HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 29th January, 2020

10.45 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 29th January, 2020, at 10.45 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Kay Goldsmith**

Telephone: **03000 416512**

Tea/coffee will be available 15 minutes before the start of the meeting

Membership

Conservative (11):	Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mrs L Game, Ms S Hamilton, Mr P W A Lake, Ms D Marsh, Mr K Pugh and Mr I Thomas
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor C Mackonochie, Councillor J Howes, Councillor M Rhodes and Councillor P Rolfe

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes from the meeting held on 16 December 2019 (Pages 1 - 6)

4. NHS North Kent CCGs - Urgent Care Review Programme - Dartford, Gravesham and Swanley CCG (Pages 7 - 228)

5. Wheelchair Services in Kent (Pages 229 - 252)

6. Procurement of Kent and Medway Neurodevelopmental Health Service for Adults (Pages 253 - 278)

7. Strategic Commissioner Update (Pages 279 - 338)

8. CCG Annual Assessment (Written Update) (Pages 339 - 354)

9. General Surgery reconfiguration at Maidstone and Tunbridge Wells NHS Trust (Pages 355 - 370)

10. Proposed changes at Moorfields Eye Hospital (written update) (Pages 371 - 388)

11. Work Programme (Pages 389 - 394)

12. Date of next programmed meeting – Thursday 5 March 2020 at 10am

EXEMPT ITEMS

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

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

21 January 2020

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 Monday, 16 December 2019.

PRESENT: Mr P Bartlett (Chairman), Mr A H T Bowles, Mr N J D Chard, Ms K Constantine, Mr D S Daley, Mrs L Game, Mr P W A Lake, Ms D Marsh, Mr K Pugh (Vice-Chairman), Mr I Thomas, Cllr J Howes, Cllr M Rhodes, Mr B J Sweetland and Mr A M Ridgers

ALSO PRESENT: Mr S Inett, Cllr R Diment and Cllr A Downing

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny) and Dr A Duggal (Deputy Director of Public Health)

UNRESTRICTED ITEMS

1. Membership
(Item 1)

The Clerk informed the Committee that Mrs Chandler was no longer a Member of the Committee.

2. Election of Chairman
(Item 3)

1) Mr Chard nominated Mr Bartlett. He was seconded by Mr Pugh. There were no further nominations.

2) RESOLVED that Mr Bartlett be elected Chair of HOSC.

3. Urgent item: Election of Vice-Chair
(Item 4)

1) As a result of Mr Bartlett being elected to the position of Chair, the Chair agreed that this urgent item be added to the Agenda.

2) Mr Bartlett nominated Mr Pugh. He was seconded by Mr Chard. There were no further nominations.

3) RESOLVED that Mr Pugh be elected Vice-Chair of HOSC.

4. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 5)

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

5. Minutes from the meeting held on 19 September 2019

(Item 6)

RESOLVED that the Committee agreed that the minutes from 19 September 2019 were correctly recorded, and that they be signed by the Chair.

6. North Kent CCGs - Urgent Care Review Programme - Dartford, Gravesham and Swanley CCG

(Item 7)

1) The Chair welcomed Cllr Downing and Cllr Diment from Bexley Council. They had been invited to attend and participate in the meeting because the Bexley health scrutiny committee had deemed the DGS CCG (Dartford, Gravesham and Swanley Clinical Commissioning Group) urgent care proposals to be a substantial variation of service for their residents. This would be the final opportunity to have their views taken into consideration in the CCG's Decision-Making Business Case.

2) Kent County Council's full Council would be considering an item at its meeting on 17 December 2019 on the establishment of a Kent and Bexley Joint Health Overview and Scrutiny Committee (JHOSC). The JHOSC would then consider the CCG Governing Body's decision in late January.

3) Dr MacDermott and Ms Adler introduced the item and provided a summary, making especial reference to the public consultation that had taken place. The CCG had received almost 16,500 responses to the survey, many of which were received in the final 72 hours.

4) The public consultation demonstrated a preference for option 1 (an Urgent Treatment Centre (UTC) at Gravesham Community Hospital). Option 2 was for a UTC at Darent Valley Hospital.

5) Consistent themes throughout the consultation related to ease of access, namely: proximity to site; amount of traffic; and parking availability. It was also clear that communication would be needed with whichever option was chosen, to ensure members of the public knew where to go with different medical needs.

6) Ms Adler explained that the next steps would be for the CCG Governing Body to consider the Decision-Making Business Case on 16 January 2020 and make their final decision (the exact timing would be confirmed and circulated to Members of the Committee). That decision would be communicated with the Bexley and Kent JHOSC in late January. There was a hope that the new urgent care model would be in place from July 2020.

7) Cllr Diment explained that Bexley's concerns were around the cross-boundary movement of patients as a result of any change to current services. If option 1 were implemented, he was concerned that residents in the east of the county would use the UTC at the Queen Mary's Hospital in Bexley, which was already very busy.

8) Ms Adler explained that the CCG had hoped to carry out some intensive work within the Bexley boundary in order to better understand how people access healthcare services and what the impact may be on Bexley services should a Kent service close or relocate. Unfortunately, it had not been possible to do that work before the end of the public consultation. The CCG were however carrying out survey work at Bexley health services on 16 and 17 December as well as in the new year. The information gathered would feed into the Decision-Making Business Case.

9) The CCG had analysed what had happened in the past when Darent Valley Hospital had been under pressure and there was no correlation with those patients travelling west to access Bexley services. Dr MacDermott stated that residents in West Kent tended to go south to the Sevenoaks Community Hospital.

10) In response to the question about patient flow, it was clarified that Medway Council had not deemed the changes to be a substantial variation of service for their residents. They were not therefore involved in the JHOSC arrangements for this issue.

11) Both options 1 and 2 would see the closure of the White Horse walk-in centre (at Fleet Health Campus). Dr Sewell explained that the contract had expired, and an interim 1-year contract was currently in place. That would expire in June 2020. There was no intention to close Fleet Health Campus. Other services were currently available at the site and would continue to be so.

12) Members questioned what would happen in the interim between the walk-in clinic closing and the new UTC model being implemented. Dr Sewell explained the walk-in centre could easily be relocated to Gravesham Community Hospital, and there was room within the Minor Injuries Unit there. There would however be additional patients at the Hospital. The challenge was for GPs to see more patients in order to reduce the demand on the walk-in centre.

13) Dr Sullivan, local member for Northfleet and Gravesend West, addressed the Committee. She felt that the walk-in centre had had a positive impact on the local community. She was concerned around access issues, especially when Northfleet became gridlocked, as it often did. The upcoming Ebbsfleet development would also see an increase in population, and additional health care services would be needed to meet their needs. She argued that the correct infrastructure must be in place before any changes were made. She reiterated the public preference for option 1 (as demonstrated in the public consultation).

14) Dr MacDermott agreed that access to healthcare services was vital. There were several workstreams underway, including the expansion of 111 services and expanding access to GPs. It was accepted that transport and accessibility were real issues. For example, in Gravesend Rural there were no bus connections to Gravesend on Sundays or Bank Holidays. The lack of accessibility was a wider issue and had to be addressed by many organisations.

15) Ms Adler explained that there been no final decision made yet in relation to the urgent care options, but that the preferred model would take into account all the information gathered during consultation exercises. The UTC model was recognised and supported by NHS England.

16) The Chairman thanked the guests for attending the Committee, and their work on the public consultation. He summarised the Committee's views for inclusion in the final Decision-Making Business Case document.

17) RESOLVED that the report be noted and asks that DGS CCG take the following views into account in their Decision-Making Business Case.

The Committee highlighted:

- concern around parking and public transport
- questions as to whether the solution would properly accommodate the rapid recent and future growth of Ebbsfleet and North Bexley
- concerns as to whether there were adequate staffing levels and provision of consultants at the proposed sites
- access to wider services at Darent Valley Hospital
- the need to retain walk in GP services
- the wider impact on both Erith and Queen Mary Hospitals in Bexley
- it had noted the preference for option 1 from the public consultation

7. Dermatology Services update
(Item 8)

1) Mr Jeffery began by highlighting four brief points:

a. DMC Healthcare took over the running of Dermatology Services from Medway Foundation Trust (MFT) in April 2019. The previous service had been failing and needed significant work put into it.
b. The initial backlog focus had been on cancer services and cancer patients, and this appeared to have been sorted.
c. The second focus was on dealing with the backlog transferred from MFT, which had also been rectified.
d. The final focus was on the waiting times being experienced by current patients which the CCG recognised were too high.

2) A Member asked what the Tele-Dermatology app was, as referred to on page 30 of the agenda. Mr Jeffery explained that it was a smart phone application that allowed nursing staff to photograph skin and share that with consultants in order to reduce waiting times.

3) Mr Inett explained that Healthwatch Kent had not received any feedback about the service since July. There had been a recent public engagement event with DMC Healthcare that had been well received.

4) Mr Inett and Mr Jeffery agreed that March 2020 was a realistic timeframe for the Service to have stabilised. At that time, Healthwatch Kent and Healthwatch Medway would undertake a piece of work to evaluate the Service, and Mr Inett offered to bring this to HOSC once complete (likely in summer 2020).

5) RESOLVED that the report be noted, and Medway CCG return to HOSC after summer 2020 with an update on performance, accompanied by the service evaluation by Healthwatch Kent and Healthwatch Medway.

8. Re-commissioning of Community Dental Care (written update)
(Item 9)

RESOLVED that the response from NHS England South East be noted.

9. Work Programme
(Item 10)

1) The Chair confirmed that the SECAmb item in March will include an update on 111 Services.

2) Mr Thomas requested that pharmacy services within hospitals be looked into (in relation to the time taken to dispense drugs to those who have been discharged but still occupy space in a ward whilst they wait for those drugs). The Chair suggested asking relevant acute Trusts this question when they attended HOSC for other items.

3) Mr Inett requested that Healthwatch Kent be involved in the Wheelchair Services item on 29 January, which the Chair agreed to.

4) RESOLVED that the work programme be noted.

10. Future meeting dates
(Item 11)

RESOLVED that the future meeting dates be noted.

11. Date of next programmed meeting – Wednesday 29 January 2020
(Item 12)

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Item 4: Urgent Care Review Programme – Dartford, Gravesham & Swanley

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: North Kent CCGs: Urgent Care Review Programme – Dartford, Gravesham and Swanley CCG

Summary: **This has been deemed a substantial variation of service by both Kent HOSC and Bexley Council's COSC**.

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

It provides background information which may prove useful to Members.

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1) Introduction

a) Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG) made the Kent HOSC aware of their Urgent Care Review programme in 2014. In line with NHS England requirements, the CCG proposes to bring urgent care services, currently located across a number of sites, together under a single Urgent Treatment Centre (UTC) model of care.

b) A public consultation ran from 12 August to 4 November 2019. The proposals as presented were to create a new UTC at either Gravesham Community Hospital or Darent Valley Hospital by autumn 2020.

2) Previous monitoring by HOSC

a) The Kent HOSC has received regular updates from DGS CCG on its Urgent Care Review programme since 2014. The Committee determined that the proposed changes amounted to a substantial variation to the local health service in January 2019.

b) Bexley Council's Communities Overview and Scrutiny Committee (COSC) also deemed the proposed changes to be a substantial variation to health services for residents of Bexley.

c) In line with health scrutiny legislation, Kent County Council and Bexley Council formed a joint health overview and scrutiny committee (JHOSC) for the purpose of health scrutiny consultation with DGS CCG.

d) Due to timescales, the Kent HOSC received a report from DGS CCG on the outcome of the public consultation at its meeting on 16 December 2019. Two Councillors from Bexley Council also attended and contributed to the

discussion. That meeting was the final opportunity for Kent and Bexley Councillors to have their views fed into the CCG's Decision-Making Business Case prior to the NHS making a decision

e) Following its discussion on the 16 December, the Committee resolved:

…that the report be noted and asks that DGS CCG take the following views into account in their Decision-Making Business Case.

The Committee highlighted:

- *concern around parking and public transport*
- *questions as to whether the solution would properly accommodate the rapid recent and future growth of Ebbsfleet and North Bexley*
- *concerns as to whether there were adequate staffing levels and provision of consultants at the proposed sites*
- *access to wider services at Darent Valley Hospital*
- *the need to retain walk in GP services*
- *the wider impact on both Erith and Queen Mary Hospitals in Bexley*
- *it had noted the preference for option 1 from the public consultation*

f) The CCG Governing Body considered the Decision-Making Business Case on 16 January 2020 and made their final decision.

g) Immediately prior to this HOSC meeting on 29 January 2020, the Bexley and Kent JHOSC will have met to consider the decision of the CCG Governing Body.

3) Next Steps

a) The Terms of Reference of the Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Committee required it to consider whether the decision of the DGS CCG on 16 January 2020 should be referred to the Secretary of State. The decision of the Joint Committee will be presented verbally to the HOSC at its meeting on 29 January 2020.

b) As the power of referral was not delegated to the JHOSC, the Kent HOSC is not bound the JHOSC's recommendation and can determine its own response to the CCG's final decision. The Committee may support the decision, not support the decision, and/or comment on the decision.

c) As set out in the Protocol for the Health Overview and Scrutiny Committee in the KCC Constitution, a substantial variation of service may only be referred to the Secretary of State for Health where one of the following applies:

i. The consultation with the HOSC on the proposal is deemed to have been inadequate in relation to content or time allowed;

ii. The reasons given for not consulting with the HOSC on a proposal are inadequate; or

iii. The proposal is not considered to be in the interests of the health service of the area.

d) If the HOSC does not feel that any of the above apply to the matter under discussion, it will not be able to make a legitimate referral. It will still be able to monitor the implementation of the service and make comments and recommendations directly to the relevant health provider or commissioner.

e) If the HOSC believes that one of the reasons above applies, it cannot make a final determination at this meeting. It must agree which of the above grounds provisionally apply and communicate this to the NHS in writing as soon as possible along with the date it will meet to make its final determination. The NHS must be given time to consider and respond to the Committee's decision.

f) The Committee will meet to consider the NHS response and any other discussions that have taken place, prior to making its final determination.

g) Any referral to the Secretary of State must contain the following:

i. Full evidence of the case for referral;

ii. Evidence that all other options for resolution have been explored, along with all additional requirements for the submission of a referral required by legislation and statutory guidance.

iii. Where the referral is on the grounds that the Committee believes the proposal is not in the interests of the health service of the area, a summary of the evidence considered must be provided, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service of the area.

h) A decision to support the CCG Governing Body decision, or support with qualifications and/or comments could be made at this meeting.

4. Recommendation

The Committee is asked to consider the decision of the DGS CCG Governing Body on 16 January 2020, along with the recommendation(s) of the Bexley and Kent JHOSC, and take one of the following actions:

a) Support the decision of the DGS CCG Governing Body and make any additional comments the Committee deems appropriate; or

b) Specify concerns that the Committee has with the decision of the DGS CCG Governing Body and invite the NHS to a future meeting of the Committee where their response to these concerns will be considered ahead of a final determination by the Committee as to whether or not to refer the decision to the Secretary of State for one of the reasons set out in 3c (i-iii).

Background Documents

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

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

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

Kent County Council (2017) 'Health Overview and Scrutiny Committee (14/07/2017)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7530&Ver=4

Kent County Council (2018) 'Health Overview and Scrutiny Committee (23/11/2018)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7923&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (25/01/2019) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7924&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (23/07/2019) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

Kent County Council (2019) 'Health Overview and Scrutiny Committee (16/12/2019) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8483&Ver=4

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Dartford Gravesham and Swanley Clinical Commissioning Group

Improving NHS urgent care services in Dartford, Gravesham and Swanley

Presentation of the decision making business case and the Clinical Commissioning Group's Governing Body decision regarding the Urgent Treatment Centre model

Prepared for the Kent Health Overview and Scrutiny Committee

Submission Date: 20 January 2020

Compiled By: Gerrie Adler, Director of Strategic Transformation
Dartford, Gravesham and Swanley and Swale
Clinical Commissioning Groups

1 Introduction

1.1 This update has been prepared for the Kent Health Overview and Scrutiny Overview Committee (HOSC) by Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG).

1.2 The Committee is presented with the urgent care review decision making business case, formed following the completion of the 12 week full public consultation regarding potential site options for a future Urgent Treatment Centre within the DGS CCG's boundary.

1.3 The decision making business case was considered by the DGS CCG Governing Body on 16 January 2020 at an extra-ordinary Governing Body meeting held in public.

1.4 The Governing Body approved the model recommended in the decision making business case for a networked urgent care services model with two linked Urgent Treatment Centres, one at Gravesend Community Hospital, and one co-located with A&E at Darent Valley Hospital.

1.5 The Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Overview Committee (JHOSC) will consider the CCG's Governing Body decision at a JHOSC meeting on 29 January 2020 before making recommendations to this Committee, and to the Bexley Communities Overview and Scrutiny Committee on 5 February 2020.

2 The Decision Making Business Case

2.1 The decision making business case sets out the information and recommendations for the CCG's Governing Body to make informed decisions about the future configuration and siting of urgent care services in Dartford, Gravesham and Swanley.

2.2 Included in the document is a summary of the case for change and the urgent care review process as outlined in the pre-consultation business case.

2.3 The decision making business case provides an analysis of the feedback received from the public consultation, including the intensive engagement exercise with Bexley residents.

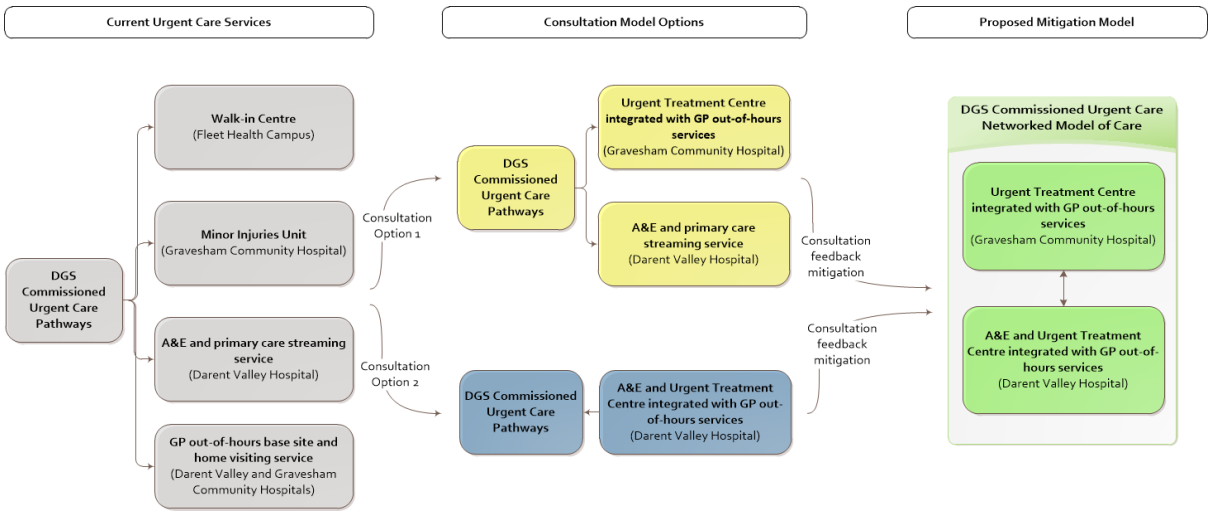
2.4 The CCG received an unprecedented number of survey responses (online and hard copy), with 16,474 surveys returned, and over 25,000 free-text responses received.

2.5 The consultation responses, analysed by an independent third party organisation, were considered by both the DGS Governing Body, and the Kent Health Overview Scrutiny Committee, and there was unanimous agreement that the CCG had met its statutory responsibility regarding the public consultation.

2.6 Bexley Communities Overview and Scrutiny Committee, made a formal decision on 16 October 2019, that the DGS CCG urgent care proposals represented a significant variation to the Bexley

population. As this was close to the end of the public consultation period it was not possible to plan additional formal engagement with Bexley residents before the end of the consultation period. An intensive engagement exercise with Bexley residents and patients using Bexley urgent care services took place after the period of purdah was lifted in December 2019 – January 2020. These engagement activities, and the feedback received, have been analysed by the same independent third party organisation and form part of the decision making business case.

2.7 The decision making business case recommends how the proposed site options could be adjusted to best mitigate the concerns raised by local people and stakeholders. **It is recommended that these issues may be best mitigated by implementing a networked urgent care services model with two linked Urgent Treatment Centres, one at Gravesend Community Hospital, and one co-located with A&E at Darent Valley Hospital.**



2.8 The case suggests a phased approach to implementation to ensure the networked model of care and/or service specification(s) meet the needs of the local population and can be delivered in a safe and sustainable way.

2.9 The ambition is to implement the new Urgent Treatment Centres as quickly as possible, in line with current contract expiry dates, whilst ensuring that quality and patient safety are not compromised.

2.10 Based on the financial modelling the networked model of urgent care will be supported by budget commitment that has a further 2% contingency assigned to it, and is profiled in line with the phased implementation approach.

3 The Decision of the CCG Governing Body

3.1 The DGS CCG Governing Body considered the decision making business case on 16 January 2020 at an extra-ordinary Governing Body meeting held in public.

3.2 The decisions of the DGS CCG Governing Body are as follows:

3.2.1 **APPROVED -** the implementation of the mitigated model of networked urgent care services with two linked Urgent Treatment Centres, one at Gravesham Community Hospital and one by Darent Valley Hospital (co-located with A&E) by the end of June 2020, as set out in the decision making business case

3.2.2 **AGREED -** further work on the detailed networked model, service specification(s) and procurement process, as identified in the key implementation and programme plan in the decision making business case, be undertaken over the coming months and refined in collaboration with the current providers of urgent care services and other key partners

3.2.3 **AGREED** - that the proposed networked model of urgent care is supported by a budget commitment that has a further 2% contingency assigned to it, and is profiled in line with the phased implementation approach.

3.3 The Governing Body also agreed on a number of actions to be incorporated in the phased implementation of the networked model, these included (but were not limited to):

3.3.1 The establishment of a Clinical Reference Group to consider the development of a robust clinical governance process ensuring the networked model of care provides a service that is both safe and of high quality across two sites. Ongoing review of clinical governance will be key to the networked model of care.

3.3.2 A communications and engagement plan to be developed to address the concerns raised during the public consultation, and to support the phased implementation approach.

4 Joint Health and Overview Scrutiny Committee Recommendation(s)

4.1 The Bexley and Kent Urgent Care Review JHOSC will consider the CCG Governing Body's decision regarding the future of urgent care services in Dartford, Gravesham and Swanley at a meeting on 29 January 2020 before making recommendations to this Committee, and to the Bexley Communities Overview and Scrutiny Committee on 5 February 2020.

5 Summary

5.1 This update and decision making business case regarding the future configuration of urgent care services within the DGS CCG boundary is presented to the Committee following consideration by the DGS CCG Governing Body on 16 January 2020.

5.2 The CCG's Governing Body approved the model recommended in the decision making business case for a networked urgent care services model with two linked Urgent Treatment Centres, one at Gravesend Community Hospital, and one co-located with A&E at Darent Valley Hospital.

5.3 The Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Overview Committee (JHOSC) will consider the CCG's Governing Body decision at a JHOSC meeting on 29 January 2020 before making recommendations to this Committee, and to the Bexley Communities Overview and Scrutiny Committee on 5 February 2020.

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NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

Urgent Care Review

Decision making business case for the review of urgent care services in Dartford, Gravesham and Swanley prepared for the Clinical Commissioning Group Governing Body

January 2020

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Executive summary

The decision-making business case sets out the information and recommendations for the CCG's Governing Body to make informed decisions about the future configuration and siting of urgent care services in Dartford, Gravesham and Swanley.

Included in the document is a summary of the case for change and the urgent care review process as outlined in the pre-consultation business case.

The document also provides an analysis of the feedback received from the public consultation and recommendation about how the proposed site options could be adjusted to best mitigate the concerns raised by local people and stakeholders during the consultation process. The recommendation to mitigate these issues by implementing a networked urgent care services model with two linked Urgent Treatment Centres, one at Gravesend Community Hospital and one co-located with A&E at Darent Valley Hospital.

This executive summary provides a brief overview of the public consultation, analysis of the responses and the post consultation process. It also describes the CCG's preferred mitigation model and the next steps.

Overview of the consultation

The formal consultation on the proposals for the location of the future Urgent Treatment Centre in Dartford, Gravesham and Swanley ran for 12 weeks from 12 August to midnight on 4 November 2019.

The CCG received an unprecedented number of survey responses (online and hard copy), with 16,474 surveys returned.

The consultation process and consultation responses were analysed and evaluated by an independent third party organisation and were published by the CCG as soon as the period of purdah was lifted on 13 December 2019.

Overall, 80% of respondents supported the siting of an UTC at Gravesham Community Hospital vs. 5% supporting an UTC at Darent Valley Hospital.

- Respondents in DA11 (area around Gravesham Community Hospital) very highly endorsed Option 1 as this option sits within their local postcode area, and is therefore much easier to access for local residents. 85% of people who claim to live in this area 'Strongly Agree' that Gravesham Community Hospital is the better site for the new UTC and 90% 'Agree overall'.

- Residents of DA2 (area around Darent Valley Hospital) are more polarised in their opinion of moving the UTC to Darent Valley Hospital. Less than half (43%) 'Strongly Agree' that it would be the best option, while nearly a third (31%) 'Strongly Disagree' with this option.

25,000 free-text responses were received within the survey and here are the range of issues or concerns that were raised by the respondents that preferred each option:

- For both groups, ease of journey was the main driver of site preference and ease of access was the main concern, followed by parking issues, and concerns about other services at the Darent Valley Hospital site

- For respondents who preferred Gravesham Community Hospital the site was easier and cheaper to reach, had better parking (availability and cost), and they shared concerns that Darent Valley Hospital facilities are already overstretched and an UTC at the Darent Valley Hospital site might lead to longer waiting times

- For respondents who preferred Darent Valley Hospital proximity to site was important, and co-location of services at the site was favoured.

Other feedback included:

- Access needs of local communities, particularly residents who may not have English as a first language or with access issues linked to deprivation or age (e.g. reliance on public transport)

- Pressures on local services, particularly the rapid growth in some areas such as Ebbsfleet Garden City, and specific concerns raised regarding the level of activity at Darent Valley Hospital

- Need for greater accessibility (especially appointments that are easier to access) and more care provided in non-acute settings, in particular general practice

General comments were made about the need for increased and continuing CCG communications when introducing new services and educating the public on the most appropriate way to access all local health services.

An intensive engagement exercise with Bexley residents and patients using Bexley urgent care services took place after the period of purdah was lifted in December 2019 – January 2020. These engagement activities, and the feedback received, have been analysed by the same independent third party organisation as reviewed the public consultation feedback. Key findings are as follows:

- Accessibility and travel times were the main drivers for patients' decisions when they need urgent care

- Bexley residents find Darent Valley Hospital relatively easily accessible by car and public transport, despite concerns regarding parking at the site, and some patients believe that co-location with the A&E department means an Urgent Treatment Centre would provide a higher quality service and provide treatment "all in one place"

- An Urgent Treatment Centre at Darent Valley Hospital is seen as a potential alternative option rather than as a first choice as there are two well regarded Urgent Care Centres within the Bexley boundary.

- A third of Bexley respondents felt there would be no impact or very limited impact for them as a result of the siting of a future Urgent Treatment Centre as they would be unlikely to use any of the alternatives in Dartford, Gravesham or Swanley.

- Whilst there was no suggestion from the initial survey that patients might look towards Bexley urgent care services, staff and doctors at both Erith Hospital and Queen Mary's Hospital commented that they saw a significant number of patients from Dartford, Gravesham and Swanley due to referrals by NHS 111, local, perceived waiting times at Darent Valley Hospital and pressures on local GP services.

Approach post-consultation

Following the public consultation, a process was undertaken to consider the issues from the consultation and identify possible mitigation to the concerns raised through the public consultation process as well as address the needs of the local urgent care system.

A Post Consultation - Options Appraisal Meeting, attended by CCG clinical, executive, commissioning, finance and communications and engagement representatives, took place on 18 November 2019 to review the pre-consultation options appraisal process, consider the public consultation activities and key themes emerging from the consultation, and agree the next steps.

The group agreed unanimously that a single site solution for urgent care across Dartford, Gravesham and Swanley was unlikely to mitigate well placed concerns raised by the public during the consultation.

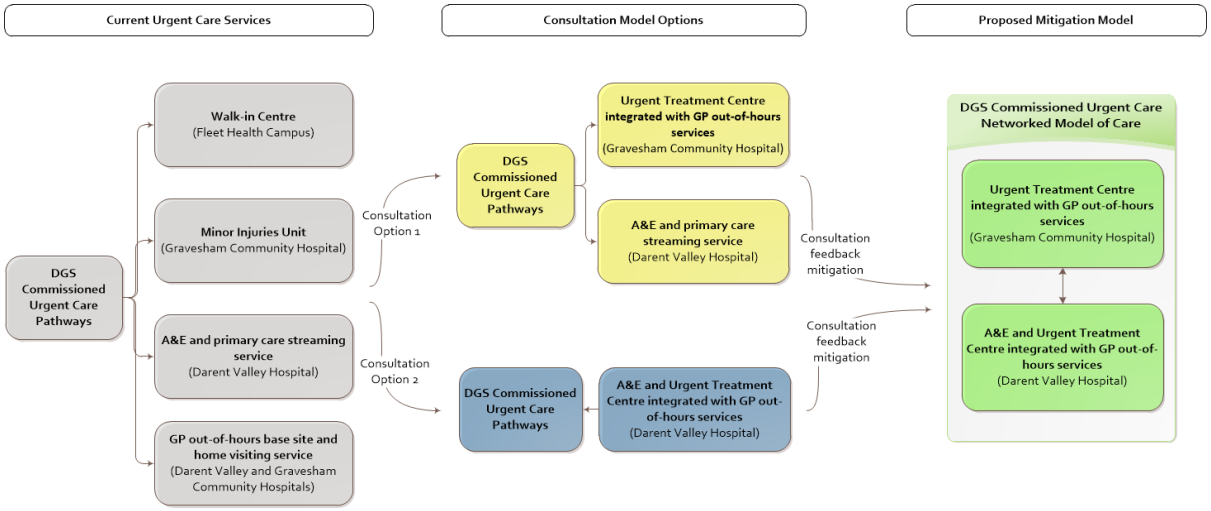
It was also agreed that the overlap between urgent, local and primary care made it necessary to consider the interdependence of these areas when identifying potential mitigations. The team also acknowledged that certain developments in primary care which could support urgent care services may take some time to materialise.

The CCG's proposed mitigation to address public concerns identified through public consultation is to provide the Urgent Treatment Centre model over two sites rather than at a single site, and for services to be networked to ensure they operate in an integrated way, as part of an urgent care system for Dartford, Gravesham and Swanley CCG's local population.

Description of mitigated model

The recommended model for the provision of networked urgent care services would involve:

- An Urgent Treatment Centre at Gravesham Community Hospital and an Urgent Treatment Centre at Darent Valley Hospital (co-located with A&E)



The rationale for the recommended networked model for urgent care is:

- Urgent care is not being transformed in isolation, but the other programmes of work are either still in their infancy or the benefits are not yet felt by the local population (e.g. Primary Care Networks, improved/extended primary care access, movement of outpatient clinics away from an acute setting)

- There was general support for the Urgent Treatment Centre model, bringing together minor ailments and minor injuries in one place.

- The consultation responses highlight concerns regarding accessing the Darent Valley Hospital site by car (including issues of congestion and parking availability on-site), and by public transport (limited access for certain routes). Concerns regarding the cost of accessing the Darent Valley Hospital site were also raised (parking, taxi costs). There were also public concerns that long standing issues at Darent Valley Hospital had not been addressed including, the perceived incapacity of the current infrastructure to cope with any additional footfall, particularly in view of the anticipated growth within the area in the coming years.

- The estimated impact of growth in the area may be clearer in the coming years

- The transformation of the local health system, including the merger of eight CCGs into one CCG and creation of the Integrated Care Partnerships can take place without additional pressures in the system.

Careful consideration has been given to identify what urgent, local and primary care services should be provided at each site, and the ways in which services could be networked to ensure the best provision of urgent care possible for the local population within existing resources.

The service specification for an Urgent Treatment Centre as part of a two site networked model of care will be adjusted if supported by the Governing Body.

Outline programme implementation plan

If the Governing Body agrees to proceed with the mitigated model, it is expected that some transition time would be required to set up governance arrangements and finalise plans to progress implementation, but this time will be kept as short as possible to support early implementation.

A phased approach would be required to ensure the networked model of care and/or service specification(s) meet the needs of the local population and can be delivered in a safe and sustainable way.

The ambition, subject to the Governing Body's approval, is to implement the new Urgent Treatment Centres as quickly as possible whilst ensuring that quality and patient safety are not compromised. We plan to have services in place by the end of June 2020 in line with the current contract expiry dates.

Financial summary of an networked urgent care model

The recommended networked model for urgent care over five years 2020-2025 is modelled to be £85m compared to the projected cost of the current urgent care service provision of £84m over the same period. This excludes the potential impact of void estate charges at Fleet Health Campus.

The financial implications of implementing a phased networked model of urgent care is inherently less risky than moving urgent care activity flows from Fleet Health campus (WIC activity) and Gravesham Community Hospital (Minor Injuries Unit) to the Darent Valley Hospital site; which would incur void estate charges at two sites.

The CCG in working with the emerging Primary Care Networks recognises that Fleet Health Campus is a prime location for the development of a primary care hub providing future services, and this would also potentially reduce the risk of incurring void estate charges.

Based on the financial modelling it is recommended that the proposed networked model of urgent care is supported by budget commitment that has a further 2% contingency assigned to it, and is profiled in line with the phased implementation approach.

The current modelling assumes implementation at the beginning of a financial year for ease of comparison and illustration to enable a decision to be made regarding the best option to implement.

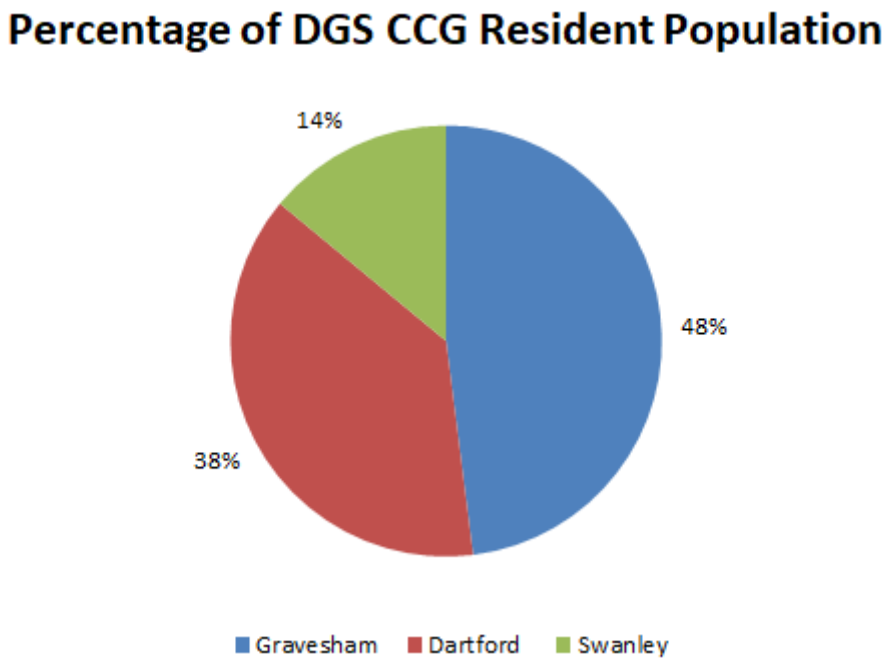
Introduction

Dartford, Gravesham and Swanley Clinical Commissioning Group

Dartford, Gravesham and Swanley (DGS) Clinical Commissioning Group (CCG) is one of eight CCGs in Kent and Medway, covering 100 square miles from Gravesend on the River Thames in the north to Dartford, Swanley and West Kingsdown in the west; New Ash Green in the south and the villages of Meopham, Cobham and Higham in the east.

Population

The CCG serves a population of circa 276,421 people (NHS Digital – 1st December 2019). Please see the percentage population distribution below based on the practice population - 12 practices in Gravesend, 9 practices in Dartford and 5 practices in Swanley.



CCG commissioned services

The CCG is responsible for commissioning:

- Urgent and emergency care, including the NHS 111 free urgent advice phone line, Accident and Emergency (A&E) and ambulance services
- Planned hospital care
- Community health services such as district nurses and rehabilitation services
- Mental health services, including for children
- Maternity and new-born services
- Medicines prescribed by GPs, consultants and other NHS practitioners
- Primary medical care (GP) services.

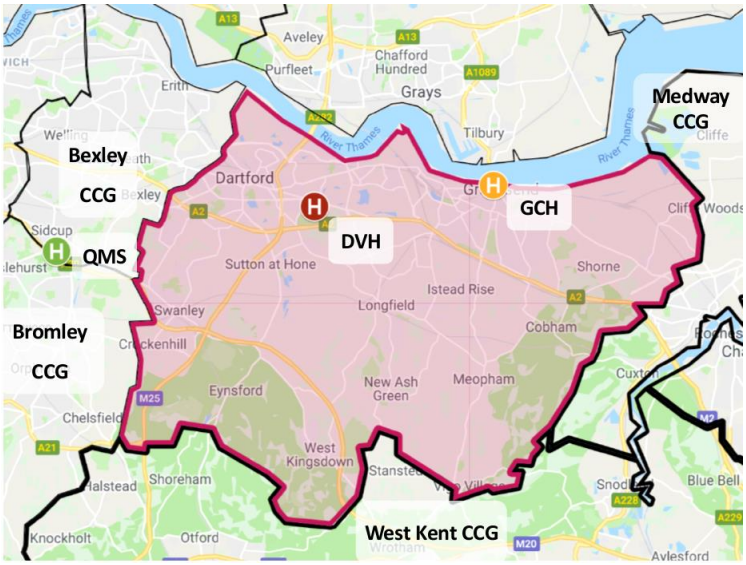
The CCG does not commission dental services; community pharmacies; specialised healthcare such as heart and brain surgery; neonatal services; secure psychiatric services; public health and health

promotion services; prison health; or healthcare for serving members of the Armed Forces (except emergency care). These are commissioned directly by NHS England.

There are currently 26 GP practices in the locality, and 7 Primary Care Networks (PCNs):

- Dartford Central PCN
- Dartford Model PCN
- Garden City PCN
- Gravesend Alliance PCN
- Gravesend Central PCN
- LMN PCN
- Swanley PCN

One acute hospital, Darent Valley Hospital (Dartford and Gravesham NHS Trust), and two community hospitals, Gravesham Community and Livingstone Community Hospitals, lie within the CCG boundary. Approximately 70% of acute activity flows to Dartford and Gravesham NHS Trust.



Geographical area covered and shared boundaries

The CCG covers the geographical area shown in the map above and shares boundaries with two London CCGs (Bexley CCG and Bromley CCG), and two Kent and Medway CCGs (Medway CCG and West Kent CCG).

Areas of deprivation

DGS CCG has 808 postcodes, within 15 LSOA's (Lower Layer Super Output Areas) that fall within the top 10% most deprived in England. A Lower Layer Super Output Area is a geographic area designed to improve the reporting of small area statistics in England and Wales[1]. These LSOA's are located

1 https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/l/lower_layer_super_output_area_de.asp?shownav=1

within the DGS CCG boundary and are located in the urban areas to the north, around the towns of Dartford, Swanscombe, Gravesend, Northfleet and Swanley[2].

More in-depth information regarding the population served by the CCG is available in the Pre-Consultation Business Case[3].

Population growth

Over the next twenty years the overall population of the local authorities in the DGS areas are expected to increase. There are two sets of population projections available at district level; the ONS projections (which take into account births, deaths and migration) and KCC's own housing-led forecasts (which also take into account local housing plans). Generally, the KCC housing-led forecasts suggest a higher level of population growth (19% for Kent as a whole between 2017 and 2037, compared with 15% using the ONS projections).

Using resident populations for the districts of Dartford, Gravesham, Sevenoaks and Swanley, the following changes are predicted:

- The under-five and 0-19 populations will increase more slowly than the population as a whole.
- The population of 65+ is predicted to increase more significantly by 55% in Dartford, 44% in Gravesham and 36% in Sevenoaks based on the ONS projections and 66%, 41% and 43% respectively based on the KCC housing-led forecasts.
- This population increase is even greater in the 85+ group, with the ONS projections suggesting increases of 78% in Dartford, 79% in Gravesham and 89% in Sevenoaks and the KCC housing-led

[2] https://www.dartfordgraveshamswanleyccg.nhs.uk/about-dgs/publications/plans-reports-strategies/ccg-annual-report-2018-19/
[3] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

forecasts 88%, 76% and 96% respectively4. Please note that both the ONS and KCC projected increases for this age group have been revised downwards in the latest figures.

The development of the Ebbsfleet Garden City and significant housing growth in the DGS area over the next ten years continues to be a significant organisational risk, both in terms of funding and other elements of resourcing such as workforce and management time. This links to the increasing public demand on healthcare services, alongside tighter financial allocations, which are making it difficult to keep up with the population growth.

Urgent care review background

The NHS Five Year Forward View (5YFV) explained the need to redesign health systems, including the urgent and emergency care services (UEC) in England for people of all ages. It stated that across the NHS, UEC services will be redesigned to integrate between Emergency Departments (ED), traditional GP out-of-hours services (OOH), Urgent Treatment Centres (UTC), NHS 111, and ambulance services; highlighting the fact that 'services need to be integrated around the patient'.

Under this model, organisations collaborate to deliver high quality clinical assessment, advice and treatment and work to shared standards and processes, with clear accountability and leadership. The Urgent and Emergency Care Review[5] and commissioning guidelines[6,7] detail how these models of care can be achieved through a fundamental shift in the way urgent and emergency care services are provided to people of all ages. Improving out-of-hospital services will mean more care can be delivered closer to home, and hospital attendances and admissions will reduce.

The most recent NHS Long Term plan, released in January 2019, strengthens that direction of travel. The plan includes a significant package of measures aimed at reducing pressures on ED. Many of the measures build on previous initiatives, including the introduction of clinical streaming at the front door to ED and the roll-out of NHS 111 services across the country.

The plan commits to rolling out UTCs across the country by 2020 so that urgent care outside hospitals becomes more consistent for patients. UTCs will be GP-led facilities and will include access to some simple diagnostics and offer appointments bookable via NHS 111 for patients who do not need the expertise available in ED. Alongside this, the plan aims to improve the advice available to patients over the phone and extend support for staff in the community by introducing a multi-disciplinary clinical assessment service (CAS) as part of the NHS 111 service in 2019/20.

Change across the urgent and emergency care system provides:

- Better support for people to self-care.
- Help for people with urgent care needs to get the right advice in the right place, first time.

4 The latest KCC projections suggest that the number of people aged 85+ living in Kent will double between 2017 and 2037 (i.e. a 100% increase). Previous estimates suggested a 130% increase over the same period.

5 http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf

6 http://www.nhs.uk/NHSEngland/keogh-review/Documents/safer-faster-better-v28.pdf

7 https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

- Highly responsive urgent care services outside of hospital so people no longer have to queue in ED.

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

- Connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

Overview of urgent care review

The review of urgent care services in Dartford, Gravesham and Swanley has been an iterative process which was first considered in 2013 with the publication of NHS England's report on 'The Keogh Urgent and Emergency Care Review' but which was first pursued at greater pace in mid-2016.

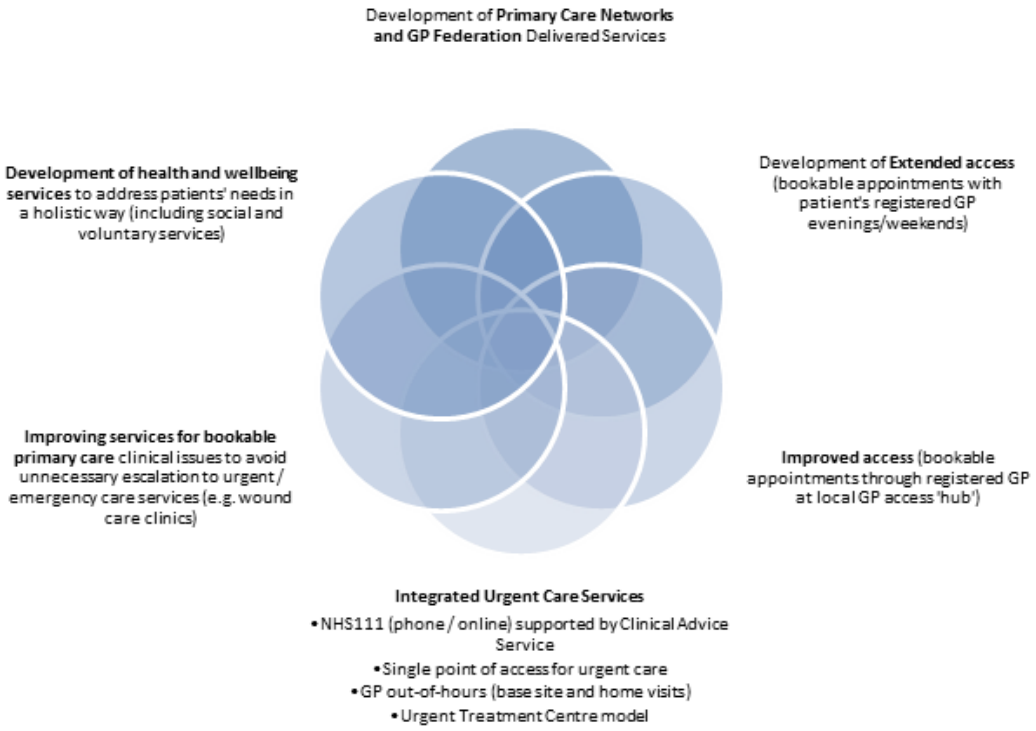
Since 2016, DGS CCG has carried out significant engagement activities with key stakeholders including patients, the public and key stakeholders from across health and social care in North Kent (including the Kent Health Overview Scrutiny Committee, Healthwatch, Engage Kent, local councillors and MPs), for their views about urgent care services in all its forms. The feedback received from the various engagement activities helped shape the programme going forwards.

In summary, the feedback identified that the current provision for urgent care services can be confusing and fragmented; with the Minor Injuries Unit, Walk in Centre, GP out-of-hours service, and the primary care streaming service operating from different sites, staffed by different types of clinicians, treating different types of conditions, with access to different types of diagnostic resources, and running different operating hours. The CCG's proposals regarding urgent care will be to implement an Urgent Treatment Centre Model which bring all urgent care services under one roof thereby making it easier for local people to navigate.

The review of urgent care services in DGS CCG is just one of a number of developments taking place within the CCG that we hope will deliver improved care for our patients as outlined in the diagram below and explored in more detail in the Pre-Consultation Business Case available on the CCG's website[8].

These developments are at various stages of design, planning and implementation:

[8] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/



In addition to these service level developments, Integrated Care Partnerships (ICP) are bringing together health and care providers and local commissioners to improve services for the local population. At the heart of the ICPs are neighbouring GP practices across Kent and Medway working together to provide community, social care and primary care services to a geography of approximately 30,000 to 50,000 patients. These groups are called Primary Care Networks (PCNs). These developments are part of the NHS Long Term Plan to ensure that NHS planning and delivery of services take account of the particular health needs of the local populations, providing more "joined up" care and treatment closer to home for patients and communities within available resources. The ICP will provide a number of services from April 2020, with a plan to go live fully in April 2021.

Purpose and scope of the Decision Making Business Case

The decision-making business case (DMBC) is a technical and analytical document that sets out the information necessary for the Governing Body to make informed decisions about the future configuration and siting of urgent care services in Dartford, Gravesham and Swanley, following public consultation on proposed changes and site options for the future Urgent Treatment Centre.

The DMBC builds on the robust process of evaluation to identify potential site options for the new Urgent Treatment Centre outlined in the pre-consultation business case[9], explores the findings from

[9] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

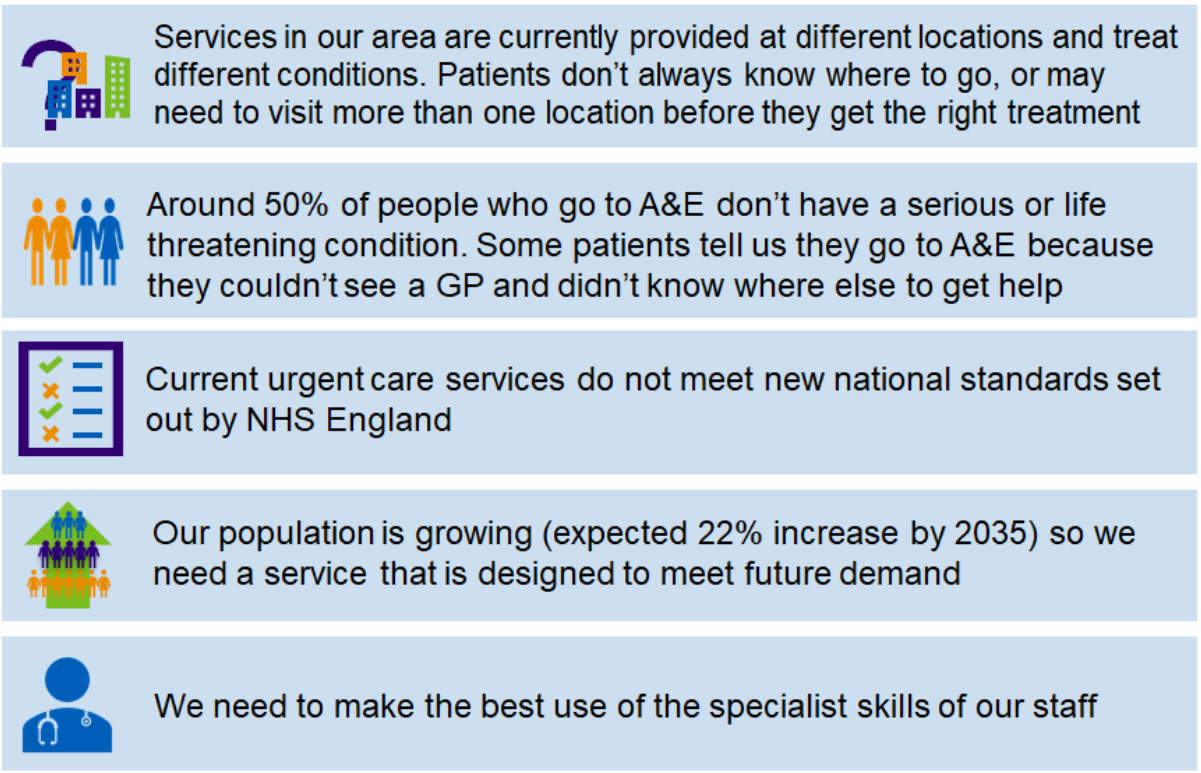
the public consultation process, and outlines the ways in which the proposed site options could be adjusted to best mitigate against the concerns raised by consultation respondents.

This document includes:

- A summary of the case for change and the Urgent Treatment Centre clinical model
- The decision-making process including the response to public consultation and the process undertaken to arrive at a preferred option
- The implications of the preferred option in terms of activity, equalities, travel and access, finance, capital, estates and workforce
- The benefits that will be realised and how they will be assessed and measured
- The next steps to support implementation and how clinical safety will be maintained in the transition period.

Case for change and proposed clinical model

Case for change



The urgent care services in Dartford, Gravesham and Swanley need to change because:

Demand keeps on growing - It is estimated that the population of Dartford, Gravesham and Swanley will have increased by 22 per cent by 2035 due to the number of new homes being built in the area. The CCG needs to make sure its services can cope with this growth and meet future demand.

We need to make sure people are getting the right service – Over 50% of the people attending A&E at Darent Valley Hospital do not have a serious or life-threatening condition and could have been seen by a nurse or GP. Making sure people get the right treatment in the right place would relieve pressure from A&E and improve the patient experience.

Current urgent care services can be confusing - Urgent care services within our area are currently provided at different locations and treat different conditions. These services are staffed by different types of clinicians with different levels of access to the equipment and/or diagnostic tests that mean that patients cannot always be treated at one site and may need to be transferred between sites to receive the most appropriate care. Patients don't always know where to go, or may need to visit more than one location before they get the appropriate treatment.

Best use of resources - There is a national NHS standard which says at least 95 per cent of patients who attend A&E should be admitted to hospital, transferred to another care provider or discharged within four hours. Like many other hospitals, Darent Valley Hospital is not always meeting this

standard and our proposal for a new Urgent Treatment Centre is intended to relieve the pressures on A&E to enable staff to focus on patients with a serious or life-threatening condition. This will also ensure that we make the best use of the specialist skills of our staff.

Changing health needs of our population - The number of people who need medical and social care due to ageing, mental health or long-term conditions is growing. We need to allocate resources to make sure we are supporting their on-going needs as well as when they need urgent care.

Access - Access to appropriate services is important to the public and to clinicians. We appreciate that waiting times for urgent care can be long and sometimes patients are referred between services because they cannot be treated at the service they first attended. We also realise that urgent care walk-in services are not always being accessed for reasons of clinical urgency, but also as a convenient means of accessing primary care (i.e. services provided by GP practices). We want to make sure there is more primary care capacity to allow patients to feel confident that they can access primary care without needing to access more expensive services, such as urgent care walk-in or emergency services if they don't need to.

Compliance with national standards - The urgent care services within Dartford, Gravesham and Swanley, although well regarded by the public, do not meet the new national standards set out by NHS England for Urgent Treatment Centres.

Proposed clinical model for the future

Our vision for the future is to develop high quality urgent care services that enable local people to access the right treatment and care in the right service when they need it.

The UTC model essentially joins the existing urgent care services for minor illness and minor injury – integrating the services currently provided separately by Minor Injuries Units (MIUs) and Walk-in Centres (WICs). Urgent Treatment Centres will provide services in line with 27 national standards, to ensure consistency across the country.

The new Urgent Treatment Centre (UTC) will play a pivotal part in ensuring patients get the right care in the right type of service when needed. By providing fast and efficient care, it will reduce unnecessary A&E attendances and help ensure the system better serves those with serious or life-threatening emergencies. Supported by NHS 111 and the Clinical Advice Service (clinical advisors supporting the NHS111 service), we envisage that the UTC will relieve pressures on the system and provide a trusted alternative where patients with non-threatening illnesses and injuries can receive quality care.

Our ambition is to deliver clinically sustainable, high quality urgent care services that are accessible to DGS residents for a minimum of 12 hours a day, 7 days a week.

The UTC will also work alongside other parts of the urgent care network including primary care, community pharmacists, ambulance and other community-based services to provide a locally accessible and convenient alternative to A&E for patients who do not need emergency care.

The UTC will be designed to assess and treat patients with a full range of minor illness and injuries, but will also be equipped to manage critically ill or injured patients who may arrive at the UTC unexpectedly or whose condition might rapidly deteriorate whilst in the service. Staff trained in adult and paediatric resuscitation will be on-site at all times.

The service will also have access to a range of diagnostics not currently available at all sites providing urgent care services (i.e. the Fleet Health Campus). Diagnostics will include bedside diagnostics, urinalysis, electrocardiograms (ECG), and x-ray facilities.

Workforce

The workforce challenges that relate to the UTC model are outlined in the pre-consultation business case[10].

A main challenge to current urgent care services, that will likely impact on the future model, is the CCG's proximity to London and the pull of workforce to the London areas. This means that it can be challenging at times for the CCG to attract and recruit sufficient numbers of appropriately skilled staff. The UTC model is led by a GP supported by a robust and effective multi-disciplinary workforce ensuring patients are seen by the most appropriate healthcare professional.

Urgent care in Dartford, Gravesham and Swanley

There are a range of services within the CCG area offering elements of urgent care. In summary these are as follows:

Walk-in Centre at Fleet Health Campus in Northfleet: Open 8am-8pm, 7 days per week. The service is led by GPs offering consultations, minor treatments and advice on self-care. No appointment necessary.

The Minor Injuries Unit at Gravesham Community Hospital in Gravesend: Open 8am-8pm, 7 days per week. The service is led by nurses who offer treatment for less serious injuries. No appointment necessary.

GPs: GPs provide many urgent care services to patients every day. We know that different GP practices have different systems for booking appointments and that patients can't always get an urgent appointment on the same day.

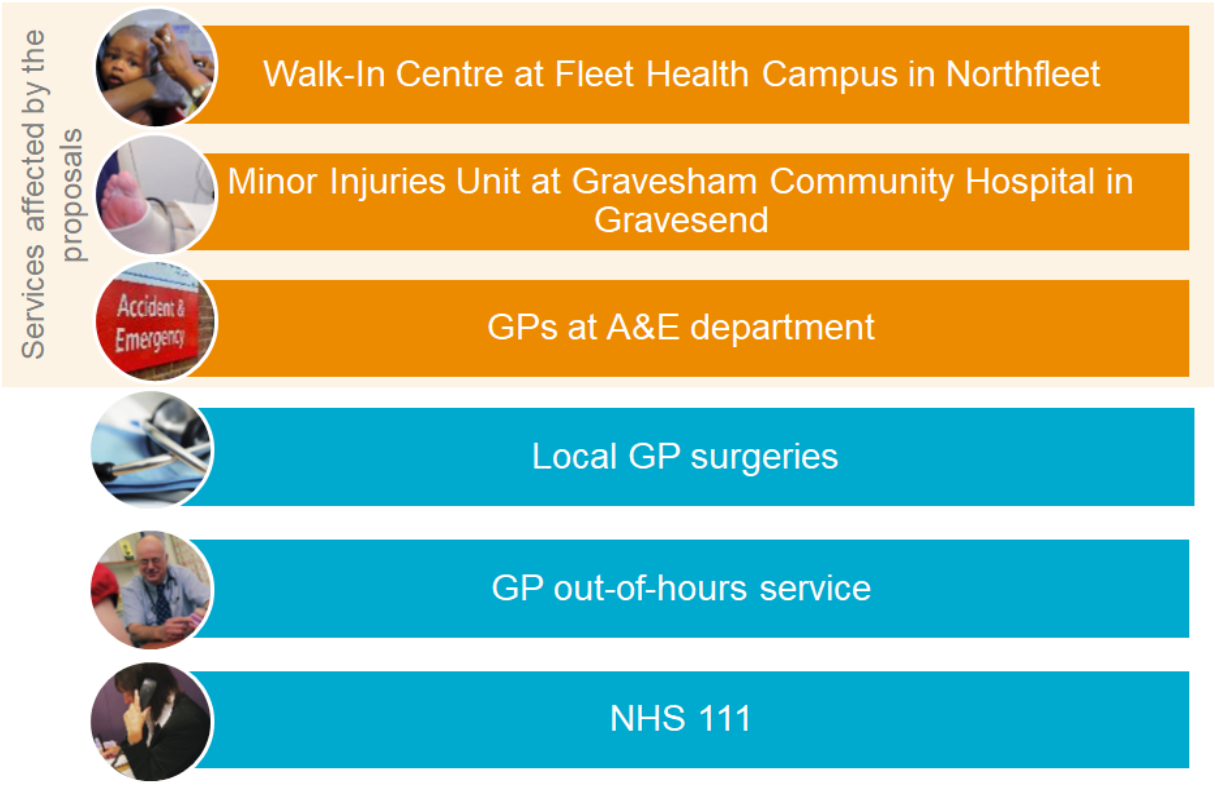
GP out-of-hours: This service provides appointments outside of GP opening hours for patients unable to wait for their GP practice to re-open. It is accessed by calling NHS 111 and offers consultations at base sites or home visits.

GPs at A&E Department: Patients arriving at Darent Valley Hospital's A&E department are assessed and then treated by A&E staff and, if more appropriate, referred to the GP-led service also on the hospital site.

[10] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

NHS 111: is the free number to call for non-emergency advice. The service is available 24 hours a day, 7 days a week. The calls are answered by highly-trained advisors and patients can also speak to a clinician when necessary. NHS 111 advisors can book an appointment for patients with out-of-hours GPs and other medical services when they are needed.

Although elements of urgent care are delivered from a number of services, the main urgent care services offering unplanned, walk-in services, and therefore those services affected by these proposed changes are highlighted in orange below:



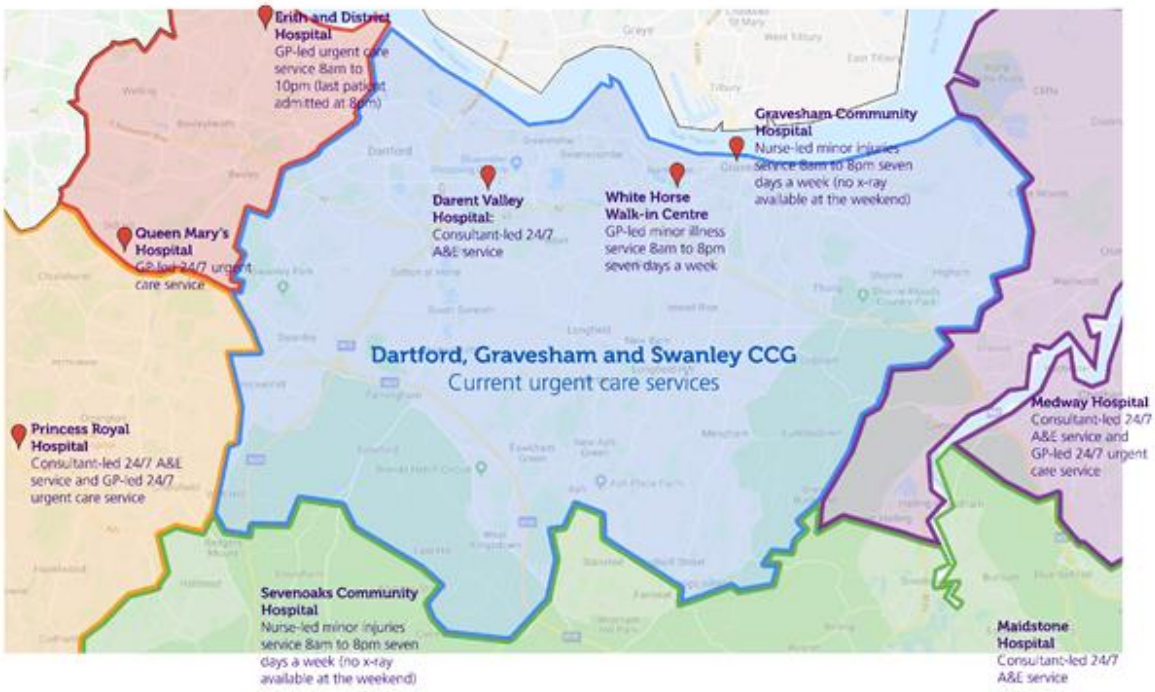
It is important to note that only the specific urgent care services at the sites outlined above will be affected. The rest of the services at each site will be unaffected by these proposed changes.

The Fleet Health Campus continues to provide primary care services and patients registered with GP practices on that site, or who access other types of services at that site, will continue to be able to do so. There are plans to provide more services at that site in future, for example, some outpatient clinics will be provided at the site rather than at the Darent Valley Hospital site.

Gravesham Community Hospital continues to offer the full range of adult and children's community services, outpatient clinics, long term condition services, rehabilitation services, x-ray and phlebotomy services as well as over 100 intermediate and social care beds.

Darent Valley Hospital continues to offer the full range of acute services currently offered at the site including the Accident and Emergency Department, outpatient and inpatient services, and diagnostic facilities.

‘Patient choice’ gives patients the freedom to choose where and how they receive NHS care and we recognise that although people may reside in one CCG area, they may access services in another area. The urgent care services on our boundaries are shown on the map below:



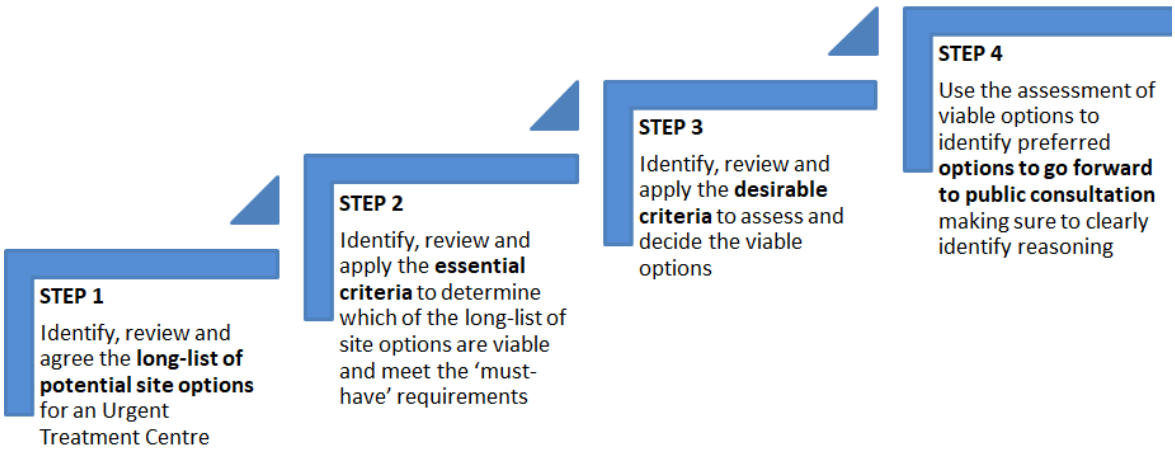
Shortlisting options for consultation

Development of options

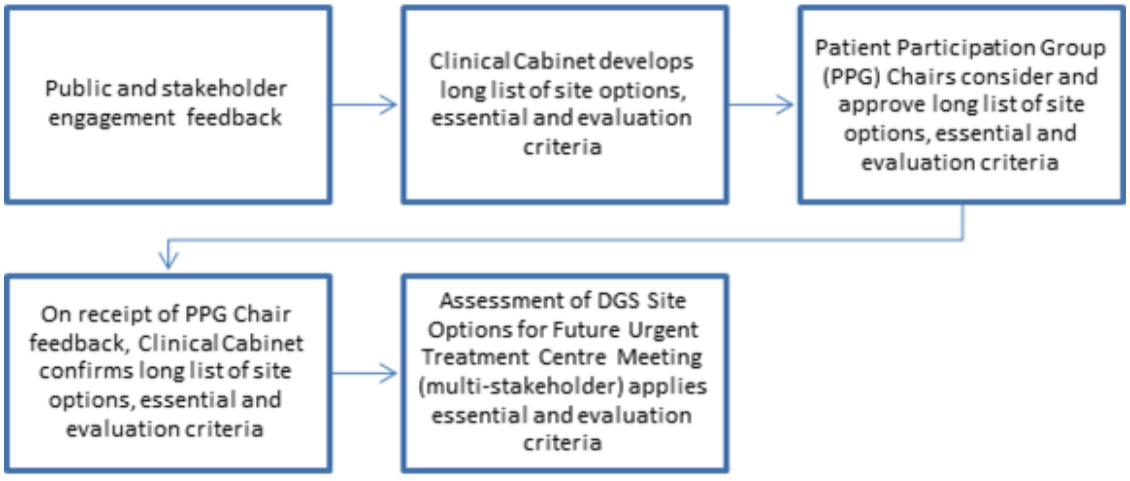
The original case for change and proposed clinical model for urgent care, which was presented to the Kent Health Overview Scrutiny Committee in July 2017, consisted of a single option for face-to-face walk-in services, that of Gravesham Community Hospital.

In April 2019, following the discontinuation of a procurement process, of which DGS face-to-face urgent care services was a part, the CCG decided to also explore the potential of co-locating the future UTC with the A&E on the Darent Valley Hospital site.

Based on the changing landscape, and the feedback the CCG received as part of the pre-consultation engagement, the CCG's long list of potential future site options was re-explored to ensure the CCG had considered all viable options, and to ensure that the process by which the site options were considered was clear and transparent. A four step options appraisal process was carried out between April and May 2019:



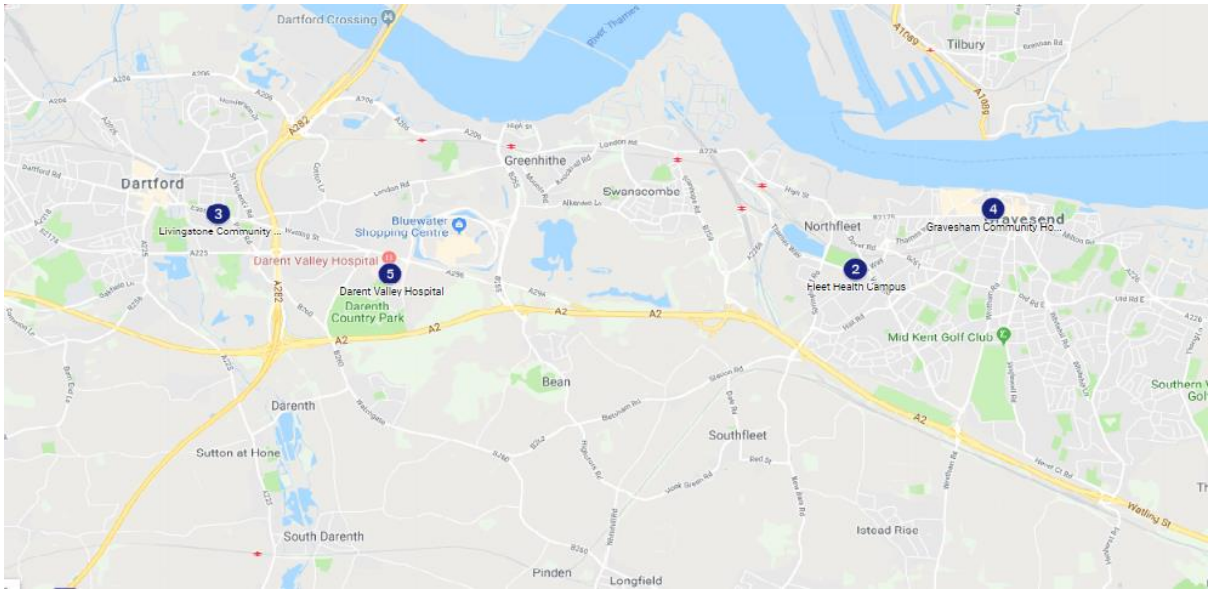
The identification of the long-list of site options, and the essential and desirable criteria to be applied to them were developed as outlined below:



In its appraisal of potential site options, the CCG considered all sites within the CCG boundary that could be reasonably made to accommodate an UTC without the need for significant investment, as well as a 'do nothing' option for comparison purposes only, as remaining unchanged would not be a viable option as it would not allow compliance with national mandate.

Options appraisal (long list)

The long-list of site options was as follows:



Option A - Do nothing
Option B - Fleet Health Campus
Option C - Livingstone Hospital
Option D - Gravesham Community Hospital
Option E - Darent Valley Hospital

Options appraisal (medium list)

Each long-list site option was considered against the essential criteria identified by the Clinical Cabinet and supported by the PPG Chairs Group to ensure the site option was viable and met the 'must have' requirements of a future UTC:

#	Essential Criteria
1	The site will support an UTC that is capable of **complying with national mandate** and delivering the 27 standards and principles for UTCs as laid out by NHS England
2	The site option is **compliant with the disability discrimination act**
3	The site will support a **fully compliant UTC without impacting detrimentally on existing services** at that site (e.g. where substantial variation to the way patients access existing

	services, such as relocation, might be required)
4	An UTC is deliverable on the site within the required **timeframe** (by July 2020 at the earliest and before autumn 2020 (Long Term Plan))
5	The site option will support an UTC that represents **value for money** and affordability

The multi-stakeholder group applied the criteria to the long-list of site options, and although the group expressed differing opinions regarding individual criterion, there was unanimous agreement on which options failed to meet all essential criteria and this is shown in the table below:

#	Criteria	Option A Do Nothing	Option B Fleet	Option C Livingstone	Option D GCH	Option E DVH
1	The site will support an UTC that is capable of **complying with national mandate** and delivering the 27 standards and principles for UTCs as laid out by NHS England		✓ 6/9 × 3/9	✓ 1/9 × 7/9 ? 1/9	✓ 9/9	✓ 9/9
2	The site option is **compliant with the disability discrimination act**		✓ 9/9	✓ 1/9 × 6/9 ? 1/9 Not scored 1/9	✓ 9/9	✓ 9/9
3	The site will support a **fully compliant UTC without impacting detrimentally on existing services** at that site (e.g. where substantial variation to the way patients access existing services, such as relocation, might be required)		× 9/9	×9/9	✓ 9/9	✓ 8/9 ? 1/9
4	An UTC is deliverable on the site within the required **timeframe** (by July 2020 at the earliest and before autumn 2020 (Long Term Plan))		✓ 8/9 × 1/9	× 9/9	✓ 9/9	✓ 9/9
5	The site option will support an UTC that represents **value for money** and affordability		✓ 1/9 × 8/9	× 9/9	✓ 8/9 ? 1/9	✓ 9/9

The application of these essential criteria resulted in the elimination of Option B: Fleet Health Campus (key concerns regarding value for money duplicating x-ray services to provide on-site, and the resultant impact of that investment on access to the site and patient experience), and Option C: Livingstone Community Hospital (key concerns regarding potential for site to deliver UTC given current condition and backlog of estate maintenance issues, and impact on existing inpatient beds).

Option D: Gravesham Community Hospital and Option E: Darent Valley Hospital were found to be viable options.

Evaluation of the options (shortlisting)

Further analysis of the potential options for consultation was carried out using five desirable criteria identified and listed in order of importance by the Clinical Cabinet. These were based on clinical considerations and previous stakeholder feedback, and were supported by the PPG Chairs.

The desirable criteria for a future UTC site were as follows:

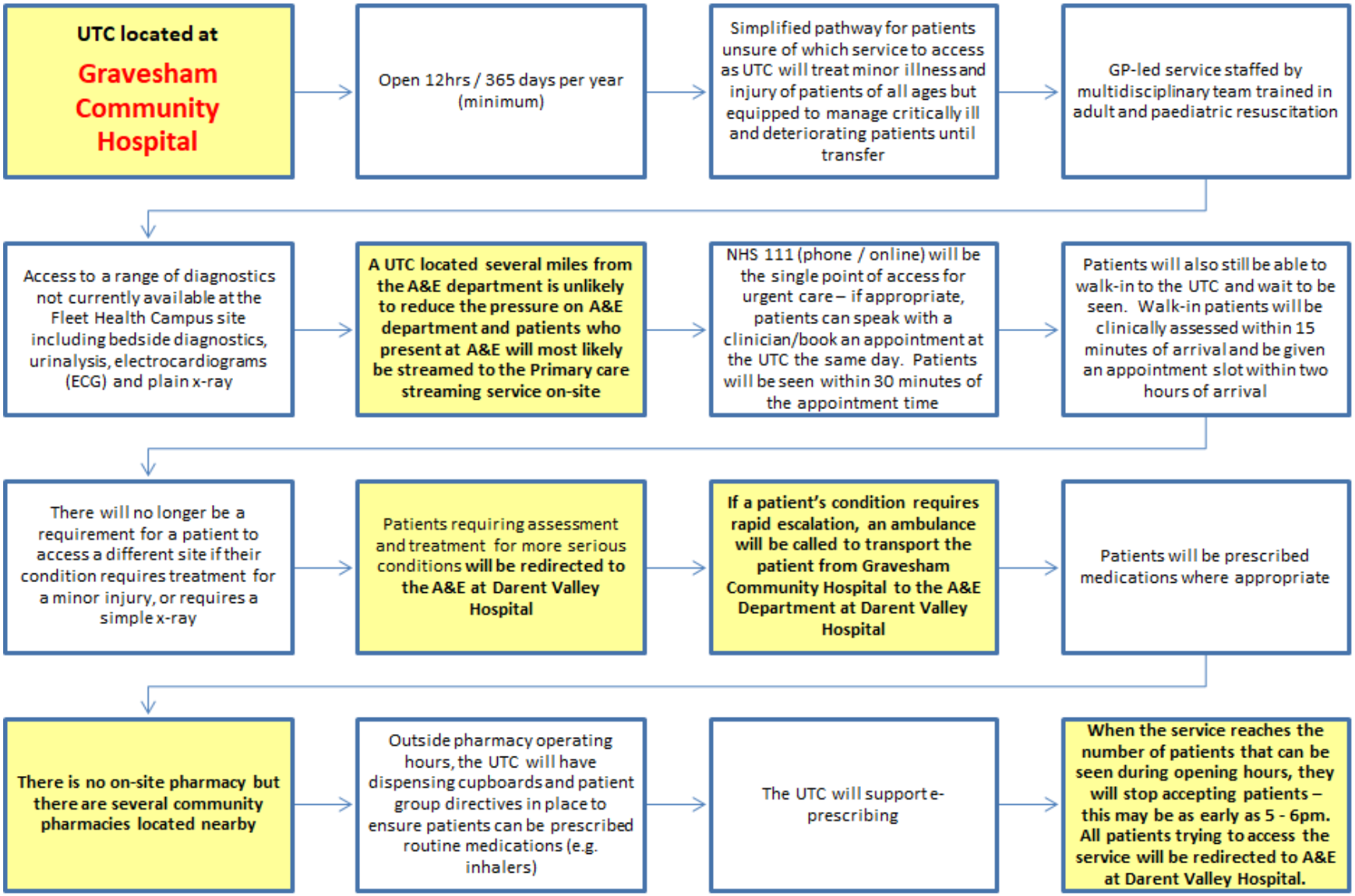
#	Desirable Criteria
1	**Strategic fit** Alignment with existing commitments and other strategic plans that address local health improvements
2	**Quality of care for all** Clinical effectiveness and responsiveness
3	**Access to care for all** Transport and other access issues
4	**Ability to deliver** Within nationally mandated timeframe
5	**Affordability and value for money** Maximum benefits for local population within available resources

The remaining options were assessed against the desirable criteria listed above and it was decided by the multi-stakeholder group that both site options (Gravesham Community Hospital and Darent Valley Hospital) should go forward to public consultation.

More in-depth information regarding the options appraisal process and the key differences between the consultation site options is given in the Pre-Consultation Business Case[11].

The key differences between these site options can be summarised in the flowcharts below (one for each site option). The text boxes highlighted in yellow show the areas in which the site options may provide different types of UTC services:

[11] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/


UTC located at
Gravesham Community Hospital
Open 12hrs / 365 days per year (minimum)
Simplified pathway for patients unsure of which service to access as UTC will treat minor illness and injury of patients of all ages but equipped to manage critically ill and deteriorating patients until transfer
GP-led service staffed by multidisciplinary team trained in adult and paediatric resuscitation
Access to a range of diagnostics not currently available at the Fleet Health Campus site including bedside diagnostics, urinalysis, electrocardiograms (ECG) and plain x-ray
A UTC located several miles from the A&E department is unlikely to reduce the pressure on A&E department and patients who present at A&E will most likely be streamed to the Primary care streaming service on-site
NHS 111 (phone / online) will be the single point of access for urgent care – if appropriate, patients can speak with a clinician/book an appointment at the UTC the same day. Patients will be seen within 30 minutes of the appointment time
Patients will also still be able to walk-in to the UTC and wait to be seen. Walk-in patients will be clinically assessed within 15 minutes of arrival and be given an appointment slot within two hours of arrival
There will no longer be a requirement for a patient to access a different site if their condition requires treatment for a minor injury, or requires a simple x-ray
Patients requiring assessment and treatment for more serious conditions will be redirected to the A&E at Darent Valley Hospital
If a patient's condition requires rapid escalation, an ambulance will be called to transport the patient from Gravesham Community Hospital to the A&E Department at Darent Valley Hospital
Patients will be prescribed medications where appropriate
There is no on-site pharmacy but there are several community pharmacies located nearby
Outside pharmacy operating hours, the UTC will have dispensing cupboards and patient group directives in place to ensure patients can be prescribed routine medications (e.g. inhalers)
The UTC will support e-prescribing
When the service reaches the number of patients that can be seen during opening hours, they will stop accepting patients – this may be as early as 5 - 6pm. All patients trying to access the service will be redirected to A&E at Darent Valley Hospital.


UTC co-located with the A&E Department at
Darent Valley Hospital
Open 12hrs / 365 days per year (minimum), but may operate longer hours
Simplified pathway for patients unsure of which service to access as UTC will treat minor illness and injury of patients of all ages but equipped to manage critically ill and deteriorating patients until transfer
GP-led service staffed by multidisciplinary team trained in adult and paediatric resuscitation
Access to a range of diagnostics not currently available at the Fleet Health Campus site including bedside diagnostics, urinalysis, electrocardiograms (ECG) and plain x-ray
The co-location of urgent and emergency care services allows patients without life threatening illness/injury to be redirected towards the UTC and therefore offers the maximum pressure to be lifted from the A&E
NHS 111 (phone / online) will be the single point of access for urgent care – if appropriate, patients can speak with a clinician/book an appointment at the UTC the same day. Patients will be seen within 30 minutes of the appointment time
Patients will also still be able to walk-in to the UTC and wait to be seen. Walk-in patients will be clinically assessed within 15 minutes of arrival and be given an appointment slot within two hours of arrival
There will no longer be a requirement for a patient to access a different site if their condition requires treatment for a minor injury, or requires a simple x-ray
Patients requiring assessment and treatment for more serious conditions will be streamed, by an experienced senior clinician, to the A&E department onsite
If a patient's condition requires rapid escalation, co-location ensures that the patient can be swiftly transferred to the A&E department without delay and without the need to call and wait for an ambulance
Patients will be prescribed medications where appropriate
There is an on-site pharmacy open within the hospital.
Outside pharmacy operating hours, the UTC will have dispensing cupboards and patient group directives in place to ensure patients can be prescribed routine medications (e.g. inhalers)
The UTC will support e-prescribing
There is no run-down time necessary at the end of the day. Patients attending after the UTC opening hours will be seen in A&E

Public consultation

Overview of consultation

The formal consultation on the proposals for the siting of the future Urgent Treatment Centre in Dartford, Gravesham and Swanley ran for 12 weeks from 12 August to midnight on 4 November 2019.

The consultation activity consisted of the distribution of printed and online consultation materials including a survey, regular engagement with the public via digital and social media channels, , stakeholder briefings, open roadshow events, structured listening events, independently commissioned work with communities with protected characteristic and sometimes described as seldom heard.

The consultation process and consultation responses were analysed and evaluated by an independent third party organisation and were published by the CCG on the CCG website as soon as the period of purdah was lifted on 13 December 2019. Stakeholders and participants of the consultation (who provided their details) were informed by email with a link to the post-consultation report. This report is shown in ***Appendix A***.

Response to Consultation Activity

The CCG received an unprecedented number of survey responses (online and hard copy), with 16,474 surveys returned containing approximately 25,000 free-text responses.

Over 21,000 consultation materials were printed and distributed. There was local news coverage of the consultation, Facebook advertising, social media messages, and 1,166 members of the public were engaged through a roadshow visiting 30 community venues including locations specifically addressing hard to reach groups. Formal meetings were held with key stakeholder groups, engagement with the public, patients, staff, local authorities, local councillors, MPs, GPs, and members of the public from protected characteristic groups. Engage Kent was commissioned to independently engage people with physical disabilities and residents of rural areas.

The CCG held three independently facilitated public listening events, one in Dartford, one in Gravesham and one in Swanley. A total of 81 people attended. These events generally followed the structure of a short presentation providing context and an overview of the proposals, followed by a plenary Q&A session, and facilitated individual table discussions.

Engagement with neighbouring areas

The CCG engaged with neighbouring CCGs and the Health Overview Scrutiny Committees in those neighbouring areas of Bexley, Bromley, Medway, and West Kent. Whilst all neighbouring boroughs expressed interest in the proposed changes Bexley Communities Overview and Scrutiny Committee (COSC), whose remit includes health and public health issues, expressed concern that the DGS proposals represented a substantial variation to NHS health services for Bexley residents.

The Bexley COSC was first contacted on 15 May 2019. The formal decision that the proposals represented a significant variation to the Bexley population was made over 24 weeks later on 16 October 2019.

A 'substantial variation' of health services is not defined in Regulations, however the key feature is that there is a major change to services experienced by patients and future patients[12].

Since 16 October 2019, discussions were held with members of Bexley COSC and Kent HOSC regarding the formation of a Joint Health Overview Scrutiny Committee (JHOSC) to consider the CCG's eventual decision regarding the siting of the future Urgent Treatment Centre.

The formation of a JHOSC was considered and supported by Kent County Council on 17 December 2019. As the COSC decision regarding substantial variation came towards the end of the public consultation period and just before the onset of Purdah, it was not possible to carry out any focused engagement before the end of the consultation period. To ensure that the CCG fully understands the views of the Bexley population an additional period of intensive engagement was undertaken consisting of:

- A survey conducted by the CCG Communications and Engagement team face-to-face with 97 people interviewed over three sessions at the following sites:
    - Erith Urgent Care Centre - (Tuesday 17 December (am) and Monday 06 January (pm)
    - Queen Mary's Hospital - Wednesday 18 December (am).
- Informal discussion with front-line staff and doctors delivering urgent care services in Bexley based at both Urgent Care Centre sites.
- A targeted listening event, conducted by DGS CCG in partnership with Bexley CCG and Healthwatch Bexley, was held on 09 January with a group of Bexley patients.

The key findings from this Bexley focused intensive engagement activities are as follows ***(Appendix C)***:

- For Bexley respondents:
    - Accessibility and travel times seem to be the main drivers for patients' decisions when they need urgent care
    - Darent Valley Hospital is relatively easily accessible by car and public transport, and some patients believe that co-location with the A&E department means an Urgent Treatment Centre would provide a higher quality service and provide treatment "all in one place". Having said this, car parking at the Darent Valley Hospital site, was also raised as a concern for Bexley residents.

[12] http://cfps.org.uk.surface3.vm.bytemark.co.uk/domains/cfps.org.uk/local/media/uploads/33.pdf

- An Urgent Treatment Centre at Darent Valley Hospital is seen as a potential alternative option rather than as a first choice as there are two well regarded Urgent Care Centres within the Bexley boundary.

- A third of Bexley respondents felt there would be no impact or very limited impact for them as a result of the siting of a future Urgent Treatment Centre as they would be unlikely to use any of the alternatives in Dartford, Gravesham or Swanley.

- Whilst there was no suggestion from the initial survey that patients might look towards Bexley urgent care services, staff and doctors at both Erith Hospital and Queen Mary's Hospital commented that they saw a significant number of patients from Dartford, Gravesham and Swanley, and this was attributed to pressures, difficulty in securing GP appointments, long waits at Darent Valley Hospital and frequent referrals from NHS 111 and GPs. Recent GP closures in Dartford were also cited.

Evaluation of public consultation process

The consultation process was independently evaluated. The independent review found that the CCG:

> *"made considerable efforts to engage widely and reach relevant groups of residents and stakeholders through an inclusive process, invited response through a variety of channels, and can provide evidence to show how the exercise met the key requirements and best practice"* ***(Appendix A page 11)***

The relevant requirements and standards in respect of public and stakeholder consultation, and the CCG's performance against those requirements and standards, along with the independent evaluator commentary, are shown in the table below ***(Appendix A pages 12 and 13)***. All requirements and standards relevant to engagement were found to have been met.

Requirement	***Comments***
The Secretary of State for Health's four tests	*(NB. only one of these relevant to public engagement)*
1. Strong public and patient engagement	*The response and participation level in this consultation was high, and a variety of channels were provided through which people gave views*
Code of Practice	
A. Consultations should be clear and concise	*The consultation document set out clear Options for location of the new UTC*
B. Consultations should have a purpose	*This consultation set out two clear Options for location of the new service, and detail is provided on the governance and decision-making process which will follow*
C. Consultations should be informative	*A great deal of information was provided about the case for change, the process for developing options and making decisions and the relative strengths of each Option*
D. Consultations are only part of a process of engagement	*This consultation builds on strong previous patient and public engagement exercises, and used existing well-established communication channels developed by the CCG and its partners*

E. Consultations should last for a proportionate amount of time	*The consultation lasted for 12 weeks, which is considered appropriate for public sector engagement exercises (set out in Code of Practice)*
F. Consultations should be targeted	*Both in respect of groups sharing protected characteristics - and more broadly – groups likely to be high-level users of urgent care, or face access issues were identified, and clear efforts made to ensure that representatives and individual voices from these groups provided insight to inform the consultation*
G. Consultations should take account of the groups being consulted	*This report provides a detailed analysis of the views of people participating in the consultation, as well as including separate independent reports focused on seldom heard groups and mitigations to perceived weaknesses in the Options* *Together, these provide a summary of views heard to inform the CCG's decision-making meeting and local authority scrutiny*
H. Consultations should be agreed before publication	*This builds on a significant period of pre-consultation development and engagement, and there was a rigorous, inclusive process through which Options were evaluated (set out in the consultation documents), and broad agreement by commissioners and providers to proceed to consultation*
I. Consultation should facilitate scrutiny	*The CCG has engaged widely during the development of the Options and consultation plans, including with local authority scrutiny - this report will form part of the papers for forthcoming review* *The consultation documents are clear about the relative strengths of each Option and the broader challenges for urgent care in Dartford, Gravesham and Swanley – this information enables well- informed analysis through which proposals can be scrutinised by stakeholders and residents*
J. Government responses to consultations should be published in a timely fashion	*Not relevant*
K. Consultation exercises should not generally be launched during local or national election periods.	*Not relevant*
Gunning Principles	
1. Consultation must take place when the proposal is still at a formative stage	*This is a genuine process to explore views between two alternative Options for location of the UTC*
2. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response	*The consultation document and other materials provided a great deal of clear, 'in context' information about the case for change and relative strengths of different Options to enable well-informed responses*
3. Adequate time must be given for consideration and response	*The consultation lasted for 12 weeks, which is considered appropriate for public sector engagement exercises (set out in Code of Practice)*
4. Feedback from consultation must be conscientiously taken into account.	*This report provides a detailed analysis of the views of people participating in the consultation, as well as including separate independent reports focused on seldom heard groups and mitigations to perceived weaknesses in the Options* *Together, these provide a summary of views heard to inform the*

	CCG's decision-making meeting and local authority scrutiny
Equality	
Equalities impacts	*Likely impacts were identified before consultation began through an Equalities Impact Assessment which was published by the CCG, and this was repeated post-consultation* *Engagement with seldom heard and equalities groups is summarised in this report and as* ***[Independent Evaluation Report*** *Appendix C] and an independent engagement exercise with three specific communities commissioned, with report at* ***[Independent Evaluation Report*** *Appendix D].*
Public sector equality duty (PSED)	*The consultation process was inclusive and participation levels high, notably by residents sharing protected characteristics: minority ethnic communities, older people, people with disabilities, faith communities (see demographic breakdown)*

Public comments on the public consultation process

Comments from members of the public regarding the consultation process, suggested improvements could be made to the publicising of the consultation and associated events, venue selection, and data availability. Concerns were also raised regarding predetermination of the consultation outcome, and concerns that proposals may represent cuts to services, or a step towards privatisation of NHS services ***(Appendix A page 8)***.

Consultation findings and key themes

The findings from the independent analysis of the quantitative and qualitative data from the public consultation are summarised below ***(Appendix A)***:

The consultation was characterised by a very large late surge in responses (last 72 hours of the 12 week consultation period), with an over-whelming majority in favour of the Gravesham Community Hospital option.

Key information regarding consultation respondents:

- 91% of responses were in a personal capacity (therefore own and uninfluenced)

- The sample of respondents skews slightly towards women over 45 years old and apparently towards those who identify as White British although 21% of respondents chose not to describe their ethnic origin. 48% of respondents identified as 'Christian'. Analysis of DGS CCG local population ethnicity, based on the most recent census data (2011)[13] shows 84% of people identified themselves as English/Welsh/Scottish/Northern Irish/British, and 16% as other ethnic backgrounds. In an attempt to provide a more up-to-date ethnicity profile for the local populations

[13] https://www.dartfordgraveshamswanleyccg.nhs.uk/members/ccg-staff-zone/equality-diversity-inclusion-tools/bme-population-breakdowns/

- 12% considered themselves to have a disability (predominantly physical disability)
- 46% of respondents have a caring responsibility (most likely of children)
- 68% of respondents have used the Minor Injuries Unit and over 50% have also used Fleet Health Campus Northfleet and A&E at Darent Valley Hospital showing that all services are very important to the local community
- 66% of respondents claim to have used a car when accessing urgent care services previously and only 11% of people said they used public transport

Whilst it is important to consider the report in its entirety, there are a few key points that can summarise the feedback received:

- There were four consistent key themes across both questionnaire and engagement events and all relate to access:
    - Proximity of the site (distance to travel to the service)
    - Traffic
    - Public transport
    - Parking

- Overall, 80% of respondents supported the siting of an UTC at Gravesham Community Hospital vs. 5% supporting an UTC at Darent Valley Hospital.
    - Respondents in DA11 (area around Gravesham Community Hospital) very highly endorsed Option 1 as this option sits within their local postcode area, and is therefore much easier to access for local residents. 85% of people who claim to live in this area 'Strongly Agree' that Gravesham Community Hospital is the better site for the new UTC and 90% 'Agree overall'.
    - Residents of DA2 (area around Darent Valley Hospital) are more polarised in their opinion of moving the UTC to Darent Valley Hospital. Less than half (43%) 'Strongly Agree' that it would be the best option, while nearly a third (31%) 'Strongly Disagree' with this option.

- 25,000 free-text responses were received. Analysis of free-text samples to establish if the responses indicate different issues or concerns between the respondents that preferred each option:

- For both groups, ease of journey is the main driver of site preference and ease of access is the main concern, followed by parking issues, and concerns about other services at the site

- For respondents who preferred Gravesham Community Hospital the site was easier and cheaper to reach, had better parking (availability and cost), and they shared concerns that Darent Valley Hospital facilities are already overstretched and an UTC at the Darent Valley Hospital site might lead to longer waiting times

- For respondents who preferred Darent Valley Hospital proximity to site was important, and co-location of services at the site was favoured

- Consultation responses did surge significantly in the last 72 hours of the 12 week consultation period. Analysis of the preferences of early and late responders was carried out to better understand the views of early and late consultation responders. The analysis revealed that Gravesham Community Hospital was the preferred site regardless of the timing of the respondent's feedback:

    - Late responders: 93% favoured Gravesham Community Hospital vs. 3% favouring Darent Valley Hospital.

    - Early responders: 75% favoured Gravesham Community Hospital vs. 22% in favour of Darent Valley Hospital.

- Other valuable comments made, all of which also relate to access issues, included feedback on the following:

    - Access needs of local communities, particularly residents who may not have English as a first language or with access issues linked to deprivation or age (e.g. reliance on public transport)

    - Pressures on local services, particularly the rapid growth in some areas such as Ebbsfleet Garden City, and specific concerns raised regarding the level of activity at Darent Valley Hospital

    - Need for greater accessibility (especially appointments that are easier to access) and more care provided in non-acute settings, in particular general practice

- General comments were made about the need for the CCG to communicate effectively when introducing new services and educating the public on the most appropriate way to access all local health services

Post consultation feedback

After the consultation period, the CCG received a letter from Gravesham Borough Council, regarding a resolution unanimously passed at the Gravesham Borough Council meeting on 17 December 2019. The resolution echoed concerns raised by Gravesham Borough Councillors and members of the public during the consultation period and featured within the consultation feedback considered in the evaluation report.

Consideration of the consultation process and activity

The consultation process and activity were considered by the CCG's Governing Body and the Kent Health Overview Scrutiny Committee to determine whether the CCG had fulfilled its statutory obligation regarding public consultation.

Consideration by the CCG Governing Body

The Consultation process and activity were considered at the Governing Body meeting on 28 November 2019.

The CCG Governing Body considered the following questions to assist its evaluation of the consultation process:

- Did the consultation secure the involvement of key stakeholders?
- Was everyone given a reasonable opportunity to state their views?
- Was it possible to engage with a diverse set of views?
- Did anyone with a significant viewpoint fail to participate?
- How do the key themes and issues arising from the consultation impact on the decision making?

The Governing Body determined that:

- The consultation secured the involvement of key stakeholders.
- The consultation gave the public a reasonable opportunity to state their views.
- The consultation engaged with the public in such a way as to welcome a diverse set of views.
- All those likely to have significant viewpoints were welcomed to participate.
- Having considered all available information, and heard the concerns of consultation respondents, that mitigations for the issues raised would be developed as part of the Decision Making Business Case (DMBC) and implementation planning.

The CCG Governing Body agreed that the extent of consultation and engagement activity undertaken during the consultation period, the number of responses received, and the consistency of the themes coming through from the feedback gathered, meant the themes arising from the consultation can reasonably be relied upon to be a fair representation of the views of the local

population across its three constituent areas (Dartford, Gravesham and Swanley), as well as those in the neighbouring areas who provided input.

Consideration by the Joint Health Overview and Scrutiny Committee

The Kent Health Overview and Scrutiny Committee (with two Bexley COSC members in attendance) met on 16 December 2019 to review and consider the consultation process and to receive an update on the next steps in the urgent care review..

The HOSC councillors (including Bexley COSC members in attendance) put a number of questions to three members of the DGS CCG urgent care review team about the consultation process, the consultation responses, the potential mitigations, and the next steps.

The HOSC Committee members reached unanimous agreement that Dartford, Gravesham and Swanley CCG has discharged its statutory responsibility regarding the public consultation into the location for an Urgent Treatment Centre. However, in view of the concerns expressed by Bexley councillors that the proposals represented a substantial variation, the committee supported the CCG's plans for additional engagement with Bexley residents to inform the final Governing Body decision.

The HOSC comments can be summarised as follows:

- The Committee recognised the access concerns raised in the public consultation responses and the opportunities for Health and Kent County Council to work together with NHS and other agencies to address access issues relating to road congestion and public transport

- The Committee discussed the two options and recognised the need to retain walk-in GP services in Gravesham, and for the public to have access to the wide range of services available on the Darent Valley Hospital site

- The Committee wanted the Governing Body decision to ensure that it addressed :

    - the growth anticipated in Ebbsfleet and north Bexley

    - the need for sufficient staffing and provision of clinicians to provide required services

    - the tight timeframe for the implementation available so that people are not left without services

- Bexley COSC attendees expressed concern that if the Gravesham Community Hospital site was chosen for the Urgent Treatment Centre, that a greater number of people living in the West of the CCG may choose to attend Bexley urgent care services (Erith Urgent Care Centre, and Queen Mary's Hospital Sidcup Urgent Care Centre) than travel east to Gravesham Community Hospital.

- The Committee raised a number of queries relating to the possibility of a two site Urgent Treatment Centre model making use of both Gravesham Community Hospital and Darent Valley Hospital

- The Committee recognised the overwhelming consultation response in favour of Gravesham Community Hospital.

The HOSC Committee members reached unanimous agreement that Dartford, Gravesham and Swanley CCG has met its statutory responsibility regarding the public consultation into the location for an Urgent Treatment Centre.

Identifying appropriate mitigation

Approach

Following consultation, a process was undertaken to identify appropriate mitigation; mitigation that might best address the needs of the local urgent care system, as well as address the concerns raised through the public consultation process.

Post-consultation – options appraisal meeting

A Post Consultation - Options Appraisal meeting, attended by CCG clinical, executive, commissioning, finance and communications and engagement representatives, took place on 18 November 2019 to review:

(i) the pre-consultation options appraisal process

(ii) consider the public consultation activities and consultation response key themes

(iii) consider the outcome of travel mapping

(iv) review the refreshed Equality Impact Assessment

(v) agree next steps.

It was agreed by the group that the desirable criteria (applied to consultation options pre-consultation) was still valid. The group considered concerns about how residents currently using the Walk-in-Centre and Minor Injuries Unit located within Gravesham might be affected under a single site UTC model as further developments in primary, local and urgent care are either:

- not yet consistently felt by the public,
- or the development is still in design stages (included but not limited to Primary Care Networks, NHS111 and Clinical Advice Service, and Integrated Care Partnerships).

The group also considered the concerns expressed, regardless of preferred option, regarding access issues at the Darent Valley Hospital site (congestion on roads, public transport, parking, parking costs). The group acknowledged these concerns regarding access and also noted that solutions were not yet in place.

The group considered public concerns re: growth in the DGS area and impact on services perceived to be 'already stretched'.

The group reached unanimous consensus that a single site solution for urgent care across Dartford, Gravesham and Swanley was unlikely to mitigate well placed concerns raised during the public consultation.

The group also agreed that the overlap between urgent, local and primary care made it necessary to consider all urgent, local and primary care needs when identifying potential mitigations, and some time may well be needed to consider the ways in which primary care developments can support the future UTC model.

The group discussed mitigating concerns raised in consultation by exploring the provision of urgent care services (currently provided by Walk-in Centre, Minor Injuries Unit and A&E) from both sites (Gravesham Community Hospital and Darent Valley Hospital) via a 'networked model of care'. This would help address the uncertainty in the current healthcare landscape as various important healthcare developments and transformational work that are currently underway, continue to progress and deliver the intended benefits to the local population; workforce and other resource considerations.

Networked model of care

A networked model of care was first outlined in NHS England's 'Urgent Treatment Centres – FAQs to support implementation' document updated in August 2019[14]. The relevant sections are provided below:

> ***"What options are there for services that may have exceptional reasons for not maintaining the minimum service offer?***
> *Designation as an UTC for services not offering the full specification should be considered exceptional. NHS England and NHS Improvement regional teams will review any requests from localities for such exceptions. To ensure patients have a clear understanding of the service offer expected at an UTC anywhere in the country, these exceptions will not be commonly granted. There may be opportunities for a limited offer to form part of an alternative community service, or to provide an enhanced offer within, e.g. an extended access hub. All services should be clearly identified within an updated and maintained DoS to enable effective referral from NHS 111 and 999 services.*
>
> ***Is it acceptable for services that do not meet the full UTC standards to operate as a 'spoke' service in hub and spoke model?***
> *Services are expected to meet all the UTC standards; however some localities may wish to explore innovative ways of achieving the standards as part of a networked model of care. This could include shared GP leadership across one or more sites or consultation via video link to clinicians in the CAS. Proposals should stand up to the following checks to ensure the UTC vision is not compromised and demonstrate:*
>
> 1. *How clinical care is improved;*
> 2. *How confusion is reduced;*
> 3. *How service offer is improved;*
> 4. *How patient flow is improved;*
> 5. *How the service offer ensures there is consistency of service provision in line with expected standards; and*
> 6. *Consistent and fail-safe access protocols are in place where required – e.g. referral and reporting process for X-ray if this is not on site.*
>
> *Regions should consider proposals on a site by site basis and proposals must be…approved through regional governance structures including approval from regional clinical lead or clinical senate. If accepted there should be clear sign posting on the DoS to the service offer and ongoing evaluation of patient flow and periodic review to ensure the service continues to pass the checks above."*

[14] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres-faqs-v2.0.pdf

Assuring the mitigated model

Background to quality assurance

The urgent care review has sought to meet all obligations in regards to statutory requirements and assurance that accompany any change to NHS services.

Throughout the programme, the urgent care review has:

- Had a clinically-led options development process where clinical, finance and commissioner expertise has been brought together to allow the CCG Governing Body to make the recommendations on service options
- Actively engaged with patients and the public and their representatives, as well as local authorities and their overview and scrutiny committees, providers and other CCGs.

There have been several different forms of assurance that have been undertaken during the urgent care review, all of which are discussed in detail in the pre-consultation business case[15]. The forms of assurance to date can be summarised as follows:

Post consultation assurance of the mitigated model

The Urgent Treatment Centre model has been assured as outlined above. The CCG's proposed mitigation to address public concerns identified through public consultation is to provide the Urgent Treatment Centre model over two sites rather than at a single site, and for services to be networked

[15] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

to ensure they operate in an integrated way, as part of an urgent care system for Dartford, Gravesham and Swanley CCG's local population.

NHSE have been consulted and have considered the mitigations suggested within this paper.

If the mitigated model is supported by the Governing Body, the detailed networked model and revised service specifications will be worked on over the coming months and will be refined in collaboration with current providers of urgent care services, GP membership, including NHS 111, primary and local commissioners and providers.

Assessing the implications of the mitigated model

Description of mitigated model

This section describes the preferred option for the future Urgent Treatment Centre Networked Model of Care in Dartford, Gravesham and Swanley.

The mitigated model is for the implementation of a networked model of urgent care ensuring all networked services combined comply with the 27 national standards for Urgent Treatment Centres.

This model will be refined over time allowing the benefits of other developments such as the extended and improved primary care access, Primary Care Networks, and the Integrated Care Partnership to be realised.

The networked model will consist of the following networked services:

- Urgent Treatment Centre at Gravesham Community Hospital and Urgent Treatment Centre at Darent Valley Hospital (co-located with A&E)

The reason the networked model of urgent care is preferred is as follows:

- Urgent care is not being transformed in isolation, but the other programmes of work are either still in their infancy or the benefits are not yet felt by the local population (e.g. Primary Care Networks, improved/extended primary care access, movement of outpatient clinics away from an acute setting)

- There was general support for an Urgent Treatment Centre model.

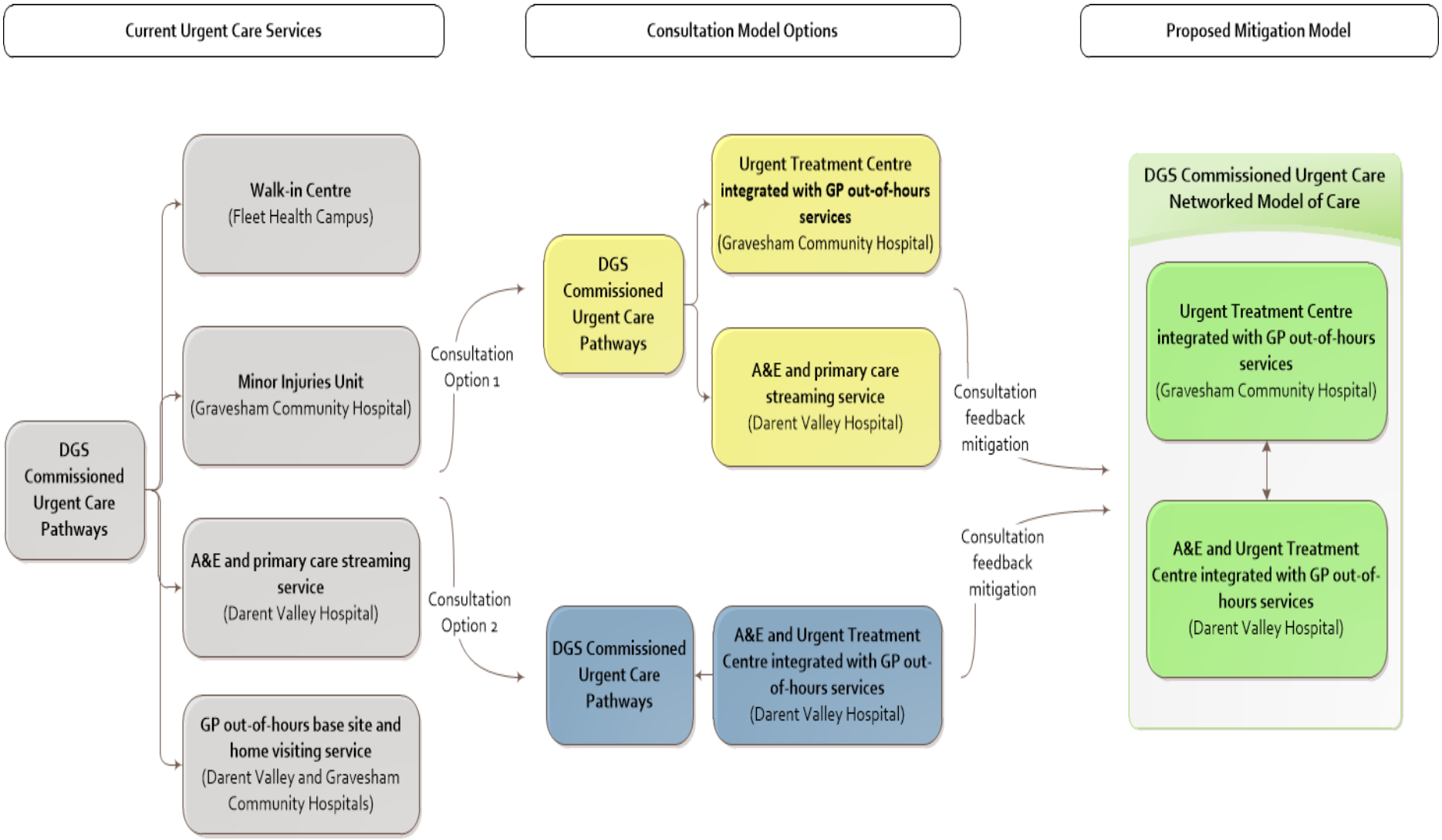
- The consultation responses highlight concerns regarding accessing the Darent Valley Hospital site by car (including issues of congestion and parking availability on-site), and by public transport (limited access for certain routes). Concerns regarding the cost of accessing the site were also raised (parking, taxi costs). The public consultation also identified that the current infrastructure at Darent Valley hospital, was unlikely to cope with any additional footfall, particularly in view of the anticipated growth within the area in the coming years.

- The impact of growth in the area is estimated but may be clearer in the coming years.

- The transformation of the local health system, including the merger of eight CCGs into one CCG and creation of the Integrated Care Partnerships can take place without additional pressures in the system.

- Concerns raised by Bexley councillors regarding potential increased use of Bexley urgent care services by Dartford patients will be addressed through the implementation of urgent care services across two sites (one of which is Darent Valley Hospital) and a robust communications plan informing local residents about local NHS services (including urgent care).

The mitigated networked model of urgent care proposed is shown in the diagram below:


Current Urgent Care Services
Consultation Model Options
Proposed Mitigation Model
DGS Commissioned Urgent Care Pathways
Walk-in Centre (Fleet Health Campus)
Minor Injuries Unit (Gravesham Community Hospital)
A&E and primary care streaming service (Darent Valley Hospital)
GP out-of-hours base site and home visiting service (Darent Valley and Gravesham Community Hospitals)
Consultation Option 1
Consultation Option 2
DGS Commissioned Urgent Care Pathways
Urgent Treatment Centre integrated with GP out-of-hours services (Gravesham Community Hospital)
A&E and primary care streaming service (Darent Valley Hospital)
DGS Commissioned Urgent Care Pathways
A&E and Urgent Treatment Centre integrated with GP out-of-hours services (Darent Valley Hospital)
Consultation feedback mitigation
Consultation feedback mitigation
DGS Commissioned Urgent Care Networked Model of Care
Urgent Treatment Centre integrated with GP out-of-hours services (Gravesham Community Hospital)
A&E and Urgent Treatment Centre integrated with GP out-of-hours services (Darent Valley Hospital)

Careful consideration has been given to identify what urgent, local and primary care services should be provided at each site, and the ways in which services could be networked to ensure the best provision of urgent care possible for the local population within existing resources.

The healthcare system is currently under significant change with the transformation of the eight clinical commissioning groups into a single Kent & Medway Clinical Commissioning Group from April 2020, the implementation of an Integrated Care Partnership in 2021, and the development of Primary Care Networks to improve the health of local populations.

The service specification for an Urgent Treatment Centre as part of a two site networked model of care will be adjusted if supported by the Governing Body. It is clear that the DGS UTC model is intended to achieve the following:

- Bring together the Walk-in Centre and Minor Injuries Unit into an Urgent Treatment Centre by July 2020
- Avoid directing additional patients currently using the Walk-in Centre and Minor Injuries Unit in Gravesham to the Darent Valley Hospital site thereby relieving additional pressure to road congestion, or car parking availability at the acute trust site
- Rejuvenate the GP triage service (also referred to as GP streaming) at the front door of the A&E at Darent Valley Hospital so that patients with issues most appropriately managed by primary care do not add to A&E pressures or longer waiting times
- Integrate services across the two networked sites supported by an effective communications and engagement campaign so that the public can have the best possible understanding of what and how they can access services at each site
- Implement the direct booking system via NHS 111 and 999 at all networked services – this will require specific software (i.e. EMIS)
- Identify if sites will operate as a 'hub' and 'spoke' networked model of care
- Close integration with GP out-of-hours services (including both base and home visiting elements) so that transition from in-hours to out-of-hours services is seamless, maximises use of technology to support effective service delivery, for example, Skype consultations
- The achievement of the 27 national standards for Urgent Treatment Centres across the network (rather than at specific sites). Any networked services will share robust clinical governance processes
- Focus on integration between urgent and local care (making every contact count[16])
- Maximise use of technology to help address workforce challenges
- More joined up working with social care and mental health
- Explore opening hours at Gravesham Community Hospital site to support peak times of attendances at A&E at Darent Valley Hospital as part of a networked model of care.

[16] https://www.makingeverycontactcount.co.uk/

Patient stories

Examples of patient journeys under the Urgent Treatment Centre model were outlined in the pre-consultation business case[17], and remain relevant to the mitigated model. With a two site networked model of care patients will have a choice of which Urgent Treatment Centre to visit and they may consider ease of access or proximity to A&E depending upon their clinical condition.

The Patient	Current Model	UTC Model
Paediatric patient	**Steve and Logan** Steve's 3-year-old son, Logan, has been restless and off his food all day. At bedtime, Steve notices Logan has a rash on his chest and arms. Steve is worried about this so could decide to use any of the current urgent care services. A paediatric patient may currently access any urgent care service. The service accessed may not be the right site for the child to receive the necessary or optimal care. This may require paediatric patients to be transferred between services. A child taken to the MIU who may require the care of a GP in relation to minor illness will not be able to be appropriately treated at the nurse led and delivered MIU, conversely a child brought to the WIC who may require treatment for a minor injury would need to be referred to the MIU or A&E for diagnostics/treatment. The WIC and MIU do not have paediatric only waiting areas – "DARENT VALLEY HOSPITAL" A&E is equipped with a paediatric only waiting room.	**Steve and Logan** Steve's 3-year-old son, Logan, has been restless and off his food all day. At bedtime, Steve notices Logan has a rash on his chest and arms. Steve is worried about this so phones NHS 111 for advice. The NHS 111 advisor books Logan an appointment at the Urgent Treatment Centre at 8pm. Depending on where Steve lives in DGS, Steve may have to travel to the new UTC by car, public transport or foot. Steve lives just a few streets from the Urgent Treatment Centre so walks there with Logan in his pushchair. Steve explains to the GP that he is worried Logan might have meningitis. The GP reassures Steve that Logan's rash is due to chickenpox. The GP gives Steve advice on how to care for Logan while he has chickenpox, and they leave the Urgent Treatment Centre. Logan is in bed asleep by 9pm. Under the UTC model a paediatric patient can present at the UTC with any minor illness or injury issue and be assess and treated by a multi-disciplinary team with immediate access to simple diagnostics. Patients will be able to leave the UTC with prescribed medication where necessary and if medications are not available from dispensing cupboards on-site, the UTC will have an on-site pharmacy or access to a nearby

[17] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

		community pharmacy.
Patient presenting with a mental health issue	**<u>Mike</u>** Mike is eighteen, and has a history of depression, for which he has seen CAMHS in the past, and now sees MIND. He is having counselling, and taking medication but things are getting worse. One night he returns at 6.30, and his mother is worried about his mental state. Patients may present with mental health issues at any urgent care service. With so many access points it is not always possible to ensure consistency in the skills and experience of staff to quickly recognise and appropriately manage patients presenting with mental health issues, whether paediatric or adult.	**<u>Mike</u>** Mike is eighteen, and has a history of depression, for which he has seen CAMHS in the past, and now sees MIND. He is having counselling, and taking medication but things are getting worse. One night he returns at 6.30, and his mother is worried about his mental state. She was previously given Kent County Council's Single Point of Access telephone number for urgent / out of hours issues 24/7 by Mike's GP, but her phone is uncharged, and she decides to take him to the Urgent Treatment Centre. Triaged as a priority at the door, Mike sees the Liaison Mental Health Nurse, who establishes a plan to upgrade Mike's support via the CRISIS team, and Mike and his mother leave for home at 10pm with firm arrangements for help to be provided intensively in the community over the next few weeks. The UTC model encourages strong links with other community urgent care services, such as mental health crisis support. All Urgent Treatment Centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.
The deteriorating patient	**<u>Chen</u>** English is not Chen's first language, and when he calls 111 complaining of 'belly ache', there are communication issues. Under the current system, Chen could be sign-posted to either the Walk-in Centre at Gravesham Community Hospital or the GP streaming service at Darent Valley Hospital. Deciding Chen may well have chest	**<u>Chen</u>** English is not Chen's first language, and when he calls 111 complaining of 'belly ache', there are communication issues, and the 111 operator books him into the Urgent Treatment Centre for safety. Once there, he is noted to be a pale, sweating man in his 50s, who obviously smokes. When asked to indicate the

	pain from his heart rather than anything abdominal, staff at Gravesham Community hospital would have to call an ambulance for Chen to be transferred to A&E. Currently staff working at different urgent care services will assess the clinical risk of presenting patients and may unnecessarily escalate patients to the A&E because their services either do not have the skilled staff required (e.g. doctors or nurses with specific skills), or the necessary equipment (e.g. diagnostics) to appropriately care for the patient if they were to deteriorate suddenly. Patients who deteriorate while receiving care at one of the current sites would need to be stabilised, and would have to wait to be transferred by ambulance to A&E.	site of his pain, he vigorously pats his chest rather than his abdomen. Deciding he may well have chest pain from his heart rather than anything abdominal, the Urgent Treatment Centre team take him straight through to the Emergency Department, where they confirm that Chen has suffered a heart attack. Chen receives immediate skilled attention, as the A&E staff have been freed from many lesser tasks by the Urgent Treatment Centre, to focus on those with life threatening conditions. Chen recovers and is able to leave hospital leaves ten days later. The new UTC model enables new larger teams of multi-disciplinary clinical staff to be based on one site with access to more extensive diagnostics than are currently provided at urgent care services If Chen attended the UTC at Darent Valley Hospital, he would have been transferred to A&E on site; if he went to the UTC located at Gravesham Community hospital, then he would be transferred to the A&E department at Darent Valley Hospital by an ambulance.

Activity implications

Activity implications of the mitigated model are explored in the financial modelling section below.

A two site networked model will allow current Walk-in Centre and Minor Injuries Unit activity to be seen at an Urgent Treatment Centre at the Gravesham Community Hospital site.

It is anticipated that an Urgent Treatment Centre at Gravesham Community Hospital will see approximately 144 patients on average per day over the 5 year modelling period.

The model will not encourage increased urgent care footfall on the Darent Valley Hospital site, but an Urgent Treatment Centre co-located with the A&E at Darent Valley Hospital, will allow patients to be streamed to the Urgent Treatment Centre and will help ease the pressures in A&E.

It is anticipated that an Urgent Treatment Centre at Darent Valley Hospital will see approximately 68 patients on average per day over the 5 year modelling period.

No assumptions have been made regarding the potential impact of NHS 111 developments on urgent care face-to-face attendances at either Urgent Treatment Centre within the networked model of care.

Estates plans

The CCG explored the estate implications of an Urgent Treatment Centre at both Gravesham Community Hospital and Darent Valley Hospital within the pre-consultation business case[18].

Gravesham Community Hospital

Space at Gravesham Community Hospital is currently under utilised.

It has been established that the site can accommodate an Urgent Treatment Centre without significant estate changes or service moves.

The siting of an Urgent Treatment Centre at Gravesham Community Hospital does mean that there will be less vacant space at the site to accommodate other services that may be developed by Primary Care Networks/GP Federation, although more space may be created by the movement of other services on the site.

Darent Valley Hospital

Dartford and Gravesham NHS Trust have confirmed to the CCG that an Urgent Treatment Centre service could be co-located with the A&E department at Darent Valley Hospital.

The current primary care streaming service would be absorbed in to the Urgent Treatment Centre service. Darent Valley Hospital also hosts the main base site for the GP out-of-hours service and this will need to be included in discussions.

It has been anticipated that the site can be made to accommodate an Urgent Treatment Centre without significant estate changes but some service moves will be required.

Travel and access implications

Travel and access implications should remain as they currently are now with existing urgent care services.

The CCG will work with Kent County Council and Dartford and Gravesham NHS Trust to address the wider issues regarding transport and access to healthcare raised through the public consultation.

Equalities implications

The Equalities Impact Assessment (EIA) last undertaken during the pre-consultation stage was refreshed following the successful completion of the twelve week public consultation. The refreshed

[18] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

EIA was reviewed and supported by the Equality and Diversity Working Group in November 2019 and is provided in ***Appendix B***.

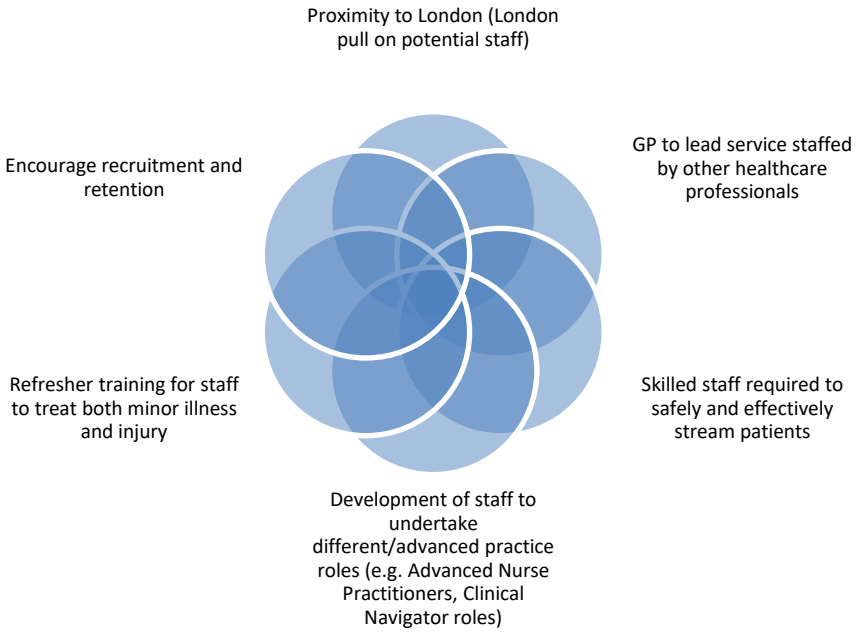
Engagement with protected characteristic groups echoed the feedback in the consultation evaluation report regarding access, and highlighted some other important points for consideration by the Governing Body:

- Access issues (including access to public transport for people without a car, limited disabled parking at Darent Valley and Gravesham Community Hospitals, road congestion issues around Darent Valley Hospital, cost of parking)
- Availability of GP appointments was a concern
- Limited British Sign Language translators for urgent care episodes
- More visual materials would be helpful e.g. video with signer because of low literacy rates
- Consideration of the following points in the Urgent Treatment Centre's service specification:
    - Staff need awareness of treating patients in distress (Mental Health) - privacy issues
    - Patients need to be assured regarding additional measures relating to privacy and dignity when treating gender reassignment patients
    - Adequate provision of privacy for breastfeeding mothers is required
    - Translation for local people with English for Speakers of Other Languages (ESOL) needs
    - For Jehovah witness patients, ensure an UTC has a "Cell machine" to re-cycle blood (in place at Darent Valley Hospital)
    - Staff awareness of religious practice (NICE guidance) and provision of a prayer room or chaplaincy service should be made available.
    - Gender equality training incorporated into all provider staff training and evidenced to the CCG as part of the Equality Delivery System (EDS2) reporting.
    - Improve staff awareness of entitlement to reclaim expenses.

Workforce implications

There are workforce implications to a two Urgent Treatment Centre site networked model of care. Implications will include those identified in the pre-consultation business case[19] and outlined earlier within this paper:

[19] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/



The current workforce may well prefer the two site model as staff may continue to work at the same site or a site very nearby. This will hopefully mean that they will have the same journey to work whether this is by car, on foot or by public transport.

It is envisaged that new and existing staff will be deployed to support a new Urgent Treatment Centre. Current urgent care skilled staff delivering services as part of the Minor Injuries Unit and Walk-in Centre would be offered the opportunity to transfer to one of the two future Urgent Treatment Centre sites.

It is hoped that the urgent care proposals will offer career development for some members of the existing urgent care workforce.

The workforce model will be set out when the service specification is finalised and after the Governing Body has considered the DMBC and decided on the future Urgent Treatment Centre configuration.

Financial impact of mitigated model

An urgent care networked model of care over two sites (Gravesham Community Hospital and Darent Valley Hospital)

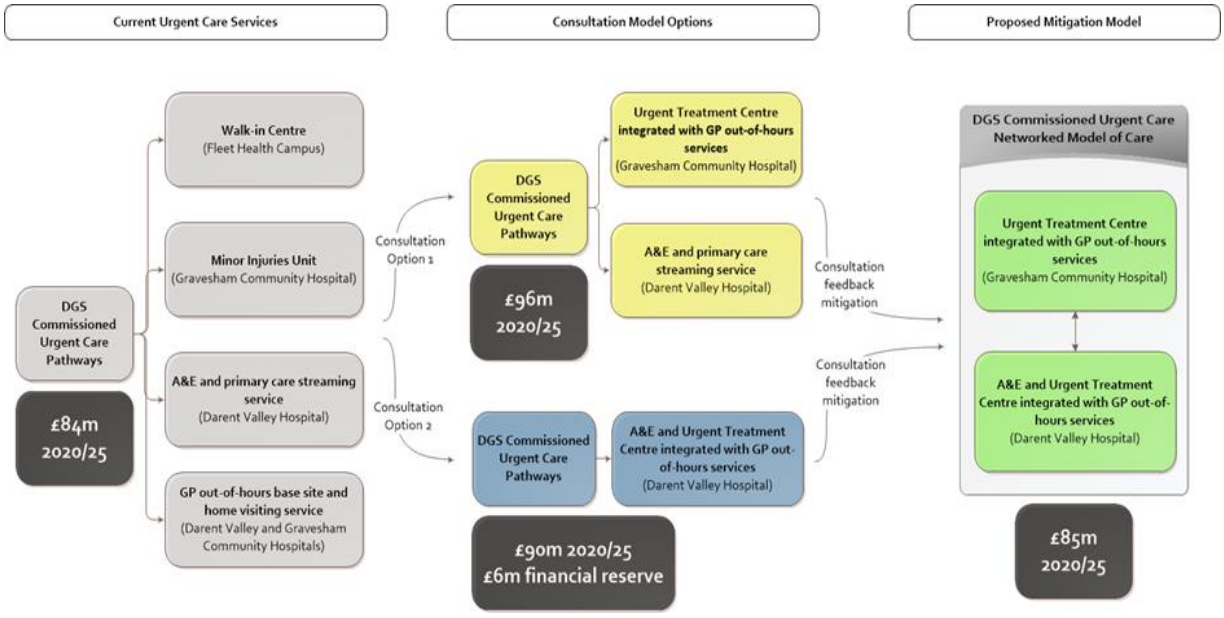
The proposed mitigation model of an urgent care networked model of care, at two sites over five years 2020-2025 is modelled to be £85m compared to the projected cost of the current urgent care service provision of £84m. This excludes the potential impact of void estate charges at Fleet Health Campus.

Financial modelling assumptions have been based on patient activity with an assessment of what the potential price would be for a unit of patient care activity in the proposed mitigated model of urgent care (consistent with all options modelled).

The CCG recognises the potential complexity of patients that would be clinically appropriate for transfer to a UTC, and in the proposed mitigation model, the unit price of urgent care activity at Darent Valley Hospital is £100 compared to the £73 unit price used for Gravesham Community Hospital. The £73 is an important benchmark to note as urgent care activity in a networked model of care is classified as a type three A&E service which currently attracts a tariff price of £73 in 2019/20.

The financial modelling assumptions utilised are based on projected activity flows that assumes:

- WiC activity at Fleet Health Campus flows to Gravesham Community Hospital
- The impact of future demographic growth
- 1% tariff future annual tariff increases
- The impact of historical activity trends
- The impact of current A&E activity including primary care streaming converted to urgent care activity flowing through the network model of care assumptions
- That current Darent Valley Hospital site activity related to urgent care does not change
- That tariff assumptions utilised for service provision, when considered in aggregate, is likely to cover the total costs of providing the service.



A summary of the financial modelling undertaken to support the development of the mitigated model is outlined in the table below:

Overall financial assessment		
Urgent care models	**5 year projected costs 2020/25 £m**	**Key notes**
Current urgent care provision (Darent Valley Hospital A&E, Gravesham Community Hospital Minor Injuries Unit and Walk-in Centre)	84.0	• Assumes current activity trends
Proposed mitigation model An urgent care networked model of care over two sites (Gravesham Community Hospital and Darent Valley Hospital)	85.0	• Assumes 33% non-ambulance A&E conversion rate at Darent Valley Hospital to Urgent Care Network on site. • Operates a dual "Urgent Care Network" tariff that is site specific - £73 for Gravesham Community Hospital site - £100 for Darent Valley Hospital site • 100% conversion of current A&E primary care streaming at Darent Valley Hospital to Urgent Care Network on site. • Assumes all current activity flows to WiC are now addressed by Gravesham Community Hospital Urgent Care Network Site

Urgent Treatment Centre and A&E at Darent Valley Hospital	89.8	• Includes a £6m reserve for additional primary/local care services (if required) • £100 UTC tariff • 33% non-ambulance A&E conversion rate to UTC • 100% conversion of current A&E primary care streaming to UTC
Urgent Treatment Centre at Gravesham Community Hospital and A&E at Darent Valley Hospital	95.9	• Includes a £0.2m reserve for additional resources required to address wound care • £100 UTC tariff • 0% conversion of current A&E Darent Valley Hospital activity

Business case pre-consultation and post-consultation modelling scenarios

The pre-consultation business case modelling focused on a single site model for each of the two consultation site options over a 5 year period (i) Gravesham Community Hospital and (ii) Darent Valley Hospital.

The full modelling can be accessed in the pre-consultation business case[20]; however the summary financial and activity modelling for each of the consultation options are detailed in attached appendices:

Current Services (Minor Injuries Unit, Walk-in Centre, A&E)	£84m projected 5 year cost ***(Appendix D)***
An Urgent Care Networked Model of Care over two sites (Gravesham Community Hospital and Darent Valley Hospital)	£85m projected 5 year cost ***(Appendix E)***
An Urgent Treatment Centre at Gravesham Community Hospital	£96m projected 5 year cost ***(Appendix F)***
An Urgent Treatment Centre at Darent Valley Hospital co-located with ED	£90m projected 5 year cost ***(Appendix G)***

[20] https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/

Sensitivities of financial modelling based on activity and an associated tariff

The business case modelling has been based on projected activity assumptions and current patient activities. The CCG currently uses the NHS payment by results mechanism where activity has an agreed contractual price that is either a national price or a locally agreed price.

The use of activity modelling with an associated price generates an aggregated overall financial price that represents the commissioned cost of the service. Where the service is of a reasonable scale and magnitude; the commissioned cost of the service should be reflective of the total actual costs of service provision. The actual costs of a service should include the ability for a provider to generate a financial margin that allows mitigation and management of any unknown operational issues that they may arise such as major incidents.

There are inherent risks that the financial modelling derived for the scenarios may not be representative of the actual costs that may be incurred by the provider of the service. This can be assessed to a degree through the procurement approach by requesting the costing details of the service to test whether the business modelling is an appropriate representation of service cost. The assessment of service cost for direct input into a service, such as dedicated staffing and equipment is relatively easy to receive assurance about; however non-direct overheads that are attributed to a service such as management overheads, estate costs, IT costs and corporate overheads are inherently more difficult.

A thorough procurement process will allow the CCG to test the validity of its modelling assumptions. The ideal condition for procurement is when there is healthy competition from many providers interested in providing the service specification. Where there is minimal or no competition to provide the service, then it is often the case that the financial envelope for procurement set by the CCG, based on its modelling assumptions, will be the eventual cost of the service.

The CCG will need to carefully consider the procurement route and market providers once an approved option is decided upon.

Implementation plan

Outline programme implementation plan

Any decision to proceed with the mitigated model is dependent on the Governing Body's consideration of the DMBC and their final decision.

Following decision-making, it is expected that some transition time would be required to set up governance arrangements and finalise plans to progress implementation, but this time will be kept as short as possible to support early implementation.

A phased approach would be required to ensure the networked model of care and/or service specification(s) meet the needs of the local population and can be delivered in a safe and sustainable way. This may be particularly important given the changing healthcare landscape. For example, once 12 months of data is available from the new NHS 111 and Clinical Advice Service (in place from April 2020), it will become clear how significantly greater levels of clinician input in to the Clinical Advice Service will impact on patient flows to face-to-face urgent care services.

Key implementation activities and programme plan

The ambition is to implement the new Urgent Treatment Centres as quickly as possible whilst ensuring that quality and patient safety are not compromised, and that services are in place by the end of June 2020 in line with current contract expiry dates.

There must be no gap in service provision as the transition from Walk-in Centre and Minor Injuries Unit, to Urgent Treatment Centre takes place. This will involve close collaboration between commissioners and current urgent care providers including Springhead Health (formerly Fleet Health), Kent Community Health NHS Foundation Trust, Dartford and Gravesham NHS Trust and IC24, as well as estate teams at Gravesham Community Hospital, Darent Valley Hospital and Fleet Health Campus.

Key issues for consideration will be as follows:

Phased Approach	**Actions**
Phase 1 February 2020 – June 2020 Establishment of Networked Model of Urgent Care	1. Amend service specification drafted for a single site (including GP out-of-hours base site and home visiting services), to accommodate a networked model of care across two Urgent Treatment Centre sites, with the engagement of all relevant stakeholders. Amendments should include, but not necessarily be limited to: • Clinical leadership, staffing, and governance arrangements • Streaming processes • Hours of operation to maximise system benefits • Use of technology to support integration between services • Performance monitoring and reporting • Confirm urgent care tariff for each Urgent Treatment Centre site • Explore the impact of a two Urgent Treatment Centre site with providers of other healthcare services e.g. NHS 111 / 999, ambulance service, mental health services, community services,

	as well as any impact on partners in social care and voluntary services that will be required to have formal links with the Urgent Treatment Centres. • Communications and Engagement plan to support the re-location of the Whitehorse Walk in Centre and establishment of UTC network
	2. Finalise estate arrangements to accommodate services on each site by July 2020.
	3. Identify most appropriate procurement route to support Urgent Treatment Centres at two sites from July 2020 in the short and long term • Ensure operational teams identified to provide Urgent Treatment Services in the short-term are able to manage services across two sites.
	4. Relocate walk-in services from Fleet Health Campus to Urgent Treatment Centre at Gravesham Community Hospital • Change classification from walk-in centre and minor injuries unit to Urgent Treatment Centre(s).
	5. Establish an Urgent Treatment Centre at Gravesham Community Hospital offering walk-in services for minor illness and minor injury (8am – 8pm) and an Urgent Treatment Centre co-located with the A&E at Darent Valley Hospital.
	6. Intensive comms and engagement activity to support the run up to changes in July 2020 - ensuring that the public and all key stakeholders fully understand the changes and what services are available within DGS, and what they should do to access the right services for the care they need. Key issues to address include: • Relocation of walk-in services from Fleet Health Campus • Change of name for urgent care service at Gravesham Community Hospital • What can patients expect from services at each site • Engagement with existing staff regarding changes and journey towards transition • Specific comms and engagement with patients on the CCG border with Bexley regarding local urgent care services.
Phase 2 July 2020 onwards Refinement of the Networked Model of Care	1. Long-term provider arrangements for Urgent Treatment Centres across two sites to be in place 2. Using data collected over the first 12 months of operation, explore the following: • Refinements to the urgent care networked model of care service specification to maximise the benefits of the Urgent Treatment Centre model (relieving maximum pressure from A&E and ensuing patients can be appropriately cared for via other networked services) • Consider if patients attending urgent care services with primary /

	local care needs can be more appropriately cared for within primary / local care • In what ways Primary Care Network delivered services can best address the needs of local populations and help support the urgent care networked model. 3. Ongoing communications and engagement activity to increase public awareness and understanding of what services are available in DGS and how to use them appropriately. 4. Finalise how urgent care fits within the Integrated Care Partnership arrangements.
Other	1. Work in partnership with Kent County Council and Darent Valley Hospital to explore ways in which access to the site can be improved (including congestion, public transport and availability of parking) to address concerns identified through the urgent care public consultation. For residents in rural areas, access to the Gravesham Community Hospital was also raised as a concern and warrants review.
	2. The CCG to review comms and engagement resources (including provision of pictorial communications for non-English speakers and provision for deaf population).

Governance arrangements for implementation

Clear, consistent and effective governance arrangements will be key to manage risks and dependencies to support implementation. The governance arrangements will build on the structures and processes that have been in place to support the urgent care review to date up to the end of March 2020, and after that point will transfer from DGS CCG to Kent and Medway CCG.

The DGS CCG current Clinical Chair will continue to maintain oversight in their new role as Governing Body member of the new Kent and Medway CCG from April 2020 onwards.

Implementation risks

The implementation of a networked model of care brings risks associated with the implementation of the Urgent Treatment Centre model, and risks of operating an effective networked model across sites. These risks will need to be carefully managed throughout implementation and beyond.

The expectation is for the implementation delivery group to identify and manage all associated risks and report progress through the internal governance process.

Communication and engagement plan

As a result of the wide-reaching public consultation, awareness of the urgent care review is fairly high amongst the general public, and key stakeholder groups including the Kent HOSC, Healthwatch,

councillors, and MPs. This means there is an 'open door' with engaged audiences which will help to achieve the communications and engagement aims going forward.

The primary aim is:

- To inform and engage key audience groups including the public, provider organisations and staff, in order to ensure shared understanding about what services are available at each site and how are these urgent care services can be accessed by patients, .

In order to achieve this aim aims the urgent care review will:

- Provide appropriate information in a timely manner, via a range of channels, to meet the needs of different audiences

- Work with local partners and providers to maximise the impact of the communications and engagement activity

- Make sure public information is consistent and clear; written and spoken in 'plain English' avoiding jargon and technical information and includes visual communications to take account of groups with low literacy rates materials will be available in other languages on request for those who do not speak English and in other formats on request to take account of those with special needs

- Regularly review and evaluate the communications and engagement approach to ensure the needs of all audiences are met.

Benefits of the proposed changes

Feedback from consultation

The consultation received an unprecedented numbers of responses; 16,474 survey responses resulting in approximately 25,000 free-text responses (the majority of which contained multiple points of feedback).

Analysis identified that there were four consistent key themes across both questionnaire and engagement events, regardless of the site preferred by the responder, and all themes identified related to access. As a result of this greater understanding of the key issues affecting the local population, the Urgent Treatment Centre configuration has been adjusted to mitigate, as far as possible, the concerns raised:

The public told the CCG…	**Proposed mitigations to the Urgent Treatment Centre model…**
Proximity of the site People are concerned about how far they might have to travel to access urgent care services.	There will be two Urgent Treatment Centres within the DGS CCG area, one at Gravesham Community Hospital (that can be easily accessed by those patients who currently use the Walk-in Centre at Fleet Health Campus, and those that access the Minor Injuries Unit at Gravesham Community Hospital), and one at Darent Valley Hospital for those patients who currently access the A&E at Darent Valley Hospital, including Bexley residents, with conditions that are not serious or life threatening.
Traffic People are concerned about how traffic and congestion around particular areas might affect how long it might take them to access urgent care.	As above. No additional footfall will be directed towards Darent Valley Hospital. As discussed with the Kent HOSC, the CCG will work together with Kent County Council and Dartford and Gravesham NHS Trust to address access issues at the Darent Valley Hospital site.
Public transport People are concerned about the availability of public transport to allow ease of access to urgent care when it is needed. People are concerned about the cost of using public transport.	As above.
Parking People are concerned about the availability of parking spaces, including disabled parking spaces, at the site of the Urgent Treatment	As above No additional footfall will be directed towards Darent Valley Hospital.

Centre. People are concerned about the cost of parking.	The CCG will continue to work with Dartford and Gravesham NHS Trust to address parking access issues at the Darent Valley Hospital site.
Other important concerns raised:	
Growth People are worried about the current and future anticipated growth in the area, and that healthcare services will be put under additional pressure.	As above. Growth has been included in the modelling undertaken to support the DMBC mitigated model. Growth is monitored by the CCG and the CCG engages with other relevant agencies to ensure requirements on health services are fully understood, and funding to support growth in the area is accessed whenever possible.
Pressures at Darent Valley Hospital People are worried about the pressures on Darent Valley Hospital	The creation of a UTC at Gravesham Community Hospital will avert the increased pressures on Darent Valley Hospital that may result from additional footfall from Gravesend. An Urgent Treatment Centre co-located on the Darent Valley Hospital site to help relieve pressures in A&E by streaming patients attending A&E with non-serious or life threatening issues to primary care practitioners.
CCG Communication and Engagement People asked to have more information from the CCG about healthcare services and how to use them appropriately People from the deaf community asked that urgent care services have better provision to communicate with them than they currently have (provision of British Sign Language translation) People who do not speak English, and those with low literacy levels asked the CCG to provide communications in visual forms to help them better understand what is being communicated	The CCG's Communications and Engagement team will devise a communications strategy to promote understanding about the urgent care services available at each UTC site and how are these urgent care services as well as other local NHS services including Primary Care. The CCG is committed to providing information in line with its obligations under the Accessible Communications Standards and will publicise the CCG offer to produce information in alternative formats on request on all its materials more widely.

The mitigated model will deliver the following benefits:

- An Urgent Treatment Centre in a town centre location, with good transport links, offering treatment for minor illness and minor injury

- An Urgent Care Treatment Centre co-located with an A&E department offering residents in Dartford and Swanley increased access to urgent care services whilst also taking the pressure off the emergency department to enable staff to attend to people with serious illnesses and injuries. An Urgent Treatment Centre located at the Darent Valley Hospital site also addresses the feedback received from Bexley residents.

- Close integration with GP out-of-hours services will support a more seamless transition from in-hours and out-of-hours services across two Urgent Treatment Centre sites

- Allows streaming (triage to the appropriate service) across two Urgent Treatment Centre sites within the networked model of care

- Networked services offering high quality, more consistent urgent care services, and compliant with the 27 national standards for urgent treatment centres

- Ensures, as far as is possible, that current access to urgent care services is protected for residents in all areas of the CCG boundary

- A two Urgent Treatment Centre site model allows the CCG to address the particular needs of our local populations as identified through the public consultation feedback - customising national strategy to address local health inequalities and areas of deprivation within the CCG boundary.

- Avoids directing any increased footfall to the Darent Valley Hospital site, but ensures that if people attend with non-serious or life threatening issues, they can be seen by primary care practitioners

- Addresses concerns of neighbours in London Borough of Bexley, who have expressed concerns that patients may access services within Bexley under a single site model, as DGS patients will have the option to attend two Urgent Treatment Centres within the CCG boundary and may also increase choice options for Bexley residents

- Offering one stand-alone Urgent Treatment Centre networked with an Urgent Treatment Centre co-located with an A&E addresses more directly the urgent care needs of local populations.

- Greater integration of services as part of a networked model of care, supporting streaming between services if appropriate

- Introduce direct booking from NHS111 in to Urgent Treatment Centre(s).

Conclusion and recommendations

Conclusions

Following the review of the pre-consultation options appraisal process and consideration of the public consultation activities and key themes, the conclusion has been reached that a single site solution across Dartford, Gravesham and Swanley was unlikely to mitigate the well placed concerns raised by the public during the consultation, nor would it address the needs of the local urgent care system.

To mitigate the issues raised by local people and stakeholders during the consultation it is recommended that the Urgent Treatment Centre model be provided over two sites rather than at a single site, and for services to be networked to ensure they operate in an integrated way and comply with the 27 national standards, as part of the urgent care system for Dartford, Gravesham and Swanley CCG's local population.

The networked model will consist of the following networked services:

- Urgent Treatment Centre at Gravesham Community Hospital and Urgent Treatment Centre at Darent Valley Hospital (co-located with A&E)

Careful consideration has been given to identify what urgent, local and primary care services should be provided at each site, and the ways in which services could be networked to ensure the best provision of urgent care possible for the local population within existing resources. These proposals will be worked through in the refinement of the Urgent Treatment Centre service specification.

The healthcare system is currently under significant change with the transformation of the eight clinical commissioning groups into a single Kent & Medway Clinical Commissioning Group from April 2020, the implementation of an Integrated Care Partnership in 2021, and the development of Primary Care Networks to improve the health of local populations.

The service specification for an Urgent Treatment Centre, as part of a two site networked model of care, could be adjusted to accommodate any future changes to the healthcare system to ensure services are fully integrated.

A phased approach would be required to ensure the networked model of care and/or service specification(s) meet the needs of the local population and can be delivered in a safe and sustainable way

The ambition, subject to the Governing Body's approval, is to implement the new Urgent Treatment Centres as quickly as possible whilst ensuring that quality and patient safety are not compromised. We plan to have services in place by the end of June 2020 in line with the current contract expiry dates.

If the mitigated model is supported by the Governing Body, the detailed networked model and revised service specifications will be worked on over the coming months and will be refined in collaboration with current providers of urgent care services, GP membership, including NHS 111, primary and local commissioners and providers.

Recommendations

- To approve the implementation of the mitigated model of networked urgent care services with two linked Urgent Treatment Centres at both Gravesham Community Hospital and Darent Valley Hospital (co-located with A&E) by the end of June 2020, as set out in the Decision Making Business Case

- To agree that further work on the detailed networked model, service specification(s) and procurement process, as identified in the key implementation and programme plan in the DMBC, be undertaken over the coming months and refined in collaboration with the current providers of urgent care services and other key partners.

- To agree that the proposed networked model of urgent care is supported by a budget commitment that has a further 2% contingency assigned to it, and is profiled in line with the phased implementation approach.

Appendices

Appendix A: Independent evaluation of consultation (November 2019)	Urgent Care Consultation - Indepe Supplementary analysis vCOMPLETE.
Appendix B: Refreshed Equality Impact Assessment (November 2019)	APPENDIX B - Urgent and Emergency Care
Appendix C: Independent evaluation of Bexley response	APPENDIX C- Independent Evaluati
Appendix D: Current Services (Minor Injuries Unit, Walk-in Centre, A&E)	APPENDIX D - Summary of financial
Appendix E: Urgent Care Networked Model of Care over two sites (Gravesham Community Hospital and Darent Valley Hospital)	APPENDIX E - Summary of financial
Appendix F: Urgent Treatment Centre at Gravesham Community Hospital	APPENDIX F - Summary of financial
Appendix G: Urgent Treatment Centre at Darent Valley Hospital co-located with ED	APPENDIX G - Summary of financial

1. ADDITIONAL ANALYSIS POINTS

1.1 WHERE THESE POINTS COME FROM

The following points are based on **additional analysis of free text comments** provided in response to Questions 5, 6 and 7.

This was undertaken after the main evaluation report was compiled. The purpose was to compare the frequency of comments for those favouring Options 1 and 2 against the headline themes to see if the data indicates different issues of interest or concern between these two groups.

1.2 Q5/6 – PREFERENCE FOR OPTION 1 / OPTION 2.

For both groups

- Ease of journey is the main driver for choice of UTC site, with this being the most commonly stated reason for **both** those preferring Option 1 **and** those preferring Option 2.

For those preferring Option 1 – Gravesham Community Hospital

- Respondents that selected Gravesham as their preference claimed it was easier, as Darent Valley Hospital is harder to access, mainly due to traffic and because it is further from where they live
- **In response to this question** parking is a significantly greater issue among those that selected Option 1. This is due both to a lack of spaces and the cost of parking at the Darent Valley site.
- Those that preferred Option 1 are more likely to believe that the facilities at Darent Valley are overstretched by current patient numbers and that it may not be able to cope with the added patient load the UTC would bring.

For those preferring Option 2 – Darent Valley Hospital

- There is an implication that those who chose the Darent Valley site as their preference did so due to their proximity to the site
- Those that selected Option 2 were more likely to cite co-location with hospital facilities as a reason, implying that respondents were in favour of the Darent Valley because they believe the hospital has on site a more appropriate set facilities to respond to urgent care needs.

1.3 Q7 – COMMENTS ON TOP 3 ISSUES: PARKING; ACCESS TO PUBLIC TRANSPORT; WAITING TIMES

For both groups

- Once again, access is the main issue, and most commonly stated by those that selected **both** Option 1 **and** Option 2
- **In responses to this question**, parking is an issue of equal concern among both groups
- Concern about the level of level of service **at the site they did not prefer** is shared by **both** those who prefer Option 1 **and** those who prefer Option 2.

For those preferring Option 1 – Gravesham Community Hospital

- Once again, the cost and general anxiety about parking at Darent Valley Hospital are the main reasons why parking is seen as an issue for respondents that preferred Option 1
- Respondents who selected Gravesham are more likely to be worried about longer waiting times
- Not enough or good enough public transport links to the Darent Valley site is another concern more commonly stated by those who preferred Option 1
- The overall cost for the patient (both parking and overall perceived cost to get to the UTC) is more likely to be cited by those in favour of Gravesham.

For those preferring Option 2 – Darent Valley Hospital

- There were no comments in response to this question which were significantly higher for those who preferred Option 2 – although it should be noted this was a small minority of respondents.

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Independent evaluation of consultation

Dartford, Gravesham and Swanley Clinical Commissioning Group

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1. EXECUTIVE SUMMARY

1.1 ABOUT THE CONSULTATION

This document contains an independent analysis of responses to the consultation about the future location of a new Urgent Treatment Centre (UTC) at **either** Gravesham Community Hospital **or** Darent Valley Hospital (DVH).

Verve has analysed the data provided to us and in the following sections we have set out to:

- Summarise the quantitative response received via the consultation questionnaire
  - Set out the proportion of responses favouring each of the two options
  - Summarising the responses to other quantitative questions (e.g. services used)
  - Where justified by the data, identifying where there may be significant differences of view between different groups of respondents.

- Review free text responses received through the questionnaire and consider alongside comments made through other channels (roadshow notes; written responses; meeting notes and comments from Listening events)
  - Identify the main themes of comments, picking out those most commonly referenced
  - Produced a high-level summary of the substantive points made by respondents during the consultation.

Based on the information provide to us, we believe that the CCG made considerable efforts to engage widely and reach relevant groups of residents and stakeholders through an inclusive process, invited response through a variety of channels, and can provide evidence to show how the exercise met the key requirements and best practice for public involvement.

1.2 ABOUT THE ENGAGEMENT

Overall the level of engagement and response to this consultation was very high:

- 16,474 questionnaires were completed or partially completed, either print or online
- 10,000 consultation documents were printed and distributed and a total of 10,200 posters and postcards circulated to promote the consultation and events along with local news coverage and Facebook advertising
- A total of 81 people attended three Listening events and a further 1,166 were engaged through a roadshow visiting 30 community venues
- The roadshow included meetings and locations specifically addressing equalities (older people; disability; parents of young children; BAME communities; faith communities) and Engage Kent were commissioned independently to engage people with physical disabilities and residents of rural areas
- Formal meetings were held with key stakeholder groups.

Written responses were invited from statutory and political stakeholders and eight were received. Healthwatch were involved throughout the process from pre-consultation and options appraisal.

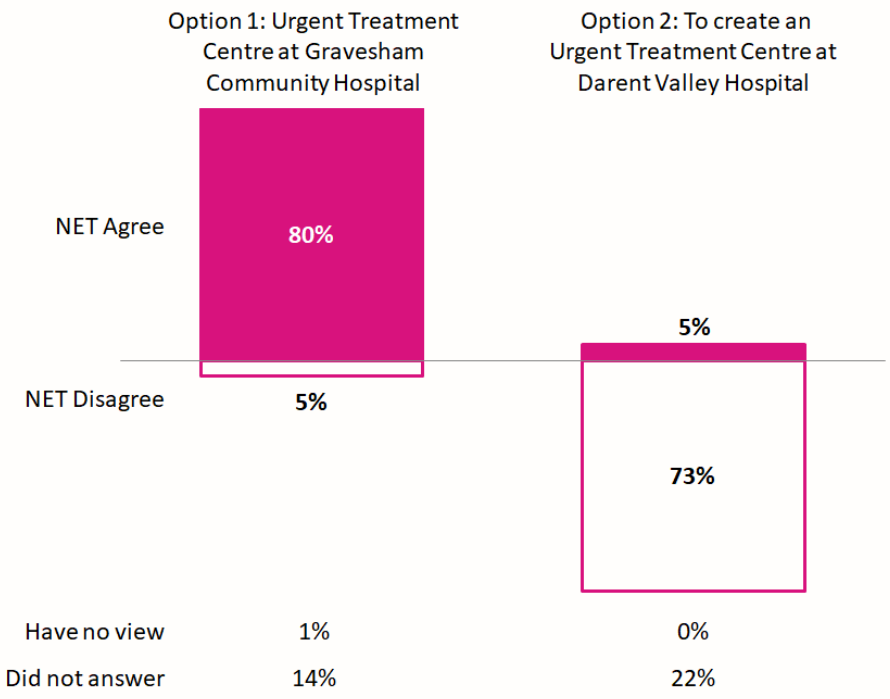
1.3 KEY FINDINGS

1.3.1 QUANTITATIVE ANALYSIS FROM THE QUESTIONNAIRE

The preferences between Options and the following break-down of participants are based on the whole questionnaire dataset (aggregating both printed and online responses).

Overall, 80% agreed or strongly agreed (NET agree) that the UTC should be located at Gravesham vs. 5% (NET agree) that the UTC should be based at Darent Valley Hospital.

Please indicate whether you agree or disagree with the two proposed options...



Base: Total (16,474)

There seems to be a very strong preference for location at Gravesham among those who live closer to the area, which people living close to DVH are more balanced in their preferences.

This consultation was characterised by a very large late surge in responses, with an over-whelming majority in favour of Option 1. Of a sample of the late responders, around 93% favoured Option 1. vs. 3% favouring Option 2.

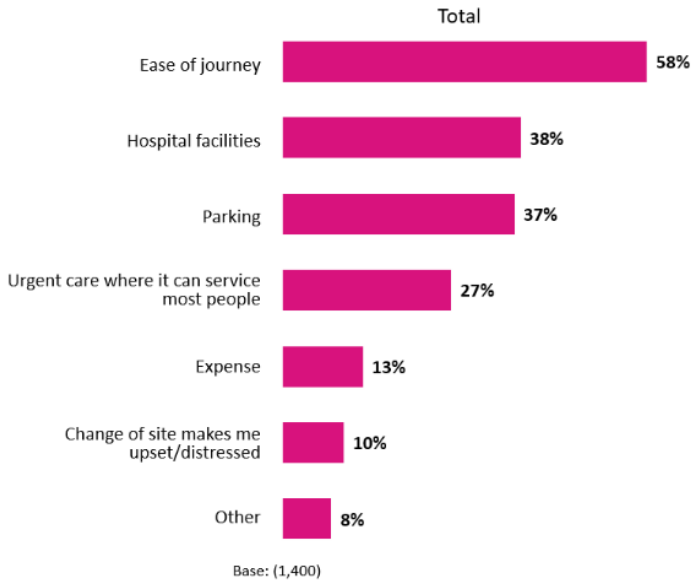
However, even among the cohort of responses received earlier (based on a sample the same size) 75% favoured Option 1. vs. 22% in favour of Option 2.

1.3.2 COMMENTS AND KEY THEMES

The questionnaire asked for additional comments explaining the reasons for views on the two Options; feedback on the impact of location, car parking, public transport and waiting times; and additional ideas and suggestions.

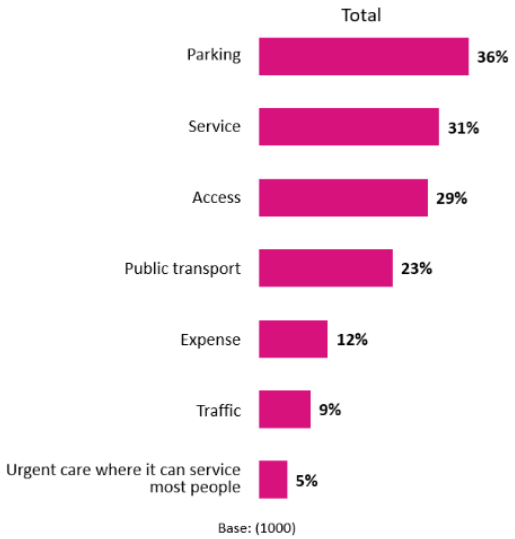
We have analysed samples of free text comments provided through the questionnaire in detail. Key themes were:

Please state your reasons for choice...

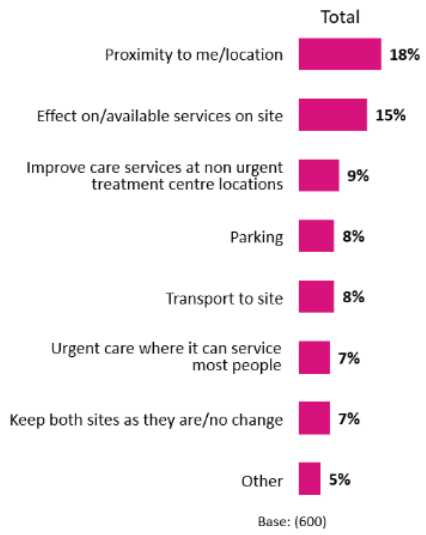


In order to draw conclusions for this report, we have undertaken detailed analyses of samples of free text comments provided through the questionnaire. Where this approach was adopted, we used sample sizes large enough to enable reasonable conclusions to be drawn and have been specific about the baseline number of responses considered in each case.

We want our changes to make it easier for people to get the right care in the right place when they need it. What impact will the proposed options have on you and your family?



We welcome any other ideas and suggestions that you would like us to consider regarding the proposed new Urgent Treatment Centre



In addition to the questionnaire responses, qualitative data was received through the roadshow and Listening events. As would be expected, these were more wide-ranging discussions and provide feedback on a broader range of topics.

Analysis of these comments shows some preferences expressed for each Option and the greatest number of comments, consistently with the questionnaire response, related to: proximity; traffic; public transport; and parking.

1.3.3 ABOUT LOCAL COMMUNITIES AND SUCCESSFUL SERVICE CHANGE

There are a significant number of comments about the need to communicate effectively when the new services when they are introduced and general views about sign-posting, including the NHS111 telephone service, and suggestions for where and how to publicise the most appropriate local services for urgent care.

There are also a significant number of comments about the access needs of local communities, particularly residents who may not have English as a first language or with access issues linked to deprivation or age (e.g. reliance on public transport). There are some specific comments about the need to integrate with mental healthcare.

The changing nature of the local population, particularly the rapid growth in some areas such as Ebbsfleet Garden City and the resulting pressures on local services, is also a common theme.

1.3.4 ABOUT URGENT CARE AND DELIVERY OF THE UTC MODEL

Main messages relating to delivery of services in the new model include concern to ensure that there are enough staff to deliver the new system, and aspects of quality and patient experience including:

- The general pressure on services, including comments about the level of activity at Darent Valley Hospital
- Opening hours and arrangements for out-of-hours urgent care
- Waiting times across all urgent care services
- The potential benefits of co-location of UTC with A&E services and having everything "in one place"
- Triage especially on-site between UTC and A&E.

Within this, a common theme is the need for greater accessibility (especially easier appointments) and more urgent care provided in non-acute settings, in particular general practice. There were also calls for the retention of GP walk-in services, not necessarily limited to urgent care.

1.3.5 ABOUT THE CONSULTATION PROCESS

More broadly, there are comments about the consultation and decision-making process, with themes including:

- That participants[1] at the events could have been better informed (e.g. with more data) and the events could have been set up better (e.g. venues)
- Suspicion expressed that the outcome of the consultation has already been decided
- That the events and the consultation could have been publicised better.

That the proposal to develop UTCs may represent:

- Cuts to services or the availability of care
- A step toward privatisation of NHS services.

[1] Please note, however, that overall feedback via evaluation sheets on the consultation events was positive (79% rated excellent or good).

2. THE CONSULTATION

2.1 CONTEXT

This document contains an independent analysis of responses to the consultation about the future location of a new Urgent Treatment Centre (UTC) at **either** Gravesham Community Hospital **or** Darent Valley Hospital.

Urgent care means care to treat illnesses and injuries that are not life threatening but require an urgent clinical assessment or treatment on the same day.

The consultation ran for a period of 12 weeks between 12 August and 4 November 2019. The consultation process was led by Dartford Gravesham and Swanley Clinical Commissioning Group (CCG). More information about the consultation can be found on the CCG website: https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/.

The consultation was part of a long-term programme, which developed proposals to create a new UTC by autumn 2020, and detailed information on the underpinning case for change, development of the clinical model and options, the NHS assurance process and engagement before consultation is contained in the Pre-consultation Business Case document (PCBC). http://www.dartfordgraveshamswanleyccg.nhs.uk/wp-content/uploads/sites/3/2019/09/Final-DGS-CCG-Urgent-Care-PCBC-09.08.19-amended-03.09.19-v2.pdf

2.2 PRE-CONSULTATION ENGAGEMENT

As set out in the PCBC, the key engagement milestones were:

- February - May 2015: Dartford Gravesham and Swanley CCG and Swale CCG Patient and Clinician Reference Groups
- November 2016: GP Engagement Event
- November 2016: Dartford Gravesham and Swanley CCG and Swale CCG Urgent and Emergency Care 'Whole Systems Event'
- 10 and 13 February 2017: Dartford Gravesham and Swanley Listening events (public and stakeholders)
- June 2017: Intensive Stakeholder Engagement Piece
- July 2017: Kent Health Overview and Scrutiny Committee
- December 2018 to March 2019: Continued engagement with residents (4000 participated and 2000 survey responses were received)
- March 2019: Briefings for local MPs
- April 2019: Engagement with the chairs of the Health Overview and Scrutiny Committees in the surrounding boroughs where residents may also be affected.

Source: PCBC

2.3 DEVELOPMENT OF THE CONSULTATION OPTIONS

Two options went forward to consultation. As set out in the consultation document, these were:

Option 1: To create an Urgent Treatment Centre by relocating services at the White Horse Walk-in to join the Minor Injuries Unit at Gravesham Community Hospital

Option 2: To relocate both the Minor injuries Unit at Gravesham Community Hospital and the services at the White Horse Walk-in to create an Urgent Treatment Centre alongside the existing A&E department at Darent Valley hospital.

Both proposed options would bring together existing services provided at the Minor Injuries Unit at Gravesham Community Hospital and the White Horse Walk-in Centre at Fleet Health Campus onto a single site.

The PCBC describes the process by which consultation options were developed from a review of potential configurations and the longlist of options which would meet the needs of the local population. This structured process involved two stages:

1. April 2019: Development of essential and desirable criteria for shortlisting
   These were proposed by the Clinical Cabinet and the Patient Participation Group (PPG) Chairs Group representing patients in Dartford, Gravesham and Swanley ratified the longlist of options and shortlisting criteria.

2. May 2019: Applying shortlisting criteria to develop options for consultation
   This process involved senior clinicians, Healthwatch, patient representatives, members of the CCG Executive team, an Equality and Diversity representative and senior staff.

The PCBC sets out how views representing patients and the public were taken into account during development of options for consultation:

- Through the programme of engagement with residents (December 2018 to March 2019), through which there was a high level of participation and which sought views on priorities and alternative models and locations
- Through defining appraisal criteria, which involved Healthwatch and patient representatives
- Through a process of confirmation and agreement of the options to go forward to consultation, which also involved Healthwatch and patient representatives.

2.4 ABOUT THE CONSULTATION PROCESS

2.4.1 BEST PRACTICE, STATUTORY FRAMEWORK AND COMPLIANCE

We understand that this consultation was conducted under the following statutory framework:

- Involvement – NHS Act 2006 (amended)
  - s14Z2 (CCGs), 242/244
  - *Planning, assuring and delivering service change for patients* guidance (NHSE) https://www.gov.uk/government/publications/consultation-principles-guidance
- Secretary of State's '4 tests'
- Equalities – Equality Act 2010
  - s149 public sector equality duty
  - Other obligations including duty to reduce inequality
- Consultation
  - Code of Practice - consultation principles (amended 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691383/Consultation_Principles__1_.pdf
  - Gunning Principles

Please note, this report is based on information and documents relating to the consultation provided by the CCG, which we have taken 'as read', and Verve's analysis of quantitative data and comments received from the CCG.

Based on this, we believe that the CCG made considerable efforts to engage widely and reach relevant groups of residents and stakeholders through an inclusive process, invited response through a variety of channels, and can provide evidence to show how the exercise met the key requirements and best practice.

In Table 1, below we have set out the relevant requirements and standards in respect of **public and stakeholder consultation** and alongside a commentary on the engagement undertaken. More detail is provided in the sections which.

In addition, the CCG has developed a communications and engagement framework which sets out its approach and ambition in respect of involving local people in this exercise. http://www.dartfordgraveshamswanleyccg.nhs.uk/wp-content/uploads/sites/3/2019/03/Helping-us-shape-health-CE-framework-July-2018-FINAL.pdf

Table 1 Commentary on how the consultation process addressed requirements and best practice

Requirement	Comments
The Secretary of State for Health's four tests	(NB. only one of these relevant to public engagement)
1. Strong public and patient engagement	• The response and participation level in this consultation was high, and a variety of channels were provided through which people gave views
Code of Practice	
A. Consultations should be clear and concise	• The consultation document set out clear Options for location of the new UTC
B. Consultations should have a purpose	• This consultation set out two clear Options for location of the new service, and detail is provided on the governance and decision-making process which will follow
C. Consultations should be informative	• A great deal of information was provided about the case for change, the process for developing options and making decisions and the relative strengths of each Option
D. Consultations are only part of a process of engagement	• This consultation builds on strong previous patient and public engagement exercises, and used existing well-established communication channels developed by the CCG and its partners
E. Consultations should last for a proportionate amount of time	• The consultation lasted for 12 weeks, which is considered appropriate for public sector engagement exercises (set out in *Code of Practice*)
F. Consultations should be targeted	• Both in respect of groups sharing protected characteristics - and more broadly – groups likely to be high-level users of urgent care, or face access issues were identified, and clear efforts made to ensure that representatives and individual voices from these groups provided insight to inform the consultation
G. Consultations should take account of the groups being consulted	• This report provides a detailed analysis of the views of people participating in the consultation, as well as including separate independent reports focused on seldom heard groups and mitigations to perceived weaknesses in the Options • Together, these provide a summary of views heard to inform the CCG's decision-making meeting and local authority scrutiny
H. Consultations should be agreed before publication	• This builds on a significant period of pre-consultation development and engagement, and there was a rigorous, inclusive process through which Options were evaluated (set out in the consultation documents), and broad agreement by commissioners and providers to proceed to consultation
I. Consultation should facilitate scrutiny	• The CCG has engaged widely during the development of the Options and consultation plans, including with local authority scrutiny - this report will form part of the papers for forthcoming review • The consultation documents are clear about the relative strengths of each Option and the broader challenges for urgent care in Dartford, Gravesham and Swanley – this information enables well-

	informed analysis through which proposals can be scrutinised by stakeholders and residents
J. Government responses to consultations should be published in a timely fashion	• Not relevant
K. Consultation exercises should not generally be launched during local or national election periods.	• Not relevant
Gunning Principles	
1. Consultation must take place when the proposal is still at a formative stage	• This is a genuine process to explore views between two alternative Options for location of the UTC
2. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response	• The consultation document and other materials provided a great deal of clear, 'in context' information about the case for change and relative strengths of different Options to enable well-informed responses
3. Adequate time must be given for consideration and response	• The consultation lasted for 12 weeks, which is considered appropriate for public sector engagement exercises (set out in *Code of Practice*)
4. Feedback from consultation must be conscientiously taken into account.	• This report provides a detailed analysis of the views of people participating in the consultation, as well as including separate independent reports focused on seldom heard groups and mitigations to perceived weaknesses in the Options • Together, these provide a summary of views heard to inform the CCG's decision-making meeting and local authority scrutiny
Equality	
Equalities impacts	• Likely impacts were identified before consultation began through an Equalities Impact Assessment which was published by the CCG, and this was repeated post-consultation • Engagement with seldom heard and equalities groups is summarised in this report and as Appendix C and an independent engagement exercise with three specific communities commissioned, with report at Appendix D.
Public sector equality duty (PSED)	• The consultation process was inclusive and participation levels high, notably by residents sharing protected characteristics: minority ethnic communities, older people, people with disabilities, faith communities (see demographic breakdown)

2.4.2 PUBLICITY

Considerable efforts were made by the CCG to ensure that local people knew about the consultation, and the activities and materials distributed are shown in Table 2, below.

Table 2 Materials and publicity

Material	Number of copies produced (or appropriate measure of activity)	How distributed (if relevant)
Consultation document	10,000 print + download	GP surgeries, hospitals, clinics, libraries, community venues (leisure centres, town halls) and roadshows and distributed at briefing sessions
Posters	5,000 printed	
Postcards	5,000 printed	
Event posters	200	
Email		Link sent to local residents mailing list (CCG's *Health Network*)
Articles in Council magazine Your Borough		Your Borough magazine is distributed door-to-door in Gravesham
Press release to launch the consultation	N/A	Coverage secured in: • Kent Online • News Shopper • Dartford and Gravesend Messenger
Social media – Facebook and Twitter	Paid Facebook ads	Targeted key community groups and series of posts / shares linked to website
Communications with staff		Consultation document cascaded to staff via Comms leads and managers in: • Darent Valley Hospital • Gravesham Community Hospital • Northfleet Health Campus

2.4.3 INFORMATION PROVIDED AND CHANNELS TO PROVIDE VIEWS

A great deal of information was provided to the public through a range of channels. Central to the public engagement was a discrete section on the CCG website, which provided both full versions of the key programme documents and also clear and well-structured information for the public in short segments which made the complex proposals as easy as possible to understand.

The website also contained an online version of the consultation questionnaire, through which some 15,549 responses were received. In addition, the public-facing consultation information was provided in a print version, with a tear-out paper version of the questionnaire which could be returned via Freepost. 925 print questionnaires were received and added to the online survey, bringing the total response to 16,474.

The CCG also undertook a roadshow and ran a series of events, details of which follow, and invited comments and views through a wide variety of channels in addition to the questionnaire:

- At a meeting or event (including CCG staff offering to attend local meetings)
- Email
- Telephone.

Views received through these channels were collated or noted by the CCG and provided to Verve. We included these comments in the evaluation which informs this report.

2.4.4 ROADSHOW MEETINGS AND EVENTS

The level of face-to-face engagement was high, and the CCG undertook a roadshow, visiting local groups, community meeting points and offering to send speakers to local meetings and events.

Three dedicated Listening events were also conducted as part of the consultation exercise, which are detailed separately below.

The events and meetings are summarised in Table 3 below, which also identifies those directly relevant to groups and communities sharing protected characteristics (as defined in the Equality Act).

A total of 1,166 people were engaged through the roadshow meetings and events.

2.4.5 LISTENING EVENTS

A total of 81 people attended a series of three listening events held to consider the Options in more depth during facilitated table discussions. The questions asked during these sessions were wider than simply considering Option 1 vs. Option 2 and included exploring issues and potential solutions.

A separate report was produced from these events to inform the consultation, which is attached in full (see Appendix C).

In addition, comments were collected from participants. Due to the broader nature of the discussions, these have been included within this analysis as a separate section along with roadshow comments.

Table 3 Listening events

Listening events		
Wednesday 16 October	Clocktower Pavilion, St Mary's Road, Swanley BR8 7BU	6.00pm - 8.00pm
Monday 28 October	Princes Suite, Princes Park Stadium, Darenth Road, Dartford DA1 1RT	6.00pm - 8.00pm
Wednesday 30 October	Kent Room, Gravesham Civic Centre, Windmill Street, Gravesend DA12 1AU	6.00pm - 8.00pm

Table 4 Face-to-face engagement with local residents

Date	Location	Time	Equalities Act
Roadshow locations and community events			
Monday 12 August	Gravesham Hospital	9.30am – 12.30pm	
Tuesday 13 August	Walk-in Centre, Fleet HC	9.30am – 11.30am	
Wednesday 14 August	Golden Girls - Shearsgreen Community Hall, North Fleet		A
Thursday 15 August	Asda Swanley	9.30am – 12.30pm	
Friday 16 August	Walk-in Centre, Fleet HC	9.30am – 12.30am	
Monday 19 August	Dartford Healthy Living Centre	1.30pm – 4.30pm	
Wednesday 21 August	Cascades Leisure Centre	9.30am – 12.30pm	
Friday 23 August	Bluewater Safer Homes	10am – 12.30pm	A
Sunday 25 August	Gurdwara Gravesend Family Sports Day	12pm – 5pm	F,G
Tuesday 27 August	Swanley Link	1pm – 4pm	
Wednesday 28 August	Darent Valley Hospital	9.30am – 12.30pm	
Thursday 29 August	Cygnet Leisure Centre	9.30am – 12.30pm	
Wednesday 4 September	Gravesham 50+	10am –2pm	A
Thursday 5 September	Dartford High Street	9.30am – 12.30pm	
Monday 9 September	Gravesham Community Hospital	9.30am – 12.30pm	
Tuesday 10 September	Swanley Link	9.30am – 12pm	
Tuesday 10 September	Walk in Centre, Fleet Health Centre	1pm-4pm	
Thursday 12 September	Asda Gravesend	9.30am – 12.30pm	
Saturday 14 September	Crockenhill Harvefayre	12pm	
Sunday 15 September	Gurdwara Gravesend Event	10am – 1pm	F,G
Thursday 19 September	Darent Valley Hospital	9.30am – 12.30pm	
Friday 20 September	Asda Swanley	9.30am – 12.30pm	
Tuesday 24 September	Dartford Healthy Living Centre	10am – 1pm	
25 September	Rethink Sangam Group - Gravesend Library		B
Friday 27 September	Gravesend Central Mosque	12pm – 2pm	G
Saturday 05 October	Caribbean Fun Day, Gravesend Borough Market	12pm-3pm	F
Monday 7 October	Gravesham Civic Centre	9.30am – 12.30pm	
Thursday 10 October	Trees Community Centre, Dartford	10am – 12pm	
Thursday 17 October	Dartford Library	10.30am – 11.30am	
Monday 21 October	White Oak Leisure Centre	10am-12pm	

Key: Where relevant to protected characteristics defined by the Equality and Human Rights Commission, these are referenced: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

A. Age	B. Disability	C. Gender reassignment
D. Marriage and civil partnership	E. Pregnancy and maternity	F. Race
G. Religion or belief	H. Sex	I. Sexual orientation

2.4.6 STAKEHOLDER MEETINGS

In addition, meetings were held with these stakeholder groups:

Table 5 Stakeholder meetings

Meeting dates	
17 July	Gravesend Labour Councillors (pre-consultation briefing)
21 August	Swanley Councillors
22 August	DGS PPG Chairs - ASDA Gravesend
28 August	A&E Delivery Board
03 October	Dartford Council staff briefings
04 October	Sevenoaks District Council

2.4.7 EQUALITIES – HOW EIA INFORMED CONSULTATION

In order to meet its equality duties (Equality Act 2010), the CCG commissioned an Equality Impact Assessment. This both identifies the likely barriers to access or drivers for inequality and also provides significant insight from engagement with equalities groups, which informed the consultation planning.

http://www.dartfordgraveshamswanleyccg.nhs.uk/wp-content/uploads/sites/3/2019/09/Equality-Impact-Assessment.docx

For the consultation engagement, all nine groups sharing 'protected characteristics' were scoped in with the addition of socially-deprived communities and rural communities. Through the consultation process, specific activities were undertaken to ensure that these groups and communities were fully engaged in the process, and where supported by the data, issues raised more commonly by these groups are highlighted within the analysis.

Groups engaged to meet this requirement included:

- Age UK Gravesend
- Dartford Elders Forum
- Gravesham 50+ Forum
- Local faith communities and venue including the local Gurdwara and Christian churches
- Gravesend Rethink Mental Health Group (meeting)
- Charities supporting disabled children and their families (e.g. We Are Beams).

A written response was also received from NW Kent Mind.

In addition, the CCG has:

- Prepared a summary of engagement during consultation with equality groups
- Commissioned an independent organisation *Engage Kent* to undertake targeted engagement with three specific seldom heard communities, through outreach visits and street surveys to gather in-depth feedback face-to-face:
  - People with physical disabilities
  - Residents in rural areas.

Both reports contain useful insights and are attached in full (see Appendices D and E).

3. EVALUATION

3.1 ABOUT THIS EVALUATION

3.1.1 THE PURPOSE OF CONSULTATION

Consultations to support NHS major service change programmes present a rare opportunity to involve local people in key decisions about their healthcare and services, and to open a large-scale dialogue about priorities and options for the future. They fulfil several different purposes which include:

- Providing an opportunity for everyone to have a say and identify the issues most important to them in a complex system
- Evaluating the preferences and strength of opinion among different groups who may be impacted differently
- Supporting decisions on proposals for change which may involve multiple objectives and trade-offs.

While they draw on similar methodologies such as questionnaires, it is important to bear in mind that consultations are not the same as either:

- Quantitative market / social research which sets out to extrapolate from a representative sample of a given population in order to estimate the views of the whole population
- Referenda which set out to establish the majority opinion on a binary question.

> *"True consultation is not a matter of simply 'counting heads': it is not a matter of how many people object to proposals but how soundly based their objections are."* [2]

3.1.2 WHAT THIS REPORT AIMS TO DO

Verve has analysed the data provided to us and in the following sections we have set out to:

- Summarise the quantitative response received via the consultation questionnaire
  - The proportion of responses favouring each of the two options
  - The responses to other quantitative questions (e.g. services used)
  - Where justified by the data, identifying where there may be significant differences of view between different groups of respondents.

- Review the free text responses received through the questionnaire and consider alongside comments made through other channels (roadshow notes; written responses; meeting notes and comments from Listening events)
  - Identify the main themes of comments, picking out those most commonly referenced
  - Produced a high-level summary of the substantive points made by respondents during the consultation.

[2] Lady Justice Arden, Court of Appeal Judgement, Royal Brompton and Harefield NHS Foundation Trust vs. JCPCT

3.1.3 METHODOLOGY

Quantitative data from the questionnaire (see Appendix A) is presented in charts and tables which summarise:

- The scale of response, showing the profile of respondents e.g. demographic characteristics (age, gender, ethnicity etc.); which services they use; special needs (e.g. disability); where they live (as far it is possible to do so)
- The overall views on Options 1 and 2 for location of the new treatment centre, indicating where the data suggests there may be significant differences between the views of different groups within the population. (These are the answers to Q5 and Q6[3])

The total preferences between Options and break-down of participants are based on the whole questionnaire dataset (aggregating both printed and online responses).

Free text comments were provided through the questionnaire on three topics:

- Reasons for preference between Options 1 and 2 (Qs 5 and 6)
- Impact of 'top three' issues on respondent / their family (Q7)
- Other ideas and suggestions (Q8).

Based on an initial sample n=100, the most common themes in responses to these questions were identified. Once the data was collected, all the comments received were reviewed and allocated to the main themes, and a further level of analysis was undertaken to sub-divide and understand comments at a more detailed level.

The categories developed for this analysis is shown at Appendix F (code frame).

Please note that each individual free text response could include multiple comments, and in some cases the answer to an individual question included up to five separate points.

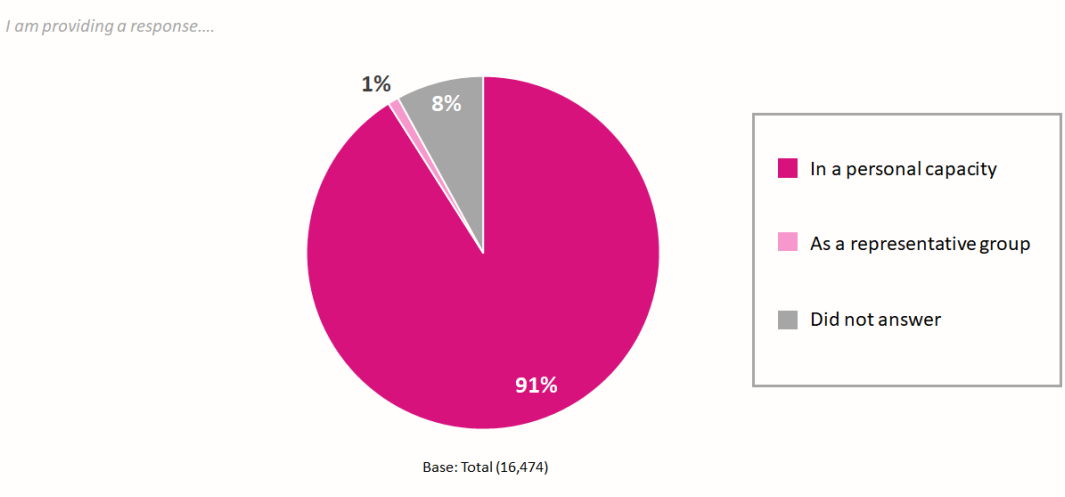
The level of response and the length and complexity of comments made were unusually high and coupled with the great bulk of response received in the final 72 hours before close of consultation, it has not been possible to analyse the free text comments fully for this initial report.

In order to draw conclusions for this report, however, we have undertaken detailed analyses of samples of free text comments provided through the questionnaire.

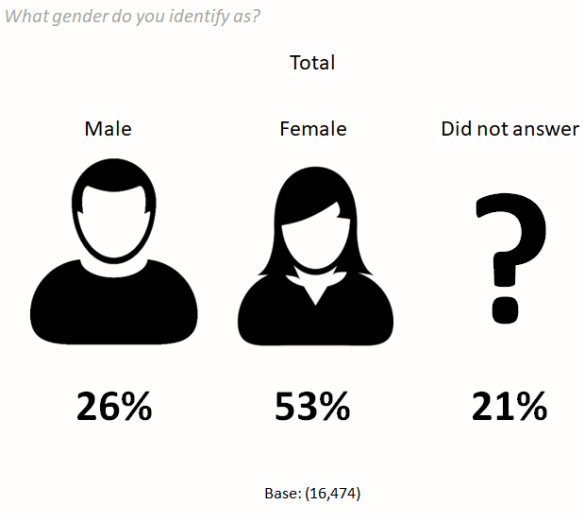
[3] Please note the question numbers differ slightly between the printed and online form – for this section we are using the online version shown at Appendix A. Written and online datasets were combined before the analysis, so both are included in the analysis.

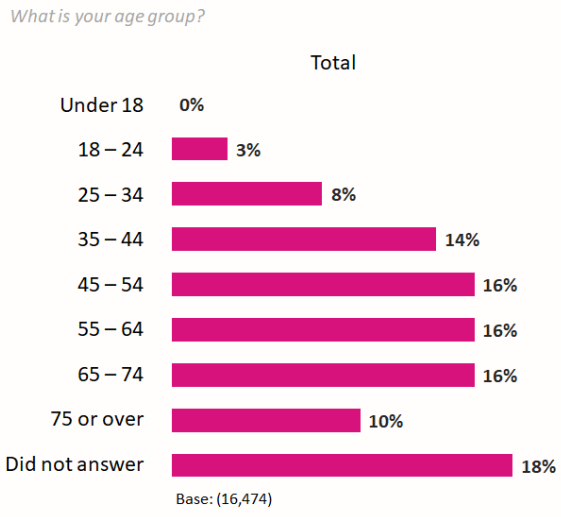
3.2 THE CONSULTATION RESPONSE

3.2.1 QUESTIONNAIRE RESPONSES RECEIVED



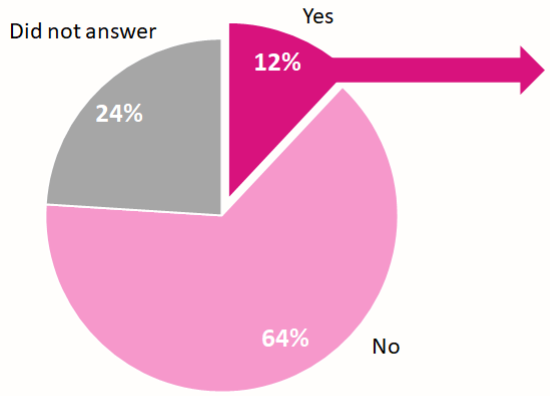
Almost all respondents were answering in a personal capacity. This would indicate that the responses given throughout the survey are their own and uninfluenced by anyone else.





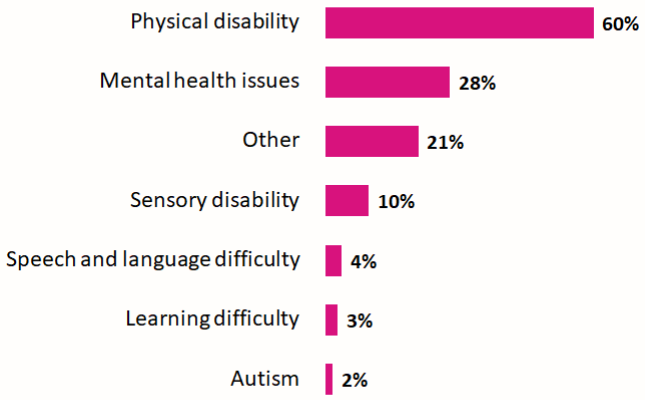
Although reasonably representative, the sample of respondents does skew slightly towards **women over 45 years old**. Around **1/5 of respondents** were unwilling to state their age or gender.

Do you consider yourself to have a disability/impairment?



Base: Total (16,474)

Disabilities/impairments experiencing....

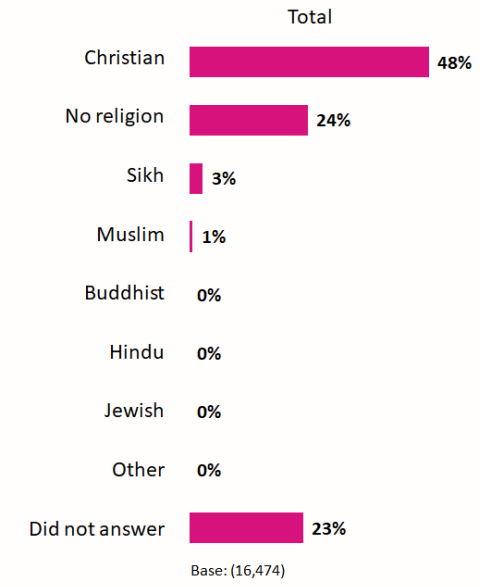


Base: Have disability/impairment (1969)

The majority of the sample **do not consider themselves to have a disability or impairment**. Of the **12% of respondents** who do have a disability, they are most likely to have a **physical disability** or a **mental health issue**.

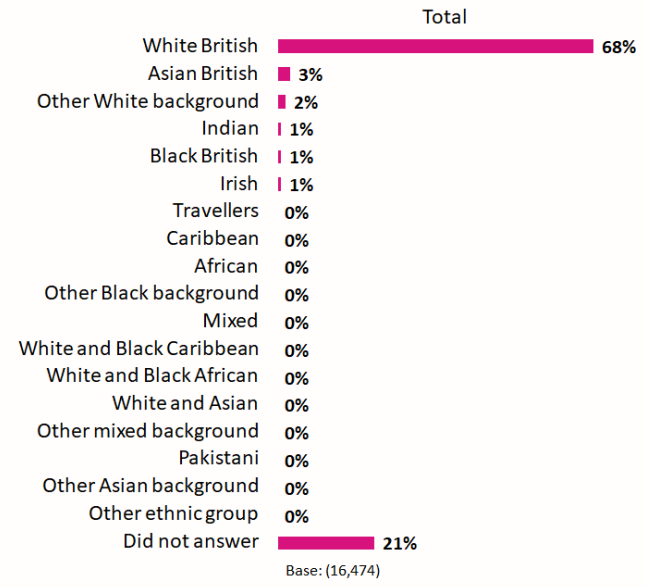
3.2.2 ENGAGEMENT BY DIVERSE COMMUNITIES

Which of the following describes your religion or belief?



Base: (16,474)

How would you describe your ethnic origin?



Base: (16,474)

The majority of those who responded describe their ethnic origin as **White British**, while 20% of respondents did not answer. **Nearly half** of the sample describe themselves as **Christian**, while a **quarter of people claim to have no religion**.

If **those who did not answer this question are excluded**, the headline figures are as shown (compared with the approximate demography of the CCG's population):

Respondents describing their ethnic origin as…	Questionnaire (%)	Population of the CCG footprint (%) (approximate)
White British	86.96%	85%
Other White background	3.68%	
A different ethnic group	9.36%	15%

This suggests that the questionnaire respondents were skewed towards those identifying as White British. The level of response by people not identifying as White British seems low given the considerable efforts made by the CCG to reach diverse communities with this exercise and the groups and meetings engaged through the roadshow.

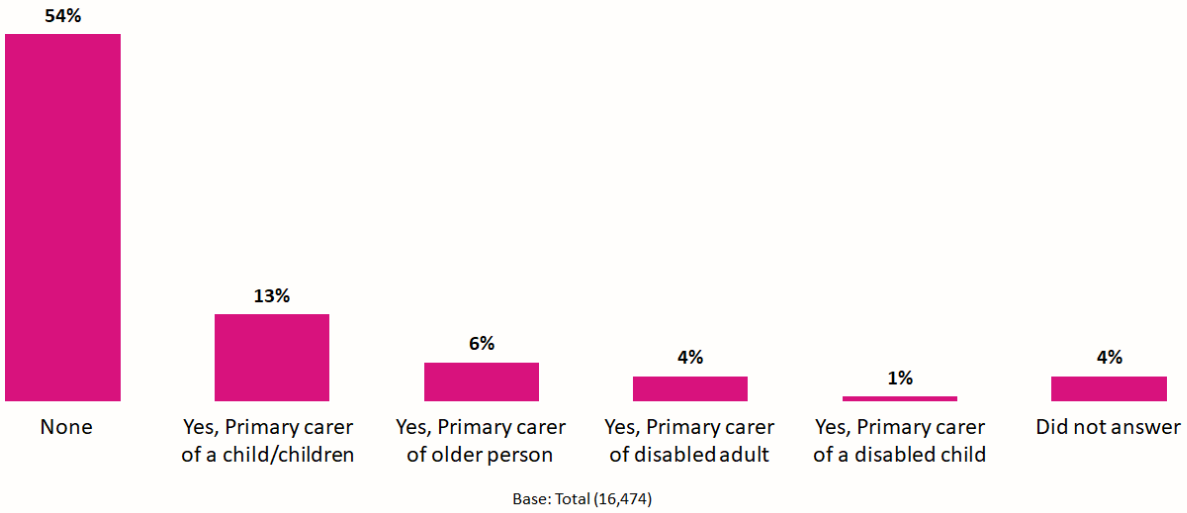
However, this should be seen in context. It is also worth noting that the age profile:

Age	Questionnaire (%)	Population of the CCG footprint (%) (approximate)
0-17 years	0.38%	24%
18-64 years	68.45%	60%
65+ years	31.17%	16%

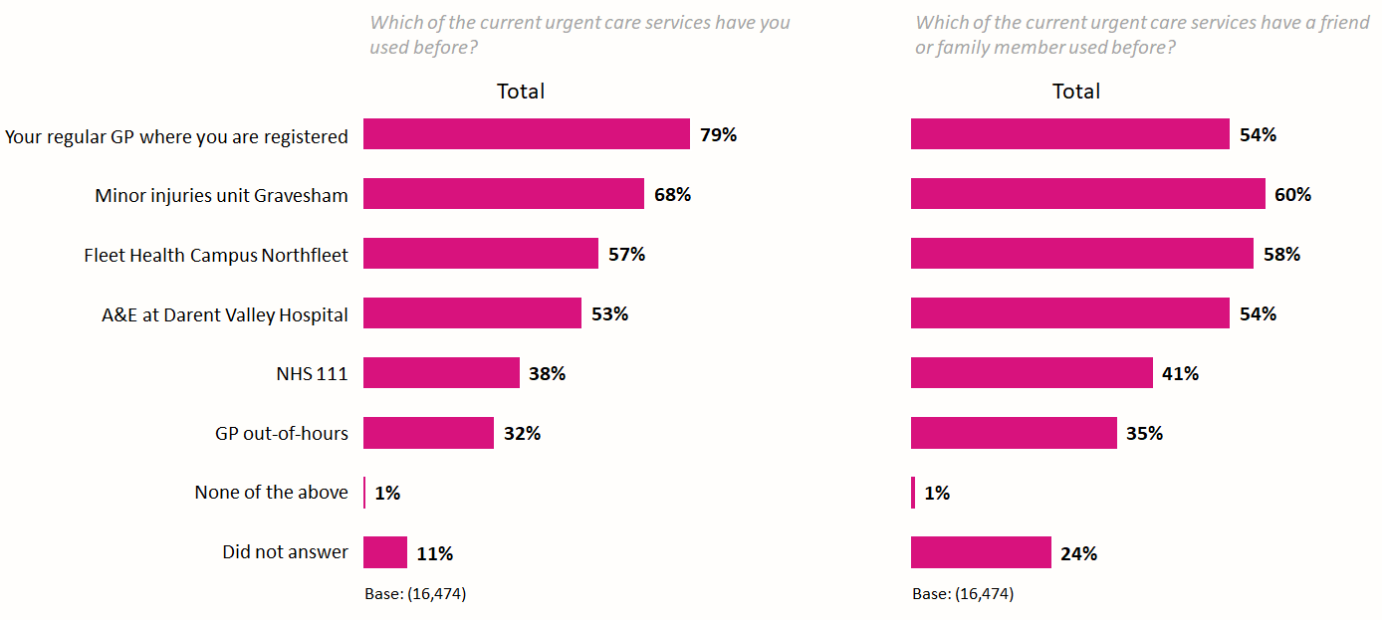
In general, non-white communities tend to be younger and elders may not use English as a first language - so if the response is significantly skewed towards older people, we may expect disproportionately overall lower participation from people not identifying as White British.

In addition, it may be that the relatively high-level of respondents identifying with a religious faith (48% Christian; 3% Sikh; 1% Muslim) suggests respondents more prepared to identify by faith than by ethnic background.

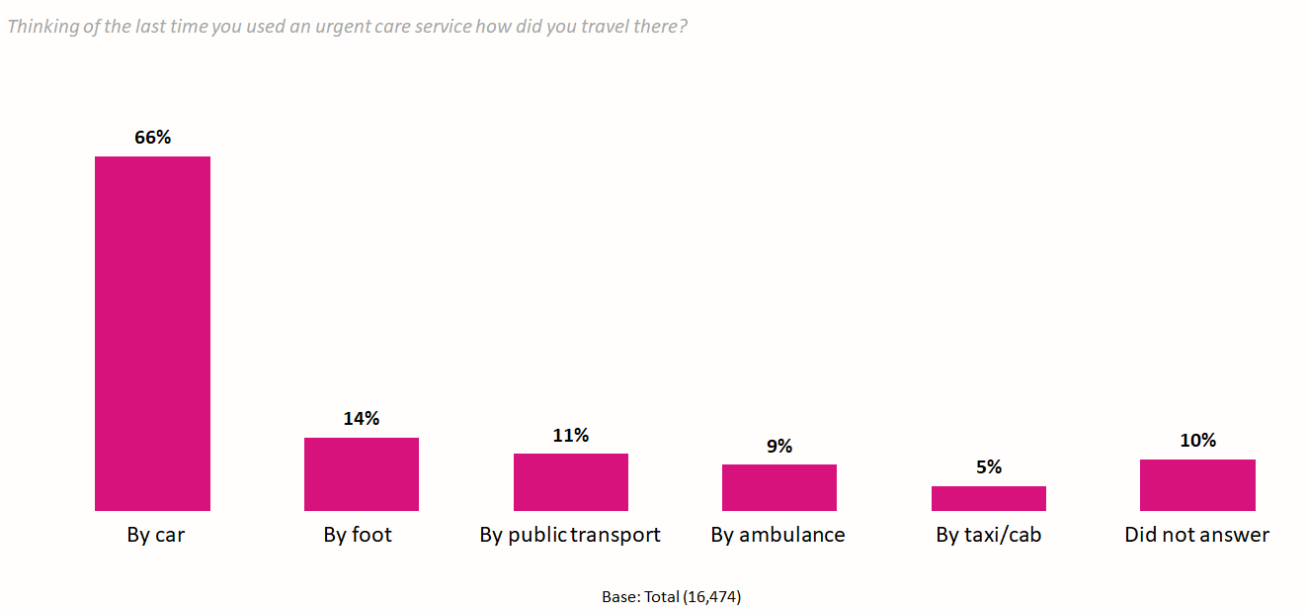
Do you have caring responsibilities?



Just over half of all respondents do not have caring responsibilities. **Primary carer of children** is the most likely caring responsibility.



Respondents use different local urgent care services, either by themselves or their friends and family. Of those responding for themselves, 68% have used the Minor Injuries Unit at Gravesham community hospital. However over half have also used Fleet Health Campus Northfleet and A&E Darent Valley, indicating that all these services have been important for the local area.



Parking facilities and traffic could be a factor in choice as **66%** of respondents claim to have **used a car** when accessing urgent care services previously. Only **11%** of people said they used **public transport**.

3.2.3 WHEN RESPONSES WERE RECEIVED[4]

There is a very large disparity in when questionnaires were received. As shown in the figure above, **over 5 times as many** people responded via the online survey **in the final weekend** of the consultation **compared to the first 51 days** of the consultation being open.

3.2.4 VOLUME OF RESPONSE

As shown in the summary response table, this consultation exercise was characterised by:

1. **An initial response of 2,440** completed or partially completed[5] questionnaires from the date the consultation opened until 30/10/11 (i.e. the first 51 days).

   The questionnaire asked for additional comments explaining the reasons for views on the two Options; feedback on the impact of location, car parking, public transport and waiting times; and additional ideas and suggestions.

   These initial responses included a high number of free text comments against all three relevant questions and notably long statements covering multiple topics.

2. **A further 13,759 questionnaires** completed or partially completed by 04 November[6] (i.e. in the final 5 days).

   Despite these later responses including fewer free text responses, this brought **the total free text comments received to 24,958** (many of these contain more than one substantive point).

We cannot be sure of the reason for this remarkable late surge in response, but one explanation is a widely circulated letter by the Member of Parliament for Gravesham (dated 28 October) which expressed strong concerns about the Option 2 location at Darent Valley Hospital and encouraging his constituents to complete the online survey.

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[4] Figure above made up of 2,008 completed and 432 incomplete surveys between 08/09 – 29/10, 11,796 completed and 1,963 incomplete surveys between 30/10 – 04/11. No postal entries after 04/11 were included

[5] The survey portal on which the questionnaire was hosted records all data entered whether or not the final command button to complete and submit the response is pressed. By the end of the exercise, 2,395 such "incomplete" questionnaires were on the system. The majority of these included valid responses, so it was agreed to include within the same dataset as "completed" forms.

[6] The completed questionnaires were collected at the end of 05 November to ensure time for all printed questionnaires received by the close to be uploaded, giving a slightly higher total for analysis of 16,474.

There are indications that the late responses were more likely to oppose Option 2 and tend to live closer to Gravesend (see also section below on geographic responses).

In order to provide as full an analysis as possible within the required timeframe, the qualitative comments were reviewed and analysed as follows:

- A sample of comments received were reviewed and the main topics noted against the main themes identified within the code frame
- Additional samples of the questionnaire responses were reviewed and analysed against the more detailed categories in the code frame.

Where this approach was adopted, we used sample sizes large enough to enable reasonable conclusions to be drawn and have been specific about the baseline number of responses considered in each case.

3.2.5 RESPONSES FROM DIFFERENT PARTS OF THE CCG CATCHMENT

The questionnaire asked respondents to give the first three digits of their postcode (Q2) with a view to enabling analysis according to where respondents live within the CCG catchment. In the event, people expressed this in a variety of ways. The most common responses were:

- First three digits (e.g. DA1)
- First segment of postcode (e.g. DA12)
- Whole postcode.

By far the highest coded postcode response was DA1 (n=6884). However due to the way the question was worded, asking for the first three digits rather than the first half of the postcode presented a challenge for analysis.

It is impossible to tell whether a response "DA1" means DA1 or DA10, DA11, DA12, etc. This is exacerbated because DA1 is at the west side of the CCG catchment and significantly closer to Darent Valley Hospital whereas the other postcodes beginning DA1 are further east and closer to Gravesham Community Hospital (which is in DA11).

However, a significant number of respondents (n=2744), despite being asked just for the first three digits, specified that they live in the DA11 postcode where Option 1 is located. A comparatively much smaller proportion of respondents live in DA2 (n=162).

This enabled direct comparison of responses by residents of DA2 and DA11 to see whether their options preferences differ, and is taken into account in the analysis (also detailed in the analysis charts) by comparing responses from:

- People who identified as living in DA2 (i.e. within the postcode area of Darent Valley Hospital)
- People who specified DA11 (i.e. within the postcode area of Gravesham Community Hospital).

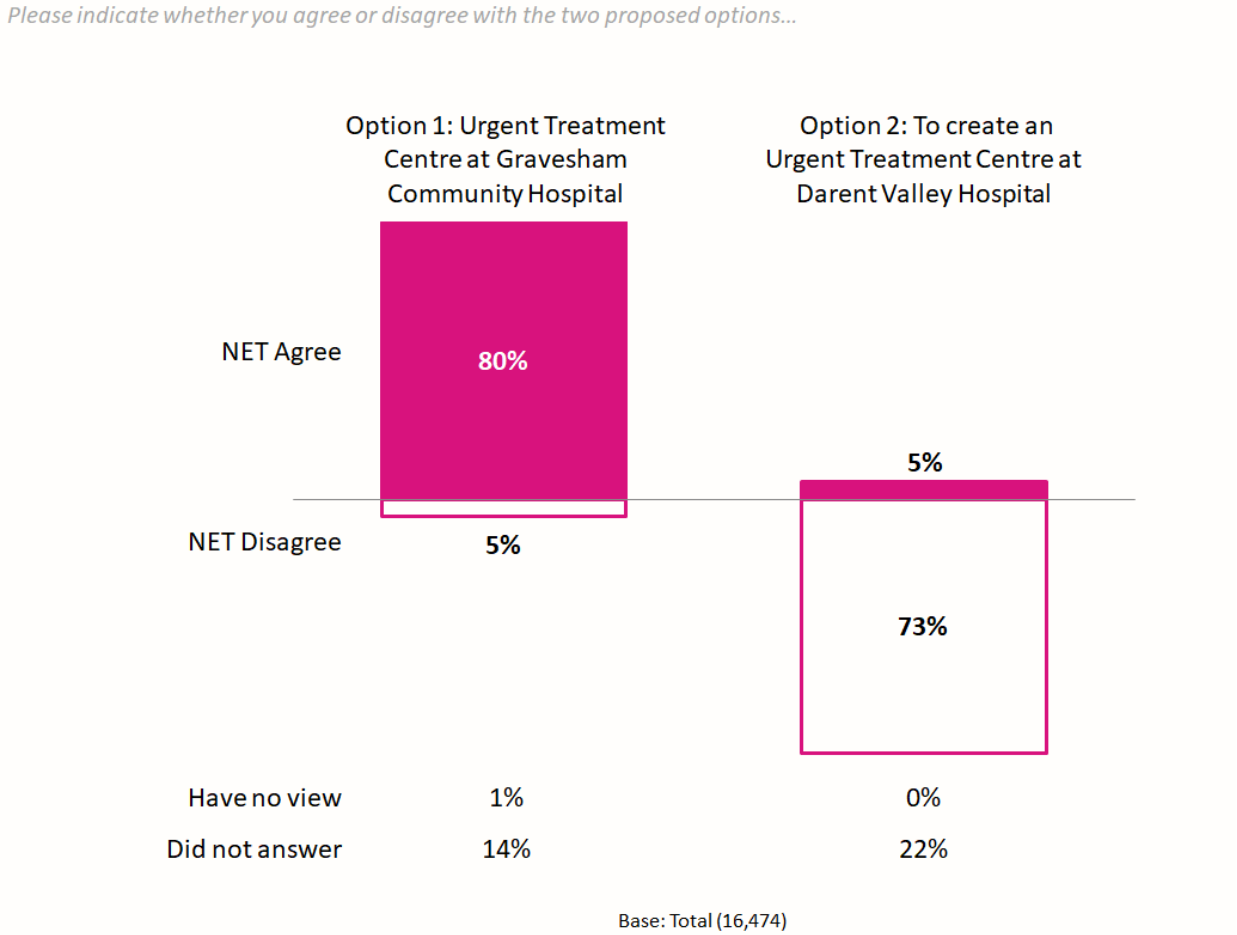
Given the volume and distribution of response, these two groups provide the most practical proxy for the populations most likely to be impacted by travel distance through choice of Option 1. Vs. Option 2.

The uneven distribution of respondents, linked to a preference for services close to home, may have influenced the higher preference towards Option 1 as many more people live in a much closer proximity to the Gravesham Community Hospital site.

4. FINDINGS AND ANALYSIS

4.1 HEADLINE FINDINGS

Please indicate whether you agree or disagree with the two proposed options...



Urgent Treatment Centre at Gravesham Community Hospital (option 1) is the overwhelming preference.

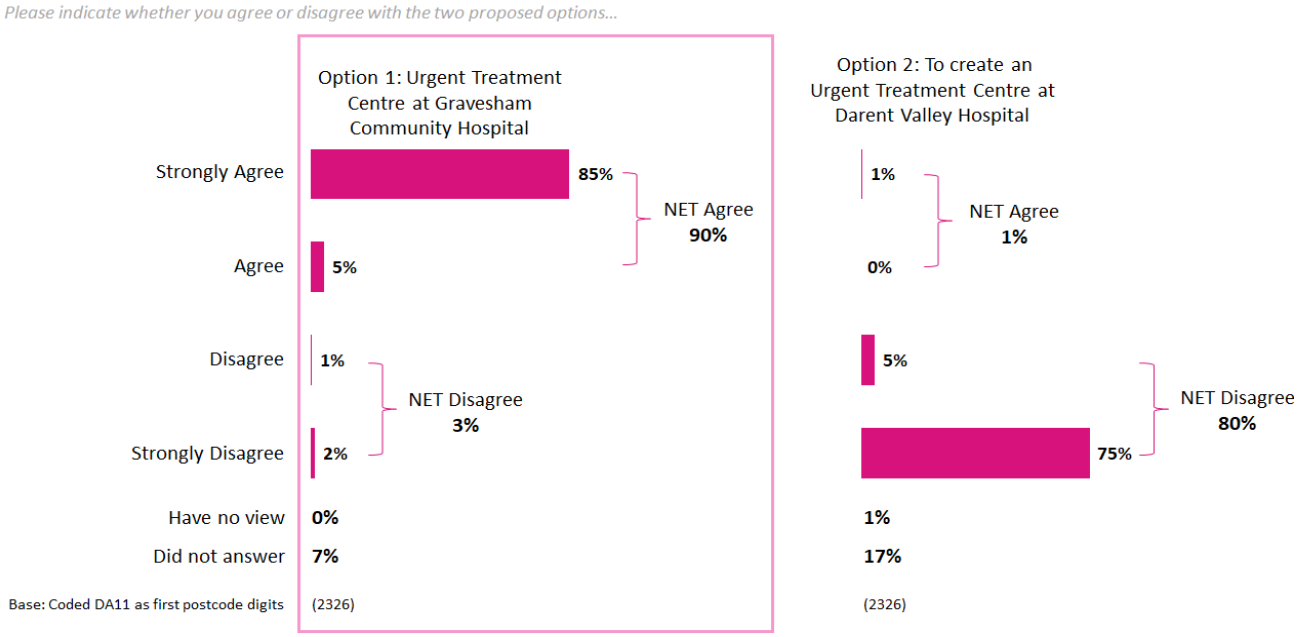
- There is a very **strong preference towards Option 1 – 75% of respondents Strongly Agree** that Gravesham Community Hospital is the right site for an urgent treatment centre (UTC)
- Consequently, there is **also high negativity towards Option 2** – only **5% agree** that it should be the chosen site for the UTC and **68% Strongly Disagree** with this option completely
- Respondents were also **significantly less likely to give any response about Option 2** with around 1/5 choosing not to give any opinion at all
- While there is no significant demographic group particularly driving the preference towards Option 1, those that do Strongly Agree with the option are **a little more likely to be over 55 years old**
- With no real demographic factors pointing towards a preference for either option, respondent choice must have a basis in more emotional or practical issues.

4.1.1 DOES AREA OF RESIDENCE MATTER?

In the charts above and below, we chose to look at DA11 and D2 more closely (DA11 being the postcode area for the proposed UTC at Gravesham Community Hospital and DA2 the postcode area for the proposed UTC at Darent Valley hospital).

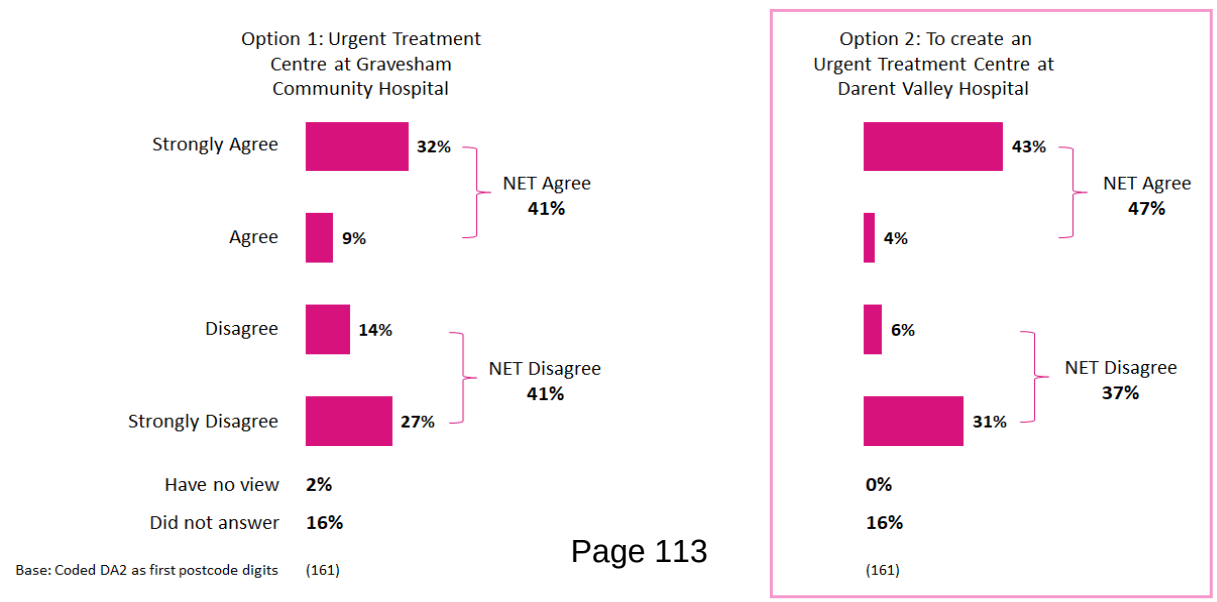
As expected, **respondents in DA11 very highly endorsed Option 1** as this option sits within their local postcode and is therefore much easier to access for local residents. **85% of people who claim to live in this area Strongly Agree** that Gravesham Community Hospital is the better site for the new UTC and **90% Agree overall**. (See chart above)

Option choice by postcode: Lives in DA11



There is not, however, as much positivity towards Option 2 among those who live in DA2. **Residents of DA2 are far more balanced** in their opinion of moving the UTC to Darent Valley hospital. **Less than half (43%) Strongly Agree** that it would be the best option, while **nearly a third (31%) Strongly Disagree** with this option. (See chart below). The responses to Option 1 echo this.

Option choice by postcode: Lives in DA2



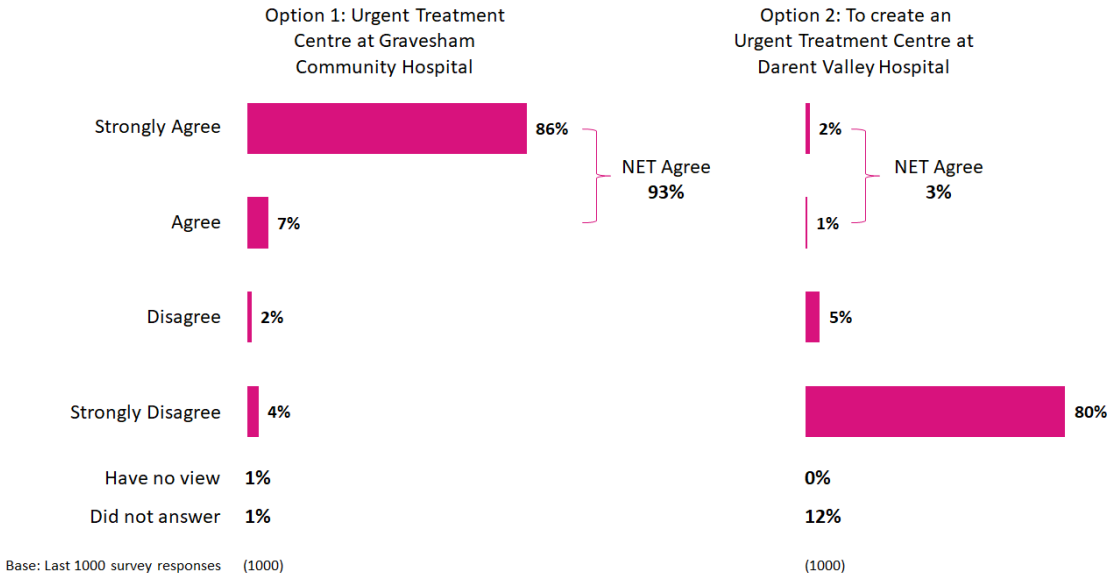
4.1.2 DOES THE LATE SURGE IN RESPONSE SKEW PREFERENCES?

A sample of the **final 1000 respondents**, who participated at the end of the study when it was experiencing very high response rates, was examined more closely.

An **overwhelming number of people** responded in favour for the UTC to be moved to Gravesham Community Hospital (Option 1). **86% of respondents Strongly Agree with Option 1, with 93% agree overall**. (See above)

Last 1000 responses from online survey (postal submissions excluded)

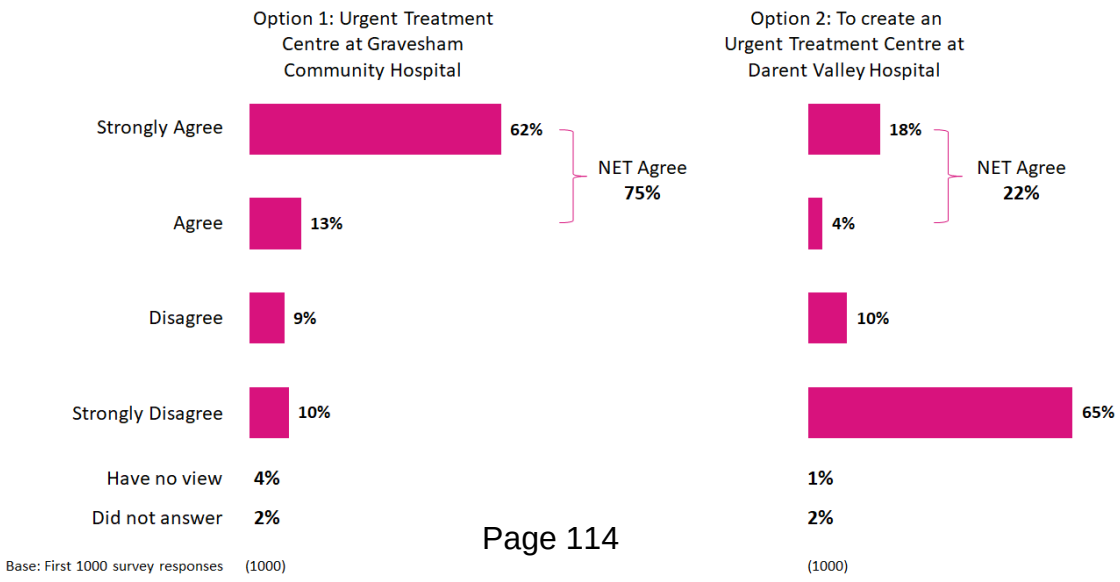
Please indicate whether you agree or disagree with the two proposed options...



However, the overall popularity towards Option 1 isn't solely driven by those who responded later. In the chart below, a sample of the **first 1000 people** to respond to the survey was also taken. It clearly shows that **Option 1 was still the preference**, even at the earlier stage of recruitment. **3/4 respondents still Agree** that Gravesham Community Hospital is the favourable choice. There is significantly more affinity towards **Option 2** within the first 1000 respondents, however **only 18% Strongly Agree** with this option.

First 1000 responses from online survey (postal submissions excluded)

Please indicate whether you agree or disagree with the two proposed options...



4.2 ANALYSIS OF COMMENTS - WHAT DID PEOPLE SAY?

Three open questions were included in the survey to gather more detailed opinions on their reasons for endorsing either option, and the issues effecting the proposed locations of the new Urgent Treatment Centre.

4.2.1 Q5/6 – PLEASE STATE YOUR REASONS FOR YOUR CHOICE

Ease of journey

How easy it is to access the UTC was the top issue driving preference between the Options.

- The main concern for respondents is their ability to access their UTC site overall, mostly in relation to the Darent Valley location
- People also had a preference towards a site that was closer to them, a subject that is more is more heavily weighted towards choosing Option 1, given how many more respondents were gathered from the DA11 postcode
- Traffic in the local area was another concern, with many seeing Darent Valley being too congested, particularly around peak or rush hour traffic. Respondents also raised concerns about how traffic might impact on patients that need urgent treatment if they are unable to access treatment in a timely manner.
- The ability to access the UTC at DVH by public transport is also an issue. Although only 11% or respondents claim to have accessed Urgent treatment services by public transport previously, they do desire a site that has frequent and easy public transport links. Some responses cite that good public transport links are necessary if it is yourself that requires urgent treatment and you are unable to drive, a sentiment shared by people who chose both sites
- Some stated that a reason for choice is the ability for elderly or sick/vulnerable patients to access the urgent treatment they require. Many believed it is unfair to ask patients who are more at risk to travel to a site which cannot be easily reached by car or public transport. Although this was mainly directed towards DVH, there were a small number of people who expressed concerns about having the UTC and Gravesham.

> Because for people east of Dartford the journey is easier. The traffic to Darent makes the journey very unpredictable.

> Anyone analysing this document should try to travel from Gravesend to Darent during rush hours or every time the Dartford crossing is fouled up and see how impossible it is.
> It is vital we keep and add to services in Gravesend.

> Easier to get to, as no public transport would get me to Gravesend hospital from where I live. At the last known amount it cost over £27 to get a taxi back from Darent Valley so no idea how much from Gravesend

> I live in Gravesend, I do not drive, I have no-one to give me a lift, I can't afford taxis, I am mentally ill and can't travel far. Too much goes to Dartford it's like Gravesend doesn't exist.

Hospital facilities – both sites

The negative or positive impact of co-located facilities on the proposed site is another consideration for respondents when making their choice:

- There is a perception that staff numbers are already stretched at larger hospital sites and the added patient numbers that an UTC would bring to the site would further limit the availability of staff, especially at Darent Valley Hospital
- Although respondents were asked to give a choice towards their preferred site, there is still some sentiment that they prefer their current provision of hospital facilities
- Some respondents felt that the location should have both UTC and A&E service on one site, the benefit of this being that the required facilities and staff would be available and they wouldn't have to travel if your treatment is upgraded from urgent to and emergency
- There are low level concerns that an adjoining A&E department will result in issues such as longer waiting times due to patients who do not know whether to categorise their issue as urgent or an emergency, or availability of staff who may need to work across both departments
- A small number of respondents also believe that the whole treatment process is much longer in larger or major hospitals. Having the UTC at a smaller, community-based site is seen as preferable for this reason.

If services are available locally, it would also reduce the strain on the A&E department at Darent Valley Hospital, leaving staff to tend to people in real need of emergency treatment.

DVH is already full to bursting and understaffed.
It's overcrowded… the temptation to send patients to AE would be greater as its on site

If someone goes to the urgent care centre and it is then decided their case needs escalated to A&E then they are already in the correct building which gives continuity of care.

Lack of staff, funding and capacity for the current structure. How would they cope with the added pressure?

Parking

Issues surrounding patient parking is also a major factor driving preference for UTC site:

- The main worry for most people is how difficult it might be to park at the DVH site with many seeing Gravesham as having alternative parking options available if the site car park is full
- Respondents also clearly indicated that felt that the price of parking at the DVH site is too high
- This is more of a problem for those who may be less able to travel on public transport but for who cost is an issue

- Cost is exacerbated as a problem if waiting times are high or treatment takes longer than expected
- There is also a perceived lack of parking spaces at Darent Valley, with concern that it can be impossible to park onsite in an urgent situation with no alternative options in the surrounding area
- The cost and availability of parking resulted in a general feeling of anxiety about the issue as a whole, and some stated their preference for a site which could at least enable parking in the local area if there is none available on site.

> Moving to Darent Valley will make it difficult for people in Gravesend and surrounding areas to access it... Parking would be extortionate, and people shouldn't have to worry about being able to afford to park to access the facilities.

> There is not enough parking to merge all these services at the same place, would be chaos and will cost everyone too much money to travel to and from it by bus or taxi

> Gravesham Community Hospital is closer to me, however there is no parking at the hospital. If you have a disability it is a long way to walk. Alternatively, Darent Valley does not have sufficient parking for the number of people already using it. Whichever option is chosen parking needs to be considered.

> The parking facilities at Darent Valley are inadequate and costly. there is nowhere else to park when the car park is full - everywhere is double yellow lines & residential areas.

Many expressed that the reason for their preference was to have a location that provides the optimal journey for the majority of residents. This suggests a site that is most accessible to the greatest number, and views were also expressed that this should take into account the accessibility issues for those with financial or mobility challenges in particular.

> Getting to Darent valley hospital is a problem for most people, if you can get there the parking is a nightmare. Many elderly people haven't got cars. Getting to Gravesend there are many bus routes. **We need to keep local services.**

> If you are feeling so unwell that you are seeking medical that you cannot get from your own GP you are not feeling well enough to get on a bus. Cost of a taxi from Gravesend area to Darent Valley would be prohibitive for most people. **Please keep this service local for local people.**

Expense

Some respondents claimed that the overall cost to them or their families was a factor in their decision making. This broke down to two specific issues:

- As previously, the price of parking is the main concern
- Although we have already seen that respondents would prefer ample public transport provision in order to access both proposed UTC sites, there are also concerns about how much it might cost to use. There are some who suggest that free transport to the UTC should be provided.

> The parking at DVH is expensive and non-existent. I have been late for appointments before due to this problem

> I remember one night at 4am having to drive there in the snow, along the A2. Parking there during the day is a nightmare and expensive & public transport very time consuming.

> My reasons are logical for me as a non-driver I have to access public transport and Gravesham community hospital is easier to get to and it comes down to cost of transport too.

4.2.2 Q7 - THE TOP THREE ISSUES LOCAL PEOPLE RAISED WITH US ABOUT THE LOCATION OF THE NEW URGENT TREATMENT CENTRE DURING PREVIOUS ENGAGEMENT WERE: PARKING, ACCESS TO PUBLIC TRANSPORT AND WAITING TIMES. WHAT IMPACT WILL THE PROPOSED OPTIONS HAVE ON YOU AND YOUR FAMILY?

Parking

As seen in the reasons for choosing their preferred site, the issue of Parking at the UTC is high on the agenda when assessing the impact of change may have on a respondent or their family.

- Provision of parking spaces is the most common issue that was raised. Many people have spoken of their experience of using car parking facilities at DVH previously and their worry that the extra patient load might affect this further under Option 2.
- Respondents also clearly indicated that they felt that the price of parking at DVH is an issue. Parking is seen to be too expensive which can also have a negative impact on patients who do not have the means or the ability to pay for parking. This is something that becomes more of a problem if waiting times are high or treatment for issues is longer than expected.
- Some respondents also expressed concern about the availability of disabled parking at the DVH site.

Having nothing local to home (Higham).... dread any appointments at Darent due to the parking!

Parking - availability and cost. Darent is already a very busy car park. Assuming the urgent treatment centre is placed here, additional car parking would need to be provided.

We are fortunate to have several vehicles to access, but parking in Gravesend would be an issue. There is more parking available at Darent Valley (albeit very very busy)

Darent Valley Hospital has problems with shortage of parking especially for the disabled. The area easily gets gridlocked. Having more emergency services would only compound the problems.

Service

The level of service a patient might receive at the new UTC site was also seen as a major issue for respondents:

- As highlighted in previous engagement studies, longer waiting times are an issue and were raised again. There is a perception that receiving urgent care at a larger hospital site, such as Darent Valley would potentially cause patients to wait longer for treatment. Larger hospitals are seen to be already overstretched by patient numbers
- Some respondents expressed an affinity towards the service they currently use and reluctance to change for this reason
- Having to travel further is a concern, and many highlighted the importance of having urgent treatment locally. Although this was mainly aimed at DVH, there were some who expressed concerns about having to travel to Gravesham
- Having the correct mix, or indeed sufficient numbers, of staff at the UTC site is another issue that some claim could affect the level of service. There is some concern that not enough new staff will be provided for the UTC site at both locations.

Longer waiting times as it will open up to bigger areas such as Dartford and Swanley.

Easier parking cut down on waiting times due to overpressure on staff at a hospital that is not big enough to cope with the amount of people & the impact of other Emergency departments in the area being closed down. Absolutely need somewhere else with the amount of houses that are being built in the Gravesham area

Waiting times for A&E are too long as the staff are under so much pressure and this new service would suffer the same

Anyone who turns up at A&E with minor injuries should be signposted to local services like the walk-in or minor injuries.
Another idea would be for local GP surgeries to offer more weekend appointments

Access

How easily accessible the site is overall is seen to be an impactful issue for respondents:

- There are concerns that the DVH site might not be easily accessible for respondents or their family in an urgent situation, many feeling that they may have to travel too far to access the care they require.

> Gravesend would be much more convenient and easier to access.

> Gravesend is much more convenient & easier to access in an emergency.
> Dartford is too far to access quickly Bus transport in Gravesend is better than to Dartford to get to in an emergency appointment

Public Transport

Service users expressed a number of worries about the level of public transport options available to them if the site is moved to Darent Valley and how this would impact them when they require care:

- Of those who gave an opinion, the main issue is how much public transport is available to them. Users feel that they would be heavily impacted by a site which does not have adequate public transport links
- Another issue relate to public transport is how quickly it can get you to the urgent treatment centre. There are concerns that standard public transport routes may take too long, stop at too many stops or travel a route which is not direct enough if the service user needs urgent treatment. Although there were some very low-level concerns about this in Gravesham, it was mainly Darent Valley where there seemed to be a perceived issue.
- Some anxiety is also felt towards having to use public transport if a service user is unwell or travelling with children.

> Public transport in the Dartford area is currently under review with less busses routed via DVH to further frustrate patients.

> Relying on public transport for really sick people just isn't enough and if it is the only the option the closer the better. being built in the Gravesham area

> The impact on me personally will be huge. Public transport is not easily accessible for me and to have to travel further will make things harder

> The public transport links between Gravesham and Darent Valley are dreadful. There is no train option at all. On one occasion I had an outpatient appointment at DVH hospital. Despite allowing 90 minutes to get there (a 15-minute car journey), I missed the appointment as no bus arrived. Getting a taxi would cost £50 plus.

Expense

A smaller percentage of respondents felt that the cost of having to use the service at a different site could impact themselves or their family, particularly among those who agreed to the Gravesham UTC site and disagreed with the Darent Valley option.

> Public transport is expensive, parking is expensive then add on long waiting times and it makes for an extremely stressful situation

> The parking at Darent hospital is often nightmarish and can also be very expensive

Traffic

Traffic is also commonly raised as potentially having impact on patients, mostly at DVH. There are many similar themes here as in response to previous questions:

- The volume of traffic a patient may have to contend with to reach the Darent Valley site
- How slowly the traffic moves in an urgent situation and the anxiety this causes is perceived to be an issue that could impact on respondents, especially those with families
- A cause for concern for some is the Dartford Crossing as a traffic hotspot. Any site near to the Dartford Crossing would appear to create an issue for them, and this would especially affect DVH.

> It would have a big impact if things were moved to DVH, travelling either by public transport or by car is always dependent on the amount of traffic, accidents and hold-ups on the road

> Traffic issues travelling to DVH especially when Dartford Crossing and the A2 is affected.

> Build up traffic in the area. Make parking at the hospital even more difficult

4.2.3 Q8 - WE WELCOME ANY OTHER IDEAS AND SUGGESTIONS THAT YOU WOULD LIKE US TO CONSIDER REGARDING THE PROPOSED NEW URGENT TREATMENT CENTRE

Generally, far fewer people responded to Q8, perhaps because respondents felt that they had ample opportunity to discuss their issues in the previous two open questions.

Location of site

- Some respondents used this opportunity to reiterate their preference for location, while others suggested alternative sites for the UTC
- Respondents also used this question to restate their preference for affirm their desire to have an UTC local to where they live, that is easily accessible for their family.

> The final decision concerning the location of the Urgent Treatment Centre should be based on what is best for the Community as a whole and not on any financial considerations.

> Gravesham hospital would be an ideal location.

Suggestions were made which echo comments to previous questions including provision of ample, cheap parking and making sure enough public transport links are available.

Available services on site

Other suggestions chiefly related to the range of services available at the UTC suggestions for an improved service, including:

- X-ray facilities are available on site
- Improving the waiting times at local GP surgeries to take pressure off the UTC
- Making sure that a well-functioning triage service is in place, particularly to reduce waiting times in A&E if co-located
- Making use of the current Gravesend maternity ward
- The need for a walk-in GP service (not necessarily linked to urgent care) if the Gravesham walk-in service is withdrawn.

> There is the old Maternity Unit in Gravesend next to Gravesham Community Hospital, why don't you knock that down and build a purpose built unit that will have ALL the facilities you need for the Urgent Treatment Centre which will cope with ALL the residents that live in the 3 Boroughs and the extra residents that will be moving into all the new Properties that are being built.

> It would be useful if this new service incorporates an out of hours x-ray service / cover. This would take the pressure off A&E for minor injuries and fractures.
> It would also be great if this service could incorporate a walk-in doctor for illnesses not just injuries, for example, prescription of antibiotics when urgently required.

4.2.4 FEEDBACK FROM ROADSHOW AND LISTENING EVENTS

4.2.5 ABOUT ACCESSIBILITY

In addition to the questionnaire responses, qualitative data was received through

- The CCG's roadshow
- Listening events.

These were more wide-ranging discussions and provide feedback on a broader range of topics.

Analysis of these comments shows some preferences expressed for each Option and the greatest number of comments, consistently with the questionnaire response, related to:

- The proximity of services and the distance and difficulty of travel
- Specifically, traffic and congestion
- Car parking at NHS sites
- Public transport accessibility.

4.2.6 ABOUT URGENT CARE AND THE UTC MODEL

There are a significant number of comments about the need to communicate effectively when the new services when they are introduced and general views about sign-posting, including the NHS111 telephone service, and suggestions for where and how to publicise the most appropriate local services for urgent care.

There are also a significant number of comments about the access needs of local communities, particularly residents who may not have English as a first language or with access issues linked to deprivation or age (e.g. reliance on public transport). There are some specific comments about the need to integrate with mental healthcare.

The changing nature of the local population, particularly the rapid growth in some areas such as Ebbsfleet Garden City and the resulting pressures on local services, are also a common theme.

Main messages relating to delivery of services in the new model include concern to ensure that there are enough staff to deliver the new system, and aspects of quality and patient experience including:

- The general pressure on services, including comments about the "busyness" of Darent Valley Hospital
- Opening hours and arrangements for out-of-hours urgent care
- Waiting times across all urgent care services
- The potential benefits of co-location of UTC with A&E services and having everything "in one place"
- Triage especially on-site between UTC and A&E.

Within this, a common theme is the need for greater accessibility (especially easier appointments) and more urgent care provided in non-acute settings, in particular general practice.

4.2.7 ABOUT THE CONSULTATION PROCESS

More broadly, there are comments about the consultation and decision-making process, with themes including:

- That participants at the events could have been better informed (e.g. with more data) and the events could have been set up better (e.g. venues)
- Suspicion expressed that the outcome of the consultation has already been decided
- That the events and the consultation could have been publicised better.

That the proposal to develop UTCs may represent:

- Cuts to services or the availability of care
- A step toward privatisation of NHS services.

4.3 MEETINGS / CORRESPONDENCE WITH STATUTORY CONSULTEES

The PCBC provides detail of involvement by local authority scrutiny and local Healthwatch organisations in reviewing the case for change and development of consultation options. During the consultation process, Table 6 shows a summary of engagement responses from these groups.

Table 6 Formal responses from statutory and political stakeholders

Statutory and political stakeholders	Who?	Document	Preference expressed? (Option 1 vs. Option 2)	Summary points (if available)
Local Authority Overview and Scrutiny	LB Bexley Communities OSC (HOSC)	Email 17/10/19	Preference expressed for Option 2 Agreed to participate in joint scrutiny arrangements	• Potential impact on services for Bexley residents (especially in Option 1), notably Queen Mary's Sidcup and Erith
	LB Bexley Health Service Development Scrutiny Sub-Group	Email 29/10/19		• Potential impact on services for Bexley residents (especially in Option 1), notably Queen Mary's Sidcup and Erith • Concern about accuracy of forecasts about which alternatives patients may choose, and need to signpost effectively
	Dartford BC Policy Overview Committee	Letter 01/11/19	Preference expressed for Option 2	• Darent Valley Hospital location more accessible by car (main roads) and public transport by bus • Note plans to build a new multi-storey care park to ease pressure at Darent Valley Hospital • Future local population growth, particularly in Ebbsfleet Garden City
	LB Bromley Health Scrutiny Committee	Email 12/08/19	Declined to comment	• Potential impact on urgent and emergency care services at Princess Royal University Hospital
Local authorities	Swanscombe and Greenhithe Town Council	Email 04/11/19	No preference expressed	• Concern at reduction of sites providing urgent care services
	Meopham Parish Council	Letter 04/11/2019	Preference expressed for Option 1	• Need to retain local urgent care services at Gravesham Community Hospital • Potential impact on GP Walk-in Centre in Northfleet • Potential impact on already busy Darent Valley A&E • Difficulty of getting to Darent Valley, especially by car

Statutory and political stakeholders	Who?	Document	Preference expressed? (Option 1 vs. Option 2)	Summary points (if available)
Members of Parliament	Gareth Johnson, MP for Dartford	Letter 31/10/19	No preference expressed	• Potential impact on other services at Darent Valley Hospital through take-up of space for UTC and additional pressure of numbers at the hospital (e.g. car parking)
	Adam Holloway, MP for Gravesham		Preference expressed for Option 1	• Travel distance / time for Gravesham residents • Gravesham Community Hospital closer to population centre, better located for public transport and more accessible (e.g. car parking)

5. APPENDICES

APPENDIX A – QUESTIONNAIRE

1. I am providing a response:

- ○ In a personal capacity
- ○ As a representative of a group

If you are responding as a representative of a group, please give details below:

2. What are the first three digits of your post code?

3. Which of the current urgent care services have you (or a friend or family member) used before? (Tick all that apply)

	You	Friend/Family
Fleet Health Campus in Northfleet (White Horse Walk-in)	☐	☐
The Minor Injuries Unit at Gravesham Community Hospital	☐	☐
Your regular GP practice where you are registered	☐	☐
GP out-of-hours	☐	☐
A&E at Darent Valley Hospital	☐	☐
NHS 111	☐	☐
None of the above	☐	☐

4. Thinking of the last time you used an urgent care service how did you travel there?

- ☐ By car
- ☐ By public transport
- ☐ By taxi/cab
- ☐ By ambulance
- ☐ By foot

Please indicate whether you agree or disagree with the two options proposed

5. Option 1: To create an Urgent Treatment Centre at Gravesham Community Hospital by moving services from the current Fleet Health Campus in Northfleet (White Horse Walk-in) to join the Minor Injuries Unit at Gravesham Community Hospital

- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly disagree
- ◯ Have no view

6. Option 2:To create an Urgent Treatment Centre at Darent Valley Hospital by moving services from the current Minor Injuries Unit at Gravesham Community Hospital and the Fleet Health Campus in Northfleet (White Horse Walk-in) to Darent Valley Hospital

- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly disagree
- ◯ Have no view

Please state your reasons for your choice

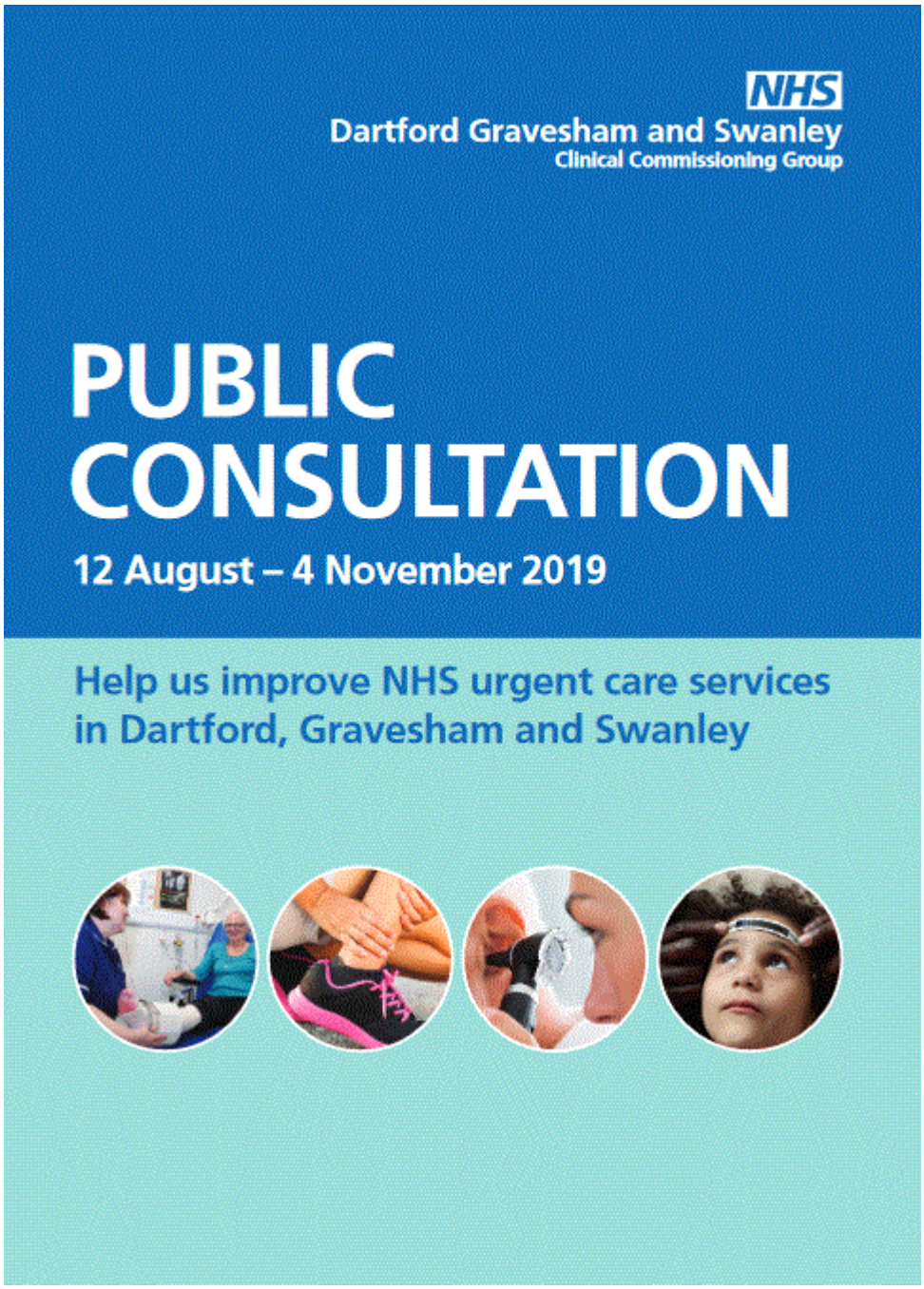
7. The top three issues local people raised with us about the location of the new Urgent Treatment Centre during previous engagement were: parking, access to public transport and waiting times.

What impact will the proposed options have on you and your family?

8. We welcome any other ideas and suggestions that you would like us to consider regarding the proposed new Urgent Treatment Centre

APPENDIX B – MATERIALS AND PUBLICITY

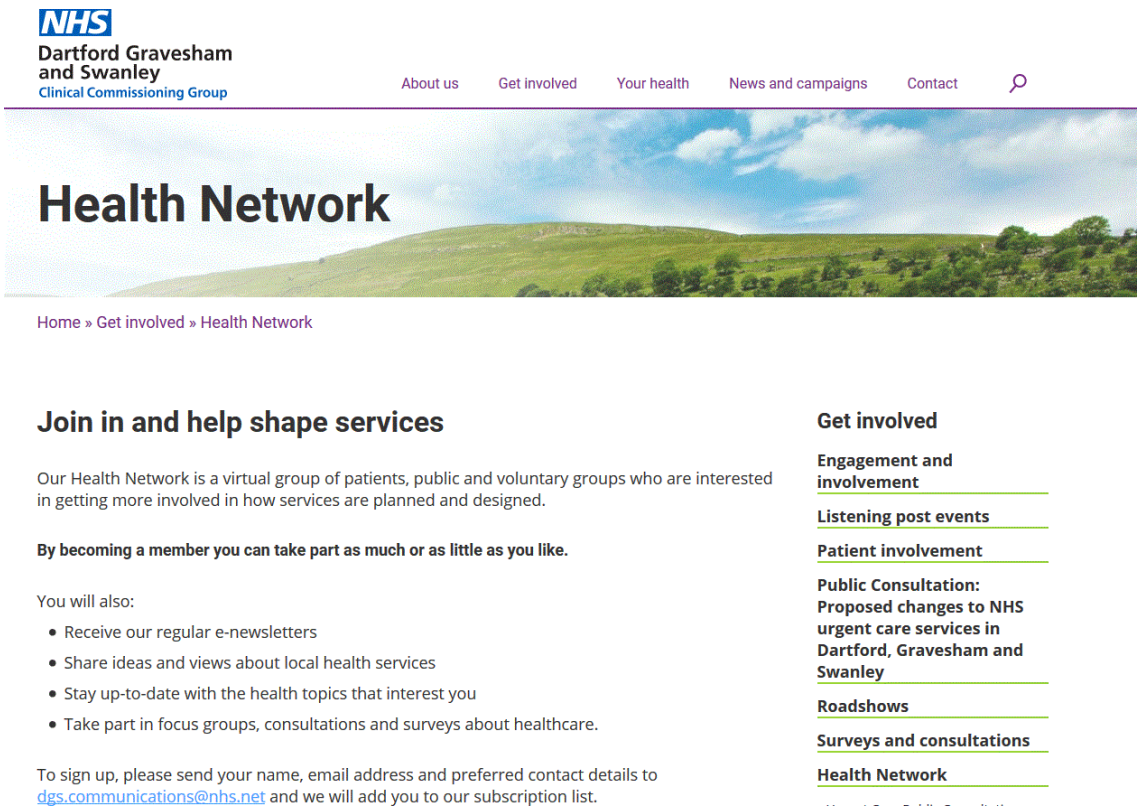
A suite of material was designed and produced to explain the options and encourage participation in the consultation



14pp document + reply-paid print questionnaire

Website consultation pages (including document download and questionnaire)

Other digital engagement through social media posts and the CCG website



Generic posters

Postcard

Promotion of events and roadshow

APPENDIX C – LISTENING EVENTS

The full report from facilitated Listening events, provided by Hood and Woolf are contained in the following pages.

HOOD & WOOLF

Dartford, Gravesham and Swanley Clinical Commissioning Group consultation on a new urgent treatment centre: Report on public consultation events

November 2019

Part 1: Executive summary

As part of a wider public consultation, Hood & Woolf were commissioned by Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG or DGS) to deliver three public meetings to support the CCG's consultation on the location of a new urgent treatment centre.

The two options for consultation were:

- Option 1: an urgent treatment centre at Gravesham Community Hospital
- Option 2: an urgent treatment centre located alongside the A&E at Darent Valley Hospital.

Both these options would mean that the current GP-led walk-in service would close, and its services be replaced within the new urgent treatment centre. Under option 2 the minor injuries unit at Gravesham Community Hospital would also close, again, with services to treat urgent minor injuries to be delivered for the local population from the new urgent treatment centre. Under both options the A&E service at Darent Valley Hospital would remain unchanged.

In addition to twelve weeks of consultation activity, three public consultation events were delivered in October; one each in Dartford, Gravesham and Swanley:

- Wednesday 16 October: Alexandra Suite, St Mary's Road, Swanley, BR8 7BU
- Monday 28 October: Princes Park Stadium, Darent Road, Dartford, DA1 1RT
- Wednesday 30 October: Gravesham Civic Centre, Windmill Street, Gravesend, DA12 1AU

We worked closely with the DGS CCG Communications and Engagement team to support them in their promotion of the events, making the most of their existing communications channels and networks, as well as seeking support from local provider organisations. Promotional activity included:

- publicity posters
- cascade correspondence and publicity to stakeholder network
- publicity information clearly posted on DGS CCG website
- traditional media – proactive press release

- social media – regular pulses of awareness raising activity, call to action and signposting on Twitter and Facebook
- promotion by other local NHS organisations through their extensive staff, stakeholder and community networks.

To make it as easy as possible for people to register for the events we used Eventbrite to set up an online registration portal. In addition, people without access to the internet were able to telephone to register to attend.

Each event followed the same format. The meeting room was set up in a cabaret style with several tables each able to seat around 8 attendees. Every venue had capacity for up to 70 attendees.

The meeting began with a context-setting and overview presentation, followed by a plenary Q&A session and then facilitated individual table discussions, where we focused conversations around the following questions:

- What do you think about these two options?
- Are there any other benefits or disadvantages for each of them we haven't already noted (as per the presentation and table materials)?
- Which are the potential disadvantages and concerns that worry you most? How could we address them?
- What other thoughts or comments about these two options do you have?
- Are there any other options we should consider?

We purposely designed the format to include both plenary and smaller, more focused, table discussions. In our experience not everybody is confident or wants to give their views to a large plenary group, although this is a helpful way to convey context-setting information and to answer common questions. In addition, plenary discussions can become dominated by one or two individuals, leaving others feeling they haven't had the chance to properly give their views too. Table discussions allow for richer, more detailed conversations and exploration of themes, and allow a greater number of people to properly 'have their say'.

The table discussions were based on a 'world café' format, with the tables set up with paper tablecloths and refreshments to create an informal atmosphere. Each table had some infographic-type materials highlighting key facts and figures, and clearly setting out the two options to prompt discussion. Facilitators encouraged discussion and invited attendees to write their thoughts on the tablecloth, so everyone had the chance to have their say. The facilitators also took on the 'main scribe' role, making sure that key points from the discussion were noted in addition to individual comments written on the tablecloths by participants.

After the table discussions, each facilitator fed back to the rest of the room some of the key headlines from their table's discussions and there was a final short plenary session in which the CCG Clinical Chair/Director of Strategic Transformation fed back to participants what they had heard and thanked everyone for their involvement. The tablecloths were collected, and the comments were written up to inform this report.

Overall 81 people attended the listening events, most of whom were in the 50 to 69 or 70+ age bracket. The feedback from the events was broadly very positive, with 79% of attendees rating the event format as excellent or good.

The key themes that emerged from the events which were common to both options in the consultation, were:

- general support for urgent treatment centres (UTCs), with participants seeing the benefits of an alternative to A&E
- concerns about ease of access to UTCs by both private and public transport, wherever it is located
- a call for more to be done to help people understand what services are available and which is the most appropriate for their needs
- comments on the wider NHS context, including other changes to services and whether these will improve access to primary care, and concerns about the availability of workforce to staff the UTC
- concerns about the changing and growing population in Dartford, Gravesham and Swanley and how this would impact on a new UTC.

The key themes and beliefs raised by event participants on option 1, a UTC at Gravesham Community Hospital, were:

- access to Darent Valley Hospital from the Gravesham area is very difficult by both car and public transport. However, access to Gravesham Community Hospital will also be difficult for people who do not live in the Gravesham area
- the population of Gravesham is too large to be without urgent care services in the local area
- there are vulnerable groups who will be particularly impacted if there is no UTC in Gravesham
- there are clinical risks to patients if there is no urgent care service in the Gravesham area, but there are also clinical risks of not having an A&E co-located with a UTC
- people living in the Gravesham area have confidence in their current urgent care services and see them as an important asset to the community. However, some people are worried that Gravesham Community Hospital would not cope with an increase in patients if the UTC were located there.

Key themes and beliefs raised by event participants on option 2, a UTC at Darent Valley Hospital, were:

- access to Darent Valley Hospital is very difficult by both car and public transport; it is difficult and expensive to park there
- there should be a UTC at Darent Valley Hospital because this would serve the largest number of people, but people in the Gravesham area will be disadvantaged
- the clinical benefits of being located alongside an A&E are very compelling, and a UTC would help to reduce pressure on A&E

- Darent Valley Hospital is very busy already and a UTC could make this worse.

The most common alternative options and mitigations suggested by attendees at the public consultation events were:

- to have two urgent treatment centres, one at Darent Valley Hospital and one at Gravesham Community Hospital
- to ensure the changes in primary care, such as the creation of GP hubs and extended opening hours deliver improvements that could help reduce the need for urgent care
- to find ways to improve access at either site by increasing parking spaces and reducing parking costs, considering a shuttle bus service or other ways of improving public transport.

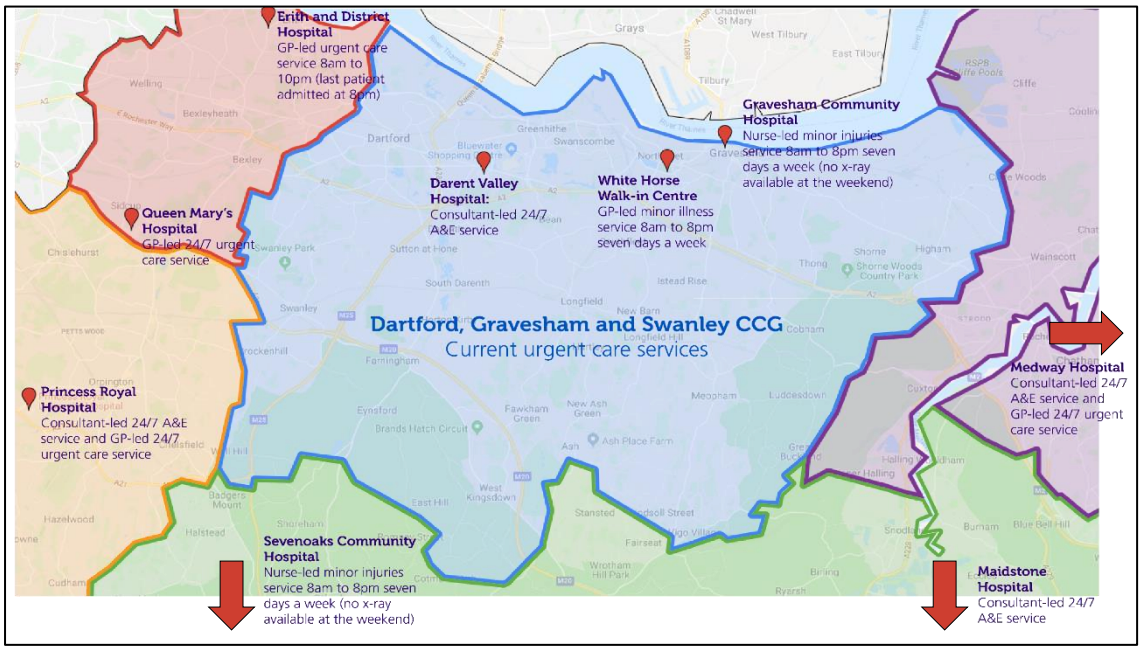
Part 2: Introduction and overview of events

1. Introduction

Hood & Woolf were commissioned in September 2019 by Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG or DGS) to design and deliver three public meetings to support the CCG's consultation on the location of a new urgent treatment centre.

As part of national NHS policy, local NHS areas are expected to reconfigure current urgent care services (usually minor injuries units and/or urgent care centres) to create urgent treatment centres, or UTCs. The new UTCs will have a consistent service offer and will need to adhere to 27 nationally set standards. They are intended to address a number of issues with current service provision, including confusion and uncertainty among the public about, when and how to access urgent care services appropriately and the growing pressure on emergency departments (A&Es), caused in part by a high number of inappropriate attendances.

At present, DGS CCG have a number of different services for people with an urgent care need, including a minor injuries unit at Gravesham Community Hospital, a GP-led walk-in service just outside Gravesham town centre, and a GP led service at Darent Valley Hospital A&E department. The map below provides more detail.



DGS began a public consultation in August 2019 on the location of a new UTC for the area. They presented two options for consultation:

- Option 1: an urgent treatment centre at Gravesham Community Hospital
- Option 2: an urgent treatment centre located alongside the A&E at Darent Valley Hospital.

Both these options would mean that the current GP-led walk-in service would close, and under option 2 the minor injuries unit at Gravesham Community Hospital would also close. Under both options the A&E service at Darent Valley Hospital would remain unchanged.

In addition to the three public meetings, the consultation comprised a number of different elements in order to gather the views of local people, staff and stakeholders, these included:

- a consultation document, which included a consultation questionnaire
- web pages on the CCG website about the consultation, with links to an online version of the consultation questionnaire
- a series of 'roadshow' events about the consultation in local communities, shopping centres and supermarkets
- targeted outreach to seldom heard groups
- social media activity.

The consultation closed on 4 November 2019 and a decision is expected in early 2020, with the new urgent treatment centre planned to open by summer 2020.

2. What we did

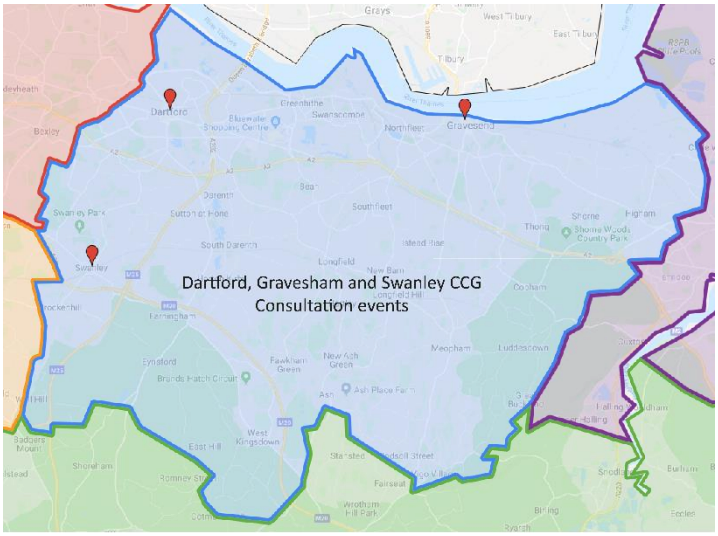
2.0 Scheduling the events

At the time of being commissioned, the DGS CCG Communications and Engagement team had already booked three venues for the consultation events to take place in October; one each in Dartford, Gravesham and Swanley:

Wednesday 16 October: Alexandra Suite, St Mary's Road, Swanley, BR8 7BU

Monday 28 October: Princes Park Stadium, Darent Road, Dartford, DA1 1RT

Wednesday 30 October: Gravesham Civic Centre, Windmill Street, Gravesend, DA12 1AU



The events were scheduled to take place on weekday evenings from 6pm to 8pm, to allow as many people to attend as possible.

The first event was originally planned for 7 October in Dartford, but at our recommendation this was rescheduled to 28 October as only a small number of people had registered to attend.

2.1 Publicising the events

The DGS Communications and Engagement team had started work to promote the events when Hood & Woolf were appointed to deliver the meetings. We worked closely with the DGS CCG Communications and Engagement team to further promote the events, making the most of their existing communications channels and networks. The table below summarises the publicity activity.

Activity	Details
Publicity posters	Posters promoting the events were displayed in community venues, GP practices and other NHS services, local shops and businesses. The poster is shown in Appendix A.
Cascade to stakeholder network	An email invitation was sent to DGC CCG's stakeholder network, which includes patient participation group members, faith and community group leaders, local branches of patient groups (e.g. Diabetes UK etc) and members of the DGS CCG Health Network. In addition, a personal email was sent to local councillors inviting them to attend and to highlight the meetings to others.
DGS CCG website	The consultation and information about the events were given a strong presence on the DGS CCG website
Traditional media	A press release was sent to local print and broadcast media. This is shown in Appendix B.
Social media	We developed some social media 'cards' for use on Facebook and Twitter (see Appendix C). The CCG published posts on their Facebook page and tweeted about the events (examples are shown in Appendix C). In addition, we issued tweets via the Kent and Medway Sustainability and Transformation Partnership Twitter account (example in Appendix C).
Promotion by other NHS organisations	We sought support from communications and engagement teams in local provider organisations, including Dartford and Gravesham NHS Trust, Kent Community Hospitals NHS Foundation Trust and Virgin Care, in promoting the events. They were asked to display posters in patient areas and to promote the events to their stakeholder networks and via their social media channels.

To make it as easy as possible for people to register for the events we used Eventbrite to set up an online registration portal. For those without access to the internet, a telephone number was included in all the publicity materials, so people could call DGS CCG to register for an event.

2.2 Event format

Each event followed the same format. The meeting room was set up in a cabaret style with several tables each able to seat around 8 attendees. Every venue had capacity for up to 70 participants.

The meeting began with a context-setting and overview presentation on the consultation given by the GP Urgent Care Lead for the CCG and the Director of Strategic Transformation. The presentation is shown in Appendix D, but in summary it covered the following:

- an overview of what urgent care is
- the 'case for change' in Dartford, Gravesham and Swanley
- an overview of current services
- details of the two options for consultation
- the currently recognised main pros and cons of each option
- an overview of other changes happening in the NHS to provide context
- a summary of key themes from feedback already heard.

After the presentation, there was a short plenary Q&A session of around 15 minutes where attendees could ask questions of the presenters. These questions were captured by the event facilitators.

Following the Q&A session, attendees participated in facilitated individual table discussions where we sought to gain greater insight into their views on the consultation options.

The table discussions were based on a 'world café' format, with the tables set up with paper tablecloths and refreshments to create an informal atmosphere. Each table had a range of information and materials to prompt discussion. Facilitators encouraged discussion and invited attendees to write their thoughts on the tablecloths, so everyone had the chance to share their views. The facilitators also took on the 'main scribe' role, making sure that key points from the discussion were noted in addition to individual comments written on the tablecloths by participants.

While discussions were allowed to flow freely, the table facilitators had five main questions to help focus the conversations, these were:

- What do you think about these two options?
- Are there any other benefits or disadvantages for each of them we haven't already noted (as per the presentation and table materials)?
- Which are the potential disadvantages and concerns that worry you most? How can we address them?
- What other thoughts or comments about these two options do you have?
- Are there any other options we should consider?

A range of additional information was available on the table to support the discussions, including:

- the consultation document
- a summary of the options and their benefits and potential disadvantages*

- a map of current services
- an overview of the case for change*
- a summary of what an urgent treatment centre is*
- a set of frequently asked questions and answers.*

The items marked with * are shown in Appendix E.

The table discussions lasted for around an hour, after which each table facilitator fed back some of the key themes of the discussions to the rest of the room.

There was a final short plenary session in which the CCG Clinical Chair/Director of Strategic Transformation fed back to participants what they had heard and thanked everyone for their involvement.

The tablecloths were collected at the end of the event and the comments were written up to inform this report. A full list of all the comments is shown in Appendix F.

3. Who came

In total 81 people attended across the three events. The breakdown of attendance was:

- Swanley: 7 attendees (NB at the Swanley event there was just one table discussion)
- Dartford: 14 attendees
- Gravesham: 60 attendees

Almost all of the attendees at the events were in the 50 to 69 and 70 plus age range. However, at the Gravesham and Dartford event there were a small number of younger attendees from the 21 to 39 and 40 to 49 age brackets.

4. Feedback on the events

At each event we asked participants to complete an evaluation form to share their feedback. The form is shown in Appendix G, but in summary we asked people to rate the following elements of the event against a scale of poor, satisfactory, good or excellent:

- parking
- venue
- accessibility
- event organisation
- format of the event
- table facilitation.

Over 65 evaluation forms were returned across all three events with an average of 81% of people selecting good or excellent against each criteria. On average 16% of the evaluation forms rated elements as satisfactory and just 3% as poor. The full feedback is shown in Appendix F.

"I found the overall event informative and was able to give views and opinions. It was a shame that not many people attended although it was publicised." - Dartford

We also invited free-text feedback comments on the event. Again, these were mostly positive with people feeding back that they found the meeting informative and liked the round table discussions and format of the event (although a minority said they would have preferred just a plenary Q&A session).

"I liked the writing on the table – easy to make notes while listening. I liked the table talks and the team joining us for the time. Their points of view are clever and enlightening." - Dartford

Some people commented that the round table format can make it difficult to hear because of the number of discussions happening at one time in the room.

There was also feedback that people were disappointed at the small numbers of attendees at both Swanley and Dartford, and they would have liked to have seen more publicity about the events in their communities.

"Felt listened to. Helpful to be able to relay what hasn't worked in the past so changes can be made for the positive in the future." - Dartford

Part 3: What we heard

Although the three meetings were quite different, with varying numbers of people attending, we were able to have detailed and insightful conversations at each event. The questions asked by participants, and the facilitated table conversations, both yielded helpful feedback about urgent treatment centres and the key concerns of local communities about what the proposed changes might mean for them.

5. Participant questions

As described above, at each event there was a short plenary Q&A session after the presentation and before the table discussions where participants could ask questions of the presenters. The questions and comments during these sessions were typically about:

- access to proposed new services, with people commonly raising concerns about:
    - whether people will understand what service to access and when, with some people raising concerns about those who don't have English as a first language and those who rely on family and friends to help them access health services
    - difficulty of access by private car because of traffic, congestion and parking, including the affordability of parking costs
    - difficulty of access by public transport, including whether it is even possible to access a site by public transport, the time it will take, the cost and whether public transport is a viable option for people who are unwell, elderly or frail
    - the cost of using a taxi to access services
- current challenges with NHS services, for example difficulties getting a GP appointment or recent closures or changes to other services, with participants seeing the proposed UTC as part of a wider downgrading or decline in local services
- the impact of the proposed changes on the most vulnerable within the community, particularly people who are elderly, frail or deprived and those who don't have English as a first language, and their family and carers
- practical considerations about the proposed options, for example what type of building work might be needed and whether the proposed sites have enough space to accommodate an urgent treatment centre
- the costs involved of implementing a UTC, and whether the proposals are about saving money
- how the consultation had been publicised and the level of awareness among the local community
- how and when a decision will be made and how it will be communicated
- the importance of communicating widely about changes to services when they happen so people understand where to go and what is available when.

The issues that were raised in the Q&A session were often discussed further during the table discussions, and unsurprisingly there is overlap between the key themes of the questions asked and

the key themes that emerged from the facilitated discussions. These are explored in more detail in the next section of this report.

6. General themes from the table discussions

Across all three events we captured over 460 written comments from attendees and the table facilitators (who were also writing the comments they heard onto the tablecloths).

The themes that emerged from each of the events were broadly similar, but with each event having a different view, dependent primarily on their geographical location and the particular needs of their local community.

6.0 Support for urgent treatment centres

Overall, most people thought that urgent treatment centres were a good idea in principle. People could see the benefit of being able to access care quickly if they were not able to see a GP, and access care for injuries and illnesses that don't require a full A&E department.

However, some people questioned why things can't stay as they are, suggesting they did not fully support the case for change. Some people said they felt that a UTC wasn't needed and instead A&E should be improved and enhanced so all urgent and emergency care is provided by A&E.

"Why do we have to change anything? Why can't they stay the same?" - Gravesend

This broad general support for UTCs by most participants came with caveats and concerns that were influenced by where they live, by their previous experience of healthcare and their current healthcare needs. These caveats and concerns are described in more detail below.

6.1 Access to services

This was by far the most commonly discussed issue at all three events. Access is a wide-reaching term, but in our evaluation of the event feedback we have used the definition 'the extent to which people are able to get the care they need from an appropriate service in a timely and convenient way'. Under this definition we have included comments about:

- whether people can reach an appropriate service in a reasonable time using the transport available to them, and that is appropriate for their condition
- whether people will have the financial ability to reach an appropriate service
- whether appropriate services will be available at a time of day, or day of the week, that is convenient (if care is not needed immediately)

"Older people don't drive, buses are infrequent. A lot of people have to take a cab and that costs a lot" - Swanley

The insights from the comments and discussions on access show that this is a very significant concern for local people at all levels of the definition.

"Access to Darent Valley Hospital almost impossible in rush hour or if there is an accident on the A2" - Gravesend

In terms of the practicalities of physically reaching urgent care, at every event almost every person made a comment, or agreed with a comment, about the specific challenges of transport in Dartford, Gravesham and Swanley.

(a) *Traffic*

Attendees at all three events frequently used terms such as "gridlock" and "standstill" to describe the traffic in the area and were clear that this traffic congestion impacted on access to local health services for those using private cars, taxis and buses. Attendees at all events, including Dartford, cited congestion issues around Darent Valley Hospital caused by the Dartford Crossing and Bluewater shopping centre.

"Gravesend is very difficult from Swanley – gridlock for whole area at times" - Swanley

(b) *Car parking*

People at all events raised concerns about the availability and cost of car parking, particularly at Darent Valley Hospital, but also in Gravesend. Many people mentioned parking further away from Darent Valley Hospital and using the bus service from Bluewater to reach the hospital.

"Parking is a nightmare at Darent Valley Hospital." – Dartford

(c) *Public transport*

In terms of public transport, many people raised concerns that for those people living in the Gravesham area, access to Darent Valley Hospital by public transport is extremely difficult. People who attended the Swanley and Dartford events were also, understandably concerned about access to Gravesend. At all the meetings people acknowledged that journeys to either Darent Valley Hospital or Gravesend from across the area can involve up to three buses, which do not always run regularly, and are expensive.

Some people noted that the bus service from Bluewater was under threat too, with a recent Transport for London consultation putting forward proposals that would make travelling by bus to health services in the area even more difficult.

Access to Gravesend is far superior to Darent Valley, even if you live in Dartford – you've more chance of getting to Gravesend than Darent. - *Gravesend*

In addition, attendees expressed concerns for people living in the more rural parts of the area and flagged that in many rural communities public transport is infrequent and there can be none at all on Sundays.

"Need to ensure council works with public transport companies to increase services – no buses on a Sunday." - Dartford

Many people questioned whether using public transport was appropriate or safe for people who need urgent care, citing concerns about people bleeding, being infectious, or becoming more unwell on the journey.

(d) *Access for vulnerable groups*

At all events, people mentioned that the cost of and time to access services needs to be taken into account, be it be the cost of car parking or of taking public transport. People talked about how those on low incomes, or those who are frail or elderly could be put off seeking the care they need because they cannot afford to make a longer journey or pay for more parking or a taxi.

"What safeguards will be put in place for vulnerable patients and those on low incomes?" - Gravesend

(e) *Opening hours*

Many attendees discussed the opening hours of the proposed UTC, with people suggesting that either the UTC should be open for longer than 12 hours, with a preference for a 24-hour service, or that the opening times should be aligned to the busiest times of current services and/or so they can better meet the needs of working people and school-aged children. Some people suggested that running the UTC from midday to midnight might make it more accessible to people and help reduce pressure on A&E services.

"If UTC is open 12 hours a day, what happens when it is shut? How will you deal with this at Gravesham?" - Swanley

6.2 Signposting and understanding what service to use

Closely aligned to access were comments about needing to ensure that whichever option is selected, there is high quality information and signposting to appropriate services.

(a) *Public awareness and information*

At all the events there was a very strong message that once a decision is made, more needs to be done to help people understand what services are available, when they are open, and what conditions they treat. Participants said they felt this would be vital to the success of the new UTC. People commented that they believe if there isn't a wide-ranging public awareness campaign, people will continue to go to A&E (if the UTC is in Gravesham) or try to access a service that is closed (if the UTC is at Darent Valley Hospital).

"The idea of an Urgent Treatment Centre is excellent but clear information about it is needed." – Gravesend

"How do you educate people about where to go? This is important" - Swanley

(b) *NHS 111 service*

Many attendees discussed concerns about the ability of NHS 111 to provide good advice about which service was most appropriate for a particular condition, with some people saying that NHS 111 is too cautious and sends an ambulance when one isn't needed, and others saying they had found NHS 111 slow to respond or difficult to access when they were not feeling well.

Attendees fed back that they felt the NHS 111 service needs to be well informed about any changes to services and better able to advise people about what to do when they are unwell.

6.3 Wider NHS context

Attendees at the events often discussed other NHS services, and other planned changes, in relation to the proposed UTC. Some people expressed concern that their negative experience of other services meant they did not feel confident that the UTC would be successful. Other participants said they thought that wider changes to services, such as the creation of GP hubs, may help to support the UTCs.

(a) *Workforce*

A common concern raised was about the availability of GPs and other healthcare professionals to run the UTC. At every event people discussed their experiences of not being able to get a GP appointment quickly. In some cases, participants said they thought at UTC would help improve access to care, but other people said they were worried that it would be difficult to find enough staff for the UTC as there are already shortages of GPs and nurses.

"UTCs will be GP led – who will these GPs be? Where will they come from?" - Swanley

At the Dartford event, attendees wanted to know whether staff at the current units have been asked for their views about the changes and were interested to know what staff thought the best option was.

(b) *GP hubs and enhancing primary and local care*

Attendees were keen to learn more about the new GP hubs and primary care networks that are being established in the area. Many were supportive in theory and hoped they would deliver in practice. Some participants talked about the potential for the GP hubs and improved primary care services to bridge a gap between local GP practices and the proposed UTC, and felt future hubs should be located in areas that didn't have a UTC, and needed to offer extended access and same day appointments.

"New GP Hub in Swanley could be used in tandem with UTC – could be third option in more local services in Hubs" - Swanley

At the Swanley event there was support for more hubs in the area because although Swanley is in between several different hospitals with a range of different urgent and emergency services, none are that easy to reach by public transport.

At the Gravesend event, some participants commented that they hadn't heard about the GP hubs, and would like to know more about them, suggesting an information need that could be addressed. Some were pleased to hear that the White Horse Walk-In Centre would become a GP hub in the future, as under both proposed options the walk-in service will close.

"Glad to hear White Horse will be a Hub but how do you get an appointment?" - Gravesend

Overall, people were also supportive of the idea of more outpatient clinics being provided locally, outside of large hospitals.

(c) *Other changes to services*

At the Gravesend event there were lots of comments about other changes to local services. The attendees at this event felt they potentially have the most to lose with the walk-in centre almost certainly closing and the potential for the minor injuries service to close as well. People talked about how they feel they have seen services downgraded and closed in recent years which has caused great concern for the community.

Similar concerns were also heard, albeit less strongly, at the Dartford and the Swanley events, with participants commenting that changes to services are viewed with cynicism and concern by local people, who see them as money saving exercises.

6.4 The changing local population

At all the events, participants discussed concerns about the future growth in the population of Dartford, Gravesham and Swanley, in light of the extensive house building in the area. Participants wanted reassurance that this population growth has been taken into account when developing the options for a new urgent treatment centre. They were concerned not only about the future sustainability of the service and its ability to cope with increasing demand, but also about how population growth would impact on traffic and transport in the area.

"Why isn't it in the centre of the population? Which site is nearest the epicentre of the population?" - Swanley

People also talked about the ageing population and the impact this may have on the types of services people need, and the ability of elderly and frail people to access services, as discussed in section 5.2 above.

Many attendees felt that the urgent treatment centre should be based where the largest populations of people are, although there was some discussion about making sure that people in more remote areas could also reach services.

7. Feedback on the specific options

Overall, those who attended the consultation events tended to favour the option that was geographically most convenient for them. However, there were still more nuanced discussions at the meetings about the strengths and weaknesses of each option.

Some of the general themes described in section 6, particularly those about travel and access, also feature strongly in the feedback on the specific options. Although we do repeat some of the feedback described above here, we felt it was important to fairly reflect the comments made about each option and we have tried to draw out more specific feedback related to the option where possible.

7.0 Option 1: a UTC at Gravesham Community Hospital

The main arguments in favour of a UTC at Gravesham Community Hospital centred around the needs of the local community and the challenges people living in the area face accessing Darent Valley Hospital.

In contrast, those who did not think this was the best option described the access challenges of traveling from the Swanley or Dartford area to Gravesend and expressed concerns about the disadvantages of not co-locating the UTC with an A&E department.

(a) *Access*

Those in favour of option 1 said that the town centre location of Gravesham Community Hospital, the relatively easy and inexpensive parking in Gravesend, and the proximity to both trains and buses meant the access to that site was more favourable than Darent Valley Hospital.

> ***Can see there is a medical advantage to the Darent Valley Hospital site BUT it is outweighed by the practical difficulties – parking, travel, cost of parking, etc and infrastructure in public transport for those who use it. - Gravesend***

People highlighted that those living in Higham to the east of Gravesend, and those in Swanscombe and Northfleet are able to reach the community hospital site by train.

Those who did not support option 1 described the heavy traffic they encountered reaching Gravesend and the time it would take to travel from Swanley to the community hospital site.

(b) *Population size*

At the Gravesend event participants felt that while their local population may not be as large as Dartford, it was still too large to be without any urgent care service, and there were similar comments at the Dartford event. While overall, those who attended the Dartford meeting supported a UTC at Darent Valley Hospital, some said they felt that removing the current minor injuries and walk-in services in Gravesend would leave residents in that area "stranded".

> ***"Concerned that 120,000 people in Gravesham may be 'cut off' from a service they have now but actually does make more sense to have [a UTC] at Darent Valley***

Hospital as near to A&E. However, need to make sure there are still some services for people in Gravesham." - Dartford

In Swanley the point was made that the decision on where to locate the UTC should be based on where the largest number of people are (i.e. Dartford), regardless of issues around traffic, parking and transport.

(c) *Vulnerable groups*

There was particular concern in Gravesend for the ability of elderly and frail people, and those who don't have English as a first language, to be able to access a service based at Darent Valley Hospital.

"I work with vulnerable families – especially where English is not their first language … How will people understand how to access them when the services change?" - Gravesend

Attendees cited the ease of access to the community hospital site for the more vulnerable in their community and were very concerned about the impact on these groups if the new UTC were at Darent Valley Hospital.

"Most first generation population of the Indian community cannot drive so it is hard to travel to Darent Valley Hospital." - Gravesend

Faith leaders from the Sikh community in Gravesham highlighted that many of the older women in their community do not drive and many don't speak English. They may rely on younger family members, who often work full time, to support them to access services. Placing urgent care services further away could have wider implications for these families.

(d) *Possible risks to patients and impact on other services*

People who supported option 1 said that they were concerned that without urgent care in the local area, people would call for ambulances because they had no other way of getting to Darent Valley Hospital, or potentially come to harm because they may try to access a service that no longer existed. Some of those who attended the Gravesend event work at the current minor injuries service and gave examples of people walking in with very serious conditions that they were able to provide immediate first aid for before calling an ambulance.

"Gravesham Minor Injuries Unit has saved many lives where people have just turned up and may not have made it to Darent Valley Hospital." - Gravesend

Those who did not support option 1 felt the clinical benefits of having the UTC located alongside an A&E department should be a priority in the decision making. They were concerned that patients who need more intensive care would be at risk if they had to be transferred by ambulance from Gravesend to Dartford. They also said they were concerned that option 1 would probably not help reduce the pressure on the A&E at Darent Valley Hospital.

"Pressure off A&E is important" - Swanley

"Preference is Darent Valley Hospital as there is no need to be transferred to another site if the condition deteriorates." - Dartford

(e) ***Confidence in current services***

There was a great deal of praise for the current services at both Gravesham Community Hospital and the White Horse Walk-In Centre. People described that they felt they got more personal care, in a more comfortable environment, and the staff had more time for them at these sites. In contrast people said they felt more "like a number" at Darent Valley Hospital and described the A&E as busy and that, at times, they felt unsafe because of aggressive or violent behaviour of others using the service.

"The walk-in service at Gravesend is brilliant – lots of positive experiences – staff care about you; it has a community feel." - Gravesend

"Darent Valley is not safe after dark, especially by the entrance to A&E with people loitering, smoking and 'domestics'." - Gravesend

7.1 Option 2: a UTC at Darent Valley Hospital

The main reasons given in support of option 2 were the clinical benefits of locating the new UTC alongside an A&E department and Darent Valley Hospital's geographically central location, particularly in terms of population density.

"Having a UTC at Darent Valley Hospital seems to make sense – has all the services and facilities etc." - Swanley

The strongest objections to this option were around access, including traffic congestion, public transport and parking issues. Some people also raised concerns about capacity at Darent Valley Hospital.

(a) ***Access***

Most people, including those who felt that a UTC at Darent Valley Hospital was the best option, acknowledged and/or expressed concern about difficult access to the site. People spoke about the very heavy traffic around the hospital, the difficulty finding a parking space and the cost of parking. People without access to a private car were very concerned about being able to quickly and easily reach the site on public transport.

(b) ***Population size***

However, in support of the site, people felt that it was geographically more centrally located for everyone living in the Dartford, Gravesham and Swanley area. At the Swanley event there was a detailed discussion about how the new UTC should be closest to the largest population(s), and that Dartford, rather than Gravesend, more closely meets this criterion.

"Which site is nearest to the epicentre? Which would be accessible to most people?" - Swanley

(c) ***Possible risks to patients and impact on other services***

At both the Swanley and Dartford events participants were persuaded by the benefits of having the UTC co-located with an A&E department. People were concerned that a stand-alone UTC could carry more risk for patients, and they spoke about how they wanted the UTC to have the clinical advantage of being able to quickly and easily transfer a patient who becomes more seriously ill to the A&E.

"Want to know that wherever you go you can get the care you need and can escalate to higher care if needed" - Swanley

Many people at Swanley and Dartford felt that reducing pressure on the A&E department should be a key factor in the decision-making process, and people said that unless there was a UTC at Darent Valley Hospital, people would continue to attend A&E, rather than travel to Gravesend.

Attendees thought it would be easier to have a front door triage system where people can be directed to the most appropriate service if the UTC and A&E are in the same place. People expressed concern that it would not be possible to turn people away from A&E, even if their condition did not really need to be seen there.

"My preference would be Darent Valley Hospital – I think it is the only way to reduce pressure on A&E as people will always be turning up at A&E not realising it isn't the appropriate place for them." - Dartford

(d) ***Confidence in current services***

At all the events, some participants talked about experiences of care at Darent Valley Hospital, both positive and negative. At the Dartford event there was discussion about how the reputation of the hospital was important, and some people did not appear to have confidence that Darent Valley Hospital would be able to deliver the best standard of care. However, there were also many people who said that Darent Valley Hospital had a good reputation and they believed it would be clinically the best place to site the UTC.

"Reputation important – I trust Darent Valley Hospital, I trust the services available." - Dartford

"In my opinion Darent Valley is a more popular site with superior care." - Dartford

Many attendees at all three events also talked about the capacity of Darent Valley Hospital to cope with additional services, with people saying they thought the hospital was already very busy and "jam packed". In contrast however, some people also raised that they didn't think Gravesham Community Hospital was big enough to cope with a UTC, and the wider range of services available at Darent Valley Hospital were an advantage.

"I don't think Gravesend is big enough to cope with the amount of influx that will go that way. Dartford is bigger and better." – Dartford

8. Suggestions for alternative options and mitigations

An important aim of the consultation events was to understand from attendees whether they felt there were other options DGS CCG should explore, and what they felt the CCG could do to mitigate people's concerns and the potential disadvantages of the two options. The most common suggestions are described below.

8.0 Two urgent treatment centres

"Keep the MIU in Gravesend and reinstate the urgent care at Darent Valley Hospital. More people will call ambulances if no easy access to MIU." - Gravesend

The strongest feedback about a possible alternative option was that there should be two UTCs for the area. Most people felt there should be a UTC at Darent Valley Hospital and Gravesham Community Hospital, although some people gave other possible locations such as Ebbsfleet, or at the White Horse Walk-In Centre.

"Why not keep Gravesend Hospital Minor Injuries Unit and merge with White Horse Walk-in. Have a small unit at Darent Valley Hospital?" - Dartford

"Have two UTCs – one in Darent Valley Hospital and one in Gravesend." - Gravesend

8.1 Enhanced primary care

As described in section 6.4 above, other attendees said that increasing access to GP services and more GP hubs with extended services could help to mitigate the impact of not having a UTC in either location.

8.2 Mitigations for access

"Should the NHS put on bus services ie a community bus?" - Gravesend

There were a range of suggestions on ways to improve access, including:

- reducing parking costs at Darent Valley Hospital
- increasing the parking spaces at Darent Valley Hospital
- having a bus service from Bluewater to Darent Valley
- implementing a local 'shuttle bus' service between different health sites across the area
- working with the local authorities to improve bus services.

"Can adaptations be made re transport/infrastructure?" - Gravesend

9. Conclusion

As set out in this report, there were a wide range of opinions about the options being presented. Overall, the feedback shows the following three key themes:

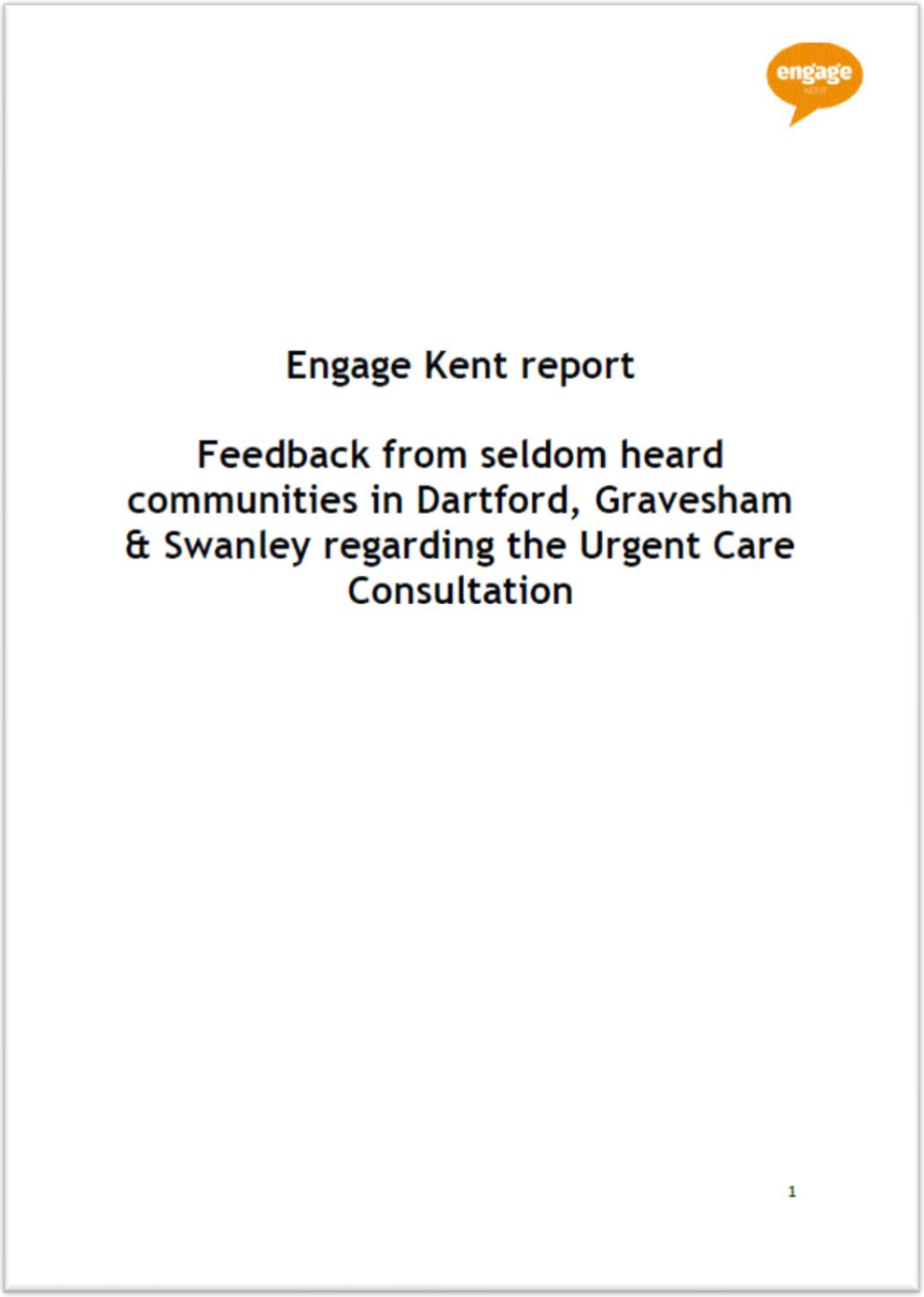
1. Those who attended the consultation events at both Dartford and Gravesend in particular, wanted to have a UTC at both Darent Valley Hospital and at Gravesham Community Hospital.
2. Those who attended Dartford and Swanley were clear that they thought there should be a UTC at Darent Valley Hospital because of the clinical benefits and to relieve pressure on A&E.
3. At all three events, attendees said they are very concerned about access to either site, by both private car and public transport.

APPENDIX D – CCG SUMMARY OF ENGAGEMENT WITH EQUALITIES GROUPS

Protected Characteristic	Engagement and issues raised
age	Engaged: Gravesend 50+ Forum, Golden Girls – public transport for people without cars, concerns whether DVH infrastructure could cope with additional service/s; disabled parking Distribution of materials to local Children Centres: no specific issues raised Face to face attendance at Temple Hill Children's Centre (Dartford) AGM; concern regarding traffic congestion to DVH, size of current A&E space at DVH and access to GP appointments generally
disability	We are Beams (Carers/ Parents of children with disabilities), Saxon Community Group Crockenhill (umbrella group for disabled people): Distributed materials and outreach Both groups raised no specific concerns BSL/Deaf Group Gravesend plus other disability groups (Engage Kent report). Mental Health – CCG team conducted focus group with Rethink Sangam Group at Gravesend Library: Issues raised included need for language translators, improved staff awareness of dealing with people in distress, difficulties getting to Gravesend from the country side parts of DGS, DVH offers more privacy than GCH when discussing sensitive matters; accessible patient records good thing so that patients don't have to repeat their stories; Extended opening hours preferred
gender reassignment	Engaged with Beaumont Society (Transgender, gay – LGBTQi group) by distributing materials and conversations with the Chair of the group: No specific issues for feedback Distributed materials to BeYou (young people from gay and transgender community) and outreach to management. No specific concerns for feedback
marriage and civil partnership	Distributed materials to local registry offices Held stall at Gravesend Gurdwara on family days: Surveys completed. Feedback in general report

pregnancy and maternity	Engaged women and families at the Maternity Clinic at Darent Valley Hospital: Encouraged to complete survey. Feedback in general report Outreach to Maternity Voices via CCG Commissioner for Maternity: no specific concerns raised
race	South Asian communities at Gurdwara Gravesend BME – African Caribbean Festival – Both these groups encouraged to complete survey and feedback in general report
religion or belief	Engaged Sikh (Gurdwara) and Muslim (Gravesend Mosque) communities Engaged with lead from Jehovah Witness Congregation: Indicated that due their beliefs, UTC would need to have a "Cell machine" to re-cycle blood and therefore DVH would be most appropriate as the hospital already has such a machine
sex	Golden Girls (over 60s club in North Fleet) public transport for people without cars, concerns whether DVH infrastructure could cope with additional service/s; disabled parking Mosque roadshow had proportionate high number of men: feedback as part of general report
sexual orientation	No specific issues identified through engagement with BE YOU and Beaumont Society
socio-economic deprived	Outreach at Dartford & Swanley Jobcentre Plus Issues around public transport, TFL proposals and costs of parking at DVH
Rural Gravesham	Engaged with patients in GP surgeries in Meopham and Istead Rise. Feedback part of general report Engage Kent report attached

APPENDIX E – ENGAGE KENT REPORT – SELDOM HEARD GROUPS



Engage Kent report

Feedback from seldom heard communities in Dartford, Gravesham & Swanley regarding the Urgent Care Consultation

1

Context

In October 2019, Engage was commissioned to undertake targeted engagement with seldom heard communities within the Dartford, Gravesham & Swanley area to gather insights and thoughts around the potential changes to Urgent Care services in the area.

The Clinical Commissioning Group had launched a public consultation to gather feedback from local residents about options for new Urgent Treatment Centres.

The brief highlighted the need to engage with three distinct communities who live and work within the area. These communities are classed as seldom heard as they do not traditionally get involved in public consultations. The target communities were:

1. People with physical disabilities
2. Residents living in rural communities
3. People living within Traveller communities

The CCG wanted to specifically understand how the two options outlined in the public consultation would affect people from these three communities.

We have spoken with 104 people face to face so far about their views.

Methodology

To meet the brief, we proposed a programme of outreach visits and street surveys to enable us to gather indepth feedback through face to face conversations. For each of the three target communities, we visited two different groups to gather a range of feedback.

Using our framework of 'seldom heard' against recent data on Health Inequalities in Kent and Medway, alongside our knowledge of local groups and communities we identified the following groups across a range of locations to reach the desired target audiences:

Target group	Geography / rationale/ conversation
People with physical disabilities	Physical disability group in in Gravesend
	Deaf community group in Gravesend
Rural communities	Village of Shorne - selected by the CCG
	Residents from Vigo - selected by the CCG
Traveller communities	Traveller site in Ash
	Traveller site in New Dunton

Two different methodologies were used to meaningfully engage these target groups

1. Outreach engagement - talking to targeted community groups geographical areas using a facilitated conversation framework.
2. Street surveys -in a range of locations, Surveyors walked around the rural villages approaching people and undertaking a short questionnaire designed to capture their reaction to the proposal and an indication of its impact in their families and communities. (Copy of facilitated conversations can be found in Appendix 2).

Quantitative findings

We've spoken with 104 people face to face during these activities so far with two further visits planned to hear from the Traveller community.

Target group	Geography / rationale/ conversation	Number of people engaged
People with physical disabilities	Physical disability group	57
	Deaf community group	15
Rural communities	Village of Shorne	15
	Residents from Vigo	17
Traveller communities	Traveller site in Ash	To be completed
	Traveller site in New Dunton	To be completed
	TOTAL	104

Qualitative findings

We have grouped the feedback for each question and after a thematic analysis have listed below the key themes in order of frequency they were mentioned. Where a significant differences or group specific issue has been identified this is reported separately.

What details or facts struck you about the current situation and the proposed options?

Parking

Of the 4 communities we spoke to, everyone we spoke to mentioned the difficulties parking at Darent Valley Hospital currently

- 'Where are we going to park if it goes to Dartford?'
- 'It's so expensive to park there'

Location

People generally wanted the Urgent Treatment Centre to be located nearest to them

- 'All the people who live in Gravesend will want it in Gravesend and the Dartford people will want it in Dartford!'
- 'Gravesend would be better for us as it is nearer'

Happy with the status quo

People were generally comfortable with the current provision but understood that A&E was over crowded

- 'Happy as it is, we go to Gravesham'
- 'We are OK as we are'
- 'Our Dr's surgery is effective and efficient, they deal with all our non-emergency needs. It's better than A&E, therefore better for us'
- 'Less queues would enable A&E to be more focused on real emergencies'
- 'It's too busy now at Darent Valley'
- 'The current situation with Darent A&E needs to be addressed'

3

What's your reaction to proposed changes?

Surprise

No-one of the 104 people that we spoke to were aware of the proposed changes to Urgent Care or had heard of the public consultation

Interpreters

All 15 members of the Deaf community wanted to know if the changes would enable them to have an Interpreter in an urgent health situation. All of them reported that currently they do not have Interpreters within the current emergency and urgent health service.

- 'It is a real challenge now for us to access urgent treatment because of the lack of interpreters. How can it be made better?'
- 'We have to write things down to try and communicate currently which is very time consuming and can result in lots of confusion'
- 'We have to rely on gestures to communicate currently in an urgent situation'
- 'I recently had urgent treatment at Darent Valley. I had to lie face down so I couldn't lip read or see the gestures. It was very scary'
- 'My Mum comes with me to interpret but I wish sometimes she could be there just as my Mum and not as my Interpreter'
- 'I struggle to get an Interpreter at routine appointments. How will it work in an urgent situation?'
- 'It is really stressful worrying about an interpreter'
- 'If I broke my leg, I wouldn't know what to do. English isn't my first language so I wouldn't be able to write down what I want to say'
- 'Doctors write medical jargon down to try and communicate with me but I don't understand'

Transport

All the residents we spoke to in rural communities were concerned about getting to the Urgent Treatment Centre. Even those who had private transport were concerned about how people would get to the Centres.

- 'Public transport is few and far between'
- It will take 2 buses to get to Darent and only 1 to Gravesham'
- 'If you knew what the A2 road was like you wouldn't make it an option'

In favour versus not convinced.....

The people we spoke to were equally divided about whether they supported the idea for Urgent Treatment Centres or not. Some felt it was a positive move and they could understand the rationale, others were not so sure. The Deaf community were primarily concerned about Interpreters. If there was going to be provision for an Interpreter service then everyone we spoke to would be in favour of it

- 'No! Don't muck us about'

- 'Leave as is'
- 'Positive - bring it on'
- 'Totally in favour'
- 'Another waste of money'
- 'Darent cannot cope as it is and couldn't handle anymore'
- 'Good proposal to reduce bottleneck at A&E less stress on both patients and staff'

Where will it be located?

Initial thoughts for most people were focused on the location of the Urgent Treatment Centre

- 'I think the obvious place is Gravesend because of the walk in, and the location. It's already very busy so let's have it there'
- 'I'm really worried about parking'
- 'Gravesend only needed to be maintained properly and it would still be a very good functioning hospital'
- 'I would like it to be nearer to me'

What is not covered in the options?

Getting to the Urgent Treatment Centre

Everyone from rural communities (32 people) commented on how they would get to the Urgent Treatment Centre regardless of where it is located.

- 'Transport for people without cars'
- 'Transport to either is difficult without a car'
- 'Bus routes are being reduced'
- 'Where is the Public transport plan?'
- 'Very limited bus service from where we live'
- 'The Public transport is being done away with which would take us to Darent Valley'
- 'Transport, especially for the elderly and non drivers'
- The infrastructure is not in place to get us to these centres'
- 'For People at Northfleet they would have to use the same busy roads to be seen at either Centre'

Parking

People felt the issue of parking hadn't been fully addressed in the plans so far. No-one we spoke to mentioned any issues with parking in Gravesend.

- 'The disabled parking at Darent Valley has been extended but it is absolutely chocka block all day every time I go there'
- 'Cost of parking. It is very expensive'
- 'Parking at Darent Valley is a big issue. If they have it there it should have its own car park, I don't want to have to walk half a mile from the car park to get there'
- 'Cost of parking at Darent Valley'
- 'Not all of us are made of money. We have to park at the ASDA and walk over'

5

Interpreters

All 15 people from the Deaf community wanted to know if there would be provision for Interpreters in the plans for the Urgent Treatment Centres

- 'Will there be a Signed Video Service which is used by other hospitals for urgent treatment?. Other hospitals use it and we hear it is good'

More services needed

- The amount of times we get sent to A&E but don't actually need to go there, that is the problem - but for some reason that is the only way we get to see any medics and that is not right.
- We need more walk-ins, there should be additions not closures.
- After opening hours (when units are closed) you will still have to go to A&E.

How would you, and people living in your village/community, be affected by Option 1 to locate to Gravesham Community Centre?

For this answer, we have grouped the responses based on the communities we visited

Physical Disability community (based in Gravesend)

- 'It will be more accessible at Gravesham in my opinion'
- 'Gravesend has that car park at the side and is near the St Georges centre, but still doesn't help if someone is disabled'
- 'I've been there and it is handy for visitors'
- 'I think it is more wheelchair friendly at Gravesend'
- 'I don't drive, so my daughter would have to take me, she is expecting a baby and I don't want to impose so I don't know how I would get there'
- 'Even the drop off and pick up area there is a problem there'

Rural communities (Vigo & Shorne)

- 'Difficult to get to without a car'
- 'Just the same as it is now'
- 'No more difficult than at present'
- '60–70% of people here in this village are old. The planners go for the cheaper option not considering people who live here'
- 'We don't all have money. Free parking at ASDA and can walk to A&E'
- This would be a better option based on the cost of public transport to get there'
- 'Whilst difficult, Option 1 would be better than the alternative'
- 'Closer than Darent Valley'
- 'Easier traffic'
- 'Better than Option 2'
- 'Would mildly improve matters'
- 'Good option as less stressful for patients'
- 'From where we live, we might go to Maidstone'

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Deaf community (based in Gravesend)

- 'Will there be access to interpreters in an urgent situation?'
- 'Nothing is currently available at Gravesham MIU for BSL interpreters'
- 'Gravesham is nearer to me so I would have more chance of getting someone to come and interpret for me'

How would you, and people living in your village/community, be affected by Option 2 to locate to Darent Valley Hospital?

For this answer, we have grouped the responses based on the communities we visited

Physical Disability community (based in Gravesend)

- 'As a wheelchair user I couldn't get to Darent Valley hospital'
- 'If they are going to shut down Gravesend, then they need to replace it with something in Gravesend'
- 'It's a pain to get to Darent Valley, and you have to get a bus there, it's easier to get to Gravesend'
- 'Darent Valley would be better for me. And in the consultation, they say that it may be more than 12 hours there, so longer than the other one. That's why I would choose that one'
- 'The cost of getting there worries me'
- 'Travel arrangements will not be easy for people in wheelchairs as many can't get on public transport'

Rural communities (Vigo & Shorne)

- 'Pain in backside'
- 'it's easier to go to Gravesend, the A2 is awful and there are always lots of accidents which stops traffic altogether'
- 'It would be impossible for people without transport of their own'
- 'We are not just statistics we are people'
- 'Too far away'
- 'Parking is a nightmare and the cost of parking is astronomical. But you have to drive there from here or take 2 buses and a train plus the walking'
- 'Travelling, cost and inconvenience - only way really to get there is by ambulance, but they don't bring you back'
- 'Totally impracticable'
- 'Difficulty in getting to Darent Valley'
- 'No public transport to get us there'
- 'No direct transport links, Would have to get a bus then a train, then another bus and the same again to get home'

Deaf community (based in Gravesend)

- 'There isn't currently an Interpreter service available at Darent Valley. Will there be in this new service?'

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- 'Will there be access to interpreters in an urgent situation?'
- 'Interpreters usually don't turn up for a booked appointment at Darent Valley currently. Will it be any different?'

What new questions have emerged for you?

- When is the walk in centre at White Horse going to close?
- Why is the Walk In Centre at White Horse going to close? It doesn't explain that in the documents
- Will there be a pharmacy open on site after 8pm so we can get medication nearby?
- The Darent Valley disabled car park is small, will they make it bigger?
- How will they address the transport problem?
- Can A&E send patience to these new units? If not, it is still blocking A&E
- Booked interpreters often don't turn up or are late for a booked appointment. How are you going to make this any different?
- In an urgent situation, I might not have found someone to come and interpret for me in time. How will you support me?
- I find it very hard to manage in an urgent health situation. How will you support me as a Deaf person?
- My whole family is Deaf. No-one can talk for me. How will you help me?
- Can someone come back and explain to us what the decision is and what we should do?

Appendix 2 Demographic profile of respondents

	Street Survey Vigo	Street Survey Shorne	Physical Disability	Deaf community
Gender				
Male	4	8	17	6
Female	7	7	40	9
Sexual orientation				
Heterosexual	11	14	57	15
Gay		1		
Not Say				
Age				
Under 16				
16-24	1			
25-34	2			4
35-59	1	1	38	7
60-74	5	4	10	2
75+	2	10	9	2
Not Say				

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engage

Ethnicity

English / Welsh / Scottish / Irish	11	15	56	12
Gypsy / Romany / Irish Traveller				
Any other White background				1
White and Black Caribbean				
White and Black African				
White and Asian				
Any Other Mixed / multiple ethnic				
Indian			1	2
Pakistani				
Bangladeshi				
Chinese				
Any other Asian background				
African				
Caribbean				
Any other Black background				
Arab				
Any other ethnic background				
Prefer not to say				

Postcodes	Vigo	Shorne		
	DA13	DA11, DA12	DA12	DA11
		ME3		

1st language

English	11	15	57	
Other				
BSL				15

Consider themselves a carer

Yes	1			
No	10	15	57	15
Not say				

Consider themselves disabled

Yes		2	57	15
No	11	13		
Not say				

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Appendix 2 : Facilitated Conversation Guide

Background

We have been asked by the NHS in Dartford, Gravesham & Swanley to talk to people about two options that are being developed for Urgent healthcare in North Kent. A public consultation is currently open to seek people's views about the options

Talking to the public

Today we are talking about Urgent Care services.

So, imagine you are ill. It's not life threatening but you do need to see a medical person on the same day. You can't wait for a GP appointment.

Currently you might go to Gravesham Minor Injuries, White Horse Walk In Clinic or to A&E at Darent Valley Hospital. Is that right?

The NHS all over the country is tasked with creating new Urgent Treatment Centres to provide urgent treatment on the same day for issues that are not life threatening.

The discussion is where would you like these Urgent Treatment Centres to be located. There are two options up for discussion:

1. Urgent Treatment Centre at Gravesham Community Hospital alongside the Minor Injuries Unit. The White Horse Walk In will close
2. Urgent Treatment Centre at Darent Valley Hospital by moving services from Gravesham Community Hospital. The White Horse Walk In will close.

Why do things need to change?

- Currently 50% of people who go to Darent Valley A&E do not have life threatening of serious illness. Many of them could be looked after elsewhere.
- The population in DGS is due to rise by 22% by 2035

Objective questions:

What details or facts struck you about the current situation and the proposed options?

What's your reaction to proposed changes?

What is not covered in the options?

Reflective questions:

How would you, and people living in your village, be affected by Option 1 to locate to Gravesham Community Centre?

How would you, and people living in your village, be affected by Option 2 to locate to Darent Valley Hospital?

What new questions have emerged for you?

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APPENDIX F – QUESTONNAIRE THEMES CODE FRAME

Q5/6 – Reason for option choice

(01) Ease of journey
- 01 -Traffic is bad/bad in Darent
- 01 - Easier by public transport
- 01 - Worse by public transport
- 01 - Hard to access
- 01 - Easier to access
- 01 - Difficult for elderly/elderly patients will find it hard to get too
- 01 - Ill or sick/vulnerable shouldn't have to travel/it's unfair
- 01 - Too far/further to travel

(02) Parking
- 02 - Not enough parking space
- 02 - More parking near by
- 02 - Parking is too expensive
- 02 - Parking makes me worried
- 02 - Find it difficult to park

(03) Hospital facilities
- 03 - Too near to A&E
- 03 - Not close enough to A&E
- 03 - Already too stretched/can't handle more
- 03 - Facilities are already good at my hospital
- 03 - Want it all in one site
- 03 - Bigger/larger/major hospitals slow the process
- 03 - Safer/better/works better/easier to be alongside A&E/with A&E

(04) Will leave nothing between Medway and other location

(05) Change of site makes me sad/upset/distressed

(06) Expense
- 06 - Parking is too expensive/costs too much
- 06 – Costs too much/is too expensive to get there
- 06 – Don't want to pay to have to get there
- 06 – Public transport is too expensive/costs too much
- 06 – I/my family/loved ones can't afford it

(07) Have urgent care/have site where there are the most people that can use it/can access it/can service most people

Q7 - The top three issues local people raised with us about the location of the new Urgent Treatment Centre during previous engagement were: parking, access to public transport and waiting times. What impact will the proposed options have on you and your family?

(01) Traffic
- 01 - Too much traffic
- 01 - Dartford Crossing is an issue/too busy
- 01 - Driving there too slow (traffic) in an emergency/urgent situation

(02) Parking
- 02 - Not enough parking space
- 02 - More parking near by
- 02 - Parking is too expensive
- 02 - Parking makes me worried
- 02 - Find it difficult to park
- 02 - Anxiety/worried about disabled parking options

(03) Access
- 03 - More difficult to access for me/my family/loved ones
- 03 - Easier to access for me/my family/loved ones
- 03 - Hard for me/family/loved ones as I/he/she/they can't drive/no access to a car
- 03 - Too far to site/further to travel

(04) Service
- 04 - Longer wait times/longer to get seen
- 04 - I like my current service
- 04 - Already too stretched/can't handle more
- 04 - Need the correct/better staff
- 04 - Need more staff/more staff required
- 04 - Important/too important to have a local service
- 04 - Safer/better/works better/easier to be alongside A&E/with A&E

(05) Public Transport
- 05 - Not enough Public transport
- 05 - Public transport is too slow
- 05 - Already good/better public transport links
- 05 - Public transport harder to use with children
- 05 - Public transport harder to use if I am sick/unwell
- 05 - Public transport harder to use for the sick/vulnerable

(06) Expense
- 06 - Parking is too expensive/costs too much
- 06 – Costs too much/is too expensive to get there
- 06 – Don't want to pay to have to get there
- 06 – Public transport is too expensive/costs too much
- 06 – I/my family/loved ones can't afford it

(07) Have urgent care/have site where there are the most people that can use it/can access it/can service most people

Q8 - We welcome any other ideas and suggestions that you would like us to consider regarding the proposed new Urgent Treatment Centre

(01) Proximity to me/location
- 01 - Keep it local to me/my family/loved ones
- 01 - Have site near Gravesend
- 01 - Have site near Dartford
- 01 - Keep Gravesham site
- 01 - Move site to new/different/other location (ANY MENTION OF OTHER LOCATON)

(02) Don't understand why it has to be moved

(03) Transport to site
- 03 - Make sure good/adequate public transport is available
- 03 - Assess current public transport options
- 03 - Provide cheaper/free public transport

(04) Parking
- 04 - Provide adequate parking room for site
- 04 - Provide cheap parking for site
- 04 - Provide free parking for site

(05) Effect on/available services on site
- 05 - Have near to A&E
- 05 - Don't have near to A&E
- 05 - Have x-ray/better x-ray/quicker x-ray available on site
- 05 - Local GP services need improvement/be better/less demand for GP appointments
- 05 - Do not affect/change/over stretch current services on site
- 05 - Shorter waiting times
- 05 - New building/facilities needed/required
- 05 - Make use of Gravesend maternity unit
- 05 - Better/better functioning triage service
- 05 - Extend/longer opening hours
- 05 - Safer/better/works better/easier to be alongside A&E/with A&E

(06) Staff
- 06 - More staff needed at Darent Valley
- 06 - More staff needed at Gravesham
- 06 - More doctors on Duty

(07) Keep both sites as they are/no change

(08) Site change is a good idea

(09) Site change is a bad idea

(10) Better communication of services available on sites/inform service users/better

(11) Expense
- 11 - Parking is too expensive/costs too much
- 11 – Costs too much/is too expensive to get there
- 11 – Don't want to pay to have to get there
- 11 – Public transport is too expensive/costs too much
- 11 – I/my family/loved ones can't afford it

(12) Have urgent care/have site where there are the most people/can access it

(13) Improve care/primary care/services at not urgent treatment centre locations/other locations

Completing the Equality Analysis Template

Section 1: Policy, Function or Service Development Details and Authorisation

This section requires the basic details of the policy, function or service to be reviewed, amended or introduced. The lead author of the analysis and the Dartford Gravesham and Swanley and Swale Clinical Commissioning Groups Equality and Diversity Lead approving the draft analysis produced must be stated.

The presence of an analysis start date and submission date reinforce that completing an EA is a process that should take place over time from the proposed change to be made through to ratification of the change by the Governing Body.

Section 2: Equality Analysis Checklist

The checklist outlines all aspects of the analysis that must be considered as part of a robust EA. The equality groups are given in a single column which also contains some guidance to help when considering each particular protected characteristic in relation to the proposed change.

The second column provides a space to summarise the evidence obtained during the EA process. **Evidence that supports a negative or positive outcome must be referred to here**. Examples of sources of evidence include:

- Checking for local or national evidence. In its simplest form this could be including findings from the Joint Strategic Needs Assessment (JSNA), or finding out more about the protected characteristic through desk based research (this might be particularly useful when checking out less familiar characteristics).
- Has any work been done with patients or patient groups locally?
- Patient Public Involvement (PPI) Leads should be able to help with this or suggest other sources of information.
- It may be that no evidence is available locally. In this case, relevant national and regional data should be sought.

Column 3 refers to any consultation or patient engagement work that may have been undertaken on the policy, function or service to be reviewed, amended or introduced. This might include patient or stakeholder involvement and engagement work. Again the relevant PPI Lead should be able to assist with this – there may already be considerable evidence available.

The remainder of Section 2 considers whether the policy/function/service development could have a positive or negative outcome on each of the protected characteristic groups and how these outcomes will be addressed. Authors must consider what action they will take to mitigate negative outcomes and these actions are taken forward into Section 3 to form an Action Plan. Named Leads and a timeframe should also be assigned to each negative outcome. If a negative outcome is identified, it is important to be mindful that it may also affect other protected characteristics.

Section 3: Action Plan

This section focuses on what the author and the organisation can do to mitigate any negative consequences they have identified at Section 2. For example;

- What can be done to mitigate the effect of the policy/function/service on that particular protected characteristic?
- Are there any resource implications?
- How quickly can this be addressed?
- It may be that is it not possible to avoid the issue - this must be acknowledged in the EA and clearly stated that it will have an impact on a particular community.

Section 4: Submission

Following completion of all sections of the EA, the draft, along with the policy, strategy or service document should be submitted to the Dartford Gravesham and Swanley and Swale Clinical Commissioning Group's Equality & Diversity Group for review and feedback. Having addressed any recommended changes, the final document can be submitted to the CCG Equality Lead for information and consideration before ratification at the next Governing Body Meeting

Equality Analysis Template

This document should be completed in conjunction with the Equality Analysis Guidance produced by the Equality & Diversity Team which can be found on LINK TO BE ARRANGED. Should you have any queries, please contact your Equality & Diversity lead at yasminmahmood@nhs.net who will be pleased to help.

Section 1: Policy, Function or Service Development Details and Authorisation	
Name of Organisation:	NHS Dartford, Gravesham and Swanley Clinical Commissioning Group
Name of the policy, function or service development being assessed:	Urgent and Emergency Care Redesign
Is this a new/existing/revised policy, function or service development?	Re-design of service
Briefly describe its aims and objectives	Re-design of urgent and emergency care within Dartford, Gravesham & Swanley (DGS) Clinical Commissioning Group in line with the Urgent & Emergency Care Keogh Review (November 2013), NHS Five Year Forward View (October 2014), the NHSE Commissioning Standards for Integrated Urgent Care (September 2015) and NHS Long Term Plan (2019). All areas in England are required to offer patients standardised and timely NHS services under the Urgent Care Treatment Centre name. DGS CCG is looking to apply the national mandate locally by creating an Urgent Treatment Centre at either Gravesham Community Hospital or Darent Valley Hospital. The new model will offer assessment, diagnosis and treatment of minor illness and injury supported by on-site diagnostics (e.g. x-ray). Patients can either book an appointment through NHS 111, or by walking in to the UTC and waiting to be seen.
Analysis Start Date:	11/09/2017: Updated: 11/2018 : Updated 11/19
Lead Author of Equality Analysis:	Angela Basoah
Equality & Diversity Lead Approved? Yes/No (please indicate) Equality & Diversity Lead Name: Date of approval:	TBC

Have any financial or resource implications been identified?	The Pre-Consultation business case and financial modelling is available https://www.dartfordgraveshamswanleyccg.nhs.uk/get-involved/public-consultation-proposed-changes-to-nhs-urgent-care-services-in-dartford-gravesham-and-swanley/
Date of relevant committee/decision-making meeting where the Equality Assessment was ratified:	TBC - 12 November 2019

Section 2 : Equality Analysis Checklist

For each of the nine protected characteristics in the table below, consider whether the policy/function/service development could have a positive or negative outcome on each of these groups. Involve service users where possible to obtain their opinion, use demographic/census data (available from public health and other sources), surveys (previous surveys or perhaps conduct one), ask PALS and Complaints for reports/data, obtain subject specific reports from providers and other published data, including findings from the Joint Strategic Needs Assessment (JSNA). Ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Age Think about different age groups and the policy/function/service development and the way the user would access it, is it user friendly for that age group? What is the age breakdown in the community/workforce? Will the change/decision have significant impact on certain age groups?	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014, In February 2017, Age UK published its findings into experiences of older age adults in accessing all areas of health and social care services, for purposes of this EIA we have drawn upon findings relating to access to and experience of emergency care services. The full report can be found here. There are approximately 134,188* Working Age Adults and 36, 336* people over the age of 65 in the Dartford, Gravesham and Swanley area *It is expected that the actual figure is higher in the DGS area as Swanley's statistics is reported collectively under Sevenoaks Local Authority and cannot be broken down into specific figures for this area.	DGS CCG carried out a 12 week Public Consultation into the two proposed options. The Consultation activity included community outreach in community venues across DGS as well as meetings with Gravesend 50+ Forum, Golden Girls (over 60s group). Distribution of materials to Children Centres (to reach parents with children 0-5 years) and face to face engagement with parents of children 0-5 at Temple Hill Children's Centre (Dartford)	Overall local people could see the benefits that a local Urgent Treatment Centre could bring to local people of ages. Feedback from residents in Gravesend suggested that the Darent Valley Hospital option would be difficult for older people to get to because they are more likely to use public transport or be reliant on family and friends to drive them. Feedback identified older residents were less likely to drive or own a car. Feedback did not identify particular positive or negative consequences for families with young children	The results from the Urgent Care Public Consultation are being analysed by an independent agency and a Decision- making Consultation Business Case is in production. The Governing Body will consider the issues highlighted in the consultation (including mitigating actions).	CCG Equality and Diversity Group - November DCBC and internal processes - December Governing Body - January Appointed Provider Ongoing (to cover monitoring stages of implementation)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Disability Think outside the box – you may not be able to see the disability. It could be physical (for instance hearing or visual impairment), unseen (for instance mental health) or a learning disability (for instance Autism). Consider for example: Accessibility – venue, location, signage, furniture and getting around Disability awareness training for staff Actively involve the service user and talk it through with them Mental Health – does this affect significant communities in the local population?	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014, https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf There are approximately 200,107* people in the Dartford, Gravesham and Swanley registered as having a disability or a Long Term Condition. *However it is expected that the actual figure is higher in the DGS area as Swanley's statistics is reported collectively under Sevenoaks Local Authority and cannot be broken down into specific figures for this area.	The CCG has an on-going commitment to ensuring local people with disabilities can access high quality local health care. As part of the CCG Consultation, we engaged with a range of groups with disabilities including: We are Beams (Parents of children with disabilities Re Think Mental health group Saxon Community Group Crockenhill The CCG also worked with Engage Kent to obtain feedback from the following groups Riverside Active Lives Group, Gravesend. (Physical disability) Deaf support group We have also given due regard to the Transforming Care for People with Learning Disabilities report and are committed to implementing its aims as part of the development of the service.	Evidence shows that those living with a disability frequently report discrimination in accessing NHS services. If these services are consolidated onto one location, there is likely to be groups of the population who have to travel further to access the services. Some of the participants of the Active Lives Group (Physically disabled) cited the following issues regarding the proposed options. GCH: "More wheel chair friendly than DVH" Gravesend has that car park at the side but still doesn't help if someone is disabled Limited disabled parking Shortage of staff at GCH Prefer GCH apart from parking DVH:Darent Valley is nearer for him so this would be better for him, I am going to tell him about these changes This may result in a negative outcome for some residents of the DGS areas https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf	The Service Specification for these services will need to ensure that the needs of all disabilities and Long Term Conditions are met so that no one with a disability will experience any form of discrimination in accessing the service. As with any NHS service, those patients on low incomes will be entitled to claim travel costs from the urgent care services. The results from the Urgent Care Public Consultation are being analysed by an independent agency and a Decision- making Consultation Business Case is in production. The Governing Body will consider the issues highlighted in the consultation (including mitigating actions).	Urgent Care Steering Group CCG Equality and Diversity Lead Appointed Provider Ongoing monitoring through various stages (including implementation and performance management of contract)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Disability (cont'd)			Both sites that have been identified as potential locations for these services have accessible parking. One site, Darent Valley Hospital, is able to provide discounted parking for £1.50 a day. The hospital website also implies that there may be the opportunity for this to be refunded. All car parks at Darent Valley Hospital are accessible. For those who rely on public transport services, Darent Valley Hospital, is served by a total of 9 buses, all of which stop at Darenth Train station. Buses serving the hospital travel from the following areas: Temple Hill (Gravesend), Woolwich, Bexley Health, Craford, Dartford, East Hill, Plumstead, New Ash Green, Ightam, Wrotham, Sutton-at-Hone, Erith, Swanley, Joyden's Wood, Keyton Cross, Wilmighton, Orpington, Shipbourne, Borough Green, West Kingsdown, Darenth.		

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Gender Reassignment Think about creating an environment within the policy/function/service development that is user friendly and non- judgemental. Does the organisation need to raise awareness / offer training? If the policy/function/service development is specifically targeting this protected characteristic, think carefully about confidentiality, training, and communication skills	Figures relating to these groups are not collated nationally or locally.	As part of the Public Consultation, the CCG team engaged with Beaumont Society (Transgender, gay – LGBTQi group) by distributing materials and conversations with the Chair of the group: Distributed materials to BeYou (young people from gay and transgender community) and outreach to management. No specific concerns for feedback	No specific issues were raised with the CCG team. However in their report, Unhealthy Attitudes Stonewall (the leading charity for LGBT+ rights) gives helpful insight into the experiences of health services of the trans community The CCG is unable to reference published data as to the number of trans-gender people living in the local community. The Department of Health estimates that the number of transsexual people (those who have undergone, are about to undergo or are currently undergoing gender reassignment treatment) in the UK is 1 in every 11,500; so for the DGS area, this will mean that it can be assumed that approximately 19 people are going through the transition process. Urgent Care services will need to provide care from an environment that offers privacy, dignity and respect. The CCG is aware that some people will wish to have access to an appointment with a clinician of the same sex as them- this is likely to apply to people of older generations. Provisions for this will need to be made as part of the service specification (by commissioners) and the provider for the services will need to demonstrate to commissioners that they are able to meet patient needs in this area.	To mitigate against potential negative impact, these services should be able to provide additional measures relating to privacy and dignity when treating members of this community. All staff working at these services will need to undergo gender equality training. The workforce of the hubs will need to be appropriately trained understanding the specific needs of this protected characteristic group. This action in built into the action plan.	CCG Equality and Diversity Lead Appointed Provider Ongoing monitoring through various stages (including implementation and performance management of contract)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Marriage and Civil Partnership Think about access and confidentiality, the partner may not be aware of involvement or access to the service Staff training to raise awareness of ensuring equal status to spouses and civil partners in all HR policies, terms and conditions and services.	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014, In the last Census a total of approximately 83,295 marriages and 284 Civil partnerships were declared in the Dartford, Gravesham and Swanley area. However it is expected that the actual figure is higher in the DGS area as Swanley's statistics is reported collectively under Sevenoaks Local Authority and cannot be broken down into specific figures for this area.	Distributed materials to local registry offices Held roadshows at Gravesend Gurdwara on family days: Surveys completed. Feedback in general report	There is a possibility that members of the community in a same sex civil partnership or marriage may experience discrimination from NHS services that is not experienced by those in heterosexual marriages. This would result in a negative outcome.	Engagement to date has not identified specific issues relating to this group To reduce the potential for discrimination, commissioners should receive assurance that the same treatment of people in same sex civil partnerships and rights of partners would be granted to other married couples in line with the Equality Act 2010. The Provider will need to ensure that all staff have attended gender equality training as a way of understanding the rights of partners in both marriages and civil partnerships The workforce of the hubs will need to be appropriately trained to understand the specific needs of this protected characteristic group.	CCG Equality and Diversity Lead Appointed Provider Ongoing monitoring through various stages (including implementation and performance management of contract)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Pregnancy & Maternity The policy/function/service development must be accessible for all e.g. opening hours Are the chairs appropriate for breast feeding? Is there a private area? Are there baby changing facilities and is there space for buggies? What are the future projections for birth rates, neo natal statistics? Will the service/decision have a significant impact on this protected characteristic?	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014,	Engaged women and families at the Maternity Clinic at Darent Valley Hospital: Encouraged to complete survey. Feedback in general report Outreach to Maternity Voices via CCG Commissioner for Maternity	No impact has been identified for this group as part of our engagement and evidence collecting. However, with predictions of the Ebbsfleet Garden City attracting more young families into the area commissioners will need to consider the potential impact of more women of child bearing age moving into the area if it is seen as an attractive area to raise families.	As part of commissioning arrangements, the CCG will need to ensure that the provider of this service is able to meet the needs of breastfeeding women and women with babies. This will mean providing facilities that allow them to breastfeed or express milk in a way that offers privacy and dignity in a way that is free from discrimination.	CCG Equality and Diversity Lead Appointed Provider Ongoing monitoring through various stages (including implementation and performance management of contract)

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Sexual Orientation Don't make assumptions as this protected characteristic may not be visibly obvious. Providing an environment that is welcoming - for example visual aids, posters, leaflets. Using language that respects LGB&T people. Staff training on how to ask LGB&T people to disclose their sexual orientation without fear or prejudice.	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014, Engagement Activities Stonewall Unhealthy Attitudes	As part of the Public Consultation, the CCG team engaged with Beaumont Society (Transgender, gay – LGBTQi group) by distributing materials and conversations with the Chair of the group: Distributed materials to BeYou (young people from gay and transgender community) and outreach to management.	No specific concerns for feedback were identified through the engagement to date. However, the Unhealthy Attitudes mentioned above gives details of the experiences that the LGB community report negative patient experiences of accessing and discriminatory treatment at NHS services. LGB youth more frequently require access to urgent Mental Health treatment than their heterosexual counterparts. In their most recent report LGBT In Britain Health Report, Stonewall provides details of the health inequalities experienced by the LGBT community. This report provides national statistics of the mental health experiences of the LGBT community. Urgent Care services may find that they are called upon to support this cohort of patients. Numbers of patients living with a mental health condition is not known in the DGS area. .	All staff working in these services will need to undergo gender equality training. Agreed working protocols for protecting young adults who present to urgent care services in mental crisis will need to be put in place to protect both their physical and immediate mental health needs but also their privacy and dignity, particularly should they disclose to staff that their distress relates to their sexuality. Though to prepare for managing a crisis, specific mental health awareness training and good links with local mental health teams should be established by the provider	Urgent Care Steering Group CCG Equality and Diversity Lead Appointed Provider Ongoing monitoring through various stages (including implementation and performance management of contract))

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Carers Does your policy/function/service development impact on carers? Ask them. Do you need to think about venue, timing? What support will you be offering?	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014, There are 31,474 registered carers in the DGS area who are not in paid employment to do so (i.e. they are doing so for a friend, family member or a loved one). However it is expected that the actual figure is higher as Swanley's statistics are reported collectively under Sevenoaks Local Authority and cannot be broken down into specific figures for this area.	The Public Consultation regarding the location of an Urgent Treatment Centre included 30 roadshows. 3 Listening events and several briefings. The team engaged We are Beams a voluntary sector group supporting Families/ Parents with disabled children	Although no specific issues were raised as part of the Public consultation, Carers, who typically live in low income house-holds, are entitled to claim back expenses from NHS services. Carers often report that they are unable to look after their own needs as they are consumed by their caring responsibilities.	The results from the Urgent Care Public Consultation are being analysed by an independent agency and a Decision- making Consultation Business Case is in production. The Governing Body will consider the issues highlighted in the consultation (including mitigating actions). .	CCG Equality and Diversity Lead Appointed Provider Ongoing monitoring through various stages (including implementation and performance management of contract))

Equality Group	What evidence has been used for this analysis?	What engagement and consultation has been used?	Identify positive / negative / no outcomes	How are you going to address issues identified?	Specify the Named Lead and Timeframe
Other Does your policy/function/ service development impact on for example, those on low incomes, who are homeless etc.?	Census Statistics, Dartford, Gravesham and Swanley Demographic Profile 2014, http://www.healthwatchkent.co.uk/sites/default/files/healthwatch_kent_traveller_report.pdf https://www.myhealth.london.nhs.uk/sites/default/files/Commissioning%20guidance%20for%20London%20-%20Homeless%20health.pdf	The Public Consultation regarding the location of an Urgent Treatment Centre included 30 roadshows. 3 Listening events and several briefings. Copy of Public Consultation Engagement report attached	Low income Household- Potential Negative Impact. There is some evidence to show that by co-locating urgent care services on to one site, that there will be cost implications for those living in low-income households due to increased reliance upon public transport and increased parking costs (where services are either not free to park or are going to experience greater demand resulting in longer waiting times / greater parking charges). The issue of access to the future Urgent Treatment Centre featured significantly in the feedback received from the public consultation.	The Governing Body to consider actions to address feedback regarding access (parking, public transport and costs) in its final decision In some cases, patients will be able to reclaim these travel costs and information as to how this can be done will be made available on site.	Urgent Care Steering Group CCG Equality and Diversity Lead Appointed Provider Ongoing (to cover monitoring stages of implementation)

Section 3 : Action Plan For any negative outcomes identified in Section 2, it is important to identify the steps you will take to mitigate consequences on the nine protected characteristics. Complete the Action Plan below to identify and record how you will address these.

In addition to the mitigating actions identified below, the Governing Body will consider issues identified during the Public Consultation period with the view to ensuring that appropriate measures are put in place to ensure that residents of Dartford Gravesham and Swanley (including those with protected characteristics) can access the health care provided at the new Urgent Treatment Centre.

Equality Group	Negative Outcome	Mitigating Action (Identify any resource/other implications)	Named Lead and Timeframe
Age	Feedback during public consultation indicate that all ages (including older people) could be affected by issues of parking and public transport to DVH	The DCBC to consider these issues in its recommendations to Governing Body	Director of Strategic Transformation (DCBC)
Disability	Potential impact on patients who are deaf who gave feedback during public consultation about the inadequacy of BSL translators. Feedback from patients with physical disabilities highlighted issues of access / disabled parking. Feedback from Mental Health Group included the need for staff to be sensitive to patient in distress or dis-oriented.	The DCBC to consider these issues in its recommendations to Governing Body.	Director of Strategic Transformation DCBC
Gender Reassignment	No specific outcomes have been identified for this group as figures are not collated for this cohort of the public however, the CCG shall commission services to mitigate against the risk of any discrimination.	Services should be able to provide additional measures relating to privacy and dignity when treating members of this community. All staff working at these services will need to undergo gender Equality, Diversity and Inclusion training.	Service provider
Marriage & Civil Partnership	Potential risk of discrimination	Ensure that Gender Equality training in built into all provider staff training and is evidenced to the CCG as part of EDS2 reporting.	, Equality Lead
Pregnancy & Maternity		As part of commissioning arrangements, the CCG will need to ensure that the provider of this service is able to meet the needs of breastfeeding women and women with babies. This will mean providing facilities that allow them to breastfeed or express milk in a way that offers privacy and dignity in a way that is free from discrimination.	Commissioner / Estates Team Service provider

Equality Group	Negative Outcome	Mitigating Action (Identify any resource/other implications)	Named Lead and Timeframe
Race		The CCG will expect to see Translation services procured to meet the most-spoken languages within the Dartford, Gravesham and Swanley areas. Details of these languages can be found at the bottom of this analysis	
Religion or Belief	Potential Risk of prescriptions breaking fasting during religious celebrations (very limited risk) Availability of a room for washing and prayer	All provider staff should undergo religious awareness training and should also follow extensive NICE guidance on this matter. Provision of a prayer room or chaplaincy service should be made available.	This will be a matter for the patient and Provider to discuss at the point of diagnosis Provider estates team.
Sex		The Service Specifications for these services will need to provide that all staff working in these services undergo Gender Equality training.	Commissioner / Service Provider
Sexual Orientation	Potential Risk of Discrimination	Ensure that Gender Equality training in built into all provider staff training and is evidenced to the CCG as part of EDS2 reporting.	Equality Lead
Carers	Potential high cost of parking	Issues regarding parking (including costs) and have featured significantly in the public consultation feedback and therefore Governing Body and Urgent Care team will be considering further actions to mitigate negative impact Make carers who are entitled to aware of how they may reclaim expenses	Director of Strategic Transformation (DMBC) Governing Body Provider Communications Team
Other	Low-income house-holds: Potential high cost of parking	Issues regarding parking (including costs) and public transport have featured significantly in the public consultation feedback and therefore Governing Body and Urgent Care team will be considering further actions to mitigate negative impact Make patients (who are entitled to aware of how they may reclaim expenses)	Director of Strategic Transformation (DMBC) Governing Body Provider Communications Team

Section 4 : Submission

On completion of all sections of the Equality Analysis Form, submit your draft along with the policy, function, or service document to the Equality & Diversity Lead.

Once reviewed, feedback and any recommended amendments will be given. Having made any necessary changes, the final version should then be submitted to the committee which will approve the paper/policy/strategy in question. The completed EA Template should be appended to the policy, function or service development documentation.

Supporting documentation:

Kent population by main language	 Kent population by main language.xlsx
Report on Public Consultation	 Report. Public Consultation Engager
Engage Kent report	 Engage Kent report for DGS CCG Urgent (
Protected characteristics	 Protected Characteristic.docx

Evaluation of Bexley response

Dartford, Gravesham and Swanley Clinical Commissioning Group

Author: Clive Caseley, Director

Date: 13 January 2020

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EXECUTIVE SUMMARY

Following a review of urgent care services, Dartford, Gravesham and Swanley Clinical Commissioning Group (CCG) led a consultation on proposals to site an Urgent Treatment Centre (UTC) at either Gravesham Community Hospital or Darent Valley Hospital (DVH).

In its initial consultation, the CCG received many responses from residents across a wide area, including Bexley and other neighbouring boroughs, although inevitably most views came from residents within Dartford, Gravesham and Swanley.

An intensive engagement followed in Bexley to complement the CCG-led public consultation - seeking to understand the likely use of services by patients across the boundaries between CCGs, the potential impact of the new UTC, and what might be done to mitigate any resulting pressures.

This document contains an evaluation of the response to this engagement. It was independently produced by Verve Communications.

Bexley patients travelling to Dartford, Gravesham and Swanley

Accessibility and travel times seem to be the main drivers for patients' decisions when they need urgent care. For some people, there is evidence to suggest that they are prepared to travel some distance in order to reduce their waiting time or obtain free parking.

For siting the new Urgent Treatment Centre (UTC), Darent Valley Hospital (DVH) is the main site in Dartford, Gravesham and Swanley which would be relevant for Bexley residents. For these residents, DVH is relatively easily accessible by car and public transport, and some patients believe that co-location with the DVH A&E means it will provide a higher quality service or that they can get treated "all in one place".

For these reasons, some residents in some parts of Bexley would – and probably already do - travel to DVH for urgent care. In particular, the absence of an A&E service within Bexley, means that DVH would be the closest option for some patients in the borough for whom colocation is important.

Bexley residents have a range of choices of walk-in urgent care services, with Erith Hospital and Queen Mary's Hospital within the borough and alternatives at Queen Elizabeth Hospital (Greenwich CCG) and the Princess Royal University Hospital (Bromley CCG) also mentioned.

Overall, therefore, Bexley residents see an Urgent Treatment Centre at DVH as a potential alternative when other options are too busy rather than as a first choice.

That said, a significant proportion of Bexley patients felt there would no impact, or very limited impact for them as they would be unlikely to use **any** of the alternatives in Dartford, Gravesham or Swanley. In all 20 people made this comment, out of 68 who provided a response on likely impacts – so around a third of the total.

There was relatively low awareness of Gravesham Community Hospital among Bexley residents – Many did not know where it is or regard it as "local". Therefore for Bexley patients most would use alternatives in other directions.

Dartford, Gravesham and Swanley residents travelling to Bexley

The initial survey undertaken by the CCG during the public consultation showed relatively little tendency for Dartford, Gravesham and Swanley patients to look towards Bexley for urgent care, although we would note the great majority of responses seem to have come from residents close to Gravesham Community Hospital.

Nevertheless, staff and doctors at both Erith Hospital and Queen Mary's Hospital commented that they saw a significant number of patients from Dartford and Gravesham. This was attributed to pressures, difficulty in securing GP appointments, long waits at DVH and frequent referrals from NHS 111 and GPs. Recent GP closures in Dartford were also cited

Overall impact

The key issue, both for Bexley residents travelling to Dartford, Gravesham and Swanley and to prevent flow of patients into Bexley is the availability of alternative walk-in services, whether at DVH or other convenient, accessible location(s).

What makes a good service?

Regardless of location, several characteristics were identified which make a good service. These include: communication with the patient's own GP, including referral back to primary care where that is more appropriate and conversely well-managed escalation if inpatient care is needed; integration and data sharing to enable a seamless service with the patient only needing to provide details once; and good links into other services – those mentioned included mental health, diabetic services, paediatrics, and on-site pharmacy.

Other comments for consideration

Car parking was also a concern for Bexley residents as it was for residents in Dartford Gravesham and Swanley who took part in the original consultation. In particular, limited availability and cost of parking at DVH and availability of free parking at Erith urgent care centre.

Several Bexley patients commented that they were not familiar with services in Dartford and Gravesham and were unaware of Gravesham Community Hospital. A significant number had visited Darent Valley Hospital and would be unlikely to visit an Urgent Treatment Centre at Gravesham Community Hospital.

1. ABOUT THIS REPORT

1.1 CONTEXT AND BACKGROUND

Following a review of urgent care services, Dartford, Gravesham and Swanley Clinical Commissioning Group (CCG) led a consultation between August and November 2019 on proposals to site an Urgent Treatment Centre (UTC) at either Gravesham Community Hospital or Darent Valley Hospital (DVH).

The CCG undertook a large-scale engagement exercise to reach residents within the catchment for its urgent care services. The consultation received a very high level of response following distribution of materials, running a series of events and roadshow activities in the community, and an online survey which received more than 16,000 responses. In addition, key stakeholders were consulted and Engage Kent commissioned to reach people with physical disabilities and residents of rural areas

Verve Communications analysed the consultation responses and undertook and independent evaluation. This considered the statutory requirements for public consultation, including NHS guidance and best practice, and was considered by the Kent Health Overview and Scrutiny Committee in December 2019.

The report and a supplementary analysis (which explores differences of views between those favouring each of the alternative site options) can be found here:

http://www.dartfordgraveshamswanleyccg.nhs.uk/wp-content/uploads/sites/3/2019/12/Urgent-Care-Consultation-Independent-Analysis-Verve-Communications-vCOMPLETEv02.pdf
http://www.dartfordgraveshamswanleyccg.nhs.uk/wp-content/uploads/sites/3/2019/12/Supplementary-analysis-vCOMPLETE.pdf

Key findings from the consultation included:

- A strong majority of respondents were in favour of locating the service at Gravesham Community Hospital, which was particularly pronounced among those living nearer to the site

- Across all elements of the consultation, the distance to services, travel times/accessibility by public transport, and availability and cost of car parking were the main issues shaping preferences

- Other considerations included co-location with A&E / acute hospital (which was seen both as a potential positive and negative for the UTC) and siting the service close to major population centres.

1.2 WHAT DOES THIS MEAN FOR BEXLEY?

Accessibility and travel times seem to be the main drivers for patients' decisions when they need urgent care. For some people, there is evidence to suggest that they are prepared to travel significant distances as a trade-off in order to reduce their waiting time or obtain free parking.

It therefore seems possible that changes to urgent care services in one CCG footprint may potentially affect services in neighbouring areas. In this case, that might mean Bexley residents travelling to services in Dartford, Gravesham and Swanley and – conversely – residents from Dartford, Gravesend and surrounding boroughs using Bexley services as an alternative.

1.3 PURPOSE OF THIS ENGAGEMENT

In its initial consultation, the CCG received many responses from residents across a wide area, including Bexley and other neighbouring boroughs, although inevitably most views came from residents within Dartford, Gravesham and Swanley.

However, the service options for Bexley residents are varied and the patterns of choices patients make could be complex. Bexley residents have a range of choices of walk-in urgent care services, with Erith Hospital and Queen Mary's Hospital within the borough and alternatives at Queen Elizabeth Hospital (Greenwich CCG), the Princess Royal University Hospital (Bromley CCG) and Lewisham Hospital (Lewisham CCG).

The purpose of this intensive engagement in Bexley was therefore to complement the CCG-led public consultation and to develop a more detailed understanding of:

- Bexley residents' use of services in the CCG footprint, and the likely scale of impact of the outcomes of decisions coming from the review
- Specifically, the likely use of UTC and preference between DVH and Gravesham
- Potential impact of plans for siting the UTC on services in Bexley, and what might be done to mitigate pressures.

2. METHODOLOGY

2.1 DATA SOURCES

The exercise was carried out between 17 December and 09 January 2020 and comprised data collection through four discrete activities:

- Questionnaire survey (quantitative) of which 56% were returned from Bexley residents
- Healthwatch report (produced for the original CCG consultation in November 2019)
- Front-line staff and doctors' comments, from Erith Hospital and Queen Mary's Hospital
- Listening event for residents in Bexley.

In this report we have compiled insights and conclusions from all of these into a single summary, which sets out:

- The scale and scope of engagement
- Quantitative charts and tables
- Key themes emerging from qualitative comments and discussions
- Appropriate conclusions.

2.2 SURVEY

The survey was conducted by the CCG Communications and Engagement team face-to-face over three sessions:

- Erith Urgent Care Centre - (Tuesday 17 December (am) and Monday 06 January (pm)
- Queen Mary's Hospital - Wednesday 18 December (am).

In total, 97 people were interviewed, using a pro forma questionnaire (see Appendix 1), which includes a mix of 'closed' questions and 'open' free text questions where respondents were able to explain their preferences. The survey also collected demographic data.

The headline findings are shown in table and charts (see section 3.1.) and qualitative comments were analysed for themes and allocated according to a code frame (see Appendix 2.) which shows the weight and number of comments received. Please note that all comments made were included and some questions invited multiple comments – the total number of comments may therefore be higher than the number of respondents.

2.3 HEALTHWATCH BEXLEY ANALYSIS

Healthwatch Bexley supported the original UTC consultation undertaken in 2019. Between August and November, Healthwatch distributed the CCG consultation documents and questionnaires, and collected 38 completed questionnaires.

As part of the original consultation Healthwatch Bexley also held informal discussions at existing community groups in Crayford and Sidcup, at which 25 people expressed their views. The groups were for older adults with Alzheimer's and their carers.

Healthwatch shared their report with DGS CCG in November. This report set out the key issues for Bexley residents, which is attached in full for reference at Appendix 3. The headlines from this are incorporated into this report.

2.4 FRONT-LINE STAFF AND DOCTORS

Front-line staff and doctors delivering urgent care services in Bexley were engaged to understand their perspective(s) on potential implications of the CCG's proposals, and to explore their ideas for ways to mitigate pressures on services in both boroughs.

Participants were based both at Erith Hospital and Queen Mary's Hospital, Sidcup.

Areas of informal discussion included:

- The profile of patients from Dartford, Gravesham and Swanley who use Erith Hospital or Queen Mary's Sidcup (QMS) urgent care
- Reasons residents in Dartford, Gravesham and Swanley might choose to use these services in Bexley
- Potential impact of plans to site a new UTC at DVH or Gravesham Hospital on Bexley services
- What actions might mitigate pressures on services in both boroughs.

2.5 LISTENING EVENT

A targeted listening event was held on 09 January with a group of Bexley patients. This was conducted by DGS CCG in partnership with Bexley CCG and Healthwatch Bexley, who were instrumental in recruiting participants to the event.

In all, around 17 people took part, and the discussions focused on:

- The potential impact of locating a UTC at DVH
- The potential impact of locating a UTC at Gravesham Hospital
- General comments about why patients might select one urgent care service over another.

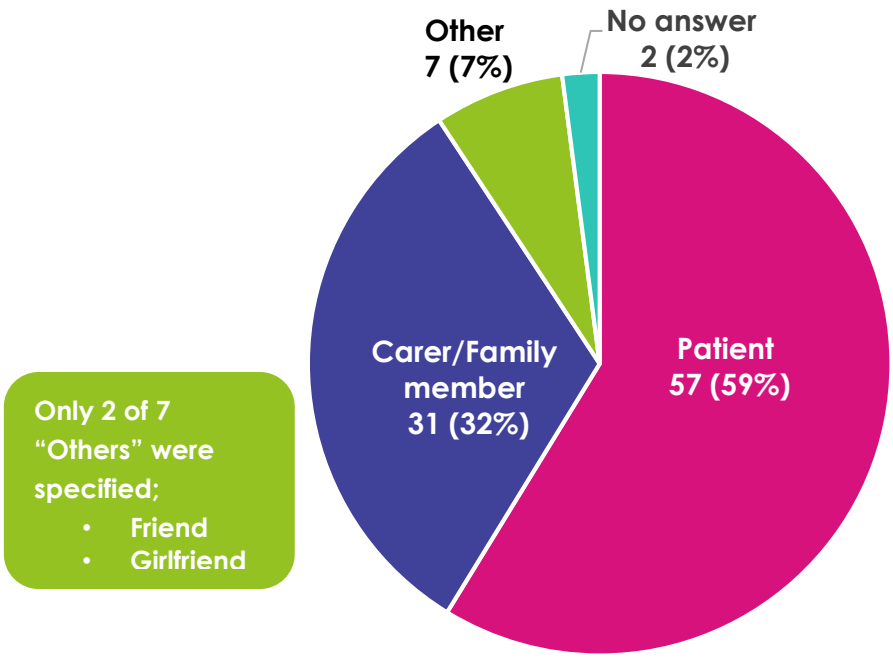
The full notes taken from these discussions are included for reference at Appendix 4.

3. ANALYSIS AND FINDINGS

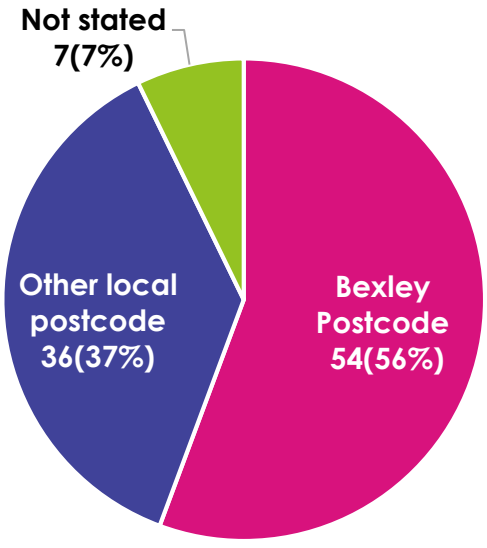
3.1 QUANTITATIVE RESPONSE

3.1.1 ABOUT YOU

Q1 - ARE YOU HERE AS A…

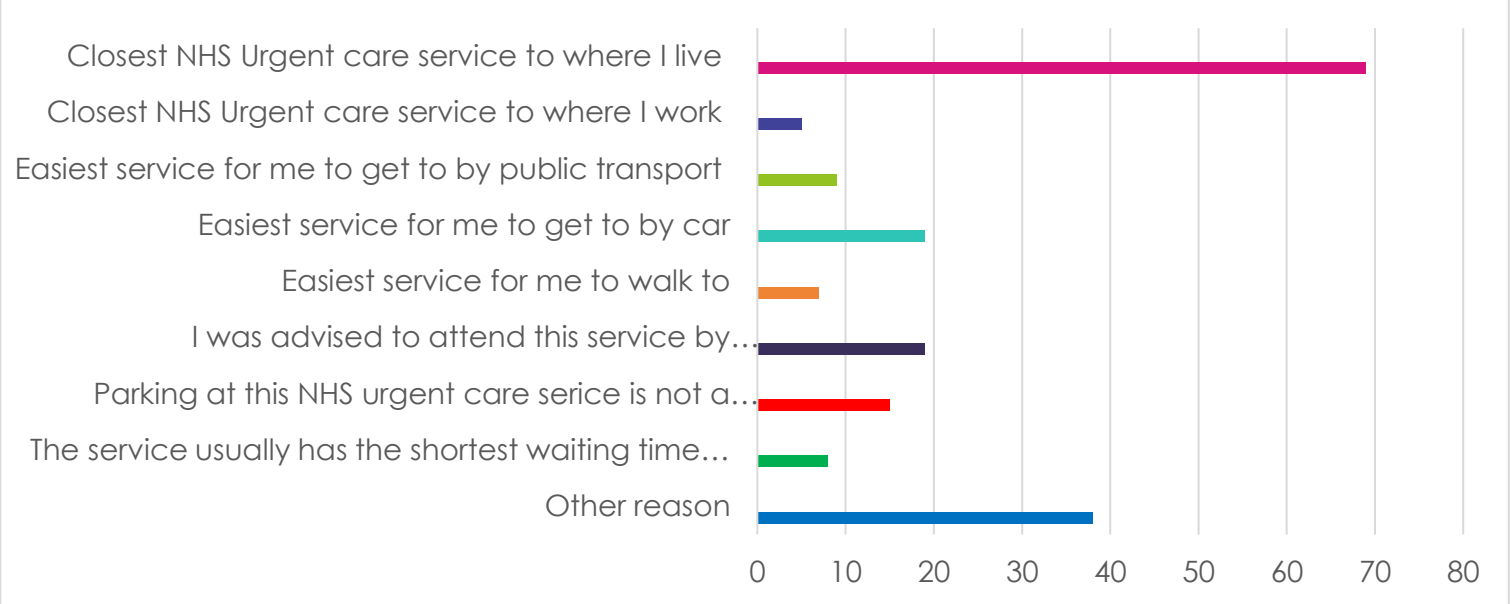


Q2 – WHAT IS YOUR POSTCODE?



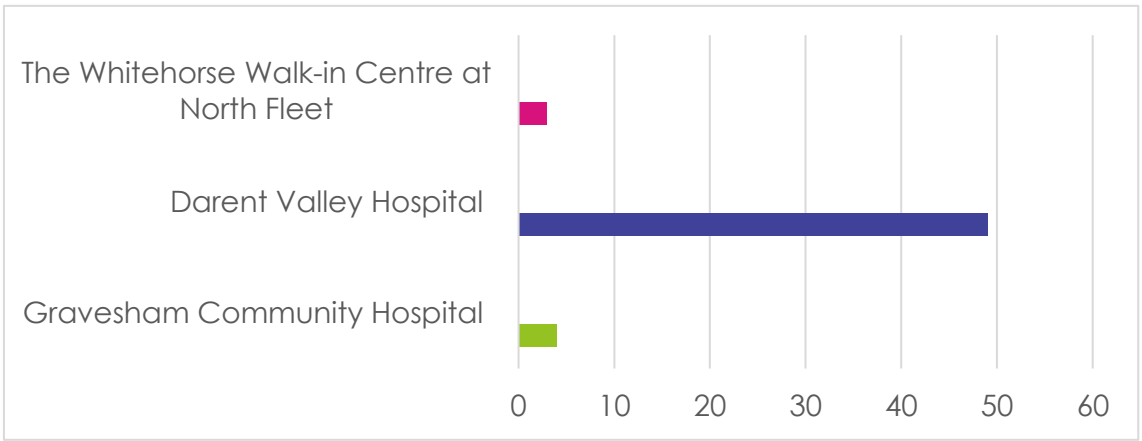
3.1.2 ABOUT YOUR VISIT TODAY

Q3 – WHY DID YOU CHOOSE TO COME TO THIS PARTICULAR NHS LOCATION FOR URGENT CARE TODAY? (PLEASE TICK AS MANY AS APPLY)

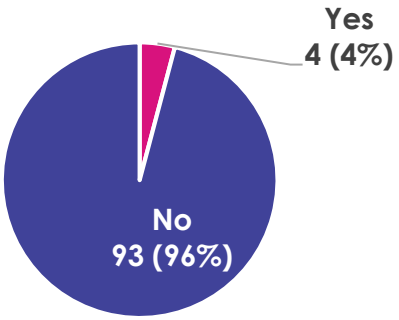


3.1.3 ABOUT THE DGS PROPOSED LOCATIONS FOR AN URGENT TREATMENT SERVICE

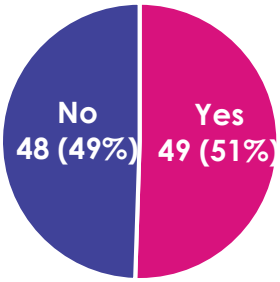
Q4 – WHICH OF THESE NHS SERVICES HAVE YOU ATTENDED BEFORE? (TICK ALL THAT APPLY)



Q5 - IF THERE WAS AN URGENT TREATMENT CENTRE AT GRAVESHAM COMMUNITY HOSPITAL WOULD YOU CHOOSE TO USE IT?

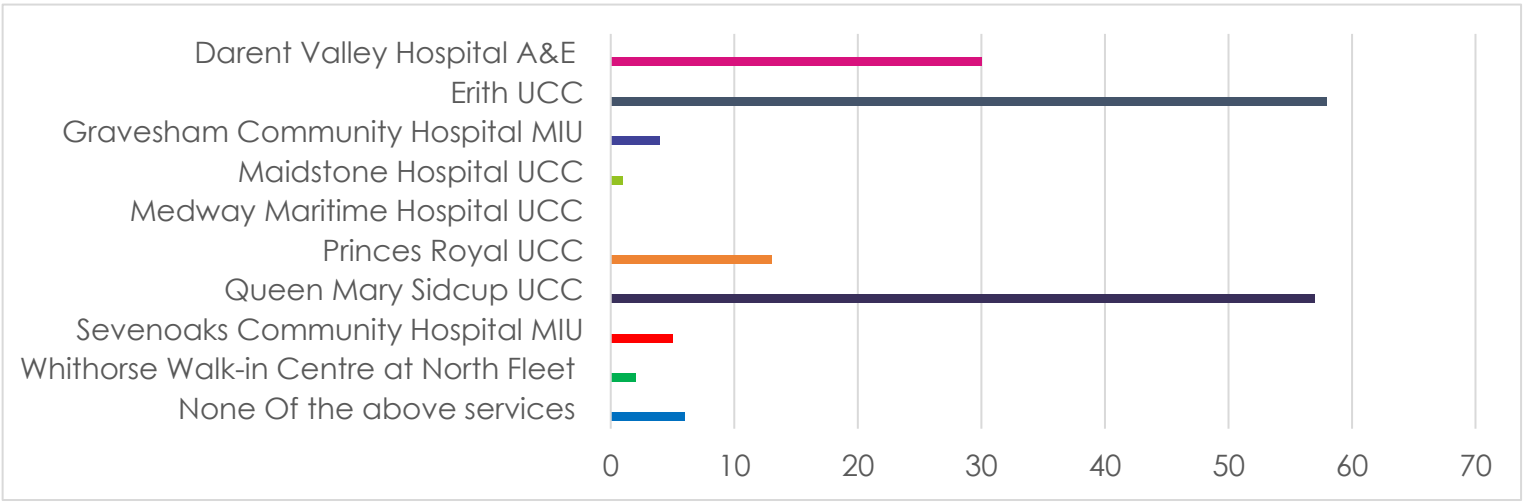


Q6- IF THERE WAS AN URGENT TREATMENT CENTRE AT DARENT VALLEY HOSPITAL WOULD YOU CHOOSE TO USE IT?



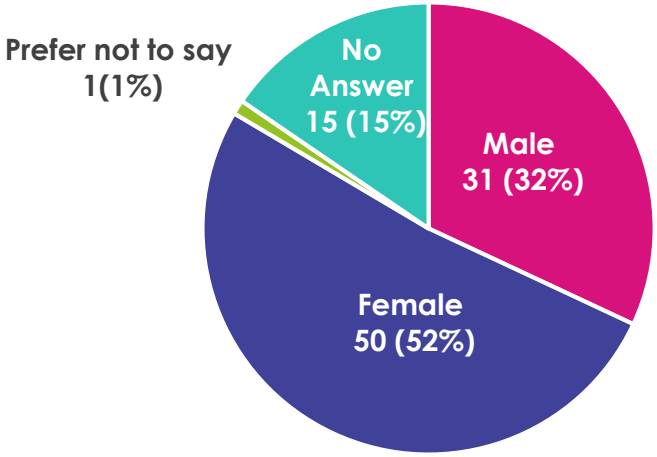
3.1.4 ABOUT OTHER NHS URGENT CARE / EMERGENCY SERVICES

Q8- WHICH OF THE FOLLOWING NHS SERVICES DO YOU ALSO USE WHEN YOU NEED URGENT TREAMENT ON THE SAME DAY AND WHY?

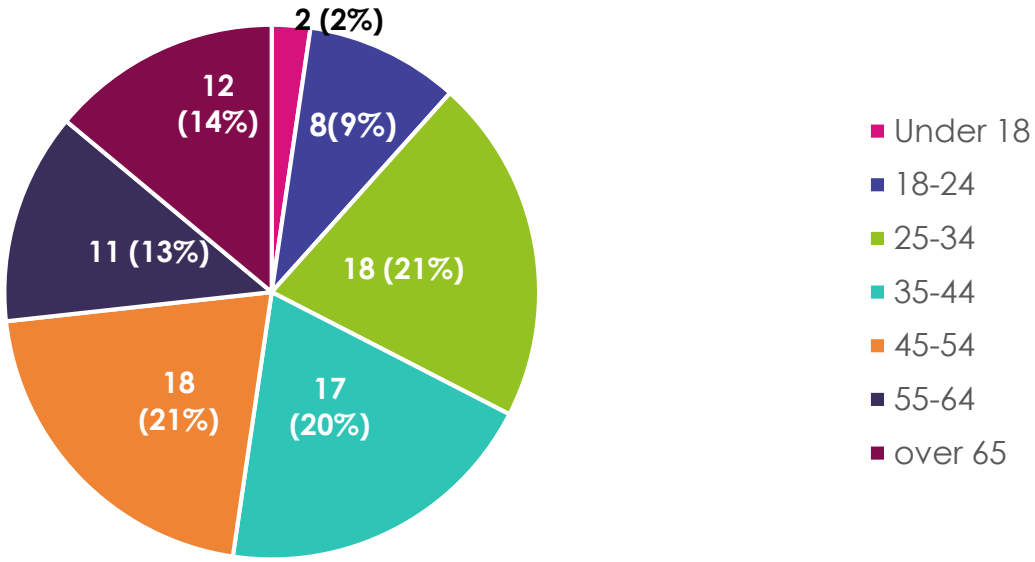


3.1.5 EQUALITIES

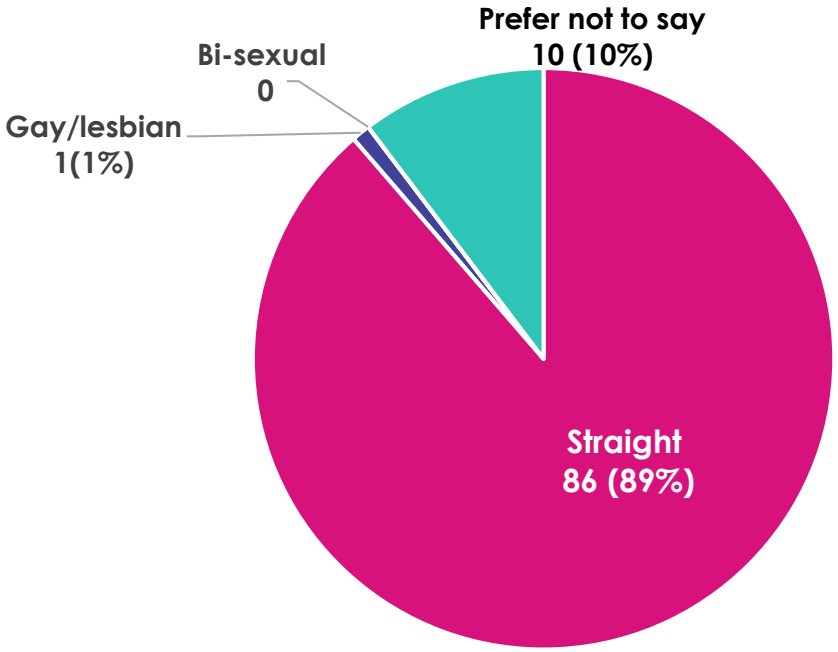
1- WHICH GENDER DO YOU IDENTIFY AS?



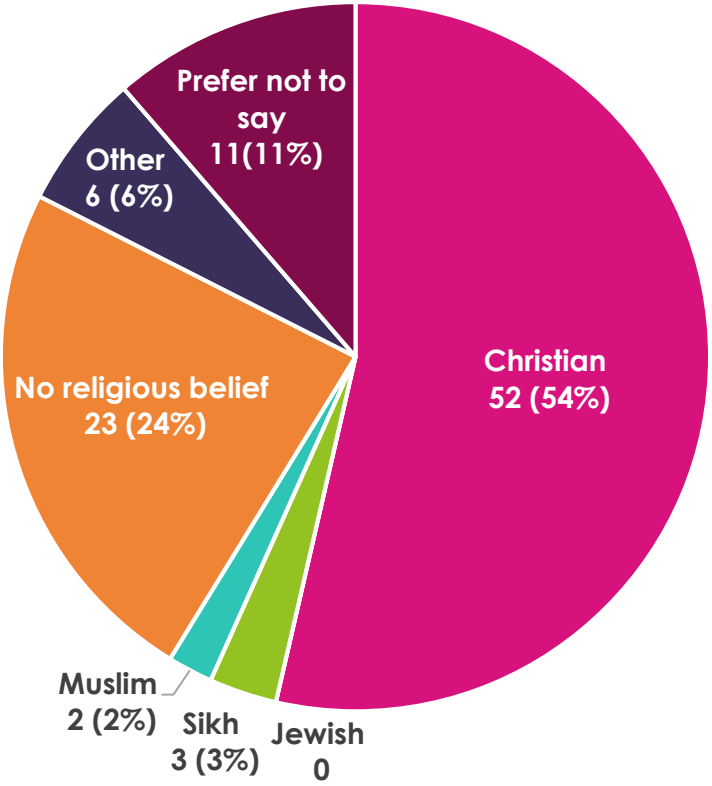
2- WHICH AGE GROUP DO YOU BELONG TO?



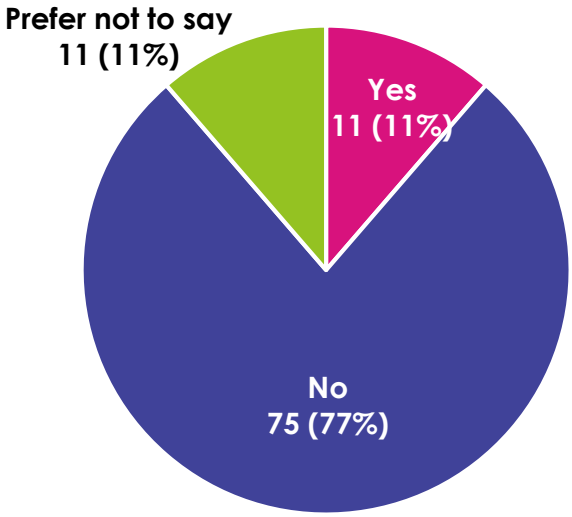
3- WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SEXUAL ORIENTATION?



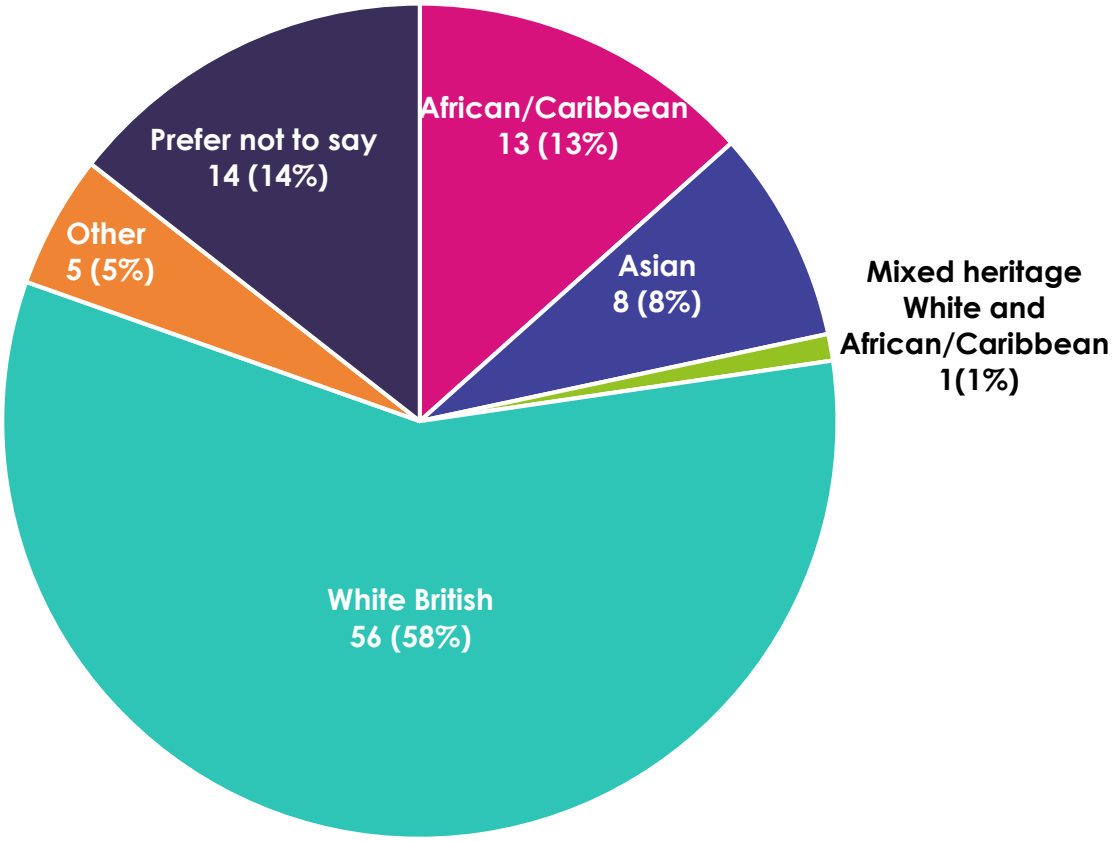
4- WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RELIGION OR BELIEF



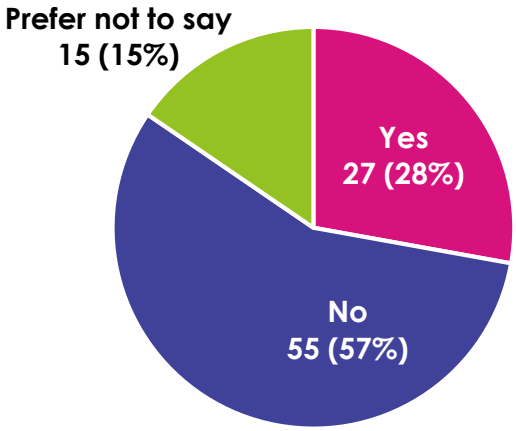
5- DO YOU CONSIDER YOURSELF TO HAVE A DISABILITY?



6- WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNIC GROUP



7- ARE YOU A CARER (FOR AN UNDER 18 CHILD OR ADULT)



3.2 ANALYSIS OF RESPONSE AND COMMENTS

3.2.1 OVERALL

It is clear from the quantitative data that the overwhelming driver for patients' urgent care choice is distance from home and perceived travel time. This is consistent across the initial CCG consultation response and this intensive engagement with Bexley residents.

In this exercise, 51% of Bexley residents said they would use DVH, with approximately even numbers commenting that it is closer to home and that it is too far away (19 and 23 respectively).

Far fewer favoured Gravesham – 4%, with a clear majority giving the reason that it is too far away.

For Bexley residents who responded to the CCG via Healthwatch Bexley, there is also a clear preference for DVH. More than 70% "strongly" favoured DVH as the location for the UTC, compared with around 13% favouring Gravesham.

This is echoed by the Healthwatch Bexley group discussions:

> *"For the majority of the Bexley residents we spoke to Gravesham was considered too far away for them to visit."*
> Bexley Healthwatch report

However, a significant proportion of Bexley patients felt there would no impact, or very limited impact, as they would be unlikely to use any of the alternatives in Dartford, Gravesham and Swanley. In all 20 people made this comment, out of 68 who provided a response on likely impacts, around a third.

> *"I don't think it will make a difference to people in Bexley"*
> Comment from patient survey

Staff at Bexley services referred to free and available parking at Erith Hospital and relatively short waiting times at both Queen Mary's Hospital and Erith

> *"Patients don't fit in neat boundaries. Sometimes its quicker and easier to use an NHS just over the boundary"*
> Staff member, Erith Hospital

Overall, the set of issues for Bexley residents closely echoes the findings from the initial CCG consultation focused in Dartford, Gravesham and Swanley residents – there is no evidence of significant differences of view between these populations.

It is clear that Bexley residents see DVH chiefly as an alternative when other options are too busy, rather than their first choice - which would probably be a more local walk-in service. However siting the UTC at DVH is seen as having positive potential to relieve pressure on current, stretched services.

> *"Hopefully it will reduce waiting times in other places"*
> Comment from patient survey

Other comments made during this intensive exercise in Bexley were less often repeated but included travel and ease of journeys.

This includes public transport (particularly the number of bus changes), traffic and drive-times, and parking (both cost and availability. DVH is seen as having good public transport links and easy to get to, but parking costs are an issue.

> *"Parking is dreadful and costly. Public transport from Slade Green and Erith is abysmal"*
> Comment to Healthwatch Bexley

> *"If had a blue badge (it) can be used at Woolwich but not DVH"*
> Focus group participant

3.2.2 CO-LOCATION WITH A&E

Co-location with A&E / acute hospital was seen by some as a positive factor in siting the UTC at DVH, because of the perception that it will be a higher quality service or that it will be possible to have treatment "all in one place", with more straightforward escalation and admission to the hospital if the patient deteriorates.

> *"Will make service quicker, more efficient. Wait at A&E are too long 5 hours... less waiting time if those not in need of A&E can be diverted to UTC"*
> Comment to Healthwatch Bexley

> *"We could get medical attention faster and at more convenient times"*
> Comment from patient survey

There was some agreement among professionals for this view, and the broader point about relieving pressure on the DVH A&E.

> *"Every borough needs one standalone UTC to cater for patients who can be seen by GP/Nurse and another UTC co-located with A&E to be able to be escalated because of more serious concerns"*
> Doctor, Erith Hospital

> *"UTC at Darent Valley Hospital: would provide hospital with more capacity to see patients"*
> Staff member, Queen Mary's Hospital

For some patients, co-location is a negative, because of long waits and accessibility issues at DVH (especially parking) and a perception that a busy A&E is not the most appropriate service for minor urgent care needs.

3.2.3 INFLUENCING DECISIONS

Familiarity is key to influencing decisions, and many comments collected through this engagement were based on personal experience.

> *"Previous experiences, good or bad, would influence the choice that people make. South of the Borough would prefer to go to Princess Royal"*
> Focus group participant

Several Bexley patients commented that they were not familiar with the Dartford, Gravesham and Swanley services – this was mentioned in respect of both, but clearly a far greater issue for Gravesham Community Hospital as a significant number had visited DVH.

> *"I don't know where this location* [Gravesham] *is,"*
> Numerous comments from patient survey

This suggests that patients from Bexley are unlikely to use an Urgent Treatment Centre at Gravesham Community Hospital.

3.2.4 MORE ON DARENT VALLEY HOSPITAL

Notes from the listening event suggest that Bexley patients are quite familiar with DVH.

> *"If I had to go to an AE, I would go to DVH. I know the site and I wouldn't feel lost there."*
> Focus group participant

Views were mixed, and included:

- Cafeteria and facilities are seen as good
- Several comments that the metal seating in waiting areas is uncomfortable
- The absence of a 24-hour pharmacy was noted.

DVH was seen by some as providing fast and effective communications, with test results and notes sent quickly and good integration with primary care.

> *"We conducted a mystery shopper at DVH and had a 95% satisfaction ratings"*
> Focus group participant

By contrast, there were some poor experiences reported and, as previously highlighted, car parking at DVH has been the subject of so many comments it must be regarded as an issue of significant concern for Bexley residents.

> *"Can parking be expanded to nearby land?"*
> Focus group participant

3.2.5 CAPACITY ACROSS THE SYSTEM

Staff and doctors at both Erith Hospital and Queen Mary's Hospital noted that they saw a significant number of patients from Dartford, Gravesham and Swanley. This was attributed to pressures and difficulty in securing GP appointments, long waits at DVH and frequent referrals from NHS 111 and GPs. The impact of recent GP closures in Dartford was also cited. Staff also commented on the increased demand on urgent care services across the system.

> *"QMS severely impacted by GP closures in Dartford"*
> Staff member, Queen Mary's Hospital

3.2.6 WHAT MAKES A GOOD SERVICE?

Regardless of location, there were several characteristics identified that make a good urgent care service:

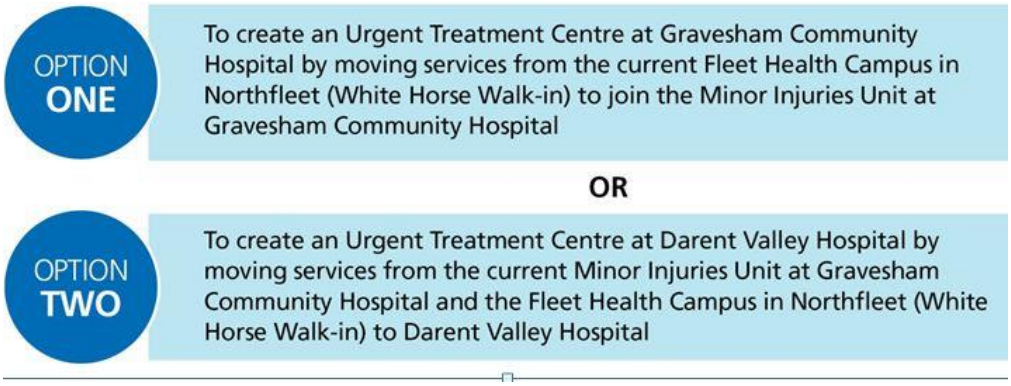
- Good liaison and communication with the patient's own GP, including referral back to primary care where that is more appropriate and conversely well-managed escalation if inpatient care is needed
- Good integration, including with patient data to enable a seamless service and the patient only having to provide details once
- Linking up with other services – those mentioned included mental health, diabetic services and paediatrics
- Late-opening pharmacy on site.

APPENDIX 1- QUESTIONNAIRE

Background

Dartford Gravesham and Swanley Clinical Commissioning Group (DGS CCG) recently ran a public consultation about the location of an Urgent Treatment Centre (UTC) for people living in Dartford Gravesham and Swanley (DGS). As Dartford lies on the borders of Bexley, residents of Bexley sometimes use NHS health services in DGS and vice versa. DGS CCG would therefore like to gain a better understanding about how DGS proposals for the location of a UTC in DGS could possibly impact on residents and patients using Bexley Urgent Care Services.

Proposals for the location of an Urgent Treatment Centre in Dartford, Gravesham and Swanley



The new Urgent Treatment Centre would treat both minor illnesses such as ear and throat infections, sickness and diahorea as well as minor injuries such as suspected broken bones, sprains and minor burns in one place.

What will we do with information we are collecting through this questionnaire?

The information gathered from patients and residents using Bexley Urgent Care services will be analysed and used as part of the patient feedback that will inform the DGS CCG's Governing Body decision in early 2020.

Urgent Care Questionnaire

About you

Q1 Are you here as a … ◯ patient ◯ carer/ family member

◯ other ……..

Q2 What is your post code …….....

About your visit today

Q3 Why did you choose to come to this particular NHS location for urgent care today (please tick as many as apply)

- ◯ Closest NHS urgent care service to where I live
- ◯ Closest NHS urgent care service to where I work
- ◯ Easiest NHS urgent care service for me to get to by public transport
- ◯ Easiest NHS urgent care service for me to get to by car
- ◯ Easiest NHS urgent care service for me to walk to
- ◯ I was advised to attend this service by ◯ NHS 111 ◯ friend / family
- ◯ Parking at this NHS urgent care service is usually not a problem
- ◯ This service usually has the shortest waiting time compared to other nearby urgent care services
- ◯ Other reason (please specify) ……..

About the DGS proposed locations for an Urgent Treatment service

Q4 Which of these NHS services have you attended before? (Tick all that apply)

- ◯ Gravesham Community Hospital
- ◯ Darent Valley Hospital
- ◯ The Whitehorse Walk-in Centre at North Fleet

Q5 If there was an Urgent Treatment Centre at Gravesham Community Hospital would you choose to use it? ◯ Yes ◯ No

Please explain the reasons for your answer

Q6 If there was an Urgent Treatment Centre at Darent Valley Hospital, would you choose to use it?
◯ Yes ◯ No

Please explain the reasons for your answer

Q7 What impact would an Urgent Treatment Centre at Darent Valley or Gravesham have on you and your family?

Please explain

About other NHS urgent care/ emergency services

Which of the following NHS services do you also use when you need urgent treatment on the same day and why?

◯ Darent Valley Hospital A&E Why

……

◯ Erith Urgent Care Centre Why

……

◯ Gravesham Community Hospital Minor injuries Unit Why

……

◯ Maidstone Hospital Urgent Care Centre Why

……

◯ Medway Maritime Hospital Urgent Care Centre Why

……

◯ Princes Royal Urgent Care Centre Why

……

◯ Queen Mary's Sidcup Urgent Care Centre Why

……

◯ Sevenoaks Community Hospital Minor Injuries Unit Why

……

Whitehorse Walk-in Centre in Northfleet Why

……

◯ None of the above services Why

……

Survey ends. Thank you very much for sparing the time to give us your feedback.

Equalities: NHS Dartford, Gravesham and Swanley CCG would like to hear from a broad mix of people and groups. You do not have to complete the next section and your views will still be taken into account, if you choose not to. However, the information you give would help the CCG analyse who we have engaged with and consider any differences or potential service adjustments that may apply to different groups

1 Which gender to you identify as? …… ◯ Prefer not to say

2 Which age group do you belong to? ◯ under 18 ◯ 18 – 24 ◯ 25 - 34
◯ 35-44 ◯ 45 -54 ◯ 55 – 64 ◯ Over 65

3 Which of the following best describes your sexual orientation?
◯ Straight ◯ gay/ lesbian ◯ bi-sexual ◯ Prefer not to say

◯ prefer to use my own term …….

4 Which of the following best describes your religion or belief?
◯ Christian ◯ Jewish ◯ Sikh ◯ Muslim
◯ No religion or belief ◯ Other ◯ Prefer not to say

5 Do you consider yourself to have a disability? ◯ Yes ◯ No

6 Which term best describes your ethnic group?
◯ White British ◯ African / Caribbean ◯ Asian ◯ Chinese
◯ Mixed heritage: White and African Caribbean ◯ Mixed heritage: White and Asian
◯ Other …….. ◯ Prefer not to say

7 Are you a carer? ◯ Yes (for an under 18 child OR adult?) ◯ No

APPENDIX 2- CODE FRAME

Table showing range and number of comments received in free text sections of questions 5, 6 and 7.

Questions and Codes	Responses	Number
5. Use Gravesham-Yes	501-550	
501	Closer to home	6
505	Closer to where I work	0
507	If I was working nearby	3
510	As an alternative nearby service	4
515	As an alternative to GP or A&E	2
518	If there was free parking	1
520	If better for / prioritised children	2
525	If better for other people (e.g. elderly relatives)	1
530	Like this service	0
550	Other	1
5. Use Gravesham-No	551-599	
551	Too far – not local	40
552	Travel issue e.g. wheelchair	1
554	QMS closer	2
555	DVH closer	1
556	Erith closer	2
560	Don't know where it is	4
570	Not appropriate / slow / poor experience	2
599	Other	2
6. Use DV-Yes	601-650	
601	Closer to home	19
607	If I was working nearby	1
615	As an alternative to GP or A&E	2
616	As an alternative if closer services busy	5
617	If walk-in is accessible	2
630	Like this service	1
635	Co-location with hospital / A&E	1
637	Accessible by road	2
650	Other	2
6. Use DV-No	651-699	
651	Too far – not local	23
654	QMS closer	2
656	Erith closer	3
657	QEH closer	1
660	Don't know where it is	1
671	Not appropriate / slow / poor experience	3
680	Parking cost / availability	1
699	Other	

Questions and Codes	Responses	Number
7. Impact	701-799	
701	None – no impact	20
705	All too far away	1
707	Specific sites easier to reach	4
710	Relieve pressure / reduce waits	6
711	More services is positive	1
712	Good for people who need UC (e.g. children, elderly)	2
715	Guarantee to be seen / availabil1ity	3
720	Provide closer alternative/ more choice	18
725	Quick to get to in an emergency	2
730	Co-location with hospital	1
735	Opening hours / convenient time	1
736	Easier journeys	4
737	Harder journeys – less accessible	2
738	Better for public transport	1

APPENDIX 3 – HEALTHWATCH BEXLEY REPORT

Public Consultation

12 August – 4th November

Dartford Gravesham and Swanley CCG re proposed changes/site of an Urgent Treatment Centre in North Kent

Option One

To create an Urgent Treatment Centre at Gravesham Community Hospital by moving services from the current Fleet Health Campus in Northfleet (White Horse Walk-in) to join the Minor Injuries Unit at Gravesham Community Hospital

Option Two

To create an Urgent Treatment Centre at Darent Valley Hospital by moving services from the current Minor Injuries Unit at Gravesham Community Hospital and the Fleet Health Campus in Northfleet

Healthwatch engagement

We visited local libraries, community groups and events in Bexley Borough to explore Bexley resident's views of the proposed location of an UTC. We distributed and collected consultation forms and held informal discussions with two local groups in Crayford and Sidcup. We collected 38 consultation forms which have been forwarded to Dartford, Gravesham and Swanley, CCG via the freepost address publicised in the back of the consultation booklet. In addition many residents took consultation booklets to complete at home and send in themselves.

Summary of the responses collected by Healthwatch via the consultation booklet questionnaire.

All 38 respondents were replying in a personal capacity.

Which of the current urgent care services have you used?

50% had used A&E at Darent Valley Hospital, 44% had called NHS 111 and 6% had used the GP out of hour's service

Which of the current urgent care services have a friend/family member used?

5.6% had used Fleet Health Campus, 77.8% had used A&E at Darent Valley hospital, 38.9% had used NHS 111 and 16.7% had used the GP out of hour's service

Transport to urgent care services

61.1% used a car to get to services, with 16.7% using public transport

Option 1 to create a UTC at Gravesham Community Hospital

26.7% disagreed and 30% strongly disagreed that UTC should be sited at Gravesham Community Hospital, with 30% not having a view. 13.3% felt it should be at Gravesham Community Hospital

Option 2- Create a UTC at Darent Valley Hospital

70.3% strongly agree and 27% agree that UC should be sited at Darent Valley Hospital with 2.7% not having a view.

Reasons for choice

Option 2 Darent Valley

The location and convenience and transport links

'Can get to Darent Valley Hospital easily'

'Accessible by bus'

'Accessible by bus 7 cheaper to get to. Darent Valley better as can use contactless on the bus'

Many felt it should be located next to A&E and may play a role in relieving the pressure off A&E so people may be diverted into appropriate services if they present at the wrong service.

'Because it is a more convenient location for me and my family. Also may relieve pressure on A& and A&E can divert people to UTC and vice versa'

'Makes sense to have at A&E, will help people go to the right place. 100% more convenient. Parking not an issue'

'To have urgent care and A&E next to each other cuts out duplication of work and hopefully relieves pressure on A&E'

What impact will the options have on you and your family?

Option 2 Darent Valley Hospital

Most comments were around transport, parking costs, waiting times and the perceived benefit of having A&E and UTC situated at the same site.

'Public transport can be difficult and expensive'

It would be good to have A&E and urgent care on the same site'

'Parking is dreadful and costly. Public transport from Slade Green and Erith is abysmal'

'Parking is expensive'

'Will make it easier for the whole family to get there'

'Will make service quicker, more efficient-wait at A&E are too long 5 hours., less waiting time if those not in need of A&E can be diverted to UTC'

Any other ideas

'Reduction in car park charges at DVH'

'I am concerned that with planned changes to bus routes from Erith/Bexleyheath to Darent Valley Hospital, access to proposed services will be restricted for Bexley residents who do not drive. For those driving, existing car parkin is already stretched beyond capacity'

'If possible 24 hour opening'

'Increase staff to reduce waiting times, but realise this is unlikely'

Informal discussion group comments

The informal discussion groups were held at existing community groups in Crayford and Sidcup. 25 people expressed their views. The groups were for older adults with Alzheimer's and their carers

Travel

60% travelled by car last time they visited an Urgent care service, with 4% using public transport and 32% traveling by ambulance.

Preferred site

Option 2 Darent Valley Hospital

60% agree that UTC should be sited at Darent Valley Hospital and 40% have no view on where it should be sited.

Reasons

Generally the same as those comments and concerns raised in the questionnaires:

Perception that UTC being situated at Darent Valley Hospital would reduce waiting times at A&E as people could be directed to the correct services without further travel or inconvenience. It was also felt that pressure would be taken off Sidcup and QE hospitals as there would be more choice locally.

Summary

Bexley residents favoured Darent Valley Hospital as the preferred choice for siting the Urgent Treatment Centre rather than Gravesham Community Hospital.

The reasons given were:

Convenience to where people lived and bus routes

Good transport and easy to get to, although parking costs were an issue.

The benefit of being situated near to A&E were an influential factor, as residents suggested people could be guided to the correct services easily, if they presented at the wrong service i.e. A&E can redirect to Urgent Treatment Centre with little inconvenience for those attending. It was felt this would work in both directions with Urgent Treatment centre redirecting people to A&E if that was the appropriate service.

For the majority of the Bexley residents we spoke to Gravesham was considered too far away for them to visit.

APPENDIX 4 – LISTENING EVENT NOTES

Bexley 9th January 2020

Participants	Why would you choose one service over another?	An Urgent Treatment Centre at Darent Valley Hospital. What impact would this option have on you and your family?	An Urgent Treatment Centre at Gravesham Community Hospital. What impact would this option have on you and your family?
Participant	Convenience of location and access to location	Parking & too expensive to park Hospital too busy Can parking be expanded to nearby land?	Too far away. Local options available
Participant	Public transport GCH e.g. how many bus changes would be involved?	Seating is uncomfortable	
Participant	Co-location with A& E is an advantage	Facilities better Facilities and café and clinics and snacks	
Participant	Previous experience determines choices		
Participant	With news in the media bout patients being mugged in the A&E, the thought then is to avoid the service at QE	Not necessarily first choice. Would use it. Traffic and where you live in Bexley would determine your proximity to the service.	We would not use this as plenty of choice locally & in Greenwich Convenience of location & access to site. Majority would not use it. If patient transport offered, maybe, otherwise not
Participant	I would choose DVH over QE – I would feel safer there.	Yes, near me	Dependent on the time of day (if early am) Transport should be offered otherwise not. Too much interference from Councillors which is why Erith has stayed as it is. In any case, you should contact 111
Participant	I wouldn't choose to go to DVH with the metal seats	No, I would not use it	Possibly residents from Crayford may access the serve. We have three options in Bexley: Erith, QM & QE – why would I go to Gravesham?
Participant	Previous experiences, good or bad, would influence the choice that people make.	No. If all others fail then it is an option	Pros & Cons – GCH has a good blood test unit. DVH has massive issues around

Participants	Why would you choose one service over another?	An Urgent Treatment Centre at Darent Valley Hospital. What impact would this option have on you and your family?	An Urgent Treatment Centre at Gravesham Community Hospital. What impact would this option have on you and your family?
	South of the Borough would prefer to go to PR		parking. Even for blue badge holders it is £1.50 p/h. Too many complaints went into TFL so decision to remove 428 bus service may be delayed.
Participant	If I had to go to an AE, I would go to DVH. I know the site and I wouldn't feel lost there.	A possibility but not a first choice. If you are near Crayford, then it is only 20 mins away	
Participant	If you have to change buses then that would be an option. Have to change busses at the clock tower. We conducted a mystery shopper at DVH and had a 95% satisfaction rating from patients. I would prefer co-location of the UCC with A&E	No – QM hospital	
Participant	Facilities, cafeteria, etc. This would influence my decision to go to DVH	NO	
Participant	If the UCC were to be at GCH, as I don't know the area, I would be reluctant to go there. You go where you are comfortable.		
Participant	Having spent 6 months visiting St Thomas (40 mins by car), I know the site inside out and I feel comfortable. It has an international reputation.		
Participant	I would see the FP if I can UCCs use – but if not suitable do not treat If out of o=hours Proximity to site and where you live in the Borough i.e. which side East or West	Would help with numbers attending Bexley UCC Bexley has a good reputation	Distance and difficult to get to Benefit of GC centre for Bexley as residents would use and not services in Bexley (which have a good reputation)
Participant	Bexley to Gravesend – I would not go that far. If very unwell, would go to closest as may not feel well enough to use public transport	I would use DVH if I had a serious condition Access / congestion issues London Hospitals do outreach to DVH & QM which is a good thing	Better option – Gravesham would be better. DVH is over subscribed Heard good reports about the services at GCH

Participants	Why would you choose one service over another?	An Urgent Treatment Centre at Darent Valley Hospital. What impact would this option have on you and your family?	An Urgent Treatment Centre at Gravesham Community Hospital. What impact would this option have on you and your family?
	Stay in Bexley & use services. Concern over communication	Good bus routes for most of the area if you choose to use them	Would help to move away from DVH and educate patients of different services they can use
Participant	Back to Patients GP Integrated Record for a patient and quick access of results Passing back to original services to go back. Links with Mental Health services Were asked about cost implications & timescales. Questions were answered	If bus route changes by TFL are approved, it could affect patients decision and could move capacity to Queen Mary's more	
Participant	Had to go to Guy's Hospital and had to wait for an interpreter for the doctor. GP/Hospital won't help with patients for eyes until a year has passed. Bexley getting new flats and population rising, hard enough to get a GP. Had to fight to get a serve. PALS helped. 2 years to get knee replacement It is never going to be enough. Not enough staff	Needs a good bus route Had advantage for people in right part of Bexley to be easier to get to but enormous access problems. Changes of TFL buses to be considered and bus times should be better at DVH. What are the closest stations? Not walkable. Would be better clinically in case of an emergency. Sat 4 hours at Queen Mary's and told to go to A&E Use Bluewater car park	What times will buses operate? Work due to start to increase capacity at Erith want to guarantee 12 hour daily service. Concern on impact to residents (western residents in Dartford area) who may find it easier to go to Erith / Sidcup. Consequential impact
Participant	Haven't been given a choice Quality services important	Doesn't think viable If had a blue badge can be used at Woolwich but <u>not</u> DVH	Where do we get a bus?
Participant	Pick one more convenient (nearest / transport)	PPI in Dartford would be upset at losing WIC Need <u>qualified</u> staff at site	Where would we go if we needed a referral?
Participant	Knowing / awareness of them being there. Convenience etc. More impacting factors	Needs 24 hr pharmacy Would go where open and see right people if problem is escalated	GP told me to go to DVH and not Erith Husband has heart condition Lots of Bexley residents that have to go to DVH as don't

Participants	Why would you choose one service over another?	An Urgent Treatment Centre at Darent Valley Hospital. What impact would this option have on you and your family?	An Urgent Treatment Centre at Gravesham Community Hospital. What impact would this option have on you and your family?
			have A&E Need to have staff to run it

Supplementary comments:

- Co-location would be an advantage over separate sites
- Is there any way parking could be expanded at DVH
- **Is there any date on the number of patients that are sent to A&E from Urgent Care? It would be interesting to find out**
- 6 hr wait at A&E, ended up in Mid Kent for operation. Long way to go when it could have been done at DVH (kidney removal). Surgeon goes to different hospitals around the county.
- Need to let people know if there are other alternative. Twice even DVH and once Woolwich nurses didn't know where to go.
- Clarify if WIC will close. (Answered: no longer be in Northfleet but catered or other options)
- Also had experience at DVH with no choice on where to go and had to have op at Medway Hospital. Not offered another option.
- Thinks should be at Gravesham. DVH cannot cope. Ebbsfleet population to rise to over 30K. Make GCH a 'proper' hospital again. WIC seems to be in no man's land at the moment. People find it difficult to get to and cannot walk it. GCH more central public transport cheaper / easier, parking better.
- Had an ultrasound scan at DVH, 3 wks later GP never got results then got done at QE and GP had results the next day.
- The theme park will cause nightmares
- A percentage of patients seen at A&E do not need to be there
- Concern over services in Bexley will be adversely affected
- DVH/Access
- Lots of patients attending for an appointment could affect patients experience e.g. eye treatments, cataracts etc.
- Turn Patients away – wasting time
- DVH – quick communications back – notes/results. Integrated notes
- Lack of beds at QM – Paediatrics mentioned
- 111 – Advice to phone GP then directed to 111
- Bexley does not have an A&E
- Preference for Darent Valley – range of staff, co-location, proximity
- GCH too far away and an unknown quantity. If only small percentage of people getting moved from UCC to A&E, then GCH definitely an option.
- GCH option preferable as needed to relieve pressure on A&E – Access / Congestion / Parking
- Why not build a new service now? 15 years on, they're selling old property. We need modern builds to accommodate people in the community.
- How do we know where to go – UCC, A&E, GP?
- Thinks NHS 111 is dangerous and things could be missed. Need people qualified to give results and more joined up services rather than seeing a nurse who cannot help as not qualified enough. Feels that (disagrees) nurses can help and different levels.
- Would use local (QM or Erith (proximity considered)) but if urgent or serious, go to DVH
- More GP surgeries = less going to hospital
- Will UTC be owned by NHS? (yes) and not farmed out to Virgin?
- A lot of places getting paramedic practitioners / same as Snr nurse practitioners
- Varying rates of referrals from GPs in Bexley to hubs etc.
- Some conditions GPs cannot deal with i.e. ophthalmic, podiatry, ENT

- GPs won't give asthma meds, has to buy over the counter. (Clinicians disagree whether asthmatic but Consultant insists patient has asthma. GP won't prescribe and has notice at surgery that says what is available over the counter)
- Postcode lottery on whether a District Nurse visits
- 3.5 years to get asthma diagnosis now have to go to Royal Brompton
- Admitted to hospital for breathing problems after 3 weeks trying to get treatment / diagnosis. Need staff
- Wrist broken – went to Sidcup and had to wait 2 weeks for it to be reset. It was bandaged up in the meantime
- Would go to DVH overall preferred (one for PRU)
- Diabetic services discussion on where services will be based / will it continue at QM? / Lewisham provides. PCNS will be looking at Community Services

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Appendix D

Summary of financial and activity modelling

Current services (Minor Injuries Unit (MIU), Walk-in Centre (WIC), Darent Valley Hospital A&E (DVH A&E))

Current Services
(Minor Injuries Unit (MIU), Walk-in Centre (WIC), Darent Valley Hospital A&E (DVH A&E))

Current system Urgent Care Flows

Site		2020/21	2021/22	2022/23	2023/24	2024/25	Five Year Total
DVH A&E	Activity	80,291	80,887	81,488	82,096	82,710	407,472
Hurley Clinic	Activity	11,546	11,681	11,818	11,956	12,096	59,097
GCH	Activity	24,443	25,920	27,486	29,145	30,906	137,900
WIC	Activity	30,248	28,736	27,299	25,934	24,637	136,854
	Activity	**146,528**	**147,224**	**148,091**	**149,131**	**150,349**	**741,323**
DVH A&E	£	12,293,825	12,480,251	12,724,006	12,915,116	13,164,723	63,577,921
Hurley Clinic	£	932,190	952,521	973,328	994,539	1,016,254	4,868,832
GCH	£	1,513,833	1,602,060	1,695,167	1,793,319	1,896,979	8,501,357
WIC	£	1,400,000	1,409,820	1,419,678	1,429,613	1,439,603	7,098,713
	£	**16,139,848**	**16,444,652**	**16,812,179**	**17,132,586**	**17,517,559**	**84,046,824**

Based on current services, £84m cost is projected over 5 years.

The following modelling assumptions were applied to the current services model

Modelling Assumptions

	Pre-Consultation Business Case	**Decision Making Business Case**
Current Activity Modelling Assumptions	Modelling uses 2016/17, 2017/18 actuals and activity assumptions for 2018/19 based on a M6 extrapolation*: • There has been an average of 5% reduction year on year in WiC activity which is assumed to continue • A&E Type 1 activity has been set at a 1% increase • MIU has been increased by 6%. *NB: Analysis of M10 A&E Type 1 actuals shows 3% over-projection in activity (2,374 fewer attendances than anticipated at M6). This is not considered significant and modelling has not been adjusted.	Unchanged
Costing Model	Modelling looks at options based on a cost per case basis. Assumptions have been made on a current cost per case basis.	Unchanged
Impact of NHS 111 and Clinical Advice Service	Modelling has not assumed any changing shifts based on developments involving NHS 111 and Clinical Advice Service as there is not yet firm evidence upon which to base assumptions. The modelling therefore reflects the 'worst case scenario' whereby these improvements do not result in reduced face-to-face attendances in any of the options.	Unchanged

UTC Tariff	In determining the tariff for UTC activity, the following guidance has been received from NHSE: "UTCs are classified as a type three A&E service (NHS Data Dictionary). Under the current rules of the national tariff payment system (NTPS) activity for type three services should be reimbursed according to the national price specified (£73 for 2019/20). The NTPS does allow for local variations to national prices. For UTCs this means activity in a UTC may be reimbursed at a different level or on a non-episodic basis if there is local agreement. Full guidance on the principles to follow when agreeing local variations are set out in the 'Locally determined prices' section' of the NTPS document." **GCH Site Option** - The modelling, and sensitivity analysis carried out, uses £100 per attendance where it is a standalone UTC with the capability of receiving redirected patients from an ED environment. £73 is used where the site is either part of an urgent care networked model of care that does not have an ED on site. **DVH Site Option** – Under this site option it is thought that a significant number of patients would be redirected away from the ED to an UTC. The modelling, and sensitivity analysis carried out, recognises the likely increased complexity of cases and uses £100 per attendance as a tariff based on the mid-point between the £73 per attendance as the lowest potential tariff point and the current ED average tariff of £150 per attendance.	Unchanged

Appendix E

Summary of financial and activity modelling

Urgent care networked model of care over two sites (Gravesham Community Hospital (GCH) and Darent Valley Hospital (DVH))

Urgent care networked model of care over two sites
(Gravesham Community Hospital and Darent Valley Hospital)

		2020/21	2021/22	2022/23	2023/24	2024/25	Five Year Total
DVH A&E	Activity	59,344	59,731	60,121	60,515	60,913	300,624
DVH UTC	Activity	24,557	24,804	25,055	25,307	25,563	125,286
Hurley Clinic	Activity	10,253	10,373	10,494	10,617	10,741	52,478
New GCH site Service Provision (historic WIC & MIU activity)	Activity	52,374	52,317	52,420	52,692	53,132	262,936
Projected system activity	**Activity**	**146,528**	**147,224**	**148,091**	**149,132**	**150,349**	**741,324**
	Finance						
DVH A&E	£	9,457,697	9,609,228	9,763,444	9,920,350	10,080,026	48,830,747
DVH UTC (£100 tariff)	£	2,455,690	2,480,391	2,505,510	2,530,746	2,556,300	12,528,637
Hurley Clinic	£	827,785	845,839	864,316	883,151	902,433	4,323,523
New GCH site service provision (£73 tariff)	£	3,823,299	3,819,151	3,826,694	3,846,528	3,878,622	19,194,294
Projected system costs	**£**	**16,564,471**	**16,754,609**	**16,959,964**	**17,180,776**	**17,417,381**	**84,877,201**

Scenario:

- Provision for all current Fleet WIC services at GCH site
- Provision for all current GCH MIU services at GCH site
- Incorporation of existing A&E primary care streaming service flows into the UTC at DVH
- The GCH tariff is assumed to be £73 in line with the national tariff for urgent care treatment centre activity
- The DVH current activity remains unaltered, but the streaming function is anticipated to divert approximately 25,000 patients per year to a co-located UTC.
- The DVH UTC tariff is assumed to be £100 per patient as per modelling assumptions.

The Urgent Care Networked Model of Care over 2 sites (DVH and GCH) is modelled at £100 tariff for the DVH site and £73 for the GCH site with a total 5 year cost of £85m

- If there was no price differential between sites the modelled cost would be £92m at £100 tariff and £82m at the £73 tariff.

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Appendix F

Summary of financial and activity modelling

Urgent Treatment Centre at Gravesham Community Hospital (GCH)

Urgent Treatment Centre

Gravesham Community Hospital (GCH)

GCH site for UTC modelled Urgent Care flows
0% conversion from non-ambulance at DVH to UTC

Site		2020/21	2021/22	2022/23	2023/24	2024/25	Five Year Total
DVH A&E	Activity	80,291	80,887	81,488	82,096	82,710	407,472
GCH UTC	Activity	54,183	54,117	54,213	54,473	54,901	271,887
Hurley Clinic	Activity	11,546	11,681	11,818	11,956	12,096	59,097
MIU - historical activity flow not assigned (wound care)	Activity	508	539	571	606	642	2,867
	Activity	**146,528**	**147,223**	**148,091**	**149,131**	**150,349**	**741,322**
UTC price basis	£100Finance						
Change Price DVH A&E	£	12,299,209	12,507,865	12,720,329	12,936,675	13,156,976	63,621,053
DVH UTC	£	5,418,334	5,411,661	5,421,282	5,447,347	5,490,055	27,188,678
Hurley Clinic	£	932,190	952,521	973,328	994,539	1,016,254	4,868,832
MIU - historical activity flow not assigned	£	37,463	40,123	42,972	46,023	49,291	215,871
	£	**18,687,195**	**18,912,169**	**19,157,912**	**19,424,584**	**19,712,575**	**95,894,435**

UTC price	£100	95,894,435	Unassigned activity reserve £	215,871
UTC price	£73	88,553,492	Unassigned activity reserve £	215,871
UTC price	£110	98,613,303	Unassigned activity reserve £	215,871

Scenario:

- Provision of current Fleet WIC services at GCH UTC
- Maintenance of Primary Care Streaming at DVH
- Enhancement of existing MIU services at GCH to be incorporated in GCH UTC
- As part of the modelling there remains a small amount of current WIC and MIU patient activity (mainly wound care) that rather than flowing to a new UTC, could be more appropriately cared for by existing services, or by future services established by the Primary Care Networks. The value and amount of this activity has been maintained within the modelling and this will enable the CCG to invest additional resources to address this activity if required.

The GCH site option is estimated to cost £95m over 5 years.

- The UTC price is modelled at £100, however if the price were £73 to £110, the model cost is £89m and £99m respectively.
- The model includes no conversion of DVH non ambulance activity to UTC.
- Wound care clinic activity is not assigned - £215,000 is held in reserve if required.

Gravesham Community Hospital Site Option	The following points have been assumed in the modelling of this option: • Wound care volume at the MIU has been calculated using additional information supplied by the sub-contracted provider which splits out the type of wound dressing that is taking place. • Over 2016/17 and 2017/18 post-op reviews and suture removal has accounted for 1.7%, and re-dressing has accounted for 13.6%, of total activity. • The modelling anticipates that 100% of suture removal and 80% of re-dressing activity will be taken care of in the UTC. • No attrition has been assumed from the WiC as it is 1.3 miles away in a more central town centre location. This is thought to represent the 'worst case scenario'. • No activity has been assumed to be redirected away from the Emergency Department at DVH to Gravesham Community Hospital UTC as it is at an off-site location and primary care streaming service under this option would still need to be in place at DVH.	Unchanged

Appendix G

Summary of financial and activity modelling

Urgent Treatment Centre at Darent Valley Hospital (DVH) co-located with the Emergency Department

Urgent Treatment Centre

Darent Valley Hospital (DVH) co-located with the Emergency Department

DVH site for UTC modelled Urgent Care flows

33% conversion from non-ambulance to UTC

	Site		2020/21	2021/22	2022/23	2023/24	2024/25	Five Year Total
	DVH A&E	Activity	59,344	59,731	60,121	60,515	60,913	300,624
	DVH UTC	Activity	59,820	60,419	61,133	61,960	62,905	306,236
	Hurley Clinic	Activity	10,253	10,373	10,494	10,617	10,741	52,478
	MIU - historical activity flow not assigned	Activity	5,283	5,602	5,940	6,299	6,679	29,803
	WIC - historical activity flow not assigned	Activity	16,102	15,297	14,532	13,806	13,116	72,853
		Activity	**150,802**	**151,421**	**152,220**	**153,196**	**154,354**	**761,994**
UTC price basis		100Finance						
Change Price	DVH A&E	£	9,457,697	9,609,228	9,763,444	9,920,350	10,080,026	48,830,747
	DVH UTC	£	5,981,986	6,041,905	6,113,257	6,195,963	6,290,480	30,623,591
	Hurley Clinic	£	827,785	845,839	864,316	883,151	902,433	4,323,523
	MIU - historical activity flow not assigned	£	389,493	417,149	446,768	478,491	512,465	2,244,367
	WIC - historical activity flow not assigned	£	745,285	750,502	755,755	761,045	766,373	3,778,959
		£	**17,402,246**	**17,664,622**	**17,943,540**	**18,239,000**	**18,551,778**	**89,801,187**
	33% conversion from non-ambulance to UTC	UTC price	£100	**89,801,187**		Unassigned activity reserve £		**6,023,326**
	33% conversion from non-ambulance to UTC	UTC price	£73	**81,532,817**		Unassigned activity reserve £		**6,023,326**
	33% conversion from non-ambulance to UTC	UTC price	£110	**92,863,546**		Unassigned activity reserve £		**6,023,326**

Scenario:

- Incorporation of existing A&E primary care streaming service flows into the UTC
- Provision of a proportion of current Fleet WIC services at DVH UTC
- Provision of a proportion of current GCH MIU services at DVH UTC
- Anticipation of some current urgent care flows to Queen Mary Sidcup Hurley Group Urgent Care Centre being diverted through patient choice to DVH UTC. The modelling for the UTC incorporates financial contingency reserves. These financial reserves are calculated on the basis that not all previous patient activity from the MIU and the WIC will transfer to a new UTC at DVH as patients may choose to access other primary and local care services instead. The financial contingency reserves will enable the CCG to invest additional resources in alternative primary and local care services, if required.

The DVH site option presents the best value UTC model at £90m over 5 years

- The UTC price modelled at £100, however, if the price were £73 to £110 model is £82m and £93m respectively
- There is a financial contingency reserve of £6m held should the CCG wish to invest additional resources in alternative primary and local care services
- The model assumes that 33% of non-ambulance emergency activity could be streamed to a co-located UTC, however, if only 23% could be streamed to UTC (at a tariff of £100); the model price would be £91m. If 43% could be streamed (at a tariff of £100), the model price would decrease to £89m.

Darent Valley Hospital Site	The following points have been assumed in the modelling of this option: • All conveyance activity will be seen by ED and not streamed to the UTC as data is not split by 'blue light' and 'normal conveyance' although it is thought that some conveyances would ultimately be streamed to UTC • WiC attrition set at 60% as assumed majority of patients will choose to access other forms of out-of-hospital care (the last Fy 2018/19, 34% of WiC activity related to patients already registered at the site and the highest number of attendances with known presenting complaints relate to coughs, rashes, sore throats and abdominal pain. It is assumed that the majority of these patients will attend registered GP or access self-care / pharmacies / NHS 111 rather than divert to DVH) • An additional 10% of activity from residential areas close to DVH site has been assumed which reduces WiC attrition to (60% reduction at GCH + 10% 'local' increase from DVH area) • 10% of patients streamed to a co-located UTC are anticipated to 'bounce back' to A&E. This figure is higher than the circa 3-5% figures achieved elsewhere but it is anticipated that it takes time for flows between A&Es and UTCs to work optimally. This presents a worst case scenario. • MIU attrition set at 23.4% (50% of HRGVB11Z – no investigation and no treatment HRGs – it is assumed the other 50% will access other existing primary, local or community care options, or access the NHS 111 service) • Following discussions with Bexley CCG, it has been assumed that some of the DGS patients currently attending the UCC at Queen Mary's Sidcup (provided by The Hurley Group) may decide to access services at DVH if an UTC were co-located with ED. It is assumed that 10% of Hurley Clinic patients would repatriate and be triaged through the UTC.	Unchanged
Clinical Audit assumptions indicating conversion rates from A&E to a UTC	• Following a scoping exercise using SUS data and a clinical audit of A&E activity at DVH, it was estimated that as many as 59% of current A&E activity could theoretically be streamed from A&E to a co-located UTC. • It was recognised that the HRG analysis and the clinical audit undertaken was fairly crude and that the outcome of 60% of total A&E activity being redirected was an overestimation. • It was therefore agreed that for the purposes of activity and financial modelling, a co-located UTC would potentially be streamed 33% of total A&E activity as this was felt to be more in line with what is currently thought to be achievable nationally. • This has also been subject to sensitivity analysis and the modelling has examined a 10% variance on either side of the 33% (i.e. 23% and 43%).	Unchanged

Item 5: Wheelchair Services Update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: Kent and Medway Wheelchair Service Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Thanet CCG and Millbrook Healthcare.

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

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1. Introduction

(a) Thanet CCG are the lead commissioner for NHS wheelchair services across Kent and Medway.

(b) Millbrook Healthcare was awarded the contract for provision of wheelchair services across Kent and Medway in April 2017. During its early months, the provider identified a larger than expected caseload including a significant number of adults and children that had been on the waiting list for more than 18 weeks, and in some cases over a year.[1]

(c) HOSC received notification from Thanet CCG in June 2018 that there was pressure on the wheelchair service provided by Millbrook Healthcare; patients were experiencing longer wait times for equipment, repairs and assessment. These concerns were echoed by Healthwatch Kent.

2. Previous monitoring by the Kent HOSC

(a) HOSC has received regular updates from the CCG and Millbrook Healthcare since July 2018. Stakeholders such as the Centre for Independent Living in Kent (CiLK), the Wheelchair Service Users Group and Healthwatch Kent have been involved in the discussions.

(b) The last formal update to HOSC was received on 23 July 2019. Millbrook Healthcare reported that there had been improvement in waiting times overall, but that service user experience continued to be inconsistent.

[1] Thanet CCG (Jan 2019) Kent and Medway Wheelchair Service Update, page 2, https://democracy.kent.gov.uk/documents/s88768/190125%20HOSC%20Briefing%20on%20Kent%20and%20Medway%20Wheelchair%20Service%20Final%20v2.pdf

(c) Healthwatch Kent had been liaising with the CCG, and had expressed an interest in carrying out an in-depth piece of work once changes had bedded in. This is included in the agenda pack.

(d) At the meeting, HOSC was notified that Millbrook Healthcare had been acquired by Cairngorms Investment Company after a decision by its Chairman to step away from the business.

(e) At the conclusion of the above meeting, the Committee agreed the following recommendation:

RESOLVED that:

a) the report be noted;

b) Thanet CCG provide a written update as soon as practically possible. The update should include:

i. Assurances that the contractual obligations would remain with the organisation under its new ownership;

ii. Details of the new company;

iii. Arrangements for existing staff;

iv. Any information relating to significant changes in the delivery of services.

c) Thanet CCG return to the Committee at the appropriate time.

(f) Thanet CCG provided two documents for HOSC in relation to point b) above. These are attached to this report for information as two appendices.

(g) In line with recommendation c) above, Thanet CCG and Millbrook Healthcare have been invited to attend this meeting and provide an update on the service performance. This is in the agenda following the above-mentioned appendices.

3. Recommendation

RECOMMENDED that the report be noted.

Appendices

A – Briefing from Thanet CCG about Millbrook acquisition

B – Briefing from Millbrook Healthcare about Cairngorms Investment Company

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (20/07/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7919&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (13/09/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8122&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (25/01/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7924&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (23/07/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

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Information for Kent Health Oversight and Scrutiny Committee – Millbrook Healthcare's partnership with Cairngorm Capital

1. **About Cairngorm Capital**

Cairngorm Capital is a specialist private investment firm that provides equity capital, strategic advice and management expertise to leading UK companies. It partners with ambitious management teams, providing financial investment which can be used to improve technology, logistics and operational processes. It shares industry knowledge, best practice and operational expertise so that strategy and plans can be implemented more quickly and successfully.

The firm is backing the management buyout led by Phillip Campling, Millbrook's Chief Executive, to acquire the shares from members of the Croll family, who are retiring or exiting the business. Phillip Campling and the rest of the Millbrook management team, including Annette Cairns (Clinical Director) and David Lock (Commercial Director) will continue to lead the business, working with Cairngorm Capital, to achieve their vision and strategic goals for Millbrook Healthcare. Aside from long-term investment and improvements to the business, all other aspects of Millbrook's operations will continue as usual.

Dr Amit Thaper, who leads Cairngorm Capital's interests in this partnership, spent several years as a surgeon in the NHS covering a number of specialties including orthopedics, emergency and trauma care so he understands the provision of healthcare as a practitioner and the interlink between the NHS and social care. After leaving the NHS, he worked at Bain & Co, a global management consulting firm, on a number of public and private healthcare projects both in the UK and the USA, which brought an international element to his expertise.

During the acquisition, Cairngorm Capital undertook in-depth market and customer research both internally and via consulting firms to increase and validate its knowledge of industry and customer requirements. These findings will shape and influence future service provision.

Across its two funds, Cairngorm Capital currently has equity capital in excess of £180m available for investments. Its focus is in growing and transforming companies to create market leaders, rather than on financial structuring. It takes a collaborative, long term view to investing and does not charge management fees or take dividends during its ownership. As at July 2019, the firm had completed 21 investments, with combined revenues of £650+m and over 4,250 employees.

2. Millbrook employees

There was a comprehensive exercise led by Phillip Campling and his management team to ensure that all stakeholders were fully briefed about the change of ownership. All employees received an email that outlined the change in ownership and what that meant for them in practice; those staff not on email were briefed by their line managers. The email was accompanied by an announcement from Colin Croll and a detailed Q&A that sought to answer as many of the initial questions that employees might have.

The written communication was supplemented by a whole company briefing led by Phillip Campling and Colin Croll, using telephone conferencing, where it was reiterated that this was solely a change of ownership and that nothing had changed in terms of employees' contracts, employment terms, reporting lines or other day to day operations. At this briefing, employees had the opportunity to ask further questions. Service centre managers have held follow-up sessions to ensure that anybody who was unable to participate on the day is fully briefed on the changes. In addition, our Clinical Director,

Annette Cairns visited the teams at Ashford and Gillingham this week to discuss the change of control in more detail.

Employees' reactions and feedback is being captured in a number of ways:

- A representative group of 40 employees, covering a range of functions and locations, are providing direct feedback on a regular basis.

- Service centre managers are eliciting feedback from their team members, to capture views and reactions at every level of the business.

- Employees can submit questions, comments and feedback to a central email address or anonymously via feedback boxes at each service centre. These are collated and the answers are shared company wide.

In the unlikely event that employees have any concerns, they are able to raise these with their line manager or Millbrook's HR team. It should be noted that the change of share ownership in Millbrook Healthcare does not change employees' contractual or working conditions.

3. **Continuity of service levels and the future benefits arising from the partnership**

This change of ownership will have no impact on service levels – it is solely the transfer of shares from the Croll family to the Millbrook management team and its strategic partner, Cairngorm Capital. There will not be changes to resources or service centres and the management and governance process will remain the same.

Every contract will continue to have the same level of investment and the same amount of working capital. It will be Millbrook's management team, rather than Cairngorm Capital or any other investor, who will determine the resourcing of both current and future contracts.

Cairngorm Capital brings the resources and expertise to improve the business and make it best-in-class. It has committed to and invested fully for Millbrook's future expansion and growth. It has allocated significant sums, which will be invested across a number of areas resulting in improvements to technology, supply chain and logistics, extensions to the Ultimate product range, all with the goal of delivering exceptional services and care to customers. The firm takes a collaborative, long term view to investing and does not charge management fees or take dividends during its ownership.

With the departure of Colin and Paul Croll, Millbrook's board has been strengthened by the appointments of Mike Kerins, who joins as non-executive Chairman and Victor Vadeneaux, a Cairngorm Capital Operating Partner, who joins as non-executive director. Both bring considerable experience of transforming businesses.

4. Stakeholder communication

All stakeholders – commissioners, suppliers and employees - have been personally notified of the change of ownership. In addition, the announcement has been posted onto each service centre's website to update service users.

In line with our statutory duties, we formally notified all of our commissioners, including Kent, of the change of control a number of weeks ago and received approvals in return.

Kent and Medway Wheelchair Service

Millbrook Healthcare partnership with Cairngorm Capital

August 2019

Situation:

An update of the Kent and Medway wheelchair service was presented at the HOSC meeting held on 23 July 2019. On the morning of this meeting a proposed change of ownership of Millbrook Healthcare was confirmed and made public and this was announced during the committee meeting. HOSC requested further assurance that the partnership between Millbrook Healthcare and Cairngorm Capital would not impact on service delivery and staff.

Background:

With the retirement of Colin Croll, former Chair of Millbrook Industries Ltd, the ownership of Millbrook Healthcare and its subsidiaries has transferred to the Millbrook Executive Management team and Cairngorm Capital.

Aside from the statutory requirement to notify all commissioners of this change, all other aspects regarding the provision of the wheelchair service for Kent and Medway remain unchanged.

Assessment:

The Millbrook management team continues to lead the business, with strategic and investment support provided by Cairngorm Capital. The company aims to provide the highest quality service and care for all service users are unchanged. The service will continue to be provided by Millbrook Healthcare Limited, from the same premises, using the same staff, all of whom continue to be employed by Millbrook Healthcare – staff will not be required to TUPE transfer. The report attached from Millbrook Healthcare provides further details.

When Thanet CCG was made aware in strictest confidence that there was a potential change in ownership, the CCG, on behalf of the other Kent and Medway CCGs, undertook due diligence including seeking advice from our contracts experts and speaking with a Director of the new holding company. The CCG was provided with assurance that a change in ownership does not alter any of the contractual terms and that there were to be no changes to Millbrook staffing, including the Executive team, as a consequence of the change in ownership.

The CCG will continue to hold Millbrook Healthcare to account for delivering the improvement plan. Millbrook Healthcare has assured the CCGs that operational capacity will be the same or greater under the new ownership and that their working capital will be the same if not more.

As part of our due diligence the CCG requested contact details of the other Local Authorities and CCGs who hold current contracts with Millbrook. Some of these had already agreed to the change in ownership and others were poised to. We approached two key organisations holding contracts with Millbrook and spoke with one of them.

Recommendation:

The CCGs understand that this may be a cause of concern for key stakeholders and we are liaising with Millbrook regarding stakeholder communications to provide re-assurance. HOSC is asked to note that the contractual obligations and contractual governance have not changed and that the CCGs continue to monitor performance to ensure the service improvement plan is delivered.

Meeting Title:	Health Overview and Scrutiny Committee		**Agenda Item:**	
Date of Meeting:	28 January 2020			
Title of Report:	Kent and Medway Wheelchair Service Update			
Author:	Tamsin Flint, Commissioning Manager, Thanet CCG			
Executive/ Lay Sponsor:	Ailsa Ogilvie, Director of Partnerships and Membership Engagement East Kent CCGs			
Finance sign-off				
This paper is for: *(please X as applicable)*	~~Approval~~	~~Decision~~	Assurance	~~Information~~
			X	
Are any members of the meeting conflicted?	~~Y/~~N			
Is circulation restricted? *(please X as applicable)*	No	Yes		
		X		

Report summary/purpose:

This report provides an update on progress to deliver improvements in service performance and quality for Kent and Medway's wheelchair service users.

Recommendation:

HOSC members are asked to note this report.

Combined impact assessments

Has the report/recommendation/proposal been impact assessed

X	Yes
	~~No (state reason)~~

Kent and Medway Wheelchair Service Update January 2020

Situation:

Following the additional funding from the eight Kent and Medway Clinical Commissioning Groups (CCGs) along with improved processes and increases in clinical and support staff put in place by Millbrook Healthcare, there is ongoing and steady improvement in the wheelchair service performance. The waiting list for assessment and equipment continue to reduce and average waiting times are shortening.

In two key areas, however, repairs within three working days and children's cases closed within 18 weeks, performance is off trajectory. Remedial Action Plans are in place and the CCG is monitoring these closely to ensure that the trajectory is met within agreed timescales.

Background:

Thanet NHS Clinical Commissioning Group commissions the Wheelchair Service, which is provided by Millbrook Healthcare on behalf of the Kent and Medway clinical commissioning groups. Following contract mobilisation Millbrook Healthcare raised concerns about the caseload inherited from the previous provider which was putting pressure on the Kent and Medway Wheelchair Service, with service users experiencing longer waiting times for equipment, repairs and assessment.

Kent and Medway CCGs agreed to fund the impact of the unbalanced caseload inherited from the previous provider, as well as the unexpected recurrent demand experienced in the first two years of the contract. They agreed that data should be reviewed at the end of the second year (2018/19) to confirm the initial funding requirement for the first two years and clarify any recurrent demand over the final three years of the contract.

Assessment:

Performance

Latest data to end of December 2019 shows evidence of continued overarching improvement with a reduction in the waiting list for equipment. The overall waiting list has reduced from its peak of 3,313 in September 2018 to 1,378 open cases at the end of December 2019. Over the last 12 months (January 2019 to December 2019) 7,348 referrals have been concluded.

Millbrook Healthcare continues to focus on those service users who have been waiting a long time and the average waiting time has halved from 31.2 weeks at the end of January 2019 to 15.88 weeks at the end of December 2019.

For repairs, the number of service users who have been waiting for a wheelchair repair for more than ten days has reduced from 132 at the end of January 2019 to 50 by the end of December 2019.

In December 2019 there were 294 repairs completed, of which 43 per cent were completed within three working days. Although there has been some improvement in the percentage of repairs completed within three working days, this is still not at the level it needs to be with service users waiting on average 6 working days for a standard repair to be completed. Millbrook is working on a number of actions to help improve repair waiting times, this has included a review of their stock carried to ensure the fast moving stock items are readily available. One of the reasons behind the average waiting time is that there have been a high proportion of specialist repairs which requires specialist parts to be ordered in. The CCG is looking at the 3 day standard repair KPI to explore whether it would be more appropriate to look at routine and specialist repairs separately as the lead times are different. A Remedial Action Plan is in place to monitor repairs performance closely.

18 week waits for children

There has been an increase in children referrals into the service over the last 6 months with an average increase of 27 children per month. In December 2019, there were 236 children on an open episode of care. Over three quarters (80.1 per cent) of these children have been waiting less than 18 weeks which is a significant improvement on where we were 12 months ago, when just over half (53.2 per cent) of children were waiting less than 18 weeks. However, there is still a way to go in order to achieve the national target of 92% and a Remedial Action Plan is in place with a trajectory of meeting this target by end of January 2020.

At the end of December 2019, there were 47 open children's referrals over the 18 week pathway. Millbrook Healthcare reviews all of these children referrals on a weekly basis and reports back to the CCG at the monthly Contract Management Committee meetings. For 31 of these open cases the reasons for delaying case closure are outside the control of the wheelchair service, if these exceptions are taken into account then performance increases to 93.2 per cent. Some examples of the circumstances which prevent Millbrook Healthcare being able to progress cases within 18 weeks include:

- Multiple appointments being cancelled by parents or failing to attend appointments (DNA's). Common reasons given for appointments being cancelled include issues with transport, parents unable to get time off work or unable to bring the service user due to their own ill health
- Service user unable to attend due to sickness or surgery/hospital appointments
- Parents requesting appointments are booked during school term time only or school holiday time only
- Parents not returning voucher paperwork in a timely manner.

18 week waits for adults

There has also been an increase in the average number of adult referrals into the service over the last six months with an average increase of 106 adult referrals per month. In December 2019, 1,142 adults were on an open episode of care, of which over two-thirds (68.2 per cent) have been waiting less than 18 weeks which represents an improvement over the last 12 months when just over a third (37.7 per cent in January 2019) had been waiting less than 18 weeks. There is not a national 18 week target for wheelchair services for adults but Millbrook Healthcare are working on a trajectory and action plan to meet the CCG's target of 90% for adults.

Service User Engagement

Following the three service user Engagement Events which were held in April and May 2019 Millbrook Healthcare has established a service improvement board involving service users, carers and family members. These meetings are held quarterly and play a pivotal role in driving further improvements in the service.

Stakeholder Engagement

The CCGs are delighted that Millbrook Healthcare now have a Community Liaison and Engagement Officer in post since November 2019. We are already seeing and hearing the benefits of having this person in post for staff at Millbrook Healthcare, service users and other organisations/forums. This role will be pivotal in building and strengthening relationships with key stakeholders. Millbrook Healthcare continues to engage with Healthwatch, the Physical Disabilities Forum and Centre for Independent Living. Both Millbrook Healthcare and the CCG are working together to help improve joined up working with other health, social care and education partners.

Personal Wheelchair Budgets

Our aim is to develop a personal wheelchair budget scheme that supports the health and wellbeing needs of service users that is easy to access and use. This will give service users wider choice regarding their wheelchair provision. We are working with service users and staff to develop information and communication material and are currently implementing a stakeholder engagement plan in order to deliver better integrated working and funding. We are entering a pilot stage, identifying potential cases from which we can learn and refine our personal wheelchair budget offer.

Quality, Safety and Improvement

Quality Visit

The CCG carried out a quality visit in December 2019 which covered a comprehensive overview of the service, including both Ashford and Gillingham sites and home visits. The purpose of the visit was to seek assurance that high quality safe care is being delivered and that systems and processes are in place to address and mitigate quality and safety risks. The visit team consisted of members from quality, commissioning, safeguarding, Infection, Prevention and Control (IPC)

backgrounds in addition to Care Quality Commission (CQC) Inspection Specialist Advisor experience.

Although the service is not CQC registered, the visit team reviewed elements of the service against the CQC's five domains framework and awarded the overall service a rating of Good. It was apparent to the visit team that there is a positive caring culture with a focus on putting service users first and this contributed significantly to the visit team awarding a strong Good for the CQC Caring domain.

The visit team found several areas within the Responsive domain that Requires Improvement; these include linking evidence of complaint – action – improvement in service delivery. Also observed was a need to improve proactive communication with service users to assist with getting repairs and adjustments right first time and to reduce incidences Did Not Attends / Was Not Broughts.

It was observed that progress has been made in recent months as to improvements in quality and safety. The CCG quality team will continue to work closely with Millbrook to help sustain and drive further improvements. Millbrook have developed an action plan that captures all recommendations from the quality visit which will be reviewed with the CCG quality team initially on a fortnightly basis.

Quality Reporting

Quality schedules (reporting requirements) have been revised to include recommendations that are required from the quality visit. The revised schedules are to be tabled at the January 2020 Contract Performance & Quality Meeting with a recommendation for them to be incorporated into revised contract particulars.

Service User Experience

Millbrook Healthcare have advised that they have set up electronic tablets in clinic areas to record feedback and are working with staff to ensure that feedback is requested from service users as routine. Paper versions will also be available to meet service users preferred methods of leaving feedback and maximise returns.

Infection Prevention and Control (IPC)

It has been highlighted that Millbrook Healthcare has a gap around a nominated IPC Lead, for which, the post is due to be recruited to. As a recommendation from the December 2019 quality visit, Millbrook Healthcare has been advised to arrange access to specialist external IPC advice. A further quality visit to Millbrook Healthcare has been arranged to take place in January 2020 at the Ashford facility with a targeted focus on the processes and procedures for decontaminating wheelchairs as this was not observed during the December 2019 visit.

Complaints

A Complaints Concerns and Compliments Steering Group has been established with service user representatives, CCG and Millbrook Healthcare colleagues working together to improve the handling of complaints and to ensure that learnings from

complaints help drive further improvements in the service and ultimately deliver better outcomes for service users.

Whilst there is no denying that the complaints process had previously not worked in the best interests of service users, relatives and carers, efforts made in the last year have seen marked improvements in the timeliness of responses and a greater deal of engagement on a local level in terms of maintaining local resolution. The newly appointed Community Liaison and Engagement Officer will also help drive this work forward.

Wheelchair Service Funding

A review of the ongoing demand for the Kent and Medway Wheelchairs contract identified an annual cost pressure of £427,350 per annum. This was not unexpected and Kent and Medway CCGs had budgeted for this in 2019/20. The funding package provided by the Kent and Medway CCGs over the past 12 months covered this cost pressure for the first two years of the contract (2017-2019), and it has been agreed that the contract value be increased to ensure this cost pressure is funded recurrently for the remainder of the contract. This will enable Millbrook Healthcare to complete their improvement trajectory and sustain waiting times in line with national and locally agreed standards.

Recommendation:

Overall improvements in service performance and quality continue to be made with the size of the waiting list and waiting times reducing for assessment and equipment provision. That said there are two key areas which are not meeting expectations and both the CCG and Millbrook Healthcare have put Remedial Action Plans in place to ensure that these areas are closely monitored and targets achieved within agreed timescales. Feedback from service users continues to improve with more positive comments being received about the service provided.

Improving wheelchair services in Kent

A Healthwatch Kent Impact Report : November 2019

healthwatch Kent

Improving wheelchair services in Kent

The story so far

People all over Kent started sharing negative stories about the wheelchair service with us. The Kent Physical Disability Forum also came to us with a host of stories.

We heard from people being discharged from hospital without no wheelchairs, people waiting months for a wheelchair and serious issues when wheelchairs needed repairing.

We took action. We shared your stories with the provider of the service, Millbrook Healthcare, the commissioner before escalating our concerns to the Health Overview & Scrutiny Committee.

A snapshot of the stories we heard

I needed a wheelchair, but nothing was available, so I was discharged in a 'normal' chair.

I waited 330 days since I was referred by my MS nurse for the wheelchair service to assess me. I then had to wait another 69 days for the actual wheelchair.

The only way my wife can get to her appointments is on a stretcher as we are still waiting for her wheelchair to be repaired

My patient has waited over a year for the wheelchair she needs. She's a child and it has still not been provided

My powered wheelchair was taken away to be fixed. It's been weeks, and in the meantime, I am stuck.

We've been working to make your voice heard

We took your feedback to the decision makers

Listening to you

We worked with the Kent Physical Disability Forum to gather feedback from people who were using the wheelchair service all over Kent.

We wanted to hear as many stories as possible about people's experiences.

Taking your voice to decision makers

The Service provider

The wheelchair service in Kent had recently been taken over by Millbrook Healthcare.

We facilitated a meeting between Millbrook, the Kent Physical Disability Forum, wheelchair user groups and the Medway Physical Disability Forum along with the commissioners of the service, Thanet Clinical Commissioning Group (CCG).

At this meeting we shared the feedback we had heard and discussed our collective concerns.

The Kent Health Overview & Scrutiny Committee (HOSC)

We escalated our concerns about the wheelchair service to HOSC which is a Committee made up of Kent County Councillors, whose role it is to scrutinise health services in Kent. This is the highest form of scrutiny within the Kent health system.

On 20 July 2018, representatives from Healthwatch Kent and the Kent Physical Disability Forum addressed the Committee about our concerns and the feedback we had heard from patients and professionals.

In response, Members expressed concerns about poor patient experience. They also raised concerns about the procurement of the contract and subsequent contract performance management by NHS Thanet CCG. They asked for immediate action to improve the service for Kent residents.

What happened?

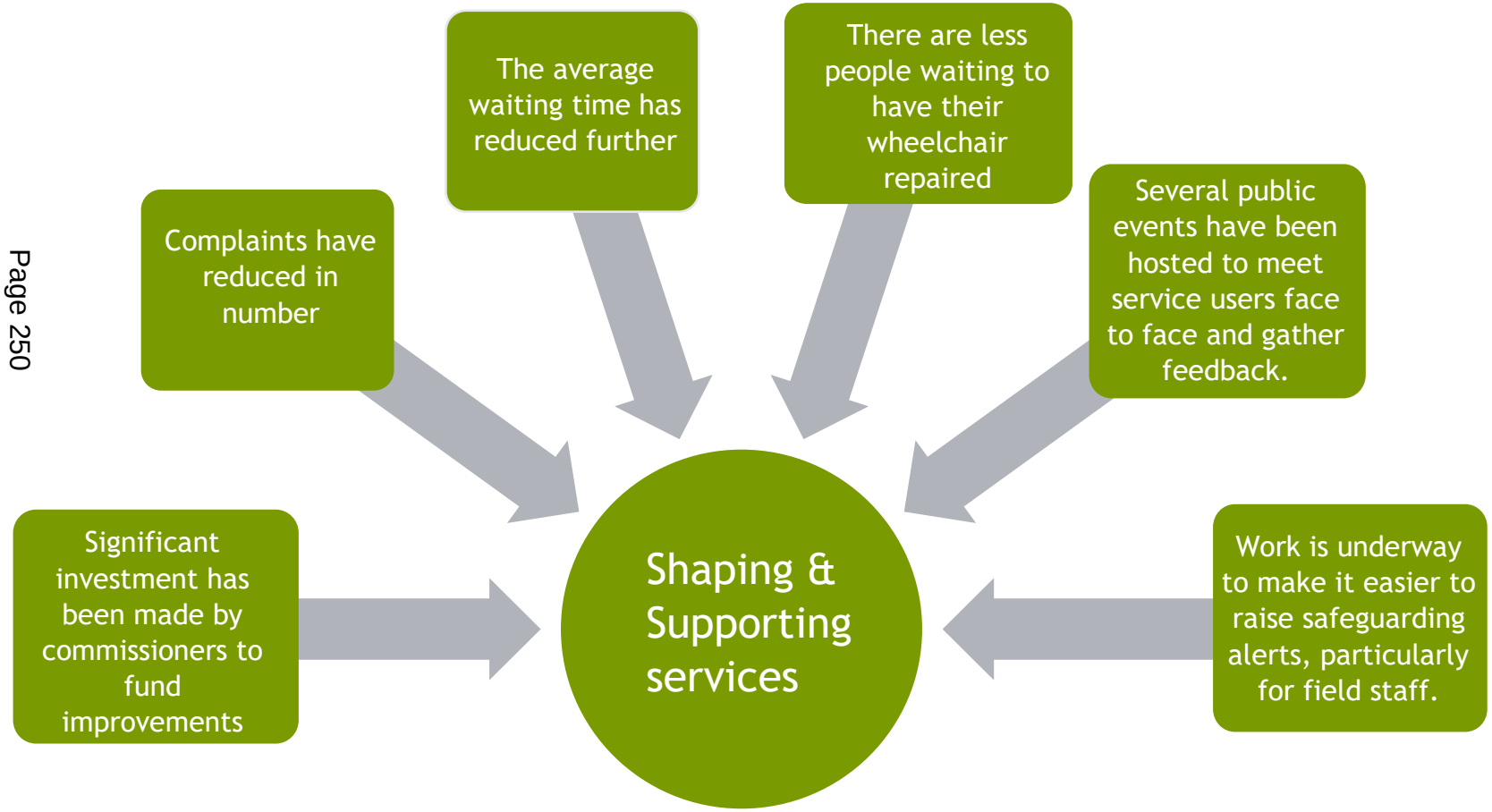
Thanks to your voice, and our intervention, wheelchair services are slowly improving.

There is still much work to be done but so far, we have seen the following improvements:

- The CCG have reviewed the service and made significant investment to fund action and improvements
- The average waiting time for patients to receive a wheelchair has reduced
- The number of people waiting more than 10 days for their wheelchair to be repaired has also reduced
- Millbrook are doing more to hear directly from service users about their experience of the service
- They have organised several events to meet people face to face and gather feedback

- Work is in progress to progress personal wheelchair budgets. Wheelchair users are involved in this plan which should roll out from November 2019
- The number of complaints about the service has reduced and patient feedback is starting to be more positive
- A review of complaints has been completed to explore how the system of responding and learning from complaints can be made better for patient
- Work is underway to make it easier for staff to raise safeguarding alerts

Our highlights



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Item 6: Procurement of the Neurodevelopmental (ND) Health Service for Adults

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: Procurement of Kent and Medway Neurodevelopmental Health Service for Adults

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Summary: This report invites HOSC to consider the information provided by Kent and Medway CCGs.

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1) Introduction

a) The Scrutiny Research Officer for HOSC received notification on 26 November 2019 that Kent and Medway CCGs would be procuring a Kent and Medway Neurodevelopmental (ND) Health Service for adults. The service will provide assessment and post-diagnostic support for adults living with an Autistic Spectrum Condition (ASC) and/or Attention Deficit Hyperactivity Disorder (ADHD).

2) Potential Substantial Variation of Service

a) The Committee is asked to review whether the procurement of a Kent and Medway ND Health Service constitutes a substantial variation of service.

b) Where the Committee deems the proposed changes as not being substantial, this shall not prevent it from reviewing the procurement and or service at its discretion and making reports and recommendations to the NHS.

3. Recommendation

If the procurement of the Neurodevelopmental (ND) Health Service for Adults is *substantial:*

RECOMMENDED that:

(a) the Committee deems the procurement of the Neurodevelopmental (ND) Health Service for Adults to be a substantial variation of service.

(b) Kent and Medway CCGs be invited to attend this Committee and present an update at the appropriate time.

If the procurement of the Neurodevelopmental (ND) Health Service for Adults is *not substantial*:

RECOMMENDED that:

(a) the Committee does not deem the procurement of the Neurodevelopmental (ND) Health Service for Adults to be a substantial variation of service.

(b) Kent and Medway CCGs be invited to submit a report to the Committee at the appropriate time.

Background Documents

None.

Contact Details

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03000 416512

Report to:	HOSC		**Agenda Item:**	
Date of Meeting:	16 December 2019			
Title of Report:	Procurement of Kent and Medway neurodevelopmental service specification.			
Author:	Adam Wickings Deputy Managing Director, West Kent CCG. Michelle Snook, Integrated Transformation Manager for Neurodevelopmental Conditions KCC/ CCG (Kent)			
Governing Body Sponsor:	Dr Simon Lundy			
Action Required:	Approval	Decision	Discussion/ Assurance	Information X
Conflict of Interest:	N	For Part 1 (delete as necessary)	For Part 2 (delete as necessary)	
Involvement of patients, carers, staff and stakeholders	Describe: Engagement and communication plan will be implemented. A pre-procurement market and engagement event has taken place and the contract will be mobilised with coproduction and codesign.			

Situation:

Kent and Medway Clinical Commissioning Groups (CCGs) have agreed to the procurement of a Kent and Medway Neurodevelopmental (ND) Health Service for Adults (18+) which will improve quality and value for money across Kent and Medway and is fully supported and identified as a priority need by the Sustainability and Transformation Partnership (STP) and the NHS England (NHSE) Long Term Plan.

Provision of assessment and post diagnostic support across Kent and Medway currently is fragmented with only east Kent providing a commissioned service. The proposed service (see draft service specification appendix 1) will improve both the access to and quality of support for people living with an Autistic Spectrum Condition (ASC) and or Attention Deficit Hyperactivity Disorder (ADHD) across Kent and Medway. It does not alter the current ND pathway which provides access to assessment, diagnosis, post- diagnostic interventions and a complex autism services.

Background:

The Kent and Medway STP have pledged to transform commissioned services as laid out within their current Transforming Care (TC) cohort and TC programme. Key findings from the Strategy for Adults with Autism in Kent and joint needs assessment highlighted gaps and inconsistencies within the pathway for people with autism and or ADHD across Kent and Medway.

NHS procurement across Kent and Medway for a new ND (autism and ADHD) Health Service will

address the current gaps in diagnostic provision whilst ensuring care for complex autism provision is sustainable, thus reducing the demand from using of out of area high cost in-patient placements. The service will bring consistency to the delivery and accessibility of ND Health Services that will be designed specifically to enable multidisciplinary practice with council services which is in line with recent updated NICE guidelines - Learning disabilities and behaviour that challenges: service design and delivery [NG93] March 2018.

The *NHSE Long Term Plan* identifies improved community-based support for autism as a priority over the next 10 years; further reducing reliance on specialist hospitals, making sure all NHS commissioned services are providing good quality health, care and treatment for autistic people and their families, ensuring equal access to, experience of and outcomes from care and treatment. Reduce health inequalities, reducing over-medicating and acting to prevent avoidable deaths. In 2017/18 Kent and Medway CCGs had a small number of complex autistic patients in need of specialist support that was not available locally and patients were sent out of area at high cost to CCGs. In 2018/19 NHSE funded a small pilot specialist service to work locally across the area. KAMCAS is the Kent and Medway Complex Autism Service and commenced service delivery in May 2018. To date this health and social care service has seen in excess of 55 patients, avoiding step-up into the TC cohort and retaining patients in locally based community services. This pilot service funding is due to cease in March 2020 and will be replaced by the proposed new ND service.

In February 2018 Public Health (PH) conducted an analysis of autism and ADHD data. Within the adult population of Kent 14,600 people are estimated as being undiagnosed for Autism (7,118) and or ADHD (7,482). Medway data for these cohorts showed within the adult population of Medway 8,061 people are estimated as being undiagnosed for Autism (1,001) and or ADHD (7,060). Kent and Medway adults' data evidences a significant undiagnosed population when compared to expected prevalence rates for this cohort. The demand for adult diagnostic service provision is unlikely to diminish over the next five to ten years

Only the east Kent CCGs commission a single ND contract with one provider, South London and Maudsley NHS Trust (SLaM). Since April 2017, this has been a pilot service for assessment, diagnosis and post diagnostic provision (adapted CBT) covering east Kent. This service covers both autism and ADHD and has extended its contract until March 2020 to align with the procurement.

Excluding east Kent, the rest of Kent and Medway CCGs use spot purchasing arrangements with SLaM for combined autism/ADHD assessments and post diagnostic treatments. They also commissioned Psicon for autism diagnostics in isolation. The use of these two providers is more complex in referral pathways as patients will either be seen in Kent for non-complex autism (by Psicon), or if complex or comorbid conditions are suspected for autism and or ADHD, referrals are required to be funded by out of area treatments (OATs) and patients are seen and assessed by SLaM in their London base.

Assessment:

The current health diagnostic pathway is difficult for patients to access due to long waiting list backlogs and the majority of post diagnostic services are not available without individual funding approved or locally available in Kent or Medway.

The new service does not alter the pathway with regards to the range of clinical interventions available, what it does provide is cohesive local access to these interventions across Kent and Medway.

The wider costs of ND conditions and lack of commissioned services have a significant impact on

the wider system, evidenced through more increasing demands on social care commissioned services to provide care packages and support to this cohort, as well as increasing demands in primary care and MH services for those with comorbid conditions.

Summary of Benefits:

Patient benefits			
	Current service	**New service**	**Change**
1	Fragmented provision / not all locally based – for ADHD diagnostic and post diagnostic ASC based in London. ADHD / Medical review – (ongoing prescribing) is sporadic / postcode lottery of GP's most without local enhanced services (LES) – patients often have to be seen in London via SLAM	Service continuity through a comprehensive Health and Social care MDT will be locally available across all areas / once LES agreements in place ADHD medication provision will provide consistency	Complete range of diagnostic services available locally within their CCG area for patients. Patient improved experience with ND services – improved satisfaction with GP once LES in place for ongoing prescribing for ADHD meds (enable tracking of prescribed drugs and costs).
2	Post diagnostic provision (Psychology) requires individual funding / sensory functional assessments are not funded / local care mental health teams (LCMHTs) do not provide mental health services for ASC patients	Post diagnostic Psychology and or occupational therapy (TO) sensory functional assessment provision available as part of core service for patients where identified need. Multidisciplinary teams (MDTs) enable holistic individual support	Complete range of Post-diagnostic services available locally within their CCG area for patients will improve patient satisfaction and support carers through individualised local care packages
3	Individual funding requests for highly complex autism support results in high cost / out of area placements for treatment	Complex autism MDT provision accessible for patients where identified need – step-up avoidance / early intervention / lower cost. Step down enabling from TC cohort to locally based treatment	Early access to complex autism MDT service enables early intervention and deescalates crisis situations accelerating to avoid step-up into TC cohort (step down enables those to return to their communities, in line with TCP objectives). Patients remain with or closer to families / carers and home environment

The detailed analysis undertaken has determined that the main benefits will be:

- Increased value for money with the removal CCGs contracting independently and the high cost of spot purchasing
- Reduced cost across the system from the reduction in CCG funded beds from demand from using of out of area high cost in-patient placements for the transforming care cohort
- Improved access to and a reduction in waiting times / waiting list backlogs for diagnosis and post diagnosis treatment and support
- Better integration (MDT between health and social care) - where patients need the support or intervention of community care, secondary care, social services or the voluntary sector this should be a seamless transition both to that provider and from that provider improving patient outcomes
- Increased confidence from primary care for ongoing medication arrangements within the ADHD pathway
- Improved patient experiences / services in local communities via local care model
- Address gaps in service provision / bring consistency to the delivery and accessibility of services
- Provide sustainable transitional arrangements for children and young people's services
- Allows option of all-age ND pathway/ future funding shift from the back (adults pathway) to the front (children's pathway)
- Early diagnosis - where we can't prevent people getting ill, we need to ensure that their condition is diagnosed early as this leads to better outcomes in most conditions. This includes helping people to self-diagnose but to also take responsibility to see their GP at the earliest opportunity
- Better care - a focused approach to prevention and early diagnosis will lead to better care options and management for individual patients; which will lead to better outcomes. Focusing on promoting patient responsibility to choose well when accessing the right services at the right time and in the most appropriate place and empowering patients to be better able to self-manage their own conditions
- Quality - improve quality to ensure services are safe, efficient and effective
- Finance - ensure value for money, directing resources to maximise benefit to make the best use of public money.

The aim of the new health service is to work in collaboration, towards integration through Neurodevelopmental (ND) MDT practice between health and social care which meets the strategic objective for both local authorities (LA) and health commissioners (HC).

Locations:

The new ND Health Service will deliver services across Kent and Medway according to activity / investment shares across CCG areas. For example, if east Kent CCGs are investing 55 per cent of the contract, 55 per cent of the activity will be delivered in this local area by providers of the service.

Communication and Engagement:

Various communication and engagement has been conducted across Kent, along with stakeholder mapping during the development of the business case which has spanned two years. In order to develop a draft service specification which was also National Institute for Health and Care Excellence (NICE) compliant, a survey questionnaire was circulated throughout current health and social care providers for their views on 'how, what and where' the service and its delivery should be provided. Detailed analysis of the results has been interwoven into the specification.

The Kent Autism Collaborative is a strategic group held by Kent County Council (KCC) which has multi-professional / organisational membership has had significant input into the development of the

specification, along with the independent service user representation group (SURG) autistic adults across Kent. Healthwatch's independent people's panel have also showed interest in the development of this service and Healthwatch have offered to consult on the new service post purdah across Kent and Medway in order to gain feedback for co-production.

A pre-procurement market and engagement event was held for Kent and Medway prospective providers to gain feedback on the proposed new service in August 2019. Feedback from this event was around codesign of any new service over the first two years of the contract.

Upon formal procurement commencement, we plan to implement a robust communications and engagement plan that will cover and cater for the needs across Kent and Medway stakeholders. This will include consulting across the system along with independent service user groups via Healthwatch.

Adult ND Pathway:

The procurement of a new ND health service will be based fundamentally on the current adult ND pathway that is now in place, but is aimed to align and provide consistency to service delivery, to reduce waiting times that result from the current fragmented commissioning and promote more integrated working between health and social care.

Apart from the main benefits of 'service location' and 'reduced waits', patients should see no change to their current pathways.

Recommendation:

HOSC is asked to provide comment on the service specification and procurement of a Kent and Medway Health Service for people with Autism and or ADHD for contract commencement by October 2020.

Risk description:

Lead Committee	Date Added	Risk Description Including Cause and Impact to CCG	Original Risk Rate	Actions Completed to Reduce Risks	Action Planned and Progress	Date By When All Actions will Be Completed	Owner / Risk Register
			0				

Supporting Paper/Appendices:

Appendix 1 service specification

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

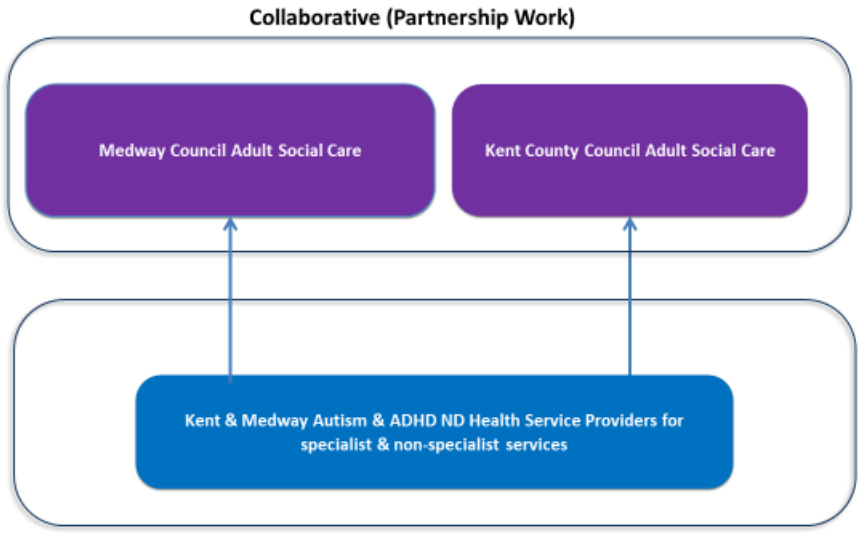
Service Specification No.	Sch2
Service	**Autism & ADHD Neurodevelopmental Health Service**
Commissioner Lead	
Provider Lead	
Period	**1st April 2020 - 30th March 2025**
Date of Review	**1st October 2020**

1. Population Needs

1.1 Autism National/local context and evidence base

This specification describes a Neurodevelopmental (ND) Health Service providing Adult Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) diagnostics, post diagnostic support, prescribing and titration services for people with ADHD and treatment for those presenting with 'Complex Autism' or behaviour that challenges (without learning disabilities). This service will work in close collaboration with both Kent & Medway Local Authorities Adult Social Care services to develop good partnership practice and wherever possible multidisciplinary teams (MDT) that are in line with NICE (National Institute for Clinical Excellence) clinical guidance on 'Autism Spectrum Disorder in Adults': Diagnosis and Management (NICE, 2012). The service will be known as 'The Kent & Medway Autism & ADHD ND Health Service' and will be a community based service across Kent & Medway. It is expected that the service will codesign the model of care with other vested stakeholders over the first 1-2 years of contract commencement.

Table.1. Kent & Medway Autism & ADHD ND Health Service



In response to section 2 of the Autism Act 2009, the Department of Health published '**Fulfilling and Rewarding Lives'**, **The Strategy for adults with autism in England (2010)**
The Government's vision is that 'All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents. It outlines five quality outcomes:
1. Adults with autism achieve better health outcomes
2. Adults with autism are included and economically active
3. Adults with autism are living in accommodation that meets their needs
4. Adults with autism are benefiting from the personalisation agenda in health and social care, and can access personal budgets
5. Adults with autism are no longer managed inappropriately in the criminal justice system

Think Autism, - Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an update (2014)
This update of the 2010 strategy sets out 15 new priority areas and reaffirms the importance of the 5 areas for action identified in the strategy aimed at improving the lives of adults with autism. The 15 priorities are set out as 'I' statements focussing on those with autism being an equal part of their communities; getting the right support at the right time during their lifetime; and people being able to develop their skills and independence and being able to work to the best of their ability:

- "I want a timely diagnosis from a trained professional. I want relevant information and support throughout the diagnostic process" is particularly relevant in that it provides a synopsis of diagnostic requirements.

Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015)
This policy document sets out the plan to shift money from hospital care to community services in order to reduce use of in-patient beds by 50% by March 2019 and fund the development of a comprehensive range of community services. By the end of 2019 the projected targets of 50% were not achieved and the programme has been further extended with a shift from focussing on planned discharge rates to an investment in community infrastructure plans which will see locally based services and resources in order to support the discharges.

NICE Quality Standards for Autism, (2014)
NICE quality standards are a concise set of prioritised statements designed to drive measureable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. https://www.nice.org.uk/guidance/qs51

Autism: Recognition, Referral, Diagnosis and Management of Adults on the Autistic Spectrum, NICE (2012)
These guidelines recommended that all local authorities should establish a specialist community based multidisciplinary team. It recommended that a range of professionals should be involved including clinical psychologists, social workers, psychiatrists, nurses, occupational therapists and speech and language therapists.

Extract from NICE guidance below. Refer to full guidance (as linked above) for exact detail. Comprehensive assessment of suspected autism should:

- Be undertaken by professionals who are trained and competent
- Be team-based and draw on a range of professions and skills
- Where possible involve a family member, partner, carer or other informant or use documentary evidence.

To aid more complex diagnosis and assessment for adults, consider using a formal assessment tool, such as:

- Adult Asperger Assessment (AAA; includes the Autism-Spectrum Quotient [AQ] and Empathy Quotient [EQ])[6]
- Autism Diagnostic Interview – Revised (ADI-R)[7]
- Autism Diagnostic Observation Schedule 2 – (ADOS-2)[8]
- Asperger Syndrome (and high-functioning autism) Diagnostic Interview (ASDI)[9]
- Ritvo Autism Asperger Diagnostic Scale – Revised (RAADS-R)[10]

The recommended approach is via MDT and Multimodal:

1) Development history i.e. ADIR, 3Di, Disco or if lack of informants (family, friends etc) then comprehensive psychological assessment detailing what developmental history we do know
2) Direct Assessment of person (ADOS2) and similar
3) Independent reports – Care Act assessment, educational assessment, other health reports.

The process should be:

i) Initial phone consultation
ii) Screening tools
iii) Assessment process
iv) Report
v) Feedback
vi) Follow up if necessary

Autism NICE Quality Standard 51 – outlines what quality provision should look like through provision of quality statements and measures. Guidance to be used in conjunction with the Autism Strategy. Full Quality Standard available at https://www.nice.org.uk/guidance/qs51

Statutory Guidance for Local Authorities and NHS Organisations to Support Implementation of the Adult Autism Strategy (2015)
The guidance focuses on the areas which section 2 of the Autism Act 20097 requires organisations to be addressed, in each case identifying what Local Authorities, Foundation Trusts and NHS bodies are already under a duty to do under legislation, what they are expected to do under other existing guidance, and what they should do under this guidance.

The Kent & Medway Complex Autism Service (KAMCAS). In 2017 Commissioners from Kent and Medway secured match funding from NHSE and Kent County Council to develop plans for a comprehensive integrated multi-disciplinary service for people with Complex Autistic Spectrum Conditions (ASC) in order to meet the obligations set out in legislation and guidance; Transforming Care required local areas to put in place a comprehensive range of services by March 2019 that would reduce reliance on specialist in-patient services for people with complex autism who formed part of the transforming care cohort. Whilst local plans for neurodevelopmental conditions, which included formal procurement of services, could not meet the March 2019 timeframe, NHSE required specialist services to be put in place within that timeframe that would see a reduction in the number of people with ASC who are in specialist in-patient units and/or a reduction in numbers admitted to such units. The interim pilot service called KAMCAS was commissioned to underpin Kent & Medway's wider Transforming Care Programme (TCP) objectives and Sustainability & Transformation Plan (STP).

1.2 ADHD – National and Local

Like autism, ADHD during adulthood is often not identified. However, ADHD is a neurodevelopmental disorder that for many people persists into adulthood. It is associated with difficulties with attention, hyperactivity and impulsivity. The costs of untreated ADHD during adulthood are high, and include poor educational outcomes, unemployment, failed interpersonal relationships, increased illicit drug use, and increased forensic behaviour. Fortunately, ADHD is amenable to effective treatment during adulthood, leading to decreased costs for the individual and society, and this is reflected in the recent NICE guidelines. It is estimated that approximately 3% of the adult population suffers from residual symptoms of ADHD during adulthood. Advantages of identification of ADHD during adulthood include decreased health and economic costs to the individual and society.

Attention deficit hyperactivity disorder: diagnosis and management NICE, 2018 (NG87). Recent updated new recommendations have been added on recognition, information and support, managing attention deficit hyperactivity disorder (ADHD; including non-pharmacological treatment), medication, follow‑up and monitoring, adherence, and review of medication and discontinuation. Local services should:

- Provide diagnostic, treatment and consultation services for people with ADHD who have complex needs, or where general psychiatric services are in doubt about the diagnosis and/or management of ADHD
- Produce local protocols for shared care arrangements with primary care providers, and ensure that clear lines of communication between primary and secondary care are maintained

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:

- meet the diagnostic criteria in DSM‑5 or ICD‑10 (hyperkinetic disorder) , and
- cause at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
- be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.
- As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health.

Transition from Children's to Adult Services
The development of a transition list of young people moving from child to adult services helps to identify their needs in terms of ADHD or ASD as they transfer to Adult Services. When young people leave children's services, their neurodevelopmental difficulties often persist (this is always the case in autism); however, they may not have access to adult services as they may not meet the threshold for secondary care services. As such, parents, children and carers often experience a sudden vacuum of support at this time of transition. It is appropriate for young people in this transition to undergo diagnostic review by the current

provider to establish their continued treatment needs (e.g. stimulants for ADHD),a needs assessment (ASD and ADHD) and timely signposting to all appropriate adult services. Adult services accepting transfers from childrens services should ensure seamless transfer across without delay or disruption to treatment (inc appropriate prescribed medication continuation).

Autism Transition
People with ASC experience very high rates of comorbidity which is often undetected and is reversible in both childhood and adulthood. Children are often in touch with CHYPS services and in receipt of appropriate treatment, but - as with ADHD - experience a 'cliff edge' in the provision of services at the point of transition to adulthood. It is therefore important to ensure at the point of entry to adult services that patients are reviewed for comorbidity by the most appropriate professional/s to enable them to access on-going treatment, or are signposted to appropriate support services. It is also important to note that many people with ASC will not require or wish for continued medical intervention, so a review at transition also provides for the giving of a 'clean bill of health' to this group and the provision of information regarding how to access support should this be necessary in the future.

ADHD Transition
ADHD is increasingly a focus of treatment during childhood. It leads to difficulties in schooling and at home, and is often associated with education and social underachievement. Treatment with stimulant drugs significantly lessens this disease burden, however, such treatment is typically unavailable after 18 years of age, which leads to spiraling health and economic costs. It is therefore important to ensure that services exist which continue to meet the needs of this group during transition and early adulthood, and that can prevent mental ill-health and social morbidity.

NHSE Long Term Plan 2019 - Autism and ADHD (p.52)
The LTP states commitment to improvements across the system in the areas of:

- 3.31. Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- 3.32. The whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing.
- 3.33. Children and young people with suspected autism wait too long before being provided with a diagnostic assessment
- 3.34. Children, young people and adults with a learning disability, autism or both, with the most complex needs, have the same rights to live fulfilling lives.
- 3.35. Increased investment in intensive, crisis and forensic community support
- 3.36. We will focus on improving the quality of inpatient care across the NHS and independent sector.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

Required Outcome Evidence that the Service User:	**Key processes to support outcome** To enable the achievement of the outcome the provider must:
1. Undergoes comprehensive assessment and treatment of their autism (ASC needs/autistic needs) and or ADHD needs. (use of a standardised referral screening tool)	Adhere to the Standard Operating Policy (SOP) which outlines procedures for: • Referral and transfer of (shared) care • Assessment using a multi – disciplinary approach with the ASC social care element including Occupational Therapists and Social Workers. • Producing a recommendation report (management plan) which includes multi-disciplinary clinical formulation and treatment plan (including diagnosis) for each patient in conjunction with the patient and other professionals involved in the patients care. • Providing the patient with information about their condition and treatment in an accessible format • Ensuring Interventions comply with all statutory, regulatory and good practice standards (CQC Essential Standards of Care and Safety, NICE guidelines) • Adhere to the timeframe (NICE guidelines / 13wks) for achievement of the above • Share information between all professionals and agencies involved in the patients care (e.g. frequency of contact). Any patient identifiable correspondence to be in accordance with GDPR / DPIA / IG guidelines, e.g. through .nhs.net to .gcsx secure email accounts. • Triage waiting list for those awaiting assessment which incorporates completion of referral form, patients questionnaire, psychometric tests (e.g. DISCO, AQ, Cambridge Behaviour Scale) to inform and assist with diagnosis (compliant with current NICE guidance) • Maintain eligibility prioritisation of access where waits occur for those most at risk
2. Receives care in an environment which is safe	Policies and procedures that comply with all legislation and guidance including but not restricted to • Complaints • Safeguarding • Clinical Governance & Prescribing Policy / Shared Care Protocol (or equivalent policies) • Equality and Diversity • Information Governance • CQC Registered • CPD / Training & Development • Mental Capacity (including presumption of capacity) • Whistleblowing • Continuing Professional Development (CPD) • Clinical supervision and appraisal.
3. Have their physical health needs properly assessed as part of the autism (ASC needs/autistic needs) assessment and treatment process *and* Has been referred to the relevant general medical service(s) for further investigation	Protocols in place that include: • Baseline physical health evaluation by primary care services (where necessary) / relevant medical history • Relevant monitoring to be undertaken in relation to any specific treatments prescribed • Action to be taken where physical health needs have been identified that require further investigation and management, e.g. detail included within recommendation report (management plan) to highlight to GP/Consultant alongside recommendation to patient.

and management as indicated.	
4. Providers evidence of policies for detailed assessment of risks to themselves and others.	• Ensure staff are trained in Risk Assessment and Management • Have robust links to other specialist Mental Health community and inpatient services for the purpose of sharing information and for obtaining opinion/ advice on specific issues. • Policy of any lone working risks which may be highlighted during referral and ensuring appropriate steps are taken to avoid risk to individuals, colleagues, patient and members of the public.
5. Experiences continuity of care when moving between services.	• Secure IT systems for the sharing of information within the service, fulfilling (or as a minimum having a plan in place) to meet IG / GDPR / DPIA requirements. • Clear transfer procedures outlined within the Operational policy that details relapse indicators, crisis and contingency plans • Clear procedures for seeking and recording the Service User's consent for the sharing of information • Ensure that information about services is available to the client in an accessible format. • Transparency in any communications to patients/representative, including information in relation to timescales, to help manage their expectations. • pass original referral to alternate providers when required, when responsible commissioners deem it appropriate to secure additional capacity from additional registered and accredited providers. Adhering to, and helping to develop, a robust process in these circumstances. • Be aware of all pathways / services incl criminal justice system providers, forensic services etc.
6. The patient's relative and/or carer, subject to service user's consent, (as appropriate) are consulted about the care they receive.	• Gain explicit patient/representative consent for the purpose of assessment, diagnosis and onward referral (when appropriate). Gather and retain information which is deemed relevant, appropriate and not excessive and clearly identifies the parties involved and their role. • Ensure that the service user's known preferences for sharing information are clearly documented in their records and that these are respected where this is compatible with assessed risks to self or others. • Ensure that when the service user does not have the capacity to give consent, the appropriate steps to arrive at a 'Best Interest' decision have been taken and recorded and agreed by the MDT working with the patient
7. Is offered access to advocacy services including, where appropriate, IMCAs and IMHAs.	• All practicable steps are to be taken to include patient representative/family/carer/advocate is included and present during assessment and able to contribute where appropriate. • Ensure that information on advocacy, IMCA and IMHA is displayed and is available in a variety of appropriate formats • Implement appropriate systems for recording whether a client is 'befriended' under the terms of the Mental Capacity Act • Provide awareness training for all staff in relation to the

	relevant legislation.
8. Is treated with dignity and respect.	Ensure all staff have a range of training at the required levels that is in line with the 'Core capabilities frameworks for supporting autistic people and people with a learning disability', Skills for Health, 2019. Including clear adherence to policy on: • Equality and Diversity (reasonable adjustments) • Information Governance. Take all steps to accommodate any patient and/or representative requirements. Have a process in place allowing for patient and/or representatives feedback to be collected, collated and reported upon (Friends & Family Test)
9. Is safely prescribed the medication to address their ADHD needs	Prescribing pathways to be agreed with the provider and commissioners: • The provider & commissioners will ensure the implementation of a Shared Care Protocol for / across Kent & Medway • The protocol is to be developed with Medicines Management Leads / commissioner support and embedded across Kent & Medway for the ongoing prescribing of ADHD medication post titration and stabilisation from the core service. • Providers will liaise, providing accessible consultancy / training to primary care GPs around any issues with ongoing prescribing for ADHD medication. Ongoing support from core service to primary care providers is essential when transferring care and must remain open between the primary care provider & the core service. Shared care should be obtained with explicit consent. • Where GPs feel it appropriate to do so, core service providers will accept transfers back from primary care to core service for prescribing stabilisation in line with the new shared care protocol / LES arrangements
10. Training & Consultancy	• Core service providers will work within current NICE guideline parameters around prescribing of medication for ADHD. Training and consultancy will be provided to all primary care (GP) providers who take part in the new shared care arrangements (LES) • A comprehensive package of training / documentation should be developed by core service providers to primary care providers along with clear systems & processes for accessible consultancy from core providers. • Training should be compliant and meet the published national competency framework (Skills for Health, 2019).

3. Scope

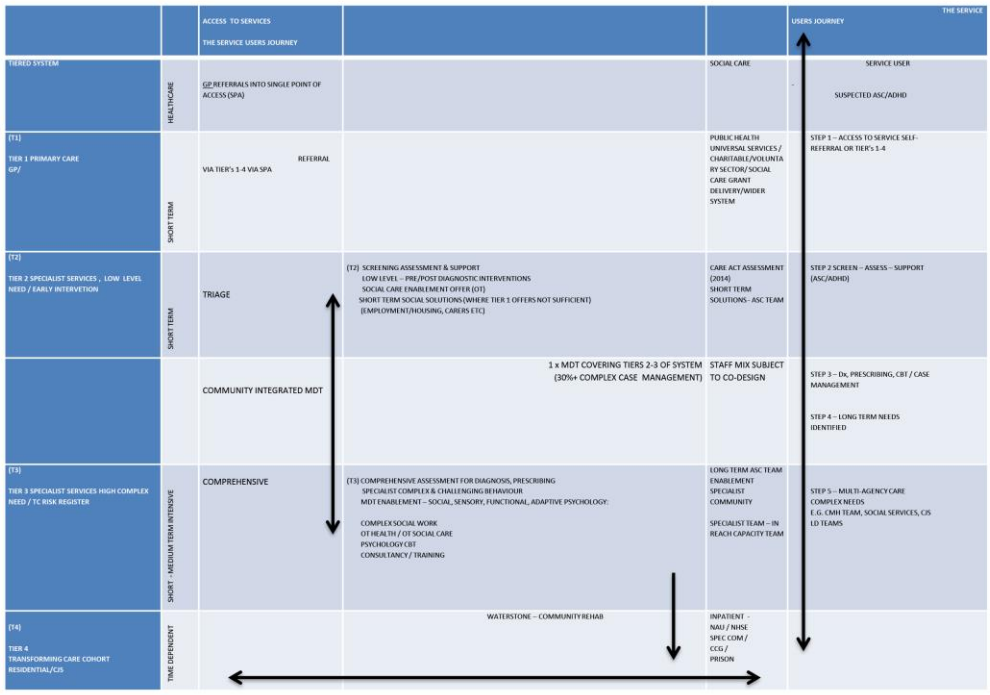
3.1 The Kent & Medway ND Autism & ADHD Service
Will provide **a service** for screening, assessing and diagnosing referrals, providing post diagnostic support, specialist care for those presenting with complex autism and prescribing and titration for ADHD; forming MDT functionality between health and social services across Kent & Medway, working in partnership with social care who provide community care assessments and/or information and advice, support care packages and other

commissioned care options, for those eligible.

3.2 Kent Integrated MDT Pathway. The overall aim of the service within a new pathway is to provide a**n** integration of health & social care provision which enables early access / intervention and treatment / support for those individuals in need, reducing demands on the wider system and promoting independence, thus reducing longer-term dependencies. The draft pathway below is subject to further codesigned with all system providers to ensure a robust model of care is developed over the first 1-2 yrs of the new health service being implemented.

Table. 2. Kent MDT Integrated Adult Pathway

KENT MDT INTEGRATED ADULT PATHWAY



The draft pathway service model comprises of bespoke clinical MDTs for ASC diagnostics and post diagnostics, Complex ASC, ADHD diagnostics and prescribing and should be based within the community to receive referrals from either primary, secondary or tertiary health care providers (GPs, CMHTs, ND Consultants, social care & other professionals) for assessment and or diagnosis of Autism and or ADHD neurodevelopmental conditions in the absence of a learning disability and make recommendations / partnership working or signpost to other providers: The service should access existing resources in mental health services for identified needs, make suggestions about how these needs could be met if existing services are not able to provide the service needed, and make recommendations about processes and staffing requirements in line with the NICE guidance on Autism Spectrum Conditions and ADHD.

3.3 Aims of Diagnostic & Post Diagnostic Support Services

- Achieve National Targets for waiting times
- Access to diagnostic services for those with suspected ASC and or ADHD
- Access to treatment for those with ADHD and ASC, including post diagnostic support
- Access to medication for those with ADHD
- Provision of a local ASC and ADHD assessment diagnosis, prescribing (ADHD) and

titration service with post diagnostic sessions for those in need, including ASC CBT, OT & SaLT.
- Ensure effective multi-disciplinary working with Social Care services.
- Improved understanding of the needs of people with ASC and or ADHD, by those supporting them to live in the community through link working, information sharing and recommendations from the dedicated assessment and diagnosis service.
- Improved care co-ordination and information between primary care, secondary and voluntary sector providers
- Appropriate signposting to voluntary and third sector organisations.
- Client shows clear understanding of diagnosis provided.

3.4 Objectives of Diagnostic & Post Diagnostic Support Services

- Service provision which accounts for individuals preferences, ie, communications, disabilities, cognitive function.
- Diagnosis provided with clear reasoning behind decision reached.
- Community (accessible) based assessment and diagnosis
- Incorporation of family/representative views and individual's developmental history and context.
- Timely response in accordance with NICE Quality Statement 51 and guidance.
- Service users and/or representatives feel informed of concise and consistent process, what it involves, and on what approximate timescale through formal correspondence.
- Complaints process established, conveyed to client (and/or representative) and handled in accordance with NHS complaints procedure.
- Seamless transition from referral, diagnosis, signposting and ongoing support.
- Data collected and conveyed in accordance with patient consent.
- As part of an integrated service, ensuring effective working practices with the social care element of the service.
- Fulfil commissioner reporting requirements as detailed in section 6 of this service specification (Activity).

3.5 Aims of Complex Autism Services

Support achieving the overall aims of Transforming Care in Kent and Medway which are:

- To work in partnership with individuals with ASC and their families and with wider stakeholders to define what good person centred care and support looks like and to develop systems and processes that will deliver it.
- To change how services are provided in order to enable people with ASC to experience truly integrated and well-coordinated health and social care that delivers improved outcomes throughout their lives.
- To ensure that integrated health and social care interventions that are provided enable people to live safe and fulfilling lives in their local community, close to the people who are important to them.
- To focus on early intervention and prevention to ensure that people's needs do not increase over time and intensive support to individuals with more complex needs or to those who are in crisis.
- To support the continuing development of a skilled and dedicated workforce through the sharing of knowledge and best practice.

3.6 Objectives of Complex Autism Service

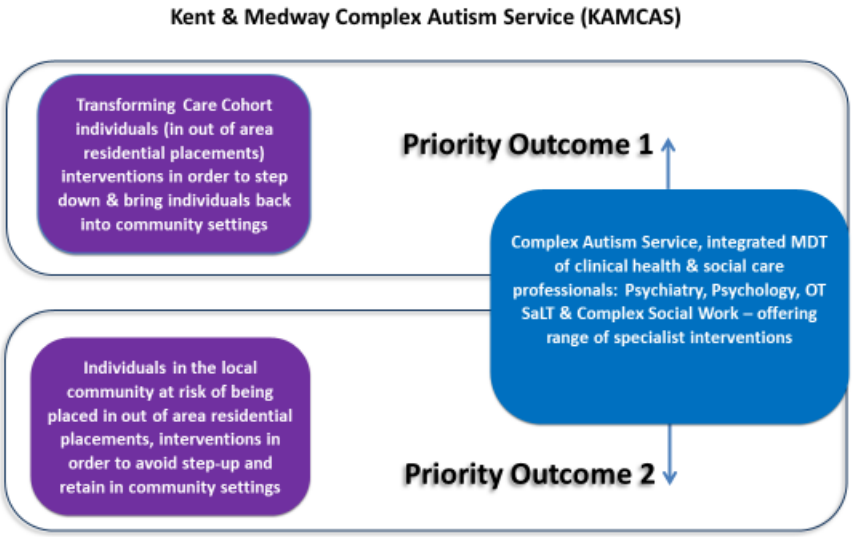
- To reduce the number of people from Kent and Medway who are in-patients in specialist ASC hospitals by offering a local community based model of care as an alternative to in-patient care.
- To reduce admission rates to specialist ASC hospitals by offering a range of clinical interventions in conjunction with existing health and social care services as part of a comprehensive package of support and treatment for people with the most complex needs
- To support complex case management by providing clinical intervention for those considered as 'highly complex with behaviour that challenges' and at risk individuals

open to adult social care within a multidisciplinary team (MDT)
- To support the development of an effective and efficient care pathway and model of integrated care and treatment for all people with ASC
- To contribute data, information and knowledge to support the development of comprehensive commissioning plans for people with ASC.

3.7 Outcomes of Complex Autism Service

The essential outcomes required for the Kent & Medway Transforming Care Programme are to reduce the current numbers of in-patients in out of area placements (known as the transforming care cohort) by ensuring there is sufficient community provisions available locally to meet their needs and to reduce the need to use / place individuals in out of area unit (high-cost) placement settings.

The service will be expected to provide the clinical element of this provision by:
Outcome 1.
To offer an alternative specialist clinical provision for those individuals (who are clinically assessed as ready to step-down) currently in – inpatient settings (transforming care cohort) due to their presenting complex ASC
Outcome 2.
To offer an alternative specialist (community-based) clinical provision for those individuals at risk of out of area – inpatient stays (who are clinically assessed as requiring in-patient treatment) due to their presenting complex ASC.
Table 3. KAMCAS



The provider will do this by:
- Offering sustainable (ongoing where needed), accessible and appropriate clinical support / specialist ASC treatments within a supported residential community setting
- Clinical interventions that encompasses best practice within NICE guidance and known frameworks for use with complex ASC
- Appropriate prescribing within NICE (2014) Guidance
- Function within a multidisciplinary team (MDT*) to ensure no silo working takes place
- Offer appropriate clinical assessments of individual needs
- Develop with a wider MDT a comprehensive plan of care (care plan) suited to the individuals needs

- Be the named care coordinator, or part of a care coordinated agency plan for the individual
- Review care plans for individuals on agreed basis (minimum of 6-12 weeks)
- Care Plan closure and or transfers of care

Benefits to service users:

- Promote holistic wellbeing and a sustainable benefit to the individual that supports the current placement setting (eg within supported accommodation or residential rehabilitation)
- Promotes a person-cantered approach to caring for the individual
- Promotes a stability of individual's ASC impacting on lifestyle for future progress onto / into a lower-level need for supported accommodation for the future (further step-down provisions)
- Reduction in dependence for individuals in requiring higher level complex need interventions on an on-going basis

3.8 Service description/care pathway

The service will provide a timely, integrated, person-centered diagnostic and assessment for ASC and or ADHD, post diagnostic ASC support in the form of OT interventions and or adapted CBT, ADHD prescribing and titration/medication review and provide consultancy to primary care ongoing prescriber where required within a shared care protocol.
Where eligible, provide Complex ASC provision for adults who present with complex needs and or behavior that challenges, offering step down provision for transforming care cohort or step up avoidance.

3.9 Population covered

Adults aged 18 and over and transitional YP's from 17.5 years as part of a transition arrangement who are registered with a GP in Kent or Medway CCG's and who do not have a learning disability.

Individuals with a confirmed learning disability receive services from Integrated Teams for People with Learning Disability.

3.10 Acceptance and Exclusion Criteria and Thresholds

3.10.1 Diagnostic & Post Diagnostic Services Acceptance criteria:

- Adults aged 18 years and over
- Adults aged 17.5 years (transitional CYPs)
- Adults without a confirmed learning disability
- Adults for whom assessment for concurrent mental health problems has been undertaken by the individual's local community mental health team, where appropriate.
- Adults whose local GP and or mental health team are aware of the onward referral.
- Where there is dispute with Learning Disability teams over eligibility, it is expected that both the ND Service and LD Teams will discuss the referral and decide which service is best suited to meet the needs of the individual within 4 weeks of receipt of referral.

3.10.2 Complex Autism Services Acceptance criteria:

- Have a diagnosed Autistic Spectrum Condition without a diagnosed Learning Disability (LD); (borderline LD cases will be considered on a case by case basis)
- Are currently an in-patient in local mental health units or in specialist out of area ASC beds
- Have been referred or are at imminent risk of admission to in-patient services for assessment and interventions for ASC and co-morbid conditions
- Will benefit from community based assessment and interventions as an alternative to in-patient care and treatment.
- Are open to adult social care service and present with highly complex and or

behaviour that challenges

3.10.3 Complex Autism Services Exclusions:

- Have a diagnosis of Learning Disability
- Are under 18 years of age (exceptions may be agreed with Commissioners if the individual is approaching 18 years old in a Tier 4 Children and Young Person bed and will transition to an adult ASC bed at age 18)
- Clearly meet the criteria for detention under the Mental Health Act regardless of the availability of community based assessment and interventions.

1. Referral Processes and Response Times

4.1 Referral routes into the diagnostic and post diagnostic services will receive referrals from GPs, social services, secondary care mental health services.

4.2 Referral routes to complex autism services will receive referrals from the core ND health service, Kent ASC Social Care Team, Medway Social Care Teams, CMHTs, Out of Area Treatment Panels (OATs) or via CTR's Care and Treatment Review Panels and NHSE (Spec Comm). GP referrals or self-referrals will not be accepted because individuals with complex needs will be referred initially to generic health and social care services.

4.3 Where an individual is identified as having moderate to severe mental health co-morbid requirements then referral to the Community Mental Health Teams may be required. Where the individual exhibits behaviour which places him/her at risk of offending then onward referral to the local forensic service for assessment may be required.
Where presenting autistic behavior is complex and or challenging and the individual is at risk of inpatient and or out of area treatment then the Complex Autism Service will assess and or treat individuals without an associated learning disability.

4.4 Recommendation (management) Report: As part of an integrated diagnostic and assessment pathway, following the completion of a Recommendation Report, copies will be provided to the referred and the referrer, allowing the individual to be referred and or signposted to the most appropriate service to meet their needs. Where a positive diagnosis is made this may necessitate a need for structured support and or assessment for eligibility of social care needs, if appropriate the individuals GP will be informed and the relevant social care team will provide a support service; community care assessments, and/or information and advice.Where concurrent mild to moderate mental health problems are identified then the individual will be referred into Primary Care Mental Health Services, e.g. IAPT Service.

4.5 Kent and Medway Joint Working Protocol for Adults with Co-existing Mental Health and Neurodevelopmental Conditions defines collaboration and joint working between MH and ND services, outlining key roles and responsibilities to ensure service users, where eligible should receive treatment appropriate to their needs from all commissioned providers.

4.6 All referrals will be received by a Single Point of Access (SPA). Referrals must be copied to the individual's GP and any relevant professionals e.g. social worker advising of the referral.

4.7 A response to the initial referrer must be confirmed within 2 weeks and an initial assessment date offered. The initial assessment will aim to be undertaken within 3 months of the referral letter (in accordance with NICE Quality Standard (QS51), dependent on demand. There will be a maximum of 4 weeks from completion of assessment to the provision of a written report with recommendations which incorporates:

- Patient details
- Report author, date and those present during assessment
- Documents seen before and during assessment
- Diagnostic tools used, purpose and respective contributors

- Referee history (e.g. developmental, family, educational)
- Referee presentation (e.g. appearance, communication, empathy)
- Diagnosis (e.g. meeting criteria, traits contributing to diagnosis, severity, further information required)
- Recommendations (e.g. Psychological and Pharmacological Interventions, further assessments, signposting).
- Treatment planning and expected timeframes.
- Sign off and assessor declaration.

In the event the patient does not attend a scheduled assessment, the provider will escalate a response through a standard procedure of 2 phone calls and 2 letters to the patient before removing the person from the waiting list.

4.8 Waiting List & Priority Criteria

Where service demand outstrips capacity waiting lists may be implemented. In such cases waits for access to diagnostic services should be kept to a minimum, targeted waiting times are 12 weeks, waits for treatment should not exceed 6 monthsPriority criteria should be implemented across all waiting lists within CCG areas. The provider should present and discuss a list of priority criteria applied with the commissioner to ensure efficacy of services. Criteria of selection should include those who present with:

- Social Services CP involvement and or safeguarding risks
- Complex comorbid MH
- Criminal Justice System (CJS) involvement
- Significant and or debilitating physical LTCs

4.9 Interdependence with other services/providers

Partnership / Integrated MDT working with KCC ASC Social Care and Medway Social Care for people with ASC will be important. Assessing, diagnosing and providing recommendations for individuals is important but being able to subsequently signpost people onto a range of enablement orientated and commissioned support services (such as supported employment) in social care settings and from the voluntary and third sector will be imperative in order to assist people in achieving their optimum level of functioning and their life aims and ambitions. Close working with local voluntary sector and bespoke commissioned services will be imperative for good Service User outcomes.

4.10 Training Sessions

Will be provided regularly for GPs within the shared care /LES arrangements to assist them in safely providing on-going prescribed ADHD medication, after stabilisation. Where there are GP concerns, consultancy will be available and if required patients may be transferred back to the specialist core service.

5. Applicable Service Standards

5.1 Applicable National Standards (e.g. NICE)

The staff in this service must adhere to their Professional Codes of Conduct and ensure that they are up to date with current methodologies, approaches and validated tools used to assess and diagnose people with ASC in the absence of a learning disability. Individuals must be able to demonstrate core competencies in their chosen professional field in the assessment and diagnosis of Autism and or ADHD.

5.2 NICE Quality Standard for Autism (QS51)

1) People with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral.
2) People having a diagnostic assessment for autism are also assessed for coexisting physical health conditions and mental health problems.
3) People with autism have a personalised plan that is developed and implemented in

partnership between them and their family and carers (if appropriate) and the autism team.

4) People with autism are offered a named key worker to coordinate the care and support detailed in their personalised plan.
5) People with autism have a documented discussion with a member of the autism team about opportunities to take part in age-appropriate psychosocial interventions to help address the core features of autism.
6) People with autism are not prescribed medication to address the core features of autism.
7) People with autism who develop behaviour that challenges services are assessed for possible triggers, including physical health conditions, mental health problems and environment factors.

People with autism and behaviour that challenges services are not offered antipsychotic medication for the behaviour unless it is being considered because of psychosocial or other interventions are insufficient or cannot be delivered because of the severity of the behaviour.

5.2.1 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The Royal College for General Practitioners has set autism as a clinical priority for 2014-17 to ensure that doctors and clinicians have appropriate training as detailed in the Autism Strategy for England.

The Adult Autism Strategy for England 2010 key recommendations and duties are:-

1. Improved training of professionals in autism
2. The recommendation to develop autism teams
3. Actions for better planning and commissioning of services, including people with autism their parents/carers
4. Actions for improving access to diagnosis and post diagnostic support.
5. Leadership structures at national, regional and local levels for delivery.

Proposals for reviewing the strategy to make sure that it is still working

5.2.2 Applicable local standards

- Maximum 3 month wait from referral to assessment to commence dependent on demand (in accordance with NICE Quality Statement 51).
- Maximum of 4 month wait from referral to completion of assessment dependent on demand
- Maximum of 4 weeks from completion of assessment to provision of written report with recommendations
- Assessments are to follow agreed protocol detailed in the Standard Operating Policy and Process documentation (providers own policies & procedures).
- The quality and consistency of assessments and recommendation reports may be subject to audit to ensure quality standards are evidenced and maintained.
- Responsive to commissioner requests in relation to quality assurance.
- Key Performance Indicators (KPIs), as detailed in section 6.3, are to be reported to commissioners on a quarterly basis. These KPI submissions will be a standing agenda item on the regular contract performance meetings.
- Patient satisfaction feedback to be used to inform service improvements and developments in partnership with commissioners. As set out in the NHS Friends & Family Test Guidance documentation.

5.2.3 Applicable Standards for Complex Autism Services

The Service will function within an evidenced-based core Clinical Model of Care, using a framework of Positive Behaviour Support Approach and Values, that is Person-Centred and supports individuals in the therapeutic delivery of:

- TEACCH (teach, expand, appreciate, collaborate, cooperate & holistic)
- SPELL (structure, positive, empathy, low arousal & links)

- PBS (Positive Behaviour Support)Values (theories and evidence base)
- Sensory Sensitivities
- Work with specialist Mental Health services for Comorbid Mental Health conditions
- Identifies and mitigates Risks & Risk Management planning
- Where appropriate, support service user involvement / development and carer involvement within care plans

The service will deliver (and or support) the functions and following processes:

- Staff training programmes (CPD) specific to the needs of the service
- Offer advice and consultancy to partner agencies who are joint working with individuals within the service
- Work within a multidisciplinary team of wider health and social care professionals where lead care coordination will be based on severity of presenting needs
- Use approved referral care pathways across Kent & Medway
- All NICE Quality Standard for Autism (QS51).

6. Applicable quality requirements and CQUIN goals

TBD

7. Location of Provider Premises

The provider/s will source suitable accommodation across Kent & Medway in order to deliver accessible services.

Hub & outreach spoke models of coverage should be defined and agreed with commissioners and subject to codesign changes

8. Individual Service User Placement

7.1 **Complex Autism Services**

The Kent and Medway Transforming Care Partnership (TCP) had a total of 78 adults in specialist CCG or NHSE commissioned in-patient beds on 31 January 2018. More than a quarter of these (N=21) had a primary diagnosis of ASC.

- CCG commissioned in-patients = 7 (Inc. 1 from Medway)
- NHSE commissioned in-patients = 14 (Inc. 3 from Medway)

Whilst it is a key objective of the Kent & Medway TCP to reduce the above numbers in treatment, this transformation is expected to take place only where individuals are ready to be returned to community settings. Clinical expertise and individual / carer and family wishes are all incorporated into any decisions taken.

7.1.2 The complex autism service & specialist rehabilitation providers:

Waterstones (Stonebridge House)

- Clinical interventions of the MDT on an ‘in-reach’ basis to individuals from Kent and Medway who are placed with the Waterstone (Stonebridge House) complex autism bespoke Residential Assessment/Rehabilitation Accommodation.
- Where the residence of Waterstone in Maidstone is required for treatment / placement stays - the clinical lead will take any final decisions on the safeguarding practice for the placement of individuals within the residential treatment unit of Waterstone. This is to ensure that any individuals are not placed ‘at risk’ within this

residence and or placement would lead to the detriment of current and or future placement needs.

- Funding decisions on placements will be followed in line with set protocols, shared and or split cost arrangements between heath & social care will be followed and authorisation will come from CCG commissioners (for health) or social care placements (via social care authorised manager)

The complex service MDT combined with bespoke placements are expected to provide a comprehensive local alternative to ongoing hospital care or hospital admission for people with ASC.

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Item 7: System Commissioner Update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: System Commissioner Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS England/ NHS Improvement.

It provides background information which may prove useful to Members.

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1) Introduction

a) HOSC has received regular updates since January 2018 on the merger of the eight Kent and Medway CCGs into a single entity. The last update to the Committee was received on 19 September 2019, prior to the STP submitting their application to NHS England.

b) The Kent and Medway STP announced on 21 October 2019 that NHS England had given conditional approval for the merger and the formation of a single CCG.

c) The STP have provided the attached report and invite the Committee to comment on its contents.

2. Recommendation

RECOMMENDED that the Committee note and provide comment on the report.

Glossary of abbreviations

CCG	Clinical Commissioning Group
ICP	Integrated Care Partnership
ICS	Integrated Care System
PCN	Primary Care Network
STP	Sustainability and Transformation Partnership

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (27/04/2018)'*,https://democracy.kent.gov.uk/mgAi.aspx?ID=47975

Kent County Council (2018) *Health Overview and Scrutiny Committee (23/11/2018)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7923&Ver=4

Kent County Council (2019) *Health Overview and Scrutiny Committee (06/06/2019)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8281&Ver=4

Kent County Council (2019) *Health Overview and Scrutiny Committee (19/09/2019)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8283&Ver=4

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HEALTH
OVERVIEW AND SCRUTINY COMMITTEE
29 JANUARY 2020

DEVELOPMENT OF SINGLE KENT AND MEDWAY CLINICAL COMMISSIONING GROUP

Report from:	Glenn Douglas, Accountable Officer Kent and Medway CCGs
	Dr Bob Bowes, Chair of Kent and Medway System Commissioner Steering Group
	Simon Perks, Director of System Transformation
Author:	Mike Gilbert, Transitional Director of Corporate Affairs, Kent and Medway CCGs

Summary

At its meeting in June 2019, the HOSC received briefings on the proposed development of an integrated care system across Kent and Medway and was informed about the proposed establishment of:

- A single CCG operating at a Kent and Medway level from April 2020 (formed through the merger of the existing eight CCGs)
- Integrated Care Partnerships, operating across local geographies of circa 250,000 to 750,000 resident population
- GP-led Primary Care Networks (PCNs), serving a registered population of circa 30,000 to 50,000, acting as the provider and delivery vehicle for local care.

This briefing provides an update summary of the work to date in establishing these arrangements, and in particular the development of the single CCG.

The Committee is asked to NOTE and COMMENT on the update.

1. Recap on Policy Framework and Background

1.1 The NHS Long Term Plan sets an expectation that integrated care systems will be established across the country by April 2021, with the driver and intended benefits being the refocus of commissioning and care provision on population health needs and addressing inequalities (unacceptable differences in health and life expectancy for some communities compared to others).

1.2 The national plan is clear that streamlined commissioning arrangements will be required to enable a consistent set of decisions and outcomes at a system level. CCGs will become leaner, more population centric organisations that support care providers (through integrated care partnerships) to partner with

other local organisations to deliver improved health and well-being, local service redesign and implement the requirements of the Long Term Plan.

1.3 In Kent and Medway, work along these lines has been underway for some time. However, whilst there have been many achievements over the past six years, there remain significant challenges that our existing organisations and arrangements have not been able to address and which have impacted negatively on care and outcomes. As a result system leaders in Kent and Medway developed a plan for an integrated care system to address these challenges through:

- Consistent outcomes being set at a 'system' level to reduce health inequalities and inequity, whilst enabling local partnerships greater freedom to decide how they develop and offer care to meet these outcomes
- Accelerated decision making and a more collective and responsive approach to addressing major challenges across Kent and Medway and reducing inequity of care
- Less competition and greater collaboration between partners
- Primary care services working as equals alongside the larger local providers.

1.4 Central to our plans is the establishment of a single CCG across Kent and Medway. This will provide a real opportunity to achieve commissioning at scale led by experienced local clinicians, backed up by service design and delivery at a more local level.

1.5 KCC continues to be actively involved in this work at a number of levels, including membership of:

- Kent and Medway Sustainability and Transformation Partnership (STP) Programme Board
- STP Non-Executive Directors Oversight Group
- System Transformation Executive Board
- Kent and Medway Clinical and Professional Board
- Joint Kent and Medway Health and Well-Being Board

2 Update on the establishment of a Kent and Medway CCG

2.1 During 2019, the eight CCGs further developed their case for change and application to merge. A huge amount of work was undertaken resulting in:

- The development of workforce and organisational development strategies and plans
- Benefits realisation mapping for the new CCG

- Refinement of the Kent and Medway 'One Team' approach, previously shared with partners

- A comprehensive engagement and communication strategy following numerous stakeholder meetings and briefings across Kent and Medway and engagement with the public: this resulted in the publication of the report 'Engaging with local people and our partners - you said, we did'

- Financial mapping and development of a medium term financial plan, linked to the K&M response to the national Long Term Plan

- Preparing the case for change document based on the above work

- Development of a single governance structure for the new organisation, taking in to account the need to reflect both a local and a system wide approach

- Detailed mapping, programme planning and risk assessment at individual function level, to ensure all aspects of current CCG work was fully understood and played in to the merger plans.

2.2 The merger application, including the above suite of documents were presented to each of the current CCG Governing Bodies and GP membership meetings during September and approved (with over 75% of the GP membership that voted in each CCG area approving the proposals). A copy of the CCG application and case for change is attached at **Appendix 1**.

2.3 Following presentation of the case for change to the NHS England mergers panel, conditional approval was given in October for the establishment of a Kent and Medway CCG from 1 April 2020. This gave the 'green light' for formal merger preparations to commence and these are now well underway.

2.4 The NHS England conditions are:

- Approval of the new CCG's constitution: the new constitution must comply with legislation, guidance and be assessed as being otherwise appropriate. *(This is a generic condition for all mergers)*

- Appointment to all statutory Governing Body roles. This relates to the CCG Accountable Officer, Chief Finance Officer, CCG Chair and the four independent and lay members. *(This is a generic condition for all mergers)*

- In year delivery of the CCG's and system wide financial recover plans and acceptable plans for future years

- NHSE review and lifting of legal directions for the four east Kent CCGs linked to financial recovery planning

2.5 Delivery plans to meet the conditions and establish the CCG from April 2020 are progressing well:

- With the planned retirement of Glenn Douglas as Accountable Officer, interviews for a permanent Accountable Officer took place on 6

December. The appointment of an Accountable Officer requires CCG Governing Body and NHS England approval. The outcome of the appointment process is therefore expected to be publicly announced in the next couple of weeks.

- Eight GP Governing Body members and eight deputies have been elected to sit on the Kent and Medway CCG Governing Body. This includes the election of:
    - Dr Navin Kumta, currently Clinical Chair for Ashford CCG
    - Dr Simon Dunn, currently Clinical Chair for Canterbury and Coastal CCG.
    - Dr Sarah MacDermott, currently Clinical Chair for Dartford, Gravesham and Swanley CCG
    - Dr Peter Green, currently Clinical Chair for Medway CCG
    - Dr Jonathan Bryant, currently Clinical Chair for South Kent Coast CCG
    - Dr Joyanta Sahu, currently a Governing Body member for Swale CCG.
    - Dr Ashwani Peshen, currently Deputy Clinical Chair for Thanet CCG
    - Dr Bob Bowes, currently CCG Clinical Chair for West Kent CCG.
- Dr Navin Kumta has been elected from the eight GP Governing Body members as The Kent and Medway CCG Clinical Chair.
- Appointments to the other Governing Body member roles including the independent lay member for patient and public engagement will be made during January.
- Appointment to a permanent Chief Finance Officer and Chief Nurse for the CCG will commence during January, following consultation with existing CCG incumbents
- A transitional CCG senior management team has been in place for a number of months. Following appointment of the Accountable Officer a permanent senior management team will be appointed from spring 2020
- Kent and Medway is currently on track to meet the financial control totals agreed with NHS England at the start of the year, albeit a number of risks to delivery remain. It is hoped that the financial directions placed on the east Kent CCGs in 2019 will be lifted prior to April 2020
- The new CCG Constitution and supporting corporate documents have been submitted to NHSE for approval

2.6 Nine CCG work streams have been established, led by existing CCG directors to oversee the merger. These include: commissioning, HR and OD, communications and engagement, digital, finance, and corporate services.

2.7 Importantly, work has also commenced on the development of the population health function which will be a core component of the new organisation alongside the commissioning function. This will involve working with partners and other agencies to ensure services are effectively commissioned and provided based on population health and well-being. The focus will be on developing outcomes and care standards that address inequity and inequality and raise care outcomes and health and well-being standards. This is a critical ambition that will require concerted effort and focus across the integrated care system over a number of years: as one of the system leaders, the CCG will need to play a pivotal role in this regard.

Transition (post April 2020)

2.8 The next couple of years will continue to be transitional, as the integrated care system across Kent and Medway takes shape. In particular, GP led primary care networks will be further developed and formal establishment of integrated care partnerships is expected from 2021. During this time the CCG will continue to host the majority of its existing functions until such time as the ICPs are ready to hold contracts and take on some of the CCG's current responsibilities.

2.9 In addition, Kent and Medway STP programmes will be hosted by the new CCG, with STP staff transferring alongside staff from the eight CCG's to the new organisation from April: CCG and STP staff will transfer to the Kent and Medway CCG under their current terms and conditions.

2.10 The STP Programme Board will continue until the integrated care system is formally established later in the year, when a new ICS Partnership Board will be established.

2.11 No staff will transfer on to the new integrated care partnerships until the CCG is fully assured that the ICPs are ready and able to take on new responsibilities, and the necessary staff consultations have taken place. Whilst this is not expected until the end of 2020 at the earliest, some CCG staff will continue to lead on ICP portfolios over the preparatory year. In the meantime CCG commissioning and patient facing teams such as medicines optimisation and primary care teams will start to work in a more integrated way with the emerging ICP providers, whilst retaining their employment with the CCG. Also, and as with provider employed staff, there will be opportunities for CCG staff to be seconded into ICP roles to ensure they are not disadvantaged.

2.12 Commissioning support and back-office teams across Kent and Medway CCGs will also work in a more consistent and streamlined way, with single operating procedures and systems being put in place. This work is already underway. As an example, within the corporate services function, which includes information governance, audit, risk, CCG estate, complaints, and committee services; a single structure has already been developed across Kent and Medway by the teams and is being consulted on with an expectation that this will be implemented in the New Year. This will reduce duplication, ensure consistency, enable staff to upskill in key areas and 'level up' the

service offer to other CCG functions. It will also improve resilience across the wider system.

Development of the Integrated Care Partnerships:

2.13 As previous noted, four ICPs have been confirmed across Kent and Medway: Medway and Swale, East Kent, West Kent, and Dartford, Gravesham and Swanley. Medway and Swale ICP will cover the whole of the existing Medway and Swale CCG areas.

2.14 Nationally, ICPs are provider led collaboratives, including primary care and voluntary sector organisations, operating across a population of up to 750,000 residents. In Kent and Medway, the ICPs also include equal stakeholder involvement, providers and health and local authority commissioning colleagues. The development of ICPs is a shift from the competitive internal market and once fully established it is planned that ICPs will hold a single contract with the CCG, enabling local system partners to decide collectively how services are developed and provided.

2.15 Whilst the three ICPs in the Kent area are still in their early stages of development, good progress is being made. KCC colleagues are actively involved in the three ICP leadership board and working groups.

2.16 The current ICP operating models, with associated work streams, are being developed to deliver the agreed systems outcomes for success and shared vision as set out in 2018.

2.17 At the core of the operating model is the principle of co-production and transparency.

2.18 All system commissioning and provider partners have leadership roles in respect of chairing working groups and there is open membership of each group to all partners. This deliberate model was introduced to give parity of ownership and control; therefore allowing all ICP organisations to be collectively responsible for the success of the workstreams, board and ICPs future as a whole.

2.19 It is well understood that in the four Kent and Medway ICPs not one organisation alone is able to mobilise and manage the ICP in its totality and therefore all members are collectively reliant on all system partners to succeed.

2.20 The 2020 shadow operating model has been designed to transition the system to ICP full mobilisation with the least amount of disruption and will ensure that the previous system structures will be redesigned and fit for purpose when the ICP mobilises its contract.

3 Risk management

3.1 There continues to be a full risk management framework in place for the system transformation programme and in particular the CCG merger programme. Risks are proactively managed through internal governance controls and reported through the governance framework to CCG Governing Bodies and the STP Programme Board as required.

3.2 The largest risk being managed at present is ensuring sufficient resourcing of the merger and transformation programmes alongside delivering business as usual, particularly during the intense winter months.

4 Engagement

4.1 As part of our merger application we were required to evidence how we effectively engaged and discussed our proposals with a range of stakeholders, including the public and Healthwatch. A large number of stakeholder and public briefings were held during the summer and autumn of 2019, the outcomes form which played in to our merger application and the 'you said, we did' document at **Appendix 2**.

4.2 In addition, a number of public and stakeholder briefings were held linked to the development of our plans in response to the NHS Long Term Plan: during the summer and autumn we ran a range of engagement activities to test our thinking and help shape our local priorities.

4.3 We continue to work with GP Members, the Patient and Public Advisory Group, Healthwatch and local stakeholder groups as we further develop and roll out our plans.

4.4 We also continue to engage with and seek the active contribution of our staff. We held a county-wide staff away day in the autumn and further events are planned for January and February. This is alongside the formal staff consultations that are required as part of the CCG merger programme

5 Financial implications

5.1 There are no financial implications to Kent County Council arising directly from this report.

6 Legal implications

6.1 A number of formal commissioning agreements are held between the Council and the Kent CCGs. As part of the merger process we are planning to review these prior to any novation or amendment.

7 Recommendations

7.1 The Committee is asked to NOTE and COMMENT on the update.

Lead officer contact

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Appendices

1. Kent and Medway CCG's merger application and summary case for change
2. Engaging with local people and our partners – You said, we did

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Kent and Medway
Clinical Commissioning Groups

Merger Application

Summary Case For Change

Version: 1.0
September 2019

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1 Executive summary

The eight Kent and Medway (K&M) clinical commissioning groups (CCGs) are pleased and excited to submit this application to become a single commissioner. We are looking forward to presenting and discussing our case for change with NHS England and NHS Improvement (NHSE/I) at the beginning of October 2019.

Our primary objective is to enable people living across Kent and Medway to have a great quality of life and high-quality care. While significant strides have been taken to collaborate as well as work more closely with our partners and providers to achieve this goal, **it is now a matter of urgency** that we build on and accelerate this joint working to address some of our key local challenges. Progressing this application, particularly clarifying the benefits we expect, has cemented our long term and collective view that we need to move forward with a merger at pace. **This will unlock short and long-term advantages, which will not be achieved without a change to the current arrangements.**

The benefits

1. Redirection of clinical and management resources closer to local front-line services and our patients

The proposed merger is a fundamental building block for a successful integrated care system (ICS), a necessary pre-cursor to innovative, vibrant and patient-centric primary care networks (PCNs) and integrated care providers (ICPs). The merger will allow us to bring together CCG clinical and managerial time to deal with the critical issues facing us now, and to redirect resource and effort to the PCNs and ICPs and therefore closer to the health and social care frontline. **Without a single commissioner in place, our ability to redirect resources, while addressing current pressures, will be hampered. It will take longer before our proposals for a fresh, shrewder approach to commissioning, provision and the new ICS result in tangible improvements.**

2. Development of a coherent service strategy and acceleration of an outcomes-based approach to commissioning and service delivery ultimately improving patients' health, wellbeing and experience of our services:

The K&M CCGs, partners and providers are committed to a new way of working and have been working towards an ICS for many months through the wider system transformation programme. As a cornerstone of the ICS, a single commissioner will:

- allow a more coherent commissioning strategy for K&M as a whole (including more specialised areas such as digital, workforce and estates)
- enable and oversee a consistent outcomes-based approach to commissioning across the system with our partners and providers moving away from bilateral, payment by results (PBR) contracts to financial and contractual frameworks that target population health improvement and maximise the potential for prevention
- provide oversight and insight across a larger area helping us identify and share best practice, deliver consistency in commissioning approach and expected outcomes, as well as help address inequity and inequality across K&M.

3. De-duplication and delivery of nationally mandated 20% CCG running costs reduction

- The establishment of a K&M-wide programme/workstreams has partly mitigated duplication of effort across eight CCGs and a complex local system. However, **the current myriad layers of commissioning management and governance can more than double our 'speed to market' and often dilute the bold and innovative proposals.** This hampers our ability to address our short and long-term constitutional and financial challenges. The K&M CCG savings requirement for 2020/21 is £4.7m, which is achievable if we merge.

Tackling the risks

Engagement on the merger with CCG constituents, staff, patients and partners has highlighted perceived risks to a single commissioning organisation. These have been addressed through, for example, the proposed organisational design or funding commitments. Our local conversations highlighted a recurring theme relating to the potential loss of the local, clinical voice engendered by our current CCGs. Aside from the establishment of PCNs, which will provide that vital 'ear to the ground' the following commitments have been agreed:

- **the new CCG will always be GP-led**, with a GP governing body majority including a GP from each current CCG until at least April 2022 and clinical representation/leadership where appropriate on all committees
- a full and robust **development programme for PCNs** enabling effective leadership within the emerging integrated care system.
- strong local patient and public representation from the CCG governing body down to individual PCNs e.g. **maintenance of patient and public lay members' effort and funding.**

Conversely, the risks of not moving to a single organisation at pace will be the potential inability to answer, at scale, our current major challenges. Examples include constitutional standards and financial sustainability, loss of momentum in development of the ICS, ICPs and PCNs, and a loss of confidence in us by staff and the public, following perceived failure to follow up on the merger engagement work carried out to date.

In short, an early merger will accelerate our vision and plans, simplify, significantly reduce inefficiency and unnecessary duplication of effort and reap benefits for our patients sooner rather than later. The merger is on our critical path to achieving better health and financial outcomes. It is the natural, next step for K&M and builds on the progress we have already made to date.

Glenn Douglas

Accountable Officer for the Kent and Medway Clinical Commissioning Groups

2 Introduction

The NHS Long Term Plan (LTP) sets an expectation that ICSs will be established across the country by April 2021. These will be based on existing sustainability and transformation partnership (STP) footprints. They will refocus commissioning and care provision on improving population health and wellbeing, address inequity and, where it is within our ability, health inequalities – the unacceptable differences in health and life expectancy for some communities compared to others.

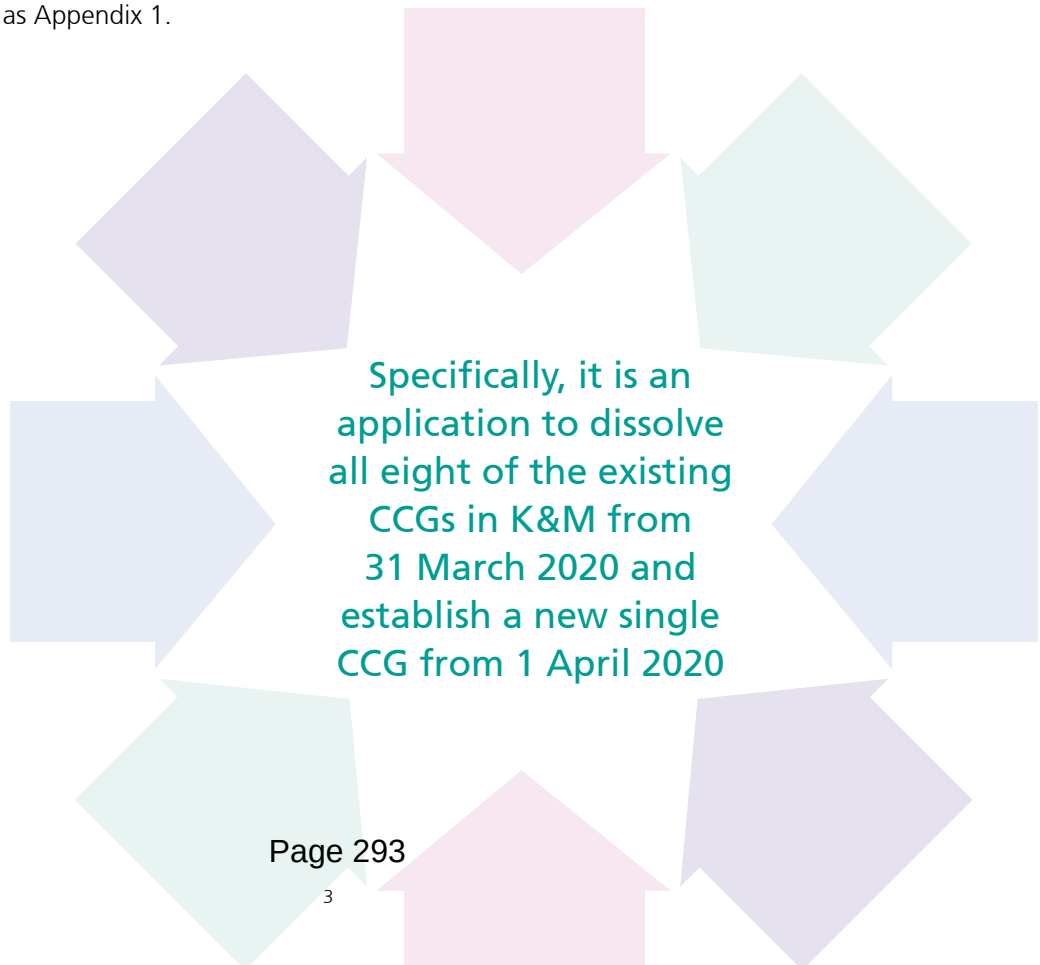
The LTP is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. CCGs will become leaner, more strategic organisations that support care providers through ICPs to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. They will also develop enhanced management capability for more specialist functions, such as estates, digital and workforce.

In K&M, we have been working towards the vision set out above for many months. We recognise that while K&M has many achievements to be proud of over recent years, there are a number of fundamental challenges (Section 4.2) we have not yet been able to tackle and which have impacted negatively on individual patient experience, care and wellbeing. Two of the primary reasons for this are the complexity and fragmentation of the current system and the inefficient duplication of effort. Partners across K&M agree that merger gives us the opportunity to act and address some of the challenges that have faced us for many years.

This application is a fundamental building block in establishing an ICS across K&M. Specifically, it is an application to dissolve all eight of the existing CCGs in K&M and establish a new single CCG from 1 April 2020. **The new organisation will be called the NHS Kent and Medway Clinical Commissioning Group and will cover the full geographical area of the existing eight CCGs.**

This application is being made in accordance with national guidance and each of the eight CCGs' constitutions. It has been approved by each of the CCG governing bodies and their GP memberships (TBC).

The application has been developed in accordance with the Equality Act 2010 and specifically the requirements of the Public Sector Equality Duty. A copy of the **combined (equality) impact assessment** (CIA) is attached as Appendix 1.



3 Background

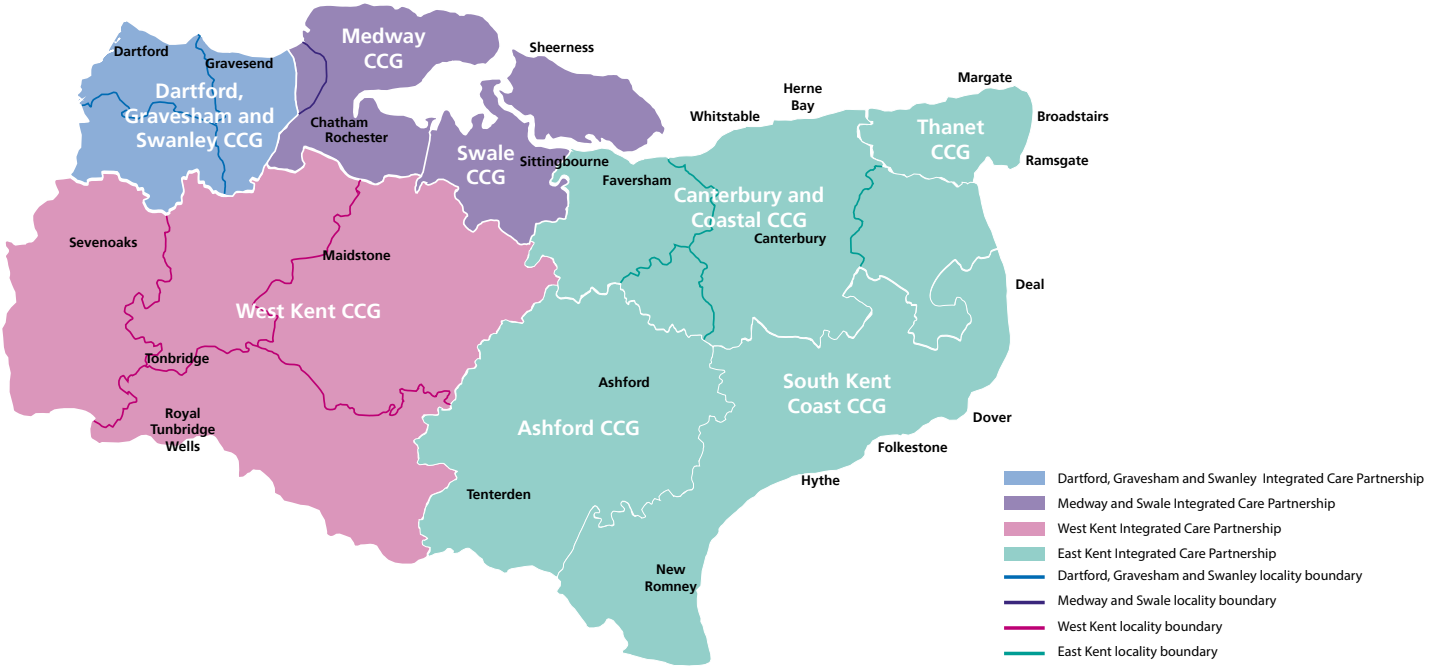
High-level information regarding the eight K&M CCGs is provided below:

	Population	Practices	Total CCG budget 2019/20 £m's
Ashford CCG	135,242	11	£179.5
Canterbury and Coastal CCG	210,353	14	£320.0
Dartford, Gravesham and Swanley CCG	274,881	28	£386.2
Medway CCG	302,150	45	£441.7
South Kent Coast CCG	221,148	28	£338.3
Swale CCG	115,565	16	£175.5
Thanet CCG	167,172	14	£245.8
West Kent CCG	460,000	55	£682.0
Total	**1,886,511**	**211**	**£2,778**

* Total budget includes primary care commissioning budget and CCG management cost budget.

Total health and social care spend including specialised services across K&M is approximately £4bn per annum.

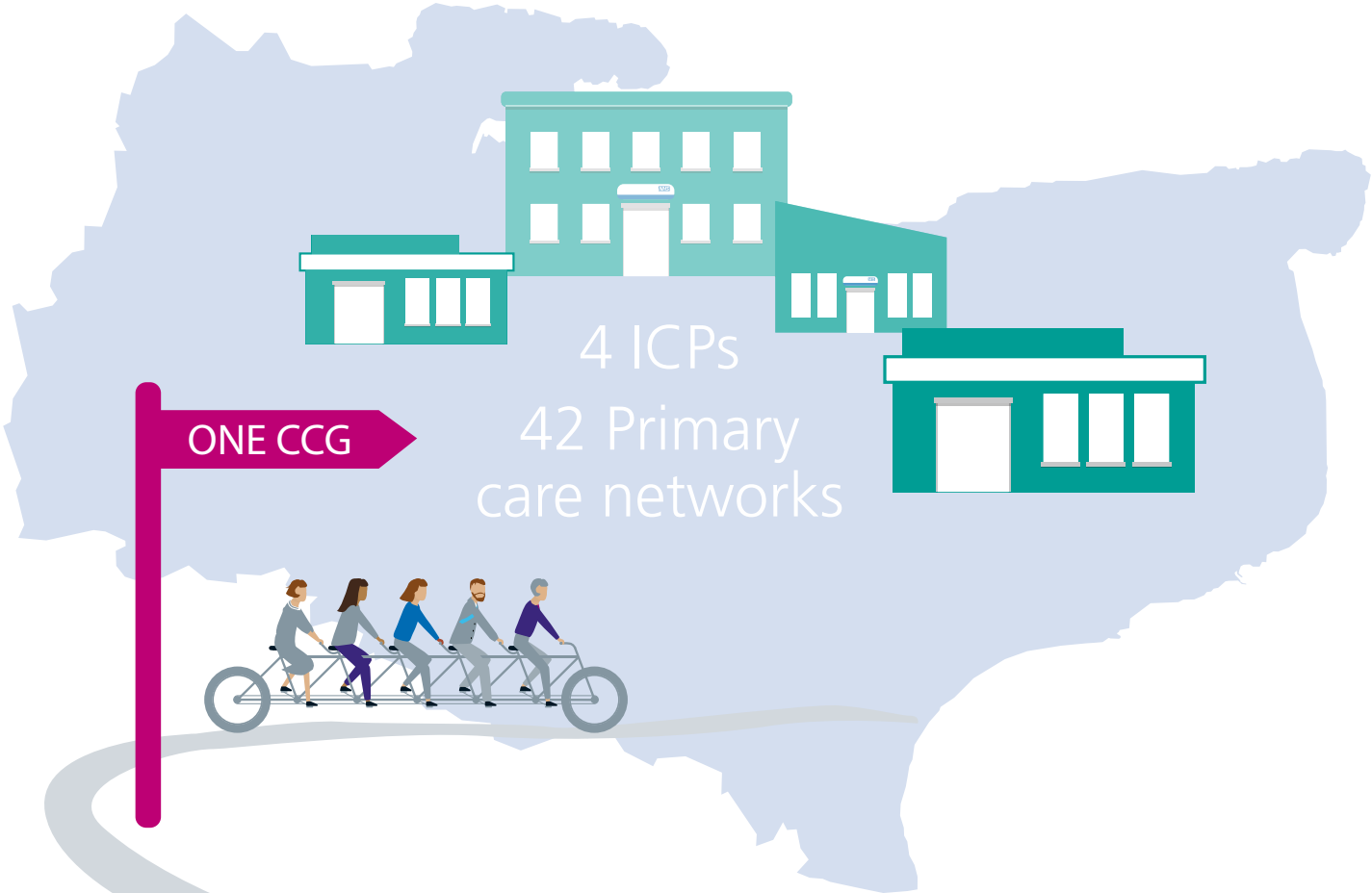
The eight CCGs combined cover the coterminous areas of Kent County Council (KCC) and Medway Unitary Authority. Kent includes the city of Canterbury in the east and the large market (county) town of Maidstone in the west. The large conurbation of Medway in the north includes the main towns of Chatham and Gillingham. Thanet in the east is one of most deprived areas in England.



This large geographical area (1,368 square miles) includes many towns and villages and rural areas, particularly in the south and east of the county; and more urban and light industrial towns in the north and the west. The county has a very long coastline and is a major transitory route for the continent through the port of Dover and Channel Tunnel in Folkestone. The number of people living in Kent and Medway is approximately 1.8 million, which is expected to grow to 2.1 million in 2031.

Many of the organisations that make up the K&M health and (integrated) care system are detailed in the Kent and Medway partners document, Appendix 2.

Section 4



The Kent and Medway context

4 Case for change: the K&M context

Section 4 provides **further context** for our local case for change. It includes a high-level view of the current health and wellbeing of our population, our track record as a nascent ICS, key challenges and our current, collective financial position.

4.1 Our population – the needs of local people

The needs of local people drive local requirements for health and social care. The appended K&M case for change 2018 (Appendix 3), published by the Clinical and Professional Board includes details of the key population health issues facing the area, which will continue to inform our ICS priorities and work plan. The key headlines are:

Population growth

From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people to K&M in circa 190,000 new homes.

Living longer, but with additional health needs

The number of older people is growing quickly and older people tend to use health and social care services more than other age groups. Growth in the number of over 65s is over four times greater than those under 65; an ageing population means increasing demand for health and social care, for example, there are currently around 12,000 people living with dementia in K&M.

Inequalities

There are widespread health inequalities across K&M with a large difference in average life expectancy across wards. For example, men residing in the most deprived areas live on average eight years less than those living in the least deprived.

Preventable long-term conditions

Over half a million people, including 19,000 children under the age of 16, live with one or more significant long-term health conditions, many of which are preventable. Furthermore, many of these people have multiple long-term health conditions; and on average total spend on a person with a long-term condition is six times more than on someone who is healthy.

Mental health

The prevalence of mental health disorders in K&M is generally in line with the rest of England, but mental health problems disproportionately affect people living in the most deprived areas. Approximately, one in 10 children aged between five and 16 years has a diagnosable mental health problem. Self-harm can be a useful mental health indicator and in K&M, self-harm rates have risen steadily since 2007. In Kent, there were around 5,900 admissions to hospital last year for self-harm and in Medway, there were nearly 600.

Children and young people

The health and wellbeing of children is a significant determinant of physical and emotional wellbeing all the way through to adulthood. The current issues facing children and young people include an average of 20% being obese or overweight, rising to nearly 30% in some areas; inadequate vaccination coverage; and just under half of all looked after children being at higher risk of developing a mental health disorder. Clinical standards for paediatric and maternity services are also not being met.

4.2 Our track record and challenges

K&M has much to be proud of. The vast majority of its population receives good care and treatment. There are many services that provide high-quality care, day after day and will continue to do so. Indeed, since the establishment of CCGs in 2013, the NHS and social care in K&M have had a number of successes making changes to local services and improving patient outcomes:

- **Out of hospital care.** Over the past couple of years, there has been a wide-spread introduction of GP-led multidisciplinary teams across K&M, working both proactively to manage the health of people with multiple health conditions, and reactively to treat them at home when they suddenly deteriorate. More services are being provided out of hospital such as multi-disciplinary teams in Medway, Canterbury and Ashford, diabetes care in west Kent, cataract clinics in Herne Bay and urgent home visiting service in south Kent. The key now is to 'industrialise' these schemes where they are making a real difference to secure better care outcomes.
- **Acute stroke services.** More than 3,000 people are treated for a stroke in K&M each year. Although hospital staff provide the best service they can, our local hospitals do not consistently meet the national standards for clinical quality because of their configuration. Following a huge amount of work over the past two years including a public consultation, the CCGs recently approved plans for the provision of three acute and hyper acute stroke units across K&M.
- **Reductions in smoking prevalence.** In the first six months of 2017, K&M recorded the highest success rates for people quitting smoking for the whole of England: 65% of smokers who attended drop in clinics in Kent, and 58% of smokers who used telephone support services in Medway, managed to stop smoking In Kent, only 15.2% of the adult population now smokes and in Medway the proportion of smokers is 19%.
- **Sustained reduction in teenage pregnancy.** The conception rate among under 18s has been steadily declining in K&M. This is as a result of years of multi-agency collaboration to ensure third sector organisations, school nurses and clinicians work together to deliver services tailored to young people.
- **Diabetes prevention programme.** The NHS Diabetes Prevention Programme (NDPP) is the first attempt to prevent Type 2 diabetes at a national scale anywhere in the world. Medway CCG and Medway Council's Public Health Team were one of the seven demonstrator sites to pilot this work. The learning from the pilots, including the adoption of a primary care case finding tool developed in Medway, has been used to inform the wider roll out across England. The NDPP has now been successfully rolled out across Kent.
- **Eating disorder services.** Services have now been redesigned to ensure there is no longer an access limit to those below a certain body mass index or an artificial divide between children's and adult services. The focus is instead strongly on the early intervention for all ages, which in turn improves individual patient outcomes and wellbeing and in the longer term reduces costs to the NHS.

However, while we have a lot to be proud of, there remain a number of fundamental challenges where the health and care system in K&M needs further focus and work:

Public health, prevention and inconsistency

- Only 2% of health and social care funding in K&M is spent on public health interventions to reduce the risk of avoidable disease and disability
- Around one in five primary school children are overweight or obese
- There are stark health inequalities across K&M. Around 1,600 early deaths each year could have been avoided with the right help and support early. This is a particular issue for people who live in deprived areas and/or who have a severe mental illness.
- Inequity of service provision. Services commissioned and provided across K&M vary by CCG.

Some of this is appropriate as the needs of the local populations differ. However, there are also inconsistencies in service provision which we need to address as a nascent ICS. While a single K&M CCG will not prescribe how local services are delivered, it will stipulate consistent and equitable minimum expected care and well-being outcomes across the system.

Capacity and capability

- Significant workforce issues. In Kent and Medway, we are behind the national average in terms of workforce growth. Our workforce supply has decreased for most workforce groups, with 6,820 full time equivalent vacancies, as depicted in the table below:

In Kent and Medway we employ more than **83,800 people across more than 350 health and social care roles.**

Workforce full-time equivalent (FTE)	
	March 2018 (FTE)
Social care	42,500
Clinical commissioners	530
Primary Care	3,630
Ambulance	3,080
Mental Health	3,670
Community	4,810
Acute	18,750
Vacancies	6,820

- Some services for seriously ill people in K&M find it hard to run round-the-clock and meet expected standards of care: all stroke patients who are medically suitable should get clot-busting drugs within 60 minutes of arriving at hospital. None of the hospitals in our area currently achieves this for all patients.

Complexity

The current commissioning system is far too complex and bureaucratic.

K&M example 1: Acute stroke services review

Initial papers and proposals were required to go through a number of individual CCG committees and other meetings. At one point, nearly 50 formal committee meetings over a six-month period were planned. The subsequent establishment of a joint committee for stroke services reduced the bureaucracy in this instance, but such solutions can only go so far given the current complexity of our system.

Standards and outcomes

- People with mental ill health have poor outcomes: the average life expectancy for people with severe mental illness is 15 to 20 years less than the average for other adults as their physical health needs are less likely to be met.
- Cancer care regularly does not meet national standards: for instance waiting times for diagnostic tests, to see a specialist and for treatment.
- Every day around one in three people in a hospital bed could get the health and social care support they need out of hospital, if the right services were available.
- Services and outcomes for people with long-term conditions are poor: as many as four in 10 emergency hospital admissions could be avoided if the right care was available outside hospital.

Finance

- We are not able to live within our means: it is estimated that by the end of this financial year (2019/20) the NHS in K&M will have overspent its planned budgets by £153m. This is excluding the benefit of non-recurrent support from the commissioner support fund and provider support fund, which reduces this overspend to circa £54m. Services could be run more productively: around £190m of savings could be made if services were run as efficiently as top performing areas in England.

Supplementary track record information

In September 2017, NHS Dartford, Gravesham and Swanley CCG was placed under directions by NHS England as a result of not meeting statutory financial duties with associated concerns regarding the capacity and capability of the senior leadership team. The CCG was released of these interventions in March 2018, having assured NHSE/I of the required improvements in both areas.

In May 2019, NHS Ashford CCG, NHS Canterbury and Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG were placed under directions by NHS England as a result of not achieving their statutory financial duties. Again, this was supplemented with concerns regarding leadership capacity. The CCGs are implementing an agreed joint financial recovery and management plan and they hope to be lifted from directions before the end of the current financial year. It is anticipated the current programme of work, as well as the benefits of a single CCG, (detailed in section 5.3 and appendix 8) including simplification, accelerated decision making, implementation of an outcomes-based/ population health approach to commissioning will significantly mitigate the original, underlying causes for the east Kent directions.

All eight CCGs in K&M have delegated responsibility from NHS England for the commissioning of primary medical care services. The CCGs plan for this to be transferred to the new K&M CCG with effect from April 2020.

4.3 Joint working to date

Despite the complexity of the local system we have a good track record of working together both as CCGs and at a K&M system level, although this needs to go much further to **enable accelerated decision making** and deliver better outcomes for our population. From a collaborative perspective we believe that we have gone as far as we can under existing arrangements and the establishment of a single CCG is the key catalyst required to **simplify, deliver a transformational change and build a strong K&M ICS**. The following demonstrates the joint working arrangements **currently** in place:

CCG joint working

Six of the eight CCGs in K&M have had joint executive teams since 2013 and from 2016 governing bodies and other committees have been meeting-in-common. In addition, independent and lay members of CCG governing bodies have increasingly shared roles across two or more CCGs. The establishment of the K&M STP and associated programme of work has accelerated this joint working:

- In autumn 2017, the first K&M CCG's joint committee, for stroke services, was established to develop the future arrangements for acute and hyper acute stroke services
- In spring 2018:
  - a single accountable officer (AO) was appointed to the eight K&M CCGs. The post holder is also the STP CEO
  - the senior management structure of the CCGs was also revised to cover two geographical footprint areas: east Kent (encompassing four CCGs); and Medway, north and west Kent (encompassing the other four CCGs). A managing director was appointed to each footprint area, reporting directly to the AO, and deputy managing directors were appointed to individual CCG and pan-footprint portfolio areas
  - functional teams, such as quality and safety, finance etc, started working more formally together within the footprint areas.
- In autumn 2018, a second joint committee was established with responsibility for other commissioning services that require a pan-county response to service development and delivery. This was because a number of critical challenges were not being effectively addressed. The committee is currently responsible for cancer and children's services with plans to add mental health. A further east Kent CCGs joint committee was also established with responsibility for specific east Kent commissioning issues, particularly relating to the proposed reconfiguration of local acute hospital services.
- Since January 2019, the K&M CCG remuneration committees have been meeting 'in-common' to ensure consistent decision making across the organisations. The CCG audit committees are also considering this.

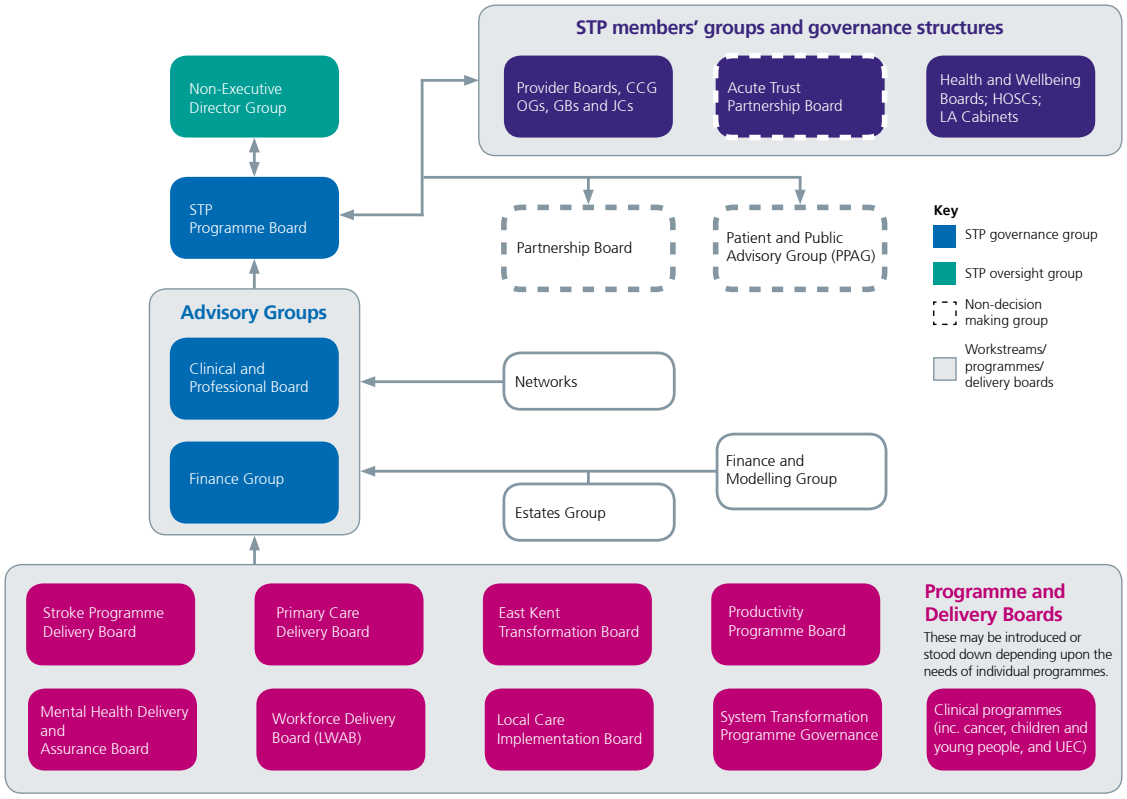
K&M example 2: joint working

While the above joint working arrangements have progressed there have also been areas where joint working has been more difficult to sustain. For example, prior to the establishment of CCGs in 2013, K&M primary care trusts (PCTs) had a single contracting team and various collaborative contracting agreements in place. While a number of these agreements continued after 2013, they have become more disparate as a result of differing contractual approaches, more recently linked to increasing individual financial pressures in each CCG. **A merged CCG presents an opportunity to bring consistency and efficiency to our market management, procurement and contracting approaches, which in turn will support accelerated improvement of financial standards.**

System transformation

At a system level, the K&M STP programme board has been in place since 2016. It has membership from the main providers and commissioners of care across the area including local authorities. The remit of the STP has been to develop and oversee shared plans for improving system-wide quality, health outcomes and efficiency.

The current governance structure for the K&M STP is depicted below:



In parallel with publication of the NHS LTP, a system transformation programme (formerly known in K&M as the system leadership programme) is now fully in place. This reports to the STP Programme Board and the statutory organisations through a system transformation executive board. The programme initiation document (PID) in Appendix 4 provides the background and governance framework in which the programme operates.

The merger will be the next natural step for K&M building on the joint working arrangements put in place to date.

4.4 Our financial position

The K&M CCGs face a significant financial challenge. The accumulated deficit position as at the end of 2018/19 is a net £87.5m (comprising six deficit CCGs £108.5m and two surplus CCGs £21m). In 2019/20, the CCGs collectively have a deficit control total of £4.7m but this position is after receipt of planned commissioner sustainability funds (CSF) totalling £34.2m. Without CSF, the position is a deficit of £38.9m. The total quality, innovation, productivity and prevention (QIPP) requirement for K&M CCGs in 2019/20 is £89.4m.

As already described, four of our eight CCGs are subject to 'directions', which require the preparation of a robust and credible financial recovery plan.

The control total for all NHS providers in 2019/20 is a deficit of £49.3m, after deployment of the provider sustainability fund (PSF), financial recovery fund (FRF) and marginal rate emergency threshold (MRET). Without these funds, the position of NHS providers across K&M is a deficit of £113.7m. Therefore, in total the wider K&M system is tasked with delivery of a control total deficit in 2019/20 of £54m. Achieving this will require considerable focus and energy, and for the system to develop new approaches of working together that lead to optimisation of care pathways and less waste within the system. The achievement of the control total in 2019/20 is an essential platform for the proposed single CCG allowing it to operate within the new landscape of the ICS, and ICPs from April 2021.

The table below shows, by CCG and in total for Kent and Medway, the accumulated surplus/deficit over the last three years and the planned forecast out turn (FOT) for 2019/20.

Kent and Medway CCGs	Pre 2017/18	2017/18	2018/19	2018/19	2019/20	2019/20	2019/20	2019/20
	Accumulated Surplus/ deficit	Surplus/ deficit	Surplus/ deficit	Accumulated Surplus/ deficit	Planned FOT Surplus/ deficit	Planned FOT CSF support	Planned FOT Surplus/ deficit	Planned FOT CSF support
	£m	£m	£m	£m	£m	£m	£m	£m
NHS Ashford CCG	-2.1	-12.2	-15.1	-29.4	-15.8	11.1	-4.7	-34.1
NHS Canterbury & Coastal CCG	5.5	-9.5	-17.7	-21.7	-10.1	10.1	0	-21.7
NHS Dartford, Gravesham and Swanley CCG	-13	-9.1	-9.9	-32	-5	5	0	-32
NHS Medway CCG	7.1	0.7	0	7.8	0	0	0	7.8
NHS South Kent Coast CCG	5.5	-7.3	-15.2	-17	-9.5	9.5	0	-17
NHS Swale CCG	-2	-3	0	-5	0	0	0	-5
NHS Thanet CCG	3.8	0	-6.6	-2.8	-3.2	3.2	0	-2.8
NHS West Kent CCG	11.5	1.7	0	13.2	0	0	0	13.2
Total Kent and Medway Commissioner	**16.3**	**-38.7**	**-64.5**	**-86.9**	**-43.6**	**38.9**	**-4.7**	**-91.6**

Section 5

Our ambition

Quality of care, quality of life

5 Case for Change: Our ambition 'Quality of life, quality of care'

As highlighted in the previous sections, the K&M system continues to face a number of strategic, operational and financial challenges. Responding to these local challenges requires a whole system transformation of how we commission and deliver services. The future model needs to be financially sustainable, demonstrate operational effectiveness through improved outcomes, deliver high quality and safe care and importantly, be responsive to the physical and mental health and care needs of the population of K&M. To deliver sustainable and responsive services **we need a simplified and consistent K&M system for which the cornerstone will be a single K&M CCG.**

Our appended STP PID (Appendix 4) and the associated project and workstreams explain the next phase of our journey while the following sub-sections summarise how we will commission differently, structure ourselves to deliver positive change and what we expect the benefits of the change to be. **The development of a K&M commissioning and population health strategy and accelerated delivery of the outcomes in our draft LTP are predicated on the basis of CCG merger in April 2020 and effective establishment of the wider ICS by April 2021.**

5.1 Our commissioning strategy

Where are we now?

Vision, strategy and STP work programme

K&M's clinical vision and strategy, **'Quality of life, quality of care',** sets out our ambition for the population of K&M to have a great quality of life through high-quality care; for them to be as healthy, fit (physically and mentally) and independent as possible; participating in their local economies and communities and able to access the right help and support when they need it. It sets out how we intend to develop and foster **a vibrant voluntary sector and a strong sense of community** in our towns and villages, where people feel connected and we support one another across the generations; and where we are in control of our health and happiness, feeling good and functioning well.

In addition to the clinical vision and strategy, senior doctors, nurses and care professionals from across the K&M system developed the aforementioned **clinical case for change** (Appendix 3) that sets out our key challenges and outlined the actions that need to be taken in the coming years. Aligned with the NHS LTP, the document included four key themes, which are being driven through current STP programme workstreams:

- Care transformation: **preventing ill health, intervening earlier and bringing excellent care closer to home.**
- Productivity: **maximising efficiencies** in shared services, procurement and prescribing.
- **Enablers:** investing in buildings, digital infrastructure and the workforce needed to deliver high-performing health and social care services.
- **System leadership:** developing commissioner and provider structures, which will deliver the greatest impact i.e. single system commissioner, integrated care partnerships and primary care networks.

Population health

K&M is one of the most advanced areas in the country in linking longitudinal patient and social care user data across health and care settings, through the Kent Integrated Dataset (the 'KID'). This gives us an opportunity to understand the health of the K&M population, including an ability to segment and stratify our population to identify "at risk" cohorts and assess the impact of proposed strategies. While we have developed leading edge approaches around the capture and linking of data we have historically failed to fully optimise this insight to drive improvements in the health of the entire K&M population. This has been largely due to a lack of consistency of approach, coupled with a system that has not been focused on population health management.

A K&M population health review has also been drafted recently, structured around the NHS LTP, that confirms key population health needs and gives recommendations across priority areas for improvement (Appendix 5).

Defining how we commission/provide services

Detailed work has already started to determine future commissioning/provider roles and responsibilities. Working with the emerging ICPs we have reviewed all current commissioning functions and considered where these are likely to fit in the new ICS. This work also includes where the commissioning support functions e.g. finance, quality and safety, HR are likely to sit in the initial phases post-CCG merger. Details are provided in the high level summary and detailed future functions worksheets (Appendices 6a and 6b).

In addition to this, we have developed an interim system operating framework (Appendix 7). This is a working discussion document entitled 'One Team' which is the term K&M are applying to our joined up working arrangements. It reflects the need to focus on the system and sub-systems rather than individual organisations, drawing expertise together from across organisations to address the key challenges, and realise opportunities for patients. The One Team approach is considered in how our functions, systems and workforce are developed and deployed.

Where do we want to be?

The work described above and the autumnal K&M response to the NHS LTP will provide strong input to a bold new K&M integrated care commissioning and population health strategy which will form the bedrock of work of the new ICS. The strategy will be co-developed with a wide range of stakeholders across our local ICS and will support both delivery of the LTP and the benefits identified to date in the merger benefits realisation plan. The K&M strategy will include our approach to the challenges set out in section 4.2 including how we intend to deploy our new integrated care system to:

- root out and eradicate (as far as we can) inequality and inequity across the K&M system
- tackle some of the individual CCG assurance rating issues and poor delivery of constitutional standards
- tackle our estates, digital and workforce challenges.

The intent is to complete the strategy in early 2020. However, we know that two key elements will be our approach to:

1. Population health management/data

Building on the KID and the population health review we need to develop our capability to maximise use of tools/data and the intelligence they provide, to support the development of population health management and establish ICP/PCN delivery plans.

We recognise that access to data and toolkits is not enough to deliver population health management. As outlined in the benefits realisation plan (Appendix 8) the development and critical mass of the a single CCG will enable us to focus on, prioritise and emphasise a consistent framework for population health management, supported by the tools and expertise to support the take-up and use of these. The K&M CCG will have a dedicated clinical lead and a lead director on its governing body with primary responsibility for population health and population health management. The lead director will act as the system senior responsible officer for this portfolio which will build on the work of the Kent and Medway Strategic Health Analytics Board and the recent Kent and Medway population health case for change, completed by the two public health teams.

2. Managing the 'K&M pound'

A further key component of the commissioning strategy will be moving towards a more sustainable financial footing. The working draft medium term financial plan (MTFP) (Appendices 9a and 9b) is expected to be finalised alongside the local response to the LTP in November 2019. Delivery of the MTFP is based on managing spend through a range of programmes:

- CCG merger and the benefits described in the benefits realisation plan
- the integration of provision, and the integration of commissioning and provision, through the development of the K&M ICS
- continued delivery of a range of provider and commissioner efficiencies, enabled through our integration plans
- the levelling up of clinical variation across the system using RightCare, GIRFT, etc. and other analysis
- supply side reconfiguration (e.g. the east Kent reconfiguration programme, the review of K&M stroke services and the consolidation of emergency vascular surgery).

How do we get there?

The subsequent sections in this document describe in detail how we intend to move forward with the new approach/strategy, including our operating framework, workforce strategy and benefits realisation. To get ourselves ready we have started re-aligning staff and functions across K&M, recognising that all CCG staff will initially transfer to the K&M CCG in April 2020:

- primary care and medicines optimisation teams will retain a local customer care/commissioning focus based on GP neighbourhood areas
- other commissioning functions and staff will start to be more aligned to place/system-based areas of responsibility during winter 2019/20, with a view to the majority working on an ICP/PCN footprint basis and ultimately being employed by these partnerships when they are mature enough to hold respective contracts (circa April 2021)
- supporting functions including finance, corporate services, communications and engagement, quality and safety, etc. will be consolidated into K&M wide teams where appropriate on a staged basis from October 2019 in preparation for CCG merger (HR, C&E and Corporate Services will be the first to consolidate). During 2020/21 further work will be undertaken to determine the structure of back-office functions pan-K&M as the new landscape emerges (and the old CCGs are closed down, with annual accounts, reports, etc.).

In parallel we:

- will continue to work on the wider system transformation programme, to develop high performing, effective delivery functions over the next two years using our existing talent pool, building on areas of strength. As new joint functions evolve (such as population health) we will then address identified gaps in skills and expertise
- will further develop our emerging K&M digital, estates and workforce strategies
- are starting to weave in the current STP programme/resources into a single CCG/future ICS programme of work.

A further key component of the commissioning strategy will be moving towards a more sustainable financial footing.

Developing outcomes-based contracts

The population health management approach outlined in the 'Where do we want to be?' section will be underpinned by a change in the way we commission. We will move from a contracting model based on inputs and activity volumes to an outcomes based framework, that incentivises and rewards based on improvements in the health of the population, at-risk cohorts and individuals. The revised ICP contract, as released by NHS England, provides the contractual vehicle for a K&M outcomes-based contract. We see the outcomes within this contract being derived from a number of sources:

- at a national level as established through the LTP (delivered through a framework established by the single K&M CCG, working with ICPs, PCNs and other partners)
- at a K&M level established through the single CCG
- at a local level through the PCNs and ICPs.

The development of this framework is a critical piece of work, which is closely aligned to the K&M response to the NHS LTP. Linking to the 'future functions' work above and central guidance, this will ensure partners from across the system work within an agreed and consistent framework when determining what and how services will be commissioned and delivered.

While much of the above would need to need to happen with or without merger approval, a successful application will help build on the energy and momentum to deliver change at pace. It will also help foster a collaborative culture between commissioners, providers and partners which in turn will allow integration to happen sooner and faster.

5.2 Our proposed operating framework

Based on this collaborative culture, the K&M operational framework represents a significant shift from historic transactional relationships to embracing clinically led, intelligence driven and outcomes-based integrated partnerships.

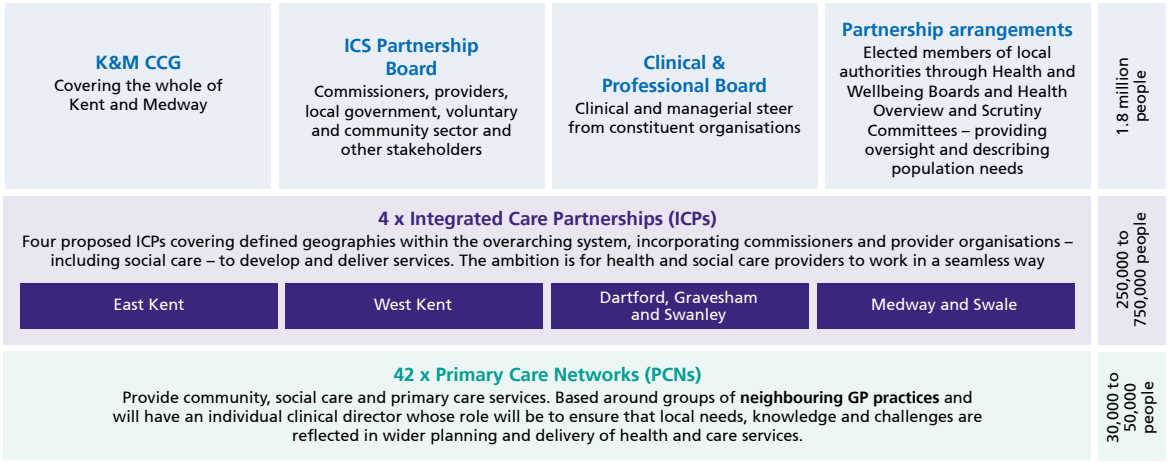
The emerging ICS

As mentioned in the previous commissioning strategy section a working draft discussion document 'One Team: the operating model for K&M' has been developed and agreed by the STP programme board detailing the transitional operating framework for K&M. It is a dynamic document that will evolve over the coming months but already gives a clear steer on the proposed relationship and remit of the ICS partnership board, the K&M clinical and professional board, the K&M joint health and wellbeing board, and the CCG.

In advance of any change in legislation and as the STP starts to transition to the ICS, system specific programmes of work will transfer their hosting arrangements to the new CCG or alternative statutory body(ies) as appropriate. The ICS partnership board will take over from the STP programme board and over the next 18 to 24 months membership of the ICS partnership board will move towards the new landscape with more focus on ICP, PCN and CCG partnerships. At an ICS level, there will be an independent chair of the ICS partnership board, in line with the NHS LTP. The K&M CCG will provide business support to the ICS partnership board and the CCG AO will be the lead senior officer working with the independent chair.

A K&M patient and public engagement (PPE) group will be established as part of the ICS infrastructure (replacing the existing group) and will link in with the respective PPE forums in the various organisations and partnerships – **a PPE 'golden thread'.**

The high level structure of the ICS is depicted below:



The K&M CCG

Recognising the need to **maintain an effective grip on operational delivery alongside organisational and transformational change,** the CCG operating framework has been developed on the basis of **minimising disruption during transition to a single CCG** in April 2020 and thereafter, to a fully functioning ICS in 2021/22.

A transitional senior management team for the eight CCGs has been in place since April 2018. This will be further bolstered over the autumn. With the impending retirement of the current AO, the appointment of a permanent AO is currently underway. Subject to successful recruitment, it is expected that the new incumbent will be in post early in 2020. The appointment of a permanent Chief Finance Officer (CFO) is planned to take place alongside the AO recruitment process, albeit six to eight weeks behind, to allow the new AO to be on the appointment panel. Permanent appointment to the other executive director and senior manager posts will take place once the AO is in post, hence the transitional senior management structure is planned to remain in place up to June 2020. This will enable a smooth transfer from eight organisations to one. The appointment of the CCG Chair and GP governing body members will start following approval of the merger application. The proposed K&M CCG constitution is in development, but the main components relating to the governance framework have been agreed. Details are provided in Appendix 10.

The senior leadership team of the new CCG will take key system leadership roles within the ICS, led by the newly appointed AO, working with the CCG clinical chair and independent ICS chair. These arrangements will build on the transitional arrangements as noted above with some additional roles identified from the commissioning and system functions review recently undertaken. **Appendix 11 outlines the transitional leadership organisational structure that will be in place across the CCG and wider system programme areas until at least June 2020**, which will give the new AO time to review existing and future requirements.

Section 5.6 (Merger Plan) details how we will effect the merger through a robust PMO approach while maintaining business as usual.

5.3 Realising our potential – benefits realisation

As we have progressed the benefits realisation analysis it has cemented our long held and collective view that we need to move forward with a merger at pace. Assumptions made locally about the opportunities of merger now have associated and measurable time and effort estimates. These estimates now provide us with the opportunity cost of not merging, not least of which will be the inability to fully release investment into our ambitious ICS. **A CCG merger will unlock short and long term advantages which will not be achieved at pace without a change to the current arrangements.**

The benefits

1. Redirection of clinical and management resources closer to local front-line services and our patients

The proposed merger is a fundamental building block for a successful ICS (ICS), a necessary pre-cursor to innovative, vibrant and patient-centric primary care networks (PCNs) and integrated care partnerships (ICPs). The merger will allow us to bring together CCG clinical and managerial time to deal with the critical issues facing us now, as well as redirect resource and effort to the PCNs and ICPs and therefore closer to the health and social care frontline **Without a single commissioner in place, our ability to redirect resources, while addressing current pressures, will be hampered and it will be longer before proposals for a fresh, shrewder approach to commissioning, provision and the new ICS result in tangible improvements.**

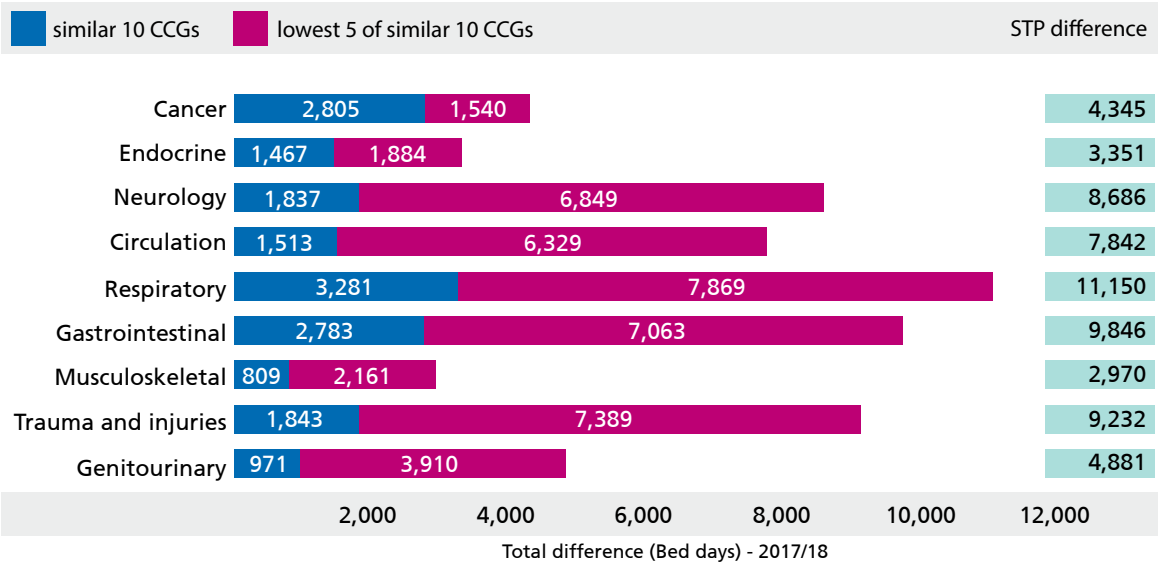
2. Development of a coherent service strategy and acceleration of an outcomes-based approach to commissioning and service delivery ultimately improving patient's health, wellbeing and experience of our services:

The K&M CCGs, partners and providers are committed to a new way of working and have been working towards an ICS for many months through the wider system transformation programme. As a cornerstone of the ICS, a single commissioner will:

- allow a more coherent commissioning strategy for K&M as a whole (including more specialised areas such as digital, workforce and estates)
- enable and oversee a consistent outcomes-based approach to commissioning across the system with our partners and providers moving away from bilateral, payment by results (PBR) based contracts to financial and contractual frameworks that target population health improvement and maximise the potential for prevention
- provide oversight and insight across a larger area helping us identify and share best practice, deliver consistency in commissioning approach and expected outcomes and help address inequity and inequality across K&M.

Information gleaned from sources such as NHS RightCare (see shared K&M CCG opportunities diagram below) provides us with a potential focus for unwarranted clinical and financial variation.

If the CCGs in this STP performed at the average of their:



3. De-duplication, accelerating improvement and delivery of nationally mandated 20% running costs reduction

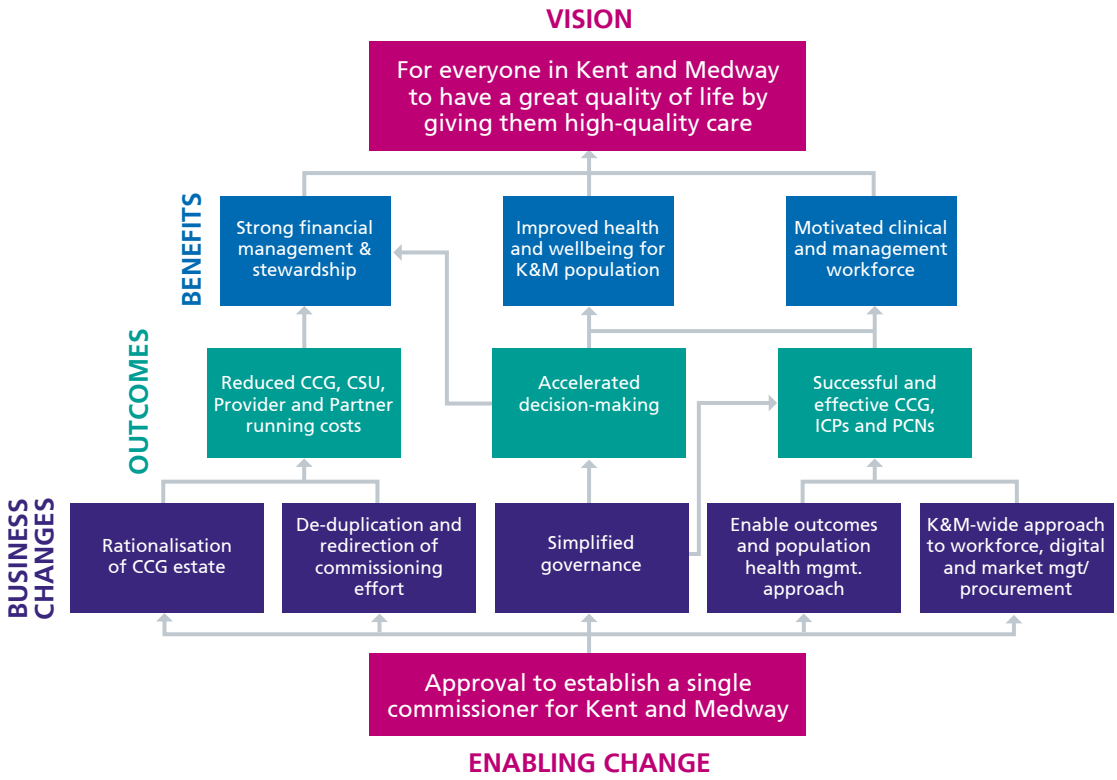
While the establishment of a K&M-wide programme, workstreams and joint committees has partly mitigated duplication and helped speed up decision making, **the current myriad layers of commissioning management and governance across eight organisations stifles decision making and can more than double our 'speed to market'. This in turn often dilutes the bold and innovative proposals** which are required to help address our short and long term constitutional and financial challenges: across K&M various national standards are continually not being achieved. We need to address this alongside making running cost savings in 20/21 of **£4.7m. Merger of the CCGs will facilitate:**

- consistent, targeted and accelerated decision making to improve poor performance and patient outcomes, such as cancer, diagnostic and mental health standards
- significant reduction in the level of duplication of tasks/resource across CCGs
- greater efficiency across the system enabling achievement of running cost savings and delivering accelerated wider financial gain.

The benefits realisation plan and mapping

All of the single system commissioner benefits are identified in the benefits realisation plan (Appendix 8). These are split into two main categories, direct benefits from the CCG merger and those subsequently enabled through a single commissioning organisation. It should also be noted at this stage of merger development, that the benefits of a single commissioner are **high-level estimates** and that as such ranges have been included. As we progress our organisational development and re-focus our STP and projects to deliver these identified benefits, more detailed work and analysis will allow for estimates with a higher degree of confidence and probability.

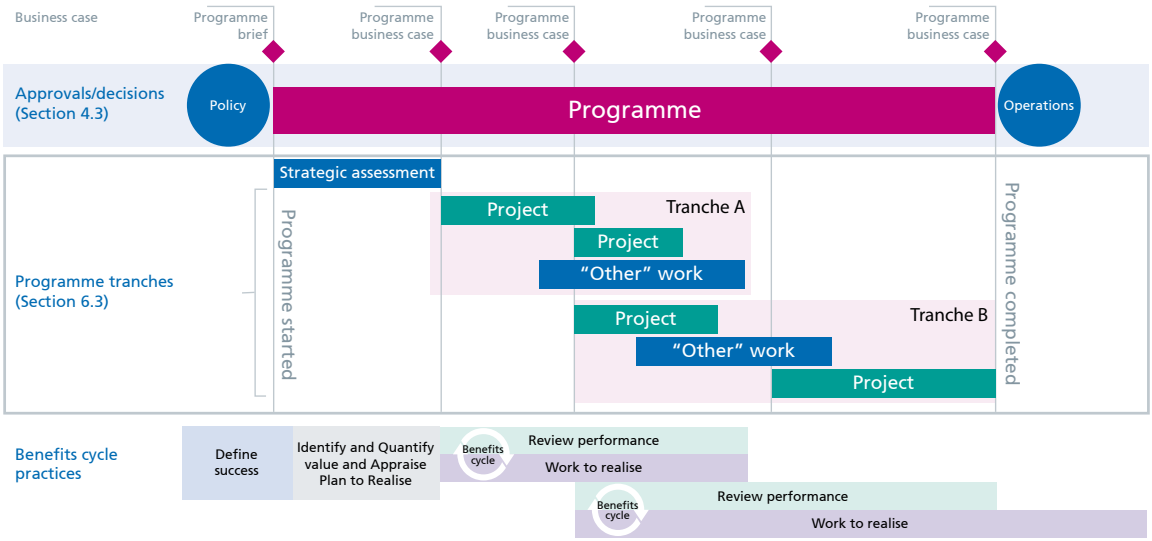
A view of how we map the approval for a single K&M CCG to benefits and our vision is shown below:



Finally, while realisation of the benefits do not come without challenges, which we have mitigated either through funding commitments or agreed OD/HR principles, **we believe these benefits far outweigh the risks.**

Measuring and tracking benefits

The benefits of merging the eight CCGs and the future transformation of the commissioning and provider landscape will be monitored and tracked by a programme management office (PMO) function, hosted within the newly merged CCG but shared across the ICPs and PCNs. It will deploy an approach similar to the government functional standard depicted below:



The PMO team will work with PCNs and ICPs to ensure that intended and stated benefits are realised within the given time period. Where they are not being realised in the timescales given, this will be escalated to the CCG, PCN and ICP leadership for resolution. The PMO will not only track the benefits of merger but the outcomes expected from the ICS as a whole. While there will undoubtedly be 'transactional' elements to track and monitor, the PMO team will have an emphasis on tracking transformational outcomes, giving system assurance in line with the culture of the ICS as a whole.

5.4 Our workforce

Our workforce will be crucial to delivering our vision and transformation is urgently needed to address the quality, service and capacity challenges scrosss health and social care.

To deliver our ambition and address the critical workforce challenges **we will develop a Kent and Medway Academy for Health and Social Care** working collectively across commissioners, providers and partners to:

- promote Kent and Medway as a great place to work
- maximise supply of health and social care workforce
- create lifelong careers in health and social care
- develop our system leaders and encourage culture change
- improve workforce wellbeing, inclusion and workload to increase retention.

We have established a STP workforce action board as part of the STP governance, made up of representatives from K&M partners. As well as supporting other STP workstreams, the workforce action board has specific workforce supporting governance groups including a primary care workforce group, a social care workforce group, and HR directors group, directors of nursing group and union group. Establishment of a single commissioner will allow for a more coherent and consistent commissioning strategy guiding and accelerating the work of the action board as well as the sub groups.

Further details on our approach to workforce challenges including the Kent and Medway Academy for Health and Social Care and how we plan to manage the transition period to a merged organisation and beyond are contained in the following appended documents with an excerpt provided below.

ID	Document name	Content
1	**Kent and Medway system workforce transformation strategy** (Appendix 12)	Sets out our ambition, strategies and plans for working together across health and care to prioritise and address our workforce challenges.
2	**NHS Kent and Medway CCG workforce and OD transition plan** (Appendix 13)	Sets out our high level plan for the work that needs to be undertaken over the next 18 months and a detailed CCG merger implementation plan.

5.5 Communications and engagement

Communications and engagement (C&E) during the past two years has been fundamental to shaping the future of our local system. We have continuously improved our ICS and merger CCG plans through extensive, clinically-led discussions with our stakeholders.

Engagement about system transformation started in January 2018, with the emphasis moving to a single CCG during 2019. Clinical chairs engaged through formal and informal face-to-face meetings, a webinar, written briefings, letters and emails. Between June and September 2019, they, with the support of senior managers, provided a series of written briefings and frequently asked questions to all stakeholders, plus face-to-face briefings to our two health overview and scrutiny committees, the Kent and Medway Health and Wellbeing Board, district and county councilors, and MPs. We also ran two surveys, which were promoted to all audiences.

The following documents set out the plan and outcomes of our extensive communications and engagement C&E activities:

ID	Document name	Content
1	**Communications and engagement plan** (Appendix 14)	Sets out our approach to informing, involving and listening to the wide range of different stakeholders we engaged as part of our merger application preparation and what we plan to do as part of the merger project
2	**'You said, we did' report** (Appendix 15)	Sets out how we responded to and incorporated merger engagement feedback into our ICS and proposed merger approach and plans.

Below is an example of how we have approached ICS and merger C&E during 2018/19:

K&M example 3: patient and public involvement

To develop recommendations for patient and public involvement in the new system, our C&E team worked with the Patient and Public Advisory Group, which has patient representatives from each of the existing CCGs including people who have protected characteristics, as well as CCG lay members, and the chief officer of Healthwatch Kent and Healthwatch Medway who is on many of our key committees. They held a series of workshops and co-produced an integrated approach to patient engagement with people able to get involved at PCN, ICP, CCG level and to form a 'bank' of experts to support all health and care providers.

The extensive communications and engagement undertaken highlighted the current complexity of our current local system. People strongly supported simplification with a single commissioner to free up time and resource for rapid changes to improve care.

5.6 Our merger plan

Pre-application (up to 30 September)

- May/Jun: PID approval, merger work-streams and ICP working group established.
- Jun/Jul: ICS 'One Team' model circulated to stakeholders.
- Jun/Jul: 1st stage 'Future Functions work' complete.
- Jan 2018 to Aug: Public engagement and survey proposals.
- Jul to Sep: Stakeholder, GP & Gov Body events.
- Jul to Sep: Governance framework (pre-constitution).
- Aug: Benefits Realisation and medium term financial planning.
- Aug/Sep: HR&OD and C&E strategies/planning.
- Sep: Agree CSU/support arrangements.
- **Sep: 8 x GP member votes and 8 x GB approval.**
- w/c 9 Sep: SCGOG/SG review.
- 27 Sep: Submission of LTP.
- **30 Sep: Application to NHS England and NHS Improvement.**

October to December 2019

- **3rd Oct: Regional Panel.**
- Oct: Centralise HR and C&E.
- Oct to Dec: Recruit AO/CFO.
- Oct to Dec: Develop ICP/ICS framework.
- **Nov: NHS England and NHS Improvement Merger Approval.**
- **Nov: Final LTP and MTFP submission.**
- Nov: Confirm merger with SBS (re ledger) and NHS Digital (re OSC code).
- Nov/Dec: Election of CCG Chair and GP GB members. Also appointment of other GB members and leads.
- Nov/Dec: Commence other CCG/ STP HR processes.
- Nov: CCG Constitution drafted.
- Confirm delegated commissioning transfer requirements.
- Dec: Stage 2 'Future Functions work' complete.
- Nov/Dec: Review/confirm CCG estate options for HQ.

January to March 2020

- Jan 20: Procure new auditors.
- Jan 20: Appoint ICS Independent Chair.
- Jan: Complete TUPE list of CCG staff.
- Jan: Constitution, SFIs and Standing Orders approved.
- Jan/Feb: CCG website and comms and engagement mechanisms.
- Jan: Inform regulatory bodies e.g. ICD, contract holders and stakeholders of merger.
- Jan to Mar: Prepare all Q&S assurance measures – safeguarding, CQC, etc.
- Jan: Confirm/prepare asset transfer arrangements.
- Jan: Confirm CCG HQ and prepare signage.
- Review CCG, STP and system PMO arrangements.
- 31 Mar: Complete HR TUPE transfer.

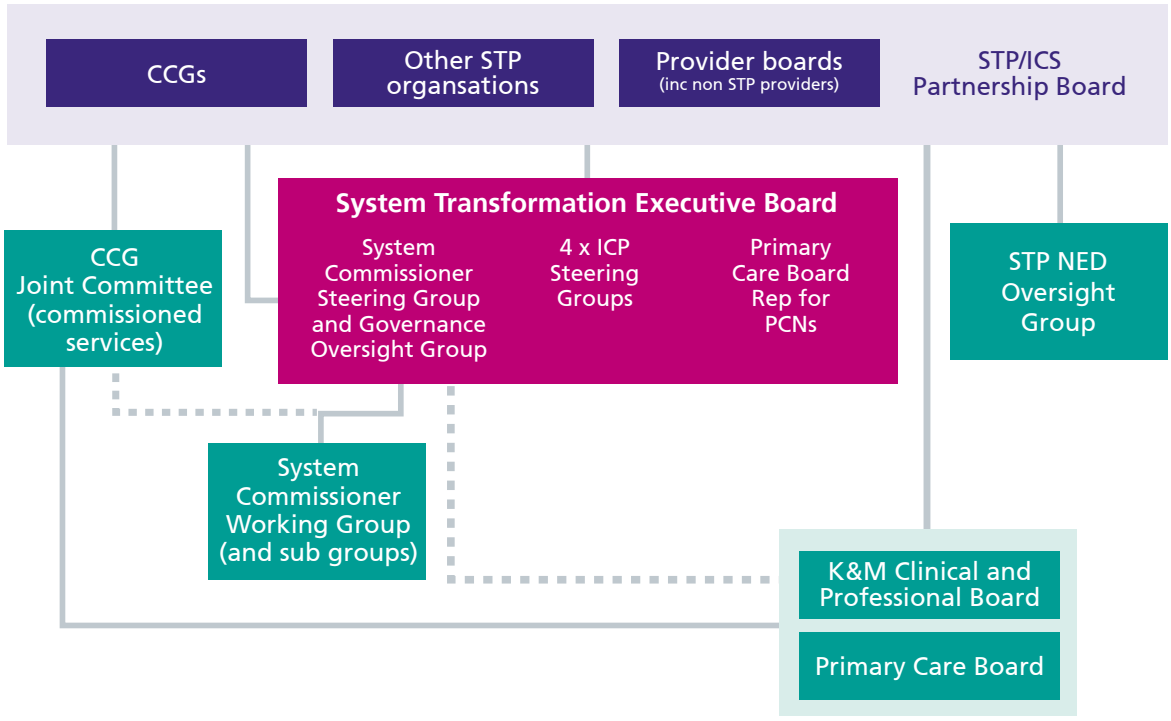
Post Merger April 2020

- **1 April: K&M CCG Operational.**
- 1 Apr: transfer e-mail accounts.
- 1 Apr: asset transfer.
- May/Jun: Year end Accounts and Annual Report.
- April: K&M Commissioning and Population Health Strategy completed.
- Spring: Revise system PMO arrangements towards new landscape.
- Spring/summer: 3rd final stage of future functions work complete.
- Close down CCG financial accounts.

The high level, merger 'Plan on a Page' is provided above. A copy of the detailed merger work programme including the individual merger workstreams is included as Appendix 16.

Delivery framework

The STP PID at Appendix 4 outlines the overarching governance arrangements for the whole system transformation, including the CCG merger (system commissioner) programme. The governance framework for the system transformation and system commissioner programmes is depicted below:



CCG Merger: Project Resourcing

The System Commissioner Steering Group (SCSG) – made up of the eight CCG Clinical Chairs, AO, MDs and PPE representative – has responsibility on behalf of the eight CCG governing bodies for oversight of the merger programme. Local authority and public health directors are also representatives on the group.

A System Commissioner Governance Oversight Group (SCGOG) provides advice and support to the SCSG on all aspects of governance. SCGOG members are the CCG independent lay members for audit.

A dedicated PMO team, led by the Director of System Transformation and the lead CCG Clinical Chair, has day-to-day responsibility for coordinating the programme on behalf of the SCSG. This reports in to an internal Executive Group made up of the AO, Managing Directors, CCG Clinical Lead, Director of System Transformation and lead Chief Finance Officer, which meet on a fortnightly basis (will start to meet weekly from November 2019).

Nine merger workstreams have been established to deliver the merger programme, each of which has a lead director(s) and HR lead – see Appendix 20. These feed in to a working group which holds the overarching merger work programme and risk register. The nine workstreams are: business intelligence, contracting and performance; commissioning and primary care commissioning; communications and engagement; corporate services and governance; digital; finance; HR, workforce and OD; and quality, safety and safeguarding. The structure we have put in place ensures there is focus on BAU and transformation as we embark on the significant changes ahead of us.

A copy of the corporate risk register for the system transformation programme detailing all the major risks of merger and the mitigating actions is attached as Appendix 17.

Engaging with local people and our partners –

How we gathered people's views, what we heard and how this shaped our proposal for a Kent and Medway Clinical Commissioning Group (CCG)

www.kentandmedway.nhs.uk

Helping local people live their best life

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1. Introduction

Between January 2018 and 30 September 2019, we asked for people's views on possible changes to how NHS services in Kent and Medway are commissioned (planned and bought) and provided.

We want people to be able to live their best life, and get great treatment, care and support when they need it.

Until people need health and care services, most have no idea how many organisations there are or how complicated it can be to find the person you need to talk to. Sometimes services duplicate one another. Sometimes there are gaps. That is not good for patients or carers, it is frustrating for staff, and it is not the best use of NHS funds.

Over the last three years we have made real progress by working in a partnership of all the 19 NHS and top tier local authority organisations in Kent and Medway.

To help us further improve care for patients and meet rising demand, we want to have a Kent and Medway integrated care system with:

- a single organisation to plan and pay for services, instead of eight clinical commissioning groups as now
- people's care and treatment provided by NHS and other services working together in a much closer way (in integrated care partnerships and primary care networks).
- The GPs who chair the existing current clinical commissioning groups (CCGs) are championing this change, working with other partners. It is happening across the country too.

To develop these ideas and understand any concerns, we spoke to:

- patients, carers and the public
- Healthwatch Kent and Healthwatch Medway
- Kent and Medway GPs, who make up current clinical commissioning groups (CCGs), the Local Medical Committee which represents GPs, and CCG governing bodies, which take decisions on commissioning
- health and social care staff
- Kent and Medway health overview and scrutiny committees which review the NHS' plans and performance
- elected representatives, including MPs and councillors
- community and voluntary organisations

This report focuses on what people told us about our proposal to merge the eight existing clinical commissioning groups (CCGs) into a single Kent and Medway CCG, and what we did as a result.

The feedback has been shared with:

- Kent and Medway Patient and Public Advisory Group
- Healthwatch Kent and Healthwatch Medway
- System Transformation Steering Group
- System Transformation Oversight Group.

All groups considered how the issues raised by different audiences can be best addressed as the programme moves forward, and changes were made as a result of the feedback.

2. Aims for engagement

3.

"You said, we did."

We reached a wide range of people by offering different ways to get involved. We published our Programme Initiation Document, a plain English summary, and an easy read version, along with frequently asked questions, on the sustainability and transformation partnership (STP) and eight CCG websites.

Most people we spoke to thought a single CCG was a good idea. Many of them were mainly interested in our other plans, to provide more joined up care for local people.

The most often asked questions about the single CCG were:

- how difficult and expensive will it be to make the change?
- will enough notice be taken of local people's needs?

GPs and the Local Medical Committee raised specific points, covered in detail below.

Overall, we received a lot of useful feedback, which helped shape our proposal.

Patients and the public

How we asked what they thought

- two surveys open to everyone in Kent and Medway, shared digitally and in hard copy. The first was completed by 234 people. The second survey is just completed and the comments are currently being reviewed (see appendix 4.3 and 4.4 for the independent analysis)
- discussions with patients and members of the public who work with us on a regular basis
- workshops with Healthwatch Kent and Healthwatch Medway members
- public meetings about the NHS Long Term Plan and our proposal for wider change.

They said...

- they agreed with the need to join up and improve health and care services
- they wanted more information on what it would mean in practice
- they asked for clear information that is easy to understand
- they said we need to involve care homes and voluntary and community organisations
- those who attended meetings said our presentation helped make sense of the new system.

  They liked the idea of:

  - lower costs and less duplication
  - improved procurement (new contracts for services)
  - ending the postcode lottery of services
  - freeing up GP time with fewer CCG committees.

  They were concerned about the idea of:

  - less focus on local areas and the potential loss of local people's views
  - the costs involved
  - the new CCG adding an extra layer of bureaucracy.

  Those who attended meetings were also concerned about:

  - how well the new CCG would manage large Kent and Medway contracts
  - whether the plans are realistic, given pressure on staff time and the need for big changes to the way they work, and to patients' expectations.
- A number of people asked if there would be formal consultation on the merger. People also had concerns about other aspects of the new integrated care system including access to GPs.

We did...

- updated the frequently asked questions on our website with more detail on the practical changes
- ran a second survey to increase our understanding of views on a single CCG
- published a plain English summary of the benefits of our proposal (appendix 4.1) and here www.kentandmedway.nhs.uk/ics
- published a summary of our workforce strategy setting out how we will recruit and retain more health and social care staff across Kent and Medway and make the best possible use of their skills and expertise (appendix 4.2).
- held a public event in each of the four integrated care partnership areas to talk about system transformation along with the priorities of the NHS Long Term Plan. Voluntary and community groups were invited as one of the ways of involving them and hearing their views.
- held a series of workshops with our Patient and Public Advisory Group (PPAG) to design the principles and model of patient and public involvement for the new system (more details below). This builds in involvement at every level
- developed a new framework for patient and public involvement across the new health and care landscape
- invited community and voluntary groups to the public events in each of the four integrated care partnership areas to talk about system transformation and the NHS Long Term Plan, as one of the ways of involving them and hearing their views.
- reviewed with Healthwatch Kent and Healthwatch Medway lessons learned from previous procurements. Held a workshop to look at the results and:
  - what could have been done better
  - how commissioning needs to change in the future
  - how we manage our resources better against a background of rising demand for services.
- Sought legal advice which confirmed that engagement rather than consultation was appropriate for a change of this type.

Healthwatch Kent and Healthwatch Medway leadership

How we asked what they thought

Healthwatch Kent and Healthwatch Medway are represented by the chief officer of Healthwatch Kent on key STP groups, including the Patient and Public Advisory Group, the Programme Board, the System Transformation Steering Group and the engagement leads network in Kent and Medway.

We also had specific discussions with the chief officer about the proposed CCG merger.

They said...

Our local Healthwatch organisations support a single CCG. They gave us guidance on communicating and engaging with patients and public about the merger.

They said we needed to:

- describe the benefits of change and the 'so what?' for patients and public
- offer reassurance there would be no reduction in access to or quality of services as a result of the proposed merger.

They also gave us guidance on how the new integrated care system, including a single CCG, should make sure local people's views are heard.

As well as discussions as part of the Patient and Public Advisory Group, they said:

- involvement needs to be part of all service developments from the very start
- the new CCG should have a single point of access for any member of staff seeking patient and public input
- the new mechanisms for involvement need to be developed quickly
- staff need training and support in how to involve patients effectively
- Healthwatch would like to be an observer on the new CCG's governing body
- Healthwatch would like to be involved in developing the outcomes framework for the new single CCG and Integrated Care Partnerships.

We did...

- We agreed on the importance of involvement, training, and to ensure committee papers do more to highlight patient and public involvement
- We agreed to set up a single point of access
- We shared proposals for a Citizens' Panel and virtual network of people from across the county (more details below) which were welcomed by Healthwatch.
- We invited Healthwatch to System Commissioner Steering Group meetings, and agreed to involve them in the outcomes work and to consider them being an observer on the new CCG's governing body.

Healthwatch have subsequently confirmed their support for the new patient and public involvement framework for the new CCG and wider ICS. Their letter can be seen in appendix x.

Governing body lay members for patient and public engagement

Each of the existing eight CCGs has a lay member who is the voice of patients and the public on the governing body.

How we asked what they thought

As well as being on the governing bodies of their CCGs, some of the lay members also sit on our Patient and Public Advisory Group.

They said...

They supported the CCGs merging to improve care for people across Kent and Medway, efficiency and effectiveness.

They were concerned about the idea of:

- loss of patient involvement
- less focus on local issues.

We did...

- held a series of workshops with our Patient and Public Advisory Group to design the principles and model of patient and public involvement for the new system (more details below). This builds in involvement at every level
- agreed the new Kent and Medway group for patient and public involvement will include the patient and public engagement lay members from our existing eight CCGs for at least a year

Kent and Medway Patient and Public Advisory Group (PPAG)

Our Patient and Public Advisory Group includes patient representatives from each of the existing CCGs including people who have protected characteristics, as well as CCG lay members and Healthwatch.

They play a key part in our local sustainability and transformation partnership, including contributing to the different workstreams, and have a great deal of knowledge and insight about the local NHS.

They have been heavily involved in designing what patient and public involvement should look like in our new CCG. As well as the standing meeting, there was a series of workshops to design the principles and model for the new system.

They said...

The new CCG will need:

- to support the lay member for engagement on its governing body to represent the whole of Kent and Medway and its constituent localities
- insight from the whole system, including patient experience data, in a central place, accessible by all staff
- links to integrated care partnership and primary care networks engagement and their information, insight and best practice
- a true co-design and patient involvement approach, including a commitment to maintain engagement with local groups.

> "A single CCG for Kent and Medway makes perfect sense. I think this is the way to go, I know what variation we have in the services we have now across different areas of Kent. This should end the postcode lottery."

Male rep, Kent Community Health NHS Foundation Trust patient engagement group, August 2019

We did...

- in line with national guidance, the CCG will have an independent lay member for Patient and Public Engagement
- the CCG will have patient and public engagement constituency representatives supporting the lay member. This will be for a transitional period in the first instance until the integrated care partnerships are formally established and have patient and public representatives on their management boards
- all levels of the Kent and Medway integrated care system will act positively, empowering their local communities and seeking not just participation but to involve the public as equal partners to meet best practice standards and deliver high quality personalised care for all. This includes at a system, place and neighbourhood level across Kent and Medway
- to offer support to primary care networks and GP practices to enhance their patient and public engagement. This could include a mix of information, guidance, toolkits, training or more practical assistance
- the single CCG will establish an integrated care system core patient and public involvement group (again, name to be confirmed) to provide continuity and give patients and the public a strategic voice and provide a route for learning from all parts of the system. Its proposed membership will include:
  - expert patient/carer representatives from all the Kent and Medway priority workstreams such as mental health, children's services, cancer, primary and local care
  - patients with a general interest in health
  - partners in the voluntary and community sector
  - patient representatives from each proposed integrated care partnership area
  - during the transitional period, the current CCGs' lay members for patient and public engagement.
- patient, client and carer-led task and finish groups will be drawn together for time-limited, focused pieces of work as the workstreams and overall programme of transformation and innovation require
- two new systems will be set up to support these groups:
  - a virtual **citizen's panel**, a network of people that is representative of the Kent and Medway population to give a public perspective on all the work programmes, or any priority issues required. Recognising that our partners in local authorities may have similar schemes, we will seek to learn from all and work together as appropriate. This will build on best practice from other areas and existing CCG health networks
  - an **insight bank** to collate and link all the existing intelligence on patient experience gathered by NHS trusts, Healthwatch Kent and Healthwatch Medway, CCG, integrated care partnerships and local authorities. These groups currently gather much patient, carer and service user experience; too often it is not used to best effect for learning and may be duplicated by different parts of the system.

This co-produced model of patient and public engagement will form the involvement approach of the new CCG.

GPs

The 211 GP practices in Kent and Medway form the GP membership of the clinical commissioning groups, which have the statutory duty to plan and purchase the vast majority of healthcare for local people.

How we asked what they thought

- meetings over many months with their CCG chairs
- a webinar open to all GPs in Kent and Medway in August 2019 (slides were shared, as well as a recording)
- email discussions.

They said...

A single CCG would need:

- to retain input from and focus on local areas
- to strengthen the voice of the public, patients and GPs in commissioning
- to retain strong support to GP services and primary care networks
- to be easily contactable
- to maintain links with local GP practices, primary care networks and integrated care partnerships
- to ring-fence GP practice and integrated care partnership budgets to support the local population
- clarity about what the CCG does as opposed to integrated care partnerships
- to improve specific services (e.g. children and young people's services) and support (e.g. GP IT).

They were concerned about the idea of one area's financial surplus being used to support a different area

We did...

We made these commitments:

- the new CCG will always be **GP-led**, with a GP majority on its governing body including a GP from each current CCG until at least April 2022, and ongoing clear and transparent clinical representation from local constituencies across Kent and Medway
- there will be **strong and effective clinical leadership and input** throughout the whole organisation
- there will be a full and robust development programme for primary care networks that will enable them to be **effective leaders** within the emerging integrated care partnerships and **reinvigorate GP services**
- **local support for GP practices** will continue as now, or be enhanced, and there will **ongoing support in integrated care partnerships** for service design and delivery
- **primary care baseline allocations** will be protected and where possible increased. There will be **transitional protection of baseline commissioning allocations** for integrated care partnerships
- **there will be strong local patient and public representation** from the CCG governing body down to individual primary care networks.

[1] *This is in addition to the formal voting process to merge the CCGs, which GP members were asked to vote on through their respective CCG membership meetings in September 2019*

Local Medical Committee

The Kent and Medway Local Medical Committee (LMC) is the voice of local GPs.

How we asked what they thought

The Local Medical Committee Medical Secretary co-chairs the STP Primary Care Board and the LMC is represented on the STP Clinical and Professional Board. The Chief Executive of the STP presented the Kent vision to the annual conference of the LMC in December 2018.

We also had specific discussions with the LMC about the proposed CCG merger.

They said...

- they understood the proposal, its context and rationale
- they knew the GPs who chair the existing CCGs supported a single CCG.

They were concerned about the idea of:

- GPs being expected to do work that was not funded through a contract
- GP practices having less influence on commissioning
- GP practices getting less support from the new CCG
- primary care networks becoming the sole voice for primary care.

We did...

- developed with the LMC a set of principles for the future
- sent a joint letter with the LMC to GPs, setting out the principles, and urging GPs to vote.

The principles:

1. Recognition of the gap between funded services and the expectations of the local care plan.
2. The integrated care partnership contract will describe outcomes to strengthen engagement and collaboration. The integrated care partnership contracts will not be let without the demonstrable sign-up of local GP practices
3. GP contract holders will be represented within the system by the Local Medical Committee as well as primary care networks.
4. No additional work will be expected of general practice without additional funding and resources.
5. Kent and Medway CCG constitution will be drafted in consultation with the Local Medical Committee.
6. GP contracts will be managed at the Kent and Medway level. Budgets will not be reduced, more likely increased.
7. GP practices and CCG will maintain local links.

CCG governing bodies

How we asked what they thought

Through formal and informal meetings, including working group meetings relating to the system transformation programme

They said...

- They were in support of a single CCG

They liked the idea of:

- removing duplication
- streamlined management structures and costs
- ability to commission at scale
- ability for services to get best value and better outcomes
- reduction in variation and the 'postcode lottery'.

They wanted to be sure the CCG keeps a focus on local needs, and hears local voices.

They were most concerned about:

- impact on CCG staff
- maintaining financial stability within their constituent areas, while also making sure funding is directed towards those areas with greatest health inequalities.

We did...

The CCG establishment and application documents were developed in line with the outcome of various governing body discussions.

The CCG chairs shared with their governing bodies:

- the commitments made to GPs
- the principles developed with the Local Medical Committee
- the principles and model for patient and public involvement developed with the Patient and Public Advisory Group
- the communications and engagement plan
- the workforce and organisational development plan.

CCG and sustainability and transformation partnership (STP) staff

How we asked what they thought

- face to face briefings over many months
- online surveys
- specific email for anonymous questions
- two all-staff sessions on 13 September.

They said...

- overwhelmingly understood the rationale for change and saw its potential benefits for patients

They wanted to know

- 'what does it mean for me?' including job security, location of workplace, team structures, future roles and responsibilities, conflicting priorities during implementation

They were concerned about:

- the impact on them as individuals and teams
- potential difficulties of implementing complex changes
- potential loss of local focus
- lack of resources (GPs, funding, staff, infrastructure)
- ability of the system to change.

We did...

- made a commitment to share as much information as we can, and be clear about when we don't yet know the answers.
- sent regular email bulletins from the STP chief executive, and from the two managing directors.
- prepared and continually revised a series of very detailed frequently asked questions.
- set up an anonymous email for staff to feedback their queries or concerns
- responded to all questions raised
- reiterated the importance of staff to the new system and the opportunities for them to develop their interests and new skills.
- shared all information developed, including plain English summary of benefits realisation plan and workforce plan.
- organised two half-day sessions on 13 September.

> "All detail is about the patient experiences. What about all the staff this affects, where do we see how it affects us? I get "patient first" approach but it's my livelihood and I love my job. Will you need all the support services, or will some go? How many staff does this affect? How many job losses? Will trusts merge?"

Health and social care colleague

Kent Health Overview and Scrutiny Committee (HOSC) and Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC)

How we asked what they thought

- formal public meetings
- informal meetings by arrangement.

They said...

Both our oversight and scrutiny committees have maintained an interest in our plans for an integrated care system with a single CCG.

Individual members of the committees expressed a range of views about the CCG merger.

They asked:

- how will social care and public health fit into the future arrangements?
- what will be the impact on primary care and workforce?
- how will the single CCG maintain transparency and avoid conflicts of interest?
- isn't this just re-creating structures of the past?

They were concerned about:

- the ability of a single CCG to meet the needs of individual districts and people
- potential for single CCG to become 'another layer of expensive bureaucracy'.

We did...

- updated them on our plans, specifically highlighting progress on all issues raised by them
- clarified the different roles of the proposed new single CCG, integrated care partnerships and primary care networks, highlighting that there will be more local focus, not less
- developed messaging on primary care networks to make it clear that they were not replacing GP practices but were a way for GPs to work together
- committed to continuing to update the committees at key points.

"I think it's a very good idea."

Member of Kent HOSC, June 2019

"You need to get over to a much wider section of the public that Primary Care Networks are not the same as GP practices."

Chair of Kent HOSC, June 2019

MPs

How we asked what they thought

- briefings with the Managing Director for their constituency
- letters to each MP.

They said...

- wo MPs from Medway sent a letter opposing the proposals because of concerns about specific local issues

We did...

- offered to meet with the MPs who opposed the merger and wrote to them to address their concerns.

Elected members of upper and lower tier councils

How we asked what they thought

- letter updating councillors of the proposals and offered them a meeting
- eight councils took up the offer and we held separate briefings with them.

They said...

- recognise the need for a single CCG to oversee integrated care partnerships and primary care networks

They liked the idea of:

- streamlining bureaucracy
- freeing up GPs to see patients
- one group (the integrated care partnership for their area) representing the whole of health and care
- strengthening GP services
- teams of health and care professionals working together to support local people

They were concerned about:

- commissioning becoming remote
- potential conflict between patient choice and locally based integrated care
- ability of health services to keep up with housing development
- districts which straddle two integrated care partnerships.

We did...

- clarified the different roles of the proposed new single CCG, integrated care partnerships and primary care networks, highlighting that there will be more local focus, not less
- gave reassurance that patient choice remains a key principle of the NHS
- explained how a single CCG will improve strategic planning, including work with council planning departments
- committed to look at issues for districts working with more than one integrated care partnership.

Voluntary and community organisations

How we asked what they thought

- letter updating them and inviting feedback
- invited them to public events in each of the four integrated care partnership areas to talk about system transformation along with the NHS Long Term Plan.

They said...

-

We did...

-

4. A multi-layered approach to engagement

The following outlines the various activities and formats that we have used in our engagement activities

Activity	Format
Stakeholder e-bulletins	Electronic STP bulletins emailed to distribution list with onward cascade. Focus on system change in January 2019, May 2019, and July 2019.
Patient networks, including CCG networks, trust networks, and practice participation groups	Presentations to standing groups (for example, West Kent patient participation group chairs) since January 2018. Email inviting people to give their views on integrated care system including single CCG, with links to the Programme Initiation Document, plain English summary Helping local people live their best life, easy read version, FAQs and survey, sent to patient networks across Kent and Medway, for onward cascade in June 2019.
Partner networks, including Kent County Council, Medway Council, Healthwatch Kent and Healthwatch Medway	Email inviting people to give their views on integrated care system including single CCG, with links to the Programme Initiation Document, plain English summary Helping local people live their best life, easy read version, FAQs and survey, sent to patient networks across Kent and Medway, for onward cascade.
Focus groups	**July** • Healthwatch members, Canterbury, Letraset Building • Dartford, Gravesham and Swanley, West Kent and Medway PPGs group • Hawkinge and Elham Valley Patient Participation Group **August** • Healthwatch members – West Kent, Angel Centre, Tonbridge • Healthwatch members Medway, Dragon Community Hub • Kent Community Health NHS Foundation Trust patient experience group

Activity	Format
Surveys	Survey on integrated care system and single CCG: June to August 2019. Promoted at face-to-face meetings with patient groups and through email cascade and online, including boosted post on Facebook. Available in hard copy and online. Survey on single CCG: August to September 2019
Online materials	Programme Initiation Document, plain English summary *Helping local people live their best life*, easy read version and FAQs on STP and all CCG websites.
Social media	Facebook and Twitter including Facebook promoted content on single CCG survey and our plans
Printed materials	Booklet and supporting slides of *Helping People Live their Best Life*, shared with patients and the public at meetings and events along with FAQs.
Briefings with district councils, MPs etc	• Ashford Borough Council • Dartford District Council • Folkestone and Hythe District Council • Kent County Council – Public Health Cabinet Committee • Maidstone Borough Council – this was extended to KCC divisional members and also MPs • Sevenoaks District Council • Swale Borough Council • Tunbridge Wells Borough Council
Briefings with CCG and STP staff	Monthly staff briefings to all CCG staff and regular briefings to STP staff. CCG and STP staff away day
Kent HOSC, Medway HASC, Kent and Medway Health and Wellbeing Board	Regular briefings throughout 2018 and 2019
Media coverage	Proactively placed media copy

Our vision is for everyone in Kent and Medway to have a great quality of life by giving them high-quality care.

Quality of life, quality of care

Thank you

We are very grateful to the Kent and Medway Patient and Public Advisory Group, CCG lay members, Healthwatch Kent and Healthwatch Medway for the support they gave in shaping and undertaking the engagement, and co-producing our model for future public and patient involvement.

The report has been prepared by the Kent and Medway Sustainability and Transformation Partnership Communications and Engagement Team. To find out more, or get it in a different format, please contact comms.kentandmedway@nhs.net

healthwatch Kent

Focus on Commissioning: A Healthwatch Kent report

January 2020

Background

The way health and social care services are commissioned in Kent & Medway is changing.

Currently seven Clinical Commissioning Groups (CCGs) commission health services for their own geographical areas. For Kent wide contracts, one CCG will take the lead to commission the service on behalf of the county.

Healthwatch Kent has a unique view of this system. We are one of the few organisations who work across all the CCGs and so we are aware of the work that has been done to involve patients in the commissioning process. We also hear directly from patients from all over Kent about their experience of the services that have been commissioned. In addition, we sit on the Kent Health Overview & Scrutiny Committee (HOSC) which scrutinises services in conjunction with our own statutory role to scrutinise changes to services to ensure the public have been truly involved and informed about service change.

From April 2020 there will be a new system of commissioning and partnership working, called an Integrated Care System, made up of:

- A **Single Strategic Commissioner**, comprising of a single CCG for Kent & Medway, along with the social care commissioning of Kent & Medway councils.
- **Integrated Care Partnerships in East Kent**, West Kent, North Kent, and Medway & Swale which will commission and deliver acute and local care within those areas.
- **Primary Care Networks** delivering primary care and local care in clusters of GP practices

This new structure means that a new process for how services are commissioned is being developed. We believe that lessons can be learned from the current commissioning structure and should be used to determine the new structure.

What have we done?

- We have reviewed a number of services that have recently been commissioned in Kent & Medway.
- The majority of services we selected have been commissioned on a County wide level and which have experienced challenges and caused disruption for patients.
- We have reviewed documents from HOSC which detail the challenges services have faced, the disruption caused to patients and the debate at HOSC and any resulting actions.
- We have combined this literature review with feedback we have heard directly from patients.
- We have been able to link this to knowledge that we have about the commissioning process and how patients and service users were involved and listened to during that process.

We reviewed the following contracts

- **Wheelchair Services**
- **Integrated Community Equipment**
- **Kent and Medway Patient Transport**
- **Children and Young People's Mental Health Services**
- **East Kent Out of Hours**
- **North Kent Dermatology Service**

What did we find?

In each of these contracts, a number of issues came to light after the new provider has started to deliver the new service including:

- **Demand** was often higher than predicted meaning patients immediately started to experience longer waiting times
- The new service inherited a **backlog** of cases which added to the already growing waiting list
- Patient information was often not transferred effectively meaning patients '**got lost**' in the system
- Contracts needed to be **reviewed** substantially within the first few months to 'true-up' the contract with the actual demand
- Additional **funding** was often needed at short notice to meet the agreed demand
- Those contracts which had been comissioned through an **integrated partnership approach** (predominantly the NHS and Kent County Council) were more successful

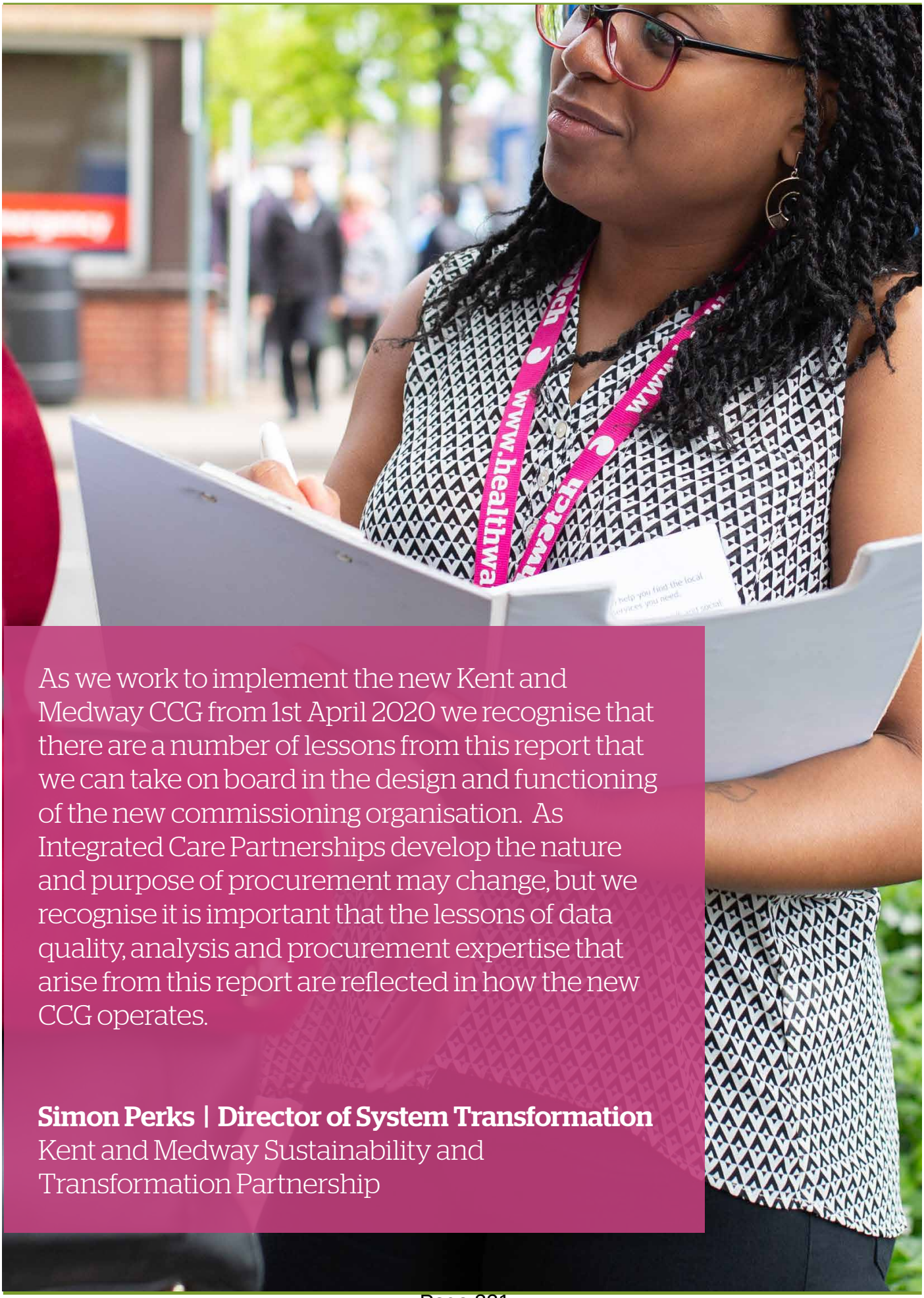
We invited key senior people from the new Integrated Care System to meet with us and explore our findings. As a result of this meeting, we have agreed a number of points.

We are grateful to Healthwatch for this report which highlights a number of key points and areas for development. The Clinical Commissioning Groups regularly review systems and processes on the basis of being 'learning organisations' and we welcome the comments in this report. We will use them to improve how we procure services for patients in Kent and Medway going forward.

By the nature of this report, the majority of the observations have been scrutinised previously by the Kent Health Overview and Scrutiny Committee through the individual reports fed back to the Committee. However, we recognise the benefit of pulling together generic issues from the reviewed procurement examples. We would want this report to be read in the context that it covers larger and more complex procurements reviewed by HOSC, and therefore is not representative of many successful and smaller procurements delivered by the CCGs that have not come under the scrutiny of the HOSC.

While we recognise the statements made in the 'What did we find?' section of the report there are two points of clarity we would wish to make. In a number of the procurements scrutinised by the HOSC, higher demand than predicted was a key issue but this was not the case in all. Also, where additional funding was required, this invariably resulted from additional demand and service activity, and was therefore a commissioning response to ensuring and maintaining timely levels of access to services.

Simon Perks | Director of System Transformation
Kent and Medway Sustainability and Transformation Partnership



As we work to implement the new Kent and Medway CCG from 1st April 2020 we recognise that there are a number of lessons from this report that we can take on board in the design and functioning of the new commissioning organisation. As Integrated Care Partnerships develop the nature and purpose of procurement may change, but we recognise it is important that the lessons of data quality, analysis and procurement expertise that arise from this report are reflected in how the new CCG operates.

Simon Perks | Director of System Transformation
Kent and Medway Sustainability and Transformation Partnership

Summary of findings for each contract

Wheelchair Services

Millbrook Healthcare took over the Kent & Medway NHS Wheelchair contract on 1st April 2017. In the first year, April 2017 to March 2018, several issues were identified:

- The quality of the initial data transfer at the start of the contract revealed some service user records were missing, incomplete or inaccurate.
- Millbrook Healthcare inherited a backlog of people who had been waiting a long time. The case load included more complex cases than they had expected.
- It was estimated that 40% of people had been waiting for more than 18 weeks at that point in time.
- The higher complexity of cases affected the ability of the service to manage the ongoing referrals.
- The demand for specialist wheelchairs was 154% higher than expected although average costs were lower than expected.

- **There were also several issues linked to funding:**

  - The CCGs could not disregard the possibility that Millbrook Healthcare may have underbid for the contract during the procurement.
  - Millbrook Healthcare over-spent their equipment budget by 21% during the first year of the contract from April 2017 to March 2018.
  - As a result, additional funding (£1,103,938) was released.

Summary of findings for each contract

East Kent Out of Hours

Primecare was awarded a contract 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).
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 CQC inspected the service in May 2017 and published their findings on August 3rd. The report stated:

- There was a failure to take into consideration the risks to the health and care of service users.
- The care needs of patients were not always assessed and delivered in a timely way.
- Staff reported that they could not access patient records.
- There were not enough staff to meet the needs of patients and there was a lack of induction and mandatory training.
- Staff did not feel fully supported by management.
- When errors were made, not all staff knew how to report incidents.
- Investigations into incidents were found to be superficial and there was limited evidence of learning from mistakes.
- There were long delays in dealing with patient complaints.

Primecare were owned by Allied Health Care who were going through financial difficulty at the time. On July 7th 2018, it was announced that Primecare had left the contract early.

Summary of findings for each contract

Patient Transport

G4S was awarded the three contracts in July 2016, which together cover every aspect of the non-emergency patient transport service for Kent & Medway.

- During the commissioning process, the activity data was inaccurate.
- During the mobilisation phase, the London activity data provided was also not accurate. It was then decided that the mobilisation of London journeys would be postponed until February 2017.
- None of the contract KPI's were met during the first 12 months of the contract.
    - The average complaints per month were 138 representing 0.6% of total patient journeys. Complaints were highest during the opening months of the contract.
- In February 2018, based on the KPI data,
    - Performance remained below the contracted levels of the 18 KPIs across all 3 contracts.
    - In the six months to February 2018 complaints averaged 64 a month representing 0.2% of total patient journeys.
- There was a 'true up' exercise undertaken in March 2018
- After the contract true-up exercise was completed in March 2018, it was concluded that the patient journey mix was different from that set out in the tender process. The review exercise identifies the following adjustments to the contract:
    - A reduction in car journeys;
    - An increase in ambulance journeys;
    - An increase in the requirement for services with a patient escort; and
    - Longer patient journeys
- This led to West Kent CCG proposing to rebase the contract according to revised activity levels which, at the time (May 2018), was being considered by the eight CCGs.
    - This would mean that the three lots were consolidated into one and the value of the contract increased from the original £13.2 million a year to £17 million a year.
    - It also meant that the KPI targets would be recalibrated with target levels reduced from between 90-95% to 80%.
- The commissioners had also recognised that whilst a KPI was a general measure of performance, the standard of performance reporting was not indicative of the full service provided. As an example:
    - For June 2018, 81% of patients arrived for their appointments within the contractual KPI, and 93% of patients arrived within 30 minutes of their allocated appointment time.

Summary of findings for each contract

Integrated Community Equipment

Kent County Council awarded the contract to NRS Healthcare for five years starting on November 30th 2015. The total anticipated contract value for the life of the contract was £45 million. This was one of the largest community equipment service contracts in the country.

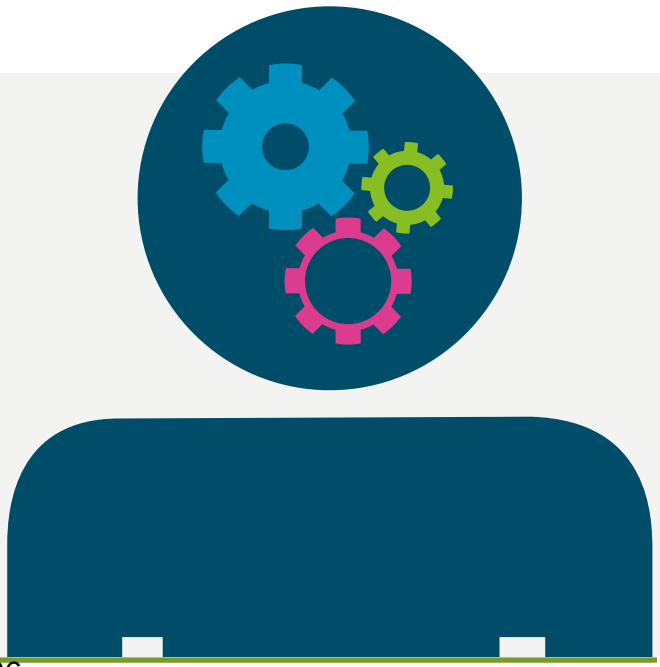
- The mobilisation of the contract needed a considerable amount of resource, determination and a strong project managed approach.
- Since NRS Healthcare took over the contract the financial visibility and performance monitoring have greatly improved.
- A number of staff left despite TUPE applying to that transfer.
- A stable team have now been recruited with a continuous recruitment campaign to cover natural attrition.
- Challenges were seen around operational efficiency, but they are reported to have settled down.
- Processes for the ordering and provision of equipment have greatly improved.
- Recycling remains a challenge and as a result of the contract's financial model, NRS Healthcare's financial viability has not been what was anticipated.

Summary of findings for each contract

Children and Young People's Mental Health Services

North East London NHS Foundation Trust (NELFT) was awarded the contract for the provision of emotional wellbeing and mental health advice and support for young people and their families across Kent. The contract started on September 1st 2017.

- Included in the invitation to tender documentation was data relating to known waiting lists provided by Sussex Partnership Foundation Trust (SPFT) and PSCION.
- However, subsequent to service transfer it was apparent that this data was inaccurate.
- The tender did not include enough detail about assessments, decisions and referrals.
- There was a lack of vigorous information relating to patients that were being cared for by EKHUFT and PSCION. This had an impact on these patients who were meant to transfer to NELFT from April 1st 2018.
- Prior to the start of the contract, it was identified that the financial envelope to meet the prescribing needs of children, particularly those in East Kent that were on the current prescribed medication by PSCION and EKHUFT, may not have been accurate.
- The volume of need was not fully understood. There were 7,000 children who needed specialist care but this had not been planned for.
- There were not enough admin staff and clinicians to handle the volume of calls to the service. At one point in NELFT were taking 600 calls a day.
- Many of the calls were from people trying to complain. The volume of complaints meant they became diverted dealing with complaints rather than addressing the issues within the service.



Summary of findings for each contract

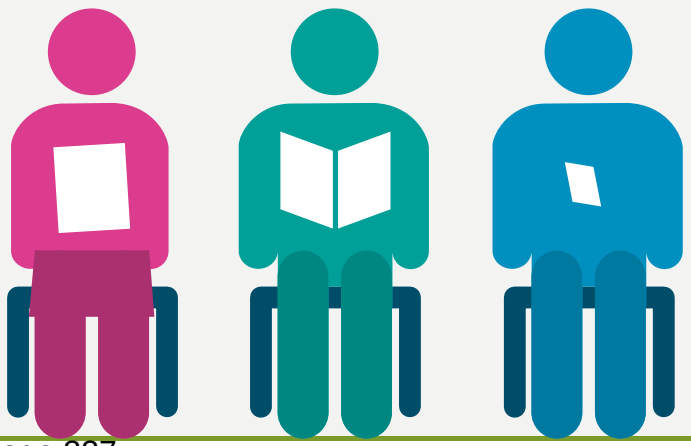
Dermatology

In September 2018 Medway Foundation Trust informed commissioners they were going to give notice on their dermatology service. DMC Healthcare was awarded the contract for the North Kent Dermatology Service from April 1st 2019.

Throughout this process a number of issues were identified including:

- A short mobilisation period meaning things weren't ready in time.
- Difficulties finding suitable premises in the area.
- Uncertainty about staff transferring from the current contract to the new service which meant it was challenging to plan clinics and staff rotas.
- Lack of clarity regarding the number of patients who were still waiting from the previous provider.
- Uncertainty about the arrangements for Multi Disciplinary Teams (MDTs) in the area.
- During this time DMC experienced a high number of calls which resulted in patients facing delays contacting DMC.
- There was a problem with the transfer of scan results from MFT to DMC affecting 30 patients

WAITING ROOM



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Item 8: CCG Annual Assessment 2018/19 (Written Update)

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: CCG Annual Assessment 2018/19 (Written Update)

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.

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1. Introduction

(a) NHS England has a statutory duty to undertake an annual assessment of CCGs. This has been carried out under the auspices of the Improvement and Assessment Framework (IAF), with the overall assessment derived from CCGs' performance against the IAF indicators, including an assessment of CCG leadership and financial management.[1]

(b) The seven Kent CCGs have been asked to provide the key actions from their improvement plans to the Committee. A written report is attached for information.

2. Recommendation

RECOMMENDED that the report be noted, and the Kent CCGs be requested to provide an update to the Committee annually.

Background Documents

NHS England (2018) *'CCG Improvement and Assessment Framework 2018/19 (CCG IAF) (8/11/2018)'*, https://www.england.nhs.uk/publication/ccg-improvement-and-assessment-framework-ccg-iaf-2018-19/

NHS England (2019) *'CCG Annual Assessment 2018/19 (11/07/2019)'*, https://www.england.nhs.uk/publication/ccg-annual-assessment-report-2018-19/

Contact Details

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[1] NHS England (2019) CCG Annual Assessment 2018/19

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Kent Health Overview and Scrutiny Committee (HOSC) Briefing: Annual assessment 2018/19 of Kent CCGs

January 2020

1. Introduction

The CCG annual assessment for 2018/19, carried out by NHS England (NHSE), provides each CCG with a headline assessment against the indicators in the CCG improvement and assessment framework (CCG IAF). The IAF aligns key objectives and priorities as part of delivering the Five Year Forward View.

The CCG IAF for 2018/19 comprises 58 indicators selected to track and assess variation across four domains including Better Health, Better Care, Sustainability and leadership across the Integrated Care System (ICS). See Appendix 1.

CCGs are rated in one of four categories: 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

Each CCG receives a letter detailing the assessment by NHSE and confirming the annual assessment, as well as a summary of any areas of strength and where improvement is needed from a year-end review.

The 2018/19 annual assessments were published on the CCG Improvement and Assessment page of the NHS England website in July 2019.

Kent CCG ratings

The headline rating for each of the CCGs is as follows.

CCG	Headline rating
NHS Ashford CCG	Inadequate
NHS Canterbury and Coastal CCG	Inadequate
NHS Dartford, Gravesham and Swanley CCG	Requires improvement
NHS South Kent Coast CCG	Inadequate
NHS Swale CCG	Requires improvement
NHS Thanet CCG	Inadequate
NHS West Kent CCG	Good

All CCGs rated Inadequate or Requires Improvement have improvement plans in place.

A summary of key actions from Kent CCGs' improvement plans is included in Appendix 2.

Appendix 1 – CCG Improvement and Assessment Framework indicators for 2018/19

Key:

- New indicators in the *CCG Improvement and Assessment Framework 2018/19* are highlighted in *italics*.

Better Health		
1	Child obesity	Percentage of children aged 10-11 classified as overweight or obese
2	Diabetes	Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children
3		People with diabetes diagnosed less than a year who attend a structured education course
4	Falls	Injuries from falls in people aged 65 and over
5	Personalisation and choice	Personal health budgets
6	Health inequalities	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions
7	Antimicrobial resistance	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care
8		Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care
9	Carers	The proportion of carers with a long term condition who feel supported to manage their condition
Better Care		
10	Provision of high quality care	Provision of high quality care: hospitals
11		Provision of high quality care: primary medical services
12		Provision of high quality care: adult social care
13	Cancer	Cancers diagnosed at an early stage
14		People with urgent GP referral having first definitive treatment for cancer within 62 days of referral

15		One-year survival from all cancers
16		Cancer patient experience
17	Mental health	Improving Access to Psychological Therapies – recovery
18		Improving Access to Psychological Therapies – access
19		People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within two weeks of referral
20		Children and young people's mental health services transformation
21		Mental health out of area placements
22		Mental health crisis team provision
23		*Proportion of people on GP severe mental illness register receiving physical health checks in primary care*
24		*Cardio-metabolic assessment in mental health environments*
25		*Delivery of the mental health investment standard*
26		*Quality of mental health data submitted to NHS Digital (DQMI)*
27	Learning disability	Reliance on specialist inpatient care for people with a learning disability and/or autism
28		Proportion of people with a learning disability on the GP register receiving an annual health check
29		Completeness of the GP learning disability register
30	Maternity	Maternal smoking at delivery
31		Neonatal mortality and stillbirths
32		Women's experience of maternity services
33		Choices in maternity services
34	Dementia	Estimated diagnosis rate for people with dementia
35		Dementia care planning and post-diagnostic support

36	Urgent and emergency care	Emergency admissions for urgent care sensitive conditions
37		Percentage of patients admitted, transferred or discharged from A&E within four hours
38		Delayed transfers of care per 100,000 population
39		Population use of hospital beds following emergency admission
40	End of life care	Percentage of deaths with three or more emergency admissions in last three months of life
41	Primary care	Patient experience of GP services
42		Primary care access – proportion of population benefitting from extended access services
43		Primary care workforce
44		*Count of the total investment in primary care transformation made by CCGs compared with the £3 head commitment made in the General Practice Forward View*
45	Elective access	Patients waiting 18 weeks or less from referral to hospital treatment
46	7 day services	Achievement of clinical standards in the delivery of 7 day services
47	NHS Continuing Healthcare	Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting
48	Patient safety	Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by CCGs
49	Diagnostics	*Patients waiting six weeks or more for a diagnostic test*
Sustainability		
50	Financial sustainability	CCG in-year financial performance
51	Paper-free at the point of care	Utilisation of the NHS e-referral service to enable choice at first routine elective referral
52	*Demand management*	*Expenditure in areas with identified scope for improvement*

Leadership across the ICS		
53	Probity and corporate governance	Probity and corporate governance
54	Workforce engagement	Staff engagement index
55		Progress against the Workforce Race Equality Standard
56	Local relationships	Effectiveness of working relationships in the local system
57	Patient and community engagement	Compliance with statutory guidance on patient and public participation in commissioning health and care
58	Quality of leadership	Quality of CCG leadership

Appendix 2 - Summary of key actions in CCG improvement plans for Kent CCGs.

Kent Health Overview and Scrutiny Committee (HOSC) Briefing: Annual assessment 2018/19 of Kent CCGs

November 2019

CCG	Key actions	Current status
East Kent CCGs	NHS England has agreed to oversee our 2019/20 financial recovery plan (FRP) for east Kent and support us by using statutory directions. The financial recovery plan will show how the CCGs ensure they operate within their annual budget in financial year 2019/20 and remains in recurrent balance in subsequent four financial years.	The financial recovery plan (FRP) for east Kent has been agreed and signed off by regulators. The CCGs' financial plan for 2019/20 aligns to the agreed FRP and in delivering the financial plan the CCGs will deliver the FRP and satisfy the lifting of legal directions relating to finance. The FRP has been signed off through governing bodies following a series of reviews, including clinically. The governing bodies have recently been updated on the FRP in detail at a development session. The FRP is monitored monthly through the contracting, finance and performance committee, and performance against the FRP reported to boards monthly. We have changed internal processes to make sure that actions are more clinically driven and owned. The east Kent CCGs are working closely with NHS England and Improvement's Intensive Support Team to give assurance against the financial commitments and adherence to plan; improve the quality of services; and bring about more effective east Kent-wide working to resolve the challenges we face together in east Kent. Only efficiencies and interventions that have a system benefit have been included within the FRP. Significant steps have already been taken to address our financial situation

		and build a sustainable NHS which focuses on providing the very best, most cost-effective patient care. The FRP feeds into the jointly agreed System Plan, and will feed into operational plans. CCGs are fully aligned with EKHUFT on activity, finance and workforce, and have spent time to check the alignment between activity, capacity and finance. The system's response to the NHS Long Term Plan is an improvement on the financial improvement trajectories set by regulators as we work across the whole STP footprint to manage risk. We have appointed a jointly funded director to coordinate the east Kent system programme management approach.
	Supporting the development of a single CCG for Kent and Medway with an integrated care partnership (ICP) and primary care networks (PCNs) in east Kent as part of the overall STP strategy.	GP members have approved the establishment of a single Kent and Medway CCG, and together with the other CCGs in Kent and Medway, we have submitted an application to establish a single CCG from 1 April 2020. 16 PCNs have been established across east Kent, giving full coverage for east Kent.
	Implementation of a digital strategy to support new workforce models.	East Kent has been selected to be part of the "Digital First Unscheduled Care Accelerator" programme that will enable clinicians to make decisions using real- time digital information. The CCGs have continued to implement the Medical Interoperability Gateway (MIG) programme, extending its coverage to all main providers.

		We have supported GPs to adopt EMIS and Vision clinical systems as well as to implement software to facilitate the linking of these systems. We are contributing to the Kent and Medway digital infrastructure refresh programme.
	Referral To Treatment (RTT) improvement linked to transforming outpatients, pathway redesign and waiting list reductions.	The numbers of patients waiting more than 52 weeks for their treatment at EKHUFT has improved significantly in 2019/20. At the end of December 2019 there were five patients waiting for treatment over 52 weeks as opposed to 80 patients at the end of December 2018. The proportion of patients waiting less than 18 weeks has improved to 83% and is exceeding the agreed improvement trajectory. Our RTT Improvement Plan continues to be progressed, through the Planned Care Task and Finish Group, with a focus on pathway redesign within key specialties (gastroenterology, dermatology, MSK, chronic pain, urology, rheumatology, ENT).
	Improve A&E discharge and flow including reducing the number of Delay Transfer of Cares (DTOCs).	We have undertaken a system demand and capacity review. There is agreement across the system that demand growth rates are higher than had been predicted but that capacity could be managed better to improve flow. We are working with EKHUFT, KCHFT and KCC to review flow across the

		urgent care system. Further work to understand the levels of growth is underway. A number of key priorities have been agreed by the east Kent system leads to address urgent care demand and flow. The implementation of Urgent Treatment Centres (UTC) is within plan. The providers issued with a direct award contract are in the process of reviewing the contracts with a view to fully implement the service within the next few weeks. However three of the five direct award sites have commenced a soft launch. Procurement of the UTCs on the acute sites to be mobilised April 2020.
	Continue work with STP on Cancer Strategy.	We have established a joint committee across the Kent and Medway CCGs to oversee implementation of the cancer strategy and continue to work on developing capacity and capability. The percentage of patients seen within two weeks for suspected cancer has been on target throughout the year and we have delivered a sustained improvement in the 62-day referral to treatment cancer standard with performance in October reaching 88.45% (target 85%).
	Dementia diagnosis rate improvement to deliver national target.	With the exception of Canterbury and Coastal CCG, dementia diagnosis rates continue to remain below the national target. We continue to implement our improvement plan including the following key actions:

		Practices continue to be sent their diagnosis rates on a quarterly basis and offered support to undertake data harmonisation. A programme of targeted support is being developed following a survey of Thanet GPs which looked to understand the gaps and challenges to diagnosis. A community geriatrician is currently undertaking comprehensive geriatric assessments in care homes in Thanet. Part of this process includes the diagnosis of dementia, where appropriate. A second GP education day, supported by the clinical network, is being planned for Kent and Medway in March. In addition Dementia United in Manchester who have successfully increased diagnosis rates have agreed to facilitate a workshop early this year to share their experiences..
	Focus on Improving Access to Psychological Therapies (IAPT) ensuring compliance with national specification.	The percentage of people that wait six weeks or less from referral to entering a course of IAPT treatment has remained above or close to the national target of 75% for the past 12 months. Recovery rates continue to exceed the national target. Access rates have dipped in Thanet and South Kent Coast due to a reduction in provider capacity but capacity is expected to increase now that tariff uplift has been agreed. In addition, work is underway with the NHSE England IAPT transformation group to develop workforce plans.
	Development of safeguarding strategy at STP level as a priority.	Governing bodies have approved a Kent and Medway-wide Safeguarding Strategy and CCGs are continuing implementation and promoting the

		sharing and spread of good practice across Kent and Medway.
	Oversight and leadership of quality improvements in EKHUFT, with appropriate escalation within CCGs and EKHUFT.	Quality oversight is undertaken at joint contract management and Quality Committee meetings. Escalation to NHS England and NHS Improvement-led System Oversight Meeting – continues monthly.
	Improve performance against CHC target re: assessments out of hospital.	We have met or exceeded the target for 85% of decision support tool (DST) assessments being undertaken outside of acute hospitals since March 2019. There is some variation in performance levels for referrals that originate from community hospitals and we are working to address this.
	Ensure delivery of special educational needs and disability (SEND) actions and share action plan.	Together with the other Kent and Medway CCGs and Kent County Council, a multi-million-pound investment programme has been identified. CCGs have created a statement of action which makes more direct links between planned actions and the outcomes for children and young people. The statement of action has been shared with the CQC and Ofsted, and is published on the KCC website. CCGs have recruited a Designated Clinical Officer for Kent and Medway, and established a Kent SEND Improvement Board. The programme of improvement is driven and monitored by the Joint

		Committee of Kent and Medway CCGs and SEND Improvement Board.
	Ensure governing bodies are fully sighted on main quality and constitutional target achievements including action and improvement required.	Governing body agendas are aligned to assurance, key risks and system recovery. CCGs have improved the integrated performance report which is a standing report to our governing bodies to enable scrutiny of performance and, where necessary, actions to address poor performance. Quality and constitutional target achievements are reviewed in further detail through the quality committee and contracting, finance and performance committee as sub groups of the governing bodies, this includes thorough review of actions and improvements and escalation of key issues to the governing bodies as required.
	Submit pre-consultation business case (PCBC) to NHSE within required timelines.	The CCGs governing bodies and the EKHUFT board have established a joint committee to oversee the development of the PCBC, and we continue to work closely with NHS England regarding their assurance process. We have continued to prioritise the east Kent transformation programme to make sure we are planning for a health system that is sustainable and delivers the very best patient care.
	20% reduction in commissioning system costs by March 2020	A recruitment control process now operates across the Kent and Medway CCGs. The submitted Long Term Plan across Kent and Medway CCGs is aligned to the admin allocations permitted by regulators, this is inclusive of the expectation for CCGs to improve system costs by 20%.

CCG	Key actions	Current status
East Kent CCGs (NHS Ashford, NHS Canterbury and Coastal, NHS South Kent Coast and NHS Thanet CCGs)		
NHS Dartford, Gravesham and Swanley CCG	Work with other CCGs to review current patient engagement activities against the domains of the NHSE Improvement Assessment Framework and learn best practice in preparation for transition to a single CCG	Joint CCG submission of NHSE Annual Evaluation template in February 2020. Ongoing
NHS Swale CCG	Work with other CCGs to review current patient engagement activities against the domains of the NHSE Improvement Assessment Framework and learn best practice in preparation for transition to a single CCG	Joint CCG submission of NHSE Annual Evaluation template in February 2020. Ongoing

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Item 9: General Surgery Reconfiguration at MTW

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: General Surgery Reconfiguration at Maidstone and Tunbridge Well NHS Trust

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

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1) Introduction

a) According to The Royal College of Surgeons, General Surgeons "have a wide range of knowledge and skills to deal with all kinds of surgical emergencies, with an emphasis on acute abdominal problems." They also carry out a large number of elective operations and are essential in supporting A&E departments.[1]

b) This item is included on today's agenda at the request of the Maidstone and Tunbridge Wells NHS Trust (MTW). It relates to a reconfiguration of services across their two sites of Pembury and Maidstone.

c) NHS commissioners and providers are required to consult with the HOSC on potential substantial variations of services affecting the population of the area covered by the Committee.

2) Potential Substantial Variation of Service

a) The Committee is asked to consider whether MTW's proposals relating to the reconfiguration of general surgery constitute a substantial variation of service.

b) Where the Committee deems the proposed changes as not being substantial, this shall not prevent the HOSC from reviewing the proposed changes at its discretion and making reports and recommendations to the NHS.

[1] Royal College of Surgeons, https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/general-surgery/

3) Recommendation

If the proposals relating to the reconfiguration of general surgery are deemed substantial:

RECOMMENDED that:

(a) the Committee deems that proposed changes to the configuration of general surgery services across the Maidstone and Tunbridge Wells NHS Trust sites are a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

If the proposals relating to the reconfiguration of general surgery are deemed not substantial:

RECOMMENDED that:

(a) the Committee deems that proposed changes to the configuration of general surgery services across the Maidstone and Tunbridge Wells NHS Trust sites are not a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

Background Documents

No documents

Contact Details

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Subject: **The reconfiguration of complex elective inpatient gastrointestinal surgery at Maidstone and Tunbridge Wells Trust**

To: **HOSC**

From: **Dr Amanjit Singh Jhund, Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust and Mr Adam Wickings, Deputy Managing Director West Kent CCG**

Date: **15th January 2020**

Purpose: **To outline the case for the reconfiguration of complex elective inpatient gastrointestinal surgery, from the Maidstone Hospital site to the Tunbridge Wells Hospital site, at MTW**

Introduction:

Maidstone and Tunbridge Wells Trust (MTW) Trust provides a wide range of general and specialist surgical services with two centres of expertise in surgery, one at Tunbridge Wells Hospital at Pembury (TWH) and one at Maidstone Hospital (MH). Both sites provide surgical outpatient consultations, endoscopy services, daycase and 23 hour stay elective surgical procedures. However, inpatient complex surgery is split, with around 5,700 patients admitted as a surgical emergency per year directed to TWH and around 600 patients per year for complex elective gastrointestinal surgery directed to MH.

This split coincided with the opening of the TWH in 2011, and the rationale at the time was to co-locate complex elective cancer surgery, including complex upper and lower GI surgery, with the cancer centre at MH. In 2013 a shared regional decision was taken that MTW would no longer provide the complex upper GI cancer surgery service.
In 2019, an internal strategic clinical service review of the surgery services at MTW identified a number of challenges and safety concerns with the current service configuration. The service review concluded it was a priority that a plan be developed to address the challenges.

1. Why do services need to be reconfigured?

The Challenges:

<u>Gaps in the continuity of care for the surgical patient</u>

In the current surgical configuration, patients requiring complex gastrointestinal (GI) surgery can face multiple handovers between surgical teams. The emergency surgical consultants are based at TWH and the specialist upper and lower GI surgeons attend TWH to undertake a block of on-call but then return to MH for to carry out their elective activity. Because of their elective commitments at MH, the upper and lower GI surgeons cannot have ongoing involvement with the patients they treated as an emergency at TWH. Patients who have had planned surgery at MH whose condition deteriorates may experience delays to their treatment awaiting emergency transfer to TWH. Patients who require emergency readmission for post op complication following planned surgery at MH are re-admitted to TWH. Both of these groups of patients, the deteriorating patient and the emergency re-admission are high risk groups. They fall under the care of the on-call teams at TWH, not under the consultant's team who operated on them in the first instance. This can cause significant issues with the continuity of care and puts significant pressure on the emergency

surgical teams. The relatively high number of handovers between surgical teams leads to frustrating repetition, additional risk, clinical delay and unnecessary increased length of stay in hospital.

Fragmented systems of working that mean the service faces additional challenges with recruitment, with training and barriers to multidisciplinary working

For all specialist staff, increasing demand, decline in numbers entering the professions and an existing shortfall create a challenge for the service. Opportunities to recruit to gaps are lost as the current fragmented service configuration is not attractive to potential recruits. Lost opportunities to recruit do not help the surgery service that has a very high spend on locum and agency staff. To put this in context, in 2018 -19 the service spent £2.8M on locum/agency medical staff and £2M on bank/ agency nurses.

The surgery service at MTW provides training for the next generation of specialists. Trainee doctors receive core and specialist training at MTW but recently the trainees have raised issues with their experience to the Kent, Surrey and Sussex region of Health Education England. Many of these issues are related to the challenges of the cross site configuration and specifically, the view that the emergency block of the rotation is for service provision rather than offering training opportunities.

Many units in England take what is regarded as a highly beneficial multidisciplinary approach to the care of patients with gastroenterological conditions. They do this by forming a Digestive Diseases Unit (DDU). A DDU is a combined medical and surgical ward where patients with gastrointestinal conditions are looked after. Surgeons and physicians work together to provide in house multidisciplinary care for all patients. This enables the team to provide higher quality care for patients with conditions requiring Colorectal Surgery, Gallstones, Hepatology, Inflammatory Bowel Disease (IBD), Lower GI (medical), Oncology with established diagnosis and Upper GI conditions including Dyspepsia. MTW does not have a DDU as the current fragmented surgical service lacks the scale and concentration of expertise required to set one up.

2. The solution

The surgical senior clinical management team, together with colleagues from other disciplines, undertook a structured option appraisal on a set of options to establish a preferred way forward. The options they explored were:

ID	Title	Option Description
1	Status Quo	Leave emergency general surgery at TW with the current cover provision.
2	Status quo plus	Leave emergency general surgery at TW but increase the consultant workforce covering the site.
3	Concentrate inpatient service at TW	Leave emergency general surgery at TW and transfer planned **cancer,** major and intermediate colo-rectal procedures (+/-UGI) from MS to TW.
4	Emergency and elective surgery at both sites.	Provide Emergency general surgery and elective cancer and major surgery at both sites.
5	Move Emergency surgery to Maidstone	Change the provision of emergency surgery from TW to MS with only planned minor surgery and day cases at TW.
6	Workforce based solution	Further review of surgical consultant workforce

7	Split patient pathway	"Northumbria model" Patients to move from TWH to MS when stable either for surgery or rehab

The clinical group assessed the options against 16 criteria. The criteria were:

- Patient pathway- Continuity of care
- Patient pathway – The number of cross hospital site patient transfers
- Patient pathway – Patient's initial emergency access
- Workforce – Ability to cover service commitments
- Workforce – Recruitment and retention
- Workforce – Training and supervision
- Strategic – Opportunities to develop the surgical service
- Strategic – Opportunities to further research and innovation
- Operational – Impact on A&E and A&E access standard
- Operational – Addresses the blocks to efficient day/ short stay surgery processes
- Operational – Achievability assessment including time taken until option operational
- Operational – Option supports whole hospital winter resilience
- Operational – Option provides for continuing adequate surgical support for the Trauma Centre
- Operational – Option can be supported by Theatres
- Operational – Option can be supported by Critical Care and Theatres
- Operational – Option can be supported by Imaging

Each of the options was scored by the clinical group on weighted criteria.
The highest scoring option was option 3: 'Leave emergency general surgery at TW and transfer planned cancer, major and intermediate colo-rectal procedures (+/-UGI) from MS to TW'
The solution would affect around 600 patients a year, who live across our region who would have had their surgery at MH but will in future have their surgery at TWH. The 5,700 emergency surgical patients a year at TWH are unaffected other than in future there will be a greater surgical presence at TWH to care for them.
The 56,000 surgical outpatient consultations a year and the 9,000 patients admitted for day case or endoscopy a year will be unaffected by the change.

The Trust then consulted west Kent CCG about the proposed approach and received the CCG's endorsement.

The urgent clinical need for change and benefits of the proposed solution

Clinicians have identified an urgent clinical need for change and identified the following benefits associated with the proposed solution:

Improved continuity of clinical personnel
Currently, clinical continuity is exceptionally poor with too many handovers, at times a lack of clarity of the line of responsibility for some patients and delays to progressing care of the sickest patients. The importance of this continuity and clear governance cannot be overstated.
The Royal College of Surgeons standards[1] state: 'Effective continuity of care is vital in protecting patient safety. It is the duty of every surgeon to convey high quality and appropriate clinical information to oncoming healthcare professionals to allow for the safe transfer of responsibility for patients…whenever possible, ensure that there is a clear line of responsibility for the patient's care at any one time…. when transferring care to an oncoming

[1] The Royal College of Surgeons. Good Surgical Practice Royal College of Surgeons

team, ensure that team members have access to all necessary clinical information about the patient.'
In the past, local surgical services have been deemed unsafe and have been closed by the Royal College of Surgery as a result of issues leading on from sub-standard governance and poor continuity of care.

Co-location of complex elective with emergency surgery will; simplify governance, reduce the number of handovers and avoid unnecessary changes of the team in charge of patient's care and simplify governance. These are issues which our clinicians recognise impact upon the quality of care.
Co-location of complex elective with emergency surgery will allow continuity of involvement and most effective use of our Clinical Nurse Specialist Team, giving patients best access to specialist nursing care

Continuity of Clinical Information
When patients have been discharged from Maidstone and suffer a postoperative complication they usually re-present to TWH and there have been problems with quality and continuity of clinical information. For the most complex care clinical information is vital. The paper records travel with the patient to Maidstone for elective surgery and are not immediately available to clinicians at TWH in the event of any early need for reassessment.

Complex Care
Patients requiring the most complex care and/or with multiple conditions are not getting the quality of service that clinicians know is possible. It is often challenging because of the configuration of services to undertake combined diagnostic and therapeutic procedures leading to a need for patients to have 2 separate anaesthetics and potential for pathway delay in some cancer treatments. The availability of theatre team skilled in emergency and complex routine surgery also has synergistic improvement on the quality of benign surgery

Excellent Perioperative Management
Dedicated surgical high dependency facilities can provide the best care available for the perioperative patient. Without the critical mass of cases allowing centralisation of specialist staff such a facility is unachievable. TWH will become a much stronger centre for perioperative surgical management with some centralisation of complex surgical workload. Enhanced operational efficiency associated with a consolidated unit which will reduce incidence of cancellation for patients and reduce delays for both emergency and urgent surgery.

Transfers for clinical reasons.
Too many patients currently have delays to their treatment pending transfer across hospital sites. The proposal is expected to lead to a reduction in the requirement and the delay caused by patient transfers from Maidstone to TWH and vice versa.

Other identified service benefits with include:
- Improved sustainability of the surgical service including improving compliance with developing seven day service requirements
- Improved training experience for surgical trainees
- Reduced reliance on the use of locum doctors. The reconfigured service will provide the emergency service workforce with more support and make the surgical work pattern considerably more attractive for hard to recruit and retain specialist clinical staff.
- Consolidation will provide an opportunity to develop a digestive diseases unit with medical gastroenterology co located with GI surgery

Patient involvement in the proposed changes
Given the urgent clinical case for change the proposed solution has been designed with clinicians rather than patients. While there has been no formal consultation process patient and staff representatives have been engaged and consulted informally. This informal consultation included discussions with patients presenting through the PALS (Patient Advice and Liaison Service) and complaints services with problems with the current service as well as with Trust Patient representatives and former staff members. Although there has been no formal co design process, in planning the Digestive Diseases Unit at Tunbridge Wells patients are being engaged in it's design and will be involved from the start. Both patients and the families of patients that have experienced problems with care have already been asked to be involved in the co-design process.

Given the urgent clinical case for change, the patient engagement undertaken and the numbers of patients affected, we recommend that HOSC agree that this is not a significant change and that we should proceed with the planned change to clinical services without formal public consultation.

The identified risks associated with the solution
The project group has identified the following risks, for which mitigation is planned associated with the preferred solution.

- A risk of increasing the bed pressure at TWH leading to a risk of cancellation of complex cancer elective patients. Mitigation plans include a new escalation policy to ensure the beds identified for cancer patients are 'ring fenced' and not used for escalation. A number of service changes and improvements to patient flow are planned across the Trust. A senior operational 'gateway decision' will be made prior to 'go live' that the planned changes have made the required and sustainable bed capacity available.
- A risk of overloading the TWH critical care capacity was considered and investment in enhanced post-operative surgical recovery, six additional enhanced care beds together with measures designed to speed the flow of patients are planned that mitigate the risk.
- A risk of inadequate surgical cover for the Maidstone site has been mitigated by ensuring there would still be a consultant surgeon on call for the site and an RMO covering the site.
- A risk that operating theatre capacity could be compromised was identified so the project group worked with the critical care and theatres teams to produce a full review of theatre schedules that has mitigated the risk
- A risk that surgical nurses may be lost to the Trust was identified. Subsequently, senior nurse engagement with the nursing teams has clarified and mitigated the risk.
- A risk was identified that appropriate consultation on medical job plans could take some months. The service identified temporary mitigations were available should the process be delayed.

Patient numbers

Patients visiting surgical services at MTW for general surgery, gynae oncology and breast surgery	**TWH**		**Maidstone**	
	Current	Future	Current	Future
Emergency surgical inpatient admissions	5700	5700	100	100
Day case admissions (includes patients for endoscopy)	4300	4300	4600	4600

Patients visiting surgical services at MTW for general surgery, gynae oncology and breast surgery	TWH		Maidstone	
	Current	Future	Current	Future
Outpatients for general surgery	24000	24000	32000	32000
In patient (ordinary) elective admissions for general surgery 'non-complex'	100	100	600	600
In patient (ordinary) elective admissions for complex general surgery LGI procedures	0	400	400	0
In patient (ordinary) elective admissions for complex general surgery UGI procedures	0	200	200	0

The proposed plan

The table above demonstrated that the planned change would mean different site of care for 600 patients per year (400 inpatient elective LGI plus 200 inpatient elective UGI,) Ten beds are required for these 600 patients. The proposed plan is therefore that in March 2020, following the easing of the pressures associated with winter, medical patient outliers in surgical beds will have eased and the surgical service will be in a position to accommodate the extra 10 beds in their current bed stock.

To assist the management of the patients there will be:

- An investment in an enhanced post-operative surgical recovery area of two beds staffed by intensive care trained nurses at TWH. These beds will meet the needs of the higher dependency care these patients require immediately post operatively.
- Six enhanced care beds will be introduced on Ward 32 to manage the pressure on the TWH ITU/HDU, improve flow and ensure that the complex post-op patients receive a higher level of monitoring.
- A streamlined operating theatre schedule has been developed and will be introduced to coincide with the reconfiguration. The Critical Care team who manage the operating theatres are using the opportunity to rationalise the whole operating theatre schedule to increase productivity and balance capacity across multiple specialties through the week.
- A senior surgeon and a resident medical officer will be rostered to provide emergency surgical cover for the MH site.
- Streamlined embedding of the complex GI inpatient surgeries at TWH
- Change to the on-call structure and rotas allowing the consultant surgeon workforce to remain responsible for both their emergency and elective inpatients.
- The longer term development of a DDU for multidisciplinary care of patients with gastrointestinal conditions

The plans for the reconfiguration are developing and input from stakeholders is sought. Approval and input from stakeholders is sought to enable detailed planning to progress. Due to Winter Pressures the earliest that the service could be ready for a ‘go live’ date is March 2020. The Trust anticipates no change in overall patient flow to the Trust and no impact on neighbouring Trusts.

Maidstone and Tunbridge Wells NHS Trust

West Kent Clinical Commissioning Group

APPENDIX – SUPPORTING PATIENT STORIES

NOTE THESE ARE NOT BASED ON REAL PATIENTS BUT ARE ILLUSTRATIVE

How will this be different for patients? (1/2)

Mary, requiring elective excision of rectal cancer

Maidstone and Tunbridge Wells NHS Trust

West Kent Clinical Commissioning Group

Before surgical reconfiguration,

Mary is a **78 year old woman** who has been **waiting for an operation** 'an anterior resection' for her rectal cancer. The **surgeon at Maidstone removes the diseased area of bowel laparoscopically and forms a temporary stoma** to protect the join in the bowel. The **surgery and recovery went well** and Mary is **discharged on the 5th post-operative day.**

At home Mary becomes **unwell and is re-admitted** to Tunbridge Wells Hospital where she is found to be in **renal failure due to de-hydration**. The **surgical team (not her original surgeon who is never made aware of her re-admission**) ask the physicians to look after her.

They correct her electrolytes and discharge her. After a few days Mary becomes **dehydrated again and is re-admitted again and again discharged** following fluid treatment. She becomes dehydrated for a third time. Fortunately, on this occasion the **surgeon who performed Mary's cancer surgery is on call at Tunbridge Wells**. The surgeon finds that Mary has been admitted and visits her on the ward. Immediately, the **surgeon diagnoses a 'high output stoma'** which requires careful management. By now Mary's renal function is very poor and she requires a **prolonged period of fluid therapy for her to be fit enough to safely undergo corrective surgery**.

The surgeon arranges for Mary to be **transferred back to Maidstone hospital for the stoma to be closed the following week**. Mary makes a good recovery and is discharged home to complete her recovery.

DISADVANTAGES OF CURRENT MODEL

- **Limited access to sub specialist opinion**
- **Unnecessary transfers across site from TWH to Maidstone**
- **Multiple admissions and discharges**
- **Multiple handovers, poor continuity of care**

How will this be different for patients? (2/2)

Mary, requiring elective excision of rectal cancer

NHS Maidstone and Tunbridge Wells NHS Trust

NHS West Kent Clinical Commissioning Group

After surgical reconfiguration

Mary is a **78 year old woman on the waiting list for and anterior resection for cancer**. The **surgeon at Maidstone removes the diseased area of bowel laparoscopically and forms a temporary stoma** to protect the join in the bowel. The **surgery and recovery went well** and Mary is **discharged on the 5th post-operative day**.

At home Mary becomes **unwell and is re-admitted to Tunbridge Wells Hospital where she is found to be in renal failure** due to de-hydration.

She is **referred back to the surgeon who performed Mary's cancer surgery**. They **instantly they diagnose a high output stoma and manage this in conjunction with the stoma nurses** using medication and diet to reduce the output.

Despite maximal intervention, the stoma output continues to be high and the **consultant arranges for the stoma to be closed later that week on his elective list** at Tunbridge Wells Hospital. Mary makes **a good recovery and is discharged home** to complete her recovery.

ADVANTAGES OF PROPOSED MODEL

- **Continuity of care under specialist**
- **Specialist opinion allows for rapid formulation of appropriate multi disciplinary care plan**
- **Good multidisciplinary working**
- **Due to effective treatment with diet and medication although surgery is required it is not delayed due to the patients physical state**

How will this be different for patients? (1/2)

Maud presenting with acute cholecystitis

Maidstone and Tunbridge Wells NHS Trust

West Kent Clinical Commissioning Group

Before surgical reconfiguration,

Maud is a 59 year old woman who develops sudden pain in her upper abdomen. She is admitted to Tunbridge Wells Hospital one Saturday and is **diagnosed with gallstones leading to acute cholecystitis**. She is **treated with antibiotics and intravenous fluids**. She appears to be **making good progress and on Monday is handed over to the care of the "red" acute team**. The consultant covering this team is on annual leave and the patients are covered by a locum middle grade doctor. **Maud becomes increasingly unwell over the next few days, the middle grade arranges a scan which confirms an empyema** (a collection of pus trapped in the gallbladder). They **ask for advice from the on call surgeon who is a colorectal specialist.**

The **specialist advises asking the radiologists to place a drain, which successfully relieves the abscess**. Maud **recovers slowly and is discharged after 7 days** in hospital with the drain in situ.

She is **referred to an upper gastrointestinal surgeon who is able to see her in clinic 8 weeks later**. Maud has been in **pain from the drain all of this time**. The surgeon removes the drain and arranges for her to be put on the waiting list for elective cholecystectomy.

Whilst waiting for this procedure Maud is **readmitted as an emergency with further pain and fever which responds to antibiotics** this time but **necessitates a further 5 day hospital stay.**

She eventually **undergoes her operation 4 months after presentation**. This is successful and she makes a good recovery.

DISADVANTAGES OF CURRENT MODEL

- **Lack of specialist upper GI input into the cases from an early stage**
- **Delay in definitive treatment (discharged home with drain in situ) with a painful and prolonged wait for treatment**
- **Lack of options for definitive surgical treatment in a timely manner**

How will this be different for patients? (2/2)

Maud presenting with acute cholecystitis

Maidstone and Tunbridge Wells NHS Trust

West Kent Clinical Commissioning Group

After surgical reconfiguration

Maud is a **59 year old woman who develops sudden pain in her upper abdomen**. She is **admitted to Tunbridge Wells Hospital one Saturday and is diagnosed with gallstones leading to acute cholecystitis**. She is **treated with antibiotics and intravenous fluids**. She appears to be making good progress and on Monday is **handed over to the upper gastrointestinal team who have an emergency gallbladder operating list that day**.

Unfortunately, the list that day is already full but Maud is **placed on the "hot gallbladder" list for the following day**.

She undergoes an **"emergency" cholecystectomy performed by a senior trainee under the supervision of an experienced consultant**. The operations is a success and she is **discharged home the following day making a full recovery.**

ADVANTAGES OF PROPOSED MODEL

- **Care handed over straight to specialist upper GI team**
- **Availability of hot gallbladder lists provides immediate opportunity for definitive surgical treatment**
- **Rapid care and pain experienced by the patient is kept to a minimum**

How will this be different for patients? (1/2)

James presenting at Maidstone with Ulcerative Colitis

NHS Maidstone and Tunbridge Wells NHS Trust

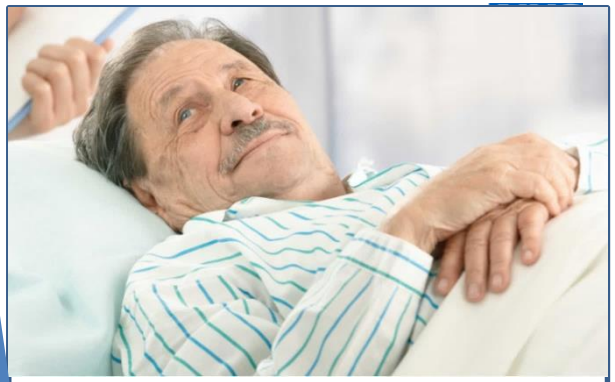
Before surgical reconfiguration, without a Digestive Diseases Unit

James is a **48 year old man, with ulcerative colitis**, who has been under the long term care of a consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a **flair up of his colitis and presents to the gastroenterology clinic.** James is **admitted to Maidstone hospital** and treatment with intravenous steroids and infliximab is started. On this occasion, James **does not respond well to the treatment** and becomes increasingly weak with his bowels opening up to 12 times a day and his albumin levels falling.

There are significant **delays in the gastroenterology team being able to obtain senior colorectal surgical opinion**. James is finally **seen on a Friday by a consultant colorectal surgeon, 10 days after his admission,** and needs to be **transferred to Tunbridge Wells Hospital for emergency surgery.**

On arrival at Tunbridge Wells Hospital the **surgical team on call, who are not colorectal specialists,** feel that James should wait for the colorectal team who will be taking over on Monday. However, on Sunday James becomes increasingly unwell with severe abdominal pain. He undergoes an **emergency laparotomy and colectomy.**

After surgery, James requires intensive care. Initially, he makes a good recovery and is returned to the ward. On the 5th post-operative day however, he **develops a wound infection requiring the wound to be opened**. He has a **large wound from the emergency surgery** and requires extensive wound management, intravenous antibiotics and the placement of a VAC dressing. He is eventually **discharged with the VAC in place which remains for a further 3 weeks**. **Throughout the admission at Tunbridge Wells he has not seen the gastroenterologist he knows or the surgical consultant who operated on him** on Sunday.



DISADVANTAGES OF CURRENT MODEL

- **Delay in referral from gastroenterologists to surgical team**
- **Extended stay in hospital waiting for plan**
- **Gaps in specialist cover**
- **The requirement for an emergency transfer from Maidstone to TWH**
- **Emergency operation required when condition worsens**
- **Unplanned surgery delays recovery**
- **Multiple handovers, poor continuity of care**

How will this be different for patients? (2/2)

James presenting at Maidstone with Ulcerative Colitis

Maidstone and Tunbridge Wells NHS Trust

After surgical reconfiguration with a Digestive Diseases Unit

James is a **48 year old man, with ulcerative colitis**, who has been under the long term care of one of the consultant gastroenterologists based at Maidstone Hospital. They have established a very good relationship over the years. He experiences a **flair up of his colitis and presents to the gastroenterology clinic** and is **admitted to the digestive diseases unit at Tunbridge Wells Hospital.**

He remains under the care of the gastroenterologist that he knows , who commences treatment with intravenous steroids and infliximab. After 72 hours it is clear that James is **not responding as well as would be hoped**. The **gastroenterologist promptly involves one of the colorectal specialist consultant surgeons who visits James with the gastroenterologist**. They decide to closely watch and wait for another few days to see if things improve. They both keep him under close observation but by the 7th day of his admission it is **decided to perform surgery**. The consultant **surgeon re-arranges a case from his elective operating list** and is able to promptly perform an **"urgent" laparoscopic colectomy**.

James is returned to ITU. Initially, he makes a good recovery and is returned to the ward. **On the 5th post-operative day he develops a wound infection**. As the **operation was laparoscopic the wound is small** and management is relatively simple. James is able to go **home with antibiotics the following day**.

Throughout his admission the gastroenterologist and surgical consultant that James knows have been involved in his care every day.

ADVANTAGES OF DIGESTIVE DISEASES UNIT

- **Continuity of care under specialist**
- **Prompt care plan**
- **Good multidisciplinary specialist cover**
- **Urgent but planned elective operation pathway available to manage urgent conditions**
- **Laparoscopic planned surgery enhances recovery**
- **Reduced stay in hospital**

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Item 10: Moorfields Eye Hospital

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: Moorfields Eye Hospital Relocation

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

It provides background information which may prove useful to Members.

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1) Introduction

a) Moorfields Eye Hospital NHS Foundation Trust provides eye health services for adult and children patients, as well as a centre for excellence for ophthalmic research and education.

b) The services provided by the Trust are commissioned by 77 CCGs as well as NHS England Specialised Commissioning across 188 CCG areas. Of the 77 CCGs, only 14 in London and Hertfordshire hold contracts worth more than £2m per annum.

c) According to 2017/18 data,[1] Kent CCGs had the following spend at Moorfields:

CCG area	Specialised Commissioning		Clinical Commissioning Group	
	Spend	**Patient numbers**	**Spend**	**Patient numbers**
Ashford	24,457	76		
Canterbury & Coastal	67,850	108		
Dartford, Gravesham & Swanley	216,742	1,020	625,918	3,278
South Kent Coast	44,196	89		
Swale	32,706	78	59,869	352
Thanet	24,188	44		
West Kent	115,369	266	550,450	2,742

[1] Letter from Sarah Mansuralli, Camden CCG, to STP Accountable Officers, dated 25 Feb 2019

2) Oriel

a) Moorfields Eye Hospital, the UCL Institute of Ophthalmology, and Moorfields Eye Charity have developed a proposal called "Oriel", which would see the Moorfields Eye Hospital move its City Road, London, services to the St. Pancras Hospital site in Camden, where a new integrated facility housing the three partners would be built.[2] The vision is for the new centre to bring together "excellent eye care, ground-breaking research and world-leading education in ophthalmology".[3]

b) NHS Camden CCG, in partnership with NHS Specialised Commissioning, has been leading the consultation on behalf of all CCGs.

c) A consultation on the proposal ran from 24 May to 16 September 2019.

d) HOSC members were given the opportunity to comment on the draft summary of the consultation findings in October (via email).

e) On 2 January 2020 HOSC members were notified via email that the Joint HOSC (comprised of five local authorities in north central London) would be considering the findings of the consultation on 31 January.

f) The CCGs Committee-in-Common will consider the final Decision-Making Business Case at its meeting on 12 February 2020.

g) Today's meeting is the final opportunity for Kent HOSC members to provide their comments to Camden CCG for inclusion in their decision-making case.

3. Recommendation

RECOMMENDED that the Committee consider and comment on the report.

Background Documents

No documents

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[2] https://www.moorfields.nhs.uk/news/consultation-launched-proposal-move-moorfields-eye-hospital-king-s-cross
[3] https://oriel-london.org.uk/wp-content/uploads/2019/05/Oriel-consultation-summary-1.pdf

KENT COUNTY COUNCIL
HEALTH OVERVIEW AND SCRUTINY COMMITTEE

WEDNESDAY 29 JANUARY 2020

Agenda Item No

X

Proposed move of Moorfields Eye Hospital's City Road services

Author: Denise Tyrrell, Programme Director, denise.tyrrell@nhs.net

Recommendations:

The Kent County Council HOSC is asked to:

- **NOTE** this update
- **NOTE** the summary of findings from the public consultation on the proposal
- **PROVIDE** feedback on summary of consultation findings
- **CONSIDER** Kent HOSC representatives attend the scrutiny of the consultation by the North Central London Joint Health and Oversight Scrutiny Committee on 31 January 2020.

1. Purpose of report

1.1. NHS Camden CCG and NHS England Specialised Commissioning, working in partnership, are leading a public consultation on the proposal to create a new centre for eye care, research and education in King's Cross with project partners UCL and Moorfields Eye Charity.

1.2. This report provides an update on the progress on the formal public consultation proposal to relocate Moorfields Eye Hospital from its site in City Road, Islington to St Pancras. The report includes the summary of findings from the public consultation on the proposal which highlights the key themes expressed through the consultation; plans in place to respond to those views; and the next steps for decision-making.

1.3. For further information and consultation documentation and the consultation findings report, please refer to the consultation website https://oriel-london.org.uk/consultation-documents/ where you can read or download the consultation document, consultation findings and other background information.

2. Introduction

2.1. On 24 May 2019, a consultation was launched to seek the views from as many people as possible about the proposal to move services from Moorfields' City Road site and build a new centre bringing together excellent eye care, ground-breaking research and world-leading education in ophthalmology.

2.2. This centre would be a multi-million pound development on land that has become available on the site of St Pancras Hospital, just north of King's Cross and St Pancras stations in central London.

2.3. NHS Camden CCG, on behalf of all clinical commissioning groups with NHS England/Improvement specialised commissioning, together with Moorfields Eye

Hospital, is leading the consultation, the outcome of which will influence and inform the Decision-Making Business Case (DMBC).

2.4. The DMBC will be instrumental in gaining clinical commissioning group and NHS England specialising commissioning support for the proposed relocation, which must demonstrate that proposals for service change demonstrate evidence to meet four tests before they can proceed. These tests include strong public and patient engagement, patient choice, clinical evidence base and support from clinical commissioners.

2.5. The Moorfields consultation programme received: 1,511 survey responses to the consultation questions, 261 other forms of responses including emails, telephone and social media; 29 formal responses; hundreds of comments from 99 open discussion workshops, and other forms of meetings. Responses have been received from as far as Devon and Dundee which indicates that the consultation approach has reached the national patient/resident population.

2.6. In line with scrutiny regulations, the North Central London Joint Health Overview and Scrutiny Committee is leading a joint scrutiny process for the consultation and proposed move.

3. Case for change – the story so far

Clinical case for change

3.1. Moorfields provides eye health services to more than 750,000 people each year. Its main site at City Road in Islington has a 24-hour ophthalmic A&E and provides a range of routine elective eye care for London residents and specialised services for patients from all over the UK.

3.2. The current facilities at City Road date from the 1890s. There is very little space to expand and develop new services; the lay-out of the buildings affects efficiency and patient access, and the age of the estate creates difficulties for installing new technologies.

3.3. The proposed centre would offer better care and significantly improve Moorfields' ability to prevent eye disease, make early diagnoses and deliver effective new treatments for more people for locally or in primary care, as well as in specialist hospital clinics.

3.4. It would bring together excellent eye care with world-leading research, education and training with the following benefits:

- Greater interaction between eye care, research and education – the closer clinicians, researchers and trainees work, the faster they can find new treatments and improve care
- More space to expand and develop new services and technology to improve care, including at home or locally, without the need for a hospital visit
- A smoother hospital appointment process, particularly where there are several different tests involved
- Shorter journeys between test areas and instantly shared results between departments, reducing waiting times and improving communications between patients and staff

- Modern and comfortable surroundings that would provide easier access for disabled people and space for information, counselling and support.

3.5 The independent London Clinical Senate has stated its support for the pre-consultation business case and, in discussions with patients and public leading up to the consultation, people were supportive of the proposed new centre, which would greatly improve care and the patient experience.

Financial case for change

3.6. Financial modelling for Moorfields undertaken at the time of developing the pre-consultation business case (PCBC) demonstrated that the capital investment for the proposal was affordable and the long-term financial position of the trust would remain sustainable.

3.7. This was based on capital costs of £344m (which includes 19% of optimism bias as well as normal planning and related contingencies), planned to be financed by a combination of proceeds from the sale of the City Road site, STP capital funding, philanthropy, and trust internal cash.

3.8. The commissioners considered the capital investment for this proposal to be affordable on the basis of assumed annual activity growth of 3%, which is consistent with historic growth levels at Moorfields based on the financial statements presented in the PCBC, which showed the latest financial year (2018/19) plan and committed to updating the baseline for the outline business case.

3.9. Additionally, projections for NHS income assume a capped income growth of 3% following occupation of the new facility in 2025/26, which is consistent with the commissioner assurance letters provided in support of the PCBC. Income growth up until occupation is assumed at 2% falling to 1% from 2022/23 due to capacity constraints at the City Road site.

3.10. Since approval of the PCBC, commissioners in partnership with Moorfields, appointed an independent consultancy to provide analytical support to develop a detailed model to show future demand, capacity and activity. This model also provides clarity on the likely impact of known education, workforce and technological innovations that will result in new models of care affecting the type and levels of service to be provided within the Moorfields site with more granularity.

3.11. The scope of this work involves looking at trends in historic activity by clinical sub-specialty and examining how new models of care could meet projected demand, both in terms of service delivery changes planned by Moorfields, specialised commissioning pathway changes and STP plans designed to shift activity from hospital to primary and community settings. In addition, it looks at possible optimisation in workforce education and technological advances.

3.12. The outputs of this updated demand, capacity and activity analysis informs the financial and economic case and provide commissioners with further assurance about the sustainability and affordability of the proposed relocation.

Commissioning of Moorfields services at City Road

3.13. 14 CCGs from London and Hertfordshire hold material (defined as >£2m per annum) contracts with Moorfields for activity at City Road, accounting for 45% of all patient activity in England. Services at Moorfields City Road are also commissioned by NHS England Specialised Commissioning.

3.14. The spend by NHS England Specialised Commissioning for Kent residents and by Kent CCGs on Kent patients that attended Moorfields Eye Hospital in 2017/18 (the latest breakdown available) was:

Kent CCGs' spend (£)	Kent CCGs' patients (number)	NHSE Specialised Commissioning spend (£)	NHSE Specialised Commissioning patients (number)
£610,319	3,094	£358,426	864

4. The preferred way forward

4.1. The main consultation document explains how Moorfields and its partners have considered various options for developing a new centre, including rebuilding and refurbishment at the City Road site.

4.2. For specialised services, London is the most accessible UK location for patients and for recruiting and retaining specialists, technicians, researchers and students. There are critical benefits from close links with other major specialist centres, research and education facilities.

4.3. Of seven potential sites on the London property market that are close to public transport hubs, the proposal for consultation puts forward the view that land available at the current St Pancras Hospital site has greater potential benefits, including:

- Enough space for the size required and potential for future flexibility
- Proximity to two of the largest main line stations in London, King's Cross and St Pancras, with Euston station also in the area
- Proximity to other major health and research centres, such as the Francis Crick Institute, the main campus of UCL, and leading eye charities, such as Guide Dogs and the Royal National Institute of Blind People (RNIB).

Accessibility

4.4. Insights from people have also raised potential challenges around the change to their journey to the proposed new centre for people who have used Moorfields services for many years.

4.5. Moorfields commissioned an independent travel analysis in September 2018 which identified that for some patients travelling to the St Pancras Hospital site, rather than the City Road site, travel times could increase on average by just over 3 minutes.

4.6. The analysis showed that overall a relatively small number of patients would see travel times increase by more than 20 minutes (less than 1.5%), with the maximum increase being 25 minutes. Most of the increases are postcode areas that are to the east of London, where access to the proposed new site could involve a longer route for some people via bigger and more complicated rail and underground stations than Old Street.

4.7. We recognise the need to engage widely with our patient community in respect of patient access and wayfinding to and from the proposed site at St Pancras, and are engaging with patients, carers, Transport for London, Network Rail, the Local Borough of Camden and other stakeholders as we progress designs for the new site.

4.8. For more information on access and travel times to the proposed location at St Pancras, please visit http://oriel-london.org.uk/public-consultation/travel-and-access/.

5. Consultation update – what we have learned so far

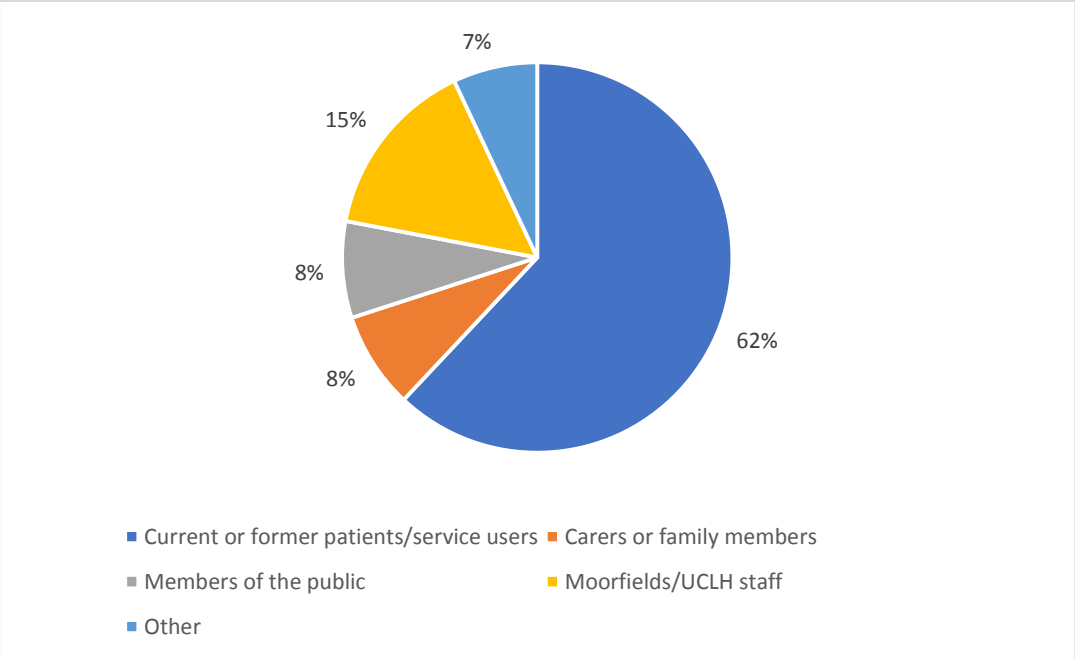
5.1. To ensure the findings of the consultation were interpreted and presented in an objective way an independent third-party provider, Participate, was appointed to manage the receipt of responses, analyse findings and produce an independent report of the process and outcome of the consultation. The findings in the consultation findings report from Participate can be found on the consultation website https://oriel-london.org.uk/consultation-documents/ and summarised here.

Overview of consultation responses

5.2. Between 24 May to 16 September 2019, the consultation programme received 1,511 survey responses to the consultation questions, of which 39 were from respondents in Kent (2.5 per cent of the total number of responses received), as well as 261 other forms of response including: emails, telephone, social media and formal responses. Ninety-nine discussion groups were held and themes noted from those were also recorded.

Who responded?

Figure 1: Respondents to the Moorfields consultation survey (all respondents)

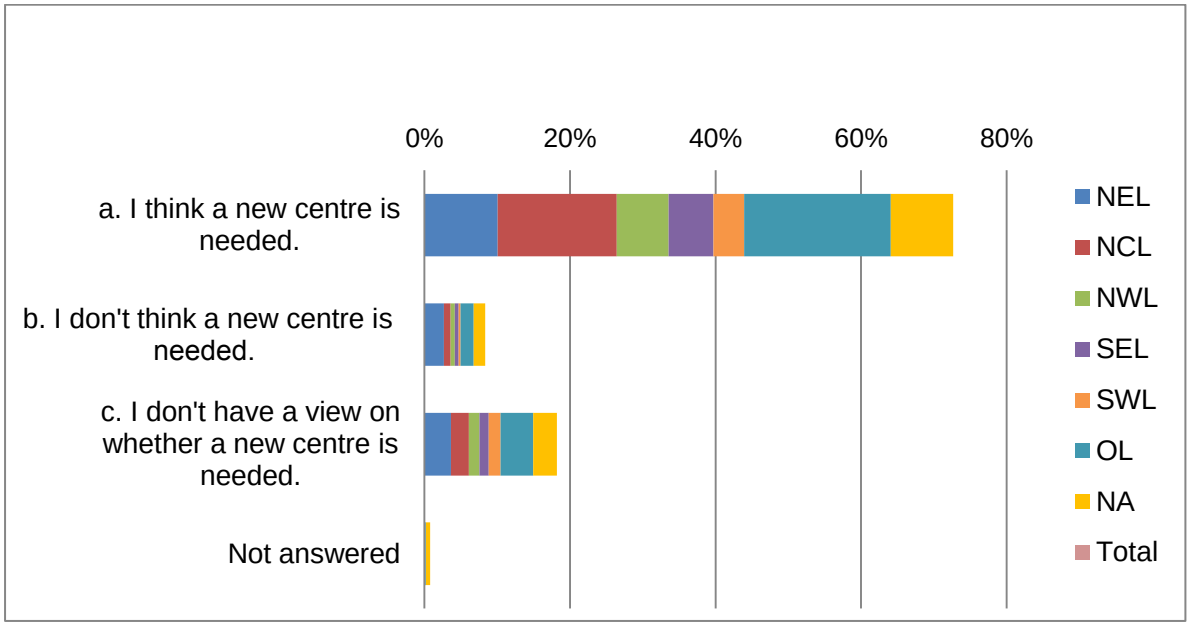


5.3. The survey responses represent a high number of current or former service users at 62% (935). Additionally, a wide range of teams, groups and organisations responded; many of which were health-related, had close links with Moorfields, or were charities related to eyecare.

5.4. What do they think of the proposals?

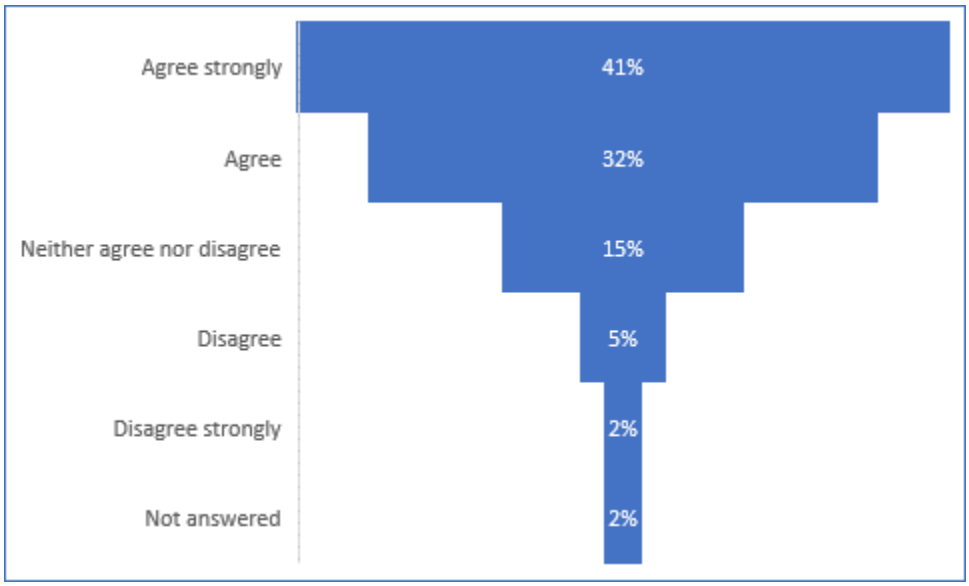
5.5. Overall there was strong support for a new centre for Moorfields Eye Hospital, with 73% (1,098) of survey respondents agreeing with the statement. Eight per cent say they don't think a new centre is needed (Figure 2).

Figure 2: Q4 – please select one of the following statements that most closely matches your view



- The minority of responses not in favour of the move are concerned with losing a historic building, loss of NHS assets and moving away from a facility and route with which they are familiar
- Some concerns were also voiced about the new site relating to:
    - The last half mile of the journey as public transport stops short of the site entrance
    - Accessibility, both in terms of travelling to the new hospital site, and in terms of navigating around it
    - A busy and heavily congested area meaning it could present difficulties for visually impaired, elderly and disabled patients
- Staff and patients expressed an interest to be kept informed of the development of the project and to have a voice in the design of the new hospital
- Stakeholders are generally positive about the move to the St Pancras site with organisations such as Royal National Institute of Blind People (RNIB) keen to be involved in the project
- 73% agree or strongly agree that it should be at the St Pancras Hospital Site with 10% stating they disagree or disagree strongly.

Figure 3: Extent to which respondents agree/disagree with the proposal that the new centre should be located at the St Pancras Hospital site (all respondents)

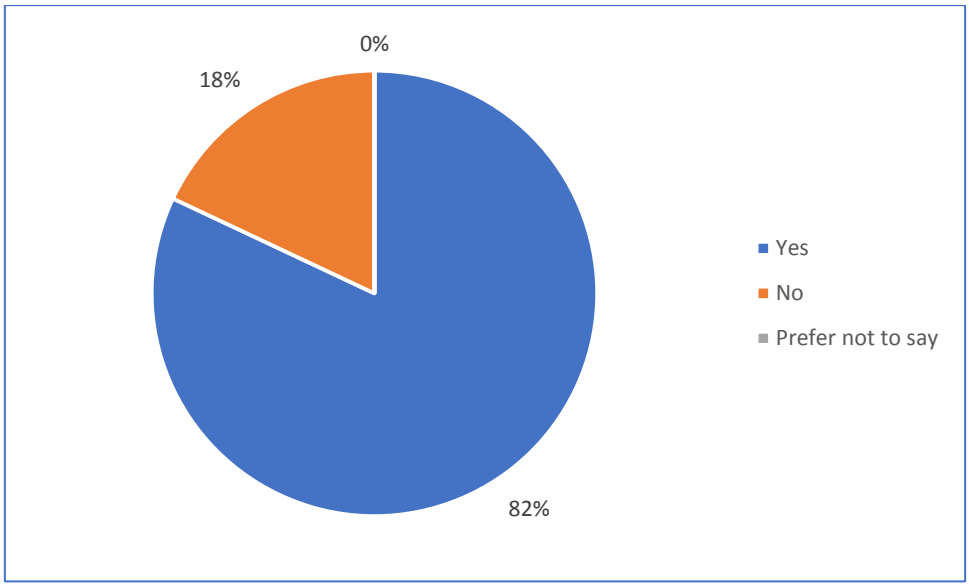


- Additionally, 81% of staff respondents strongly agreed or agreed with the proposed location, with just 7% strongly disagreeing/disagreeing that the centre should move to St Pancras
- We received feedback on alternative locations. These were considered as part of the options review process
- Stakeholders also provided an extensive list of suggestions relating to the implementation of the new hospital
- Some stakeholders expressed a desire for ophthalmology services to be delivered locally where possible, and were keen to seek reassurance around the future of Moorfield's network sites
- The relationship between the Oriel programme and Transport for London and Camden Council were highlighted as key to the success of the project, especially around integrated transport and planning permission.

5.6 **Key highlights for Kent**

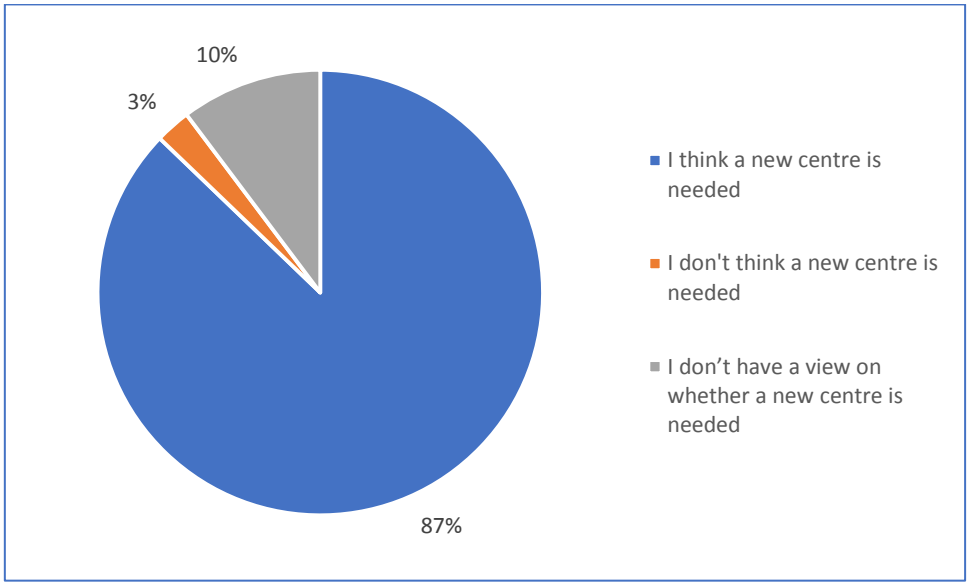
Out of a total 1,511 survey responses received, 39 of those were from Kent residents.

Figure 4: Kent residents who use Moorfields' service at City Road



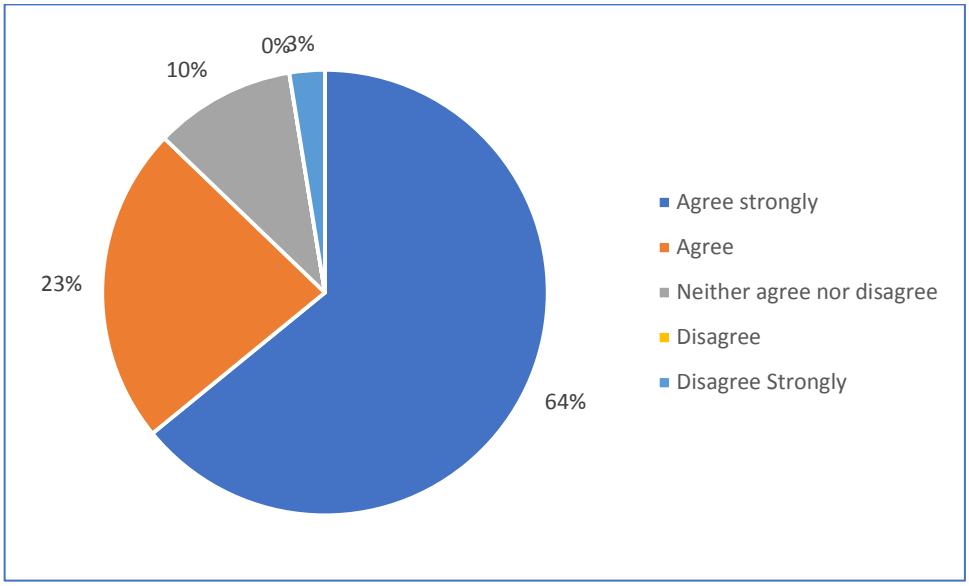
5.7 Nearly nine in 10 of those who responded (87%) think a new centre is needed, with six per cent saying they disagreed, and only three per cent saying they did not have a view whether a new centre is needed.

Figure 5: Kent residents who think a new centre is/is not needed



5.8 And 87% strongly agree, or agree, with the proposal to locate the new centre at the St Pancras Hospital site, with only three per cent disagreeing or strongly disagreeing.

Figure 6: Kent respondents who agree/disagree with the proposal to locate the new centre at the St Pancras Hospital site



5.9 Patients, staff and residents were contacted and engaged through various focus group meetings and discussions, including a discussion on the proposal as part of a wider clinical governance day for Moorfields staff at Darent Valley.

6. How we have engaged with people

6.1. Our approach has been an emphasis on active participation, as well as seeking written responses to the proposals. The programme of consultation activities included open discussion workshops, discussions with key groups and meetings on request.

6.2. We understand from listening to people that they are apprehensive about how any change would be managed with minimal disruption, smooth transition and continuity of service. To make sure that we address these concerns we have considered how issues of equality affect service users in the proposed changes.

6.3. The Equalities Act 2010 places duties on health and care organisations to reduce health inequalities and ensure that service design and communications should be appropriate and accessible to meet the needs of diverse communities.

6.4. To ensure that the NHS has paid 'due regard' to the matters covered by Public Sector Equality Duty, we have undertaken an integrated health inequality and equality impact assessment (HIEIA) process which is designed to ensure that a project, policy or scheme does not discriminate against any disadvantaged or vulnerable people or groups.

6.5. We have worked with organisations that led us to people with a range of protected characteristics, so that we captured their views on the proposal itself and any potential impact on equality. There were over 40 meetings and conversations with people with protected characteristics and rare conditions. They included networks of children and young people, older people, people with learning disabilities, mental health problems, physical disabilities, multiple disabilities and sensory impairment. We also met people from LGBTQ+ and BAME groups, including people with these characteristics and who have sight loss.

6.6. Assessment of the impact of the proposals on these groups, as well as its ability to reduce inequalities between patients, has been undertaken in two phases. Both have been led by independent organisations and represent an objective assessment of the likely impact of the proposals.

6.7. We have also engaged with partners in London, Essex, Hertfordshire and Kent, as well as further afield; providing briefings to overview and scrutiny committees and Healthwatch.

6.8. And we have heard from residents in north, south, east and west London, Essex, Hertfordshire, Bedfordshire, Suffolk and Norfolk. Over a quarter of survey responses have come from people who live outside London.

Main feedback from engagement

6.9. The main themes of feedback during this engagement have not changed during the consultation, and remain as follows:

Clinical quality

6.10. The issue most highlighted as "very important" by people is high quality clinical expertise. Overall, it was stated that clinical quality is more important than any travel issue, which could be overcome.

Transport to and from the proposed St Pancras site

6.11. There were several aspects listed that were key concerns for people in regard to travel and transport to and from the St Pancras site. The main themes included:

- Travelling the last half mile
- Engaging with Transport for London
- Help with travel
- Difficulties posed by King's Cross being a busy area.

Accessibility to the proposed site

6.12. A number of suggestions and solutions were listed to help with accessibility to the proposed new centre. For example, having a green line and tactile flooring, moving bus stops, operating a meet and greet facility, installing better signage.

Accessibility around the proposed site

6.13. Improved accessibility around any potential new centre was identified as important. It was considered crucial that staff, service users, carers and representatives from supporting groups and charities are involved in the design and development of the proposed centre to ensure it meets a wide range of needs.

Patient experience

6.14. Improving patient experience through:

- Good communication
- Better patient facilities for treating service users and allowing for improved privacy.

There were comments on the benefits and drawbacks of gender specific wards, toilets and non-gender specific areas.

Transition to the proposed new centre

6.15. Managing the transition to the proposed new centre included communicating progress updates using a multi-channel communication approach. Some groups expressed the need to include people with disabilities and other protected characteristics in the design of the new centre. It was felt that no-one knows better about what is accessible and what doesn't work than the users themselves. The breadth of involvement during the consultation was commended.

7. How we are responding to what people say

7.1. Since the consultation was launched in May 2019, we have been seeking responses from a wide range of people from across the country, using both online and face-to-face channels.

Co-production workstreams

7.2. Given the repeating pattern of feedback, which has continued since January 2019, a clear and consistent view is emerging about how the proposal could affect people.

7.3. To respond to this, we set up six co-production workstreams to help coordinate and translate consultation feedback into proposed elements of programme delivery. These six workstreams are as follows:

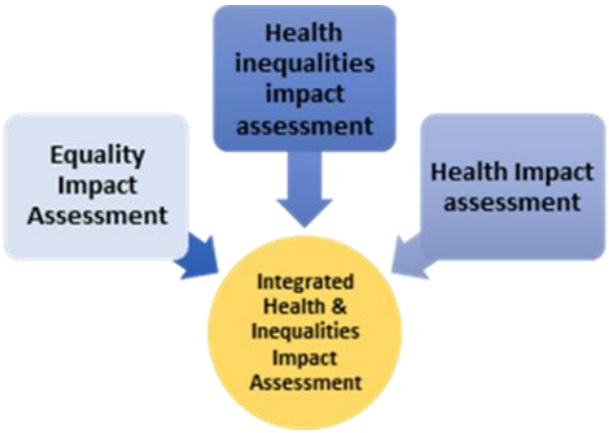
- Accessibility – getting to the proposed site
- Accessibility – getting around the proposed new centre
- Improving the patient experience
- Managing transition
- Innovation and research
- Options refresh – a task and finish group of patient and public representatives is already involved in the options refresh.

7.4. These co-production workshops, whose membership includes representatives from the Oriel Advisory Group (patient group), patients and residents, as well as experts from RNIB, Transport for London, and other interested parties, began in July and continued through into October and beyond.

Integrated health inequalities and equality impact assessment

7.5. As part of the consultation process, we have commissioned a full integrated health inequalities and equality impact assessment.

7.6. An integrated impact assessment supports decision-making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Equality Sector Duty.



7.7. The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services.

7.8. The aim of the report is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative implications of the proposed change.

Phase 1	Phase 2	Phase 3
A rapid scoping report to identify potentially impacted groups to inform pre-engagement activities	A desktop review of "best practice evidence" to identify and develop relevant health outcomes and understand priorities and challenges for key groups.	A revised and final Integrated Health and Inequalities Impact Assessment published to reflect the results of the public consultation

7.9. Phase 3 of the integrated impact assessment is now complete and published on https://oriel-london.org.uk/consultation-documents/

Accessibility workshops

7.10. The first co-production workshop took place on 31 July. The group, was attended by people with sight loss, carers and members of the Royal National Institute for the Blind (RNIB), Guide Dogs, South East Vision, London Vision, Organisation for Blind African and Caribbean's, Thurrock CCG, Herts Vision and Beyond Sight Loss as well as building designers AECOM. The group discussed the current routes to the proposed new site, as well as some of the new technologies that could be used to support people on their journey.

7.11. Further accessibility workshops have taken place in September and October designed to build on these initial discussions.

Intensive engagement periods

7.12. As a result of this earlier engagement, we have undertaken an intensive two-week engagement period at Moorfields City Road site, with 'talk to me' volunteers, tasked with one clear mission – to get visitors and staff talking about Oriel and the proposal. A special Oriel information hub in the centre of the City Road site was set up, staffed by the Oriel team with clinicians on hand to answer questions about the proposed relocation and how it may affect patients was held. This was combined with increased social media and media outreach work, as well as a mailing to stakeholders via the Oriel mailing list and OAG as a final push for views and responses.

7.13. The inclusion of a letter about the proposal in all appointment letters continues to generate a steady number of emails and phone calls to the consultation team from people keen to provide their views.

7.14. This resulted in an impressive level of engagement despite the summer break. In just one week, the number of survey responses rose significantly with 156 surveys completed, plus an additional 100 conversations about Oriel had by colleagues with patients, carers and staff throughout the week.

Stakeholder communications update

7.15. In August, we issued a strategic update email to stakeholders across England, which covered the main themes from consultation so far together with a summary of the proposal. It also explained how we are engaging with people and gave information on the co-production workstreams.

7.16. **All STP and CCG leads** were asked to forward it to their local authority/ OSC and other local stakeholders, such as Healthwatch and other voluntary organisations to provide an update on progress and reminding them of the end-date of the consultation in writing, to ensure they responded within the timescales.

7.17. **The 14 CCG communication and engagement leads** were asked to arrange for an agenda item on their patient and public reference groups and other representative groups.

7.18. On 23 October, we published on our website, and issued an email to stakeholders across England inviting them to share views on the findings in the draft Consultation Findings Report, in particular highlighting anything that has not been captured in this initial draft. Comments were received and incorporated into the consultation findings report which can be found at https://oriel-london.org.uk/consultation-documents/

8. Assurance and scrutiny

Quality assurance

8.1. The Consultation Institute (tCI) is a well-established not-for-profit best practice institute, which promotes high-quality public and stakeholder consultation. It provides an independent quality assurance service for consultations and was commissioned by the consultation programme board to review documentation, plans and processes prior to consultation, ensuring best practice standards are observed.

8.2. In July 2019, the tCI's quality assistance team undertook a mid-term review, which confirmed the programme's compliance with best practice standards at that stage.

8.3. Preparations for the review and the main meeting with the tCI involved members of the consultation team from Moorfields, Camden and Islington CCGs and NHS England

Specialised Commissioning. It was an opportunity to consider our reach, adapt our approach and respond to feedback.

8.4. The tCI assessor commended our plan to develop the initial proposal for consultation through the co-production workstreams.

The Secretary of State's four tests

8.5. The 2014/15 mandate from the Secretary of State to NHS England outlined that any proposed service changes by NHS organisations should be able to demonstrate evidence to meet four tests before they can proceed.

- Strong public and patient engagement
- Patient choice
- Clinical evidence base
- Support from clinical commissioners.

8.6. NHS England's bed closures test: In April 2017, NHS England introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures. (Detail at Appendix A).

9. Post-consultation steps and decision-making process

9.1. The consultation closed on 16 September 2019 following an extensive 16 week consultation period to offset any negative impact of running a consultation during the month of August. Responses received have been independently analysed and a draft consultation outcome report developed.

9.2. This draft report was published on 23 October 2019 and shared widely as we sought feedback on the findings and any recommendations.The final consultation report was published on 13 January 2020.

9.3. Following this, representatives from the Consultation Programme Board, CCG Governing Body members and NHS England Specialised Commissioning will consider the report in the context of the Decision Making Business Case, as well as other influencing factors, such as the Secretary of four tests and the recommendations of the London Clinical Senate.

9.4. These will then be summarised in the Decision-Making Business Case to assist CCGs, through the Committee in Common to be held on 12 February 2020, in their decision-making on the proposals. Specialised commissioners will follow NHS England's governance processes in their decision-making.

9.5. The outcomes of the consultation will also be presented to North Central London Joint Health Oversight and Scrutiny Committee on 31 January 2020.

9.6. Subject to approval of the Decision-Making Business Case, Moorfields would then proceed to develop its Outline Business Case. Feedback provided during the consultation process will be used to inform the Trust's proposals in the business case and next steps. Should the Outline Business Case and Full Business Case receive approval from NHS England/Improvement, Moorfields will go on to implement the proposal, taking into consideration themes from the consultation and recommendations from commissioners.

9.7. NHS England/Improvement requires Moorfields to submit a Strategic Outline Case, Outline Business Case and Full Business Case for approval for their capital investment proposals.

10. Timeline

September 2019	Consultation closed
October 2019	Draft consultation outcome report published for feedback to make sure the summary is an accurate reflection of views https://oriel-london.org.uk/consultation-documents
13 January 2020	Published: • Proposed Move of Moorfields Eye Hospital's City Road Services Consultation Findings Report 24 May – 16 September 2019 • Report on consultation with people with protected characteristics and rare conditions • Integrated Health Inequalities and Equality Impact Assessment (IIA) These reports are published on https://oriel-london.org.uk/consultation-documents/
31 January 2020	Presentation of the outcome of the consultation to the NCL JHOSC
12 February 2020	Decision-making by the 14 CCGs Governing Bodies Committees in Common
February	Announcement of decision.

Appendix A

The Secretary of State's four tests

The 2014/15 mandate from the Secretary of State to NHS England outlined that any proposed service changes by NHS organisations should be able to demonstrate evidence to meet four tests before they can proceed.

- **Strong public and patient engagement:** Robust and strategic stakeholder engagement has been undertaken since 2013. Strengthening patient engagement for the project has been a priority in 2018/19, hearing from more than 1,000 people, including people of varying ages, interests and backgrounds; people living with mental health problems, learning disabilities, physical disabilities and sensory impairment; and included professionals such as optometrists, social care staff and sight care experts from the voluntary sector.
- **Patient choice:** Access to the current care pathways would remain the same, with the existing full range of services continuing to be delivered from a new site, including the transfer of emergency surgery and ophthalmic A&E care. Based on the current proposals to relocate the hospital from City Road to the St Pancras hospital site, there would be no change to district hubs, local surgical centres and community-based outpatient clinics. Patient choice would be improved from a quality perspective as the proposed streamlined, modern and fit-for-purpose estate footprint would allow a more efficient patient journey time through the hospital and provide a higher quality experience for patients.
- **Clinical evidence base:** The proposal gives the opportunity for integration between cutting-edge clinical care and cutting-edge research. This would have a huge impact on the quality of clinical care with patients having more access to the research from UCL. This will be central to the design of the proposed new hospital, providing a platform to create more efficient clinical journeys and continue to deliver innovative care currently hampered by the ageing estate. The London Clinical Senate has reviewed these proposals and confirmed that the proposal has a clear clinical evidence base for the proposed move from Moorfields' City Road site to a new, purpose-built integrated facility at the St Pancras hospital site.
- **Support from clinical commissioners:** Moorfields' services are commissioned by 109 CCGs across the country and NHS England Specialised Commissioning. Some 14 CCG commissioners hold significant contracts. NHS Islington CCG and NHS Camden CCG have been significantly involved in the process to consult on the proposal to transfer services to the St Pancras hospital site. NHS England specialised commissioners are the single largest commissioner of services at the trust.

NHS England's bed closures test: In April 2017, NHS England introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures. There are no plans to reduce beds, therefore this test does not apply.

ENDS

Item 11: Work Programme 2020

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 January 2020

Subject: Work Programme 2020

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee (HOSC).

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1. Introduction

a. The proposed Work Programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.

b. The HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services to bring an item to the HOSC's attention, as well as taking into account the referral of issues by Healthwatch and other third parties.

c. The HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.

d. The HOSC is requested to consider and note the items within the proposed Work Programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2. Recommendation

The Health Overview and Scrutiny Committee is asked to **consider** and **note** the report.

Background Documents

None

Contact Details

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

5 March 2020		
Item	**Item background**	**Substantial Variation?**
South East Coast Ambulance Service update	To receive a general update, including an update on the procurement of the new 111 CAS service	-
East Kent Hospitals University NHS Foundation Trust - CQC Inspection of Children's and Young People's Hospital Services / general update	To receive a general update on the performance of the Trust	-
Children & Young People's Emotional Wellbeing & Mental Health Service	To receive an update on the CCG contract with NELFT	-
East Kent Orthopaedic services	To receive a general update on the provision of services	-
Kent and Medway STP – Publication of the Primary Care strategy	For information, following publication of the strategy	-
The Maidstone and Tunbridge Wells Stroke Service	To receive an update following the closure of the Tunbridge Wells stroke unit	-
Review of Frank Lloyd Unit, Sittingbourne	To receive an update on the proposed closure of the mental health unit	Yes
Transforming Health and Care in East Kent	To receive an update on the East Kent Transformation	Yes *

29 April 2020		
Item	**Item background**	**Substantial Variation?**
Medway NHS Foundation Trust - performance update	To receive a general update on the performance of the Trust	-
East Kent CCGs Financial Recovery Plan	To receive an update on the financial position of the East Kent CCGs	-

** Formal scrutiny lies with the Kent & Medway JHOSC, but Kent HOSC Members will continue to receive updates for their information*

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Urgent Care provision in Swale	To receive greater clarity around the plans for Urgent Care provision in Swale	To be determined
Pathology Services	The changes were not deemed to be substantial, but Members wanted to receive updates on the move toward a single service	No
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Members requested an update at the “appropriate time” during their meeting on 1 March 2019	-
Publication on the local Workforce Strategy	To discuss the Strategy once published	-

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

Kent and Medway Joint Health Overview and Scrutiny Committee NEXT MEETING: 6 FEBRUARY 2020		
Item	**Item Background**	**Substantial Variation?**
Transforming Health and Care in East Kent	Re-configuration of acute services in the East Kent area	Yes
Assistive Reproductive Technologies	Consideration of proposed changes to fertility services	Yes
Specialist vascular services	A new service for East Kent and Medway residents	Yes
Changes to mental health provision (St. Martin's Hospital)	KMPT's plans for the St Martin's (west) former hospital site, under their Clinical Care Pathways Programme	Yes
Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Committee NEXT MEETING: 29 JANUARY 2020		
Item	**Item Background**	**Substantial Variation?**
Urgent Care provision in Dartford, Gravesham and Swanley	Plans for Urgent Care provision in the Dartford, Gravesham and Swanley area	Yes

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