KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Monday, 28th September, 2020

2.00 pm

Online

AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Monday, 28th September, 2020, at 2.00 pm
Online

Ask for: **Kay Goldsmith**
Telephone: **03000 416512**

Membership

Kent County Council — Mr P Bartlett, Mr D Daley, Mr K Pugh, and Mr B Sweetland

Medway Council — Cllr B Kemp, Cllr T Murray, Cllr W Purdy and Cllr D Wildey (Chair)

In response to COVID-19, the Government has legislated to permit remote attendance by Elected Members at formal meetings. This is conditional on other Elected Members and the public being able to hear those participating in the meeting. This meeting will be streamed live and can be watched via the media link on the webpage for this meeting here.

County Councillors who are not Members of the Committee but who wish to speak at the meeting are asked to notify the Chairman of their question(s) in advance.

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

Item		Timings*
1.	Apologies and Substitutes	
2.	Election of Chair	
3.	Election of Vice-Chair	
4.	Declaration of interests by Members in items on the Agenda for this meeting	
5.	Minutes from the meeting held on 6 February 2020 (Pages 1 - 8)	

6. Dermatology Services update (Pages 9 - 12)

7. Provision of Mental Health Services - St Martin's Hospital (Pages 13 - 44)

8. East Kent Transformation Programme (Pages 45 - 94)

9. Assistive Reproductive Technologies Policy Review - written update (Pages 95 - 98)

10. Date of Next Meeting: To be confirmed

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

18 September 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.

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KENT COUNTY COUNCIL

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Thursday, 6 February 2020.

PRESENT: Cllr D Wildey (Chair), Cllr B Kemp, Cllr T Murray, Cllr W Purdy, Mr P Bartlett (Vice-Chairman), Mr D S Daley, Mr K Pugh and Mr D L Brazier

ALSO PRESENT: Ms L Gallimore

IN ATTENDANCE: Mr J Pitt (Democratic Services Officer, Medway Council), Mrs K Goldsmith (Research Officer - Overview and Scrutiny) and Dr D Whiting (Consultant in Public Health, Medway Council)

UNRESTRICTED ITEMS

17. Membership
(Item 1)

Members noted the change in Membership as per the agenda. Sue Chandler was no longer a member of the Committee and was replaced by Bryan Sweetland.

18. Apologies and Substitutes
(Item 2)

Apologies were received from Mr Bryan Sweetland who was substituted by Mr David Brazier.

19. Election of Vice-Chair
(Item 3)

1) Mr Wildey proposed, and Mr Pugh seconded that Mr Bartlett be elected as Vice-Chair of the Committee. There were no further nominations.

2) RESOLVED that Mr Bartlett be elected as Vice-Chair of the Committee.

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

There were no declarations of interest from Members of the Committee.

21. Minutes from the Meeting held on 10 September 2019
(Item 5)

1) Dr David Whiting from Medway Council had been recorded as “Whiting” in the draft minutes. This had been amended.

2) RESOLVED that the minutes of the meeting held on 10 September 2019 are correctly recorded and that they be signed by the Chair.

22. Specialist Vascular Services Review
(Item 6)

In attendance for this item: from NHSE/I Specialised Commissioning: Fiona Hughes (Programme Lead), Su Woollard (Transformation Delivery Manager), Sue Whiting (Chief Operating Officer), Carol Wood (Deputy Regional Head of Communications and Engagement). From East Kent Hospitals University Foundation Trust: Simon Brooks-Sykes (Strategic Programme Manager), Noel Wilson (Lead Vascular Surgeon). From Medway Foundation Trust: David Sulch (Medical Director).

1) The Chair welcomed the guests to the meeting and asked that they introduce themselves and provide a brief synopsis of the service change.

2) Key points from the agenda papers included:

a. The clinical need for change was driven by national standards set by the Vascular Society.

b. The review covered East Kent and Medway.

c. The broad clinical agreement was for an arterial centre to be situated in East Kent, though the exact location would be decided as part of the East Kent Transformation Programme.

d. The proposed interim model, discussed at the previous JHOSC meeting, was for a single arterial centre to be housed at the Kent and Canterbury Hospital site.

e. Since the last meeting, there had been an emergency move of the Abdominal Aortic Aneurism Repair (AAA) service from Medway Maritime Hospital to the Kent and Canterbury Hospital. This was required following staff shortages in December at the Medway site which led to concerns over patient safety. Patients would still receive their assessment at Medway Maritime Hospital, it would only impact AAA intervention and emergency surgery.

f. The number of emergency patients had reduced over recent years, in part down to the success of the screening programme.

g. There was no evidence that outcomes at Medway Foundation Trust were poor.

3) Members voiced their disappointment at the amount of time the proposed move had been underway – the process had begun in 2014. One Member commented that in its early stages, the evidence had supported Medway receiving the main arterial centre, but over time the numbers had fallen and that was no longer viable.

4) Dr Sulch explained that the county's population was not big enough to sustain two Main Arterial Centres. Two thirds of the population that accessed vascular services were nearer to East Kent than Medway. One of the benefits of the changes would be the standardisation of the patient experience, with service users receiving the same level of care regardless of where they are from.

5) Members noted a typing error on page 15 of the agenda. Ms Hughes acknowledged that the wording in the second paragraph should read "move the AAA service from Medway" as opposed to "to Medway".

6) Dr Wilson explained that the AAA Screening Programme was offered to all men when they reached 65 year of age. In Kent and Medway, around 11,000 men were screened per year, across 35 venues, with an up take of around 82%. Around 1% of those screened found a swelling in the aorta, down from 3-4% in the past. Dr Wilson felt that this was a positive sign the population was getting healthier.

7) Dr Wilson addressed Members' concerns about staffing levels by confirming that there was adequate staffing at both sites, with Medway consultants working from Canterbury, as well as providing support at the Medway and Maidstone sites. For the clinical team, emergency surgery was not their main source of work. There was a full-time specialist nurse at Medway and Vascular services would not be removed from that site. It was very much intended to create a strong system across all sites that would benefit all patients.

8) Members were informed that there were four Interventional Radiologists based at Medway. In addition, all new vascular surgeons were receiving training in that area of medical imaging, which added to the security of delivering the service.

9) Members noted the Equality analysis data from page 25 of the agenda. Referring to the increased risk of developing vascular disease if a person was from a black or ethnic minority community, members pointed out that the ethnic mix of the local population continued to grow and change as people moved into the area. A Member expressed a view that Medway had a relatively high ethnic minority population compared to many parts of Kent. A Member considered that the likelihood of increased prevalence made the possibility of Medway not having full vascular provision more concerning. Concern was also raised about the ability of the model to sustain day surgery in Medway and the availability of preventative support. Dr Sulch confirmed that those trends had been taken into consideration when designing the new service and that there would still be non-urgent vascular provision in Medway. It was considered that the model would provide a good level of vascular surgical support for other services.

10) A person's risk was also higher if they had diabetes. Dr Wilson acknowledged that on-going support would be required by those suffering with diabetes, and that support would continue to be provided locally. He highlighted the importance of prevention and primary care in trying to combat the rising numbers.

11) Dr Sulch referred to the general improvement in the management of public health. However, he warned that there was a risk for population growth to overtake those improvements.

12) A Member highlighted the continued push from central government to build more houses and questioned how that policy correlated with the NHS drive to make savings. Dr Wilson confirmed the NHS did factor population trends into their future planning. They were looking to develop their staff and resources in order to make the service sustainable for the future population.

13) In terms of pre-engagement, Members were disappointed to read that attendance at the patient and public events had been low. Ms Hughes said this was not through a lack of effort on the team's part. Over 200 letters had been sent out. Ms Wood explained that the service area did not generate the same level of engagement that other services might, especially if people accept the rationale behind the change.

14) During the next round of engagement, Ms Wood explained they would look to involve organisations in the third sector, such as Diabetes UK, the British Heart Foundation and Healthwatch. She was still expecting the events to be user focussed, drawing on the views of those who understood the risks and benefits. But the wider population, if interested, would be able to provide feedback via online consultation material.

15) The Chairman expressed a view that the Kent and Medway Stroke Review Consultation had not taken into account concerns raised and hoped that engagement in relation to vascular services would be a more positive experience. Another Member asked whether the planned engagement would take place across Kent and Medway or in specific areas and whether it would be possible to engage with those that had used the screening programme. Ms Wood said she would look into the idea of engaging with those that had accessed the screening programme. Two engagement events had been planned but locations had not yet been determined.

16) In terms of the next steps, Ms Hughes explained that the detailed proposal for the interim model was being worked through with the CCGs and STP. She hoped the next set of engagement would commence around April/May time and that they would come back to the JHOSC around that time. She agreed to circulate the dates of the engagement events once confirmed.

17) The Chair asked the Committee and its guests to note the content of an email from a member of the public regarding the proposed changes (appended to these minutes). There were no additional comments. NHS attendees undertook that a response to the questions raised would be provided to Members following the meeting.

18) RESOLVED that the report be noted.

23. East Kent Transformation Programme
(Item 7)

In attendance for this item: Lorraine Goodsell (Deputy Managing Director, East Kent CCGs), Liz Shutler (Deputy Chief Executive, East Kent Hospitals University Foundation Trust), Tom Stevenson (Acting Director Communications and Engagement, Kent & Medway STP)

1) The Chair welcomed the guests to the Committee and asked them to introduce the item. Ms Goodsell summarised the development of the options

for the future of acute hospital services in East Kent. The two options included in the draft pre-consultation business case (PCBC) had been evaluated against five criteria and assessed against a “do-minimum” scenario.

2) The finalised PCBC would be submitted to NHS England in April 2020. A public consultation would follow taking any feedback into consideration.

3) Mr Stevenson advised that the consultation plan was in development, as per the report in the agenda pack. Multiple ways and styles of engaging the public would be used. He did not think a region wide mail drop would be used, because evidence suggested the recognition rate was low compared to its high cost. A Member asked that this be considered carefully as some residents relied on receiving information through the post. A final consultation plan would be shared with JHOSC before going public.

4) A Member asked about the hurdle criteria and its application to the Quinn Estate option (where Quinn Estates would provide the shell of a hospital building under option 2). Ms Shutler explained that commercial risk was assessed under a different set of criteria. The CCGs had subsequently commissioned a commercial risk assessment (CRA) around the Quinn Estates option which had resulted in a number of recommendations. Ms Shutler offered to ask the CCGs if this document could be shared with JHOSC Members.

5) A Member questioned the wording “there are no significant flows of patients from outside of east Kent” on page 57 of the agenda pack. Ms Shutler explained that the statement referred to patient flow for emergency services, not specialist services. The number of patients accessing specialist services from outside of East Kent accounted for a small number of their overall footfall, though they would still be consulted.

6) A Member felt that the two options under consideration were very different and would lead to polarisation during the consultation. Ms Shutler explained that there were common themes to both options:

    a. A desire to split elective and non-elective surgery so that elective patients did not have their appointments cancelled during peak times;

    b. Centralising the specialist services offered due to their clinical dependencies;

    c. Non-A&E sites would become Integrated Care Hospitals and 86% of patients would still access services at their local hospital.

7) In relation to interaction with social care and Social Services, Ms Goodsell affirmed that NHS staff were working closely with those in social care. In addition, the move to Integrated Care Partnerships would see colleagues from mental health trusts, Kent County Council and other care providers working together as a whole system. The consultation would also consider the impact of each option on other services.

8) It was confirmed that the decision-making group "East Kent Sustainable Health Committee" would form part of the governance structure at the new Kent and Medway CCG.

9) The Chairman expressed a view that the outcome of the Kent and Medway Stroke Review had not sufficiently taken into account the public's views. Mr Stevenson clarified that whilst the consultation was a way of seeking views from stakeholders, the feedback gathered was just one element of the decision-making process. The feedback would be evaluated by an independent organisation who would produce a feedback report for consideration by the commissioners, who would then make a final decision.

10) Ms Goodsell affirmed that feedback received over the previous years had already influenced the final two options. For example, travel times were given a greater weighting in the evaluation criteria due to the amount of concern about this. Also, midwifery birthing units had been added into the options, which they did not in earlier iterations. In time, the CCG would need to produce a report setting out how it responded to the consultation.

11) The Chair thanked the guests for their presence.

12) RESOLVED that the report be noted.

24. Provision of Mental Health Services - St. Martin's Hospital
(Item 8)

In attendance for this item: Karen Benbow (Senior Responsible Officer, South Kent Coast CCG) and Jacquie Mowbray-Gould (Chief Operating Officer, KMPT)

1) The Chair welcomed the guests to the meeting. The KMPT and CCG were working together to improve mental health services across Kent and Medway. The mental health unit St. Martin's was part of this review.

2) Since the previous updates to HOSC and HASC, the Cranmer Ward (in the west hospital site) had been temporarily shut with patients moving to the Heather Ward. That closure had resulted in a temporary reduction in the number of mental health beds available, though so far that had not had any negative impact on the provision of services.

3) Ms Benbow explained that a key part of the review was bed modelling, which was underway. The data would provide a clear evidence base for changes that may result.

4) A Member voiced her concern at the proposed reduction in the number of mental health beds at a time when the national press were reporting a shortage in such beds. She felt that stronger community services were not appropriate for all and inpatient care was still required and also that community services currently lacked resilience to cope with a reduction in acute beds.

5) Ms Mowbray-Gould confirmed that community services could be beneficial for those that were experiencing mental distress, but that inpatient provision was

absolutely still necessary for some. The review was an opportunity to look at reinvestment and looking at ways of working. For example, a signposting service had been introduced and was already having a positive impact on the number of patients accessing a bed for a short period of time (Kent's figure was higher than the national average). Feedback from those using the signposting service had been positive.

6) There were also additional resources available (or would soon become so) such as Safe Havens and the already established Crisis home teams.

7) A Member was concerned that individuals requiring support may be missed during the transitional arrangements. She also feared the additional community support may not come to fruition.

8) Ms Mowbray-Gould explained that the incumbent system had suffered from fragmentation across both commissioning and provision. But the national focus on mental health, along with the creation of Integrated Care Partnerships, had meant that the service was in a more positive and recognised position than it had been in the past. There was a genuine opportunity for change.

9) In answer to a question about patients with dementia, Ms Mowbray-Gould explained that there were no plans to close any dementia beds. St Martin's had four such beds (currently vacant), though they were only used when no other service was available. Partnership working, such as through the Kent & Medway dementia programme, was key in this area.

10) The Chair thanked the guests for their attendance at the meeting.

11) RESOVED that the report be noted.

25. Date of Next Meeting: To Be Determined
(Item 9)

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Item 6: Dermatology Services Update

By: Kay Goldsmith, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 28 September 2020

Subject: Dermatology Services Update

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

It provides background information which may prove useful to Members.

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1. Introduction and Background

(a) Dermatologists are specialist physicians who diagnose and treat diseases of the skin, hair and nails.[1]

(b) DMC Healthcare was awarded the contract to deliver this service to residents of Medway, Dartford, Gravesham, Swanley and Swale from 1st April 2019. The previous service had been failing and there was a significant backlog of patients waiting for treatment.

(c) On 23 June 2020, it was announced that the Kent and Medway CCG had suspended the contract with DMC Healthcare following new data which indicated there were risks with continuing with it.

(d) This situation has been scrutinised by both Medway's Health and Adult Social Care Overview and Scrutiny Committee (HASC) and Kent County Council's Health Overview and Scrutiny Committee (HOSC). As the service is accessed by both Kent and Medway residents, the Medway HASC has requested that the matter be brought to the JHOSC.

2. Joint Scrutiny

(a) Regulation 21 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 allows a local authority to scrutinise any matter relating to the planning, provision and operation of the health service in its area. In addition, regulation 30 of the above Act also allows two or more local authorities to appoint a joint committee and carry out these functions where it considers this appropriate.

(b) The JHOSC has the power to make recommendations and reports to the CCG on any matter it has reviewed under regulation 21, as well as to the referring health scrutiny committees in Kent and Medway.

[1] British Association of Dermatologists, What is a dermatologist? www.bad.org.uk

3. Legal Implications

(a) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the local authority health scrutiny function. The provisions in the regulations relating to proposals for substantial health service developments or variations are set out in the body of this report.

4. Financial Implications

(a) There are no direct financial implications arising from this report.

5. Recommendation

The JHOSC is invited to note and comment on the report.

Background Documents

Kent County Council (2020) *'Health Overview and Scrutiny Committee (22/07/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8496&Ver=4

Medway Council (2020) '*Health and Adult Social Care Overview and Scrutiny Committee (18/08/20)*' https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=4768&Ver=4

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Kent and Medway
Clinical Commissioning Group

JOINT HEALTH

OVERVIEW AND SCRUTINY COMMITTEE

28 SEPTEMBER 2020

Dermatology Briefing

Nikki Teesdale – Associate Director of Commissioning

NHS Kent and Medway Clinical Commissioning Group (CCG) suspended DMC Healthcare's contract to provide dermatology services in Medway, Swale, Dartford, Gravesham and Swanley on 19 June 2020. This decision was taken to ensure patient safety after the CCG identified concerns about the provider's ability to meet NHS standard contract requirements.

Dermatology is the medical term for the treatment or management of skin conditions which can include rashes, lesions, lumps on the skin, changes to moles and skin cancer.

Sussex Community Dermatology Service (SCDS) provides dermatology services across Sussex, Surrey and Kent with a proven track record of service delivery for more than 10 years, working in acute hospital trust and community locations. The additional expansion of services across Kent will depend on a commissioning review that is being undertaken by the NHS commissioners and stakeholders .

DMC had provided a Minimum Data Set of open patient referrals to a data processing organisation: Source Group who carried out a validation exercise of this data. The validation exercise was completed by the end of August 2020 with 8,126 patients having been transferred to SCDS.

Sussex Community Dermatology Service had been commissioned to see new routine patients once priority patients had been treated. To date **98% of the high risk patients** have been seen and treated by the SCDS and 18 Week Support Team. There were 5500 patients transferred to SCDS as a backlog of follow up appointments, this has been **reduced by 50%.**

The service continues to receive new referrals and has the capacity to see more than 500 new patients per week. There will be approx. 10,000 outpatient appoints available during Q3 for North Kent patients, because of this capacity the *outpatient waiting times will reduce to 14 weeks* (and under) by the end of November 2020. SCDS have a target of 8-10 week wait maximum for routine appointments. All patients referred on a 2 week wait pathway have been seen and continue to be seen within 2 weeks and all cancer surgical waits are less than 2 weeks for new patients and new cancers.

Patients with newly diagnosed cancer and inflammatory skin disease are being seen and linked to other specialist services as required. This includes skin cancer support services provided at Queen Victoria Hospital and oncology services provided by Maidstone Hospital. Multidisciplinary clinics – which bring a range of clinicians from different specialities across provider organisations

together, are being held on a weekly basis to discuss complex cases and ensure patients are receiving optimum care.

Clinics have taken place at Rainham Healthy Living Centre, High St, Rainham and Fleet Health Campus, Vale Rd, Northfleet. There is sufficient clinical space at the end of September 2020 to deliver surgical volumes, paediatric dermatology, and specialist support clinics for biologics, systemic, isotretinoin, biopsies, patch-testing and PDT. Additional clinical space has allowed for further clinical recruitment to the service.

An independent harm review has been commissioned which means all patients will be clinically reviewed and assessed to see if delays to treatment have caused harm. Any patient outcome found to have been impacted by the delays will be investigated as a serious incident with patients contacted to ensure duty of candour is followed.

DMC Healthcare and the CCG have agreed in principle to a mutual termination of the dermatology contract. At the time of writing this report the CCG is unable to comment as to the future of the service but will provide a verbal update at the meeting

Item 7: Mental Health Services - St Martin's Hospital, Canterbury

By: Kay Goldsmith, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 28 September 2020

Subject: Provision of Mental Health Services - St Martin's Hospital (west), Canterbury

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

It provides background information which may prove useful to Members.

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1. Introduction

(a) Kent and Medway NHS and Social Care Partnership Trust (KMPT) and the Kent and Medway CCG are working together to improve mental health services across Kent and Medway. The mental health unit at St Martin's (west site) in Canterbury is part of this review.

(b) St Martin's Hospital (east) houses the Heather Ward (formerly named Samphire Ward). The west site housed the Cranmer ward, but this facility has been shut due its unsuitability. The site has been sold to Homes England, with money from its sale being invested in local mental health services.

(c) The plans for St Martin's fall under KMPT's Clinical Care Pathways Programme. Best practice and national policy in mental health care advocates caring for people as close to home as possible and reducing reliance on hospital admission unless it is clinically necessary.[1]

(d) A key part of this review is ensuring there are the right number of mental health inpatient beds available to meet the needs of local people both now and in the future.[2] Inpatient beds for those suffering from dementia are not part of this review.

2. Recent Scrutiny

(a) The Kent and Medway JHOSC received an update from the NHS on 6 February 2020. At that time, KMPT and the CCG had commissioned independent bed modelling to help inform their decision on the number of inpatient beds required. The outcome of that work was expected later that month.

[1] Kent & Medway CCG (2020) Transforming mental health care services in Kent and Medway – proposed changes at St Martins site (west) in Canterbury, https://democracy.kent.gov.uk/documents/s95759/JHOSC%20update%20Jan%202020%20FINAL.pdf

[2] ibid

(b) The Cranmer Ward had been temporarily shut at that time, with patients moving to the Heather Ward. The closure had resulted in a temporary reduction in mental health beds, "though so far that had not had any negative impact on the provision of services".[3]

(c) The Committee was told about alternative provision, such as Safe Havens and Crisis home teams.

(d) At the end of the discussion, the Committee resolved to note the report.

3. Joint Scrutiny

(a) Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have under consideration for a substantial development or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment.

(b) The Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) considered the proposals relating to the St. Martin's Hospital site on 20 August 2019. They determined that the reconfiguration constituted a substantial variation in the provision of health services in Medway.

(c) The Kent Health Overview and Scrutiny Committee (HOSC) considered the item on 1 March and 23 July 2019. The Committee also deemed the changes to be a substantial variation in the provision of health services in Kent.

(d) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 20134 the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) may:

- make comments on the proposal;
- require the provision of information about the proposal;
- require the relevant NHS bodies and health service providers to attend before it to answer questions in connection with the consultation.

(e) The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State. This only applies in certain circumstances and the local authority and relevant health body must take reasonable steps to resolve any disagreement in relation to the proposals.

[3] Kent County Council (2020) 'Kent and Medway Joint NHS Overview and Scrutiny Committee (06/02/20)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8624&Ver=4

[4] When NHS bodies and health services consult more than one local authority on a proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation.

(f) The JHOSC may consider whether the reconfiguration should be referred to the Secretary of State under regulation 23(9) of the 2013 Regulations. The Committee must recommend a course of action to the relevant Overview and Scrutiny Committees.

(g) The JHOSC cannot itself refer a decision to the Secretary of State. This responsibility lies with the Kent County Council HOSC and/or the Medway Council HASC.

4. Legal Implications

(a) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the local authority health scrutiny function. The provisions in the regulations relating to proposals for substantial health service developments or variations are set out in the body of this report.

5. Financial Implications

(a) There are no direct financial implications arising from this report.

6. Recommendation

That the JHOSC consider and note the report.

Background Documents

Kent County Council (2019) *'Health Overview and Scrutiny Committee (01/03/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7926&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

Medway Council (2019) *'Health and Adult Social Care Overview and Scrutiny Committee (20/08/2019),* *https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=4522&Ver=4*

Kent County Council (2020) *'Kent and Medway Joint NHS Overview and Scrutiny Committee (06/02/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8624&Ver=4

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Mental Health Transformation in Kent and Medway

Update for the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC)

1. Introduction

Kent and Medway NHS and Social Care Partnership Trust (KMPT) and the Kent and Medway Clinical Commissioning Group (formerly led by the East Kent CCGs before the CCG merger to form NHS Kent and Medway CCG on 1st April 2020) have been working together to improve adult mental health services across Kent and Medway. This includes changes to acute adult inpatient services at St Martins Hospital in Canterbury.

Presentations on the St Martins programme were made to the Kent Health Overview and Scrutiny Committee (HOSC) in July 2019 and the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) in August 2019. A further update was presented to the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC) at its meeting on 6th February 2020.

This update has been developed to give JHOSC members the latest information from the programme and to seek their advice and views on next steps.

2. Context

CCG merger

As JHOSC members will be aware, all eight Kent and Medway clinical commissioning groups merged into a single Kent and Medway CCG on 1st April 2020, meaning that this single CCG now holds commissioner responsibility for the St Martins programme, along with other mental health related work streams and programmes. The St Martins programme will align with these Kent and Medway wide priorities for transforming adult mental and dementia services.

Coronavirus

As with all health and care systems across the county, the NHS in Kent and Medway has been focussed on the emergency response to the coronavirus pandemic, meaning that longer term transformation programmes have been paused over the past few months. While there is still a significant operational focus on coronavirus, KMPT and the Kent and Medway CCG are keen to re-start discussions with JHOSC members about the next steps and priority areas for this work.

Before the pandemic, the St Martins programme had achieved one of its core objectives of moving patients into the new Heather Ward on the St Martins (east) site. It had also received a final report of bed modelling to assess demand for acute adult inpatient beds over the next five years and formed a clinical reference group to guide further work.

This paper has been developed to:

- update JHOSC members on the successful move of patients from the old Cranmer Ward to Heather Ward;
- explain how the programme will be aligned with other Kent and Medway mental health transformation work under the umbrella of a single CCG;
- present the results of the bed modelling work for adult mental health inpatient services undertaken at the end of 2019;
- update members on the clinical reference group's work to date; and,
- Continue discussions about appropriate patient and public involvement including the need for formal public consultation.

3. About the St Martins programme

Background and context

Best practice and national policy in mental health care is increasingly focused on caring for people as close to home as possible and reducing reliance on hospital admission unless it is clinically necessary. As with many other health and care systems across the country, commissioners and providers in Kent and Medway are focussed on making improvements to community-based services with the aim of treating, caring for and supporting people in more effective ways both in and outside of hospital. At the same time, there is a need to review how existing beds are used and where they are located; to look ahead to future demand, as well as making the best use of staff, estates, facilities and budgets in the years to come.

246 general acute mental health inpatient beds are currently available across Kent and Medway, split across seven sites and broadly designated as either for younger adults or older adults, but also used on a 'needs led' basis.

Impact of the coronavirus on acute inpatient mental health services

In line with the national picture, the onset of the COVID-19 pandemic in March 2020 created a level of suppressed demand – evident both in the community teams for adults and older adults, to the order of between 47% and 64%, with less or little reduction in inpatient admissions or demand for crisis services.

Some modelling work has been undertaken using historic data which takes account of seasonal variation. The aim of this piece of work was to estimate the expected number of referrals or admissions per calendar month. This works shows that:

- Community Mental Health Team (CMHT) referrals are expected to peak in September at around 15% above the expected figure for the time of year;
- Community Mental Health Services for Older People (CMHSOP) show returning referrals are weaker than CMHT, but closer to the expected.

- Admissions for younger and older adults are also close to or exceeding expected levels.

Improvements at St Martins Hospital

KMPT and the Kent and Medway CCG have been working together to improve the facilities at St Martins Hospital in Canterbury, which includes four acute mental health wards catering for older people and younger adults who need inpatient care. At the St Martins Hospital (west) site, the old asylum-style building contained one ward, Cranmer, a 15-bed inpatient ward for people aged 65 and over, for the assessment and treatment of acute mental health difficulties (such as severe dementia) and frailty. The building was of poor quality and its design and layout, even if upgraded, would not have met the modern standards expected for patients, families and carers, and staff. Whilst acknowledging the work of the staff based within Cranmer ward, the Care Quality Commission (CQC), repeatedly highlighted the need to provide care from a safe, modern, fit-for-purpose environment. In response to these concerns and the drive to improve patient care, Cranmer ward was closed and KMPT left the St Martins (west) site in February 2020. St Martins (west) has been sold to Homes England for £6.32million. The money from the sale will be invested in local mental health services across Kent and Medway where it is most needed.

A planned upgrade to one of the wards on the St Martin's (east) site, now known as Heather Ward, was completed in early 2020, offering a much higher standard of facility for inpatients. Patients from Cranmer ward moved to Heather ward in February 2020. All changes were discussed with patients, families and staff who were fully supportive of the move, recognising the many benefits to both patients and staff as a result. There is a firm commitment to their ongoing involvement in future plans and proposals.

Moving the beds from Cranmer into Heather ward (essentially amalgamating two former wards into one) means that there will be a temporary 15 bed reduction in the number of adult inpatient acute beds available across Kent and Medway while a review of the ideal clinical model for adult mental health patients and the number and location of beds currently available, against current and predicted future demand, is completed. Commissioners and providers are confident, from looking at the data and inpatient demand and activity over the last 12 months, that even with this current temporary reduction, sufficient beds are available now and in the short-term, to ensure that people who need a stay in hospital can be treated in the right environment to suit their needs.

4. Service improvement initiatives – reducing reliance on hospital admission

In February 2020 the JHOSC was updated on three initiatives that KMPT has already introduced to improve services and which have helped to reduce reliance on admitting people to hospital when they need urgent care. These projects are enabling people to

receive more of the care and support they need without necessarily being admitted as an inpatient. They are enabling the health and care system to make better use of inpatient bed capacity and ensure that there is access to inpatient care for people who need to be admitted to hospital, hence the ability to move the beds from Cranmer onto Heather ward.

Improving 'patient flow' and discharge planning

This project looks at whether people need to be admitted to hospital and helps patients to go home sooner, once they are clinically ready to leave, by having a clinical team focused on supporting more effective discharge arrangements. Following the introduction of the team there was an initial decrease in admissions of 11% and that progress has continued with a further decrease since October 2018 of 16%. This equates to a daily average drop in the admissions rate from 6.9 to 5.8 – i.e. one person fewer, every day, being admitted.

- The number of beds occupied by patients in the adult acute service has reduced by 6% since the introduction of the team.
- The number of days that patients who had been assessed as clinically well enough to leave hospital but remained in a hospital bed whilst waiting for community and social care arrangements to be put in place, has reduced by 24%.

The need to admit patients requiring general acute care to beds outside of Kent and Medway (to supplement capacity within Kent and Medway) has reduced from a high point of 70 placements outside of Kent and Medway in 2017 to zero in the early part of 2020 (allowing patients to be cared for nearer to their own homes).

However, there has been a minimal increase in out of area bed use post Covid, which amounts to a total of 38 bed-days, equivalent to 0.18% of total bed days. The patients concerned were repatriated quickly and there has been no subsequent upward trend.

The success of this project has led to additional investment which has enabled the development of a 24/7 service which now includes dedicated staff who help ensure services are in place to care for patients in their own communities, allowing them to be discharged as soon as clinically appropriate.

The team are committed to learning from patient experience and regularly invite patients to meet with them to reflect on their care. Through this, clinical teams continuously and actively learn and adapt working practices to reflect the needs of patients, their families and carers.

Offering urgent care support and a signposting service 24/7 as an alternative to inpatient treatment when clinically appropriate.

This project has been developed to offer short term help and advice with the aim of ensuring that people access the longer term support they need. For example, by referring people to housing, alcohol and substance misuse services and third sector support organisations. This service:

- is staffed by experienced mental health professionals providing practical psycho-social support over a 24-hour period for patients in emotional distress, but who have been assessed by a clinician and who don't need to be admitted to an inpatient hospital bed;
- ensures inappropriate hospital admission is avoided for people in distress, who may previously have been admitted to hospital due to a lack of any other service available;
- helps connect people with third sector organisations, who can provide ongoing help and support, and can help reduce people feeling lonely and isolated;
- works as an outpatient service that people can be referred to 24 hours a day, seven days a week; and,
- is available and accessible for patients across Kent and Medway.

People using this new service have praised it, saying:

> *"I came in a broken lady and left 24 hours later repaired all in the right places – fantastic"*
>
> *"I came here with no hope and after a few hours I believe my life will change for the better. Thank you"*
>
> *"The staff were all amazing in raising my confidence and making me feel safe, calm and welcome and worked hard all day and night to meet my needs."*
>
> The Trust completed an evaluation of the first 8 months of this new service which demonstrated that the service met all of its objectives (admission numbers reduced, increasing numbers of people diverted from hospital stays into more appropriate treatment and support, improving outcomes for people brought in on Section 136 of the Mental Health Act) with over 300 people being successfully helped by the service before returning home (patients who would otherwise probably have been admitted to hospital). The evaluation also showed high levels of satisfaction with the service from patients using it, who generally consider the outcome of the intervention preferable to being admitted to hospital, as the statements above indicate.

It is planned to re-evaluate the data in in February 2021 when an additional 12 months information about the impact will be available, but KMPT remain confident that

significant numbers of people are avoiding hospital admission by using the Support and Signposting Service, and that there remain high levels of satisfaction.

Community Crisis Services

Whilst the Support and Signposting Service and the work of the Patient Flow Team will not have an impact on hospital based place of safety provision for people detained on Section 136, the aim is to deescalate crisis and prevent a detention on Section 136 whenever possible using community crisis alternatives. Safe Havens that had been offering virtual and telephone support across Kent and Medway during the COVID crisis are opening their doors during Autumn 2020. The Safe Havens offer a rapid diversion from hospital and A&E, where police, ambulance and paramedics can bring an individual in crisis to be greeted and supported by skilled and experienced staff, specialising in crisis de-escalation.

There has been significant NHS investment in mental health services across Kent and Medway and Kent and Medway CCG is currently scoping the options available to enhance community crisis alternatives via NHSEI transformation funding which becomes available 01 April 2021 – 31 March 2024.

Reducing the 'length of stay' for older people

This project was set up after it was identified that some older people were staying in hospital for longer than clinically necessary. It is widely agreed that this is not good for patients, with an estimated ten days of bed rest for healthy older people equating to ten years of muscle ageing with attendant loss of function. It also has the knock-on effect of reducing the number of beds available. Several factors were causing the prolonged stays, including delays in making sure that care was in place for people at home and in the community when they were ready to leave hospital.

Teams have worked hard to streamline and improve processes to make faster, more efficient decisions about admitting older people to hospital and getting them ready to go home again. By working more closely together and making decisions in partnership with patients and families they have been able to join up the way that clinical decisions are made about admission and discharge so that people don't need to stay as long in hospital and can recover in their own homes.

In the eight months between March 2019 and October 2019 length of stay has reduced by 14.9% compared to the previous eight months. The average length of stay reduced from about 84 days in February 2019 to 72.4 days as of January 2020. The average length of stay has since reduced further and is currently 70.5 days.

These projects are already delivering benefits including a better experience of care for patients and their families. Feedback from patients, families and carers to clinicians has demonstrated that they welcome earlier discharge back home with good community

support and are pleasantly surprised that this is a viable option. Families have also said that arranging what is known as a 'care programme approach' for people within a week of their admission has been a positive move as they have had their chance to share their concerns early and gain a better understanding about how their family member will be assessed and treated as well as being involved in planning for their discharge from hospital.

5. Stakeholder engagement and scrutiny

Stakeholder engagement around the St Martins programme has focussed on ensuring that affected patients, families and staff members have been involved in, and understand, the need for changes to the way that services are provided at St Martins. Relevant scrutiny committees have been kept informed of developments with information presented to the Kent HOSC and Medway HASC in July and August of 2019. At these meetings, committee members were clear that they believed the reduction of 15 beds as a result of changes at St Martins constituted a significant variation in service and, as such, any final decisions about the future provision of beds lost as a result of the shift of location of Cranmer beds to Heather ward should be subject to formal public consultation. In light of this decision by both the Kent and Medway scrutiny committees, an update on the St Martins programme was presented to the Kent and Medway JHOSC on 6th February 2020 (attached as Appendix 1).

A period of targeted and tailored engagement was planned by communications and engagement teams from KMPT and the CCGs, to inform the development of a pre-consultation business case and lay the groundwork for any formal consultation required but this was put on hold at the advent of the coronavirus pandemic in March 2020.

6. Bed modelling – outcome

Our February 2020 update to JHOSC noted that independent bed modelling was commissioned by the programme in November 2019 with a final report due in February 2020. We committed to updating JHOSC members on this work and would welcome discussion with members as to whether the bed modelling report has any materially different outcome on views around substantial variation of services.

About the bed modelling

The key question being addressed through this project, as agreed by the St Martin's Joint Programme Board (comprising commissioner, provider and local authority colleagues), was: *To identify how many inpatient beds are required across Kent & Medway for people with general acute mental health inpatient needs over the medium to long term (2024 & 2029) in the context of changes in underlying population health needs taking account of recent and planned service developments that improved patient flow and evidence-based alternatives in community settings.* This work modelled demographic growth in the Kent and Medway population, the current and predicted incidence and prevalence of mental health need, and the impact of recent

national benchmarking reports, alongside available data. It is intended to inform future planning around the number of inpatient beds and other service capacity which will be required to meet future need. The full report is attached as Appendix 2.

Key points to note are:

Whilst the availability of beds over the last two years has varied due to refurbishment and other factors, 246 beds were available across the county at the time of undertaking this modelling. (The report also details analysis of occupied bed days which when calculated equates to 243 beds – as individual beds may not be available on certain days for operational reasons). This makes no material difference to the findings of the report.

The outputs for the model above for 2024, assuming the realisation of the benefits from patient flow and community developments, suggest that this capacity is sufficient, but that by 2029 it is likely to be up to 17 beds short of requirements unless additional interventions or improvement in patient flow are realised. There is also a risk that were continued benefits from planned service developments not fully realised, this level of additional capacity could be required as early as 2024, hence the importance of ongoing monitoring.

Independent bed modelling report conclusion 1: In light of the findings summarised above it will be important to monitor the impact of existing service changes that are aimed at improving flow and providing alternatives to admission.

During the bed modelling process it was clear that additional interventions and improvements to patient flow were being considered, and that the full list of evidence-based interventions noted above had not been fully maximised. Two areas of particular focus were raised as being either early in the planning phase or a recognised priority for development, these being:

- The modelling suggested that the growth in underlying demand for ***services for older people***, including those with dementia, would be a greater pressure than that for younger adults and that there were fewer potential interventions that could address this underlying growth in need. It is also the case that occupancy in the Older People's Mental Health (OPMH) bed base has been higher with a small number of very long lengths of stay being experienced. This suggests the need to prioritise additional measures, in partnership with a wider range of partners including social care and housing providers, to improve services for older people with mental health needs in the community and at home in order to reduce the pressure on these beds.

- The evidence around the impact of ***improved primary care*** services is growing, although it may have a longer lead time to impact on acute bed needs. There are existing projects across Kent, and elsewhere, that are developing new models of care for meeting mental health needs in primary care, with appropriate support from specialist services.

These are only two examples, although in the light of the modelling they are most likely to address the rise in bed requirements in the latter part of the 2020s. The extent of benefit that could be derived from these developments, that might in turn address some of the future demand for inpatient beds, has not as yet been modelled and therefore has not been included in the bed modelling report.

Independent bed modelling report conclusion 2: There is potential to further improve patient flow and reduce the length of stay of a cohort of older people with mental health conditions that could, when evidenced and modelled, offset and delay the impact of underlying increases in demand from demographic change.

Independent bed modelling report conclusion 3: The modelling could also demonstrate the potential benefits in terms of bed requirements from the development of enhanced primary and community care support to people with mental health needs.

7. Clinical leadership

A group of primary care and secondary care clinicians have been brought together as a Joint Clinical Reference Group for Kent and Medway to build on the work to date and develop a clinical model of care for adult acute mental health services, taking into account the current and future need for inpatient beds.

This will ensure any potential future changes to mental health inpatient provision are clinically-led, are based on clinical evidence and best practice, and result in the best outcomes for patients. The group met twice prior to pausing at the outset of the coronavirus pandemic and members have reviewed the bed modelling work to understand the potential need for inpatient capacity in future years (2023/24). In addition to this they will consider the type of inpatient beds that may be required to meet patients' needs (for example, psychiatric intensive care beds and locked rehabilitation beds) and will consider how best to strengthen services in the community to mitigate the need for inpatient beds; for example, improvements in dementia care that support patients to be cared for more appropriately and safely in the community. KMPT's new medical director is a consultant in old age psychiatry and her expertise will be valuable in helping to develop a new focus on this area.

Work is currently in progress to re-establish the clinical reference group to ensure that this piece of work is taken forward as a matter of priority.

8. Key questions/areas that require agreement and resolution

The St Martins programme is overseen by a Joint Programme Board (JPB) comprising senior leaders and representatives from commissioner, provider and local authority partner organisations as well as expert advisors on communications and engagement. The JPB has considered the results of the bed modelling and initial discussions from the CRG as well as responding to input from scrutiny committee members and advice from NHS England and NHS Improvement. Key questions and areas that require resolution are listed below.

1. We have sought legal advice as to whether the removal of 15 beds from a Kent and Medway acute inpatient bed base on a four to five year basis can be considered 'temporary' as we believe this informs whether this constitutes a significant and substantial variation in service and whether a formal public consultation is required. It is important to note that patients locally continue to have access to inpatient care on the St Martins site.

   The advice we have received suggests there is not a definitive answer to this question but supports the view that further discussion with JHOSC (as we had planned) once the bed modelling information was available would help to arrive at an agreed position.

   Key issue: is a reduction in inpatient bed capacity until 2024 'temporary' or something more permanent, and therefore requires formal consultation (in addition to the planned and ongoing comprehensive engagement with local authorities, patients, carers, staff, stakeholders and local communities on these issues and service developments) – however strong the clinical case for change?

2. If a formal public consultation is not required, both the CCG and Trust consider it to be necessary and prudent to carry out a comprehensive but proportionate public engagement/involvement programme around the changing model of care, in line with best practice and guidance.

3. The size and shape of this programme would not be limited to the proposed reduction of inpatient beds in the short-term, but inform the work of the Joint Clinical Reference Group for Kent and Medway to develop the longer term clinical strategy, improve outcomes and patient experience and inform future commissioning decisions. This work will include the learning and examples from other systems such as the Sussex Clinical Strategy developed by the Sussex Partnership NHS Trust and endorsed by partner organisations.

9. Recommendation

The Kent and Medway JHOSC is asked to:

- consider and comment on the information included in this update
- provide their steer on whether the new information provided by the bed modelling means that the short-term reduction in bed numbers still constitutes a substantial variation of service
- In light of the above, what a proportionate level of involvement with the local authorities via the JHOSC, patients and the public would look like and whether, in their view, they think the change warrants formal public consultation or whether a detailed involvement and engagement programme would be sufficient
- To note any other changes to the programme's scope and alignment with other Kent and Medway mental health work programmes.

ENDS

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Appendix 1

Transforming mental health care services in Kent and Medway – proposed changes at St Martins site (west) in Canterbury

Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC)

6 February 2020

1. Introduction

The Kent and Medway NHS and Social Care Partnership Trust (KMPT) and the Kent and Medway Clinical Commissioning Groups, are working together to improve mental health services, demonstrating a shared ambition to make sure that everyone across Kent and Medway has access to safe, high quality and effective mental health services when they need them.

Presentations were made to the Kent Health Overview and Scrutiny Committee (HOSC) in July 2019 and the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) in August 2019 in relation to temporary changes to acute inpatient services at St Martins Hospital in Canterbury. This update covers the progression of our work to understand the current capacity and future demand for adult inpatient mental health beds in light of KMPT's ongoing enabling projects to deliver more care, treatment and support closer to home if clinically appropriate.

2. Delivering best practice in Kent and Medway – progress to date

Best practice and national policy in mental health care, as with physical health care, is increasingly focused on caring for people as close to home as possible, reducing reliance on hospital admission unless it is absolutely clinically necessary.

KMPT and Kent and Medway CCGs have initiated this clinically-led programme of work to look at making improvements to community-based services with the aim of treating, caring for and supporting people in more effective ways both in and outside of hospital.

An integral part of this work is to make sure that there is the right number of inpatient beds available to meet the needs of local people both now and in the future, as well as making the best use of staff, estates, facilities and budgets in the years to come. To inform our work we have commissioned some independent bed modelling, the outcome of which is expected in February 2020. This will model demographic growth in the Kent and Medway population, the current and predicted incidence and prevalence of mental health need, and the impact of recent national benchmarking

reports, alongside available data. This work will inform future planning around the number of inpatient beds and other service capacity which will be required to meet future need.

A group of primary care and secondary care clinicians have been brought together as a Clinical Reference Group to ensure any future changes to mental health inpatient provision are clinically-led, are based on clinical evidence and best practice, and result in the best outcomes for patients.

Work has begun to develop a process for the development and appraisal of potential options for the permanent re-location of services currently provided on Cranmer Ward, but the outcome of the bed modelling and significant clinical input is required, before this work can be completed. A formal options appraisal process, led by an independent analyst, and informed by ongoing discussions with staff, patient and stakeholders, will support the development of this work in due course.

3. Better outcomes for local people – ongoing work to improve patient experience

KMPT has already introduced several initiatives to improve services, some of which have helped to reduce reliance on admitting people to hospital when they need urgent care. They have found alternative and better ways to provide the care, treatment and support needed including: **improving 'patient flow' and discharge planning**; offering **urgent care support and a signposting service 24/7** as an alternative to inpatient treatment when this is clinically appropriate; and, **reducing the length of stay for older people**.

The success of these projects, and other additional community initiatives, means that there have been fewer admissions to hospital due to improved community care over the last three years. In June 2016 there were 302 inpatient admissions, 50 of which were out of our area, compared to 210 in May 2019 where all acute admissions were cared for in Kent and Medway facilities (a small number of female patients requiring specialist, intensive care were treated out of the area). If people do need hospital care, they don't need to stay in for as long because more support is now available in local community settings and closer to home.

4. Changes at St Martins Hospital, Canterbury

We are making some temporary changes at St Martins Hospital in Canterbury, which houses several mental health units catering for older people and younger adults who need inpatient care. A planned upgrade to Samphire Ward (soon to be re-named Heather Ward) at St Martins Hospital (east) has been completed, offering a much higher standard of facility for patients of all ages.

At the St Martins Hospital (west) site, the old asylum-style building contains one remaining ward, Cranmer, a 15-bed inpatient ward for people aged 65 and over, for the assessment and treatment of acute mental health difficulties (such as severe dementia) and frailty. The building is of poor quality and, even if upgraded, the design and layout of the building means it will not meet the modern standards we expect to provide for our patients, families and carers, and staff. Whilst acknowledging the work of the staff based within Cranmer ward, the Care Quality Commission (CQC), has repeatedly highlighted the need to provide care from a safe, modern, fit-for-purpose environment. In response to these concerns and the drive to improve patient care, we have committed to closing that ward and leaving the St Martins (west) site in early 2020.

The west part of the St Martins site has been sold to Homes England and the money from the sale will be invested in local mental health services across Kent and Medway where it is most needed.

Patients from Cranmer ward will be moved to Samphire (Heather) ward in February 2020 on a temporary basis until a final decision is made by commissioners about how adult mental health care should be organised across Kent and Medway in the future.

All changes to date have been discussed with patients, families and staff and they will continue to be closely involved as plans progress.

5. Developing options for the future

We want to make sure that people are cared for as close to home as possible and in the right environment to meet their needs. Sometimes this will mean a hospital bed but we must also give consideration to developing safe, accessible and effective services and support at home and within the community.

Over the coming months we will be listening to and working with patients, their loved ones, families and carers, staff, stakeholders and the general public about services, looking for ideas and input to inform the development of options for providing the right levels of inpatient care across Kent and Medway. We have some way to go before we have any firm proposals to discuss but we are committed to making sure that our mental health services support local people, so that they get the right care, in the right place, at the right time.

6. Recommendation

The Kent and Medway JHOSC is asked to note progress with this work. We will continue to engage and update JHOSC and welcome members' input. Further updates will be provided over the coming months.

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Kent & Medway Mental Health beds simulation modelling report

Whole Systems Partnership

February 2020

Contents:

1 Context

1.1 Local requirement

The Kent & Medway system is currently undertaking a range of demand and capacity modelling work supported by the Whole Systems Partnership (WSP) in the context of the NHS Long Term Plan and for Five Year Forward View for Mental Health services. Commissioners for Mental Health services wished to explore future bed capacity requirements across the system in the context of changing population health needs and service developments designed to provide improved outcomes for people with the most complex needs. They recognise, in line with national policy, that more services could be provided in community settings either through improved response to crisis and/or a more proactive approach to care.

The key question being addressed through this project, as agreed by local stakeholders, was:

To identify how many inpatient beds are required across Kent & Medway for people with specialist acute mental health needs over the medium to long term (2024 & 2029) in the context of changes in underlying population health needs taking account of recent and planned service developments that improved patient flow and evidence-based alternatives in community settings.

The project was carried out between November 2019 and January 2020 in partnership with Kent & Medway Partnership Trust (KMPT), the provider of specialist mental health services, and consisted of:

- An initial senior officer briefing to set out and agree the scope for the work;
- The gathering of relevant population health and service data to inform the building of a prototype system dynamics model that addressed the key question;
- The sharing of this prototype model with a stakeholder group so as to demonstrate initial findings and explore additional factors that needed to be taken into account;
- Further refinement of the model and the re-presentation of high-level findings to the stakeholder group;
- The preparation of this report and sharing of the systems model for the purposes of monitoring progress for the impact of service developments and therefore future bed capacity requirements.

1.2 National review of bed requirements

In November 2019 the Strategy Unit of the Midlands and Lancashire Commissioning Support Unit published a report commissioned by the Royal College of Psychiatrists entitled "*Exploring Mental Health Inpatient Capacity*". This review looked at two indicators in particular, namely levels of bed occupancy and the frequency of out of area placements for inpatient care. It compared all 42 Sustainability and Transformation Partnerships in England, of which Kent & Medway is one. The report stressed the importance for good quality care of managing occupancy levels within reasonable limits (its recommended level being 85%), minimising if not eradicating out of area placements and the importance of investing in high quality community services as a means of realising these goals.

In its evidence for the Kent & Medway system it identified bed occupancy levels of around 90%, but with a slight downward trend, minimal out of area placements and a lower than expected rate of admissions to inpatient beds, all suggesting a good track record of developing appropriate and effective community support.

1.3 Current beds in the Kent & Medway system

At the time of undertaking this review there were 243[1] beds available across the Kent & Medway system split across 7 sites and broadly designated as either for Younger Adults (YA) or for Older Adults (designated OPMH). Note that the scope of this modelling does not include Psychiatric Intensive Care or services for children and young people. Admission to a bed in the K&M system is based on a combination of proximity and need, which gives some flexibility in the use of the bed stock. This is illustrated in Figure 1 which shows the percentage of occupied bed days for people based on their diagnosis. Because of the flexibility with which it is possible to use the current inpatient services KMPT have adopted a target of 90% occupancy rather than the 85% noted above. Our modelling, however, does explore the implications were an 85% target adopted.

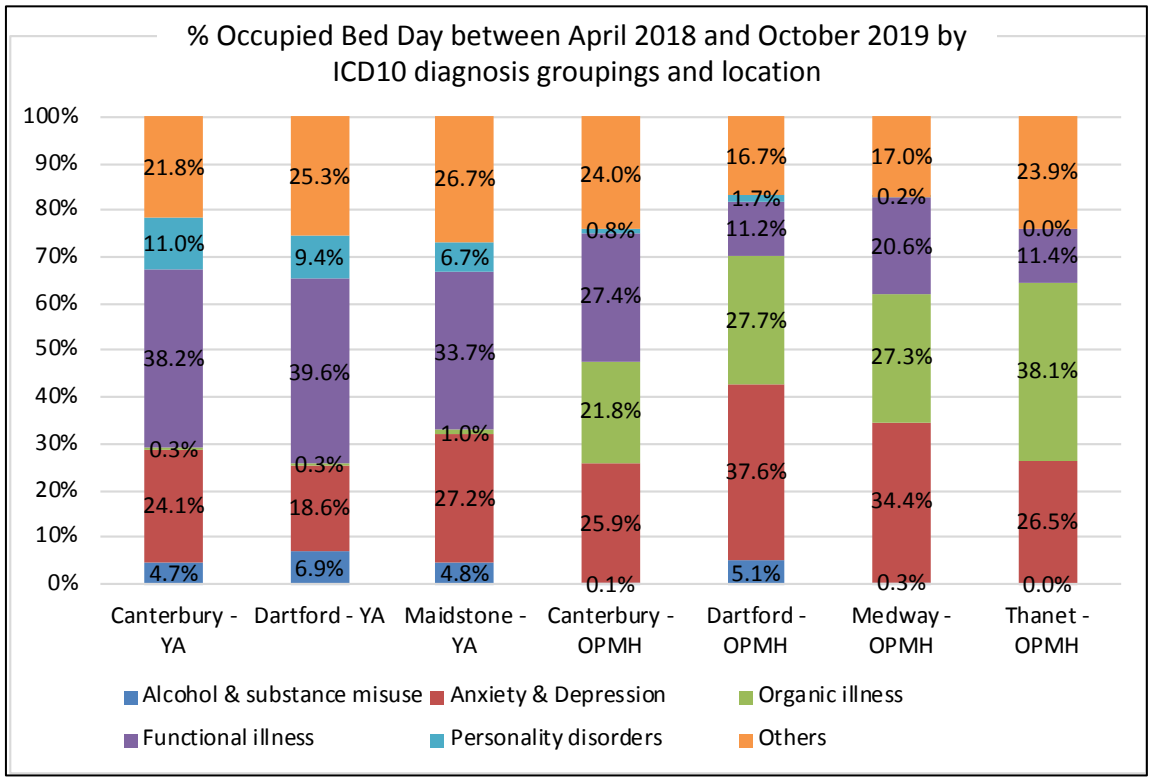

Figure 1 The percentage of occupied bed days by diagnosis group across current sites

2 Population health needs

2.1 Future needs

WSP has been working with Kent County Council in recent years to develop a whole population cohort model that generates forecasts of population health needs into the 2030's based on risk factors that are evidenced to impact on the incidence of a range of health conditions. This modelling includes estimates of the future incidence and prevalence of

[1] Bed days were calculated using Trust data for available bed days for each month and at each site and then dividing this by the days in that month. This led to a small discrepancy against the number of beds notionally available when added up by ward due to individual beds occasionally being classed as not being available for different reasons. The number of beds available using the alternative method would have been 246, which is the actual number of beds offered by the Trust when at full capacity. This makes no material difference to the findings of this report.

severe and enduring mental health needs (SEMI) and dementia, both of which are drivers of demand and therefore capacity requirements in specialist mental health beds.

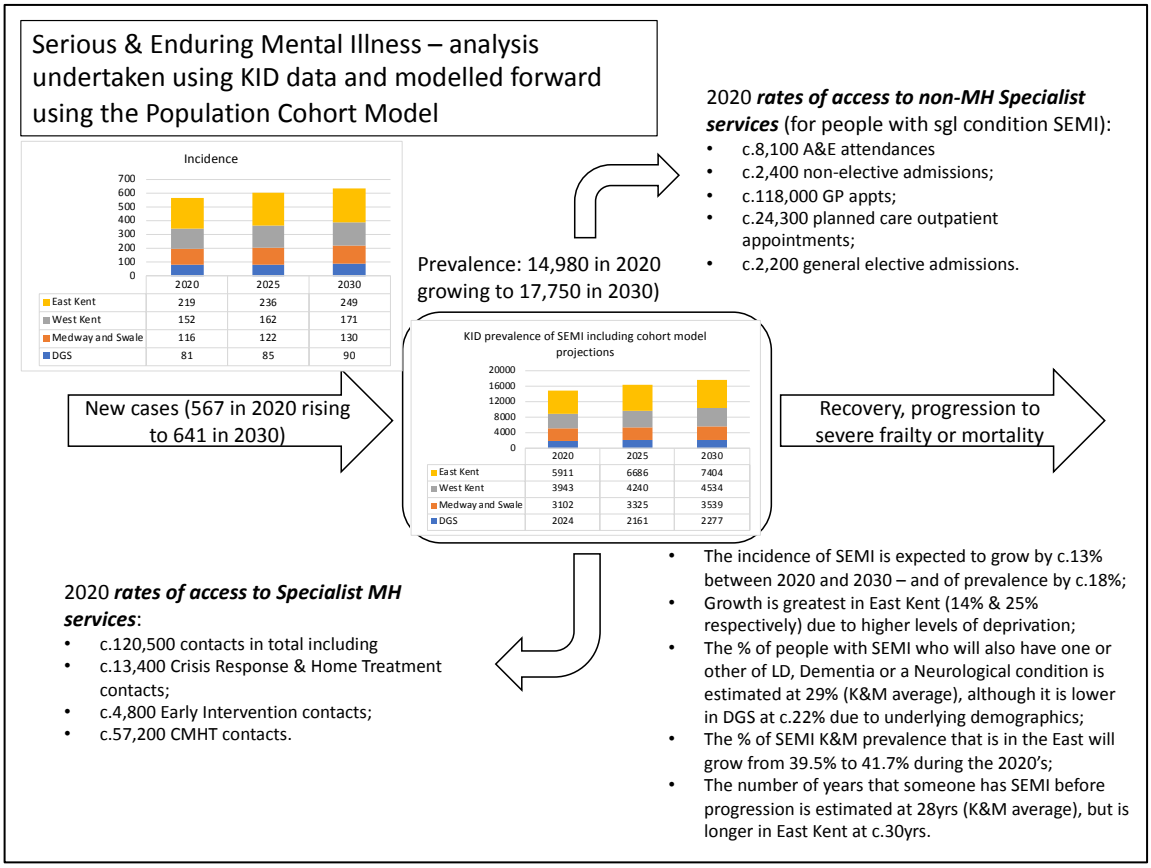

Figure 2 Summary of incidence and prevalence for SEMI across Kent & Medway

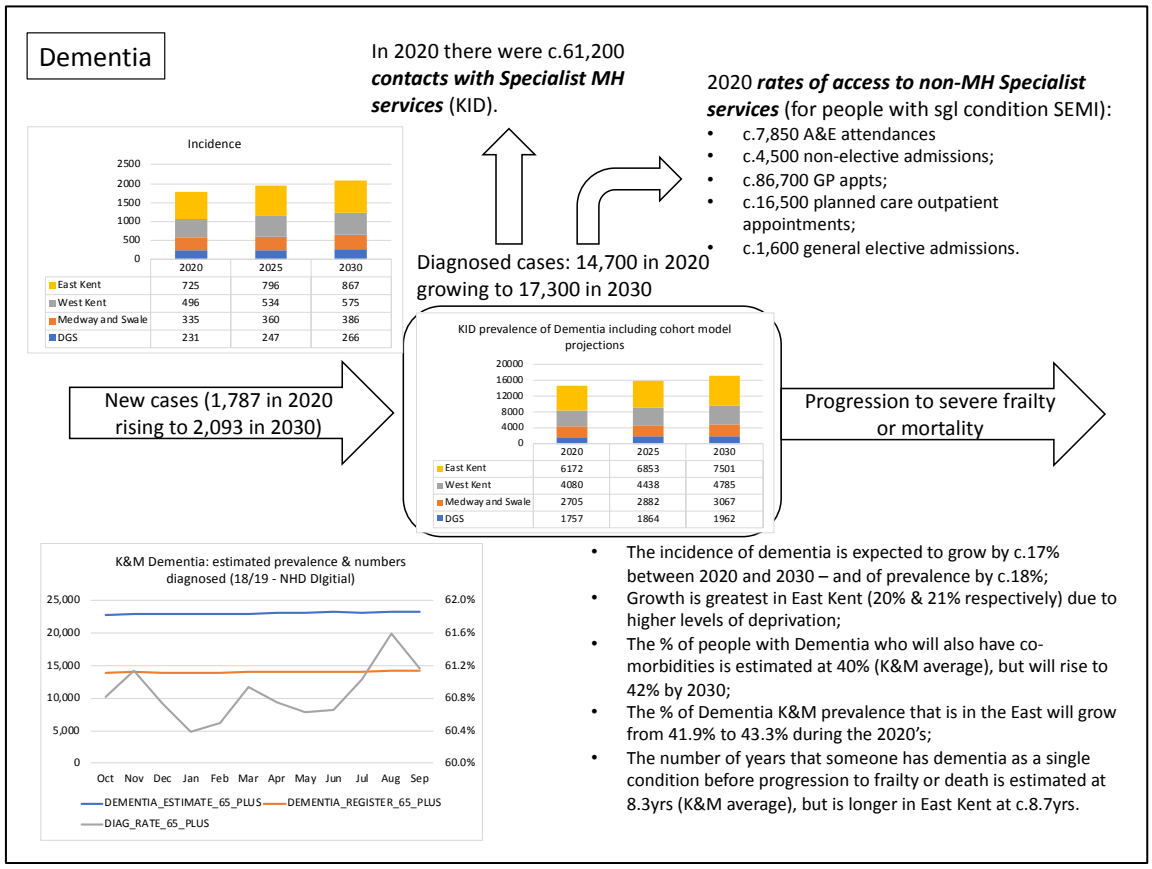

Figure 3 Summary of incidence and prevalence for Dementia across Kent & Medway

Figure 2 shows the output from our population health modelling for people with severe and enduring mental health needs. The key output from this modelling suggests an increase of 18% between 2020 and 2030 for the whole of Kent & Medway. This demand driver shows some variation between the CCGs due to a combination of underlying population changes and deprivation. Figure 3 shows the equivalent model outputs for people with dementia, which also suggests an increase in prevalence of 18% between 2020 and 2030.

For the modelling of acute specialist mental health bed capacity, the prevalence has been used as an underlying demand driver, which means that without any other service developments or new interventions the number of beds required would need to increase to meet this rising demand.

2.2 The demographic impact on bed requirements for Kent & Medway

Figure 4 shows the model output for bed requirements to the end of 2029 based on demographic changes only from mid-2019. It should be noted that:

1. Our modelling for bed requirements from January 2017 to early 2019 shows a close match to actual bed requirements (the red and the pink lines for 2017 and 2018 in Figure 1). We have generated the modelled outputs by using initial rates of access, demographic change and the implementation of the Patient Flow Team (PFT), for which see later. This gives us confidence that the model projections will be reliable if what is planned with respect to service developments occurs – note again that Figure 1 does not include any further benefits from current service developments and therefore acts as a do-nothing baseline rather than what is actually expected.
2. Without further developments to improve patient flow and community services in the short to medium term (2020-2022) bed capacity is sufficient to meet demand, but not to

achieve the 90% occupancy target – by 2023 bed capacity would not be sufficient leading to the likelihood of requiring out of areas placements.

In the next section we will explore the impact of the planned service enhancements and explore whether they are sufficient to address this underlying growth in demand for inpatient beds.

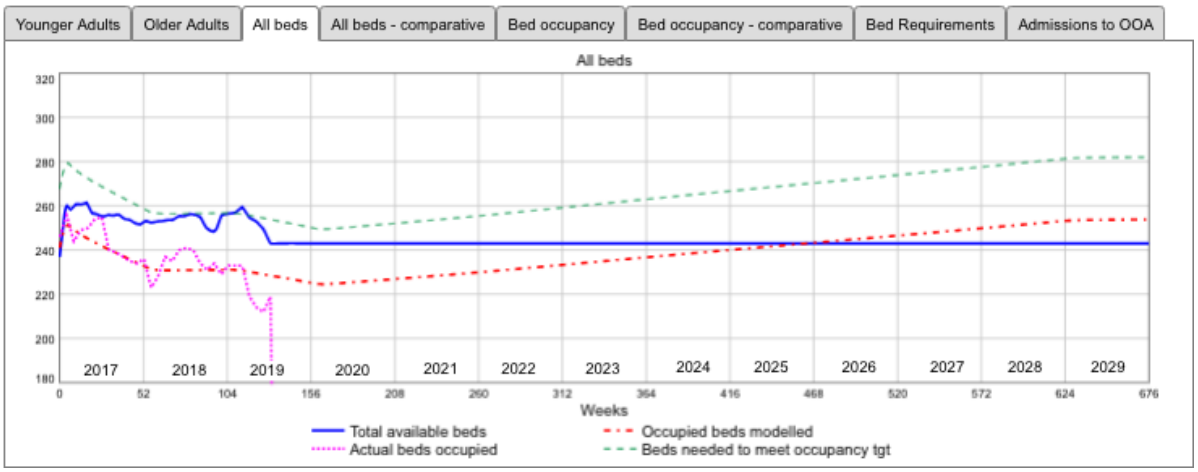

Figure 4 The projection of inpatient bed requirements based on demographic impact only (90% occupancy)

3 Service developments

The National Review of Bed Requirements report noted above identified a number of community services or interventions with proven efficacy, namely:

- Early Intervention Services;
- Cognitive-behavioural therapy;
- Family Interventions;
- Good quality primary care mental health services;
- IAPT;
- Helplines and crisis cafes;
- Enhanced Psychiatric Assessment;
- Supported housing and recovery colleges.

In addition, the NHS Mental Health Implementation Plan identified the following as having an impact on the requirements for inpatient beds:

- The development of Individual Placement and Support (IPS) enabling people with severe mental illnesses to find and retain employment;
- Access to NICE-approved care packages within 2wks for first episode psychosis;
- Crisis resolution and home treatment services;
- Acute hospital liaison services;
- Reducing/eliminating all inappropriate out of area placements.

The Kent & Medway system has invested in a number of these or equivalent service developments in recent years and continues to do so, learning from systems elsewhere and monitoring local impact through KMPTs Business Intelligence function. Through the engagement process it was agreed that three recent or currently being developed service

developments that could be quantified in terms of their impact on acute bed requirements could be modelled to identify their relative and cumulative impact on acute bed requirements. These are illustrated in Figure 5 and described in detail, along with the assumptions adopted, below.

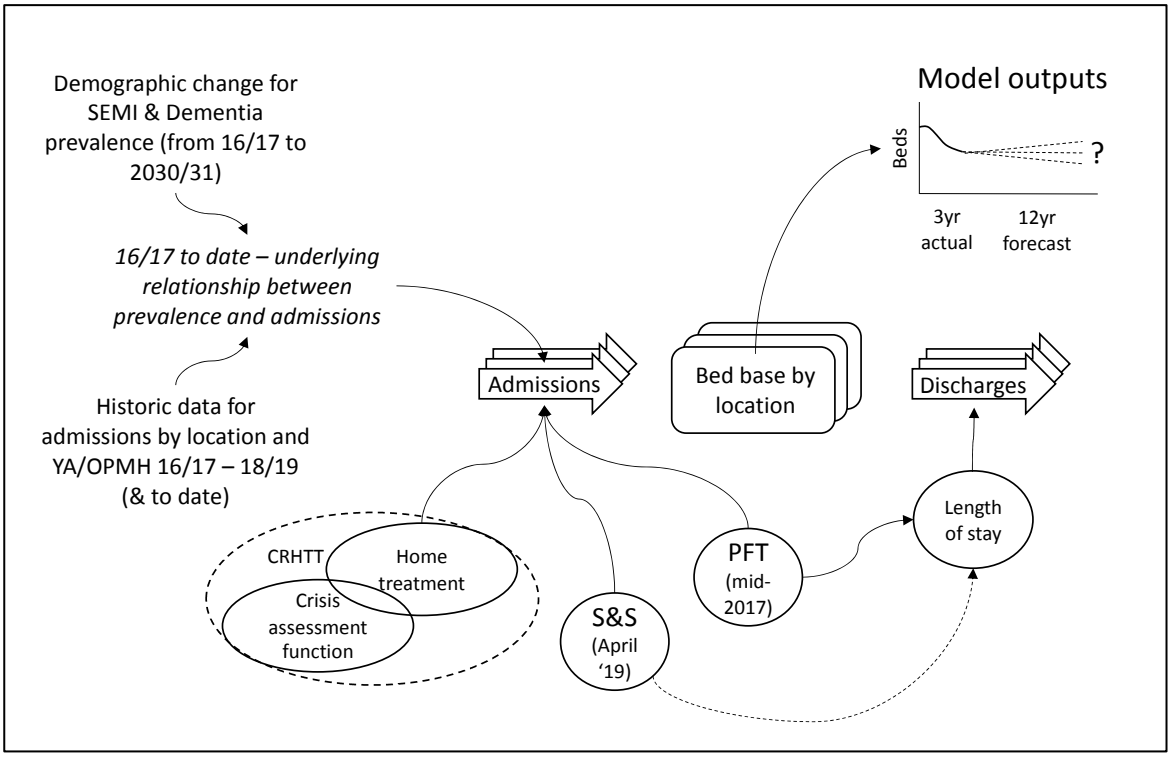

Figure 5 System model conceptualisation combining underlying demographic changes and services transformation to produce a modelled output of future bed requirements

The 'logic' and assumptions adopted in the model are as follows:

1. The Patient Flow Team (PFT) was implemented during 2017 on a test basis, with full 24/7 coverage implemented from March 2019. This team co-ordinates admission to, and discharge from the Trust's acute beds. Careful monitoring of the impact of this new service identified the extent to which it reduced the requirement for inpatient beds. It was also considered by the stakeholder group that there were further benefits to be accrued by refining this approach. We calibrated our model to replicate the impact of the PFT over the early period of implementation and simulated the impact of further refinements going forward. Our assumption from mid-2019 is that the PFT team will achieve further reductions in lengths of stay averaging 4 days, an assumption that can be modified in the light of ongoing monitoring.
2. The Urgent Care 'support & signposting' services (S&S) was introduced in April 2019. Its function is to identify those with the potential to benefit from alternative services, including Home Treatment, and therefore reduce admissions to an acute bed. Early monitoring of this service enabled us to estimate the longer-term impact on acute bed requirements arising from this service. Our assumption, based on the service model, local monitoring and professional engagement, is that 20% of referrals to the S&S service will result in a saved admission to an inpatient bed.
3. Our analysis suggested that the Crisis Resolution and Home Treatment services (CRHT) had been undertaking an increasing number of assessments as a result of pressures in the system, thus reducing its ability to undertake Home Treatment as an alternative to an acute hospital admission. The redesign of this service leading to

enhanced capacity to undertake assessments within the team, and in other places such as through Liaison Psychiatry in the acute sector, is reversing this trend and will therefore have a positive impact in reducing in-patient admissions.

These three interventions are considered to have sufficiently robust local evidence, backed up by being consistent with national policy and good practice, to warrant being included in the modelling as moderating the underlying increase in need arising from underlying demand drivers, as outlined in a previous section of this report.

4 Findings

4.1 The impact of service developments on future bed requirements

Figure 6 illustrates how the model can be used to activate the three key interventions outlined above. These interventions can be turned on separately or together – in this report we described the combined effect on bed numbers, although the model is being made available to local planners so that alternative scenarios or assumptions can be explored.

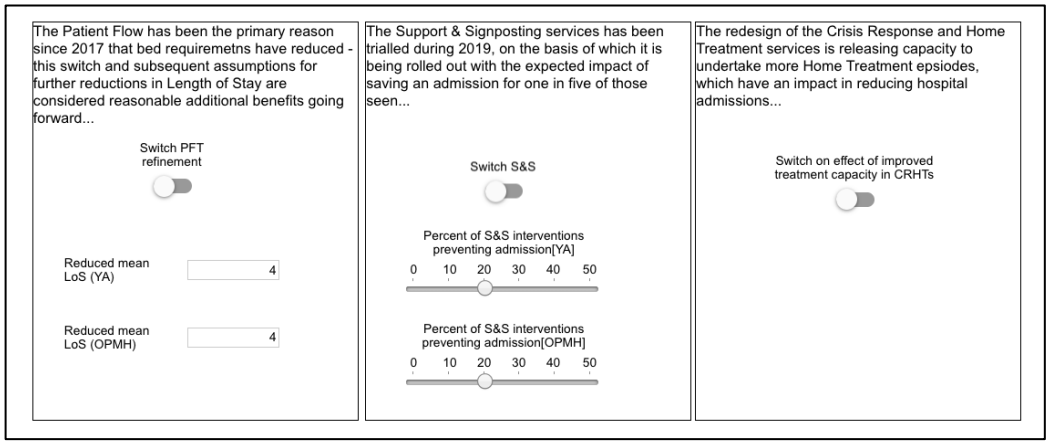

Figure 6 Model interface illustrating the ability to activate service developments in order to explore impact on bed requirements

The combined effect of these service developments on bed requirements is shown in Figure 7. It indicates that:

1. Using a target occupancy rate of 90% the number of beds required remains largely below the currently available bed stock of 243 through to 2025, although there are a small number of occasions when this is exceeded.
2. As we enter 2026 the number of beds required using 90% occupancy begins to exceed those available, and by 2029 the additional bed requirement is between c.10 to 15 beds.

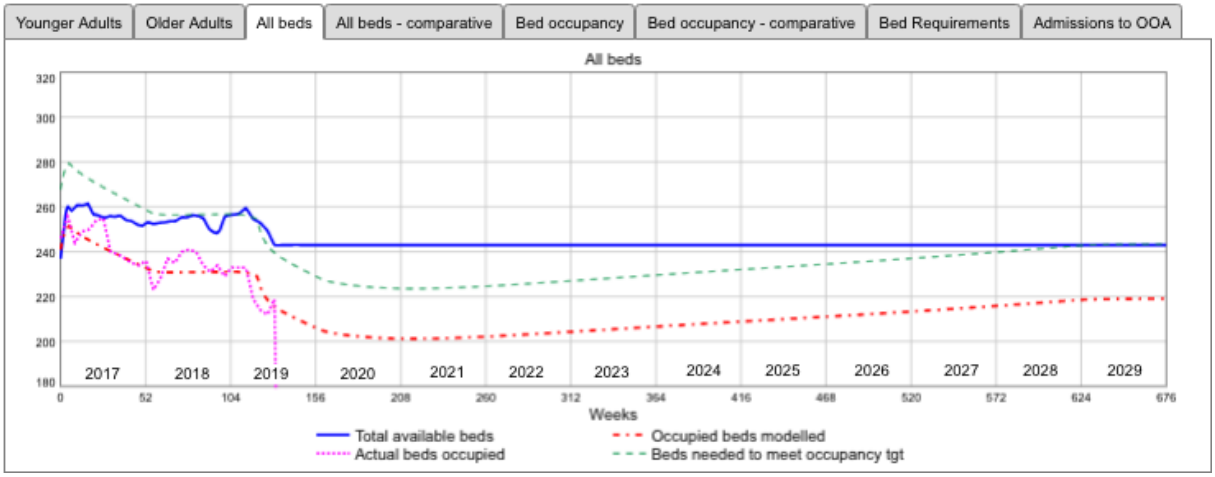

Figure 7 Bed requirements under the combined scenario of service developments

Figures 4 and 7 show a smoothed output to give the overall effect of underlying changes. However, there is in reality an element of random distribution for rates of admission to an inpatient bed. To illustrate this we have identified the natural variation from historic data and applied this to future projections, as shown in Figure 8. This suggests that bed requirements to achieve 90% occupancy when the service developments described above are activated (runs 2-10 in Figure 8) are between 220 and 240 between 2020 and 2022 but rise to between 240 and 260 by 2029. This is c.40 beds fewer that the do nothing scenario (run 1 in Figure 8).

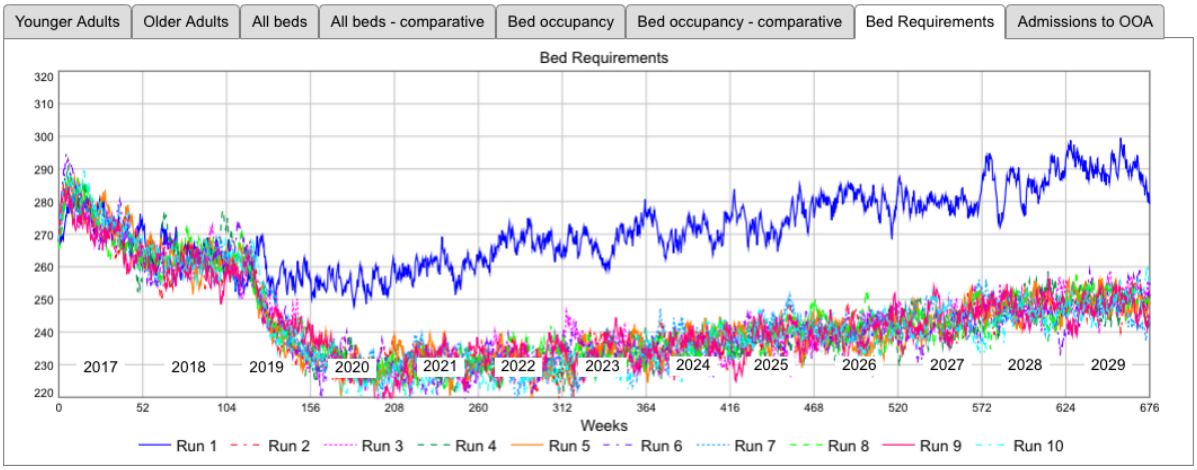

Figure 8 Range of bed requirements reflecting background variation

4.2 Out of Area Placements

Sustaining the current position with regard to minimal reliance on ***out of area placements*** is also important. To simulate this we have assumed that were occupancy to rise above 90% at any point in time the likelihood of there needing to be an out of area placement begins to increase, becoming certain were occupancy to hit 100%. This provides a 'buffer' where the flexibility with which beds can be used begins to reduce but does not cause out of area placements routinely. This is consistent with experience over the past 2-4 years.

Figure 9 suggests that despite the potential need for either further development of alternates to admission or additional bed capacity in the latter part of the 2020's the risk of out of area placements remains slim, although does start to emerge on a small number of occasions toward the end of the modelling period. For this exercise we have retained the underlying variation as OOA placements are most likely to occur when there are 'spikes' in demand over and above the long term trend.

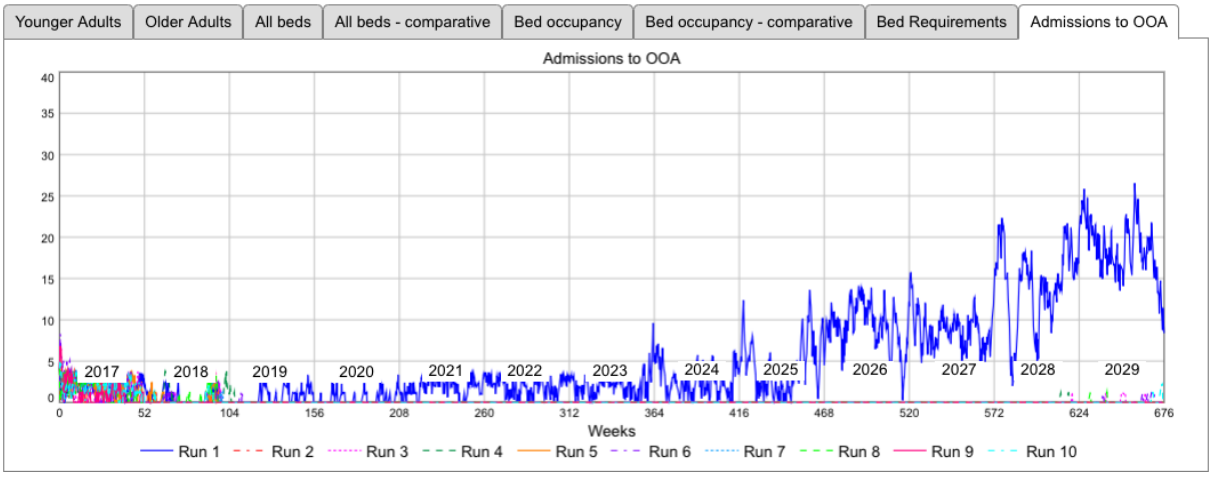

Figure 9 The likelihood of out of area placements with no further service developments (run 1) and with developments (runs 2-10)

4.3 Variations to assumptions

4.3.1 Variations in the impact of new service developments

The default assumptions for this modelling have been based on evidence from early implementation and the views of stakeholders gathered to review the modelling. However, we need to test the sensitivity of the model to alternative assumptions for impact. In this case we have reduced further reductions in average length of stay arising from the PFT from 4 to 2 days and have also reduced the percentage of Support and Signposting interventions that save an admission from 20% to 10%. Figure 10 illustrates the impact (run 3) compared with the full impact (run 2) or no impact at all (run 1). A further scenario based on reduced impact from PFT and S&S and no benefits from the enhancement of CRHTs is shown as run 4.

The latter (run 4) is clearly a worst-case scenario and would indicate the need for c.240-45 beds (at 90% occupancy) during 2020 and through to 2022, with further increases in beds to c.270 by 2029.

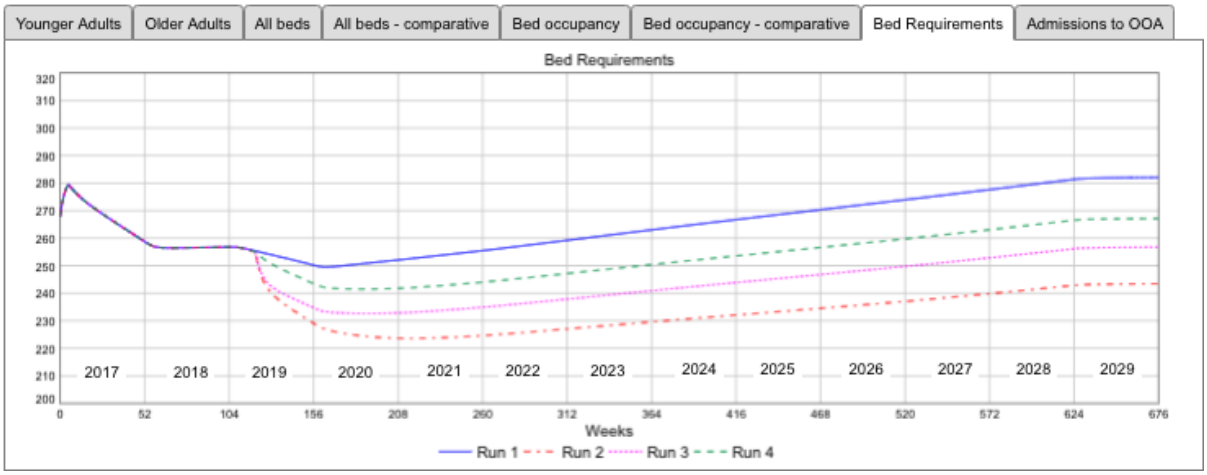

Figure 10 Bed requirements were the impact of new service developments to be reduced

4.3.2 Variations in occupancy targets

As noted previously whilst the national recommended occupancy target is 85% the flexibility with which capacity can be used across the K&M system has led to the local adoption of 90%. Figure 11 illustrates the impact of adopting the 85% target on the number of beds required (run 3) compared to the 90% target (run 2) or the 'do nothing' scenario using the 90% target (run 1). It can be seen that the number of beds required under this scenario would be in the

order of 240 in 2021 but will then begin to rise to between c.260 by the end of the decade without the development of further improvements in patient flow or alternatives to admission.

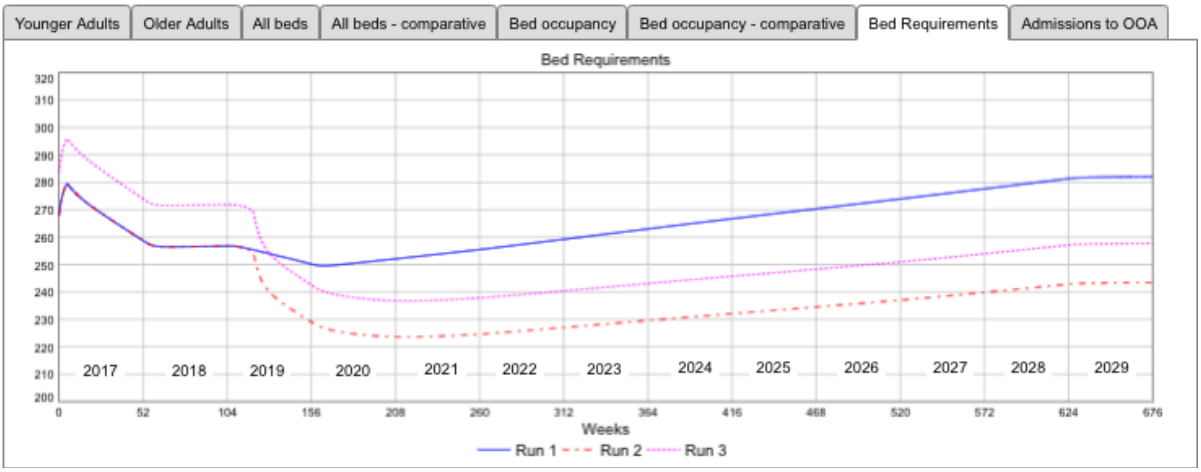

Figure 11 The impact on bed requirements under different occupancy targets

5 Conclusions

This piece of modelling work has been conducted in a way that maximises the available data and evidence locally; adopts the population health modelling that now informs the wider K&M demand and capacity work; and has ensured sufficient local engagement to arrive at a consensus on the model boundaries, level of detail and assumptions concerning the impact of service development and new interventions.

The 'exam question' remains '*how many beds do we need*', but the answer cannot be as simple '42'! Local partners will need to steer their way through a number of uncertainties, which means that the continued monitoring and learning from the implementation of service changes needs to continue. The findings from this modelling are summarised in the table below. The 'preferred\expected' requirements are highlighted in bold.

Description of scenario:	**Occ. tgt**	**Bed requirement**	
		2024	**2029**
No further benefit derived from service interventions	90%	260-280	280-300
	85%	275-295	295-315
Full realisation of benefit from service interventions	***90%***	***225-245***	***240-260***
	85%	240-260	255-275
Reduced benefit (by 50%) of service interventions	90%	240-260	250-270
	85%	250-270	270-290

Table 1 Bed requirements under different scenarios

Whilst the availability of beds over the last two years has varied due to refurbishment and other factors, 243 were available at the time of undertaking this modelling. The outputs for the model above for 2024, assuming the realisation of the benefits from patient flow and community developments, suggest that this capacity is sufficient, but that by 2029 it is likely to be up to 17 beds short of requirements unless additional interventions or improvement in patient flow are realised. There is also a risk that were continued benefits from planned service developments not fully realised that this level of additional capacity could be required as early as 2024, hence the importance of monitoring.

Conclusion 1: That in the light of the findings summarised above that it will be important to monitor the impact of existing service changes that are aimed at improving flow and providing alternatives to admission.

During the engagement process it was clear that additional interventions and improvements to patient flow were being considered, and that the full list of evidence-based interventions noted above had not been fully maximised. Two areas of particular focus were raised as being either early in the planning phase or a recognised priority for development, these begin:

- The modelling suggested that the growth in underlying demand for ***services for older people***, including those with dementia, would be a greater pressure than that for younger adults and that there were fewer potential interventions that could address this underlying growth in need. It is also the case that occupancy in the OPMH bed base has been higher with a small number of very long lengths of stay being experienced. This suggests the need to priorities additional measures, in partnership with a wider range of partners including social care and housing providers, to improve services for older people with mental health needs in the community and at home in order to reduce the pressure on these beds.
- The evidence around the impact of ***improved primary care*** services is growing, although it may have a longer lead time to impact on acute bed needs. There are existing projects across Kent, and elsewhere, that are developing new models of care for meeting mental health needs in primary care, with appropriate support from specialist services.

These are only two examples, although in the light of the modelling they are most likely to address the rise in bed requirements in the latter part of the 2020's. The extent of benefit that could be derived from these developments in terms of addressing the rise in expected beds has not as yet been modelled, hence not being included in this report.

Conclusion 2: That there is potential to further improve patient flow and reduce the length of stay of a cohort of older people with mental health conditions that could, when evidenced and modelled, offset and delay the impact of underlying increases in demand from demographic change.

Conclusion 3: That the modelling could also demonstrate the potential benefits in terms of bed requirements from the development of enhanced primary and community care support to people with mental health needs.

Item 8: Transforming Health and Care in East Kent

By: Kay Goldsmith, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 28 September 2020

Subject: East Kent Transformation Programme

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

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

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1. Introduction

(a) The programme of work under consideration for this item has been in development for a number of years. In November 2017 the NHS announced a 'medium list' of two potential options and has been working since then on developing these options.[1] The shortlist of options was announced on 16 January 2020.[2]

(b) The two options are:

i. Two site emergency department model with William Harvey Hospital as the Major Emergency Centre

ii. One site emergency department model with Kent and Canterbury Hospital as the major Emergency Centre

(c) At its last discussion, JHOSC were informed that the final pre-consultation business case (PCBC) would be submitted to NHS England in April 2020. The consultation plan was in development.

2. Joint Scrutiny

(a) Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have under consideration for a substantial development or variation in the provision of health services

[1] https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/delivering-our-future/
[2] https://kentandmedway.nhs.uk/latest-news/nhs-leaders-in-east-kent-confirm-shortlist-for-hospital-improvements/

in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment.

(b) The Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) considered the proposals relating to Transforming Health and Care in East Kent on 16 October 2018. They determined that the reconfiguration constituted a substantial variation in the provision of health services in Medway.

(c) The Kent Health Overview and Scrutiny Committee (HOSC) most recently considered the item on 21 September 2018. The Committee has also deemed the changes to be a substantial variation in the provision of health services in Kent.

(d) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 20133 the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) is meeting for the first time of this issue. The JHOSC may:

- make comments on the proposal;
- require the provision of information about the proposal;
- require the relevant NHS bodies and health service providers to attend before it to answer questions in connection with the consultation.

(e) The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State. This only applies in certain circumstances and the local authority and relevant health body must take reasonable steps to resolve any disagreement in relation to the proposals.

(f) The JHOSC may consider whether the reconfiguration should be referred to the Secretary of State under regulation 23(9) of the 2013 Regulations. The Committee must recommend a course of action to the relevant Overview and Scrutiny Committees.

(g) The JHOSC cannot itself refer a decision to the Secretary of State. This responsibility lies with the Kent County Council HOSC and/or the Medway Council HASC.

[3] When NHS bodies and health services consult more than one local authority on a proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation.

3. Legal Implications

(a) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the local authority health scrutiny function. The provisions in the regulations relating to proposals for substantial health service developments or variations are set out in the body of this report.

4. Financial Implications

(a) There are no direct financial implications arising from this report.

5. Recommendation

The JHOSC is invited to consider and note the report.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (27/04/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7846&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (08/06/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7918&Ver=4

Kent County Council (2018) '*Health Overview and Scrutiny Committee (20/07/2018)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7919&Ver=4

Kent County Council (2018) 'Health Overview and Scrutiny Committee (21/09/2018)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

Medway Council (2018) 'Health and Adult Social Care Overview and Scrutiny Committee (16/10/2018), https://democracy.medway.gov.uk/mgAi.aspx?ID=19800

Kent County Council (2020) 'Kent and Medway Joint NHS Health Overview and Scrutiny Committee' (06/02/2020),

Item 8: Transforming Health and Care in East Kent

https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8624&Ver=4

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JOINT HEALTH

OVERVIEW AND SCRUTINY COMMITTEE

28 SEPTEMBER 2020

A SUMMARY OF PROGRESS FOR THE RECONFIGURATION OF ACUTE HOSPITAL SERVICES IN EAST KENT:

Report from:	**East Kent Transformation Programme**
Author:	Lorraine Goodsell -Interim Lead Director - East Kent Transformation Programme, Kent and Medway Clinical Commissioning Group

Introduction

The purpose of this document is to provide an overview to the committee on progress with the East Kent Transformation Programme including the status of the pre consultation business case (PCBC) and a revised consultation approach taking into account the unique circumstances of COVID-19.

Background

The NHS in Kent and Medway has been developing plans to improve health and care across east Kent. This includes developing specific proposals to change and improve the way services are delivered at the three major hospitals in east Kent. Local doctors and other clinical leaders are working together to develop proposals to change the way that services are organised to better support our ambitions for delivering improvements in health and care and to respond to changes in the way in which we treat people with serious illness. This work, known as the East Kent (EK) Transformation Programme, outlines an ambitious and exciting plan for east Kent, based on the vision for everyone set out in the national *NHS Long Term Plan*.

In January 2020, we confirmed that two options for improving hospital services had been shortlisted following a detailed options development process. We also confirmed the two options would be included in a pre-consultation business case which was due to be reviewed by NHS England and NHS Improvement as part of their assurance processes, prior to being formally considered in due course for consultation by what would become Kent and Medway CCG Governing Body [following the proposed merger of Kent and Medway's CCGs which happened in April 2020] . Both options, as set out in January 2020, include major improvements to hospital care and local care in east Kent, with significant new investment to deliver high quality hospital services for local people.

The pre-consultation business case sets out proposals for the reconfiguration of acute hospital services in east Kent, underpinned by changes that are already underway to strengthen and expand the delivery of local care and improve prevention of ill-health, to enable people to stay well and live independently. It is based on work undertaken by NHS organisations and partners in east Kent since 2015 to develop proposals for meeting the changing health and care needs of local people in a sustainable way.

Progress to date

This document details key activities undertaken since the last update to JHOSC in February 2020. The JHOSC last received an update on the East Kent Transformation Programme at its meeting on 6th February 2020, before the wider emergency response to the COVID-19 pandemic temporarily paused the programme. The update given to the JHOSC at that meeting was a comprehensive

overview of work undertaken on the development of the options and the PCBC over the last year. It included a summary of the consultation plan and an indicative timeline for the submission of the PCBC to NHSE/I as part of the NHS assurance process for major service change. This update has been developed to give committee members an overview of the work undertaken since the programme re-started at the end of June 2020.

Recommendations:

- JHOSC members are asked to note the progress update provided in this report.
- JHOSC members are asked to review and provide any feedback on the revised and refreshed public consultation plan, which has been updated to take account of COVID-19 and the new environment for engagement and consultation.

1. Context

We have an ambitious and exciting plan for east Kent, based on the vision for everyone set out in the national *NHS Long Term Plan*. We want people to enjoy quality of life and quality of care, with healthcare that meets their varied and changing needs and helps them live the lives they want to lead. Our plan, which is in line with the *NHS Long Term Plan*, focuses on preventing ill-health, delivering better support and properly joined-up care in the optimal setting for everyone, and improving care quality and outcomes, particularly for people with the conditions that cause most deaths and disability.

Patients will be supported to understand and manage their own health. This will give them much greater control and enable real-time management of health issues for people with long-term conditions, avoiding the deterioration which can happen during waits to be seen. Care will be truly patient-centred, rather than patients feeling as if the care they receive takes little account of what is important to them.

People in deprived communities, family carers and those who are at higher risk of ill-health will understand how to remain healthy and will be helped and enabled to maintain and enhance their physical and mental health and wellbeing.

Services will work on the principle that 'no door is the wrong door', guiding people to the place that can best help them, backed up by digital technology and strong connections between Local Care (care delivered outside of hospitals) and acute hospital-based care, with the patient at the centre of decision-making.

As part of delivering this ambitious vision for the future, we plan to establish excellent Local Care (out of hospital) services in every community, embracing integration between health and social care services to best meet people's day to day health and care needs in a joined up way. In turn, we want to support and reshape hospital services so that everyone in east Kent has access to state-of-the-art services in high quality facilities, making the best possible use of the acute hospitals we have in east Kent, as well as the specialist expertise of the local health and social care workforce.

There will be three excellent hospitals in Ashford, Canterbury, and Margate. These will work together and with other services to meet people's changing needs, whether that is for emergency or ongoing treatment for the most serious illnesses and injuries, for day to day care such as outpatient appointments and day surgery, or for multifaceted, multidisciplinary support for people's lifelong health and wellbeing.

The prospect of working in highly skilled, ground-breaking teams, in high quality facilities, will attract NHS colleagues to east Kent hospitals. It will enable existing colleagues to make best use of their expertise, addressing workforce challenges and improving the clinical sustainability of our services. Most importantly, patients will receive quality care that meets their needs.

We plan to increase the number of inpatient beds in east Kent after a recent review of East Kent Hospitals' admissions data against national *Get It Right First Time*

programme (GIRFT) benchmarks concluded that there is a shortfall in general and acute beds at the trust.

To support delivery of our vision and ambition for health and care in east Kent described above, we have been developing a pre-consultation business case for the investment required to reconfigure the way we deliver some of our acute hospital services. This is the result of extensive work over the last five years by clinicians and leaders from across the NHS and social care in east Kent. All major providers and the local authority have contributed to its development with east Kent commissioners. Extensive engagement with colleagues, patients, carers, the public and other stakeholders has guided and informed this work.

This PCBC is a comprehensive technical and analytical document that will provide the information and evidence to support NHS Kent and Medway Clinical Commissioning Group (CCG)[1] to assess and decide to consult on the options it presents for changing acute hospital services in east Kent. It sets out in detail the case for change; the proposed new clinical models of care that will help meet the challenges and opportunities described in the case for change; the robust process undertaken to develop options for how those clinical models may be delivered and to identify, assess and evaluate the proposals for change; the final set of proposals and the benefits we expect from them; and the assurance process, including the evidence for meeting the Government's 'five tests' for reconfiguration. The PCBC will also allow national regulators to assess and assure our proposals for service change.

The current focus of our work to support delivery of our ambition for east Kent, and the scope of the pre-consultation business case we are developing, covers the following healthcare services in east Kent:

- urgent and emergency care services
- specialist inpatient services (including those provided for a wider population beyond east Kent)
- paediatrics
- maternity
- planned care.

Services currently located at Royal Victoria Hospital and Buckland Hospital are outside of the scope of this PCBC.

[1] Modelling for our PCBC was undertaken before 1 April 2020 when the four east Kent clinical commissioning groups were replaced by a single clinical commissioning group (CCG) for Kent and Medway. Data is therefore broken down to show the picture for each of the four former clinical commissioning groups: NHS Ashford CCG, NHS Canterbury and Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG.

2. Draft submissions

Since our last update to JHOSC, we have worked closely with NHS England/ Improvement colleagues and submitted two draft iterations of the PCBC, as per pre-COVID agreed timelines, with a view to gaining their feedback and guidance so that the final PCBC meets all of the regulator's assurance requirements and meets the deadline for consideration of capital funding as part of the government's national autumn spending review. (Members should be aware that capital allocation requirements have recently changed in that availability of capital funding must be earmarked prior to public consultation).

These submissions took place as planned on 31 March 2020 and 14 August 2020 following endorsement, of those drafts, from our provider boards, STP/ICS Partnership Board and approval from Kent and Medway CCG Governing Body.

Each draft submission contained some additional information compared with previous draft submissions. Changes included, for example, greater, more granular detail on the clinical models and early lessons learned from the COVID-19 pandemic which will likely affect the future service and estate design. For example, increases in the use of digital technology and building in flexibility to increase ITU bed capacity should it be needed for any future resurgence of the COVID-19 (or any other) pandemic.

3. Ongoing work to finalise the PCBC

We are aiming to submit the next draft of our PCBC to NHS England/ Improvement in early October 2020. Ongoing work to that point includes refreshing the draft Integrated Impact Assessment and Commercial Risk Assessment, and finalising clinical content, our financial case and consultation plans.

4. Review of the consultation plan

As JHOSC members are aware, we will be undertaking a formal public consultation on the plans for east Kent within a new context; a post-COVID landscape where many tried and trusted engagement methodologies - including face to face meetings - may be restricted or unworkable within what is being described as 'the new normal'. Part of our work over the past three months has been a thorough review and refresh of the consultation plan which was presented to and supported by JHOSC members in February 2020. We have drawn on new research, emerging thinking, and experiences from a wide range of sources to inform the plan, enabling us to respond to the uncertainties of a COVID-19 world. We have been positive in our approach, acknowledging these uncertainties but also embracing them as an opportunity to do things differently, finding new and creative ways to engage with audiences and stakeholders. Our aim is to 'COVID-proof' consultation activity, utilising a range of appropriate new technologies, methodologies and mechanisms to respond to the constraints of consulting within the 'new normal' as they emerge but ensuring we still

have effective ways to communicate, engage and consult with a wide spectrum of groups and individuals.

Our detailed consultation plan is a working document which will continue to be updated as we prepare to launch the consultation. This reflects the need to be flexible and adaptive in our approach to this consultation, particularly within the context of the COVID-19 pandemic and any potential local issues resulting from the UK's exit from the European Union.

We welcome feedback from the JHSOC on our revised consultation plan, which is attached at Appendix A to this paper.

5. Next steps

Pending final amendments, the next draft of the PCBC is on schedule to be considered by the Kent and Medway CCG Governing Body on 1 October 2020 for review and approval prior to being sent to NHS England by 6 October 2020.

The next draft will also be discussed with the following organisational boards in advance of the Kent and Medway CCG Governing Body:

- East Kent Hospitals NHS University Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- South East Coast NHS Ambulance Foundation Trust
- Kent Community Health NHS Foundation Trust.

Following submission of the draft PCBC in early October, we will work with NHS England in the autumn of this year through their standard assurance process for reconfiguration and service change programmes. We anticipate the PCBC being considered for national capital funding allocation in the autumn spending review.

Allocation/identification of capital will allow the PCBC to then be considered by the Kent and Medway CCG Governing Body in a decision to formally consult the public on the proposals. We anticipate the consultation starting in early February 2021. Following consultation, all the responses will be collated and independently analysed and presented in a report to the Governing Body for consideration. The business case will be refreshed, and the proposals may be refined. A final set of proposals will be presented to the Kent & Medway CCG Governing Body in a Decision-Making Business Case, with an aim for a final decision on any proposed service change by the end of 2021. Subject to the outcome of consultation, it is intended that changes to hospital services will start being made from 2023.

It should be noted that each stage of this timeline is subject to assurance processes as well as the demands and current status of the COVID-19 pandemic at any time over the coming months.

Patient, public, staff and stakeholder engagement and communication will be maintained throughout all phases of the programme and we will continue to regularly update the JHOSC on our plans and progress.

Recommendations

- JHOSC members are asked to note the progress update provided in this report.
- JHOSC members are asked to review and provide any feedback on the revised and refreshed draft public consultation plan, which has been updated to take account of COVID-19 and the new environment for engagement and consultation, attached.

Lead officer contact

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Kent and Medway Clinical Commissioning Group

Transforming health and social care in Kent and Medway

NHS

East Kent transformation
Our consultation plan

Plan for formal public consultation activity on behalf of the Kent and Medway NHS Clinical Commissioning Group

WORKING DRAFT DOCUMENT

Working draft

Version dated: 09 September 2020

Content

1 Introduction

The review of hospital services in east Kent has been a major programme of work within the Kent and Medway health and care system, with the former four GP-led clinical commissioning groups (CCGs) in east Kent and East Kent Hospitals University NHS Foundation Trust working together on this review since 2015. Following the merger of the CCGs into a single clinical commissioning group for Kent and Medway on 1 April 2020, the new Kent and Medway Clinical Commissioning Group is responsible for this significant area of work, including the formal public consultation on the two options for the future shape of hospital services.

Extensive pre-consultation engagement with patients, the public, NHS staff and other key stakeholders has taken place during the life-cycle of the review. We have shortlisted two options for potential changes to acute hospital services and are now preparing for a formal public consultation. We are aiming to run the consultation from February 2021 for 12 weeks (subject to any potential pause in the programme timeline for COVID-19 related focused operational activity and/or requirements). The pre-consultation business case (PCBC) setting out the proposals in detail will be published at the meeting of the Kent and Medway CCG Governing Body when a decision is made to formally consult on the proposed options, based on that business case. The consultation document and supporting consultation materials will be based on the technical detail within the PCBC.

No final decisions will be taken on the future shape of acute hospital services in east Kent until after the consultation has closed and an independent analysis is completed and presented to the Kent and Medway CCG Governing Body, along with all other related evidence and data, for consideration as part of a 'decision-making business case (DMBC)'.

More background to the proposals is available at [insert web address when known].

1.1 Pre-consultation engagement

A significant amount of pre-consultation engagement has been carried out with local people, patients and carers, communities, clinicians and other frontline staff, elected representatives and stakeholders across east Kent. Initially this began with shaping the east Kent Case for Change and developed to focus on developing potential options to deliver improved and more sustainable hospital services for local people. Our pre-consultation engagement work is detailed in the PCBC and supporting documents. Published engagement reports from the pre-consultation period are available at https://kentandmedway.nhs.uk/eastkent [check/confirm up to date web address when known]

1.2 About this plan

This is a working document and will continue to be developed as we progress towards the consultation. This plan sets out how we will approach a formal consultation on reconfiguring hospital services in east Kent. It has been informed by best practice principles and guidelines from NHS England/NHS Improvement, the Cabinet Office, and the Consultation Institute. It builds on the approach used for the Kent and Medway stroke review consultation (2018) which was endorsed and commended by NHS England and the Kent and Medway Joint Health Overview and Scrutiny Committee. We are also building on the experience and feedback from our pre-consultation engagement work for the east Kent hospitals case for change and development of options. We are grateful to Healthwatch Kent, the Kent and Medway Patient and Public Advisory

Group, and CCG lay members for patient and public involvement, for their comment and input into the plan.

Our plan has undergone a thorough review in light of the coronavirus pandemic in 2020 and now responds to the uncertainties of a post-COVID world. We have been positive in our approach, acknowledging these uncertainties but also embracing them as an opportunity to do things differently, finding new and creative ways to engage with audiences and stakeholders through a range of different channels.

Building flexibility – planning for different scenarios

COVID-19 – a new approach to consultation

We will be undertaking this public consultation within a new context; a post-COVID landscape where many tried and trusted engagement methodologies - including face to face meetings - may be restricted or unworkable within what is being described as 'the new normal'.

The pandemic has also seen an unprecedented shift to digital and online communication, with a significant rise in remote or home working and people using technologies such as Zoom to keep in contact with their loved ones. While it is tempting to see this shift to digital as evidence that the barriers to virtual consultations have been swept away, we know that some areas of the county with higher levels of deprivation cannot access the internet and their views are just as vital as those that can. There are others too who may be digitally excluded, through lack of skill, access to technology, or desire to engage in that way. We therefore need to refocus our efforts on print and physical collateral and distribution as part of our planning as much as on expanding and exploiting digital means to engage.

Lockdown restrictions have eased over the past three months although new legal limits on social gatherings and localised lockdowns as infection rates rise demonstrate how the situation is highly complex and subject to change. This has the potential to divert attention and resources from consultation activity and presents additional challenges in terms of planning and delivering activity.

COVID-19 has had a significant impact on the working lives of staff across all health and care sectors. On the front line, staff across all care settings and specialities have undergone unprecedented levels of stress as they have focussed on dealing with the immediate COVID crisis and in planning for a potential resurgence. Many support and back office functions have been forced to adopt a remote working set-up to keep staff safe and comply with government guidelines. We should not underestimate how changes to working environments and patterns may bring new restrictions where we might previously have engaged with ease. We have also considered how much 'head space' staff have for considering long term questions about the configuration of services while they are grappling with a new reality and are focused on delivering care in challenging conditions today. There may be fatigue and cynicism amongst some staff groups as a result of COVID and we will be respectful of attitudes as we position the consultation as a key opportunity for health professionals and staff of all types to influence the future.

The expertise and local knowledge of partner organisations' internal communications teams will be invaluable in steering staff-related engagement during the consultation. We will apply the same principles to staff engagement as to other stakeholder groups; looking to maximise digital

channels and interactions where possible but also recognising the need for and possibilities of home-based and non-digital approaches.

Public confidence is an issue with many people feeling hesitant about resuming some activities. Recent research from Ipsos MORI found that significant numbers of Britons remain anxious about many aspects of life returning to normal, particularly where these are in enclosed spaces or with large groups of other people1. While attitudes may change over time, we should plan for every eventuality, recognising that for some groups, engagement preferences may have permanently changed. How we best reach people at home is a primary consideration for our consultation planning.

There are lessons that can be learned from the pandemic, with some discussion amongst influencers and opinion leaders about patient and public participation during the crisis. Commentary from The King's Fund's and National Voices refocuses our attention on the importance of listening and responding to the views and experiences of patients and the public, whatever the circumstances: 'Too often efforts to understand what goes on for people and to respond to their needs and aspirations can feel like a nice to have rather than a key part of how to deliver health and care services effectively. It is tempting for services to extend this view into crisis periods by saying 'We don't have time to do it', but now, more than ever, health and care services need to base their decisions on the reality people experience.'2

The NHS occupies a prominent place in the public's consciousness and as a result of COVID-19, the profile of our health service has never been higher. The pandemic has seen an unprecedented outpouring of affection and interest in the NHS, with public shows of appreciation and fundraising efforts making headlines and fostering a new sense of interest and loyalty. As a result, people are more likely to engage on the future of their local health services. Research from Healthwatch showed that two-thirds of people in England say they are more likely to act to improve health and social care services since the outbreak of COVID-193. We believe that this may make consultation activity such as telephone polling especially effective as people who previously might not have wanted to talk about the NHS have a new interest in getting involved.

Although public affection and interest is positive, we will also need to be sensitive to those who have been adversely impacted by COVID-19. Voluntary and charity sector groups are key partners during service reconfiguration and during consultation, helping information exchange and fostering discussions with patients and families who might otherwise be difficult to reach. In an article 'Time to unmute the patient voice' published on 16 July 2020, Health Service Journal correspondent Sharon Brennan concluded that 'patients may be more distrustful, charities have less time to campaign or engage and services already have rapidly changed, but if the NHS is to reduce health inequalities in its covid reset, patients must be both heard and listened to'4.

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[1] 'How comfortable are Britons with returning to normal, as coronavirus concern rises again?' 2 July 2020 https://www.ipsos.com/ipsos-mori/en-uk/how-comfortable-are-britons-returning-normal-coronavirus-concern-rises-again

[2] Shielded Voices: hearing from those most in need, The King's Fund – 26 May 2020 https://www.kingsfund.org.uk/blog/2020/05/shielded-voices-covid-19

[3] Healthwatch 'Because we all care' – 8 July 2020 https://www.healthwatch.co.uk/news/2020-07-08/help-health-and-social-care-services-recover-covid-19-becauseweallcare

[4] https://www.hsj.co.uk/expert-briefings/the-integrator-time-to-unmute-the-patient-voice/7028054.article?mkt_tok=eyJpIjoiTXpGbU5URXlOV0prWlROayIsInQiOiJFNlgwdHdiZkc3cnVPTlJxR2tQb3NscXU1MmkwXC9Ha0J5WDVVeklRU21DdmQ0WUVDXC9nQ1lkYmRQVVY5a1FSeEZRN0FMT1Q0K21FZWRcL2Z6blJHXC9PaCtLTjN0NkNFZ3I1RFwvK0Y1TW4wQWx2U0NqUU1XUmQxbWtxQ0xuODF5Zk1uIn0%3D

Reviewing our relationships and partnerships with the voluntary, community and charity sector will be an important next step in developing our plans.

We recognise these challenges and opportunities require a different mindset for consultation planning and we have reviewed our proposed activities, channels, and materials to ensure they adapt to the 'new normal'.

Implementation of this plan will be overseen by the communications and engagement workstream of the East Kent transformation programme on behalf of the Kent and Medway Clinical Commissioning Group. The plan will be formally shared with the Kent and Medway Joint Health Overview and Scrutiny Committee, and Healthwatch Kent, for their comment before being approved by the Sustainable Healthcare in East Kent Committee and the Kent and Medway CCG Governing Body prior to launching the consultation.

EU Exit

In addition to the uncertainties generated by COVID-19, we are aware the transition period following the UK's exit from the European Union comes to an end from the beginning of January 2021. While the exact details of any final agreements with the European Union have yet to be finalised, we are aware that there are concerns about the impact on Kent, especially around road and traffic congestion. Again, this may lead to attention and resources being diverted from consultation activity. We should also consider public perceptions and concerns about the impact of these scenarios on our ability to consult effectively. To address this, our engagement and activity planning will also take account of the practical implications of any emergency response, especially in relation to travel and transport.

Local elections 2021

We are aware that local elections are expected to be held on 6th May 2021 for English local councils, thirteen directly elected mayors in England and 20 police and crime commissioners. In March 2020, the government announced that elections scheduled to take place on 7th May 2020 would be delayed for a year in response to the COVID-19 pandemic. This postponement was legislated under the Coronavirus Act. The seats up for election are those contested in 2016/17.

The Cabinet Office issues strict guidelines for all public bodies during the run-up to local elections. During this time, specific restrictions are placed on the use of public resources and the communication activities of public bodies such as NHS organisations. This pre-election period – often referred to as 'purdah' - is designed to avoid the actions of public bodies distracting from or having influence on election campaigns. We will follow these guidelines along with other NHS organisations across the country. Should our consultation fall within the 'purdah' period, we have plans to adapt our consultation activity to respect these guidelines, including extending the consultation period, phasing public-facing activity appropriately and pausing proactive engagement and involvement activity during the pre-election period, thus ensuring that our consultation is as through and robust as possible. We will be clearer on this nearer the time once more pre-election information and guidance has been issued but are confident that sufficient contingency and flexibility has been built into our plans to allow is to respond appropriately.

2 Consultation scope

The consultation will focus on two shortlisted options for reconfiguring acute hospital services in east Kent, including proposals for changing:

- specialist services
- emergency care
- complex inpatient care (which is dependent on the above)
- low risk inpatient planned surgery, and
- midwife-led maternity services.

The proposals for change are set within the context of related plans to improve Local Care services (e.g. general practice and community-based services) to provide more day-to-day health services and care away from acute hospitals.

A full list of services affected will be part of the consultation materials. The hospital services affected by these proposals are part of East Kent Hospitals University NHS Foundation Trust (EKHUFT) and provided across three acute sites: William Harvey Hospital (Ashford); Kent and Canterbury Hospital (Canterbury); and the Queen Elizabeth The Queen Mother Hospital (Margate).

We know that people want to hear and comment on how improvements to care and services provided outside of hospitals such as ambulance services, general practice, NHS community services and social care services would be delivered to support the hospital based changes. Information on this will be provided during the consultation and comments sought.

Section 6 provides more information on how we are developing the specific questions for the consultation questionnaire.

2.1 Geographical scope

In geographical terms, the consultation will cover the four former clinical commissioning group areas in east Kent (Ashford; Canterbury and Coastal; South Kent Coast; and Thanet). All eight former clinical commissioning groups (CCGs) in Kent and Medway came together to form NHS Kent and Medway Clinical Commissioning Group on 1 April 2020.

There are no significantly large flows of patients into east Kent for day-to-day hospital services; however we will ensure neighbouring areas are informed about the proposals and residents in border areas who may use East Kent Hospitals' services are invited to respond to the consultation.

In addition, East Kent Hospitals provide some regional specialist services, with residents from other parts of Kent, Medway, Surrey and Sussex either travelling to the hospitals in east Kent or receiving care at satellite centres run by East Kent Hospitals' services affected by the proposals.

These include:

- haemophilia outpatient services
- inpatient renal services
- specialist cardiac services (primary percutaneous coronary intervention [PPCI])
- neuro rehabilitation services
- some vascular services, dependent on the outcome of a separate consultation to create an interim arterial centre for Kent and Medway by summer 2021.

We will target users, and patient groups representing users, of these specialist services as part of our consultation activity to inform them and to make sure they have an opportunity to comment on the proposals.

3 Consultation approach

3.1 Statutory duties and legislation

This consultation plan has been designed to ensure we deliver effective patient and public engagement as part of our obligations and legal duties under:

- The five tests for service change laid down by the Secretary of State for Health and Social Care
- The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)
- The Equality Act 2010

In addition to meeting statutory duties, our plan has been developed with sufficient flexibility to ensure we can adapt to the uncertainties that COVID-19 brings. Discussions with stakeholders and our own review of activity and emerging thinking about consulting and engaging post-COVID means we will particularly:

- exploit and expand digital and online engagement
- focus on how to engage with the digitally excluded

ensure we make significant effort to engage with those who are seldom heard, including any new groups such as shielded patients (under COVID rules) who may find their usual ways of engaging in community discussions restricted. We will use trusted channels and effective networks such as those found within the community and voluntary sector to reach these audiences and well as commissioning specific, focussed research during the consultation period.

3.2 Consultation principles

The principles set out below underpin our consultation plan and have shaped the content and activity being developed and our approach to evaluating the results. More detail on each principle is provided in appendix A.

- Consulting with people who may be impacted by our proposals
- Consulting in an accessible and flexible way
- Consulting well through a robust process
- Consulting collaboratively
- Consulting cost-effectively
- Independent evaluation of feedback.

3.3 Consultation aims and SMART objectives

We will deliver a formal public consultation in line with best practice that complies with our legal requirements and duties. We will also reflect the circumstances and restrictions imposed by the ongoing response to COVID-19. Our aims for the consultation are to:

- raise awareness of the public consultation and how to contribute across all affected geographies

- collect views from the full spectrum of people who may be affected – including a wide range of staff and professional groups, patients, carers, stakeholders, and the public - gathering feedback from individuals and representatives
- ensure we use a wide range of methods to reach different audiences including activities that target specific groups with protected characteristics and seldom heard communities
- ensure those methods reflect the physical and attitudinal changes to consultation and engagement as a result of the COVID-19 pandemic
- explain how the proposals have been developed and what they could mean in practice, so people can give informed responses
- ensure that we preserve the integrity and legality of the consultation to the best of our ability should COVID-related circumstances threaten to undermine, or derail planned activity
- meet or exceed our reach target within the timeframe and budget allocated
- consider the responses and take them into account in decision-making, with sufficient time allocated to give them thorough consideration.

SMART objectives

Specific, measurable, achievable, realistic and time-bound (SMART) objectives are key to ensuring that communications and engagement activity can be accurately assessed and measured. This is particularly important within the context of consultation activity where the results of our work will inform the development of the decision-making business case and play an integral part in the assurance process.

Our SMART objectives for the consultation are:

SMART objective	Measure/assessment
Target for reach - Informing a minimum of 14,000 people about the proposals during the consultation period with 2000 direct engagements	To be achieved through activity set out within this plan (outputs) and evaluation of social media, media, research, face-to-face and virtual events, focus groups, letter box drops etc
Target for responses – 2000 separate responses to the consultation	Collecting a minimum of 2000 responses to the consultation (including surveys, focus groups, emails, social media interactions, phone calls, letters, comments at events)
Focus on demographic 'hot spots' e.g. groups and areas that have a higher reliance on/likelihood of being impacted most by the proposed changes to health services will have the opportunity to engage and respond during the consultation period.	Informed by the programme's Integrated Impact Assessment, this will be achieved by working with partner organisations involved in the programme as well as Healthwatch, local patient groups, community networks and outreach activity to seek out opportunities to engage and consultation responses. Assessment will be through demonstrating opportunities to engage and feedback received

SMART objective	Measure/assessment
	from identified groups and areas.
Protected characteristics, seldom-heard/hard-to-reach groups – targeted engagement work through focus groups, surveys, links with local networks to demonstrate that all protected characteristics are represented within the consultation feedback, and that seldom heard voices are represented in the consultation responses.	Activity will be based on information drawn from the Equalities Impact Assessment as well as existing intelligence and information from Healthwatch and its groups and networks as well as local commissioners and providers. Assessment will be through demonstrating opportunities to engage and feedback received from identified groups.
Staff involvement - ALL affected staff have the opportunity to complete a survey/access information on the proposals or join an event during the consultation period.	Using a variety of appropriate channels (as set out within this plan) to ensure all staff have the opportunity to feedback. Assessment will be based on the opportunities to engage and responses received from NHS staff in east Kent, and/or their representatives.
Patients, families and carers involvement - ALL patients in affected services, their families/carers have the opportunity to respond to the consultation.	Using a variety of appropriate channels (as set out within this plan) to ensure all affected patients, their families/carers have the opportunity to respond to the consultation. Assessment will be based on the opportunities to engage and responses received.
Stakeholder attitudes – the East Kent Transformation team will deliver proactive, effective and positive engagement with key groups and influencers during the consultation period.	Positive attitude feedback from at least five different stakeholder groups by the end of the consultation period, to include: voluntary and community sector, democratic representatives, patient representatives (e.g. Healthwatch/PPGs/other patient fora), clinical/staff representation or group.
Delivery within an agreed budget	TBC once amount is agreed/identified.

4 Target reach

Our consultation plan and the activities it outlines will ensure that we consult with a representative sample of the population potentially affected by the proposals and that we undertake dedicated activity to collect views from representatives of all nine protected characteristics under equalities legislation. We will deliver targeted engagement activities to reach individuals and groups which represent people with these characteristics.

As set out in our SMART objectives above, the target for reach will be a key measure of success in our evaluation of the consultation. We are setting two key targets based on previous experience of planning and delivering consultations; one for informing people about the proposals/consultation (minimum of 14,000 with 2,000 direct engagements) and one for actual

responses (2,000). The targets have been set to balance informing people and collecting a wide range of responses with delivering a cost-effective consultation within a proportionate budget.

Following desk research across a range of recent consultation plans on similar reconfigurations, it is evident that setting SMART objectives does not appear to be standard practice. However, we believe SMART objectives should sit at the heart of any robust consultation plan to ensure we can measure and evaluate the effectiveness of our activity. The SMART objectives in this plan have been developed based on wide-ranging experience as well as the consultation activity during the acute stroke services review across Kent and Medway in 2018 where the consultation plan was commended by the JHOSC[5].

The quality of feedback, and ensuring it comes from a representative group of the population, is as important as the overall quantity of responses. Provided we reach a representative group we can be reassured that we will capture a full range of significant views, ideas, issues, and concerns.

4.1 Informing people

Our objective is to ensure a minimum of two percent of the east Kent population has been informed about the consultation proposal. The total registered population of east Kent is circa 700,000; so two percent is 14,000. This is the target to reach people with information about the consultation (e.g. directly through engagement activity, through social media, traditional media, paid-for advertising etc.).

It would be possible to hit this target purely with 'paid for' advertising in print and broadcast media and social media. However, it is also important that people hear about the proposals through direct engagement (through virtual, face-to-face, and one-to-one activities) which allow them to ask questions before giving their views. As such, within our target for informing people, we are also setting a sub-target to have a minimum of 2,000 direct engagements. Section 7 of this plan outlines our planned activity to reach this target, including public and staff meetings/focus groups, street surveys and telephone surveys.

4.2 Responses

Our target is to collect 2,000 responses that can be considered as part of the consultation analysis. This would include all comments which express an opinion on the issues being consulted on. They may be comments made, for example, by people attending consultation events (virtual and physical), completed formal questionnaires, emails and letters, social media comments, and phone calls to the consultation line.

5 Stakeholder mapping

Through our pre-consultation engagement work we have identified and worked with a wide range of stakeholders. We have grouped our stakeholders into eight categories with detailed sub-groups within each category:

Our consultation audiences

[5] https://kentandmedway.nhs.uk/stp-workstreams/stroke/july-jhosc-update/

Patients and public	Staff
• East Kent residents • EKHUFT patients/service users and carers – including those in border areas to the east Kent catchment (see below) • KMCCG's Patient and Public Advisory Group or successor group/forum • Patient and carer support groups • Voluntary, community and local business groups including Kent Stronger Communities • Healthwatch Kent • Healthwatch Medway • Those who are seldom heard • Protected characteristics groups (under equalities legislation) • Campaigners (groups and individuals) • EKHUFT governors and membership • Other NHS Foundation Trust governors and membership • CCG local health/engagement networks • GP patient participation groups • Patients and carers, and/or their representative groups, who use county-wide specialist services provided by EKHUFT and live outside the east Kent area (see below)	• EKHUFT (inc. trade unions) • Community Trust - KCHFT • Ambulance Trust - SECAmb • Mental Health Trust - KMPT • Commissioners – KMCCG and NHSE Specialised Commissioning team • General Practice (inc. Primary Care Network clinical directors and primary care teams) • Local authority (inc. social care and public health teams)
Elected representatives (east Kent and bordering areas)	**Regulators/scrutiny**
• MPs • Joint HOSC (Kent and Medway) • County Councillors (Kent and Medway) • District/City Councillors • Parish/Town Councillors	• NHS England & NHS Improvement • Care Quality Commission • Healthwatch Kent • Healthwatch Medway • Joint Health Overview and Scrutiny Committee • Joint Health and Wellbeing Board
System leaders	**Clinical experts and professional bodies**
• EKHUFT Board • Kent and Medway CCG Governing Body • East Kent Integrated Care Partnership development board • Provider Trust Boards (community,	• South East Clinical Senate • Kent Local Medical/Dental/Pharmacy Committees • Royal colleges • Academic Health Science Network

mental health, ambulance) • Kent and Medway STP/emerging ICS • Kent County Council executive team • District council executive teams	• Kent Medical School/universities
Media	**Out of area stakeholders**
• Local and regional newspapers, radio, TV and online • Trade press • National press	• EKHUFT patients living outside east Kent • Residents of neighbouring CCGs • Staff of neighbouring CCGs • MPs and councillors in neighbouring areas • Governing bodies and boards of CCGs and providers in areas neighbouring east Kent

In addition, to the patient and public stakeholder groupings identified above, an Integrated Impact Assessment carried out as part of the east Kent transformation programme's pre-consultation phase has identified there are several protected characteristics and other vulnerable groups which have a disproportionate or differential need for the hospital services under review. These groups are:

- Children and young people (under 16s and those aged 16-24)
- Older people (65 years and over)
- People with a disability
- Gender reassignment
- Pregnancy and maternity
- Race and ethnicity
- Sex
- Sexual orientation
- People living in deprived areas.

There will be targeted engagement activity during the consultation to get feedback from these groups.

Our consultation activity plan (appendix C) details our strategy for engaging different audiences. For all audiences, we will encourage them to respond with their own views and to help us promote the consultation by cascading information through their own networks. In light of the COVID-19 pandemic this approach becomes increasingly important; where groups and networks have trusted and effective channels in existence, as well as effective new methods to continue communicating and engaging on issues, we should seek to maximise their help in getting information to target groups.

6 The consultation questions and document

There will be a formal questionnaire as part of the consultation, although letters and other open comments will be welcome. We will be asking people for feedback covering:

- people's views on centralising specialist services

- people's views on separating low risk elective inpatient surgery from emergency and higher risk surgery
- the specific proposals set out in Option 1 and Option 2
- the potential impact (positive or negative) of the proposals on patients, relatives, carers and staff
- the potential impact (positive or negative) of the proposals on wider services outside of hospitals
- how far people think the proposed changes help to embrace the opportunities and address the challenges set out in the case for change
- whether there is further evidence, insight and ideas that have not been considered.

The specific questions to be asked in the consultation are being developed in partnership with the Kent and Medway Patient and Public Advisory Group and an independent research/engagement organisation to ensure we design clear and non-leading questions. There will be a mixture of ranking style questions, asking people how strongly they agree or disagree with specific points plus open questions with a free text response.

It will be clearly stated that we are not asking people to choose their preferred option; but we will record it if people do so. Naturally, neither of the proposed options will appeal to everyone, and there will be lots of different views about which is best, and what alternatives we might consider.

The results of consultation are an important factor in health service decision-making, and one of a number of factors that need to be taken into account. Information, views and feedback are vital in helping to shape the future of services and are considered alongside clinical and other evidence and best practice.

Before the GPs and other clinicians on the governing body of NHS Kent and Medway CCG make the decision about which proposal to implement, they will consider a wide range of factors including the responses to our consultation. Other factors will include what the clinical evidence shows will deliver the greatest improvements to care, how services can be safely staffed for the long term and which proposal offers the best value for money. Their decision will be based on information that demonstrates which changes offer the greatest improvements for the greatest number of people in east Kent and those in border communities using east Kent services.

6.1 The main consultation document

In line with best practice criteria for consultation documents, our main consultation document will include:

- the objectives of the consultation
- details of how people can contribute to the consultation and how feedback will be used
- details of how patients and the public have been involved so far
- a balanced view of why service improvement is required, setting out both potential benefits and disadvantages
- details of the proposals with relevant, clear and transparent information
- details of the specific options for change and the implications of no change, with pros and cons for each option
- a set of key questions to guide responses
- email, freepost address and telephone contacts for responses
- contact details for a consultation team who will respond to questions, complaints or comments about the consultation process

- a list of the partners leading the consultation
- the dates of the consultation period (start and finish).

In addition, the consultation document will be:

- written to be as concise and accessible as possible, using jargon-free simple language
- widely available in printed format free of charge
- available online through the consultation website (and linked to from EKHUFT and other partners' websites)
- available online in large print and as an 'easy read' summary
- available in other formats and languages on request.

We will test the draft document and other consultation materials with our Patient and Public Advisory Group or any successor group or forum to ensure content is clear and understandable to people with no prior involvement in the proposals.

7 Consultation activities and materials

Our consultation activities have been designed to reach and collect feedback from a broad range of audiences through a mixture of channels. How people want to participate in public consultations varies widely, and we must offer different ways for people to participate.

Our plans take account of people having varying levels of interest and prior involvement in the proposals. Some will have been actively involved in the proposals through work to develop the original east Kent case for change or developing and assessing the options. Others will find out about the plans for the first time through the formal public consultation.

All consultation activity has been developed to work with the restrictions and changes brought about by COVID-19. Much of the previously proposed activity has been adapted to address social distancing and lockdown constraints, however simply shifting to remote or online engagement does not work for every group or audience. The 'digital divide' means any overreliance on technology risks some groups becoming even more 'seldom heard'. We know that areas with higher levels of deprivation will be less likely to engage digitally and may be restricted because of low bandwidth or lack of data. Similarly, some older people don't want to engage through digital methods (whilst others do). Post-pandemic, the importance of printed materials has increased as has the use of postal services to reach people. We have developed a plan that exploits and expands digital and online engagement whilst focussing on how to effectively engage with the digitally excluded.

7.1 Engagement activities

(locality numbers refer to the former east Kent CCGs prior to the CCG merger in April 2020)

Engagement activities	Frequency, numbers, format
Affected hospital services	We will work directly with specific services affected by the proposals to promote the consultation to their patients. The impact of COVID-19 means that we are unlikely to be able to do this directly (within waiting areas for example) but we will proactively write to patients encouraging them to get involved in the consultation. We will make flyers available for hospital waiting areas, highlighting where printed

Engagement activities	Frequency, numbers, format
	and virtual consultation documents and resources can be found.
Public events	Government guidelines on social distancing as well as public confidence in attending events means that we have revisited the scope and number of public events in our consultation plan. We think it is unlikely that we will be able to safely run 'town hall' style sessions with a large number of attendees at present and are, instead planning for a mix of virtual events as well as some, smaller, face-to-face sessions on specific areas covered by the consultation – looking at services or examining areas of concern such as travel and access. The flexibility offered by online and digital channels means that it will be easier to respond to additional demand for meetings (provided representatives are available) than it would be to host additional physical meetings. We anticipate our public events will include: • Physical public meetings – where possible and adhering to social distancing guidelines. We are looking at offering eight public events - two in each former CCG area, one in the daytime and one in the evening – in venues where social distancing could be maintained. Numbers would be limited with attendees required to register in advance. Individuals would not be able to attend more than one event to ensure that as many different people as possible have the opportunity to attend. • Online public meetings – 'bite-sized' Zoom forums on service/subject-specific issues to maximise engagement • Virtual 'drop in' exhibition with ability to gather information on the proposals and give comment on them. Details of all events will be available on the consultation webpages and publicised through media, social media and other channels.
Street surveys	**300 target –** Surveys will be undertaken to collect feedback from seldom heard and protected characteristic groups. Rural and deprived area focus. Structured discussion to capture responses. Should there be insufficient inhouse capacity to undertake this work we will commission a specialist independent agency to take forward the surveys. In light of COVID-19, surveys will focus on areas with higher levels of footfall, even during lockdown e.g. supermarkets, pharmacies and post offices.
Focus groups	**10-12 events -** Dedicated events with up to 10 recruited attendees per event. Structured presentation and discussion with specific remit to collect feedback from patients, carers and relatives of services affected and seldom heard / protected characteristic groups. We recommend this work is commissioned from an independent specialist agency.
Telephone surveys	**750 – 1000 target** - Structured discussions to capture responses from a representative sample of the target population. To be commissioned from an independent specialist research agency and

Engagement activities	Frequency, numbers, format
	targeting specific groups identified in the integrated impact assessment. Telephone surveys will be particularly useful in the event of localised or general lockdowns, with heightened interest in local and national NHS services meaning that more people will be inclined to respond to a researcher. We will flex this work to respond to the wider circumstances during the consultation period and use this method to get responses from as wide a range of respondents as possible.
Patient / community group visits and online events	Attending by invitation and where feasible existing meetings of established patient / community groups. Structured presentation and discussion.
Hospital site roadshow / display stands	A display to rotate around main sites/services during the consultation period to engage patients and hospital staff.
EKHUFT staff events	Internal communications team to co-ordinate staff events, information provision, and discussions for affected services/sites.
CCG staff events	KMCCG communications team to co-ordinate internal events, information provision, and discussions.
South East Coast Ambulance staff events	Internal communications team to co-ordinate internal events, information provision, and discussions.
Other NHS providers staff events	Internal communications teams to co-ordinate internal events, information provision, and discussions.
County and district council staff	Internal communications teams to co-ordinate internal events, information provision and discussions.
Councillor and MP briefings	Presentations to existing meetings, JHOSC, HWB, Offer of briefings to council meetings at county and district/city level (in addition to formal updates to JHOSC). Parish/town council presentations on request. 1-2-1 and/or group briefings for MPs. All of these can be offered virtually and if, possible, we will in addition look at ways of doing some of these on a face-to-face basis.
Online webinars / chats	We will explore options for a series of targeted live online discussions providing opportunities for staff, members of the public, and partner organisations to discuss the proposals with key clinical / executive leaders of the programme.

7.2 Staff engagement

The proposals we will be consulting on affect a wide range of staff and professional groups and we will ensure that all voices from ‘board to ward’ are heard. All staff across health and social care will be asked to feedback into the consultation through the main survey and contact points, rather than having a staff specific survey. We will ensure that a variety of methods are available, recognising both the restrictions and opportunities of COVID-19 to do things differently.

We have made a commitment to staff who may be affected by the proposals that they will hear about them through us first. This is vital if we are to show consideration and respect to our staff. This builds on our approach prior to consultation, involving staff in the design and development of the proposals and keeping staff updated throughout.

Staff are also often local residents, patients, and carers, with the same concerns as other members of the public about health and care services. It is essential that they are aware of and engaged about the consultation and have the opportunity and means to tell us what they think.

In advance of the consultation launch, staff who may be affected by the proposed changes will be briefed on the proposals and options for consultation, and made aware of the opportunities to attend briefings (face-to-face and virtual) to discuss the proposals and give their views. It should be noted that at this stage the individual impact for staff and 'what this means for me' will not be known in detail (not least as no decisions on the future shape of services have yet been made). This public consultation is not a substitute for any employer/employee consultation on job roles and shouldn't be seen as such. However, the potential for uncertainty and concern amongst staff is noted and every effort will be made to provide as much information as possible to staff so they can feedback their views on the proposals, as well as to listen to and answer questions to the best of our ability that staff may raise.

Following the launch of the consultation, our staff engagement approach will include the following activities:

7.2.1 Staff events

Events/briefings (virtual and face-to-face where possible) for health and social care staff, including hospital teams, GPs and their practice staff and primary care teams, ambulance, community, public health and social care teams.

The aims of the events will be to:

- provide detailed information and to answer questions which enable people to make a considered response to the consultation
- gather rich feedback on benefits, concerns, issues and potential mitigations
- explain the proposals and enable leaders and clinicians to be questioned and to understand the balance of opinion by exploring views on the options.

7.2.2 Line manager support materials

We will provide line managers/team leaders with a range of briefing and support material about the consultation so they can speak with confidence about the proposals during team and one-to-one meetings.

7.2.3 Existing internal communications channels

Intranets, newsletters and bulletins, staff briefings and existing meetings and fora will all be used to engage with staff.

The communications and leadership teams in provider organisations will be responsible for this activity, using materials developed by the programme team. The programme team will contact and distribute materials to GP practices, via practice forums and promote the consultation via existing bulletins to GPs and their practice staff. We will also seek to work through existing networks to reach wider primary care teams and independent contractors such as dentists, pharmacies, and opticians.

7.3 Consultation materials

7.3.1 Accessible and inclusive consultation materials

We will endeavour to prepare all our public facing consultation materials in simple jargon-free language. We will continue to work with patient and public representatives (including CCG lay members, CCG patient forum members and others) as part of our drafting and testing process to make sure materials are clear and easy to read.

An exception to note will be the technical content of the detailed pre-consultation business case. Whilst this will be a publicly available document, it is a technical document for an informed audience and parts of it may not be easily digestible for the general public. If people raise questions about the content of the PCBC we will endeavour to explain specific points in simple terms as part of responding to correspondence during the consultation.

Produce an 'easy read' summary consultation document and response form

This nationally recognised scheme uses words and pictures to effectively communicate with people with learning disabilities. It can also be helpful for those people who don't have English as their first language. We will produce a summary consultation document in this format, commissioned from an accredited provider of 'easy read' materials who will test the material with an appropriate user group to ensure it is understandable. This document will be cascaded through our voluntary community sector contacts, sent or taken to relevant focus groups and meetings, and will be available online.

Visual and hearing impairments

A plain text large print version of the consultation document will be published online. Printed copies will be provided on request. The plain text document will meet the requirements for text readers to support people with more significant visual impairments. Braille and audio versions of the main consultation materials will be made available on request.

We will commission a British Sign Language video to summarise the proposals and explain how deaf people can get full details and respond to the consultation.

Foreign language translation and interpreting

We are aware that not everyone speaks English and will offer a translation/interpreting service on request. This will be noted on the back of key documents in the 10 top languages across the area.

7.3.2 Summary of materials

Materials	Frequency, numbers, format
Core documents	
Main consultation document	Content and format to be developed with patient and public representation and in discussion with members of the JHOSC, Healthwatch and NHS England
Summary leaflet	Short A5 document explaining core points of the proposals and consultation, providing links to further materials and events, and encouraging responses

Flyers	Flyers for easy and effective distribution will be an important element of our consultation collateral, used across a wide range of audiences and locations. They will publicise the consultation and signpost to more information and how to respond.
Questionnaire	Questions to be developed in discussion with Patient and Public Advisory Group (or successor group or forum) and with support from expert external advisors There will be online, printed and easy read options of the core response questionnaire
Alternative formats	**Easy read** version of summary leaflet published online, and links cascaded to stakeholders **Large print** copy of consultation document and leaflet published online, and links cascaded to stakeholders **British Sign Language** video summary of the proposals **Translations** of specific documents on request **Other alternative formats** developed on request
Material for online / public events	
Consultation webpages	Dedicated section of KMCCG website linked from NHS trust and partner websites. Providing all relevant documents, details of public meetings, feedback options, news updates, questions and answers, patient scenarios etc.
Videos	Selection of videos covering overall proposals and service specific impacts. Interviews with key clinical and other spokespeople, patients and carers to help engage our target audiences, disseminate key information, share understanding and encourage responses to the consultation.
Animation	Short animation with summary of overall proposals and encouraging people to find out more and respond.
Digital display screens	Slides for display on digital screens in waiting areas at hospital and GP surgeries. Potential use of videos/animation depending on format.
Presentations	Range of presentations for delivery at public events, focus groups, council meetings etc.
Frequently Asked Questions	Initial list for consultation launch. Additions added to website during course of consultation. Service specific FAQs in addition to overall plans.
Service specific factsheets/infographics	Individual factsheets / infographics to explain impact on specific services e.g. maternity, paediatrics, A&E, planned operations.
Printed display material	
Pop-up banners	For display at hospital sites and use at events
Posters	For display at hospital sites, GP surgeries, libraries, town halls, job

	centres etc. Full list of distribution to be confirmed following further review of opportunities with private organisations such as supermarkets.
Drinks mats	Targeted use of paid advertising in pubs using printed drinks mats to highlight the consultation dates and where to find details. This approach was suggested by PPAG members during the initial development of this consultation plan, as an innovative and effective way to reach younger audiences who are more difficult to engage in consultation through more traditional methods. It was also felt that this approach might be an effective mechanism to reach seldom heard communities in areas of deprivation, for whom, pubs play a central role in the life of their community We recognise that this may not be as effective if there is another general or local lockdown that affects local pubs and hostelries and will review the potential use of this product nearer the time, however it is a relatively simple tactic to bring to life and lends itself well to media and social media activity.
Pharmacy bag advertising/inserts	Targeted use of paid advertising in pharmacies using printing on prescription bags or flyers to insert. Selective use to reach people from seldom heard communities in areas of deprivation. In a lockdown scenario this could be extended to encompass bigger swathes of the population.
Coffee cup holders	Targeted use of paid advertising, recognising that as lockdown eases, many cafes and food outlets have responded with a new focus on takeaway services to attract customers.
Staff pay slips	Flyers to attach/insert messages in EKHUFT payslips and / or printed message inside payslips.
Social media	
Free	Regular promotion through social media accounts of the CCG, hospital trust and other partners to promote key messages and encourage responses to the consultation.
Paid for adverts and post boosting	We will develop a costed plan for regular adverts and post boosting through Twitter / Facebook over the course of consultation. Targeting audiences by geography and demographics.
Partner/stakeholder publications	
Articles for editorial in local publications	Series of articles to send to existing publications including council (county, district, town/parish) newsletters and magazines, CCG health networks, NHS trusts, GP Patient Participation Groups, Healthwatch, voluntary sector etc
Adverts in local publications	If free editorial is not possible in key publications, we will consider paid adverts based on cost vs audience reach.
Paid media advertising	
Newspapers	Series of adverts across east Kent titles through consultation period.

	Highlight key proposals and ways to find out more and respond.
Radio	Advert on east Kent stations repeated at times throughout the consultation. Highlight key proposals and ways to find out more and respond.
Pubs and pharmacies	See information in “printed display material” section.
Media releases / interviews	
Print, online and broadcast media	Series of proactive releases and broadcast interviews during the consultation to raise awareness and encourage feedback. Reactive responses to media queries provided throughout the consultation.

7.4 Media approach

We will work proactively with the media during the consultation. East Kent and surrounding areas have a diverse range of media outlets, from ultra-local publications to wider Kent and Medway focussed news outlets. All are important in shaping and reflecting public perception and reaction to health and care changes. We will work with them to communicate key messages for the consultation and to signpost more detailed information to the population of east Kent and wider in Kent and Medway. We will identify appropriate editorial and advertorial opportunities.

We will issue regular media releases throughout the consultation period to local newspapers, local radio and community magazines (including newsletters produced by residents’ associations, parish, borough and district councils, community, faith and voluntary groups etc).

During the consultation we will adhere to the following key principles for working with the media:

- Establish a media programme of promoting case studies, inviting journalists to events and facilitating interviews with key clinicians involved in the development of the proposals
- Provide clinical spokespeople wherever possible to explain the reasons for change and our proposals, (supporting them appropriately in this role)
- Work closely with local journalists and ensure they are fully briefed on the reasons for the consultation and why local clinicians believe the proposals for change will improve services and meet the challenges and opportunities described in the case for change
- Invite members of the media to all relevant engagement events and meetings, to maintain transparency throughout the process
- Work with communications teams at all partner organisations to make sure messages are consistent
- Respond to all media enquiries in a timely and helpful manner
- Regularly monitor the media and ensure that inaccurate information about the consultation and proposals are rebutted
- Evaluate all media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.

We will use a mixture of submitting editorial content/media releases to get free coverage and some paid for advertising where this is felt to be cost effective.

The media audiences we will target with information about the consultation include:

- All local newspapers
- Professional journals such as Health Service Journal, Pulse, Hospital Doctor, Nursing Times, Nursing Standard and GP magazine

During the consultation period, we expect extensive reactive media work. We will also seek to ensure that messaging on the wider aspects of improving local care are covered alongside responding to issues focused on the hospital service options – so that we are telling the 'whole story' for patients, carers and the public.

7.5 Activities and materials for audiences outside East Kent

EKHUFT provides some regional specialist services, with residents from other parts of Kent, Medway, Surrey and Sussex either travelling to the hospitals in east Kent or receiving care at satellite centres run by EKHUFT services affected by the proposals.

These include:

- haemophilia outpatient services
- inpatient renal services
- specialist cardiac services (primary percutaneous coronary intervention [PPCI])
- neuro rehabilitation services
- some vascular services, dependent on the outcome of a separate consultation to create an interim arterial centre for Kent and Medway by summer 2021.

Engagement activity to reach patients and carers/relatives for these regional services will be delivered directly through the services with a mixture of written information and members of the consultation team attending services to carry out structured interviews/surveys, where it is safe and appropriate to do so. We will use service-specific factsheets to ensure people are clear how the options affect the regional services and what the proposals would mean for them.

We will write to key stakeholders including MPs, council representatives, primary care leaders and Healthwatch in areas outside of east Kent from which patients use EKHUFT's regional services. We will provide information about the consultation and invite them both to respond and to cascade information to their local networks. Face-to-face and virtual meetings and briefing sessions will be offered on request.

8 Distribution channels

We will distribute a range of consultation materials using online and physical channels to meet the varying preferences of our target audiences and stakeholders; balancing the need to make hard-copy materials available with our usual 'digital by default' approach and delivering a cost-effective consultation.

We have reflected on the constraints of the pandemic in distributing materials to people. We can no longer rely on a broad range of touchpoints (libraries, GP surgeries, schools etc) seeing high levels of footfall or even being available as an outlet for consultation information. Instead we have considered where contact points exist for people even when the most rigorous social distancing measures are in place. Essential services such as supermarkets, food shops, pharmacies, and post offices all offer opportunity to engage and offer information to people. This can be achieved

with stalls, posters, information tables and boards. With supermarket home deliveries on the rise, we will explore the opportunity to include flyers with shopping deliveries. We are also looking for more domestic or residential communal areas such as mail tables and post areas within tower blocks and apartment buildings as well as leaflet drops and mailshots to targeted postcodes and groups.

We will use direct distribution by the central consultation team as well as requests to a wide range of partners and interested groups to cascade information through their own networks. Given the above, our approach will be balanced using the full range of different channels of communication: face-to-face activities, digital and news media. We hope this will ensure that all people are able to get involved in a way that best suits them.

8.1 Digital distribution

Channels	Materials
Websites	We will use a section of the Kent and Medway CCG website as our online consultation hub. Content for the east Kent transformation programme has to date been hosted on the Kent and Medway STP website www.kentandmedway.nhs.uk/eastkent. This page will be redirected to the relevant page on the KMCCG website for the duration of the consultation. The online consultation hub will host all consultation information in one place, with quick links on every page to clearly highlight key documents and online feedback channels. It will also include an events diary and document store including the more technical PCBC document and appendices. The EKHUFT website will include a page with details of the consultation and links to direct people to the relevant page on the KMCCG website. Other NHS and social care partners will also be asked to publish a consultation page linking to the consultation hub. The old east Kent CCG websites will still be live and their 'Get involved' pages will have automatic redirects set to take people to our consultation hub on the KMCCG website.
Email bulletins	We will build on our existing e-bulletin for the east Kent transformation programme and issue regular updates through the consultation period. This directly reaches an audience of around 850 key stakeholders and individuals including: all district, town and county councillors, parish council central contacts, MPs, and a wide range of patient and public representatives and voluntary/community groups. Contacts in the hospital trust and partners including Healthwatch Kent and other NHS providers cascade the bulletins on to their wider distribution lists. We will also provide content about the consultation for our partners to include in their own e-bulletins/newsletters during the consultation.
Social media	Twitter and Facebook will be used to keep online stakeholders informed, and to signpost and facilitate discussion, during and after the consultation period.

Channels	Materials
	The STP accounts and the new KMCCG accounts will be the main channels; although links will also be made with accounts run by the hospital trust and other partners. We will use paid advertising on social media to promote the consultation to people in the east Kent area.
Online video	We will produce a series of short videos to support the consultation and these will be available through a YouTube channel and links promoted through our social media account and e-bulletins.

8.2 Physical distribution

Copies of printed materials (main document, summary, posters, display stands etc.) will be made available at physical locations where footfall and contact can be guaranteed.

With all distributions we will include details of how to request further copies as required.

Location type (sites in east Kent)	Materials (per site)
Leaflet drop to targeted groups and postcodes	Flyers – (number tbc)
Flyer inclusion with supermarket deliveries – tbc, idea being explored, subject to agreement	Flyers – (number tbc)
Communal areas of tower blocks and housing estates	Summary leaflet/flyers (numbers tbc) Posters (1)
Supermarkets - tbc	Summary leaflet/flyers (numbers tbc) Posters (1)
Post offices	Summary leaflet/flyers (numbers tbc) Posters (1)
Schools – to be advised	Summary leaflet/flyers (20) Posters (1)
Acute hospitals (3)	Main consultation doc. (no. tbc) Summary leaflet/flyers (no. tbc) Posters (no. tbc) Pop-up banners (4)
Community hospitals/health centres (12 KCHFT, 6 EKHUFT)	Main consultation doc. (10) Summary leaflet/flyers (100) Posters (4) Pop-up banners (1)
General practice (68)	Main consultation doc. (5) Summary leaflet/flyers (50) Posters (2)
Pharmacies (tbc)	Summary leaflet/flyers (25) Posters (1) Pharmacy bag advertising

Location type (sites in east Kent)	Materials (per site)
Libraries (tbc)	Main consultation doc. (10) Summary leaflet/flyers (50) Posters (1)
Town halls (6 = KCC and 5 district/city)	Main consultation doc. (10) Summary leaflet/flyers (50) Posters (2) Pop-up banners (1)
Leisure/sports centres (tbc)	Summary leaflet/flyers (20) Posters (2)
Job centres (tbc)	Summary leaflet/flyers (20) Posters (2)
Children's centres (tbc)	Summary leaflet/flyers (20) Posters (1)
Foodbanks and community stores (tbc)	Summary leaflet/flyers (20) Posters (1)
Citizens Advice (tbc)	Summary leaflet/flyers (20) Posters (1)
Local COVID volunteer groups (tbc)	Summary leaflet/flyers (20) Posters (1)
Clinical Commissioning Group offices (4)	Main consultation doc. (10) Summary leaflet/flyers (25) Posters (4)
Healthwatch offices (tbc)	Main consultation doc. (10) Summary leaflet/flyers (25) Posters (1)
Public consultation events	Main consultation doc. Summary leaflet Pop-up banners

9 Collecting responses

We will provide the following mechanisms for people to respond to the consultation:

- a questionnaire with specific questions about the proposals (print, online and easy read)
- Freepost address
- email address
- phone line/voicemail
- telephone polling
- targeted focus groups

- online and digital meetings and events - including virtual exhibitions; Zoom meetings with key spokespeople on specific areas such as maternity and paediatrics, urgent and emergency care, frailty and planned surgery; social media sessions; and webinars
- physical, face-to-face meetings and events – adhering to social distancing guidelines, hygiene protocols and in locations and venues where people will feel confident about attending
- targeted outreach work through voluntary and community groups and organisations to reach seldom heard audiences and those with protected characteristics.

All feedback, whether verbal or written, will be collected, logged, and considered. Respondents will be encouraged, but not required, to use the main questionnaire.

10 Analysis of consultation responses

10.1 Mid-consultation

Throughout the consultation period we will monitor responses to identify any demographic or other trends which may indicate a need to adapt our approach regarding consultation activity or refocus efforts to engage a specific group/locality.

10.2 Post-consultation

In line with best practice for a consultation of this nature we will commission an independent research/engagement organisation to analyse the responses and produce a non-biased objective report summarising all feedback. The independent report will identify trends and themes from the consultation responses. The Kent and Medway Clinical Commissioning Group will consider the consultation feedback in full and decide what actions need to be taken in response.

The independent organisation will be sent all feedback gathered across all channels, including for example: formal questionnaires, notes from public meetings, individual response letters, social media posts, petitions submitted by campaign groups.

Comments provided to the independent organisation will by anonymised with the exception of social media posts where people have already accepted they are publishing comments attributable to their social media account. Individual responses will also be published as part of the post consultation reports.

11 Impact of consultation on outcomes and decision-making

A public consultation is not a referendum and we will not be asking people to vote for one option or another. What we will be seeking from the consultation responses is to fully understand the impacts (positive and negative) that people believe the proposals will have, to understand issues and concerns and how they might be mitigated, and to provide an opportunity for any additional evidence, data or alternative proposals and solutions to be put forward that would meet the opportunities and challenges described in our Case for Change. Feedback will be used to shape the final proposals and allow us to consider mitigating actions for any concerns that are raised.

Consultation responses will be used alongside a range of other evidence gathered as part of the decision-making process (including clinical, financial, workforce, estate, travel time evidence etc) and any other relevant information which may become available before a final decision. Consultation responses will be used to:

- help decide which option is taken forward

- identify if changes are needed to the option taken forward
- identify actions to progress opportunities to improve / mitigate concerns raised.

This decision-making process will comply with the NHS England guidance 'Planning and Delivering Service Changes for Patients'.

After the consultation has closed, and the independent report has been considered by the clinical commissioning group, the consultation team will publish a formal response and activity report for the public consultation. Based on best practice guidance, this report would include the following information:

- Introduction and background
- Review of case for change
- Review of proposed changes
- Number of consultation responses and how many were deemed suitable/usable
- Summary of respondent demographics
- Summary of responses to consultation
  - Summary of responses to the specific consultation questions
  - Summary of themes in responses, including themes not covered by the specific questions
- How the CCG will address concerns
- Link to website where responses can be viewed
- Recap of final decision-making process and next steps.

This report will draw on the independent evaluation of consultation responses report. It will be available online, with printed copies available on request.

12 Measure of a successful consultation

The success of our consultation will be measured against the aims and SMART objectives set out in this plan, including:

- the depth and breadth of responses/feedback on the proposals
- the targets for reach set out in this plan
- feedback from respondents on the process of the consultation, including their views on how the consultation has been conducted within the context of the pandemic
- feedback from JHOSC, Healthwatch and NHS England post consultation
- whether we meet our statutory and legal duties during the consultation.

13 Resourcing plan

To deliver an effective best practice consultation we will commit sufficient resources, including internal staff, specific expertise from external agencies, and a non-pay budget for a range of essential expenditure. The impact of the pandemic must be reflected in the resources that are allocated to this work. Some of the activity we are recommending to 'COVID-proof' our consultation approach will be more expensive than earlier drafts of our plan developed before the pandemic. Additional capacity, resources and attendant costs should work need to pause and re-start at short notice may also incur additional costs. An increase in print budget is an example of where costs might rise, or to increase telephone polling numbers if a local lockdown is experienced during the consultation period for example.

It is recommended that investment is secured so that the process may be run properly, effectively and robustly. An effective consultation will produce rich feedback and insights to improve the overall quality of decision-making and service design, and in turn, the quality of patient outcomes and experience in the future. This approach will not only make sure we meet our statutory duties around involvement and consultation, it will also help mitigate the risk of successful legal or other challenge to the consultation process at a later stage, which then incurs further cost and time delays. It is important to note that consultations tend to be challenged on process which can lead to long delays, potential re-consultation and increased costs. Perhaps most importantly, successful challenge to a programme such as this also has opportunity costs for patients in delays to making improvements to services.

13.1 A dedicated consultation team

Running a public consultation exercise is challenging and requires a core team that has sufficient capacity, is resilient, professional, and ideally consistent to take the programme through from start to finish. This team will consist of health and care leaders, clinical leaders, in-house communications and engagement staff and additional capacity and expertise commissioned from external suppliers. We will build flexibility into the team to reflect the potential for staff to be diverted elsewhere because of the pandemic.

Planning and delivery of the consultation activities/materials will be led by the communications and engagement workstream of the east Kent transformation programme, however, the consultation team will consist of a wider group, additionally including:

- Clinical leaders from CCG and EKHUFT
- Executive and programme leaders from CCG and EKHUFT
- Project management office and administrative support.

13.2 Non-pay resources

Identifying the costs for non-pay materials and resources, ranging from design of, typesetting and printing documents, bulk mail distribution, and advertising, to venue hire and independent analysis of consultation responses is a work in progress. We will use the 2018 stroke services consultation as a realistic benchmark and, factoring in increased costs as a result of changing activity to meet the challenges of COVID-19, arrive at a realistic budget for communications and engagement activity for the consultation.

14 Conclusion

The COVID-19 pandemic has prompted a thorough review of our consultation plans to ensure that they meet the requirements of our changed circumstances whilst also allowing us to deliver best practice and fulfil our statutory consultation duties. We will make the most of appropriate new technologies, methodologies and mechanisms to respond to the constraints of consulting within the ‘new normal’ as they emerge but we still have effective ways to communicate, engage and consult with a wide spectrum of groups and individuals.

Once consultation is underway, we will maintain a flexible approach to assessing the effectiveness of the activities identified in this plan, especially in light of COVID-19; and will amend our approach as appropriate. Significant changes to the approach, including the need to protect the integrity of the consultation because of COVID-related requirements would be discussed and approved through the programme governance. This would include the Sustainable Healthcare in East Kent committee (SHIEK), recommendations to the Kent and Medway CCG

Governing Body, and briefings provided to the Joint Health Overview and Scrutiny Committee and NHS England and NHS Improvement.

15 Appendix A – Consultation principles and statutory duties

15.1 Our consultation principles

Consulting with people who may be impacted by our proposals

- We will engage people across the demography and diversity of the populations in east Kent (and relevant areas beyond east Kent) to gather a fair representation of views and feedback from groups including; the working population, seldom heard groups, those with protected characteristics, people who have used the services affected (as patients, relatives or carers) and those who may do so in the future.
- We will monitor and evaluate our consultation process consistently and in a systematic way, including capturing feedback and comments from events, meetings, surveys, discussions and individual responses.
- We will monitor responses being received during the consultation period to assess progress on where, how and from whom we are receiving feedback, so we can target/amend our activity to address gaps in feedback geographically or demographically.
- We will make sure that there are 'no surprises' for staff whose jobs may be affected by the review. We will ensure they are aware of the process, understand how their roles may be impacted and understand how they can give their views during the consultation.

Consulting in an accessible way

- We will provide a range of physical and digital opportunities for people to hear about the proposals and provide their views, including group and one-to-one options for discussions.
- We will produce a range of public facing information to explain the proposals in a clear and consistent way, avoiding jargon and explaining technical issues in 'plain English'.
- We will consider all requests for translations and accessible formats and discuss with individuals the most effective way to provide the information they need.
- We will publish the detailed technical/clinical information supporting the proposals online to ensure transparency.
- We will reach out to people where they are, in local neighbourhoods and through local networks.

Consulting well through a robust process

- We will make sure local people and staff working in organisations affected by the proposals have confidence in our consultation process, ensuring it is open, transparent and accessible.
- We will be clear and up front about how views can influence decision-making, explaining it will not be possible to accommodate all views and why difficult decisions have to be made.
- We will make sure a wide range of people are aware of our consultation even if they choose not to participate.
- The consultation will run for a sufficient length of time to allow people to give their views and we will provide regular reminders about progress and the closing date.
- We will use a mix of qualitative and quantitative methodologies to allow for both volume and richness of response

- We will strive to ensure we are acknowledged locally and nationally to have undertaken a meaningful and effective consultation process.
- The results of our consultation and the feedback received will be thoroughly and conscientiously considered and used to inform decision-making.

Consulting collaboratively

- We will work collaboratively with individuals, stakeholders, and partner organisations to make the most of the opportunities of partnership working to reach out to as many people as we can in a meaningful way.
- Our information will be relevant to local groups, being clear about what the proposals mean for each geographical area and for each group of people taking account of their interests, diverse needs and preferences.

Consulting cost-effectively

- We will assign an appropriate budget to enable an effective consultation and will strive to ensure our consultation budget is spent wisely and used effectively in terms of reach and response, delivering good value for money throughout. Some costs will be increased as a result of COVID-19, for example, higher print costs because of the need to ensure greater availability of hard copy materials and the ability to flex activity such as telephone surveys to respond to local circumstance.

Independent evaluation of feedback

- We will work with independent providers to deliver key consultation work and to analyse the results to ensure an objective outcome.
- The analysis of feedback will be done independently, and the independent report(s) will be shared publicly.

15.2 Statutory duties and legislation

This consultation plan has been designed to ensure we deliver effective patient and public engagement, involvement, and consultation as part of our obligations and legal duties under:

The five tests for service change laid down by the Secretary of State for Health and Social Care – test one is to evidence strong patient and public involvement.

The National Health Service Act 2006 (as amended by the Health & Social Care Act 2012)

- **Section 242**, requires the NHS to make arrangements to involve patients and the public in planning services, developing, and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.

- **Section 244** requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees).

- **Section 14Z2** requires CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
  - in the planning of the commissioning arrangements by the CCG
  - in the development and consideration or proposals by the CCG for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
  - in decisions of the CCG affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

- **Section 14T** requires CCGs to have regard to the need to reduce health inequalities between patients in access to health services and the outcomes achieved.

- **The Equality Act 2010** - requires us to demonstrate how we are meeting our Public Sector Equality Duty, and how we take account of the nine protected characteristics of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

16 Appendix 9B – Developing our consultation plan

16.1 Internal development and sign-off

Within the governance structures of the east Kent transformation programme this consultation plan has been developed, reviewed, and approved by the following groups:

- **Communications and engagement workstream**
  The communications and engagement workstream for the programme prepared the initial plan and discussed options for the different activities and channels; using the experience of those involved in the recent Kent and Medway acute stroke services consultation and other large and complex consultations to consider what worked well and what could be improved upon. We reviewed the stakeholder groupings and the cascade channels available through all the partners involved in the programme.

- **Transformation Delivery Board**
  Clinicians and other health care professionals and staff have been involved in the development and delivery of pre-consultation engagement activities. The East Kent Transformation Delivery Board has advised and commented on plans and activities and will receive regular reports on the consultation once it is underway.

- **Sustainable Health and Care in East Kent subcommittee**
  The committee reviewed the consultation plan in December 2019 as part of reviewing the overall PCBC prior to submission of the draft to NHS England and NHS Improvement, and reviewed it again in August 2020. The committee will do a further final review of the consultation plans as part of the internal governance ahead of the Kent and Medway CCG's decision to launch consultation.

- **Kent and Medway CCG Governing Body**
  The Kent and Medway CCG Governing Body is now the decision-making body for the east Kent transformation programme, following the merger of the eight former Kent and Medway CCGs in April 2020. The Kent and Medway CCG Governing Body receives assurance and recommendations about the programme from the Sustainable Health and Care in East Kent subcommittee. The Governing Body reviewed the PCBC, including this consultation plan, in August 2020. It will do a further final review of the PCBC and supporting plans, and be informed by them, when it makes a decision to consult on the proposed options and to formally launch consultation.

16.2 Kent and Medway STP Patient and Public Advisory Group

In April 2019, PPAG reviewed and commented on an initial summary of the consultation activities and channels being considered. A final draft of this plan will be reviewed and endorsed by PPAG or any equivalent public and patient representative group or forum aligned with, or part of, the new Kent and Medway CCG.

16.3 Healthwatch

The chief executive of Healthwatch Kent was involved in the wider programme developing the proposals and as chair of PPAG up to July 2019. As a specific piece of work, we asked Healthwatch to review a draft of this plan and received their feedback in December 2019. They provided positive comments and suggestions which have being incorporated into the final detailed consultation activity planning. We also asked them to provide a second review of this plan in light

of the COVID-19 restrictions, recognising that they will have a view on effective and appropriate methods of engagement as a result of the pandemic. The results of that review were received in August 2020 and said: 'Overall, this is a comprehensive plan giving widespread opportunities for East Kent residents and those further afield to input into the consultation.'

16.4 Joint Health Overview and Scrutiny Committee (JHOSC)

Medway Council has expressed a wish to be involved in the consultation through a joint HOSC. We discussed a summary of the consultation plan with the Kent and Medway JHOSC in February 2020. The arrival of the COVID-19 pandemic has led to a thorough review of planning and activity and we will seek JHOSC's views on our 'COVID-context' activity during the development period and when a final version of the full plan is taken to the JHOSC prior to consultation launch. As part of the formal consultation we will also consult directly with the JHOSC on the proposals themselves.

16.5 NHS England

The communications and engagement team for South East England have reviewed and commented on our consultation plan as we have developed it and will continue to have further input and review as part of the overall PCBC submission at key points in the process during August and September 2020. A comprehensive and robust plan for consultation is one of the requirements for a successful 'Stage two Gateway' assurance conducted by NHS England.

17 Appendix C – Activity plan for the consultation period

The table below provides a provisional timetable for core consultation activity. We are scoping the idea of delivering 'themed' weeks during the consultation period to allow focus on specific areas such as A&E, maternity, county-wide specialised services, and so on, through developed content for media, social media and meeting channels. The benefits of this approach are that activity can be targeted more effectively at groups and audiences and messages about how the proposals relate to specific services or groups can be given greater clarity and profile. Flexibility will be built into this approach to enable us to respond to national or high-profile policy developments or public interest.

Our current timescales anticipate a launch of formal public consultation in early February 2021, running for an anticipated 14 week period (the 12 standard weeks, plus two to accommodate the Easter holiday period) and allowing flexibility in response to the potential impact of COVID-19. This means that a likely six week 'purdah' period, potentially starting at the end of March 2021 would fall around week 6 of the consultation period. Our consultation plan sets out a timeline for the activity described within the plan, describing four week phases of activity as well as acknowledging the potential need for a two week extension due to the Easter holidays. We have already planned to hold the majority of our public-facing activities during the earlier weeks of the consultation, with mid-point reviews of responses factored in so that the second half of the consultation period focusses on eliciting responses from any sectors, communities and groups where response rates have been low.

Once consultation is underway, we will maintain a flexible approach to assessing the effectiveness of the activities identified in this plan, especially as a result of COVID-19; and will amend our approach as appropriate. Significant changes to the approach, including the need to protect the integrity of the consultation because of COVID-related requirements would be discussed and approved through the programme's governance. This would include the Sustainable Healthcare in East Kent committee (SHIEK), recommendations to the Kent and Medway CCG Governing Body, and briefings provided to the Joint Health Overview and Scrutiny Committee and NHS England and NHS Improvement.

Consultation phase	Activity summary
Preparation for formal consultation	• Development and final sign off for all consultation materials and preparation ready for printing. • Planning and booking advertising for consultation publicity. • Planning and booking of consultation events – both physical and virtual • Preparation of consultation online hub on KMCCG website. • Final development of distribution list for print and electronic delivery of consultation materials. • Establish process for providing consultation materials in alternative formats/languages.
Pre-launch of formal	• Ongoing stakeholder engagement to ensure there are no

Consultation phase	Activity summary
consultation	surprises with key audiences such as MPs, councillors, staff, and patient representative groups to ensure widespread understanding of the consultation when it happens. • Informal meetings with staff who may be directly affected by the proposals (including trade unions). • Publication of venues/timings of key public meetings running during consultation period. • Print and distribution of hard copy materials to start once final content approved.
Launch day	• Online publication of core consultation materials and response questionnaire. • Media and stakeholder launch event – this may be physical or virtual depending on a range of factors including COVID-19. • Media release issued to local and regional media. • E-bulletin to full stakeholder list announcing consultation launch and linking to online materials including details of public events.
Weeks 1 – 6	• Telephone polling and street surveys commence to ensure representative sample from across the consultation catchment area including seldom heard and protected characteristic groups. • Print, radio and social media advertising to promote consultation (week 1). • If possible, display stands in place at main hospital sites. • Focus groups with patients, carers, relatives from services affected by proposals – online and face-to-face. • Attendance at existing meetings of stakeholder groups (virtual and face-to-face) • Hospital and primary care staff events (virtual and face-to-face) • Initial review of engagement activity reach and feedback to identify demographic or other trends requiring adaptation of plans (week 4). • E-bulletin to full stakeholder list with reminder of public events (both virtual and face-to-face) and encouraging responses to formal questionnaire (week 5). • Majority of public events held during weeks 1 – 6. • Print, radio and social media advertising to promote consultation • Consultation mid-point review report to Transformation Delivery Board and SHIEK subcommittee (week 6/7). • Review of engagement and feedback from seldom heard/protected characteristic groups to confirm if further targeted activity is needed. • Mid-point media releases to encourage further editorial coverage of the consultation (in addition to paid advertising).
6-12– during the pre-election 'purdah' period	• Pause proactive engagement and involvement activities – including editorial and advertorial media work - when the pre-election period begins, but keeping the online consultation questionnaire open, reactively responding to requests for documents or information and continuing to accept all responses

Consultation phase	Activity summary
	and feedback offered to us in response to the consultation during that time. • Restart the proactive engagement and involvement activities as soon as we are able to do so after the elections have taken place (respecting the need to wait for a period of time – 24/48 hours - after the results are made public). •
Weeks 12-18 subject to confirmation of an extension – the current timeline of a February 2021 launch would mean that the consultation would be running during the Easter period, with Easter Sunday falling on 4 April 2021	• E-bulletin to full stakeholder list and social media activity with reminder encouraging responses (week 12). • Print, radio and social media advertising to promote consultation (weeks 12 and 13). • Attendance at meetings of stakeholder groups (virtual and face-to-face) • Hospital and primary care staff events (including virtual and face-to-face). • Further targeted street / telephone surveys if required following analysis of initial activity. • Email reminders to key partner/stakeholder organisations encouraging submission of formal responses to the consultation. • Review of feedback and engagement activity to consider if extension to consultation period is needed (week 12). • E-bulletin to full stakeholder list and social media activity to encourage responses (week 13). • Print, radio and social media advertising to promote consultation (penultimate week of consultation). • Final targeted street / telephone surveys if required to fill gaps in engagement with seldom heard/protected characteristic groups.
Consultation close	• Media release on close of consultation (final week). • E-bulletin to full stakeholder list with high level summary of consultation activities and details of next steps to analyse and publish results. • Removal of consultation displays from main hospital sites. • Update to online hub to confirm consultation close • Closure of online questionnaire • Email to partners where hard copies of consultation materials were delivered requesting displays to be removed.
Post consultation	• Independent analysis of consultation feedback and drafting of reports. • Presentation of consultation feedback to Clinical Commissioning Group. • Presentation of consultation feedback and next steps to Joint Health Overview and Scrutiny Committee. • Publication of consultation feedback reports including information on next steps towards decision making and implementation.

Item 9: Assistive Reproductive Technologies (ART) Policy Review - written update

By: Kay Goldsmith, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 28 September 2020

Subject: Assistive Reproductive Technologies (ART) Policy Review – written update

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

It provides background information which may prove useful to Members.

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

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1. Introduction

(a) Assistive Reproductive Technologies (ART) are medical procedures that are primarily used to assist infertility. An example is in vitro fertilisation (IVF).

(b) NICE guidelines (CG156, section 1.11 "Access Criteria for IVF"[1]) recommend that the NHS funds up to three full IVF cycles for women aged under 40.

(c) Across Kent and Medway, there is a single policy relating to ART and it entitles eligible patients two IVF cycles.

(d) In order to achieve financial sustainability, CCGs nationwide have been considering whether to reduce the number of funded IVF cycles available to eligible patients. One such review was underway in Kent & Medway. The proposal presented to JHOSC in October 2018 was for a maximum of one full IVF cycle per each eligible patient. East Kent CCGs decided not to progress with the review. [2]

(e) At its meeting on 12 October 2018, the JHOSC had expressed grave concerns about the potential for different levels of provision for IVF cycles across Kent and Medway.[3]

[1] https://www.nice.org.uk/guidance/cg156/chapter/recommendations#access-criteria-for-ivf
[2] ibid
[3] Kent County Council (2018) 'Kent and Medway NHS Joint Overview and Scrutiny Committee (12/10/2018)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8154&Ver=4

2. Joint scrutiny

(a) The Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) determined that the ART Policy Review was a substantial variation in the provision of health services in Medway on 18 January 2018.

(b) The Kent Health Overview and Scrutiny Committee (HOSC) deemed the policy review to be a substantial variation on 26 January 2018, in the provision of health services in Kent.

(c) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013[4] the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was convened and has met to discuss ART services on two occasions (12 October 2018 and 10 September 2019).

3. Next Steps

(a) The Kent and Medway CCG and Medway Council (who commission the service on behalf of the CCG) informed Kent County Council's Scrutiny Research Officer on 24 August 2020 that the ART Review had been suspended.

(b) There remains a single schedule of policies in place across Kent and Medway, which includes two cycles of IVF for eligible patients. This element of ART provision has not changed.

(c) Part of the review had been around including Donated Genetic Material (DGM) in the ART schedule of policies. It has been confirmed that this was agreed, and that the routine procurement of the service now includes this.

(d) Whilst the review is not currently progressing, the Kent and Medway CCG will continue to monitor the service and propose changes as and when necessary.

4. Recommendation

RECOMMENDED that the Committee suspend their scrutiny of Assistive Reproductive Technologies until the Kent and Medway CCG decide to restart their review.

[4] When NHS bodies and health services consult more than one local authority on a proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation.

Background Documents

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

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

Medway Council (2018) '*Health and Adult Social Care Overview and Scrutiny Committee (18/01/2018)*', https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3727&Ver=4

Kent County Council (2018) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (12/10/2018)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8154&Ver=4

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