KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 6th February, 2020

2.00 pm

Darent Room, Sessions House, County Hall, Maidstone

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 6th February, 2020, at 2.00 pm	Ask for:	**Kay Goldsmith**
Darent Room, Sessions House, County Hall, Maidstone	Telephone:	**03000 416512**

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

Membership

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

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

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

Item — Timings*

1. Membership

2. Apologies and Substitutes

3. Election of Vice-Chair

4. Declaration of Interests by Members in items on the Agenda for this meeting

5. Minutes from the Meeting held on 10 September 2019 (Pages 1 - 6)

6. Specialist Vascular Services Review (Pages 7 - 30)

7. East Kent Transformation Programme (Pages 31 - 74)

8. Provision of Mental Health Services - St. Martin's Hospital (Pages 75 - 82)

9. Date of Next Meeting: To Be Determined

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

29 January 2020

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

KENT COUNTY COUNCIL

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 St George's Centre - St George's Centre on Tuesday, 10 September 2019.

PRESENT: Mrs S Chandler (Deputy Chair), Cllr D Wildey (Chair), Cllr B Kemp, Cllr T Murray, Cllr W Purdy, Mr D S Daley and Mr K Pugh

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

UNRESTRICTED ITEMS

9. Membership
(Item 1)

Members of the Kent & Medway NHS Joint Overview and Scrutiny Committee noted the membership listed on the Agenda.

10. Apologies and Substitutes
(Item 2)

Apologies were received from Mr Bartlett.

11. Election of Chair
(Item 3)

(1) Mrs Chandler proposed and Cllr Purdy seconded that Cllr Wildey be elected as Chair of the Committee.

(2) RESOLVED that Cllr Wildey be elected as Chair.

12. Election of Vice-Chair
(Item 4)

(1) Mr Pugh proposed and Mr Daley seconded that Mrs Chandler be elected as Vice-Chair of the Committee.

(2) RESOLVED that Mrs Chandler be elected as Vice-Chair of the Committee.

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

There were no declarations of interest.

14. Minutes from the meeting held on 12 October 2018
(Item 6)

RESOLVED that the Minutes of the meeting held on 12 October 2018 are correctly recorded and that they be signed by the Chair.

15. Assistive Reproductive Technologies (ART) Policy Review
(Item 8)

Stuart Jeffery (Deputy Managing Director, NHS Medway Clinical Commissioning Group) and Michael Griffiths (Programme Lead, Children and Families, NHS Medway Clinical Commissioning Group) were in attendance for this item.

(1) The Chair explained that as he anticipated that the discussion in relation to this item would be relatively short, he had decided to vary the order of the Agenda and take this as the first substantive item of the Agenda.

(2) NHS representatives explained that the consultation previously discussed with the Committee was on hold. There were several barriers to further progression. However, the need to make certain changes had been flagged up and Kent and Medway was now in line with the law and the rest of the country.

(3) In response to a question it was clarified that the IVF offer across Kent and Medway was the same. It was further explained that the contract was out of date so on behalf of all the Kent and Medway CCGs, NHS Medway was moving ahead with a procurement on the basis of the existing policy. This was not expected to change as the CCGs moved to becoming a single CCG.

(4) In discussion with Members, it was explained that demand for ART had remained steady over recent years, but changes have meant new groups, such as same-sex couples, have become eligible and this may increase demand. It was also established that once the CCGs were ready to progress, the normal consultation and engagement process would be followed.

(5) RESOLVED that the report be noted.

16. Kent and Medway Specialist Vascular Services Review
(Item 7)

Simon Brooks-Sykes (Senior Strategic Development Manager and Programme Manager for the Kent and Medway Vascular Clinical Network, East Kent Hospitals University NHS Foundation Trust (EKHUFT)), Fiona Hughes (NHS England and NHS Improvement - Specialised Commissioning), Dr David Sulch, Interim Medical Director, Medway NHS Foundation Trust), Liz Shutler (Deputy CEO for EKHUFT and

Executive Lead for Programme), and Dr Noel Wilson (Consultant Vascular Surgeon, EKHUFT) were in attendance for this item.

(1) The Chair introduced the topic and expressed concerns that there did not seem to have been much detail in the report as to what progress had been made since the last time the Committee met to discuss this topic almost a year ago previously and that information requested at this previous meeting had not been provided.

(2) In providing an introductory overview on behalf of the NHS, Fiona Hughes said that she appreciated that there had not been an update in the interim period and that the focus of NHS Specialised Commissioning was the need to reinvigorate the process.

(3) NHS representatives then proceeded to provide the background. In 2012, the Vascular Society produced service specifications for the UK. These were revised in 2015 and updated in 2018. The core feature was that as a result of the clinical complexity and population demand, there needed to be a centralisation of high-risk care. A single arterial centre (the 'hub') would need to be established with other hospitals in the geographical areas delivering non-arterial services; these hospitals would be the 'spokes' in the proposed vascular networks. The overriding difference between the hub and spokes is that the former would be the only one with inpatient beds so that patients requiring a bed would be directed there. This applied to both planned and unplanned care. Other care would be delivered closer to home with day case and outpatients still being delivered at local hospitals along with diagnostics.

(4) Moving on to the service standards for vascular work, it was explained that these were very clear and covered the volumes of activity, timelines for interventions, and the need for equitable service across the network.

(5) On the geographical spread of the network, it was explained that patients seen at Tunbridge Wells and Darent Valley Hospitals had a patient pathway that directed them to St. Thomas' in London for specialist work.

(6) Clinical representatives explained that vascular surgical work mainly focused on three areas – aortic aneurysms, peripheral vascular disease, and carotid endarterectomy.

(7) Several comments and questions from Members referred to the recent proposals for acute and hyper acute stroke services and the connections and comparisons with vascular services. It was explained that while vascular disease covered a broader range of conditions, including cardiac care and dementia, the total amount of inpatient care and vascular surgery (planned and unplanned) was around a third the number of stroke patients. This meant fewer consultants were needed and a single hub. The only surgical

intervention that was of direct relevance to stroke care was carotid endarterectomy. No more than 1 in 10 stroke patients would require this and it was important to ensure this was a high-quality service with consultants carrying out a sufficient volume of this procedure. Medway Foundation Trust did not see a high enough volume of cases to continue as a standalone vascular centre, whereas Kent and Canterbury Hospital did.

(8) Members asked a range of questions covering changes since the case for change in 2015. Specific concerns were raised about travel times and workforce. Particular reference was made to safety concerns that had been raised by staff at Medway Foundation Trust at the previous meeting. One of the causes for concern was that Kent and Canterbury did not have an accident and emergency (A&E) department.

(9) NHS representatives explained that it was not that unusual for there not to be an A&E department on the same site. There were advantages to not having one on the same site as other disciplines would not squeeze the vascular service by taking up theatre time and beds. There were, however, other concerns relating to support services. Vascular patients often have co-morbidities. Doctors David Sulch and Paul Stevens had carried out a review in January of this year. 8 patients were considered in multi-disciplinary meetings and assurances were produced that good support and medical care was available, with critical care being particularly strong. There were no concerns about the support on site. The number of patients covered by the hub and spoke network would be 800,000 and 6 consultants were needed to cover this population. There were the 8.5 full-time equivalents available.

(10) Interventional radiology was also discussed. This was a complicated area as half of the interventional radiology work at Medway was non-vascular, this service would need to be located and available there still. As there were 7 interventional radiologists in Kent, with 3 in East Kent, there may be a need to restructure. Six were needed for a rota and the local NHS were looking to recruit.

(11) Overall, the views of the team at Medway were deemed as having undergone a ‘sea change’. Where there was once uncertainty about the need for change, there was now a desire to get on with the changes and end the uncertainty, which impacted recruitment. It was explained that the working practices for doctors and nurses needed clarifying and the formal staff consultation needed to be undergone. The view of NHS representatives was that the majority were willing to move.

(12) There was no upper time limit on travel times but as 2/3 of the inpatient work related to residents of East Kent, locating the hub at Canterbury had the least impact on travel times. Depending on commissioning decisions and patient choice, there could be increased patient flow from Tunbridge Wells and Darent

Valley in the future. Evidence from rural areas suggested travelling around an hour did not affect the patient outcomes. Travel times were only an issue in an emergency situation, and these tended to be for haemorrhages, ruptured aneurysms and limb threatening events. Due to screening, ruptured aneurysms were declining. Currently Medway saw one vascular emergency case per day.

(13) Concerns were raised about the financial impact on Medway Hospital and the erosion of facilities and services there, particularly in view of the prevalence of health inequalities in Medway. The suitability of Kent and Canterbury Hospital to host a vascular hub was also questioned. It was explained that vascular services were not profitable and risk sharing would need careful consideration.

(14) NHS representatives went on to explain that rather than an A&E department, the important elements to have on the site of the hub were an intensive care unit, theatre, and renal dialysis. Kent and Canterbury had all three. Inpatient renal dialysis had been centralised at Kent and Canterbury since at least 1995. There was often a clinical need to continue renal and kidney dialysis during vascular inpatient treatment and this was available at Canterbury. A lot of work had been spent on developing the right patient pathways and on arriving at hospital, vascular patients did not go to A&E but went direct to the service. The NHS representatives advised that it was anticipated that a hub at Kent and Canterbury would be operational from spring 2020.

(15) In response to questions from Members, information was provided on the screening programme and NHS representatives undertook to provide a link to the criteria for screening to Officers for circulation to Committee Members. In sum, across the whole of Kent and Medway, all men were invited to an ultrasound during their 65th birthday year. These tests were delivered at 36 venues across the area. Men were 6-7 times more likely to be affected but there were pathways in place to identify high risk women and others who may need to be screened. Around 11,000 were invited each year and Kent and Medway had one of the highest uptakes in the country at 84%. Three outcomes from the screening were possible – a normal aorta; a problem diagnosed to be monitored; and a consultant referral. 30-35 patients a year needed surgery as a result of this screening. Kent and Canterbury treated these patients.

(16) Several comments were made that the word ‘interim’ was misleading when the proposed service change would last 5-10 years, and this was accepted by the NHS. Investment was not affected by use of the word.

(17) The NHS clarified that they were carrying on with a process of engagement, rather than a consultation with several options. Three events were being arranged and 200 letters had been sent to service users, and 117 calls had been made. There was also an online survey.

(18) The NHS also explained that they had learnt from the experience of the stroke review to project population numbers forwards, particularly in the context of an ageing population which would be at higher risk of aneurysms. The Chair asked for a heat map to be able to track patient movements. It was confirmed that this was being produced and the request was made for this to be shared as soon as possible and to be provided as part of the next meeting on this issue.

(19) Several requests were made regarding information to be provided to the Committee for its next meeting: a written report on any engagement/consultation activities, including a geographic breakdown of this activity; more information on renal and interventional radiology services; data on where patients came from as well as where they were treated, and what numbers of patients came from areas of deprivation; more information on the timetable for change; and information on prevention.

(20) RESOLVED that:

(a) the Committee has considered the report and that it be noted, and

(b) that the NHS be invited to return to the Committee at a time to be determined with the information requested.

Item 6: Kent and Medway Specialist Vascular Services Review

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 6 February 2020

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 background information which may prove useful to Members.

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1. Introduction

(a) Vascular services manage the treatment and care of patients with vascular disease relating to disorders of the arteries, veins and lymphatic system. The diseases can be managed by medical therapy, minimally invasive catheter procedures and surgical reconstruction.

2. Background

(a) An NHS review commenced in 2014 because both East Kent Hospitals University Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) were failing to deliver against either the national specification for specialist vascular services or the guidelines from the Vascular Society.

(b) The catchment area for the Vascular Services review is East Kent and Medway, which has a combined population of approximately 800,000. Those services currently provided in North and West Kent are not included in the review.

(c) The case for change was agreed in 2016 and a review process identified a clinical “hub and spoke model” (i.e. a single inpatient hub in Kent & Medway supported by a number of spokes across the region).

(d) The broad clinical agreement was that in the long term, an arterial centre (the inpatient hub) should be located in East Kent (subject to consultation). The exact location in East Kent will be determined by the outcome of the East Kent Transformation Programme which is still ongoing. There is therefore a need for an interim solution.

(e) The proposed interim solution is for a single arterial centre to be housed on the Kent and Canterbury Hospital site, with a non-arterial centre on the Medway Maritime Hospital site.

3. Joint Scrutiny

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

(b) The Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) considered the Kent and Medway Specialist Vascular Services Review on 11 August 2015. They determined that the reconfiguration constituted a substantial variation in the provision of health services in Medway.

(c) The Kent Health Overview and Scrutiny Committee (HOSC) considered the item on 17 July and 9 October 2015. The Committee also deemed the changes to be a substantial variation in the provision of health services in Kent.

(d) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013[1] the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) was convened and has met to discuss vascular services on 6 occasions since January 2016. The JHOSC may:

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

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

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

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

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

(h) The JHOSC most recently considered the Vascular Services reconfiguration at its meeting on 12 October 2018 and 10 September 2019. At the 10 September 2019 meeting, the Committee agreed the following:

RESOLVED that:

(a) the Committee has considered the report and that it be noted, and

(b) that the NHS be invited to return to the Committee at a time to be determined with the information requested.

(i) With reference to the second part of the recommendation above, the draft Minutes contain the following:

Several requests were made regarding information to be provided to the Committee for its next meeting: a written report on any engagement/consultation activities, including a geographic breakdown of this activity; more information on renal and interventional radiology services; data on where patients came from as well as where they were treated, and what numbers of patients came from areas of deprivation; more information on the timetable for change; and information on prevention.

4. Legal Implications

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

5. Financial Implications

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

6. Recommendation

The JHOSC is invited to:

- NOTE and COMMENT on the report.

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

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

Kent County Council (2019) '*Kent and Medway NHS Joint Overview and Scrutiny Committee (10/09/2019)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8413&Ver=4

Contact Details

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Joint Health Overview & Scrutiny		
MEETING/ DECISION MAKER:	**Joint Health Overview and Scrutiny Panel**	
MEETING/ DECISION DATE:	**February 6th 2020**	E 9999
TITLE:	**Kent & Medway Vascular Network Update**	
WARD:	All	
List of attachments to this report: No attachments		

1. Purpose

NHS England, Specialised Commissioning South East attended the Joint Overview and Scrutiny on 10th September 2019, to discuss a recommended move to an Interim Main Arterial Centre based at Kent and Canterbury Hospital for specialised inpatient vascular activity

Specialised Commissioning discussed our intention to engage with patients and return to the Overview and Scrutiny Committee with the outcome of the engagement as well as detail on patient activity numbers. However, before that was possible, an urgent need arose which required an immediate change to the Aortic Aneurism Repair (AAA) part of the service.

NHSE/I Specialised Commissioning SE have committed to updating the committee regarding progress.

This paper is in four parts.

Part One. Background

Part Two. Emergency Move of Aortic Aneurism Repair (AAA) Procedures from Medway Foundation Trust (MFT) to East Kent Hospitals University Foundation Trust (EKHUFT)

Part Three. Proposed Engagement for move of AAA

Part Four. Update on recommendation to move to an Interim Main Arterial Centre (MAC) based at Kent and Canterbury Hospital.

Please note:
The move of the AAA service does not pre-empt the existing process regarding the establishment of the interim Main Arterial Centre (MAC) on the Kent and Canterbury Hospital site, the progress on which is discussed in Part Four of this paper.

Part One. Background

Introduction

As previously presented, the requirement for the establishment of a Vascular Network for Kent & Medway is for clinical reasons in line with national initiatives rather than any business driven need.

The Case For Change, which JHOSC colleagues have already had sight of is based on the need to ensure appropriate standards of clinical care, and for information can be found here:

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/02/case-for-change-kent-medway-vascular-review.pdf

What is vascular disease?

Vascular disease affects veins and arteries. It may cause blood clots, arterial blockages and bleeds which can lead to strokes, amputation of limbs and conditions such as aneurysms that might threaten life if left untreated.

Specialised vascular services which are commissioned by NHSE/I Specialised Commissioning provide treatment for:

- **Aortic aneurysms** – where a bulge in the artery wall is caused by arterial disease that can rupture. Treatment for this may be planned before the bulge reaches a critical size, or as an emergency if it ruptures;
- **Carotid artery disease**, which can lead to stroke; and
- **Arterial blockages**, which can put limbs at risk.

All these treatments are clinically specialised and need a skilled team available 24 hours a day, every day of the year, to provide this service and support patients.

What prompted the review of the current service?

In an effort to ensure specialised services are of the highest standards of quality and safety no matter where people live, NHS England worked with clinical and commissioning experts and patients across the country to develop a National Service Specification (NSS) detailing what services should provide.

After reviewing the evidence and conducting a national programme of patient and public engagement the Vascular Society of Great Britain and Ireland and the team of experts and patients that developed the service requirements recommended that in order to ensure safety and deliver best practice, specialised vascular services should have:

- A minimum population of at least 800,000 in a specified area to ensure an appropriate volume of patients are seen each year
- Twenty four hour, seven day a week vascular surgery and interventional radiology with on-call rotas staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists

- All arterial surgery with a dedicated vascular ward provided at a vascular centre to ensure that highly experienced staff are treating sufficient patients to maintain their skills
- Access to cutting edge technology including a hybrid operating theatre for endovascular aortic procedures such as endovascular aortic aneurysm repair and combined open and interventional radiology procedures.
- Vascular surgeons who work closely with specialist nurses, interventional radiologists, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and in emergency medicine amongst other specialities to provide a comprehensive multi-disciplinary service.

What did the review include?

NHS England & Improvement (NHSE/I) in collaboration with East Kent Hospitals University NHS Foundation Trust and Medway NHS Foundation Trust reviewed both emergencies and planned specialist vascular treatment at hospitals in Kent and Medway.

This includes outpatient care (e.g. appointment with a specialist), day care treatment (e.g. an operation where you go home the same day) and inpatient treatment (an operation requiring you to stay in hospital), which we are describing here as specialist treatment.

The review did **not** include varicose vein surgery, heart disease, heart surgery or the management of the common types of stroke.

What happens now?

Kent and Canterbury Hospital is treating above the minimum numbers of core index procedures for specialised services, whilst Medway is not.

Currently patients requiring an inpatient stay following vascular surgery attend the Kent and Canterbury Hospital in Canterbury or Medway Maritime Hospital in Medway either through an elective pathway (e.g. planned operation) or an emergency pathway (e.g. via A&E).

An elective pathway is where the patient is referred for non-urgent treatment by their GP.

An emergency (or non-elective) pathway is where the patient is admitted as an emergency.

For elective patients, the initial referral will normally be for an outpatient appointment. These currently take place at:

- Medway Maritime Hospital, Gillingham
- Maidstone Hospital
- Tunbridge Wells Hospital
- William Harvey Hospital, Ashford
- Queen Elizabeth The Queen Mother Hospital, Margate
- Kent and Canterbury Hospital, Canterbury.

Patients requiring emergency or elective inpatient vascular surgery are currently treated at Kent and Canterbury Hospital and Medway Maritime Hospital.

What needs to happen in the future?

Establishing the interim Main Arterial Centre at Canterbury will ensure an ongoing high standard of care for all Kent and Medway patients and is driven by clinical need as outlined above.

To ensure patients get the highest standards of care in hospitals in Kent and Medway, that meets all the recommended criteria for specialist vascular services:

- Patients will continue to go to their local hospital (as listed above) to ensure that most care will be delivered as close as possible to people's homes. This includes outpatient appointments, tests, scans, and day procedures.
- Day surgery would continue to be provided in Medway and Canterbury, as it is now.
- Specialised Inpatient emergency or particularly complex operations will in future be delivered at the main arterial centre.
- Elective inpatient operations will in future be delivered at the main arterial centre.
- Non Elective (Emergency) Inpatient operations will in future be delivered at the main arterial centre.
- Bringing inpatient services together into a 'main arterial centre' will ensure that patients have access to a sustainable consultant-led vascular service 24/7, every day of the year in line with the National Specification.

2018 Activity

In 2018, a further review of vascular service in Kent and Medway, acknowledged that the future permanent location of the 'main arterial centre' for Kent and Medway would be determined through the East Kent transformation programme (part of the local Sustainability and Transformation Programme).

The proposed options in the transformation programme are still in the evaluation stage and are yet to be finalised. It is likely to take several years to complete this process and deliver the changes within East Kent.

PART TWO Emergency Move of Aortic Aneurism Repair (AAA) Procedures from Medway Foundation Trust (MFT) to East Kent Hospitals University Foundation Trust (EKHUFT)

Introduction

Following clinical advice from the Medical Director of Medway Foundation Trust, NHS England, Specialised Commissioning, South East temporarily moved AAA patients from Medway Maritime Hospital, Medway Foundation Trust to the Kent and Canterbury Hospital on 6 January 2020.

A patient safety concern arose due to staff shortages in the Vascular team at MFT in late December 2019 with the decision taken to move the AAA service to Medway as soon as was practically possible.

A briefing was sent to Overview & Scrutiny Colleagues ahead of the move which came into effect 6th January 2020.

There is ongoing and continuous review of the service.

Aortic Aneurysm Repair (AAA) – Improved resilience.

East Kent Hospitals University Foundation Trust (EKHUFT), have sufficient clinical team members and infrastructure to continue to undertake local referrals for AAA surgery and assume management of those patients currently being cared for MFT. Patients from Maidstone currently treated at MFT will be now be transferred to Kent and Canterbury Hospital. Kent patients currently accessing services will be unaffected.

The collaboration of the two Vascular teams on a single site improves the robustness of the clinical on call arrangements for AAA repair.

Pathway change

AAA procedures can be divided into planned (elective) procedures (the majority of the work) and unscheduled intervention in patients who present as an emergency.

The pathway change involves:

Elective Surgery:

Patients will undergo their assessment at MFT as they do now. Individual cases will be discussed in the Vascular network AAA multi-disciplinary team meeting (MDT) (as now), hosted by the MAC.

AAA intervention will be undertaken at Kent and Canterbury Hospital. The current Vascular team at MFT will support this treatment pathway.

Emergency Surgery:

All emergency AAA patients that present to MFT will be resuscitated and transferred to Kent and Canterbury Hospital where on-call consultant cover will be in place. These transfer arrangements are already well established from other sites.

Where the ambulance crew suspect a patient might require intervention for a AAA, South East Coast Ambulance Service (SECamb) will convey the patient directly to Kent and Canterbury Hospital.

SECamb were consulted on and approved this change in the emergency pathway.

How many patients will be affected by the move of AAA surgery from MFT to Canterbury?

Potential

The following information has been obtained using NHS England commissioning data and the National Vascular Registry as a projection of potential patient numbers.

Approximate Patient Numbers Per Annum.	NVR Data	HESS IT analysis from Trusts and NHSE
Elective AAA	15-24	
Unscheduled AAA	5-12	
Total	20-36	44

Analysis of Actual 2018/19 (Time/Distance)

Of the 21 patients receiving AAA surgery in 2018/19, overall a move to Kent & Canterbury increases travel time and distance. 1 patient would have had a reduced travel time of 9 minutes had they gone to Kent & Canterbury for their treatment.

Of the 21 patients 5 were treated on an emergency basis (non elective) and 16 were treated on a planned basis (elective), which means they had a date for their procedure and attended hospital on that date.

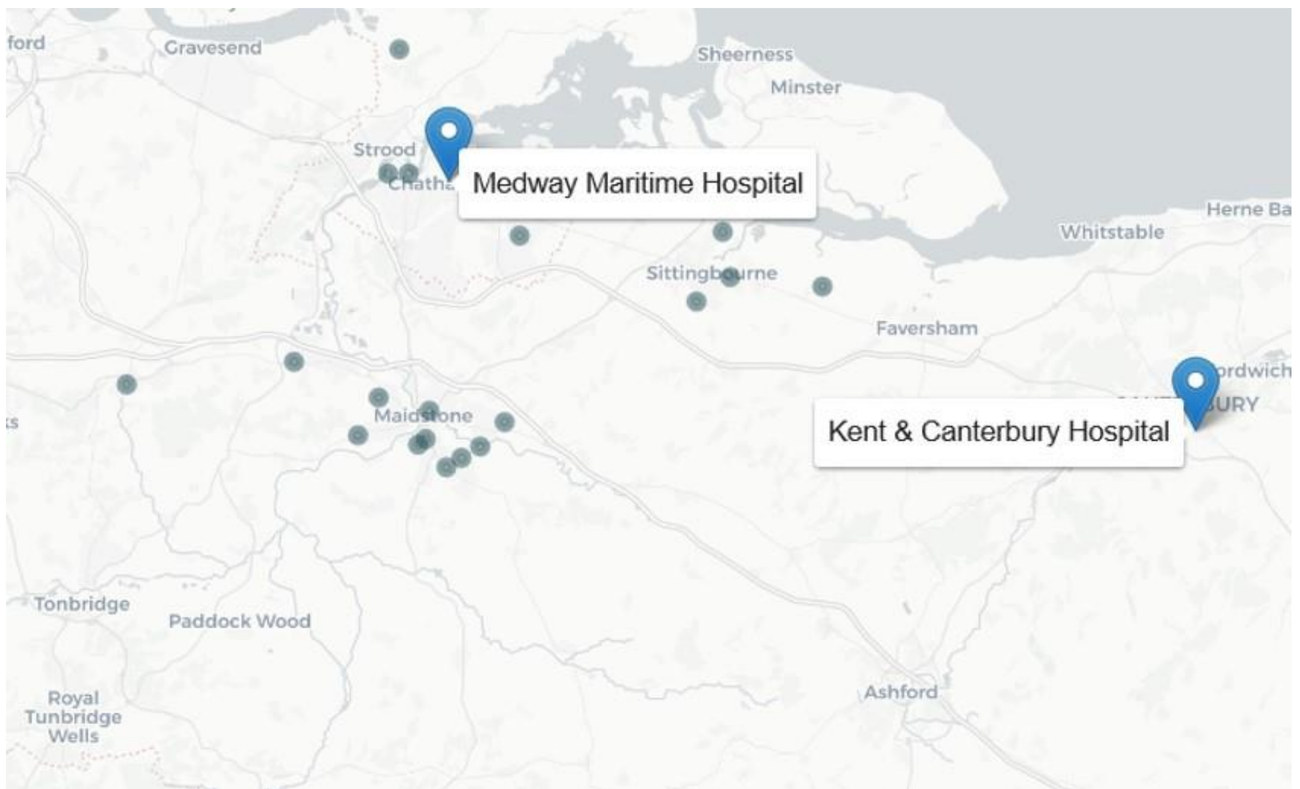
The total increase in distance travelled by all AAA patients in 2018/19 is 382 miles, giving an average increase by patient of 18 miles.

In terms of time travelled, the total time increase in hours is approximately 363 minutes (6 hours) which equates to approximately 17 minutes average increase per patient.

The maximum increase in travel time is 36 minutes, the minimum is a reduction of 9 minutes. The maximum increase in travel distance is 31.3 miles, the minimum is a reduction of 9.6 miles.

The map below shows patient location 2018/19 in relation to both Medway Foundation Trust and Kent & Canterbury Hospital.

Location Map of AAA Patients 2018/19



Impact on other Inpatient Specialised Vascular Services at Medway Foundation Trust.

All other specialised Vascular surgery services will continue to be performed at Medway Foundation Trust until the Interim MAC at Kent and Canterbury Hospital process has been completed. Assurances have been received from MFT regarding the stability of the remaining service and clinical teams from both Trusts continue to work together.

There are monthly meetings of the Clinical and Operational Group chaired by the MFT Medical Director, and with membership of a range of clinical and non-clinical staff from both EKHUFT and MFT (with invitations also sent to Maidstone and Tunbridge Wells NHS Trust.

There is a weekly Multi-disciplinary Team meeting (MDT) with all clinicians from both Trusts that includes representation from IR, vascular and anaesthetics to discuss case mix and patient conditions.

There is also a weekly M&M Meeting (mortality and morbidity meeting) with all clinicians above to review clinical performance.

Part Three. Draft Engagement for Interim Move of AAA

Introduction

The draft communications and engagement strategy below outlines how NHS England Specialised Commissioning, plans to inform and involve stakeholders, patients and local people in proposal to make the temporary move of AAA procedures from Medway to Kent & Canterbury (as outlined in Part Two of this paper), an interim move until such time as the permanent location of the Main Arterial Centre is decided upon, in line with the National Vascular specification.

Draft Communications and Engagement Strategy

NHS England has been working with partners, led by senior surgeons, in developing detailed proposals to provide these vital services.

An emergency temporary move of Aortic Aneurism Repair (AAA) Procedures from Medway Foundation Trust (MFT) to East Kent Hospitals University Foundation Trust (EKHUFT) took place with effect from 6th January 2020 due to staffing shortages.

Transforming health and social care in Kent and Medway, a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council is looking at the future of services across the whole area.

However, it will take some time for these wider changes to take place. Meanwhile a sustainable vascular service for East Kent is needed in the interim. We continue to work with clinicians to develop a proposal that we think is the best temporary solution.

EKHUFT, have sufficient clinical team members and infrastructure to continue to undertake local referrals for AAA surgery and assume management of those patients currently being cared for at MFT. Patients from Maidstone currently treated at MFT will be now be transferred to Kent and Canterbury Hospital.

The collaboration of the two Vascular teams on a single site improves the robustness of the clinical on call arrangements for AAA repair.

We are proposing to engage with the public and service users about making this temporary move an interim solution in accordance with our duties under section 13Q.

Background

Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and veins, but not diseases of the heart and vessels in the chest. These disorders can reduce the amount of blood reaching the limbs or brain or cause sudden blood loss if an over-stretched artery bursts. Vascular specialists also support other medical treatments, such as major trauma, kidney dialysis and chemotherapy.

Complex Vascular surgery covers:

- Abdominal Aortic Aneurysms (AAA)
- Screening people for AAA
- Strokes (such as Carotid Endarterectomy (CEA) or Transient Ischaemic Attacks (TIAs or mini-strokes)
- Poor blood supply to the feet or legs

There are also roles for vascular surgery supporting other major specialities e.g. trauma, neurosurgery, cardiac surgery, dermatology, clinical laboratory services, nephrology, plastic surgery, and other disciplines. Vascular patients are often treated by other specialties including cardiology, renal, diabetology and podiatry.

In common with other specialties, there is strong national clinical consensus that patients who need vascular surgery receive better quality care when they are treated by specialists who deal with a high volume of patients and who, therefore, have significant expertise in this field.

Approach

Legal and policy context

The legal context for this document is the duty to involve the public (section 13Q) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has a statutory duty to 'make arrangements' to involve the public in commissioning services for NHS patients.

The section 13Q duty is aimed at ensuring that NHS England acts fairly in making plans, proposals and decisions in relation to the health services it commissions, where there may be an impact on services. The duty requires NHS England to make arrangements for public involvement in commissioning.

Public involvement in commissioning is about offering people ways to voice their needs and wishes, and to influence plans, proposals and decisions about their NHS services. Patients and the public can often identify innovative, effective and efficient ways of designing and delivering services if given the opportunity to provide meaningful and constructive input.

There are four tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

In addition, NHS England's service change guidance states:

> ***Effective proposals should have on-going involvement with staff, patients and the public. Proposing organisations should avoid presenting a fully worked up set of service change options to the public unless there has been on-going dialogue.***

.

Working in partnership

The work will be co-ordinated through the Communications and Engagement workstream which reports to the Kent & Medway Vascular Programme and which will comprise CCG, NHS England and Trust communications together with representation from Healthwatch.

Pre-consultation

Reviews of vascular services have been ongoing since 2014 and patients have been involved throughout.

In 2019 over 200 letters were sent out inviting patients and their families to attend one of three patient and public events, to be held in Maidstone, Medway and Canterbury.

3 people attended the event in Maidstone on 16th September (although 8 people had accepted the invitation) and 9 people attended the event in Rochester on 18th September. Participants comprised people with vascular conditions and family members. Other attendees were from NHS England, the Kent and Medway Vascular Network, Vascular Consultant/Clinical Lead and the Executive Medical Director, Medway Foundation Trust.

A member of the Kent and Medway NHS Joint Overview and Scrutiny Committee also attended the second event.

Despite the wide invitation, only two people asked to attend the Canterbury session so, with their agreement, this was changed to individual telephone interviews which were conducted on 25th September.

How has pre-engagement informed the proposals?

All participants in the 2019 engagement were extremely positive about their experiences as inpatients at both Medway and Canterbury, suggestions for improvement to the service in general have been fed back to the Trusts via the clinicians who attended.

There was agreement for the need to consolidate specialist resources. The clinical leads discussed the need to ensure that future vascular services meet the required standards, as specified in national guidelines and attendees welcomed this and understood that requirement.

Live Engagement on interim move of AAA surgery

- To communicate openly and widely about how the public views in phase one have helped influence the interim model.
- To communicate openly and widely that no change is not an option. Provide a clear explanation about how the interim option that has been developed, with a proactive campaign and direct engagement with patients, public and key stakeholders with the aims of:

- ensuring understanding of the reasons for the change
- ensuring understanding that this is an interim option for safety reasons pending consultation and engagement around wider Kent and Medway reconfiguration.
- enabling commissioners and the service providers to understand issues for patients, public and key stakeholders ensuring the final model has taken these into account

In both cases the objectives are:

- To provide clear and consistent messages and information to all stakeholders
- To explain the option and the benefits to patients
- To allow patients and the public to voice any concerns/raise issues/ask questions about the chosen interim option
- To gain views on associated services (for patients undergoing amputation for example)
- To balance any negative perception and concerns
- To increase public confidence in NHS England as a listening and responsive commissioning organisation.

Informal Engagement

If Overview and Scrutiny agrees that an informal engagement can be undertaken in this phase, the approach will be to inform of the chosen option and ask whether any concerns need to be taken into account in its implementation. This process will not ask for views on options. This will not constitute a statutory process and will be conducted over a much shorter time frame.

Specific drop in events

Held in a range of locations across Kent and Medway (likely two), in accessible venues and at a variety of times to give people a range of choices.

These events will give people an opportunity to hear an update on the proposals, how their views have helped shape them and have the opportunity to talk with those involved in the programme – particularly, but not exclusively, clinical leaders.

Working closely with the community and voluntary sector

The community and voluntary sector have wide ranging communications networks. We will aim to work with the CVS through events they host directly with their clients to get their views – this often works well with hard to reach groups. We will also supply information through their distribution channels.

Collaboration with CCGs Trusts and Healthwatch to make use of existing engagement channels

The workstream members will aim to use all.

Online opportunities to respond to the engagement/consultation

The engagement will be made available on the NHS England consultation hub. This is the central online resource for all NHS England consultation and engagement projects. It provides a mechanism for consultation documents to be uploaded and for people to provide their feedback.

Engage with staff

NHS staff will be engaged, with briefings organised at their place of work and including senior trust staff. Staff are key influencers of patient views and also members of the public and use local health services themselves, so briefings will focus on the case for change as a whole, not just their role as employees. The aim will be to ensure staff have had the opportunity to understand the impact of the changes to the way they work

Robust media approach

There will be a responsive, agile and robust media handling plan including proactive briefing about the proposals. A media sharing protocols will be created.

Multi-channel communications

People get their information from a variety of different sources. Social media and websites together with other existing communications mechanisms such as newsletters will be used.

As the key clinical leaders are not always likely to be available. We propose to produce a video communicating the engagement's key messages which will be made available on websites and presented at events.

Materials in appropriate formats

NHS England has an Accessible Information Standard which sets out expectations for communications for those with disabilities (see Section 5).

Our Equality Impact Assessment also indicates a potential need for translations into languages other than English.

Key messages

There will be a core narrative and a set of key messages around the proposals themselves, using terms that will be applied consistently across all materials.

Overarching messages

We will develop services which are:

- High quality with excellent outcomes for patients;
- Developed in line with the best available evidence to increase the chance of survival for patients;
- Can be sustained, despite future challenges; and
- Offer a good patient experience.

We are committed to:

- Engaging and involving stakeholders, partners and the public to find out what matters most to people;
- Making sure all the feedback received is considered as part of the decision making process;
- Being open and transparent throughout the consultation process.

Supporting messages

- Surgeons at all of the hospitals have worked together to develop this option.
- We want to end uncertainty for patients and for staff
- We want to provide safe, high quality services in line with the recommendations of the experts (Vascular Society of Great Britain and Ireland)
- The need for vascular surgery is reducing due to improving health of the population.
- The impact of a reducing number of smokers and better care for people with diabetes means the demand for vascular surgery will continue to reduce.
- The way vascular services are provided has also changed from major surgical procedures to less invasive techniques which require specialist training and the introduction of preventative surgery which reduces the risk of stroke.
- To ensure services remain safe and high quality it is important that surgeons remain practiced in these specialist techniques which means they should undertake a minimum number of procedures to maintain their expertise
- The number of surgeons available to provide these services is limited and hospitals may experience difficulty in recruiting enough to provide sufficient cover for existing rotas.
- No change is not an option

Target dates:

Pre-consultation	Live-engagement	Analysis and reporting	Decision	Implementation
Feb – March	March/April	April-May		
Development of communications and engagement strategy	Engagement launch	Responses analysed	Decision taken	Implementation – communication and engagement to be done by the providers
Stakeholder analysis	Activities logged for audit trail	Report written	Stakeholders updated on outcome	
Approval of business case by EKHFT, MTW, MFT Boards	All feedback stored in line with Data Protection		Communicate decision to patients / public	
Establishment of Patient Reference Group				
Plan and schedule engagement events x 2				
Develop engagement material				
Work with voluntary sector on reach and breadth				
Stakeholder briefings				
Media briefing				

Analysis and reporting

During this phase all feedback will be analysed. A report will also be written following agreed approvals process and signed off.

Decision making

The report will be available for the public and for overview and scrutiny and will also be presented at the relevant CCG and provider board meetings.

A media and communications plan will be required for the decision.

Implementation

Communications for this phase to be led by providers.

1 Risks and Issues

All proposals to change hospital services inevitably face some challenges that are not specific to the proposals in question or the area in which they are taking place. These include:

- Emphasis among local people and opinion-formers on importance of hospital, sometimes to the exclusion of other services
- Fear of loss of local services
- Fear that local hospital will become unsustainable
- Concern about travel to get to appointments or visit loved ones
- Fear of longer distances or poor roads leading to safety risks
- Local people and politicians equating services in local hospital with status of the area

NHS England's responsibility is to put forward a service proposal which will give the best possible outcomes to patients across the whole geography. Any engagement will inevitably generate noise and interest, and this is to be expected. What is important is the approach that is applied to engagement/consultation and making sure it is as robust as possible, following due process.

Equality analysis

Evidence
What evidence have you considered? People with diabetes are at a higher risk of vascular disease. Prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of activity. Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorders. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions. NHS England now has an accessible information standard which needs to be considered/adhered to in the engagement https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-er-july-15.pdf
Age Patients using vascular services tend to be older. Although there is an increasing prevalence of older people using online services it will be important for the communications and engagement process to consider the needs of older people by producing some documentation in print/large print to allow for age-related changes in vision.

Disability
• Because a proportion of patients accessing vascular services have diabetes it is likely that some will have visual impairment beyond the usual age-related changes in vision. This means that the consultation will need to be available in alternative formats. These patients may be unable to drive and may have difficulties accessing public transport, consideration needs to be given to whether they will be able to attend meetings. • Arterial disease in some patients requires lower limb amputation which will also affect accessibility to attend meetings • Patients with chronic mental health problems and learning disability (particularly Down's syndrome) are at increased risk of diabetes and arterial disease. There will be a requirement for easy read versions of documentation
Gender reassignment (including transgender) No impact
Marriage and civil partnership No impact
Pregnancy and maternity No impact
Race Diabetes is more common in people of South Asian origin with earlier onset of significant arterial complications. People of Afro-Caribbean origin are more prone to high blood pressure which may be more difficult to control than in other groups, hence increased incidence of renal disease and stroke. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design. It will also be appropriate to make translations available for people whose first language is not English.
Religion or belief Patients whose religion or belief does not allow blood transfusion or particular blood products will have complications relating to accessing vascular services.
Sex Vascular disease is more likely to affect men than women. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design.
Sexual orientation No impact
Carers As vascular patients tend to be older and may already have disabilities (or develop a disability as a result of vascular surgery/amputation) they may already have a carer or may need the support of a carer. The consultation will seek to engage with carers to understand the impact of the proposals and possible solutions such as community transport for visitors.
Other identified groups. Parts of Medway CCG have areas of socio economic deprivation. Smoking, obesity and low levels of activity are more common in areas that have socio economic deprivation. As these lifestyle risk factors are also linked to prevalence of diabetes (and therefore risk of vascular disease) the communications and engagement must consider the

communications needs of this group. A review by Ofcom indicates that socio economic deprivation influences access to information technology, which can itself be a form of social exclusion.

However, more recent research by Public Health England for the One You campaign shows people aged 40-60 in lower socio economic groups are heavy users of mobile communications including text messaging and digital social media such as Facebook. The mix for the campaign needs to take these preferences into account.

Part Four. Update on Recommendation to move to an Interim Main Arterial Centre (MAC) based at Kent and Canterbury Hospital

Introduction

In April 2019, to comply with the national clinical guidance, NHS England/Improvement recommended that an interim main arterial hub should be located at the Kent & Canterbury Hospital until such time as the longer-term transformation programme happens.

Whilst the temporary AAA move has stabilised the service, all Trusts involved are clinically in agreement with this recommendation and are committed to working together to further develop the vascular network and ensure the very best care for patients in Kent and Medway, and to this end regular meetings are now held between the Trusts.

As per Part Two of this paper, there are monthly meetings of the Clinical and Operational Group chaired by the MFT medical director, and with membership of a range of clinical and non-clinical staff from both EKHUFT and MFT (with invitations also sent to MTW)

There is also a weekly Multi-disciplinary Team meeting (MDT) with all clinicians from both Trusts that includes IR, vascular and anaesthetics to discuss case mix and patient conditions

There is also a weekly M&M Meeting (mortality and morbidity meeting) with all clinicians above to review clinical performance

Ongoing Engagement

NHS England South (South East) has been leading a review of specialised vascular services in Kent and Medway. The review started in December 2014 and has involved patients, relatives and members of the public throughout, to ensure that their experiences and views inform the development of future services.

In September 2019 patients and their families attended one of two patient and public events, held in Maidstone and Medway. Two people with vascular conditions took part in guided telephone discussions. The events and discussions were designed to:

- outline the clinical recommendations from the Kent and Medway review of specialist vascular services
- outline the clinical model, obtain participants' views and consider any issues/questions they may have;
- understand what people think works well and what could be improved in developing future services
- outline what happens next

The Public Engagement Agency (PEA™) was commissioned to support the delivery of the events and telephone interviews and write-up the findings from these activities. This report provided an overview of the content and key findings.

Overview

Over 200 letters were sent out inviting patients and their families to attend one of three patient and public events, to be held in Maidstone, Medway and Canterbury.

Key findings

All participants were extremely positive about their experiences as inpatients at both Medway and Canterbury, suggestions for improvement to the service in general have been fed back to the Trusts via the clinicians who attended.

Regarding the proposals, there was agreement for the need to consolidate specialist resources, understandable concerns were discussed with attendees at length.

The clinical leads discussed the need to ensure that future vascular services meet the required standards, as specified in national guidelines and attendees welcomed this and understood the requirement.

Specialised Inpatient Vascular Procedure Review - November 2019

A detailed review of procedures highlighted CCG commissioned activity which may need to move.

Next Steps

This detail is currently being worked through with CCGs and the STP as to how the interim Main Arterial Centre will be taken forward.

Once this is worked through, we would expect to update Overview and Scrutiny colleagues.

Should a need for engagement/consultation emerge from this, we will discuss with JHOSC at that time and may seek to include alongside the engagement for AAA as outlined in Part Three of this document, if appropriate.

Contact	england.speccomm-southeast@nhs.net

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Item 7: East Kent Transformation Programme

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 6 February 2020

Subject: East Kent Transformation Programme

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

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

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1. Introduction

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

2. Joint Scrutiny

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

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

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

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

(d) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013[3] the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) is meeting for the first time of this issue. The JHOSC may:

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

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

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

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

3. Legal Implications

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

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

4. Financial Implications

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

5. Recommendation

The JHOSC is invited to:

- CONSIDER and NOTE the report.

Background Documents

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

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

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

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

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

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JOINT HEALTH

OVERVIEW AND SCRUTINY COMMITTEE

6TH FEBRUARY 2020

A SUMMARY OF EVALUATION PROGRESS FOR OPTIONS FOR THE CONFIGURATION OF HOSPITAL SERVICES IN EAST KENT:

Report from: **East Kent Transformation Programme**

Author: Lorraine Goodsell, Deputy Managing Director East Kent Clinical Commissioning Groups

Introduction

The purpose of this document is to provide an overview to the Committee on progress with the East Kent Transformation Programme since our last update.

Background

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

Progress to Date

This document details key activities undertaken over the last year.

Evaluation Summary

Two options for the configuration of hospital services in east Kent were selected for evaluation against five criteria as set out below:

1. Clinical Sustainability
2. Accessibility
3. Implementable
4. Strategic Fit
5. Financial Sustainability

Each option was assessed independently of the other, against a "Do Minimum" control option. The evaluation process focussed on the options appraisal of acute hospital reconfigurations.

An evaluation panel consisting of The Sustainable Healthcare in East Kent Joint Committee voting members was called upon to review each of the five criterion and to award scores based on each option's outcomes, compared to the Do Minimum. As the Do Minimum is the key comparator, it was agreed that it would score zero across all five criteria

1. Pre Panel and Programme Assessment

1.1 Development and assessment of the standardised templates

Analysis was undertaken by the Trust, STP workforce and estates leads and independent experts, to respond to each of the evaluation questions in the form of a standardised template.

These templates were designed to ensure consistency in the evaluation response approach and were populated with support from the CCG leads.
These templates were reviewed through and signed off by the East Kent Transformation Programme to ensure robust scrutiny, impartiality and transparency of the analysis undertaken.
Once the templates were signed off and endorsed by the East Kent Transformation Programme, the content of the templates became the basis of the evaluation reports, developed by the CCG.

1.2 Development of the evaluation reports

The endorsed contents of the templates were systematically summarised into a series of evaluation reports to enable the Evaluation Panel to review outcomes against the "Do Minimum" and score accordingly.

To aid the Evaluation Panel in its systematic review of each option, separate reports were prepared comparing each option against the "Do Minimum".

The five reports were reviewed and endorsed through the East Kent Transformation Programme governance structure, before being distributed to the Evaluation Panel in advance of the Panel sessions.

The corresponding templates were also included within the appendices section of the reports to ensure that the panel members had all evidence available to them to support their scoring.

2. The evaluation panel and report

The Panel comprised of an independent chair, as well as scoring members. The role of the independent chair was to mediate discussions during the panel sessions and to facilitate consensus on scores awarded. The scoring members were voting members of The Sustainable Healthcare in East Kent Joint Committee

Three separate panel sessions were held in September, the:

- first session took place on 4th September to evaluate accessibility and strategic fit;
- second session took place on 11th September to evaluate financial sustainability and whether proposals were implementable; and
- final session took place on 18th September to evaluate clinical sustainability.

Subject Matter Experts (SME) were available before each scoring session of the panel, to provide expert knowledge and additional guidance to the scoring members. However, the scoring members deliberated scores in isolation with the independent chair to ensure and maintain impartiality. Members of the East Kent Transformation Programme were also present to provide support to scoring members.

3. Draft Pre Consultation Business Case, Clinical Senate Review & NHSE/I assurance

3.1 Draft pre-consultation business case

A mature draft of the PCBC was finalised and endorsed through our programme governance during October as detailed below:

• Transformation Delivery Board:	21st October 2019
• System Board:	29th October 2019
• The Informal seminar of Sustainable Healthcare in East Kent Joint Committee:	30th October 2019
• Mature draft of the PCBC shared with NHSE/I and the Clinical Senate for review:	11th November 2019

3.2 Clinical Senate review

The Clinical Senate has reviewed the draft PCBC in advance of final submission to NHSE and NHSI in accordance with the major service change assurance processes. Inclusive of all clinically related elements, the review included, but is not limited to, the case for change. The Senate also reviewed shortlisted service configuration

options, including the proposed clinical models and standards for ED; Urgent and Acute Care (inclusive of critical care); Planned Care; Cancer sub-specialties; and Paediatrics.

The recommendations from the Senate will be incorporated into the final report that will be submitted to NHSE/I.

4. Finalising the PCBC

4.1 Internal Governance

The steps that will be completed to finalise the PCBC are detailed as follows:

- Completion of additional work identified as required for the final draft of the PCBC including incorporating the recommendations from Clinical Senate and initial review by NHSE/I/E.
- Final draft to be reviewed through internal governance process by end of February 2020.
- Final draft PCBC, endorsed by Provider Boards and Joint Committee, by end of March 2020.

4.2 Key Planning Assumptions/ NHSE/I Assurance Process

NHSE/I will receive a final draft PCBC in April 2020 and consultation will follow conclusion of assurance process

5. Next Steps

The timescale for delivery of the revised PCBC means that a final draft, that addresses actions identified by the Senate, will be completed by12th Feburary.This will allow for the PCBC to be reviewed and agreed in accordance with CCG and provider governance processes.

The evaluation panel will meet again in February to review:
•the information requested for assurance at the panel meetings in September;

•issues that have been considered through the change control process and may present a material change to the outcomes from evaluation; and

•information that may present a material impact to the PCBC and evaluation of options, this includes responses to Clinical Senate recommendations.

6. Appendix

1. The Evaluation Process
2. Options Summary (including do minimum)
3. Evaluation Criteria

Lead officer contact

Lorraine Goodsell,
Deputy Managing Director
East Kent Clinical Commissioning Groups

Appendix 1 The Evaluation Process

The end to end evaluation process involves three key stages:

Objectives

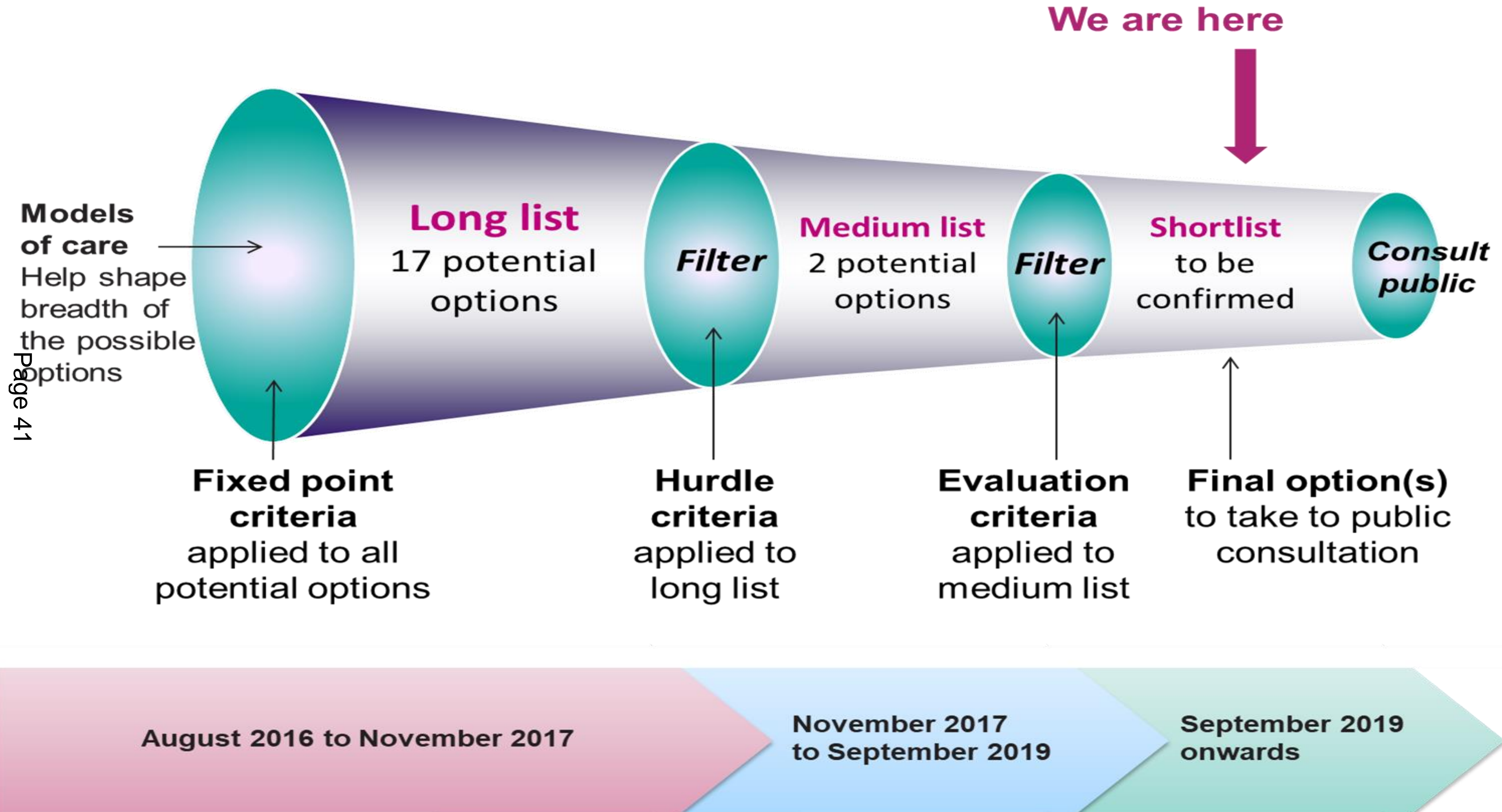
Key objectives of the evaluation process include:

- Provide an objective and transparent framework for the assessment of all possible UEC reconfiguration options
- Derive a manageable shortlist of options from the longlist of options
- Ensure that shortlisted options would enable East Kent local health economy's objectives to be met

The three key stages of the evaluation process

- **Stage 1: Hurdle Criteria (completed):** Application of agreed hurdle criteria with a clear threshold which the options either pass or fail
- **Stage 2: Ranking Criteria (completed):** Where multiple permutations of the same reconfiguration model (e.g. "one UEC site" or "two UEC site") are qualified, the options are ranked to select the best option of that type
- **Stage 3: Full Evaluation (current) :** This will form the final detailed evaluation stage

Options development and assessment



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Application of hurdle criteria

- Following the completion of the previous first stage of evaluation, a proposal from Quinn Estates (land developer) to provide a "hospital shell" on/adjacent to the Kent and Canterbury Hospital site for a single Major Emergency Centre was received

- This inferred a substantial and material capital benefit to the East Kent health economy. This option was agreed to be included in the original medium list, announced in November 2017

- Following an assessment from EY, a decision was taken to rerun the first stage evaluation in order to put the newly emerged option through the same degree of scrutiny and rigour as other options to clarify whether this option passed the hurdle stage

- Reapplying the hurdle criteria to the long list of options, included revising the hurdle criteria

The Hurdle Criteria

The table below summarises the hurdle criteria that was applied. Please note, that strategic fit is greyed out to highlight that it was not used as a hurdle criteria, but was taken forward as a criterion in the full evaluation.

#	Criteria	Criteria Description
1	**Is the potential configuration option clinically sustainable?**	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?
2	**Is the potential configuration option accessible?**	• **Urgent Care:** East Kent patients can access a UEC site within 60 minutes • **Trauma:** Trauma Units are on route to the major trauma centre (MTC); i.e. going to the trauma unit for stabilisation does not take the patient away from the MTC) • **Trauma:** the proportion of patients with **45min** access to a trauma unit is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH) • **Cardiac:** all Kent and Medway patients can reach pPCI centre within 90 minutes • **Stroke:** 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes) • **Vascular:** 95% of the East Kent population can access vascular services within 60 minutes
3	**Is the potential configuration option financially sustainable?**	• Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?
4	**Is the potential configuration option implementable?**	• Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?
5	**Is the potential configuration option a strategic fit?**	

Medium list of options

- Stage 1 (hurdle criteria) and stage 2 (ranking criteria) took the long list of seventeen options down to two options

- It should also be noted in July 2018 - there was a proposal of an independent review of the capital costs of Option 9 (a single emergency model at William Harvey Hospital). This review was taken forward and confirmed that capital costs did not meet the hurdle criteria for financial viability

- The medium list of options included:

Option 1: Two site ED model with William Harvey Hospital as the Major Emergency Centre

Option 2: One site ED model with Kent & Canterbury Hospital as the Major Emergency Hospital

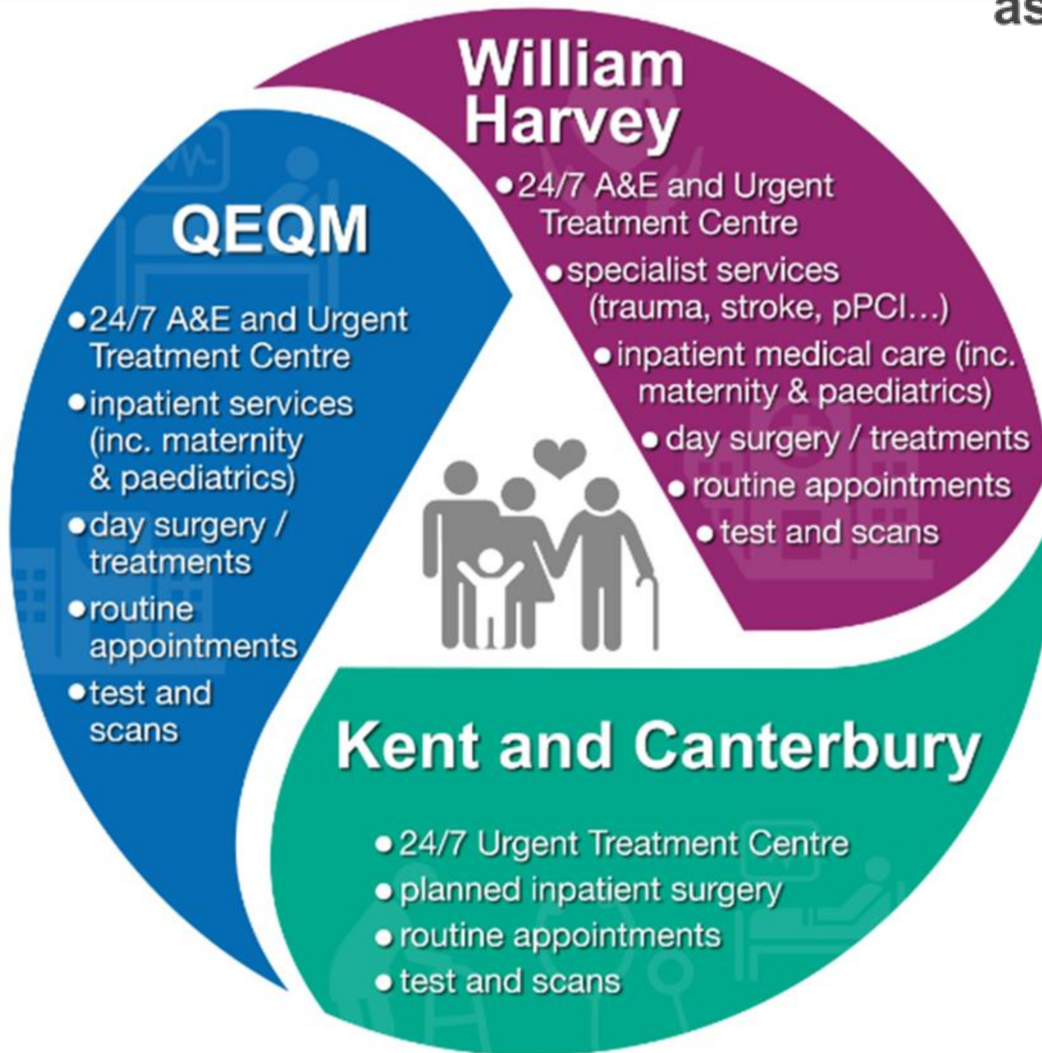
- During the final and detailed stage of the evaluation (stage 3) option 1 and 2 was also reviewed against a do – minimum option

Appendix 2 Options summary

	Option 1	Option 2
Urgent care for illness and injury	All hospitals	All hospitals
Day surgery and outpatient care	All hospitals	All hospitals
Complex inpatient care (includes consultant-led maternity, inpatient children's and acute medical services)	QEQM and William Harvey	Kent and Canterbury
Emergency care (including A&E and critical care)	QEQM and William Harvey	Kent and Canterbury
Specialist services (e.g. heart attack, stroke, trauma…)	William Harvey	Kent and Canterbury

Option 1

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

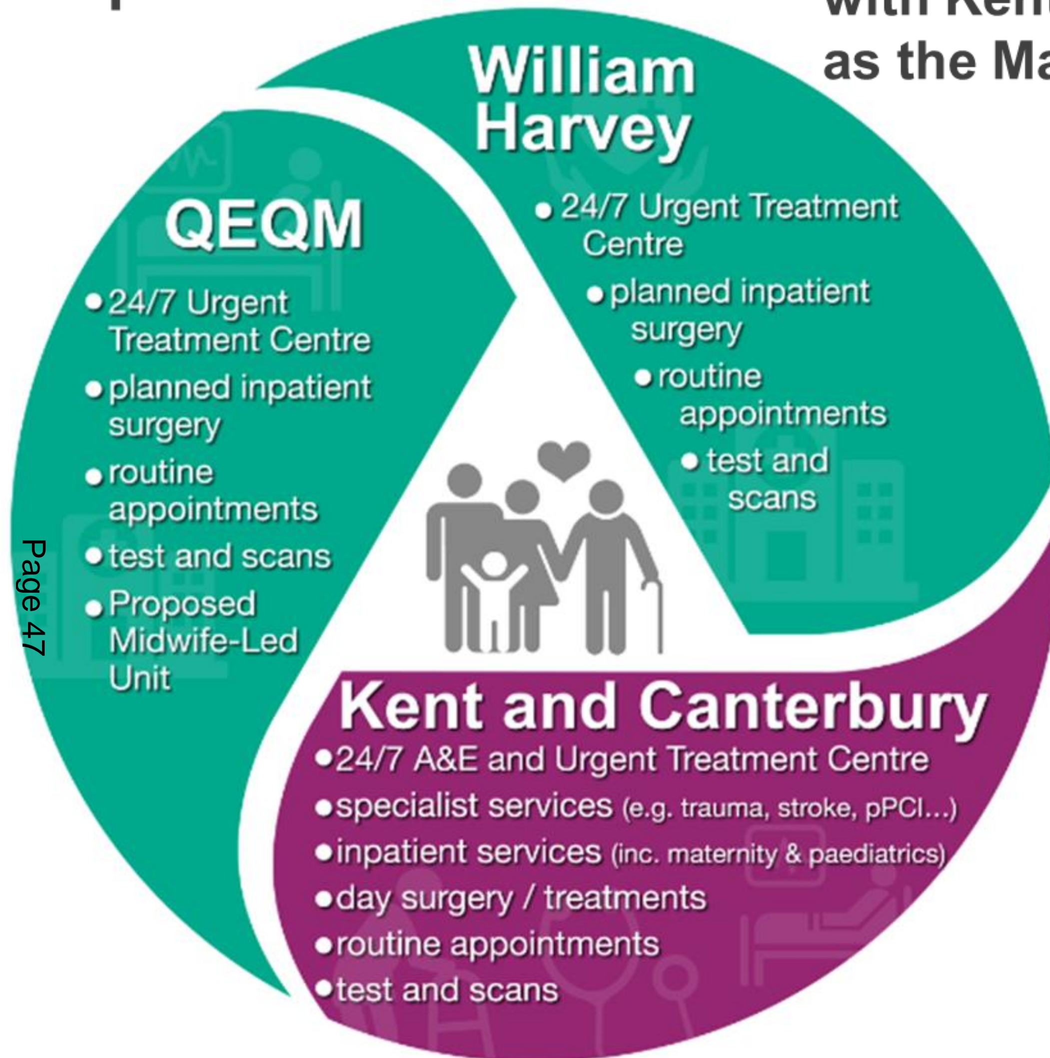


Option 1 has the following key acute changes:

- Permanent 2 site emergency medicine
- 2 critical care units
- 1 site elective surgery (low risk cases)
- 1 site stroke (HASU/ ASU)

Option 2

One site emergency department model with Kent & Canterbury Hospital as the Major Emergency Centre



Option 2 has the following key acute changes:

- Changes to a single site emergency medicine
- 1 critical care unit
- 1 or 2 site elective surgery (low risk cases) - to be confirmed
- 1 site stroke (HASU/ ASU)
- Single site obstetric and paediatric services
- Introduction of 1 standalone Midwife Led Unit at QEQM

Options summary

What is the 'do-minimum' option

Deciding whether to shortlist the options involved comparing them to a scenario without significant change. For this programme the do minimum has two elements:

Some planned improvements which would continue regardless of these proposals, including:

- delivery of 7 day working across the three sites
- establishing hyper acute stroke units in Kent & Medway
- do minimum includes changes or developments that are likely to happen within the next 12 years; including a range of agreed capital investment projects.

The modelling for do minimum scenario also needs to assume that some temporary changes made in recent years go back to their original model:

- Kent and Canterbury would return to taking emergency medicine admissions (but would not have a full A&E – the removal of full A&E services was formally consulted on previously)
- emergency medicine and critical care units at all three sites
- piloting of single site elective orthopaedic surgery reverts to two sites.

Options summary

Why compare against a ‘do-minimum’ option

The NHS Capital Investment Manual states:

The ‘Do-minimum’ option should be retained as a baseline in the shortlist since the implications of doing the minimum must be assessed and understood. It may be that a ‘do minimum’ option is not acceptable, or possible. However, the ‘do minimum’ option must then be included as a baseline so that the extra benefit and costs of other options can be measured against it. This will involve understanding the cost of merely maintaining the current level of service, over the full lifetime of the project. The effect of doing minimum might be that the life of the option is limited.

Significant resource input may be required just to maintain the status quo: that is, doing the minimum. Buildings or plant may have to come to the end of their useful life and may require replacement or upgrading. If the throughput of patients is increasing, maintaining service provision may take additional costs in staff, energy and other running expenditures.

Appendix 3
Evaluation criteria used in evaluating the medium list options

The evaluation criteria outlined on the following slides was used to score the medium list options against the 'Do-minimum'. While there is recognition that the 'Do-minimum' is not a sustainable option for the future, it is being used as the 'control' group to assist with objectively scoring both options. More detail on the 'Do-minimum' can be found in the next section.

Criterion	Sub-criteria	Evaluation questions
1. Is the configuration clinically sustainable and are able to deliver required quality standards?	**1.1) Quality: workforce**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow each organisation to operate working patterns that are safe and compliant with regulatory standards? b) Impact on delivering a sustainable workforce, improving the recruitment and retention of suitably skilled staff across the East Kent health and social care system?
	1.2) Quality: Clinical recommendations and standards	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow services to be configured in alignment with the Clinical Senate's recommended co-dependencies? b) Improve adherence to NHS policy (e.g. seven-day working and FYFV) and Royal College standards of care and conveyance standards?
	1.3) Quality: patient experience and performance	In comparison with the 'do minimum' scenario, to what extent do the options: a) Provide a better experience for patients as determined by nationally recognised and validated tools (i.e. Patient Reported Outcome Measures)? b) Improves overall performance (i.e. RTT, A&E, and cancer) ? c) Deliver hospital sites that best meet the quality standards for buildings?

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
2. Is the potential configuration option accessible?	**2.1) Emergency Travel Times**	In comparison with the 'do minimum' scenario, to what extent do the options: Enable emergency ambulance travel times to be in line with the following national / locally agreed standards. • 95% of the east Kent population can access an A&E department within 60 minutes. • The east Kent population can access a trauma unit for stabilisation within 60 minutes. • 95% of the Kent & Medway population can access the pPCI centre within 100 minutes (to enable a call-to-balloon time within 150 minutes). • 95% of the east Kent population can access a stroke unit within 60 minutes (to enable a call-to-needle time within 120 minutes). • 95% of the east Kent population can access vascular services within 60 minutes.
	2.2) Distance to hospitals	In comparison with the 'do minimum' scenario, to what extent do the options: (a) Enable the greatest number of people to receive appropriate hospital care at the site closest to home (b) Enable the greatest number of people from deprived communities to receive appropriate hospital care at the site closest to home
	2.3) Car/public transport travel times	In comparison with the 'do minimum' scenario, to what extent do the options: Enable patients requiring an inpatient stay and visitors (i.e. carers and relatives) to have the shortest travel times (a) By car (b) By public transport

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
3. Is the potential configuration option implementable?	**3.1) Time to implement**	Which option can be successfully delivered in the shortest times scale?
	3.2) Delivery risks	In comparison with the 'do minimum' scenario, to what extent do the options present any risks of delays or failure to deliver owing to: a) Council planning or resource consent requirements? b) Number of delivery partners? c) Operational complexity and decant arrangements? d) Funding from external source to the NHS?
	3.3) Transition period	In comparison with the 'do minimum' scenario, to what extent do the options: a) Maximise value from investments made during the transition period to support the sustainability of vulnerable services (minimises sunk costs) b) Enable the capital investment required to be phased over the transition period?

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
4. Does the potential configuration option align strategically?	**4.1) long-term sustainability**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Enable longer-term sustainability for the system (e.g. to avoid the need to reconfigure in the next 5-7 years following implementation)
	4.2) Impact on neighbouring systems	In comparison with the 'do minimum' scenario, to what extent do the options: a) Impact on neighbouring systems and other providers through outward flow
	4.3) Research, innovation and education	In comparison with the 'do minimum' scenario, to what extent do the options: (a) Support research, education and innovation current and developing research and education? (b) Provide opportunities to develop innovative practice that improves patient outcomes?
5. Is the potential configuration option financially and economically sustainable?	**5.1) System affordability and I&E performance**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Support a financially viable system across East Kent? b) Which option gives the best steady state I&E performance after year 10
	5.2) Net present value	In line with the STP evaluation methodology, which option gives the best 30/64 year net present value? (whole of system lens, including capital costs)
	5.3) Economic Impact	In comparison with the 'do minimum' scenario, to what extent do the options: a) Impact on employment opportunities within local communities

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JOINT HEALTH
OVERVIEW AND SCRUTINY COMMITTEE

6TH FEBRUARY 2020

A SUMMARY OF THE CONSULTATION ACTIVITY PLAN AND CONSULTATION DOCUMENT STRUCTURE FOR THE NHS EAST KENT TRANSFORMATION PROGRAMME

Report from: **East Kent Transformation Programme**

Author: Tom Stevenson, Acting Director of Communications and Engagement, Kent and Medway Sustainability and Transformation Partnership

Summary

This document is in two parts:

- Summary of the consultation activity plan for when the transformation proposals go to full public consultation
- Draft content structure for the main consultation document

The purpose of this report is to provide an overview to the Committee on planning for public consultation and seek feedback as part of our statutory duty to consult with the Committee on both the proposals and our processes for public consultation.

The full consultation plan and a version of the near final consultation document will be brought back to JHOSC for a further review and endorsement ahead of launching a formal consultation.

Progress to Date

The consultation activity plan and consultation document structure have been developed with feedback from the Kent and Medway Sustainability and Transformation Partnership Patient and Public Advisory Group and Kent Healthwatch.

1. Introduction

The following is a summary of our draft consultation plan for the East Kent transformation proposals. The full plan will be finalised as part of completing the Pre-Consultation Business Case for submission to NHS England/NHS Improvement. Also attached is a summary of the proposed content for the main consultation document.

Consultation with JHOSC
As part of the process of consulting with JHOSC on our proposals and how we intend to run a formal public consultation we would welcome JHOSC's feedback on these two draft documents (consultation activity plan and consultation document structure).

- **Consultation plan** – Comments would be appreciated on general themes, specific activities and materials identified in the plan; and whether JHOSC believe there are gaps in the current draft plans. We would particularly welcome comment from JHOSC on the level of consultation activities outside the east Kent area as this is still to be built into the draft plans.

- **Consultation document structure –** Comments would be appreciated on the overall structure proposed, detail required in specific sections, and the summary of proposed supporting factsheets and other materials.

The full consultation plan and a version of the near final consultation document will be brought back to JHOSC for a further review and endorsement ahead of launching a formal consultation.

Consultation length and timings
The consultation will be a minimum of 12 weeks and if necessary will be extended if there are overlaps with significant holiday periods. We cannot confirm timings for the consultation until we have further feedback from NHS England/NHS Improvement through their assurance processes.

2. Consultation scope

The consultation will focus on:

- Two options for reconfiguring acute hospital services in east Kent, including:
    - emergency departments (A&E)
    - specialist inpatient services;
    - services that are interdependent with the above
    - elective surgery

- Related plans to improve local cares services (e.g. general practice and community based services) to provide more care away from acute hospitals

A full list of services affected will be part of the consultation materials.

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

Geographical scope

In geographical terms, the consultation will cover the four CCG areas in east Kent (Ashford; Canterbury and Coastal; South Kent Coast; and Thanet), although all eight CCGs in Kent and Medway are merging into a single organisation from April 2020.

We have analysed patient flows from areas outside of east Kent for all EKHUFT emergency and specialist care services affected by the proposals and discussed these with neighbouring CCGs and trusts. There are no significant flows of patients from outside of east Kent however we will ensure neighbouring areas are informed about the proposals and residents in border areas who may use EKHUFT services will be invited to respond to the consultation.

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

- Haemophilia outpatient services
- Renal services
- PPCI
- Paediatric surgery

3. Consultation approach

Statutory duties and legislation

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

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

Consultation principles

Our consultation plan has been shaped to meet the following principles:

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

Consultation objectives

We will deliver a formal public consultation in line with best practice that complies with our legal requirements and duties. Our specific objectives for the consultation are to:

- Raise awareness of the public consultation across all the geographies affected

- Explain how the proposals have been developed and what they could mean in practice, so people can give informed responses.

- Collect views from the full spectrum of people that may be affected, gathering feedback from individuals and representatives of those affected.

- Ensure we use a range of methods to reach different audiences including activities that target specific groups with protected characteristics and seldom heard communities.

- Meet or exceed our reach target within the timeframe and budget allocated.

- Consider the responses and take them into account in decision-making, with sufficient time allocated to give them thorough consideration.

Accessible and inclusive consultation materials

We will endeavour to prepare all our public facing consultation materials in simple jargon free language. We will continue to use our Patient and Public Advisory Group as part of our drafting and testing process to make sure materials are clear and easy to read.

An exception to note will be the technical content of the detailed pre-consultation business case. This will be publically available but may not be easily digestible for the general public. If people raise questions about the content of the PCBC we will endeavour to explain specific points in simple terms as part of responding to correspondence during the consultation.

Specific accessible format materials will include:

- An 'Easy Read' summary consultation document and response form.
- A plain text, large print version of the consultation document and summary leaflet. Plain text documents will meet the requirements for text readers to support people with more significant visual impairments.
- Braille and audio version of the main consultation materials will be available on request.
- A British Sign Language video to summarise the proposals and explain how deaf people can get full details and respond to the consultation.
- A foreign language translation/interpreting service will be provided on request. This will be noted on the back of key documents in the 10 top languages across the area.

4. Consultation reach

The consultation activities will ensure that we consult with a representative sample of the population potentially affected by the proposals and we will have dedicated activity planned to collect views from representatives of all nine protected characteristics. We will deliver targeted engagement activities to reach individuals and groups which represent people with these characteristics.

We will measure two key elements of the consultation reach; one for informing people about the proposals/consultation and one for actual responses. The activities are being planned to balance informing people and collecting responses with delivering a cost effective consultation.

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

5. Stakeholder mapping

Through our pre-consultation engagement work we have identified and worked with a wide range of stakeholders. We have grouped our stakeholders into 8 categories with detailed sub-groups within each category:

Patients and public	Staff
• East Kent residents • EKHUFT patients/service users and carers • Patient and Public Advisory Group • Patient and carer support groups • Voluntary, community and local business groups • Seldom heard • Protected characteristics groups • Campaigners (groups and individuals) • EKHUFT governors and membership • Other NHS Foundation Trust governors and membership • CCG local health/engagement networks • GP Patient Participation Groups	• EKHUFT (inc. trade unions) • General Practice in East Kent • East Kent focussed CCG teams • Ambulance Trust • Community Trust • Mental Health Trust • Social care

Elected representatives (East Kent and bordering areas)	Regulators
• East Kent MPs • JHOSC • County councillors • District/City councillors • Parish/Town councillors	• NHS England/NHS Improvement & NHS Improvement • Healthwatch Kent • Healthwatch Medway
System leaders	**Clinical experts and professional bodies**
• EKHUFT Board • CCG Governing Body • Provider Trust Boards (community, mental health, ambulance) • Kent and Medway ICS leadership • Kent County Council executive team • District council executive teams	• South East Clinical Senate • Kent Local Medical/Dental/Pharmacy Committees • Royal colleges • Academic Health Science Network • Kent Medical School/universities
Media	**Out of area stakeholders**
• Local and regional newspapers, radio, TV and online • Trade press • National press • Social media	• EKHUFT patients living outside east Kent • Residents of neighbouring areas • MPs and councillors in neighbouring areas • Boards of providers in areas neighbouring east Kent

In addition, to the patient and public stakeholder groupings identified above, an Integrated Impact Assessment carried out as part of the pre-consultation phase will be used to identify groups that may have a disproportionate need for the services affected by the proposals. There will be targeted engagement activity during the consultation to get feedback from these groups.

6. The consultation questions and document

There will be a formal questionnaire as part of the consultation, although letters and other open comments will be welcome. The questions will be developed to capture feedback covering:

- How strongly people agree or disagree with the model of centralising specialist services
- The potential impact (positive or negative) on patients, relatives, carers and staff
- The potential impact (positive or negative) on wider services outside of hospitals
- Whether there is further evidence, insight and ideas that have not been considered.

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

It will be clearly stated that we are **not asking people to choose their preferred option**, but we will record if people do so. Public consultation is not a referendum /vote so the total number of responses for or against a specific option captured during the consultation is not the deciding factor when the joint committee of CCGs makes a final decision.

The draft structure of the main consultation document is attached at the end of this paper and we would welcome comments from JHOSC members.

7. Consultation activities and materials

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

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

Engagement activities

Engagement activities	Frequency, numbers, format
Public listening events	**12 events** - up to 100 audience per event, mix of presentation, open questions and table discussion. Open invitation with details published through media and other channels.
Street surveys	**300 target -** Commissioned from an independent agency with a specific remit to collect feedback from seldom heard and protected characteristic groups. Rural and deprived area focus. Structured discussion to capture responses.
Focus groups	**12 events -** Dedicated events with up to 10 attendees per event. Structured presentation and discussion with specific remit to collect feedback from seldom heard and protected characteristic. Commission from independent agency.
Telephone surveys	**500 target** - Structured discussions to capture responses - commission from independent agency and targeting specific groups identified in the integrated impact assessment.

Patient / community group visits	Attending existing meetings of established patient / community groups. Structured presentation and discussion. Delivery split across internal consultation team and independent research agency.
Online webinars / chats	We will explore options for live online discussions with key clinical / executive leaders of the programme.
Hospital site roadshow / display stands	A display to rotate around main sites/services during the consultation period to engage patients and hospital staff.
EKHUFT staff events	Internal communications teams to co-ordinate staff events for affected services/sites.
CCG staff events	CCG communications to co-ordinate internal events.
South East Coast Ambulance staff events	Internal communications to co-ordinate internal events.
Other NHS providers staff events	Internal communications to co-ordinate internal events.
County and district council staff	Internal communications to co-ordinate internal events.
Councillor and MP briefings	Presentations to existing meetings, JHOSC, JHWBB, Offer of briefings to council meetings at county and district/city level (in addition to formal updates to JHOSC). Parish/town council presentations on request. 1-2-1 and/or group briefings for MPs.

Staff engagement

All staff across health and social care will be asked to feedback into the consultation through the main survey and contact points; rather than having a staff specific survey or contact point. Following the launch of the consultation, our staff engagement approach will include the following activities:

- **Events/briefings** - for health and social care staff, including: hospital teams, GPs and their practice staff, ambulance, community, primary care and social care.

- **Line manager support materials** - so they can speak with confidence about the proposals during team and 1-2-1 meetings.

- **Existing internal communications channels** - intranets, newsletters, staff briefings and existing meetings and fora will all be used to engage with staff.

We will contact and distribute materials to GP practices, via practice forums and promote the consultation via existing bulletins to GPs and their practice staff.
We will also seek to work through existing networks to reach independent contractors such as dentists, pharmacies and opticians.

Consultation materials

Materials	Frequency, numbers, format
Core documents	
Main consultation document	Content and format is being developed with input from the STP Patient and Public Advisory Group, Healthwatch, and NHS England/NHS Improvement.
Summary leaflet	Short A5 document explaining core points of proposals, providing links to further materials and events, and encouraging responses.
Fliers	For circulation to main sites and use at events. We will cost the option of a direct door to door distribution across the whole of east Kent as part of our planning. However, previous experience with the stroke consultation showed door distribution is high cost but has limited impact in raising awareness / response rates.
Questionnaire	Questions to be developed in discussion with Patient and Public Advisory Group and with support from expert external advisors. There will be online, printed and easy read options of the core response questionnaire.
Alternative formats	**Easy read** version of summary leaflet published online and links cascaded to stakeholders. **Large print** copy of consultation document and leaflet published online and links cascaded to stakeholders. **Translations** of specific documents on request **Other alternative formats** developed on request.
Material for online / public events	
Consultation webpages	Dedicated section of KMCCG website, NHS Trust and partner websites. Providing all relevant documents, details of public meetings, feedback options, news updates, questions and answers etc.
Videos	Selection of videos covering overall proposals and service specific impacts. Interviews with key spokespeople, patients and carers to help engage our target audiences, disseminate key information, share understanding and encourage responses to the consultation.

Animation	Short animation with summary of overall proposals and encouraging people to find out more and respond.
Digital display screens	Slides for display on digital screens in waiting areas at hospital and GP surgeries. Potential use of videos/animation depending on format.
Presentations	Range of presentations for delivery at public events, focus groups, council meetings etc.
Frequently Asked Questions	Initial list for consultation launch. Additions added to website during course of consultation. Service specific FAQs in additional to overall plans.
Service specific factsheets/infographics	Individual factsheets / infographics to explain impact on specific services e.g. maternity, A&E, planned operations.
Printed display material	
Pop-up banners	For display at hospital sites and use at events
Posters	For display at hospital sites, GP surgeries, libraries, town halls, job centres etc. Full list of distribution to be confirmed following further review of opportunities with private organisations such as supermarkets.
Drinks mats	Targeted use of paid advertising in pubs using printed beermats to highlight the consultation dates and where to find details – seeking to reach younger audiences and seldom heard communities in areas of deprivation.
Pharmacy bag advertising/inserts	Targeted use of paid advertising in pharmacies using printing on prescription bags or fliers to insert. Selective use to reach people from seldom heard communities in areas of deprivation.
Staff pay slips	Flyers to attach/inserted messages in EKHUFT payslips and / or printed message inside payslips.
Social media	
Free	Regular promotion through social media accounts of the STP, CCGs, hospital trust and other partners to promote key messages and encourage responses to the consultation.
Paid for adverts and post boosting	We will develop a costed plan for regular adverts and post boosting through Twitter / Facebook over the course of consultation. Targeting audiences by geography and demographics.

Partner/stakeholder publications	
Articles for editorial in local publications	Series of articles to send to existing publications including: council (county, district, town/parish), CCG health networks, NHS trusts, GP Patient Participation Groups, Healthwatch, voluntary sector etc
Adverts in local publications	If free editorial is not possible in key publications we will consider paid averts based on cost vs audience reach.
Paid media advertising	
Newspapers	Series of quarter page adverts across East Kent titles through consultation period. Highlight key proposals and ways to find out more and respond.
Radio	Adverts on East Kent stations repeated at times throughout the consultation. Highlight key proposals and ways to find out more and respond.
Pubs and pharmacies	See information in "printed display material" section.
Media releases / interviews	
Print, online and broadcast media	Series of proactive releases and broadcast interviews during the consultation to raising awareness and encouraging feedback. Reactive responses to media queries throughout the consultation.

Media approach

Our media approach will be proactive during the consultation period. In the consultation catchment area the local media continues to be important in influencing public perception and reaction to all aspects of health and care changes and we will work with them and communicate key messages for the consultation through the channels they provide.

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

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

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

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

8. Distribution channels

We will distribute a range of consultation materials using online and physical channels to meet the varying preferences of our stakeholders; balancing the need to make hard-copy materials available widely with delivering a cost effective consultation.

Virtual distribution

Channels	Materials
Websites	A new website for the Kent and Medway CCG will be our online consultation hub. Current information on the development of the proposals on the STP website (www.kentandmedway.nhs.uk/eastkent) will be transferred to the new site as background to the consultation. The website will host all consultation information in one place including an events diary and document store with the more technical PCBC documents. The hospital trust and other NHS and social care partners will be asked to publish links to the consultation site.
Email bulletins	We will build on our existing e-bulletin for the east Kent transformation programme and issue regular updates through the consultation period. This directly reaches an audience of 850 [at Jan 2020] key stakeholders and individuals including: all district, town and county councillors, parish council central contacts, MPs, and a wide range of patient and public representatives and voluntary/community groups. Contacts in provider trusts and partners including Healthwatch Kent will be asked to cascade the bulletins on to their wider distribution lists.
Social media	Twitter and Facebook will be used to keep online stakeholders informed, and to signpost and facilitate discussion, during and after the consultation period. A central KMCCG account will be the main channel though links will be made with accounts run by the hospital trust and other partners.
Online video	We will produce a series of short videos to support the consultation and these will be available through our YouTube channel and links promoted through our social media account and e-bulletins.

Physical distribution

The physical distribution of our consultation materials will focus on the locations below. With all distributions we will include details of how to request further copies as required.

Location type (sites in EK)	Proposed materials (per site)
Acute hospitals (3)	Main consultation doc. (no. tbc) Summary leaflet (no. tbc) Posters (no. tbc) Pop-up banners (2)
Community hospitals/health centres (12 KCHFT, 6 EKHUFT)	Main consultation doc. (10) Summary leaflet (100) Posters (4) Pop-up banners (1)
General practice (68)	Main consultation doc. (5) Summary leaflet (50) Posters (2)
Pharmacies (tbc)	Summary leaflet (25) Posters (1) Pharmacy bag advertising
Libraries (tbc)	Main consultation doc. (10) Summary leaflet (50) Posters (1)
Town halls (6 = KCC and 5 district/city)	Main consultation doc. (10) Summary leaflet (50) Posters (2) Pop-up banners (1)
Leisure/sports centres (tbc)	Summary leaflet (20) Posters (2)
Job centres (tbc)	Summary leaflet (20) Posters (2)
Children's centres (tbc)	Summary leaflet (20) Posters (1)
Clinical Commissioning Group local offices (4)	Main consultation doc. (10) Summary leaflet (25) Posters (1)
Healthwatch offices (tbc)	Main consultation doc. (10) Summary leaflet (25) Posters (1)
Public consultation events	Main consultation doc. Summary leaflet Pop-up banners

9. Collecting responses

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

- A questionnaire with specific questions about the proposals (print, online and easy read)
- Freepost address
- Email address
- Free phone line/voicemail
- Face to face through the range of meetings identified in the consultation plan

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

10. Analysis of consultation responses

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

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

11. Measure of a successful consultation

The success of our consultation will be measured against:

- the aim and objectives set out in this plan
- the depth and breadth of responses/feedback on the proposals
- feedback from respondents on the process of the consultation
- feedback from JHOSC, Healthwatch and NHS England/NHS Improvement post consultation
- whether we meet our statutory and legal duties during the consultation

12. Resourcing

A dedicated consultation team

This team will consist of in-house communications and engagement staff and additional capacity and expertise commissioned from external suppliers. Planning and delivery of the consultation activities/materials will be led by the communications and engagement workstream, however, the consultation team will consist of a wider group, including:

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

Non-pay resources

Identifying the costs for non-pay materials and resources, ranging from printing documents, bulk mail distribution, and advertising to venue hire and catering costs is a work in progress. The budget to cover all non-pay costs of communications and engagement activity for the consultation will be finalised following feedback on our planned activity from JHOSC and NHS England/NHS Improvement.

13. Conclusion

The full consultation plan in its final version will set out how we will be assured that the public consultation will gather effective feedback to help inform the final decision making process and meet statutory/legal requirements.

Once consultation is underway we will maintain a flexible approach to assessing the effectiveness of the activities identified in this plan; and will amend our approach as appropriate. Significant changes to the approach would be discussed and approved through the East Kent Transformation Delivery Board and briefings provided to the Joint Health Overview and Scrutiny Committee and NHS England/NHS Improvement.

PART 2

Consultation document content plan – draft for discussion

This is a draft content plan for discussion with the Patient and Public Advisory Group, NHS England, Healthwatch, JHOSC and other key partners. It covers the main consultation document and also gives an overview of other supporting materials being considered.

The **target audience** (in terms of the level of detail to provide) is a member of the public who has not been previously engaged in the pre-consultation engagement stage. This means the main document is aiming to:

- provide sufficient detail for a member of public to respond with an informed view on the proposals
- ensure we meet statutory and best practice requirements for a formal public consultation document
- ensure people looking to analyse the proposals in more detail have clear links to the main PCBC and supporting documents

We expect the main document to be **no more than 48 pages** (including a pull out questionnaire) in order to cover the detail required.

Section title	Content summary	Notes
Translation / alternative format information	Summary of how to request translations and alternative formats. Include links to material already available on website (easy read, BSL video)	inside cover
Content page		1 page
Introduction	• high level points from case for change and proposals, with graphic summary of options showing services affected • highlight box covering what doesn't change i.e. services that will remain on all three sites in all options • how your feedback will be used – summarise the decision making process and that consultation informs the decision but is not a vote/referendum • list of the partners leading the consultation • How people should read the document/answer questions as they go through each section so people find it easy to answer the questions.	2 pages max (ideally 1)

Current challenges and the improvements needed	• The case for change – why is the NHS proposing this? • Our vision for improving services Including case studies showing benefits seen in services already centralised on a single site e.g. renal, vascular with facts & figures where possible	Length tbc 4 pages max
What has happened so far	**Developing and shortlisting options** • Brief summary of options evaluation process from longlist through to shortlist. Include explanation of the "do minimum" scenario that options were evaluated against. Referring to detail in PCBC if people want to read more. • Highlight box answering question on why all services on all three sites isn't included in the final options. **Pre-consultation stakeholder engagement** • High level summary of key engagement activities that have shaped the options **You said, we did** • Summary of themes identified from pre-consultation engagement work and changes made to the proposal as a result	2 pages - infographic format with figures on numbers engaged
The options	**Summary of the clinical model** Showing what is consistent across both options and core services that will continue on all three hospital sites in both options. **Hospital services options** Tables/infographics summarising the 2 options in easy to compare format. Text summary of how each option performs in each of the 5 core evaluation criteria. **Local care improvements** High level summary linking to supporting factsheet documents as additional reading for area specific plans and progress on local care.	2 page spread 1 page for each option on facing pages

	Impact on areas outside east Kent Summary of how different options affect patient flows to/from nearby acute trusts. Impact on regional services provided by EKHUFT linking to supporting factsheets for additional reading.	1-2 pages – potential for section to be taken out and used as a standalone document to explain to people living outside east Kent
Financial impact	Summary of investment required in each option and how the proposals support addressing the east Kent financial deficit position.	1 page
Concerns already raised	Highlights key issues identified from pre-consultation engagement work, with short response to each issue (Question & Answer format): • travel times and costs • potential loss of other services at hospitals that lose emergency and specialist inpatient care • all three hospitals need all services with more beds not less • staffing shortages	Max 4 pages - Ensures balance of consultation document by highlighting potential disadvantages of the changes
Giving your views	Outline of different ways people can get involved and respond: • attending public meetings • requesting speakers to attend meetings • reading more detailed information in the PCBC and supporting factsheets • completing the questionnaire or writing a response letter • email and phone contact details for the consultation team	1 page
Next steps	Commitments to publish outcome of consultation and outline of decision making process.	1/2 page
Glossary	Core terms used through the document	1 page

Questionnaire	Pull-out freepost return questionnaire. 8 page maximum including core questions and demographics questions	Clarify option to include additional pages with comment if people need more room. Flag online link to questionnaire as alternative way to complete

Factsheets (Single A4 double sided print) covering:

- Local care improvement plans (either four area specific documents or one longer document covering all areas)
- Individual hospital services and how they are delivered in the different options, including facts & figures and where possible case studies
  - A&E
  - Specialist inpatient services
  - Maternity
  - Elective/planned surgery
  - Out-patients (clarifying that all three sites will continue to provide out-patient services. Include activity figures.)
  - Regional services for patients beyond east Kent (potentially service specific to use as main document for patients from outside east Kent)

REPORT ENDS

Lead officer contact

Tom Stevenson,
Acting Director Communications and Engagement
Kent and Medway Sustainability and Transformation Partnership

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Item 8: St Martin's Hospital, Canterbury

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 6 February 2020

Subject: Review of St Martin's Hospital, Canterbury

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

It provides background information which may prove useful to Members.

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1. Introduction

(a) Kent and Medway NHS and Social Care Partnership Trust (KMPT) and the East Kent CCGs attended the Kent HOSC on 1 March 2019 and notified the Committee about the future of the old St Martin's (west) former hospital site. These plans fall under KMPT's Clinical Care Pathways Programme (which aims to develop and support the review and implementation of quality care pathways, expanding and developing the use of information management technology, and through a closer alignment of its built environment to the needs of services)[1].

(b) KMPT has sold the site to Homes England and is required to vacate the premises by April 2020. Only one ward remains open, Cranmer, which provides 15 beds for older adults.

(c) Senior clinicians had been reviewing the available options over the past year and at the meeting on 1 March 2019, two options were proposed:

i. Maintain the current inpatient bed base within the KMPT estate;

ii. Support a net reduction of 9 beds by clearly evidencing the impact of additional services to reduce patient flow and length of stay.[2]

2. Joint Scrutiny

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

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[1] KMPT (2019) KMPT Mental Health Update for HOSC (p.5) (https://democracy.kent.gov.uk/documents/s89252/KentHOSC-KMPTReport-Mar19v0.8.pdf)

[2] Ibid (p10)

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

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

(d) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013[3] the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) is meeting for the first time of this issue. The JHOSC may:

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

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

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

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

3. Legal Implications

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

4. Financial Implications

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

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

5. Recommendation

The JHOSC is invited to:

- CONSIDER and NOTE the report.

Background Documents

Kent County Council (2019) *'Health Overview and Scrutiny Committee (01/03/19)'*,
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7926&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (23/07/19)'*,
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

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

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

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

6 February 2020

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

4. Changes at St Martins Hospital, Canterbury

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

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

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

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

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

5. Developing options for the future

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

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

6. Recommendation

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

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