

SUSTAINABLE HEALTH CARE EAST KENT JOINT COMMITTEE
 (Held in public)
Thursday 28 February 2019
10.00 am – 1.00 pm
The Dining Room, The Grand Hotel, The Leas, Folkestone, Kent, CT20 2XL
Chair: Bob Deans

Voting Members in attendance:		
Dr Jonathan Bryant	JB	Clinical Chair South Kent Coast CG
Dr Navin Kumta	NK	Clinical Chair, Ashford CCG
Chris Morley	CM	Lay Member PPE, Ashford CCG
Dr Chee Mah	CM	GP South Kent Coast CCG
Alistair Smith	AS	Lay Member for Governance, South Kent Coast CCG
Dr Markus Maiden-Tilsen	MMT	GP Thanet CCG
Clive Hart	CH	Lay Member, Thanet CCG
Dr Santhosh Sebastian	SS	Deputy Clinical Chair, Canterbury CCG
Dr Jihad Malasi	JM	Clinical Chair, Thanet CCG
Alistair Challiner	AC	Secondary Care Clinician, Canterbury & Coastal CCG
Apologies from Voting Members:		
Dr Simon Dunn	SD	Clinical Chair, Canterbury & Coastal CCG
Non-Voting Members:		
Caroline Selkirk	CS	Managing Director, East Kent CCGs
Lorraine Goodsell	LG	Deputy Managing Director, East Kent CCGs
Dr Darren Cocker	DC	Chair Clinical Models Group
Michael Ridgwell	MR	Deputy Chief Executive, Kent & Medway Sustainability and Transformation Partnership (STP)
Sarah Vaux	SV	Chief Nurse, East Kent CCGs.
Evelyn White	EW	Transformation Leadership Support
Liz Shutler	LS	Deputy Chief Executive, East Kent Hospitals University Foundation Trust
David Meikle	DM	Turnaround Director East Kent CCGs
Julia Rogers	JR	Director, Communications & Engagement, Kent & Medway Sustainability and Transformation Partnership (STP)
James Pavey	JP	Regional Operations Manager (East) South East Coast Ambulance Service NHS Foundation Trust (SECAmb)
Apologies from Non-Voting Members		
Glenn Douglas	GD	Chief Executive, Kent & Medway Sustainability and Transformation Partnership (STP)
Minutes:		
Margaret Christofides		PMO Support
Belinda Hunnisett		PMO Support

012/19	<p>Welcome and Introductions</p> <p>The Chair welcomed all to the meeting being held in public. He informed that seven questions had been received from the public and will address them at the relevant item on the agenda. He asked that any further questions to be submitted at the end and will be picked up later by the CCGs.</p> <p>Fire escape routes were indicated and likewise direction for toilets. A reminder that hearing loops are available if required.</p> <p>The Chair briefly explained the purpose of the meeting, i.e. to update on the progress over the last twelve months and the way forward for options evaluation and on-going process.</p> <p>Also to note that the meeting is being recorded and would be available to listen to at a later date:</p> <p>https://soundcloud.com/km_healthandcare/eastkentjointcommittee-28022019</p> <p>A welcome was extended to those who have dialled in but are not present.</p>	Action
013/19	<p>Declarations of Interest</p> <p>Julia Rogers declared her father is Chairman & Press Officer for CHEK (Campaign for Healthcare in East Kent).</p> <p>Bob Deans declared his brother is involved in Momentum in Plymouth.</p> <p>Action: Declaration forms to be completed and returned as stated.</p>	BD & JR
014/19	<p>Quoracy</p> <p>The Chair confirmed that the meeting was quorate for the purposes of this meeting.</p>	
015/19	<p>Minutes for approval:</p> <p>The previous minutes of the meeting held in public on 30 November 2017 were agreed subject to the following change:</p> <p>Alistair Challiner requested that his name be removed from the minutes (page 13, line 9) as he was not present at the meeting. Alistair Smith confirmed that his name should be inserted instead.</p>	
016/19	<p>Application of Hurdle Criteria</p> <p>Slides on hurdle criteria were presented, explaining the evaluation process designed to enable the East Kent Transformation Programme to meet their objectives:</p> <ul style="list-style-type: none"> • Provide an objective and transparent framework for the assessment of all possible UEC reconfiguration options. • Derive a manageable shortlist of options from the longlist of 	

options.

- Ensure that shortlisted options would enable East Kent local health economy's objectives to be met.

The three key stages of the evaluation process were noted as:

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

The first application of the criteria, as discussed at the joint committee meeting in November 2017, saw one option emerging. However, at that point we were approached by a developer (Quinn Estates) offering to provide the gift of a shell of a hospital in Canterbury, which provides the opportunity to provide a major emergency centre facility in Canterbury. This type of centre is a hospital providing twenty-four hour, seven days a week, consultant led facility providing a range of more specialist services.

The gift of a shell of a hospital represents a substantial gift and we felt it would be unreasonable not to consider it. However, as this option had not been through the process of applying hurdle criteria, the process was reapplied, including assessing the option enabled by the gift of a shell of a hospital. This ensured this option was subject to the same degree of rigour as other options considered at the hurdle stage.

Another important point to note is, to ensure consistency, from hurdle criteria to full evaluation; we build on the same criteria but go into more detail. Full evaluation can also see criteria supplemented and enhanced but the criteria used in full evaluation remain consistent to those used at the hurdle stage.

Whilst reapplying the hurdle criteria, the opportunity was taken to review the hurdle criteria that were used, including:

- Concern on cost as building costs in the public sector were rising due to indexation. This potentially could render all options unaffordable against the previous financial thresholds that were used. Therefore, a threshold of £25m per annum revenue costs (in terms of the cost of servicing capital) was set as the revised affordability threshold.
- The previous delivery timeline of 2020/21 would not be met by any of the options, so the timeframe for delivery was extended. Previously access was partly considered implicitly through the strategic fit criteria. Engagement has shown this is a key issue and a range of access requirements have been considered against the access criteria (other aspects of the strategic fit criteria will be considered in full evaluation)

In summary, from seventeen options stage 1 and 2 of the evaluation process has resulted in two options being identified for full evaluation (this will be discussed later on the agenda).

In July 2018 Option 9 (a single emergency model at William Harvey Hospital, Ashford) was discounted at hurdle stage on the basis it is not financially sustainable – as part of the ongoing quality assurance of the process the capital costing were independently reviewed. This review confirmed the original decision that the option did not meet the hurdle criteria for financial viability.

The medium list of options included:

Option 1: Two sited ED model (with William Harvey Hospital operating as the Major Emergency Centre and Queen Elizabeth the Queen Mother Hospital operating as an emergency centre)

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

To note that during the final and detail stage of the evaluation (Stage 3) option 1 and 2 will also be reviewed against a do minimum option (with the do minimum modelling the return of emergency care service to the Kent and Canterbury Hospital but not an accident and emergency department - further details are provided in the agenda item on evaluation process and timeline).

Questions:

Question was asked about the use of the word gift and in particular regarding the due diligence around the developer and their offer. Is it a gift or is there some sort of transaction going on and trying to dictate health care policy in East Kent?

It was confirmed that there would be no financial input from NHS for the build of the shell of the hospital, but the NHS would need to fit out and equip the shell. As a general principle, 50% of the total cost of a new hospital is the shell and external infrastructure and 50% is the internal fit-out.

The Trust have already carried out significant due diligence. The commissioners, as part of their considerations around the implementable criteria within the full evaluation process, will conduct further detail due diligence.

It was asked what can we expect from due diligence?

It was highlighted that generally with a project of this nature, involving a significant build, we would see the commissioner develop a pre-consultation business case and consult, then develop a decision making business case and the agreement of a preferred option. After this the trust would then through procurement appoint a developer and delivery a full business case. The position with this programme of work is different; the option would not make it through the application of hurdle criteria without the gift of the shell of a hospital from the developer. However, this places an onus on commissioner undertaking due diligence as part of the

<p>017/19</p>	<p>The commissioner will treat this in a similar way to a prequalification questionnaire as if a restricted procurement was being run.</p> <p>It was added that the commissioners are looking to external support to undertake the due diligence which would focus on financial standing, commercial considerations, tax issues, etc.</p> <p><i>A concern was raised around due diligence and a number of other aspects of the project, i.e. planning permission, external infrastructure and road changes. The supply of utilities to the site will need massive road changes. Do we have commitment from the District Council for the planning and County Council for the infrastructure changes?</i></p> <p>The group was informed that we have to submit the business case to NHS England. The commissioners cannot go out to consultation until all questions have been fully answered and NHS England believe that the option is viable. These issues will need to be looked at as part of this process as the questions you ask are intrinsic to whether the option is viable against the implementable criteria. This is challenging and complex to evaluate but we are sighted on these and working through them ahead submission of our business case to NHS England.</p> <p><i>Another question was asked if we have any indication of timescales of the gift. Do we have to wait until the developer has completed other plans to provide the funds to enable the gift and, therefore, do we have any idea of which year the shell will be available?</i></p> <p>It was confirmed the commissioners are conscious of the scheduling of different aspects of the developer's proposal. Part of the due diligence will look at this. As the project requires the shell to be built up front, it is a challenge around implementation that we have through the evaluation process.</p> <p><i>It was advised that accessibility is one of biggest issues, particularly for the population of Thanet. One of the obligations for any of the councils should be that traffic arrangements and roads are amended for any of the options and asked if there has been any commitment from the councils to support?</i></p> <p>It was highlighted whilst there is no written commitment received, the councils are aware and this is part of the planning discussions. For example, under Option 2 there would a need for a new access off the A2 and this is part of the plan. In addition, significant works are being carried out to improve the traffic flow at the moment on the M20. However, it's acknowledged that this is a good point that needs careful consideration.</p> <p>Reports from recent public engagement activity</p> <p>The slides were presented detailing the pre-consultation public engagement which took place during October 2018 and January 2019.</p> <p>The report summarises the key themes across this phase of engagement work where NHS leaders and independent researchers spoke to more than 1,000 people face-to-face and 750 people responded to a questionnaire.</p>	
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It included 10 public meetings, an online and paper survey, street surveys and group meetings with the seldom heard, focussed conversations with maternity and paediatrics, and face-to-face meetings and an online survey with out of area service users.

Key themes from the public were:

- General support for Case for Change – this was highlighted by people’s personal experiences, the public welcomed providing more local services and in general saw the benefits of bringing specialist services together but requested more evidence needed the solutions being proposed are the right ones to deliver our ambitions
- More details needed on options development and assessment
- Concern around travel times and transport
- Concern around workforce and capacity to deliver
- Clarity needed on urgent treatment centre plans
- Additional information needed for consultation to help people to give their views.

The presentation also outlined the recommendations within the report and the next steps to ensure that we continue to engage with patients and public throughout the programme. The committee then discussed the report and supporting appendices.

Members of the committee welcomed the reports and acknowledge the quality and comprehensiveness of the engagement work.

The committee’s discussions and comments included a need to: Consider the timing of establishing the travel advisory group (recommended in the report) given some details of the potential options are not yet confirmed.

Consider current performance of ambulance services and the potential impact of change. South East Coast Ambulance confirmed they were fully committed to participating in the programme.

Acknowledge in the title of all the appended reports that the transformation work covers local care as well as hospital services.

Consider the strength of responses received from Thanet residents and what more can be done to consider local needs.

Develop better understanding amongst the public on the differences between urgent and emergency needs and the services available for each.

Be aware of engagement fatigue given the length of the programme and to refresh how we engage going forward.

Recognise the importance of Primary Care Networks and general practice in supporting/enabling the potential changes to hospital services.

	<p>Recognise the positives of primary and secondary care working together to develop improvements to services.</p> <p>Provide more information on exactly what services will look like under the options being developed.</p> <p>Recognise how the feedback from engagement is already being used by the clinical models group to shape changes to the services being proposed.</p> <p>Continue to engage seldom heard/hard to reach groups, noting that the pre-consultation engagement work did actively engage a wide range of groups including the Nepalese community in Dover and Folkestone.</p> <p>Consider the workforce challenges and opportunities across local care and hospital services in the short, medium and long term; including considering the Nuffield Trust report on smaller hospitals.</p> <p>The Committee agreed the recommendations within the report and noted the need to continue effective engagement as the programme progresses.</p>	
<p>018/19</p>	<p>Service Models</p> <p>The service models slides were presented.</p> <p>The overarching vision is to significantly improve the health and wellbeing of east Kent's residents. 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.</p> <p>For 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).</p> <p>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.</p> <p>The developing models of care will sit behind an Integrated Care Partnership (ICP) across east Kent and deliver six levels of integrated care.</p> <p>Level 1: Self Care Level 2: General Practice, Level 3: Primary Care Networks, Level 4: Extended Community Services, Level 5: Acute Hospital Care Level 6: Specialist Care</p> <p>The outer 2 levels demonstrate the different hospital-based services we expect to find across our acute sites in the future.</p>	

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.

An overview was provided of the three current options and key service changes:

Do Minimum:

Two site emergency department model (William Harvey Hospital (WHH) and Queen Elizabeth Queen Mother Hospital (QEQM)) with acute medicine at Kent & Canterbury Hospital, noting this:

- Reverts to 3 site emergency medicine (with A&E departments on two sites).
- Maintains three critical care units
- Reverts to elective orthopaedics provided on two sites
- Stroke services (through a combined Hyper Acute Stroke Unit / Acute Stroke Unit) provide on one site in line with the stroke review

Option 1:

Two site emergency department (ED) model with William Harvey Hospital as a major emergency centre (MEC) and Queen Elizabeth the Queen Mother as emergency centre (EC), noting this results in:

- Emergency medicine provided on two site (with two emergency departments))
- Two critical care units
- A trauma unit and primary percutaneous coronary interventions (pPCI) provided at the MEC
- One site elective surgery.
- Stroke services (through a combined Hyper Acute Stroke Unit / Acute Stroke Unit) provided at the MEC

Option 2:

One site ED model with Kent & Canterbury Hospital as the MEC, noting this results in:

Single site emergency medicine (with one emergency department)

- One critical care unit
- A trauma unit and pPCI provided at the MEC
- 1 or 2 site elective surgery (low risk) (remains under review.)(TBC)
- 1 site stroke (HASU/ASU)
- Single site consultant-led obstetric and paediatric services at the MEC
- Introduction of 1 standalone Midwife led Unit (MLU) at the QEQM

Key features of service models include:

1. **Outpatients** : 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
2. **Frailty**: 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 urgent care frailty pathway will ensure patients are cared for in the most appropriate setting
3. **Urgent Treatment Centres (UTCs)**: the intention is to have UTCs on all 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
4. **Paediatrics**:
 - a. **Option 1** WHH providing acute inpatient services, a paediatric oncology shared care unit (POSCU), neonatal intensive care (NICU) and paediatric surgery (inpatient and day cases); QEQM providing acute inpatient services, a special care baby unit and (SCBU) and paediatrics surgery (inpatient and day cases)
 - b. **Option 2** K&CH providing acute inpatient services, POSCU, NICU and all paediatric surgery (inpatient and day cases)
5. **Maternity**: Under Option 2 standalone midwife-led units were considered in addition to the centralised consultant-led obstetric unit and co-located midwife led maternity unit. The preferred option is one standalone unit in Margate. As part of the detailed evaluation – further analysis will be undertaken

It was highlighted that the development of service models has taken account of feedback from clinicians and patients received through the recent engagement events. In Option 2 changes include the provision of outpatient services at all three sites and a standalone midwife led unit. It was noted that a number of elements of the proposed service models or evaluation include significant improvement plans such as transformation of outpatients and the roll out of the new UTC model

Questions:

It was asked whether Option 2 includes outpatient provision at K&C and suggested assurance will be needed on existing outpatients in community hospital and private care networks are being expanded to.

Two questions was raised:

- *With regard to outpatient appointments – the figure on slide 20 states approximately 250,000 appointments per annum. Then on slide 22 it gives an estimated reduction of 30% reduction in outpatient appointments. How were these figures derived?*
- *With regard to maternity services, is the ambulance service geared up to transporting all the emergency maternity cases to Canterbury? Thanet is a deprived area with a high level of pregnancy and the impact of increased travel time associated with transporting mother in labour from Thanet to other hospitals needs to be carefully considered*

The group was advised the projected improvement figures regarding outpatients were based on national guidance and reductions delivered in other areas. Maternity travel times will be considered further during evaluation. It was emphasised that the full range of pre and post-natal services would continue at the QEQM. The only element of change was birthing. It was also noted that SECAMB were fully engaged in the transformation programme.

A question was raised on how we will look at clinical risk.

A range of factors was noted and information will be applied including a variety of evidence gathered following the implementation of similar changes elsewhere. It was suggested that SECAMB, with clinical colleagues could be involved in a risk evaluation, which will look at a historic cohort of patients and the impact on their clinical outcomes, should they have had to travel further (in line with the travel times against the options under consideration).

The position around urgent treatment centres on the hospital site was also noted and work is in progress around the out-of-hospital centres. It was stressed location of urgent treatment centres will be very important and needs to be considered within the transformation programme.

The importance of self-care was highlighted and the need to promote healthy eating and looking after ourselves. People's life styles impact on health and, as such, we need to promote self-care.

It was noted that this is an item for discussion with public health colleagues and should be an important aspect of the transformation programme.

It was suggested women are happy with midwives supporting their births and that the quality is very good but many women want a consultant available if needed. It was also suggested that the public indicates a preference to give birth close to home, have a consultant on-hand and be close to an emergency department.

It was confirmed that patient feedback had influenced the proposal model of care for maternity. A number of expectant mothers are trying to understand what a midwife led unit will look like as we do not have any at the moment. Continuous engagement is needed to help develop the service models.

In relation to maternity, the Clinical Chair of Thanet CCG highlighted that this is a critical piece of work, particularly for Thanet patients.

The recent engagement relating to the improving health to prevent stroke was noted. At a future meeting, work on prevention and how to address issues locally we will report back. The approach of local campaigns has been discussed with KCC and a piece of work is currently being undertaken in South Kent Coast CCG with Dr. Jonathan Bryant and some GPs in Folkestone to identify what the issues are and set up a campaign.

It was suggested that there are apps available for patients to monitor their own health; technology is out there helping to reduce health

inequalities. It was agreed that an update on prevention would be helpful at a future meeting.

The need for an integrated approach to data sharing to facilitate joined up care was raised. Patient records to be available not only to GPs but to mental health services, pharmacy and social care etc. Where are we with this and when will records being available?

It was noted the tactical interim changes that are being made to use MIG. This system enables data sharing and support clinicians to make more informed decisions about patient care.

It was confirmed that the use of MIG is already happening with many GP practices and highlighted its usefulness especially for Saturday clinics at other surgeries as it enables access to records more readily.

The committee was informed about the Kent and Medway Care Record (KMCR) project. The development, procurement and mobilisation of a single shared health and social care record for Kent and Medway is a key deliverable of the Kent and Medway Sustainability and Transformation Plan (STP).

The aim of the Kent and Medway Care Record project (KMCR) is to design, procure and mobilise a single shared care solution which will enable health and care professionals involved in an individual's care to view electronic patient records currently held in numerous provider point of care systems. The view of an individual's record will be accessed via an integrated solution. The specification for the solution has been developed over the last year with a range of inputs from clinicians, professions and digital colleagues from across Kent and Medway including, CCGs, acute, community, mental health and social care. The development has also involved GPs, out of hours providers and SECamb.

It was agreed to approve the contents of the paper.

019/19

Evaluation Process and Timeline

The committee were informed that we are currently at stage three of a full and detailed evaluation process which will result in an option or options for public consultation. Evaluation reports will be reviewed in June/July 2019, and more clinical and public engagement will need to take place before the evaluation panels. The evaluation outcome will be signed off by this committee. The scoring process was also explained: each option will be scored against five criteria and all are weighted equally. This work is overseen by the East Kent Options Evaluation working group.

Questions:

It was asked why a scoring system using numbers was chosen.

It was confirmed the methodology has come about after discussion with wider stakeholders but, as part of the constant self-testing of the process, Michael undertook to look at this again.

	<p><i>The ability of SECAmb's to cope with the changes was questioned.</i> It was confirmed SECAmb have been involved in the whole process as they are a critical component.</p> <p><i>It was queried why equal weighting was applied</i> The committee was advised this was due to feedback from engagement events and wider discussion. And as part of due diligence, this will be tested continually.</p> <p><i>It was asked whether a sensitivity analysis was planned</i> It was confirmed sensitive analysis were being run all the way through, as dictated by good practice.</p> <p>It was asked whether the workforce group were looking to attract nurses, pharmacists and community staff, and this was confirmed.</p>	
020/19	<p>Public Questions</p> <p><i>1. Given the continued delay in the reconfiguration, what are the risks to patient care, and also the costs of delaying?</i></p> <p>Patient care remains everyone's priority and we are continuing to make smaller changes to improve current performance in hospital services and local care. Maintaining older buildings before new buildings/refurbishments are complete would have some capital cost. However, getting the pre-consultation business case right is an essential step which must happen before we can bid for funding and progress to consultation. If this stage is not done properly it could cause significant delays in later stages of the reconfiguration.</p> <p><i>2. If option 2 is best, new build first, could progress to consultation now?</i></p> <p>Consultation cannot begin until the detailed evaluation stage has been completed, a pre-consultation business case produced and reviewed by NHS England, and the source of funding confirmed. For example, even with Option 2 that involves the gift of a shell of hospital from the developer, there is also a requirement for significant public capital to fit out the shell (there would be no point building a shell of a hospital unless it can be turned into a functioning hospital).</p> <p><i>3. Evaluation questions x 2</i></p> <p>The Chair confirmed these questions had been covered during the meeting. He also asked for any final comments but none were received.</p> <p>The Chair asked for approval and the committee subsequently approved.</p> <p>The sub criterion was also approved subject to review and comment.</p> <p><i>A written reply has been sent covering the full list of the 7 questions submitted.</i></p> <p>Meeting closed at 12.20.</p>	