KENT AND MEDWAY SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

Service Models and Hurdle Criteria – Stroke Service

Introduction

1. This paper summarises the service models and hurdle criteria that have been developed for stroke services through the Kent and Medway Sustainability and Transformation Partnership (STP). Changes to stroke services have implications for the patients from High Weald Lewes Havens (HWLH) CCG who look to Kent and Medway providers for the provision of stroke care.
2. The service models and hurdle criteria were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway. The development and progress of the design phase has been regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate[1] and their feedback has been taken into account in preparing the final versions that are now being presented.

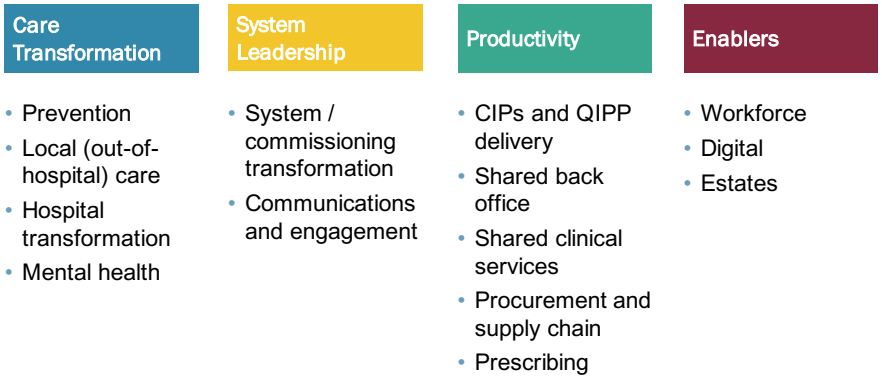
Context

3. Sustainability and Transformation Plans were proposed in the annual NHS planning guidance Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 issued in December 2015[2]. This outlined the triple aim of the plans was to address: health inequalities; quality failings and under-performance against NHS Constitution targets; and financial challenges.
4. The further development of Sustainability and Transformation Plans, and a further recognition that these arrangements are about collective system leadership through the change of name to Sustainability and Transformation Partnerships, was outlined in Next Steps on the Five Year Forward View[3] published in March 2017. The October STP submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:

[1] Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders. This includes reviewing proposed changes through bringing together a range of healthcare professionals with patients to review proposals presented to them. This is also part of the NHS England service change assurance process.

[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

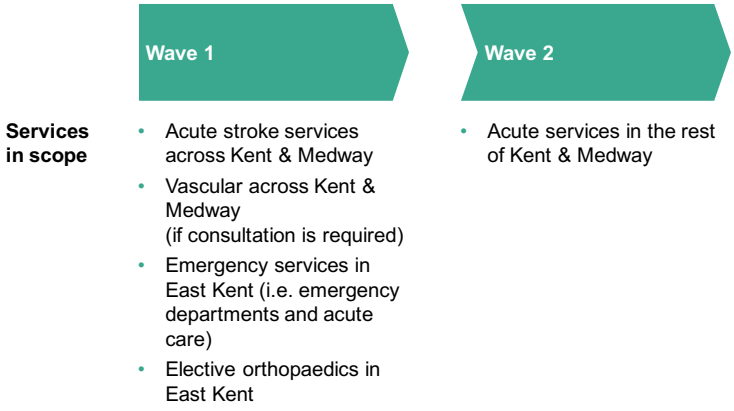
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf



5. Workstreams were established to take forward each of the above areas, comprising clinicians, leaders and practitioners from across Kent and Medway NHS and local authority organisations. They have been meeting since the autumn of 2016 and test and discuss their work with both the programme's Patient and Public Advisory Group (including its precedessor the PPEG) and the programme's Partnership Board as part of an ongoing programme engagement infrastructure.

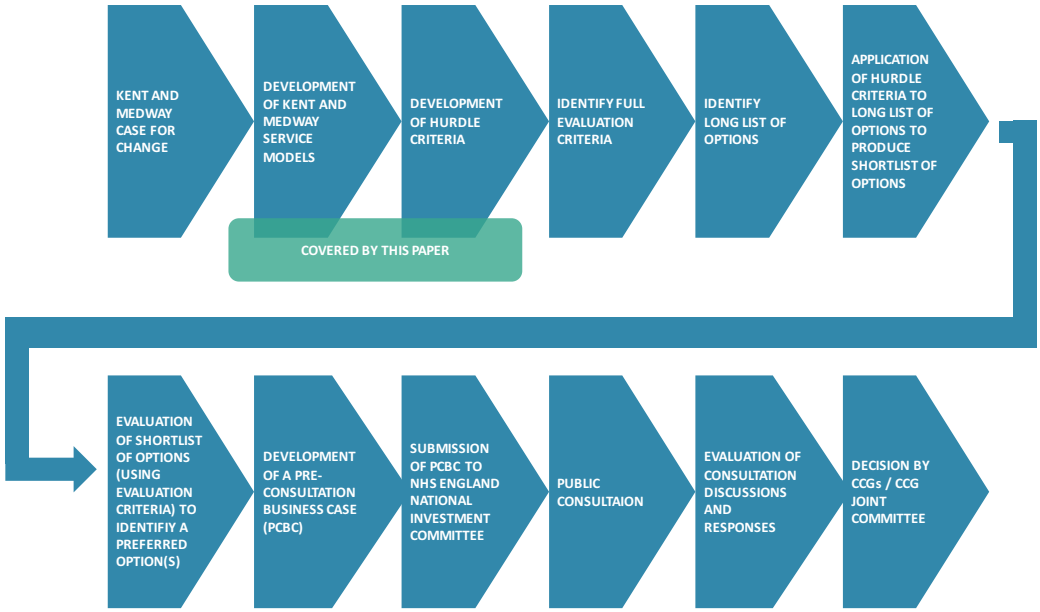
6. The STP Programme Board took stock of the progress being made by these workstreams in February 2017. It was recognised that different parts of the Kent and Medway area were at different stages in relation to their readiness and development.

7. The STP stocktake concluded from an analysis of patient flows within Kent and Medway that there are negligible potential activity flows from East Kent to the rest of Kent and Medway. It was proposed that it is possible to consult on service changes in East Kent around urgent and emergency care alone, though the impact on future options in the rest of Kent and Medway will need to be considered. Therefore, two waves of public consultation are proposed to be undertaken within a clear strategic framework for all of Kent and Medway:



8. It is envisaged that any consultation on the reconfiguration of stroke services will take place in early 2018, subject to agreement from NHS England and consultation with relevant health overview and scrutiny committees.

9. In moving to consultation we are following a process that covers a number of stages as outlined in the following diagram (as outlined in the process diagram this paper covers the proposed service models and hurdle criteria for stroke services):



Case for change

10. The Kent and Medway STP Clinical Board has prepared a technical case for change[4] which has been used to prepare a more accessible public facing case for change to support engagement with patients, carers, local communities and stakeholders[5].

11. These documents outline the strategic rationale for why change is needed. While there is much to be proud of about health and social care services in Kent and Medway, there are several issues that we need to tackle; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care through self-management, ill health prevention and earlier diagnosis. The following provides a summary of the case for change:

	Case for change	Our ambition
Health and wellbeing	• Our population is expected to **grow by 414,000 people** by 2031. Growth in the number of over 65s is **over 4 times greater** than those under 65; an aging population means **increasing demand for health and social care**. • There are **health inequalities** across Kent & Medway; in Thanet, one of the most deprived areas of the county, for example, a woman living in the best ward for life expectancy in Thanet can expect to live **almost 22 years longer** than a woman in the worst. The main causes of early death are **often preventable**. • Over **500,000 local people live with long-term health conditions**, many of which are preventable. And many of these people have multiple long-term health conditions, dementia or mental ill health.	• Create services which are able to meet the needs of our changing population • Reduce health inequalities and reduce death rates from preventable conditions • More measures in the community to prevent and manage long-term health conditions
Quality of care	• There are over 1,000 people who are **in hospital beds who could be cared for elsewhere if services were available.** Being in a hospital bed **for too long is damaging for patients** and increases the risk of them ending up in a care home. • We are **struggling to meet performance targets** for cancer, dementia and A&E. This means people are not seen as quickly as they should be. • Many of our local hospitals are in 'special measures' because **of financial or quality pressures** and numerous local nursing and residential homes are **rated 'inadequate' or 'requires improvement'**.	• Make sure people are cared for in clinically appropriate settings • Deliver high quality and accessible social care across Kent and Medway • Reduce attendance at A&E and onward admission at hospitals • Support the sustainability of local providers
Sustainability	• We are **£110m 'in the red'** and this will rise to **£486m by 20/21** across health and social care if we do nothing. • Our **workforce is ageing** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time and there are high numbers of temporary staff across health and social care.	• Achieve financial balance for health and social care across Kent and Medway • To attract, retain and grow a talented workforce

SOURCE: Kent and Medway 5yrFV

[4] http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/Kent-Medway-Case-for-Change-technical-doc-FINAL-UPDATED.pdf
[5] http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf

12. The position outlined in the case for changes provides further details of the challenges against the triple aims of STPs (as outlined in Point 3), namely:

    i. health inequalities – there continue to be significant health inequalities within Kent and Medway, with the main causes of early death often being preventable:

    ii. quality failings and under-performance of NHS Constitution targets – with large numbers of patients not supported in the most appropriate setting of care, widespread non-delivery of NHS Constitution targets and a significant number of organisations facing quality challenges; and

    iii. financial challenges – a net over-performance on £110m in 2015/16 on the NHS total system budget which is projected to rise to £486m by 2020/21.

13. The challenges outlined above, and in more detail in the case for change, impact detrimentally on the health and lives of the population we service and on the sustainability of NHS and social care services. The strategic remit of the STP is to address these challenges.

Stroke services

14. More detailed information on the stroke service model is included in Appendix 0.

15. In 2015/16 approximately 2,500 acute stroke patients were supported in the seven acute hospitals in Kent and Medway. Currently all of these hospitals provide acute stroke care and, following the immediate acute episode, patients are either discharged without further rehabilitation or discharged back to their home with a community rehabilitation package or to a new home, such as a residential care home, that is suitable for their needs.

16. In 2015/16 only half of all patients were admitted within four hours and this performance is below the national average. In addition:

    i. all hospitals only provide five-day stroke consultant face-to-face cover;

    ii. none provide seven-day consultant ward rounds;

    iii. less than 50% of patients receive thrombolysis within 60 minutes; and

    iv. performance against Sentinel Stroke National Audit Programme (SSNAP) is variable and inconsistent.

17. Currently patient volumes are too small to deliver clinical sustainability hyper acute stroke units on all seven acute hospital sites. In particular, there are significant challenges that cannot be met with the current service model with all seven hospitals providing acute stroke care. We need to ensure there is 24/7 consultant availability with a minimum of six trained thrombolysis consultant physicians on rota and consultantled ward round seven days a week. This will be supported by a multi-disciplinary team including nurses, physiotherapists and occupational therapists.

18. In order to achieve the above we need to consolidate stroke services on fewer sites to ensure there are sufficient volumes of patients supported on each site to sustain the staffing numbers. For Kent and Medway this means delivering a combined hyper acute stroke unit and acute stroke unit service on a smaller number of sites. In practice for Kent and Medway this means developing hyper acute stroke units that support volumes of more than 500 patients and less than 1,500 confirmed stroke patients.

19. Alongside the acute stroke provision it is recognised that we need to develop robust early supported discharge and rehabilitation services.

20. Information is included in Appendix Π on the number of patients from outside of Kent and Medway that receive stroke care from local hospitals.

Hurdle criteria

21. As with the clinical models, the hurdle criteria has been developed through the hospital care workstream, with clinical and patient engagement, and then reviewed and signed-off by the STP Clinical Board prior to being approved by the STP Programme Board.

22. Through consideration of the service models we will identify a long list of options around potential service changes. As outlined in the process diagram at Point 11, these will be evaluated using the hurdle criteria. An option must meet the requirements of each of the hurdle critieria or it will be rejected. This means that through assessing the long list of options by applying the hurdle criteira a shortlist of options will be generated. This shortlist of options will go forward to more detailed evaluation. The following hurdle critieria are proposed:

Criteria	Description in relation to application against long list of options for stroke services
Is the potential configuration option clinically sustainable?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively?
Is the potential configuration option implementable?	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view
Is the potential configuration option accessible?	• Can the population access services within a window of 120 minutes from call to needle?[6]
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?
Is the potential configuration option financially	• Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting*

[6] Using 95% accessing services within 60 mins (off-peak) as a proxy

sustainable?	*more at PFI sites, this will be considered in detail at evaluation stage)*

Summary

23. As indicated at the start of this paper it is envisaged that consultation will take place in 2018 on stroke service provided in Kent and Medway. This paper provides an update and information on the service model and hurdle criteria that have been used to provide the initial assessment of options.