HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th July, 2017

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th July, 2017, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (12):	Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas and Mr M Whiting
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor L Hills, Councillor J Howes, Councillor M Lyons, and Councillor T Searles

Webcasting Notice

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item Timings*

1. Membership

   Members of the Health Overview and Scrutiny Committee are asked to note the membership listed above.

2. Election of Vice-Chairman

3. Substitutes

4. Declarations of Interests by Members in items on the Agenda for this meeting.

5. Minutes (Pages 5 - 10)

6. EKHUFT Operational Issues (Pages 11 - 16) 10:05

7. Kent and Medway Sustainability and Transformation Plan (Pages 17 - 34) 10:45

8. North Kent CCGs: Urgent & Emergency Care Programme (Pages 35 - 70) 11:30

9. West Kent CCG: Edenbridge Primary and Community Care (Pages 71 - 80) 12:00

10. Mental Health Rehabilitation Services in East Kent (Written Briefing) (Pages 81 - 86)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

**Timings are approximate*

John Lynch
Head of Democratic Services
03000 410466

6 July 2017

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 3 March 2017.

PRESENT: Mr M J Angell (Chairman), Mr N J D Chard (Vice-Chairman), Mrs A D Allen, MBE, Mr H Birkby, Mr A H T Bowles, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Ms D Marsh, Mr C R Pearman, Cllr J Howes, Cllr N Heslop and Mr S C Manion (Substitute) (Substitute for Mr D L Brazier)

ALSO PRESENT: Mr S Inett and Dr M Parks

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer) and Mr A Scott-Clark (Director of Public Health)

UNRESTRICTED ITEMS

80. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

(1) Mr Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.

81. Minutes
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 27 January 2017 are correctly recorded and that they be signed by the Chairman.

82. Kent and Medway Sustainability and Transformation Plan
(Item 4)

Michael Ridgwell (Programme Director, Kent & Medway STP), Liz Shutler (Director of Strategic Development and Capital Planning EKHUFT) and Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) were in attendance.

(1) The Chairman welcomed the guests to the Committee. Mr Ridgwell began by outlining the three objectives of the Sustainability and Transformation Plan (STP): improving quality and performance; reducing health inequalities and addressing the financial challenge. He reported that these objectives could only be achieved by health and social care organisations working together.

(2) Mr Ridgwell stated the Case for Change set out why change in Kent & Medway was required including variable outcomes for patients, workforce challenges and financial deficit. The STP was looking to develop local care proposals to resolve these issues. Following a stocktake, the STP Programme Board had agreed that there would be two waves of consultation. The first

wave of consultation would focus on service change in East Kent along with stroke and vascular services; the second wave would look at transformation in the rest of Kent & Medway. He noted that the STP had been identified as one of four national pathways and would be exploring innovative ways to improve efficiency and productivity. He stated that further engagement with stakeholders including the patients and public was a priority.

(3) With regards to acute sustainability in East Kent, Ms Shutler explained that the main issue was the provision of emergency medical services across three sites; locum, temporary and permanent staffing was required to reinforce staffing levels. She stated that the Trust was looking at a range of different options which included proposals to move and/or reduce services provided on each site. She stated that there were no plans at present to implement any of the proposals; the Trust was continuing to work on the proposals and would engage with staff and the public. She stressed that any decision to implement a proposal would be based on patient safety. Mr Perks noted that the CCGs were working with the Trust and endorsed the planning being undertaken to provide sustainable services in East Kent.

(4) Members enquired about the proposed models of care Mr Ridgwell stated that models of care would be brought back to the Committee; local care based models were being developed to create sustainable primary and community care at scale. Mr Perks stated the importance of provider organisations, including social care, in developing care models to meet the needs of the patient. He highlighted the work of Dr Ribchester at Estuary View who had developed a care model which brought together a multi-disciplinary team to support GPs in providing patient-centred care.

(5) In response to a specific question about 300 bed reductions in East Kent, Mr Perks explained that 300 patients in East Kent, as part of a cohort of 1000 patients across Kent & Medway, were not in the appropriate care setting; they were occupying an acute hospital bed and not receiving hospital medical treatment. The STP was looking to develop a model of care which would enable these patients to receive appropriate care outside of a hospital setting.

(6) A number of comments were made about prevention, the provision of services in London, public engagement and sustainability. The guests were in agreement about the importance of prevention and scaling it up as part of the STP. Ms Shutler highlighted that the services provided in London were specialist and it was inappropriate for these to be replicated locally. Mr Ridgwell stated that access to specialist services in London would always be part of the range of services available to patients in Kent. Ms Shutler explained that a number of engagement events had been held and further would be planned as the STP was developed. Mr Inett reported that people attending the listening events understood the aspirations of the STP.

(7) RESOLVED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee at the appropriate time.

83. Gluten Free Services in West Kent
(Item 5)

Bob Bowes (Chair, NHS West Kent CCG) and Adam Wickings (Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Bowes began by explaining that the proposal was an aspect of the CCG's Financial Recovery Plan. He stated that the CCG had received feedback from the consultation and was forming recommendations.

(2) Members made a number of comments about the importance of exemptions if the proposal was accepted; the greater availability and reduction in costs of gluten-free products; and the previous withdrawal of routine provision of gluten-free products in East Kent.

(3) Mr Inett noted that Healthwatch Kent had acted as a critical friend to the CCG during the consultation and would be publishing a report with their findings. Dr Parks stated that GPs would require support from the CCG, to implement the withdrawal of gluten free products on prescription, if the proposal was agreed.

(4) RESOLVED that NHS West Kent CCG:

(a) take into account the views expressed by Committee Members when forming recommendations for the Governing Body;

(b) submit a report to the Committee when a final decision has been made by the Governing Body.

84. West Kent CCG: Financial Recovery Plan
(Item 6)

Bob Bowes (Chair, NHS West Kent CCG) and Adam Wickings (Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) Dr Bowes began by apologising for not consulting with the Committee about the implementation of the measures as set out in the financial recovery plan. He reported that the urgent measures were taken as preventative action to avoid further impacts on services in the next financial year. Mr Wickings stated that the implementation of the measures had been a difficult decision but would enable the CCG to achieve the financial position which had been agreed by NHS England.

(2) A number of comments were made about activity levels, cancer diagnosis and pathway redesign. Dr Bowes explained that activity in the first nine months had exceeded the planned level of activity for the whole year. Dr Bowes stated that the two-week cancer pathway would not be affected by the measures. He reported that West Kent CCG had a lower number of A&E cancer diagnoses and their GPs were above average for identifying cancer. Mr Wickings highlighted that pathway redesign was required to reduce activity and expenditure as additional funding was not expected. Dr Bowes noted that elective orthopaedic surgery would be reviewed as part of the pathway redesign; he reported that only 50% of patients who had knee surgery thought it was worthwhile 18 months after their surgery. He noted that the CCG was also looking to move away from payment-by-results contracts. Mr Wickens stated that payment-by-results had incentivised activity and caused tension between commissioners and providers.

(3) Mr Inett enquired about the involvement of patients in the decision making about the financial recovery plan. Dr Bowes acknowledged that the CCG had not engaged as widely as it could have done; CCG members and the Chairs of the Patient Participation Groups had been consulted.

(4) RESOLVED that the Committee:

(a) expresses disappointment about the lack of prior notice and consultation by the CCG with the Committee about these proposals;

(b) is notified, in good time, as any further proposals are developed by the CCG.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 25 May 2017.

PRESENT: Mr M J Angell, Mrs P M Beresford, Mr A H T Bowles, Mrs S Chandler, Mr N J D Chard, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton, Mrs S Prendergast, Mr K Pugh, Mr I Thomas and Mr M Whiting

IN ATTENDANCE: Mr J Lynch (Head of Democratic Services)

UNRESTRICTED ITEMS

1. Election of Chairman
(Item 3)

(1) It was duly proposed and seconded that Mrs S Chandler be elected Chairman of the Committee.

(2) RESOLVED that Mrs S Chandler be elected Chairman of the Committee.

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Item 6: EKHUFT Operational Issues

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 July 2017

Subject: EKHUFT Operational Issues

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals NHS University Foundation Trust.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 29 January 2016 the Committee considered proposals to reclarify the model of care provided by the Emergency Care Centre at the Kent & Canterbury Hospital, Canterbury due to regulatory action by Health Education Kent Surrey and Sussex (HEKSS).

(b) On 3 June 2016 the Committee considered an update on the implementation of the new model of care.

(c) On 21 March 2017 the Committee was notified by the Trust that HEKSS had recommended the removal of a cohort of junior doctors from the Kent and Canterbury Hospital to the other main hospital sites in Ashford and Margate.

(d) On 10 April 2017 the former Committee was notified by the Trust that hyper acute stroke services would be temporarily moved from the Kent and Canterbury Hospital to the other main hospital sites in Ashford and Margate.

(e) On 13 June 2017 the new Committee was notified by the Trust that from 19 June there would be an emergency transfer of urgent care services from the Kent and Canterbury Hospital site on a temporary basis following the removal of the junior doctors.

2. Recommendation

RECOMMENDED that the reports be noted and East Kent Hospitals NHS University Foundation Trust be requested to:

(a) provide a timeline outlining its response to regulatory action and emergency transfer of services;

(b) present an update to the Committee about its long term strategy for acute sustainability in East Kent at the appropriate time.

Background Documents

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (29/01/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=36905

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6259&Ver=4

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

NHS
East Kent
Hospitals University
NHS Foundation Trust

Emergency Transfer of acute medicine - Kent & Canterbury Hospital

1. Background

1.1 East Kent Hospitals announced on 21 March that Health Education England (HEE), which oversees junior doctor training, required the Trust to move half (38) of the junior doctors at the Kent & Canterbury Hospital (K&C) to the Trust's other two hospitals at Ashford and Margate.

1.2 This is because a shortage of permanent consultants and a heavy reliance on locum doctors has impacted on the supervision and training for junior doctors. As a teaching Trust, EKHUFT has to make sure that junior doctors have access to senior doctors to support them.

1.3 The Trust has struggled to recruit and retain permanent consultants and has been briefing the Health Overview and Scrutiny Committee on these pressures for the last 18 months. There has also recently been some unexpected long-term sickness, maternity leave and resignations due to career changes. This is compounded by is also a national shortage of consultants and very demanding, and therefore unattractive, rotas caused by stretching services and resources across three sites.

1.4 As a result on 19 June 2017 half of the junior doctors were moved from K&C to the William Harvey Hospital (WHH) in Ashford and the Queen Elizabeth The Queen Mother Hospital (QEQMH) in Margate.

1.5 There has not been a full A&E at K&C since 2005 when services at the Trust were reconfigured. The A&E then became an emergency care centre which dealt with minor injuries and minor illnesses and also accepted some other emergency cases, but not general surgical emergencies.

1.6 The Emergency Care Centre became the Urgent Care Centre in July 2016 when patients attending the K&C were 'streamed', to see a GP for minor illness, a nurse for minor injuries and the hospital team via an Acute Medical Unit if the patient's complaint was more serious.

1.7 These changes resulted in improved provision for junior doctors. However, the current difficulty in recruiting substantive consultants led to concerns by HEE and the General Medical Council (GMC) and their decision to remove the junior doctors on 19 June.

2. Prioritising patient safety

2.1 On Friday, 9 June, the Trust's Board made the decision to move some services at K&C to its other two sites. This is because without the junior doctors the Trust could not continue to provide those services safely. This is called an emergency transfer of services. It can only be made on a temporary basis and does not require public consultation because it is an emergency move made to ensure services and patients are safe.

2.2 Ambulance travel times from the K&C are 28 minutes to WHH and 38 minutes to QEQMH. National best practice and evidence shows that treatment by paramedics in the ambulance and specialists highly trained to treat your condition and available 24/7 when you get to hospital, has a greater impact on the outcomes for patients than shorter travel times.

2.3 This is why the Trust has for some time taken many patients with complex trauma and heart attacks straight to the WHH in Ashford; and patients with emergency vascular conditions, such as an aortic aneurysm to the K&C, because that is where the experts are and where patients will have the best chance of survival and recovery.

2.4 The Trust has a strong safety record and has made these changes so it can continue to ensure it provides safe services for patients, as well as appropriate training and supervision of junior doctors. In December 2016 the Care Quality Commission reported significant improvements in the quality of care and leadership at the Trust and it was removed from quality special measures in February 2017. The Trust has one of the lowest mortality rates and the best outcomes for trauma patients in the country.

3. What this means for patients

3.1 The changes affect people who require urgent medical care for conditions such as heart attack, stroke and pneumonia. As part of the temporary changes hyper acute stroke services were moved on 10 April 2017. Patients are no longer brought to the K&C Urgent Care Centre by ambulance as an emergency. They are now taken by ambulance straight to Margate or Ashford.

3.2 The majority of services at the K&C are not affected. For example, surgical services, chemotherapy services, renal, vascular, urology services and outpatient clinics are not affected. There continues to be a 24/7 minor injury and illness service at the hospital.

3.3 Patients who have a planned operation or outpatient appointment, an x-ray, blood test or therapy session at the K&C, are not affected and are seen and treated at K&C as usual.

3.4 Most stroke services remain unchanged at the K&C, including outpatient appointments and rehabilitation services. The hospital's stroke ward remains open and continues to care for patients recovering from a stroke.

3.5 The Trust has ensured that as many patients as possible can still be cared for in Canterbury. In all, the temporary changes affect up to 50 of the 900 people who attend the hospital each day. Around 35 patients a day will no longer be brought to the K&C's Urgent Care Centre.

3.6 The ambulance service has reported that the road works on Kennington Road, expected to last until 5 September, have not unduly affected its service. We have also opened a rear access to the William Harvey Hospital for ambulances and staff, to assist other traffic flow for relatives. Road works are a regular occurrence on Kent roads and these have been planned for in the same way.

4. Actions to create capacity at Margate and Ashford

4.1 The Trust has been planning carefully and working closely with the ambulance service and other parts of the NHS and social care, with oversight from its regulators, to ensure the temporary transfer is safe and effective.

4.2 Measures to ensure that there is sufficient capacity at the other two sites include:

- providing more capacity in community care settings for people who are well enough to leave hospital but are not yet able to return home
- improving patient pathways and increasing consultant cover (available through fewer rotas) improving patients' discharge within the hospitals so they are not waiting longer than they need to leave hospital
- increasing the amount of "ambulatory" care so more patients who need urgent treatment can be treated on the day they come in, and go home the same day
- additional ambulance capacity and patient transport vehicles
- extending 7 day services to therapies, pharmacy and cardiac catheterization laboratories

4.3 Once patients are well enough, we aim to discharge them home or to a nursing or residential care facility. If patients are medically fit to leave our hospitals in Margate or Ashford but need to remain in hospital we may transfer them to the K&C to continue their rehabilitation. This decision would include an assessment of clinical need and where patients live. This will only happen if patients are well enough, and by using properly qualified staff and transport by ambulance.

4.4 As a result of the emergency transfer, 24 beds at K&C are not currently needed and have closed. At WHH eight inpatient beds have been changed from inpatient to ambulatory care beds, at QEQM 7 beds have been changed from inpatient to ambulatory care beds.

5. Stakeholder and patient communication

5.1 On 21 March 2017 the Trust informed staff and patients and wrote to partners, stakeholders, HOSC members, Trust members and announced in the media, the decision by HEE that it was moving some junior doctors and therefore some services would be moving from K&C in two to three months on a temporary basis. Further communications were sent out on 10 April about the changes to hyper acute stroke services; and on 12 June following the Board's decision and in advance of the remaining changes.

5.2 The Trust has worked with Healthwatch Kent to develop patient information available for the Trust to use, and has also cascaded information via the community health learning disability teams, nursing homes, Age UK and the Stroke Association.

5.3 The Trust understands and shares the public's strength of feeling about the NHS. The Trust has and is taking up regular opportunities to engage with the public at listening events led by the clinical commissioning groups, at public meetings e.g. held by CHEK and Faversham Health Matters, as well as regular engagement with staff.

5.4 During purdah the Trust was restricted in attending one public meeting but representatives took down all questions raised and these have been answered and are available on the Trust's website. The Trust agreed with the campaign group running the public meeting on a date to reschedule the meeting and this took place with Trust doctors, the Chief Executive and NHS commissioners attending to answer questions on 16 June.

5.5 The Trust regularly communicates and meets with local MPs, this has recently included the new member of parliament for Canterbury.

6. Action to address the shortage of consultants

6.1 The Trust can only reverse the changes when it has recruited sufficient substantive consultants to run the services and the General Medical Council and Health Education England are satisfied that it can provide appropriate supervision and training for medical trainees at K&C again.

6.2 The Trust continues to actively recruit permanent consultant doctors including holding regular national and international recruitment campaigns, placing targeted adverts in publications such as the British Medical Journal, work with recruitment experts who specialise in recruiting doctors, and use targeted social media adverts. Posts are often advertised for consultants to work for the Trust rather than individual hospitals to increase the opportunity to attract applicants.

6.2 A new website for the public sector has been launched in east Kent called Take a Different View specifically selling the advantages of relocating to east Kent.

6.3 The Trust is also looking closely at how it can make the roles more attractive to consultants, for example, by reviewing our research opportunities, relocation incentives and working patterns.

7. Improving healthcare in East Kent for the future

7.1 This situation is an illustration of why there needs to be a move to a more sustainable way of providing hospital care which includes making the best use of the Trust's three hospitals at Canterbury, Margate and Ashford, with greater additional support for people in their local communities.

7.2 The longer-term vision is for a comprehensive reconfiguration of services to improve the quality and safety of care the Trust can offer and takes advantage of the advances in medicine which have resulted in better care, from specialist teams, leading to far better outcomes for patients, and meets the long-term needs of our changing population.

7.3 The proposals include organising our services across our three existing hospital sites so that we have an emergency care hospital with A&E and specialist services, a second emergency care hospital with A&E and a third hospital with GP-led 24/7 urgent care, planned care and specialist intensive rehabilitation.

7.4 This early thinking was informed by conversations with the public, staff and clinicians. We are now working with the public to develop more detailed proposals for the future of health and social care and options for which sites should provide which services. This will be consulted on as part of a public consultation led by the Clinical Commissioning Groups in East Kent, we hope that will be early in 2018.

7.5 Our early thinking means providing acute medical services on two of our three hospital sites in the future. The temporary changes we are making now may still be in place when we reach public consultation on the STP. If this is the case, the Trust will focus on implementing any longer-term reconfiguration once the final decision is made on where and how services are provided.

7.6 The Trust fully supports the bid for a medical school for Kent and Medway. The most important factors in attracting doctors are hospital services that deliver the best care, offer attractive services, manageable rotas and working conditions for staff. This is the Trust's vision for its hospitals and having a Medical School locally will add to that attraction.

7.7 Longer-term changes do not stop a new hospital being built in the future but, even if the funding was available now, it would take at least 10 years before it could be built. It is clear that it is not possible to sustain services as they are now without making changes and the benefits for patients of transforming care would not be realised.

7.8 Canterbury and Coastal Clinical Commissioning Group has commissioned work to scale up the plans it has been developing to increase the amount of local care in the area through better co-ordination between primary care and community services. For example, there is work across the health and social care system to develop a frailty pathway so that more older people needing urgent care can be cared for at home or in a community bed, starting this autumn.

3 July 2017

Item 7: Kent and Medway Sustainability and Transformation Plan

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 July 2017

Subject: Kent and Medway Sustainability and Transformation Plan

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided about the Kent and Medway Sustainability and Transformation Plan.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) Every health and care system in England is required to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency (NHS England 2016).

(b) To deliver these plans, local health and care systems came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within each footprints have been working together to develop STPs with the aim of delivering genuine and sustainable transformation in patient experience and health outcomes. A Kent and Medway STP footprint was established covering all eight Kent and Medway CCGs over a footprint population of 1.8 million (NHS England 2016).

(c) On 3 June 2016, 2 September 2016, 25 November 2016 and 3 March 2017 the Committee considered an update on the Kent and Medway Sustainability and Transformation Plan. On 3 March 2017 the Committee considered the progress of the STP and agreed the following recommendation:

- *RESOLVED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee at the appropriate time.*

2. Recommendation

RECOMMENDED that the report on the service models and hurdle criteria for the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee at the appropriate time.

Background Documents

NHS England (2016) *'Sustainability and Transformation Plans (01/05/2016)'*, https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

Kent County Council (2016) *'Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6259&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (02/09/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=41836

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)', https://democracy.kent.gov.uk/mgAi.aspx?ID=42584*

Kent County Council (2017) *'Health Overview and Scrutiny Committee (03/03/2017)', https://democracy.kent.gov.uk/mgAi.aspx?ID=43699*

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

KENT AND MEDWAY SUSTAINABILITY PARTNERSHIP

Service Models and Hurdle Criteria

Introduction

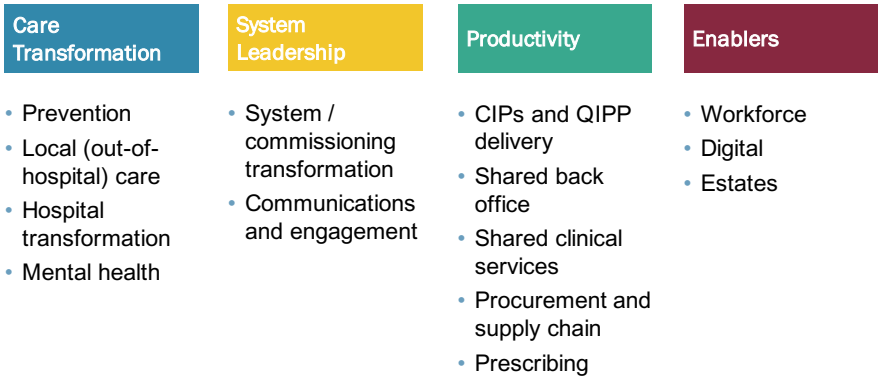
1. This paper summarises the service models and hurdle criteria that have been developed through the Sustainability and Transformation Partnership (STP) and asks for support for these from Kent and Medway clinical commissioning group (CCG) governing bodies, trust boards and local authority committees.
2. This paper covers:
    i. Local care model
    ii. Emergency department service delivery model
    iii. Acute medical service delivery model
    iv. Stroke service delivery model
    v. Elective orthopaedic service delivery model
    vi. Urgent care / elective orthopaedics and stroke hurdle criteri
3. 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 regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement 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

4. 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.
5. 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

[1] Clinical Senates have been established to be a source of independent, strategi advice and guidance to commissioners and other stakeholders. This includes reviewing proposed changes through bringing together a range of health care 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

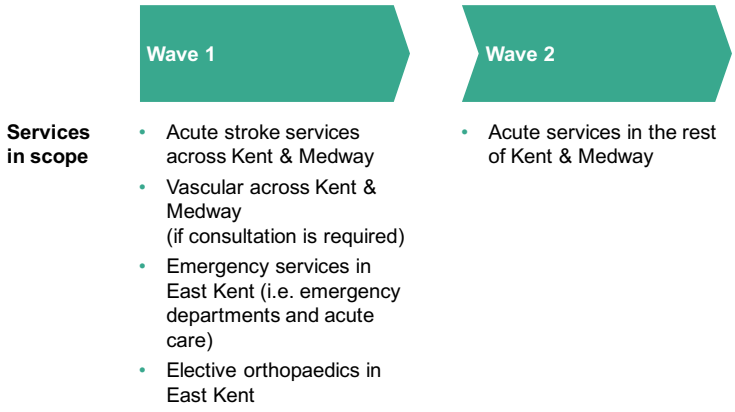
submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:



6. Work streams 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 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 and as one strand of engagement activity

7. The STP Programme Board took stock of the progress being made by these work streams 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.

8. 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 but undertaken within a clear strategic framework for all of Kent and Medway:

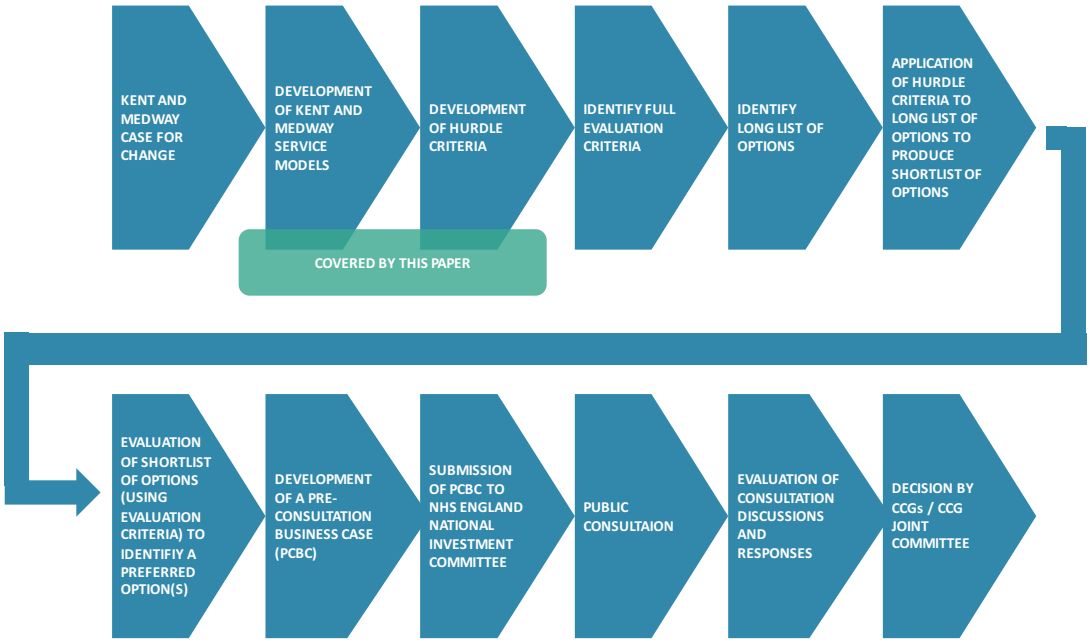


9. It had previously been hoped to consult on proposed wave 1 service changes in 2017 but a number of delays have been incurred, including the:

   - need to undertake more public engagement;

- need to put in place joint decision-making arrangements across the CCGs, which require a change to some of the CCG constitutions;
- impact of purdah due to the local and general election[4]; and
- not wishing to start any consultation too close to the Christmas holidays.

10. It is now envisaged that any required consultation would not take place until 2018.
11. 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):



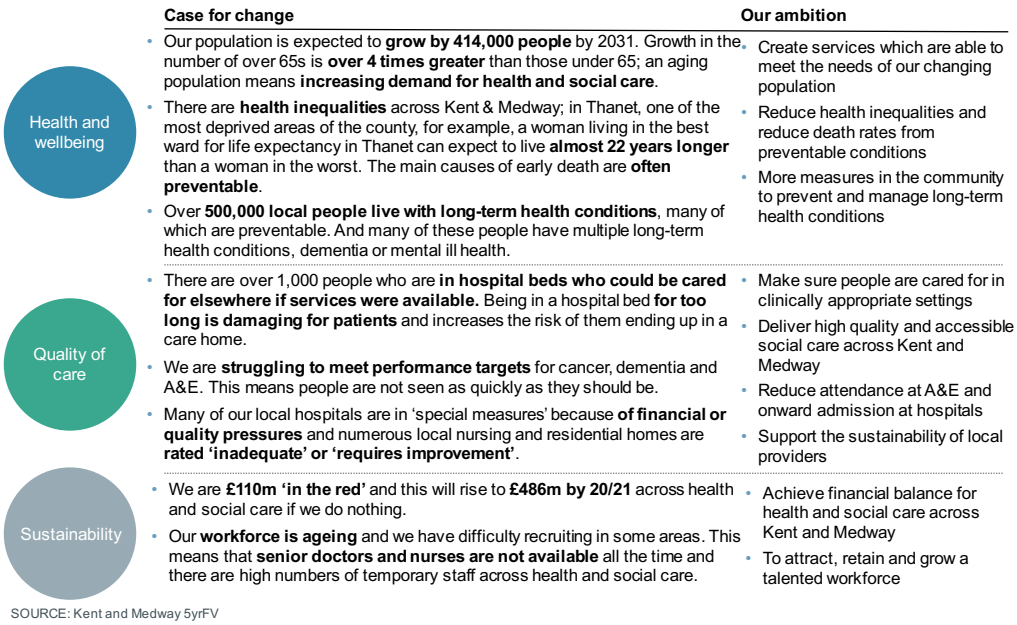
Case for change

12. The Kent and Medway STP Clinical Board has prepared a technical case for change[5] which has been used to prepare a more accessible public facing case for change to support engagement with patients, carers, local communities and stakeholders[6].
13. These documents outline the strategic rationale for why change is needed. Whilst 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:

[4] The term 'purdah' is used across central and local government to describe the period of time immediately before elections or referendums when specific restrictions on the activity of civil servants and other public bodies are in place in order to ensure there is no breach of Section 2 of the Local Government Act 1986 (this states to "not publish any material which, in whole or in part, appears to be designed to affect public support for a political party")

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

[6] http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf



SOURCE: Kent and Medway 5yrFV

14. The position outlined in the case for changes provides further details of the challenges against the triple aims of STPs (as outlined in Point 4, 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.

15. 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.

How our service models link together

16. Through developing our local care services we will be able to offer care closer to the patients home. It is recognised that many elderly patients are supported in acute hospital settings inappropriately, when there needs would be better met in a non-acute setting (e.g. outside of a hospital). This is outlined in the Kent and Medway Case for Change and it is well documented that supporting these patients in an acute setting has a detrimental impact on their long-term outcomes.

17. Whilst it is vital to develop our local care services, we also recognise that there will always be circumstances where individuals need to access secondary care. We are therefore developing revised models for emergency care, covering emergency departments (accident and emergency departments) and acute medical care, as well as for stroke care. However, our aim is to minimise reliance on secondary care, including facilitating discharge from the acute setting at the earliest opportunity.

18. Where it has been necessary for an individual to be admitted to acute care our Local Care and acute medical model will facilitate timely discharge, as outlined below for the elderly frail:

	1. Upon admission	2. Reduce time spent in a bed	3. Optimise the discharge process	4. Facilitate re-ablement and return to independence
Hospital care	• Assess patient for function and care needs on day 1 • Assessment needs to include cognition – early recognition of dementia/delirium	• Day 2 mobility plan • Work on mobility every day • Transparency within hospital to measure LOS >10 and medically fit • Trigger reviews of long stays • Early role of pharmacy in meds review	• Advance care plan • Discharge process run by community (below) • Early provision of discharge medication	• Enhanced transport offer
Interface	• Access to care record • Ownership retained by community teams • Direct link made between hospital team and community MDT to capture requirements • Planned day of discharge agreed by MDT • Determine social care means testing	• Daily MDT discharge meeting including community and care coordinators, nursing and medical team • Ensure assessment of care need has been made • Ensure funding decision is made	• Ensure rapid decision made about care packages required (e.g. within 2 hours) • Ensure care record reflects needed details of ongoing care	• Single point of access that works across CCGs in STP • Access to patient record • Better use of telemedicine and tele care to manage people out of hospital
Local care MDT	• Carers consulted by MDT about support needed	• Discussion with self-funders for care needs • Home environment assessed to see meets anticipated needs on discharge at the point of admission	• Discharge to assess • Care package in place (self/public) • Home modifications made • Carers prepared for requirements	• Support carers to reable • Provision of rapid response • Shift therapy workforce to out of hospital • Night sitting • Support individual decision making

19. We have also developed a revised elective orthopaedic service model. Whilst it is possible for elective orthopaedic services to operate on a standalone basis there are a number of interdependencies that need to be taken into consideration, in particular:

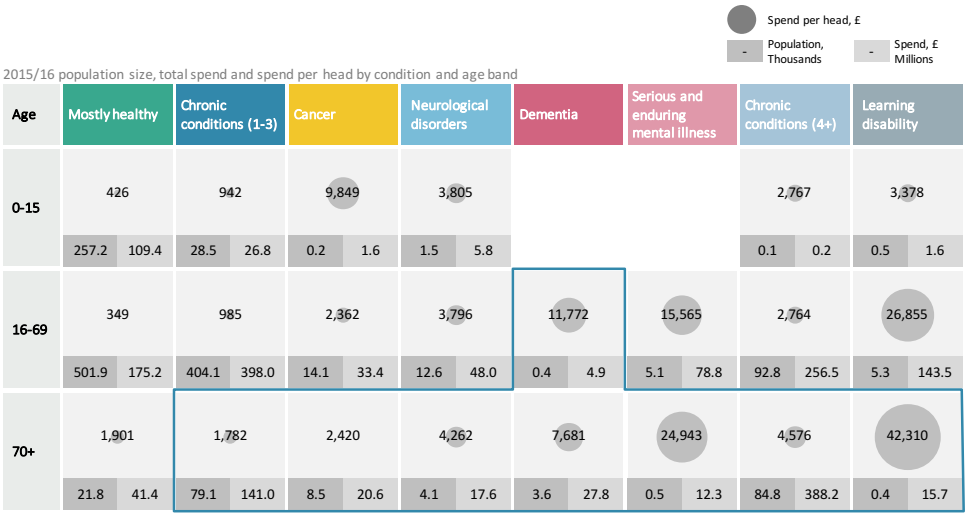
- the critical clinical service co-dependencies for orthopaedic elective work are anaesthetics and access to simple diagnostics, which need to be available on the same site; and
- the level of complexity of the procedures that can be undertaken is determined by access to Level 2 critical care facilities on site.

Service model for local care

20. The STP has prioritised the development of local (out-of-hospital) care. This is in recognition of the vital role these services play, including the current challenges they face as outlined in the case for change. This is also in response to what local people have said they want in recent years' insight work about more joined up services, better access to primary care and more support with staying well and managing their own care, and, importantly, in recognition that it is difficult to make change to the way hospital care is delivered without developing these services.

21. The Kent Integrated Dataset[7] has been used to interrogate spend and this has identified that approximately 32% of resources are used on 12% of the population, namely the elderly frail population, with multiple complex needs:

[7] Kent is one of the early implementers of the linked dataset initiative in England. The KID is possibly the largest linked dataset of its kind and one of the very few programmes with ambition to link data across the wider public sector. The Information Governance (IG) agreement behind the KID is that it can only be used for planning purposes, and cannot be used for informing direct patient care.



Notes: KID data covers 55% of population and 32% of spend for scope area. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. non-PbR acute activity). Children's social care, CAMHS, prescribing costs and continuing care costs are not included. People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to "mostly healthy" segments. KID data quality issues cause some people with long term conditions (incl. physical disability and SEMI) to be categorised erroneously as 'mostly healthy', artificially raising those segments' spend and populations.
Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 31/03/2017

22. Therefore, the focus of the work around local care has been on developing new service models to support this group of individuals but is now looking at how other groups of patients and users are now supported, e.g. children with complex needs, the mostly healthy with urgent care needs, adults with chronic conditions.

23. Our proposed service model for older people with complex needs model has been built around eight key interventions:

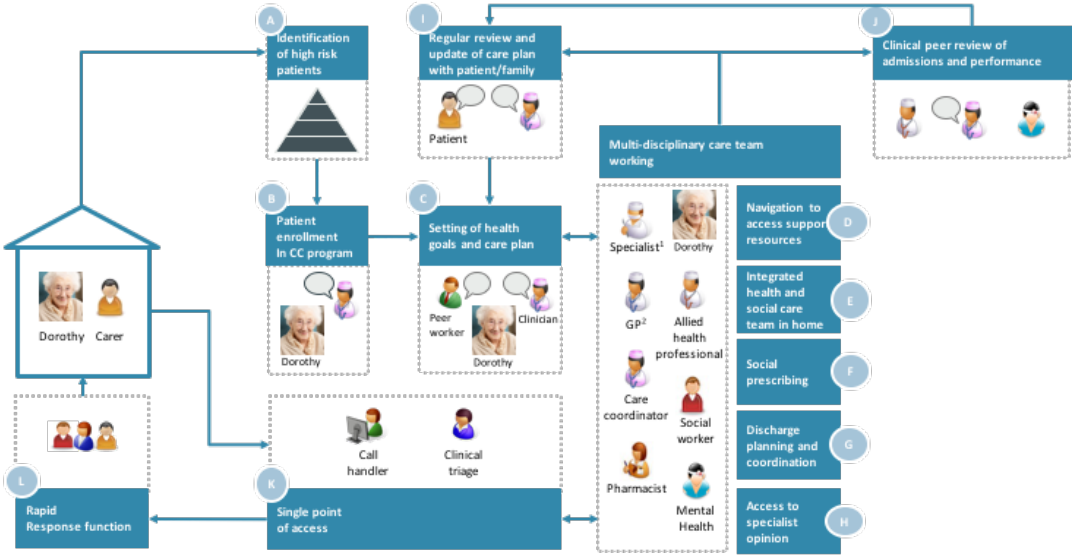
Source: K&M STP Local Care workstream, Carnall Farrar

24. These interventions will be delivered through a revised service model that sees the integration of primary and community services working in multi-disciplinary teams. Key components of this working arrangement include:

PROCESS STAGE:		DESCRIPTION:
A	Identification of high risk patients	• Patients are identified through a monthly KID data refresh, highlighting their appropriateness to be cared for by the "older person complex care and support model", and are placed on their local MDT list to be assessed • Alternatively, patients are identified by clinicians in the community or in hospital care they are in contact with and are placed on their local MDT list to be assessed
B	Patient Enrollment in complex care programme	• Patients are informed of the older people with complex needs model and asked if they would like to enroll, informed of what the model requires and what the initial steps will be to ensure efficient inclusion
C	Setting of health goals and care plan	• There are two conversations, one with a peer and another with a clinical MDT member, ensuring personal goals and care and support needs are identified in partnership with the patient and their carers • Peer and clinical conversation outputs are captured in a care and support plan owned by the patient • The plan is used as the primary focus for the holistic care of an individual and is accessible to all teams interacting with the patients and by the patient themselves
D	Navigation to access support resources	• Case managers and care navigators support condition management, integration of services and care according to the patient's care plan and are supported by "social prescribing"
E	Integrated health and social care team in home	• MDTs deliver integrated care and support to both the patient and their carer
F	Social prescribing	• The MDT uses a highly accessible and user friendly digital directory of community resources for the patients, their carers and health and social care professionals, facilitating robust social prescribing practices • The MDT also work to empower people to become or remain highly engaged regarding their own health and wellbeing
G	Discharge planning and coordination	• The community MDT (led by the patients care navigator or case manager) in-reach into the hospital to assist with and speed up the discharge process using a patient's care and support plan to determine change in need and plan for additional care and support requirements in the community upon discharge
H	Access to specialist opinion	• MDT GPs, community nurses and consultants can access specialist healthcare professionals through various communication channels, who have time dedicated to answering questions regarding specific patients • MDT clinical staff have rapid access to diagnostic services (diagnostic and result) to quickly inform a clinical decision about a specific patient
I	Regular review and update of care plan with patient/ family/peer	• Annually, patients review their care plan with their peer supporter and with their CM/CN, ensuring their personal goals and care and support needs are still being fully and effectively addressed • The care and support plan is updated as a result of these reviews • MDTs meet regularly and when needed, to discuss and review the needs of specific individuals within the patient cohort

J	Peer review of admissions and performance	• Any admissions are clinically peer reviewed to understand the reasons and to learn for the future
K	Single point of access	• Patients with a care plan, their carer, the GP and community services have access to a single number (SPoA) that can be used when patients are experiencing an urgent health or social care need, and that provides individualised support through access to their care and support plan
L	Rapid response function	• The SPoA is used to access the MDT rapid response function, which guarantees a 2-hour response time when required, 24 hours a day • Patients receive and initial assessment by an MDT first responder who determines their short-term needs • When required, the patient and their carers will be supported for a short time period post-intervention, including a telephone and home visiting service • People requiring further clinical care will be transferred to the appropriate service quickly and efficiently

25. The above components of the service model are depicted below as a flow diagram that outlines the model of how it is intended that local care would be delivered:



1 Specialists in both inpatient or outpatient settings 2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

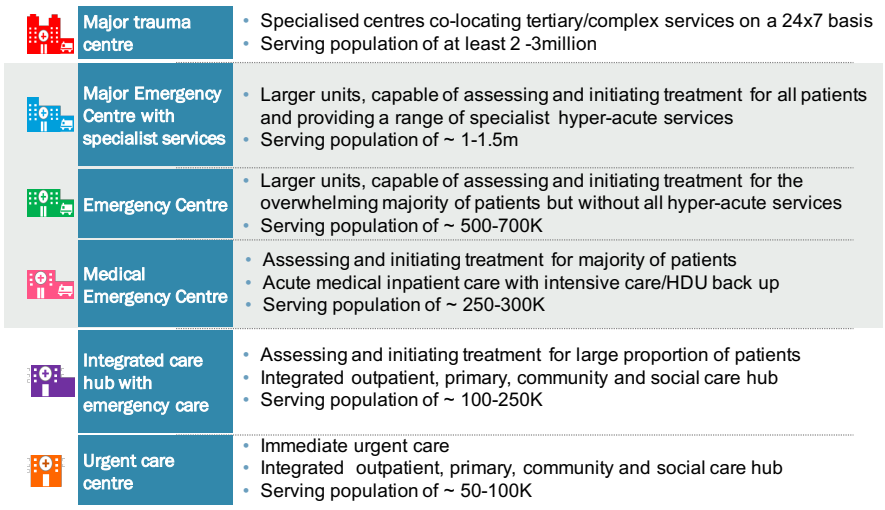
Emergency department clinical model summary

26. At present emergency department (ED) services are delivered at all seven acute hospitals sites in Kent and Medway. In 2015/16 there were 219,812 major emergency department attendances (including 254,441 adults and 57,507 children) and 311, 948 minor emergency department attendances (including 156,084 adults and 63,728 children). Emergency department attendances have grown by 3.6% per year over the last three years in Kent and Medway (the national average is 2.6%). Conversely, performance on the four-hour waiting target has deteriorated over the last two years; in

2015/16 on average 86% of people were discharged from emergency departments within four hours, compared to 92% nationally.

27. Some providers in K&M have amongst the worst patient satisfaction scores in the country. Patient stories show the current system is characterised by long waits, multiple contacts with health care professionals, and poor patient experience. A range of interventions are being developed to avoid emergency department attendances, as outlined in the previous section on our local care model. A new model for emergency departments will incorporate triage to the most appropriate pathway.

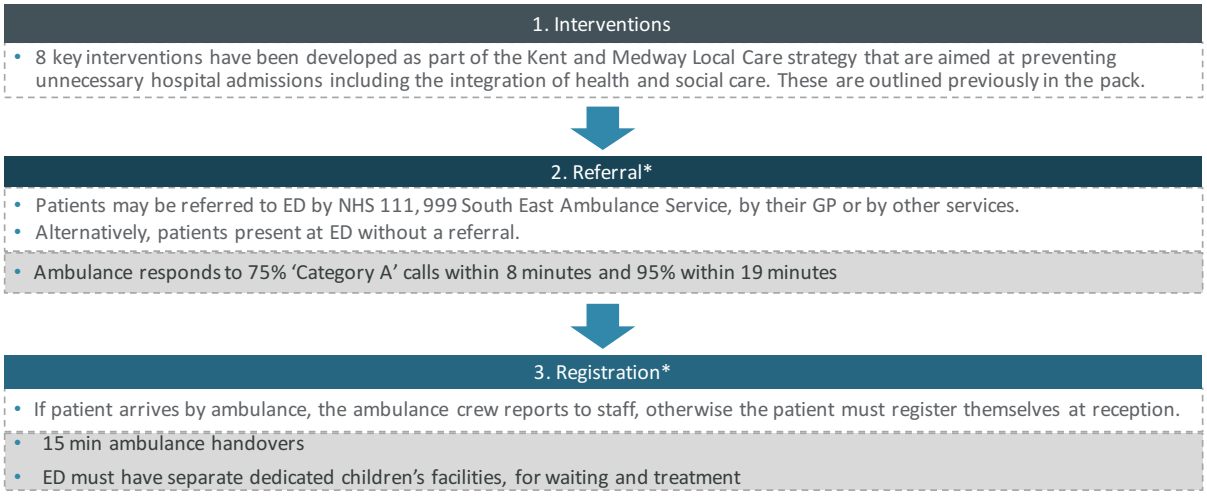
28. The models in the Keogh report have been used as a basis for developing building blocks of services (i.e. the service models we would see our current hospitals develop to become):



Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

29. The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.

30. The following diagram outlines the standard process that patients attending an emergency department would expect to experience:



4. Assessment

- Patients undergo a comprehensive** pre-assessment by a nurse or doctor before further actions are taken. This is called triage and will ensure people with the most serious conditions are seen first. Sometimes further tests need to be arranged before a course of action can be decided.
- No patient waits >12 hours on a trolley
- Presence of a senior ED doctor (ST4 or above) as a clinical decision maker 24/7

5a. Treatment or transfer

- Treatment or transfer: If situation is complicated, the patient my be seen by an ED doctor or referred to a specialist unit.
- 24/7 On site senior support within the core specialties
- Presence of a named paediatric consultant with a designated responsibility for paediatric care
- Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability Interventional radiology services for highest acuity patients are available within one hour of referral

5b. Discharge*

- Discharge: If nurse or doctor feels situation is not a serious accident or emergency, the patient may be sent home and asked to refer themselves to a GP, referred to a nearby urgent care centre, minor injuries unit or referred to a GP on site.
- Consultant accredited in Emergency Medicine [CCT holder] on the Emergency Floor Consultant between 08:00 and 24:00, 7 days per week

* Category A calls relate to immediately life-threatening incidents

* Many places across Kent and Medway are introducing a first step based on the Barking, Having and Redbridge (BHR) 'Redirection' where the eyeball 'streaming' takes place by a GP or Consultant who in less than 4 minutes will assess the patient and redirect out to community services, GP's, Pharmacy, Minors/UCC, or hot clinics'. Those that remain go through the comprehensive triage.

** The detail of these aspects of the model is being developed as part of the local care work stream.

Acute medicine

31. At present acute medical care is delivered at all seven acute hospital sites in Kent and Medway and there were 115,626 medical admissions in 2015/16.

32. The population registered with GPs in Kent and Medway is 1.8 million (i.e. includes patients from outside the area registered with local GP practices). The population is forecast to grow over the next five years, with a majority of growth occurring in the elderly population. Partly linked to this there are rising numbers of emergency admissions and bed occupancy across Kent and Medway.

33. In a recent bed audit, there were 1,007 patients in hospital beds who are medically fit to leave their current setting of care (as at 22nd November 2016). The vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital.

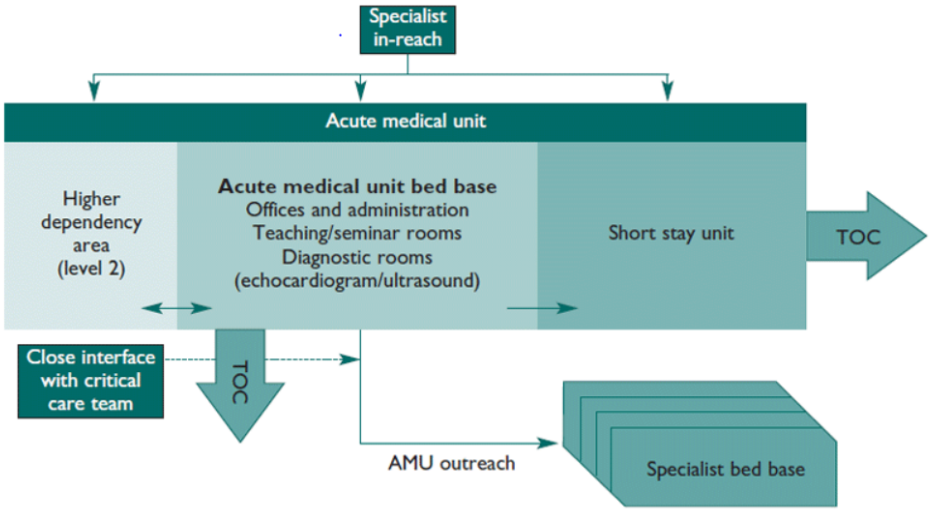
34. In line with national policy, the NHS aspires to provide seven day services but workforce constraints are challenging the delivering of this, including the inability to put in place 24/7 consultant cover in hospitals across Kent and Medway for those who need acute medicine.

35. The Kent and Medway acute medical care model is partially consolidated, but is still largely based on historic dispersal of services. Acute emergency medicine is currently delivered from seven sites using a variety of models. All Trusts aspire to deliver best practice models but constraints with capacity, estate and workforce only allow this to happen to varying degrees.

36. Our proposed service model covers:

- streaming to a fully functioning acute medical unit to reduce acute admissions;
- timely and appropriate discharge from the emergency department supported by schemes (e.g. such as occurs in the voluntary sector Take Home & Settle service in East Sussex);
- reduced non-elective length of stay, incorporating the NHS England pathway for people with dementia;
- Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models; and
- delivery of 7-day services in acute medicine to allow timely access to a senior specialist medical opinion.

37. The term Acute Medical Unit (AMU) has been defined by the Royal College of Physicians (RCP)[8] as 'a dedicated facility within a hospital that acts as a focus for Acute medical care for patients that have presented as medical emergencies to hospitals.' The report provides a detailed description of the rationale and requirements for an AMU but allows for local design. The structure of an AMU is schematically represented below:



38. Ideally an AMU should be co-located with other acute and emergency services as part of an emergency floor incorporating the ethos of Emergency Ambulatory Care. Strong clinical (medical and Nursing) and operational leadership is essential for an AMU to function successfully.

39. In delivering the acute medical take through an AMU a number of key principles need to be adopted:

- Assessment of acutely ill patients by competent clinical decision makers supported by appropriate levels of diagnostic support
- All areas follow the ethos of treating patients in an ambulatory model unless deemed otherwise by exclusion criteria
- Nominated medical, nursing and operational leads are in place working in the department on a regular basis

[8] Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time.* Report of the Acute Medicine Task Force. London: RCP, 2007.

- Integration and collaboration of key acute services e.g. emergency department, critical care, AMU and key support services e.g. pharmacy and therapies
- Consistency of quality medical care 24 hours a day, 7 days a week
- Specialist medical in-reach when required in a timely way 7/7

Stroke services

40. 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 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

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

    i. 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.

42. 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 of all seven hospitals providing acute stroke care. We need to ensure there is 24/7 consultant availability with a minimum 6 trained thrombolysis consultant physicians on rota and consultant led ward round 7 days a week. This will be supported by a multi-disciplinary team including nurses, physiotherapists and occupational therapists.

43. 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 over 500 patients and less than 1500 confirmed stroke patients.

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

Elective orthopaedics

45. There are 7,921 elective orthopaedic inpatient and 13,331 elective orthopaedic day case procedures undertaken in hospitals in Kent and Medway (plus 2,110 inpatient and 425 day case procedures in private hospitals under “choose and book arrangements”, which give patient a choice about where they receive treatment). The majority of the people having these procedures are older (with most procedures in the 64-69 age band).

46. In addition, Kent and Medway acute providers outsource approximately a further 2000 elective orthopaedic procedures each year to private hospitals and there are an additional 6,000 patients waiting for elective orthopaedic procedures across the area, with referral levels for elective procedures varying between CCGs and between practices. Some hospital waiting lists for planned care are long and growing. The number of cancellations on the day of the operation are increasing.

47. Right Care[9] analysis shows a potential significant opportunity in musculoskeletal elective bed days across the patient pathway, circa £8m compared to peers, and an additional £1.8m related to areas such as falls and primary care prescribing.

48. All acute hospital sites in Kent and Medway deliver a mixture of elective (planned) and non-elective (unplanned / emergency) orthopaedic services, with the exception of Kent & Canterbury Hospital which does not undertake any non-elective activity and Maidstone General Hospital which does not undertake any non-elective orthopaedic surgery.

49. Our proposed service model is based on:

- a focus on prevention and self-care and the benefit of a community-led integrated musculoskeletal (MSK) pathway;
- a set of principles including standardised approach, use of multi-disciplinary teams, one-stop services, senior support and better use of digital technology;
- a greater use of multi-disciplinary teams, consultant feedback, earlier discharge planning and ring-fenced elective beds; and
- consolidation of elective orthopaedic surgery onto fewer sites will lead to an improvement in outcomes.

50. The following diagram outlines our proposed service model:

1	MDT clinic	• Identify frail patients to follow proactive care for older people undergoing surgery (POPS) pathway • Combined clinic with consultant, extended scope physio, GPwSI allows in clinic triage to most appropriate clinician • Greater co-working between community staff, primary care and consultants – orthopaedic qualified nurses play a key role • Lower average staff cost per appointment • Spinal injections • Focus on MSK pathway
2	Preoperative assessment	• Conducted at first outpatient appointment; if patient found not fit then plan reviewed same day • Greater use of self-assessment to support, which patients can complete from home • Ensure social circumstances support the treatment plan, pre-booking of rehab/post-op package of care prior to admission
3	Re-check prior to surgery	• Contact at 48-72 hours before day of surgery to reduce late cancellation • Ensure patient is well and still wants surgery
4	Short-notice reserve list	• Ensures effective use of theatre capacity by filling gaps caused by late cancellation
5	Consultant-level feedback	• Transparency of list utilisation, case volumes per list • Peer challenge • Team working to increase available capacity by reducing cancelled sessions due to leave
6	Effective planning for discharge	• Discharge planning at preoperative assessment • Referral to discharge services earlier in the process (i.e. before admission) • Access to community support services
7	Enhanced recovery	• Consistent application of Enhanced Recovery Pathway (ERP) pathways • Clear expectations of predicted length of stay for patient
8	Ring-fenced elective beds	• Reduction in wasted theatre time • Reduction in infection risk for elective cases
9	Theatre utilisation	• Scheduling of theatre cases to optimise utilisation • Ensure critical equipment is scheduled to maintain the order and running of the list

[9] RightCare is an NHS England programme aimed at improving people's health and outcomes by promoting that the right person has the right care, in the right place, at the right time, making the best use of available resources. It uses data and evidence to highlight unwarranted variation to support quality improvement.

Hurdle criteria

51. As with the clinical models, the hurdle criteria have been developed through the hospital care workstream, with clnical and patient engagement, and then reviewed and signed-off by the STP Clinical Board, ahead of being approved at the STP Programme Board.

52. 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 to them, a short list of options will be generated. This shortlist of options will go forward to more detailed evaluation:

Criteria	Description in relation to application against long list of options for emergency care, acute medicine and elective orthopaedics	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 effective?	• 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, this may mean that some organisations have a net negative financial impact as well as some have a net positive impact.	• 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?	• Is the maximum travel time (by car) an average of one hour or less?	• Can the population access services within a window of 120 minutes from call to needle?[10]
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?	• Does it implement the outcome of other recent consultations or designation processes?

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

Is the potential configuration option financially sustainable?	• Must not increase the 'do nothing' financial baseline	• Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting more at PFI sites, this will be considered in detail at evaluation stage)*

Summary

53. As indicated at the start of this paper it is envisaged that consultation will take place in two waves, with the first services that are intended to be consulted on being:

    i. Acute stroke services across Kent and Medway

    ii. Emergency services in East Kent (i.e. emergency departments and acute care)

    iii. Elective orthopaedics in East Kent

54. The HOSC is asked to consider the contents of this paper.

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Item 8: North Kent CCGs: Urgent & Emergency Care Programme

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 July 2017

Subject: North Kent CCGs: Urgent & Emergency Care Programme

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 27 January 2017 the Committee considered an update following the re-establishment of the urgent and emergency care programme in North Kent. The scope of the programme had changed from the one originally presented to the Committee on 10 October 2014 and 26 January 2016. The Committee agreed the following recommendation on 27 January 2017:

- *RESOLVED that the report be noted and NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG be requested to present the case for change and proposed clinical models to the Committee in March.*

(b) The former Chairman agreed to a request from NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG to postpone the item until after the KCC election.

(c) NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG have asked for the attached reports to be shared with the Committee:

NHS Dartford, Gravesham and Swanley CCG	pages 37 - 54
NHS Swale CCG	pages 55 - 70

The appendices referred to in the NHS Dartford, Gravesham and Swanley CCG paper regarding the engagement events can be viewed here – https://democracy.kent.gov.uk/ecCatDisplay.aspx?sch=doc&cat=14757

The appendices referred to in the NHS Swale CCG paper regarding engagements events can be viewed here – https://democracy.kent.gov.uk/ecCatDisplay.aspx?sch=doc&cat=14756

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the proposed changes to urgent and emergency care in North Kent constitute a substantial variation of service.

(b) Where the HOSC deems the proposed changes to urgent and emergency care in North Kent as not being substantial, this shall not prevent the HOSC

from reviewing the proposed change at its discretion and making reports and recommendations to the CCG.

(c) Where the HOSC determines the proposed changes to urgent and emergency care in North Kent to be substantial, a timetable for consideration of the change will need to be agreed between the HOSC and CCG after the meeting. The timetable shall include the proposed date that the CCG intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

3. Recommendation

If the proposed change to urgent and emergency care in North Kent is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the proposed changes to urgent and emergency care by the North Kent CCGs to be a substantial variation of service.

(b) North Kent CCGs be invited to submit a report to the Committee in six months.

If the proposed change to urgent and emergency care in North Kent is *substantial*:

RECOMMENDED that:

(a) the Committee deems proposed changes to urgent and emergency care by the North Kent CCG to be a substantial variation of service.

(b) North Kent CCGs be invited to attend the September meeting of the Committee.

Background Documents

Kent County Council (2014) '*Health Overview and Scrutiny Committee (10/10/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

Kent County Council (2016) '*Health Overview and Scrutiny Committee (26/01/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6256&Ver=4

Kent County Council (2017) '*Health Overview and Scrutiny Committee (27/01/2017)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7507&Ver=4

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

NHS Dartford, Gravesham and Swanley

Clinical Commissioning Group

Urgent and Emergency Care

The Case for Change and Proposed Clinical Model of Care

Report prepared for:	Kent County Council [KCC] Health Overview and Scrutiny Committee [HOSC] 14 July 2017
Reporting Officer:	Patricia Davies, Accountable Officer, NHS Dartford, Gravesham and Swanley Clinical Commissioning Group and NHS Swale Clinical Commissioning Group
Report Compiled By:	Gerrie Adler, Portfolio Programme Director, NHS Dartford, Gravesham and Swanley Clinical Commissioning Group and NHS Swale Clinical Commissioning Group

1. Introduction

1.1 A report on the urgent and emergency care programme was presented to the Committee in January 2017. Within this report Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG) and NHS Swale Clinical Commissioning Group (Swale CCG) proposed to present the case for change and proposed clinical models to the Committee in March 2017.

1.2 Following three listening events held across DGS and Swale CCG areas in February 2017, the CCGs identified that additional time was required to compile the case for change, and to refine the proposed clinical model options before passing through internal governance processes.

1.3 Further to the urgent care update presented to the Committee in January 2017, this report has been prepared by DGS CCG to present the Committee with the urgent and emergency care review case for change, and to present the potential urgent and emergency care model options based on a review and consideration of national requirements, feedback gained from engagement events held with GPs, a 'whole system' event that took place in November 2016 and a listening event held with the public in February 2017, as well as resource and financial considerations.

1.4 The model options include the re-procurement of NHS111 services, supported by an enhanced Integrated Clinical Advice Service (ICAS) with improved system interoperability, and the re-procurement of GP out-of-hours services.

1.5 The DGS model option includes the centralisation of walk-in services to form an Urgent Care Centre at the Gravesham Community Hospital site, and the re-design of services based at Fleet Healthcare Campus. This re-design may include increased general practice and extended primary care access to 8pm Monday to Friday, and 8.30am to 1pm on Saturdays, as well as health and wellbeing hub services.

1.6 On the advice of the Consultation Institute, and in order to ascertain the level of engagement or consultation required, the CCG conducted a Community Impact Assessment in June 2017 by talking to a range of local stakeholders including local politicians, GP practice staff as well as local people and patients. Feedback was sought regarding the key elements of the urgent care proposals, and particularly the proposed move of the Walk in Centre at the Whitehorse Surgery in Northfleet, to Gravesham Community Hospital which is 1.3 miles away. There appeared to be minimal appetite for a more formal consultation process, especially as most stakeholders broadly supported the proposals. Based on the findings of the Community Impact Assessment, the CCG proposes to conduct a full range of engagement activities between August 2017 and October 2017, using a variety of channels and methods to ensure the local people are fully informed and appropriately engaged. This will include an online survey, and at least three events – one for providers and key stakeholders to work up draft specifications for services, another with GPs (PLT) to build on the specification, and a third one with patients and public to test the specification and refine before going out to tender.

1.7 The Committee is asked to consider the case for change and the potential model options to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

2. The Development of the Case for Change and the Proposed Model of Care

2.1. The case for change and the emergent clinical model of care are based upon nationally mandated changes, as well as on the feedback received from local clinical and operational leaders, patients and the public gained at various engagement and listening events.

2.2. All engagement activities undertaken thus far have asked for attendees to give their views of local, urgent and emergency care models, rather than solely on the urgent and emergency care element. The CCG recognises that the outcome of any review will need to complement other transformational programmes (e.g. GP Forward View, and the Sustainability and Transformation Plan) and therefore cannot be considered in isolation. Part of urgent care is currently delivered within primary care (e.g. same day urgent GP appointments and 2, 4 and 6 hour GP dispositions from NHS111), and the future direction of travel is seeing more primary care services supporting Emergency Departments (ED) by identifying patients who can be most appropriately seen and treated within primary care. Feedback gained at these events that relate to local care plans and the primary care strategy have been considered in the design and refinement of the urgent and emergency care model described below.

2.3. The engagement events undertaken that have helped shape the case for change and emergent model of care are as follows:

2.3.1. **February - May 2015: DGS and Swale CCGs Patient and Clinician Reference Groups** to identify a potential solution (e.g. hub and spoke model).

2.3.2. **November 2016: GP Engagement Event.** 32 of the CCG's 34 practices were represented by 48 GPs as well as other members of multi-disciplinary team. Attendees were asked: (i) for their opinions on urgent care using an extract from recent BMA GP survey, (ii) to consider the ways in which extended hours might be provided in primary care (including working with the GP Federation), (ii) to vote on whether they wished to work collaboratively with other GPs to provide area specific extended access, and (iii) to review proposed models for local, urgent and emergency care. A summary of the feedback received is attached in ***Appendix A.***

2.3.3. **November 2016: DGS and Swale CCGs Urgent and Emergency Care Whole Systems Event** which saw over 80 attendees from across health and social care in North Kent. The event brought together patient representatives, voluntary sector organisations, hospital clinicians, GPs, out-of-hours providers, community staff and commissioners to collaborate and discuss possible future models of care in DGS and Swale CCG areas. Presentations and workshop sessions allowed the delegates to work together to tackle

issues and focus on improving patient access, promoting appropriate health services and breaking down organisational barriers to improve patient experience. A summary of the feedback received is attached in ***Appendix B.***

2.3.4. **February 2017: DGS Listening Events.** Listening events were held across DGS and Swale CCG areas to hear how the public (including some community groups/organisations) felt about the potential model and to better understand the ways in which the model might affect people. One event was held in Shorne primarily for DGS residents. Attendees were asked to (i) share and discuss the review of urgent and local care conducted to date - including feedback from previous patient and public engagement, (ii) provide an overview of future proposals and the emerging urgent and local care models, and (iii) get patient and public feedback on the model to help inform the next stage of its development. A summary of the feedback received at these listening events is attached in ***Appendix C.***

3. National and Local Context

3.1. In November 2013, the Keogh Review - End of Phase One Report outlined the case for change and proposals for improving urgent and emergency care services in England. The report highlighted five areas for the future of urgent and emergency care;

3.1.1. Provide better support for people to self-care

3.1.2. Help people with urgent care needs to get the right advice in the right place, first time

3.1.3. Provide responsive urgent care services outside of hospital so people no longer choose to queue in the Accident and Emergency (ED) department

3.1.4. Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise the chances of survival and a good recovery

3.1.5. Connect all urgent and emergency care service together so the overall system becomes more than just a sum of its parts

3.2. The findings of this report were further supported by the publication of the NHS Five Year Forward View in October 2014, which stated that urgent and emergency care services will be redesigned to improve integration between emergency departments (ED), GP out-of-hours services, urgent care centres, NHS 111 services and ambulance services.

3.3. Between February and May 2015, DGS CCG, in partnership with Swale CCG, and Medway Clinical Commissioning Group (Medway CCG), pursued a programme of activity across North Kent which began to look at urgent care. In both DGS and Swale CCGs, patient and clinician reference groups were held and a potential solution was identified which was based around a hub and spoke model.

3.4. In June 2015, DGS CCG took a local decision to pause the programme due to the recognition of the emerging impact of the Ebbsfleet development on the local health economy; an impact which required further analysis before the programme could be moved any further forward.

3.5. In July 2015, a national programme pause was applied. CCGs received a letter from Dame Barbara Hakin which focused on the need to ensure a functionally integrated 24/7 urgent care access, treatment and clinical advice service incorporating NHS 111 and out of hours. With NHS 111 previously out of scope of the urgent care redesign, programmes were paused pending publication of further guidance.

3.6. In September 2015, guidance was published within the Commissioning Standards Integrated Urgent Care, which focused urgent care redesign on the planned reconfiguration of urgent and emergency care services to enable 'commissioners to deliver a functionally integrated 24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice'. Central to this vision is the promotion of NHS111 as a single point of access for urgent care, supported by the introduction of a 'clinical hub' or Integrated Clinical Advice Service (ICAS) that will assess patient needs and advise on the most appropriate course of action (including enabling the patient to self-care where appropriate), and/or onward referral. This will provide access for the public to a wide range of clinicians whilst also providing advice to health professionals in the community so that no decision has to be made in isolation.

3.7. In October 2015, the national programme pause was lifted, and in May 2016, the DGS CCG local programme pause was lifted.

3.8. In June 2016, the urgent and emergency care programme was re-established in line with the Commissioning Standards - Integrated Urgent Care (September 2015) which focus on the following:

3.8.1. The commissioning of NHS111 as the telephony single point of access for urgent care providing a call handling, initial triage and signposting service.

3.8.2. The provision of an Integrated Clinical Advice Service (ICAS) to support NHS111 with telephony clinical triage, multi-disciplinary team advice, guidance and referral, ensuring no decision is made in isolation.

3.8.3. The GP out-of-hours service (including base sites and home visits).

3.8.4. System interoperability to enable greater integration.

3.9. Other face-to-face aspects of urgent and emergency care services, and the points at which urgent and emergency care overlaps with the requirements and proposals laid out for the General Practice Forward View, and the Kent and Medway Sustainability and Transformation Plans (STP), have also been reviewed, and although not all the requirements are addressed within the urgent and emergency care potential model, care has been taken to ensure the outcomes of different programmes are complementary. This has included consideration of the following:

3.9.1. Extended primary care access by March 2019 and the provision of urgent same day bookable appointments within primary care.

3.9.2. Primary care managed urgent care service to support the acute trust to avoid unnecessary ED attendance and/or hospital admission, deliver the 4 hour ED standard and meet ambulance handover times.

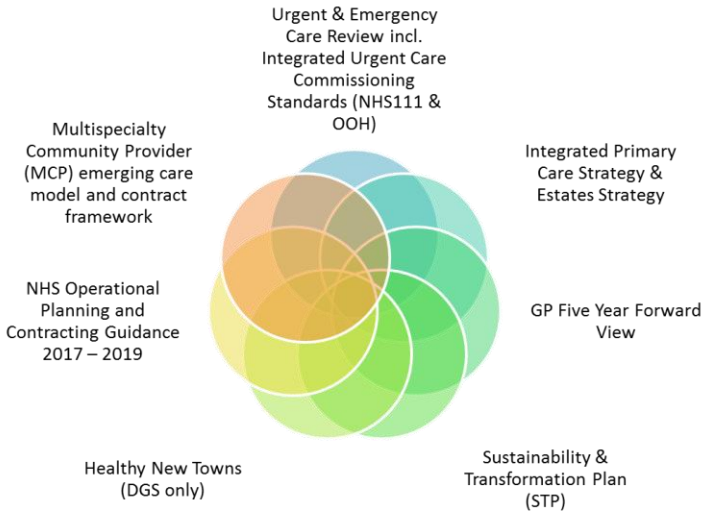
3.9.3. Workforce and workload issues.

3.9.4. Increased use of technology and improved interface between general practice and hospitals.

3.9.5. Preventative support services and the ways in which self-care can be encouraged from NHS111 and ICAS without the need for a face-to-face consultation, where clinically appropriate.

3.9.6. Increase efficiency and implement demand reduction measures whilst addressing predicted growth.

3.10. The full spectrum of national guidance that influences this case for change is as follows:



3.11. The Kent and Medway Sustainability and Transformation Plan (STP) is currently in development and aims to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, co-ordinated care that is easy to access, and enables people to stay well and live independently and for as long as possible in their home setting.

4. Why is Change Necessary?

4.1 The local NHS system is no longer designed to meet the needs of the local population and in some areas the CCG, and their respective GP membership, are struggling to deliver the quality of care to which they aspire, and that their patients want.

4.2 Changes need to be made to the ways in which local and urgent care are provided in order to ensure that general practice is sustainable now and in the future.

4.3 Local, urgent and emergency care services are struggling under the weight of demand.

4.3.1 Darent Valley Hospital – Performance against the 4 hour Emergency Department Constitutional Standard for 2015/16 and 2016/17 has fallen short of the target of 95%.

4.4 Funding for services is limited, and finding appropriately skilled and experienced staff is a challenge for all areas of health and social care. At times this can lead to different services competing for the same key clinicians.

4.5 There is therefore a duty to ensure public money is spent wisely on services that really address the needs of the local population.

4.6 The boroughs of Dartford, Gravesham and Swanley are planning for significant housing growth and economic development between now and 2030 with the most rapid increase between 2015 and 2025. Population growth is estimated to be in the region of 22% by 2035. This will undoubtedly have an impact on the healthcare requirements for the area.

4.7 The largest age group growth is in people 85+ (bringing increased needs for health and social care).

4.8 A high proportion of patients are attending the emergency department who do not have life threatening emergencies and this is evidenced by the fact that 50% of patients who attend emergency department are discharged to their GP or discharged with no follow-up care. Whilst some of these patients would have been most appropriately cared for within an emergency department, a high proportion of these patients may be more appropriately cared for by primary care clinicians.

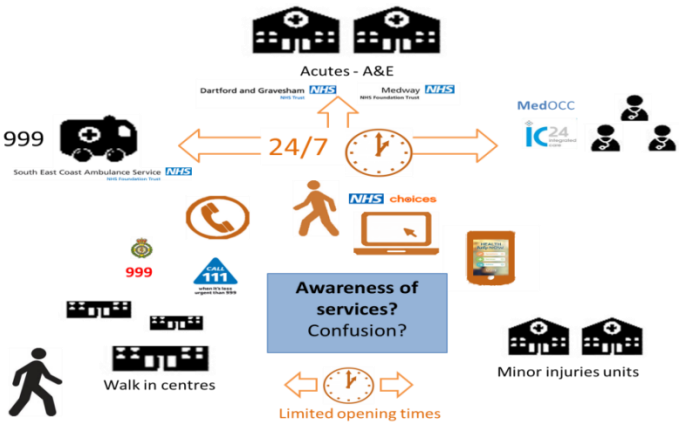
Other key facts about local emergency department (ED) November 2015 - October 2016**:**	**DGS**
ED rate per 1000 population	307
ED attendances discharged to GP / discharged with no follow-up	5 in 10
Average waiting time - emergency department	3.2 hrs
Emergency department attendance growth	7%

4.9 There are a large number of patients with long term conditions and mental health needs within the CCG area who may benefit from having more clarity regarding available support outside an acute Trust or emergency department.

Key facts about patients with long term conditions and mental health issues (2015/2016):	DGS
People living with LTC - Diabetes Register	13,004
People living with LTC - CKD Register	10,003
People living with LTC - Cancer Register	5,765
People living with LTC - Chronic Obstructive Pulmonary Disease (COPD)	4,419
People with Mental Health	1,818
People living with LTC - Palliative Care Register	827

4.10 DGS and Swale CCGs have asked patients, the public, and representatives from across health and social care in North Kent for their views about why change is necessary. Detailed feedback received from the engagement activities is included in ***Appendices A – C***. A high level summary of the key points and themes raised is outlined below:

4.10.1 The healthcare landscape is overly complex and it is often difficult for patients, the public, and sometimes even clinicians, to successfully navigate their way through the many services available as shown below:



4.10.2 Patients sometimes access services inappropriately because, for example, they may be worried about a healthcare problem but do not know where to go, or because it is not possible to access their GP immediately.

4.10.3 Brand strength influences public behaviour and the strongest brands (i.e. GP and emergency department) have the most significant demands placed upon them, and despite all previous efforts to change public behaviour, they continue to be the most accessed/used services.

4.10.4 The needs of patients have changed (increasingly elderly population, living longer with long term conditions).

4.10.5 Patients want more local, out-of-hospital care.

4.10.6 The current system supports competition rather than collaboration, and communication between services / providers needs to be improved.

4.10.7 There is a void in care/support for patients following urgent and emergency care attendance/treatment.

4.10.8 There is an education gap for patients and clinicians.

4.10.9 Patients need to take more responsibility for their health and local services should better support self-care.

4.10.10 Doctors may over-medicalise patients because they want to 'do something'.

4.10.11 The current system has resource problems in terms of funding and availability of appropriately trained staff.

5. What Sort of Change is Necessary?

5.1 The changes to the integrated urgent care system must address the eight key elements outlined by NHS England by 2020. These elements are as follows:

5.1.1 A patient can make an appointment out-of-hours in a single call

5.1.2 A patient can make an appointment in the in-hours period

5.1.3 Data can be transferred between providers

5.1.4 The Summary Care Record is available in the hub and elsewhere

5.1.5 Care plans and patient notes are shared

5.1.6 The number of patients speaking to a clinician increases above the current level of 22% by the implementation of a Clinical Hub (40-60% by 19/20)

5.1.7 The capacity for NHS111 and OOHs is jointly planned

5.1.8 There is joint governance across Urgent and Emergency Care Providers

5.2 In addition to this, over the course of many months, a structural clinical model that spanned local, urgent and emergency care has emerged and has been presented at each engagement event in order to encourage feedback and to better understand the needs of the public. Feedback received relating to urgent and emergency care has been considered when refining model options.

5.3 Detailed feedback received from the engagement activities is included in ***Appendices A – C***. A high level summary of the key points relating to the structural model are outlined below:

5.3.1 Simplify the health landscape and make services easier to access

5.3.1.1 Limit the number of entry points and avoid duplication

5.3.1.2 Standardise access times and link to contractual agreements

5.3.2 Ensure services are integrated

5.3.3 Cater to both urban and rural populations and address healthcare inequalities

5.3.4 Consider brand strength or GP, 999 and ED, and the influence on public behaviour/perception

5.3.5 Consider the creation of a seamless 24/7 GP service

5.3.6 Other clinicians should help support GPs. Introduce GP consultant model (specialist generalist)

5.3.7 Identify the patients who need to see a named GP, any GP, or another health professional or voluntary sector support (care navigators).

5.3.8 Limit access to the ED (Emergency Department) – requiring clinical referral.

5.3.9 Encourage and support prevention and self-care

5.3.10 Enable a patient to access virtual triage assessment by app or phone

5.3.11 Ensure services are affordable and sustainable both now and in the future

5.3.12 Specific feedback relating to each CCG area is given in **Appendices A – C**, and feature within the potential model below.

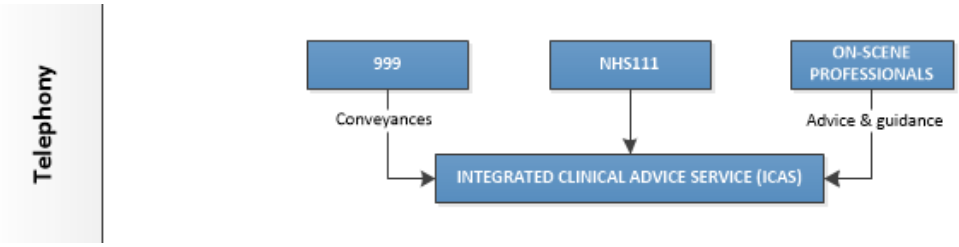
6. Potential Model and Critical Paths

6.1. Development of Potential Model

6.1.1. The potential model has been agreed, based on a review and consideration of national requirements, and feedback gained from engagement events held with GPs, the 'whole system' event that took place in November 2016 and listening events held in February 2017. Model options have been agreed by both the Executive Team and senior clinicians.

6.1.2. There are two key elements to the model (i) telephony services (requiring the re-procurement of NHS 111 and the design and procurement of an Integrated Clinical Advice Service (ICAS) which includes current 'GP Speak to' services), and (ii) face-to-face services (including all unscheduled, walk-in, urgent care services).

6.2. NHS111 and Integrated Clinical Advice Service (ICAS) Telephony Services



6.2.1. To provide economies of scale, and to ensure resilience for the NHS111 service, the North Kent CCGs (i.e. DGS, Swale and Medway), together with West Kent CCG, are pursuing re-procurement of a single NHS111 service to cover all areas. The intention is that the service would 'go live' in April 2019.

6.2.2. The ICAS builds on the team of clinicians already supporting the NHS111 service, and will be developed in line with both NHSE guidance and the Commissioning Standards for Integrated Urgent Care, and will be procured across the North Kent CCGs only. The intention is that the service would 'go live' in April 2019 in line with NHS111.

6.2.3. The Integrated Urgent Care Commissioning Guidance states that it anticipates that that up to 60% of all calls to NHS111 could be transferred to a clinical hub, or ICAS (this figure currently sits at approximately 26%), and that the ICAS will also provide clinical support to On-Scene Professionals.

6.2.4. The NHS111 number will remain free to call and will still be available 24 hours a day, 7 days a week to ensure patients have easy and swift access to urgent care. It will be the single point of access for urgent care, however patients and the public should be enabled to access integrated urgent care via alternatives routes to the telephone i.e. digital online platforms.

6.2.5. Patients dialling NHS111 will be triaged by a Health Care Advisor, and then be directed as appropriate to a range of multidisciplinary clinicians and services. Patients with complex problems requiring early assessment by a clinician will be identified quickly and transferred to speak to the appropriate clinician.

6.2.6. The current NHS111 service is supported by a team of clinicians, mainly paramedic and nursing staff, and the requirement is to enhance this clinical support service by procuring an ICAS. The ICAS has not yet been designed, but may include one or more of each of the following professionals; specialist or advanced paramedics, nurses with primary, community, paediatric and or urgent care experience, mental health professionals, prescribing pharmacists, dental professionals, senior doctors with

appropriate primary care competencies. Additional clinicians may also be included depending on local need.

6.2.7. A comprehensive electronic Directory of Services will support accurate and appropriate signposting and onward referral.

6.2.8. System interoperability will allow safeguarding alerts, special patient notes, including end of life care plans and recent contact history, to be available at the point of access to ensure appropriate assessment of patient need. In addition, as a minimum the Summary Care Record will be available to all clinicians in the ICAS.

6.2.9. NHS111 and the ICAS will help support patients to self-care where appropriate, or where a patient needs to have a face-to-face assessment/consultation, clinicians working in the ICAS will have the capability to make an electronic referral to the service that can best deal with the patient's needs, as close to the patient's location as possible.

6.2.10. The re-procurement of the existing NHS111 service and the enhancement of the existing clinical support (ICAS) are not thought to represent a significant variation. It is recognised however that there should be some communication activities undertaken with the public to promote the services.

6.3. Prevention and Self-Care

6.3.1. DGS CCG is committed to improving health prevention activities, and where clinically appropriate, encouraging and supporting patients to self-care.

6.3.2. The plans around prevention and self-care are based on our belief that more people can take greater responsibility for their own health and wellbeing through, for example, attending the sorts of clinics/services that may be available in Community Campuses/Health and Wellbeing Hubs in the future as part of the Primary Care Strategy Programme.

6.3.3. The urgent care model aims to increase the support people have when accessing urgent care, either through the telephony or face-to-face elements of the model, so that they can be supported, where clinically appropriate, to care for themselves more successfully, and to know when and how to seek support if they need it.

6.3.4. The CCG believes information, education and technology can help support people and patients to become more proactive about self-care and this has been explored with the public at the Listening Events.

6.4. Potential Model Options

6.4.1. Critical Path

6.4.1.1. The telephony elements of the model will 'go live' in April 2019.

6.4.1.2. The change to the face-to-face elements of the model (discussed below), once agreed, is intended to be operational from July 2019.

6.4.1.3. Piloting of services may be possible in existing estate before July 2019.

6.4.2. Challenges

6.4.2.1. **Population Growth** – Between 2016 and 2035 the DGS CCG population is set to grow by circa 22% with the most rapid growth by 2025. This growth varies by area e.g. in Dartford there is an expected 43% population increase by 2026. Developments identified in the adopted Local Plans will result in an additional population of 57,749 people assuming a minimum of 2.4 people per unit of accommodation and requiring an additional 32 GPs at a minimum. Additional resource must be secured in order to address this growth and improve health outcomes and continue to deliver critical targets.

6.4.2.2. **Staffing** – Workforce issues need to be addressed to ensure there are sufficient staff with the required level of skills and experience. This includes working with GP member practices, and other providers, to explore ways in which the multi-disciplinary team can help support each other, but also to identify ways in which recruitment and retention issues can best be addressed.

6.4.2.3. **Health Inequalities** - Dartford is ranked at 170 nationally, among the most deprived council areas, with Gravesham ranked at 124 and Sevenoaks ranked 272 out of the 326 local authorities. Areas of Dartford, Gravesham and Swanley are within the bottom quintile (lowest 20%) on the national deprivation scale.

6.4.2.4. **Health and Social Care** – To realise the benefits of the potential clinical model in terms of patient experience, quality of care and avoidance of unnecessary ED attendance / hospital admission it is important that health and social care providers work collaboratively across organisational boundaries to help support the urgent care proposals.

6.4.3. Key Elements of the Potential Clinical Model

6.4.3.1. **Planned Appointments** – Under the potential model practices would continue to operate as they currently do, including the offering of urgent same day appointments. Ways in which urgent same day appointment capacity can be increased will be explored as part of the Primary Care Strategy discussions.

6.4.3.2. **GP Out-of-Hours Services** – The potential model aims to deliver greater integration between in and out-of-hours GP services with the aim to create a more seamless 24/7 GP function, and there will be closer integration between the GP service, NHS111, ICAS and other urgent care services. The GP out-of-hours service would continue to offer home visits where clinically required, and offer out-of-hours face-to-face consultations at a base site. Both elements of the

service may include the use of a multidisciplinary team to support the out-of-hours GP function (e.g. paramedic or nurse practitioners). This will represent a significant move towards the introduction of the GP as consultant model.

6.4.3.3. **Centralisation of Walk-in Services and Re-Design of the Services based at Gravesham Community Hospital and Fleet Healthcare Campus.** Simon Stevens, Chief Executive Officer for NHS England, and Jim Mackey, Chief Executive Officer for NHS Improvement, have identified that the fragmented nature of out-of-hospital services made services unable to offer patients adequate alternatives to ED and this is impacting upon the ability of many NHS systems to provide ED services within the required standards. Based on feedback from engagement events, and guidance from NHS England and NHS Improvement, within the potential model non-ED urgent walk-in services would be centralised (this does not include same day or urgent GP appointments which would continue to be available at local practices). NHS111 will be the single point of access to urgent care, and after the service is re-procured , and supported by an enhanced clinical support service (Integrated Clinical Advice Service), it is anticipated that there will be a reduction in the need for face-to-face consultations in and out-of-hours. The reduced number of patients who still need to access walk-in urgent care services, such as those provided by the Walk-in Centre and Minor Injuries Unit, will be able to access these services at Gravesham Community Hospital. The Minor Injuries Unit services would remain on the Gravesham Community Hospital site, and the Walk-in Centre services would relocate from the Fleet Health Campus to the Gravesham Community Hospital site (approx. 1.3 miles away). These services would together form an Urgent Care Centre on that site. A re-design of the services at Fleet Healthcare Campus may then include increased general practice, and extended primary care access to 8pm Monday to Friday, and 8.30am to 1pm on Saturdays. As part of the re-design of both sites, other health and wellbeing services will be considered.

6.4.3.4. **Emergency Department (ED) Primary Care Streaming** – Attendances to Emergency Departments continue to increase, and a proportion of these patients have clinical concerns that could be dealt with by primary care services. Streaming these patients out of highly pressured EDs, to co-located GP led primary care services, ensures that patients receive the care that they need, whilst improving patient experience by ensuring that the standards around ED waits are more consistently achieved. There are several options for primary care streaming models. Primary care, GP led streaming within ED is a new NHS England development initiative, and will be in place at Darent Valley Hospital ED from October 2017. In line with best practice principles identified by NHS England, it will operate extended hours and will consist of an experienced and suitably qualified ED nurse who will work to agreed streaming criteria to determine if patients need to be seen by a primary care service, or by the ED. A

primary care, GP led service will be co-located with the ED and will see and treat appropriate patients within the four hour wait standard.

7. Intensive Stakeholder Engagement - Community Impact Assessment

7.1. The CCG sought advice from the Consultation Institute regarding whether the proposed centralisation of the Walk-in Centre and the Minor Injuries Unit at Gravesham Community Hospital would require a full public consultation.

7.2. On the advice of the Consultation Institute, and in order to ascertain the level of engagement or consultation that may be required, the CCG conducted a Community Impact Assessment by talking to a range of local stakeholders.

7.3. This intensive piece of stakeholder engagement was carried out in late June 2017 with the aim to determine whether local people considered the proposed changes to be substantial or controversial. In line with best practice, it was carried out in large part by an independent organisation and feedback documented. Feedback was sought regarding the key elements of the urgent care proposals, and particularly the proposed move of the Walk in Centre at the Whitehorse Surgery in Northfleet, to Gravesham Community Hospital which is 1.3 miles away.

7.4. This intensive engagement comprised:

7.4.1. Telephone interviews with local politicians and GP practice staff conducted independently by the Public Engagement Agency (PEA™)

7.4.2. Discussions with 85 local people and patients using the Walk-in Centre and neighbouring GP practices (conducted by CCG staff during one day, evening and weekend day)

7.5. **Telephone interviews** were conducted with councillors representing the five wards most directly impacted by the proposed changes: Coldharbour; Northfleet North; Northfleet South; Painters Ash; Pelham; and with a representative from each of the three GP practices in the same location as the Walk-In Centre (i.e. The Forge, Whitehorse Surgery, and The Gateway practices).

7.6. The full report on the community impact assessment is attached in ***Appendix D***.

7.7. In summary, the following key themes emerged from the telephone interviews:

7.7.1. Nearly all respondents agreed that urgent care services need to change although concern was voiced about how successful the change would be;

7.7.2. Most people said the proposal to move the Walk-in Centre was a good idea. Positive feedback included reducing waiting times; reducing the pressure on GPs; Gravesham hospital is more accessible; good public transport – buses and trains; better use of resources; one point of access; improved access to GPs

7.7.3. 4 people were less positive and their concerns included: need to decentralise, be more local; need to add not reduce services; could be seen as cost-saving; concern about privatisation; parking at the hospital is limited/always full; transport may be difficult at the starting point of the journey; potential for increasing waiting times

7.7.4. GP "superhubs" and extended GP hours were welcomed as a way of reducing waiting times and being more responsive to people who worked

7.7.5. Concerns were funding, clinical staffing, losing the personal touch, increased workload, staff retaining their jobs

7.7.6. People need to be educated on how to use the services more appropriately

7.7.7. People need ongoing information about the proposed changes

7.8. Participants were asked what else the CCG should do to gain people's views and feedback. A range of approaches were offered, including:

7.8.1. Giving people information about the changes: what and why

7.8.2. Using networks; speaking with resident associations

7.8.3. Using social media, such as website, twitter

7.8.4. Writing to people; putting information in newspapers

7.8.5. Conducting surveys; running focus groups and workshops

7.8.6. Providing information via the surgeries

7.9. One person said there should be a consultation if people were overwhelmingly against the proposals. Another said while consultation is a good thing it doesn't inspire the general public – the CCG needs to go out and talk to people and keep them informed.

7.10. The need to inform and communicate more effectively with people who might use services was an important theme. Ensuring people had confidence in the new services being provided (and how to access them), will be an important element of success.

7.11. Respondents were clear that any changes made must result in better patient experiences and outcomes but provided differing views, about whether a perceived centralisation of services would deliver the improvements required.

7.12. The patients who took part in the **face-to-face interviews** came from the following areas: Gravesend, Northfleet (including close proximity to the Walk-in Centre), Dartford, Greenhithe, Swanscombe, Chalk, Longfield, Meopham, and one patient from Rochester. This included a number of patients who lived very local to the Walk-in Centre. Ages ranged from teenage to 80+ and 35 males were interviewed compared with 50 females. The patients came from a variety of ethnic backgrounds.

7.13. In summary, the following key themes emerged from the face-to-face interviews:

7.13.1. 71% (60 people) thought it was a positive thing that it could move to the Gravesham Hospital site

7.13.2. Only eight people felt it was a negative thing, and the rest (12) gave neutral views

7.14. Positive feedback included:

7.14.1. Better accessibility for a wider population

7.14.2. Better public transport links

7.14.3. Easier to find

7.14.4. Co-location with the Minor Injuries Unit would make it easier to use services in the right way.

7.15. Negative feedback included:

7.15.1. Parking could be an issue as patients would need to pay

7.15.2. If the small number of parking spaces on site were taken, town centre parking could be costly.

7.16. The patients who were spoken to face-to-face on site were largely positive about the possible move of location to Gravesham Hospital and this included some people who lived very local to its current site. It should be stressed that many of those who felt it would be a positive move, mentioned the parking issues.

7.17. Of those who thought the potential move was positive, 31 stated that it would be more accessible for patients than the current Walk-in Centre.

7.18. Better transport links were also given as a plus side to the move with many people thinking of the benefits for others who live out of the town centre but who could benefit from the improved transport links.

7.19. Some of the patients who lived within a short walk of the current Walk-in Centre said they did not feel the proposed move was negative because they were likely to benefit from more GP appointments available at Fleet Healthcare. They also said they would be happy to travel a mile into town to the Walk-in Centre if needed and it would not be a problem.

7.20. Of the 60 patients who said it would be a positive move, 18 felt parking could possibly be an issue for some people; solutions they suggested included more parking on site, making parking free, creating a drop off point, and using nearby carparks for free parking.

7.21. Of the eight people who said it would be a negative move, three didn't want it to move at all, one felt hospitals were not a place for people to see a GP and felt there would be stigma involved, four felt having to travel further was an issue, and one suggested a Walk-in Centre should also be put at Darent Valley Hospital.

7.22. Some people felt locating the Walk-in Centre alongside the minor injuries unit was a positive move and that it would help people understand how to use services better.

7.23. This feedback has, in the opinion of the CCG, confirmed that local people do not see the plans to relocate the Walk-in Centre as controversial.

7.24. In terms of future stakeholder engagement, based on the findings of the Community Impact Assessment, the CCG proposes to act in line with the assessment findings. There appeared to be minimal appetite for a more formal consultation process, especially as most stakeholders broadly supported the proposals.

7.25. The CCG proposes to conduct a full range of engagement activities between August 2017 and October 2017, using the variety of channels and methods identified by the respondents and outlined above, to ensure the local people are fully informed and appropriately engaged. This will include a roving roadshow with CCG staff talking to local people in supermarkets, Gateways, health centres and hospitals, an online survey, focus groups with residents groups and audiences identified by an Equalities Impact Assessment, and at least three events – one for providers and key stakeholders to work up draft specifications for services, another with GPs (PLT) to build on the specification, and a third one with patients and public to test the specification and refine before going out to tender.

8. Conclusions and Recommendation

8.1. The Committee is requested to note the content of this case for change and proposed model of care and to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

8.2. The model options include the re-procurement of NHS111 services, supported by an enhanced Integrated Clinical Advice Service (ICAS) with improved system interoperability, and the re-procurement of GP out-of-hours services.

8.3. The model option includes the centralisation of non-ED urgent care walk-in services at the Gravesham Community Hospital site and the re-design of the services based at Fleet Healthcare Campus. The proposed model features the potential relocation of the Walk-in Centre service to Gravesham Community Hospital (1.3 miles away) in 2019, and a possible re-design of the service at Fleet Healthcare Campus to include increased general practice provision and extended primary care access.

8.4. On the advice of the Consultation Institute, and in order to ascertain the level of engagement or consultation required, the CCG conducted a Community Impact Assessment in June 2017. Based on the findings of the community impact assessment, the CCG proposes to conduct a full range of engagement activities between August 2017 and October 2017, using a variety of channels and methods to ensure the local people are fully informed and appropriately engaged.

NHS Swale Clinical Commissioning Group

Urgent and Emergency Care

The Case for Change and Proposed Clinical Model of Care

Report prepared for:	Kent County Council [KCC] Health Overview and Scrutiny Committee [HOSC] 14 July 2017
Reporting Officer:	Patricia Davies, Accountable Officer, NHS Dartford, Gravesham and Swanley Clinical Commissioning Group and NHS Swale Clinical Commissioning Group
Report Compiled By:	Gerrie Adler, Portfolio Programme Director, NHS Dartford, Gravesham and Swanley Clinical Commissioning Group and NHS Swale Clinical Commissioning Group

1. Introduction

1.1 A report on the urgent and emergency care programme was presented to the Committee in January 2017. Within this report Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG) and NHS Swale Clinical Commissioning Group (Swale CCG) proposed to present the case for change and proposed clinical model to the Committee in March 2017.

1.2 Following three listening events held across Swale and DGS CCG areas in February 2017, the CCGs identified that additional time was required to compile the case for change, and to refine the proposed clinical model options before passing through internal governance processes.

1.3 Further to the urgent care update presented to the Committee in January 2017, this report has been prepared by Swale CCG to present the Committee with the urgent and emergency care review case for change, and to present the potential urgent and emergency care model options based on a review and consideration of national requirements, feedback gained from engagement events held with GPs, a 'whole system' event that took place in November 2016 and two listening events held in Swale with the public in February 2017, as well as resource and financial considerations.

1.4 The Swale model options include the re-procurement of NHS111 services, supported by an enhanced Integrated Clinical Advice Service (ICAS) with improved system interoperability, and the re-procurement of GP out-of-hours services.

1.5 The model proposes that similar services remain at both Sittingbourne Memorial and Sheppey Community Hospitals, but that the ways in which services are integrated will deliver benefits to patients.

1.6 Ways in which urgent same day appointment capacity can be increased in future will be explored as part of the Primary Care Strategy discussions and this may include the provision of some or all urgent same day appointments from centralised 'hub' locations rather than from each individual GP practice.

1.7 The changes to the Swale urgent care model are not considered to be significant as proposals do not involve a change to the way in which patients access services, and no formal public consultation is currently planned. Swale CCG intends to carry out further engagement activities with a range of key stakeholders, and with the public, including co-design of the service specification, commencing in July 2017.

2. The Development of the Case for Change and the Proposed Model of Care

2.1. The case for change and the emergent clinical model of care are based upon nationally mandated changes, as well as on the feedback received from local clinical and operational leaders, patients and the public gained at various engagement and listening events.

2.2. All engagement activities undertaken thus far have asked for attendees to give their views of local, urgent and emergency care models, rather than solely on the urgent and emergency care element. The CCG recognises that the outcome of any review will need to complement other transformational programmes (e.g. GP Forward View, and the Sustainability and Transformation Plan) and therefore cannot be considered in isolation. Part of urgent care is currently delivered within primary care (e.g. same day urgent GP appointments and 2, 4 and 6 hour GP dispositions from NHS111), and the future direction of travel is seeing more primary care services supporting Emergency Departments (ED) by identifying patients who can be most appropriately seen and treated within primary care. Feedback gained at these events that relate to local care plans and the primary care strategy have been considered in the design and refinement of the urgent and emergency care model described below.

2.3. The engagement events undertaken that have helped shape the case for change and emergent model of care are as follows:

2.3.1. **February - May 2015: DGS and Swale CCGs Patient and Clinician Reference Groups** to identify a potential solution (e.g. hub and spoke model), and Swale CCG made further progress by holding both a GP Engagement Event, and a Market Engagement Event. A summary is attached in ***Appendix A***.

2.3.2. **November 2016: DGS and Swale CCGs Urgent and Emergency Care Whole Systems Event** which saw over 80 attendees from across health and social care in North Kent. The event brought together patient representatives, voluntary sector organisations, hospital clinicians, GPs, out-of-hours providers, community staff and commissioners to collaborate and discuss possible future models of care in DGS and Swale CCG areas. Presentations and workshop sessions allowed the delegates to work together to tackle issues and focus on improving patient access, promoting appropriate health services and breaking down organisational barriers to improve patient experience. A summary of the feedback received is attached in ***Appendix B.***

2.3.3. **February 2017: Swale Listening Events.** Listening events were held across Swale and DGS CCG areas to hear how the public (including some community groups/organisations) felt about the potential model and to better understand the ways in which the model might affect people. Two such events were held in Swale, one in Queenborough and another in Sittingbourne, due to the very different issues facing residents of the localities of Sittingbourne and the Isle of Sheppey. Attendees were asked to (i) share and discuss the review of urgent and local care conducted to date - including feedback from previous patient and public engagement, (ii) provide an overview of future proposals and the emerging urgent and local care models, and (iii)

get patient and public feedback on the model to help inform the next stage of its development. A summary of the feedback received at these listening events is attached in ***Appendix C.***

3. National and Local Context

3.1. In November 2013, the Keogh Review - End of Phase One Report outlined the case for change and proposals for improving urgent and emergency care services in England. The report highlighted five areas for the future of urgent and emergency care;

3.1.1. Provide better support for people to self-care

3.1.2. Help people with urgent care needs to get the right advice in the right place, first time

3.1.3. Provide responsive urgent care services outside of hospital so people no longer choose to queue in the Accident and Emergency (ED) department

3.1.4. Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise the chances of survival and a good recovery

3.1.5. Connect all urgent and emergency care service together so the overall system becomes more than just a sum of its parts

3.2. The findings of this report were further supported by the publication of the NHS Five Year Forward View in October 2014, which stated that urgent and emergency care services will be redesigned to improve integration between emergency departments (ED), GP out-of-hours services, urgent care centres, NHS 111 services and ambulance services.

3.3. Between February and May 2015, Swale CCG, in partnership with DGS CCG, and Medway Clinical Commissioning Group (Medway CCG), pursued a programme of activity across North Kent which began to look at urgent care. In both Swale and DGS CCGs, patient and clinician reference groups were held and a potential solution was identified which was based around a hub and spoke model. Swale CCG made further progress and held both a GP Engagement Event, and a Market Engagement Event.

3.4. In July 2015, a national programme pause was applied. CCGs received a letter from Dame Barbara Hakin which focused on the need to ensure a functionally integrated 24/7 urgent care access, treatment and clinical advice service incorporating NHS 111 and out of hours. With NHS 111 previously out of scope of the urgent care redesign, programmes were paused pending publication of further guidance.

3.5. In September 2015, guidance was published within the Commissioning Standards Integrated Urgent Care, which focused urgent care redesign on the planned reconfiguration of urgent and emergency care services to enable 'commissioners to deliver a functionally integrated

24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice'. Central to this vision is the promotion of NHS111 as a single point of access for urgent care, supported by the introduction of a 'clinical hub' or Integrated Clinical Advice Service (ICAS) that will assess patient needs and advise on the most appropriate course of action (including enabling the patient to self-care where appropriate), and/or onward referral. This will provide access for the public to a wide range of clinicians whilst also providing advice to health professionals in the community so that no decision has to be made in isolation.

3.6. In October 2015, the national programme pause was lifted.

3.7. In June 2016, the urgent and emergency care programme was re-established in line with the Commissioning Standards - Integrated Urgent Care (September 2015) which focus on the following:

3.7.1. The commissioning of NHS111 as the telephony single point of access for urgent care providing a call handling, initial triage and signposting service.

3.7.2. The provision of an Integrated Clinical Advice Service (ICAS) to support NHS111 with telephony clinical triage, multi-disciplinary team advice, guidance and referral, ensuring no decision is made in isolation.

3.7.3. The GP out-of-hours service (including base sites and home visits).

3.7.4. System interoperability to enable greater integration.

3.8. Other face-to-face aspects of urgent and emergency care services, and the points at which urgent and emergency care overlaps with the requirements and proposals laid out for the General Practice Forward View, and the Kent and Medway Sustainability and Transformation Plans (STP), have also been reviewed, and although not all the requirements are addressed within the urgent and emergency care potential model, care has been taken to ensure the outcomes of different programmes are complementary. This has included consideration of the following:

3.8.1. Extended primary care access by March 2019 and the provision of urgent same day bookable appointments within primary care.

3.8.2. Primary care managed urgent care service to support the acute trust to avoid unnecessary ED attendance and/or hospital admission, deliver the 4 hour ED standard and meet ambulance handover times.

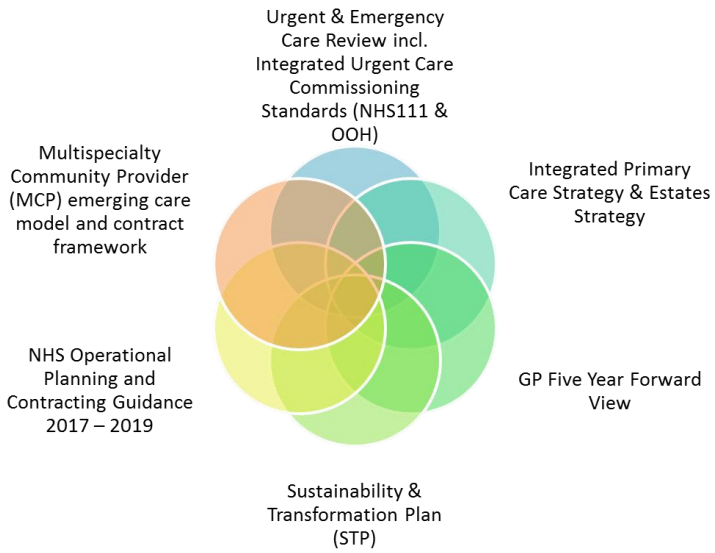
3.8.3. Workforce and workload issues.

3.8.4. Increased use of technology and improved interface between general practice and hospitals.

3.8.5. Preventative support services and the ways in which self-care can be encouraged from NHS111 and ICAS without the need for a face-to-face consultation, where clinically appropriate.

3.8.6. Increase efficiency and implement demand reduction measures whilst addressing predicted growth.

3.9. The full spectrum of national guidance that influences this case for change is as follows:



3.10. The Kent and Medway Sustainability and Transformation Plan (STP) is currently in development and aims to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, co-ordinated care that is easy to access, and enables people to stay well and live independently and for as long as possible in their home setting.

4. Why is Change Necessary?

4.1 The local NHS system is no longer designed to meet the needs of the local population and in some areas the CCG, and their respective GP membership, are struggling to deliver the quality of care to which they aspire, and that their patients want.

4.2 Changes need to be made to the ways in which local and urgent care are provided in order to ensure that general practice is sustainable now and in the future.

4.3 Local, urgent and emergency care services are struggling under the weight of demand.

4.3.1 The flow of patients from Swale to Medway NHS Foundation Trust for urgent and emergency care services necessitates the need for Swale and Medway CCGs to work together to design urgent and emergency care services.

4.3.2 Medway NHS Foundation Trust – Performance against the 4 hour Emergency Department Constitutional Standard for 2015/16 and 2016/17 has fallen short of the target of 95%.

4.4 Funding for services is limited, and finding appropriately skilled and experienced staff is a challenge for all areas of health and social care. At times this can lead to different services competing for the same key clinicians.

4.5 There is therefore a duty to ensure public money is spent wisely on services that really address the needs of the local population.

4.6 The largest age group growth is in people 85+ (bringing increased needs for health and social care).

4.7 A high proportion of patients are attending the emergency department who do not have life threatening emergencies and this is evidenced by the fact that over 50% of patients who attend emergency department are discharged to their GP or discharged with no follow-up care. Whilst some of these patients would have been most appropriately cared for within an emergency department, a high proportion of these patients may be more appropriately cared for by primary care clinicians.

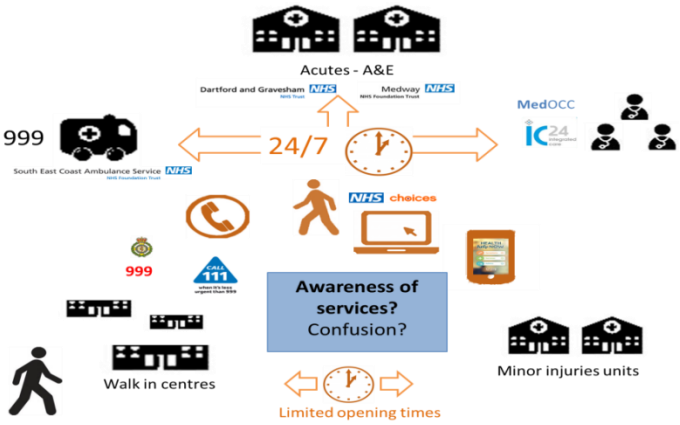
Other key facts about local emergency department (ED) November 2015 - October 2016**:**	**Swale**
ED rate per 1000 population	205
ED attendances discharged to GP / discharged with no follow-up	6 in 10
Average waiting time - emergency department	3.4hrs
Emergency department attendance growth	11%

4.8 There are a large number of patients with long term conditions and mental health needs within the CCG area who may benefit from having more clarity regarding available support outside an acute Trust or emergency department.

Key facts about patients with long term conditions and mental health issues (2015/2016):	**Swale**
People living with LTC - Diabetes Register	6,367
People living with LTC - CKD Register	3,532
People living with LTC - Cancer Register	2,756
People living with LTC - Chronic Obstructive Pulmonary Disease (COPD)	2,493
People with Mental Health	725
People living with LTC - Palliative Care Register	158

4.9 Swale and DGS CCGs have asked patients, the public, and representatives from across health and social care in North Kent for their views about why change is necessary. Detailed feedback received from the engagement activities is included in ***Appendices A – C***. A high level summary of the key points and themes raised is outlined below:

4.9.1 The healthcare landscape is overly complex and it is often difficult for patients, the public, and sometimes even clinicians, to successfully navigate their way through the many services available as shown below:



4.9.2 Patients sometimes access services inappropriately because, for example, they may be worried about a healthcare problem but do not know where to go, or because it is not possible to access their GP immediately.

4.9.3 Brand strength influences public behaviour and the strongest brands (i.e. GP and emergency department) have the most significant demands placed upon them, and despite all previous efforts to change public behaviour, they continue to be the most accessed/used services.

4.9.4 The needs of patients have changed (increasingly elderly population, living longer with long term conditions).

4.9.5 Patients want more local, out-of-hospital care.

4.9.6 The current system supports competition rather than collaboration, and communication between services / providers needs to be improved.

4.9.7 There is a void in care/support for patients following urgent and emergency care attendance/treatment.

4.9.8 There is an education gap for patients and clinicians.

4.9.9 Patients need to take more responsibility for their health and local services should better support self-care.

4.9.10 Doctors may over-medicalise patients because they want to 'do something'.

4.9.11 The current system has resource problems in terms of funding and availability of appropriately trained staff.

5. What Sort of Change is Necessary?

5.1 The changes to the integrated urgent care system must address the eight key elements outlined by NHS England by 2020. These elements are as follows:

5.1.1 A patient can make an appointment out-of-hours in a single call

5.1.2 A patient can make an appointment in the in-hours period

5.1.3 Data can be transferred between providers

5.1.4 The Summary Care Record is available in the hub and elsewhere

5.1.5 Care plans and patient notes are shared

5.1.6 The number of patients speaking to a clinician increases above the current level of 22% by the implementation of a Clinical Hub (40-60% by 19/20)

5.1.7 The capacity for NHS111 and OOHs is jointly planned

5.1.8 There is joint governance across Urgent and Emergency Care Providers

5.2 In addition to this, over the course of many months, a structural clinical model that spanned local, urgent and emergency care has emerged and has been presented at each engagement event in order to encourage feedback and to better understand the needs of the public. Feedback received relating to urgent and emergency care has been considered when refining model options.

5.3 Detailed feedback received from the engagement activities is included in ***Appendices A – C***. A high level summary of the key points relating to the structural model are outlined below:

5.3.1 Simplify the health landscape and make services easier to access

5.3.1.1 Limit the number of entry points and avoid duplication

5.3.1.2 Standardise access times and link to contractual agreements

5.3.2 Ensure services are integrated

5.3.3 Cater to both urban and rural populations and address healthcare inequalities

5.3.4 Consider brand strength or GP, 999 and ED, and the influence on public behaviour/perception

5.3.5 Consider the creation of a seamless 24/7 GP service

5.3.6 Other clinicians should help support GPs. Introduce GP consultant model (specialist generalist)

5.3.7 Identify the patients who need to see a named GP, any GP, or another health professional or voluntary sector support (care navigators).

5.3.8 Limit access to the ED (Emergency Department) – requiring clinical referral.

5.3.9 Encourage and support prevention and self-care

5.3.10 Enable a patient to access virtual triage assessment by app or phone

5.3.11 Ensure services are affordable and sustainable both now and in the future

5.3.12 Specific feedback relating to each CCG area is given in **Appendices A – C**, and feature within the potential model outlined below.

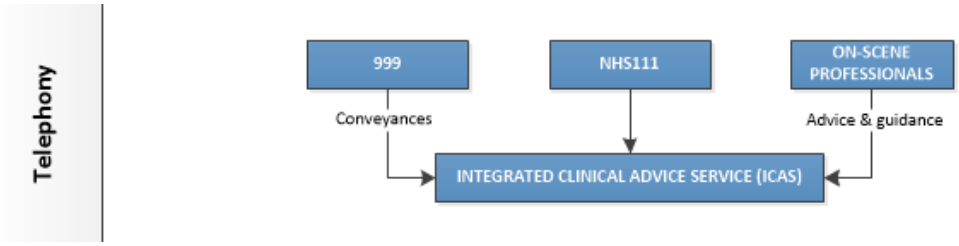
6. Potential Model and Critical Paths

6.1. Development of Potential Model

6.1.1. The potential model has been agreed, based on a review and consideration of national requirements, and feedback gained from clinician and patient reference groups, the 'whole system' event that took place in November 2016 and listening events held in February 2017. Model options have been agreed by both the Executive Team and senior clinicians.

6.1.2. There are two key elements to the model (i) telephony services (requiring the re-procurement of NHS 111 and the design and procurement of an Integrated Clinical Advice Service (ICAS) which includes current 'GP Speak to' services), and (ii) face-to-face services (including all unscheduled, walk-in, urgent care services).

6.2. NHS111 and Integrated Clinical Advice Service (ICAS) Telephony Services



6.2.1. To provide economies of scale, and to ensure resilience for the NHS111 service, the North Kent CCGs (i.e. DGS, Swale and Medway), together with West Kent CCG, are pursuing re-procurement of a single NHS111 service to cover all areas. The intention is that the service would 'go live' in April 2019.

6.2.2. The ICAS builds on the team of clinicians already supporting the NHS111 service, and will be developed in line with both NHSE guidance and the Commissioning Standards for Integrated Urgent Care, and will be procured across the North Kent CCGs only. The intention is that the service 'go live' is in April 2019 in line with NHS111.

6.2.3. The Integrated Urgent Care Commissioning Guidance states that it anticipates that that up to 60% of all calls to NHS111 could be transferred to a clinical hub, or ICAS (this figure currently sits at approximately 26%), and that the ICAS will also provide clinical support to On-Scene Professionals.

6.2.4. The NHS111 number will remain free to call and will still be available 24 hours a day, 7 days a week to ensure patients have easy and swift access to urgent care. It will be the single point of access for urgent care, however patients and the public should be enabled to access integrated urgent care via alternatives routes to the telephone i.e. digital online platforms.

6.2.5. Patients dialling NHS111 will be triaged by a Health Care Advisor, and then be directed as appropriate to a range of multidisciplinary clinicians and services. Patients with complex problems requiring early assessment by a clinician will be identified quickly and transferred to speak to the appropriate clinician.

6.2.6. The current NHS111 service is supported by a team of clinicians, mainly paramedic and nursing staff, and the requirement is to enhance this clinical support service by procuring an ICAS. The ICAS has not yet been designed, but may include one or more of each of the following professionals; specialist or advanced paramedics, nurses with primary, community, paediatric and or urgent care experience, mental health professionals, prescribing pharmacists, dental professionals, senior doctors with appropriate primary care competencies. Additional clinicians may also be included depending on local need.

6.2.7. A comprehensive electronic Directory of Services will support accurate and appropriate signposting and onward referral.

6.2.8. System interoperability will allow safeguarding alerts, special patient notes, including end of life care plans and recent contact history, to be available at the point of access to ensure appropriate assessment of patient need. In addition, as a minimum the Summary Care Record will be available to all clinicians in the ICAS.

6.2.9. NHS111 and the ICAS will help support patients to self-care where appropriate, or where a patient needs to have a face-to-face assessment/consultation, clinicians

working in the ICAS will have the capability to make an electronic referral to the service that can best deal with the patient's needs, as close to the patient's location as possible.

6.2.10. The re-procurement of the existing NHS111 service and the enhancement of the existing clinical support (ICAS) are not thought to represent a significant variation. It is recognised however that there should be some communication activities undertaken with the public to promote the services.

6.3. Prevention and Self-Care

6.3.1. The CCG is committed to improving health prevention activities, and where clinically appropriate, encouraging and supporting patients to self-care.

6.3.2. The plans around prevention and self-care are based on our belief that more people can take greater responsibility for their own health and wellbeing through, for example, attending the sorts of clinics/services that may be available in Community Campuses/Health and Wellbeing Hubs in the future as part of the Primary Care Strategy Programme.

6.3.3. The urgent care model aims to increase the support people have when accessing urgent care, either through the telephony or face-to-face elements of the model, so that they can be supported, where clinically appropriate, to care for themselves more successfully, and to know when and how to seek support if they need it.

6.3.4. Swale CCG believes information, education and technology can help support people and patients to become more proactive about self-care and this has been explored with the public at the Listening Events.

6.4. Potential Model

6.4.1. Critical Path

6.4.1.1. The telephony elements of the model will 'go live' in April 2019.

6.4.1.2. The change to the face-to-face elements of the model (discussed below), once agreed, is intended to be operational from July 2019.

6.4.1.3. Piloting of services may be possible in existing estate before April 2019 but this has yet to be explored fully.

6.4.1.4. The changes to the urgent care model are not considered to be significant and no formal public consultation is currently planned. Swale CCG intends to carry out further engagement activities with key stakeholders and the public, including some co-design elements specifically relating to the design of the service specification, commencing in August 2017.

6.4.2. Challenges

6.4.2.1. **Population Growth** – The population of Swale is 108,489 with a projected increase of 7.5% over the next 5 years. The population is split with 43,832 in Sheppey with a more defused population in rural areas and 64,657 in Sittingbourne and surrounding areas with a high percentage living in densely populated areas. Sheppey has the highest distribution of adults of working age and the highest distribution of over 65 year olds. There is an additional seasonal summer growth in the Sheppey population of between 30,000 and 40,000 holiday makers in the summer. The CCG's Local Plan has been subject to examination by the Inspector who has determined there is a need for an increased target to an additional 13,129 dwellings by 2031. Assuming 2.4 people per dwelling this gives a population increase of 31,661. The Swale Borough Council area includes Faversham which is not part of the CCG area so the likely population increase for our CCG is around 85% of the total i.e. circa 27,000.

6.4.2.2. **Health Inequalities** – Swale is the third most deprived district within Kent with Sheppey and Murston areas identified as being in the bottom quintile (lowest 20%) on the national deprivation scale. Swale has the lowest life expectancy in the region – 79.3 years compared to an average of 80.9 years in Kent and Medway. 28% of adults are classified as obese in Swale with the highest proportion on Sheppey. 73% of all deaths relate to cancer, circulatory and respiratory disease. The number of admissions to hospital due to alcohol specific conditions has been rising year on year since 2001

6.4.2.3. **Health and Social Care** – To realise the benefits of the potential clinical model in terms of patient experience, quality of care and avoidance of unnecessary ED attendance / hospital admission it is important that health and social care providers work collaboratively and across organisational boundaries.

6.4.3. Key Elements of the Potential Clinical Model

6.4.3.1. **Same Services Improved through Integration** The potential model for Swale CCG represents an improvement to the current services offered, but does not represent a significant variation to current services due to the need to cater to the whole of the Swale population, including those on the Isle of Sheppey. Patients will be able to continue to access the same types of services in the same place as they currently do but there will be greater integration between services on each site, and between services across the two sites. Accessing available services will be less complicated and will be supported by centralised reception functions at each site and the possible use of Care Navigators. The potential model can begin to be worked on immediately in the form of procurement activities which are planned to commence after further public and stakeholder engagement.

6.4.3.2. **Walk-in Services –** The potential model addresses the feedback we have received from the public, and from the whole system event. The model therefore maintains urgent care walk-in services at both Sittingbourne Memorial and Sheppey Community Hospital. There was strong feeling from the public that there needed to be closer integration of Minor Injury and Walk-in Centre services on the Sheppey site and this will be addressed through the re-procurement exercise.

6.4.3.3. **GP Services In and Out-of-Hours** – Under the potential model practices would continue to operate as they currently do, including the offering of urgent same day appointments. There will be greater integration between in and out-of-hours GP services with the aim of creating a more seamless 24/7 GP function. The GP out-of-hours service will retain current services in terms of base sites and home visits, and may include the use of a multidisciplinary team to support the out-of-hours GP function (e.g. paramedic practitioners). This will represent a significant move towards the introduction of the GP as consultant model. Ways in which urgent same day appointment capacity can be increased in future will be explored as part of the Primary Care Strategy discussions and this may include the provision of some or all urgent same day appointments from centralised 'hub' locations rather than from each individual GP practice.

6.4.3.4. **ED Primary Care Streaming -** The flow of patients from Swale to Medway NHS Foundation Trust for urgent and emergency care services necessitates the need for Swale and Medway CCGs to work together to design urgent and emergency care services. This proposal is being led by Medway CCG. The proposal is for an Urgent Care Centre (UCC), operating 24 hours a day / 7 days per week, incorporating out-of-hours and walk-in provision, to be co-located with Medway Maritime Hospital ED. Patients will be streamed by a senior clinician into the most appropriate pathway and setting. These include the ED, Minor Injuries Unit, Frailty Pathway, and Paediatrics or directly to an acute assessment unit, hot clinic or ambulatory pathway. It will offer advice on self-care, pharmacy guidance and prescribing, access to primary care treatment including GPs and Nurse Practitioners, a Minor Injury Unit and home visits. The UCC will also include mental health services enabling swift access for patients as required and will be supported by diagnostics (X-Ray, USS, and Pathology). It will also be supported by social care with support from the Integrated Discharge Team and Discharge to Assess as required. Medway and Swale CCGs will collaborate to ensure the local population is appropriately consulted. The proposed changes mean that Medway Maritime Hospital will continue to provide services for Swale residents. Given the availability of a walk in centre, MIU and GP OOH services within Swale, Medway's proposed relocation of the Medway Walk-In Centre to the Medway Maritime Hospital site is expected to have minimal impact for the local Swale population. However, Medway and Swale CCGs are working together to ensure that Swale residents have the opportunity to comment on the proposed changes within

Medway, this will include a public event during the summer period. Medway CCG recently presented their consultation document before the HASC and it is included here for information – **Appendix D.**

7. Engagement Plans

7.1. The changes to the Swale urgent care model are not considered to be significant as proposals do not involve a change to the way in which patients access services, and no formal public consultation is currently planned. Swale CCG intends to carry out further engagement activities with a range of key stakeholders, and with the public, including co-design of the service specification, commencing in July 2017.

7.2. The engagement plan includes two events with local audiences. These events include:

7.2.1. 26 July 2017: Event in Sittingbourne with selected providers and key stakeholders to determine a draft specification for the services

7.2.2. 30 August 2017: Event for public and other stakeholders to examine and refine the draft specification for the services

7.3. In addition, there are plans to talk to local people about urgent care in the CCG roving roadshows which will be held in public areas such as supermarkets, Gateways, and health centres throughout the summer.

8. Conclusions and Recommendation

8.1. The Committee is requested to note the content of this case for change and proposed model of care and to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

8.2. The model options include the re-procurement of NHS111 services, supported by an enhanced Integrated Clinical Advice Service (ICAS) with improved system interoperability, and the re-procurement of GP out-of-hours services.

8.3. The clinical model proposes that similar services remain at both Sittingbourne Memorial and Sheppey Community Hospitals, but that the ways in which services are integrated will deliver benefits to patients. The changes to the urgent care model are not considered to be significant as proposals do not involve a change to the way in which patients access services, and no formal public consultation is currently planned.

8.4. Swale CCG intends to carry out further engagement activities with a range of key stakeholders, and with the public, including co-design of the service specification, commencing in July 2017.

Item 9: West Kent CCG: Edenbridge Primary and Community Care

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 July 2017

Subject: West Kent CCG: Edenbridge Primary and Community Care

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS West Kent CCG.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 25 November 2016 the Committee considered an item on local care in West Kent which included emerging proposals for primary and community care in Edenbridge.

(b) On 27 January 2017 the Committee considered an update about the proposals to co-locate the GP surgery and community services in Edenbridge. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the Committee does not deem the proposed changes to primary and community care in Edenbridge by NHS West Kent CCG to be a substantial variation of service;

  (b) West Kent CCG be invited to submit a report to the Committee in June with the outcome of the public consultation;

  (c) the Committee will re-consider in June whether the proposed changes to primary and community care in Edenbridge represents a substantial variation of service.

(c) NHS West Kent CCG have asked for the attached reports to be shared with the Committee:

CCG Paper	pages 73 - 76
Consultation Feedback Report – Executive Summary	pages 77 - 80

The full consultation report can be viewed here - http://www.westkentccg.nhs.uk/get-involved/redesign-health-services-for-edenbridge

2. Potential Substantial Variation of Service

(a) In accordance with the agenda recommendation of 27 January 2017, the Committee is asked to review whether the proposals to changes to primary and community care in Edenbridge constitutes a substantial variation of service.

(b) Where the HOSC deems the proposed changes to primary and community care in Edenbridge as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCG.

(c) The CCG will be asked to formally notify the Committee of its decision on the proposals following its Governing Body meeting on 25 July.

3. Recommendation

If the proposed change to primary and community care in Edenbridge is *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposed changes to primary and community care in Edenbridge by NHS West Kent CCG to be a substantial variation of service.

(b) West Kent CCG be invited to attend the September meeting of the Committee and present an update following the decision taken by the CCG Governing Body on 25 July.

If the proposed change to primary and community care in Edenbridge is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the proposed changes to primary and community care in Edenbridge by NHS West Kent CCG to be a substantial variation of service.

(b) West Kent CCG be invited to submit a written report to the September meeting of the Committee to notify them of the decision taken by the CCG Governing Body on 25 July.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=42582

Kent County Council (2017) *'Health Overview and Scrutiny Committee (27/01/2017)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=43321

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

NHS
West Kent
Clinical Commissioning Group

Update on Edenbridge Consultation

Adam Wickings

July 2017

Patient focused, providing quality, improving outcomes

1. Introduction and background

1.1 Health services in Edenbridge are mainly provided by GPs in Edenbridge Medical Practice and by Kent Community Health NHS Foundation Trust (KCHFT) in people's own homes and in the Edenbridge and District War Memorial Hospital (the Hospital). These services are commissioned for the Edenbridge population by NHS West Kent Clinical Commissioning Group (the CCG). These three organisations routinely work together and discuss how to meet the current and future needs of people in Edenbridge.

1.2 In 2016 it was clear that the cramped GP practice and the aging hospital were already struggling to meet the needs of a growing population and to provide modern standards of care in cost-effective settings. The hospital includes a very small inpatient unit (14 beds) which is not up to date, is not used in the main by Edenbridge patients and is expensive because of its small scale.

1.3 A 'listening process' was carried out between May and July 2016 to get the views of local residents, the Hospital League of Friends and KCHFT staff in a series of meetings and events. In total 307 people attended meetings and 434 responded to the engagement document and survey. There was general support for expanding GP and other services locally. There was also concern about the future of much loved hospital, a demand for more information and for the public to be involved in the planning process.

1.4 Following the 2016 engagement exercise, the health service commissioners and providers went on to develop various options and carry out equality impact assessments of these. The options of doing nothing or expanding/re-furbishing the current sites were ruled out for many reasons including high costs, problems relating to staffing and not meeting future needs. The options that emerged focused on the following critical factors:

- Whether the hospital and GP surgery were to combine on a single site
- Which site(s) to use
- If there was to be a new build
- If there would still be inpatient beds
- If there were to be new services.

1.5 It was clear and well recognised by the public that doing nothing was not possible. In order to progress to make any changes, CCGs are required to develop consultation proposals and documents and have these agreed by NHS England. In December the CCG had outline consultation plans agreed with NHS England and consultation took place between February and April 2017.

1.6 The 2017 consultation was on the following options.

a) Build on a new site without inpatient beds (**Option 1a**)

b) Build on a new site with inpatient beds (**Option 1b**)

c) Build on the existing hospital site without inpatient beds (**Option 2a**)

d) Build on the existing hospital site with inpatient beds (**Option 2b**).

1.7 After weighing up pros and cons of these four possible options, the commissioners and providers preferred option was for a new site to be developed with no inpatient beds (Option 1a).

1.8 A 24 page document describing the situation and rationale for change and identification of the four options was presented to local people in a public consultation running from 1 February to 26 April 2017. The outcome of the Consultation was independently assessed for the three consulting parties by the University of Kent. Their report is attached as Appendix A.

2. Current actions and next steps

2.1 The Medical Practice and KCHFT have reviewed the consultation and the report from the University. They will be writing to the CCG in the first week of July. The CCG Governing Body will then review the consultation, the report and the reported views of the practice and the Trust at the Governing Body meeting on the 25 July. At that meeting the Governing Body will agree on which option to proceed.

2.2 The CCG and KCHFT have meanwhile proceeded to advertise for a full-time Project Manager and interviews are taking place in July. On the basis of the final CCG decision, a project plan will then be developed to include discussions with local councils and with potential developers. An outline business case will also be developed and funding possibilities further explored, including possible bids for capital.

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CHSS
University of Kent
Centre for Health Services Studies

HEALTH SERVICES FOR EDENBRIDGE:

EVALUATION OF PUBLIC CONSULTATION

June 2017

Linda Jenkins
Public Health Specialist, Centre for Health Services Studies, University of Kent

Dr Rowena Merritt
Research Fellow, Centre for Health Services Studies, University of Kent

EXECUTIVE SUMMARY

This report is an evaluation of a public consultation on developing health services in Edenbridge and the surrounding villages. The consultation was carried out between February and April 2017 by the three organisations responsible for planning, commissioning and providing local services. A consultation document was widely distributed along with a survey inviting views on the plans and a variety of other means were used to engage people such as meetings, briefings, flyers and social media. The public response to the consultation was largely in the form of replies to the survey and the questions and concerns raised by people attending the public meetings. These have been analysed alongside a smaller number of responses generated from correspondence with members of the public, meetings with specific groups and presentations to local organisations.

The consultation attracted 432 people to public meetings and 1159 who completed the survey. Due to high numbers attending public meetings it was not possible to have the round table discussions as planned, and this may have prevented the consultation from obtaining a more considered response to the consultation questions. However, the survey questions were the same as those that would have been used in group discussions, and the higher than expected response to the survey from a broader demographic means that more ***individual views*** have been included in the evaluation. It is also likely that people attending the public meetings were able to raise a wider range of concerns in the unstructured Q&A sessions than might have emerged from round table discussions.

The overall view of local people was very positive about the plans. It was widely felt that GP and hospital services for Edenbridge and surrounding villages were already over-stretched and unable to meet needs. In the survey, almost all (94%) agreed that a combined hospital and surgery was the solution, and only 2.6% disagreed. Many (79%) supported the preferred option that the new facility should be on a new site and without inpatient beds. What people said and wrote showed a general acceptance that current services were neither cost-effective nor efficient and needed updating, and many welcomed the opportunity to have a wider range of services in the town on a single site. They felt that the plans had the support of medical staff, that co-location and more space might lead to better co-ordination of services, better recruitment prospects and greater ability to cope with population growth. Although there was least support for the options with inpatient beds, it was quite often commented that inpatient beds were still required, especially for elderly people and because travel to other hospitals was difficult for some.

There was widespread agreement that difficult choices had to be made (92% in the survey agreed), that there was limited money and it had to be used effectively (94% agreed), and that there was an opportunity to secure the future of both the GP surgery and the hospital that needed to be taken (96% agreed).

People were asked in the survey to pick out three statements they thought were most important to consider regarding planning future care for the area, with the following getting greatest support:

- ‘Reducing travel so that people can get treatment and care as close to home as possible’ (chosen by 68%)
- ‘Having the most up to date and efficient equipment and facilities’ (64%)
- ‘Designing healthcare to meet the changing needs of the community/population’ (60%)

Regarding developing better local services, having 'As wide a range of services as possible in Edenbridge' was most popular (51% in the survey gave this as their ***top priority,*** and 71% put this in their ***top three*** priorities). Using new technology, having healthcare staff working as a team, providing holistic care, and bringing services that have traditionally only been provided in larger hospitals came next down the list with between 13-17% putting these as their ***top priority***, and between 49-58% ranking them in their ***top three***.

When asked to choose the single most important additional service people would like to see, 'Preventative health checks' and 'Maternity services, ante-natal care and post-natal parenting support' came out top for 22% and 17% respectively in the survey (with 39% and 37% putting these in their top three). These choices were followed by 'Increased opening hours for the Minor Injury Unit', 'End of life and respite care' and 'Oncology (for people with cancer)'. Lowest on the priority list were 'Ophthalmology (medical and surgical eye problems)', 'Dietetics (run by dietician, a clinic for people for whom there are dietary or nutritional concerns)', 'Audiology/hearing aid services' and 'Access to social services'.

Responses and the general mood of meetings were largely very supportive of change and modernisation. However, there were some people expressing concerns about losing inpatient beds in Edenbridge and others wanting to retain the site or the heritage of the War Memorial Hospital. The support for the Memorial Hospital and what it represented was clear, however only a few expressed a strong view that it should be retained and most participants seemed content if it was remembered and commemorated in some way. Strongly expressed views disagreeing with the proposals were only expressed by a very small number of people in the consultation. The broad view was that a newly built combined hospital and GP surgery on a larger site would lead to better access to a wider range of services that would attract staff and was required to meet the needs of a growing population.

The full consultation report can be viewed at http://www.westkentccg.nhs.uk/get-involved/redesign-health-services-for-edenbridge

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Item 10: Mental Health Rehabilitation Services in East Kent

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 July 2017

Subject: Mental Health Rehabilitation Services in East Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent & Medway NHS and Social Care Partnership Trust (KMPT) and East Kent CCGs.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 25 November 2016 the Committee considered an item about the transformation of mental health rehabilitation services in East Kent including a proposal to close the Davidson ward at St Martins Hospital, Canterbury. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the Committee does not deem the redesign of mental health rehabilitation services in East Kent to be a substantial variation of service.

  (b) East Kent CCGs and KMPT be invited to submit a report to the Committee in six months.

2. Recommendation

RECOMMENDED that the report on mental health rehabilitation services in East Kent be noted.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)',* https://democracy.kent.gov.uk/mgAi.aspx?ID=42586

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
03000 412775

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Health Overview and Scrutiny Committee

July 2017

Update on the report on the Transformation of Mental Health Rehabilitation Services for east Kent.

This paper provides the Kent County Council HOSC with an update on the transformation of the Kent & Medway NHS Partnership Trust (KMPT) mental health rehabilitation services in east Kent. The HOSC supported the proposed transformation plans in October 2016.

1. Background

The HOSC supported the proposals presented by KMPT and east Kent CCGs to redesign the Rehabilitation Service for people with severe and enduring mental illness in East Kent.

Rehabilitation Services play a pivotal role within the mental health system as a whole, working in an integrated way with acute psychiatric wards, Out of Area Treatments (OATS), Forensic psychiatric services, community and third sector services. The primary aim of Rehabilitation services is to support service users to attain optimal independence. These services specialise in working with people whose long term and complex needs cannot be met effectively by general mental health services. Use of health and social care resources by this group can be particularly intensive and can take a number of years due to the user groups complex needs profile - compounded by co-morbidities like poor physical health, substance misuse or cognitive difficulties.

The overall vision for the redesigned rehabilitation service is that people are supported close to home, rather than through a variety of out of area placements. The redesigned service works in partnership with housing providers to ensure there is a tiered approach to supporting people move into their own tenancy within East Kent.

2. Strategic Context

The Five Year Forward View for Mental Health and the East Kent Adult Mental Health Strategy (2016 -2021) both clearly identify the need for individuals to be able to access ‘high quality services close to home’, and the proposed Rehabilitation Service transformation supports this direction of travel. In addition the strategy also lays out a trajectory for services to increasingly move away from a ‘bed based’ focus to a more community based intervention, and as such this proposal meets those criteria from a commissioning perspective.

The East Kent Mental Health Strategic Improvement Group, on behalf of the four east Kent CCGs and Kent County Council, have considered this transformation proposal and support its objectives and will ensure that mental health commissioners will be involved in the strategic oversight of the process, also ensuring that there is active service user and carer engagement at all stages of the redesign of the service.

2. Proposed Method

The process of the redesign of the rehabilitation service will be undertaken in a number of steps.

1.The closure of the Davidson ward at the St Martin's site in Canterbury, the current patients on Davidson unit will be supported in the three other inpatient rehabilitation units in East Kent, staffing will be increased in these units during this transition phase. 2. Clinical evidence supports the view that the patient population who are currently receiving in-patient care on Davidson would have their therapeutic needs better met in an adaptive stepped care pathway. This was approved by the Kent County Council HOSC.

3. The development of a rehabilitation community team in East Kent

4. Working with housing association to develop a range of supported accommodation to support patients

5. To return patients from expensive out of area placements to their local communities, and support them to maintain their placements.

The planned closure of the Davidson Unit, this financial year, was the first phase of a plan of total redesign across Kent and Medway for rehabilitation services. The philosophy was driven by key documents including the Joint Commissioning Panel for Mental Health Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs, which sets out a desire for patient with severe and enduring mental illness to be supported in community settings, close to their home, rather than in institutional wards. This supports a whole systems approach including a range of inpatient and community services.

3. Update for the proposed change

1. The Davidson Unit at St Martins is now closed and the resources have been re allocated to begin to establish a fully responsive rehabilitation service within the community. Patients from Davidson were supported in the three other inpatient rehabilitation units in East Kent. Staffing was increased in the existing units during the transition period.

2. Working groups have been set up with commissioners, service users and carers to develop the rehabilitation community team, based on local need.

3. The existing community based services will be further enhanced ensuring collaborative working with multi agencies including the third sector to provide an effective, safe and seamless service.

4. KMPT has begun working with housing associations to increase the range of supported housing to facilitate patients' rehabilitation and their recovery.

5. KMPT is working closely with the CCG's in east Kent and has identified and understood the patients in the out of area beds, and has identified a cohort of patients to return to the county, supported by the rehab community team. KMPT is working with a local housing provider to facilitate this.

4. Recent CQC inspection

Since the last paper to the HOSC, KMPT was inspected by the CQC for the second time, at the first inspection the rehabilitation services received a rating of 'requires improvement', they have subsequently received a rating of 'Outstanding', which is the highest rating the CQC can award, and was partly based on the services transformation plans.

5 Clinical Commissioning Groups

It is to be noted that the four east Kent CCGs have been fully involved in this work and are supportive of the direction of travel at all stages.

6.Conclusion and recommendations

The HOSC are asked to note the progress on the closure of Davidson Ward and the move towards the community based model of care, endorsed by the CQC, and are asked to support the direction of travel for this ongoing transformation moving forward.

Report prepared by Angus Gartshore, Director Community Mental Health Services; Kent & Medway NHS Partnership Trust

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