Report summary/purpose:

The East Kent Transformation Programme is continuing to progress with the development of a pre-consultation business case for the reconfiguration of its Urgent and Emergency Care (UEC) services. A key component of this work, is the development of service models for the health and care system of East Kent. The overarching vision is to significantly improve the health and wellbeing of East Kent’s residents through meeting their health and social care needs in the right place at the right time. This means increasing the time that people can be supported and manage their conditions at home, reducing the need for avoidable acute care. Further to this, for all acute and specialist care needs we want to ensure our population receives the highest quality of care, which is provided in a safe and sustainable way.

Following the application of the hurdle criteria and the creation of the medium list of options the programme created the Clinical Models workstream to lead on the generation of the future clinical models for East Kent as well as developing the future service models which align to the different UEC reconfiguration options within the PCBC. Key components of the Clinical Models Group (CMG) include:

- Developing the future clinical and service models across local, integrated and acute care. These models have all been approved through the governance process and were signed off at the East Kent Joint Committee workshop in January 2019.
- Key inputs in designing these models came from the Clinical Senate, the public engagement events, clinical expertise and nationally recognised models of care.
- The CMG members consist of clinical and non-clinical members across the CCGs and provider organisations across East Kent, of which have all been engaged in the process of developing and signing off these models of care.

The developing models of care will sit behind an Integrated Care Partnership (ICP) across East Kent and deliver six levels of integrated care (Self Care, General Practice, Primary Care Networks, Extended Community Services, Acute Hospital Care and Specialist Care).
**Recommendation:**

The Joint Committee is asked to:

a) Consider and approve the contents of the paper, including the developing models of care that sit behind the Integrated Care Partnership (ICP) across East Kent

**Governance**

The paper including appended reports has been reviewed by the Transformation Delivery Board, Clinical Review Group and System Board.
East Kent Transformation Programme

Update on Service Models

Sustainable Health Care in East Kent Joint Committee
28 February 2019
Agenda item 018/19
Development of the Future Health System - Led by the Clinical Models Workstream

East Kent are currently in the process of designing a health system for the future. The overarching vision is to significantly improve the health and wellbeing of East Kent’s residents through meeting their health and social care needs in the right place at the right time.

There is an increased focus on promoting healthy choices, self care and supporting the health and care need of our population at home, or as close to home as clinically appropriate. For our residents that require extensive, acute or specialist intervention we want to ensure they receive the highest quality of care by a team of dedicated professionals in our acute setting(s).

Following the application of the hurdle criteria and the creation of the medium list of options the programme created the Clinical Models workstream to lead on the generation of the future clinical models for East Kent as well as developing the future service models which align to the different UEC reconfiguration options within the PCBC.

- The Clinical Models Group (CMG) has developed the future clinical and service models across local, integrated and acute care. These models have all been approved through the governance process and were signed off at the East Kent Joint Committee workshop in January 2019.

- Key inputs in designing these models came from the Clinical Senate, the public engagement events, clinical expertise and nationally recognised models of care

- The CMG members consist of clinical and non-clinical members across the CCGs and provider organisations across East Kent, of which have all been engaged in the process of developing and signing off these models of care

The following slides outline the developing Integrated Care Partnership (ICP) across East Kent and a high level focus of the differences in acute care across the medium list options, 1 and 2 as well as the ‘Do Minimum’.

There are a number of detailed models of care that sit behind the ICP that continue to be developed through various workstreams within the PCBC Transformation Programme and wider. The current drafts are included within the appendices.
East Kent as an Integrated Care Partnership
Future service provision has been designed in line with delivery across six levels of care to form an Integrated Care Partnership (ICP)

Across East Kent we are designing our future health system based on levels of care allowing us to deliver the most used, and clinically appropriate, services as close to home as possible. The focus of the reconfiguration is to increase the time that people can be supported and manage their conditions at home, reducing the need for avoidable acute care.

Further to this, for all acute and specialist care needs we want to ensure our population receives the highest quality of care, which is provided in a safe and sustainable way.

The outer 2 levels demonstrate the different hospital based services we expect to find across our acute sites in the future. The 4th level describes services that will be delivered across the community and Integrated Care Hospital (ICH) sites.

The inner 3 levels make up the community and ‘out of hospital’ service provision for the population of east Kent. Levels 2 and 3 are centred around Integrated Case Management, with a focus on helping people to stay well, supported to self-care and have access the right services when needed at level 1.
The future of General Practice service provision

General Practice will remain the foundation of care for the population of east Kent. Strengthening work is underway to continue to build on good practice and transform the way GPs work, extending access to on-the-day appointments and widening the services and diagnostics available within local practices to allow practices to support the local population with long term conditions.

- Extended access to planned and unplanned appointments
- Outpatient services for follow up non-acute treatment
- Diagnostic and screening services
- Signposting across health and social care services
- Multi professional delivered care
- Practice based teams providing holistic care to patients and serving the health needs of local communities
The creation of Primary Care Networks will support sustainability across east Kent and support GPs to deliver Integrated Case Management (ICM) for their population. The networks and integrated hubs will bring together health, social care voluntary sector and council services based around practice populations of 30,000 to 50,000.
The future of Integrated Care Hospitals and extended integrated community services

Further development of integrated care across east Kent will provide coordinated care through integrated case management. The creation of Integrated Care Hospitals will provide a wide range of existing acute/community services that do not require specialist or acute care provision but instead offer additional support to patients who cannot be managed within their own home.
The future of Acute Hospital Care across East Kent

Acute services will provide 24/7 urgent and emergency care that includes a 24/7 ED, maternity, paediatrics, non-elective surgery and critical care. The acute services will have strong links back to the community, through integrated working and the Rapid Transfer Service.
The future of Specialist Services across East Kent

Specialist services have been designed to serve the whole east Kent population in a centralised model, due to their small numbers and requirement for dedicated specialist teams.
There are up to three different types of hospitals that will exist across East Kent in the future

This slide describes the different types of hospitals that may exist across EK in future, the model is cumulative from left to right, with a MEC designed to deliver all services within an EC and an ICH, and likewise an EC will deliver all ICH services. It is important to note that across the MEC locality there is the potential that some services may be delivered from a different location or in a different way to maximise the use of all estate across the hospital locality, this is further broken down in the table on the right, below.

**MAJOR EMERGENCY CENTRE (MEC)**

The MEC will be a major emergency site that assess and initiate treatment across a range of specialist and hyper-acute services including trauma, acute stroke, vascular services. They are designed to serve a population of up to 1.5 million.

- **Option 1:** WHH
- **Option 2:** K&CH

**EMERGENCY CENTRE (EC)**

An EC provides care and treatment for across acute services, including an ED, emergency surgery and medical inpatient services. They will also deliver maternity and paediatric services. They are designed to serve a population of up to 700,000.

- **Option 1:** QEQM
- **Option 2:** -

**INTEGRATED CARE HOSPITAL (ICH)**

ICH’s will be an integrated campus that offer a wide range of urgent and planned care through a number of delivery partners across primary, community and social care. They are designed to serve a population up to 150,000.

- **Option 1:** K&CH
- **Option 2:** WHH & QEQM

Under both options EK plans to deliver all services within each locality, however there is potential that some services will need to be delivered across other estate within the MEC locality to maximise utilisation of all existing capacity. Across Option 1 and 2 this looks slightly different, the table below shows the breakdown of these services;

<table>
<thead>
<tr>
<th>Services that may not be delivered on the MEC site but locally within the surrounding area</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk planned Inpatient surgery</td>
<td>-</td>
<td>- Low risk planned Inpatient Surgery</td>
</tr>
<tr>
<td>Step down care support beds</td>
<td>-</td>
<td>- Step down care support beds</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>-</td>
<td>- Rehabilitation services</td>
</tr>
<tr>
<td>A proportion of planned Day case surgery</td>
<td>-</td>
<td>- A proportion of planned Day case surgery</td>
</tr>
</tbody>
</table>

[Diagram showing the different types of hospitals with options for each]
Option Overview
Do Minimum:
Two site ED model (WHH & QEQM), with acute medicine at KCH

Do Minimum has the following key acute changes:
• Reverts to 3 site emergency medicine
• 3 critical care units
• Reverts to 2 site elective orthopaedics
• 1 site stroke (HASU/ ASU)
• 3 site 7 day working
• Agreed capital projects
## Do Minimum:

High level service description by site;

<table>
<thead>
<tr>
<th>William Harvey Hospital</th>
<th>Kent &amp; Canterbury Hospital</th>
<th>Queen Elizabeth Queen Mary Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care</strong>: ED, assessment areas and co-located UTC and Frailty Unit</td>
<td><strong>Urgent Care</strong>: UTC, Assessment inc. Frailty Unit, Diagnostics Surgery: Critical care, Vascular and urology surgical specialties</td>
<td><strong>Urgent Care</strong>: ED, assessment areas and co-located UTC and frailty unit</td>
</tr>
<tr>
<td><strong>Surgery</strong>: Planned and unplanned surgical specialties (except vascular and urology) and critical care, Acute Med: Acute inpatient services for all medical specialties, Women’s Services: Obstetric Led unit, co-located MLU, gynaec inpatient services</td>
<td><strong>Acute Med</strong>: Acute inpatient services for all medical specialties (except stroke)*, Paediatrics: Paediatrics day case surgery (excluding some specialties which are WHH only)</td>
<td><strong>Surgery</strong>: Planned and unplanned surgical specialties (except vascular and urology) and critical care, Acute Med: Acute inpatient services for all medical specialties (except stroke).</td>
</tr>
<tr>
<td><strong>Paediatrics</strong>: Acute inpatient services, POSCU, NICU and paediatric surgery &amp; day cases</td>
<td><strong>Planned Ambulatory Care</strong>: Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy, inpatient renal, inpatient clinical haematology services and radiotherapy</td>
<td><strong>Women’s Services</strong>: Obstetric Led unit, co-located MLU, gynaec inpatient services including oncology</td>
</tr>
<tr>
<td><strong>Planned Ambulatory Care</strong>: Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</td>
<td></td>
<td><strong>Paediatrics</strong>: Acute inpatient services, SCBU and paediatrics surgery &amp; day case (excluding some specialities which are WHH only)</td>
</tr>
</tbody>
</table>

**How is this different compared to current service delivery?**

### WHH

<table>
<thead>
<tr>
<th>Services currently delivered on this site that no longer will be:</th>
<th>Services that will be delivered on this site that currently aren’t:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Urgent Treatment Centre</td>
<td>- Hyper Acute Stroke</td>
</tr>
</tbody>
</table>

### KCH

<table>
<thead>
<tr>
<th>Services currently delivered on this site that no longer will be:</th>
<th>Services that will be delivered on this site that currently aren’t:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Acute stroke*</td>
<td>- Urgent Treatment Centre</td>
</tr>
</tbody>
</table>

### QEOM

<table>
<thead>
<tr>
<th>Services currently delivered on this site that no longer will be:</th>
<th>Services that will be delivered on this site that currently aren’t:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Acute Stroke</td>
<td>- Urgent Treatment Centre</td>
</tr>
</tbody>
</table>

* Stroke admissions and acute medicine and were temporarily removed from KCH in April 2017 and June 2017 respectively.
Option 1:
Two site ED model with WHH as the MEC

Option 1 has the following key acute changes:

• Permanent 2 site emergency medicine
• 2 critical care units
• 1 site elective surgery (low risk)
• 1 site stroke (HASU/ ASU)
• 7 day working
## Option 1:

**High level service description by site:**

<table>
<thead>
<tr>
<th>MEC: William Harvey Hospital</th>
<th>ICH: Kent &amp; Canterbury Hospital</th>
<th>EC: Queen Elizabeth Queen Mary Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care:</strong> ED inc. Level 2 Trauma, assessment areas and co-located UTC and Frailty Unit</td>
<td><strong>Urgent Care:</strong> UTC, Assessment inc. Frailty Unit, Diagnostics</td>
<td><strong>Urgent Care:</strong> ED, assessment areas and co-located UTC and frailty unit</td>
</tr>
<tr>
<td><strong>Surgery:</strong> Acute inpatient surgery for all surgical specialties and critical care, Acute Med: Acute inpatient services for all medical specialties, Women’s Services: Obstetric Led unit, co-located MLU, gynae inpatient services including gynae-oncology Paediatrics: Acute inpatient services, POSCU, NICU and paediatric surgery &amp; day cases Planned Ambulatory Care: Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</td>
<td><strong>Planned Ambulatory Care:</strong> Outpatients, Adult Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</td>
<td><strong>Surgery:</strong> Acute inpatient surgery (except vascular) and critical care, Acute Med: Acute inpatient services for all medical specialties (except stroke), Women’s Services: Obstetric Led unit, co-located MLU, gynae inpatient services Paediatrics: Acute inpatient services, SCBU and paediatrics surgery &amp; day case (excluding some specialities which are MEC only) Planned Ambulatory Care: Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</td>
</tr>
<tr>
<td><strong>Specialist services:</strong> centre for specialist services in east Kent</td>
<td><strong>Adult planned inpatient surgery:</strong> Low risk Ortho, ENT, Breast, Urology and Gynae surgery</td>
<td><strong>Planned Ambulatory Care:</strong> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</td>
</tr>
</tbody>
</table>

### How is this different compared to **current** service delivery?

**WHH**

<table>
<thead>
<tr>
<th>Services currently delivered on this site that no longer will be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Urgent Treatment Centre</td>
</tr>
<tr>
<td>- Gynaecology oncology</td>
</tr>
<tr>
<td>- Urology</td>
</tr>
<tr>
<td>- Vascular</td>
</tr>
<tr>
<td>- Inpatient Renal services</td>
</tr>
<tr>
<td>- Haemophilia services</td>
</tr>
<tr>
<td>- Inpatient clinical haematology</td>
</tr>
<tr>
<td>- Neurology</td>
</tr>
<tr>
<td>- Hyper Acute Stroke</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services that will be delivered on this site that currently aren’t:</th>
</tr>
</thead>
</table>

**KCH**

<table>
<thead>
<tr>
<th>Services currently delivered on this site that no longer will be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Acute medical inpatient services (inc. stroke, cardiology etc.)*</td>
</tr>
<tr>
<td>- Critical Care</td>
</tr>
<tr>
<td>- Urology</td>
</tr>
<tr>
<td>- Vascular</td>
</tr>
<tr>
<td>- Paediatric Surgery</td>
</tr>
<tr>
<td>- Inpatient Renal services</td>
</tr>
<tr>
<td>- Haemophilia services</td>
</tr>
<tr>
<td>- Inpatient clinical haematology</td>
</tr>
<tr>
<td>- Neurology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services that will be delivered on this site that currently aren’t:</th>
</tr>
</thead>
</table>

**QEVM**

<table>
<thead>
<tr>
<th>Services currently delivered on this site that no longer will be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Gynaecology oncology</td>
</tr>
<tr>
<td>- Acute Stroke</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services that will be delivered on this site that currently aren’t:</th>
</tr>
</thead>
</table>

* Stroke admissions and acute medicine and were temporarily removed from KCH in April 2017 and June 2017 respectively.
Option 2: One site ED model with K&CH as the MEC

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) - to be confirmed
• 1 site stroke (HASU/ ASU)
• Single site obstetric and paediatric services
• Introduction of 1 standalone MLU
• 7 day working
## Option 2:

### High level service description by site;

<table>
<thead>
<tr>
<th>WHH</th>
<th>MEC: Kent &amp; Canterbury Hospital</th>
<th>QEQM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICH: William Harvey Hospital</strong></td>
<td><strong>ICH: Queen Elizabeth Queen Mary Hospital</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Services currently delivered on this site that no longer will be:</strong></td>
<td><strong>Services that will be delivered on this site that currently aren’t:</strong></td>
<td><strong>Services currently delivered on this site that no longer will be:</strong></td>
</tr>
<tr>
<td>- Emergency Department</td>
<td>- Urgent Treatment Centre</td>
<td>- Emergency Department</td>
</tr>
<tr>
<td>- Acute medical inpatient services (inc. Stroke)</td>
<td>- A proportion of Day case surgery</td>
<td>- Acute medical inpatient services (inc. Stroke)</td>
</tr>
<tr>
<td>- Inpatient unplanned surgery</td>
<td>- Urgent Treatment Centre</td>
<td>- Inpatient unplanned surgery</td>
</tr>
<tr>
<td>- Women’s Health services (inc. maternity)</td>
<td>- Emergency Department inc. Trauma</td>
<td>- Women’s Health services (inc. maternity)</td>
</tr>
<tr>
<td>- Paediatrics (inc. surgery, neonatal and acute inpatients)</td>
<td>- Inpatient unplanned and high risk planned surgery</td>
<td>- Paediatrics (inc. surgery, neonatal and acute inpatients)</td>
</tr>
<tr>
<td>- Critical Care</td>
<td>- Women’s Health services (inc. maternity)</td>
<td>- All inpatient medical services (inc. pPCI, H&amp;N Cancer)</td>
</tr>
<tr>
<td>- Specialist services (inc. pPCI, H&amp;N Cancer)</td>
<td>- Paediatrics (inc. surgery, neonatal and acute inpatients)</td>
<td>- Acute Stroke</td>
</tr>
</tbody>
</table>

### How is this different compared to current service delivery?

**WHH**
- Services currently delivered on this site that no longer will be:
  - Emergency Department
  - Acute medical inpatient services (inc. Stroke)
  - Inpatient unplanned surgery
  - Women’s Health services (inc. maternity)
  - Paediatrics (inc. surgery, neonatal and acute inpatients)
  - Critical Care
  - Specialist services (inc. pPCI, H&N Cancer)

**KCH**
- Services currently delivered on this site that no longer will be:
  - Urgent Treatment Centre
  - A proportion of Day case surgery

**QEQM**
- Services currently delivered on this site that no longer will be:
  - Emergency Department
  - Acute medical inpatient services (inc. Stroke)
  - Inpatient unplanned surgery
  - Women’s Health services (inc. maternity, gynaecology)
  - Paediatrics (inc. surgery, neonatal and acute inpatients)
  - Critical Care

**ICH: Queen Elizabeth Queen Mary Hospital**
- Services that will be delivered on this site that currently aren’t:
  - Urgent Treatment Centre
  - A standalone MLU
Service Models Appendix

28 Feb 2019
Outpatients
The outpatient model across East Kent requires radical modernisation to support key national and local strategies

Each year in east Kent the acute hospitals deliver around 850,000 outpatient appointments. Outpatient services are often the first point of contact that most elective care patients have with secondary care. Getting things right at this stage of the pathway can have significant benefits in terms of patient safety, quality and cost further downstream.

The basic model for delivering outpatient services in east Kent has remained relatively unchanged for many years. Numerous attempts to reduce the number of outpatient appointments have been explored and trialled in the past but these have had limited success in the past. A new focus on models of care and a decommissioning of out-dated models of care is required.

The management and delivery of outpatient services is frequently complex, often requiring the co-ordinated delivery of parallel and/or sequential process steps by a range of clinical and non-clinical staff across many disciplines and departments.

To date, the East Kent Transformation Programme has not yet explored the opportunities and benefits that could be delivered through improving the provision of outpatient services. It is clear that there is significant scope for delivering improvements to the way outpatient services are currently being delivered, which will deliver efficiencies for the health economy, improve ability to meet RTT and other KPI's and most importantly, significantly improve the process and service experienced by our population. Our population will experience improvements in access, lower levels of inappropriate referrals and increased amount of work-up prior to first appointments.

The need to change the way in which outpatient services are delivered in east Kent is supported by a number of key national and local strategies and factors:

- Projections of increasing outpatient demand in the future, as a result of demographic change, suggest that different ways of managing demand and capacity need to be found to prevent the current system from overloading, becoming unaffordable and unsustainable;
- Changes in the medical training and workforce mean that current models of outpatient care will become increasingly unsustainable;
- Scientific and technological advances now provide alternative means of managing and monitoring certain conditions;
- There is an increasing focus nationally on the need to modernise outpatient services and this will form a major part of the soon-to-be published NHS Plan.

Consequently, continuing to provide outpatients in the same way cannot be considered as a viable option, particularly in the current financial climate of a real reduction in revenue against a backdrop of increasing demand.
CMG, through the reconfiguration work, has identified specific need to redesign outpatient services across East Kent to provide a sustainable and equitable service

Establishment of a system wide OP transformation programme is essential for the acute reconfiguration to provide sustainable and equitable service models across both options, for the whole of East Kent. Whilst the driver for reconfiguration remains focused around acute services, CMG agreed that it is important that planned outpatient service delivery continues to be delivered across the 6 current localities, irrespective of option. Further to this, CMG agreed that delivery of outpatients should be done within the most appropriate care setting, in the most appropriate way across either Primary or Secondary care.

Option 2 highlights the most significant problem for Outpatient delivery across the 6 existing locations as there will be extremely limited estate / facilities available at K&CH to continue to deliver nearly 250,000 appointments each year. Although EKHUFT are currently working through estates planning to maximise their ability to deliver OP services at K&CH, this will only be achievable through transformation. This information has led the CMG to conclude that it is essential for EK to transform the delivery of Outpatients to ensure the local population of Canterbury continue to have access to the vast majority of Outpatient services in their local area, whether at K&CH or within the community.

It is expected that the Outpatient Transformation Programme will enable Primary and Secondary care to not only deliver fewer secondary care appointments but also transform the delivery of appointments to maximise the use of technology and ensure that all appointments are delivered in the most clinically appropriate and convenient way for both the patient and workforce.

The Outpatient Transformation Programme will be established separately to the PCBC timeline and therefore delivery of this transformation is expected quicker than the overall Acute redesign, which should ensure the deliverability of either of the UEC options that are being considered under the PCBC.

The following slides outline the priorities and proposed programme design for the East Kent Outpatient Transformation Programme.
 Establishment of the East Kent Outpatient Transformation Group (EKOTG) will enable transformation across the system as a whole

EKOTG held its inaugural meeting on 8th November 2018 to discuss the task that it had been set. The scale of the task is considerable and will require the implementation of new models of care across many clinical pathways. Changes will have to be led and owned by clinical teams across primary and secondary care if they are to become embedded into new systems of working. The starting point for the discussions was to agree a set of core principles which the Group felt should form the foundation of the east Kent outpatients modernisation programme.

These six core principles are:

1. Do no harm – eliminate treatments which provide no clinical benefit or do harm.
2. Carry out the minimum appropriate intervention – the principle that treatment should begin with basic proven tests. The minimum possible treatment should be performed to achieve the desired results.
3. Organise staff by the ‘only do what only you can do’ principle, where all people working for the NHS in east Kent should operate at the top of their clinical competence.
4. Work to the principle that it is the individual’s clinical need that matters when it comes to deciding treatment
5. Create a new relationship between the public and the east Kent NHS, based on openness and sharing information
6. Empower patients to take control of their care and the treatment they receive.

The transformation process will start with challenging the concept of both what an ‘outpatient’ is and what ‘outpatient services’ are and to transform the way in which we understand, diagnose and manage care with greater focus on pre-referral and continuing care. This should help to ensure that more people receive the right care, from the right person, at the right time, in the right place.

There are significant opportunities to improve the way in which outpatient services are managed and delivered in east Kent. The EKOTG has set itself an ambitious target to modernise outpatient services and has set an expectation that the new model for outpatient services in east Kent should pursue a “best in class” approach that is innovative, efficient, productive and fit for the 21st century. Changes to the outpatient model must be centred around the needs of the patient whilst using resources efficiently to ensure that demand is in balance with activity.
The EKOTG project charter describes the overarching transformation programme

1. Objectives:
   - To create a modern, fit-for-purpose Outpatient model across East Kent health economy that fits with the future vision of the system
   - Design of an Outpatient model that supports the 6 core principles that form the foundation of the programme
   - To generate in-year efficiencies within priority specialties to support ‘quick win’ financial and operational improvements

2. Enablers:
   - Technology and digital solutions to support efficiency and productivity improvements
   - Whole system engagement and change
   - Diagnostic access within Primary Care
   - Agreeing contracting/commissioning arrangements

3. Opportunity:
   - The EKOTG estimate that a successful outpatient transformation programme could reduce new outpatient referrals from primary care by around 30% and could reduce traditional follow-up attendances to the acute setting by around 60%. These reductions will not be a total removal of this activity. Patients that currently attend an acute location for their new OPD appointment may, in the future, have this appointment provided in a different location or/and possibly also through a different medium: i.e. it will still need to happen, just in a different way than at present. Similarly, for follow-ups; currently the Trust does not ask patients to come back for a follow-up appointment unless it is absolutely clinically necessary. In the future, the majority of these patients will still need a follow-up, however, that follow-up may happen differently i.e. through technology, via a phone call, text message or VC or by another provider.

4. Resource Requirements:
   - This programme will require both dedicated project resource across both EKHUFT and commissioner/primary care. Slide 6 outlines the expected resource requirements from both organisations

5. Initial Priority Specialties – areas of possible ‘quick wins’
   - Gastroenterology
   - Neurology
   - Urology
   - Gynaecology
   - Orthopaedics
   - Dermatology
   - Ophthalmology

6. Key Areas of Focus

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Referral pathway improvements</td>
<td>➢ Pre-referral: GP access to advice / agreed referral criteria by specialty, ➢ Referral: access for GPs to refer straight to test/specialist, ➢ Agreed and formalised primary care work up/diagnostics prior to first appointment ➢ Exploration of self-referral pathways</td>
</tr>
<tr>
<td>(ii) Demand &amp; Capacity (EKHUFT Internal Efficiencies)</td>
<td>➢ Redesigning services to deliver them in the most appropriate care setting by the most appropriate workforce model ➢ Developing new and standardised clinic templates for specialties ➢ Improving clinic utilisation / booking &amp; scheduling</td>
</tr>
<tr>
<td>(iii) Shared care to ensure delivery of care in the most appropriate place</td>
<td>➢ Follow up pathways to be completed in the community, by primary care where appropriate ➢ Agreed pathways and expectations for activity completed by primary care ➢ Standardised structured follow up / LT management plan (shared care record)</td>
</tr>
<tr>
<td>(iv) Technology</td>
<td>➢ Digital solutions for OP apt delivery (Skype, Tele-health) ➢ Patient empowering technologies to manage OP journeys ➢ Technology to support Primary Care manage, assess and refer appropriate patients ➢ Digital health tech that allows patients to self manage and support remote monitoring by MDT / GPs</td>
</tr>
<tr>
<td>(v) Primary Care Development</td>
<td>➢ Primary Care working differently to be able to manage pre-referral and follow ups ➢ Use of GPwSI and nominated GPs across specialties to develop networked offering of advice</td>
</tr>
</tbody>
</table>
The programme will be delivered in cohorts of specialities, with each specialty developing an individual improvement plan

- Prioritising the specialties into cohorts for delivery will outline the order of delivery across the OP specialities
- The first 3 key areas of focus identified on the previous slide will provide the core improvements expected across all specialities, with individual improvement plans developed across these. The 2 enabler work streams will work alongside the specialties and develop improvement plans that will have cross-cutting priorities. The plans will include both overarching activities/improvements as well as specialty specific solutions

**Rationale for specialty approach**
- One size does not fit all; end to end pathway project to improve efficiency
- Proof of concept; roll out planning leads to more sustainable delivery
- High priority specialties can be initial focus to drive required improvements in year
- Individual specialty improvement plans drives engagement and supports long lasting improvements

**How will enabler work streams support specialty plans?**
- Enabling overarching activities; e.g. digital solutions for delivery of OP, shared care records/management plans across Primary and Secondary Care
- Specialty specific solutions; e.g. digital health solutions to support patients self manage specific conditions and remote monitoring abilities for GP/MDT to manage conditions
The programme will be governed through both EKHUFT and EK CCG Boards with links to the reconfiguration programme through the CMG.
New model of care will allow our frail and elderly population to have access to a wide range of services to support their ongoing and short term urgent/emergency needs

► The Frailty model consists of three core elements as outlined in the diagram below;

- **Acute & Specialist Care;**
  - Acute Intervention and nursing care with comprehensive Geriatrician input (Inc. medical & surgical liaison)
- **Step-up interventional care;**
  - Extended Community Services to provide quick interventions, and where appropriate a short stay within Frailty units to prevent pts becoming acutely unwell
- **Out of Hospital & Primary Care Services;**
  - Co-ordinated, integrated case management across GP, PCN’s and the community MDT’s working together, centred around patients to keep them well

Geriatric led services to support the emergency needs of our acutely unwell frail patients. Acute and Specialist care services are likely to include;
Acute nursing care, medical and surgical liaison service for continual Geriatric input into any care plan, Rapid Transfer Services

Rapid assessment and access to interventional care to support frail patients for all urgent needs, with the aim to prevent requirement for acute care. Step-up, interventional care services are likely to include;
Community clinics, POC testing across PCN’s, Comprehensive Geriatric Assessment (CGA) as part of Frailty Assessment Unit services ** Interface services **

Foundation of ongoing, long term care and management for our frail, elderly population. Out of hospital services are likely to include;
Falls Prevention, Social Prescribing, 3rd Sector, ICM (MDT care co-ordination including CGA), Rapid Response, ART, in-reach services into residential/care homes

► The out of hospital element of the frailty model is part of the wider ICM approach that works to proactively support and manage patients within the community
► Patients are expected to flow between the levels as their needs escalate and de-escalate, ensuring they are only within Secondary Care when their medical and/or surgical needs require acute and specialist intervention
The urgent care frailty pathway will ensure patients are cared for in the most appropriate setting

- Below describes the high level patient flow through frailty services
- Transfer of care back to community (discharge home) can happen at any point across the pathway when patient is assessed to be medically optimised with (if needed) the necessary at home support in place

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Urgent Treatment Centres
Introduction: Aligning the national UTC programme with the East Kent PCBC

The Urgent Treatment Centre (UTC) programme provides a national mandate to review the current urgent care provision and address patient and public feedback on the confusing mix of services currently available. A key element of the programme is the roll-out of standardised UTCs in accordance with the national specification of 27 standards by December 2019.

Urgent care provision is a key component of the overall service model for urgent and emergency care services, with the expectation that UTC’s will enable fewer attendances within ED and allowing patients to be seen in the most appropriate setting.

Therefore, the service model for UTC’s and the forecasted activity, income and cost changes linked to this will need to form part of the final PCBC for the reconfiguration of urgent and emergency care (U&EC) services within east Kent. Specifically two key outputs will be required:

1. A description of the service model for urgent care services within east Kent
2. The activity and financial modelling linked to the proposed urgent care model will need to be fed into the system-wide model for the reconfiguration of U&EC services

This document sets out at a high-level the service model for urgent care within east Kent, and the proposed approach to completing the activity and financial modelling for UTCs.
Service model: Urgent Care provision in East Kent

East Kent has a wide range of minor illness and minor injuries services across multiple providers. However, existing services lack consistency and the pathways are not clear to professionals (especially SECAmb) or patients. With the need to mobilise UTCs by December 2019, an assessment of patient need, service coverage and the compliance level of existing services against the UTC standards is required. This will need to be considered within the context of the wider system transformation, which includes but is not limited to:

- The development of the East Kent Primary Care Standard to improve consistency in provision across the patch
- Improved primary care access through the establishment of GP access hubs

With these pieces of work in mind, there is a need to explore opportunities to meet the UTC requirements by December 2019 whilst improving the urgent care provision across EK. This could include delivering an integrated model of urgent care that enables the standards to be met within existing provision. However, emerging evidence indicates that a standalone UTC is ineffective at reducing acute demand if located within 7 miles of an acute site, as patients continue to flow on to the A&E departments close by. This indicates that an alternative model of urgent care provision is required between hospital sites and in the community:

- Hospital sites – the proposal is to establish a 24 hr GP led UTC at the front door of each of the acute hospital site streaming of patients as they come to the front door. The aspiration with this model is to minimise the activity into the A&E department and improve the flow of patients to care settings that is most appropriate for their needs

- In the community – the proposal is to develop a networked approach to delivering the UTC model across the existing providers of urgent care. Through the use of collaborative working models and alliance arrangements, providers will collectively deliver against the UTC standards and adopt greater consistency in service provision and a simple to understand and use system for the public
Service model: The three main hospital sites will each have 24/7 GP Led UTC model, in both reconfiguration options

In both of the urgent & emergency care (UEC) reconfigurations the UTC model across the three sites will be consistent. Therefore a single delivery model has been designed, in line with national specifications, and is described below:

UTC model on hospital sites will act as the ‘front door’ for all walk-in, and appropriate GP/111 referred patients and any minor injury/illness patients conveyed by ambulance for initial triage and clinical streaming.

➢ Opening Hours: 24/7
➢ Services available*: Minor Injuries and Illness, Mental Health, social care and community team support services
➢ Access to diagnostics: urinalysis, ECG and X-ray, POC testing

The UTC will also be able to transfer acutely unwell patients that require further care or acute interventions as appropriate. Patients that require acute intervention will be transferred to either the ED or the relevant Assessment Unit (AMU, SAU, GAU etc.). In line with the frailty model any frail, elderly patients that require further support or assessment but are not acutely unwell can be transferred to the Frailty Assessment Unit on site.

*shown separate for graphical purposes only, patients will be seen by the most appropriate clinician available
Service model: In the community a networked approach across existing providers of urgent care will be adopted to support the delivery of the UTC standards

An integrated approach to the mobilisation of UTCs will be adopted in the community:

- Existing provision would continue, maintaining the current wide range of access to urgent care available, but the adoption of the Primary Care Standard will improve consistency of services within primary care including current LESs and other additional services will be required to deliver in accordance with the UTC standards

- Collaborative working models and alliance arrangements will be further utilised across existing providers of urgent care to maximise current resources available to meet the population needs whilst meeting the standards for UTCs

- Changes to the delivery of urgent care will ensure that any procurement and consultation requirements are addressed.

Outside of the PCBC a new programme of work focused on UTC’s will begin in January and will support the development of the UTC model in the community as well as finalising the details for the UTC’s on the hospital sites. The CMG and overarching PCBC governance will receive regular updates on the progress to inform PCBC developments.
Paediatrics
# Future Service Model for Paediatrics

<table>
<thead>
<tr>
<th>Option 1: 2 site ED, WHH as MEC</th>
<th>Option 2: single site ED, K&amp;CH as MEC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery:</strong> two site model for day case, inpatient, elective and non-elective paediatric surgery, to be based at WHH and QEQMH. K&amp;CH will have no inpatient or day surgery for children.</td>
<td><strong>Surgery:</strong> single site model for all elective and non-elective paediatric surgery, to be based on the MEC. QEQMH &amp; WHH will have no inpatient or day surgery for children.</td>
</tr>
<tr>
<td><strong>Unplanned/urgent &amp; emergency services:</strong> Under option 1 the vision is to have a Children’s Assessment Unit (CAU) co-located to ED (1 QEQMH, 1 WHH), ran 24hrs but not admitted (23hr stay). Currently, 12hrs a day service on both sites, move to 23hrs would extend the service. The units will be separate to ED and ran by ANPs specialised in paediatrics. Piloting model for ANPs and want to continue to expand this. All GP referrals would be directed to either of the CAUs, no services at K&amp;CH.</td>
<td><strong>Unplanned/urgent &amp; emergency services:</strong> Under option 2 the vision will be to have a paediatric ED with CAU co-located within K&amp;CH. It is expected that the UTC’s on the other sites will have 12hr CAU service, that will receive GP referrals only. CAU will be very policy driven re transfer protocol to the MEC with clearly defined pathways. GP referral system will need to be robust in what can be sent ‘locally’. Medical cover will be provided by consultants doing OP clinics across sites (9-5). Model will look very similar to Salford model.</td>
</tr>
<tr>
<td><strong>Acute Medical Inpatients:</strong> inpatient wards will be located on both the MEC and EC (WHH and QEQMH).</td>
<td><strong>Acute Medical Inpatients:</strong> inpatient ward will be located on the MEC (K&amp;CH).</td>
</tr>
<tr>
<td><strong>NICU/SCBU:</strong> located on same sites as maternity services. MEC (WHH) will have a NICU, EC (QEQMH) will have a SCBU.</td>
<td><strong>NICU:</strong> located on same site as maternity services. MEC (K&amp;CH) will have a NICU.</td>
</tr>
<tr>
<td><strong>POSCU:</strong> single site, based on the MEC (WHH).</td>
<td><strong>POSCU:</strong> single site, based on the MEC (K&amp;CH).</td>
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</tbody>
</table>
Maternity model under option 2
As part of UEC Option two standalone MLUs were being considered in addition to the centralised Obstetric unit and co-located Midwife Led Maternity Unit (MLU)

Standalone MLU’s are not being considered under UEC 1 as Maternity Services are not changing from current service provision and in line with previous consultation, the two obstetric led units with co-located MLUs is the preferred model under UEC 1.

Maternity services under UEC 2 will see a significant change to current service provision, and EKHUFT have undertaken additional analysis to understand the need and viability of inclusion of Standalone MLU’s to support access and choice. The table below describes the different MLU options under consideration;

<table>
<thead>
<tr>
<th>MLU 1</th>
<th>MLU 2</th>
<th>MLU 3</th>
<th>MLU 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 standalone unit in Margate</td>
<td>1 standalone unit in Ashford</td>
<td>2 Standalone units (Margate and Ashford)</td>
<td>No standalone MLUs</td>
</tr>
</tbody>
</table>

**Standalone MLUs – 4 Options to consider**
The standalone units will be delivered in addition to the centralised Obstetric Unit & co-located MLU in Canterbury
Approach: the MLU sub-options needed to be assessed further to determine a preferred option to form part of the detailed evaluation

The four MLU sub-options identified on the previous slide need to be evaluated in further detail to understand which models are viable and which is the preferred option to take through to the detailed evaluation

Below describes the hurdle criteria applied to obtain viable options and the further steps required to reach a preferred option;
Decision: MLU 1 – Inclusion of a standalone unit in Margate has been selected as the preferred option

Stage 1

Identification of viable options

Following initial analysis MLU 2 and 3 were excluded.

MLU 3 – 2 standalone unit option was discounted due to clinical sustainability. Volumes of activity and workforce across East Kent would not support sustaining 3 MLUs including the co-located MLU.

MLU 2 – 1 standalone unit in Ashford was discounted because although volumes of activity would make a unit viable this population have alternative choices for standalone birthing units that will likely make the unit unviable for that reason

This resulted in two viable options: MLU 1 and MLU 4

Stage 2

Position Statements

Of the Two viable options - MLU 1 and MLU 4 – each of the organisations were invited to analyse the analysis and present a preferred option

Trust Position

• EKHUFT’s EMT supported the Care Group’s paper which outlines MLU 1 as a preferred option.

Commissioner Position

• Clinical and Financial viability would result in MLU 1 being the preferred option. However the paper outlined further work into workforce sustainability and strategic fit within the LMS STP strategy is needed in order to fully evaluate the option

SECAmb impact assessment

• SECAmb have undertaken an initial impact assessment to outline the key safety risks and high level financial impact that each of the sub-options would have on SECAmb and these will be picked up through the detailed evaluation

Stage 3

Preferred Option to be evaluated as part of UEC2

The preferred option MLU 1 will be assessed as part of the all encompassing UEC2 options under the detailed evaluation

CMG will work with Maternity Commissioner and LMS to ensure that the detailed evaluation contains the required questions to ensure maternity services are fully tested within the full evaluation