



AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 26th January, 2018, at 10.00 am Ask for: **Lizzy Adam**
Council Chamber, Sessions House, County Telephone: **03000 412775**
Hall, Maidstone

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 and
Mr I Thomas and Vacancy
- Liberal Democrat (1): Mr D S Daley
- Labour (1): Ms K Constantine
- District/Borough Councillor L Hills, Councillor J Howes, Councillor M Lyons, and
Representatives (4) Councillor T Searles

UNRESTRICTED ITEMS

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

Item

1. Membership
2. Substitutes
3. Declarations of Interests by Members in items on the Agenda for this meeting.
4. Minutes (Pages 3 - 18)
5. Transforming Health and Care in East Kent (Pages 19 - 52)
6. Financial Recovery in East Kent (Pages 53 - 56)

7. East Kent Out of Hours GP Services and NHS 111 (Pages 57 - 62)
8. Assistive Reproductive Technologies (ART) Policy Review (Pages 63 - 106)
9. Kent and Medway Integrated Urgent Care Service Programme (Written Briefing) (Pages 107 - 112)
10. Kent and Medway Emergency Care Performance (Written Briefing) (Pages 113 - 126)
11. SECamb Regional Sub-Group (Written Briefing) (Pages 127 - 138)
12. Date of next programmed meeting – Friday 2 March 2018

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)

Benjamin Watts
General Counsel
03000 416814

18 January 2018

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, 24 November 2017.

PRESENT: 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, Ms K Constantine, Mr D S Daley, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Cllr L Hills, Cllr J Howes, Cllr M Lyons, Cllr T Searles and Mrs R Binks (Substitute) (Substitute for Mr M Whiting)

ALSO PRESENT: Mr S Inett

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

UNRESTRICTED ITEMS

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

(Item 2)

- (1) Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.
- (2) Mr Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.
- (3) Cllr Lyons declared an Other Significant Interest as a Governor at East Kent Hospitals University NHS Foundation Trust.

26. Minutes

(Item 3)

- (1) RESOLVED that the Minutes of the meeting held on 20 September 2017 are correctly recorded and that they be signed by the Chair.

27. EKHUFT Operational Issues

(Item 4)

Liz Shutler (Director of Strategic Development & Capital Planning & Deputy Chief Executive, EKHUFT), Lesley White (Divisional Director, East Kent Hospitals University NHS Foundation Trust), Simon Perks (Accountable Officer, NHS Ashford & NHS Canterbury and Coastal CCGs) and Hazel Smith (Accountable Officer, NHS South Kent CCG and NHS Thanet CCG) were in attendance for this item.

- (1) The Chair welcomed the guests to the Committee.

- (2) Members enquired about the appointment of a permanent Chief Executive and Chair and the Trust's Financial Recovery Plan. Ms Shutler explained that Susan Acott and Dr Peter Carter OBE had joined the Trust as interim Chief Executive and Chair of the Trust. It was anticipated that interviews for a permanent Chair would take place in January with interviews for a permanent Chief Executive taking place as early as February. Ms Shutler noted that the Trust had a deficit target of £19m by the end of the financial year. She reported that the Trust was making good progress and had already delivered on over £30m of cost improvement savings. She noted that given the size of the organisation, the Trust's deficit was relatively low in comparison to other Trusts across the system. In response to a comment about saving targets resulting in service cuts, Ms White explained that savings related to efficiencies. She gave an example of the savings made within the Urgent Care and Long Term Conditions division; due to the successful recruitment of permanent middle grade staff in A&E, the division had made significant savings against agency spend. Ms Shutler noted that it was not efficient for the Trust to provide services on all sites; it was important for specialist services and teams to be co-located together.
- (3) Members asked about the pay award and staff recruitment particularly consultant recruitment at Queen Elizabeth The Queen Mother (QEQM) Hospital. Ms White explained that the pay award was a national issue. She noted the Trust was looking at new roles, particularly for Band 4 nurses and more senior nursing roles, to enable staff as part of their career development to move into specialist roles. She reported that the Trust was working to recruit medical staff both in the UK and abroad. Vacancies were being advertised in the BMJ and the Trust was looking to attract staff by offering clinical specialisms; flexible working; shared posts in the community; and potential research posts with universities. Ms Shutler noted that the Trust had advertised 74 consultant posts and recruited 55 staff including 22 staff that had joined since June; however the Trust continued to have gaps in medicine and geriatric roles. Ms White stated the Trust had recruited two new consultants to the QEQM Hospital since June; a Respiratory Consultant who had subsequently left and a Geriatrician. She reported that the Trust was continuing to actively recruit to posts across all three sites.
- (4) A number of comments were made about sickness absence, the flu vaccine and appraisals. Ms Shutler acknowledged that the sickness absence was above the Trust's 4% target and committed to providing the Committee with a briefing about sickness absence. She stated that the Trust had worked hard to encourage and increase the number of staff choosing to have the flu vaccine; for every staff flu vaccination, the Trust was donating a flu vaccine to Africa. The Trust's target was for 70% of staff to have the flu vaccine; 58% of staff had had the vaccine which was the highest percentage ever achieved by the Trust. Ms Shutler noted the importance of appraisals and the Trust was working to improve the staff appraisal rate; the national staffing survey had identified a high staff appraisal rate by the Trust.
- (5) A Member enquired about the declaration of a Code Black at the QEQM Hospital. She explained that a Code Black at QEQM Hospital had not been declared to external partners. Due to a high level of activity at both the William Harvey Hospital and QEQM Hospital, the Trust had internally declared Code

Black the previous night and had implemented additional activities to support A&E and emergency medical admissions which had included increased consultant activity, ward rounds, nursing and management support. It was anticipated that the sites would be downgraded to Code Red by lunchtime. Ms Shutler noted that codes were reviewed and changed throughout the day depending on activity levels. She reported that the actions in the emergency care improvement plan were beginning to make a difference; in the last week the Trust compliance rate for the A&E 4 hour target had improved to 80% in comparison to 70% in September.

- (6) In response to a specific question about the establishment of a medical school, Ms Smith explained that there was a national process for creating new medical schools; a key element in the national criteria for the creation of a new medical school was being able to evidence a deficit in local GP workforce. She stated that a bid for a medical school in Kent & Medway had been submitted and an announcement by Higher Education Funding Council for England (HEFCE) and Health Education England (HEE) was expected in March 2018; if the bid was successful, the medical school would open in the 2020/21 academic year. The bid was supported by the University of Kent and Canterbury Christ Church University; in addition to every NHS organisation, local authority and Member of Parliament in Kent & Medway. She noted that the bid focused on primary care and psychiatry and had partnered with an existing medical school, Brighton University, to ensure General Medical Council agreement to the proposed curriculum. Ms Shutler added that the Trust, along with the other Kent & Medway acute trusts, were supportive of the bid and noted that the medical school would be for the whole of Kent and Medway.
- (7) The Chair invited Steve Inett, Chief Executive, Healthwatch Kent to comment. Mr Inett stated that he wanted to assure the Committee that Healthwatch undertook regular visits to the Trust's sites to gather patient experience and shared these experiences with the Chief Nurse as part of its regular meetings with the Trust. Healthwatch had been invited to attend an oversight group which had overseen the move of junior doctors from the Kent & Canterbury Hospital site and had been involved in the drafting of letters and press releases to patients about those changes.
- (8) The Chair stated that whilst the early indications of improved A&E performance were welcome, it was important that the improvements were sustainable. She recommended that regular written updates on A&E performance should be provided to the Committee to enable them to monitor performance.
- (9) RESOLVED that:
 - (a) the reports be noted;
 - (b) East Kent Hospitals NHS University Foundation Trust be requested to provide an verbal update at the appropriate time;
 - (c) the Committee receives regular written updates on A&E performance at the Trust.

Cllr Lyons, in accordance with his Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust, withdrew from the meeting for this item and took no part in the discussion or decision.

28. Kent and Medway Sustainability and Transformation Partnership
(Item 5)

Michael Ridgwell (Programme Director, Kent & Medway STP), Simon Perks (Accountable Officer, NHS Ashford & NHS Canterbury and Coastal CCGs), Hazel Smith (Accountable Officer, NHS South Kent Coast and Thanet CCGs), Liz Shutler (Director of Strategic Development & Capital Planning & Deputy Chief Executive, EKHUFT) and Lesley White (Divisional Director, East Kent Hospitals University NHS Foundation Trust), were in attendance for this item.

- (1) The Chair welcomed the guests to the Committee. The Chair noted that the Committee had received an [additional report](#) regarding reconfiguration of services in East Kent and the focus of the discussion would be on the new information rather than the general STP update which had been printed as part of the agenda. Ms Smith confirmed that the additional report had been published as part of the papers for the East Kent Joint CCG Committee.
- (2) Ms Smith began by updating the Committee about the development of local care in East Kent which would not be subject to public consultation; GPs were working together to develop primary and community care to support their local populations of 30,000 – 60,000. She noted that a frailty pathway developed at a Kent & Medway level was being implemented locally with the same model across East Kent. In addition to this, she reported that five specialties, including rheumatology, cardiology, diabetes, and the tiers of care to support those specialties at a primary and secondary care level had been identified. She reported that in Thanet three primary care homes had been developed in Margate, Ramsgate and Quex & Broadstairs to bring together GP practices in those areas; the aim was for the homes to provide services relevant to their populations and strengthen primary care. In Margate the CCG was working with the District Council to relocate relevant services, such as the Margate Task Force, to be part of the home. In South Kent Coast all GP practices had come together to form the Channel Health Alliance which had been contracted to provide three primary care hubs in Dover, Deal, Folkestone; an additional hub to support Hythe and Romney Marsh was being developed. Mr Perks noted, in addition to GPs working together and taking responsibility for their populations as part of the development of local care, there were tangible benefits; the provision of a multidisciplinary team at the Estuary View vanguard had reduced urgent care admissions by 7%.
- (3) Mr Ridgwell stated the importance of a local care model across Kent & Medway to meet the rising demand. He noted that the issues raised in the previous item, EKHUFT Operational Issues, had highlighted the case for change to acute services in East Kent.
- (4) Ms Shutler began by outlining the engagement with the Committee over the last 18 months including the presentation of the East Kent and Kent & Medway Cases for Change. She reported that urgent and emergency care and orthopaedic services had been identified as priority areas as it was not

feasible for the Trust to continue to provide a large number of services across three hospital sites due to the sustainability of the rota, recruitment and the training of junior doctors. She noted the importance of local care in supporting the Trust; at any one time the Trust had 250-300 patients who did not require hospital care and could be discharged if alternative provision was available.

- (5) Ms Shutler stated that the potential options for urgent and emergency care and acute medicine had been developed using the Keogh Review and a commissioned review of clinical adjacencies by the South East Coast Clinical Senate. She noted that the options did not include a major trauma unit because of the large catchment population of two-three million people required to support very specialist services such as neurosurgery and cardiothoracic surgery; patients would continue to travel to access the major trauma centre at King's College Hospital in London.
- (6) Ms Shutler explained that hurdle criteria had been applied to a long list of options which included:
 - each of the existing hospital sites operating as: a major emergency centre with specialist services; or an emergency centre or medical emergency centre; or an urgent care centre or integrated care hospital.
 - a new hospital on a "Greenfield" (i.e. on a new site);
 - consolidation of existing hospitals onto one site; and
 - consolidation of the existing hospitals on to two sites, by closing an existing hospital.
- (7) For the clinical sustainability criteria, Ms Shutler explained the catchment populations required to deliver specialist services were reviewed. The Trust currently provided specialist vascular, renal, trauma and cardiac services to a population over one million which had indicated that the Trust could support one major emergency centre with specialist services. The population in East Kent was 695,000 which indicated that the Trust could also support an emergency centre to assess and initiate treatment for the majority of emergency services. The Keogh guidance stated that emergency departments with over 40,000 attendances were required to be co-located alongside acute medicine and intensive care. There were over 110,000 attendances in East Kent which suggested that East Kent could support two emergency centres including a major emergency centre with specialist services but no more than two emergency centres due to workforce. None of the options were removed at this stage.
- (8) For implementable criteria, Ms Shutler reported the Trust had looked at the cost and timescale to build a new hospital or remove services from one site. The estimated cost of a new build was over £700 million and recent examples of new build hospitals of a similar size in Derby and Glasgow took 9 - 11 years to build. She stated that a Greenfield or single site options on a current acute site were removed as options due to the cost and not being implementable by 2021.
- (9) For the accessibility criteria, Ms Shutler noted that a travel time of one hour or less by car had been set. Analysis found that the entire East Kent population

was within one hour's car drive of emergency, urgent care and acute medical services and all options remained.

- (10) For the strategic fit criteria, Ms Shutler highlighted that two measures were taken into account. The first was the national and regional designations which included the designation of a percutaneous coronary intervention (PCI) service and trauma unit at the William Harvey Hospital. The second was public consultations undertaken in the early 2000s which had resulted in the removal of the Accident & Emergency department at the Kent & Canterbury Hospital. She explained that taking these two measures into account the William Harvey Hospital had been identified as the major emergency centre with specialist services; with the Queen Elizabeth The Queen Mother (QEQM) Hospital becoming the second emergency centre and the Kent & Canterbury Hospital becoming an integrated care hospital or urgent care centre.
- (11) For the financially sustainable criteria, Ms Shutler stated that the final option to be tested was whether the QEQM Hospital should be an emergency centre or medical emergency centre. She reported that due to the significant capital costs of making the QEQM Hospital a medical emergency centre, it was concluded that the site would need to be an emergency centre. This resulted in option one as outlined in the additional report with William Harvey Hospital as the major emergency centre with specialist services, QEQM Hospital as second emergency centre and the Kent & Canterbury Hospital becoming an urgent care centre.
- (12) Ms Shutler explained that the Trust had received a proposal from a commercial third party, to build the shell of a new hospital on or adjacent to, the current Kent & Canterbury Hospital site. It was proposed that the new hospital would be a single major emergency centre with specialist services in Canterbury and be supported by two peripheral hospitals at the William Harvey and QEQM sites. She noted that whilst the proposal sat outside of the process to date, legal advice stated that it would be unreasonable not to consider the proposal from the developer and it was therefore being considered as an additional option, option two.
- (13) With regards to the elective orthopaedic services in East Kent, Ms Shutler reported that the long list of eight options included:
- no inpatient orthopaedics unit on any of the Trust's three acute hospital sites in east Kent but a centralised Kent and Medway unit in west Kent;
 - a single east Kent inpatient orthopaedic unit on one of the three hospital sites;
 - all combinations of two orthopaedics units on two of the acute hospital sites;
 - an inpatient orthopaedics unit on all three hospital sites.
- (14) For the clinical sustainability criteria, Ms Shutler highlighted evidence from the South East Clinical Senate that had suggested that elective units undertaking more than 3,000 joint procedures a year would enable the delivery of higher standards of care and improvements for patients and would improve the efficiency of the service. As the Trust undertook more than 3000 joint procedures a year, it demonstrated that East Kent could support its own

elective surgery and therefore the only options going forward would be delivered from one, two or three sites.

- (15) For the implementable and accessibility criteria, Ms Shutler stated that only 43 elective inpatient orthopaedic beds would be required in East Kent, it had been concluded that the service could be delivered from any one, two or three of the current EKHUFT sites which were all within the hour travel time.
- (16) For the strategic fit and financially sustainable criteria, Ms Shutler noted that previous consultations had reduced the number of sites for inpatient orthopaedic services from three to two in 2004/5 due to workforce pressures; the three site options had therefore been discounted.
- (17) Ms Shutler stated that the hurdle criteria had produced a medium list of six options:
 - Only Kent and Canterbury Hospital (K&C)
 - Only QEQM Hospital (QEQM)
 - Only William Harvey Hospital (WHH)
 - Both K&C and WHH
 - Both K&C and QEQM
 - Both WHH and QEQM
- (18) Ms Shutler noted that the medium list options for both urgent, emergency and acute medical care and planned inpatient orthopaedic care in east Kent would now be discussed in more detail by the East Kent Joint CCG Committee who would assess which options should go forward to public consultation next year.
- (19) The Chair requested that the final options be brought to the Committee prior to the start of the public consultation; Ms Smith confirmed this. Ms Shutler invited the Committee to attend public events which will be held as the options were evaluated further. The Chair enquired about patient flow between East Kent and its neighbouring areas. Mr Ridgwell explained that whilst the initial findings indicated that patient flows between the different areas was limited, which would be further tested as part of the detailed evaluation of the options and the NHS England assurance process, he noted that these proposals sat within the wider Kent and Medway strategic framework.
- (20) The Chair invited Paul Carter, Leader of Kent County Council, to speak. Mr Carter expressed concerns about the lack of investment in local care and the focus of reconfiguring acute services in East Kent only. He highlighted that population growth in East Kent may require one major emergency centre and two emergency centres to support this and the need for a new hospital in Canterbury. He suggested that the current proposals were sufficiently concerning to warrant a potential referral to the Secretary of State for Health.
- (21) Mr Ridgwell acknowledged that the financial position was difficult but as part of the STP's investment case, spending was being re-profiled to invest in local care. He stated that the challenges faced by the acute sector in East Kent were more pronounced than the rest of Kent and Medway and required urgent action. Ms Shutler commented that analysis of patient flow had shown that

when services were changed in East Kent, patients did not flow to West Kent. She noted that discussions were taking place in West Kent about urgent care services but due to the operational issues in East Kent, urgent change was required and they were unable to wait for the rest of Kent & Medway. She stated the creation of a single emergency centre with specialist services would require 900 - 1000 beds and become the 17th largest A&E in the country; similar new build hospitals in Birmingham & Derby had cost £700 - 900 million. She noted that the proposal from the developer was significant as there would be less capital costs but there was a risk to the timescale.

- (22) Members commented about travel times particularly those from deprived areas who may not have access to a car or from rural areas. Ms Shutler explained that the entire East Kent population was within one hour's car drive of the Trust's three sites including Faversham and Swale. This finding had been verified by Basemap, a piece of software which used data from journey at peak and non-peak times via satellite navigations systems. Ms Shutler committed to share the travel data with the Committee. She noted that an Equality Impact Assessment had been commissioned which would look at social demographic factors such as car ownership; Mr Ridgwell committed to sharing the Equality Impact Assessment with the Committee. Ms Shutler stated that if a 30 minute travel time had been applied as a hurdle criteria, it would have indicated that services should be provided on all three sites which was not sustainable. She reported that travel times had previously been discussed at the Committee and public events. She noted as part of the changes to outpatient services, the Trust had paid Stagecoach £400,000 to provide additional bus routes which now paid for themselves.
- (23) In response to a specific question about the difference between the current model and option one, Ms Shutler acknowledged that whilst the transfer of acute medicine and junior doctors from the Kent & Canterbury Hospital was an emergency and temporary move due to workforce pressures, until a decision was made following public consultation, emergency services were technically provided from three sites. She noted that the Trust currently provided a range of specialist services across three sites including PCI and trauma at the William Harvey Hospital, renal and vascular at the Kent & Canterbury Hospital and gynaecology at the QEQM Hospital; in option one, these specialist services would be moved to a single major emergency centre. In terms of elective orthopaedic services, she reported that the number of patients had increased by 75% over four years, and pressures from emergency and medicals services had resulted in an increasing number of elective procedures being cancelled. The proposal for orthopaedic services was for it to be delivered from one or two site depending on the urgent care option chosen.
- (24) Members enquired about workforce. Mr Ridgwell stated whilst additional money would be welcome, it would not resolve the workforce shortages; the delivery of services was required to change. He stressed the importance of having optimally configured and modern services alongside multidisciplinary teams to attract and retain staff. Ms Smith reported a Kent & Medway framework was being developed to support staff's training and development. She gave the example of a national programme which recruited pharmacists into primary care; pharmacists in Shepway and Dover were working with GPs

to support care homes and their staff with medicine management. She noted that a single bank for staffing was being developed across Kent & Medway.

- (25) Members asked about the medical school, joined up working and the STP. Ms Smith confirmed that the medical school was not predicated on a new build site in Canterbury. The focus of the bid for a medical school was to support primary care development as set out in the national criteria. She highlighted that whilst the medical school would be in Canterbury, it would support hospitals across Kent and Medway. Mr Perks acknowledged that the NHS needed to better demonstrate how these proposals were joined up with the STP. He stated that the STP had joined up elements of planning including local care and it was important that the NHS was able to show the Committee successful work being undertaken. Mr Ridgwell noted that there was a significant focus on improving integrated working and efficiency and productivity as part of the STP.
- (26) The Chairman invited Steve Inett, Chief Executive, Healthwatch Kent to comment. Mr Inett noted that the impact of social care, particularly in relation to patient flow, as part of hospital reconfigurations. He stated the importance of senior KCC leaders participating in upcoming engagement events.
- (27) The Chair concluded the discussion. She stated that the proposed changes were predicated on local care and it was important that the Committee had a clear understanding of the local care model. She stated that Members had challenged some of the assumptions regarding the proposed options and requested that the guests reflect on these. She noted that it had been difficult to consider the additional information and invited the NHS to present to the Committee again in January.
- (28) RECOMMENDED that the report on the Kent and Medway Sustainability and Transformation Partnership be noted and a full update on the proposed reconfiguration of services in East Kent be presented to the Committee in January.

Cllr Lyons, in accordance with his Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust, withdrew from the meeting after the presentation and took no part in the discussion or decision.

29. East Kent Out of Hours GP Services and NHS 111

(Item 6)

- (1) Due to the amount of time taken to discuss other items on the Agenda, the Chairman determined to postpone consideration of this item until the next meeting.

30. NHS preparations for winter in Kent 2017/18

(Item 7)

Ivor Duffy (Director of Assurance and Delivery, NHS England South (South East)); Rachel Jones (Director of Commissioning and Performance, NHS Dartford, Gravesham & Swanley CCG & NHS Swale CCG); Simon Perks (Accountable

Officer, NHS Ashford & NHS Canterbury and Coastal CCGs) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

- (1) The Chair welcomed guests to the Committee. Mr Duffy introduced the Winter Preparedness report, highlighting the fact that planning for winter had begun during the previous year and that two 'wash up' exercises were undertaken. He noted that the 2017 assurance processes had been much more robust, with considerable joint working and information sharing with NHS England and other relevant partners, supported by significant testing of the plans to confirm that they were practical and effective.
- (2) Responding to Member questions regarding the seasonal flu vaccination uptake, Mr Duffy advised the Committee there was no authority to require anyone to receive the flu vaccine, NHS England had contributed significant resources to provide for social care staff and partners who wished to receive the vaccination.
- (3) Mr Wickings advised the Committee that the previous winter had posed challenges for the West Kent health economy, particularly in relation to patient discharge management involving care home provision and other factors. He advised that work had been undertaken, supported by some additional BCF funding, which had addressed these issues to some extent, reducing the discharge delays. Mr Wickings explained that work was ongoing around the Home First approach, which sought to ensure that those with the most significant frailty could have needs addressed appropriately in a way that minimised any delays to discharge; this involved ensuring processes were in place to manage ongoing care assessments and support plans outside of the hospital setting. Mr Wickings commented that while the planning work had been positive and that progress had been made, winter always presented significant challenges to the NHS and he assured the Committee that these challenges were taken very seriously.
- (4) Ms Jones highlighted the challenges in the North Kent health economy related to domiciliary care. She advised that work was ongoing to engage with relevant providers to identify solutions. While this had not yet addressed all issues, Ms Jones advised the Committee that preparations were better in 2017 than they had been in the previous year. Ms Jones also commented on the specific issues relating to Darent Valley Hospital as a key link with London whereby its demand level for care and support resources included patients from outside the CCG area.
- (5) Mr Perks highlighted the specific issues affecting the East Kent health economy, including having one of the worst performing A&Es in the country. This meant that there was a risk around capacity to handle surges in demand over the winter period. He noted that in previous winters, East Kent had managed most issues fairly well, with a surplus beds being available. However, the changes to acute care meant that this would not necessarily continue. Mr Perks commented that joint working with key partners was ongoing, which was expected to allow some other parts of the health care sector to take some of the pressure when demand surges occurred. He highlighted the positive impact of the joint working, advising the Committee that the silo working which had been criticised previously had been replaced

by a much more co-operative partnership approach to managing key issues around health and social care.

- (6) Mr Duffy commented work was being undertaken by NHS England to ensure best use of the BCF funding to support effective hospital flow, whereby patients could be moved and managed where it was most appropriate, taking into account both the patient's needs and service capacity. This had been presented to the Kent Health and Wellbeing Board. He also explained that work was being done around the mutual aid programme to help support effective sharing of resources around the county to deal with pockets of demand surge.
- (7) Responding to Member questions, Mr Duffy explained that NHS England had been supporting effective communication about the availability of primary care services over the Christmas period. This involved ensuring appropriate advertising and information sharing was put in place. Mr Perks commented that the East Kent Hospitals communications team, now under a single director, had developed a more cohesive message around accessing services appropriately. This included making people more aware about the services available from the minor injury units, pharmacists and self-care advice. He advised that it was hoped that this approach would reduce unnecessary demand at A&E. Mr Perks and Mr Duffy confirmed that these communication programmes would include appropriate methods to reach different parts of the community, such as social media, apps, online information and leaflets. Mr Perks highlighted the benefits of the Waitless App, which directed people to the most appropriate service, taking into account waiting times. He noted that the usefulness did depend on patients being able to access transport to get to alternative care sites. Members agreed with the positive use of the Waitless App.
- (8) RESOLVED that the report be noted and NHS England be requested to provide an update about the performance of the winter plans to the Committee at its June meeting.

The meeting was adjourned at 12:45 and reconvened at 13:30.

31. West Kent CCG: Over The Counter (OTC) Medicines

(Item 8)

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

- (1) The Chairman invited West Kent CCG representative, Dr Bowes, to update the Committee on the decision of the CCG governing body to amend its prescribing policy so that over-the-counter medicines would no longer be prescribed for minor ailments.
- (2) Dr Bowes apologised to the Committee that the process followed in developing the proposals had not been in line with that set out to the Committee at previous meetings. He advised the Committee that it was important to note that the CCGs were not able to enforce changes to what GPs were and were not allowed to prescribe due to GPs' contracts with the General Medical Council. However, Dr Bowes explained that the CCG was of

the view that when made aware of the significant cost implications of prescribing over the counter medications, many patients were happy to purchase their own for short-term use for minor ailments. He confirmed that this proposal would not dictate how GPs prescribed but that by highlighting the issue, it was hoped that it would lead to change in prescribing habits and that this would equate to around £300,000 worth of savings out of the £1.7m budget currently in use. Providing clarification to the Committee, Dr Bowes confirmed that the proposal was a recommendation to GPs, rather than a directive.

- (3) Members commented on the importance of encouraging healthier lifestyles to minimise a reliance on regular medication.
- (4) Responding to questions from Members, Dr Bowes explained that approximately 80% of patients did not pay for prescriptions and that it was this patient group that may be asked to buy low cost, short term prescriptions over the counter as part of the proposal. He reassured the Committee, that the free prescription patient group did not get this entitlement based on their financial situation in the majority of cases, so it was not expected that there would be any significant negative impact and he reiterated that when given the appropriate advice by GPs regarding purchasing over the counter medication, most patients were agreeable to this approach. Dr Bowes advised the Committee that where patients did still require a prescription, based on medical assessment, appropriate prescriptions would still be issued. He confirmed that the proposal would mean that where many consultations already involved doctors providing information leaflets to help patients self-manage, this could now also include a recommendation to purchase the relevant over-the-counter medication themselves. Dr Bowes also highlighted the Pharmacy First scheme, which provided an alternative method of accessing free prescriptions without additional medical consultation.
- (5) In response to comments, Dr Bowes agreed that whilst people were using the Pharmacy First scheme, it still had a greater potential. He recognised that it was important to ensure a balance between appropriate access to primary care for medical consultations and seeking pharmaceutical advice outside these care settings. This helped relieve pressure of GPs and still allowed patients to access the help they needed. Dr Bowes clarified that the Pharmacy First scheme involved pharmacists prescribing medication as appropriate, without the need for the patient to visit a doctor. However, he noted that this would also mean that those who were advised to purchase their own medication but were unable to afford them could still obtain prescriptions via a pharmacist when appropriate.
- (6) Dr Bowes also addressed comments from Members regarding returned, unused medications and the provision of infant formula. He advised that where a medical reason necessitated the prescribing of infant formula, this would still happen in line with normal prescribing practice. He noted that many prescription formulas were more than standard formula, which should be taken into account. In terms of returning medication, he explained that safety and the risk of tampering were crucial factors in the approach and it was a national level decision given the wide reaching implications.

- (7) Responding to comments, Dr Bowes and Mr Wickings explained that the target areas identified in the reports referred to the sampling undertaken as part of the equality impact assessment and clarified that there was no intention that the proposed scheme was going to be applied differently in different areas within the CCG. The Committee requested that further information was provided regarding the patient sampling and engagement undertaken around the proposals and the CCG representatives agreed to provide this.
- (8) In response to a question regarding GP adoption of new practices and policies, Dr Bowes advised the Committee that there was a commitment at all levels within the CCG, including GPs, to identifying appropriate measures to save money to ensure good quality care could continue in the future in the face of significant financial challenges. He also commented that the West Kent CCG health economy had recovered fairly well despite the challenges but this did not change the need to work hard on efficiency. Mr Wickings reassured the committee that the recommendations from the CCG to GPs were developed in collaboration with GPs, so there was engagement and discussion prior to any notification or implementation of any proposals.
- (9) The Chairman summarised the discussion, noting that the Committee had requested the item as part of expressing its disappointment in not being consulted more fully as the proposal was developed.
- (10) RESOLVED that the Committee:
- (a) expressed disappointment about the lack of consultation by the CCG with the Committee about its review of prescribing policy for over-the-counter medicine for minor ailments;
 - (b) proposed that a joint protocol is developed which sets out how the Committee and its NHS counterparts will jointly reach a view as to whether or not a proposal constitutes a “substantial development” or “substantial variation.”

32. Assistive Reproductive Technologies (ART) Policy Review

(Item 9)

Stuart Jeffery (Chief Operating Officer, NHS Medway CCG) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

- (1) Mr Jeffery advised the Committee that Medway CCG was the lead CCG for IVF and all assistive reproductive technologies (ART) in Kent. He introduced the report which outlined proposals for a review of the service. Mr Jeffery explained that the review outlined was undertaken as part of the CCG’s standard review cycle but also because it had become evident that the service offer provided by Kent and Medway was different to that offered in rest of the country, notably that Kent and Medway were offering two cycles of therapy when other health areas only offered one or fewer. He also noted that it had recently been identified that the current policy may have discriminated against same sex couples, which was an issue the CCG was keen to address as soon as possible. He advised that the report set out the process, timeline and planned consultation work as part of the review, which would latterly involve

bringing the proposals back to the Committee for further consideration in due course.

- (2) Steve Inett, Chief Executive, Healthwatch Kent, extended an offer to support stakeholder engagement to assist the CCG with capturing public views and identifying potential issues. He also queried how the CCGs were planning to align ongoing service changes to ensure effective consultation. Mr Jeffery, explained that consultation planning was ongoing and that stakeholder engagement was planned, with potential for agencies to be employed to support this work. Mr Wicking noted the large scale of the Kent and Medway area and that it contained a significant range of different population and stakeholder groups. He also explained that work was undertaken by the Commissioning Support Unit (CSU) to try to plan and programme in consultation and engagement activity so that the schedule was not overwhelming or confusing for stakeholders. Mr Jeffery reassured the Committee that the planned consultation work would involve using professional organisations to support obtaining a representative sample of views.
- (3) Responding to questions regarding the proposed reductions, Mr Jeffery explained that each cycle included one frozen embryo and one fresh embryo. This meant that the current two cycle approach involved four embryos and it was proposed that this drop to two, in line with wider practice nationally.
- (4) Responding to a question regarding the planned provision for patients who may require ART in order to conceive as a result of injury or trauma, Mr Jeffery advised the he would confirm the full policy details and provide the information in due course.
- (5) Mr Jeffery reassured the Committee that there was no appetite in the CCG to completely remove ART provision but there was a recognition that it was appropriate to review and change the way it was provided. As per the early stage proposals, it had been assessed that a reduction from two cycles to one cycle of treatment was appropriate. Mr Wickings also commented that the CCG was basing the proposals on the best expert advice and that while it would not choose to implement such reductions, there were many difficult decisions to be taken and in light of the financial challenges, not saving money in one area would mean having to save money in other areas of medicine. Responding to further comments, Mr Wickings advised that the CCGs were aware of the sensitivity of the subject but was committed to being honest about the drivers behind the change, notably the requirement to find savings while still maintaining critical care issues.
- (6) Mr Jeffery advised the Committee that the information provided represented the plans as far as they had been developed and that the CCG's policy unit was still working to finalise the proposals to be put out to consultation. He assured the Committee that the detailed proposals would be provided in January, when the CCG would also ask the Committee to advise on whether the matter should be considered as a substantial variation of service.
- (7) Responding to questions regarding service variations across the county, Mr Wickings explained that CCGs had been striving to operate on a Kent and

Medway wide basis when planning service changes. He clarified that this approach was positive but not always possible as each CCG has authority to make its own decisions. He was hopeful, however, that the majority of Kent and Medway CCGs would make similar decisions around this service, preventing problematic service variations around the county. Mr Jeffery commented that the planning and development of the policies did involve significant engagement and discussion with a range of CCGs and that this often encouraged greater consistency.

(8) RESOLVED that the Committee:

- (a) notes that a review of the Assistive Reproductive Technologies (ART) policy is being undertaken by the Kent & Medway CCGs;
- (b) requests that the proposed revised policy is presented to the Committee in January in order for it to make a determination about the proposals constituting a substantial health service development or variation.

33. Healthwatch Kent: Annual Report (Item 10)

Steve Inett (Chief Executive, Healthwatch Kent) was in attendance for this item.

- (1) Steve Inett presented Healthwatch Kent's Annual Report. He highlighted the following points:
 - The report sought to present a balance between activities taken by Healthwatch Kent (HWK) and the outcomes that had been achieved. This reflected the collaborative approach Healthwatch endeavoured to take when working with the Council and the NHS.
 - HWK's 70 volunteers were reviewing their role to identify how they could offer best value. Mr Inett commented that their commitment was excellent, supported by HWK's recent receipt of the Investors in Volunteers award.
 - HWK's budget during the period covered by the Annual Report had been at £666,000 (10% reduction from the year before) and that this budget had since been reduced by a further 20% to £511,000. Mr Inett explained that some of the funding had previously been put aside to support engagement work within their operational budget but that this area had largely had to cease because of the budget cuts.
- (2) Responding to questions, Mr Inett explained that work was ongoing to shift the public focus on to the Healthwatch volunteers, as historically the paid staff had been more visible through organisation engagement.
- (3) Members commented on the positive work conducted by Healthwatch, noting in particular the progress made with engaging with Gypsy and Traveller communities. Mr Inett confirmed that engaging with seldom heard communities was a key priority for Healthwatch. Part of this work involved working in different districts to enable engagement across the county and across all the protected characteristics. He also noted the support provided by KCC's Gypsy and Traveller service in engaging with the community. Mr Inett

highlighted that the work with the seldom heard communities had led to the development of the Help Card which allowed those in need to discreetly ask for assistance. He noted that the majority of CCGs and practices have signed up to this programme. Linked with this activity, Mr Inett highlighted Healthwatch's support of the Accessible Information Standard from NHS England. Healthwatch had requested updates from all NHS trusts on how they assess people's additional communication and support needs, as it was now a legal requirement to do so. He advised the Committee that Healthwatch have been visiting Kent hospitals to test staff's knowledge of these processes.

- (4) Responding to questions, Mr Inett confirmed that the funding for Healthwatch Kent was from the Department for Health, administered and commissioned via Kent County Council.
- (5) In response to a question regarding the new physical disability forum, Mr Inett advised that the forum was very successful and that attendance varied depending on the types of meetings being held. Some sessions were open sessions to gather public views from a wider group and that these were supported by smaller working group sessions aimed at developing plans for progressing the issues raised through the wider forum. He highlighted the positive work already achieved; recommendations had been shared with relevant agencies, including the promoting of research and assessments conducted by other organisations that have struggled to connect with appropriate authorities.
- (6) RESOLVED that the report be noted and Healthwatch Kent be requested to provide an update to the Committee annually.

Mr Chard, in accordance with his Disclosable Pecuniary Interest as a Director of Engaging Kent, withdrew from the meeting for this item and took no part in the discussion or decision.

Item 5: Transforming Health and Care in East Kent

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: Transforming Health and Care in East Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent CCGs.

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

1. Introduction

- (a) On 24 November 2017 the Committee considered a report regarding the potential medium list options for urgent and emergency care and acute medicine and elective inpatient orthopaedics in East Kent. The Committee agreed the following recommendation:
- *RECOMMENDED that the report on the Kent and Medway Sustainability and Transformation Partnership be noted and a full update on the proposed reconfiguration of services in East Kent be presented to the Committee in January.*

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to provide an update in March.

Background Documents

Kent County Council (2017) '*Health Overview and Scrutiny Committee (24/11/2017)*',
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7533&Ver=4>

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Transforming Health & Care in East Kent

**Presentation to the Health Overview &
Scrutiny Committee**

26 January 2018



What have we already shared with HOSC:

Information to date:

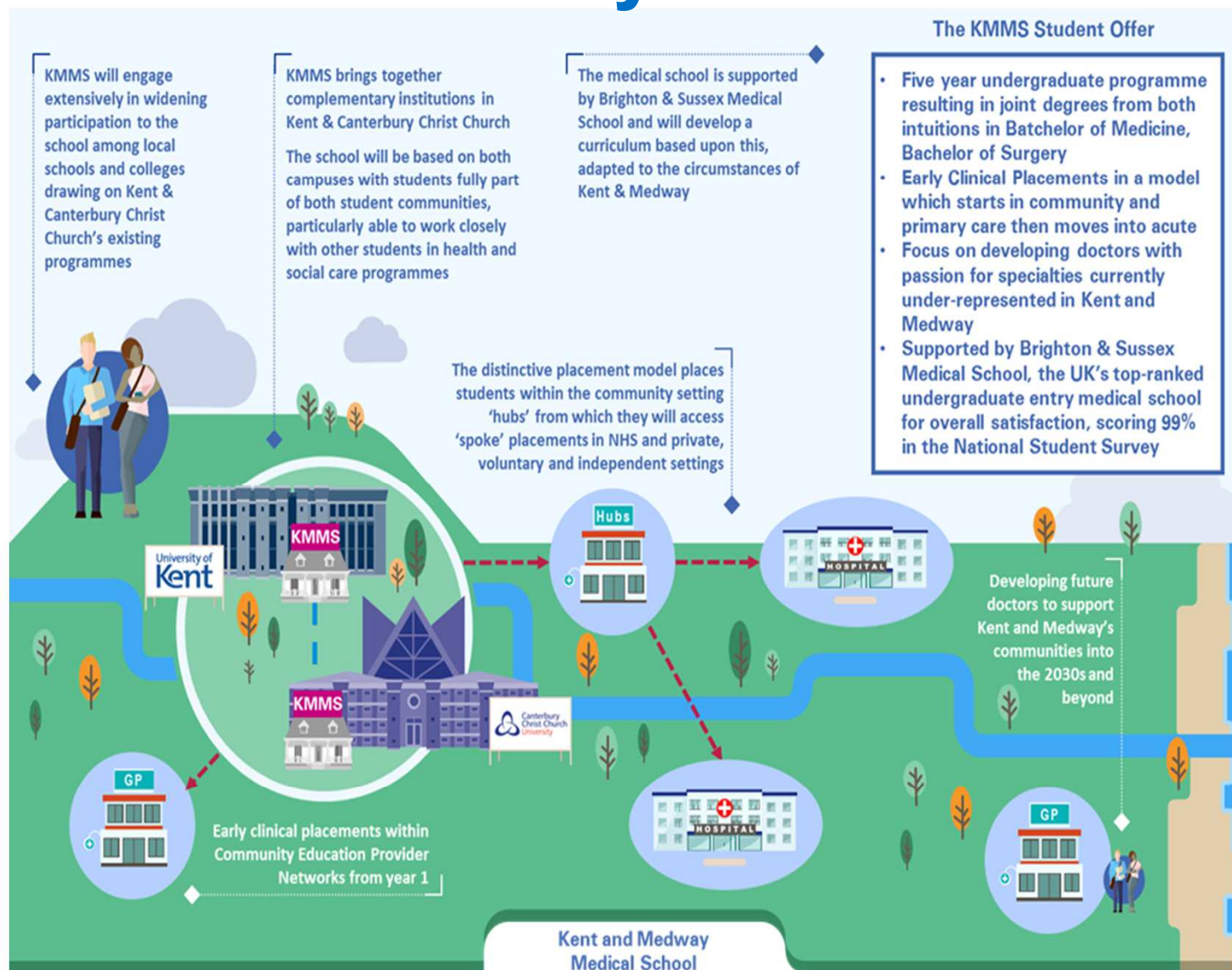
- Case for change in East Kent
- Long list of options and application of the hurdle criteria
- Medium list of options – options 1 & 2
- Local care developments

Requests for additional information:

- Medical School proposal and application
- Assurance that the changes and developments proposed are the right changes
- Local care development – detail on developments that provide assurance on the development of capacity & capability
- Recognition and mitigation of the challenges in achieving the planned changes and improvements



Kent and Medway Medical School



Transformation of Acute and Local care services in East Kent

Update



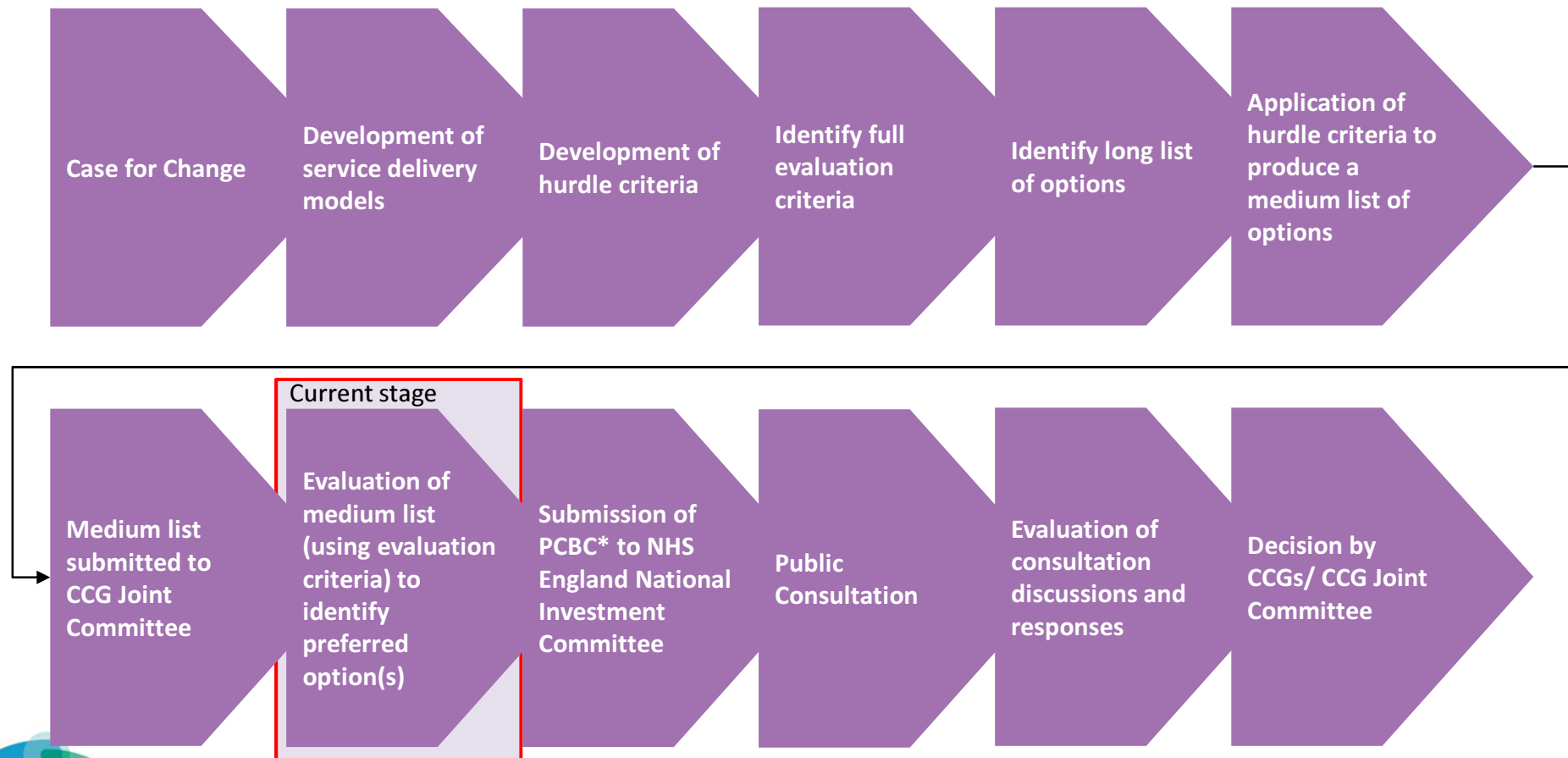
What do we already know:

- **Case for Change** established – ‘do nothing’ (ie a three site option) is not sustainable. Progression of the strategic changes offers sustainable solutions to the current challenges across patient pathways such as urgent care, workforce challenges and quality of services.
- Public support for the development of new local care models that support changes of hospital care
- Public **listening events** undertaken in spring and autumn were broadly supportive of the proposed changes . Key themes to address further included: developing local care; transport and access; specialist centres
- EKHUFT has developed a strategy for the future provision of acute services on the “Keogh” model for urgent care. Across East Kent this translates to a three site proposal - a Major Emergency Centre with Specialist Services, an Emergency Centre and a Medical Emergency Centre.
- **‘New build’ offer** from Canterbury developer. Legal opinion was that this was a materially significant offer that should be considered.
- Application submitted for a **Kent & Medway Medical School** located in / outside Canterbury



Where are we in the process:

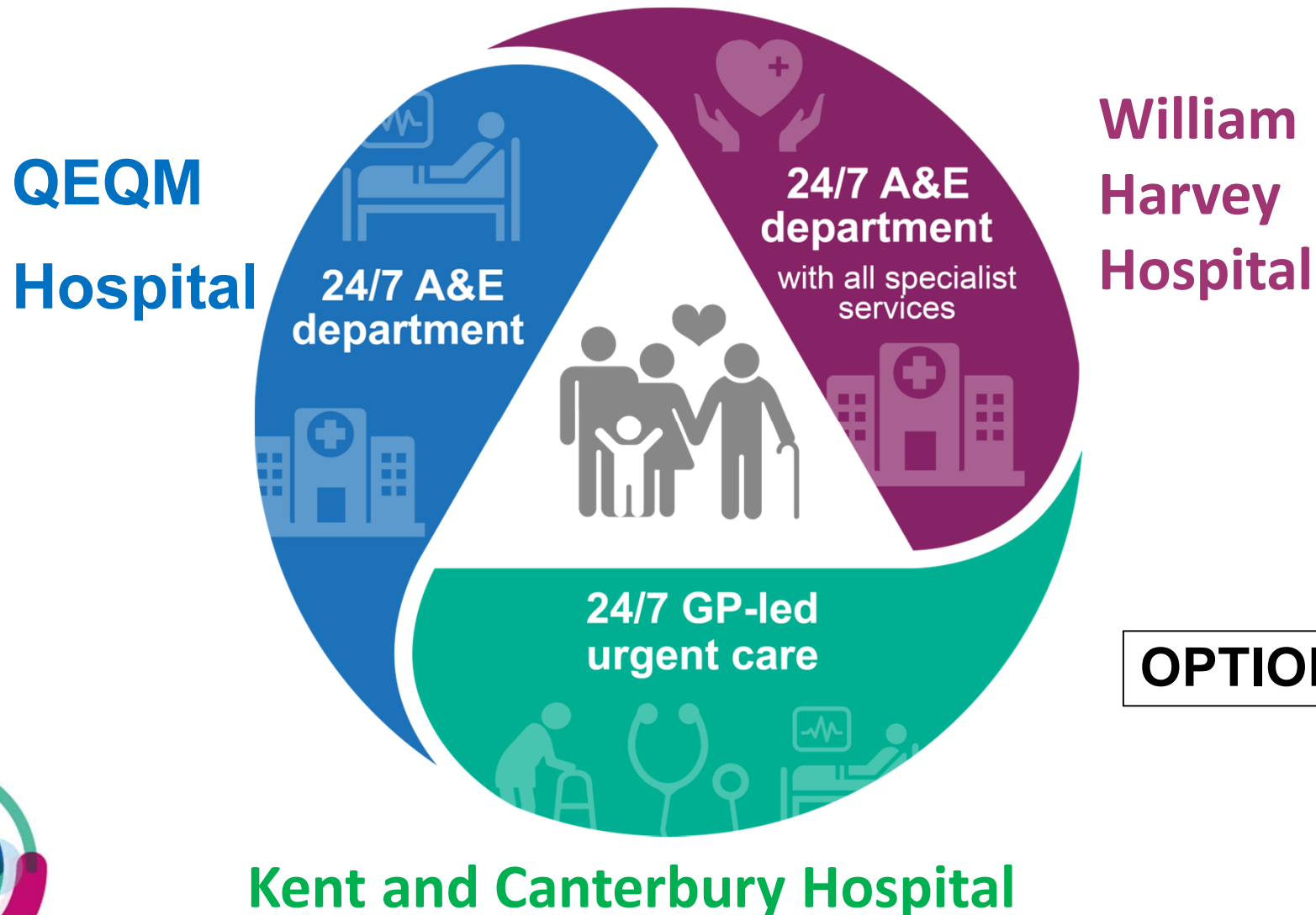
There is a clearly defined process that the health system across East Kent needs to follow in order to make any changes. This process starts with the case for change and progresses through to public consultation and formal decision making.



NB - This stage involves multiple stakeholder reviews as part of the agreed evaluation process

*PCBC = Preconsultation Business Case

The East Kent 'medium list' has two potential options.
Option 1 is the output from the application of the hurdle
criteria to the long list of options



Option 2 is the “developer offer” which following legal advice has been included at this stage of the process. The detail of the “offer” and what it could provide continues to be worked through.

OPTION 2

**A single major
emergency hospital**
for all east Kent

**24/7 GP-led
urgent care**

**Other services
could include**
diagnostics
(e.g. x-ray),
day surgery,
outpatients services
and rehabilitation



**One 24/7 A&E
department**

All specialist services
(e.g. trauma, vascular and
specialist heart services)



**24/7 GP-led
urgent care**

**Other services
could include**
diagnostics
(e.g. x-ray),
day surgery,
outpatients services
and rehabilitation



**William Harvey
Hospital**

QEQM Hospital

**Kent and Canterbury
Hospital**



What services could patients expect in local care under options 1 & 2?

- Maintained local access to local services in particular to those frequently used
- Development of local care
 - Hubs / CHOCs / Primary Care Homes
 - Integrated Case Management
 - Skills and service developments for local access to specialist care (eg Tiers of Care)
- Local access to Outpatient Services and travel for specialist services needing to be co-located with major emergency unit
- Additional opportunities to access urgent care
 - Minor injury / illness units
 - Treatment centres
 - Extended diagnostic services



What is local care?

- Local care is care not in a main hospital
- Through the development of local care we aim to:
 - **prevent ill health** by helping people stay well
 - **deliver excellent care, closer to home**, by connecting the care you get from the NHS, social care, community and voluntary organisations
 - give local people the right support to **look after themselves** when diagnosed with a condition
 - **intervene earlier** before people need to go to hospital
- Clear vision that:
 - promotes and maintains local access to care
 - Develops Primary Care at scale (eg CHOCs / Hubs / Primary Care Homes)
 - Seeks to strengthen integration of how services and care are delivered (eg integrated case management)



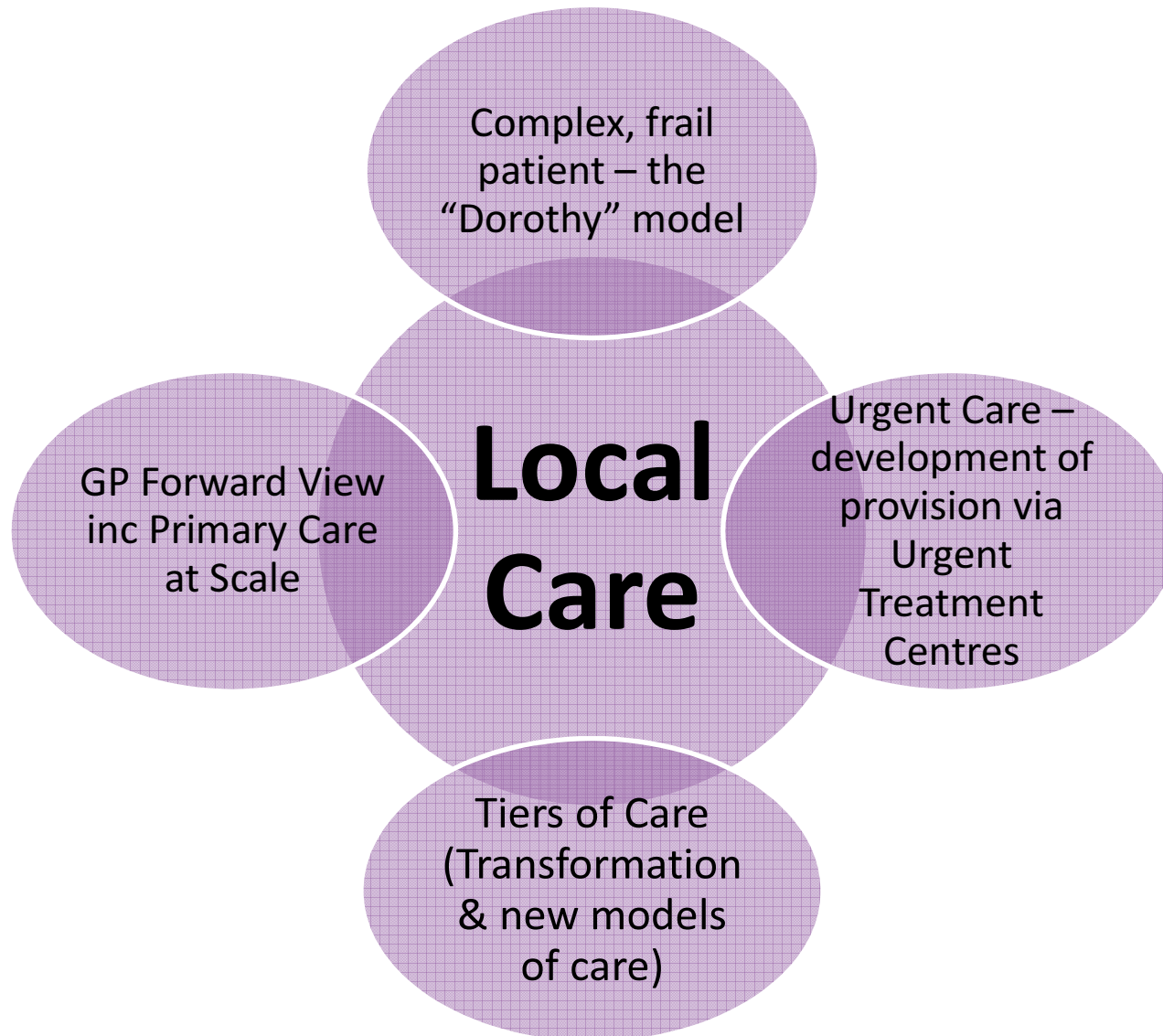
Local Care Development

- Changes to health and care provision across East Kent are complex with the drivers of change increasingly more prominent and a priority.
- Changes to hospital services cannot be achieved in isolation and are predicated on the development of local care.
- Patient behaviours and expectations will be critical to the successful delivery. How services are delivered in the future will look different to how these are currently accessed.
- East Kent reconfiguration encompasses not only changes to where care is delivered from but also how with the development of new models of care and ways of working.

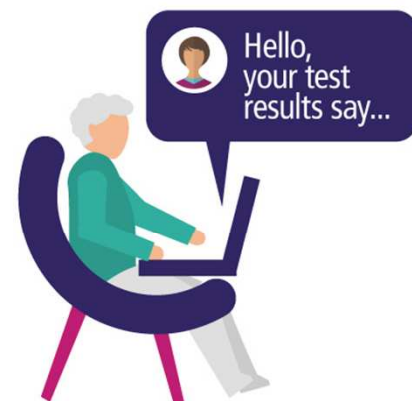


Local care implementation plans in place for each locality supporting the investment case

What is the vision for local care development in East Kent?



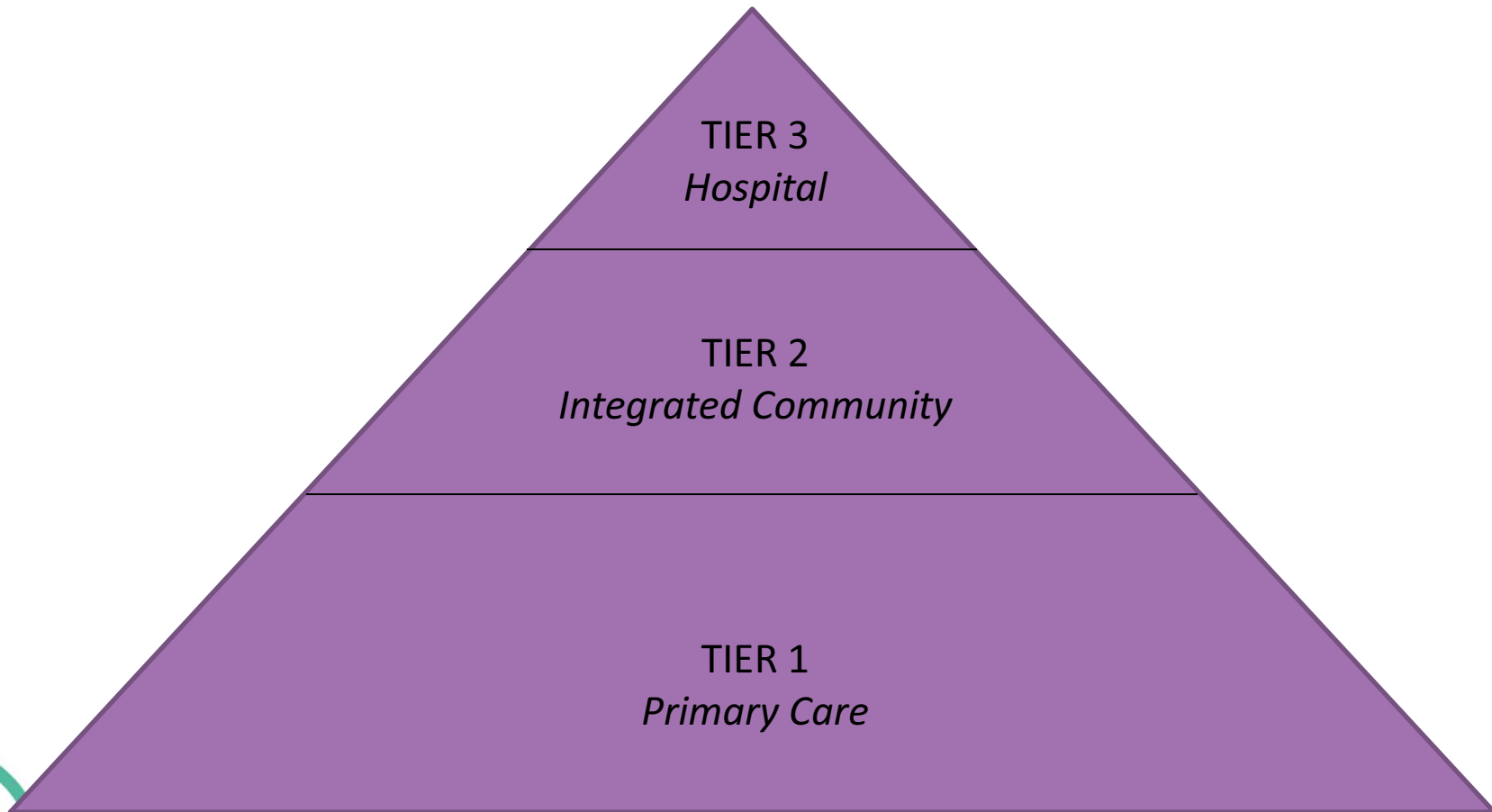
The “Dorothy” model



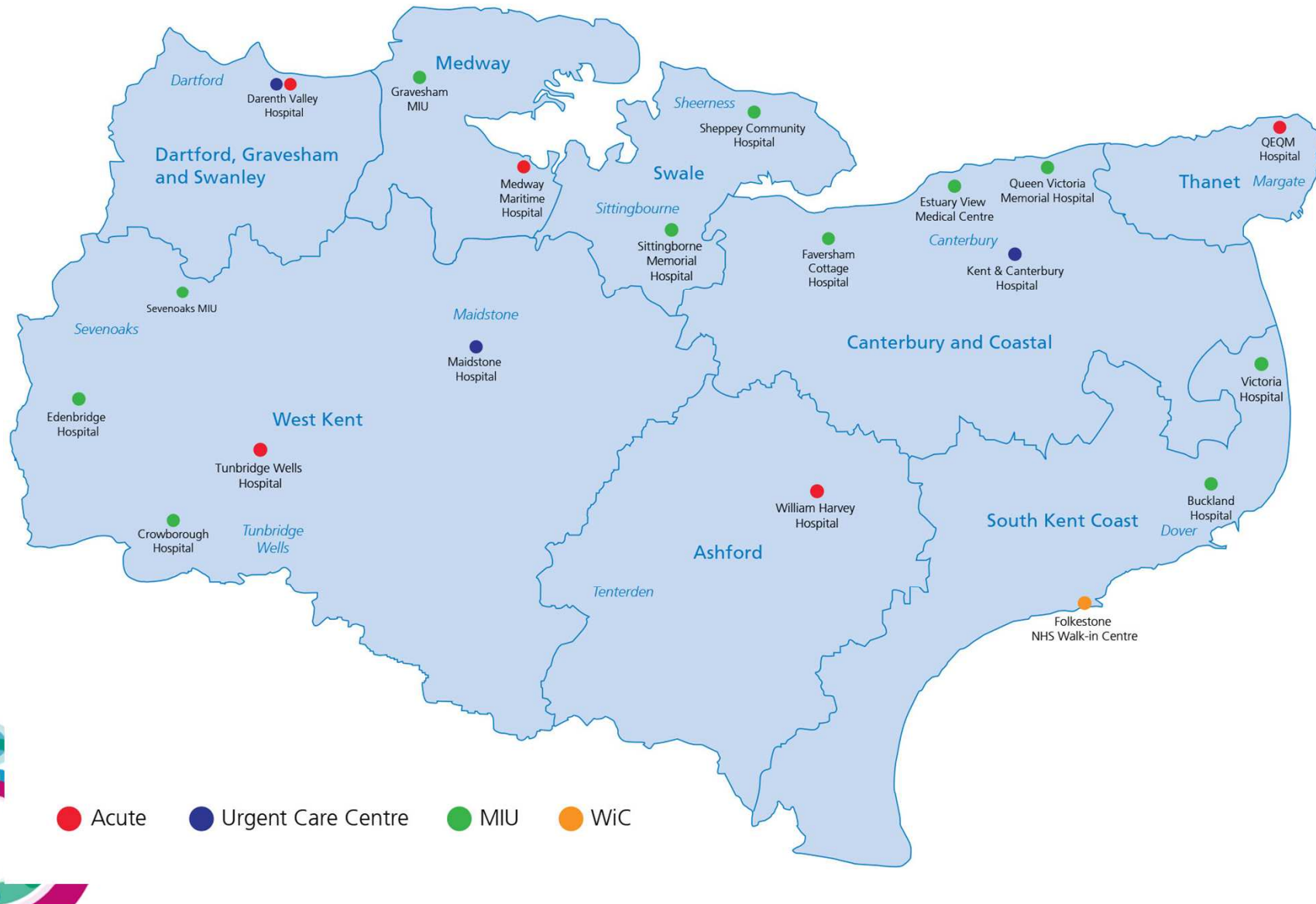
Our 8 ambitions for Dorothy and those like her



Tiers of Care (TOC) –a programme aimed at transforming and developing the way in which services are delivered making the full use of skills and capacity across the system.



Urgent Care – increasing local and alternative provision for minor injury



Urgent Care – provision of MIUs / WICs and move to Urgent Treatment Centres

- Current A&E activity suggests that a proportion of attendees could be seen and treated through alternative service models in local care.
- Alternative provision currently available with increasing access and use by the local population for example:
 - Estuary View – X-ray, Mobile MRI, Ultrasound
 - Herne Bay – Plain x-ray
 - Faversham – Plain x-ray
- Range of services available including treatment for minor injuries including diagnostics facilities and minor illnesses through GP led services.
- Plans over the next 3 years to develop current facilities further and extend the range of services available locally.

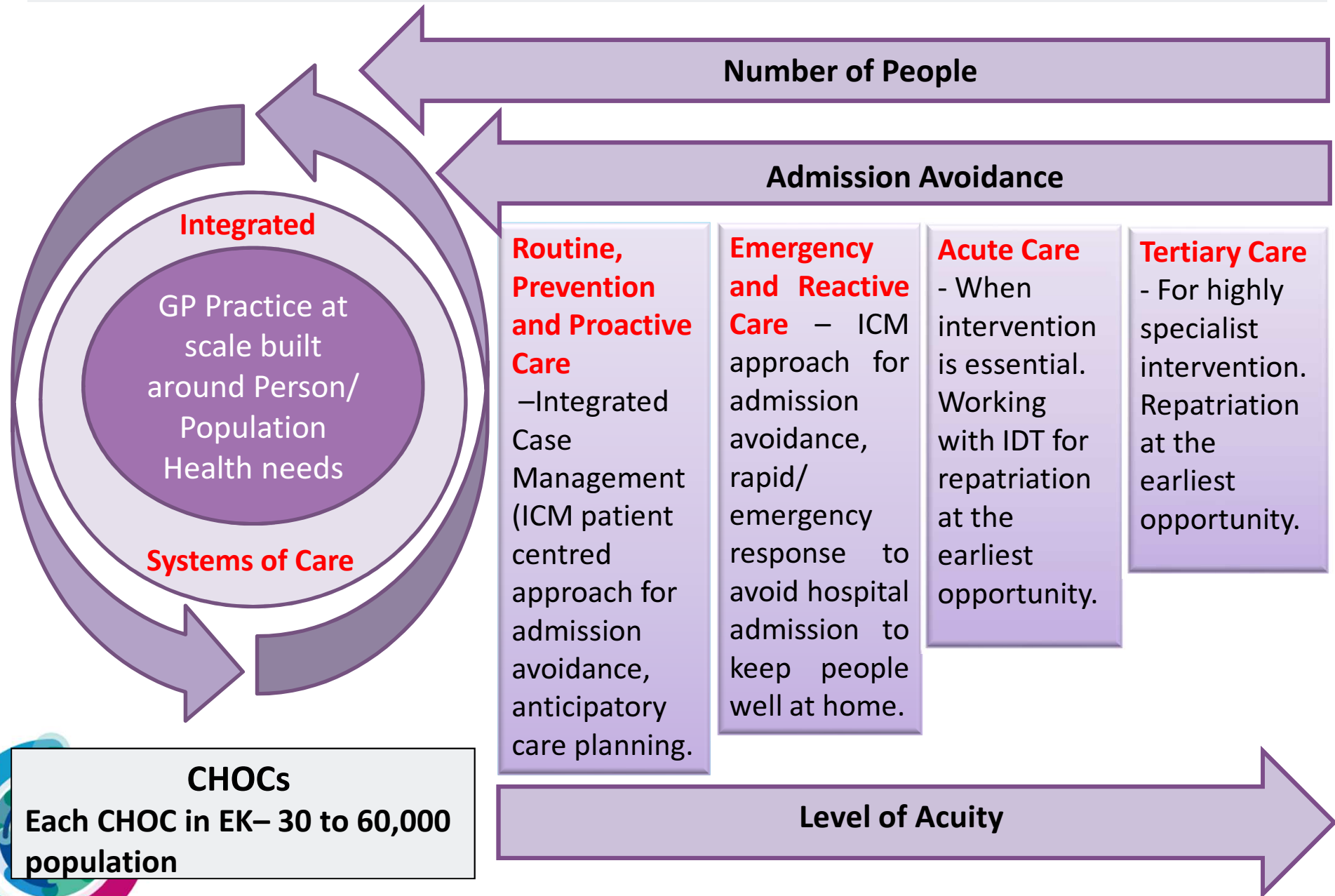


GP Forward View – Primary Care at Scale



GP Practice at Scale: Health, Social Care, Voluntary and Community involvement working together at scale – The Community Hub Operating Centre (CHOC) model

Page 38



Integrated Case Management workforce

CHOC core team includes:



Health and social
care coordinator

Pharmacist

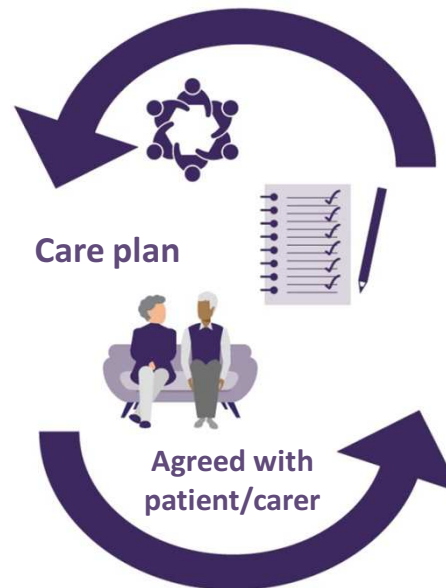
GP

Community nurse
/ LTC Nurse

Geriatrician

Allied Health Professional

Our Integrated Case
Management (ICM) Approach



Social Care
representative / social
worker

Mental Health worker

Social Prescribing

Nurse Specialist

Administrator

Additional members which vary locally:



Integrated
Discharge
Team



Police



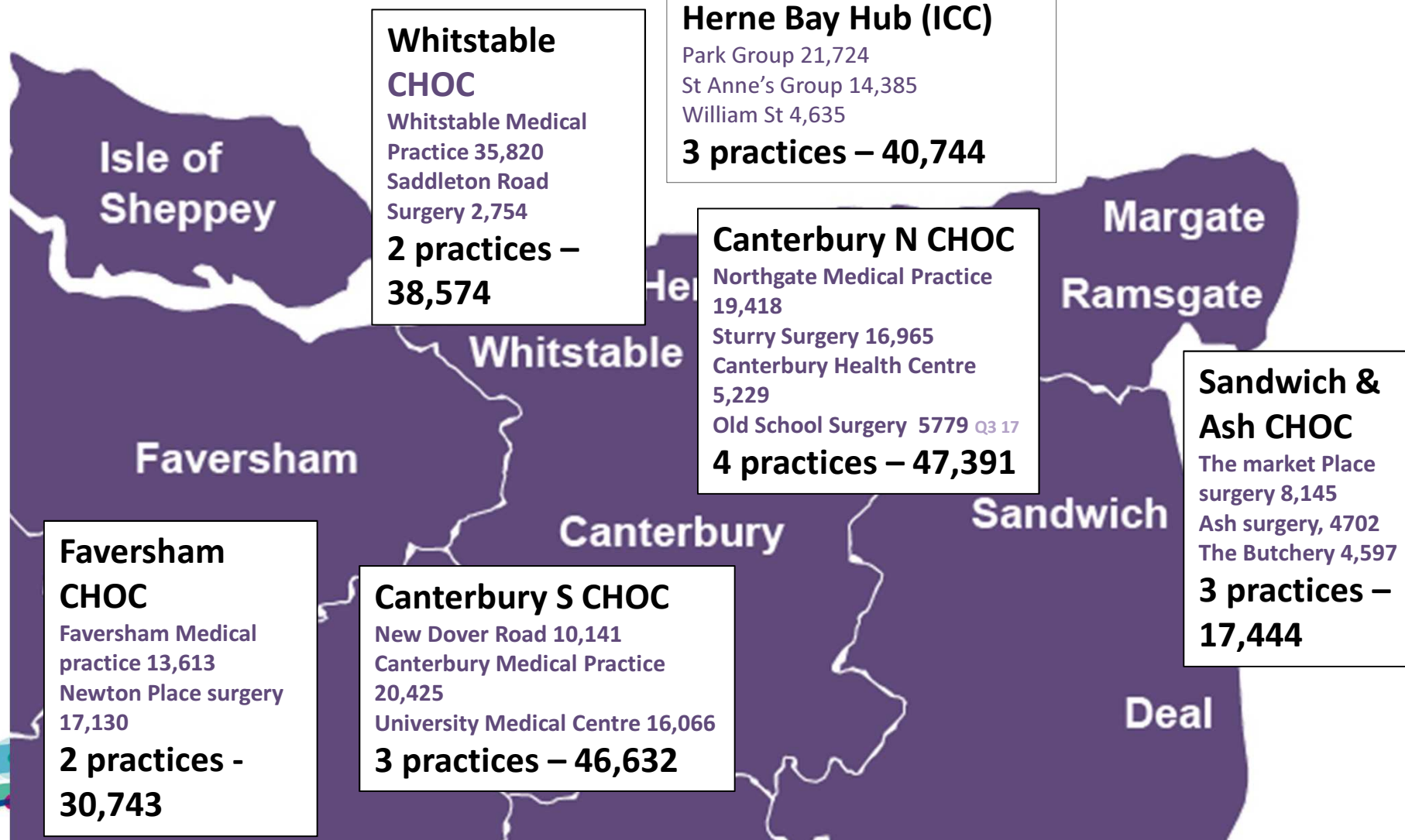
Fire and
rescue



Acute
specialists

Encompass Community Hub Operating Centres (CHOCs) & Herne Bay Hub (ICC)

Five CHOCs – 180,784 patients & One ICC -

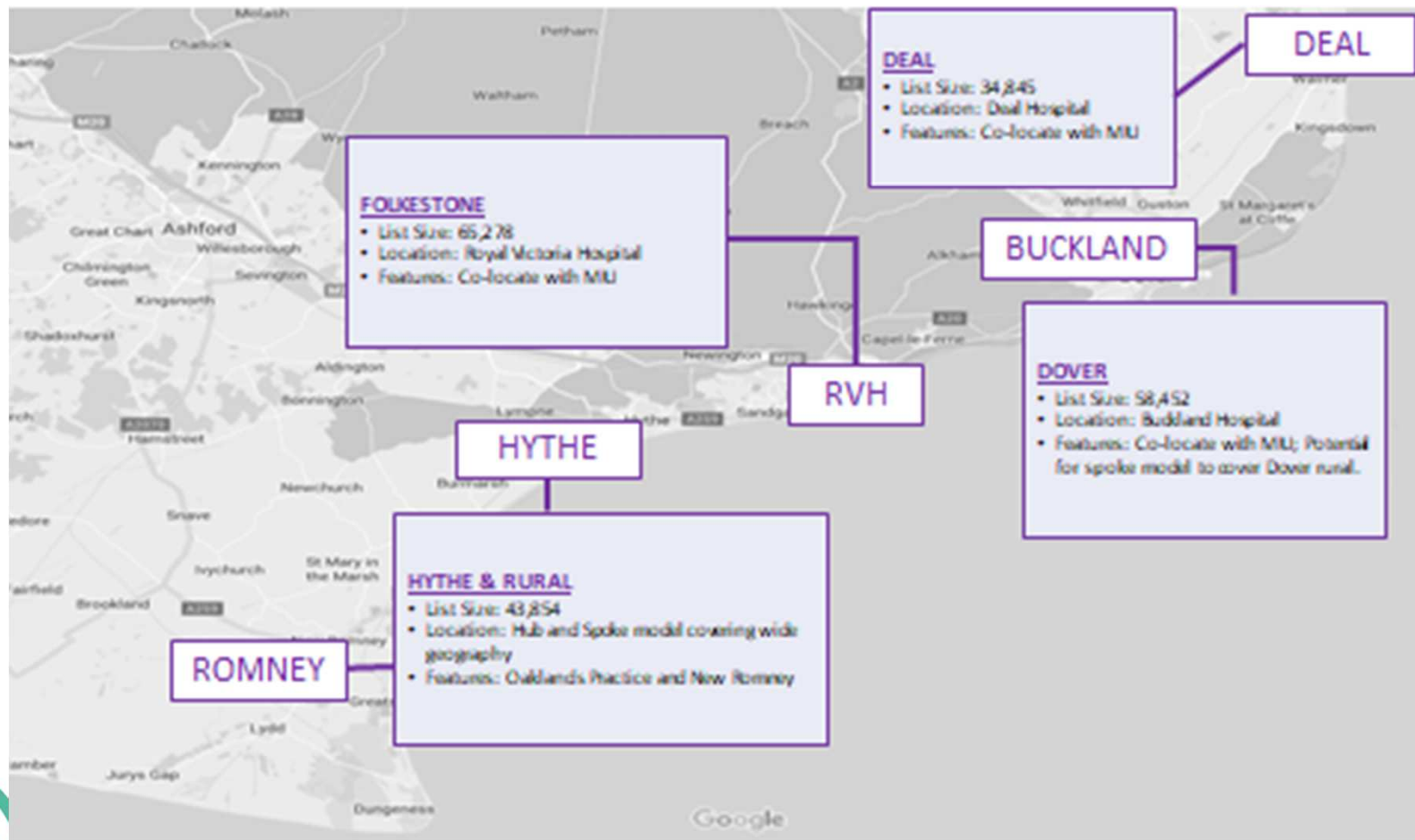


Canterbury & Coastal

Current Service Provision (What we have now)	Option 1 – proposed services	Option 2 – proposed services
<p>Enhanced GMS (extended services)</p> <p>Primary Care at Scale - GP Practices working collectively</p> <p>GP Forward View (GPFV) Access – 8am to 8pm, Saturdays & Sundays either in individual practices or at CHOC/ICC level.</p> <p>5 Community Hub Operational Centres (CHOCs): Faversham; Whitstable; Canterbury South; Canterbury North; Ash and Sandwich delivering an integrated case management approach via integrated multidisciplinary teams which include a core team.</p> <ul style="list-style-type: none"> Integrated Care Centre at Herne Bay Minor Injuries Units/Urgent Treatment Centres: <ul style="list-style-type: none"> Urgent Treatment Centre – Estuary View MIU inc plain x ray – Faversham MIU – inc plain x ray - Herne Bay Community Hospitals with circa 80 beds: <ul style="list-style-type: none"> Faversham Cottage Hospital Whitstable and Tankerton Hospital Queen Victoria Memorial Hospital, Herne Bay <p>Outpatient Services offered at Estuary View</p> <p>Estuary View – X-ray, Mobile MRI, Ultrasound</p>	<p>MIU's convert to UTCs – Universal</p> <div> <p>Primary Care Extended Services - Universal</p> <p>Primary Care GPFV access - Universal</p> <p>Primary Care at Scale – Universal</p> <p>MIU's convert to UTCs – Universal</p> <p>Polyclinics operating within CHOCs to include full range of ambulatory, day case and diagnostic interventions</p> <p>Out of Hospital Beds: non acute beds – geography to be defined but possibly Estuary View and K&CH</p> <ul style="list-style-type: none"> Rehab Respite Joint Social/Health Facilities Extra Care Facilities <p>Fully Integrated multidisciplinary teams (primary care, community, mental health, social care etc)</p> <p>Move from health intervention to well-being interventions engaging health, social care, housing, education, voluntary sector etc</p> </div>	<p>MIUs/Urgent Treatment Centres – requirement to be reviewed</p>

South Kent Coast

About Us – 205,000 patients, 4 Localities



South Kent Coast

Current Service Provision (What we have now)	Option 1 – proposed services (What we could be provided in the future)	Option 2 – proposed services (What we could be provided in the future)
<ul style="list-style-type: none"> Primary Care Practices Minor Injuries Unit GP Access Hub (smaller scale) Long Term Condition Teams (KCHFT) Range of health and care provision – not contracted or provided as one model 	<ul style="list-style-type: none"> Primary Care Practices Primary Care Access Hubs – Minor Illness, physio and mental health (8-8 with 7 day access) <ul style="list-style-type: none"> - Integration of the Hubs with Minor Injuries Units to ensure seamless service for all Home Visiting and Rapid Response Service - 2 hour response Integrated Care Teams – multidisciplinary care teams of KCHFT and Primary Care. Including: <ul style="list-style-type: none"> Multi-Disciplinary Team meetings using Anticipatory Care Plans to ensure proactive care Specialist care, support and specialist interface services – acute, medicines management, end of life care, therapies and rehab, health and wellbeing, mental health. Frailty approach - Longer appointments for Frail, elderly and medically complex patients Primary Care Diagnostics Hubs Access to GP care record for all providers with patient consent Communities of Practice – training and education for all staff within localities / hubs 	

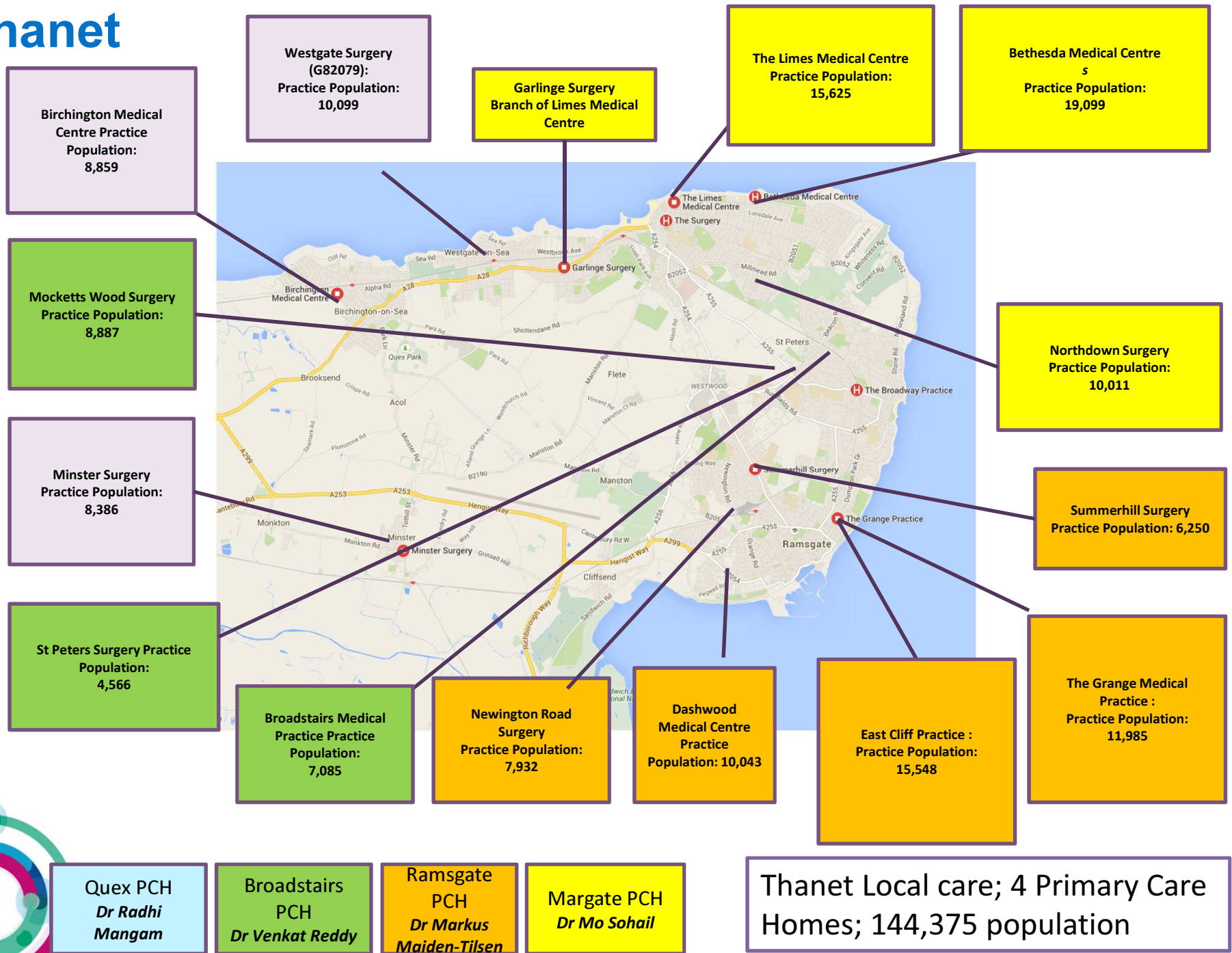


South Kent Coast – the development of local care has identified a number of projects for future development. The aim of these developments is to maintain local access to the services needed. Examples include:

- Sub-acute provision for medically unwell patients is under development. This will be dependent on the availability of acute support to provide a safe service in the community. Including the decision on bed provision for observation/monitoring to prevent avoidable admissions.
- Capital investment in the local estate to support planned service developments and the development of hubs
- Development of Dementia village by East Kent Hospitals University NHS Foundation Trust



Thanet



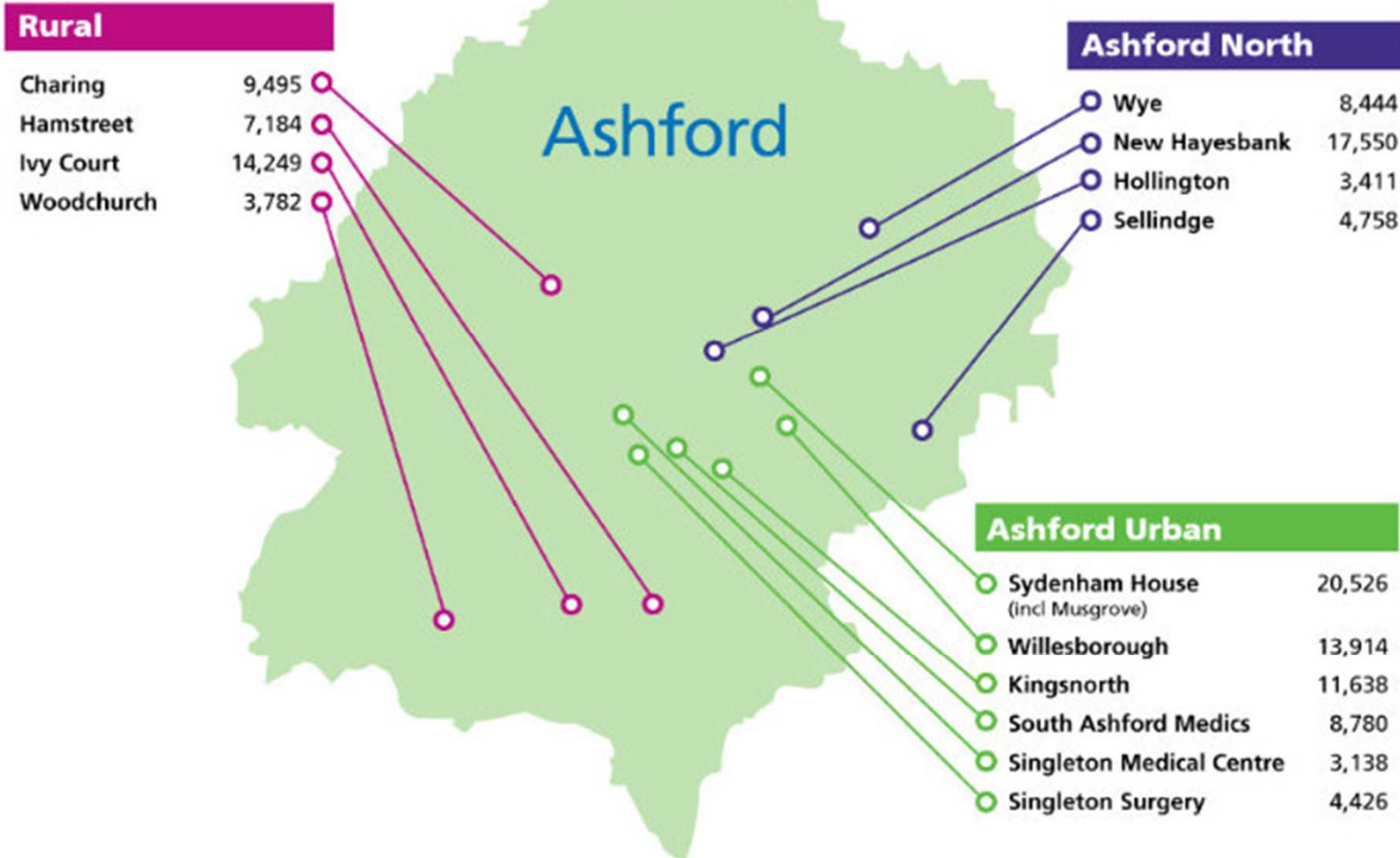
Current Service Provision	Option 1 – proposed services	Option 2 – proposed services
Primary Care <ul style="list-style-type: none"> Extended Primary care Access in place in all 14 practices Primary Care Urgent care triage in all practices and some discrete primary care services (ACT) delivering same day urgent care access Enhanced Frailty pathway Primary Care at Scale - x 3 in place with developing integrated service delivery and collaborative working. 	<p>Full range of current provision with GP services including extended/improved access ie 8 to 8 primary care access and 7 day service. This may also be a primary care resource available evenings and weekends at the QEQM site supporting the ED.</p> <p>Integrated Urgent care centre within QEQM using QEQM as an integrated community asset; delivering integrated screening, ambulatory care and frailty assessment and short term support.</p> <p>To include frailty beds for assessment and stabilisation.</p>	<p>As in current provision the full range of GP services including extended/improved access ie 8 to 8 primary care access and 7 day service.</p> <p>In Option 2 the QEQM site will be one of the primary care access points, the unit will be a primary care led integrated urgent care centre.</p>
Integrated services <ul style="list-style-type: none"> Integration includes community services, voluntary sector and KCC. Care navigation in place in a number of practices in partnership with voluntary sector and KCHFT. Integrated clinics with KCHFT including continence, wound care and diabetes. 	<p>Integrated frailty team with rotational staff prioritising admission avoidance and discharge.</p> <p>Frailty pathway integrated with secondary care and maximising beds within the community for step up and step down and 72 hour frailty beds within QE site</p>	<p>Potential services at QEQM:</p> <ul style="list-style-type: none"> - Diagnostics - Step up /down beds for frailty - Health and Well being services supported by integrated health and care - Frailty beds across Thanet hubs accessed via integrated hub and ART/frailty team, integrated with secondary care
Urgent Care response Acute Response team (ART) E-ART; GP streaming within QEQM ED	<p>Health and Well Being services within both hubs and an access point within QEQM</p>	<ul style="list-style-type: none"> - Primary care led urgent care centre at QEQM - Integrated Ambulatory care within each hub - Dementia facility including step up/down beds and Day facility (tbc)
Out of Hospital Beds Health and Social Care Integrated in patient unit at Westbrook house including; <ul style="list-style-type: none"> CHC Dementia beds in Westbrook House Social care dementia beds Intermediate care beds (health and Social care) GP access beds (step up care) 	<p>Integrated Out of Hours services led by Thanet primary care</p> <p>Fully integrated health and well being teams at PCH level</p> <p>Out patient services delivered in the two Thanet Primary care hubs with secondary care clinicians.</p> <p>Primary care Urgent care; same day access in each hub inc QEQM</p>	

Thanet – the development of local care has identified a number of projects either planned or underway that aim to maintain local access to the services needed. Examples include:

- Building 2 Primary care hubs; Margate and Westwood Cross delivering GMS plus integrated health and social care services, specialist clinical support in partnership with acute care, health and well being services, social prescribing, community support.
- Development of outpatients services both in the new hubs and local practices including cardiology, respiratory and MSK services. (Flexed to take increased activity to support the secondary care changes)
- Developing primary care urgent care response (triaging and dedicated teams being developed across primary care)
- Developing Clinical network with primary care and secondary care in particular ED, AMU and frailty consultants. Proposals to maximise the QEQM ground floor as an integrated community asset; integrated screening, triage, assessment, and intervention for frail complex patients
- Integrated urgent care management within ED and streaming. These are all under development and will support either future option



Ashford cluster

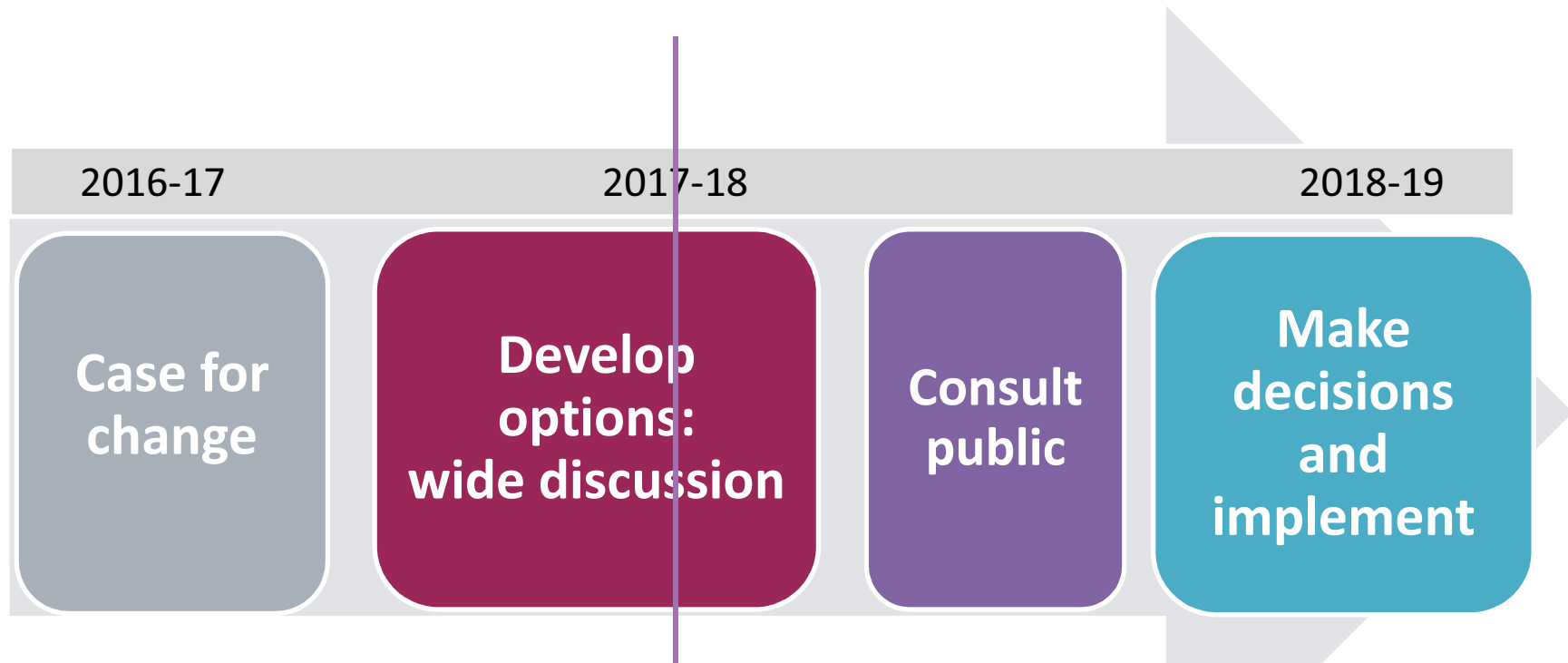


Ashford

Current Service Provision	Option 1 – proposed services	Option 2 – proposed services
<p>Enhanced GMS (extended services)</p> <p>GPFV Access – 8am to 8pm, Saturdays & Sundays either in individual practices or at Hub level.</p> <p>Primary Care at Scale GP Practices working collectively</p> <p>3 Hubs: Rural</p> <ul style="list-style-type: none"> • Urban • North <p>Hubs deliver an integrated case management approach via integrated multidisciplinary teams which include a core team of but not limited to:</p> <ul style="list-style-type: none"> • GP • Adult Social Care • Community & District Nursing • Health & Social Care Co-Ordinator • Voluntary Sector - Social Prescribing. • Pharmacist <p>Minor Injuries provided through an enhanced service across all hubs.</p>	<p>Primary Care Extended Services - Universal</p> <p>Primary Care GPFV access - Universal</p> <p>Primary Care at Scale – Universal</p> <p>Polyclinics or shared facilities operating within Hubs to include full range of ambulatory, day case and diagnostic interventions</p> <p>Fully Integrated multidisciplinary teams (primary care, community, mental health, social care etc)</p> <p>Move from health intervention to well-being interventions engaging health, social care, housing, education, voluntary sector etc</p>	



What is next....



Next step – evaluate the medium list to develop the option(s) to consult on



Evaluation process: This marks a critical stage in the assessment of the underlying detail that sits behind options 1 and 2 using an agreed set of evaluation criteria.



Evaluation criteria – planned public engagement throughout January to assist in developing the detail on how the criteria should be applied.

QUALITY CARE 


Will it improve patient care?

ACCESS TO CARE 

Can patients get there?

AFFORDABILITY 

Is it affordable and good value for money?

STAFFING 

Do we have the right number of staff?

DELIVERABILITY 

Is it implementable in the timeframe?

RESEARCH and EDUCATION 

Will it support research and education?



Item 6: Financial Recovery in East Kent

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: Financial Recovery in East Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent CCGs.

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

1. Introduction

- (a) On 20 September 2017 the Committee considered a report about the financial recovery plans for Ashford and Canterbury CCGs. The Committee agreed the following recommendation
- *RESOLVED that the report on financial recovery in Ashford and Canterbury CCGs be noted and an update presented to the Committee in January.*
- (b) The East Kent CCGs have asked for the attached report to be presented to the Committee.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to provide an update in March.

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (24/11/2017)'*,
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7533&Ver=4>

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Health Overview and Scrutiny Committee Briefing

Financial recovery in east Kent

January 2018

Introduction

The four CCGs in east Kent individually and collectively are expected to contain expenditure to their given resource limit and this forms the basis of plans submitted at the beginning of the financial year.

In view of the relatively low levels of resource increase received each year by the CCGs and the increases in demand and expectations, CCGs are expected to develop transformation and recovery plans to ensure expenditure still remains within resource limits no matter what the changes in demand and public expectations are.

Overall position as at the end of December 2017

At the end of December the four CCGs were still reporting centrally that financial balance was their target, however there was some £18m of remaining financial risk remaining to resolve by the end of March 2018. £18m represents approximately 2 per cent of the four CCG's turnover.

Of the four CCGs, one Thanet was within a £1m of achieving financial balance, two, Canterbury and South Kent Coast within £5m of achieving financial balance and one Ashford within £12m of achieving financial balance. It should be noted that Ashford started the financial year with a structural deficit of £7m.

Challenges in 2017/18

Apart from the initial financial challenge at the beginning of the financial year, further pressures have become evident as the year progressed including; additional cost pressures arising from the Kent and Canterbury emergency service moves, generally increased pressures on urgent care, financial pressures arising from main contract activity and in respects of placements, drug costs and other items. The overall savings target for the year required to achieve financial balance and address in-year pressures was £96m, around 10 per cent of CCG turnover.

Financial Recovery Plan 2017/18

The financial recovery plan for the four CCGs that was designed to deliver ideally financial balance but certainly no worse than an £18m deficit figure currently represented as an unmitigated risk. The financial recovery plan is made up of four parts:

The delivery of service transformation with a concentration on delivering services locally, out of hospital and in a more integrated way. These initiatives concentrated on services for those with long-term conditions and those who were frail. The original annual target for these initiatives amounted to £36m in a full year. The expected savings this year are £4m with delays in implementation and the retention of hospital capacity during the winter months being the key reasons for under delivery.

Active management of contracts with service providers and others and in particular to ensure that the CCGS only paid for services that had been delivered and delivered to acceptable standards. The original annual target for these initiatives amounted to £44m in a full year. The expected savings this year are £22m with taking a constructive view on long-term relationships and positive service transformation being the main reasons for under delivery.

Enhanced budgetary control, specifically improved medicines management and placement management and better controls over small scale and independent sector contracts. The original annual target for these initiatives amounted to £12m in a full year. The expected savings this year are £4m with the lead in time for placement reviews and unexpected increases in the cost of drugs being the main reasons for under delivery.

Implementation of Kent and Medway agreed NHS menu of opportunity items and reduction in management costs and charges. The original annual target for these initiatives amounted to £4m in a full year. The expected savings this year are £1m with the lead in time for placement reviews and unexpected increases in the cost of drugs being the main reasons for under delivery.

Management of financial recovery programme

This occurs weekly at CCG joint level and monthly in respect of CCG Governing Body and NHS Review. Appropriate discussions take place with partners and contractors. Where required quality and equality impact reviews are undertaken before deciding on any relevant savings proposal.

Initiatives under consideration

The four east Kent CCGs are currently considering implementing a small group of savings schemes based on a Kent and Medway analysis of a list of initiatives that have been introduced elsewhere in the NHS. These initiatives include improved prescribing guidance for gluten free foods, ensuring support for infertility treatment meets NICE guidelines, reducing direct GP use of MRI scans to ensure capacity is available for urgent cancer patients. Decisions on these matters are under consideration and quality impact assessments are currently being progressed. An update on these initiatives will be available in March.

Item 7: East Kent Out of Hours GP Services and NHS 111

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: East Kent Out of Hours GP Services and NHS 111

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent CCGs.

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

1. Introduction

- (a) On 3 June 2016 the Committee received a report from the East Kent CCGs which provided an update about the outcome of the East Kent integrated urgent care service procurement combining NHS 111, GP Out-of-Hours and new care navigation service.
- (b) On 25 November 2016 the Committee considered an update about the implementation of the new East Kent integrated urgent care service contract provided by Nestor Primecare Limited.
- (c) On 20 September 2017 the Committee was provided with an update following Primecare being rated as Inadequate and being placed into Special Measures by the Care Quality Commission (CQC) on 3 August 2017. It was confirmed at the meeting that Primecare would be leaving the contract early on 7 July 2018. The Committee agreed the following recommendation:
 - *RESOLVED that:*
 - (a) *the report be noted;*
 - (b) *the East Kent CCGs be requested to provide a written update to the Committee in November and a verbal update in January;*
 - (c) *the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.*
- (d) On 24 October the Committee was notified that Primecare had opted to exercise its right to serve an accelerated notice period of three months on Friday 29 September 2017. On 14 November the Committee was formally notified that Integrated Care 24 (IC24) would take over the contract from the beginning of December.
- (e) The East Kent CCGs were subsequently requested to provide a verbal update to the Committee on 24 November 2017. The item was deferred at the meeting, due to the amount of time taken to discuss other items on the Agenda.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to provide an update in March about the out of hours bases.

Background Documents

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* (25/11/2016)',
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6263&Ver=4>

Kent County Council (2017) '*Health Overview and Scrutiny Committee* (20/09/2017)',
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4>

Kent County Council (2017) '*Health Overview and Scrutiny Committee* (24/11/2017)',
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7533&Ver=4>

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Health Overview and Scrutiny Committee Briefing
East Kent NHS 111 and GP out of hours services
January 2018

Author: Sue Luff, Head of Contracts

Sponsor: Simon Perks, Accountable Officer

Background

Primecare was commissioned in 2016 to provide an integrated NHS 111 and GP out of hours (GP OOH) service across the four east Kent Clinical Commissioning Groups (CCGs) following a competitive procurement process. The aim of the service was to provide a seamless transition for patients between NHS 111 and GP out of hours services. The lead CCG for the contract is NHS Canterbury and Coastal CCG.

Following a planned mobilisation phase, the GP OOH service went live on 28 September 2016 with NHS 111 following shortly afterwards in a phased approach starting from November 2016.

The contract has been closely performance managed on a monthly basis since the service went live. A key part of this process is to monitor the arrangements to ensure that patients are provided with a safe, effective service and that patient experience is reviewed regularly and lessons embedded into the service.

Regular contract management identified some concerns in relation to quality of care. The CCG has been working with Primecare to oversee improvements and support Primecare to make the necessary changes.

Care Quality Commission inspection

The CQC carried out an inspection in May 2017 and the report was published on 3 August. The CQC report identified a number of concerns and the overall rating was inadequate. The provider was placed in special measures. The concerns identified by the CQC replicated concerns that the CCG had already raised with Primecare.

Following the inspection, the CQC took enforcement action against the provider, namely the issuing of three warning notices.

The warning notices covered:

- **Safe care and treatment** (care and treatment must be provided in a safe way for service users). Primecare had failed to ensure that the risks to the health and care of service users were properly assessed, particularly in respect of reporting, recording and learning from significant events.
- **Good governance** (systems or processes must be established and operated effectively). Primecare demonstrated a lack of key senior staff, used interim staff, staff were not fully

aware of their roles and responsibilities, the disaster /recovery plan was unclear, and there was an absence of patient feedback.

- **Staffing** (sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed). Primecare did not have enough staff to meet the needs of patients and there was a lack of induction and mandatory training.

Primecare ratings for each area inspected

Are services safe? Inadequate

Are services effective? Inadequate

Are services caring? Requires improvement

Are services responsive to people's needs? Requires improvement

Are services well-led? Inadequate

The full inspection report can be viewed on the [CQC website](#).

Progress since previous report to the HOSC

The NHS England Quality Oversight Group for Primecare continues to meet regularly to both provide support, hold Primecare to account and to ensure timely action to addresses the concerns raised during the CQC inspection.

Primecare exercised its right to serve an accelerated notice period of three months on 29 September 2017, in accordance with a joint agreement signed by both parties on 30 August 2017. This followed several weeks of intensive support from the CCG to enable the provider to deliver the required service.

The notice period was due to expire on 31 December 2017. However, the CCG took the view that to implement a new service during the holiday period would not be sensible and therefore took the decision to implement a new service on 1 December.

The CCGs have signed an agreement with Integrated Care 24 (IC24), a not for profit social enterprise, to take over the running of the NHS 111 and GP OOH service. IC24 has more than 25 years' experience providing healthcare services, including GP OOH care and NHS 111 services across the east and south of England.

IC24 is completely committed to providing patients with a safe and efficient service and will be working closely with the CCGs and all other healthcare providers across east Kent to ensure they receive a good and safe service.

Current situation

The new contract with IC24 was successfully implemented on 1 December 2017.

To support the ability to implement a safe service within the short time period it was agreed that IC24 GP OOH service would initially not re-open the bases in Deal, Herne Bay and Romney Marsh. However, this will be fully reviewed by the end of February 2018 and will involve representation from patient groups and Healthwatch. The initial meeting is planned on 8 February.

IC24 is an experienced provider of NHS 111 and GP out of hours services. IC24 operates the integrated urgent care service in both Norfolk and South Essex. It also operates the NHS 111 service in North Essex and the out of hours GP led service in West and North Kent, Surrey, Sussex and Northampton. The organisation also provides the nurse-led healthcare at the Sheppey Cluster of prisons. These services cover 6.4million people. In October, 70,322 patients used the 111 service and 49,144 used OOH.

In the last year IC24 has implemented a clinical assessment service in Norfolk and Waveney, has moved to a locality model and has reduced corporate services to move resources to the 'front line'. IC24 has also introduced a raft of 'people focused' initiatives such as a staff forum and a reward and recognition scheme to ensure that staff are consulted on decisions and change within the organisation, and are recognised for their contributions.

Whilst the holiday period has been challenging across all provider the initial performance measures from IC24 are positive with compliance against the required performance measures.

Next Steps

The team will work with IC24 to fully develop the service so that it is in line with the national standards.

This will include:

- Development of the Clinical Advice Service to support care for patients needing support from other agencies such as mental health and pharmacy
- Extension of the professional advice line for care homes to support fast access to advice
- Implementation of direct booking into GP practices where patient requires assessment from GP
- Implementation of MiDos, the national directory for patient services and advice for self-management
- Working towards the national workforce competency framework
- Development of partnerships across all out of hours GP led services such as the GP in A/E project
- The working group will be extended to include patient representation and will be launched at the 8 February meeting.

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Item 8: Assistive Reproductive Technologies (ART) Policy Review

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: Assistive Reproductive Technologies (ART) Policy Review

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

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

1. Introduction

- (a) On 24 November 2017 the Committee considered a report regarding a review of Assistive Reproductive Technologies (ART) policy in Kent and Medway. The Committee agreed the following recommendation:

▪ *RESOLVED that the Committee:*

- (a) *notes that a review of the Assistive Reproductive Technologies (ART) policy is being undertaken by the Kent & Medway CCGs;*
- (b) *requests that the proposed revised policy is presented to the Committee in January in order for it to make a determination about the proposals constituting a substantial health service development or variation.*

2. Potential Substantial Variation of Service

- (a) Medway Health and Adult Social Care Overview and Scrutiny Committee considered this item on 18 January 2018 and determined that the proposed policy changes did constitute a substantial variation of service. If the HOSC determines the proposed service change to be substantial, the Joint HOSC will need to be convened.
- (b) If the HOSC deems proposed policy changes as not being substantial, this does not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to Medway CCG.
- (c) If the HOSC determines proposed policy changes to be substantial, a timetable for consideration of the change will need to be agreed between the Joint HOSC and Medway CCG. The timetable will include the proposed date that Medway CCG intends to make a decision as to whether to proceed with the proposal and the date by which the Joint HOSC will provide any comments on the proposal.
- (d) If a Joint HOSC is established, the power to refer to the Secretary of State will not be delegated to the joint committee, the power to refer will

Item 8: Assistive Reproductive Technologies (ART) Policy Review

remain with the individual committees (Kent HOSC and Medway HASC) which appointed the joint committee.

3. Recommendation

If the proposed policy changes are *not substantial*:

RECOMMENDED that:

- (a) the Committee does not deem proposed policy changes to be a substantial variation of service.
- (b) Medway CCG be invited to submit a report to the Committee in six months.

If the proposed policy changes are *substantial*:

RECOMMENDED that:

- (a) the Committee deems the proposed policy changes to be a substantial variation of service.
- (b) a Joint HOSC be established with Medway Council.

Background Documents

Kent County Council (2017) '*Health Overview and Scrutiny Committee (24/11/2017)*',

<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7533&Ver=4>

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

26 JANUARY 2018

ASSISTIVE REPRODUCTIVE TECHNOLOGIES – POLICY REVIEW

Report from: Stuart Jeffery, Chief Operating Officer, NHS Medway
Clinical Commissioning Group

Author: Michael Griffiths, Partnership Commissioning
Programme Lead, Children and Families

Summary

This report follows the paper that was presented to the Health Overview and Scrutiny Committee in November 2017, advising of a review of the policies relating to the review of Assistive Reproductive Technologies that is to be undertaken by the eight Kent and Medway Clinical Commissioning Groups.

In line with many health economies across England, Kent and Medway, CCGs are considering a range of difficult decisions to ensure that overall financial risks are minimised. CCGs have agreed to review the policies relating to ART.

1. Budget and Policy Framework

- 1.1 Assistive Reproductive Technologies (ART) are funded by Clinical Commissioning Groups (CCGs).
- 1.2 NHS Medway CCG is the lead commissioner for ART services for the eight CCGs across Kent and Medway.

2. Background

- 2.1 The review will focus on two aspects:
 - Ensuring that the number of funded cycles is both affordable and reasonable. This may result in a reduction to the number of IVF cycles that are funded for eligible patients.
 - Considering the funding of assisted conception treatments using donated genetic materials for all patient groups. A complainant highlighted that the current policy effectively excludes same sex couples access to NHS funded fertility treatment due to their requirement for donated materials.

- 2.2 This report outlines the national and local context with regard to ART policy development and proposes an approach to reviewing the current Kent and Medway CCGs' ART policies. In addition, the attached documents identify the current schedule of policies, and the potential changes that the review may bring about, and seeks the view of the Committee as to whether such changes would constitute a significant variation to health services.
- 2.3 Under Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Kent. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it.
- 2.4 Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers ("responsible persons") to consult a local authority about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment. Where more than one local authority has to be consulted under these provisions those local authorities must convene a Joint Overview and Scrutiny Committee for the purposes of the consultation and only that Committee may comment.
- 2.5 If this Committee and Medway Council's Health and Adult Social Care Overview and Scrutiny Committee were to both determine that the proposals constitute a substantial health service development or variation the responsible persons will have to consult the Kent and Medway Joint Health Scrutiny Committee and only that Committee may make comments and require information on the matter.
- 2.6 The terms "substantial development" and "substantial variation" are not defined in the legislation. Guidance on health scrutiny published by the Department of Health in June 2014 suggests it may be helpful for local authority scrutiny bodies and responsible persons who may be subject to the duty to consult to develop joint protocols or memoranda of understanding about how the parties will reach a view as to whether or not a proposal constitutes a "substantial development" or "substantial variation".

3. National and Local context

- 3.1 Please see appendix one, which provides the national and local context for this work.

4. Proposed service development or variation

- 4.1 The review will focus on two aspects:

- Ensuring that the number of funded cycles is both affordable and reasonable. This may result in a reduction to the number of IVF cycles that are funded for eligible patients.
- Considering the funding of assisted conception treatments using donated genetic materials for all patient groups. A complainant highlighted that the current policy effectively excludes same sex couples access to NHS funded fertility treatment due to their requirement for donated materials.

5. Advice and analysis

- 5.1 CCGs in Kent and Medway have now considered the potential impacts of a review of ART policies, and agree that a review should be undertaken. The proposed process for the review of policies relating to the number of cycles and use of donated genetic material is outlined below.

6. Review timeline

- 6.1 It is proposed that engagement with members of the public and stakeholders takes place between February and April 2018, with the decision relating to the review to be presented to each CCG in July / August 2018. A new schedule of policies would be published and implemented after this time.

7. The consultation and engagement process

- 7.1 When considering significant changes to public services, CCGs have a legal duty to involve the public.
- 7.2 In order to ensure that a region-wide policy is maintained, CCG Chief Operating Officers (COOs) will oversee this policy review and discuss progress at regular region-wide meetings.
- 7.3 The North and East London Commissioning Support Unit (NEL CSU) will lead on engagement processes with members of the public and with patient support groups, with support from individual CCGs.
- 7.4 The process of public engagement will be carried out through online questionnaires which would be hosted on each CCG's website and promoted via social media channels and public meetings in each CCG area.
- 7.5 A full engagement plan will be developed by NEL CSU in the coming weeks. In addition, the report that is presented to the Health Policy Reference Group will include equality and diversity impact assessments for consideration by the Group.

8. Risk management

8.1 Risks associated with reviewing the schedule of ART policies include:

Risk	Description	Action to avoid or mitigate risk	Risk rating
Poor response to engagement process	Should there be a poor response, CCGs may be required to amend the approach to the review, thus causing increased costs and a delay to the proposed timeline.	Clear communication and engagement plan to be developed and implemented. Individual CCGs must support the proposed process	E3 <i>E = very low probability 3 = marginal impact</i>
Lack of input from one or more CCGs	CCGs are under pressure in a number of areas and it is possible that this work is not prioritised by all eight CCGs in Kent and Medway. This would cause a delay to the process and could potentially destabilise the review and engagement phase.	All CCGs are actively involved with this process at present, via Chief Operating Officers. All CCGs are represented on the HPRG and will take decisions via their own governance routes.	E3 <i>E = very low probability 3 = marginal impact</i>
CCGs are unable to agree the outcome of the policy review	At the conclusion of the review, there is the chance that consensus is not reached across the eight Kent and Medway CCGs. This could lead to the implementation of different policies in CCG areas and give rise to allegations of a “postcode lottery” for health services.	This risk must be tolerated to respect the sovereignty of individual CCGs.	D3 <i>D = low probability 3 = marginal impact</i>
Challenge from patient groups/ reports in local media	ART services are highly emotive and proposed changes could lead to reputational damage for CCGs.	Clear communication and engagement plan to be developed and implemented to help mitigate this risk.	B2 <i>B = high probability 2 = critical impact</i>

9. Financial implications

9.1 The Health policy Support Unit estimate that should Kent and Medway CCGs reduce to one cycle of NHS funded IVF per eligible couple, this would have a cost saving of approximately £666k p.a. across Kent and Medway CCGs. Potential financial savings are identified in more detail in appendix one.

9.2 Depending on the outcome of the review relating to the use of donated genetic materials, there may be a cost pressure for Kent and Medway CCGs.

This cost pressure is being calculated, and further work relating to the cost of the proposed review will be undertaken by the Health Policy Support Unit throughout the review, for consideration by the Health Policy Review Group.

10. Legal implications

10.1 The legal implications are set out with in the report and in particular Section 2.

11. Recommendation

11.1 The Committee is asked to note the review of Assistive Reproductive Technologies (ART) policies, set out in the report, in light of the financial challenges faced by Clinical Commissioning Groups (CCGs), and note the review process set out in section six of the report.

11.2 The Committee is further asked to determine whether the proposed policy changes constitute a significant variation in health services

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Appendices

Appendix 1 - Review of Kent and Medway CCGs' policies on assisted reproductive technologies (ART) – Paper for HOSCs, provided by NEL Commissioning Support Unit

Appendix 2 - Existing schedule of policies relating to Assistive Reproductive Technologies

Appendix 3 - Substantial Variation Questionnaire

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Review of Kent and Medway CCGs' policies on assisted reproductive technologies (ART) – Paper for HOSCs

Purpose

Kent and Medway CCGs are considering undertaking a review of their current policy on in vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI)¹. This paper details the change to policy that is being considered and the estimated impact this change might have on the local health economy.

Background

Although NICE Clinical Guideline 156 ([CG156](#)) *Fertility problems* (2013) recommends the NHS fund up to three full² IVF cycles, with or without ICSI, for eligible couples where the woman is aged under 40 years, it is widely acknowledged that this level of provision is unaffordable to the NHS in most areas.

[Fertility Fairness](#) audits the number of NHS funded IVF cycles provided by English CCGs. In May 2017 they reported:

- Five CCGs (2.4%) have decommissioned NHS funded IVF and provide 0 cycles
- 61% of CCGs offer 1 NHS funded IVF cycle³ for eligible patients
- 23% of CCGs offer up to 2 NHS funded IVF cycles³ for eligible patients
- 13% of CCGs offer up to 3 NHS-funded IVF cycles³ for eligible patients

In recent years there has been a marked reduction in access to NHS funded IVF in England. Fertility Network UK reports the number of CCGs offering three cycles of IVF has reduced by 46%, from 50 in 2013 to 27 in 2017. Thirteen CCGs have made reductions to provision of fertility treatment since the beginning of 2017. Across England, there are potential further cuts ahead with

¹ During IVF, eggs are removed from the woman's ovaries and fertilised with sperm in a dish. The best one or two embryos that are created are then placed in the woman's womb a few days later. If there are a number of unused good quality embryos left following a treatment cycle, these may be cryopreserved (frozen) for use in later cycles, called frozen embryo transfers. The procedure for ICSI is similar to that for IVF, but instead of fertilisation taking place in a dish, a single sperm is injected directly into each egg by an embryologist.

² NICE define a full cycle of IVF as one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryos i.e. a fresh cycle and an undefined number of subsequent frozen cycles.

³ IVF 'cycle' is not defined but it is likely to refer to the number of fresh cycles available to eligible patients.

a number of CCGs currently consulting on reducing or stopping their NHS funded fertility treatment.

Due to the financial challenges they are currently facing, Kent and Medway CCGs are considering reducing the number of IVF cycles they commission, and a process has been proposed to facilitate a policy review.. Additional work summarised in a report will include: consideration of NICE recommendations, a review of relevant published research evidence, current Kent and Medway activity and expenditure, other English CCGs policies, views and opinions of local clinicians and fertility clinics, estimated impact of change to policy on local health economy, and equality analysis. Kent and Medway CCGs will determine future policy on the basis of this report.

Comparison of current policy and potential future policy

Currently Kent and Medway CCGs offer eligible couples a maximum of four embryo transfers including no more than two transfers from fresh IVF cycles; this equates a maximum of either:

- two fresh IVF cycles plus two frozen embryo transfer cycles or
- one fresh IVF cycle plus three frozen embryo transfer cycles.

This may be considered locally as up to two ‘full’ IVF cycles, though it does not comply with the NICE definition of ‘full’ cycles which does not put a limit on the number of frozen embryo transfers undertaken.

The potential future policy that is being considered would be a maximum of:

- one fresh IVF cycle and one frozen embryo transfer cycle (also see Annex 1).

This may be considered locally as one ‘full’ IVF cycle, though as above, it does not comply with the NICE definition of ‘full’ cycles. See Table 1 for comparison of draft policy wording.

Table 1 – Comparison of current Kent and Medway IVF policy and potential future policy

Current policy	Potential future policy (draft)	Change
Eligible couples requiring IVF, with or without ICSI, will have available to them a maximum of four embryo transfers including no more than two transfers from fresh cycles	Eligible couples requiring IVF, with or without ICSI, will have available to them a maximum of one fresh IVF cycle and one frozen embryo transfer cycle.	Reduction in number of cycles available.
In order to access NHS funded IVF, with or without ICSI, patients will be required to fulfil relevant eligibility criteria.	In order to access NHS funded IVF, with or without ICSI, patients will be required to fulfil relevant eligibility criteria.	Unchanged.
Cryopreservation of supernumerary embryos will be funded for a maximum of two years following each fresh cycle.	Cryopreservation of supernumerary embryos will be funded for a maximum of two years following the fresh cycle.	Materially unchanged.

In order to access NHS funded fertility treatment, Kent and Medway patients must fulfil a number of eligibility criteria addressing: duration of subfertility, the woman's age, previous IVF cycles undertaken, the BMI of the woman, smoking status of the couple, ovarian reserve of the woman, previous children and previous sterilisation. Eligibility criteria are reapplied before each cycle of treatment is started. There is no plan to review these eligibility criteria.

For people meeting specific eligibility criteria, Kent and Medway CCGs also fund intrauterine insemination (IUI) using partner sperm, sperm washing for couples where the male partner has HIV and fertility preservation (egg, sperm or embryo cryopreservation and subsequent IVF) for people who are due to undergo gonadotoxic treatments. There is no plan to review these policies.

Assisted conception treatments (ACT; i.e. IUI and IVF) using donated genetic materials (eggs, sperm or embryos) and involving surrogates are not currently funded for any patient groups in Kent and Medway. These policies are currently under review. Because of the complex clinical, equalities, legal and ethical issues relating to ACT using donated genetic materials and involving surrogacy these policy reviews will run in parallel but will be separate from the policy review to consider reducing the number of IVF cycles.

Potential impact of changes to IVF policy

Table 2 shows the estimated impact on patients and expenditure should CCGs choose to move from their current policy (maximum of four embryo transfers including no more than two transfers from fresh IVF cycles) to reduced provision (maximum of one fresh IVF cycle and one frozen embryo transfer cycle). The estimates set out in Table 2 are based on the available data from 2016/17 provided by the lead commissioner (Medway CCG) in March 2017.

The [Human Fertilisation and Embryology Authority](#) (HEFA) publish statistics relating to treatment and success rates for all UK fertility clinics. The below percentages show the average chance of a live birth after one, two, three and four cycles of IVF for women aged under 40 years:

- One cycle – 32%
- Two cycles – 49%
- Three cycles – 58%
- Four cycles – 63%

Table 2 – Estimated impact of changes to Kent and Medway CCGs' IVF policy (annual)

CCG	Current policy		Potential future policy	
	Maximum of four embryo transfers including no more than two transfers from fresh IVF cycles		Maximum of one fresh IVF cycle and one frozen embryo transfer cycle	
	Number of patients receiving treatment	Expenditure	Number of patients no longer receiving two 'full' cycles	Reduction in expenditure
Ashford	28	£115,700	15	-£43,600
Canterbury and Coastal	45	£182,200	23	-£79,100
Dartford, Gravesham and Swanley	72	£291,600	32	-£95,800
Medway	96	£372,400	34	-£97,800
South Kent Coast	39	£167,400	15	-£46,300
Swale	25	£119,400	13	-£40,700
Thanet	27	£131,500	10	-£27,500
West Kent	176	£806,600	74	-£235,100
Kent & Medway Total	508	£2,186,700	216	-£665,900
Estimates based on 11 months of data from 2016/17 from local clinics contracted to undertake ART for the Kent and Medway CCGs' population (extrapolated to 12 months) plus nine months of activity from 2016/17 from Guy's and St Thomas' NHS Foundation Trust for North Kent CCGs only (extrapolated to 12 months). Any additional activity from other providers has not been captured here. Data provided by Medway CCG in March 2017.				

This briefing note was written in December 2017 by the NEL CSU Health Policy Support Unit (HPSU).

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Annex 1

Draft policy option for discussion

In-vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI)

- Eligible couples requiring IVF, with or without ICSI, will have available to them a maximum of one fresh IVF cycle and one frozen embryo transfer cycle.
- In order to access NHS funded IVF, with or without ICSI, patients will be required to fulfil relevant eligibility criteria⁴.
- Cryopreservation of supernumerary embryos will be funded for a maximum of two years following the fresh cycle

⁴ In order to access NHS funded fertility treatment, Kent and Medway patients must fulfil a number of eligibility criteria addressing: duration of subfertility, the woman's age, previous IVF cycles undertaken, the BMI of the woman, smoking status of the couple, ovarian reserve of the woman, previous children and previous sterilisation. There is no plan to review these eligibility criteria.

Kent and Medway CCGs' schedule of policy statements for assisted reproductive technologies (ART)

March 2016

Issued by: SE CSU Health Policy Support Unit (HPSU)

On behalf of: Kent and Medway Clinical Commissioning Groups (NHS Ashford Clinical Commissioning Group [CCG]; NHS Canterbury and Coastal CCG; NHS Dartford, Gravesham and Swanley CCG; NHS Medway CCG; NHS South Kent Coast CCG; NHS Swale CCG; NHS Thanet CCG; NHS West Kent CCG)

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Purpose of document

This document lists all Kent and Medway CCGs' policies related to assisted reproductive technologies (ART), i.e. the policy statements for:

- In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)
- Intra-uterine insemination (IUI) using partner sperm
- Surgical sperm retrieval
- Sperm washing
- Fertility preservation for patients receiving gonadotoxic treatments
- Assisted conception treatments (ACT) using donated genetic materials
- ACT involving surrogates
- Time-lapse systems for embryo incubation and assessment
- Adherence compounds in embryo transfer media for ART

It also sets out the specified eligibility criteria patients are required to fulfil in order to access NHS funded ART.

Scope

NICE (2013) define assisted reproductive technologies (ART) as *“any treatment that deals with means of conception other than vaginal coitus; frequently involving the handling of gametes or embryos”*.

The policies listed in this document only apply to couples who are registered with a Kent and Medway GP.

Patients are required to fulfil specified eligibility criteria in order to access NHS funded ART. Relevant eligibility criteria for each ART policy are listed in Table 1. CCGs have put in place eligibility criteria for access to ART in order to focus resources on groups of patients most likely to have successful outcomes, and prioritise groups of patients who are most likely to have the greatest need. See Appendix A for the rationale for specific eligibility criteria.

These eligibility criteria are only applicable to the ART policies set out in this document. They do not apply to:

- Investigations for general fertility problems and the primary treatment of conditions found during such investigation
- Medical treatment to restore fertility (for example, the use of drugs for ovulation induction)
- Surgical treatment to restore fertility (for example, laparoscopy for ablation of endometriosis)
- Pre-implantation genetic diagnosis, commissioning of which falls under the remit of NHS England
- Services for members of the armed forces and some veterans, commissioning of which fall under the remit of NHS England

Other forms of assisted reproductive technologies are not included. New developments in assisted reproductive technologies or new information on existing technologies will be dealt with through the agreed local processes.

The NHS in Kent and Medway follow Department of Health (DH) guidance on NHS patients who wish to pay for additional private care (2009) in relation to ART, the principals of which are as follows:

- The NHS should never subsidise private care with public money, which would breach core NHS principles

- Patients should never be charged for their NHS care, or be allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS
- Patients should not be able to choose to mix different elements of the same treatment between NHS and private care
- To avoid these risks, there should be as clear a separation as possible between private and NHS care.

See Appendix B for more details.

Table 1 – Kent and Medway CCGs' eligibility criteria for ART policies

Eligibility criteria		Policy ¹						
		IVF/ICSI	IUI using partner sperm	Surgical sperm retrieval	Sperm washing	Cryopreservation of embryos or oocytes	Cryopreservation of sperm	ACT using cryopreserved materials
Duration of sub-fertility	Funding will be available for couples with unexplained infertility, mild endometriosis or mild male factor infertility ² , who have been having regular unprotected sexual intercourse and attempting to conceive for at least 24 months. Where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, patients can be referred directly for IVF treatment, with or without ICSI.	✓		✓				✓
Age of woman	Funding is available where the woman is aged under 40 years. Women must start medication with the ART provider before their 40th birthday; women must only be referred to fertility clinics if there is adequate time to complete work up. If the woman reaches the age of 40 during treatment, the current full cycle will be completed but no further full cycles will be available. A full cycle of IVF treatment, with or without ICSI, should comprise one episode of ovarian stimulation and the transfer of resultant fresh and frozen embryo(s), in line with the relevant policy.	✓	✓	✓	✓	✓		✓
Previous cycles	Couples will <i>not</i> be funded if either partner has already had three previous fresh cycles of IVF, with or without ICSI, irrespective of how these were funded. This means that eligible couples will be funded: <ul style="list-style-type: none"> Two fresh cycles of IVF, with or without ICSI, if no previous fresh cycles have been funded by the NHS, or if they have already received one non-NHS funded fresh cycle One fresh cycle of IVF, with or without ICSI, if the couple has already received one NHS funded fresh cycle or two non-NHS funded fresh cycles 	✓	✓	✓	✓	✓	✓	✓

¹ The following are not routinely funded for any patient group and therefore eligibility criteria do not apply: ACT using donated genetic materials, ACT involving surrogates, time lapse systems for embryo incubation and assessment, adherence compounds in embryo transfer media for ART

² Two or more semen analyses have one or more variables below the 5th centile.

Eligibility criteria		Policy ¹						
		IVF/ICSI	IUI using partner sperm	Surgical sperm retrieval	Sperm washing	Cryopreservation of embryos or oocytes	Cryopreservation of sperm	ACT using cryopreserved materials
	Overall, eligible couples will be funded for a maximum of four embryo transfers (including no more than two transfers from fresh IVF cycles), in line with the relevant policy. An abandoned IVF cycle is one where an egg collection procedure has not been undertaken. Once egg collection has commenced, this is considered a complete cycle and will count towards one of the couples' NHS funded and 'previous' cycles.							
BMI of woman	Women must have a body mass index (BMI) within the range 19-30 kg/m ²	✓	✓	✓	✓	✓		✓
Smoking	Couples will <i>not</i> be funded if either partner smokes tobacco	✓	✓	✓	✓	✓	✓	✓
Ovarian reserve	Women should have an AMH of more than 5.4 pmol/l	✓	✓	✓	✓	✓		✓
Previous children	Neither partner in a couple should have a living child from their relationship or any previous relationship. A child adopted by the couple or adopted in a previous relationship is considered to have the same status as a biological child. 'Child' refers to a living son or daughter irrespective of their age or place of abode.	✓	✓	✓	✓	✓	✓	✓
Previous sterilisation	Funding will not be available if sub-fertility is the result of sterilisation ³ in either partner	✓	✓	✓	✓	✓	✓	✓

³ Where patients have consented to sterilisation

ART policies

Kent and Medway CCGs' ART policies are set out in the following pages:

1. In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)
2. Intra-uterine insemination (IUI) using partner sperm
3. Surgical sperm retrieval
4. Sperm washing
5. Fertility preservation for patients receiving gonadotoxic treatments
6. Assisted conception treatments (ACT) using donated genetic materials
7. ACT involving surrogates
8. Time-lapse systems for embryo incubation and assessment
9. Adherence compounds in embryo transfer media for ART

1. In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)

Background

IVF may be an option for a range of patients including women with blocked fallopian tubes and those with unexplained infertility, mild endometriosis, and mild male factor infertility for whom expectant management has not resulted in natural conception. Indications for ICSI include severe deficits in semen quality, azoospermia, and failed or very poor fertilisation during previous IVF cycles.

During IVF, eggs are removed from the woman's ovaries and fertilised with sperm in a dish. The best one or two embryos that are created are then placed in the woman's womb a few days later. If there are a number of unused good quality embryos left following a treatment cycle, these may be cryopreserved (frozen) for use in later cycles, called frozen embryo transfers. The procedure for ICSI is similar to that for IVF, but instead of fertilisation taking place in a dish, a single sperm is injected directly into each egg by an embryologist.

Policy

- Eligible couples requiring IVF, with or without ICSI, will have available to them a maximum of four embryo transfers including no more than two transfers from fresh cycles
- In order to access NHS funded IVF, with or without ICSI, patients will be required to fulfil relevant eligibility criteria set out in Table 1.
- Cryopreservation of supernumerary embryos will be funded for a maximum of two years following each fresh cycle⁴

Rationale

Eligible couples are funded for up to two full cycles of IVF with or without ICSI rather than three – as recommended by NICE Clinical Guideline 156 – because Kent and Medway CCGs have concluded that extending provision of IVF/ICSI to three full cycles for eligible couples is currently unaffordable in the context of local priorities. When making resource allocation decisions in this context, CCGs need to take into account the needs of the populations suitable for ART, as well as their wider population.

Local clinicians agree the NHS should fund cryopreservation of supernumerary embryos for two years as this is a reasonable time period for infertile patients to complete a full IVF/ICSI cycle⁴. Patients will have the opportunity to fund continued cryopreservation of any unused embryos for future self-funded FET after the NHS funded storage period concludes.

See Appendix A for the rationale for eligibility criteria.

⁴ Cryopreservation of embryos for couples undergoing IVF, with or without ICSI, for fertility preservation prior to receiving gonadotoxic treatment is addressed by a different policy

2. Intra-uterine insemination (IUI) using partner sperm

Background

IUI has previously been used as a treatment for fertility problems such as unexplained infertility, mild endometriosis and mild male factor infertility. It can also be used as an alternative to vaginal sexual intercourse, for example, where there is a disability that prevents vaginal intercourse.

During IUI, sperm are inserted into the uterine cavity around the time of ovulation. IUI can be carried out in a natural cycle, without the use of drugs, or the ovaries may be stimulated with oral anti-oestrogens or gonadotrophins. IUI can be undertaken using partner or donor sperm; this policy addresses the former circumstances only. Procedures involving donor genetic materials are not funded within the local NHS for any patient group (this is addressed in a separate policy).

Policy

- Up to six cycles of IUI with partner sperm will be funded as a treatment option for eligible couples:
 - who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem
 - who are clinically indicated to receive IUI following a successful sperm washing procedure where the man is HIV positive (access to NHS funded sperm washing is addressed in a separate policy)
- In order to access NHS funded IUI using partner sperm, patients will be required to fulfil relevant eligibility criteria set out in Table 1.

Rationale

NICE clinical guidelines (CG156) no longer recommend IUI for people with unexplained infertility, mild endometriosis or mild male factor infertility because a review of the literature concluded that IUI without stimulation is no better than expectant management. It is unclear if IUI with stimulation is more effective than expectant management for these groups, however it is likely to increase the risk of multiple pregnancies, which is the single biggest risk of fertility treatment.

See Appendix A for the rationale for eligibility criteria.

3. Surgical sperm retrieval

Background

Surgical sperm retrieval is indicated in cases of male sub-fertility where there is testicular sperm production but an absence of sperm in the semen (azoospermia).

Surgical sperm retrieval is a set of techniques for collecting sperm from within the male reproductive organs for use in ICSI. ICSI involves an embryologist selecting a single sperm from the sample and injecting it directly into an egg. The fertilised egg (embryo) is then transferred to the woman's womb. The development of ICSI means that as long as some sperm can be obtained (even in very low numbers), fertilisation is possible.

Policy

- Eligible couples where the male has obstructive azoospermia will have one surgical sperm retrieval procedure funded
- In order to access NHS funded surgical sperm retrieval, couples will be required to fulfil relevant eligibility criteria set out in Table 1
- Surgical sperm retrieval will not be available if sub-fertility is the result of sterilisation (where patients have consented to sterilisation)
- Where the procedure is successful, couples can access IVF with ICSI, in line with the relevant policy
- Cryopreservation of surgically retrieved sperm will be funded for a maximum of two years

Rationale

NHS funded surgical sperm retrieval is only available to patients with obstructive azoospermia because the available evidence suggests that the success rate for surgical sperm retrieval is good for men with obstructive azoospermia (between 85% and 100% depending on the procedure). Success rates are lower for men with non-obstructive azoospermia (between 44% and 88% depending on procedure). Furthermore, studies have found that outcomes of ICSI using testicular sperm from men with non-obstructive azoospermia are generally inferior compared to those with obstructive azoospermia.

See Appendix A for the rationale for eligibility criteria.

4. Sperm washing

Background

Sperm washing is a process that has been developed to minimise the risk of onward transmission of HIV, primarily to the female partner and subsequently the unborn child. The purported utility of sperm washing rests on the premise that HIV-infected material is carried primarily in the seminal fluid rather than in the sperm itself. The technique involves purifying sperm from seminal fluid. The sperm is then used in assisted conception treatments such as IUI or IVF/ICSI.

Sperm washing is normally indicated for couples who wish to have a child where the male is HIV-positive and the female is HIV-negative, or to minimise the risk of transmission of resistant virus in HIV seroconcordant couples. The use of sperm washing has also been proposed in couples where the male is hepatitis C positive and the female is negative.

Policy

- One sperm washing procedure will be funded within the local NHS for couples where the man is HIV positive and either he is not compliant with HAART or his plasma viral load is 50 copies/ml or greater and where the female partner is HIV negative
- Where the procedure is successful, couples may access IUI or IVF, with or without ICSI, depending on their clinical circumstances, in line with the relevant policy
- In order to access NHS funded sperm washing and subsequent assisted conception treatments, patients will be required to fulfil relevant eligibility criteria set out in Table 1

Rationale

According to NICE CG156, the evidence shows that sperm washing appears to be very effective in reducing viral transmission; no cases of seroconversion of the woman or the baby have been documented. In comparison with pregnancy outcomes following ACT without sperm washing, higher live full-term singleton birth rates are seen with IVF following sperm washing. This is likely to be because couples undergoing sperm washing were having ACT to avoid HIV transmission rather than for fertility problems. In a comparison of pregnancy outcomes for different ACT methods using washed sperm, IUI cycles had fewer singleton live births than IVF cycles with and without ICSI; IUI also had fewer multiple births. This may reflect the transfer of more than one embryo in IVF cycles.

Sperm washing is unavailable on the NHS for couples where the male is hepatitis C positive, because NICE CG156 recommends that couples who want to conceive and where the man has hepatitis C should be advised that the risk of transmission through unprotected sexual intercourse is thought to be low.

See Appendix A for the rationale for eligibility criteria.

5. Fertility preservation for patients receiving gonadotoxic treatments

Background

The treatment of cancer frequently involves the use of radiotherapy and/or chemotherapy. These treatments can impact on fertility, either by direct injury to the ovaries or testes from radiotherapy or via systemically administered chemotherapeutic agents. Some treatments for autoimmune disorders such as systemic lupus erythematosus, multiple sclerosis and Crohn's disease can also have gonadotoxic effects. In some cases the individual's fertility will return after their treatment is completed but in other cases fertility never returns, or is severely impaired.

ART can offer an opportunity to affected patients to preserve their fertility prior to the start of potentially gonadotoxic treatment. Preservation of fertility normally involves cryopreservation of semen, oocytes or embryos. Following completion of the potentially gonadotoxic treatment, patients can undergo assisted conception treatments such as IUI, IVF, with or without ICSI, or frozen embryo transfer (FET) using their cryopreserved materials.

Policy

- Cryopreservation of sperm, embryos or oocytes will be available for fertility preservation for eligible patients due to receive gonadotoxic treatments
- In order to access cryopreservation of sperm for fertility preservation, men will be required to fulfil relevant eligibility criteria set out in Table 1
- In order to access cryopreservation of embryos for fertility preservation, couples will be required to fulfil relevant eligibility criteria set out in Table 1
- In order to access cryopreservation of oocytes for fertility preservation, women will be required to fulfil relevant eligibility criteria set out in Table 1.
- Women undergoing gonadotoxic treatment should have access to a consultation with an NHS fertility specialist before and after undergoing gonadotoxic treatment
- Storage of sperm, embryos and oocytes should be funded for up to ten years after cryopreservation
- NHS funding of cryopreservation of materials will cease where:
 - Fertility is established through tests or conception
 - A live birth has occurred
 - The patient dies and no written consent has been left permitting posthumous use
- In order to access assisted conception treatments using cryopreserved materials, couples will be required to fulfil relevant eligibility criteria set out in Table 1

Rationale

NICE CG156 recommends offering sperm cryopreservation to men and adolescent boys who are preparing for medical treatment for cancer that is likely to make them infertile. For women of reproductive age who are preparing for medical treatment for cancer that is likely to make them infertile, CG156 recommends offering oocyte or embryo cryopreservation as appropriate if:

- they are well enough to undergo ovarian stimulation and egg collection, and
- this will not worsen their condition, and
- enough time is available before the start of their cancer treatment.

Storage of cryopreserved material is recommended for an initial period of 10 years.

While no separate recommendations are made by NICE for other populations of people receiving gonadotoxic treatments, the NICE Guideline Development Group (GDG) felt that the recommendations made in the guideline should be extrapolated to other groups within the population who may be at risk of losing their fertility due to treatment.

See Appendix A for the rationale for eligibility criteria.

6. ACT using donated genetic materials

Background

ACT such as IUI, IVF with or without ICSI, and FET can be undertaken using donated sperm, oocytes (eggs) or embryos. Donor conception can be an option for patients:

- who are not producing eggs/ sperm
- whose own sperm or eggs are unlikely to result in the conception of a baby
- where there is a high risk of passing on an inherited disease
- who are single or in same sex relationships

Policy

- Procedures involving donor genetic materials are not funded within the local NHS for any patient group
- Funding of procedures involving donor genetic materials abroad will not be reimbursed by the local NHS

Rationale

When making resource allocation decisions in this context, CCGs need to take into account the needs of the populations suitable for assisted reproductive technologies, as well as their wider population. The decision to not fund assisted conception treatments using donated genetic materials was taken on the basis of the relative clinical- and cost-effectiveness of different interventions and absolute affordability following consideration of the established principles and priorities agreed by the CCGs.

In the UK, donated genetic materials are in short supply, with demand commonly exceeding supply. An unintended consequence of any policy making ACT using donated genetic materials available on the NHS locally may be that patients could seek NHS funded treatments abroad. This is undesirable as clinics may be unregulated and treatments undertaken could pose significant health risks to patients.

7. ACT involving surrogates

Background

Surrogacy is when a woman who is not the intended mother carries and gives birth to a baby for a couple or individual who want to have a child. Partial surrogacy uses sperm from the intended father and an egg from the surrogate. Here, fertilisation is usually facilitated by artificial insemination or IUI. Full surrogacy involves IVF, with or without ICSI, and the implantation of an embryo which is not created using the surrogate's eggs.

Full or partial surrogacy may be considered an option for women who have a medical condition that makes it impossible or dangerous to get pregnant and/or give birth, for example:

- absence or malformation of the womb
- recurrent pregnancy loss
- repeated IVF implantation failures

Partial surrogacy can also be considered an option for single men and male same sex couples.

Policy

- Assisted conception treatments involving surrogates are not funded within the local NHS for any patient group

Rationale

Surrogacy was not included within the scope of NICE CG156.

There are significant medico-legal issues involved in surrogacy arrangements that would pose risks to an NHS organisation funding this intervention.

The Surrogacy Arrangements Act 1985 states that commercial surrogacy is illegal in the UK.

However, the surrogate can be paid reasonable expenses such as travel expenses and loss of earnings. The HFEA states that fertility clinics cannot identify surrogates for their patients.

Surrogacy arrangements are not legally enforceable, even if a contract has been signed and the expenses of the surrogate have been paid. The surrogate will be the legal mother of the child unless or until parenthood is transferred to the intended mother through a parental order or adoption after the birth of the child. This is because, in law, the woman who gives birth is always treated as the mother.

There is an absence of evidence on the long-term psychological impact or social consequences for commissioning couples, surrogates or children born to surrogates.

8. Time-lapse systems for embryo incubation and assessment

Background

Traditionally, assessment of embryo quality has been achieved by removing embryos from a conventional incubator daily for evaluation by an embryologist under a light microscope. Recently, time-lapse systems (TLS) have been developed which can take digital images of embryos at frequent time intervals. This allows embryologists, with or without the assistance of computer algorithms, to assess the quality of the embryos without physically removing them from the incubator.

Policy

- Time lapse systems for embryo incubation and assessment are not funded within the local NHS

Rationale

Time-lapse systems were not included within the scope of NICE CG156.

According to the available evidence, there is considerable uncertainty regarding the likely benefit of using time lapse systems for Kent and Medway NHS ART patients.

9. Adherence compounds in embryo transfer media for ART

Background

Adherence compounds such as hyaluronic acid (HA) and fibrin sealant have recently been introduced into subfertility management with the aim of increasing the success rate of assisted reproductive technologies (ART). Adherence compounds are added to the embryo transfer medium to increase the likelihood of embryo implantation, with the potential for higher clinical pregnancy and live birth rates.

Policy

- Adherence compounds in embryo transfer media for assisted reproductive technologies are not funded within the local NHS

Rationale

Adherence compounds were not included within the scope of NICE CG156.

According to the available evidence, an increase in live birth rates was not observed where a single embryo transfer strategy was used or in patients with good prognosis, suggesting the benefits to Kent and Medway NHS patients may be limited considering:

- In Kent and Medway, eligibility criteria are in place for access to ART to ensure resources are focused on patients most likely to benefit from treatment i.e. those with a good prognosis.
- The Human Fertilisation and Embryology Authority (HFEA) have implemented a national strategy to reduce the number of multiple pregnancies by promoting the use of single embryo transfer; this is supported by recommendations in NICE CG 156.

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- SE CSU Health Policy Support Unit (2015) *Assisted reproductive technologies – Final report*
- ART Impact Equality Analysis (2015)

Appendix A – Rationale for criteria for NHS funding of ARTs

Criteria		Rationale and comments
Duration of sub-fertility	<p>Funding will be available for couples with unexplained infertility, mild endometriosis or mild male factor infertility⁵ who have been having regular unprotected sexual intercourse and attempting to conceive for at least 24 months.</p> <p>Where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, patients can be referred directly for IVF treatment, with or without ICSI.</p>	<p>NICE Clinical Guideline 156 (CG156) recommends couples with unexplained infertility try to conceive for a total of two years, before IVF with or without ICSI is considered. There is good evidence that waiting for three years will not be beneficial to the vast majority of patients who have not conceived after two years. In addition, waiting a third year may reduce the success rates for couples who go on to have IVF because the chance of a live birth following IVF treatment falls with rising female age.</p>
Age of woman	<p>Funding is available where the woman is aged under 40 years. Women must start medication with the ART provider before their 40th birthday; women must only be referred to fertility clinics if there is adequate time to complete work up.</p> <p>If the woman reaches the age of 40 during treatment, the current full cycle will be completed but no further full cycles will be available. A full cycle of IVF treatment, with or without ICSI, should comprise one episode of ovarian stimulation and the transfer of resultant fresh and frozen embryo(s), in line with the relevant policy.</p>	<p>NICE CG156 concludes that treatment with IVF is cost effective for women aged under 39 years. There is considerable uncertainty about whether IVF is cost effective in any sub-groups of women aged between 40 and 42. The clinical and health economic evidence is overwhelming in indicating that IVF should not be offered to women aged 43 years or older. Analysis of local data confirms that IVF is less cost effective for couples where the woman is aged between 40 and 42 than those aged 39 and under.</p> <p>Referring clinicians must ensure 39 year old patients have adequate time to complete work up in order to start medication with the ART provider before their 40th birthday.</p> <p>Cryopreservation of supernumary embryos is funded for a period of two years for all eligible patients. During this period, women who turn 40 can complete their current full cycle; depending on previous treatment and the embryos available, this may be up to three frozen embryo transfers.</p>
Previous cycles	<p>Couples will <i>not</i> be funded if either partner has already had three previous fresh cycles of IVF, with or without ICSI, irrespective of how these were funded.</p> <p>This means that eligible couples will be funded:</p> <ul style="list-style-type: none"> Two fresh cycles of IVF, with or without ICSI, if no previous fresh cycles have been funded by the NHS, or if they have already received one non-NHS funded fresh cycle One fresh cycle of IVF, with or without ICSI, if the couple 	<p>NICE CG156 states that there is an inverse relationship between IVF success and the number of prior unsuccessful attempts. A maximum of three NHS funded IVF cycles is recommended by NICE CG156. There is a reduced likelihood of a live birth for the 4th cycle for women who have had previous IVF cycles.</p> <p>NICE CG156 recommends that if an egg collection procedure is undertaken, this should count as a full cycle and one of those that is offered on the NHS.</p>

⁵ Two or more semen analyses have one or more variables below the 5th centile

Criteria		Rationale and comments
	<p>has already received one NHS funded fresh cycle or two non-NHS funded fresh cycles</p> <p>Overall, eligible couples will be funded for a maximum of four embryo transfers (including no more than two transfers from fresh IVF cycles), in line with the relevant policy.</p> <p>An abandoned IVF cycle is one where an egg collection procedure has not been undertaken. Once egg collection has commenced, this is considered a complete cycle and will count towards one of the couples' NHS funded and 'previous' cycles.</p>	
Body mass index of woman	Women must have a body mass index (BMI) within the range 19-30 kg/m ²	<p>NICE CG156 states that low body weight is recognised as an important cause of hypo-oestrogenic amenorrhoea. In women, weight loss of over 15% of ideal body weight is associated with menstrual dysfunction and secondary amenorrhoea when over 30% of body fat is lost. Restoration of body weight may help to resume ovulation and restore fertility.</p> <p>Women with BMI over 30 kg/m² take longer to conceive, compared with women with lower BMI, even after adjusting for other factors such as menstrual irregularity. For infertile anovulatory women with a BMI of over 29 kg/m², there is evidence that a supervised weight loss programme or a group programme including exercise, dietary advice and support helps to reduce weight, resume ovulation and improve pregnancy rates.</p>
Smoking	Couples will <i>not</i> be funded if either partner smokes tobacco	<p>NICE CG156 states that smoking is likely to reduce women's fertility. In addition, maternal and paternal smoking can adversely affect the success rates of assisted reproduction procedures, including IVF.</p> <p>There is insufficient evidence currently to suggest nicotine replacement therapies or electronic cigarettes (e-cigarettes) have a negative effect on fertility or the outcome of ART and therefore patients who use them should not be excluded from NHS funded treatment.</p>
Ovarian reserve	Women should have an AMH of more than 5.4 pmol/l	NICE CG156 states that ovarian reserve is effective in predicting response to IVF. The anti-Müllerian hormone (AMH) test has significantly less inter- and intra-menstrual cycle variability compared with follicle-stimulating hormone (FSH) testing. Also, AMH can be measured at any point during the menstrual cycle.
Previous children	Neither partner in a couple should have a living child from their relationship or any previous relationship. A child adopted by the couple or adopted in a previous relationship is considered to have the same status as a biological child. 'Child' refers to a living son or daughter irrespective of their age or place of abode.	It is recognised nationally that NHS organisations need to focus their budgets on patients who have the most need and can obtain the maximum health gain. Local priority is therefore being given to those who are completely childless.

Criteria		Rationale and comments
Previous sterilisation	Funding will not be available if sub-fertility is the result of sterilisation ⁶ in either partner	Sterilisation is offered within the NHS as an irreversible method of contraception. Considerable time and expertise are expended in ensuring that individuals are made aware of this at the time of the procedure. CCGs consider it inappropriate that NHS funds are used in reversing these procedures.

⁶ Where patients have consented to sterilisation

Appendix B – Q&A on the interface between NHS and private ART treatment

Can patients use sperm, eggs or embryos obtained privately or obtained during private treatment in NHS funded cycles?

No. Department of Health (DH) guidance states: *patients should never be... allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.*

Can private patients access NHS funded drugs and/or tests?

No. DH guidance states: *The patient should bear the full costs of any private services. NHS resources should never be used to subsidise the use of private care.*

Can NHS patients pay for additional aspects of care not funded by the local NHS?

No. DH guidance states: *patients should never be... allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.*

Can patients who have undergone NHS-funded ART, pay for continued cryopreservation of any unused sperm, eggs or embryos for future self-funded treatment after the NHS funded storage period concludes?

Yes, because the NHS element of care and the private element of care can be delivered separately.

For more information see NHS Choices: <http://www.nhs.uk/chq/Pages/2572.aspx>

Health Overview and Scrutiny

Assessment of whether or not a proposal for the development of the health service or a variation in the provision of the health service is substantial

A brief outline of the proposal with reasons for the change

Commissioning Body and contact details:

NHS Medway CCG is the responsible commissioner on behalf of the eight CCGs in Kent and Medway

NHS Medway CCG, Fifty Pembroke Court, Pembroke, Chatham Maritime, Gillingham, Chatham ME4 4EL

Current/prospective Provider(s):

BMI Chelsfield Park, Orpington
CARE Fertility, Tunbridge Wells

Outline of proposal with reasons:

In line with many health economies across England, Kent and Medway CCGs are considering a range of difficult decisions to ensure that overall financial risks are minimized. CCGs have agreed to review the policies relating to Assistive Reproductive Therapies.

The review will focus on two aspects:

- Ensuring that the number of funded cycles is both affordable and reasonable. This may result in a reduction to the number of IVF cycles that are funded for eligible patients.
- Considering the funding of assisted conception treatments using donated genetic materials for all patient groups. A complainant highlighted that the current policy effectively excludes same sex couples access to NHS funded fertility treatment due to their requirement for donated materials.

Intended decision date and deadline for comments (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require the local authority to be notified of the date when it

is intended to make a decision as to whether to proceed with any proposal for a substantial service development or variation and the deadline for Overview and Scrutiny comments to be submitted. These dates should be published.

A decision relating to the proposed changes would be taken following the review and public engagement, prior to formal ratification by individual CCGs.

According to the proposed timeline, this would likely be in August or September 2018.

Please provide evidence that the proposal meets the Government's four tests for reconfigurations (introduced in the NHS Operating Framework 2010-2011):

Test 1 - Strong public and patient engagement

- (i) Have patients and the public been involved in planning and developing the proposal?
- (ii) List the groups and stakeholders that have been consulted
- (iii) Has there been engagement with Healthwatch?
- (iv) What has been the outcome of the consultation?
- (v) Weight given to patient, public and stakeholder views

- (i) Have patients and the public been involved in planning and developing the proposal?

At this juncture, the public have not been consulted on the proposals. The proposed review of ART services includes strong engagement with the public and with relevant patient groups, relating to the number of funded cycles of IVF.

In addition, whilst elements of the review relating to ART services using donated genetic material will be considered by the Kent and Medway Policy Review and Guideline Committee (PRGC), there will be engagement with stakeholders including patient groups such as Fertility Network UK and Stonewall as per the normal clinical policy review process.

- (ii) List the groups and stakeholders that have been consulted

Public engagement has yet to take place in relation to this proposal, however strong engagement with the public and stakeholders will form an essential part of the proposed review.

- (iii) Has there been engagement with Healthwatch?

Not at this stage, but Healthwatch Kent and Healthwatch Medway will be engaged throughout the process.

- (iv) What has been the outcome of the consultation?

N/A

(v) Weight given to patient, public and stakeholder views

Significant weight will be afforded to the feedback gained via the engagement process throughout the review.

Test 2 - Consistency with current and prospective need for patient choice

Notwithstanding impacts on the current provider landscape, patient choice will not be negatively impacted as a result of the proposed review. For some patient groups, such as those requiring use of donated genetic material, there is the potential for eligibility for NHS funded provision that is currently not supported by the existing schedule of policies for ART services.

Test 3 - A clear clinical evidence base

- (i) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?
- (ii) Will any groups be less well off?
- (iii) Will the proposal contribute to achievement of national and local priorities/targets?

- (i) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?

For groups of patients requiring the use of donated genetic material, there is the potential for clinical outcomes to be delivered by future ART services, where services and outcomes are currently not funded.

- (ii) Will any groups be less well off?

For other groups of eligible patients, there is the potential for clinical outcomes of NHS funded services to be negatively impacted should CCGs conclude that a reduction in the number of funded cycles of IVF is appropriate following the review process.

The Human Fertilisation and Embryology Authority (HEFA) publishes success the following information on their website, relating to success rates for IVF:

“The below percentages show the average chance of a birth after one, two, three and four cycles of IVF depending on your age. After four cycles, there are very small increases in the average chance of a birth across all ages. 85% of people have one or two cycles of IVF. Only 5% of people have more than three cycles.

Chances of a live birth – women under 40

One cycle – 32%
Two cycles – 49%
Three cycles – 58%
Four cycles – 63%”

As such, a reduction from two to one cycle of NHS-funded IVF services would reduce the likely chance of a birth from 49% to 32%. Further investigation of issues relating to this potential change will be reviewed by the Health Policy Support Unit (HPSU) throughout the review. Such issues will include the impact of additional stress that may be faced by eligible couples on knowing that there is only one NHS funded cycle of IVF available to them. These issues will be considered in the report that the HPSU provides to the Kent and Medway Policy Review and Guideline Committee.

(iii) Will the proposal contribute to achievement of national and local priorities/targets?

Depending on the outcome of the review, there is the potential for financial savings to be made by CCGs across Kent and Medway. In the wider context, this would support the achievement of local priorities and targets within the respective health economies across Kent as CCGs would be able to reinvest this funding into other priority areas of healthcare provision.

Test 4 - Evidence of support for proposals from clinical commissioners – please include commentary specifically on patient safety

CCGs across Kent and Medway will be reviewing the schedule of policies for ART services as outlined on page one. This decision has been taken after discussion between Chief Operating Officers, and ratified by respective governance procedures.

It is not anticipated that patient safety will be negatively affected as a result of the proposed review. ART service providers commissioned by CCGs would be required to provide services that meet the high levels of quality and patient safety that are currently demanded by CCGs.

Effect on access to services

- (a) The number of patients likely to be affected
- (b) Will a service be withdrawn from any patients?
- (c) Will new services be available to patients?
- (d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

(a) The number of patients likely to be affected

There are currently approximately 500 patients accessing NHS funded ART services across Kent and Medway, per annum. Modelling of potential impact

on patient numbers identifies that the number of patients that would be eligible for services, should the number of NHS funded cycles of IVF reduce from two to one, would reduce to approximately 215. As such it is estimated that approximately 285 patients would be affected by proposals to reduce the number of NHS funded cycles of IVF to one.

Numbers of patients that would be affected as a result of the introduction of the use of donated genetic material is harder to estimate and would depend on the scope of such interventions that would be included in the future schedule of policies.

Should ART services using donated eggs and sperm for all patient groups be included within the future schedule of policies, this is likely to affect approximately 190 patients across Kent and Medway, per annum. Should the future policy be by use of donated sperm only for all patient groups, this is likely to affect approximately 160 patients per annum across Kent and Medway.

If the future schedule of policies were to include the use of eggs and sperm for same sex couples only, it is estimated that this would affect approximately 90 patients per annum across Kent and Medway. If the future schedule of policies makes provision for NHS funded treatment for same sex couples using donated sperm only, it is estimated that approximately 60 patients would be affected across Kent and Medway per annum.

(b) Will a service be withdrawn from any patients?

The potential reduction of NHS funded cycles of IVF would mean that in future those patients that are not successful in achieving a birth as a result of their first cycle of IVF would no longer be eligible for a second cycle of IVF funded by the NHS.

(c) Will new services be available to patients?

The potential inclusion of ART services using donated genetic material would mean that there would be patient groups that are not currently eligible for NHS funded services that would be able to access funded provision in the future.

(d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

The potential outcome of the review would not necessitate a change in the way that patients access NHS funded Assistive Reproductive Technology services.

Demographic assumptions

- (a) What demographic projections have been taken into account in formulating the proposals?
- (b) What are the implications for future patient flows and catchment areas for the service?

Patient numbers outlined above are based on the current access rates of ART services across Kent and Medway. Given the relatively low numbers of eligible patients accessing NHS funded ART services, likely increases in the population of Kent and Medway would have a marginal impact on the numbers of patients that would be affected by the potential policy changes resulting from the outcome of the review.

The low number of patients accessing services would mean that there would not be a significant impact on patient flows and catchment areas. There are a number of patients accessing other ART services contained within the existing schedule of policies, such as Intra-uterine insemination (IUI) using partner sperm (for example patients who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem), who would continue to access services with no change.

Diversity Impact

Please set out details of your diversity impact assessment for the proposal and any action proposed to mitigate negative impact on any specific groups of people?

A diversity impact assessment will be undertaken by the HPSU throughout the review. This will be presented to the Policy Review and Guidance Committee for consideration prior to a decision being taken.

In light of the proposed changes, it is anticipated that that there will not be a detrimental impact on any particular patient group, and there may be a positive impact for eligible patients who are in same sex relationships.

Financial Sustainability

- (a) Will the change generate a significant increase or decrease in demand for a service?
- (b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)
- (c) What would be the impact of 'no change'?

- (a) Will the change generate a significant increase or decrease in demand for a service?

Commissioners do not wish to presuppose the outcome of the review process, which will have an impact on expenditure that is committed to ART

services.

Depending on the outcome of the review and the subsequent decisions that are made by CCGs, the proposals could provide financial savings or could increase the level of funding that CCGs commit to funding ART services.

- (b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)

The decision to review the number of cycles of NHS funded IVF treatment that eligible patients are offered is driven by financial implications. CCGs in Kent and Medway, as elsewhere in the country, are under significant financial pressures and difficult decisions relating to the relative prioritisation of health care interventions are required.

Elements of the review relating to the use of donated genetic material are not driven by financial implications, but instead are driven by issues relating to equity of access to NHS funded treatment for same sex couples.

- (c) What would be the impact of 'no change'?

The impact of 'no change', which is a potential outcome of the review process, would mean that NHS-funded ART services would be unaffected in the future. It would not provide any financial savings to CCGs and would mean that CCGs in Kent and Medway remain part of the 23% of CCGs offering two funded cycles of IVF treatment (with 63.4% offering zero or one funded cycle, and 13% offering three funded cycles). In addition, 'no change' would not address issues relating to equity of access to NHS funded Assistive Reproductive Technology services for same sex couples.

Wider Infrastructure

- (a) What infrastructure will be available to support the redesigned or reconfigured service?
- (b) Please comment on transport implications in the context of sustainability and access

Regardless of the outcome of the policy review process, It is not envisaged that additional infrastructure would be required to support future services, or that there would be implications relating to transport for patients.

Is there any other information you feel the Committee should consider?

No

Please state whether or not you consider this proposal to be substantial, thereby generating a statutory requirement to consult with Overview and Scrutiny

NHS Medway CCG does not consider the proposed changes to the schedule of policies for Assistive Reproductive Technology services to be a substantial variation in health services.

Item 9: Kent and Medway Integrated Urgent Care Service Programme
(Written Briefing)

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: Kent and Medway Integrated Urgent Care Service Programme
(Written Briefing)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway CCGs.

It is a written briefing only and no guests will be present to speak on this item.

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

1. Introduction

- (a) On 20 September 2017 the Committee was provided with an update regarding East Kent Out of Hours GP Services and NHS 111. As part of the Committee's deliberations, it agreed the following recommendation:
 - *the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.*
- (b) Adam Wickings, Senior Responsible Officer for the Kent and Medway Integrated Urgent Care Service Programme, will provide a verbal update to the Committee at its next meeting on 2 March 2018.

2. Recommendation

RECOMMENDED that the report be noted and Adam Wickings, Senior Responsible Officer for the Kent and Medway Integrated Urgent Care Service Programme, be invited to provide a verbal update to the Committee on 2 March 2018.

Background Documents

Kent County Council (2017) '*Health Overview and Scrutiny Committee (20/09/2017)*',
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4>

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Report to Kent Health Overview and Scrutiny Committee
Kent and Medway Integrated Urgent Care Service programme
Written briefing for the meeting on 26 January 2018

From Adam Wickings, Chief Operating Officer, West Kent CCG, on behalf of all Kent and Medway CCGs

Background

The Kent Health Overview and Scrutiny Committee (HOSC) received a number of reports about various aspects of integrated urgent care during 2017 and asked for an update in January 2018.

The previous reports included the 'Case for Change' from NHS Swale CCG and NHS Dartford Gravesham and Swanley CCGs about their urgent care programme in July 2017. This included the local face-to-face urgent treatment services and the telephony (NHS 111 and clinical assessment service).

NHS West Kent CCG described their urgent care services in their report in September. The east Kent CCGs joined into the programme for the telephony services and this was verbally reported to the September HOSC meeting and included within the report on East Kent OOH and NHS 111 in November HOSC.

The CCGs are jointly procuring an integrated urgent care service (IUCS) in line with the national specification. A considerable amount of engagement with the public about the planning for an IUCS has been taken in local health economies across Kent and Medway: a report of this can be provided on request.

This briefing is to update members on the IUCS across Kent and Medway.

Service overview

The IUCS combines access to urgent care via telephone through NHS 111, and ultimately through on line access. It will include a clinical assessment service (CAS) with a range of clinicians – including GPs, nurses and pharmacists.

Alongside the telephony element are the face-to-face urgent treatment services to provide out of hours primary care, walk in and minor injuries services as previously described by the CCGs.

There will be joint clinical governance arrangements across the services and an active collaboration with the developing GP cluster/federations and the more specialist providers such as mental health.

The service overall will cover all nine elements of the national IUCS specification:

<https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf>

The face-to-face element will also meet the national Urgent Treatment Centre specification:

<https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf>

Procurement process

The CCGs are working together to procure the service. A programme board has been established, including clinical leads, CCG executive leads and Healthwatch colleagues. This board is steering the procurement programme, with the decision making remaining with individual CCG governing bodies.

The intention is to procure the telephony (111 and CAS) across the whole of Kent and Medway as one lot.

The north Kent CCGs and Medway will also be procuring their face-to-face services, as described in the case for change last July, jointly with Medway CCG as Lot 2 within the same procurement. East and west Kent CCGs are not procuring the face-to-face services as they already have providers within contract.

Telephony Services	<p style="text-align: center;"><u>LOT 1</u></p> <p style="text-align: center;"><u>KENT & MEDWAY CCGs:</u></p> <p style="text-align: center;">NHS 111 / ICAS – Commencing 1 April 2019</p>		
Face-to-Face Services	<p style="text-align: center;"><u>LOT 2</u></p> <p style="text-align: center;"><u>KENT & MEDWAY CCGs:</u></p>		
	<p style="text-align: center;"><u>DGS CCG:</u></p>	<p style="text-align: center;"><u>SWALE CCG:</u></p>	<p style="text-align: center;"><u>MEDWAY CCG:</u></p>
	<p style="text-align: center;">Urgent Treatment Centre at Gravesham Community Hospital</p>	<p style="text-align: center;">Two Urgent Treatment Centres (+ mobile facility) at Sheppey Memorial Hospital and Sheppey Community Hospital</p>	<p style="text-align: center;">Urgent Treatment Centre at MFT</p>
	<p style="text-align: center;">GP-led-out-of-hours (base site and home visits)</p>		
	<p style="text-align: center;">Phased mobilisation:</p> <p style="text-align: center;">GP-led OOH – 1 April 2019</p> <p style="text-align: center;">UTC – 1 July 2019</p>		<p style="text-align: center;">Commencing</p> <p style="text-align: center;">1 April 2019</p>

Existing contracts for the relevant services are coming to an end in March 2019 and therefore the procurement is on a timeline to start the redesigned services by 1 April 2019, with a phased implementation for the urgent treatment centres in Dartford, Gravesham and Swanley and in Swale.

Benefits of the integrated service model:

The IUCS will simplify the system for patients. It will provide greater access to clinical advice, will allow direct booking for face-to-face appointments where required – in urgent treatment centre or with out of hours GPs and will reduce the duplication and transfers between different parts of the system.

The combination of procuring a telephony provider (including clinical assessment) across the whole area, and having the local face-to-face services embedded within each community are significant:

- Economy of scale for telephony & CAS
- Local integration for face-to-face services – front door of Emergency Departments (where possible), linking GP out of hours services and Urgent Treatment Centres, enabling booked and walk in urgent care

- Able to work closely with developing primary care organisations
- Collaboration between providers through integrated governance
- Opportunities for formal provider partnerships and/or bids for several lots.

There are challenges, not least the workforce and digital infrastructure to support the model. The potential providers will be asked to provide innovative solutions to the challenges and to demonstrate how they will respond to local needs.

Timescale and next steps

The specifications for the two lots have been developed over recent months with a wide range of engagement on the model with clinicians, local providers, patients and public. The specifications follow closely the national requirements for integrated urgent care and for Urgent Treatment Centres with the emphasis on relationships and collaboration between the different parts of the system. The CCGs are currently working through the approval process with the intention of initiating the procurement process in mid-February 2017.

The expectation is for evaluation of the providers and approval of preferred bidders by August to allow for almost eight months of mobilisation prior to going live April 2019.

Healthwatch, clinicians and the relevant specialists are working with the commissioners on the evaluation criteria and participating in the evaluation process.

Once the preferred bidder is identified and the contract awarded, a detailed mobilisation plan will be agreed and implemented, working with a wide range of partners in the system.

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Item 10: Kent and Medway Emergency Care Performance (Written Briefing)

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: Kent and Medway Emergency Care Performance (Written Briefing)

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

It is a written briefing only and no guests will be present to speak on this item.

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

1. Introduction

(a) On 24 November 2017 the Committee considered an item on the NHS preparations for winter in Kent 2017/18. The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and NHS England be requested to provide an update about the performance of the winter plans to the Committee at its June meeting.*

(b) In advance of the June meeting, the Kent CCGs have been requested to provide an interim update about emergency care performance over the Christmas and New Year period for this meeting. The CCGs have provided the attached reports to be shared with the Committee:

Emergency Care Performance in East & West Kent	pages 115 - 118
Emergency Care Performance in North Kent	pages 119 - 124
Kent 999 and 111 Performance	pages 125 - 126

(c) If Members have any specific questions on these reports and require a response, please contact the Scrutiny Research Officer before or after the meeting.

2. Recommendation

RECOMMENDED that the report on emergency care performance over the Christmas and New Year period be noted and the NHS be requested to provide a review of the 2017/18 winter plans and performance to the Committee at its June meeting.

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (24/11/2017)'*,

<https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7533&Ver=4>

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Health Overview and Scrutiny Committee Briefing

Kent and Medway emergency care performance in east and west Kent

January 2018

Background

This paper provides members of the Kent County Council Health Overview and Scrutiny Committee (HOSC) with an overview of emergency care systems in east and west Kent, including performance over the Christmas and New Year period.

It provides information on the actions taken by the system to support the pressures experienced by acute hospitals to ensure the safe and timely care of patients in the local area over the challenging winter months.

It also provides an update on SECamb 111 and OOH performance.

East Kent Local A&E Delivery Board

Emergency care whole-system improvement plan

The NHS in east Kent is committed to improving the A&E 4 hour performance standard (the waiting time for patients to be seen, treated and admitted to a hospital bed or discharged).

The NHS in east Kent is delivering a whole system emergency care improvement plan which was launched on 26 September 2017, which focuses on:

- Admission avoidance – increasing access to appropriate support in primary and community care so that patients attend A&E only when emergency treatment is necessary
- Decongesting the emergency departments to improve patient experience and make it easier for patients to be seen and treated
- Improving patient flow within and out of our hospitals. (Our clinical teams are exchanging learning and good practice from each other as part of a 12-week, rapid improvement programme, to kick start improved flow throughout the hospital)
- Recruiting substantively and increasing our workforce, including extending services like access to therapists and a 7-day cardiac catheter laboratory
- Communicating to the public appropriate alternatives to A&E and prevention.

Funding to increase capacity

East Kent's NHS has been successful in a bid for money from NHS England to increase capacity over the whole health system for this winter.

East Kent has been allocated £1.9m, to buy more packages of care for patients who are living with dementia or who have challenging behaviour; more beds in the community for non-weight bearing patients; additional hospice beds for fast track end-of-life patients; and additional health and social care beds for patients who have been in a hospital bed unnecessarily for more than seven days.

Update on performance

East Kent saw an improvement in its performance for patients admitted, transferred or discharged within four hours in October (75.35 per cent) and November (79.9 per cent). Demand during the latter part of December, especially among older patients with complex conditions affected this performance with a reduction to 73.6 per cent for the month.

This performance for December reflects demand and increasing acuity of patients, which is being felt across the whole country. While patients are being cared for safely, congested emergency departments designed to care for half the number of patients they are seeing at peak times, do not provide a good experience for patients and need to be expanded and modernised.

East Kent's clinical strategy includes capital investment to provide modern and more spacious emergency care facilities. The strategy will deliver more local care options, manageable rotas, co-location of specialist services and teams and certainly for staff, making east Kent a more attractive place to work.

West Kent Local A&E Delivery Board

Whole system improvement plan

The NHS in West Kent is committed to improving the A&E 4 hour performance standard (the waiting time for patients to be seen, treated and admitted to a hospital bed or discharged). The West Kent LA&EDB is collectively responsible for delivering whole system urgent and emergency care improvements with support from both NHS England and Improvement, with a focus on:

- Admission avoidance; Home Treatment Service – increasing access to appropriate support in primary and community care so that patients only attend A&E or Emergency Departments (ED) when emergency treatment is necessary
- Working with NHS experts ECIS and 2020 to analysis the flow and improve the EDs, enhancing patient experience by providing efficient and effective care in a timely manner
- Improving patient flow through and out of our hospital. Working with the Home First Board to improve the discharge process by assessing and supporting a greater cohort of patients in their own homes

Development of the Home First Pathway 3, for those patients whose care and treatment can be delivered outside of the acute hospital, for example in a care home. This has allowed us to **deliver** greater bed capacity in MTW

- MTW Focus on Stranded (length of stay >7days) and Super Stranded patients (length of stay >21 days) and understand where inefficiency exist in the current process, reducing length of stay and Delayed Transfers of Care (DTOC) and effectively increasing bed capacity.

Funding to increase capacity

West Kent LA&EDB has been successful in a bid for money from NHS England to increase capacity and develop a number of schemes which have supported the whole health system over the winter period. This collaborative work has resulted in a reduction of the number of Delayed Transfers of Care (DToc) (December 3.8 per cent), but we still have significant opportunities to further improve the both the health and social care systems

West Kent has been allocated £1.2m, to provide financial support to a number of schemes promoting effective and efficient discharge; Pathway 1 assessment in a patient's own home and a short period of additional support while the patients regain independence. Pathway 3; longer term rehab and care in a non-acute hospitals setting. Increased capacity in the Home Treatment service and providing a hospital at home service in West Kent, linking with MTW to maximise the Ambulatory care approach to care.

Update on performance

In January, NHS England published the December 4 hour waiting time figures for all Trusts. Maidstone and Tunbridge Wells NHS Trust is continuing to slowly improve, with 84.8 per cent of patients admitted, transferred or discharged within four hours overall, compared with 85.1 per cent nationally. This does not reflect the significant operational pressures experienced on a number of days particular after the Christmas and New Year bank holidays. Both social and health care staff have worked tirelessly to maintain quality of care to all patients in challenging environments.

During December we have seen an increase in the acuity of patients (particular those with respiratory presentations and complications) coming into the A&E departments, along with increased high levels of demand being felt across the whole country.

Ambulance handovers delays have on the whole been well controlled in West Kent, we have worked closely with SECAmb to identify any period when delays have increased and we used additional resources and clinicians to help assess and handover patients in a timely safe manner.

SECAmb 999 and 111

SECAmb 999 and 111 approached the winter period using their normal demand planning methodology, with additional focus on specific days during the Christmas and New Year period.

Covering key shifts both operationally and in the control room, as well as in the 111-call centre, was a priority to ensure that sufficient resourcing levels were in place to meet planned demand.

Whilst demand was expected to increase over the festive period, the SECamb 999 service, experienced an increased level of sustained demand over the 26 and 27 December as well as the 1 and 2 January in its 999 service.

During other challenging days, notably the 24 and 25 December as well as New Year's Eve, the Trust successfully managed its responsiveness to patients. Senior Management and Executive support was maintained throughout this period on 24/7 basis.

During the week following New Year, performance targets started to be achieved but as SECamb entered the second week of January, performance once again has proven challenging. SECamb 999 missed its C1 & C2 and call answering targets during this period and for the month of December, although performance on the highest priority calls was above national average for December.

Handover delays at the hospitals also contributed to the pressure placed on the 999 service with 3,200 operational ambulance hours lost to delays during the 10-day festive period. The 999 service, despite the pressures, conveyed to hospital approx. 5 per cent fewer patients than the same period last year.

The KMSS 111 service also experienced a significant increase in the number of calls that it was receiving during this period, reaching 9,000 calls on the 23 and 24 December, which was a record number when the predicted demand was circa 6,000 calls.

Despite this demand and during the period of escalation, the 111 service continued to act as a gateway for patients and maintained a high level of clinical quality to support the most vulnerable patients.

SECamb's 999 and 111 services worked collaboratively in response to the increased demand and escalation, as well as working alongside other system partners, to ensure that patients were supported during this operationally challenging time.

In addition to this the 111 service maintained and at times increased its number of Clinical Coach floor-walkers, which proved invaluable in reviewing non-emergency ambulance dispositions, as well as ensuring that suitable patients were signposted to appropriate pathways e.g. Walk in Centres, Minor Injury Units, and Urgent Care Centres.

The 111 service did suffer the 'knock-on' effects of an 'Out of Hours' and Primary Care service equally in escalation, but despite this, the clinical performance of 111 was exceptionally strong with a clear focus on patient care and protecting the wider healthcare system throughout this period.

Briefing to Kent County Council HOSC Friday 26 January 2018

Subject: NHS Dartford, Gravesham, and Swanley (DGS) and Swale Clinical Commissioning Groups - Update on emergency and urgent care during the Christmas and New Year period 2017/18, actions taken to support the system and current performance

Date: Report compiled 10 January 2018

Introduction:

This paper provides members of the Kent County Council Health Overview and Scrutiny Committee (HOSC) with an overview of the North Kent urgent and emergency care system over the Christmas and New Year period. It also provides information on the actions taken by the system to support the pressures experienced by Medway Maritime Hospital (managed by Medway NHS Foundation Trust (MFT)) and Darent Valley Hospital (managed by Dartford and Gravesham NHS Trust (DGT)) to ensure the safe and timely care of patients in the local area over the challenging winter months.

Background:

Although reporting to separate Local A&E Delivery Boards (AEDBs), a number of providers for both DGS and Swale CCGs are the same, while Swale also share some providers with Medway CCG, therefore a North Kent approach is taken for managing winter pressure and surge.

During 2017, DGS and Swale CCGs with colleagues from Medway CCG worked with their partner organisations across the health and social care sector to prepare for the challenges of the winter months.

Using both local expertise and the lessons learned from the North Kent system in previous years, robust plans were developed, refined, tested and implemented to provide the necessary assurances while strengthening partner relationships and developing a mutual understanding of the pressures across the system.

Since October, weekly conference calls have been held with providers across the North Kent urgent care system to provide insight and understanding of any pressures the system or individual organisations are experiencing and providing system support where necessary.

Using the NHS England/NHS Improvement Operational Pressures Escalation Levels (OPEL) Framework determines the escalation status for both the DGS and Medway and Swale systems.

During periods of escalation to OPEL 3, these whole system calls are held daily. These move to twice daily when the escalation status of the system is OPEL 4.

Between the periods of 1 November until 10 January, the DGS system has reported OPEL 4 status on one occasion for a period of 1 day on 2 January, the Medway and Swale system has reported OPEL 4 status on two occasions, 2-3 January and 6-9 January. The collaborative working across partner organisations is demonstrated by the swift de-escalation of the system.

Performance and challenges faced for each provider:

1. DGT and MFT A&E performance against waiting time standard

Planning trajectories were agreed for delivery of the A&E standard with CCGs and Acute hospitals at the start of the year against the national standard of 95%, however the expectation is that all AEDB systems should maintain 90% across winter

The agreed local targets and performance against the targets by each local AEDB system can be seen below:

Darent Valley Hospital (DVH) and MIU:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 Plan	89.0%	89.5%	90.0%	90.0%	90.0%	92.7%	90.0%	90.4%	90.0%	80.0%	85.0%	95.0%
Performance	86.4%	85.3%	90.7%	93.3%	91.2%	93.4%	90.0%	90.9%	84.2%			

Medway Foundation Trust (MFT) and MIU (from October):

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 Plan	89.0%	89.5%	90.0%	90.5%	92.5%	92.0%	93.0%	93.5%	94.0%	94.0%	94.0%	95.0%
Performance	80.8%	87.7%	91.1%	88.5%	87.7%	83.8%	87.9%	90.5%	83.5%			

In DVH, the locally agreed target was consistently achieved until December.

While in MFT, the local target has only been met once, in July – demonstrating the challenges across this system.

Higher levels of activity and acuity across the whole of Kent and Medway have been reported during December (substantiated by South Coast Kent Ambulance Trust) with DVH and MFT being no exception to this.

Tables 1 and 2 below show the daily 4 hour performance/attendances for the past month

Table 1: DGT Daily 4 hour performance / attendances

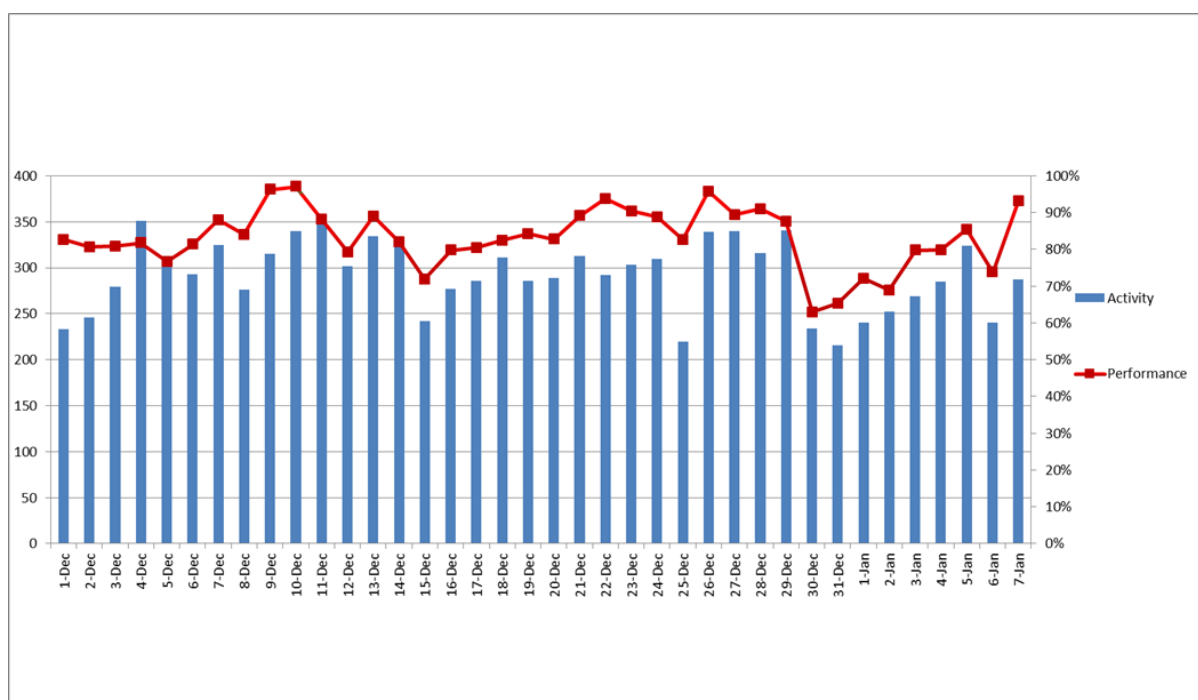
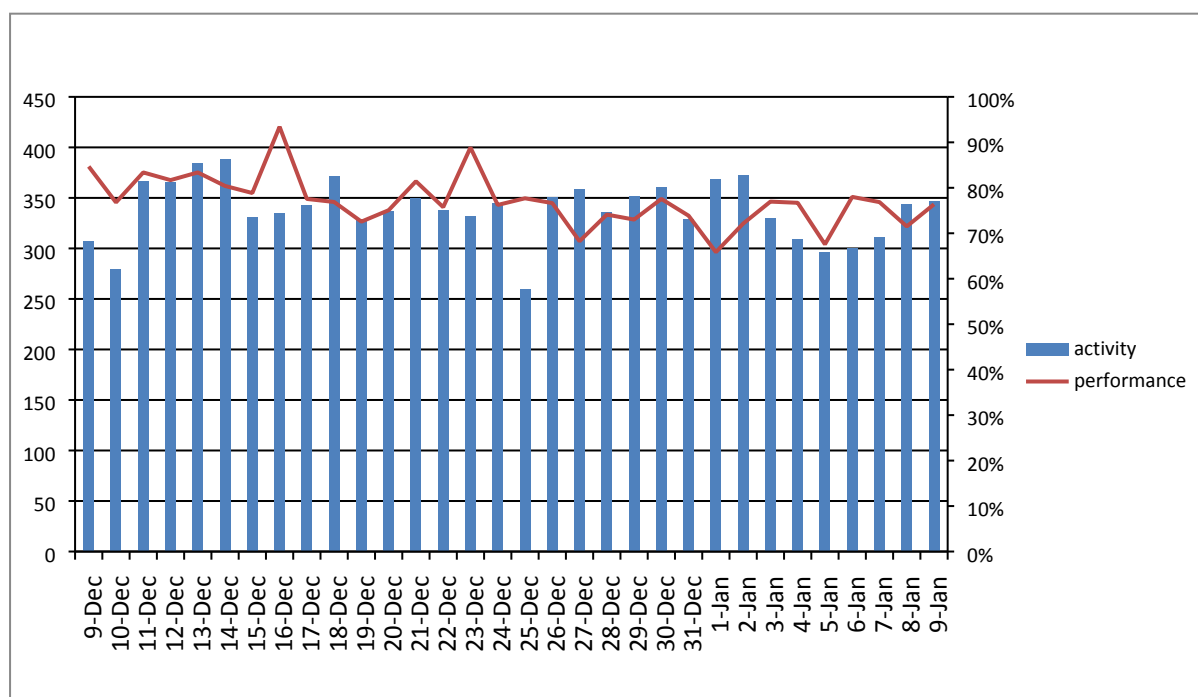


Table 2: MFT Daily 4 hour performance/attendances



The nationally mandated streaming of appropriate patients to a GP service based in the emergency department (ED) was successfully introduced in both DVH and MFT in October, with around 50% of patients seen by the GP service as opposed to ED.

In mid-December the government announced the opportunity to bid for winter monies for systems to implement schemes to support the system during the winter period.

The DGS system submitted a bid of £1.3million, the Medway and Swale system submitted initiatives totalling £1.1million. Both bids were successful and all initiatives have either been implemented or are on track to be implemented (some schemes require more lead in time than others and most are staffing resource dependent).

2. NHS 111/Out of Hours (OOH) – IC24 DGS / MedOCC Swale

IC24 (DGS) /MedOCC (Swale) - As part of the winter funding bid OOH services were funded for additional capacity to support the system, providing cover for home visits for the frail elderly to help management in their own home, avoiding unnecessary ED attendances and admissions. A report on NHS 111 and SECamb performance is attached as an appendix.

3. South East Coast Ambulance (SECamb)

Focussed work between SECamb and the acute trusts was undertaken throughout the summer to improve on ambulance handover delays, reducing the potential negative impact on patient safety and experience.

This has resulted in a notable reduction in delays. In addition, SECamb implemented the mandated national Ambulance Response Programme on 22nd November, altering their process around the screening of calls and response times.

After the New Year period, a surge in activity has been experienced by SECamb, putting SECamb at the higher level of their Demand Management Plan. An alternative number to 999 was issued to GPs to call for those patients where there is no immediate threat to life (i.e. when it is not for example a cardiac arrest, stroke, heart attack), to prevent delays in responding to calls for those who may be experiencing a life threatening emergency.

A report on NHS 111 and SECamb performance is attached as an appendix.

4. Community and Local Authority Providers

Virgin Care (for DGS and Swale), Medway Community Healthcare (for Medway/Swale), Kent County Council (for DGS and Swale):

As providers of ongoing community/social care support and beds for patients no longer requiring acute level care, these providers have been working closely with the acute trusts to support timely discharges of medically optimised patients. The providers are supporting both acute trusts to identify patients to discharge with support at home or step down into a community bed. The three providers have flexed their admission criteria to accept a wider range of patients to accommodate, for example those that may be waiting for a more complex package of care.

Assessments for longer term needs and continuing healthcare funding are also being undertaken in the community as opposed to in an acute hospital bed.

NB. In addition to KCC, Medway Council is also part of the Medway/Swale system.

5. Minor Injury Units (MIUs), Walk in Centres (WiCs), Primary Care

Kent Community Health NHS Foundation Trust (DGS and Swale MIUs), Fleet Healthcare (DGS WiC), Dulwich Medical Centre (Swale WiC), Primary Care

As part of the planning process and through winter funding, a number of GP practices extended their opening hours and capacity, offering appointments over the Bank Holiday weekend. The MIUs increased their staffing to manage predicted surges in activity during this period.

Efforts to provide and advertise alternatives to ED, particularly over the Bank Holiday periods, was a central focus. Communications supporting the national and local 'Choose Well' campaigns have been published on provider and CCG websites, in local newspapers, via social media i.e. Facebook and Twitter.

Unfortunately, utilisation proves variable, with the MIUs still seeing relatively low numbers of attendances and the WiCs' activity remaining fairly consistent, even when the emergency departments appear to be experiencing significant pressures.

In DGS, Kent Community Health NHS Foundation Trust provided vital system support during a local outbreak of meningitis in December. By providing staff and securing/delivering sufficient vaccines urgently for those who had come into contact with affected patients, they prevented further spread of the disease and averted significant numbers of critical admissions.

Work over the next 18 months will continue to develop the Urgent Treatment Centre models in both DGS and Swale (local plans around this were previously presented to the HOSC in July 2017).

Next steps: Mitigating plans for the remainder of winter 2017/18

Whilst the framework for managing the 2017-18 pressures was agreed with all partners, the systems are constantly reviewing and adapting their approaches and arrangements as required. Below are some of the local actions being taken in addition to those that were already agreed within the winter plan:

1.	Admissions Avoidance
	<ul style="list-style-type: none"> • Additional assurances sought from 111 and OOH providers around sufficient rota fill/clinical expertise, to support the system out of hours • Dedicated direct bleep numbers for senior clinicians for advice and guidance in both acute trusts • Use of NHSE primary care monies to provide additional out of hours/peak time capacity • Additional clinical support in EoC for 999 and in call centres for 111 • Review of 111 DoS to ensure mapped appropriately • Continued promotion of alternative services through websites, local media and social media • Proactive focus in primary care for management of long term condition patients
2.	Emergency Department
	<ul style="list-style-type: none"> • Older Adult consultants in EDs providing case identification, early intervention and alternative management strategies for elderly/frail patients to avoid admission where clinically appropriate • Other senior clinicians/medics in ED to support decision making • Additional Emergency Nurse Practitioners within ED facilitating flow, increasing nursing capacity, enhancing patient care and supporting junior staff • Social care in ED supporting patients with social needs to return home with appropriate support
3.	Internal Waits
	<ul style="list-style-type: none"> • Senior clinical support to facilitate discharges 7 days a week • Cancellation of elective care in hospitals line with national policy to free up bed capacity • Exec led Delayed Transfers of Care (DToCs) teleconferences held daily to discuss DToCs from the acute and community setting with actions taken to maximise potential capacity and support flow. These calls have resulted in a significant reduction in DToCs within the acute setting with MFT reducing from 38 for the same period last year to 4. DVH DToCs at this point last year were 18 and this has now reduced to 7 at the time of writing • Continuation of daily exec calls at weekends to identify and action any blockages preventing discharge • Discharge profiling of all providers to ensure proactive approach to discharge • Additional senior medical/MDT ward rounds in community hospitals to ensure all patients are reviewed and discharges optimised • Criteria for beds in the community flexed as far as appropriate • Buddying staffing arrangements in place across local authority and community health teams • Implementation and utilisation of additional NHSE winter funding to support additional capacity and patient flow • Trusted Assessor model in place to prevent delays with patients returning to care homes from a stay in an acute bed • Discharge to Assess models in place
4.	Operational Resilience
	<ul style="list-style-type: none"> • A timetable of system teleconferences have been scheduled with additional calls put in place as required/agreed. In addition the daily exec conference calls are held with all relevant partners to reduce DToCs • Additional STP CEO level daily K&M wide teleconferences implemented along with the STP

	<p>wide urgent care steering group to support system operability across the wider footprint</p> <ul style="list-style-type: none"> • Increased use and refinement of the SHREWD system that collects and shares information from provider partners to highlight pressures and opportunities within the system to prevent escalation and support rapid de-escalation • Additional resilience across the NK CCGs' Director on Call arrangements by doubling the resource available to support both systems out of hours
5.	External Waits
	<ul style="list-style-type: none"> • Additional work with relevant care homes to ensure patients are assessed in a more timely way and discharged in advance of the weekend • Continued assurances sought from local authority regarding availability of packages of care and enablement services • Additional communications with care agencies to ensure awareness of their role in system escalation, timely assessment and availability of service provision. • Local Authority escalation arrangements in place for purchasing off framework and funding approvals
6.	Communications and Engagement
	<ul style="list-style-type: none"> • Additional primary care communications undertaken (including elective care pause extension, clinical capacity made available through cancellation of elective care and therefore enhanced access to advice and guidance for GPs from the acute hospitals in support of avoiding GP urgent referrals • Appropriate navigation information on answerphones • A refresh of additional public facing communications undertaken

Appendix A

This appendix is an update on the performance of 111 and SECamb countywide. It is an appendix to Dartford, Gravesham and Swanley and Swale CCGs' report on emergency and urgent care during the Christmas and New Year period 2017/18.

SECamb 999 and 111 approached the winter period using their normal demand planning methodology, with additional focus on specific days during the Christmas and New Year period. Covering key shifts both operationally and in the control room, as well as in the 111-call centre, was a priority to ensure that sufficient resourcing levels were in place to meet planned demand.

Whilst demand was expected to increase over the Festive period, the SECamb 999 service, experienced an increased level of sustained demand over the 26th & 27th December as well as the 1st & 2nd January in its 999 service. During other challenging days, notably the 24th & 25th December as well as New Year's Eve, the Trust successfully managed its responsiveness to patients. Senior Management and Executive support was maintained throughout this period on 24/7 basis. During the week following New Year, performance targets started to be achieved but as SECamb entered the second week of January, performance once again has proven challenging. SECamb 999 missed its C1 & C2 and call answering targets during this period and for the month of December, although performance on the highest priority calls was above national average for December. Handover delays at the hospitals also contributed to the pressure placed on the 999 service with 3,200 operational ambulance hours lost to delays during the 10-day festive period. The 999 service, despite the pressures, conveyed to hospital approx. 5% fewer patients than the same period last year.

The KMSS 111 service also experienced a significant increase in the number of calls that it was receiving during this period, reaching 9000 calls on the 23rd and the 24th December, which was a record number when the predicted demand was c6000 calls. Despite this demand and during the period of escalation, the 111 service continued to act as a gateway for patients and maintained a high level of clinical quality to support the most vulnerable patients. SECamb's 999 and 111 services worked collaboratively in response to the increased demand and escalation, as well as working alongside other system partners, to ensure that patients were supported during this operationally challenging time. In addition to this the 111 service maintained and at times increased its number of Clinical Coach floor-walkers, which proved invaluable in reviewing non-emergency ambulance dispositions, as well as ensuring that suitable patients were signposted to appropriate pathways e.g. Walk in Centres, Minor Injury Units, and Urgent Care Centres. The 111 service did suffer the 'knock-on' effects of an 'Out of Hours' and Primary Care service equally in escalation, but despite this, the clinical performance of 111 was exceptionally strong with a clear focus on patient care and protecting the wider healthcare system throughout this period.

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By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 26 January 2018

Subject: SECamb Regional Scrutiny Sub-Group (Written Briefing)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided about the SECamb Regional Scrutiny Sub-Group.

It is a written briefing only and no guests will be present to speak on this item.

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

1. Introduction

- (a) The SECamb Regional Scrutiny Sub-Group was established in November 2016 to scrutinise South East Coast Ambulance Service NHS Foundation Trust's (SECamb) response to the findings of the recent Care Quality Commission (CQC) inspections and the Trust's wider recovery plan.
- (d) The sub-group is comprised of two representatives from each of the six health scrutiny committees in the South East: Brighton & Hove, East Sussex, Kent, Medway, Surrey and West Sussex. The Kent representatives are Mrs Chandler and Mr Angell.
- (e) The sub-group last met on 17 October 2017 and the notes from the meeting are attached in **Appendix 1**.
- (f) Following the publication of SECamb's performance figures in the Trust's October board papers, Cllr Bryan Turner, Chair of the HOSC SECamb Regional Scrutiny Sub-Group, wrote to the Trust's Chief Executive on behalf of the Sub-Group to express concern about the Trust's performance in relation to response times and call handling. The Sub-Group's letter is attached in **Appendix 2** and the Trust's response is attached in **Appendix 3**.
- (f) The next meeting of the Sub-Group is planned for February/March 2018. The Agenda and papers will be shared with the Committee in advance of the meeting to enable Members to have the opportunity to propose questions for the Kent representatives to ask.

2. Recommendation

RECOMMENDED that the notes of the SECamb Regional Scrutiny Sub-Group on 22 October 2017 be noted.

Appendix

Appendix 1 - SECAMB Regional Scrutiny Sub-Group Notes (22 October 2017)

Appendix 2 – Letter to SECAMB Chief Executive

Appendix 3 – Response from SECAMB Chief Executive

Background Documents

None

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A meeting of the South East Coast Ambulance Service (SECamb) NHS Foundation Trust – Regional HOSCs Sub-Group held at SECamb Headquarters, Crawley on Tuesday 17 October 2017

Present: Mr Bryan Turner (Chairman, West Sussex HASC); Cllr Ken Norman (Chairman, Brighton & Hove HOSC); Cllr Ann Norman (Member, Brighton & Hove HOSC); Cllr Mike Angell (Vice-Chair, Kent HOSC); Cllr David Mansfield (Member, Surrey Wellbeing and Health Scrutiny Board)

In Attendance: Daren Mochrie (Chief Executive, SECamb); Jon Amos (Acting Executive Director of Strategy and Business Development, SECamb); Mark Whitbread (Consultant Paramedic, SECamb); Claire Lee (Officer, East Sussex HOSC); Andrew Baird (Officer, Surrey WHSB); Nuala Friedman (Officer, Brighton & Hove); Lizzy Adam (Officer, Kent HOSC) and Helena Cox (Officer, West Sussex HASC)

Apologies: Cllr Colin Belsey (Chair, East Sussex HOSC); Cllr Ruth O’Keefe (Vice-Chair, East Sussex HOSC); Cllr Sue Chandler (Chair, Kent HOSC); Cllr Wendy Purdy (Chair, Medway HOSC); Cllr David Royle (Chair, Medway Children’s OSC); Dr James Walsh (Vice-Chairman, West Sussex HASC); Giles Rossington (Officer, Brighton & Hove HOSC) and Jon Pitt (Officer, Medway HOSC)

CQC re-inspection report key findings and Trust response

1. Daren Mochrie, highlighted to members the key themes from the recent Care Quality Commission (CQC) re-inspection report and feedback from the Quality Summit, which was held on 5 October. The Trust was disappointed with the overall rating but was pleased with the pockets of good and outstanding practise, particularly in relation to 111.

2. Two ‘Notice of Proposal’ had been issued to the Trust in relation to Medicines Management and 999 call recording, which had since been withdrawn due to significant improvements since the notice had been issued. In relation to 999 recording, there were issues with the telephony platform and this was on the Trusts risk register. Improvements had been made and the issues were now a small number. A paper would be presented to the Trust Board to seek approval to replace the telephony platform to resolve issues of technically finding calls and the static on the line. The Trust had brought in a member of staff to help with the issues and Mr Mochrie was confident that the Trust would have a grip on this. The replacement platform would be funded from money received as the Trust was in special measures. BT was also recording the line to trace any fall out calls. It was asked what the target would be in relation to numbers of calls recorded/completed. This would be between 95-100%.

3. The Trust had 17 ‘must-do’s’ set by the CQC. Eleven task and finish group (these built on the success of the medicines management task and finish group chaired by Mr Mochrie) had been set up and were chaired by a member of the executive leadership team, to monitor a comprehensive action plan and ensure rigour and grip in terms of improvement. Mr Mochrie’s presentation focused on an example of some of the ‘must-do’s’, which included:

- **Incident Reporting** – There was a need to improve incident reporting and reduce the current backlog. It was asked how many serious incidents the Trust reported each month, to which members were told that there was

about 400 incidents a month which were reported but around one a week was then considered to be a serious incident, so approximately 50 per year. Members were told of the good relationship which the Trust had with other blue light colleagues, although a vitally important relationship for the Trust was with other health colleagues in relation to serious incidents. Mr Mochrie expressed his wish to make the organisation more of a 'learning organisation', minimising mistakes and learning from those that did occur.

- **Safeguarding** – Members were informed that the Trust had not necessarily had the right resource in the key areas but there were some improvements and plans in place for all staff to complete level 3 safeguarding training.
- **Staffing in EOC** – Staffing in the control centre on 999 call handling was a challenge since we had moved to the new EOC. There is a robust plan in place to recruit new staff and plans to recruit a more multidisciplinary clinical workforce. Since the move to the new EOC we have implemented seamlessly a new command and control system. On 22 November, the national Emergency Response Programme (ERP) would be implemented at the Trust.
- **Improved ACQI – Heart Attack** – A strategy would be implemented across the Trust in relation to improving clinical outcomes for, in this example, heart attack patients. A new health informatics system would be in place by March 2018 which would provide more meaningful data and audit. Members were informed that the Trust had 70 Critical Care Consultant Paramedics who were targeted to patients who were really sick, with a critical care hub within the control centre. Members were informed that Mark Whitbread, a consultant paramedic, had been employed by the Trust to drive the strategy, embed it within the organisation and engage with staff.
- **Staff Engagement** – The Trust planned to design solutions from the bottom up and had held a number of local staff engagement sessions across the Trust. It was early days but there were signs of improvement, with a 200% increase in the response rate for the staff Friends and Family test. Feedback from the unions was also improving. Work would continue and the importance of the leadership team leading by example was emphasised.

4. Mr Mochrie emphasised that much more pace was needed on what was required to be done and the year would focus efforts on areas within the overall Trust strategy and the various different work streams to take the organisation forward. The Trust's project management office was wrapping around the task and finish groups to ensure evidence of improvement .

5. In terms of the Quality Summit and discussions with partners, Mr Mochrie highlighted the importance of handover delays at emergency departments across the Trust area and that this was something that needed to be addressed as a whole system and would have a significant impact on the performance of the Trust and patients. Members agreed that they would like to receive monthly performance/handover delay statistics to identify hotspot areas, which would allow HOSCs to ask the question of local health partners if required. Regarding the cleaning of vehicles once a patient had been handed to an acute trust, members were informed that it would be for the paramedics to decide whether they would need to visit a make ready system or not to be prepared for the next job.

6. SECAMB had not previously had a surge management plan, unlike the acute trusts and other ambulance trusts such as London, so was working with partners to put a surge plan in place before the winter. To address demand and handover delays system solutions were required in the community as well as emergency

departments as it was not a good use of paramedic time to be spending hours on scene trying to secure additional pathways or looking after patients in emergency departments awaiting handover. In terms of handover delays, it was asked where the area sat nationally. Members were informed that there were hospitals in the patch which were in the top 10 hospitals nationally for delays. Mr Mochrie explained that there was work underway with commissioners in regard to demand and capacity modelling to ascertain whether it had the right baseline funding to meet demand or whether additional investment in SECamb was required. Mr Mochrie's view is that by investing in the right ambulance model it could take pressure off other parts of the system. For example if SECamb transported 10% less patients to attending emergency departments this would have a significant benefit to the whole system but this model needed funded. Between now and January, the Trust would work with commissioners and an external company – Operational Research in Health (ORH) to undertake a demand and capacity review and there needed to be a conversation with all stakeholders on any potential models which would be planned for January 2018 onwards.

7. An enquiry was made as to what staff turnover levels were at the Trust. Members were informed that the turnover of advanced paramedics was high as they could receive higher paid rates working at acute trusts or in Primary care. This is why this needs included in the demand capacity modelling. It was also asked what impact there had been on the ambulance service in regard to Friday/Saturday call outs for issues related to the use of alcohol. Members were informed that with better data collection the Trust would be able to understand this more but like most ambulance Trusts alcohol related calls were significant during these times. There were additional issues regarding falls, in that there were not 24/7 fall prevention team support so an ambulance was called to lift patients, so more work was needed with local authorities and Careline and nursing homes to try and address the problem. Members agreed that receipt of SECamb on data regarding call outs to care homes/falls/alcohol/mental health would be incredibly useful and give councillors the opportunity to take issues forward. Mr Amos highlighted that the data was available at a high level and could be shared in order for the importance to be highlighted.

Professor Lewis report - key findings and Trust response

8. Mr Mochrie informed members that the Professor Lewis had identified issues of a culture of bullying and harassment at the Trust, which was disappointing but the Trust was taking appropriate action including individual investigations to address this. The Trust Board had agreed that the report should be made publically available as they did not wish to hide the findings contained in the report and want to encourage an open and honest culture. The Board would receive a further report at the end of the month regarding the strategy moving forward and continued efforts to strengthen staff engagement. An additional member of staff with an OD/cultural background had been employed to drive this work forward.

Quality Improvement Plan (QIP)

9. Mr Amos informed members that a revised QIP was to be presented to the Trust Board next week, with measures which could be tracked on a weekly/monthly basis and was much more focused on key performance indicators. There were challenges of balancing finances, quality and performance and the focus on a

demand and capacity review would assist this. It was agreed that the revised QIP would be presented to members at the next meeting of the sub group.

10. Members were informed that the Trust had not formally been notified whether NHSI would keep the Trust in special measures but believed this would not be reviewed until the Trusts re-inspection next year.

Performance and Clinical Outcomes

11. Members noted that a paper regarding performance and clinical outcomes was not attached so would be circulated separately. Challenges of staff turnover in the control room were discussed, these were due to multifactorial factors and were typical of overall system pressures regarding workforce. The impact of control room relocation to Crawley was starting to be seen regarding control room turnover although all call centres tended to have a high turnover of staff. A lot was being done regarding recruitment processes. All control centre staff were being trained on the national ambulance response programme. The impact of the temporary relocation of services from Kent & Canterbury Hospital was raised. Mr Amos informed Members that the Trust was working with East Kent CCGs who had agreed short-term funding to resource additional journeys; as a result, there had been no real impact on the Trust's performance. Focused work with NHS Improvement was being undertaken to reduce handover delays particularly at the Ashford site.

12. In terms of headlines, the capacity to answer calls in the control room was a core focus and the impact on Red 1/Red 2 response times, as was patient safety and wait times. The Trust was looking at those patients in the 'tail end' who wait longer than 8 or 9 minutes. From 22 November the national ambulance response programme would be adopted by the Trust and Red 1 and Red 2 calls would disappear and be replaced by new clinically led targets.

13. There was a new online system for appraisals and e-learning for staff across the Trust which allowed staff to access these when they are out and about. It was early days but there had been uplift in the numbers of staff completing training and feedback had been positive. Regarding quality, historical backlogs were being cleared with extra staff being brought in to help. Financially the Trust was to achieve £15m of efficiencies this year which was on track but there were pressures in other areas.

Ambulance Response Programme (ARP)

14. Mr Amos presented members with details of the new national Ambulance Response Programme (ARP). Currently the Trust had 60 seconds to answer a call and deploy a resource at which time the clock starts for an 8 minute response. There are a large number of patients within that cohort and doesn't differentiate well, with multiple resources being sent to one patient in order to hit targets. There are approximately 750,000 duplicate calls a year. The ARP was developed working with patients groups and changes the order in which questions are asked, using technology to identify the location of the caller. The time allowed prior to resource despatch has been extended to 4 minutes for calls other than cardiac arrest to ensure the right resource goes to the right patient. The national review saw no patient harm as a result of the changes and positive feedback had been received from staff, patients and stakeholders.

15. The four new categories were detailed as follows, with a response by an ambulance in the first instance, expected for the first two:

Category	Target Time	Example	Target
Category 1	7 minutes	Cardiac, life threatening	50% within target time
Category 2	18 minutes	Stroke, critical burns	50% within target time
Category 3	120 minutes	Late stages of labour, non-severe burns, diabetes	90% within target time
Category 4	180 minutes	D&V, infections	90% within target time

16. The longer terms challenges emerging from the ARP were that there would need to be a change to the mix of vehicles needed, as SECamb had a large number of cars at the moment. Ambulance Trusts would be monitored and the first set of data which would show the impact on SECamb would be available in January. Local issues in East Sussex regarding maternity provision were raised due to the target time of 120 minutes to reach women in the later stages of labour and that work would be needed to communicate rationale to the public. Uninjured falls were cited as a hidden group as patients could wait 3-5 hours for assistance. Staff in the control room will continually monitor and re-prioritise if necessary. It was asked how categories related to the out of hours service, the benefit of a new platform would make it easier to refer category 4 calls to the out of hours service with an automated referral system. It was agreed that the presentation slides would be shared with members after the meeting.

Surge Management Plan

17. Mr Amos informed members that discussions were currently ongoing with partners regarding a surge management plan for the Trust to ensure that there could be prioritisation and balance of risk. It was planned to share details with the sub group at the next meeting.

Cardiac survival to discharge data

18. Mark Whitbread, Consultant Paramedic, informed members that he had been employed by the Trust to ascertain how outcomes for those patients treated for cardiac arrest can be improved and shared data regarding analysis of cardiac arrest data over April – June 2017. Mr Whitbread explained the use of 'utstein' figures when considering cardiac arrest data so that figures across the country could be compared like for like. The higher survival rate figures relating to the Isle of Wight needed the caveat of the small numbers the data was based on. Data was being reviewed by the Trust Board on a monthly basis. However, the Trust was struggling to receive outcome data from some acute trusts across SECamb's area, especially St Peters, Chertsey, although there was no mandate for trusts to share this data. Six to twelve months of data was needed to breakdown to understand the geography and be under constant review.

19. The current cardiac arrest data for SECamb in 2016/17 was 22.2%, the Trust wished to raise this to between 30-40%, going above 40% would be extremely challenging. A rise of 1 or 2% was also quite hard.

20. Mr Whitbread had presented the Trust Board with a number of recommendations based on his work so far. One of these was related to public education and promote resuscitation and access to defibrillators. Calls are to be triaged correctly so that a response is despatched quickly and can reach a specialist centre when required. Members noted that there was only one specialist centre in Kent, with other options based at Brighton and St Georges, London. The recommendations were short, medium and long term. Members were informed that the Fire Brigade Union had called on their members to reject a proposal to be able to co-respond with the ambulance service.

21. Members discussed the location of defibrillators and agreed to speak to their local communities to ensure that defibrillator cabinets are not locked and available to be used quickly when needed.

Date of Next Meeting

22. It was agreed that the next meeting of the sub group would be held in late January/early February 2018. Claire Lee would liaise with the Trust on possible dates.

Members of the sub group were given a tour of the control room followed the conclusion of the meeting.

Mr Bryan Turner

Chairman
Health and Adult Social Care Select Committee

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website: www.westsussex.gov.uk

County Hall
West Street
Chichester
West Sussex
PO19 1RQ



15 November 2017

SENT BY EMAIL

Daren Mochrie
Chief Executive
South East Coast Ambulance Service
NHS Foundation Trust
Nexus House
4 Gatwick Road
Crawley
West Sussex
RH10 9BG

Dear Daren,

SECAMB Performance and HOSC support

I am writing on behalf of all the HOSC Chairs in the SECAMB area in light of the performance figures reported to the October Trust Board meeting. I am sure you will understand that we feel the need to place on record our significant concern about the performance levels reported, particularly in relation to response times and call handling which were very significantly below target. This level of performance was notable enough to be reported in the media and to generate questions and concerns locally.

As you know, we had some discussion on performance challenges at our recent regional HOSCs Sub-Group meeting, although the performance report itself had inadvertently been omitted from the papers. We noted the contributory factors you mentioned, particularly abstraction of EOC staff for training on the new CAD and Ambulance Response Programme (ARP), recruitment issues linked to the move of EOCs to Crawley and a focus on addressing the lengthier waits for red category calls, perhaps at some detriment to the 8 minute standard performance. We also noted the range of action the Trust is taking to improve and the planned transition to ARP standards from 22 November.

The HOSCs appreciate the extent of challenges facing SECAMB and welcome the new leadership you are bringing to addressing these. Committees wish to be constructive in our role as a 'critical friend' to the Trust and to support the achievement of the Trust's improvement plan. In order to undertake this role to best effect we would emphasise the importance of sharing performance data with us on a regular and timely basis which will enable HOSC Chairs and Members to provide a rounded and accurate picture in response to queries, as well as to raise questions with our local commissioners and providers where appropriate.

We discussed sharing data on handover delays with the HOSCs on a monthly basis, given the impact of these delays on overall Trust performance. The HOSCs would also like to request an interim update on overall performance in early December to tie in with the Trust's Board at the end of November.

We look forward to a more detailed discussion and a further performance report, to include early data based on ARP standards, at our next meeting to be arranged for early February.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'BYm', with a long horizontal flourish extending to the right.

Cllr Bryan Turner
Chair, West Sussex HASC
Chair, Regional SECAMB HOSCs' Sub-Group

Cc: Cllr Ken Norman, Chair, Brighton and Hove HOSC
Cc: Cllr Colin Belsey, Chair, East Sussex HOSC
Cc: Cllr Sue Chandler, Chair, Kent HOSC
Cc: Cllr Wendy Purdy, Chair, Medway HOSC
Cc: Cllr Ken Gulati, Chair, Surrey HOSC
Cc: Jon Amos, SECAMB Acting Director of Strategy and Business Development



Nexus House
Gatwick Road
Crawley
RH10 9BG

24th November 2017

www.secamb.nhs.uk

Dear Colleague

Thank you for the letter and the continued support of the HOSCs with our improvement journey. Please find attached the October data which will be presented to the November board meeting next week. As you note we have had significant challenges for a range of reasons, as discussed and summarised in your letter.

Whilst the overall October picture remains disappointing we have seen improvement in recent weeks, despite increasing pressure across the system. In particular, our call answer in 5 seconds for the last 3 weeks has been between 69-71%. Whilst there is more work to do to achieve the national target of 95% this marks a significant improvement compared to performance in recent months. This has in turn supported improvement in our response time performance metrics for the early part of November, with a 10% improvement in Red 1 response performance and 4% improvement in Red 2 response performance in the last 3 weeks as compared to October. It should however be noted that the Trust successfully transitioned to the new Ambulance Response Programme targets on the 22nd November so full month reporting won't be consistent again until December data, reported in January.

We have recently appointed a Programme Director to work with partners to improve hospital handover and formed a regional group, chaired by an acute Trust Chief Executive and supported by regulators, to drive improvement and share best practice. One of the early tasks of this group will be to review our data provision and develop information which can be regularly share with acute Trusts and stakeholders. As soon as this is available we will begin to share this with HOSCs on a regular basis. Finally, if you would like to discuss any aspect of this letter further please do not hesitate and contact Mr Jon Amos, Acting Director of Strategy and Business Development

Yours Sincerely

Daren J Mochrie, QAM

Chief Executive Officer

South East Coast Ambulance NHS Foundation Trust

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