

Sustainable Acute Medical Care in Kent Joint Committee

Thursday 30 November 2017

09.00-11.00am

The Grand Hotel, The Leas, Folkestone, Kent CT20 2XL

MINUTES

Present

Ashley West, Chair

Voting Members in attendance

Dr Navin Kumta, Clinical Chair, Ashford CCG

Chris Morley, Lay Member PPE, Ashford CCG

Dr Simon Dunn, Clinical Chair, Canterbury & Coastal CCG

Dr Dan Moore, GP Canterbury & Coastal CCG

Jackie Bell, Lay Member for Governance, Canterbury & Coastal CCG (Delegate for Alistair Challiner)

Dr Jonathan Bryant, Clinical Chair, South Kent Coast CCG

Dr Chee Mah, GP South Kent Coast CCG

Alistair Smith, Lay Member for Governance, South Kent Coast CCG

Dr Tony Martin, Clinical Chair, Thanet CCG

Dr Markus Maiden-Tilsen, GP, Thanet CCG

Clive Hart, Lay Member PPE, Thanet CCG

Apologies from Voting Members

Dinesh Sinha, Secondary Care Clinician

Alistair Challiner, Secondary Care Clinician, Canterbury & Coastal CCG

Non-Voting Members in Attendance

Hazel Smith, Accountable Officer, South Kent Coast and Thanet CCG's

Glenn Douglas, Chief Executive Kent & Medway Sustainability and Transformation Partnership (STP)

Jonathan Bates, Chief Finance Officer, Thanet and South Kent Coast CCG's

Alison Brett, Interim Chief of Nursing and Quality Ashford and Canterbury & Coastal CCGs

Apologies from Non-Voting Members

Simon Perks, Accountable Officer, Ashford and Canterbury & Coastal CCG's

In Attendance

Matthew Capper, Company Secretary, East Kent CCG's

Absent

None

Minutes

Lynette Merry, Project Administrator, East Kent Programme Office

Belinda Hunnisett, PA to Hazel Smith

001/17 Introduction and Apologies

The Chair opened the meeting and thanked welcomed everyone attending.

The Chair, Ashley West, introduced himself as currently the acting Chair of Dartford, Gravesham and Swanley (DGS) CCG and has been with the CCG for four and a half years. The Chair is also the Deputy Chair of DGS and a Lay Member for Governance, Chair of the Audit Committee at DGS, a member of the Governing Body of Swale as a Lay Member for Governance of the Audit Chair. The Chair also informed the committee that he is not a clinician and has not worked in the NHS.

The Chair has been asked to be an independent Chair of the first meeting of the Joint Committee.

The introduction included routine domestic requirements, turning off mobile phones, fire alarm instructions and location of toilets and disabled facilities.

The Chair informed the committee and members of the public that the meeting was being recorded and that this would be available on the STP website in the future.

The Chair outlined the purpose of the meeting as the first meeting of the Joint Committee and whilst this was a meeting in public it was not a Public Meeting. It is essential the meeting is conducted without interruption. There will be two opportunities for members of the public to ask questions for 15 minutes at the beginning of the meeting and a further 15 minutes at the end of the meeting.

Introductions from all committee members followed.

Questions from the Public (Part 1)

The Chair confirmed the questions and points raised by the public would be covered within the meeting and some would be answered directly within this session.

The public raised the following points and questions:

- **xxxxxxxx** made the following 3 points:
 - i) The general strategy of developing primary care needs to be supported by hospital care on all 3 sites.
 - ii) A question about timescales and the suggestion to look at a longer period than the stated 3-5 years
 - iii) Is the Medical School application being taken into consideration and the positive implications for services and staff in the area?
- **xxxxxxxx** asked about the consultation document which was published on the website. Paragraphs 81-87 of the document lacked detail and it was difficult to understand the hurdle criteria and the final part of the document was about orthopaedic services. Mr Sewell commented that these appeared to be 3 separate documents which had not been put together well and were difficult to understand.
- **xxxxxxxx**, Shepway Pensioners Forum requested confirmation on whether the document presented was an update on the STP.

The Chair confirmed these points will be answered within the meeting.

A member of the committee responded that the document being referred to here is not an update on the STP but is work that is within the STP's broad spectrum and the documents for this meeting and the advertisement of this meeting was made public on Friday 24 November at 11am and the information has been available since that point online. A member of the committee agreed to send a paper copy. It was confirmed that the paper presented for discussion and decision to the Joint

Committee was not an update on the STP. The Joint committee were being asked to consider the work to date following the case for change and application of the hurdle criteria in preparing a medium list of options to take forward.

- **xxxxxxxxxx** asked the committee how embarrassed they were about putting the 3 hospitals in East Kent against each other. We need to have 3 hospitals for the future. Why should Canterbury and the surrounding areas not be entitled to equal healthcare as Ashford and Margate.

The Chair asked Hazel Smith and Glenn Douglas to reply as part of the STP strategy. Hazel Smith replied that the committee would be discussing the process to get to the medium list of options in terms of how to take forward Emergency Services and Orthopaedic Services. In the meeting it will be explained how the offer from a private developer has been considered and will be reviewed going forward as part of the process.

Glenn Douglas agreed with Hazel Smith and added that the purpose of the meeting today is moving to the next step, which involves an evaluation of the options presented, further analysis and due diligence and through the defined process the recommendation of a shortlist of option(s) and the business case to take these forward pre a formal public consultation later in 2018.

The Chair summarised that the responsibility of the CCG is to ensure patients are provided with the best quality possible and the STP is seeking to organise the resources that we have to ensure it is done as efficiently as possible.

- **xxxxxxxxxx** asked how do the proposals align with the proposal in the original STP paper of losing up to 300 beds in East Kent.
- **xxxxxxxxxx** asked a question about why the process is so dependent on previous decisions.

The Chair confirmed these points will be answered within the meeting.

- **xxxxxxxxxx** also asked why a press release had gone out today on BBC news advocating that there is going to be a decision today about a new hospital in Canterbury with the reduction of A&E at Ashford and Margate.

Hazel Smith replied that she is aware of the content of the press release that was sent to the media to reflect and it is very clear that the content of this meeting is about moving the process from the long list of options to make a decision about the next medium list of options. We will then need to do a lot of work and evaluation before a decision can be made in early 2018 about which options go forward to public consultation and there is not a final decision today.

Formal Meeting commenced

001/17 Apologies

Matthew Capper confirmed apologies had been received from Dinesh Sinha, Alistair Challiner and Simon Perks.

002/17 Terms of Reference – to note

Matthew Capper confirmed the inclusion of the Terms of Reference was to note.

003/17 Quorum

Matthew Capper confirmed that the committee was quorate.

004/17 Declarations of Interest

Matthew Capper confirmed that these had been circulated. No further declarations were made by committee members.

006/17 Kent & Medway Sustainability Partnership, Establishing the Medium List of Options Paper

The Chair moved on to the main part of the meeting which had two parts; Urgent and Emergency Care and Elective Orthopaedic Services.

Hazel Smith introduced Colleagues from the East Kent Hospitals Trust; Liz Shutler, Deputy Chief Executive and Paul Stevens, Medical Director who would be providing the detail on this item.

Hazel Smith reminded the committee where they are in the process. It was suggested that the paper that had been circulated was taken as read and it is important to remember that the plans sit within the context of the STP and that statutory responsibility for public consultation on remains with the Clinical Commissioning Groups (CCGs). The following consultations are planned in 2018 Urgent and Emergency Care, including Acute Medicine in East Kent, Elective Orthopaedics in East Kent and Stroke Services across Kent & Medway.

Reference was made to Page 3 of the paper (paragraph 11) where it sets out clearly the process gone through so far, this is a very linear process. For the minutes it should be noted that all 4 CCG's Governing Bodies have received a detailed 3 hour presentation to ensure that all members of the Governing Bodies have the full detail that sits behind the process and work to date...

In terms of the process this started off with the Kent & Medway Case for Change, which was agreed by all 4 Governing Bodies. This was followed by the development of Kent & Medway Service models and the development of hurdle criteria. It is important to remember that the hurdle criteria is utilised to take us from a long list of options to a medium list of options. Both logistically and from a pragmatic perspective it would be unreasonable to then do the detailed due diligence on every single option. Therefore the hurdle criteria do produce a Yes or No answer as the process is worked through to enable us to move towards a more pragmatic and appropriate list of options to consider. The hurdle criteria have been discussed in public at meetings and also at Governing Bodies and also by colleagues in provider organisations, the STP meeting structure which all of our Clinical Chairs around the table are members of and also the STP Programme Board. The hurdle criteria have then been signed off by all 4 CCG Governing Bodies. Then further work has been done on identifying the full evaluation criteria and identifying the long list of options that all 4 Governing Bodies have taken the time to look at the detail.

At the moment we are at the point where we applying those hurdle criteria to that long list of options and so the paper then sets out very clearly what the impact of those hurdle criteria.

Hazel Smith asked Liz Shutler to provide more detail.

Firstly Liz Shutler acknowledged one of the questions from a member of the public that the paper is not clear and will try to draw out more clarity in the presentation today.

Liz Shutler responded to another point made by a member of the public regarding the 300 beds and advised that further work had been done. In the hospital they had looked retrospectively over a period of 1 year looking at all of the inpatients in beds, looking at the acuity of those patients and how sick they were during their stay and worked through a methodology that said at some point in their stay they could have been care for somewhere else; in a nursing home, their own home or with a package of care. They didn't need to be in a hospital bed. When that was worked out in bed days, at any one time in the acute trust, there is around 250-300 beds that are full of patients that do not need to be there. That is much aligned with the work that the CCG's have been doing around local care. That audit has been undertaken a number of times and it was found to be the case at various points in the year.

In terms of the 300 beds some work as part of the STP projected forward population growth, the aging population and growth in long term conditions. In the STP we are consistent that we would look to reduce the number of beds across our 3 hospital sites by 189 of those 300 beds. This aligns with local care plans being developed by the CCG's.

On Urgent Care, point 27 in the Paper explains about the work used to evidence base how we looked at Urgent and Emergency Care commonly referred to as the Keogh model. The model categorises levels of urgent and emergency care ranging from the most complex major trauma unit through to urgent care centres which would be run by primary care practitioners. There are 6 categories of care that are used and the work looked at the population base that would need to serve that type of centre and it also looked at the clinical adjacencies of services that needed to be provided on the site.

Taking the first one which is a fixed point in all of the options, at the moment for Kent & Medway, Kings in London is our major trauma centre. The centre serves a population of 2-3 million and also has services such as neuro surgery and cardio thoracic surgery on site. As a county we do not have a population large enough to support a major trauma centre so in all of our options Kings remains the major trauma centre.

The main areas that we looked at in the paper were the next 3 categories down:

- A Major Emergency Centre with specialist services for a population of 1 to 1.5 million. Clinical services that would be co-located on that site are hyper-acute, cardiac, PPCI services, stroke, vascular and a trauma unit.
- An Emergency Centre serving a population of 500,000 to 700,000 with a 24/7 consultant delivered A&E, emergency surgery and acute medicine and ITU services.
- A Medical Emergency Centre for a population of 250,000 to 300,000 which would still have consultant led A&E, acute medicine and critical care but the surgical services, paediatrics and obstetric services would have moved off.

Those are the 3 main areas and categories that we looked at.

Then a long list of options was drawn up considering each of those scenarios on our 3 main sites. We also considered building a new hospital on a new site in Canterbury because Canterbury City Council had identified a green field site just off the A2. Also talked about was consolidating all of our hospitals onto one existing site. We also looked at closing an existing hospital, selling off the land and re-providing those services to the other 2 sites. So we started with a long list of around 9 options.

There were two points highlighted on the 5 hurdle criteria. First, that there had been engagement with the public on the hurdle criteria identified at 7 meetings held around East Kent. Second, they are

yes or no answers so as this is worked through some options can fall out at each stage and do not get to the next criteria. These were:

1. Clinically sustainable – 3 measures were used; the catchment population, throughput and workforce
2. Can it be implemented – a 5 year period to 2021 was chosen because that was the period we were asked nationally to plan for as part of the STP
3. Accessibility – this was one of the more controversial ones and always is in East Kent when we look at consulting around service configuration; public car travel time of an hour
4. Did it fit with previous decisions, looked at 2 things; national and regional designation processes and previous consultations undertaken that had moved services. Both of those sets of decisions were followed by significant capital investments in those sites.
5. Affordable – particularly linked to the timescales of the STP.

Clinically Sustainable

An explanation followed about how the hurdle criteria were worked through. The first thing that was measured was the Major Emergency Centre with specialist services. Currently in East Kent a range of specialist services are provided. For specialist services a catchment of 1-1.5 million is required. Most of our specialist services meet this catchment population so that said we can sustain a single Major Emergency Centre with specialist services in East Kent.

For the Emergency Centre, the Keogh work talks about a population of 500-700,000. East Kent currently has a population of 695,000 and looking forward to 2021 that moves up to 700 -725,000 so East Kent can support one Emergency Centre. But East Kent is a rural area so throughput was also looked at. The Keogh work also talked about throughput and the number of major A&E attendances that come in and services that would be needed to support 40,000 major attendances at an A&E. In a single year East Kent hospitals sees just over 110,000. This suggests that 2 Emergency Centres can be supported.

Medical Emergency Centres were looked at in particular the staffing and consultant body. The Royal College identifies that for an Acute Medical Unit with 12 hour cover 10 medical consultants are required. East Kent currently has 20, which suggests 2 units can be provided.

Implementable

Testing whether the green field site build or the build on a hospital site and the closure of an existing site and relocation to the other 2 sites were going to be implementable. Some work was done on capital costs and looked at providing the number of beds on a single site and identified that would cost over £700 million to build on a single site. Even on an existing site it would be that. If local care was not successful in reducing those beds it would have been over £800 million. Closing a site and re-providing services was over £500 million. Looking nationally at recent developments such as Glasgow, Derby, and Birmingham it took 9-11 years to deliver so these 3 options were ruled out as they were not implementable by 2021.

Accessible

Travel times to assess access were considered. At this point no options were removed.

Strategic Fit

There were discussions around designations. There were 2 national and regional designations, one for trauma units across Kent & Medway ran by the South East Trauma Network independently from us as an organisation. Three trauma units were identified in Kent & Medway, one at the William Harvey, one at Medway and one at Pembury. The second national designation was for PPCI services and that identified the William Harvey as the site for PPCI in Kent & Medway. William Harvey has the majority of services aligned to a major emergency centre with specialist services in East Kent. This identified the William Harvey.

Consultations

A range of consultations had been undertaken in 2003 that identified a pattern that if there was 2 Emergency Centres the second would be at QEQM. That placed Kent & Canterbury as an integrated care hospital with an urgent care centre led by primary care.

Financially Sustainable

This looked particularly at the capital consequences of making QEQM a Medical Emergency Centre. This would need an additional build for 136 beds with more theatres and ancillary space at the William Harvey which began to raise the capital costs higher.

So at the end of the application of the hurdle criteria that gave us the first option of the William Harvey as the Major Emergency Centre with specialist services, QEQM as the 24/7 A&E Department with generic district hospital services and Kent & Canterbury as the GP led urgent care.

At that point the offer from developer came in for the single emergency hospital for East Kent. Legal advice was taken. The legal advice concluded that it was a material new option that could not have been envisaged at the beginning of the hurdle criteria, so we were advised to place it alongside the option that has come through the hurdle criteria to be assessed in the new stage. Directly addressing a question from a member of the public Liz Shutler clarified that it was the legal advice that said we should not go back and try to apply the hurdle criteria to the new option because it is materially different.

Hazel Smith clarified the recommendation around urgent and emergency care which leaves us with 2 options. One option through the process we have set that has been agreed through the CCG's and STP which is a Major Emergency Centre with specialist services at the William Harvey. QEQM as the 24/7 A&E Department with generic district hospital services and Kent & Canterbury as the GP led urgent care. The additional option that has not been through that process, but we have had legal advice that we need to run that alongside as we go through further due diligence and understand whether going forward that is an option we should be considering as well.

The Chair asked for questions and comments from the 4 CCG's Clinical Chairs.

- Dr Tony Martin asked a question was raised about the closeness of the William Harvey to West Kent, which takes catchment from there. Had there been consideration of what loss of catchment might be if the main acute centre was moved away from that point.
- Dr Simon Dunn raised a concern over the time period of 2021 and a need to plan further ahead. How far are we tied to 2021?
- Dr Simon Dunn also raised concerns around workforce in the acute sector and also local care.
- Dr Simon Dunn also commented on the catchment area and asked how applicable the Keogh numbers are.

- Dr Navin Kumta confirmed that at Ashford CCG they have considered and are happy with the options and process it has gone through and the criteria applied. Dr Kumta raised one question about Vascular services (figure 2), and is the plan to move to a service population of 1.4 in a single arterial centre solid with no risk.
- Dr Jonathan Bryant asked about the hurdle criteria and travel times, commenting that travelling to have an elective procedure does not have the same urgency as seeking urgent care. The travel time in the hurdle criteria is 60 minutes by car and people who live on the Romney Marsh want to know they are well served with these options.
- Dr Jonathan Bryant commented on Option 2 and that more detailed capital costs and the timeframes are needed for the late entry of the new build hospital option.

The Chair asked for any other comments from the committee.

- Clive Hart commented about the hurdle criteria but on access the hour criteria but if services are moved from one hospital to another a significant proportion of the population will be at the outer limits on travel times. All need to bear this in mind with future decisions.

Responses to the questions were:

- In response to why 2021, there is the dilemma of ensuring strategic fit but also recognising the case for change that we have all looked at and signed off. The challenges of running the health services in the current configuration in primary care and secondary care and the need to get on with the right thing quickly within a more strategic context.
- In terms of the impact on West Kent, if the Major Emergency Centre with specialist services is not in Ashford how would that impact on West Kent? In terms of the modelling work that has been done so far there has been some detailed work looking at where the boundaries of each consultation ought to sit and that is why stroke sits in a much broader geography. The flows of services in terms of what we are looking at today very much relate to East Kent. The due diligence for the additional option that has been put in front of us has not been done yet.
- Liz Shutler clarified that the question was if the emergency centre moved to Canterbury and confirmed that no detailed modelling had been done yet. But if it was the QEQM further modelling had been done on that. If the specialist services were not in East Kent, quite a number of those services are not provided elsewhere in Kent & Medway so if there was not Major Emergency Centre with specialist services in East Kent it would mean travelling over 2 hours to places in London for some of those services.
- The response on workforce confirmed that this is a major challenge. One of the reasons in the Case for Change that we cannot continue to provide every single service on each of our 3 sites in East Kent is that we cannot attract the workforce. That is not about not going out and trying to recruit but the intensity for the consultants and the rotas that they work compared to rotas that are on offer elsewhere in other hospitals it is really difficult to recruit and retain people.
- In terms of the Keogh work and the population in terms of travel, the catchment populations are related to the throughput issue and are therefore relevant. We also asked the South East Coast Clinical Senate, led by a renal consultant from Brighton but also has nurses and doctors from all

of our geographies, to relook at the Clinical Adjacency work. They reinforced many of the clinical adjacencies that were in Keogh.

- In two weeks' time Vascular will go to the Joint Health Overview Scrutiny Committee (JOSC) and the specialist commissioners are supporting us around a single vascular unit in Kent & Medway for arterial inpatient services. Because of the clinical adjacencies that will need to be based in the Major Emergency Centre with specialist services.
- One of the things that needs to be tested for the new build is the timeframe. This is a significant issue because it is related to the sale of houses and building the shell of a hospital which would need to be fitted out at an initial estimated cost of around £250 million. It supports looking at that further because it is significantly less than £750-£800 million green field site.
- There has been a lot of discussion about the access criteria and 1 hour. Reinforcing that point, if the access criteria had been set at less than 1 hour, for example 30 minutes, every single option that didn't provide all of the services at all 3 sites would have been knocked out. Criteria was needed that differentiated and knocked out options that were inappropriate. Moving forward the work will not be looking at the hour, it will be looking at access and travel times for the different options and weighing those up against some of the other criteria in the paper and that will be informed by the impact quality assessment. So the 1 hour will not be carried forward to the next stage, it was used at hurdle criteria and will be left there.

The Chair asked Dr Paul Stevens, Medical Director EKHUFT for comments.

Paul Stevens made a point to support the argument using renal services as an example of how the time has had to be moved over the years. It is apparent to everyone that not everything can be done everywhere and have never been able to do that with renal services because is a very specialised service. In terms of provision of inpatient care this can only be done in one place in the whole of Kent & Medway but what we have done over the years is to try and provide as much care as possible local to patients. We do that through a network of satellite units which is effectively providing local care and some patients do some highly complicated dialysis themselves in their own homes. That is self-care supported by our staff and using IT in innovate ways to do this. Moving forwards in health care in the whole of this country we need to get smarter to survive. These are points the committee needs to keep in mind as it deliberates.

The Chair invited Jonathan Bates, Finance Director to comment from the finance point of view.

Jonathan Bates informed the committee that the financial arrangements that have been discussed today went through the individual CCG's and also the STP finance group where senior finance professionals from the hospitals, CCG's, mental health and community services are involved.

Jonathan Bates also reiterating Hazel Smith's comment about the 2021 date because current arrangements are not sustainable either financially or from a workforce point of view. Speed and making a change now are important.

Thirdly on the Major Emergency Unit at Canterbury the costings for that have not been run through the STP Finance Group, so that is consistent with the general theme of today, the initial work has been done but not in the same detail.

The Chair asked Glenn Douglas if there were any further points:

Glenn Douglas commented that around the population we need to be able to move to the next level to understand it more fully and the impact it will have on the rest of Kent and also the Conquest Hospital. That piece of work needs to be done. Generally there has been some really good questions and challenges about the next step forward but the reality is we need to be at the next stage to answer those questions.

Looking at specialist services and the geography of Kent there is always going to be a tendency to a specialist service in East Kent because of the drain from part of West Kent and the A21 corridor into London. That is why there has been a differentiation and development of services across East Kent, particularly around the lack of proximity to those services in London. A lot of West Kent drives into the East Kent services. If all of those can be addressed through the next stage and the hurdle criteria gets to a particular point where we have shortlisted options, then to an extent they then get pushed aside and the job is done from scratch, re-looking at those services again. The timing is important, it is critical for the STP that we start to hit not just financial targets but also quality issues. Currently across Kent & Medway we are not hitting quality service standards either. Any option should be seen to be improving continually with a significant improvement by 2021, but if there is a good strategic option that goes outside that timescale it would be remiss of the committee not to give that a priority during this process and lost sight of the bigger strategic picture. The STP is very clear that it wants to see the right strategic solution and not be constrained by the timescale. If the timescale goes outside significantly we would have to be assured collectively that we can still deliver what is needed in that timescale as well.

The Chair asked the committee for questions and comments. The following questions and comments were raised:

- Dr Markus Maiden-Tilsen asked if assuming all in primary care have a finite budget; has the impact on integration from primary care into secondary care been considered.

Jonathan Bates commented that when a change is made the other services around that change will be assessed as part of the whole system cost at the next level. So costs will not be assessed for services not affected by these changes but the whole system cost will be assessed and this will pick up the local care element of it.

- Are we talking about the running costs after and not just the initial build costs?

Jonathan Bates confirmed this included the running costs after.

- Dr Dan Moore asked for clarity on the 2021 timeframe selected because of national directive or locally chosen.

Glenn Douglas responded that the 2021 date is nationally directed. STP's have a directive to provide plans for 2021, but this is a moment in time. It does not mean that we cannot be in the middle of doing something in 2021.

The Chair asked Hazel Smith to sum up and pick up any outstanding points.

Hazel Smith confirmed the committee had reached paragraph 87, the recommendation of the two options. There has been a consensus from the committee that the recommendation should be taken forward but that there is a considerable amount of work to do to answer the questions from the

committee that have been set out in terms of taking this to the next stage and looking at those two options in great detail. The guidance from Glenn Douglas in terms of almost being seen to start from scratch is really important now we have got to a stage where we have a manageable number of options to consider.

Under the Terms of Reference the Chair sought consensus on the proposal and recommendations in paragraph 87 and asked the Joint Committee members to give their agreement. All confirmed agreement. None were against. There was a consensus in agreement.

The Chair moved on to the second part of the meeting, Orthopaedic Services.

006/17 ELECTIVE ORTHOPAEDIC SERVICES

Hazel Smith confirmed that the process if the same and invited Liz Shutler to present how the hurdle criteria were applied to get to the medium list in the paper:

Liz Shutler explained the paper starts with some context setting the scene for Elective Orthopaedic Services in East Kent. The waiting list has grown by 75% over the last 4 years. Because of the increasing number of emergency patients that are coming in to services, a larger amount of operations are being cancelled than ever before. That is because we have emergency services and elective services on the same site. Patients are waiting in excess of 35 weeks, which has grown by 50% in the last 3 years.

The evidence suggests that providing elective services away from emergency services on a separate site outcomes can be improved significantly and there is an opportunity to become more efficient.

A long list of around 8 options was considered:

1. A single inpatient East Kent Orthopaedic unit at any one of our 3 hospitals.
2. Re-providing inpatient Orthopaedics at all 3 hospital sites.
3. Every potential combination of 2 sites.
4. Not having an inpatient Orthopaedic centre in East Kent with a single unit being provided for the whole of Kent & Medway.

Exactly the same hurdle criteria and exactly the same measures were applied.

The key findings and outcomes were:

Clinically Sustainable

The South East Coast Clinical Senate had done some work looking at the number of joint operations that need to be done to provide local services. They were clear that nationally it was evidences that 3000 or more orthopaedic joint operations a year you can provide a local service. East Kent hospitals does undertake over 3000 elective inpatient joint operations a year. On those criteria alone a local service should be offered and a single service in West Kent was knocked out.

Two other issues came up in the analysis around that; placing that option at Maidstone was modelled but there was a significant proportion of the population, around 45000 people, who could not reach that within the hours car travel time so it failed on that option too.

We do not have a provider who is willing to invest in the 100 beds and 15 theatres so that option fell out under clinically sustainable.

Implementable

The local care assumptions around reductions were taken into account, musculo skeletal referrals to the trust were around a 25% reduction and were left with a service that utilised around 43 beds. Moving 43 beds to any one of the sites or a combination of sites, particularly given the diagnostics and theatres are already on those sites, we did not feel that there was something that was differential under the criteria that would knock any of the further options out.

Accessible

In the hours travel time applied was exactly the same as before, the catchment populations could reach inpatient elective orthopaedic centres within an hour, so that did not differentiate.

Strategic Fit

In 2003 we had looked at number of inpatient elective sites that we could provide as part of that consultation.

Workforce

For workforce issues we had identified that providing it on 3 sites was not sustainable and had moved to 2 inpatient elective sites, so the 3 site centre was knocked out at that point.

Financially sustainable

This was similar to implementable, there was no differentiating factor.

That left us with a medium list of 6 potential options. A single site on one of our sites and a number of two site options.

The Chair asked the 4 CCG Clinical Chairs for comments and questions.

The following comments and questions were raised:

- Dr Simon Dunn commented that in Canterbury there were some questions around the number of patients seen in the independent sector under the NHS and how do those numbers factor into the figures that have been provided?
- Dr Simon Dunn also raised points about workforce and the way workforce is used, the Clinical Board discussions about productivity and using theatre time efficiently; if this is done does it negate the reason behind a single centre?
- Dr Tony Martin echoed Dr Simon Dunn's comments and asked does this approach work in scattered rural areas like Devon and Cornwall or Scotland? Thanet understands the removal of the options here, but we have not fully supported some of the arguments and a lot more work needs to be done on this in the next phase. The next process almost needs to revisit and start from scratch. More work is needed to take it to the next phase and give us hurdle criteria for the next part which we can all sign up to.
- Dr Jonathan Bryant was broadly in support of separating emergency from elective orthopaedics but keen to see quality, looking at the hurdle criteria there has been an emphasis on travel times. For orthopaedics the focus should be on excellent quality and outcomes rather than the convenience of close to home.
- Dr Navin Kumta commented that the main issue is the workforce and quality and the next stage is critical, to really be transparent about whether the elective being in a trauma centre is more attractive to orthopaedic surgeons or less attractive to orthopaedic surgeons to work in.

The Chair asked for any other questions or comments.

The following were raised by Alistair Challiner:

- Clarification on Option 3. Is it predicated on the assumption that Option 2, the previous one may not go forward and if Option 1 was there then Option 3 would not be, so which comes first?
- There an assumption that there is a reduction in activity and 25% moves into primary care sector or the out of hospital sector. It does not make reference to whether the assumptions about growth and overall activity has also been taken into account in the model.

Hazel Smith reviewed previous questions and did not comment further on those points.

Paul Stevens responded to the question about productivity and the rural question. On productivity the national Get It Right First Time (GIRFT) programme started in Orthopaedics. The message from this is that on an 'all day' list 4 plus joints will be done. What the GIRFT programme has been doing in Gloucestershire was to separate acute from elective and they have achieved better outcomes for elective orthopaedic operating in terms of length of stay, revision rates and infection rates and also improved outcomes in their emergency care pathway hitting 95% plus consistently.

Liz Shutler responded to the question about the independent sector and clarified that in those 300 joints and nearly 5000 operations we have played in the activity that we place with the independent sector, but not activity where people choose to go elsewhere.

Liz Shutler also responded to clarification on Option 3 question that when the hurdle criteria was applied and just looked at Option 1, the William Harvey fell out as the single Orthopaedic centre because of the additional capital that would have to be invested on that site. When the developer option was played in that made a significant difference. So there is a link that will come out as the issues in terms of the split between elective and emergency are replayed and talked about in each of the options as we move forward in the next stage. Growth has been played in.

The Chair checked the committee were satisfied with the answers.

- Clive Hart made a further point was made about travel and the fact that orthopaedic patients are more likely to be less mobile when they are travelling by the very nature of their condition and also those in deprived areas do not have their own cars and private transport. Recuperation is also important and patients need their families nearby, it is important for patient recovery. These points should be taken into account moving forward to the next stage.
- Dr Tony Martin raised an further comment was made about the link with primary care and the issue that primary care is under considerable strain and pushing 25% into primary care needs to be taken into supported and not assume it is going to happen.

The Chair asked Hazel Smith to respond.

Hazel Smith commented on the question about investment in primary care and confirmed agreement with an earlier response from Jonathan Bates, as in emergency and urgent care the need to be clear about where the MSK pathway sits in primary care, the interface into secondary care and that we are very clear about that.

Hazel Smith also responded to a public question from earlier in the meeting about the relationship between workforce and the medical school. An application for the medical school has been made by the two Universities in Canterbury; the University of Kent and Canterbury & Christchurch University.

The application was made on the 23 November 2017 and the national process finished in March. In relation to its relevance within this process is that the application is predicated on an innovative model of education which focuses on primary care and psychiatry as primary reasons for the application. It is not related to needing or having a teaching hospital sitting alongside it. It would be a medical school for the whole of Kent & Medway. The other part of the question that was asked was the potential impact of having a medical school which should have a very positive effect in terms of opportunities in primary care and secondary care. That also includes making sure services provided are ones people want to work in.

Hazel summarised that there has been consensus from the committee about this option but there are some questions and work to be done in terms of considering next steps. There is further work to be done to demonstrate very clearly and with appropriate national evidence and any papers tabled to this committee going forwards in terms of access, relationship of quality, capacity and the opportunity for this to be innovative. The key point is that there is a lot more work to do.

The Chair asked for consensus on The Elective Orthopaedic Services from the Joint Committee members and this was given.

006/17 Reviewing the Evaluation Criteria

Liz Shutler informed the committee that there is an enormous amount of work to do, over the next month putting together the information needed to begin to apply the criteria will be January/February 2018, involving members of the public, stakeholders and staff.

There will be some processes to go through in terms of capital, pre-consultation business case around February/March then broadly April/May getting out to consultation. There are a number of stages to get through in those timescales.

Hazel Smith introduced Louise Dineley the East Kent Programme Director to give a brief overview of the timescales.

Louise Dineley provided an overview for the committee advising that the timescales are governed by strict processes and it is important that we follow that. We can be clear about what the next 2 months looks like. In terms of the subsequent stages some are within our control, it will also involve the work of this committee and also ongoing engagement with a number of stakeholders, including the public. There are clear elements of building up the business case then further assurance processes we need to work, which is a series of stages working with regulators and NHS England in terms of the wide and further oversight to the work that has been done within East Kent, its fit locally with Local Care, Finance and Prevention. There are 7 national tests that have to be satisfied which are independently assessed, through NHSE's oversight and assurance meetings and then as we go forward to the next stages to the Investment Committee and sign off of the finances. Until we have gone through all of those stages which are predicated on decisions like today, we will need to have a working timeline.

The committee all agreed they were happy with the process and timeline.

- Dr Markus Maiden-Tilsen made a further comment about the evaluation criteria for the Elective Orthopaedics for further clarity on the workforce impact is the link to primary care and third sector and it is really important this is taken into consideration.

- An equality impact assessment is needed because people in deprived areas are less likely to have the transport and are more likely to fall ill in the first place and need care more than people who have easier access to services.

The Chair clarified with the committee that the points raised at the meeting would be picked up.

- Alistair Smith raised question about the evaluation criteria. Getting to this stage has been a yes/no issue but going forward it is not going to be a yes/no issue it is going to be looking at it all. So does one area have more weighting than another? How do you determine weighting? How that process if evolved needs to be clear about how we weight everything and key determining factors.

Hazel Smith responded and agreed, confirming this needs to be built into the timeline and in terms of developing the evaluation criteria further very much ensure there is full engagement within the different geographies of the 4 CCG's and to make sure that through the STP we have the best advice possible, supported by the Clinical Board and Programme Board of the STP.

A few further points were made:

- Looking forward there needs to be a positive local bias in the work that is done and to look across East Kent and do whatever we can locally.
- Decision making should not be binary and traditional.
- Clarified local care is not GP's it is all services provided and working with them.
- More flexible models are needed and looking around the country and push to make things local where possible.
- There are 3 areas that need to be explicit; affordability, overall financial benefit and deliverability.
- How easy will it be to deliver, it is not a stop gap it is a continuum.
- A specific question in the hurdle criteria on medical school would be useful.

The chair concluded that the question of public engagement in the process is very important, particularly public engagement in the criteria setting.

Louise Dineley responded to this point informing the committee that to date there has been a range of engagement events at which the evaluation criteria were tested, these events included the Public Listening Events which were held in the early summer months. Drawing on today's and comments from other forums there are plans to engage further on the criteria over the next 6-8 weeks. We also need to make sure that is accessible to different groups and not just through the websites. Further details around that engagement will be published.

The Chair asked the committee if all were in agreement with the evaluation criteria subject to the amendments and with the next steps and the main part of the meeting was concluded.

AOB

No further items were raised

Glenn Douglas commented that the meeting had been a really helpful process, with good comments that can be used both from the committee and public to make sure we get the right result and we should make sure that we do everything we can to get the best possible result for all patients within East Kent.

The Chair summed up on behalf of the committee to thank all of the tremendous hard work that has been put into the proposals. Clearly we are facing change and the important thing is to improve the quality of the service to all patients.

007/17 – Questions from the public (Part 2)

- **XXXXXXXXXX** thanked the panel for the detail put online and noted that there is more work to do. He said that the strategy of building up primary care was crucial and needed investment and to be supported by hospital care at all three sites. He queried the timing of three to five years, suggested that the team look at a longer term. He advised that the team should avoid the rigid system trying to be imposed on them and that Liz Shutler's classification should be re-thought. He also queried whether the application for a medical school had been taken into account.

HS responded that the University application was fully supported by the Local Authorities, etc. and that under graduates working in that setting as well as inter-professional training were important and part of the vision. Hub and spoke important on Kent & Medway basis.

- **XXXXXXXXXX** said that the 30 page document was daunting and that some elements needed to be rewritten. He noted that paragraphs 1-81 were good, logical, and sensible and used the hurdle criteria. Paragraphs 81-87 were about the commercial initiative and lacked detail, and there was no application of the hurdle criteria. He asked whether the tail was swinging the cat? Paragraphs 88-135 on elective orthopaedics didn't reflect the criteria. He noted that there was no mention of workforce. He said that he was getting more detail from the newspapers about Quinn estates than he did from this document. He stated that the STP was governance-driven and that the reduction in bed numbers and £20 million savings were driven by cuts. He said that a Freedom of Information (FOI) request he had made revealed that STP costs were £6 million to date to develop resources for this programme.

Glenn Douglas responded and agreed that it was a significant amount of money but that it was worth spending some money to achieve their aims and that the NHS would be doomed if we didn't do it, and the NHS centrally is endeavouring to make the best use of the money. He said that developing services for the future does cost money. It was about making sure we have the right level of local care and non-hospital services. He corrected the figure of £20 million cuts, saying they were not cuts per se, and the question from the government and NHSE centrally was how do we make the best use of resources and that our intention is to get the best possible "bang for our buck" going forward. GD also added that if more money or help is needed to deliver the STP we would say so.

Jonathan Bryant confirmed that all CCGs are developing solutions to move care closer to peoples' homes. He said that the strategy is how to use what we have more wisely, looking more at preventative and local care. He added that with the limited funds we have, we can use them more efficiently taking them out of hospital and using them closer to people's homes.

- **XXXXXXXXXX** stated that the hurdle criteria were applied to the first option, but that the public have had no assurance that the hurdle criteria were applied, or will ever be applied, to option two. He also stated that on the question of Orthopaedics the hurdle criteria were applied less meticulously, and queried why there was a different set of criteria. He said he felt reassured that the team had said there is still a great deal of work is still to be done.

Hazel Smith responded that the hurdle criteria will not be applied to the commercial option. If this had been done when the offer was made from the developer this would have slowed the process

down. Hazel reiterated that, as Liz Shutler had explained earlier, clear legal advice had been given, which was to run it alongside, and that we needed to be clear on exactly what we had been offered.

Simon Dunn asked if the hurdle criteria have not been applied up to this point will it be applied equally from now on and Hazel Smith confirmed that is the case.

- **XXXXXXXXXX** asked about ACOs and whether CCGs supported the move to ACOs. She noted that the STP depended on good community services and voiced concerns about whether we can develop these. She asked if they would be bundled into ACOs and queried whether any bidding will be open to the private sector for the ACOs, and stated that this would be the Americanisation of the NHS.

She also queried whether the NHS had any input into KCC's cutting of bus services, many of which were local to hospitals.

Simon Dunn replied that ACOs have had three name changes as people struggle to describe a way of providers working together in an alliance contract. He said that that teams needed to sit down together, including staff from the acute hospital, community, mental health colleagues and work out a contract that means they can work together, and about how they work together.

Glenn Douglas agreed with Simon Dunn and added that there is no plan or suggestion in Kent & Medway of involvement in the private sector, other than where they are providing a service. He stated that the ACS single control total had to be a good thing.

MMT stated that he was aware of changes in Thanet and that they have worked hard to make threat into opportunity. Organisations, teams, services, charities and closer links to social care have all been established.

- **XXXXXXXXXX** from the Over 50s Thanet Forum voiced a concern that information was not reaching everyone, including staff of the CCGs, and queried whether the doctors getting the message out to the public, and whether the PPGs were getting the message out?

Chris Morley commented that in Ashford they do their best to take the message out through PPGs to filter down to GP surgeries. Previously, the PPEG was on an east Kent basis but this is not a Kent & Medway wide PPAG. He confirmed that there are different challenges but he welcomed input and contributions to the meetings. Clive Hart added that there have been Listening Events which all the Clinical Chairs attended, as well as work with the third sector and with children's partnership groups. He acknowledged that there were difficulties in getting the message across, but found that online was perfect. He believed they were doing everything they could.

- **XXXXXXXXXX** stated that two options were now going forward, and that a decision would be needed. He queried how and when this would be done, which bodies would be involved and what part public participation would play in it.

HS confirmed that a decision would be made by this committee at each stage. There would be further consultation and it would be this committee who considered the end result. It would be a long and detailed process. She confirmed the long and detailed process that Louise Dineley had described and said that it would be months before they could come back with a timeframe for public consultation.

- **xxxxxxxxxx** asked about the 189 beds that should be in the community. She asked for assurance that it wouldn't go ahead until those 189 beds are in the community. And she asked that the question about buses be answered.

HS confirmed that transport would always be an important question we would need to resolve and that the NHS had an on-going relationship with Stagecoach re the movement of Out Patient services. At the Health and Overview Scrutiny Committee the previous week, HS reported that a councillor from Herne Bay was clear about the positive changes of bus services. HS confirmed that we need to work with Stagecoach and KCC to make sure we have the right infrastructure. Hazel agreed to pick up with KCC if we have missed information on bus times changing.

SD said that he echoed the questioner's concerns and that if a bed was shut, that bed should be provided somewhere else. He confirmed that we have to prove where that care is going to be provided, otherwise NHSE wouldn't let us take the proposal forward.

- A question was asked about the Health and Social Care Bill, clauses relating to the EU and whether STPs could be sued by private health care providers. Is there any way that all STPs in the UK could say we don't want to be sued, is there anything about predatory providers?

GD clarified he was worried by the potential takeover of NHS by the private sector. Referring to the system in America, he confirmed that mainly charities are providers and all of the money is in insurance. GD agreed that there needs to be a debate about the NHS but there is no indication of privatisation, that is not the intention of the STP. GD added that the private sector is used and that most GPs are, in technical terms, "private" already. He said he STP body does not include people who represent the private sector, it is all public sector bodies.

- **xxxxxxxxxx** asked why there have been no discussions about the planning permission for the new shell hospital. She asked how the committee can give a two month timeline when there are so many unknowns.

It was confirmed that for Option 2 the programme team is working on unknowns.