Transforming health and social care in Kent and Medway

NHS

Dear Cllr Constantine,

It was a pleasure to meet with you on Tuesday 6 March and discuss the stroke consultation proposals and wider plans for healthcare in east Kent.

Many thanks for taking the time to contact me about our proposals for stroke services in Kent and Medway. As a HOSC member, we have valued your steer and insights as the stroke review has progressed and now we are at a formal consultation stage, it is very useful to hear from you as an elected representative. We understand that people in Thanet have concerns about the proposals and we appreciate you highlighting these with us and giving us the opportunity to respond to them. Please see the answers to your questions in the order that you have asked them below.

Looking across Kent which area has the highest stroke rates, and what type of strokes?
The following wards have had highest numbers of strokes, on average, over the last 3 years (more than an average of 5 strokes per year) – Thanet wards are highlighted in yellow:

Barming	Heath	Romney Marsh
Barton	Heron	Rusthall
Bean and Darenth	Hythe	Salmestone
Beaver	Little Stour and Ashstone	Sheerness
Beltinge	Middle Deal and Sholden	Sheppey East
Birchington North	Milton Regis	St Margaret's-at-Cliffe
Birchington South	Nethercourt	Sutton Valence and Langley
Blean Forest	New Romney	Swalecliffe
Borden and Grove Park	North Downs East	Tenterden North
Brent	North Willesborough	The Meads
Bridge	Northwood	Walmer
Chestfield	Painters Ash	Weald Central
Cliftonville East	Pembury	Weald East
Eastry	Rainham North	Weald South
Folkestone Central	Ringwould	Westgate
Frittenden and Sissinghurst	River	Westgate-on-Sea
Gillingham South	Rochester South and Horsted	Woodstock
Hartley and Hodsoll Street	Roman	Wrotham, Ightham and Stansted

Around 85% of these strokes are caused by a blood clot (a cerebral infarction) (based on ICD10-codes). However, only between 10-20% of patients are suitable for clot-busting drugs in their initial treatment.

In 2016-17, of the top 20 areas with the highest incidence of stroke in Kent & Medway, only 2 were in Thanet CCG (with 7 in South Kent Coast CCG). There are also some wards in Thanet that have a

lower than average incidence of stroke (e.g. Central Harbour and Sir Moses Montefiore) compared to the average across Kent and Medway.

Can you be unequivocal that all stroke patients will arrive at the WHH within 1 hour. (Blue lit or otherwise).

We have spent a significant amount of time modelling the travel times as part of the development of these proposals.

For stroke we look at the time it takes from the 999 call being made to the patient receiving a brain scan and beginning appropriate treatment. This is known to as 'call to needle' time, with 'needle' referring to patients being given clot-busting drugs should they need them. It is important to note that only 10 to 20% of patients are suitable for these drugs. Within this overall timeframe, there are other elements we can measure, including:

1. Time from 999 call to ambulance arriving (response time)
2. The time the ambulance crew spend on scene
3. The journey time to the hospital
4. The time from arrival at hospital to starting treatment (door to needle).

Our travel modelling has looked primarily at point 3 – journey times to hospital, but we have also factored in the other elements in our modelling.

We have looked at journey times from each 'LSOA' in Kent and Medway. LSOAs or Lower Layer Super Output Areas are geographic areas designed to improve the reporting of small area statistics in England and Wales. Lower Layer Super Output Areas are generated to be as consistent in population size as possible. The minimum population is 1000 and the mean is 1500.

All five of the consultation options mean that 99.9 per cent of journey times by blue light ambulance would be 60 minutes or less, and no-one would need to travel for more than 61 minutes. For all the options, over 90 per cent of people could reach a hyper acute stroke unit within 45 minutes by both ambulance and car. Around 75 per cent of people could reach a hyper acute stroke unit within 30 minutes by both ambulance and car. In developing our shortlist of potential options, we rated the options with the shortest journey times for the most people more positively.

People having a stroke (acute stroke patients) who dial 999 would always be conveyed by blue-light ambulance to the hyper acute stroke unit for their area, and the travelling times we set out in the stroke consultation are realistic for blue-light ambulances, no matter how frustrating the traffic for other road users.

In Kent, we work to the South East Clinical Network 'call to needle' ambition of 120 minutes. However, it's worth noting that this ambition is more stringent than national best-practice guidelines, published by the Royal College of Physicians and endorsed by NICE, which say that patients should get clot-busting drugs, if they need them as soon as possible, ideally within 3 hours of symptoms starting (and at most within 4.5 hours). Between 10 and 20 per cent of stroke patients may need this clot busting therapy (thrombolysis).

The table below gives an example using the longest modelled travel time of 61 minutes as well as the actual average times supplied by SECAMB based on their latest data.

	Modelled times	**Actual SECAMB data**
Time from 999 call to ambulance arriving (response time)	National response time target: 18 minutes	Average response in Thanet:15 minutes
The time the ambulance crew spend on scene	20 minutes	20 to 30 minutes

The journey time to the hospital	61 minutes	Average blue light times from Thanet to William Harvey are around 45 to 50 minutes
The time from arrival at hospital to starting treatment (door to needle)	30 minutes (for HASU with dedicated team on hand)	30 minutes (for HASU with dedicated team on hand)
Total 'call to needle' time	129 minutes	110 to 125 minutes

Currently one in three patients do not get a brain scan in the recommended time, and only half the patients in Kent and Medway who need it get thrombolysis within 120 minutes. This is primarily because patients are taken to busy A&Es where they may wait to be seen and there are not stroke specialists consistently available in every unit 24 hours a day, 7 days a week. This would not be the case with dedicated hyper acute stroke units with sufficient staff and scanning facilities to meet patients as the ambulance arrives and speed them through for their brain scan.

In addition, for all stroke patients including the 80 to 90 per cent for whom clot-busting drugs are not appropriate, the most significant factor to support their recovery is being treated in a specialist unit, in the first 72 hours after their stroke, with a specialist team of doctors, nurses and therapists able to give them intensive therapy, care and treatment 24 hours a day, seven days a week. We know from the evidence that this is the influential factor in reducing death from potential follow-on complications after the stroke (e.g. infection, deep vein blood clots, heart attack), reducing long-term disability and enhancing recovery.

We understand that people are concerned about longer travel times to a hyper acute stroke unit however, it is important to remember that ambulance paramedics are skilled professionals who begin assessment as soon as they arrive and provide care throughout the journey, who would link to the specialist stroke team on route so that everyone is fully prepared for the arrival of the patient. The ambulance service's call handlers are also an essential part of identifying potential strokes and ensuring patients are taken to the most appropriate hospital and receive a quick response when they arrive.

Will all patients requiring a clot busting drug (door to injection) receive this in all cases, within 1 hour?

Under these proposals our 'door to needle' target time is 30 minutes, not an hour. This is realistic in hyper acute stroke units where there is a dedicated team of specialists on hand 24 hours a day, 7 days a week. These teams would be on hand, ready to receive patients as soon as they arrive at hospital, assess, scan and begin appropriate treatment within a 30-minute window. The incidence of stroke across the whole of Kent and Medway is around 3,000 strokes per year. Although clearly patients don't present in a 'regular' timed pattern throughout the year this would equate to about 3 patients per day arriving at each hyper acute stroke unit for urgent treatment. The experience for these patients would be very different to what happens now where they are taken into a general A&E department and may find themselves waiting for specialist assessment alongside patients with other conditions and emergencies. The proposals are intended to bypass this and to get the patient directly to the specialist team, consistently, seven days a week.

Between 10-20 per cent of stroke patients may need clot busting therapy. The national guidelines says that patients should get clot-busting drugs, if they need them as soon as possible, ideally within 3 hours of symptoms starting (and at most within 4.5 hours of stroke). In the South East, we have set ourselves the even more stringent standard of patients getting clot-busting drugs, if they need them, within two hours of calling for an ambulance.

Our proposals mean that they will be able to receive clot-busting treatment – if clinically indicated – within that two-hour timescale wherever they are in Kent and Medway. When developing our proposals, we considered that an hour was the maximum acceptable journey time by ambulance, to allow enough time once a patient gets to a hyper acute stroke unit to have a scan and be given clot busting drugs if needed.

Can you confirm what exact investment from the £40 M will go into the ambulance service so that 999 stroke call outs will be responded to promptly.

£1m per year revenue cost is included for the ambulance service in the current financial calculations and the planned investment should these proposals go ahead. The exact nature of the investment will be determined as part of the development of the decision-making business case. For more detail see Appendix R of the Pre-Consultation Business Case https://kentandmedway.nhs.uk/wp-content/uploads/2018/01/Appendix-R-Financial-case.pdf .

What is the planned target time for an ambulance and suitable qualified paramedics to arrive at a stroke patient in Thanet?

The national targets for the ambulance service for getting to stroke patients (call to arrival) is an average of 18 minutes, with 90% within 40 minutes. SECAMB currently achieves an average of 18 minutes and 90% within 35 minutes [source: ambulance quality indicators for category 2 calls, December 2017]. The vehicle attending a suspected stroke victim is now an ambulance rather than a car (as it has been until recently), so patients can be immediately transferred to hospital rather than wait for a second vehicle to arrive to transport them to hospital.

How many ambulances and fully qualified paramedics do we have in Thanet, where are they located? What are the plans to modify this in line with proposed changes?

SECAMB have provided the following answer to this question:

The number of ambulances available varies by hour of the day/day of week to match the varying patterns of demand. At peak times, when we see the highest levels of demand, we have up to 25 ambulances on duty in Thanet, reducing to approximately ten ambulances during the early hours of the night when activity is at its lowest. In addition, we also have up to six response cars on duty, including our specialist clinicians (Critical Care Paramedics and Paramedic Practitioners).

The proposals outlined in the consultation document are not about an overnight change. Once a decision is made, a detailed implementation plan will need to be developed ahead of any changes being made. SECAMB would be fully involved in the development of this plan, to ensure that we can safely respond to the new service delivery model at the point changes are made. As part of the proposed changes, £1m of additional investment has been identified as needed and allocated to SECAMB in the pre-consultation business case considered by the Joint Committee of Clinical Commissioning Groups leading the consultation.

What are the workforce plans to recruit and train more paramedics, Stroke consultants, Stroke nurses, physiotherapists etc?

During the development of the potential options, stroke survivors, local people and staff consistently expressed concerns about the number of staff currently (current stroke services work with a number of vacancies within teams) and acknowledged the challenge in that more staff would be needed to establish hyper acute stroke units in Kent and Medway. They emphasised the importance of getting the staffing right. There is a national shortage of stroke consultants and specialist stroke nurses and therapists. All the options would mean we need to recruit additional consultants, but we have evaluated the options which require the fewest additional consultants more highly. It is also better for us to concentrate these scarce doctors and stroke specialist nurses and therapists, in fewer hospitals to provide the highest quality care around the clock, rather than spread them too thinly across more hospitals.

If the proposals go ahead, we will develop a detailed staff development and recruitment plan as part of establishing hyper acute stroke units. We know from other areas around the country that hospitals with hyper acute stroke units find it easier to recruit stroke consultants and other specialist stroke staff because they are professionally a more attractive place to work, offer better opportunities for professional development and allow staff to care for patients in line with national best practice.

What is the plan to give clot busting treatment to stoke victims in Thanet. Will this be done in the ambulance?

People in Thanet who suffer a stroke that requires clot-busting treatment will receive that treatment in the same way as any other patient; in a hospital once the necessary diagnostic procedures have been conducted to make sure that clot busting therapy is suitable for them. The necessary diagnosis, which requires a brain scan, and this particular treatment cannot be delivered in an ambulance.

Best quality care is where patients can get clot-busting drugs, if they need them, as early as possible but ideally within two hours of calling for an ambulance. Therefore, we considered that an hour was the maximum acceptable journey time by ambulance, to allow enough time once a patient gets to a hyper acute stroke unit to have a scan and be given clot busting drugs if needed. Between 10-20 per cent of stroke patients may be suitable for clot busting therapy.

Will all Stroke patients be taken to WHH?

If a decision was made to establish a hyper acute stroke unit at the William Harvey Hospital, then patients who have had a stroke or a suspected stroke living/located closest to the William Harvey Hospital compared to the other potential sites, would be taken to that unit to receive treatment. People who call for an ambulance would be taken by the ambulance to the nearest hyper acute stroke unit to them.

Are you currently certain that you have adequate staff to deploy to the three locations? (Some staff may choose not to travel from a current base to a new one) will they be sufficient to cover an expanded population, which takes in South London and East Sussex.

We don't currently have the staff we need to provide stroke services to the standard we would like across the six sites providing urgent stroke care. Proposals to create three HASUs will help to consolidate staff and resources. However, we will still need to recruit additional staff.

We know from staff feedback that most specialist stroke staff support the development of hyper acute stroke units to improve the quality of care for patients. We believe that setting up three hyper acute stroke units would improve recruitment and retention in the medium to long term, however, there may be short term disadvantages.

The changes would mean that some existing staff would be asked to change where and how they work. For some staff the impact of these changes on work and home life may not be acceptable and we might be at risk of losing some of our stroke staff. If changes were unsuitable for individuals, we expect that most would be able to move to alternative roles within their current hospital allowing them to stay on the same site.

We will not be 'taking in an expanded population'. 257 people a year who are not resident in Kent and Medway already receive emergency stroke treatment in our hospitals as that may be the nearest point of treatment for them and therefore we must factor those potential patients into our planning. We don't expect this number to change significantly if the proposed changes go ahead.

To be clear too, we have factored in projected population growth, the impact of housing developments etc into our modelling.

Can Thanet be included as one of the options for a location of a hyper acute stroke unit? Given the equality impact assessment. Can you please state that you will make it clear in the consultation that Thanet could 'come back in'?

The options have been developed and shortlisted for consultation following a rigorous process of evaluation and testing. However, the purpose of any public consultation is to understand public views and opinions and to ensure that the proposals stand up to challenge and scrutiny. No decisions have been made yet about the future of urgent stroke services in Kent and Medway.

We are not only consulting on the location of any potential hyper acute stroke units but are also asking people across Kent, Medway and our border areas:

- if they agree that there are good reasons to make changes to stroke services in Kent and Medway
- if they agree we should move to a 'hyper acute stroke unit' model of emergency stroke care,
- if they agree three units is the right number.

We want local people to tell us about any issues, concerns or ideas that they may have. We know that there is considerable strength of feeling in Thanet about the proposals, and that information will go back to the Joint Committee to be considered along with other consultation responses and all the other evidence and data gathered as part of the stroke services review.

People have asked why we haven't suggested having four specialist units, which could include the QEQM. Our detailed evaluation process showed that having four or more hyper acute stroke units in Kent and Medway would not be achievable due to the level of staffing needed, and the requirement for each unit to see at least 500 confirmed stroke patients a year. The table below shows why the evaluation excluded different numbers of potential sites:

Number of potential hyper acute stroke units (HASUs)	**Reason for exclusion**
One HASU	Too many stroke patients for a single unit Travel times too long for many people Not resilient (e.g. in case of fire/flood, outbreak of infectious disease etc)
Two HASUs	Travel times too long for many people Not resilient (e.g. in case of fire/flood, outbreak of infectious disease etc)
Four to seven HASUs	Not enough staff to cover 24/7 Not all units would see required minimum of 500 patients per year

The evaluation of possible three-site options (using criteria that was tested and agreed with clinicians, patients, the public and their representatives) was 'blinded' so those involved in the evaluation, did not know which sites they were considering. A summary of the reasons different options were not evaluated as favourably as others, and therefore were excluded from the shortlist, is shown in the table below.

Option	**Reason for a less favourable evaluation, and therefore exclusion from shortlist**
Options including QEQM plus two sites outside east Kent	Other beneficial clinical services that are desirable to support a hyper acute stroke

	unit are not available at QEQM Travel times for a proportion of south Kent coast would be too long
Options including both QEQM and William Harvey	East Kent Hospitals University Foundation Trust (EKHUFT) said they would not be able to run two HASUs due to challenges recruiting sufficient staff across both sites

What % of the Kent population are currently within 1 hour car journey to a stroke unit. I note your comments yesterday about Thanet being 63 minutes away.

We have spent a significant amount of time modelling the travel times as part of the development of these proposals. All five of the consultation options mean that 99.9 per cent of people could reach a hyper acute stroke unit by blue light ambulance within an hour and no-one would need to travel for more than 61 minutes. For all the options, over 90 per cent of people could reach a hyper acute stroke unit within 45 minutes by both ambulance and car. Around 75 per cent of people could reach a hyper acute stroke unit within 30 minutes by both ambulance and car. In developing our shortlist of potential options, we evaluated the options with the shortest journey times for the most people more positively.

People having a stroke (acute stroke patients) who dial 999 would always be conveyed by blue-light ambulance to the hyper acute stroke unit for their area, and the travelling times we set out in the stroke consultation are realistic for blue-light ambulances, no matter how frustrating the traffic for other road users.

Details on travel times for each option is shown in the consultation document and further information is on our website at www.kentandmedway.nhs.uk/stroke

How many people in Kent will potentially be located with access within one hour of two acute stroke units?

Option A	1,946,883 (88% of total population)
Option B	1,923,858 (87% of total population)
Option C	1,551,472 (70% of total population)
Option D	1,632,935 (74% of total population)
Option E	1,867,895 (84% of total population)

Re workforce we are lacking in consultants if we do move to 3 specialist units can we be sure that we will have enough staff to populate them? Including the extra population from East Sussex and South London.

We know from staff feedback that most specialist stroke staff support the development of hyper acute stroke units to improve the quality of care for patients. We believe that setting up three hyper acute stroke units would improve recruitment and retention in the medium to long term. We are far more likely to attract specialist staff – including stroke consultants - if we establish specialist units where staff can build their experience and skills and provide much better standards of care and better patient outcomes with deliverable 24/7 staffing rotas.

Kent and Medway hospitals treat 257 people a year from south London and East Sussex (this number is based on a three-year average of actual activity as reported by acute trusts across Kent and Medway) as they may be nearest to a Kent and Medway hospital when they suffer a stroke or a suspected stroke. Our modelling and analysis suggests that this number is unlikely to change significantly if hyper acute stroke units are established across Kent and Medway.

Is this the beginning of downgrading services in QEQM?

This is about creating specialist stroke centres based on strong clinical evidence to deliver better treatment and outcomes for patients i.e. reducing death and disability for all stroke patients in Kent and Medway. All hospitals within Kent and Medway play a vital role in caring for local communities and the location of stroke services would not alter this. Evidence from elsewhere in the country shows that hospitals do not need to have a hyper acute stroke service in order to provide or retain an Accident and Emergency Department nor to be busy, vibrant hospitals providing a range of services.

What Stroke services will be offered at QEQM after this restructure?

If the proposals are agreed and implemented, only acute and emergency/urgent stroke services would be affected. Rehabilitation and support services that local people rely on to help them recover from a stroke would still be available at QEQM and in local communities.

How has the CCG arrived at a decision to make the people with the worst health outcomes, travel the farthest? Are Thanet residents needs expedient when weighed against the needs across Kent?

We looked very carefully at deprivation. We know that people from the most economically deprived areas of the UK are around twice as likely to have a stroke and are three times more likely to die from a stroke than those from the least deprived areas. This is due to the strong association between deprivation and stroke risk factors such as higher levels of obesity, physical inactivity, an unhealthy diet, smoking and poor blood pressure control.

However, actual figures for Thanet show there is no clear correlation between deprivation and average stroke incidence over 3 years. Thanet has 10 times as many people in deprived areas than West Kent but the strokes per head of population is only marginally higher (2.1 vs 1.8). The area with the highest incidence of stroke is in Westgate-on-Sea and is relatively deprived (IMD English Index of Multiple Deprivation score of 3 – one being highest deprivation, 10 being lowest), but three of the top ten areas with the most strokes in Thanet have an IMD score of 6 or 7. This shows that high deprivation does not automatically equal higher incidence of stroke, and vice versa.

The impact of the proposals on deprived communities has been extensively reviewed as part of the integrated impact assessment. Work has been done to develop mitigation strategies for deprived communities who may have difficulty accessing services whichever option is chosen (there are pockets of deprivation across Kent and Medway). For example, giving consideration to the cost and availability of car parking for relatives of stroke patients; working with local public transport providers to identify ways to improve access; working with local voluntary sector organisation for support with transport; and exploring options for carers and relatives to stay overnight especially if they are further away from home.

Further work will be done on this as part of the development of the Decision-Making Business Case.

A robust process was followed to develop the proposed model of urgent care for stroke victims to improve outcomes for everyone served by Kent and Medway hospitals.

A shortlist of thirteen three-site options for further evaluation was agreed using a set of ‘hurdle criteria’. This part of the process ensured that there were no options with over five per cent of the population who would have to travel over 60 minutes to access stroke services

The evaluation criteria and approach to assessing against them were agreed through an iterative process with input from a range of stakeholders including patients and the public, clinicians, commissioners and providers. Through input and iteration across these meetings, the thirteen options were assigned an evaluation against each agreed evaluation sub-criterion under the five evaluation domains, using a five-point scale (++, +, /, -, - -).

The evaluation across all five evaluation domains, including their respective included sub-criteria, was brought together into a single evaluation matrix. The purpose of the matrix was to allow a review of the options in the round. The matrix allows for the identification of potential themes that might be considered more or less important in the decision-making process, without ascribing a weighting.

A number of evaluation workshops were held, where the options were anonymised or 'blinded', so participants were not aware of the sites. Participants were asked to review this anonymised version of the evaluation matrix. Following three evaluation workshops, additional review from the Stroke Clinical Reference Group, the South East Clinical Senate, the Stroke Programme Board, Health Overview and Scrutiny and NHS England assurance, commissioners agreed the shortlist of five options recommended for consultation.

The number of stroke patients would be between 1-2 per day who would be taken to a hyper acute stroke unit from Thanet if these proposals are adopted. The evidence would indicate that those patients would be less likely to die and less likely to have more long-term disability than if they weren't taken to a specialist unit. The biggest impact, on a far greater number of people, in terms of reducing health inequalities, is and will continue to be addressed in Thanet through prevention of ill-health, promotion of wellbeing and improved primary care and local hospital services. For example, effective assessment and management of patients with high blood pressure, through GP led services in Thanet, is one of the key factors that will have a positive impact on stroke incidence, other conditions and the health of the local population. Health inequalities we know are also addressed through the wider determinants of health such as housing, employment, education etc. This is why in Thanet, as elsewhere in Kent and Medway, the NHS continues to work with local authority and other partner agencies and local people to reduce health inequalities in the local population.

Can Thanet residents be assured that following the extra time they have spent in the ambulance, compared to other Kent residents, they will be the very front of the queue as a priority for urgent treatment?

Under each of the five of the shortlisted options, a hyper acute stroke unit at William Harvey would see around 1200 stroke patients each year, an average of 3.3 a day. Under the proposals, hyper acute stroke units would be run by dedicated teams of stroke specialists available 24/7. These teams would be alerted that the patient was on route in the ambulance, be ready to meet the patient on arrival, and begin assessment, diagnosis and appropriate treatment straight away. Unfortunately, this is not something we can guarantee 24 hours a day, seven days a week at present.

All patients – wherever they are from - would be assessed, triaged and treated according to the urgency of their clinical needs. However, with relatively small numbers of patients coming through the door each day, it is unlikely that teams would be so stretched that they could not attend to each patient immediately on arrival.

Depending on where people live, the ambulance journey to reach a hyper acute stroke unit may be longer than being taken to their nearest hospital, but what is most important is the speed and quality of care they receive once they reach the hyper acute unit. People have a much better chance of surviving and making a full recovery if they travel further but are treated in a specialist unit.

Will the 38% online petition and paper petition I have stated be counted as part of the consultation? (this wasn't answered at the 31st Jan meeting).

Yes, all feedback we receive during the consultation period will be logged and analysed and included in the report that will be considered in detail by the Joint Committee of CCGs later in the year. People are welcome to submit other evidence, views and insights to us for the Joint Committee of CCGs to consider.

Whilst it is important to remember that public consultations are not votes or referendums, the Joint Committee of CCGs will thoroughly consider all the evidence and data gathered throughout the review and consultation process.

What provision will this model, 7 > 3 bring for the better linking of discharge and social care, how will that be managed? What are the specific plans for Thanet where social care can be inconsistent and is a difficult role to recruit to? Which companies will be involved in this?

As we refer to in our consultation document, improving stroke services is part of a wider programme across Kent and Medway to improve health and care, involving all the local NHS organisations, Kent County Council and Medway Council. We are looking at what needs to be done differently to bring about better health and wellbeing, better standards of care, and better use of staff, funds and other resources. The changes to hospital-based stroke services are being developed alongside and in alignment with other work on improving hospital services, developing more local care outside of hospitals, and improving mental health and social care.

This includes the care and support that people have after they have had a stroke in a home or community setting. We believe it is imperative that we move forward with a decision on improvements to urgent hospital-based stroke services, but we will continue to align stroke improvements, and particularly further work on rehabilitation and follow-on care, to our wider sustainability and transformation partnership programme. You can read more about this work on our website https://kentandmedway.nhs.uk/workstreams/.

The only organisations involved in the provision of urgent stroke services or who would qualify to run a hyper acute stroke unit are NHS provider organisations.

Can the social care staff be 'bought back in house' rather than being outsourced to private providers?

Currently social care services are provided by a range of different organisations. These services are commissioned in Kent and Medway by Kent County Council and Medway Council, and you would need to discuss this in more detail with those authorities.

How many operations at QEQM have been cancelled due a lack of post hospital social care in the last 36 months?

We have asked East Kent Hospitals NHS Foundation Trust and will respond to this as soon as we have further information.

Also, as population ages will the likelihood of stroke increase and has this been modelled to see the scope of increase? How does that affect Thanet?

Yes, the modelling work that we've undertaken during the review has looked at multiple factors affecting the local population and how growth may impact on the future need for services. We have looked at both the increasing size and ageing of the local population and the reducing numbers of people who have strokes due to improvements in health education and in primary care clinicians, such as GPs, identifying people at risk of a stroke and working with them to reduce that risk (for example, by stopping smoking or losing weight). Overall, we think this means that the total number of people who have a stroke in Kent and Medway is likely to stay about the same over the next 10 years.

This view, that the ageing population is countered by the decrease in the number of people having stroke resulting in a flat number of total strokes, has been the conclusion of several national reviews and can be seen in data from the last few years. Therefore, although Thanet CCG has 23% of its population over 65 we do not expect the number of strokes to significantly increase.

As NHSE have released figures today 1st February '18, saying that 20% of strokes occur in 40 - 59 age bracket, does this affect the plan in any way?

Although the modelling of future stroke takes into account the age of the population, it does not assume that all strokes are in the over 70 population. It also looks at the deprivation of the population which is not linked to age.

Will firefighters be expected to attend stroke victims (save for those that are involved in a fire or accident situation)?

SECAMB have provided the following answer to this question:

No, any response to stroke patients will be by blue light ambulance, unless they are categorised as a 'Category 1' due to their clinical presentation e.g. the patient is reported to be unconscious or not breathing, when it is possible a fire crew may be sent if they can be on scene more quickly. However, even in these circumstances, an ambulance is still sent and required to attend the patient.

Can the CCG comment on the broader workforce issues which are 'upstream' that the Government need to deal with?

Questions about national or government policy should be put to national organisations or the government or its representatives.

We have our own workforce programme as part of the wider health and care work across Kent and Medway that is looking at local issues around recruitment and retention of staff across health and social care. For example, there is a campaign in place to attract staff to come and work in east Kent (www.takeadifferentview.co.uk), and there are agreements between organisations to find ways to share the approach to workforce challenges rather than resorting to old ways of competing for scarce specialist and other staff.

Can the CCG comment on the challenge of meeting increasing clinical need and equality challenges without the full funding required being made available?

We are very unlikely to see any more significant increases in health and social care budgets in the near future. Our budgets are not rising at the same pace as costs and demand. While more funding is always welcome, there are opportunities for commissioner and provider organisations to work more closely together and use the financial and human resources that we have at our disposal more effectively.

Should we scrap STPs, and start again with resources, including adequate budgets aligned to patient need, rather than being aligned to the current plan to save £486M

Sustainability and Transformation Partnerships are established national policy that we are working to in line with our statutory obligations as NHS and social care organisations. At the heart of our ambition as the Kent and Medway Sustainability and Transformation Partnership, is the desire to create a health and social care system that reflects and anticipates the needs of all residents both now and in the future. Our work programmes are all designed to design and develop services that bring about better health and wellbeing, better standards of care, and better use of staff and funds. For example, our new approach to local care is entirely designed to meet the needs of individual patients, and local care systems will be designed to meet the needs of the communities they serve.

We have a finite budget for health and social care activity which for Kent and Medway is c£3.5 billion, and we need to make sure that we use that money and our existing resources to the best of our ability. That budget is not being cut, but we are looking to make sure that the system is financially sustainable over time. With rising – and different – demand, and increasing costs, £486million represents the size of the deficit that we anticipate we will have if we do not make changes to the way we work. We want to make sure that we have safe, high quality and sustainable

health and social care services in place for people in Kent and Medway, using the resource we have to get the best outcomes we can.

Once again, many thanks for taking the time to contact me. I am sure we will continue to discuss these and other issues and am very happy to continue that dialogue.

Yours sincerely,

Patricia Davies

Senior Responsible Office for the Kent and Medway Stroke Services Review and Accountable Officer Dartford, Gravesham and Swanley and Swale CCGs