Kent and Medway STP
Patricia Davies, SRO,
Stroke Services Review
Stroke Consultation
km.stroke@nhs.net

20 April 2018

Improving urgent stroke services in Kent and Medway – BMA response

Dear Ms Davies

The BMA welcomes the opportunity to respond to the Kent and Medway STP consultation ‘Improving urgent stroke services in Kent and Medway’. The BMA is a voluntary, professional association that represents all doctors from all branches of medicine across the UK. Over 140,000 practising doctors are members, as are nearly 20,000 medical students. The BMA is an independent trade union, a scientific and educational body and a limited company, funded largely by its members. The South East Regional Council represents members across Kent, Surrey and Sussex.

In summary, the BMA is supportive of the proposals to deliver improved healthcare services to Kent and Medway where these changes are evidence-based and beneficial to patients. We believe however that further consideration needs to be given to the workforce implications of these proposals.

This response has been informed by the BMA’s national Policy Directorate and Member Relations Department and endorsed by the BMA’s South East Coast Regional Council Executive.

I have attached our full response as an appendix.

With kindest regards.

Yours sincerely,

Hugh Townsend
BMA Regional Co-ordinator
Consultation process and guiding principles

The BMA supports the way in which this consultation has been carried out and welcomes the listening events and other communications to clinicians and members of the public across Kent and Medway. The multiple engagement channels have been helpful and we would welcome this approach for future STP consultations.

We are particularly pleased to note that the proposals appear to be evidence based and we welcome the statement that ‘changes are not driven by the need to save money’\(^1\). The BMA’s General Practitioners Committee and Central Consultants and Specialists Committee (CCSC) developed some guiding principles for service reconfiguration and we would like to draw your attention to these principles. In brief, reconfiguration must:

- Be evidence-based
- Enhance the standards of patient care across a health economy
- Be clinically-led in partnership with patients
- Be safe
- Include clear reporting of agreed outcome and financial data
- Include an impact assessment before a planned reconfiguration is implemented

Reconfiguration must not:

- Be driven purely by financial or political pressures
- Undermine existing services to the detriment of patient care

We are confident that you will share these principles which are also broadly similar to the five pledges made in Lord Darzi’s report – Leading Local Change\(^2\).

The hyper acute model

Whilst we generally agree that a ‘shorter journey to a hospital without a hyper acute stroke unit can be worse for stroke patients than a longer journey to a hyper acute stroke unit’\(^3\), some of our members have expressed concern at the fact that specialist stroke services will be concentrated on just three sites with hyper-acute stroke units. In an ideal world the whole population should be within half an hour of such units and there is a danger that some of the most deprived population areas in Kent could be worst impacted by not being within this journey time. However, we also recognise the current financial challenges and workforce shortages which are an important factor in determining the number of hyper acute stroke units.

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Page 24- Improving urgent stroke services in Kent and Medway, Our consultation document
These proposals make the assumption that everyone with symptoms suggestive of a stroke will be transferred by ambulance, that ambulance service will always correctly identify patients with a stroke and that, consequently, no patient with a stroke will attend A&E. In reality, it is likely that a significant number of patients (particularly the elderly with co-morbidities, those with co-existing neurological impairment and those with complex or unusual presentations) will continue to present at their nearest hospital. Furthermore, patients already in hospital for another condition may develop a stroke whilst an inpatient. Hence, the lack of any proposals for secondary transfer is a concern. Clear, explicit and 24/7 transfer pathways should be urgently agreed and communicated whichever option is selected. Further consideration needs to be given to the fact that a significant number of patients will continue to present themselves to their nearest A&E departments.

Whilst we have seen some evidence (published in the BMJ) of the benefits of hyper-acute models, these are based on two big metropolitan pilots (London and Manchester). Whilst other UK areas have followed suite, we are not aware of wider studies as to benefits outside urban areas. We have also been presented with some evidence that benefits of stroke units especially hyper acute stroke units may be overestimated. We also recognise that patients want compassion and care close to home and are aware of evidence of an association between worse health outcomes the further a patient lived from the healthcare facilities they needed to attend.

The proposals are focused on hyper-acute and fail to address rehabilitation which is an integral part of stroke care. We would like to see further information on plans for stroke rehabilitation services.

For all these reasons we do not think it appropriate for the BMA to endorse a specific model for the delivery of hyper-acute stroke services. However, we seek reassurance that if hyper-acute stroke services are to be centred on a small number of sites as currently proposed, then these sites will remain designated on a geographical, rather than trust-specific, basis, that evidence from other areas will be carefully considered and that secondary transfers and rehabilitation services will be considered further.

**Workforce**

We note that there are significant workforce implications associated with this model both on staff directly involved and those for whom there is a knock-on effect and we would be happy to be involved in the further detailed work required in this area.

It is vital that the stroke network also engages primary care in pathway development so as to ensure a fully integrated approach, including with regard to training and developing General Practitioners. In this regard we would hope that the LNC and GP Hubs would play an important role.

We note assumptions in the consultation that setting up three hyper acute stroke units would improve recruitment and retention in the medium to long term which may be the case but is not guaranteed. However, we are pleased that there is recognition that there may be disruption

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4 letters in the Lancet (2015, 385, 1394 – 6)
and would seek assurances that proper HR processes would be followed and that impacted staff will be given a range of options so as not to lose these valuable staff from the area. We would also like to see further detail about proposals to offer ‘better opportunities for professional development’ (page 27) as our experience under recent financial constraints has been that these opportunities have often diminished rather than increased in the region.

We are aware of the very real challenges recruiting staff to East Kent and hope that the STP will look to address this in other ways, working with East Kent Hospitals University NHS Foundation Trust in particular to improve the attractiveness of posts in the area.

There doesn’t appear to have been much consideration regarding the knock-on effect to vascular, imaging and surgical and staffing requirements and we would be concerned should these services also end up centralised on three sites.

Summary

We are unable to comment on either the specific site options or the proposal to move to three hyper acute stroke units other than to reference some of our member’s views and concerns which we hope will be further considered. In particular we hope that secondary transfers and rehabilitation will be considered further.

We believe that workforce implications and assumptions require further consideration and would be happy to be involved in this.

Whatever the consultation outcome, the BMA believes that it is vital that once the consultation has been completed there is increased engagement with clinicians in the region in order to communicate changes and develop a willingness to implement any changes which could make improvements to patient care. The priority must be to improve the quality of urgent stroke services for patients.