Establishing the medium list of options for east Kent hospital services

HOSC, 24 November 2017
Challenges in east Kent

In some areas you are **twice as likely** to end up in hospital because of a problem that could have been avoided if it had been better managed in primary care.

The equivalent of 10 days bed rest can have the same impact on the muscles as roughly **10 years of ageing** for people over 80.

At any one time there are around **300** people in hospital beds who could be discharged if the right support was available elsewhere.
The STP vision for Kent and Medway

Helping you stay well
PREVENTION: Doing much more to help you stay well so you don’t develop some of the illnesses we know can be caused by unhealthy lifestyles

Doing more out of hospital
LOCAL CARE: Redirecting more of our resources into local care services so we can offer more care out of hospital

Making acute services more effective
HOSPITAL CARE: Organising acute hospital services better
Improving hospital care

East Kent only
• Urgent and emergency care acute medicine
• Elective orthopaedics

All Kent and Medway
• Stroke – three hyper-acute stroke units
• Vascular – single arterial centre and enhanced non-arterial centre
How decisions are made

We are here

- Long list of potential options
  - Filter
- Medium list of potential options
  - Filter
- Short list of potential options
  - Consult public

- Fixed Point Criteria applied to all potential options
- Hurdle Criteria applied
- Evaluation Criteria applied
- Final option(s) to take to public consultation
Potential options for urgent and emergency care and acute medicine
## Guidance for urgent and emergency care

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>What</th>
<th>Services offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Major trauma centre</td>
<td>Specialised centres co-locating tertiary/complex services on a 24x7 basis</td>
<td>Neurosurgery, Cardiothoracic surgery, Full range of emergency surgery and acute medicine, Full range of support services, ITU etc</td>
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<tr>
<td>2</td>
<td>Major Emergency Centre with specialist services</td>
<td>Larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist hyper-acute services</td>
<td>Hyperacute cardiac, stroke, vascular services, Trauma unit, Level 3 ICU, Moving towards 24x7 consultant delivered A&amp;E, emergency surgery, acute medicine, inpatient paeds, Full obstetrics and level 3 NICU</td>
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<tr>
<td>3</td>
<td>Emergency Centre</td>
<td>Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services</td>
<td>Moving towards 24x7 consultant delivered A&amp;E, emergency surgery, acute medicine, Level 3 ICU, Inpatient paeds and obstetrics with level 2/3 NICU</td>
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<tr>
<td>4</td>
<td>Medical Emergency Centre</td>
<td>Assessing and initiating treatment for majority of patients, Acute medical inpatient care with intensive care/HDU back up</td>
<td>Consultant led A&amp;E, Acute medicine and critical care/HDU, Access to surgical opinion via network, Possibly paeds assessment unit and possibly midwife-led obstetrics</td>
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<tr>
<td>5</td>
<td>Integrated care hub with emergency care*</td>
<td>Assessing and initiating treatment for large proportion of patients, Integrated outpatient, primary, community and social care hub</td>
<td>GP-led urgent care incorporating out of hours GP services, Step up/step down beds possibly with 48 hour assessment unit, Outpatients and diagnostics, Possibly midwife-led obstetrics</td>
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<tr>
<td>6</td>
<td>Urgent care centre*</td>
<td>Immediate urgent care, Integrated outpatient, primary, community and social care hub</td>
<td>As above but no beds</td>
</tr>
</tbody>
</table>

*Note: Levels 1-5 serve a population of at least 2-3 million, while Level 6 serves a population of at least 100-250K.*
Long list

We started with a long list of possible options

We considered any of our three acute hospitals as:
- a **major emergency centre** with specialist services
- an **emergency centre** or medical emergency centre
- an **urgent care centre** or integrated care hospital

We also considered:
- Building a new hospital on a new site
- Consolidating our hospitals onto one existing site
- Closing an existing hospital
Hurdle criteria

We then asked five questions to help filter out the options that are not viable

1. Is the option **clinically sustainable**?
2. Can we **implement** it?
3. Can people **access** the services?
4. Does it fit with **previous decisions**?
5. Is it **affordable**?
Applying the hurdle criteria

### Possible configurations

| 1. | WHH – any service can be here |
| 2. | QEQM – any service can be here |
| 3. | K&C – any service can be here |

| 1. | WHH – MEC with specialist services |
| 2. | QEQM – EC, MedEC |

| 1. | WHH – MEC with specialist services |
| 2. | QEQM – EC |

1. Is it clinically sustainable?
2. Is it implementable?
3. Is it accessible?
4. Is it a strategic fit?
5. Is it financially sustainable?
Medium list: two potential options

OPTION 1

QEQM Hospital

24/7 A&E department

24/7 A&E department with all specialist services

24/7 GP-led urgent care

William Harvey Hospital

Kent and Canterbury Hospital
Medium list: two potential options

**OPTION 2**

A single major emergency hospital for all east Kent

- One 24/7 A&E department
  - All specialist services (e.g. trauma, vascular and specialist heart services)
- 24/7 GP-led urgent care
- 24/7 GP-led urgent care

Other services could include diagnostics (e.g. x-ray), day surgery, outpatients services and rehabilitation

William Harvey Hospital

Kent and Canterbury Hospital

QEQQM Hospital
Potential options for elective inpatient orthopaedics
Long list

1. A single east Kent inpatient orthopaedics unit on any of each of the three hospital sites
2. An inpatient orthopaedics unit on all three hospital sites
3. Combinations of two orthopaedics units on any two of the acute hospital sites
4. No inpatient orthopaedics unit in east Kent.
Hurdle criteria

We then asked five questions to help filter out the options that are not viable.

1. Is the option \textit{clinically sustainable}?  
2. Can we \textit{implement} it?  
3. Can people \textit{access} the services?  
4. Does it fit with \textit{previous decisions}?  
5. Is it \textit{affordable}?
Applying the hurdle criteria

1) Is it clinically sustainable?

- Any 1, 2 or 3 sites option for east Kent

2) Is it implementable?

- Any 1, 2 or 3 sites option for east Kent

3) Is it accessible?

- No more than 2 in-patient elective orthopaedic centres located on any site in east Kent.

4) Is it a strategic fit?

- No more than 2 in-patient elective orthopaedic centres located on any site. All single site configurations, with the exception of a WHH single site configuration, will be taken forward.
### Medium list: Elective orthopaedics

Applying the hurdle criteria left six potential options for elective inpatient orthopaedics services:

1. Only Kent and Canterbury Hospital (K&C)
2. Only QEQM Hospital (QEQM)
3. Only William Harvey Hospital (WHH)
4. Both K&C and WHH
5. Both K&C and QEQM
6. Both WHH and QEQM
What happens next
Next steps

- **Long list of potential options**: Filter
- **Medium list of potential options**: Filter
- **Short list of potential options**: Consult public
- **Fixed Point Criteria** applied to all potential options
- **Hurdle Criteria** applied
- **Evaluation Criteria** applied
- **Final option(s)** to take to public consultation

We are here, Next step
Evaluation criteria

**QUALITY CARE**
- Will it improve patient care?

**ACCESS TO CARE**
- Can patients get there?

**AFFORDABILITY**
- Is it affordable and good value for money?

**STAFFING**
- Do we have the right number of staff?

**DELIVERABILITY**
- Is it implementable in the timeframe?

**RESEARCH and EDUCATION**
- Will it support research and education?
Timeline

2016-17  
Case for change

2017-18  
Develop options: wide discussion  
Consult public

2018-19  
Make decisions and implement

Next step – evaluate the medium list to develop the option(s) to consult on