEC Clinical Senate a further piece of work was commissioned. Details of this can be found in section 7.2.3 (6 P11). The mitigations for any increased demand have been approved by the CRG, SPB and JCCCG.
Option B carries the significant risk that bed capacity will be taken up by South East London residents at the expense of K&M residents.	London have already reconfigured stroke services and patients have access to a number of units within 30 minutes. SEL commissioners and London Ambulance Service have confirmed they do not wish to change their commissioning or current transfer protocols. Bexley CCG have confirmed patients will flow as they do now.

Medway Council continued

Medway Feedback	Response
Option B unnecessarily and disproportionately affects areas of higher deprivation.	The full range of impacts are identified in the Integrated Impact Assessment (Appendix SS) and the IIA workshops will develop specific mitigations. Travel and access has been highlighted and the Travel Advisory Group will make recommendations to the JCCCG to ensure all mitigations to support local communities are put into place.
Medway Council is concerned about changes to the evaluation criteria and methodology: • Criteria priority order was removed • Additional sub criteria were added • Scoring keys were changed • Composite methodology was changed • The impact of the PRUH were not appropriately considered	Detailed responses to these concerns and questions have been responded to separately. The detail of the selection of the preferred option is detailed in section and this has been expanded to detail the amendments (section 6.1) and a log of changes has also been included in Appendix QQ.
Medway are concerned that the location of HASUs outside of Medway will increase health inequalities.	The evidence from all other implementations have demonstrated a reduction of health inequalities and an improvement in all patients outcomes. This is also supported in the IIA report at Appendix SS.

Medway Council continued

Medway Feedback	Response
The changes appear to have been made to provide assistance to areas outside of K&M.	The purpose of stroke review has always been to improve services for all patients who have a stroke or suspected stroke and would attend a hospital in Kent and Medway.
The PRUH failed to deliver an implementation plan.	The PRUH did deliver a plan and attended the Delivery Panel held on 4th September. The plan they submitted can be found at Appendix W.

Bexley Council Feedback

Bexley Feedback	Response
We consider that the decision-making business case could be strengthened even further if it were clearer on the significance of the impacts of the stroke review on the PRUH. Given that the hospital is outside the Kent and Medway STP area, the link between the ability of the PRUH to cope with any increased activity and the deliverability of the options may not be immediately clear, but this is a key issue.	Agreed. The PRUH response to the Deliverability Panel process has been included in Appendix W. The impact of that information is demonstrated in section 6.2.
We think the impacts of future population growth should be carefully considered as part of the decision making process and that the Bexley aspect needs further narrative within the documentation being used as part of the final decision making process.	Agreed. We have undertaken further work on future population growth, specifically in relation to the ageing population and potential impact on stroke admissions to K&M HASU/ASUs. This additional work can be found at Appendix EE and in section 7.2 (6 P11)

Bexley Council continued

Bexley Feedback	Response
We hope that both the SEL STP and LAS will be collaboratively engaged in discussions to agree the postcodes for the DVH catchment and to agree protocols for conveying Bexley patients to DVH and any ambulance transfers that may subsequently be required.	Agreed. The SEL STP and LAS have engaged with the programme and have considered the travel time modelling. Bexley CCG and LAS have confirmed they would expect their patients to flow as they do now. They LAS and London commissioners will continue to be involved during implementation to ensure detailed plans, including catchment postcodes are agreed.
We note that there is a work stream to consider the rehabilitation model across Kent and Medway and would hope that LB Bexley's Director of Adult Social Care will be engaged as these discussions continue as clearly there will need to be some understanding or alignment of processes across Kent, Medway and SE London.	Agreed. The rehabilitation work stream will include representatives from Bexley. It is worth noting that London has already delivered HASU and ASU and K&M are working with them on lessons learned, including the development of rehabilitation as referenced in section 7.2.

Questions and comments submitted for today's meeting

Please see attached documents;

1) "Questions for JCCCG" – public
2) JHOSC feedback and Medway Minority Report

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

Final DMBC and key changes from PCBC

Chapter	Overview	Key changes from the PCBC
Chapter 1: Introduction	Describes the background, progress and key stakeholders in the Stroke Review	None
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	None
Chapter 3: Clinical vision for the future	Describes the clinical model for stroke, from prevention through to Rehabilitation	• Pathways for Stroke Mimics and transfers from Non HASU hospitals • More detail around the Prevention Plan • More detail provided around the plan to deliver a rehabilitation business case by Spring 2019
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	None
Chapter 5: Public consultation	This section describes the public consultation on the five shortlisted options, details key themes arising from the consultation and our responses	In reflection of issues raised from consultation, more detail has been provided around how the projected increase in stroke incidence will be managed

Final DMBC and key changes from PCBC

Chapter	Overview	Key changes from PCBC
Chapter 6: Identifying the preferred option	This chapter describes the process undertaken to identify a preferred recommended option for service change	Some further detail provided around the de-anonymised nature of the evaluation data
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	Following from Clinical Senate recommendations, more detail and assurance have been provided around: • SECAmb ability to deliver • Rationale behind 3 day length of stay reduction and ability to deliver
Chapter 8: Assessing the implications of the recommended preferred option	This chapter details the implications of the recommended preferred option on quality, activity, travel and access, equalities, workforce and finance	More detail has been provided around: • Workforce assumptions that underpin the preferred option including more detail on the initiatives planned and in place • The financial assumptions section has been re-worded and simplified

Final DMBC and key changes from PCBC

Chapter	Overview	Key changes from PCBC
Chapter 9: Implementation plan	This chapter details the implementation plan for the recommended preferred option and proposes a 2 phase approach to implementation	Following feedback, it has been emphasised that the 2 phase approach will be subject to further analysis, discussion and agreement
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	None
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 across Kent and Medway and the expected timeline for decision making	None

Assuring the preferred option

- The Stroke Review has sought to exceed its obligations in meeting the statutory requirements and assurance that accompany any major change to NHS services
- Clinical proposals have been reviewed at three stages by the South East Coast Clinical Senate
  - Recommendations of these reviews have been incorporated into the proposals.
- The evaluation process and pre-consultation engagement was assured by NHS England and approval to undergo consultation was dependent on this assurance
  - This included a review of the proposals by the National Investment Committee in January 2018
- We have formally consulted with the Joint Health Overview and Scrutiny Committee and engaged with individual Health Overview and Scrutiny Committees across the four relevant local authorities
  - We have used their feedback and challenge to refine our proposals at every stage of the process
- The Stroke Review has met the four tests and three conditions for reconfiguration set out by the Secretary of State and CCGs have complied with their duties under the Equalities Act 2010

Assessing the implications of the preferred option (1)

We have looked at the impact of the preferred option on quality, activity, travel and access, equalities, workforce and finance

- There would be higher quality, more consistent care in hospital for urgent stroke services with the development of hyper acute and acute stroke units
- There would be greater access to specialist staff and equipment and quicker treatment times
- Some patients would have to travel further for the urgent aspects of their stroke care, with the maximum journey time being 63 minutes however, consolidating hospital stroke services will save lives and reduce disability

Assessing the implications of the preferred option (2)

- There would be a combined HASU/ASU unit at Darent Valley Hospital (34 beds), Maidstone General Hospital (38 beds) and William Harvey Hospital (52 beds), with a small outflow to Eastbourne General Hospital (2 beds)
  - Robust protocols have been developed and would be put in place to transfer any patient at a hospital without a HASU/ASU who is suspected of having a stroke
- There would be an increase in specialist stroke staff including additional consultant, nurses and Allied Health Professionals
- Financial sustainability would be improved with a reduction in the K&M deficit however, the service remains loss making. Following feedback from providers and to ensure sustainability, the JCCCG has committed to a further financial review as part of implementation

Consideration of Integrated Impact Assessment

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	• Protocol for patients suffering a stroke at 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 ensure a strong STP focus and plan in place 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

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 of a HASU and for thrombolysis to be given within 120 minutes of calling 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	• Form a Travel Advisory Group to better understand any transport strategies which can help to mitigate any travel 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 • We will form a Travel Advisory Group to better understand any transport strategies which can help to mitigate any travel impacts

Implementation plan

- If a decision is made today to progress with our preferred option, ambition is to implement the new services as quickly as possible whilst ensuring that quality and patient safety are not compromised
- Local clinical leaders have initially proposed that a two-step approach to implementation would be the most effective
  - HASU/ASUs at Maidstone and Darent Valley Hospitals would go live in March 2020
  - William Harvey Hospital would go live in spring 2021
- The proposed two-step approach will be rigorously tested as part of implementation preparation
- We will establish a Stroke Review Implementation Board, a clinical lead will be appointed across Kent and Medway and a senior clinician will oversee the changes at each site.
- Key implementation activities have been agreed in principle and a proposed programme plan has been developed
- Maintaining quality and workforce have been identified as the highest risk areas and mitigations have been agreed
- A communications and engagement plan has also been developed

Benefits of the proposed change

- The main areas of benefit expected to be delivered by the reconfiguration of stroke services are:
  - Improved clinical outcomes for patients
  - Improved experiences of care for patients and their carers
  - Improved experiences for staff, due not only to improvements in patient care, but also improved team and multi-disciplinary working and increased opportunities to maintain and enhance skills
  - Supporting the delivery of clinically and financially sustainable services
- Plans have been made to monitor progress against the benefits from the outset using an agreed set of measures
- We have an ambition to achieve a SSNAP A rating at all three units within 6 months of launching the HASU/ASUs

Resolutions

Taking into account all of the evidence that has been made available to JCCCG members, the JCCCG is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality acute stroke care for patients in, and residents of, Kent and Medway

1. To agree and adopt the acute stroke service models with 3 HASU/ASUs as described in Section 3
2. To agree the establishment of these joint HASU/ASUs at Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital as described in section 6.4
3. To agree that when the HASU/ASUs are developed that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth, the Queen Mother Hospital and Kent & Canterbury Hospital

Resolutions

5. To note the integrated impact assessment of the preferred option as set out in Section 8.4 and agree the establishment of a Transport Advisory Group to make recommendations on travel issues as part of implementing the plans
6. Agree the current financial impact and confirm a review of long term financial sustainability will be undertaken as part of implementation
7. To agree the key performance benefits set out in Section 10.4 and agree to set up the benefits monitoring system outlined in Section 10.5
8. To agree that a business case for stroke rehabilitation services is needed as a matter of urgency and will be presented to the JCCCG not later than spring 2019
9. To agree the adoption of the governance model and resourcing plan set out in Section 9.3

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill

Resolutions

Taking into account all of the evidence that has been made available to JCCCG members, the JCCCG is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality acute stroke care for patients in, and residents of, Kent and Medway

1. To agree and adopt the acute stroke service models with 3 HASU/ASUs as described in Section 3
2. To agree the establishment of these joint HASU/ASUs at Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital as described in section 6.4
3. To agree that when the HASU/ASUs are developed that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth, the Queen Mother Hospital and Kent & Canterbury Hospital

Resolutions

5. To note the integrated impact assessment of the preferred option as set out in Section 8.4 and agree the establishment of a Transport Advisory Group to make recommendations on travel issues as part of implementing the plans
6. Agree the current financial impact and confirm a review of long term financial sustainability will be undertaken as part of implementation
7. To agree the key performance benefits set out in Section 10.4 and agree to set up the benefits monitoring system outlined in Section 10.5
8. To agree that a business case for stroke rehabilitation services is needed as a matter of urgency and will be presented to the JCCCG not later than spring 2019
9. To agree the adoption of the governance model and resourcing plan set out in Section 9.3

Agenda

Welcome and introductions	Mike Gill
The process so far	Rachel Jones
The public consultation – what we did	Steph Hood
Questions, comments and feedback throughout the process	Rachel Jones
Developing the decision making business case	Rachel Jones
Committee discussion	All
Committee decision	All
Next steps and close	Mike Gill