Transforming health and social care in Kent and Medway

# Transforming Health and Care in East Kent Update July 2018

## Background

1. This paper updates the Kent Health Overview and Scrutiny Committee and focuses on the:
    - Context - case for change
    - Updated NHS England assurance process
    - Clinical Senate Review
    - Revised programme arrangements
    - Service models and options under consideration
    - Programme plan
2. The paper brings together a number of areas of discussion into one document and updates on the next steps.

## Context - case for change

3. On 4th August 2016 local health and social care leaders from east Kent published a technical document and public facing leaflet called *"Better health and care in east Kent: time to change",* describing the reasons why health and social care in east Kent need to be transformed and set out a future vision for health and social care:

    https://kentandmedway.nhs.uk/where-you-live/plans-east-kent/case-change-east-kent/

4. This identified that:
    - In some areas we are struggling to deliver the quality of care we want to consistently (e.g. local people tell us they find it hard to get a GP appointment, and too many people have to wait too long in A&E or to see a specialist);
    - That our population is changing, both growing and the number of elderly people with multiple comorbidities is increasing (i.e. the number of people with one or more additional diseases in addition to their primary disease or disorder);
    - Whilst we are living for longer, we are also living with more long-term conditions, such as diabetes, dementia and heart disease which increases demand for health and care services but requires a different sort of service to those of the past;
    - More treatments nowadays can be offered out of hospital or with shorter hospital stays because of new medicines and medical techniques, but our services are not designed to take the full advantage of these new developments;
    - We struggle to find enough staff to deliver services in east Kent and we need to attract staff with the right skills and experience to deliver the best quality services;
    - We don't have unlimited financial resources, so we need to use what we have wisely and spend our funding in a way that will maximise outcomes for the people we serve.

5. The east Kent case for change, was further supplemented by a Kent and Medway Case for change published in April 2017, which was updated in March 2018:

   https://kentandmedway.nhs.uk/stp/caseforchange/

6. We believe health and social care services in east Kent can and should be better. Finding new and innovative ways of working, and at the very least, ensuring we can consistently deliver services to the quality standards expected nationally, will make east Kent more attractive to potential employees and help us keep hold of the great staff we already have. The East Kent Transformation Programme has been established to plan and deliver the changes we need to deliver the best possible healthcare to the population we serve.

### Updated NHS England assurance process

7. In order to progress to consultation the CCGs will need to present a pre-consultation business case to NHS England, which outlines proposals and how they build on the case for change. This document is the focus of the NHS England assurance process and needs to be approved by NHS England before we, through the East Kent CCG Joint Committee, can take a decision on whether to proceed to consultation. It also forms the starting point for a Strategic Outline Case (SOC) as required by NHS Improvement.
8. In March 2018 NHS England updated its guidance detailing how it will undertake the assurance of substantial service developments or variations, *"Planning, assuring and delivering service change for patients"*:

   https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

9. The previous iteration of the guidance identified four key tests of service change:
   - Strong public and patient engagement;
   - Consistency with current and prospective need for patient choice;
   - Clear, clinical evidence base;
   - Support for proposals from clinical commissioners.
10. Meeting these four tests remains a requirement and there must be clear and early confidence that a proposal satisfies these. The amended guidance formalises a requirement for proposals to meet a set of additional requirements:
    i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of any bed closures, and that the new workforce will be there to deliver it; and/or
    ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).
11. Of particular relevance to the development of the east Kent proposals, is the increased focus outlined in the revised guidance around capital implications of proposals. In order to get approval from NHS England and NHS Improvement to launch a formal consultation exercise, revenue and capital implications need to be detailed in the pre-consultation business case and there needs to be confidence that these implications are sustainable (i.e. that costs can be met). The guidance emphasises that it is essential that only those options that are sustainable in service, economic and financial terms are offered publicly to consultation. No service change option can be taken forward to public consultation:

- Unless there is a high degree of confidence that it would be capable of being delivered as proposed;
- If it implies an unsustainable level of capital expenditure and/or projected spend profiles that cannot be reconciled to available resources, and the revenue will not be affordable;
- Unless all options are affordable within commissioner revenue allocations and provider revenue financial targets.

12. The guidance also acknowledges that capital resources available to the NHS for transformational change are currently severely constrained and a degree of national phasing/prioritisation will be inevitable at least for the remainder of the current government Spending Review Period. Service change schemes which require capital financing, such as the proposals under development in east Kent, will require the explicit support of NHS England and NHS Improvement in writing and, where appropriate, following discussion with the Department of Health and Social Care before public consultation can commence.
13. To enable the revised requirements relating to assurance around capital intense schemes to be met, the pre-consultation business case will need to set out for all options going to consultation an assessment of capital and revenue affordability for each option which includes:
    - Summary financial statements and supporting financial modelling which shows the impact of each option on commissioners/providers revenue financial position supported by activity, income and cost modelling, which is sufficiently robust for both commissioners and providers to be confident that options would be sustainable;
    - Confirmation of assumptions made in the financial modelling for both commissioners and providers, e.g. commissioner growth in allocations, provider inflation, efficiency savings;
    - Reconciliation of the scheme's financial impacts to the STP financial plan;
    - Credible activity/throughput analysis that translates sustainably to the scale of infrastructure change anticipated;
    - A clear assessment of the financial benefits of the scheme, e.g. provider efficiency savings, system reductions in activity levels and the basis of these calculations;
    - A high-level source and application of capital funds, to demonstrate capital costs and how these are expected to be funded (it should be noted that every effort should be made to generate local capital funding including land disposals or internally generated capital and initial assessments of this should be included);
    - Indicative capital costs recorded using the mandated Department of Health process and recognisable benchmarks and which assume compliance with all applicable design, technical, building and space standards and known site constraints, and key adjacencies should be identified;
    - Indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels;
    - Confirmation of support from all commissioners proposing the scheme and acknowledgement from all providers who will be significantly affected by the scheme that their views on any impact on them have been sought.
14. Through the assurance process, all options requiring capital will be assured prior to consultation by NHS Improvement and NHS England, and, where appropriate, through them the Department of Health and Social Care to ensure for each option that:
    - It would be sustainable in service and revenue and capital affordability terms, with an identified source of capital;
    - The scheme size is proportionate;



- It would be capable of meeting applicable Value for Money (VfM) tests and Return on Investment (ROI) criteria.

15. We are clear that the options being considered in east Kent will require large volumes of capital (e.g. within the definition within the guidance all options under consideration require over £100m or more of capital to be sourced by the NHS, including Option 2 that would require this in addition to the potential gift of the shell of a hospital to NHS). The new guidance indicates these schemes will be required to provide more detail and be subject to higher levels of scrutiny and assurance than previously, prior to going out to consultation. This will include where options require capital above £100m the scheme being considered by the NHS Improvement Resources Committee and requiring a letter of support from the NHS Improvement Chief Finance Officer.
16. In summary, this means prior to being given permission to move to formal public consultation by NHS England and NHS Improvement, we will need to identify in detail the capital and revenue implications of all proposals and identify that these costs are affordable. In addition, the source of capital will need to be identified ahead of proceeding to consultation in order to provide confidence that a proposed option could be delivered. As part of the process around identifying sources of capital, and in-line with the revised guidance, we are seeking advice from NHS Improvement and NHS England (and through them, the Department of Health and Social Care and HM Treasury).
17. Whilst we understand and welcome the need for this additional level of detail and assurance, the key implication for our programme of work in east Kent is that it requires more work ahead of formal public consultation and across a number of potential options.

## South East Coast Clinical Senate Review

18. The NHS England guidance on assurance also identifies, "*Where the clinical case for change is complex, commissioners may require an independent clinical review. For CCG led schemes this would most likely be through the clinical senate, although in some cases (for example, very specialist services) it may be appropriate to obtain a review from another independent source such as a royal society or clinical networks."* Clinical Senate have been established to be a source of independent, strategic advice and guidance to commissioners and more information can be found at:

    www.england.nhs.uk/ourwork/part-rel/cs/

19. In recognition of the complexity of the proposed changes in east Kent we are commissioning an independent review from the South East Coast Clinical Senate and this is built into the programme plan. The outcome of this process will be included within the submission of the pre-consultation business case to NHS England.
20. The Clinical Senate Review will focus on the tests that will be applied through the NHS England assurance process but will not look at the financial aspects of the proposal. Rather the Senate review will focus on ensuring there is a:
    - Clear articulation of patient and quality benefits;
    - The clinical case fits with national best practice;
    - An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.
21. The exact terms of reference for each review will need to be agreed with the Clinical Senate by the CCG Joint Committee but as a minimum will include reviewing the clinical evidence base underpinning proposals so that the review meets NHS England's requirements for the assurance process.
22. The Clinical Senate will establish a team of independent clinical experts to undertake the review. The review team will be formed by professionals with relevant experience of the clinical issues

under consideration (e.g. covering primary care; public health; community and social care; secondary care; and tertiary care).

## Revised programme of work

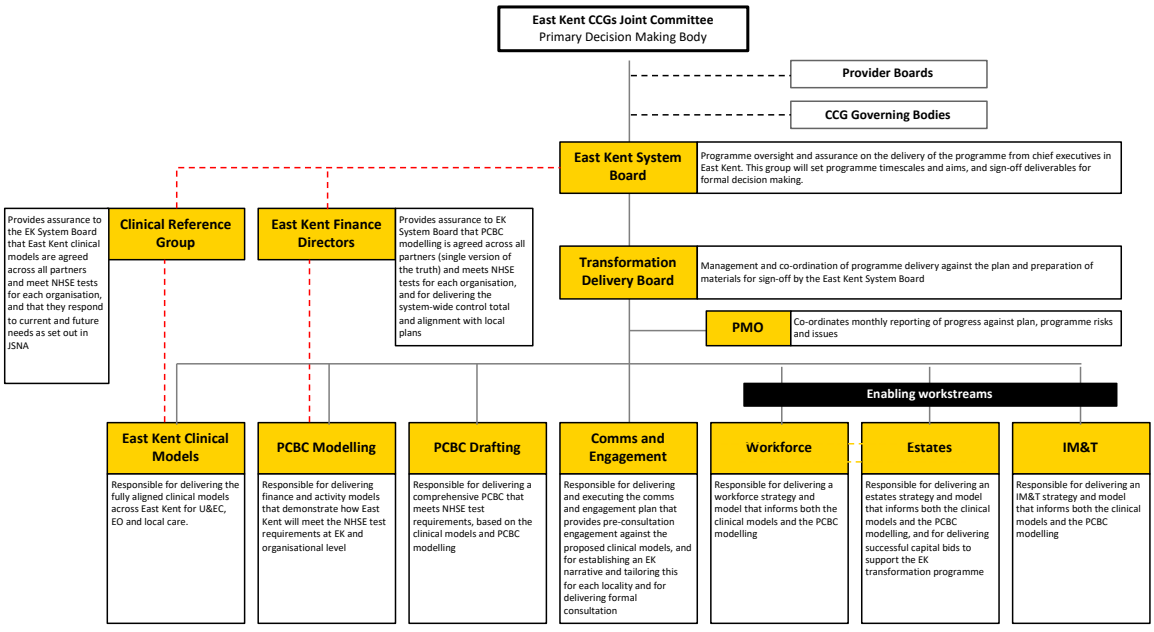
23. We have been undertaking a readiness assessment in order to better understand what more needs to be done to deliver the pre-consultation business case for changes to the way services are delivered in east Kent. This has highlighted a number of areas for further development and strengthening, including:

    - Ensuring that planning discussions are joined up in recognition that that the pre-consultation business case will need to present a system proposal and not be sector or organisationally focused (e.g. in recognition of the revised NHS England planning guidance we cannot just be acute service focused in how we describe and align our plans for change);
    - Ensuring the Case for Change is focused on hospital changes but also needs to reflect the wider changes required, for example in local (out of hospital) care;
    - Reviewing and updating our internal governance arrangements Ensuring that evidence, information and documentation underpinning any proposals is more specific to east Kent;
    - Ensuring that 'whole system' engagement can be described in the pre-consultation business case.

24. These findings have been reviewed, along with the output of the emerging actions in response to these, at the East Kent Systems Board as well as the East Kent Joint Committee of Clinical Commissioning Groups. These finding have been used to inform a revised governance structure and work plan for the programme, the aim of which is to:

    - Strengthen clinical engagement (including clinical leadership and contribution) within the design and delivery of the programme; with the re-establishment of a clinical models group and clinical reference group.
    - Refresh membership across all workstreams to ensure full system representation, engagement and contribution to the work (thinking, planning and delivery), i.e. so that the work is wider than just an acute focus.

25. The outlined new governance structure is shown on the following diagram:



26. The governance structure reports to the East Kent CCGs Joint Committee, which has overall responsibility for the programme of work delegated to it by the four east Kent CCGs. Reporting to this is the East Kent System Board that is a chief executive level group and will have two streams of work reporting to it:

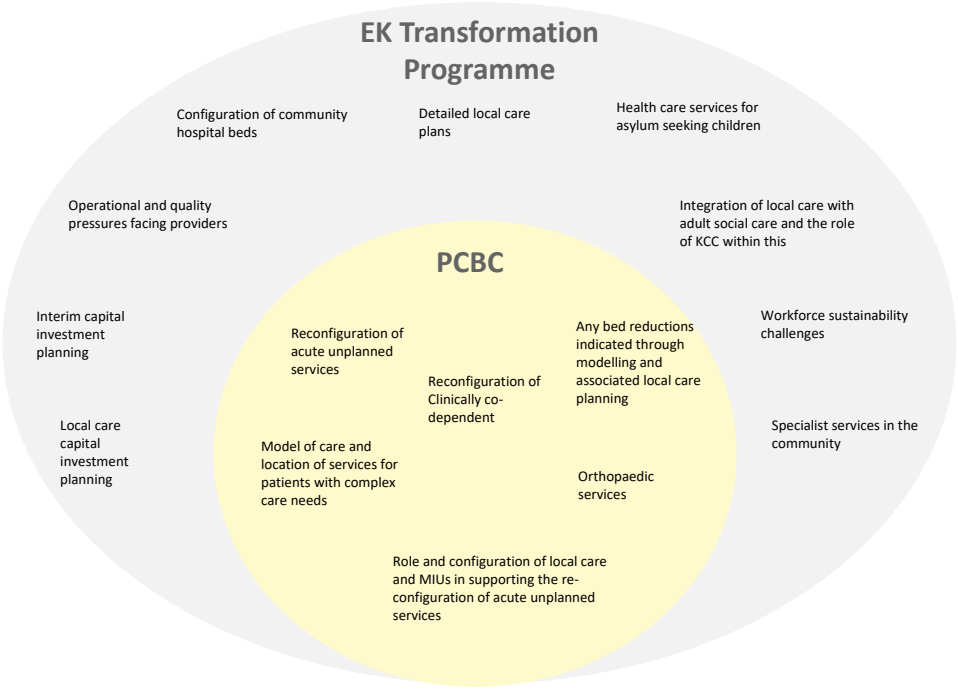
    - the strategic change programme (as outlined in this paper);
    - the shorter-term service improvement work that we have underway to deliver improvements on our immediate activity and financial performance objectives.

27. In recognition of the additional tests associated with the NHS England assurance process, we have been reviewing the scope of the Transformation Programme specifically to confirm what now needs to be additionally covered by the pre-consultation business case. We have therefore reconfirmed the scope of the services for inclusion within the pre-consultation business case as:

    - The reconfiguration of acute unplanned (e.g. emergency) hospital services;
    - Co-dependent clinical services that need to be reconfigured to support the new service model for unplanned care (including more specialist and planned services where there is an interdependency in relation to supporting clinical services or bed base, e.g. orthopaedic services);
    - The model of care and location of services for patients with complex care needs;
    - The role of local (out-of-hospital) care and minor injuries units (MIUs) in supporting the re-configuration of acute unplanned hospital services.

28. The configuration (as opposed to role) of minor injuries units and community hospital beds is currently out-of-scope for the East Kent Transformation Programme.

29. A distinction is being made between the scope of the programme as outlined above that will require consultation, and therefore included within the pre-consultation business case, and the services that are part of the wider transformation programme and subject to ongoing development and refinement but do not necessarily equate to substantial variation. This is shown in the following diagram:



## Revised service models and options under consideration

30. Local care is a new model of delivery of integrated health and care services, delivered close to where people live. It will be developed through a collective commitment of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well. This involves redesigning health and care services specifically around the needs of local populations, whether for an older person, someone with complicated health problems, a busy parent or carer with young children or others who need support, or a vulnerable young person.

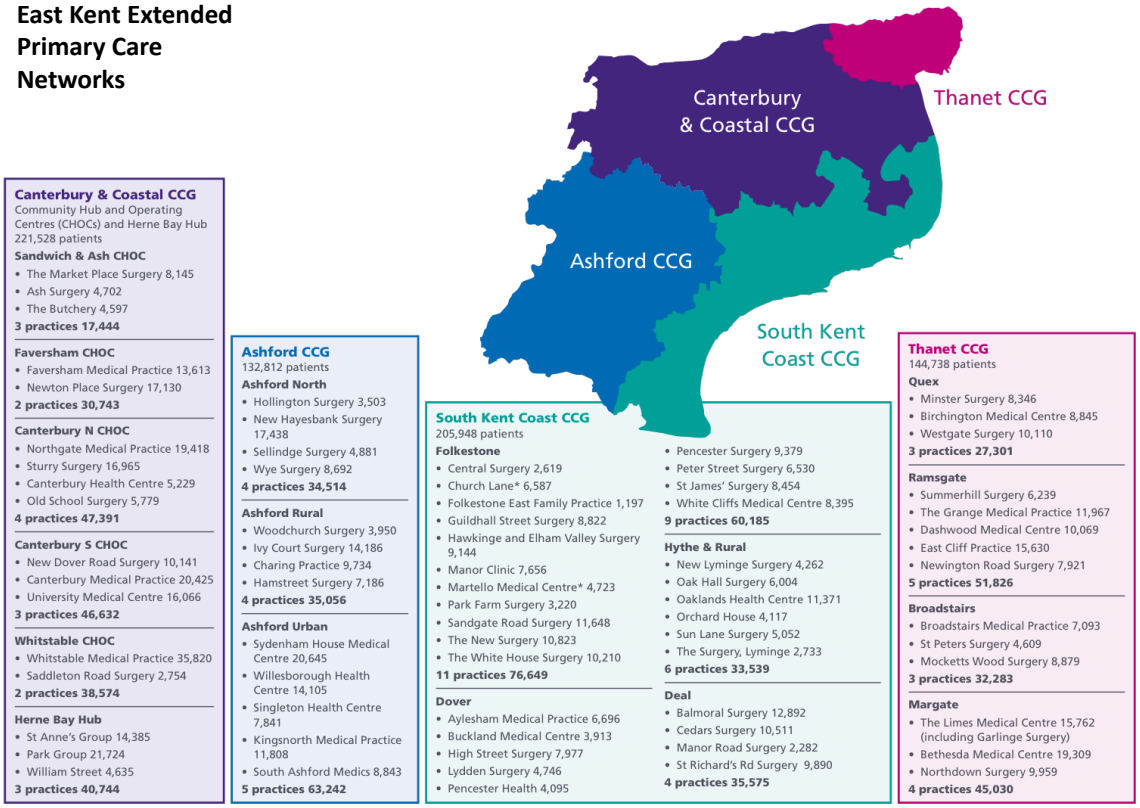
31. In 2018/19 the focus is to develop integrated teams, around GP practices working at scale for populations of 30-50,000. Generically for planning purposes these are being termed extended primary care networks (previously known as community hub operating centres (CHOCs), primary care homes (PCHs), hubs, localities). These networks will work in an integrated way with and across all local stakeholders to support the local population.

32. The extended primary care network will:

- Support the long-term provision of primary care services including practices working together as federations (virtually and/or physically) and through this provide more specialist clinics in their surgeries, reducing the need for patients to go to hospital, and provide easier access to services that patients can contact from their home, or via their GP to provide an alternative to what would otherwise be an A&E attendance;
- Provide joined-up care, from an entire team of health and care experts, so patients can see the right professional first time, enabling the delivery of coordinated and integrated health and social care services so that they provide care around a centrally held care plan in an efficient and holistic way;
- Use integrated case management for frail patients to ensure proactive support that can respond to patients needs in a timely manner;
- Work with local hospitals to ensure patients are only admitted when necessary and are able to return home as quickly as possible with the right support;
- Make best use of technology, develop new roles with different skills, and share specialist skills across their area;
- Collaborate to offer more appointments, opening some surgeries until 8pm Monday to Friday and having some slots at weekends too;
- Work with community and voluntary groups, social care and district and borough councils to develop support for people's wellbeing, helping them to look after their own health and develop stronger communities;
- Make a really strong case for improved facilities where the population can get modern care in a modern setting;
- Educate and facilitate the population in monitoring and improving their own health and promote self-care, as well as engaging with patients and provide the education and basic skills needed to allow them to manage and provide their own care;
- Provide the short-term level of care needed immediately upon discharge to allow a patient to live independently in their place of residence;
- Position mental health staff consistently in all care settings to support and direct care for patients with mental health issues and prevent mental health issues developing especially among those with long-term physical health conditions.

33. The following map details the current proposed extended primary care networks in east Kent (these have been referred to under a range of different names including clusters, primary care homes, community hub operating centres (CHOCs), hubs or localities):

**East Kent Extended Primary Care Networks**




34. The majority of care delivered by the NHS is provided outside the acute hospital setting. It is estimated that currently 90 per cent of contacts with the NHS is within primary and community care such as GP services, community nursing and therapy services (such as physiotherapy). However, when an individual needs more specialised acute care we want to deliver the best and most effective care possible, that consistently meets national quality standards . The acute hospitals in east Kent generally provide good care but this isn't the case for everyone all of the time as outlined in the case for change documents. There is a recognition that an unacceptable number of people have:

    - To wait too long to be seen in an emergency;
    - Their planned operations cancelled;
    - To come to hospital for treatment or advice that could be provided closer to home or at home;
    - To stay longer in hospital than is best for them because other services are not available;
    - Experienced a variable quality of care depending on where and at what time they are seen.

35. As part of delivering good acute hospital care we believe:

    - For acutely unwell patients this means consultant-led and delivered services which will give people the best treatment and chance of recovery if they are taken seriously ill or have a catastrophic injury;
    - For patients who need a routine operation this means excellent, accessible and predictable services which take place on time, all year round, enabling people to get back to normal life sooner;

- We could make routine appointments, tests and screening services more readily available, using technology to bring services closer to where people live.

36. For patients this means the individual:
    - Will only come to hospital if that is the best place for them;
    - Will access highly specialist care when it's needed;
    - Will be treated sooner – with shorter waits for planned surgery;
    - Will spend less time in hospital as they will be seen and treated by a specialist team;
    - Will get home sooner with the right support to continue their recovery.
37. We are proposing to create a specialist hospital in east Kent (a major emergency centre, where all the specialist services, including for the most serious emergencies, are based on one site). The options currently under consideration are:

| **Potential Option 1** | **Potential Option 2** |
|---|---|
| This option involves an estimated £170million NHS investment, which is under review, to enable three vibrant hospitals, including:<br>• A much bigger, modern, A&E (a major emergency centre) at William Harvey Hospital, Ashford, which would also provide services for people that need highly specialist care (such as trauma, stroke, vascular and specialist heart services) in east Kent;<br>• An expanded, modern A&E (an emergency centre) at Queen Elizabeth the Queen Mother Hospital (QEQM), Margate, with inpatient care for people who are acutely unwell, emergency and day surgery, maternity and geriatric care;<br>• Investment in beds and services at Kent and Canterbury Hospital which would have a 24/7 GP-led Urgent Treatment Centre, and services including diagnostics (such as X-ray and CT scans), day surgery, outpatient services and rehabilitation.<br>Under potential option 1, current estimates[1] suggest that 97 in every 100 hospital visits (more than 1.2million) for advice and treatment would see patients continue to go to the same hospital as they do now. In the future.<br>All three hospitals would continue to be vibrant sites, where patients would continue to get | This potential option involves an estimated £250million NHS investment, which is under review and in addition to the shell of a hospital being made available to the NHS, to develop:<br>• a new hospital at the Kent and Canterbury Hospital and refurbishment of some of the current hospital buildings, which would provide a single 24/7 A&E and all specialist services (such as trauma, vascular and specialist heart services) for the whole of east Kent;<br>• 24/7 GP-led Urgent Treatment Centres at both the William Harvey and QEQM hospitals, as well as diagnostics (such as X-ray and CT scans), day surgery, outpatient services and rehabilitation.<br>Option 2 has been included because a private developer has offered to donate to the NHS land and the shell of a new hospital in Canterbury, as part of a development of 2,000 new homes, which includes an access road from the A2. It would be subject to planning permission.<br>Under this option, current estimates[2] suggest that approximately 65 in every 100 hospital visits for advice and treatment (65 per cent / over 855,000) would see patients |

[1] Based on modelling of 2016-17 hospital activity,

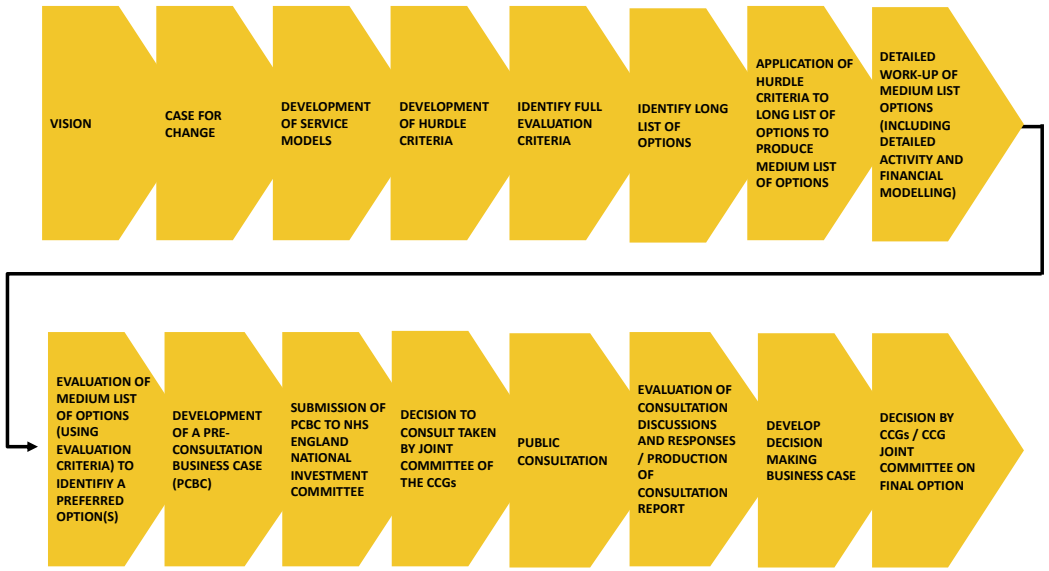
[2] Based on modelling of 2016-17 hospital activity

| | |
|---|---|
| most of their care locally, with a small proportion of patients travelling to a different hospital for the most specialist care (i.e. the sort of care that most of us don't need routinely). | continue to go to the same hospital as they do now. In the future. |

38. The creation of a specialist hospital (as a major emergency centre for east Kent) is proposed because evidence shows that you are more likely to survive and recover well if you are treated by a highly specialist team, available 24/7, who see and treat sufficient patients to keep up their skills. This already happens for many services for seriously ill patients:
    - If you are really badly injured (a trauma patient) or have the most serious kind of heart attack you would already now be taken straight to the William Harvey Hospital in Ashford;
    - If you need treatment for gynaecological (women's) cancer you would have this now at the QEQM;
    - If your child is born prematurely they will be cared for now at the William Harvey Hospital, or if they need a complex operation would be treated in London;
    - If you need treatment in hospital for kidney disease or blood disorders, this would currently be undertaken at the Kent and Canterbury hospital.
39. By combining specialist services into one hospital, we can improve care by giving patients the highly specialist treatment they need, more quickly, from a single expert team available 24/7, whose expertise is built up by seeing lots of patients with the same condition, instead of stretching specialist services across multiple hospitals.
40. Evidence shows that being treated by a specialist team, who are experts in their field who see and treat a high volume of similar conditions, is more important for a better outcome and recovery than the travel time to the hospital itself.

**Programme Plan**

41. The process we are following has been developed based on the learning from other areas on how to deliver NHS service reconfigurations. This is summarised in the following diagram:



42. Our process for change has reached the 'medium list' stage and detailed evaluation and development of the pre-consultation business case is now taking place to meet the requirements of the new NHS England assurance process. In summary:

- We started with a detailed assessment of clinical standards for each service to identify which services needed improving first – these were urgent and emergency care (including acute medicine) and planned orthopaedic services;
- We then considered in detail how services could change, identifying the best models of care that would improve standards;
- Then, we worked to design and agree a set of questions and criteria (hurdle criteria) against which we could assess many possible options for where services could be organised;
- We tested these questions and criteria with clinicians, health and care partners, patients, carers and the public earlier this year;
- They helped us refine the questions and criteria and told us how important they felt each of them to be in assessing the options available to us;
- This process resulted in one potential option for where future urgent, emergency and specialist hospital services could be located;
- An additional potential option has been added at the medium list stage as a developer offered to donate to the NHS the shell of a hospital connected to the Kent and Canterbury Hospital.

43. As outlined in the section of this paper on the NHS England assurance process, a key component of the work focuses on refining the capital requirements and building the case that this is an accurate reflection of the required investment and that east Kent is the priority for this investment. A key component of this is to understand how demand on services changes. The approach being adopted is outlined in the following diagram:


44. The above outlines the approach we are adopting. Namely, we identify current demand for services and:

i. Project how this increases over time based not only on demographic growth but also in relation to non-demographic growth, e.g. to take account of the planned increase in the number of houses in east Kent (changes in health technology and prevention are also considered where these are likely to have an impact on demand for healthcare services);

ii. Through considering the planned service models in relation to the development of both local and acute services, future demand is then re-apportioned to the appropriate settings of care;

iii. By understanding the future demand on services by setting of care, within the context of the revised service models, it is then possible to model the required estates and workforce;

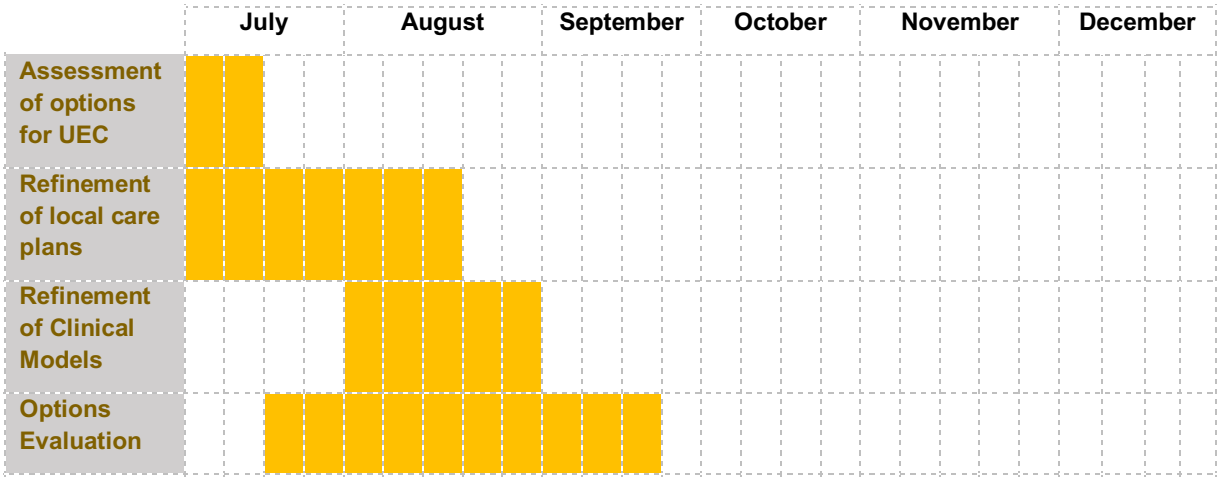
iv. Through understanding the estates and workforce requirements, along with a range of other costs, it is possible to develop the financial model (this needs to be considered from both a commissioner and provider perspective, i.e. to ensure providers are able to deliver the services within the funding available to them through the contracts they enter into and that the commissioners are able to afford the services within the allocations they receive from NHS England).

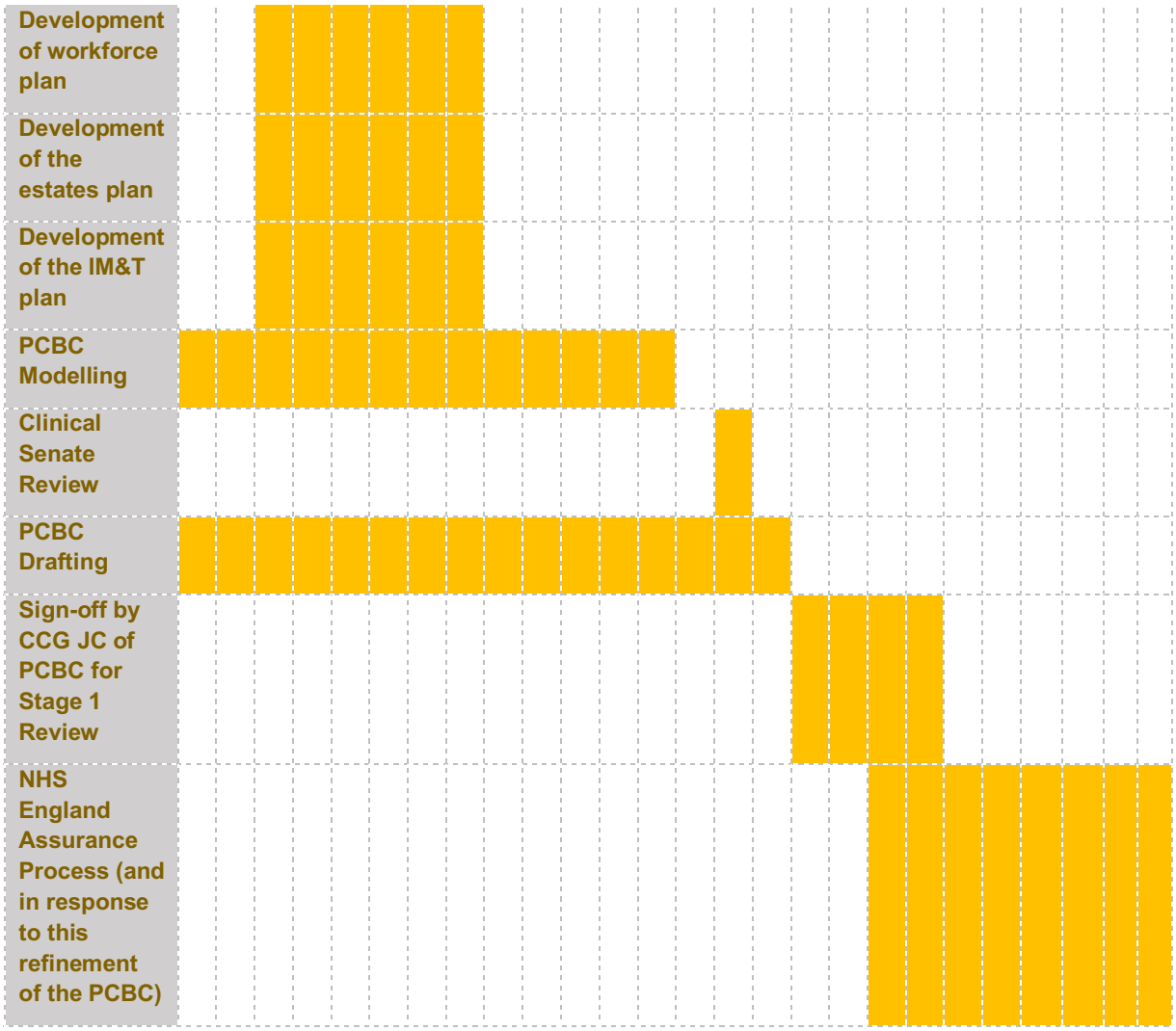
45. Detailed modelling in line with the above is in progress, this includes assessing the two current potential options before we decide what to consult on formally.

46. The key inputs and deliverables we are focusing on in order to establish the pre-consultation business case cover:

- Refinement of urgent and emergency care options;
- Refinement of local care plans;
- Refinement of clinical models;
- Options evaluation;
- Development of the workforce plan;
- Development of the estates plan;
- Development of the digital plan;
- Business case modelling;
- Draft of the pre-consultation business case (bringing together the component parts into the business case document).

47. The above items are outlined on the high-level programme plan detailed below:






48. The above anticipates the submission of the draft pre-consultation business case to NHS England, for it to be taken through the assurance process detailed earlier in this document, in the autumn of this year. Engagement with stakeholders and the HOSC will be an ongoing process but we would look to formally consult and present the pre-consultation business case to the HOSC once it has been through the NHS England assurance process.

49. We have a detailed communications and engagement plan that sits alongside this programme of work. There has, to date, been a significant amount of engagement and involvement of stakeholders, staff, patients, carers and local communities in the:

    - Case for change;
    - Development of evaluation criteria for assessing potential options;
    - Early thinking around the 'model of care' that would see the development of a major emergency centre for east Kent, alongside enhanced local care delivered in local communities and closer to people's homes.

50. There is more work to be done as we start to develop more granular detail on the model of care and potential options that would deliver it, and our communications and engagement work will continue alongside this. We are keen to work with our local communities to find solutions together to the challenges we face in delivering high quality, sustainable services for the long-term. This work will continue ahead of formal public consultation on our shortlisted proposals.

51. We would like to present to the HOSC at its next meeting an assessment of in-flows to East Kent University Hospitals NHS Foundation Trust in relation to the impacted services (e.g. an assessment of patients from CCGs other than the four in east Kent who use the trusts services). The majority of these patients will be from other parts of Kent. However, some patients will be from areas covered by other local authority areas, e.g. Medway Unitary Authority whose patients use the William Harvey Hospital for some coronary care and East Sussex County Council where some of their population look to the same hospital for their acute care. We would also look to present this information to the HOSCs covering these other areas. This will allow the committees in the other areas to form a view on the materiality of potential changes in relation to their populations and whether there is a case to form a joint committee.

**Summary**

52. The HOSC is:

- asked to discuss and note the contents of this report; and
- we also request that the HOSC receives a paper at its next meeting detailing the number of patients from other council areas that look to East Kent University Hospitals NHS Foundation Trust to provide acute care.