Item 7: East Kent Hospitals NHS University Foundation Trust Clinical Strategy Review.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: East Kent Hospitals NHS University Foundation Trust Clinical Strategy Review.

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1. Background

(a) Representatives of East Kent Hospitals NHS University Foundation Trust attended the meeting of 3 February 2012 to present and discuss the initial work being undertaken in the development of its clinical strategy. An extract from the Minutes of this meeting is attached for information.

(b) The Committee requested the opportunity to receive an update in due course.

2. Recommendation

That the Committee consider and note the report.

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Extract from the Minutes of the Health Overview and Scrutiny Committee meeting, 3 February 2012[1]

Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals NHS University Foundation Trust), Noel Wilson (Divisional Medical Director for Surgical Services, East Kent Hospitals NHS University Foundation Trust), Robert Rose (Divisional Director for Urgent Care and Long Term Conditions, East Kent Hospitals NHS University Foundation Trust), Carmen Dawe (Assistant Director of Marketing and Fundraising, East Kent Hospitals NHS University Foundation Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and explained that the Chief Executive of East Kent Hospitals NHS University Foundation Trust had requested the opportunity for the Trust to bring the work being done on developing a clinical strategy to the Committee. The subject had also generated some media interest in the East of the County and so the Chairman hoped there would be clarification around it as a result of the day's meeting.

(2) Trust representatives outlined the main features and drivers of the review. It had begun in October 2010 to look at various clinical issues and those raised by the need to continue to provide core services as well as enable healthcare closer to home. No decisions around service configuration had been made but the Committee would be continually involved in the Trust's developing strategy.

(3) The whole development of the strategy needed to be seen in the context of a shift of emphasis nationally from the work which had been done to improve planned care, such as the 18-week pathway, and towards improving emergency care. Emergency care was a high risk area, and one of the drivers for change was the Royal College of Surgeons report, *Standards for Emergency Care.* Members had a summary of this document in their Agenda pack and several Members highlighted the finding in the report that 80% of surgical mortality arises from unplanned/emergency surgical intervention and it was clarified that this referred to 80% of deaths which occurred as a result of surgery. The emergency surgery mortality rate for the Trust was below the national average, but this was not seen as a reason for complacency.

(4) The same principles around clinical care applied in East Kent as they did elsewhere, such as in West Kent, and would continue to do so and there were areas where work was being done with West Kent, such as vascular surgery.

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[1] Complete set of Minutes for 3 February 2012 available at::
https://democracy.kent.gov.uk/documents/g3977/Printed%20minutes%2003rd-Feb-2012%2010.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=1

(5) Consultants were rightly involved in planned care, but emergency care could be improved by involving them more at the 'front door' of hospitals to establish a quality care plan for emergency patients with a one stop assessment. Consultant acute physicians had already been brought into front door services and EKHUFT achieved 97% against the 4-hour A&E target in January, which is a very challenging month.

(6) Consultants needed to be supported by appropriately skilled teams and so achieving this raised workforce issues. There was a need to maintain locally accessible services, but there was also a requirement for specialisation of services in some areas. This had happened with cardiac care being centralised at the William Harvey Hospital in Ashford. There had also been centralisation of vascular surgery. Breast surgery was an area of increasing specialisation and there was also the requirement to develop a Level 2 Trauma Unit at William Harvey. In addition, some specialist centres were not in Kent at all. Trust representatives explained that the 'hub and spoke' model was applicable in many areas.

(7) In relation to transfers to the Trauma Unit, the Trust representatives explained that this would only be necessary in a minority of cases, and in many instances, the necessary skills were present at the Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate meaning treatment would continue to be provided locally in Thanet.

(8) The specific issue of travel times was raised by Members with the response given was that travel times were based on clinical evidence, which supported the idea of taking patients further to access specialist services. More broadly, Trust representatives explained that they were concerned about transportation issues where the transport network was geared more towards going into London than travelling across East Kent. A transport group was being established and this would work with the emerging Clinical Commissioning Groups and the Ambulance Trust to look at such issues as travelling between sites.

(9) There was a potential knock on effect to elective surgery and Trust representatives explained that a clear separation between emergency and elective teams was being made. Currently a 24 hour emergency theatre (known as a CEPOD theatre, referring to *The Confidential Enquiry for Peri-operative Deaths*) was kept specifically for emergency surgery and one discussion was around whether to invest in a second. The development of trauma rotas was geared to an aspiration towards having dedicated teams. This was a whole workforce issue and the review needed to look at the currently available workforce as well as what sorts of skills would be required in the future. Consultants were costly, but there were ways of working smarter.

(10) This was demonstrated by the Trust in response to specific concerns raised by Members about the future of services at the QEQM. Dealing with heart attacks and strokes, for example, was seen as a core service

to deliver locally in Thanet. Bringing consultants to the front door of the hospital meant that many patients would be able to be dealt with as ambulatory cases, rather than having to be admitted as inpatients. Where there may need to be some specialisation is in using such medical advances as treatments to directly dissolve clots in the brain. Similarly with gastroenterology, there had been no discussions about moving services from QEQM as this is a core medical component of the services provided by the hospital, and in terms of surgery, it would only involve the very specialist kinds of care.

(11) Further examples of services being developed at the QEQM were provided. More investment was being made in CT scanners. The Trust was looking to introduce a pathway model of care, already introduced in Peterborough, for fractures of the neck of the femur which would see patients under the care of medical consultants, and benefitting from surgery available at QEQM.

(12) As with travel times, Trust representatives provided information on the evidence base. There were a wide range of different measures and more were being developed specifically around the patient experience. This was collected and published. The example of vascular care was given, where there were national peer reviews and data available down to the level of individual surgeons. This connected with a point raised by a Member about the tension between a focus on process and a focus on care, to which NHS representatives felt that as the processes did impact on the patient outcomes, the two things went together.

(13) The Trust felt this could further be seen in the priority it gave to dealing with healthcare associated infection. East Kent Hospitals had very low MRSA and C. diff. rates but were not complacent and the separation of elective and emergency care was a core element in keeping rates low. The achievements the Trust has made in reducing length of stay also made an important contribution.

(14) As with the previous item, the Chairman looked to the Committee to make a specific resolution on this issue rather than simply noting the report and asked Mrs Green to suggest one which would be appropriate.

(15) AGREED that the Committee notes the high level of concern of residents in East Kent to any proposed changes and that the HOSC will continue to monitor the situation very closely and scrutinise any further developments as and when they emerge to ensure we look after the best interests of Kent residents.