KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Friday, 12th October, 2018

10.30 am

Darent Room, Sessions House, County Hall, Maidstone

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Friday, 12th October, 2018, at 10.30 am
Darent Room, Sessions House, County Hall, Maidstone

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

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

Membership

Kent County Council	Mr P Bartlett, Mrs S Chandler, Mr D Daley and Mr K Pugh
Medway Council	Cllr T Murray, Cllr W Purdy, Cllr D Royle and Cllr D Wildey

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Membership Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee are asked to note the membership listed above.	
2.	Election of Chair	
3.	Election of Vice-Chair	
4.	Declarations of Interests by Members in items on the Agenda for this meeting	
5.	Minutes (Pages 5 - 10)	
6.	Kent and Medway Specialist Vascular Services Review (Pages 11 - 26)	10:35

7. Assistive Reproductive Technologies (ART) Policy Review (Pages 27 - 38) 11:30

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

4 October 2018

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

KENT COUNTY COUNCIL

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 Council Chamber - Sessions House on Monday, 22 January 2018.

PRESENT: Cllr W Purdy (Chair), Mrs S Chandler (Vice-Chairman), Cllr T Murray, Cllr D Royle, Cllr D Wildey, Mr M J Angell, Mr P Bartlett, Mr D S Daley and Mr K Pugh

ALSO PRESENT: Cllr J Hunt and Cllr C Belsey

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer) and Mr J Pitt (Democratic Services Officer, Medway Council)

UNRESTRICTED ITEMS

31. Membership

The Chair informed Members that Mr Bartlett had replaced Mr Whiting as a member of the Committee.

32. Minutes

(Item 3)

RESOLVED that the Minutes of the meeting held on 12 December 2017 are correctly recorded and that they be signed by the Chair.

33. Kent and Medway Hyper Acute and Acute Stroke Services Review

(Item 4)

Michael Ridgwell (Programme Director, Kent and Medway STP), Patricia Davies (Accountable Officer, NHS Dartford Gravesham and Swanley CCG and NHS Swale CCG and Senior Responsible Officer, Kent & Medway Stroke Review), Steph Hood (STP Communications and Engagement Lead, Kent & Medway STP),Dr Mike Gill (Chair, Joint CCG Committee), Cllr Belsey (Chair, Health Overview & Scrutiny Committee, East Sussex County Council) and Cllr Hunt (Chair, People Overview and Scrutiny Committee , Bexley Council) were in attendance.

(1) The Chair welcomed the guests to the Committee including Councillor Belsey from East Sussex County Council and Councillor Hunt from Bexley Council who had been invited to participate in the meeting prior to the establishment of the new JHOSC. Following a request from the Joint CCG Committee, the Chair noted that she had agreed for the report regarding the proposed options and consultation plan to be considered as an urgent item. She stated that it was considered urgent as it was not available at the time of publication and the Committee had requested to have the opportunity to consider and comment on

the proposed options and consultation plan prior to the start of the public consultation.

(2) Ms Davies began by introducing the NHS guests. She highlighted the aim of the clinicians, stakeholders and stroke survivors involved in the review to implement hyper acute stroke services in Kent and Medway which would bring a significant and positive impact for the residents within Kent and Medway, as well as the wider population. She stated that she sought the Committee's support to move forward with the review.

(3) Dr Gill advised the Committee that the current model, with stroke services, being provided on six out of the seven acute hospital sites in Kent & Medway, was unsustainable. He noted that the sites were not consistently meeting national quality standards, did not provide 24/7 access and did not have the workforce to deliver best practice through hyper acute stroke units. He highlighted the role of clinicians in the review; in order to meet the national standards, it was proposed that stroke services would be consolidated onto three sites.

(4) Ms Davies reported that under the current model 24/7 access to onsite consultants, brain scans and clot busting drugs were not consistently available. She noted that a combined hyper acute stroke unit and acute stroke unit was proposed, the first 72 hours of inpatient care would be on the hyper acute unit with follow up care being provided on the same site in an acute stroke unit. She stated that there would be a range of benefits of consolidating stroke services including reduction in morbidity and mortality and fewer people living with long-term disability following a stroke. She assured the Committee that the whole pathway was being reviewed including prevention and rehabilitation.

(5) With regards to governance, Ms Davies explained that the process had been overseen by the Stroke Programme Board for the past three years which included CCGs, providers, stroke survivors and the Stroke Association. She noted that Professor Tony Rudd who was the national lead for stroke had provided advice and scrutiny to the Stroke Clinical Reference Group to ensure the proposals were in line with national best practice. She stated that the Kent & Medway Stroke Review Joint Committee of CCGs had been established; it was made up of 10 CCGs including the 8 Kent & Medway CCGs, Bexley CCG and High Weald Lewes and Haven CCG. She noted that Bexley was the main CCG area to be affected by the potential changes from the South London area. She highlighted that the first formal meeting of the Joint Committee would be held on 31 January 2018. She reported that decisions about the location of stroke services will not be taken at this meeting; the decision will be taken in early September after formal public consultation, once all the feedback and evidence had been considered.

(6) Mr Ridgwell informed the Committee that an Integrated Impact Assessment (IIA) had been undertaken by Mott MacDonald and would be taken to the Joint CCG Committee. The IIA looked at the impact of the proposals on the population and had concluded that whilst there would be a significant benefit in terms of health, there was a detriment in terms of access. A number of groups had been identified who may have a disproportionate need for stroke services

including the elderly, disabled and people from BAME. Mr Ridgwell noted that mitigations were being developed to address the findings from the IIA.

(7) Ms Hood noted that the public consultation was expected to launch on 1 February 2018 and would run for a ten-week period. During this time a range of activities would be undertaken including two listening events in each CCG area, focus groups, telephone surveys particularly with the affected populations identified in the IIA, one-to-one stakeholder engagement, digital and social media campaigns.

(8) Members commented about ambulance travel times, the inclusion of neighbouring hospitals on the map in the consultation document and the centralisation of services. Ms Davies informed the Committee that, in all five options, 98% of the population would be within 60 minutes of a stroke site by ambulance. She noted that travel times had been calculated using the Isochrone system which had been cross-referenced with data from sat navs to generate travel times from different points. She explained that SECAmb had been integral to the review. She reported that Dr Fionna Moore (Medical Director, South East Coast Ambulance NHS Foundation Trust) was confident that the reconfiguration of the service would lead to a clearer pathway which enable the Trust to improve their response and achieve the hyper acute stroke standards. Ms Hood welcomed the comment made about the maps; she stated that she would provide feedback to the design team. Dr Gill reminded the Committee that the hyper acute stroke unit would provide specialist care beyond the clot busting treatment and whilst it was important to acknowledge risks around travel times, evidence showed that centralised services reduced morbidity and mortality rates.

(9) Members sought clarification around the weighting given to each criteria, public health messaging and election purdah. Ms Davies explained that feedback from the majority of stroke survivors revealed that they were more interested in going to a specialist centre rather than their local hospital. Ms Hood noted that in the draft public consultation document, participants would be able to give feedback on the assessment criteria. She reminded the Committee that the consultation process was not a vote or referendum. She explained that the Joint CCG Committee had a duty to take into account all feedback including clinical evidence, financial information and public consultation feedback. She stated that they were looking to align the consultation with the re-run of the FAST campaign. Ms Hood noted that legal advice regarding the local election in Bexley stated that the consultation period could continue as long as Bexley Council was content to respond to the consultation prior to the start of purdah.

(10) A Member enquired about the impact of the stroke review on the reconfiguration of acute services in East Kent. Mr Ridgwell stated that the Kent HOSC was due to receive an update on Transforming Health and Care in East Kent on 26 January. He explained that two options, as part of the East Kent transformation, were being considered; one would focus emergency services at Queen Elizabeth The Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH); the other was to build a new hospital at Kent & Canterbury Hospital which would have implications on the other two hospitals. He explained that WHH was included in all options due to patient volumes, workforce availability and the colocation of other specialist services on the site.

He explained that if specialist services at WHH were to move because of the acute reconfiguration in East Kent, stroke services on the site would be reviewed.

(11) In response to a question about £40 million investment and workforce, Mr Ridgwell confirmed that a large proportion of the £40m investment would be spent on capital. He stressed that the stroke review was not about saving money; an investment was required to improve the quality of services. He noted that NHS England had requested that capital funding was secured before the launch of the consultation. He noted that the Joint CCG Committee would consider the implications of potential patient flow to neighbouring areas. Ms Davies advised the Committee that the Clinical Reference Group was working closely with providers to engage existing staff, support transfers as well as recruiting to new posts. Mr Ridgwell stated that by optimally configuring services, it would improve the ability to recruit.

(12) A Member commented about the inclusion of populations from Bexley and East Sussex, the variation of capital investment required for each option and the implementation period. Ms Davies explained that the long list of options included a number of options, which were rejected, as they would have involved large volumes of patients being treated outside of Kent & Medway and would have negatively impacted on services in London particularly at the Princess Royal University Hospital. Mr Ridgwell stated the importance of looking at the totality of population which had resulted in notifying the health scrutiny committees in Bexley and East Sussex in October 2017 who had subsequently determined the proposals to be significant for their local areas. He noted that similar conversations had taken place with Bexley and High Weald Lewes and Haven CCGs in March 2017 who also believed the proposals to be significant for their populations. Mr Ridgwell noted that variation in capital spending was due to the type of building work required to deliver quality care which ranged from refurbishment to new infrastructure. Ms Hood reported that self-assessments carried out by each provider trust indicated that the implementation would be phased and take between 12 – 18 months.

(13) Members asked about the consultation document, evaluation criteria and rehabilitation. Ms Hood confirmed that the consultation document and survey would be available on the website; hard copies of the questionnaire would also be available with the provision of a freepost address. Ms Davies commented that the all five options scored highly in quality, access and workforce criteria. Ms Davies assured Members that whilst the review was strongly focused on acute stroke care, work was being undertaken on stroke prevention and rehabilitation. She noted that a working group, chaired by Tara Galloway (Head of Stroke Support, Stroke Association), was looking at stroke rehabilitation in order to identify the gaps and ensure patients would be offered rehabilitation as close to their homes as possible.

(14) The Chair invited Cllr Hunt and Cllr Belsey to comment. Cllr Hunt stated that Bexley Council's Monitoring Officer had advised that its purdah period had no impact on the planned consultation. He expressed concerns about the potential removal of services from Darent Valley Hospital and impact on Princess Royal University Hospital. He commented about the reach of the public consultation to residents in Bexley, the consideration of the public

consultation document by the Committee in a private briefing and increasing the number of sites to four. Ms Hood explained that the target audience was across the 10 CCG areas. She reported that the consultation document was still in draft form and required checks for accuracy before final publication; she noted that the five options were already in the public domain. Mr Ridgwell clarified that the options that presented a higher risk of outward patient flow were removed as part of the options appraisal; modelling was based on access to the nearest hyper acute stroke unit. Dr Gill stated that a four-site model would not be sustainable as it would not meet minimum patient volumes.

(15) Cllr Belsey requested that neighbouring authorities were notified about future meeting dates in good time which Mr Ridgwell agreed to.

(16) RESOLVED that the NHS be requested to take note of comments made by Members about the proposed options and consultation plan.

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Item 6: Kent and Medway Specialist Vascular Services Review

By: Lizzy Adam, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 12 October 2018

Subject: Kent and Medway Specialist Vascular Services Review

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

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

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1. Introduction

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

(2) On 11 August 2015 the Medway Health and Adult Social Care Overview and Scrutiny Committee considered the Kent and Medway Specialist Vascular Services Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *The Committee agreed that the reconfiguration of vascular services constituted a substantial variation and noted the arrangements in place for Kent Health Scrutiny Committee to be consulted which may necessitate the need for a Joint Health Scrutiny Committee to be established.*

(3) On 17 July and 9 October 2015 the Kent Health Overview and Scrutiny Committee considered the Kent and Medway Specialist Vascular Services Review. The Committee's deliberations on 9 October resulted in agreeing the following recommendation:

- *RESOLVED that:*

  (a) the Committee deems the proposals to be a substantial variation of service.

  (b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

(4) Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 states that where relevant NHS bodies and health service consults more than one local authority on any 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 and only 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.

(5) The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. A decision on whether to make a report to the Secretary of State would be a matter for the Kent County Council Health Overview and Scrutiny Committee and/or the Medway Council Health and Adult Social Care Overview and Scrutiny Committee to make rather than the JHOSC.

(6) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was therefore convened and has met on 8 January, 29 April, 4 August, 28 November 2016 and 12 December 2017 for the purpose of the consultation on the Kent and Medway Specialist Vascular Services Review. On 12 December 2017 the Committee's deliberations resulted in the following recommendation:

- *RESOLVED that the Vascular Review Programme Board be requested:*

  (a) to note the comments about recruitment, local care, consultation and the financial position;

  (b) to present the final model and key recommendations to the Committee prior to approval by NHS England Specialist Commissioning.

2. Legal Implications

(1) 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.

3. Financial Implications

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

4. Recommendation

The JHOSC is invited to:

- CONSIDER and COMMENT on the report;
- REFER any relevant comments relating to the interim option to NHS England Specialised Commissioning.

Background Documents

Kent County Council (2015) *'Health Overview and Scrutiny Committee (17/07/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5841&Ver=4

Kent County Council (2015) *'Health Overview and Scrutiny Committee (04/09/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=32939

Medway Council (2015) '*Health and Adult Social Care Overview and Scrutiny Committee (11/08/2015)*', http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=3255&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (08/01/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6314&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (29/04/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=6357&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (04/08/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=7405&Ver=4

Kent County Council (2016) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (28/11/2016)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=42591

Kent County Council (2017) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (12/12/2017)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=46700

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Kent and Medway Vascular Services Review
JHOSC Briefing October 2018

Paper presented to:	Kent and Medway Joint Health Overview and Scrutiny Committee
Paper subject:	Update report; Kent and Medway Vascular services Review.
Date:	12.10.18
Prepared by:	Oena Windibank Programme Director K&M Vascular Review Michael Ridgwell, K&M STP Programme Director
Senior Responsible Officer:	James Thallon; Medical Director NHS England South East
Purpose of Paper:	To update the JHOSC on the K&M Vascular review process and the interim option appraisal

Executive Summary

This briefing is to advise the Kent and Medway Joint Overview and Scrutiny Committee (JHOSC) of progress of the K&M Vascular review and to seek a view on the recommendation noted.

Specialist Vascular care is provided within Kent and Medway by two acute Trusts (East Kent Hospitals Foundation NHS Trust (EKHUFT) and Medway Foundation NHS Trust (MFT)). Neither of these Trusts are currently fulfilling either the requirements of the national specification for this service or the guidance from the Vascular Society. They predominantly serve patients from the east of the county with Guys and St. Thomas' hospitals (GSTTH) in London receiving patients from the west and north of Kent. GSTTH is fully compliant with the national specification and with the Vascular Society guidance.

NHSE commissioned a review of the service within Kent late 2014 to make recommendations for resolving the non-compliance and ensuring a safe, high quality sustainable service for Kent and Medway residents going forward.

A case for change was developed and agreed and an options appraisal process undertaken and a joint overview and scrutiny committee established between Kent County Council and Medway Unitary Authority early 2015 to oversee and review the process.

There has been a range of public engagement events throughout the review informing both the case for change, the options appraisal and the model of care. A clinical reference group has underpinned the review with members of both EKHUF and MFT, with representation from GSTTH and other acute hospitals in Kent. The reference group also includes external clinical advice from an external interventional radiologist and a vascular surgeon (representing the Vascular Society).

The review process has identified a clinical model, based on best practice, of a single in-patient arterial centre in Kent and Medway supported by a number of spokes and one of those to be an enhanced spoke unit. The proposal as agreed by both Trusts and clinicians is for the arterial centre to be in east Kent. The current patient flows into GSTHH from the west and north of the county will not be impacted by this decision unless it is patient choice to receive their care in Kent and Medway (it is anticipated that a centre of excellence within Kent and Medway will encourage more patients to attend this service).

Both Trusts have formed a network (as per Vascular Society recommendations) and have developed a business case for the development of this model. This will include detailed

pathway modeling, transitional arrangements and the final site configuration recommendations.

In May 2018 the K&M vascular network identified concerns and raised these with the review Programme Advisory Board (PAB). These concerns focused on the interim period until the final decision is approved and the service established. Namely, the East Kent Transformation Programme is likely to take five to seven years to implement and a final solution for vascular, if in east Kent, will need to align to the timeline. It was questioned whether it was appropriate to wait for this period of time before making changes to vascular services or whether an interim solution was required.

The network was unable to reach a consensus on the interim model and arrangements and requested that a commissioner decision was made with regard to both the need and site of any interim arrangement. Therefore, in July/August 2018, the PAB undertook an options appraisal process which included a self assessment from both Trusts and a review of the findings form the review processes to date.

A panel from NHSE specialised commissioning, the review SRO, the K&M STP and external clinical advice have made a recommendation for consideration by NHSE specialised commissioning based on the available information. This recommendation will be considered by Specialised Commissioning South who will undertake the necessary due diligence between now and the end of November 2018 in order to reach an 'in principle' decision. If approved, this will require the development of a detailed business case following completion of key lines of enquiry that will then require approval via organisational governance processes.

The recommendation to specialised commissioning at this stage is that:

- Due to the likely timeline for a final solution being a minimum of 5 to 10 years the panel assessed it is unacceptable for no interim arrangements to be put in place to stabilise both the service and deliver improved outcomes for K&M patients.
- This recommendation is supported by the Getting it Right First Time (GIRFT) review of both services in 2018 with an ongoing requirement to make improvements now and the recent CQC findings at EKHUFT that strategic changes should not delay improvements being made to service delivery.
- Therefore a recommendation is made to put an interim solution in place.
- The panel assessed the available information and determined that East Kent provided the most suitable interim option for the inpatient Arterial Centre supported by an enhanced spoke at Medway.
- If agreed 'in principle' key lines of enquiry will be identified that will inform a business case, clearly evidencing the requirements to deliver against this recommendation

The following are of note:

- This business case for both the final solution of a single arterial centre and for the proposed interim solution will require approval by NHSE specialised commissioning.
- Specialised Commissioning South will consider the recommendation for the interim solution with a timeline for an 'in principal' decision by the first week of December 2018.
- If this direction of travel is approved public consultation is anticipated as the interim solution will be in place for a number of years and is likely to be a significant service change. The interim and final changes will impact of circa 200 patients per year regardless of the site approved.
- The JHOSC had been appraised and consulted on the process to this point
- The K&M Vascular network has a clinical forum established and the development of this interim model will be led through this group.

Current position

1. The Kent and Medway Vascular Review commenced in December 2014 in response to a commissioner led derogation[1] for both Trusts providing vascular surgery within Kent and Medway (East Kent Hospitals University NHS Foundation Trust (EKHUFT) at the Kent and Canterbury Hospital (K&CH) and Medway Foundation NHS Trust (MFT)). This review was led through establishment of a programme approach under the governance of a multi-stakeholder Kent and Medway Vascular Programme Advisory Board (PAB).

2. There are approximately 900 patients per year who receive inpatient specialist vascular surgery and on average 530 of those are treated within Kent and Medway. This is split across EKHUFT and MFT, with EKHUFT seeing more patients as the Trust is the provider of the AAA (abdominal aortic aneurysm) screening programme and hence planned AAA repairs are currently undertaken within the Kent and Canterbury Hospital site in Canterbury for patients from all parts of Kent and Medway. In addition to the specialist vascular services delivered by EKHUFT and MFT, a proportion of patients from the north and west of the county travel into South London to Guys and St. Thomas' Hospitals Trust for their surgery. This accounts for around 30% of the total activity.

3. The review identified a number of issues and developed a clear case for change which has been agreed by the PAB membership and presented to the Joint Overview and Scrutiny Committee (JHOSC). The case for change identified the inability of the two Kent and Medway Specialist Vascular provider Trusts, East Kent Hospital Foundation Trust (EKHUFT) and Medway Foundation Trust (MFT) to deliver against either the national specification for specialist vascular services or the guidelines from the national Vascular society for Great Britain and Ireland. The assessment illustrated that workforce is a key limiting factor for both trusts alongside the population numbers to deliver the required activity volumes for the core index procedures. There is a clear recognition that the sustainability of the services and improvement of patient outcomes is severely limited by these and other key issues.

4. Key gaps in compliance identified include;

    - The lack of a vascular network across Kent and Medway.
    - The number of people served by both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) is below the 800,000 minimum which is recommended by the Vascular Society.
    - That the total number of some of the core index procedures undertaken is either borderline or below the recommended numbers within both Trusts.
    - The number of consultants is currently lower than required and the sustainability of consultant led 24/7 vascular and interventional radiology (IR) rotas (as required) is challenging. Indeed at the current time there is no guarantee that a patient with an emergency presentation will see a consultant with the requisite skills.

[1] NHS England has committed to ensure all patients requiring treatment from a specialised service have access to the same standard of service and the same clinical policy wherever they live. This approach was subject to consultation in later 2012 / early 2013. Detailed service specifications for specialised services, including vascular, were developed and these detail what NHS E as the commissioner requires from a service in terms of clinical practice, evidence base, quality standards and access criteria. Where providers were unable to move to the agreed common standards by April 2013, NHS England put in place time limited exceptions (or derogations) allowing providers to continue providing essential quality services for their patients whilst working to meet the new rigorous and coherent service specifications. The vascular services in Kent and Medway continue to be unable to meet the specified NHS England standards, hence remain in "derogation".

5. More recently, building on the case for change, a Getting It Right First Time (GIRFT)[2] review in 2018 identified a number of key issues for both of the Trusts (as reported at Kent and Medway PAB 29.3.18):

   - A hub and spoke model is required
   - Volume and outcomes to be addressed
   - The timelines for carotids and aneurysms (carotid endarterectomy (CE) and AAA surgery) to be addressed
   - Timelines to ward an issue
   - There is a need to focus on lower limb improvements
   - There are significant differences between both sites:

Outcomes	MFT	K&CH
AAA; 60 per year required	53	98
Carotid Endarterectomies; 40	24	78
Timeline to treatment for CE; 14 days max (7 days best practice)	33%	86%
Average LoS	18	8
National screening timeline	62 days (max 87)	44 days (max 50)

6. The lack of ability to deliver the national recommendations and to have sufficient levels of activity negatively impacts on the Trusts' ability to recruit and retain staff. This position is unlikely to alter until there is a decision on the future of Kent and Medway vascular services and the issues of low activity volumes addressed.
7. The assumption that the population from the north and west of the county which currently uses South London services could be redirected into Kent and Medway services was not supported through the review. This was due to both historical patterns of clinical behavior and patient choice, supported by current commissioners. The review concluded that if a centre of excellence were present within Kent and Medway then this may impact positively on both of these issues.
8. The recommendation of the review was to create a Vascular Network across Kent and Medway with a single arterial centre (e.g. to undertake the higher risk and complex procedures) supported by non-arterial centres with one operating as an enhanced non-arterial centres (e.g. a hub and spoke model). This model would be available to all Kent and Medway residents but no commissioning changes would be made to alter the current flow into south London.
9. This recommendation has been accepted by both Trusts and by Guys and St. Thomas' hospitals who provide services for the west and north of the county currently. This has also been supported through public engagement and the JHOSC.
10. A Kent and Medway Vascular Network has been established between EKHUFT and MFT and has developed a draft business case for consideration by NHS England Specialised Commissioning. Following detailed work with both clinical communities and patients the recommendation within the business case is for the arterial centre to be within EKHUFT and the non-arterial centre within MFT (subject to consultation if required).

[2] **GIRFT** is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice through benchmarking clinical services with their peers.

11. In line with the Keogh review of urgent and emergency care (2013) we would expect vascular services to be located on the site of a major emergency centre (MEC). The future location of the major emergency centre in East Kent will be determined through the East Kent Transformation Programme and be subject to public consultation. Currently two options are under development: Option 1 which see the MEC at the WHH in Ashford; and Option 2 that sees the MEC at Canterbury. Thus, the location of the inpatient arterial hub, if this is to be in east Kent, will be determined by the outcome of the East Kent Transformation Programme and the proposed consultation process.
12. All the options in East Kent see a major capital development at one of their main sites. Experience from elsewhere demonstrates that the process of securing capital, developing the pre-consultation business case, gaining agreement to consult and then consulting with the public and relevant stakeholders themselves, approval by the CCGs of a preferred option, development / sign-off of a Full Business Case and then finally undertaking the build will take between **five and ten years**, with seven representing good progress in most circumstances. The current EK urgent and emergency care pre-consultation business case is being modeled on a seven-year plus time period.

Interim solution

13. Due to the length of time it will take to put in the long-term timeline associated with the East Kent Transformation Programme, the need has been identified for interim solutions for a range of services (where there is a strong case for change and / or concerns about the sustainability / viability of services). Vascular is one such service and during the interim period, while the final site is both agreed and implemented, the Kent and Medway Vascular Network has been charged with ensuring the following four critical deliverables are in place across the network.
    i. A joined-up approach to multidisciplinary teams / meetings, i.e. operating as a single approach across both services rather than within individual organisations
    ii. Maximization of use of resources
    iii. Improved and consistent outcomes for all Kent and Medway patients
    iv. A single surgical consultant on call rota
14. Despite some progress towards collaborative working with shared multidisciplinary teams / meetings (MDTs and MDMs) starting to take place there has been no progress on delivering a single on call rota or making significant progress on improving outcomes across Kent and Medway patients.
15. In the intervening period of the review there has been insufficient improvement on the key areas of non-compliance for either Trust and the outcomes for the core procedures remain unchanged.
16. Following a discussion at the PAB in May 2018 it was confirmed that despite the network Board being established and clinical relationships being built, there was little chance of improving or sustaining outcomes or creating a single on call rota without putting an interim model in place and the next section of this document explores the rationale for putting in place an interim solution.

Case for change for an interim model

17. The key issues within the original case for change remain and limited progress has been made in addressing them.
18. Whilst there has been some improvement in staffing this is insufficient and does not fulfill best practice requirements. There are concerns regarding the sustainability of the current workforce. There has been little progress against improving outcomes for patients and

this is unlikely to change if the current service provision remains until the final solution is implemented.

19. Vascular inpatient activity continues to be delivered at both hospital sites and despite the network being established neither unit is compliant with the national service specification (NSS), i.e. remain in derogation. This is consistent with the original case for change and relates particularly to low consultant numbers and low total numbers of population served.

20. The key issues currently include;

- The current timeframe for implementing a final disposition of vascular services in east Kent is likely to be an absolute minimum of five years, with seven years representing good progress and up to ten years is possible. During this time there is unlikely to be any progress on addressing the issues evidenced in both the case for change and GIRFT review. As such it is unlikely that the services will be able to preserve or enhance clinical outcomes within a reasonable time frame for patients.
- The lack of an agreed interim model perpetuates the current tensions between the two clinical teams impacting on making real progress on collaborative working. This negatively impacts on the ability to deliver the required clinical improvements (as noted by GIRFT) and the objective of improving. This, and the uncertainty of the timeline for implementation of the final model outlined in the point above, continues to impact of recruitment and retention and this is unlikely to stabilize without clarity.
- Despite some progress towards working collaboratively there remains absence of a current clinical consensus around an interim operational model and this is impacting on implementation of well-established best practice guidance.
- Both Trusts are under considerable pressure with their wider operations including the urgent and emergency care pathways and there is a risk that this may impact on the vascular services if they are not stabilised in this interim period.
- The JHOSC are anxious to understand why the agreed changes have not been formally agreed and implemented (and through this improvements to patient outcomes being delivered).

21. In summary, NHS England has identified that:

i. The K&M Vascular network has confirmed that they remain committed to the agreed long-term model and their preferred site for the arterial centre is within east Kent. They are unable to address the case for change and subsequent recommendations without an interim option being agreed (i.e. the network has been unable to find an agreed interim arrangement that addresses the case for change and delivers the GIRFT recommendations).

ii. The implementation of the final model is unlikely to be earlier than five years minimum and most likely to be seven years plus. This was assessed by external clinical advice, the regional medical Directors, Specialised commissioning and the STP as unacceptable in relation to improving clinical outcomes for patients in Kent and Medway. It was strongly felt that an interim solution needed to be identified and implemented that delivers benefits to patients.

iii. Recruitment and retention in this period of uncertainty is challenging, this is a specialist clinical area where staff have a number of choices and will be unlikely to choose an unstable area and/or an area where clinical outcomes are not optimal.

iv. There is a considerable risk that delaying implementation for a number of years (as likely) will further destabilise the existing service and workforce.

22. In conclusion, the risk of destabilisation of the existing service and workforce whilst awaiting implementation of the final solution is considerable. Awaiting a long-term model to deliver the required clinical improvements and deliver best practice for patients is

assessed as unacceptable.

23. On the basis of the above NHS England, with the support of the STP, has proposed that an interim model is required and an options appraisal of the interim model needed to be undertaken.

Interim Model Options Appraisal

24. NHS England, supported by the providers and the STP, has identified four potential options for the interim solution. The options have focused on the delivery of the arterial centre on one of the two existing sites (K&CH or MFT) and the remaining site to operate as the non-arterial spoke. Table 1 details the four options.

Table 1; Possible interim options

Option 1	Maintain current arrangements and accept the risks relating to workforce and improved quality
Option 2	Maintain the services on both sites and establish a shared on-call rota
Option 3	Interim single arterial centre on the K&C site and non-arterial centre on the MFT site
Option 4	Interim single arterial centre on the MFT site and non-arterial centre on the K&C site

25. Initially the network considered the interim solutions but were unable to reach an agreement on the preferred option and have advised the PAB that this requires a commissioning decision. Therefore, NHS England, as the lead commissioner and supported by the PAB, has undertaken a table top exercise reviewing the interim options against the evaluation criteria within the business case.

26. In evaluating the interim options, the PAB has drawn upon the review of the clinical models that identified the long-term solution (i.e. the proposal for a single arterial centre to be located in east Kent). This has included adhering to the key principles of the original review, namely:

- Minimum population numbers served to enable the minimum numbers of core index procedures able to be performed
- Delivery of the required number consultant vascular and IR consultants to deliver a 24/7 rota
- Dedicated vascular facilities including wards and hybrid theatre(s)

27. It should also be noted that within the original review:

The Kent and Medway Clinical Reference Group, which supported the PAB in undertaking the original review of the long-term solution, agreed that the option of sharing a consultant rota across two sites was not clinically safe or sustainable. The Vascular Society has supported this model only in exceptional circumstances which are not relevant within Kent and Medway.

- Minimum population requirements and patient flows were reviewed. Following lengthy discussions, the PAB agreed that the existing flows of the west and north of the county into London were fit for purpose and should not be altered through commissioning decisions as part of the review. Any patient flow changes should be due to patient and clinical choice which may occur if a new Kent and Medway service became a centre of excellence.
- Detailed analysis of travel times and access was also reviewed including travel time modeling undertaken both externally and by SECAmb. Agreement was reached that there is no specific travel time target as key is the need for clear transfer protocols

between non-arterial centres and the arterial center. SECAmb noted that travel times were also dictated by individual patient clinical presentation. Therefore, the review recommended that an hour travel time form the time of referral to a specialist vascular unit was to be used as a guide not a target. The review of the patient flows indicated that access within the recommended travel and clinical assessment time is not an issue for patients accessing either site (i.e. east Kent or Medway), This remains relevant for any interim model.

28. Whilst the above relate to the review of the long-term options, it was felt the above three points were relevant in relation to identifying an interim solution. Therefore, the issue of access / travel times and the patient flows / volumes has not been reviewed as part of the identification of an interim option. This would undermine already approved principles and be counter to the outcome of that appraisal process. Clinical adjacencies have been reviewed in relation to the adjacencies to A&E and are considered in the options appraisal by the panel.

29. A number of key additional elements were identified that were felt to require consideration during the process for identifying an interim option. These included:

    a. Is the current position sustainable from a quality, finance or workforce perspective, namely:

        i. If the outcomes cannot be improved during an interim arrangement due to the lack of a single rota, is it acceptable to continue with variable outcomes for Kent and Medway residents through the current arrangements within the two services / will an interim solution improve outcomes for patients across Kent and Medway?

        ii. What are the financial impacts of an interim solution?

        iii. What are the workforce implications of an interim solution?

        iv. Which option provides the best chance of achieving a sustainable service that can deliver improved outcomes across Kent and Medway?

    b. Capacity; the ability of either Trust/site to take on the activity with minimum disruption and to manage within the Trust pressures currently

    c. Overall deliverability of the plans set out by the Trusts, namely:

        i. The ability to deliver within a reasonable time frame,

        ii. The degree of change required within the site

        iii. Ability to deliver within the capacity restraints and service challenges currently in place in both Trusts?

        iv. Which option can be delivered within the earliest safest timeframe?

    d. Clinical safety; the impact of clinical adjacencies and management of additional demand within the clinical demands of the unit at the time

    e. Strategic fit; the impact of wider strategic plans and the long-term solution agreed by the Board

30. It was recognised that engagement with providers was a vital component of the process to identify an interim solution. Therefore, each trust has been asked to consider their ability to deliver an interim option. This included reviewing the key additional elements noted above and self assessing against these.

31. Both Trusts currently operate a single IR rota that supports both vascular patient and non-vascular urgent /emergency care. In either scenario it is proposed that the resident IR team at the arterial centre will continue to support both patient cohorts. This requires consideration of the IR requirement and provision at the non-arterial centre. Discussions are underway to identify an agreed model however a shared rota across Kent and Medway is not a popular choice with a number of IR consultants. Further detail has been

requested with regard to delivery of the Interventional radiology service (IR) this includes consideration of both vascular and non-vascular IR.

32. **Therefore, further work is required in settling the future disposition of IR services, and an initial response has been sought from the Trusts.** A detailed risk assessment will in due course be required to ensure safe and consistent delivery of both vascular and non-vascular IR using the network approach currently in place across the existing Kent and Medway non-vascular sites (Darent Valley Hospital (Dartford), Maidstone Hospital, Pembury Hospital (Tunbridge Wells), Queen Elizabeth the Queen Mother Hospital (Thanet) and William Harvey Hospital (Ashford)).
33. An assessment meeting was held on the 31st August 2018. Membership of the panel and contributions to the decision making included:
    i. An external consultant vascular surgeon and Vascular Society representative
    ii. The Kent and Medway STP Programme Director
    iii. NHSE Specialised Commissioning
    iv. NHE England, Medical Director (South East) and Review Programme SRO
    v. NHS England, Regional Medical Director Specialised Commissioning (South).
34. Both Trusts self assessments and responses were duly considered, alongside the findings of the original clinical models work by the PAB clinical reference group and the most recent GIRFT findings.
35. The initial assessment indicated that an **interim option is required** due to the significant period it will take to implement the final model. To delay improvement or risk deterioration of current clinical outcomes for patients across Kent and Medway was not regarded as acceptable by any panel member. Previous JHOSC meetings have clearly identified concerns re delay in resolving this issue and the need to progress to improve outcomes for patients and ensure a sustainable K&M service. The move to a single arterial centre, in line with the sought-after long-term solution, was felt to have demonstrated a range of quality and sustainability benefits (i.e. moving the Kent and Medway services out of “derogation”). Waiting for these benefits to be delivered through the implementation of the long-term service model for east Kent, was felt to leave a large portion of the Kent and Medway population with a service level below the mandated quality standard for an inappropriate length of time. This led the group to discard the “as is” option (i.e. Option 1).
36. The group further reviewed the information available in relation to Option 2 to 4.
37. **On the basis of the information available the recommendation is that this should be on the Kent & Canterbury site.**
38. The key points leading to this decision include that this option:
    i. is assessed as having the best capacity and clinical ability to deliver the interim solution with minimum disruption (the current capacity at the K&C site for both beds and ITU space with no significant capital investment was a key consideration)
    ii. this option is also likely to minimise any impact of emergency vascular care on the existing A&E pressures
    iii. puts the interim service within the trust that is the favoured option for delivering the long-term solution
    iv. recognises current outcome data that indicates better outcomes from the K&C based service
    v. ITU capacity and costs and potential time to reconfigure associated with creating an interim solution at MFT limit the option of MFT as the arterial centre

39. The concern of stakeholders in relation to the co-adjacency of emergency vascular services and an emergency department were discussed (i.e. recognising that consultant led emergency care is not provided at the K&CH). It was noted that the NHS England review, led by Sir Bruce Keogh (2013) into urgent and emergency care recommends the location of vascular services within a major emergency centre (MEC), as proposed in the long-term solution for Kent and Medway (as outlined earlier in this paper). This is an issue for an interim move to the current K&HC site, which does not have a consultant-led emergency department on site. However, the panel were advised that whilst this is the optimum position (i.e. co-location of a vascular service on a site with a consultant-led emergency department) there is precedent for vascular arterial centres to be located on sites without an emergency department and, through robust development of patient pathways, these have been able to meet the required quality standards. It was also noted that the existing arrangements in K&CH have been in place for a number of years with no impact on patient outcomes; indeed K&CH outcomes are confirmed as good. The panel agreed that this was not a determining factor for choosing an interim solution but that the preferred long-term solution remained co-location of the inpatient arterial centre in a MEC (i.e. alongside a consultant-led emergency department). This concern would however require careful consideration by the clinical members of the network to establish comprehensive clinical pathways.

40. All options had a number of inherent risks. Those associated with Option 3 will need to be addressed as part of the process going forward. The initial risks identified are outlined in Table 3.

Table 3: Initial risk assessment:

Risk	Initial mitigation
Staff unwilling to move to the preferred site	• Assess ability of existing networks to facilitate effective transfer of clinical staff between service locations • Assess risk and ability of preferred site to manage activity safely with existing staff • Assess ability to recruit additional staff externally for the interim model
Inability to deliver both a vascular and non-vascular IR rota	• Assess risk for vascular and non-vascular patients • Assess ability to deliver activity from within the preferred site IR establishment • Put in place agreed clinical protocols for urgent and emergency IR and surgical access on the non-arterial site
Cohesion of the network and robustness of joint working across the arterial and non-arterial site	• OD plan for the network including engagement work commissioned
Challenge on an interim move by key stakeholders	• Ensure clarity re the need for an Interim model • Ensure clarity re this being an interim move with consultation for a long-term solution to be undertaken • Engagement with the JHOSC and key stakeholders prior to implementation

Process next steps

41. **The recommendation identified in this paper will go to NHSE Specialised Commissioning in October 2018 for approval in principle**. This decision to be taken by the end of the first week in December 2018. During this period a number of key lines of enquiry may be addressed to further inform this decision.

42. **If approved in principle, NHSE specialised commissioning will further identify key lines of enquiry to inform a business case**. This will include the requirement for EKUHFT to work in partnership with MFT across the network, outlining the viability of the proposal and including an implementation plan for the interim solution (with a timeline for delivery and detailed assessment of the risks and benefits).

43. A range of specific issues were identified, which will need to be identified in the business case:

    a. Clear clinical protocols for managing both emergency and urgent vascular assessment and intervention on the non-arterial hospital sites across Kent and Medway (excluding Darent Valley Hospital, Maidstone Hospital and Pembury Hospital who are supported by the London pathway)

    b. Review models for rehabilitation and repatriation, and establish clinical protocols

    c. A robust IR rota and pathway to support non-vascular patients at the non-arterial sites across Kent and Medway (excluding Darent Valley Hospital, Maidstone Hospital and Pembury Hospital who are supported by the London pathway)

    d. An implementation plan that includes timelines, risk mitigation actions and costs

    e. Consideration of the ability to repatriate appropriate patients to the non – arterial centre for recovery/rehabilitation

    f. A workforce plan outlining required staffing and how this requirement will be met

    g. Clarity on any financial investment and or risk required with the interim proposal.

44. Public consultation plan to be developed with regard to implementing an interim option

45. The K&M Vascular network to ensure that the clinical members are fully sighted and engaged to developing the interim model. It is key to the success of both the interim and long-term model that the network is strengthened and develops a network approach to the model of care supporting both patients and staff within the service.

Public and stakeholder engagement.

46. Public engagement events have been considered due to both the length of time since previous engagement events but also due to the delays in delivering a final solution. In the event of an interim solution being approved a formal consultation may be required due to the length of duration of any interim solution.

47. A formal consultation plan is being developed and will be shared with the JHOSC and will be aligned to the likely East Kent Consultation as appropriate.

48. A K&M vascular network event was held on the 20th September with detailed discussions on the process and recommendations for an interim model. There continue to be concerns with regard to the clinical pathways required to ensure safe sustainable services and the impact on interventional radiology. This is particularly key for non-vascular interventional radiology. The network will continue to develop clinical pathways and protocols to address these concerns and the business case for the interim model will be required to address any clinical concerns before it can be approved.

49. Feedback from the JHOSC in October 2018 to be conveyed to Specialised Commissioning. The JHOSC members to be advised of the decision and any additional requirements as identified by Specialised Commissioning as part of both the initial in principle decision making and the formal decision. Regular updates on progress of an interim model , if approved to be provided to the JHOSC.

50. The JHOSC is asked to;

- Note the report and discuss the recommendations
- Advise on the recommendations and next steps
- Advise on the proposal for consultation with regard to the interim option

Item 7: Assistive Reproductive Technologies (ART) Policy Review

By: Lizzy Adam, Scrutiny Research Officer to the Kent Health Overview and Scrutiny Committee

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 12 October 2018

Subject: Assistive Reproductive Technologies (ART) Policy Review

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

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

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1. Introduction

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

(2) On 18 January 2018 the Medway Health and Adult Social Care Overview and Scrutiny Committee considered the Assistive Reproductive Technologies (ART) Policy Review. The Committee agreed the following recommendation:

- *The Committee determined that the Policy Review of Assistive Reproductive Technologies was a substantial development of or variation in the provision of health services in Medway.*

(3) On 24 November 2017 and 26 January 2018, the Kent Health Overview and Scrutiny Committee considered the Assistive Reproductive Technologies (ART) Policy Review. The Committee agreed the following recommendation on 26 January 2018:

- *RESOLVED that:*

  (a) the Committee deems the proposed policy changes to be a substantial variation of service;

  (b) a joint HOSC be established with Medway Council.

(4) Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 states that where relevant NHS bodies and health service consults more than one

local authority on any 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 and only 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.

(5) The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. A decision on whether to make a report to the Secretary of State would be a matter for the Kent County Council Health Overview and Scrutiny Committee and/or the Medway Council Health and Adult Social Care Overview and Scrutiny Committee to make rather than the JHOSC.

(6) The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) has therefore been convened for the purpose of the consultation on the Assistive Reproductive Technologies (ART) Policy Review.

2. Legal Implications

(1) 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.

3. Financial Implications

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

4. Recommendation

The JHOSC is invited to:

- CONSIDER and COMMENT on the report;
- REFER any relevant comments relating to the Assistive Reproductive Technologies (ART) Policy Review to NHS Medway CCG

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

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Assistive Reproductive Technology services – policy review

1. Background

In order to achieve financial sustainability, CCGs are considering whether to reduce the number of cycles of IVF that are funded for eligible couples, as a part of a number of difficult decisions. A review of the current policy relating to vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI) has been proposed across Kent and Medway, to determine the best course of action.

NICE Clinical Guideline 156 (CG156) *Fertility problems* (2013) recommends the NHS fund up to three full[1] IVF cycles. Across Kent and Medway CCGs, there is currently a single schedule of policies relating to Assistive Reproductive Technology services; this schedule of policies provides entitlement of two cycles of IVF for eligible patients. These cycles are not deemed to be 'full' cycles as outlined within NICE guidance, but instead entitle a patient to two cycles consisting of one fresh IVF and one frozen embryo transfer per cycle

This paper provides a progress update, information relating to the appetite for the policy review across Kent and Medway CCGs, and the costs associated with the potential policy changes arising as a result of the review.

2. Proposed policy changes and financial implications

2.1 Number of IVF cycles for eligible patient

The potential future policy that is being considered would be a maximum of one fresh IVF cycle and one frozen embryo transfer cycle.

This may be considered locally as one 'full' IVF cycle and would represent a maximum of two embryo transfers. As above, it does not comply with the NICE definition of 'full' cycles. Of all CCGs in England, 61% currently fund one cycle of IVF treatment.

It is anticipated that reducing the number of funded IVF cycles from two to one will provide a financial saving of approximately £650k - £680k per annum across Kent and Medway.

The breakdown of this potential saving is identified below:

CCG	Approximate level of saving
Ashford	-£43,600
C4G	-£79,100
DGS	-£95,800

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

Medway	-£97,800
SKC	-£46,300
Swale	-£40,700
Thanet	-£27,500
West Kent	-£235,100

2.2 Inclusion of the use of donated genetic material

Assisted conception treatments (ACT; i.e. Intra Uterine Insemination (IUI) and IVF) using donated genetic materials (eggs, sperm or embryos) and involving surrogates are not currently funded for any patient groups in Kent and Medway.

CCGs have received complaints from same sex couples who are not able to access assisted conception treatments under the terms of the current policy. As the lead commissioner for ART services, NHS Medway CCG believes that the policy review should also consider whether the use of donated genetic material should be introduced into the schedule of policies for ART. NHS Medway CCG is of the view that a policy change is required in this area to ensure that the CCG is meeting its obligations in relation to areas of law such as the Equality Act 2010.

It is proposed that this element of the review is not considered alongside any public consultation that would be required during the review of the number of IVF cycles. This area contains complex clinical, equality, legal and ethical issues, and will be led by the NEL CSU Health Policy Support Unit. Consideration of issues relating to the use of donated genetic materials will be undertaken by the Policy Recommendation and Guidance Committee (PRGC), and the Health Policy Reference Group (HPRG). The PRGC will be discussing this item on 4th October and making recommendations to the HPRG thereafter.

The potential costs associated with the policy change to include the use of donated genetic materials would depend on the exact nature of the policy change. There are different options relating to the policy change in this area; these, and their respective estimated costs, are outlined appendix one. This is an extract from the full report, written by the Health Policy Support Unit, that will be considered as a part of the review process.

The estimated cost impact of funding ACT using donor sperm is £501,500 per year across Kent and Medway. The equivalent estimated cost of funding ACT using donor oocytes is £179,800 as detailed in Appendix 1.

3. Current position of each CCG relating to the policy review of number of IVF cycles

There is currently a single set of policies for Assistive Reproductive Technology Services that apply to all patients throughout Kent and Medway. NHS Medway CCG is the lead commissioner for ART services.

3.1 North and West Kent CCGs

Following discussions at CCG Governing Bodies, CCGs in North and West Kent have previously agreed to proceed to pre consultation engagement phase. NHS Medway CCG has completed this stage of work, Swale and Dartford, Gravesham and Swanley CCGs have previously undertaken work in this area and have commenced further engagement work in this area via a small number of public engagement events. West Kent CCG have planned their pre consultation engagement, which will commence shortly.

3.2 East Kent CCGs

East Kent CCGs have advised NHS Medway CCG that they do not wish to progress with the review relating to a reduction in IVF cycles that eligible patients can access.

The position across Kent is summarised in the table below:

CCG	GB agreement to undertake review?	Pre-consultation engagement work commenced?	Pre-consultation engagement work concluded?
Ashford	No	No	No
C4G	No	No	No
DGS	Yes	Yes	No
Medway	Yes	Yes	Yes
SKC	No	No	No
Swale	Yes	Yes	No
Thanet	No	No	No
West Kent	Yes	No	No

3.3 Issues arising as a result

The impact of the decisions that has been made by East Kent CCGs is potentially significant. The feedback gained from Medway's pre consultation engagement contains references to a 'postcode lottery' and the desire of patients to avoid such a position. Should the consultation and review proceed in North and West Kent but not in CCGs in East Kent, and the decision be made that a reduction in provision of NHS funded IVF cycles is appropriate in North and West Kent, there will need to be two separate sets of policies across Kent.

Areas of consideration should include:

- The potential for reputational damage throughout Kent, but mostly in relation to CCGs in the North and West of the county.
- The implications of such a split across Kent would have to be worked through with NHS England as a part of the assurance process.
- The impact on the forthcoming procurement for ART services, which is set to take place following the outcome of any policy review. The procurement will need to be structured in such a way that the two different sets of policies are able to be accommodated.

4. Risk analysis

Risks associated with the policy review are outlined below:

RISK NO	DESCRIPTION of RISK (There is a risk that…)	RAISER	Consequence/IMPACT (Which will cause….)	RISK OWNER	**ORIGINAL SCORE** (Consequence x Likelihood)	**CURRENT LIKELIHOOD** Rare (1) Unlikely (2) Possible (3) Likely (4) Almost Certain (5)	**CURRENT CONSEQUENCE** Negligible (1) Minor (2) Moderate (3) Major (4) Catastrophic (5)	**CURRENT SCORE** (Consequence x Likelihood)	Progress on action including date updated Action taken to reduce the impact and/or probability of becoming an issue (mitigation)
1	CCGs are legally challenged should the decision be made to continue the review and reduce the number of cycles of IVF that are funded for eligible patients	Michael Griffiths	A legal challenge would require significant CCG reource to work through, and potential additional legal costs.	Stuart Jeffery	12	3	4	12	CCG Governing Bodies to take this risk into consideration
2	Potential of different levels of IVF funding across Kent and Medway	Michael Griffiths	Reputational risk across CCGs relating to a lower level of provision for couples seeking IVF services.	Stuart Jeffery	10	5	2	10	This risk is dependent upon the decisions tat are taken by CCG Govnerning Bodies relationt to the progressions of the review. Effective communication to members of the public will be required.
3	Not proceeding with policy review causes a financial risk to CCGs	Michael Griffiths	Potential financial savings, a key driver for the potential policy review, are not made, and the CCGs are required to find additional financial savings elsewhere	CCG COOs	5	5	1	5	The level of financial pressure on CCGs will be small. This risk is not avoidable should the review of IVF policies not take place.
4	Risk to timeline	Michael Griffiths	The potential for different policies across Kent and Medway is a barrier to the NHSE assurance process, thus requiring further work up of plans and extension of the review timeline	Stuart Jeffery	9	3	3	9	Early discussions with NHSE in relation to this work and the respective decisions of CCGs across Kent and Medway would help to mitigate this risk.

5. Next Steps

Medway, Dartford Gravesham and Swanley, Swale and West Kent CCGs are planning on progressing with the proposed policy review relating to the number of IVF cycles, and will undertake a formal public consultation as a part of this process.

As lead commissioner for ART services, NHS Medway CCG believes that the financial benefits of considering a reduction of IVF cycles should be subject to formal consultation with members of the public, and that consideration should be given to the use of donated genetic materials.

Issues relating to the use of donated genetic materials will be considered by the PRGC on the 4th October and the HPRG thereafter. The outcome of these meetings will determine any future policy changes in this area; these changes will be included in future ART policies across Kent.

1 Impact assessment

The impact of changing the existing Kent and Medway policy to fund ACT using donated genetic materials is estimated below. These estimates should be treated with caution as they are based on HFEA reported activity from 2016 which includes both NHS and privately funded cycles; this has the following limitations:

- NHS funding of ACT using DGM is not available throughout the UK and where it is, limitations on the number of cycles available and eligibility criteria are variable. Overall demand may therefore be underestimated.
- Although the HFEA activity relates only to women aged under 40 years, as per the Kent and Medway CCGs eligibility criteria, those who have self-funded treatment may not fulfil additional eligibility criteria most NHS organisations have in place (e.g. no previous children).
- NHS organisations have in place limitations on the number of cycles of treatment they will fund – normally 6 cycles of IUI and 1 or 2 cycles of IVF/ICSI. There is no equivalent limitation on the number of cycles patients who self-fund treatment can undertake.

See Table 1.4 for a full list of assumptions used in calculations along with comments regarding their limitations.

1.1 ACT using donor sperm

The estimated annual impact of funding IUI and IVF using donor sperm can be found in Table 1.1.

Table 1.1 – Estimated annual impact of funding ACT using donor sperm for Kent and Medway patients where the woman receiving treatment is aged under 40

	IUI using donor sperm	IVF using donor sperm (fresh and frozen)	**All ACT using donor sperm***
Number of cycles	127	87	**215**
Expenditure	£191,100	£310,400	**£501,500**
Live birth	18	30	**47**
Cost per live birth	£10,800	£10,500	**£10,600**

**Figures do not add up due to rounding.*

1.2 ACT using donor oocytes

The estimated annual impact of funding IVF using donor oocytes can be found in Table 1.2.

Table 1.2 – Estimated annual impact of funding IVF using donor oocytes for Kent and Medway patients where the woman receiving treatment is aged under 40

	IVF using donor oocyte and partner sperm (fresh and frozen)	IVF using donor oocyte and donor sperm (fresh and frozen)	**All IVF using donor oocyte**
Number of cycles	27	15	**42**
Expenditure	£117,800	£62,000	**£179,800**
Live birth	9	5	**14**
Cost per live birth	£13,000	£13,000	**£13,000**

1.3 ACT involving surrogates

The estimated annual impact of funding ACT involving surrogates can be found in Table 1.3.

Table 1.3 – Estimated annual impact of funding ACT involving surrogates in Kent and Medway

	IVF using surrogates (fresh and frozen)
Number of cycles	**6**
Expenditure	**£15,800**
Live birth	**2**
Cost per live birth	**£10,000**

Table 1.4 – Assumptions used in impact calculations

Assumption	Source	Comments
Estimated numbers of cycles of ACT using DGM undertaken on Kent and Medway patients are based on 2016 UK data in women aged under 40.	Fertility treatment 2014-16: Trends and Figures and accompanying datasheet (HFEA, 2018).	Includes both NHS and privately funded cycles. This data may not accurately predict the number of Kent and Medway patients presenting for treatment – the reasons for this are outlined above.
Estimated numbers of cycles of IVF using surrogates for Kent and Medway patients are based on 2016 UK.	Fertility treatment 2014-16: Trends and Figures and accompanying datasheet (HFEA, 2018).	As above. In addition, as overall numbers are small the HFEA do not report data by age range. The total number has been used which may overestimate activity.
Live birth rates for ACT using DGM are based on 2016 UK data in women aged under 40.	Fertility treatment 2014-16: Trends and Figures and accompanying datasheet (HFEA, 2018).	As outlined above HFEA data may not represent the Kent and Medway NHS patients accessing treatment. People accessing NHS funded treatment must be subfertile – HFEA data will include data on same sex couples and single women who are fertile. Estimates may therefore be higher than actual number of live births.
Live birth rates for IVF using surrogates are based on 2016 UK data.	Fertility treatment 2014-16: Trends and Figures and accompanying datasheet (HFEA, 2018).	As above. In addition, as overall numbers are small the HFEA do not report data by age range. The overall success rate has therefore been used.
The Kent and Medway population represents 2.77% of the UK population.	ONS 2016 population for UK: 65,648,100. ONS 2016 population for Kent and Medway: 1,820,435.	Applying this proportion to the HFEA activity means demographic variations in the population are not taken into account.
Estimated costs are as follows: • IUI using donor sperm: £1,500 • IVF using donor sperm: £4,773 • IVF using donated oocyte: £6,500 • IVF using donor sperm and oocyte: £7,500 • Frozen embryo transfer (FET): £783 • IVF using a surrogate: £6,500	Average cost of a Kent and Medway CCG funded IVF/ICS cycle at commissioned providers in 2017/18 is £3,773. The equivalent cost for FET is £783. Price lists obtained from clinic websites for private treatment indicates donor sperm costs ~£1,000 and IVF using donor eggs costs £6,500.	NHS commissioners might expect to pay slightly lower costs than those paid for private treatment. Additional costs for drugs etc. may be applicable.

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