HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th June, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th June, 2014, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (3):	Mr A D Crowther, Mr J Elenor and Mr C P D Hoare
Labour (2):	Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor P Beresford, Councillor Mr M Lyons, Councillor S Spence, and Councillor C Woodward

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item	Timings
1. Substitutes	

2. Declarations of Interests by Members in items on the Agenda for this meeting.

3. Minutes (Pages 7 - 18)

4. Membership

   (1) Members of the Health Overview and Scrutiny Committee are asked to note that:

      (a) Mr Hoare has replaced Mr Latchford as a UKIP representative on this Committee.

      (b) Mr Elenor has replaced Mr Crowther as the UKIP group spokesperson on this Committee.

5.	Community Care Review: NHS Ashford CCG and NHS Canterbury & Coastal CCG (Pages 19 - 26)	10.00
6.	East Kent Outpatients Services: Consultation Update (Pages 27 - 104)	10.45
7.	Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital (Pages 105 - 112)	11.30
8.	Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia (Written Update) (Pages 113 - 118)	12.00
9.	Kent and Medway Adult Mental Health Inpatients Review (Written Update) (Pages 119 - 130)	12.05
10.	Kent Community Health NHS Trust: Community Dental Services (Written Update) (Pages 131 - 134)	12.10
11.	Child and Adolescent Mental Health Services (Written Update) (Pages 135 - 138)	12.15

12. Date of next programmed meeting – Friday 18 July 2014 @ 10:00 am

Proposed items:

- Kent Health and Wellbeing Strategy: Update
- Maidstone and Tunbridge Wells NHS Trust: Service Development
- Patient Transport Services

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

29 May 2014

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 11 April 2014.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer, Mr C R Pearman, Cllr P Beresford, Cllr M Lyons and Cllr R Davison (Substitute) (Substitute for Cllr Chris Woodward)

ALSO PRESENT: Mr A H T Bowles, Mr S Inett, Mr T Gates and Mrs J Whittle

IN ATTENDANCE: Ms D Fitch (Democratic Services Manager (Council)) and Mr A Scott-Clark (Acting Director of Public Health)

UNRESTRICTED ITEMS

30. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

(1) Mr Nick Chard declared a Disclosable Pecuniary Interest as a Non-Executive Director of Healthwatch Kent.

(2) Councillor Michael Lyons declared an other significant interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

31. Minutes - 7 March 2014
(Item 3)

(1) In relation to Minute no 28 the Chairman informed the Committee that:

- A meeting had been organised for Friday 9 May with the Chairman, Vice-Chairman, Group Representatives, Steve Inett and Tish Gailey to consider how the work of Healthwatch Kent could support the work of the Committee.

- The Chairman had written to the Chief Executives of the four acute hospital trusts in Kent and Medway with a request for a small group of Members to meet with the Director of Finance to look at the Trust's financial performance in 2013/14 and projected forecast for 2014/15. Two responses were received. This working group would initially look at acute trusts' finances and report back to the Committee.

- The Chairman had invited Roger Gough to HOSC in July or September to give an update on integration.

- The Scrutiny Research Officer circulated details of the NHS Leadership Academy after a request from Members for information on the future leadership of the NHS.

- A briefing note on GP recruitment and retirement was being produced for Members by the NHS England Kent and Medway Area Team.

(2) RESOLVED that the Minutes of the Meeting held on 7 March 2014 are correctly recorded and that they be signed by the Chairman.

32. Child and Adolescent Mental Health Services (CAMHS)
(Item 4)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dave Holman (Head of Mental Health Programme Area and Sevenoaks Locality Commissioning, NHS West Kent CCG), Lisa Rodrigues (Chief Executive, Sussex Partnership NHS Foundation Trust), Lorraine Reid (Managing Director, Specialist Services, Sussex Partnership NHS Foundation Trust), Simone Button (Divisional Director, Children and Young People's Services, Sussex Partnership NHS Foundation Trust) and Jo Scott (Programme Director, Sussex Partnership NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. Mr Ayres began by acknowledging that the Committee had given NHS West Kent CCG and Sussex Partnership NHS Foundation Trust (SPFT) a challenging time at the previous meeting particularly in regard to the length of wait for an initial assessment. The CCG had recognised at the January meeting that CAMHS was not a good service when it was taken over by SPFT; the Trust had a significant task to turn around the service. The CCG and SPFT had taken HOSC's recommendations seriously and had spent a long time working together to get the service back in line. By the end of August, the following targets should be met: referral to assessment within 4 – 6 weeks; urgent referral within 24 hours; and referral to treatment within 8 – 10 weeks.

(2) Mr Ayres had been assured by the CCG's clinical team that once an initial assessment had been held, the quality and performance of the service was good. SPFT had not fully recruited in Kent however, the full time vacancy rate was low enough for temporary staff to be recruited. The CCG had been working with Steven Duckwork from NHS England's South East Coast Strategic Clinical Network. He was supporting the CCG to review Tier 4 services and their interface with Tier 3 and identify a best practice CAMHS service to benchmark against services in Kent. CAMHS was recognised as a national challenge, a number of national reviews had been launched and the CCG and SPFT were involved with those.

(3) The CCG now had an agreement with KCC and NHS England to reintegrate the commissioning of CAMHS with a lead commissioner and single specification for the service. It was acknowledged that it had not been sensible for different sections of the service to be commissioned by three different commissioners. The Kent Health and Wellbeing Board had approved this direction of travel. The CCG were also working with the Police to commission a Section 136 place of safety for children which had not been commissioned under the previous arrangement. The CQC were inspecting safety and safeguarding arrangements in NHS West Kent CCG and NHS Dartford,

Gravesham and Swanley CCG with a focus on CAMHS during the week of the meeting. No emergency findings had been identified at the time of the meeting; an emerging view from the CQC would be published within a month.

(4) Mr Brookbank noted that he had received letters expressing concerns with CAMHS in Kent from The Rt Hon Greg Clark MP and Julian Brazier TD MP. He had also received an email from Patrick Leeson and Andrew Ireland regarding the integration of CAMHS commissioning.

(5) Ms Rodrigues commented on SPFT's decision to bid to run CAMHS in Kent. CAMHS was an important service which SFPT already delivered in East Sussex, West Sussex and Brighton and Hove. The Trust was under no illusion about the challenge it had taken on when it bid for the contract. SPFT agreed with the commissioners that a three year improvement plan would be needed to improve CAMHS in Kent. SPFT were now 18 months into the plan; they had increased the number of whole time equivalent staff to 274; carried out a number of geographical moves; made improvements to IT and mobile communication systems and introduced a 24 hour service; in addition to running the existing service. In July 2013, the average wait for an initial assessment was 32 weeks; by February 2014 the wait had been reduced to 7 weeks. However the number of referrals particularly urgent referrals was higher than anticipated. In February 2014, 79 of 112 emergency referrals had been out-of-hours and were all assessed within 24 hours. The number of standard referrals had increased from 772 in February 2013 to 952 in February 2014.

(6) Ms Rodrigues highlighted the challenges to SPFT and their staff. Referrals had increased with improved access; in addition to a 10% national increase. NHS England was conducting a rapid review into the national increase. With three different commissioners; it was easier for children and young people to access higher level services rather than lower tier services. Staff were feeling beleaguered following negative media coverage which contained anecdotal and historic allegations; there was an unrealistic expectation in the press of what the service could achieve in the time that SPFT had been responsible for the service. Ms Rodrigues stressed that SPFT would continue to make improvements and was committed to improve the service in Kent.

(7) Mrs Whittle was invited to comment. She explained that the Health and Wellbeing Board would be looking at the commissioning arrangements for all CAMHS tiers. She had concerns with the referral pathways and waiting times for tier 2 and 3 services. It was important that children and young people could access the correct treatment at the right time particularly with the increased demand. She felt that the provider had been set up to fail with the backlog they had inherited; however both KCC and the PCT were not aware of the backlog at the time of commissioning. She acknowledged that the services were performing much better than three years ago. Mrs Whittle suggested that the Health and Wellbeing Board report regularly to this Committee about the progress of reintegrating the commissioning arrangements.

(8) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired if referral to routine assessment was the same as referral to treatment. Mr Ayres explained that if

performance in the contract was being met, a child or young person would be assessed within 6 weeks and treated within 10 weeks. The wait for assessment was currently 7 – 8 weeks which compressed the time available for treatment. Ms Reid noted that an assessment often had an element of treatment with homework tasks being set for the next appointment.

(9) A Member acknowledged and expressed sympathy with SPFT staff working in challenging circumstances; the Member proceed to ask what lessons had been learnt about the commissioning process. Ms Rodrigues explained that SPFT had experience of taking on a number of services. When a service was re-tendered like the CAMHS contract in 2012, it suggested there were issues with the original contract. It was reported that SPFT had a similar experience in Hampshire three years ago; the Trust had benefitted from this experience and were able to implement change much faster in Kent than in Hampshire. Ms Reid added that SPFT inherited staff with low morale; some of who had tendered for the CAMHS contract on behalf of their previous organisation. She explained that it took at least 18 months for staff to settle into a new organisation and sign up to the new model. Further, when SPFT took up the contract, all the commissioning arrangements changed too. Ms Reid stated that discussions with HOSC regarding CAMHS had been very helpful; the commissioner and provider were working more closely together.

(10) In regards to lessons learnt, Ms Reid expressed that she would have introduced a less complex management of change but would have still implemented the same model. Mr Ayres stated that the CCG should not have undertaken the procurement with a commissioning team who had no knowledge of running the service. The CCG also recognised that there had been an information vacuum in the transition from the old to the new provider. Knowledge capture would be built into reviews for future contracts. Mr Ayres explained that neither the contract nor provider of CAMHS were poor. Both the commissioner and provider, initially, had not dealt with problems fast enough; things are beginning to be turned around. Most of the actions from the last HOSC meeting had been enabling actions rather than delivering results.

(11) A question was asked about the transition to adult mental health services. Ms Scott explained that it depended on the issue; the majority of young people did not need to transfer to the adult section if they had been successfully treated beforehand. Children with continuing needs were transferred to adult services which began six months before the young person's 18th birthday with the adult and children services working together. Adult mental health services in Kent were provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT). The CCG sets both KMPT and SPFT transitional targets. Mr Holman acknowledged that transition had always been a problem. From a contract view, it was important for the contract to align with SPFT and KMPT to ensure a smooth transition. Transition would be part of the integrated commissioning review.

(12) A number of comments were made about the recent KCC Select Committee on Commissioning, joint commissioning and the importance of performance management. A Member questioned the NHS' experience in commissioning. Mr Ayres admitted that the NHS was not good at commissioning and contracting; every three years the NHS was restructured which had prevented

the development of good commissioning teams. For West Kent CCG, he explained that it would take another year to build a confident commissioning team; external expertise would be brought in. The amount of CAMHS activity in Kent had been higher than anticipated in the contract. If the CCG had been dealing with a commercial provider, a cost premium would have been associated with the additional activity. Cooperation between partners in the NHS, such as the CCG and SPFT, was very helpful as there was recognition that a child needed to be seen rather than an associated cost. Mr Ayres was keen to improve joint working with Kent County Council to ensure clearer interactions with education and young peoples' services; and to learn from their expertise with commissioning and procurement.

(13) A further question was asked about the provision of information given to bidders during the tendering process. Mr Ayres acknowledged the information given to the provider had been poor. The CCG had discovered that with the former block contract, counting activity had been poor; therefore information given to the bidders was flawed. In addition, Mr Holman explained that there was a growing need for CAMHS in Kent; providers needed to be kept informed about the additional services required.

(14) A Member expressed concerns that SPFT performance had got worse since the January meeting; the Member referenced figures provided by The Rt Hon Greg Clark MP. Ms Rodrigues clarified that the figures provided in the report to HOSC were correct. In response to Mr Clark's letter to SPFT, Mr Ayres explained that if the contract was broken down into very small areas, some areas performed better and worse over time. The contract did not set out individual targets for small geographical areas. A Member expressed their disappointment that waiting times by area had not been included in the report; this information had been provided at the last meeting in January.

(15) A number of questions were asked about the use of inpatient beds and the development of a Section 136 suite in Kent. Ms Scott explained that Kent and Medway had a high number of bed users due to the historic set up of community services. A home treatment service to look after children and young people in their homes had recently been introduced. This had reduced the number of children and young people who required an inpatient bed. There was a national shortage of beds with a one in, one out system. The home treatment service also facilitated early discharge from an inpatient bed as children and young people can be supported at home. Mr Holman acknowledged that it was not acceptable for children to be going out of county to a Section 136 suite. A place of safety was being developed in Dartford; it was due to open on 1 May 2014 as an interim arrangement. It had the support of the Police and South London and Maudsley NHS Foundation Trust (SLaM); a place of safety in Kent would relieve bed pressure for SLaM.

(16) In response to a specific comment about KCC's duty to safeguard Looked After Children as part of its corporate parenting role, Ms Rodrigues acknowledged that it was very important to safeguard Looked after Children as they were more likely to need the support of the CAMHS service There were a large number of Looked After Children in Kent with London Boroughs' placing children in the county.

(17) A series of questions were asked about mental health funding and staffing levels at West Kent CCG. Mr Holman explained that funding for mental health services as a whole was low. Funding for children and young people was even lower despite 75% of first mental health difficulties happening between the ages of 14 – 24 years. Mr Ayres noted that staffing had increased from 6 – 60 staff at West Kent CCG since April 2013. The transition to CCGs had been very disruptive for the whole of the NHS; 54 of the CCG's staff had moved from within the NHS.

(18) Members enquired about staff morale, feedback on the effectiveness of treatment and appointments in school holidays. Ms Reid explained that morale was a very important issue for SPFT. There had been a significant programme of change, negative media coverage and an increased demand for services which had increased stress and lowered morale. To boost morale, SPFT had engaged staff in the business continuity plans, improved the physical working environment and increased the number of staff. SPFT were also expert providers of mindfulness training which had been made available for staff. Ms Reid stated that the Trust received lots of feedback from children and young people about their treatment. Children and young people were also involved in advising on treatment programmes. All treatments were based on NICE guidance. Ms Rodrigues explained that SPFT ran services all year round including the school holidays. The CCG had asked SPFT to be tougher on patients who were offered an appointment in the holidays and then cancelled them.

(19) A Member highlighted a case which had been brought to their attention. A child who was originally referred for Tier 3 services was escalated to Tier 4 inpatient bed. The child had received extremely good treatment. The child was subsequently discharged on the understanding that one-to-one treatment would be continued at home. There has been no contact with the child since being discharged. Mr Ayres encouraged the parent or carer to complain. Ms Scott asked for the Member to pass her the contact details, with the parent's permission, outside of the meeting and said that it would be looked at immediately after the meeting.

(20) In response to a specific comment about SPFT being set up to fail, Ms Rodrigues explained that this was not the case. The Trust was confident that they would meet the needs of children and young people in Kent and Medway. The Trust was 18 months into their three year transformation programme and staff were working very hard. Ms Rodrigues welcomed the opportunity to return to the Committee to update them on progress in six months.

(21) RESOLVED that:

(a) this Committee continues to be concerned for the CAMHS service in Kent and recommends that the commissioning of this service is investigated by KCC and West Kent CCG.

(b) West Kent CCG be asked to give due regard to the recent KCC Select Committee on Commissioning.

(c) West Kent CCG and Sussex Partnership colleagues be invited to the Committee meeting in 6 months' time and the CCG submit two monthly update reports to the HOSC.

33. Patient Transport Services
(Item 5)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and Dean Souter (Control and Planning Manager, NSL Care Services) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. Mr Ayres began by updating the Committee on developments following the January meeting. At the beginning of the year, the contract was significantly underperforming. The contract had since been reset and stabilised and the six key targets were on a trajectory to be achieved by June. An independent monthly performance report had been introduced; figures from the February report were beginning to show improvement with day-to-day variation narrowing. By early June, the CCG would know if a recovery had been achieved.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about the additional costs to the contract. Mr Ayres explained that there were three components to the additional costs. The first, £100,000 was a financial settlement for additional costs incurred between July and December. Both the commissioner and provider were found to be culpable. The second, £600,000 was to cover the costs of additional staff being transferred to the provider which had not been disclosed to bidders. The third, £1.6 million per annum, resulted from the re-basing of the contract. Mr Ayres noted that with these additional costs, NSL would have still won the contract. He reported that from June there were would be no further recovery plans; if performance was not turned around, the CCG would l seriously reflect on the future of the contract.

(3) A Member raised concerns about the quality of service provided by NSL. Mr Ayres explained that two key learning points had arisen from the tendering process. Firstly the contracting team should have included a manager with knowledge of running a Patient Transport Service to evaluate the quality of the bid. Secondly the CCG should have better understood the balance between quality and price. NSL scored significantly higher on quality and value for money. Mr Ayres accepted that this was a failure of the commissioners to show due diligence. Mr Souter reported that NSL successfully ran services in Shropshire, Herefordshire and the East Midlands. These areas recognised NSL as quality service provider. In response to the increased patient activity, NSL had invested in 75 new staff and 15 new vehicles in Kent to improve quality. He stated that NSL committed to continuing to provide an improved service for the people of Kent.

(4) A question was asked about the recovery plan and the target to meet 'most' Key Performance Indicators (KPI) by Easter. Mr Ayres reported that there were 20 KPI; he understood that 15 -16 KPI had been met. The six critical targets were due to be met by June:

1. Delivering a renal patient to an appointment
2. Collecting a renal patient from an appointment
3. Delivering an outpatient to an appointment

4. Collecting an outpatient from an appointment
5. Collecting a discharge patient within three hours
6. Collecting a discharged patient within two hours

(5) Mr Ayres explained that the CCG was provided with weekly unvalidated data; he would be able to provide validated data to the Committee in April. There was a delay in receiving validated data due to contractors and volunteers of NSL submitting records manually rather than on electronic handsets which were used by NSL staff. There had been a reduction in the number of extreme events but this had not impacted on contract performance.

(6) A number of questions were asked about performance management and terminating the contract. Mr Ayres reported that the CCG were deeply concerned about the performance of the contract. A final decision would be taken in June by the Commissioners using May's data. The CCG was working with senior managers from the acute hospital trusts on what the new arrangements would look like if the contract was terminated. If necessary there would be a managed transition to the new arrangements. Mr Ayres stressed that the money for overperfoming contracts came from contingencies rather than reducing care in a different service. He welcomed the opportunity to develop joint working with the Council and to become involved with the recent Select Committee on Commissioning.

(7) A Member raised a concern about the amount of time taken to transfer a patient from a hospital to a secure unit. Mr Ayres encouraged the Member to raise a complaint.

(8) RESOLVED that Mr Ayres and Mr Souter be thanked for their attendance and contributions to the meeting along with their answers to the Committee's questions, and that a written update be submitted to the Committee in July.

34. Faversham Minor Injuries Unit
(Item 6)

Simon Perks (Accountable Officer, NHS Canterbury and Coastal CCG), Andrew Bowles (Leader of Swale Borough Council and KCC Member for Swale East) and Tom Gates (KCC Member for Faversham) were in attendance for this item.

(1) The Chairman welcomed Mr Perks and asked him to introduce the item. Mr Perks began by updating the Committee on progress. At the November meeting, the Committee raised a number of serious and legitimate concerns about the procurement and lack of engagement with stakeholders. The Committee asked the CCG to set aside the decision to close the Minor Injuries Unit (MIU) and rethink the proposals. Mr Perks reported that the governing body had actioned the Committee's recommendation and secured an extension of the contract until September 2014.

(2) Fresh engagement work began in December with a number of public meetings; in January a steering group chaired by the Mayor of Faversham was established with local stakeholders. Stakeholders included a retired PCT Finance Director and three Faversham GPs. Through the steering group, the

CCG had been able to share information regarding finance and activity forecast with a much wider stakeholder group. At the last steering group meeting, it was acknowledged that putting together a specification which was accessible and to the required standard with the money available would be incredibly challenging. Further, if the specification was not right, it would not be viable to put out to tender. The CCG and steering group were looking at other service elements which would make it affordable and viable to the provider. The original specification with the x-ray facility had made the previous tender unviable. The eight options for the Faversham MIU would be discussed at the next meeting of the steering group on 15 April; the most likely model for the unit is access Monday to Friday between 08.00 – 18.00 with an x-ray facility. It was also proposed that there would be direct access for GPs to make a referral for an x-ray.

(3) The Chairman invited Mr Gates and Mr Bowles to speak. Mr Gates thanked the Committee for their recommendation; full consultation with the people of Faversham had now been carried out as a result. Mr Gates highlighted that the MIU covered a larger area than just Faversham; it included 17 parishes and a large number of tourists in the high season. Mr Gates enquired about the proposed models for the service.

(4) Mr Perks explained that proposed models included options for different opening hours and running with and without an x-ray service. Through engagement activities, it was found that most people currently use the service Monday to Friday between 08.00 – 18.00; rather than the weekends and evenings which had been anticipated by the CCG. It was important that the unit met the needs of the community to be viable as the smallest MIU in Kent. The CCG were hoping to attract users who had previously attended the Estuary View Medical Centre and the Kent and Canterbury Hospital. The CCG had also examined the Edenbridge model as part of the option development.

(5) Mr Bowles also expressed his gratitude to the Committee, in particular to Mr Chard and Miss Harrison, for championing this issue on behalf of the people of Faversham and Swale East. He believed that Mr Perks had learnt a lot from this experience and that the CCG were moving in the right direction; the original process would have been successful if the CCG had been more inclusive. Mr Bowles enquired if the steering group's recommendations would be reported back to the CCG governing board and asked for an assurance that if the service was continued it would be fully advertised.

(6) Mr Perks explained that in the old and new specification, the CCG required the provider to appropriately signpost people to the unit. The profile of the unit had been raised following the closure announcement in November. Mr Perks stated that he and his staff had learnt a lot from this process especially in making use of local knowledge and skills. This knowledge had been used in the review of community services which would be discussed at the Committee's June meeting; the CCG had been actively engaging with the local community about the future development of community hubs. Mr Perks gave assurance that the recommendations from the steering group would be taken to the CCG governing body and to the Canterbury Health and Wellbeing Board.

(7) Members of the Committee then proceeded to ask a series of questions and make a number of comments. Several Members commended the CCG for their honesty about the learning which had taken place since November.

(8) A question was asked about the approximate population of Faversham and number of MIU users per month in comparison to Edenbridge. It was explained that Faversham had a population of 25,000; in comparison to Edenbridge which had 8,000 residents. On average, there were 550 visits to Edenbridge MIU and 450 visits to Faversham MIU per month despite the larger population in Faversham. Mr Perks explained that the steering group had been cautious with the numbers; if patients were not well signposted to the service or had heard about the threat of closure they were unlikely to use the service.

(9) A number of comments were made about the importance of moving services out of hospitals into the community and the value of these services to local communities.

(10) Mr Inett noted that he had attended the steering group meeting and it had been positive. Healthwatch Kent would be visiting Faversham MIU the following day to further gather patients' views. Healthwatch Kent was keen to facilitate an event with commissioners to develop best practice public engagement; they would like to use Faversham MIU as a positive example of community engagement. Mr Inett observed that people often stepped forward when there was the threat of closure, especially hospitals, but it was much harder to engage with hard-to-reach groups or motivate the community when services were not easily defined.

(11) A Member suggested, following a number of agenda items at the meeting which had highlighted weaknesses with procurement and commissioning, that an invitation to Member training on commissioning should be extended to CCGs.

(12) RESOLVED that it's guests be thanked for their attendance and contributions to the meeting along with their answers to the Committee's questions, and that they return to the Committee within three months to give an update on the consultation and final outcome of the steering group review before a final decision is made by the CCG governing body.

35. Redesign of Community Services and Out-of-Hours Services - Swale
(Item 7)

Patricia Davies (Accountable Officer, NHS Swale CCG), Ken Pugh (Cabinet Member for Community Safety and Health, Swale Borough Council) and Andrew Bowles (Leader of Swale Borough Council and KCC Member for Swale East) were in attendance for this item.

(1) The Chairman welcomed Ms Davies to the meeting and asked her to introduce the item. Ms Davies began by explaining that the provider of the out-of-hours contract had been changed on a temporary basis following recommendations from the Keogh Review relating to Medway NHS Foundation Trust and listening exercises with the public and Swale Borough Council. The original

out-of-hours contracts were commissioned in 2010 by East Kent and West Kent PCTs where IC24 won the contracts. The contracts were due to expire in March 2014; most CCGs in Kent had extended their contract with IC24 until 2016.

(2) Recommendations from the Keogh Review and the Emergency Care Intensive Support Team at Medway NHS Foundation Trust indicated the need for coordination of non-elected out-of-hours care in Medway and Swale. Prior to 31 March 2014, out-of-hours services in Medway were provided by Medway On Call Centre (MedOCC) whilst the service in Swale was provided by IC24; this had caused problems with inappropriate admissions and discharge.

(3) In addition, NHS Swale CCG was encourage to look at a review of community services, community nursing and out-of-hours services as part of the Keogh Review recommendations. The CCG had held a series of engagement events and governing body meetings where members of the public raised concerns regarding the difficulty accessing IC24 services at the weekends and evening; travelling long distances to Canterbury for out-of-hours appointments and the perceived lack of access to visiting services on the Isle of Sheppey.

(4) NHS Swale CCG had therefore transferred the out-of-hours services to MedOCC for twelve months. This would enable further public engagement and the procurement of the out-of-hours services to link up with other procurements including MIUs and Walk-In Centres. Ms Davies congratulated IC24 and MedOCC for their tireless work and reaching a solution together.

(5) The Chairman invited Cllr Pugh and Mr Bowles to speak. Cllr Pugh explained that Swale Borough Council had worked extremely closely with the CCG to review out-of-hours and community services. As Cabinet Member for Community Safety and Health at Swale Borough Council, he fully endorsed the report and approach of the CCG to engage with the public as part of the full procurement.

(6) Mr Bowles explained that as Leader of Swale Borough Council and Chair of the Health and Wellbeing Board in Swale he welcomed the way forward proposed by NHS Swale CCG. He believed that there would be genuine consultation with the public, the decision would not be rushed and would result in the right decision being made for Swale.

(7) A Member asked about the NHS England review of the walk-in centre at Sheppey Hospital. The Committee had been involved with the set-up of the walk-in centre and the Member believed that this was something the Committee should continue to be involved with. Ms Davies explained that the contract for the walk-in centre was currently held with NHS England. The provider of the walk-in centre also held the primary medical services contract which was commissioned by NHS England. The contract would be split and the walk-in centre element would come under the CCG. The contract had been extended until 2016 to enable the CCG to successfully procure and consult with the local community.

(8) RESOLVED that the Committee determines the proposed service change as a substantial variation of service and that a timetable for consideration of the

change would be agreed between the HOSC and NHS Swale CCG after the meeting. (The timetable would include the proposed date that the NHS Swale CCG intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal).

36. Folkestone Walk-In Centre: Written Update
(Item 8)

(1) A Member highlighted concerns with engagement work carried out in Deal and questioned its replication in Folkestone.

(2) RESOLVED that report be noted and the Chairman write to NHS South Kent Coast CCG, prior to the visit to Deal Hospital, requesting an outline of the engagement work carried out in Deal.

37. East Kent Out-of-Hours Services: Written Update
(Item 9)

(1) A Member asked for further details regarding the additional costs resulting from the contract variation with the current provider, the working group and a timescale for procurement.

(2) RESOLVED that the e report be noted and the Chairman seek written clarification in regards to the additional costs resulting from the contract variation with the current provider, the working group and a timescale for procurement.

38. East Kent Outpatients Consultation: Written Update
(Item 10)

(1) A Member raised concerns that non-clinical staff were redeployed on 1 April prior to the independent analysis of the consultation.

(2) RESOLVED that the report be noted and the Chairman to write to EKUHFT to clarify the concerns raised regarding the redeployment of non-clinical staff prior to the independent analysis of the consultation.

39. Date of next programmed meeting – Friday 6 June 2014 at 10:00 am
(Item 11)

Item 5: Community Care Review: NHS Ashford CCG and NHS Canterbury & Coastal CCG

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Community Care Review: NHS Ashford CCG and NHS Canterbury & Coastal CCG

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Ashford CCG and NHS Canterbury & Coastal CCG.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) NHS Ashford and NHS Canterbury & Coastal CCG have asked that the attached report be presented to the Committee.

(b) Dr M Eddy and Mr A Crowther visited Victoria Memorial Hospital in Deal on 29 April with representatives from NHS South Kent CCG and Kent Community Health NHS Trust. The visit was arranged for Members to gain a better understanding of the nature of the site and the services currently provided as well as have the opportunity to hear about how commissioning plans for developing community and outpatient services on the East Kent Coast were developing.

3. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report.

Background Documents

None.

Contact Details

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Progress report on the NHS Ashford and NHS Canterbury and Coastal CCG Community Care Review
June 2014

1. Introduction

In September 2013 NHS Ashford Clinical Commissioning Group (CCG) and NHS Canterbury and Coastal Commissioning Group initiated a project to review health and social care services provided within a community setting. The objective of the project was to improve how the two CCGs commissioned community-based services with the view to ensuring that these services were high quality, value for money and relevant to the current and future needs of patients and service users. The first phase of this project is now complete and the two CCGs would like to share the outcomes and conclusions of the project to date and ask for the HOSC's input to the intended direction of travel.

2. Background

NHS Ashford CCG and Canterbury and Coastal CCGs are committed to providing health services closer to people's homes. Following authorisation, the CCGs inherited a significant number of community-based contracts from the former Eastern and Coastal Primary Care Trust. These contracts cover a number of different services including (but not limited to) community nursing, rehabilitation, physiotherapy, mental health and children's services. To ensure that these services are high quality, value for money and fit for the changing health needs the CCGs initiated a review of a cross-section of these services. This review was carried out in the broader context of tighter healthcare budgets and an ageing population.

3. The Project Scope and Approach

To make the project manageable the scope of the project covered all community based services excluding mental health and children's services. However members of the project team were briefed to ensure that the principles established through the review would be applicable to all community-based services. A dual approach was established for the project looking at:

1. Actions which could be taken tactically to remove duplication of payments (without directly affecting services)
2. Strategic options for improving the commissioning of community-based services.

Five workstreams were established to organise the project effectively:

1. Contracting and Procurement
2. Customer and Market Analysis
3. Finance and Information
4. Patient and Public Engagement
5. Quality and Safety

The project reported into the CCGs' governing bodies and member practices. Kent County Council Social Services were involved throughout the project through regular engagement and a

joint transformation board. Engagement with patients was carried out through a specially commissioned survey and the CCGs' patient participation groups. Voluntary organisations were also consulted as the project progressed.

4. The Findings

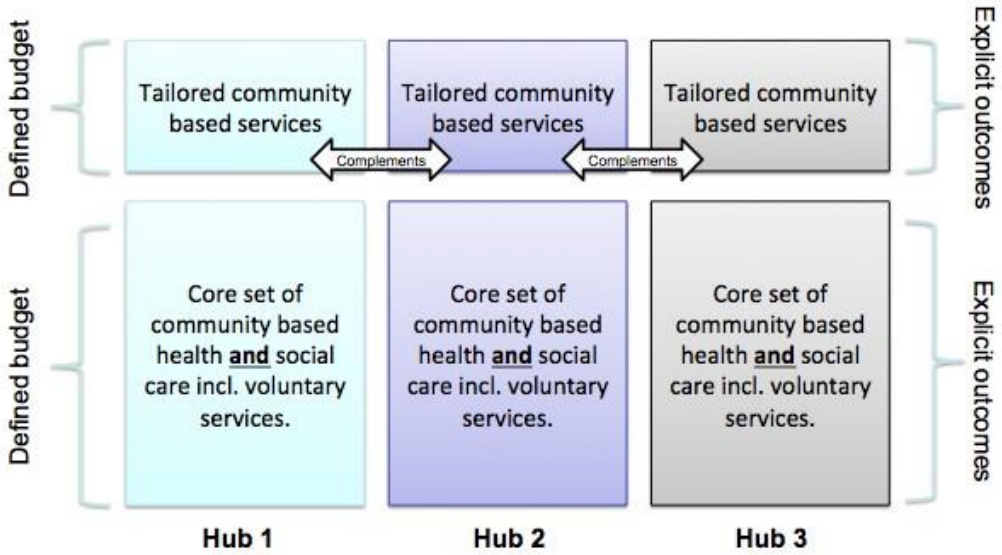
The findings of the review were presented incrementally to the governing bodies and member practices to ensure that progress and momentum was maintained. The principle findings are displayed in the table below:

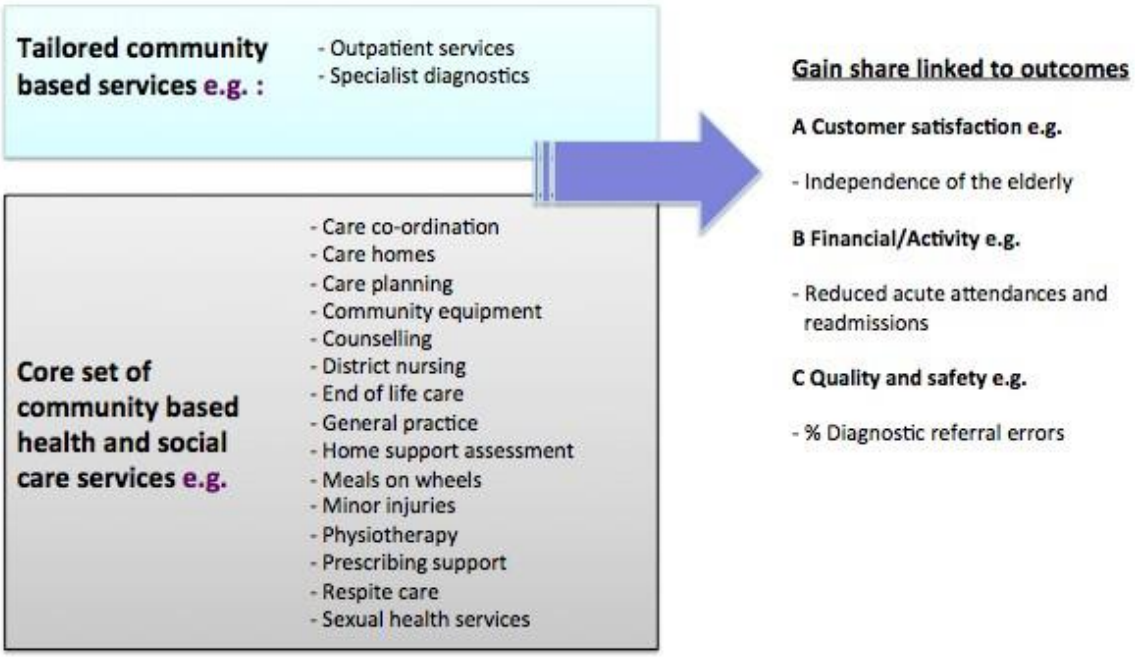
Workstream	Observations
1. Contracting and Procurement	• Large number of contracts • Impacts not defined or measured well • Can inhibit collaboration
2. Customer and Market Analysis	• Significant proportion of spend on treatment • Duplication of service across health and social care • The "well" consume a high proportion of community services
3 Finance and Information	• Investments not driven enough by value for money • Insufficient information on performance of services • More community spend does not necessarily mean better outcomes or patient experience
4. Patient and Public Engagement (from survey)	• GP seen as key but primary care access seen as an issue • Communication an issue • Care planning not widely understood or recognised
5. Quality and Safety	• Quality generally good • Specific areas of improvement • Quality and safety can be affected by lack of health and social care collaboration

5. A new approach

Given the findings of the review the CCG drafted a set of principles on which to move forward. These principles will underpin all commissioning of community-based services in the future shown in the diagram below.

The project team has also drafted a framework for commissioning community-based services, looking to ensure that health, social care and voluntary services are based around individuals and the communities in which they live and work. The framework has been termed **Community Hubs** and will be based around our clustering of GP practices and the local communities which they serve**.** The basic premise is that the CCGs will commission an integrated suite of health, social and voluntary from local providers within a defined budget but with more service-user centric outcomes. Selection and design of these services will be carried out in partnership with local patients, services users, provider and partner organisations. Consequently the services will be based on the needs of our local population. The Community Hub concept is outlined in the diagram below.

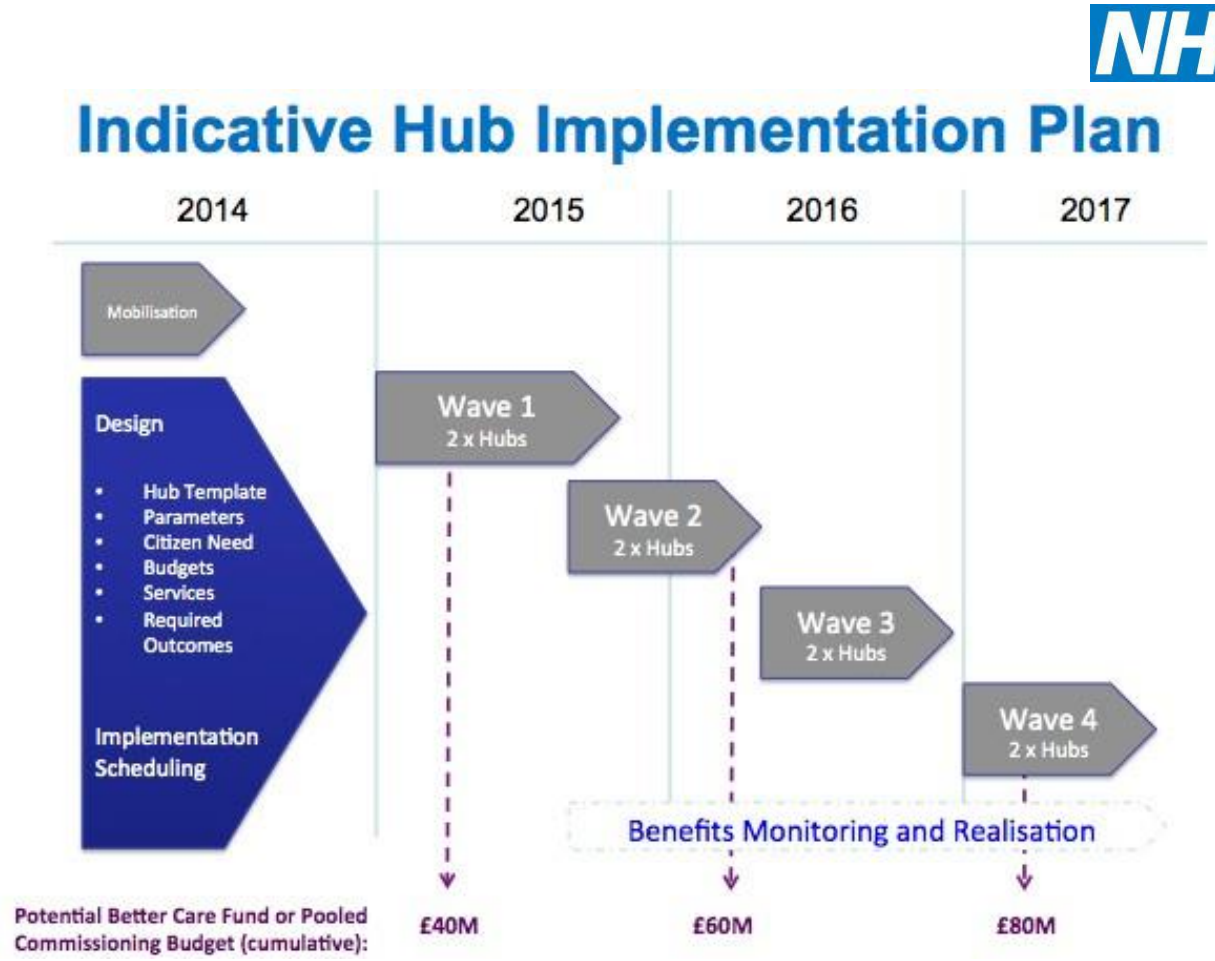




Lastly, the CCGs have developed a "value for money" approach whereby we will work collaboratively with our providers over the next year to establish the value received by our patients for those community-based services where the outcomes are not clear or measured. This approach will allow the CCGs to recommission on the basis of information received back from our providers.

6. Next steps

The Community Hub concept has, thus far, been received well by our partners, providers and patients. The intention is for the project to move from the exploratory and high-level design phase into detailed design and implementation work. A joint appointment of a manager has been made by the CCGs and Kent County Council to lead this work. The current implementation plan and the link between this work and the Better Care Fund is shown in the diagram below:



7. Input from HOSC required

The Kent HOSC is asked for its view on the progress to date to help inform the detailed design and implementation phase of the project.

Simon Perks
Accountable Officer
June 2014

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: East Kent Outpatients Services: Consultation Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the East Kent Outpatients Consultation.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) Representatives from East Kent Hospitals University NHS Foundation Trust initially attended the Health Overview and Scrutiny Committee on 7 June 2013 to discuss the Trust's developing clinical strategy.

(b) The outpatients' strategy was one of the areas of particular focus during this meeting. The recommendation agreed by the Committee on 7 June 2013 was the following:

- *AGREED that the Committee thanks its guests for their attendance and contributions today, agrees that the proposed changes to outpatient services and breast surgery services do represent a substantial variation of service and look forward to receiving further updates in the future; and also requests that East Kent Hospitals NHS University Foundation Trust take on board the Committee's comments regarding public consultation before the Trust takes any final decision on wider consultation.*

(c) On 11 October 2013 the Committee considered a written update provided by East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. At the conclusion of this item, the Committee agreed the following recommendation:

- *AGREED that the Committee note the report, ask the NHS to take on board the comments and questions raised by the Committee and that a small group be formed to liaise with the NHS on the draft consultation document.*

(d) Dr M Eddy, Mr R Latchford, OBE and Councillor Michael Lyons formed a working group to read and comment on the draft consultation document.

(e) On 11 April 2014 the Committee considered a further written update provided by East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the Chairman to write to EKUHFT to clarify the concerns raised regarding the redeployment of non-clinical staff prior to the independent analysis of the consultation.*

(f) Miss A Harrison was invited to observe the option re-appraisal for the North Kent Coastal site on 22 April. The re-appraisal was held following new information and comments received during the consultation and to incorporate additional information which had been requested by members of the public.

(g) Dr M Eddy and Mr A Crowther visited Victoria Memorial Hospital in Deal on 29 April with representatives from NHS South Kent Coast CCG and Kent Community Health NHS Trust. The visit was arranged for Members to gain a better understanding of the nature of the site and the services currently provided as well as have the opportunity to hear about how commissioning plans for developing community and outpatient services on the East Kent Coast were developing.

2. Summary of the Consultation

(a) Towards the end of 2010, East Kent Hospitals University NHS Foundation Trust (EKUHFT) began work on developing their clinical strategy. Four work streams were established:

- Emergency care;
- Trauma;
- Outpatients; and
- Planned care.

(b) The consultation covered part of the outcomes of the work from the Out-Patient Clinical Strategy Group. The public consultation ran from 9 December 2013 to 17 March 2013 (extended from the original date of 9 March). The results of the consultation will be analysed independently by the University of Kent and then proceed for decision by the Boards of Canterbury and Coastal CCG and EKHUFT.

(c) The core proposals within the consultation involve consolidating outpatient services from the current 15 sites to 6. 5 of these sites are those owned by EKUHFT:

1. William Harvey Hospital, Ashford;
2. Kent and Canterbury Hospital, Canterbury;
3. Queen Elizabeth The Queen Mother Hospital, Margate;

4. Buckland Hospital, Dover; and
5. Royal Victoria Hospital, Folkestone.

(d) The sixth site is to be in the north Kent coast area. Several sites are considered, with the consultation document naming Estuary View Medical Centre as the preferred option.

(e) Based on travel times for patients in Canterbury and Coastal, Thanet, Ashford and South Kent Coast CCG's areas, choosing these six sites (including Estuary View) will lead to an increase in the percentage of patients within a 20 minute drive of outpatient services than is currently the case (83.5% compared to 70%).

(f) NHS Canterbury and Coastal agreed to partner EKUHFT on the consultation. Ashford, Thanet and South Kent Coast CCGs decided that they would be consulted by the Trust on the proposals.

(g) A couple of other service developments are mentioned in the consultation document, but were not covered in the consultation. NHS South Kent Coast CCG is separately working on services to be provided from Deal Hospital. NHS Swale CCG is also separately commissioning a one-stop outpatient centre in the Sittingbourne area, creating a seventh site for outpatient services. According to the business case for the outpatients clinical strategy the seventh site, along with service innovations, is key to realising the benefits of the strategy.

3. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report.

Background Documents

Agenda, Health Overview and Scrutiny Committee, 7 June 2013
https://democracy.kent.gov.uk/mgAi.aspx?ID=25151

Agenda, Health Overview and Scrutiny Committee, 11 October 2013
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5075&Ver=4

Agenda, Health Overview and Scrutiny Committee, 11 April 2014
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5396&Ver=4

Consultation on Outpatient Services in East Kent, East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group.

Outpatients Clinical Strategy Full Business Case, East Kent Hospitals University NHS Foundation Trust

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East Kent Hospitals University NHS
NHS Foundation Trust

Progress report on the Outpatient Consultation in east Kent
Kent Health Overview and Scrutiny Committee
June 2014

1. Introduction

In November 2013 the Out-Patient Clinical Strategy (OPCS) Full Business Case was endorsed by the East Kent Hospitals University Foundation Trust (EKHUFT) Board. The OPCS subsequently went to Public Consultation from Dec 2013 - March 2014. The NHS Canterbury and Coastal Clinical Commissioning Group (C&C CCG) agreed to partner EKHUFT in the consultation process.

The outcome of the consultation is to be discussed at the EKHUFT Board in June 2014 and C&C CCG Governing body in early July following engagement with the Kent Health and Overview Scrutiny Committee (HOSC). The final decision on the outcome of the consultation will be based on an independent analysis of the process, undertaken by the University of Kent, which was commissioned by Kent and Medway Commissioning Support (KMCS).

2. Background

The Trust currently operates a comprehensive range of outpatient (OP) services from its three acute sites at the William Harvey Hospital in Ashford (WHH), Kent and Canterbury Hospital, Canterbury (KCH) and The Queen Elizabeth the Queen Mother Hospital, Margate (QEQMH). In addition to these three acute sites, the Trust also provides a range of outpatient and diagnostic services from the Royal Victoria Hospital Folkestone (RVH) and Buckland Hospital Dover (BHD), both of which the Trust owns.

The Trust also delivers outpatient services from a number of community hospital sites which include Faversham Hospital (FH), Whitstable and Tankerton Hospital (W&T), Queen Victoria Memorial Hospital in Herne Bay (QVMH) and Victoria Hospital in Deal (VHD). These sites are not in the ownership of the Trust. On these sites, the Trust is a sub-tenant of the Kent Community Health Services Trust, which is itself a tenant of NHS Property Services.

Finally, in addition to the above sites, the Trust has local agreements to deliver a range of "specialty specific" outpatient services throughout the local area in facilities owned by other organisations (other Trusts' properties and at GP surgeries). These specialty specific outpatient services include dermatology, paediatrics, obstetrics and midwifery services, renal, therapy clinics and neurological nurse-led clinics.

The Clinical Strategy's key principles are based on improving the quality of the Trust's out-patient services and improving access for the local population. Specifically they include:

- improved patient access based on local postcodes;
- each site offering a broad spectrum of specialities;
- a maximum 20 minute travel time for patients by car to their clinic appointment;
- offering an extended working day to enable a greater choice of appointment times;
- offering a one stop model to reduce the follow up attendances and improve efficiency;
- the introduction of telemedicine to reduce face to face contacts for some patients;
- increasing income to the Trust by attracting patients currently being referred to other Trusts in Kent;
- ensuring outpatient facilities are fit for purpose and upgraded where necessary;
- the implementation of speciality specific criteria i.e. increasing the length of sessions / the working day: and
- working with key transport providers to improve access to sites by public transport.

EKHUFT has reviewed its outpatient services with staff, patients and a wide range of stakeholders to see how it could improve the quality of care and offer more local access. Recognising that the NHS, alongside all public services, is being challenged to make the best use of resources, the Trust engaged in a consultation on outpatient services to gather feedback on a range of proposed changes to these services. The key proposals in the consultation were to:

- reduce the number of facilities used for outpatient clinics from 15 to 6;
- offer a wide range of services across most specialities including diagnostic support;
- extend clinic hours from 07.30 -19.00 and Saturday mornings to improve patient choice and access and make more effective use of staff time;
- increase the number of people who are within a 20 minute drive of outpatient services;
- invest in the clinical environment to support high quality clinical services and an improved patient experience;
- develop a one-stop approach more widely than is currently seen in services;
- expand the use of technology to reduce follow up appointments and support patients, monitoring their progress at home or in Primary Care; and
- invest £455,000 in extending / modify public transport routes provided by Stagecoach.

3. The option appraisal process

The Trust's Investment Benefit Scoring Model was used for the option appraisal process. The model has three sections:

- quality;
- commercial; and
- strategic fit.

Each of these sections has sub sections which ask questions and are scored from 0 -100%. The model has been included as Appendix One.

The initial scoring was undertaken for each of the four potential north Kent coast sites in 2013. The merits of the sites were considered and discussed by the team and information supplemented by photographs of the areas. The results of the scoring exercise led to Estuary View being identified as the Trust's preferred site on the North Kent Coast.

In April 2014 the Trust and C&C CCG re-visited the four potential sites being considered for the sixth clinical site on the north Kent coast. This was following concerns being raised and new information being presented during the consultation process. These predominantly related to the fact that people believed the data gathered on the four sites was outdated and various changes had been made to the estate, as well as to an inaccurate calculation of the car parking spaces at QVMH.

To re-assess the community hospitals, the visiting team from EKHUFT needed information from NHS Property Services which owns the three community hospitals at Faversham, Herne Bay and Whitstable. Following the site visits, a second option appraisal was undertaken by a team including clinical and managerial staff from EKHUFT and the C&C CCG. The option appraisal was also overseen by a member of the HOSC.

The criteria used are available publicly on the Trust's website and reflect the additional areas members of the public requested to be included mainly around the deprivation of the different communities, the size of the populations of the coastal towns and the predicted housing and population growth. Subsequent to the April re-assessment, further information and site plans for QVMH have been sent through by NHS Property Services. A further re-assessment has therefore been set up for the end of May 2014. As plans for modification to either Whitstable and Tankerton Hospital or Faversham Hospital have not been received from NHS Property Services, the Trust has concluded that these premises are not suitable for modernisation to provide the required levels service.

The final scores will be presented to the C&C CCG in July and EKHUFT Trust Board in June 2014.

4. The consultation process

The Trust has engaged with all local Clinical Commissioning Groups (CCGs) in east Kent over the last two years. Ashford, Thanet and South Kent Coast CCGs decided that they would be consulted by the Trust about the proposed changes to outpatient services, whilst Canterbury and Coastal CCG agreed to partner the Trust in the process.

The consultation on outpatient services took place from 9 December 2013 to 17 March 2014. The consultation was extended (from the original closing date of 9 March) to allow for requests for additional meetings in Herne Bay and Faversham, which both took place on 13 March 2014.

Throughout the consultation a range of methods were used to promote the consultation process including:

- advertisements in December and January were placed in local papers and online via the Kent Messenger newspaper group across east Kent;
- two BBC Radio Kent interviews;
- news items on BBC South East and Meridian at launch and subsequently on 13 March 2014 covering the second public meeting at Herne Bay;

- adverts or articles in Clinical Commissioning Group newsletters, HealthWatch alerts and various patient and voluntary groups' newsletters;

- 3,005 emails were sent to local councilors, MPs, health network members (local people and organisations who have registered an interest in health and working with their local clinical commissioning group), voluntary and community organisations, NHS organisations, professional committees, local authorities, patient reference groups, patient participation groups, carer organisations and HealthWatch Kent with a request to consider the information, respond and pass the information on;

- the Trust website had a dedicated online site with all the information available and NHS Canterbury and Coastal Clinical Commissioning Group website had suitable links to the Trust website. Social media such as Facebook and twitter was also used to promote the consultation;

- a standing item at the NHS Canterbury and Coastal Clinical Commissioning Group governing body meetings held in public from December 2013 to March 2014;

- 500 posters on display, 3,000 full consultation documents and 14,000 summary documents were distributed to GP practices, hospital waiting areas, all outpatient clinics, libraries, community centers; gateway centers pharmacies and local councils across east Kent. They were also available at focus groups, public meetings and patient meetings or events that the Trust and engagement team were invited to attend;

- consultation documents were available in large print and an easy read version for people with communication difficulties which were available online and at every meeting;

- the Trust staff and KMCS engagement team were invited to attend six patient groups who requested more information to answer any questions and enable patients and carers to respond to the consultation. The Trust also went to Dover Adult Strategic Partnership and the Thanet District Council Scrutiny Committee; and
- an online email address and telephone number was given so that people could request additional information, ask questions or request copies of the consultation document.

During the consultation there were a series of 12 public meetings held at varied times. These were advertised as part of the whole consultation detailed above. Generally at these three hour public meetings, Liz Shutler Director of Strategic Development and Capital Planning and Marion Clayton Divisional Director, Clinical Support Services presented information on the proposals, the reasons for it, the principles for improving services, the early engagement which influenced the strategy, the outcome expected of the proposals, the steps taken during the review, the options considered for the sixth site on the north Kent coast, potential improvements in bus transport routes and how people could contribute their views.

This was followed by half an hour open question and answer session, then round table discussions. Those conversations were recorded and collated and have been logged and sent to the University of Kent for the independent analysis of all responses.

At a few of the meetings the number of people attending was so large there was insufficient space to safely accommodate the round table discussions. Instead, an extended question and answer session was held followed by staff remaining to talk to individuals and answer any remaining questions. At each meeting there were evaluation sheets to learn how the events had worked for people and an opportunity for people to put forward written questions.

Throughout the review care was taken to reach those communities of need who have expressed an interest in the review.

In addition to the public meetings, the University of Kent has conducted four focus groups with people from distinct communities of need including those with learning disabilities, mental health service users, people with physical disabilities and people for whom English is a second language, to ensure their views on outpatient clinics were included in the consultation.

As part of the consultation there was an open offer to attend any group or organisation that would like to know more and would prefer that the Trust staff and engagement team come to their meeting rather than attend the public meeting. Seven different patient and community groups took up this offer.

5. Current position post Consultation

Responses to the consultation have been logged and sent to independent researchers from the University of Kent who have collated and analysed the information and produced a final report for the East Kent Hospital University Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. The overall response was: 41 telephone enquiries, 65 emails and letters, 273 online and 205 paper completed surveys, and two petitions were received from the Labour Party in Herne Bay signed by 1,260 and The League of Friends of QVMH signed by 6,000. Approximately 1,330 people attended 12 public meetings, and a further 39 took part in four focus groups, with approximately 100 at the additional meetings attended by members of the Trust and KMCS Engagement team.

The report from the Kent University evaluation has been received by both the Trust and the CCG and is available for consideration by the HOSC at Appendix Two. The report, along with the outcome of the HOSC discussion will be available to the C&C CCG Governing body and EKHUFT at their respective Board meetings at the end of June and in early July.

6. Findings of the Consultation

It is clear that there was a relatively low overall engagement in percentage terms of the east Kent population. In terms of the improvements detailed in the consultation, overall the proposal to extend working hours and improve the range of out-patient services was received well and with little opposition voiced in the consultation events and focus groups.

The proposal to increase the number of people within the 20 minute drive time received a less positive reaction. The two main concerns raised were the use of the 20 minute criteria and the focus on drive time and not on public transport. Explanations on the criteria and details of the transport plan with Stagecoach were emphasised at every meeting.

The reduction of sites and acknowledgement of the pressure to reconcile quality service provision, along with finite budgets generated some agreement. However, some concerns were also raised about the proposed reduction. Public transport and access were the two main reasons for concern.

Estuary View Medical Centre as the Trust's preferred sixth site met with mixed reaction. Some noted the benefits of the site, whilst patients from Herne Bay and Faversham largely opposed the move. The main reasons given for the opposition was transport / access issue

and the lack of demographic information in the decision making. As stated above, this issue was built in to the second option appraisal.

There was some criticism over the accuracy of the initial option appraisal process due to an initial inaccurate measure of the car parking capacity at Herne Bay. This was corrected early in the consultation process and recognised as part of the presentation at each event.

Other issues raised were linked to alterations to the Community Hospital sites since the first visits in 2013. These issues were all addressed and considered in the second option appraisal.

The utilisation of new technology and the one stop approach to clinics was largely positively viewed.

7. Next steps

Following the second option appraisal on April 22nd 2014 information was received from NHS Property Services regarding a potential refurbishment of the QVMH. A third option appraisal meeting was therefore held on May 29th 2014. The scoring at this meeting will be re-evaluated based on this information and the final scores and analysis will be presented to the Canterbury and Coastal CCG Governing body and the EKHUFT Board at their meetings in June 2014.

In addition, further consideration is being given by C&C CCG to offering GP and community service led outpatient services to communities across East Kent. This work is linked in to the CCG's plans to provide community hubs.

8. Recommendations

The Kent HOSC is asked to agree that the public consultation process has met the required standards as set out in the Health and Social Care Act. Feedback from the Kent HOSC will be discussed at the EKHUFT Board at the end of June 2014 and the C&C CCG Governing body in early July 2014.

The Canterbury and Coastal CCG Governing body and the EKHUFT Board will then reach a decision on the way forward, based on the information, findings and outcome of the consultation.

INVESTMENT BENEFIT SCORING MODEL

Name

QUALITY BENEFITS	WEIGHTING	0% NO IMPACT	10%	20% LOW IMPACT	30%	40% MODERATE IMPACT	50%	60% MEDIUM IMPACT	70%	80% SIGNIFICANT IMPACT	90%	100% EVIDENCE OF SIGNIFICANT IMPACT	OVERALL IMPROVEMENT %	OVERALL IMPROVEMENT SCORE
EFFECTIVENESS To what extent does this business case and/or development improve the outcomes of care?													0%	
Effectiveness Score	25	0	2.5	5	7.5	10	12.5	15	17.5	20	22.5	25	0%	0
EXPERIENCE To what extent does this business case and/or development improve the experience of care?													0%	
Experience Score	20	0	2	4	6	8	10	12	14	16	18	20	0%	0
SAFETY To what extent does this business case and/or development improve the safety of care?													0%	
Safety Score	30	0	3	6	9	12	15	18	21	24	27	30	0%	0
TIMELY To what extent does this business case and/or development improve the timeliness of care?													0%	
Timely Score	15	0	1.5	3	4.5	6	7.5	9	10.5	12	13.5	15	0%	0
EFFICIENT To what extent does this business case and/or development improve the efficiency of care?													0%	
Efficient Score	5	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	0%	0
EQUITABLE To what extent does this business case and/or development improve the equity of care?													0%	
Equitable Score	5	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	0%	0
TOTAL QUALITY SCORE	100													0

COMMERCIAL BENEFITS	WEIGHTING	0% NO IMPACT	10%	20% LOW LEVEL ACHIEVEMENT	30%	40% MODERATE ACHIEVEMENT	50%	60% MEDIUM LEVEL ACHIEVEMENT	70%	80% SIGNIFICANT ACHIEVEMENT	90%	100% FULL ACHIEVEMENT	OVERALL IMPROVEMENT %	OVERALL IMPROVEMENT SCORE
EBITDA To what extent does this business case and/or development meet the target financial return of 10%													0%	
EBITDA Score	40	0	4	8	12	16	20	24	28	32	36	40	0%	0
RETURN ON CAPITAL EMPLOYED To what extent does this business case and/or development meet the target financial return of 10%													0%	
ROCE Score	30	0	3	6	9	12	15	18	21	24	27	30	0%	0
PAYBACK PERIOD To what extent does this business case and/or development meet the target breakeven period of 3 years?													0%	
Payback Score	15	0	1.5	3	4.5	6	7.5	9	10.5	12	13.5	15	0%	0
FINANCIAL RISK To what extent does this business case support the avoidance of financial penalties for non-achievement of core targets?													0%	
Financial Risk Score	15	0	1.5	3	4.5	6	7.5	9	10.5	12	13.5	15	0%	0
TOTAL FINANCIAL SCORE	100													0

STRATEGIC FIT	WEIGHTING	0% NO FIT	10%	20% LOW LEVEL FIT	30%	40% MODERATE FIT	50%	60% MEDIUM LEVEL FIT	70%	80% SIGNIFICANT FIT	90%	100% FULL ACHIEVEMENT	OVERALL IMPROVEMENT %	OVERALL IMPROVEMENT SCORE
COMMISSIONING INTENTIONS (ACTIVITY & DEMAND) Does the proposal address long-term commissioning intentions of the GPC's as well as National Policy? Is there sufficient demand to support sustainable service delivery?													0%	
Activity Score	20	0	2	4	6	8	10	12	14	16	18	20	0%	0
BEST USE OF RESOURCES Does the proposal support the need for the Trust to make the best of its resources with benefit for all users?													0%	
Best Use Score	20	0	2	4	6	8	10	12	14	16	18	20	0%	0
CLINICAL STRATEGY Is the proposal congruent with the published service Clinical Strategy?													0%	
Clinical Strategy Score	20	0	2	4	6	8	10	12	14	16	18	20	0%	0
WORKFORCE/ DELIVERABILITY Is the proposal deliverable in terms of workforce availability and is the overall scope deliverable?													0%	
Workforce Score	20	0	2	4	6	8	10	12	14	16	18	20	0%	0
DELIVERING INNOVATION Does the proposal provide an innovative approach to improving health care, increasing market share, reputation or improving financial returns?													0%	
Innovation Score	20	0	2	4	6	8	10	12	14	16	18	20	0%	0
TOTAL STRATEGIC SCORE	100													0

OVERALL RAW SCORE	300	0
QUALITY BENEFITS	30	0
COMMERCIAL BENEFITS	40	0
STRATEGIC FIT	30	0
OVERALL WEIGHTED SCORE	100	0
		LOW IMPACT

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CHSS
University of Kent

Centre for Health Services Studies

Evaluation of the Outpatients consultation in East Kent.

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May, 2014

Commissioned by:

Kent and Medway Commissioning Support on behalf of
East Kent Hospitals University NHS Foundation Trust and
NHS Canterbury and Coastal Clinical Commissioning
Group




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Centre for Health Services Studies (CHSS)

CHSS is one of three research units of the University of Kent's School of Social Policy, Sociology and Social Research and contributed to the school's recent Research Assessment Exercise 6* rating. This puts the school in the top three in the UK. CHSS is an applied research unit where research is informed by, and ultimately influences, practice.

The Centre is directed by Professor Stephen Peckham and draws together a wide range of research and disciplinary expertise, including health and social policy, medical sociology, public health and epidemiology, elderly medicine, primary care, physiotherapy, statistical and information analysis. CHSS supports research in the NHS in Kent and has a programme of national and international health services research. While CHSS undertakes research in a wide range of health and health care topics, its main research programmes comprise:

- Ethnicity and health care
- Health Psychology
- Palliative care
- Public health and public policy
- Primary care

Researchers in the Centre attract funding of nearly £l million per year from a diverse range of funders including the ESRC, MRC, Department of Health, NHS Health Trusts and the European Commission. For further details about the work of the Centre, please contact:

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Introduction

CHSS undertook to support Kent and Medway Commissioning Support (KMCS: acting on behalf of East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group) in undertaking an independent analysis of a consultation on Outpatient services in East Kent. The aim of the consultation was to gain opinions from the public of a proposed Outpatient Clinical Strategy that intends to improve local access to, and facilities for, Outpatient services, and to offer a wider range of services on each site.

CHSS advised on the survey, evaluated the consultation process, ran focus groups and carried out quantitative and qualitative analysis of the responses gathered during the consultation period (9th December 2013 to 17th March, 2014 - originally 9th March but period was extended). Ethical approval was not required for a consultation process, but ethical principles have been adhered to regarding data confidentiality and informed consent for the focus groups.

Background

East Kent Hospital University NHS Foundation Trust (the Trust) currently provide a comprehensive range of general Outpatient services from its three acute sites: the William Harvey Hospital in Ashford (WHH), Kent and Canterbury Hospital, Canterbury (KCH) and The Queen Elizabeth the Queen Mother Hospital, Margate (QEQMH). Outpatient services are those where a patient attends a hospital or clinic, but does not stay overnight, and may include a consultation with a clinician, diagnostic tests such as phlebotomy, X-ray or MRI, and a treatment plan being discussed, or treatment being given.

The Trust also provides a smaller range of general outpatient and diagnostic services from the Royal Victoria Hospital Folkestone (RVH) and Buckland Hospital Dover (BHD) and a number of community hospitals which include; Faversham Health Centre (FH), Whitstable and Tankerton Hospital (W&T), Queen Victoria Memorial Hospital in Herne Bay (QVMH) and Victoria Hospital in Deal (VHD).

In addition to these, the Trust has delivered a range of “specialty specific” Outpatient services throughout the local area in various facilities owned by other Trusts and at GP surgeries.

These specialty specific outpatient services include: dermatology, paediatrics, obstetrics and midwifery services, renal, therapy clinics and neurological nurse-led clinics, and have grown out of various arrangements over the years.

As part of a wider clinical strategy over the last two years, the Trust has reviewed its outpatient services with staff and patients and a wide range of stakeholders to see how the Trust could improve the quality of care and offer strong local access to services. Recognising that the NHS, and all public services, is being challenged to make the 'best' use of resources.

What the Trust was consulting about.

With this in mind, the Trust has engaged in a consultation on outpatient services to gather feedback on a range of proposed changes to these services. The key proposals in the consultation are:

- To reduce the number of facilities used from 15 and concentrate services on six sites;
- To offer a wider range of Outpatient services across all specialities, including diagnostic support, from the six sites proposed;
- To extend the clinical working hours from 7.30 a.m. to 7.00 p.m., to offer better access to patients, and make more effective use of staff time including offering Saturday clinics from 9 a.m. to 11.30 a.m.;
- Increase the number of people within a 20-minute drive of outpatient services;
- To invest in the clinical environment to support high quality clinical services, and offer a comfortable patient experience in a welcoming environment, at all six facilities;
- To develop the one-stop approach that is currently offered in breast surgery, urology and dermatology across more services;
- To expand the use of technology such as telehealth and telemedicine to reduce unnecessary follow up appointments and support patients monitoring their progress at home or in a GP practice.

The proposed changes set out in the consultation will not affect certain services (i.e., renal services, children's community services, vascular screening, midwifery- led community services, and nurse-led neurology clinics).

The consultation process

East Kent Hospitals University NHS Foundation Trust spent two years developing their proposals for improving Outpatient services across east Kent. The Trust surveyed patients for their views, spoke to staff and tested their ideas with a range of stakeholders via a series of presentations and discussions at 130 meetings. The range of stakeholders included GPs as clinical commissioners, local authorities, voluntary and community sector organisations, patient and carers groups and the Trust's governors and members. Overall, the Trust estimates that 4,000 people took part in this early phase and the Trust developed their plans based on the feedback received.

Between 9th December 2013 and 17th March 2014, East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group (CCG) held a consultation across east Kent on the proposals to Outpatient services. This period included additional time to allow extra public meetings to be held.

The consultation process used a wide range of means to involve people: public meetings, focus groups, online and paper surveys, by offering to attend local meetings and using social media to elicit people's views. The consultation documents (17,000 printed copies) were provided in various formats and distributed via GP practices, hospital waiting areas, all outpatient clinics, libraries, community centres, gateway centres, pharmacies, and local councils across east Kent. Consultation documents were also available at focus groups, public meetings and patient meetings or events that the Trust and engagement team were invited to attend. Members of the public could provide their feedback on the proposals via a dedicated telephone line, by email/letter, by completing a survey, and/or by attending a public meeting.

Efforts were made to publicise the process through the media, networks of organisations and local contacts across east Kent. This was picked up and repeated in various local papers particularly in areas where it excited local interest such as: Deal, Herne Bay, and Faversham, but also more widely by the media. During the consultation there were a series of 12 public meetings, held at varied times, in which a formal presentation was given setting out the plans for Outpatient services. Over the course of the consultation period, this presentation was

adapted in response to feedback from the public. For example, slides were included to explain the structure of the NHS and explain travel provision for all areas – not just the local area.

At the public meeting, local people had the opportunity to ask questions and comment upon the proposals. The Trust also accepted invitations to various patient groups and local authority meetings where a similar discussion was had, and recorded. CHSS at the University of Kent was asked to provide four focus groups for community members who might have specific needs from NHS services that should be taken into consideration.

The overall response was: 41 telephone enquiries, 65 emails and letters, 273 online and 205 paper completed surveys. Three local CCGs (NHS Ashford, NHS Thanet, & NHS South Kent Coast) also sent letters to EKHUFT in response to the consultation. In addition, two petitions were received- one from the Labour Party in Herne Bay signed by 1,260 and a second from The League of Friends of QVMH signed by 6,000. Approximately 1,330 people attended 12 public meetings, and a further 39 people took part in four focus groups run by CHSS. Approximately 100 people attended nine additional meetings in which members of the Trust and KMCS Engagement team were present to discuss the proposals.

All of the responses received have been recorded and collated by KMCS, then passed to CHSS to analyse within this report. In addition to collecting and analysing the data, CHSS were also asked to evaluate the consultation process, the discussion of which can be found at the end of the report.

Survey analysis

One way the public could offer their view to the consultation was by responding to a survey. The survey was distributed in the form of a pullout section, as part of the widely distributed full and summary consultation documents. It could also be completed online from a link posted on the consultation website. In the following section, responses to the survey are described in terms of the number completed, demographics of who responded and how they heard about the consultation, levels of support for and disagreement with the consultation questions and factors associated with these.

Number of responses and response rates

From the launch of the consultation in early December 2013 up to the end of the consultation period in March 2014, 478 people completed the survey, with 205 returning the pull-out paper surveys and 273 completing it online. The paper response rate was low (less than 2%) given that over 16,000 consultation documents were distributed, nevertheless the number of people giving their views through the survey compared well to similar consultations and fell within the range this consultation had anticipated. It is not possible to calculate the online response rate without knowing how many people became aware of the consultation and its website through the variety of methods used to promote the consultation.

The standard of completion for the paper survey was good overall. For example, over 95% provided gender, age, and postcode. A slightly lower proportion did not state their ethnicity; however, overall the standard of completion indicates a good quality survey and response rate. The main consultation questions were similarly well completed on paper returns. Although for the online surveys, demographics and how people heard about the consultation were completed to the same level, the main consultation questions and comments were answered by a lower percentage (74-84%) online. As the questions did not seem to be sensitive ones, or to be difficult to answer on paper, the level of missing data must be due to other differences. For example, people who did not complete the paper survey may not have returned it, whereas partially completed internet responses would automatically have been submitted.

Who responded

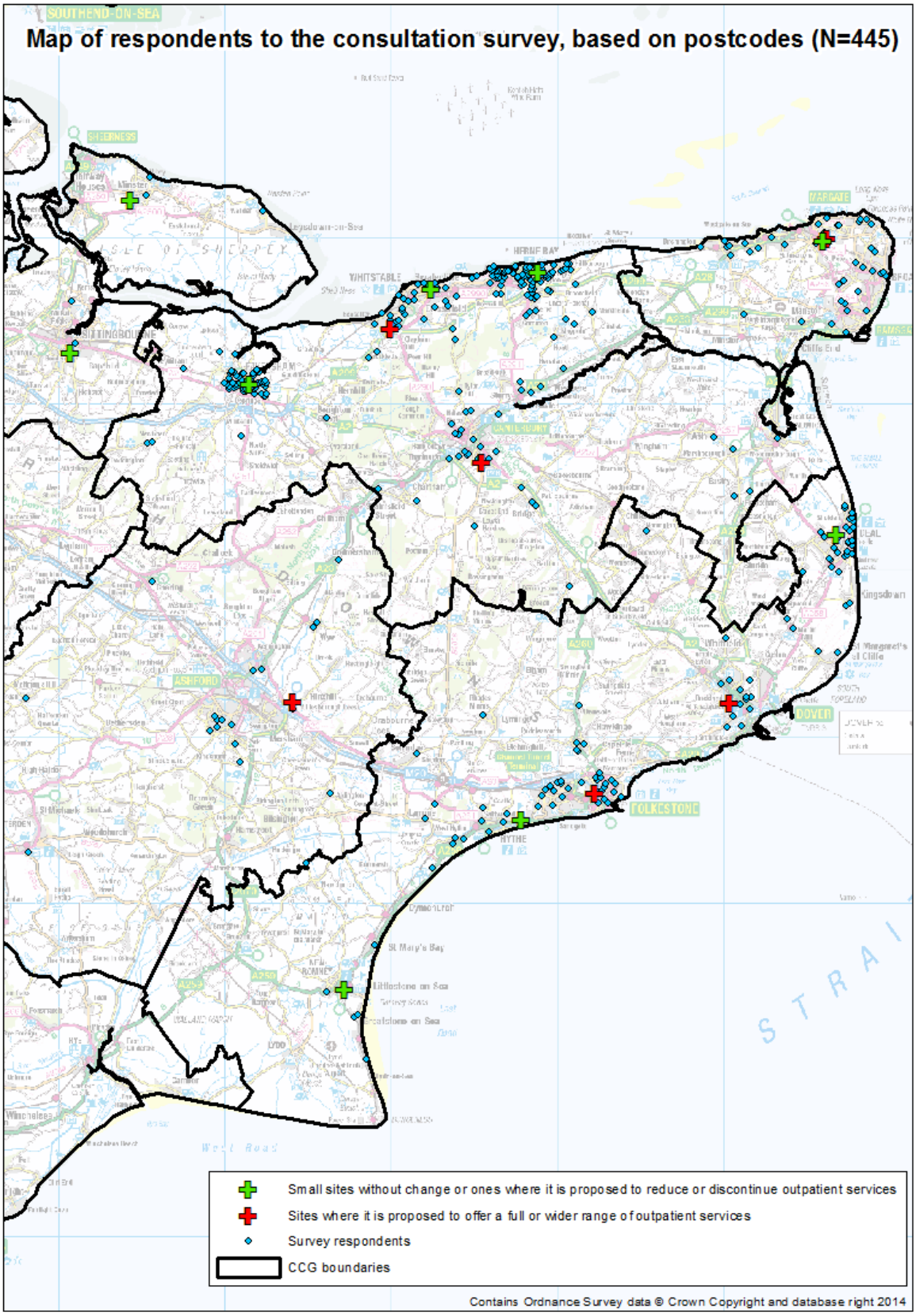
People between the ages of 17 and 91years (mean age = 60 years) completed the survey, with the majority (66%) aged 55 and over. There were more replies from women (64%) compared to men (36%). Most survey respondents described their ethnicity as White - British or Irish, with 11% saying another ethnic group or preferring not to answer.

Online respondents were more likely than those replying on paper to have a long-term condition (68% compared to 46%) or a disability (21% compared to 13%). The percentage of carers (11%) was the same for both methods of responding. People completing the survey online also tended to be younger with more 35-65 years and fewer aged 65 years and over using that method.

In terms of gender and ethnicity, the demographic profile of responses was as expected for surveys of the public, but did include a large proportion of older people, which may account for the higher numbers with long-term conditions and disabilities. The higher response rate from older people, and those with disabilities, was appropriate for a consultation aiming to get the views of people most likely to be affected by changes to outpatient services.

A map of survey respondents' postcodes shows where they lived in relation to the existing and proposed outpatient services in east Kent (see Figure 1, p 8). The map shows that many survey responses came from people living in coastal areas, for example, they were densely clustered in Faversham, Whitstable, Herne Bay, Deal and Folkestone. Replies in the Margate area were more scattered. There were some parts of the east Kent area with very few replies, including rural areas where populations are low, and Ashford town which is largely unaffected by the consultation proposals. There were hardly any responses from Sittingbourne, the Isle of Sheppey and Romney Marsh, which was not surprising as these are areas with low level existing Outpatient services, and where no changes have been proposed.

Figure 1 Map of where respondents to the consultation survey live



Looking at the CCG catchment area in which people live, the greatest numbers of survey replies were from NHS Canterbury & Coastal (282 or 59%) and NHS South Kent Coast (112 or 23%) CCGs, with considerably fewer from NHS Thanet (41 or 8.6%), NHS Ashford (21 or 4.4%) and NHS Swale (5 or 1.0%) CCGs. For the purposes of this analysis, people were allocated to a CCG using the postcode they gave. The first part of the postcode was used to identify the towns where people lived.

Within the two CCGs with the highest numbers of responses (NHS Canterbury & Coastal, NHS South Kent Coast), some areas are more affected by the proposals than others, for example the towns of Faversham, Whitstable, Herne Bay, Deal and Sandwich. Perhaps not surprisingly, over half of the survey replies came from these areas, with 235 from Faversham, Whitstable and Herne Bay (ME13, CT5, CT6), and 43 from Deal and Sandwich (CT14, CT13).

People came to hear about the consultation through a variety of ways. Those replying on paper were most likely to have heard about the consultation by attending a GP practice (32%), an outpatient clinic (15%) or a meeting about the consultation (18%). (There was however some differences between the A4 and A5 format survey respondents.) Online respondents were more likely to have heard about the consultation from 'other' means such as emails, leaflets/flyers and social media (29%), reading a newspaper (23%) or from searching online (10%). Irrespective of which reply format was used, 12% of respondents had heard about the consultation through friends or family. Respondents were asked to write in what 'other' ways they heard about the consultation, and the most frequently cited were through leaflets/flyers, Facebook/Twitter, email, work and notices in libraries.

Levels of agreement with consultation questions and comments

At the beginning of the survey, the principle aims of the proposals were set out in seven key consultation statements or questions giving people the opportunity to indicate how strongly they agreed or disagreed with the aims of the proposals. They presented people with a range of replies from 5 = 'Strongly agree' to 1 = 'Strongly disagree'. The bar charts in this section show the distribution of replies for all the survey respondents, with additional charts to highlight where there were variations in the response between sub-groups of the public. The

sub-groups were chosen to uncover where there might be differing views, and to avoid the results being distorted by high numbers of responses from small geographical areas. With this in mind, three sub-groups were created: people living close to the major areas of proposed changes in services, people who were likely to be heavier users of outpatient facilities (with health problems or over 75), and people who completed an online response or not.

Although a big overlap might be expected between the 'heavier users' this was not the case. For example, 142 people had disabilities, long-term conditions or were carers, and 60 people were 75 or over, with a relatively low proportion (only 39 people) falling in both categories; hence, the groups with long-term conditions/carers and people aged 75 or over have both been retained in the analysis. Analysis by CCG area of residence and by mode of response (on paper or online) rarely added anything that had not already been seen in other sub-groups.

In the results that follow the sub-groups are colour-coded in charts. Charts are shown only when noteworthy or significant results have been found, and they are always given in the same order: all responses; responses by area of residence; responses from people with disabilities/long-term conditions/carers; and finally people age 75 or over.

There were also five open-ended questions in the survey, where people could provide written comments. Not all people completing the survey wrote comments- from those that did around 1500 comments were generated across the five questions. In this section of the report, analysis of survey comments has been restricted to developing a coding frame and using this to categorise comments on approximately half of the paper surveys to give a flavour of what was written. The survey comments have been incorporated in to the qualitative analysis of comments made during other parts of the consultation.

In the text that follows the percentage agreeing refers to the 'agree' and the 'strongly agree' options added together. Likewise, the percentage disagreeing combines 'disagree' and 'strongly disagree'. In selecting noteworthy results for the consultation process we have highlighted areas that might be of concern because there were high levels of disagreement with the key consultation statements (using a threshold of 20% or more disagreeing), and

where there were differences between sub-groups' responses of 5 or more percentage points, as these were likely to be statistically significant variations.

Q1. The Trust can improve access to outpatient services by offering a greater range of clinical outpatient services from each outpatient centre (refers to Table 3 on page 21 in consultation document).

The majority (62%) agreed with this, but a substantial 27% disagreed (Fig 2). Disagreement rose for the high responding areas (49% in Deal/Sandwich, Fig 4, and 36% in Faversham, Whitstable and Herne Bay, Fig 3) and the online responders (33%). However rather more people who had disabilities, long-term conditions or were carers went along with this statement that there would be a greater range of services from each consolidated centre (71% of this group agreed and 18% disagreed, Fig 6). Likewise levels of agreement were higher for people aged 75 and over (67% agreed and 16% disagreed, Fig 7). Even for consultation survey respondents not living in affected areas, 11% did not think that the proposals would lead to better access to a greater range of outpatient services.

Figure 2: Consultation question 1 - All respondents

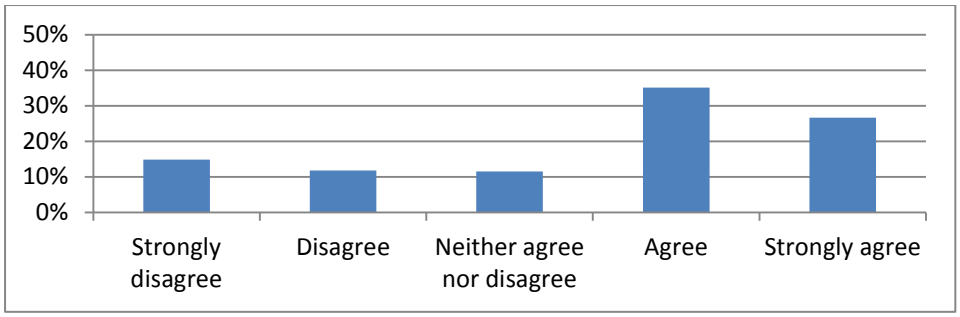


Figure 3: Consultation question 1 - Faversham/Whitstable/Herne Bay respondents

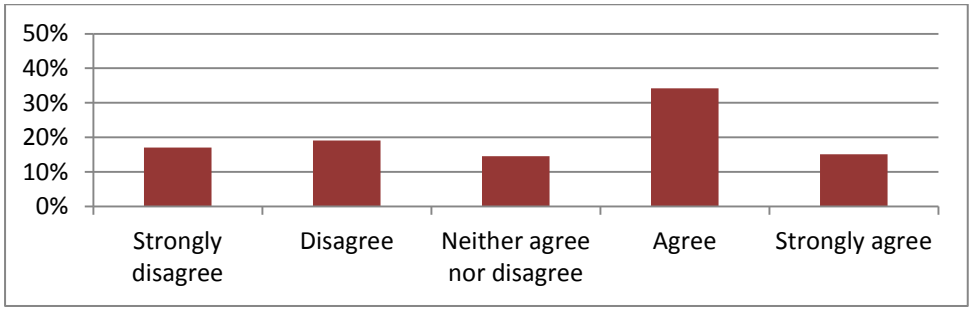


Figure 4: Consultation question 1 - Deal/Sandwich respondents

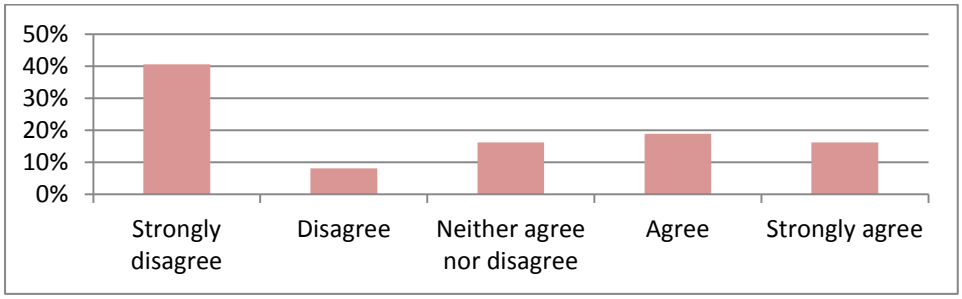


Figure 5: Consultation question 1 – Areas with lower response rates possibly because areas less affected by changes

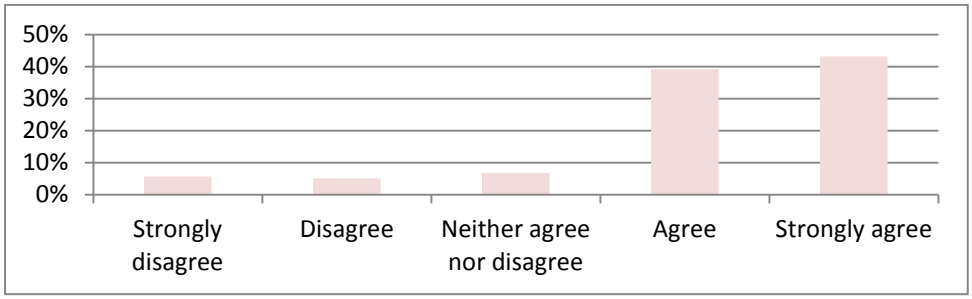


Figure 6: Consultation question 1 - Respondents with disabilities, long-term conditions or are carers

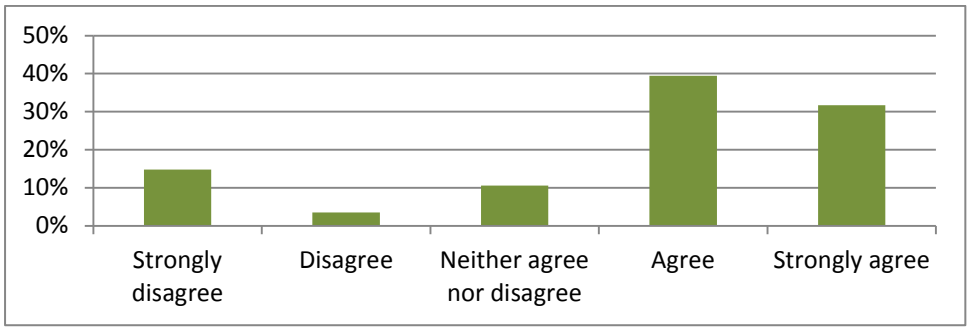
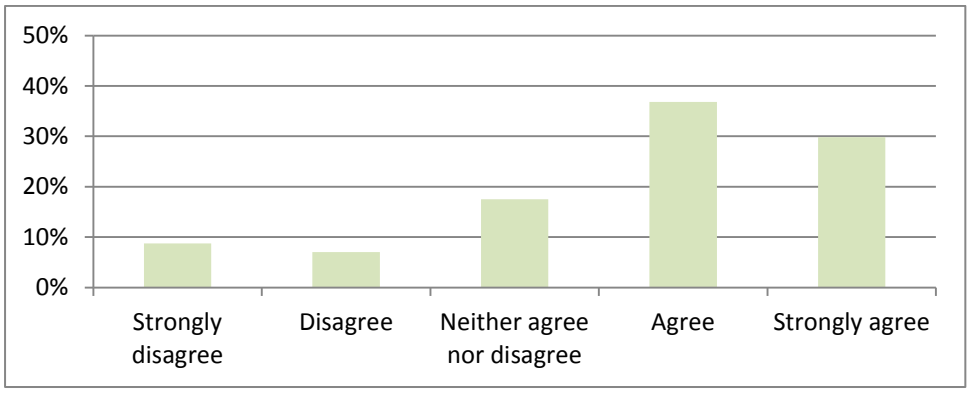


Figure 7: Consultation question 1 - Age 75+ respondents



Q2. The Trust can improve access by extending the opening times of the outpatient clinics; early mornings, evenings and Saturdays.

There was a high level of agreement with this statement (84% agreed and 9% disagreed, Fig 8) and this did not vary by CCG or for people with disabilities, long-term conditions or carers. Fewer survey responders in the Deal/Sandwich area (71%) agreed with the advantages of extended opening hours, and 16% disagreed (Fig 9). There was least disagreement (3%) with this statement from people aged 75 and over, and from those living in less affected areas (Fig 10). This response could be explained by the fact that people who did not wish to use or benefit from extended opening hours, could at the same time agree with the statement that such changes can improve access.

Figure 8: Consultation question 2 - All respondents

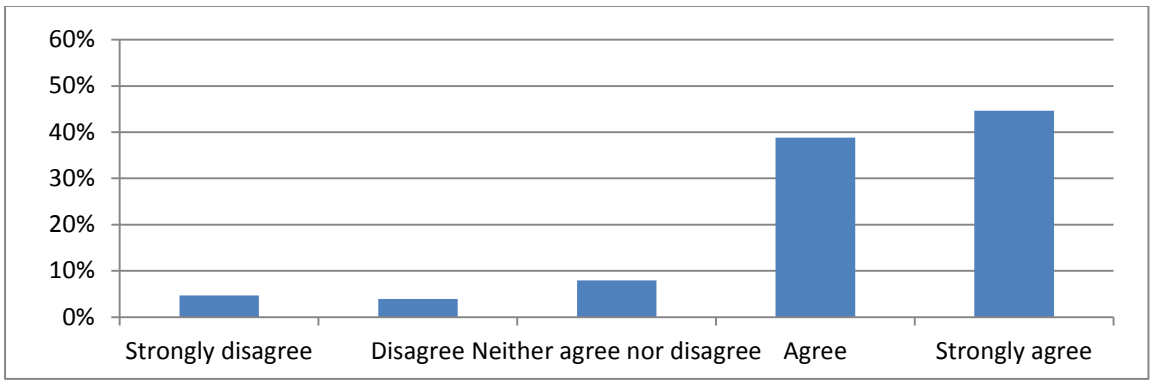


Figure 9: Consultation question 2 - Deal/Sandwich respondents

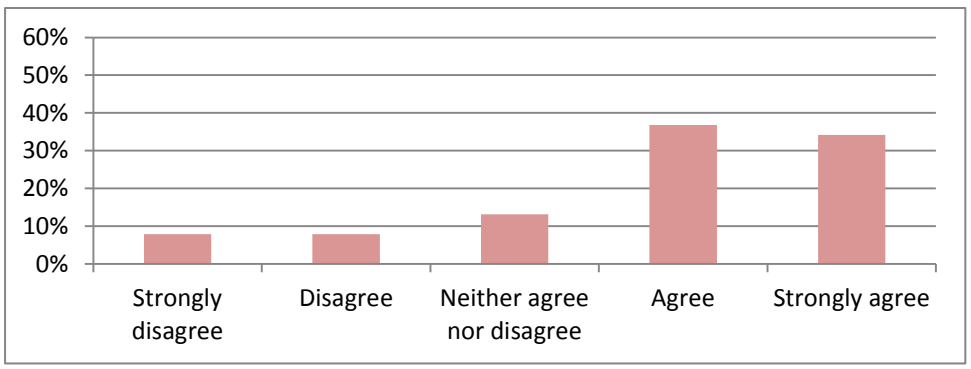
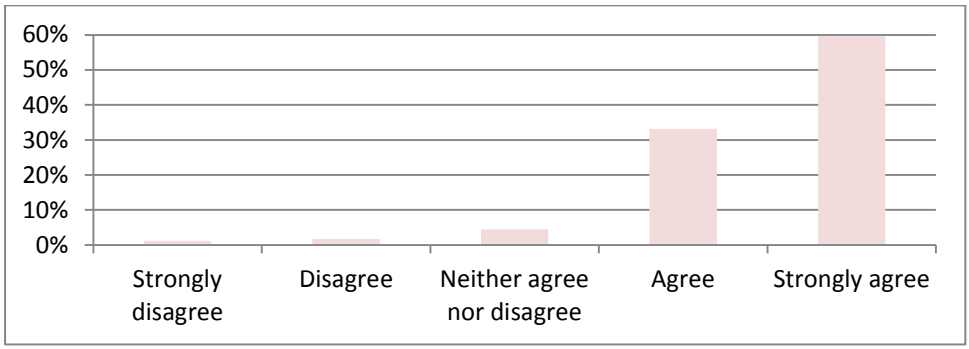


Figure 10: Consultation question 2 – Areas with lower response rate possibly because areas less affected by changes



Q3. Access to services can improve by increasing the number of people within a 20 minute drive of a fully equipped outpatient clinical centre.

This statement had least consensus and highest levels of opposition. A small majority (54%) agreed and nearly a third (33%) disagreed overall (Fig 11), and this increased to 40% of survey respondents living in NHS Canterbury & Coastal CCG area, and those replying online. As many as 31% of people aged 75 years and over did not agree with the 20 minute drive pledge (Fig 16), as well as 24% of people living in NHS South Kent Coast CCG, and 24% of survey responders who had disabilities, long-term conditions or were carers (Fig 15). Around half living in the high responding areas disagreed with the 20 minute pledge, with 45% in Faversham, Whitstable and Herne Bay (Fig 12), and 54% in Deal/Sandwich (Fig 13) clearly unhappy with the consultation process making this assertion about access to outpatient clinics. Survey respondents who lived in less affected areas were also sceptical that more people would be within a 20-minute drive of the proposed facilities, with 12% disagreeing with this statement (Fig 14).

Figure 11: Consultation question 3 - All respondents

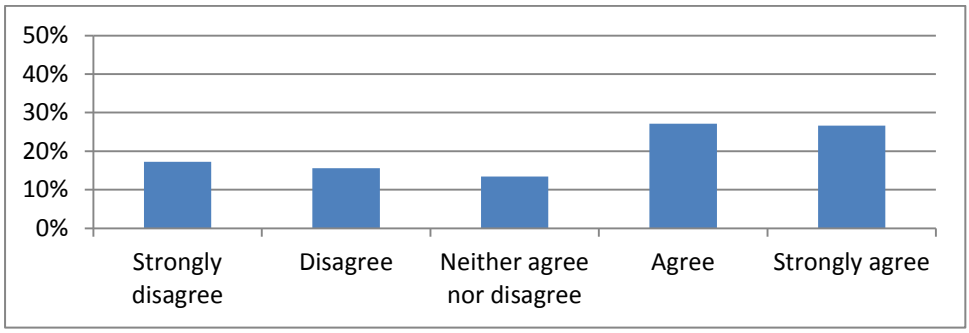


Figure 12: Consultation question 3 - Faversham/Whitstable/Herne Bay respondents

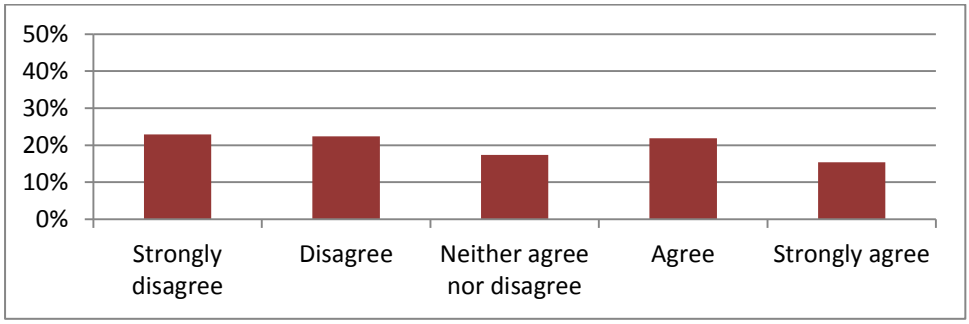


Figure 13: Consultation question 3 - Deal/Sandwich respondents

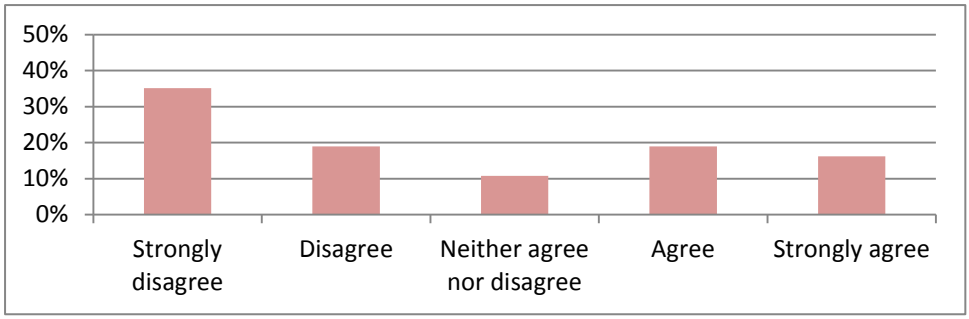


Figure 14: Consultation question 3 - Areas with lower response rates possibly because areas less affected by changes

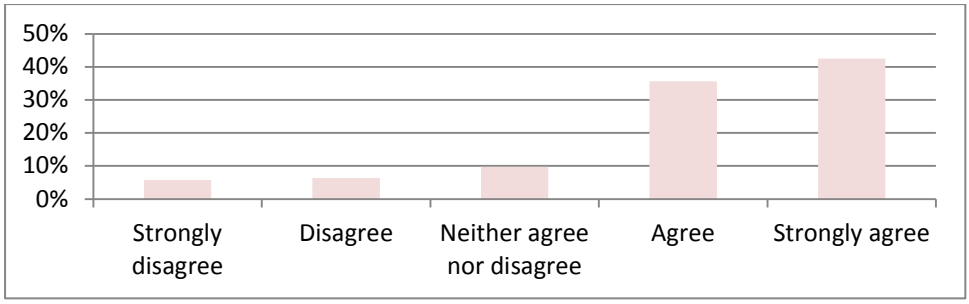


Figure 15: Consultation question 3 - Respondents with disabilities, long-term conditions or are carers

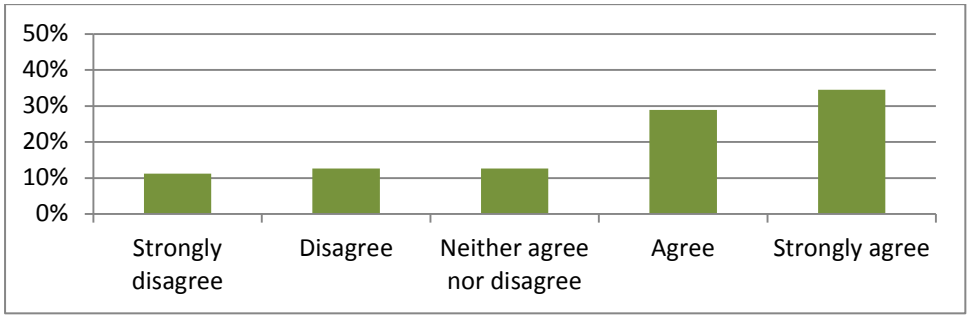
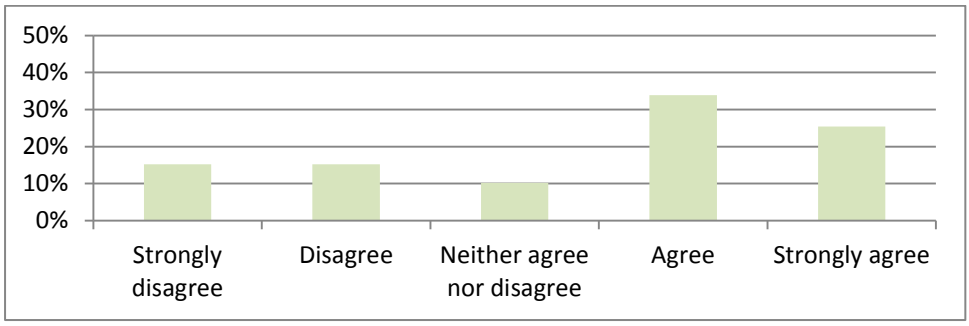


Figure 16: Consultation question 3 - Age 75+ respondents



Q4. The Trust can improve the quality of patient experience by improving the quality of the buildings and the patient environment.

A substantial proportion, nearly two-thirds agreed with this statement (64%), with 20% neither agreeing nor disagreeing and 16% disagreeing (Fig 17). This varied little by CCG, for the high responding areas or for people most likely to use outpatient services, as can be seen from those living in least affected areas (Fig 18).

Figure 17: Consultation question 4 - All respondents

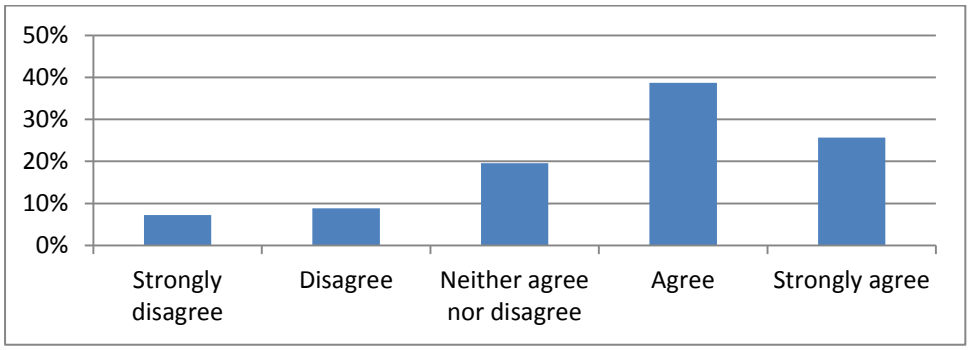
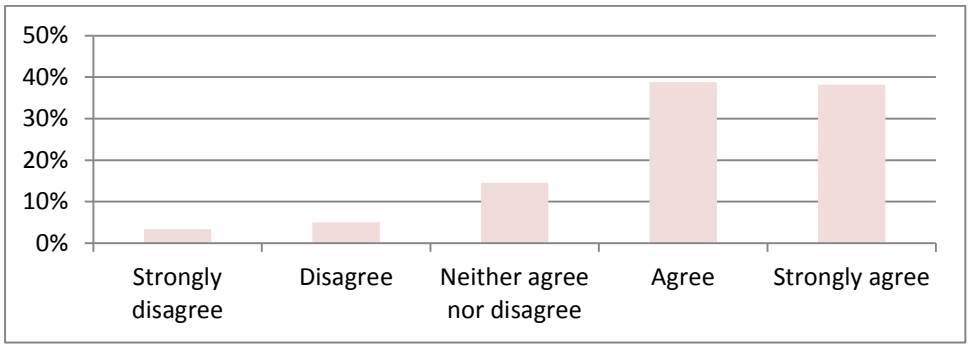


Figure 18: Consultation question 4 - Areas with lower response rates possibly because areas less affected by changes



Q5. The NHS needs to make effective use of all resources.

There was over-whelming support for this statement overall (85% agreed and very few disagreed 4%, Fig 19), and in areas least affected this rose to 96% showing a strong majority appreciate the need to make effective use of all NHS resources (Fig 20).

Figure 19: Consultation question 5 - All respondents

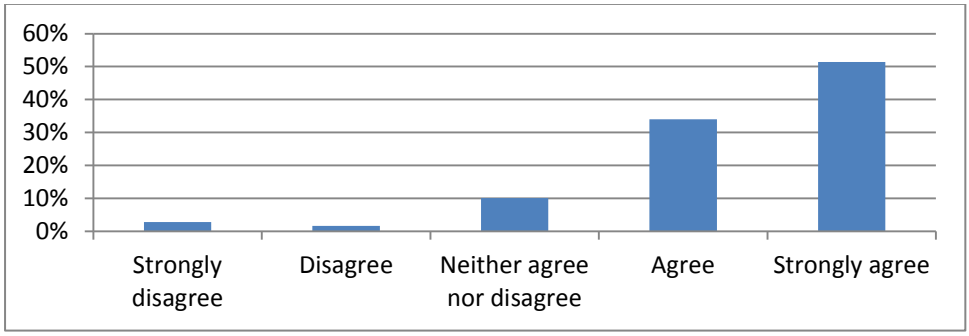
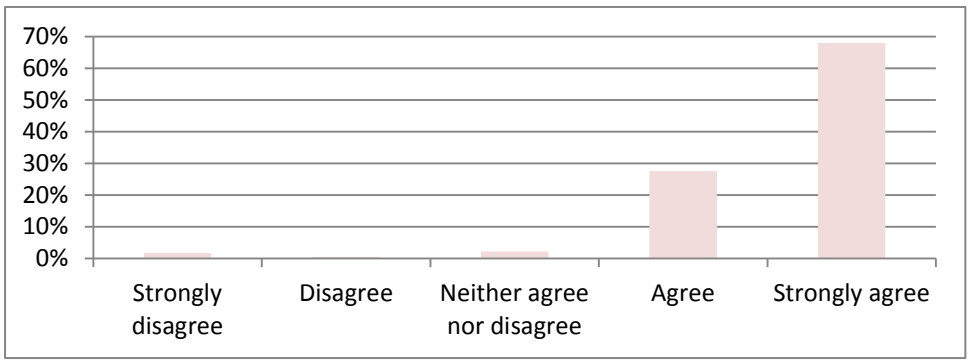


Figure 20: Consultation question 5 - Areas with lower response rates possibly because areas less affected by changes



Q6. Are there any other ways we could improve outpatient services?

Of 104 comments analysed from the paper survey returns very few were positive (2%) and a considerable number of these had concerns or were doubtful about the quality of service (75%), such as the coordination of communications and booking, and likely delays or waiting times. See table 1 for a summary of these.

Q7. The Trust proposes to consolidate its outpatient clinical services on to six sites. What are your thoughts on the proposal to have six outpatient clinics?

Of the 105 comments analysed there was considerable agreement with the consultation proposals, but about half felt the changes would make services worse, and others voiced

concerns about the facilities being offered, access to these, and the feeling that the changes were in the interests of the providers rather than the patients.

Q8. Are there any other aspects of the facilities that you think should be considered?

There were fewer comments, and these focused on concerns about making greater use of public transport, for specific people and services, making efficient use of resources and developing other facilities.

Q9. The Trust's preferred choice for the sixth outpatient clinic is Estuary View Medical Centre. What are your thoughts on the preferred option?

People were divided on this. There were many who agreed, but also others who thought travel distance and travel time were problems and that the facilities would not be improved. There were also critical views on the use of NHS resources and the consultation process.

Q10. The trust could make better use of technology to monitor patients in their own home: do you support this?

The majority was in agreement with this statement (73% agreed and 14% disagreed, Fig 21), although this decreased for people in the Deal/Sandwich area who seemed less keen on the use of technology in their homes, since 64% agreed with this statement and 20% disagreed (Fig 22). Older people and those with health problems were not significantly different from the overall response, and for respondents who did not live in the areas most affected by the consultation, there were still 9% who did not support greater use of technology in people's homes (Fig 23).

Figure 21: Consultation question 10 - All respondents

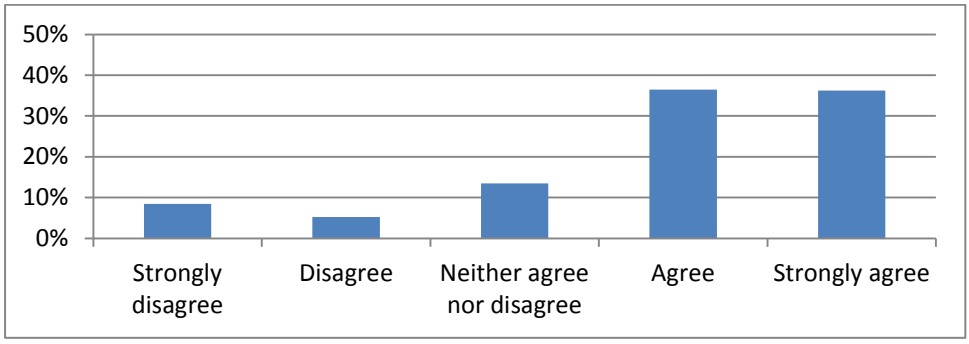


Figure 22: Consultation question 10 - Deal/Sandwich respondents

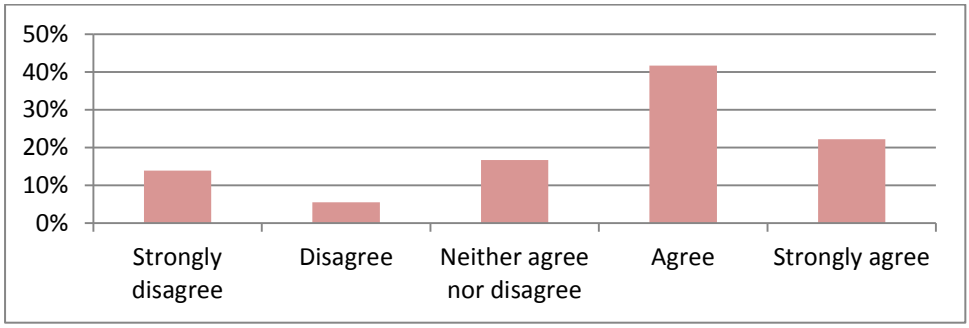
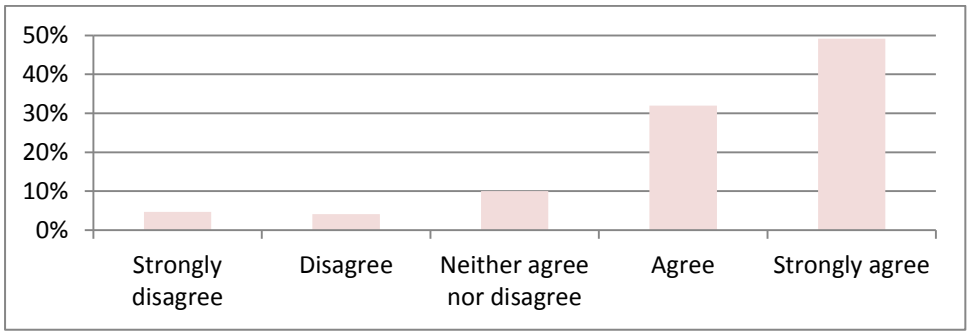


Figure 23: Consultation question 10 - Areas with lower response rates possibly because areas less affected by changes



Q11. Consolidating on six sites allows the trust to expand the one-stop approach over the next two to three years: do you support this?

The majority (62%) agreed, but as many as a quarter (25%) disagreed with this statement (Fig 24). Opposition was much greater for survey responders living in Deal/Sandwich where over half (55%) disagreed of the 33 people who replied (Fig 26). The percentage against consolidation to expand the one-stop approach also increased in other areas: to 30% in NHS Canterbury & Coastal CCG, 34% in Faversham/Whitstable/Herne Bay (Fig 25), and 32% among online responders. Although 73% of those with disabilities, long-term conditions or who were carers supported this statement (Fig 28), at the other end of the scale as many as 13% of this group strongly disagreed with expanding one-stop outpatient services. There were also some strong views among those aged 75 and over with 68% agreeing and 16% strongly disagreeing (Fig 29). For people who did not live in areas most affected by the consolidation of sites, 9% did not support an expansion (Fig 27).

In the comment following this question there were views for, against and doubts or concerns in similar proportions to seen in the previous comments with a tendency to repeat points that had already been made.

Figure 24: Consultation question 11 - All respondents

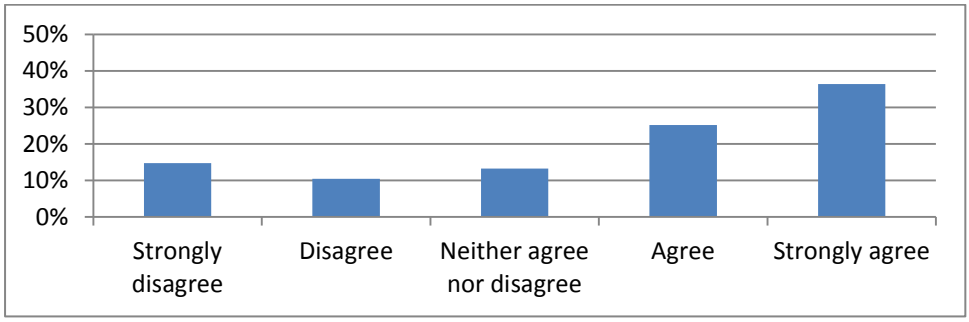


Figure 25: Consultation question 11 - Faversham/Whitstable/Herne Bay respondents

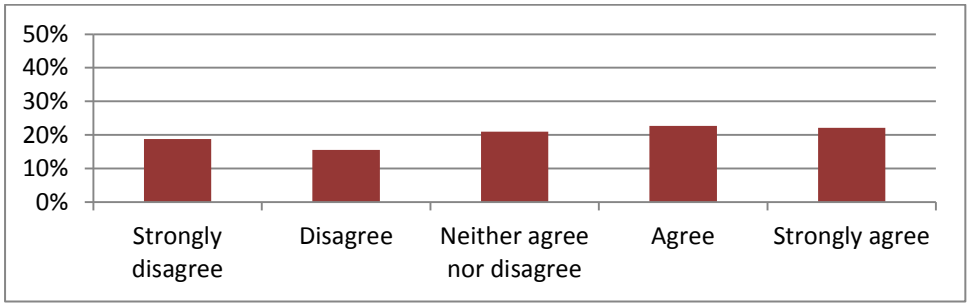


Figure 26: Consultation question 11 - Deal/Sandwich respondents

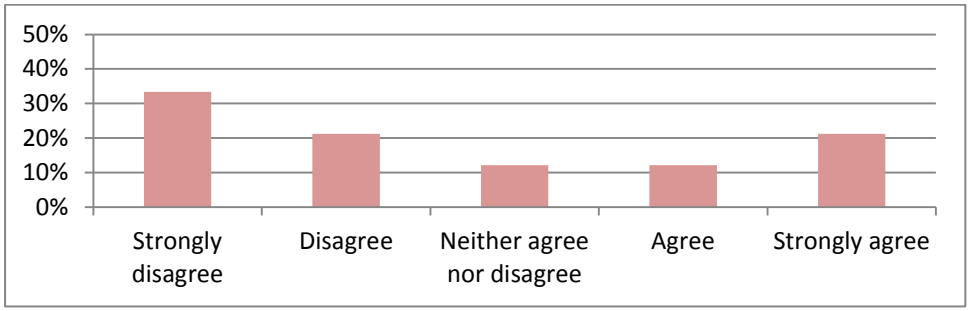


Figure 27: Consultation question 11 - Areas with lower response rates possibly because areas less affected by changes

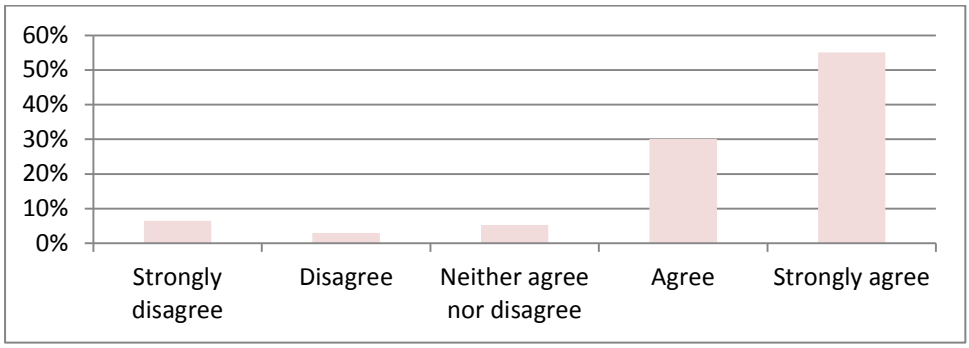


Figure 28: Consultation question 11 - Respondents with disabilities, long-term conditions or are carers

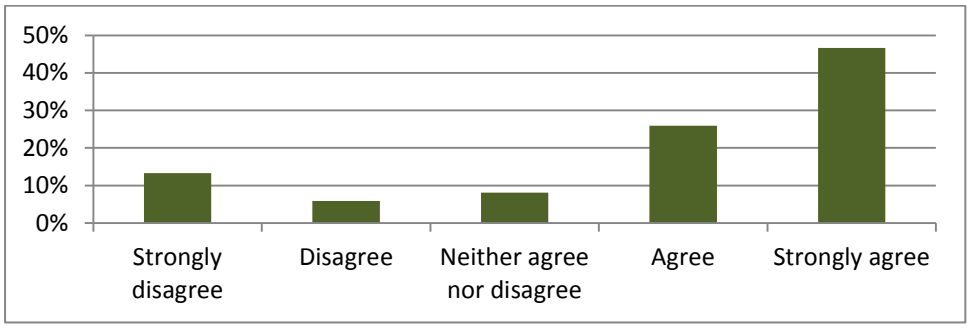
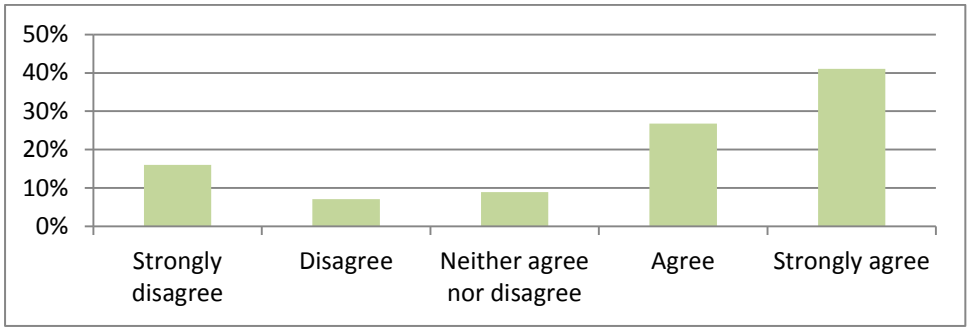


Figure 29: Consultation question 11 - Age 75+ respondents



Q12 Further comments on the approach of expanding the one-stop outpatient clinic

There were fewer comments written in this section, but those that were raised concerns about how well the one-stop clinic would work. People also wrote their final comments in this section regarding the whole consultation - often repeating comments they had already made. See Table 1 categorising a sample of survey comments.

Given this tendency to repeat the same points in several places on their survey, a broad summary of the survey comments to all the open-ended questions (questions 6-9 and question12) is given below.

Compared to the ticked box questions in the survey where the majority view was in support of the consultation questions, the open questions gave people the opportunity to raise their concerns, the comments written on the paper survey returns give the impression of more deep-seated and widespread concerns about the proposed changes (see Table 1, p 25). Less than 20% of the comments were positive about the changes, nearly a half voiced doubts or

concerns about how well the proposed changes would work, and just over a third thought the changes would make things worse. Comments in favour were predominantly about the improved facilities that would come from consolidation on to six sites, the choice of Estuary View, and expanding the one-stop clinic approach.

Negative comments were from people who thought that the outpatient service already worked very well, that service consolidation would lead to a worse service, and it would be more difficult to get to. Concerns were raised about a whole variety of aspects of the proposals for change, and these included: access (sometimes to a specific service), service quality (such as delays, waiting times and doubts about the co-ordination required to make one-stop service work), use of NHS resources, and how there were better things that could have been done with the money. There were also some criticism of the consultation process and whether it would have any effect on decisions being made.

Key points from the survey

Following widespread publicity and a large number of consultation documents being handed out, the response of 478 completed surveys was in line with expectations and commensurate with other similar consultations. This response rates gives an indication that there was a considerable level of public interest and engagement with the process. Although there was majority support for the proposed changes; it should also be noted that some opposition to the consultation proposals and process was voiced, particularly in written comments in the survey.

The survey had a geographically uneven response, with most people taking part coming from NHS Canterbury & Coastal CCG and NHS South Kent Coast CCG, and within NHS Canterbury & Coastal CCG the strongest response came from Faversham, Whitstable and Herne Bay residents.

A majority of people supported all seven key consultation questions relating to the main principles for improving outpatient services, but for some of these questions there were proportions of people who disagreed. Greatest support was noted for making effective use of NHS resources (Q5), and agreement that access could be improved with longer clinic opening hours (Q2). There was also good support for making greater use of new technology (Q10).

However, respondents from Deal/Sandwich area were less likely to see the benefits of longer opening hours and new technology. People responding to the survey were more ambivalent about the importance of improving the patient experience/ buildings/ environment (Q4). The most contentious part of the survey was that access would be improved by increasing the number of people within a 20-minute drive of a fully equipped outpatient centre (Q3). There was also some scepticism that access would be improved by providing a greater range of services from each location (Q1), and expanding the one-stop approach (Q11). The greatest opposition on the three most contentious survey questions came from people living in Deal/Sandwich and Faversham/Whitstable/Herne Bay.

As already mentioned, in contrast to the levels of agreement on the tick-box questions recording levels of agreement or disagreement, the comments on the survey forms were far more negative, and raised many concerns and doubts about the proposals effect on aspects of future outpatient service.

These findings are based on a reasonably large number of responses representing a cross-section of the public, with the highest levels of response from those living in the most affected areas. Overall, the survey showed there was support for the proposed changes. Alongside this level of agreement, there were also a proportion of respondents (up to a half of Deal/Sandwich responses) who disagreed with some aspects of the consultation and through the free text comments voiced a wide range of concerns.

Table 1: Survey comments by subject matter and whether supportive of change

Categories	Sub-categories	Total	In favour	Against	Have concerns
Access	Journey: distance, time, cost	31			
	Ease of using public transport	34			
	Ease of using car	2			
	For specific people (older, without car, etc)	18			
	For a specific service, eg Margate, fracture clinic	16			
	For people in Deal/Sandwich area	8			
	For people in Herne Bay/Faversham area	15			
	For other specific areas, eg Lydd	7			
	Other access	8			
Facilities	Proposed changes in services	101			
	Parking space and charges	12			
	Clinic capacity, seating	6			
	Other developments suggested	4			
	Other facilities	7			
Quality of service	Communication and co-ordination, incl booking and test results	19			
	Delays and waiting times	23			
	One-stop clinic	22			
	Patient choice	1			
	Patient rather than provider-orientated	5			
	Overall service	5			
	Other service quality	2			
Use of NHS resources	Efficiency	12			
	Use of non-NHS premises	7			
	Other resource use	11			
Miscellaneous	Views on the consultation	13			
	Views on change being needed	21			
	Views on developing other facilities	7			
	Views on better ways of working	11			
	Other miscellaneous	2			
Total comments coded (from 123 paper responses)		430			

Key: The darker the shading the more comments were made (0-4 no shading, 5-9, 10-24, 25+)

Analysis of round table questions at consultation meetings

Questions from the survey were also asked at round table discussions, held as part of the public consultation meetings. These round table discussions took place immediately after the main presentation and enabled people to break out in to smaller groups and reflect on the proposals in more depth. Each small group was facilitated by someone with extensive knowledge of the consultation (e.g., Trust employee, KMCS representative) who was able to answer specific queries about the proposals on a one-to-one basis.

Questions from the consultation survey were asked and completed by the facilitator after the initial discussions. This process generated survey response data, alongside more in-depth comments that were used in the qualitative analysis. The responses to the survey questions were taken to represent the overall level of agreement and/or disagreement around the table; hence, this score does not reflect individual opinions, but instead the overall impressions of those at each table.

At five of the consultation meetings (Deal and both events in Herne Bay & Faversham), the audience was deemed too large to effectively run these round table discussions. At the consultation in Hythe, the audience was relatively small: hence, these discussions were incorporated in to the Q & A session. Therefore, only data collected from six of the consultation events was used in this analysis.

As with the survey questions, responses were scored from 1 = ‘seriously disagree’ to 5 = ‘strongly agree’- higher scores were indicative of stronger levels of agreement with the statement. Seven questions were asked, the results of which are detailed below in Table 2.

Table 2. Descriptive statistics for survey data collected at table discussions

Question	Number of group responses	Min	Max	Mean
1. Access to OP services will improve by offering greater range of clinical services?	22	2	5	4.25
2. Access will be improved by extending the opening times of the OP clinics?	22	4	5	4.50
3. Access to services can improve by increasing the number of people within a 20 minute drive?	17	2	5	3.65
4. The Trust can improve quality of patients experience by improving quality of buildings?	17	3	5	4.12
5. NHS has to make effective use of all resources; do people recognise and support this?	19	2	5	4.42
6. How do people feel about new technology being used in NHS?	17	3	5	4.32
7. How do people feel about the one-stop clinics?	17	4	5	4.82

From looking at the mean values in Table 2, the numbers suggest that people in the round table discussions were in moderate to strong agreement with most of the proposals put forward. This level of overall level of agreement was similar to overall levels reported in the individual survey findings, when comparing the same geographical areas (note: table discussions were not held at Deal, Herne Bay and Faversham).

The main difference from the individual survey responses was the greater support for one-stop clinics after the table discussions. This could be a consequence of people at the table discussions having the opportunity to discuss in person the proposals; hence, any concerns or queries about the one-stop model could be addressed.

Qualitative analysis

Introduction

To gain an in depth understanding of the public reaction to the proposals set out in the consultation, responses from a number of forums were analysed utilising a reliable and valid qualitative analysis method termed The Framework Method (Ritchie & Spencer, 2011). This method involves the identification of commonalities and differences in the qualitative data, thereby developing themes and subthemes from which broad conclusions can be drawn.

Data used in this analysis was generated by comments made at the 12 public consultation meetings and subsequent table discussions (6 of the 12 events), four focus groups run by the CHSS, nine local meetings attended by the Trust and KMCS, 65 letters and emails, and comments provided in the survey (both paper and online). Data from the four focus groups was recorded and transcribed verbatim. In the consultation events and table discussions, written notes were made at the time by representatives of KMCS and subsequently forwarded to CHSS.

The principle aim of running focus groups was to gain the opinions of those who may be less likely to attend a consultation event or complete the survey. For example, individuals with learning disabilities, chronic health problems, and individuals who do not have English as a first language. With these criteria in mind, KMCS approached 31 organisations and 87 Patient Participation Groups (PPGs) across the South Kent Coast, Thanet, Canterbury & Coastal, and Ashford to offer the opportunity of participating in a focus group. Subsequently CHSS ran four focus groups with Mencap in Deal, Dover Disability Group, an ESOL class in Dover, and the mental health support group Thanet Speakup CIC. These focus groups typically ran for 1 hour and followed a guide developed by CHSS and KMCS (see appendix B).

KMCS and the Trust also attended eight meetings with Locality PPGs in Dover and Shepway. These included the Stoma Support Group based at Buckland Hospital, Epilepsy Here in Canterbury, Faversham and St Peter's Surgery PPGs. Members of the Trust also

attended the Dover Adult Strategic Partnership (DASP) meeting to discuss the Outpatient consultation and plans for the new Dover Hospital and attended the Thanet Health Overview and Scrutiny Committee.

The data generated from these sources is presented in four parts, reflecting the main areas covered by the consultation proposals: first the principle measures proposed by the Trust for improving outpatient services, second the reduction of sites, third choosing the North Kent site, and fourth the future improvements using new technology and the one-stop approach. Within each section, the responses are broken down in themes and subthemes to reflect the main topics that emerged from the responses gathered.

Part One: Proposals to improve outpatient services.

Views on a number of proposed improvements to Outpatient services in east Kent were sought, as set out in the consultation documents. These improvements were:

1) To increase the range of services at each of the six sites;
2) To extend opening hours;
3) More patients receiving outpatient care within a 20-minute drive;
4) To modernise facilities.

Improvement One: Increasing range of services

The first improvement focused on increasing the range of clinical Outpatient services that, going forward, would be available from each of the six clinics. Responses to this question drew some positive feedback, focusing on the benefit of visiting fewer sites for treatment and the subsequent impact this would have on travel and time spent in clinics. Respondents also recognised spreading Outpatient services across numerous sites may not be the best utilisation of resources, and that consolidation of services and equipment had the potential to improve patient care.

Alongside these positive views about expanded services, cautionary views were also expressed. While recognising the benefit, it was also noted that although services would increase at some sites, the extent to which people would benefit may not be universal. For example, people cited the need to consider outlying villages and the impact of having to travel further, despite a broader range of services being on offer. When discussing this

limitation, a number of respondents referred to those living in the Romney Marsh area as being particularly disadvantaged.

"Agree with the principal – need to recognise how it is delivered to areas like Romney Marsh." (Folkestone: Table discussions)

"People on the Marshes, Deal are slightly cut off but will have Dover." (Margate: Table discussions)

Improvement Two: Extending opening times

The second improvement focused on extending the opening times of Outpatient clinics. Positive feedback for this improvement was noted in the table discussions at the consultation events and at the focus groups. The prevailing theme throughout this positive feedback focused on the increase in choice and flexibility that extending hours would provide for patients, especially those in employment and education. The quotes below highlight this feeling.

"Yes, it is an improvement, it offers greater flexibility. It will give patients more "choice" (Dover: Table discussions)

"This will help support patients who work, better to offer greater flexibility". (Whitstable: Table discussions)

"If you're working and you need to see a doctor you can either have the choice of the morning before you start work or after you finished work. Yeah, that's brilliant". (Dover: Focus group)

In addition, people also highlighted that extending opening times will utilise staff and facilities to the full and potentially mitigate car-parking problems, as the demand on parking will be spread over a longer period.

Alongside these positive comments, a number of concerns were also raised covering three broad areas: staffing and logistics of a longer working day, public transport coverage for the extended hours, and issues around implementation of the extended service.

i) Staffing

Of these three concerns, the most often cited were concerns about staff working hours. For example, how this extension of working hours would be viewed by Consultants.

"What is Consultant perception of these changes" (Whitstable: Table discussions)

"Have the consultants agreed to it though?" (Dover: Focus group)

More broadly, concerns were also raised about the logistics of implementing a longer working day for all staff and whether sufficient medical staff could be provided for the additional opening hours.

"How will it actually work when you increase working hours – what about staff and cover?" (Ashford: Consultation Q & A)

"What are the staff implications? It seems that you may need to increase your staffing levels. There are implications for staff to deliver this, often services have a bottle neck due to lack of staff – will there be an increase in staff to do this?" (Canterbury: Consultation Q & A)

ii) Transport

The second theme to emerge was focused on more practical concerns about whether public transport would be available to enable patients to make full use of the extended hours. For example, the issue around bus passes not being valid until a certain time was highlighted by people in the consultation events and in the focus groups.

"Some patients coming to Outpatient services who need to use bus pass, who can't get on the bus before 9.00am so the extended hours will not work for them. You need to think about this when you book their appointments". (Dover: Consultation Q & A)

In addition, concerns were raised about weekend appointments as reduced bus services often run at these times, and consequently may not accommodate travel needs to and from outpatient clinics.

"Access to public transport might be an issue in the evenings and on Saturday's." (Canterbury: Table discussion)

iii) Implementation

This theme encompassed practical suggestions to make the proposed extension of services work well. For example, the need to communicate with patients to ensure they know about the extended hours was emphasised. A number of responses cited the extension of hours in GP surgeries as an example of how anticipated demand for services did not materialise.

"They tried extended hours at the GP surgeries but they were too small to continue. They offered late night appointments but there was no demand for the increase, or perhaps people did not know it was available. You need to make an effort ensure receptionists inform people." (Dover: Consultation Q & A)

There was also a sense from the focus groups and the consultation events that people would like to see opening times extended even further (e.g., later in the evening, Saturday afternoons & Sunday) to offer increased choice, but also in recognition of the need for more appointments if the number of patients at each site is to increase.

"I don't think an hour in like in the morning and an hour evening is going to make much of a difference. So if they opened it like at the same time in the morning and two hours of an evening or two hours earlier in a morning then you've got the two hours rather than just the one either side. And Saturday afternoons / Sundays." (Margate: Focus group)

Improvement Three: More patients receiving outpatient care within a 20-minute drive of a fully equipped Outpatient clinic.

i) Concerns and Worries

Responses to this improvement were heavily focused on the accuracy of the 20-minute drive time set as a parameter in the consultation document. This query was raised in consultation

events across all 10 of the locations visited, in letters and emails written by members of the public, and by participants in a number of the focus groups. Within this complaint, two main themes emerged from the responses.

First, there was a general unhappiness with using the 20-minute criteria – people questioned why such a seemingly arbitrary number had been used to describe one of the key improvements.

"Your proposal makes sense but wish you hadn't put in 20 minutes travel time as this is a red herring and will make problems for you. My experience of going to Tenterden tells me it takes much longer, likewise Romney Marsh." (Ashford: Consultation Q & A)

"…… they've really upset people or antagonised people by saying everybody within the whole patch can get to a hospital within 20 minutes." (Dover: Focus Group)

Second, people questioned the use of travel times based on car journeys as opposed to using public transport journey times. It was widely acknowledged by people across all forums that if public transport journey times were taken into consideration, then a reduced proportion of people would have access to outpatient care within 20-miuntes. Although the documentation clearly states 'drive' in the description, the overriding feeling was that by using this term the consultation document did not accurately reflect the reality of how many people travel to outpatient appointments.

"Transport is very important for Health. It's totally dishonest to talk about travel times by car, when only what % of the population haven't got cars." (Folkestone: Consultation Q & A)

".....Lot of the slides based in 20 minutes travel time in car what about patients on public transport?" (Herne Bay: Consultation Q & A)

"Also '20 minutes by car' is a distressing statement because so many people have to come by public transport." (Margate: Consultation Q & A)

Responses also indicated concerns that the 20-minute travel time did not account for parking once at the hospital and additional time it might take the elderly or people with disabilities to access outpatient services. In addition, concerns were raised that even if travelling by car, the 20-minute drive time is unrealistic when taking in to account how driving conditions can change according to time of day. For example:

".....I was going to say that because it depends what time of day. If you've got an appointment at six o'clock it's rush hour so it's going to be longer than 20 minutes." (Margate: Focus Group)

ii) Positive feedback

Despite the overall negativity concerning the use of the 20-miute drive criteria, some positive feelings were expressed. For example, people recognised that travelling to a fully equipped clinic could potentially decrease overall journey times due to utilisation of the one–stop model. If patients were able to attend numerous appointments in a single session, then this would negate the need for further journeys.

"Yes, each of the sites will have more facilities so it is recognised that it will improve access, especially with One Stop Clinics." (Whitstable: Table discussions)

"Less travelling time for patients experiencing 5 different appointments across 3 sites, so my observation is that it is not about the "20" min travel time but in total that there will be less travel." (Dover: Consultation Q & A)

iii) NHS investment in transport

At the consultation events the Trust outlined plans to invest £455,000 in improving public transport services for North Kent, Dover, Sandwich, and Deal. During the consultation events, subsequent table discussions, and to a lesser extent in letters received from the public, concerns were raised as to whether spending NHS funds on transport infrastructure was a sensible use of money. Responses questioning the spending broadly fitted in to two main areas of concern. First, people expressed doubt about how sustainable any changes to services would be once the investment ended.

"Will services you are proposing be viable? They wouldn't be put on by public transport provider, what happens after NHS funding runs out." (Folkestone: Consultation Q & A)

"You are planning to spend £500,000 on transport over what period and for how long?.....After the 3-4years we will be back to square 1?" (Faversham: Consultation Q & A)

Second, responses in the most part from consultation events in Faversham and Herne Bay questioned whether the funds allocated for transport improvements should instead be invested in modernising and maintaining existing facilities.

"I don't want to see this Trust wasting money on buses, I want it spent on clinical services, x-ray facilities…..Don't pay for a bus, pay for x-ray!" (Faversham: Consultation Q & A)

Improvement 4: Modernising facilities and investing in the buildings and equipment, to make the environment more welcoming.

The proposal to invest in buildings and equipment received positive responses in both consultation events and focus groups. Overall, responses indicated that people did see a need for this investment, with a number of different areas for investment emerging as key themes. First, responses gathered from a number of the table discussions and focus groups supported an investment specifically in waiting areas, with mention of improving the quality of seating areas (e.g., quality of chairs provided, number of chairs), improving access for wheelchair users and signage. Second, the notion of investing in technology with the recognition that this has the potential to improve patient care was also welcomed. When asked what *other* improvements the Trust could make with the investment, three main themes emerged from the responses: communication, parking, and staff.

The most frequently cited improvement broadly focused on communication between patients and clinicians, with a number of specific requests for more information being given when a clinic is running late.

"I would have really appreciated being told clinic was running late – we weren't allowed to eat or drink in that area. An electronic display with information about the time running would help this". (Ashford: Table discussion)

Parking was mentioned in a selection of table discussions, consultation events, and the focus group in Deal. In summary, people expressed a wish for more parking and the location of disabled parking at William Harvey Hospital to be moved.

Finally, regarding staff, various improvements were offered, mainly from the table discussions. The suggestions focused on increasing staff numbers, staff training, and enhancing the staff-patient relationships (e.g., information about staff in the clinic).

If you're going to increase the size (of Outpatients), you've got to increase the staff." (Dover: Focus group)

In general the proposal to invest was positively received; although some people questioned the rational for investing money in this way. Responses collected in both focus groups and table discussions highlighted the feeling that the quality of care received is often paramount to the patient- not necessarily the quality of the building they visit, and maybe in light of this, investment should be focused on staff and patient services instead.

"Rather spend funding on staff and equipment than on buildings and patient facilities." (Canterbury: Table discussions)

Part Two: Reduction of sites

The second part of the analysis focuses on the proposal to reduce the number of sites that deliver outpatient services from 15 to 6, whilst making these 6 sites bigger and increasing the range of services available at each of the 6 sites.

Agreement with the proposal

Responses gathered from a number of the table discussions, focus groups and survey comments indicated agreement with this proposal. For example, comments gathered as part of the survey included:

"It's a good idea to offer more services in a single location and so the reductions in sites make sense." (Survey comment)

"Excellent - bearing in mind the advantages and an increase in the number of 'one stop' clinics." (Survey comment)

More specifically, people also noted the need for the NHS to rationalise its resources and reduce the number of sites. For example, quotes illustrating this notion include:

"It makes sense to have fuller, better facilities in fewer places in order to maximise resources, both clinical and financial." (Survey comment)

"Originally read plans thought it was about cuts, but if more services are available and equitable (i.e. each site offer same range) then that's better." (Margate: Table discussions)

"Agree that the savings made by reducing the number of sites as it means re-investing in the local health care." (Whitstable: Consultation Q & A)

A number of responses gathered from the focus groups, table discussions and survey comments indicated a positive, but cautious approach to the reduction in sites. Alongside these comments, views were also expressed regarding how the reduction of sites would affect certain sections of the community- for example, wheelchair users and the elderly. There was also concern about how public transport services would accommodate the needs of those who would need to travel further.

"Good idea, but would need a much improved public transport service, with late running times after last appointments." (Survey comment)

Disagreement with the proposal

Although positive comments were made about the proposal to reduce sites offering outpatient services, a higher volume of critical comments were recorded. Concerns covering various themes were expressed across all 12 consultation events, in the focus groups, in letters and emails written by members of the public, and finally in comments collected as part of the survey. A number of comments reflected a general unhappiness about the reduction of sites

which came across strongly in the first Herne Bay consultation event and in focus groups run in Canterbury, Deal, and Dover. For example:

"Well I can't see how they can say to us that the patients have more say, more choice and yet we're being reduced again in choice!" (Dover: Focus group)

"Why six sites only, would make more people happy with greater spread of sites?" (Whitstable: Table discussions)

Specific concerns broadly fell in to two main topics: public transport provision and capacity, both of which are discussed below.

Public transport concerns

A high number of respondents expressed worry about how public transport provision would facilitate visiting a site that potentially could involve a longer journey. These concerns were expressed in focus groups, consultation meetings and letters from the public. Responses focused on the length of bus journeys, the frequency of services to and from the sites, distance from the bus stop to the site, and the routes buses take.

"Needs improvement (transport), a lot of areas still disadvantaged. It's not just about bus transport. If necessary it's a long march from bus stop in town. After your appointment, you have to wait for buses - Has thought has been given to a direct route?" (Dover: Table discussion)

"Dover as a replacement for Deal is utterly unrealistic. ..... public transport is expensively inconvenient and often impossible." (Deal: Letter 14)

"Transport – Number 10 bus route is biggest problem – need one that goes straight down the motorway, current route makes people feel ill." (Hythe: Consultation Q & A)

In addition to these general concerns about transport, three sub themes emerged within this topic that warrant a separate examination due to the extent of the comments offered.

i) Access issues in South Kent Coast

A number of concerns focused specifically on the impact to those living in the South Kent Coast (SKC) area. These concerns were again expressed at consultation events in Ashford, Folkestone, Hythe, in letters/email sent to the Trust and in focus groups held in Margate and Shepway. Respondents called for further consideration of the needs of patients in Hythe and Romney March area. In addition, concerns were also raised by local MP Damian Collins in a letter to the Chief Executive, and in the DASP meeting attended by members of EKHUFT. These concerns emphasised the transport challenges and limited access to healthcare that people living in this area are currently experiencing.

"For Lydd, New Romney, Hythe – better public transport would be really beneficial. It takes 40 minutes in a car, and an hour on a bus." (Folkestone: Consultation Q & A)

"Romney Marsh/Lydd has been left out. There are some people who will have problems accessing one of the six sites." (Hythe: Consultation Q & A)

"I am deeply concerned about the impact for us at the town and coast of Lydd and surrounding marsh area. Travel time to and from hospitals, together with lack of public transport..... has to be an important consideration." (Letter: 26)

Comments reflecting these concerns were not only made by people who reside in the SKC, but were also made by people who live outside this area. For example, in the Margate focus group concerns were expressed about how the proposed changes could affect the South Kent Coast area.

ii) Access issues for specific populations

A second concern raised was how the reduction of sites may affect people across all areas who are elderly, disabled, in a wheelchair, and/or without a car. These views were expressed in many of the consultation events across the region (i.e., Deal, Faversham, Folkestone, Herne Bay, and Margate), at focus groups in Canterbury, Margate, and Dover, and via letters/emails received from members of the public.

Responses from Deal were predominantly focused on the impact on an elderly population who no longer drive, and potentially find accessing public transport difficult. The two quotes below summarise the feelings expressed in this area:

"I live in Deal, I am 81 and my wife is of a similar age ... it would be very difficult for us if many of these services were moved to Buckland or elsewhere. I no longer drive - buses would be very difficult and taxis expensive. Hospital /volunteer transport often not available." (Email: 22)

"I would ask the hospital to think about those people in Deal who find hard to travel and ask hospital to think about those people and also ask the CCG to think about that again." (Deal: Consultation Q & A)

Responses from other areas also reflected concerns about the elderly, while also illustrating specific concerns about how the reduction in sites would affect those without access to a car and the cost implications of travelling further for those on lower incomes. Quotes below from Faversham and Canterbury exemplify these feelings:

"We have poor people who are not affluent. If you don't have a bus pass, for example a young mum with 2 children, how are they going to afford it? You need to think about accessing transport." (Faversham: Consultation Q & A)

"I'm not suggesting individual people do not want to improve the system, but looking at what the document says it does show some disadvantages for people relying on public transport." (Canterbury: Focus group)

This type of concern was expressed in the Herne Bay consultation in relation to the proposed sixth site in Whitstable (see Part Three for in-depth analysis). The quote below highlights concerns about the location of this site for people who do not have access to a car.

"What about the 20/25% of people who haven't got a car or can't catch a bus. They will have to travel to Whitstable High Street and then catch another bus up to Estuary View? It will be a long and torturous journey." (Herne Bay: Consultation Q & A)

The focus group in Margate with Speakup CIC – a charity supporting people with mental ill health- also highlighted concerns. In the discussions, it was felt by many in the group that asking people with mental ill health to travel further for services would be detrimental to their health and potentially could increase feelings of anxiety about the visit. Quotes from the group illustrate this:

".....many people (with mental health problems) have difficulty travelling.....for people who find it difficult to get on buses/ public transport for travelling it really does compromise their ability to access services if they can't get something local." (Margate: Focus group)

iii) Impact on patient transport and volunteer driver schemes

Focus groups in Deal and Dover also highlighted concerns about the impact of travelling to sites over a larger area, could have on patient transport and volunteer drivers.

"…..some of the places that people actually live in, they're so short staffed sometimes (volunteer drivers). So it's trying to get people to places is difficult, whereas in Deal it's just up the road from you." (Deal: Focus group)

"And also have they taken into consideration those that are entitled to travel by hospital transport? You're going to have a larger area to pick people up from so if you're picked up first and you're going to go all round the rural back roads, what time are you going to get up to the hospital, what state are you going to be in by the time you get there and what state are you going to be in by the time you get delivered home?" (Dover: Focus group)

Part Three: Choosing the North Kent site: Considering sites in Faversham, Whitstable, Tankerton, and Herne Bay.

This section of the analysis focuses on the location of the sixth Outpatient clinic, proposed to be on the North Kent coast. Responses analysed in this section came from questions raised at

the consultation events, the subsequent table discussions at these events, focus groups run by CHSS and KMCS, and finally letters and emails sent by members of the public.

Criteria used to compare four potential sites

In the focus groups and table discussions people were first asked what they thought about the points the Trust used to compare the sites.

i) Agreement with points used

Comments made in support of the points utilised by the Trust were identified in table discussions held at the Whitstable, Dover and Folkestone consultation events. For example, in two of the Whitstable table discussions people highlighted that the options appraisal had considered all the relevant criteria.

ii) Disagreement with points used

Although support for the points used was noted in some discussions, the majority of comments reflected a number of concerns, voiced at consultation events in Herne Bay (across both events), Faversham (across both events), Whitstable, Canterbury, and Margate. Furthermore, comments made in the table discussions at these events reiterated the issues raised. In addition, focus groups held in Faversham and letters received from residents in Herne Bay also expressed doubts about the criteria used.

Responses from Herne Bay suggested the facilities at QVMH had been incorrectly evaluated. For example, the descriptions of 'car parking on site being limited' and 'the limited availability of X-ray' were highlighted as being incorrect assessments of the current facilities at QVMH. In one letter, the following statement emphasises the dissatisfaction with the parking appraisal:

".....parking at QVMH is already greater and easier to access contrary to what is stated in your consultation document."(Letter 4: Herne Bay)

The quote below summarises the main concerns about the appraisal of facilities at QVMH.

"..... X-ray and ultrasound is classified as limited availability – but it can be used 7 days a week if commissioned, rather than 4 days. Also, the Queen Victoria has a fully equipped operating theatre that can be used for anything. Estuary View does not have an MRI Scanner only the potential for one." (Consultation Q & A: Herne Bay)

In Faversham views expressed in the consultation events and focus groups highlighted that additional parking spaces were available and the appraisal criteria would have benefited from acknowledging this.

"Faversham has twice as many pay and display spaces as Estuary View. If this is based on the options appraisal this is so flawed." (Faversham: Focus Group)

In both Faversham consultation events, concerns were also expressed that facilities currently available in Faversham are not being utilised effectively and, although currently four Outpatient services are available, people felt services could be increased using current facilities. The example was given of Newton Place Surgery, which was not included in the appraisal, but was highlighted as having available clinic rooms.

At the Whitstable consultation event a number of concerns were expressed regarding the appraisal criteria of Whitstable and Tankerton Hospital (W&T). For example, responses expressed dissatisfaction in describing W & T as non-compliant with DDA guidelines and, in doing so, did not reflect recent changes to parking and waiting areas. Furthermore, it was felt that improvements in general maintenance and upgrading to the building had not been acknowledged. Concerns were also raised that distinctions between services provided by EKHUFT and Kent Community Health NHS Trust (KCHT) were not made. Consequently, people viewed this as a confusing and inaccurate assessment of the services provided by the W&T. The following two quotes from the Whitstable consultation event illustrate these concerns:

"...Whitstable and Tankerton is not showing as having Physio/OT/Speech and Language therapy, but these are provided by KCHT not by EKHUFT." (Whitstable: Consultation Q & A)

"The table which is a summary of the option appraisal isn't correct. You say Whitstable & Tankerton is non-compliant with DDA, but new disabled bays make it more compliant." (Whitstable: Consultation Q & A)

Other points the options appraisal should have considered

The consultation also asked what other points the options appraisal should have considered. In analysing these responses, three main topics emerged- transport links and access to the sixth site, demographics in the local area of the sixth site, and ownership of the sixth site options.

i) Transport links and Access

The suggestion to include transport and ease of access in the options appraisal came from letters, focus groups and table discussions in Canterbury, Dover, Faversham, Herne Bay, and Margate.

For example, Herne Bay residents expressed concern the appraisal did not adequately consider the needs of those who would access Estuary View by public transport.

"Estuary View is not at this time on a bus route and many older people do not drive so the most vulnerable will be the hardest hit."(Herne Bay: Letter 6)

"Takes little or no consideration of hundreds who fall in to the categories of elderly, infirm, immobile, confused or without use of public transport." (Herne Bay: Letter 25)

A view reiterated by individuals in table discussions in Margate, Dover, & Canterbury and in the Q & A at the Faversham consultation event. For example:

"Ensuring good public transport access important (enhanced transport services).
Need to look at transport access to sixth site." (Dover: Table discussions)

"*Ease of accessibility is key for patients, this is the key criteria. Problem with public transport only, very difficult for people from Herne Bay and Faversham." (Margate: Table discussions)*

ii) Demographics

A second consideration raised was in relation to the demographics of the areas being considered for the sixth site. Responses indicated the need for the option appraisal to reflect information about projected population growth and specific demographics (e.g., age of local population). This suggestion was particularly strong in responses from Herne Bay via the

consultation events and letters. From these sources, two concerns in particular were highlighted - the notion that the population of Herne Bay is expected to increase compared to that of Whitstable and the population of Herne Bay includes a higher proportion of elderly and frail people. These concerns are illustrated in the following quotes taken from the consultation Q & A in Herne Bay and letters from members of the public:

"Herne Bay has highest number of people and highest levels of deprivation, highest rising population, you are putting services in an area which have less need. You should put it in centre of need, by choosing Estuary View you are not doing it." (Herne Bay: Consultation Q & A)

"One very important point that has totally been left out of this plan is the future development of the North Kent coastal area..... very little development in Whitstable but massive increase in Herne bay." (Herne Bay: Letter 5)

The need to consider demographics of an area was also highlighted in relation to Outpatient service provision in Faversham and Ashford.

iii) Ownership of estate

A final minor theme emerged in Canterbury at the table discussions, from the Herne Bay consultation event and letters written by residents. Responses called for the ownership of Estuary View and QVMH to be included as a comparator in the options appraisal. People expressed concern that Estuary View is a privately owned company and not owned by the NHS. Quotes from the Herne Bay consultation event and, from one of the letters sent to the Trust, illustrate this point:

"Estuary view is a private business and all profits and financial gain will be to the benefit of the owners, whereas any monies earned by QVMH will surely be reinvested within the NHS." (Herne Bay: Letter 3)

"Queen Vic – NHS doesn't own land but don't own Estuary View either. Land at Queen Vic bequeathed to people of Herne Bay by Lord Dence." (Herne Bay: Consultation)

Table discussions in Canterbury also touched upon this topic:

"There is an issue of ownership of buildings and services. I am not happy about a non- NHS owned hospital being used (Estuary View). It's a major threat to those of us who want to preserve a public NHS." (Canterbury: Table discussions)

Finally, a number of single responses indicated a selection of other items they would like to see being considered as part of the options appraisal. These included disabled facilities, baby changing, toilet facilities, and current staffing levels.

In consideration of the feedback received from the public, the Trust has offered to re run the options appraisal regarding the choice of the sixth site on the north Kent coast. This will be completed in collaboration with NHS Canterbury and Coastal CCG and members of the Health Overview and Scrutiny Committee to ensure the process is transparent. Up to date information from NHS property services will be used in the new appraisal. Furthermore, the Trust has also confirmed demographic criteria and access to the sites via public transport will be included in the criteria.

Site specific feedback

The concluding questions in this part of the consultation asked people to identify their thoughts on the advantages and disadvantages of each site. Most of the subsequent responses (advantages and disadvantages) focused on Estuary View specifically; hence, the analysis below reflects this.

Advantages of Whitstable, Estuary View as sixth site

Support was expressed for the sixth site being located at Estuary View in table discussions at Ashford, Dover, Canterbury, Folkestone, Margate, and Whitstable. Specific reasons for this support highlighted the high standard of the facilities and resources available at the site, the ability for the site to host one-stop shop clinics, and the impression that better diagnostics would be available at this site.

"Everybody recognised need to have facilities/space to deliver improvements. Agree Estuary View on scoring looks that it offers more and appears best placed. When looking at preferred options it is designed to meet the modern ways of working." (Folkestone: Table discussion)

"Estuary View seems very well organised, and has good facilities." (Canterbury: Table discussion)

Disadvantages of Whitstable, Estuary View as sixth site

Alongside support for Estuary View as the sixth site, concerns were also raised from a number of sources. These concerns could be broadly categorised under four themes: capacity concerns at Estuary View, transport links and access to Estuary View, and parking capacity at the site.

i) Capacity at Estuary View

Concerns as to whether the Estuary View site would be able to accommodate increased numbers of patients using Outpatient services were raised in both of the Herne Bay consultation events, in letters written by Herne Bay residents, and in one of the table discussions at Whitstable. Expressions of concern were made as to whether Estuary View could accommodate the whole range of Outpatient services in the space available.

"You're going to increase 2 services and bring in 20 services at Estuary View don't think they can cope with those numbers." (Herne Bay: Consultation Q & A)

"Estuary View faces potentially disastrous prospect of being totally overwhelmed or at best providing an inferior service." (Herne Bay: Letter 25)

"20 new clinics at Estuary View, what guarantees have you they will cope?" (Herne Bay: Consultation Q & A)

ii) Transport links & access to Estuary View

Public transport provision to Estuary View was also highlighted as a potential barrier. The lack of a regular, direct bus service was cited in letters from Herne Bay residents. There was also scepticism about how effective, in the long-term, investment in local bus services would be.

"It might sound like a good investment (triangle route) but I have to tell you that bus companies tend to honour such arrangements in the short term only to renege on the deal later because mostly elderly passengers with bus passes use (the service)." (Herne Bay: Letter 4)

In conjunction with these apprehensions, people also highlighted the belief that Estuary View was a difficult place to access by foot from the bus stop, with specific concerns expressed for elderly and disabled service users. These concerns are reflected in the example responses below:

"The group expressed concern that Estuary View is difficult to access on foot or by bus." (Canterbury: Table discussion)

"The comment that it is a 5-10 minute walk from the bus stop is insulting to those who are disabled and or may need a pram/wheelchair."(Herne Bay: Letter 8)

iii) Parking at Estuary View

The final concern noted mainly from the consultation events in Herne Bay, but also to a lesser extent in the table discussions at Dover and focus group in Faversham, was parking capacity at Estuary View. Questions were raised as to whether, with an increased number of patients using Outpatient services at this site, the current car park would be sufficient.

"If treatment is to be condensed in EV what are the provisions for parking. It will need a huge car park."(Email 38)

"Patients cannot get disabled people on and off the buses and there is not enough parking? : When the Car park in Herne Bay is full you can park in street, at Estuary View you have to park on a private estate across a busy road." (Herne Bay: Consultation Q & A)

A minor sub theme that emerged as part of discussions on the sixth site location was the question of having a seventh site. The location of where this site should be was inconsistent, but this suggestion was made my people in Herne Bay and Faversham. In addition a minority questioned the inclusion of Faversham in the consultation appraisal options because of its proximity to Swale- by including this site it was felt QMVH suffered in the appraisal due to the 20-minute driving criteria.

It should also be noted that a number of people felt reluctant to comment on the choice of the sixth site as they felt the changes would not affect them directly. Such reflections were noted

at table discussions and focus groups in Ashford, Canterbury, Dover, Folkestone, and Margate.

"If you're going to change something in the Whitstable and Herne Bay area, they're the people you consult!" (Dover: Focus group)

Part Four: Future Improvements

The fourth and final part of the analysis focuses on future improvements the Trust would like to make. Specifically the Trust would like to make better use of new technology to allow clinicians to monitor patients' health in their own home and utilise Telemedicine that could improve access to healthcare by using remote consultations between health professionals.

Positive feedback about using this technology

Positive feedback was received about using this type of technology. Some responses indicated they either had benefited from this type of technology before or would be willing to use in the future. As for why people thought this to be beneficial, reduction in travel, increasing patient choice and relieving some of the pressure on outpatient services were all cited.

In addition, a number of people agreed in principle with the idea of using this type of technology, but highlighted certain caveats to using it. For example, it was felt that maintaining patient choice and keeping a face-to-face option available for some people would be crucial (i.e., those who feel less comfortable about using technology, or speak English as a second language).

"Could be used for /instead of follow-up appointments may be. As long as patients have a choice so they can be seen if really wanted to be seen." (Canterbury: Table discussion)

People also emphasised the need for technology and supporting systems to be piloted to ensure when rolled out to the wider community it works as expected.

Concerns about using this technology

Some concerns were also raised about using this type of technology. People preferring face-to-face consultations, fears about using this type of technology and how some elderly people would adapt to it and finally practical concerns about the implementations, were all highlighted as potential barriers for usage.

"Needs joined up thinking to make it work GP's need to be quite organised to schedule in time on telemedicine. Have to do 2 or 3 way booking (conference call)." (Folkestone: Table discussion)

Increasing the One-stop approach

The Trust would also like to develop the 'one-stop' approach being used by a few services. This will mean that on the same day of the patient's first appointment, they will also have all relevant diagnostic tests (e.g., X-rays, blood tests) performed, a treatment package proposed based on these tests and a convenient date for treatment or operation will be arranged.

Positive feedback about the approach

A positive response to this idea was noted at a number of Consultation events and focus groups.

"The One Stop Shop proposal is one of the best parts of this. Is it working elsewhere?" (Canterbury: Consultation Q & A)

"As an aspiration it sounds good – almost too good to be true – but I'd like to see it happen." (Hythe: Consultation Q & A)

Alongside these general comments of support, people highlighted specific reasons why they thought this approach could be a positive introduction to Outpatient services. First, it was noted that having all diagnostic tests and consultant appointments completed in one day would reduce anxiety. Second, having all appointments in a single day would reduce the amount of overall travel and time spent at Outpatients.

"When I have gone for a doctor's appointment at the hospital, I sometimes then don't get results from my tests or a letter to my doctor. This will be an advantage of the One Stop; it won't be like this and will know results on the same day." (Ashford: Table discussion)

"One stop is good idea, rather than take lots of time off, regardless of where the sixth site is." (Whitstable: Table discussion)

Considerations in regard to One-stop

Alongside these positive comments, a number of caveats were also highlighted. First, as with telemedicine, the need to run a pilot beforehand was emphasised and maintaining a choice to opt-out if patients desire. The greatest number of comments was generated in response to practical concerns about how the one-stop model would be implemented. Specific concerns focused on scheduling of appointments, length of time spent at Outpatients, and capacity at sites. Furthermore, overall concerns were expressed in regards to how realistic an aim is it to expect all the different services to coordinate effectively and how sustainable the one-stop approach will be. The selection of quotes below illustrates these concerns.

"But what worries me is that we're talking about you going to see your consultant in this one-stop system but there are other consultants, all of whom need access to the MRI, to the blood testing – the phlebotomists and what-have-you – so all of a sudden there's going to be a rush of people. So your appointment was for ten o'clock in the morning- you could still be there at three o'clock in the afternoon in this one-stop…" (Dover: Focus group)

"I am worried about the assumption that the One Stop will work? I'm concerned that you will need to open at 7.30am for people to access the service and may still be sitting there at 9.30pm, surely it is much better to do numerous visits and not waste resources." (Herne Bay: Consultation Q & A)

"While theoretically this is laudable (one-stop), in an overstretched demand for services we are sure that practically this is an impossibility." (Herne Bay: Letter 3)

"We cannot believe that specialists' investigations will be reported in time for same day service." (Deal: Letter 27)

Other reservations about the one–stop approach focused on the impact of parking and travel. Concerns focused on the potential increase in cost and an increase in the pressure on parking spaces if required to be on site for longer.

"Will the one stop shop lead to more people being at the hospital for longer with increased parking costs?" (Broadstairs: Focus group)

"My concern is adding to the pressure on car parking/ spaces." (Folkestone: Consultation Q & A)

The impact on the volunteer driver services was also raised as a concern:

"If you've got to rely on volunteer transport no way they're going to wait for two hours." (Dover: Focus group)

Finally, effective communication between different groups of staff and keeping patients informed was also seen as integral to the effective implementation of the one-stop clinic.

"Understanding from patients will be key; they need good information up front about one stop. Education and info for patients about "what to expect" from one longer appointment." (Dover: Consultation Q & A)

"Administration and clinical need to talk to each other." (Ashford: Table discussion)

"Admin to support and pre-assessment to ensure the process is smooth." (Whitstable: Table discussion)

Official responses to the consultation

Alongside feedback from the public, a number of official responses from organisations were sent to the Trust. Representatives from NHS South Kent Coast CCG, NHS Thanet CCG, and NHS Ashford CCG wrote to the Trust to express their general support of the proposals, whilst also reiterating concerns highlighted by residents in their local area at the public meetings (e.g., 20 minute drive time criteria, provision of services for those less mobile, and access to sites via public transport). The Trust responded to these letters, addressing the specific concerns highlighted by each CCG.

The Council of Governors at the Trust discussed the Outpatient proposals at its meeting on March 10th. In the official notes of this meeting, it was recognised that a large majority of the Council of Governors expressed support for the Trust's proposals, but also wanted to highlight specific concerns in response to those raised by members of the public at the consultation meetings. For example, the Governors highlighted the impact on travel times for people whose local service is being reduced and recommended the Trust recognise the significant level of public opposition in Deal, Faversham, and Herne Bay. Mention was also made of inaccuracies in the option appraisal information provided in the consultation document; however, the Council of Governors also welcomed the Trusts decision to re run the options appraisal for the North Kent coast site.

Three local Members of Parliament – Damian Collins, Charlie Elphicke, and Julian Brazier- also wrote to the Trust on behalf of their constituents. The focus of these letters varied according to the author. For example, Julian Brazier (MP for Canterbury and Whitstable) responded to concerns about parking shortages at Estuary View by reiterating the number of spaces available (135) and highlighting the room for expansion if necessary. Damian Collins (MP for Folkestone and Hythe) highlighted concerns regarding the impact on the elderly of longer journeys to Outpatients and access to services for his constituents in the Romney Marsh area. Finally, Charlie Elphicke (MP for Dover and Deal) emphasised the dissatisfaction of the proposal on behalf of the residents of Deal. All letters were responded to by Stuart Bain, Chief Executive of EKHUFT.

Finally, as highlighted in the introduction, two petitions were received from the Labour Party in Herne Bay signed by 1,260 and The League of Friends of QVMH signed by 6,000.

Public feedback on the consultation process

Throughout the different forums of feedback, members of the public also provided their own reflections about the consultation document and consultation process. Regarding the consultation document, responses indicated three main reflections:

1) Some information provided in the document was viewed as inaccurate (e.g., 20 minute drive, criteria used in the options appraisal).

"Main concern is selection of information and criteria used to build it- how have you decided upon the travel time of 20 minutes by car as main criterion?" (Email 35)

"Request for the document to be updated as this is a public document and gives a false impression of the services delivered at each site." (Whitstable: Consultation Q & A)

2) Certain types of additional information to be included in the consultation document. For example, the overall time span of the proposed changes, an explanation of the postcode analysis, clarification of NHS structure and how outpatient services fit in to this.

"It would have been useful if a simple flow chart had been used to illustrate the NHS structure and where outpatient services fitted in." (Herne Bay: Letter 2)

"Large proportion of the general public does not understand the difference between hospital and community providers. Clarification requested in the public document." (Whitstable: Consultation Q & A)

3) Finally, there was an element of cynicism regarding the phrasing of the questions in the consultation document.

"The questions (in the survey) were either totally irrelevant or carefully worded to ensure that you would receive the answers you required." (Herne Bay: Letter 11)

The questions in the consultation process have nothing whatsoever to do with siting of services. There is a massive extrapolation form these very limited questions." (Deal: Letter 27)

A selection of people also reflected on the management and implementation of the consultation process. Comments indicated concerns about how widely the consultation had been advertised, whether enough engagement with specialist groups had taken place (e.g., volunteer and patient transport), the timing of the meetings, and specifically to Herne Bay the organisation of the consultation meeting.

The final reflection coming through from the responses was a feeling that, to a certain extent, the key decisions had already been made and hence the process did not represent a *'true'* consultation. These views were expressed at consultation meetings in Deal, Faversham, and Herne Bay, in focus groups and via letters sent to the Trust. A selection of quotes from these sources illustrates these concerns.

"They have a very much favoured site which they were selling to us and we were all then supposed to say, "That's a wonderful idea." (Dover: Focus group)

"You know, you're asking us for our opinions but actually it's not going to make a lot of difference actually at the end of the day." (Margate: Focus group)

"I attend the open meeting..... advertised under the misnomer of it being a public consultation ... I have not spoken with 1 person who came away feeling that it was anything other than an appeasement exercise , merely meeting the need to 'consult'." (Herne Bay: Letter 7)

"This consultation is great, but if you're decided, then is it a true consultation? If it is you, would ask us first." (Faversham: Consultation Q & A)

However, in contrast, positive feedback about the process was also noted, broadly acknowledging the difficulty of the decision and that some consideration of the transport concerns had been taken on board with the investment of money in this area.

"On a positive note, there was a public meeting in Deal organised by the Council and the biggest concern was transport, so I was really impressed you have already thought about transport." (Shepway: Focus group)

"Facts must be clear on what Trust is intending. Impressed with improvement in buses, shows you (the Trust) have listened to people." (Dover: Table discussions)

Evaluators reflections on consultation process

The Department of Health in July 2010 introduced the 'four tests' against which current and future reconfiguration would need to be assessed. The Secretary of State identified these four tests as:

- support from GP commissioners;
- clarity of the clinical evidence base;
- consistency with current and prospective patient choice and;
- strengthened public and patient engagement.

Regarding the first test, letters expressing formal confirmation of the support from the three CCGs involved (NHS Ashford, NHS South Kent Coast & NHS Thanet) were received. Alongside the expression of support, all three CCGs also set out the caveats which they asked the Trust to consider in the implementation phase. NHS Canterbury and Coastal chose to partner the Trust in the consultation process to give their organisation a chance to make their decision based upon the detailed feedback gathered during the consultation process from patients, stakeholders and their local communities.

Furthermore, a representative from NHS Canterbury and Coastal has taken part in the re run of the options appraisal with the Trust, and reported on it. The representative will also be attending the Kent County Council Health Overview and Scrutiny Committee in June to hear the Committee's views; before a final decision on the proposals is made.

Taking in to consideration the formal confirmation of support from the three CCGS, and collaboration with the Trust of NHS Canterbury and Coastal, it is our assessment that this bench mark has been passed and the proposals for Outpatients services have the broad support of local commissioning groups.

In terms of the second test 'clarity of clinical evidence base', guidelines highlight that before service reconfiguration takes place, the strength of the clinical evidence and support from senior clinicians whose service will be affected needs to be considered.

The current proposals for Outpatient services have been discussed at Trust Board and in forums where senior clinicians, including the Medical Director and the Divisional Medical Directors, were present. Furthermore, each Division has also been represented on all working groups by either the Divisional Director or the General Manager who work closely with the Specialty leads and communicate the on-going work to them. Other consultants and senior nurses were met with individually to discuss the implications for their respective services, and what the changes will mean to these services. Developing the strategy for Outpatients has been a collaborative process between the Trust and clinicians in each speciality and, in taking this approach, the Trust have met the criteria for the benchmark under clarity of clinical evidence base.

Finally, in the guidelines, it stipulates that public, patients and staff be involved in the planning development, consultation and decision making in respect of the proposals (p.6).
The consultation was advertised widely by the Trust and KMCS to a range of groups via launch emails sent to Health Networks in Ashford, Canterbury, Thanet, and South Kent Coast, over 150 voluntary organisations (e.g., Red Cross, Rethink Carers, Thanet Disability Forum, Age UK Thanet, & Diabetes- UK Thanet), local and county councillors, east Kent MPs, other NHS organisations, CCG accountable officers, PPG locality groups, and Kent Healthwatch.

Alongside alerting stakeholders by email, hard copies of the consultation document were widely distributed to GP practices in NHS Canterbury and Coastal, NHS Ashford, NHS Thanet, and NHS South Kent Coast CCGs, local libraries, Outpatient clinics, acute hospitals, gateway centres, district and borough councils, pharmacies and at the consultation meetings. In addition, a number of newspaper ads were placed in local newspapers covering the east Kent area informing local communities of the opportunity to participate in the consultation. Engagement via social media was also utilised, with both the EKHUFT Twitter feed (62 tweets) and Facebook page disseminating information about the consultation.

Considering the extent of the consultation in the local community and the range of options offered to encourage public engagement it is the assessment of the evaluating team that the Trust fulfilled its statutory obligation under public engagement. In addition, the Trust reacted to public concerns about the options appraisal and consequently adjusted the criteria to be

used in the re run. This example illustrates that the Trust considered public opinion and responded to it by adapting the proposal.

In addition to 'the four tests' benchmark, Governmental guidance on consultations published November 5th, 2013 (Cabinet Office, 2013) provide a code of practice to help policy makers make the right judgements about when, with whom and how to consult.

The governing principle of these guidelines is that real engagement, with those who will be affected, is sought. In these guidelines it highlights that consideration should be given to including more informal methods of consultation (e.g., public meetings, focus groups, surveys) rather than reverting to only a written form. With this in mind, we believe the current Outpatient's consultation meets this recommendation. Various informal avenues were offered to the public to enable them to engage with consultation and were well-attended.

The guidelines also stipulate that efforts should be made to engage with vulnerable groups- a suggestion that was taken on board in the consultation with efforts to reach these groups via focus groups. The evaluation team would conclude that on both counts the Trust has passed the benchmark on providing real engagement opportunities and engaging with vulnerable groups.

Main findings of consultation

- Answers from the survey responses indicated that the majority of people supported all seven key consultation questions. Alongside this though, there were proportions of people who also disagreed with the proposals.

- When asked about whether the Trust could improve access to Outpatients services by offering a greater range of services from a smaller number of clinics, responses from the survey highlighted the majority of respondents agreed (62%) compared to disagree (27%) . Breaking down responses to focus on specific CCG areas (e.g., NHS Canterbury & Coastal, & NHS South Kent Coast) elicited different proportions of disagreement. For example, levels of disagreement increased to 49% in South Kent Coast and 36% in Canterbury & Coastal. In the focus groups, the proposal to improve

the range of Outpatient services was in general received positively, with little opposition voiced.

- Survey responses indicated a high level of agreement with the proposal to extend opening times, with 84% of people agreeing. This level of agreement was the second highest in the survey, indicating a high level of support. Responses in the focus groups also broadly supported this proposal.

- The proposal to increase the number of people within a 20-minute drive of an outpatient's clinic received, overall, negative reaction. This was especially evident in the consultation events and focus groups. Two main concerns highlighted with this proposal were the use of the 20-minute criteria and the focus on drive time- not on public transport journey times. To some extent, the scepticism about the proposals was reiterated in the overall survey responses with a relatively small majority of respondents (54%) agreeing with the proposal compared to levels of disagreement (33%). Breaking down response by CCG area, levels of disagreement rose to 40% in NHS Canterbury and Coastal CCG.

- The Trusts proposal to improve the quality of the patient experience was met with a strong level of support in response to the survey questions (64%). Responses from the focus groups also suggested support for this proposal and highlighted the desire for NHS funds to be spent on staffing and equipment, instead of improvements to buildings.

- Survey responses highlighted strong support overall for the NHS to make effective use of all resources, with 85% agreeing and 4% disagreeing. Levels of support for this statement rose to 96% in the areas that would be least affected by the proposed changes.

- The reduction of sites generated some agreement and acknowledgement of the pressure to reconcile services; however, feelings expressed across all forums of feedback also highlighted concern about the proposed reduction. As part of the survey, 105 comments were made in response to this question – approximately half of

these comments felt the proposed changes would make services worse and expressed concern about the facilities being offered. In the consultation events and focus groups, increased difficulty with public transport and access were the two main reasons motivating these concerns.

- When asked about choosing the sixth site some responses did note the benefits of Estuary View as an appropriate site to host the expanded Outpatient clinics. Opposition to Estuary View as the sixth site was strongly expressed in Herne Bay and Faversham. The main reasons for the opposition were transport/access to Estuary View and a lack of consideration regarding demographics of the areas involved. As noted in the section above, the Trust has offered to re run the options appraisal taking in to consideration these two points. Comments made as part of the survey broadly replicated these concerns- some responses indicated agreement with Estuary View as the preferred site, while other responses noted increased travel distance as a drawback. Some respondents not directly affected were hesitant to comment.

- The utilisation of new technology (i.e., telehealth and telemedicine) was viewed in the consultation meetings and focus groups with positive, but cautious feelings about how these changes would be implemented. The majority of survey responses (73%) agreed with the notion that the Trust could make better use of technology to monitor people in their own home.

- Concerning implementation of the one-stop approach, again in the focus groups and consultation events responses broadly indicated a cautious but positive response to the proposal. Survey responses indicated the majority of people agreed (62%) compared to disagreed (25%) with the proposal. Breaking down responses by geographical area, 55% of responders living in Deal/Sandwich and 34 % in Faversham/Whitstable/Herne Bay disagreed with the proposed one-stop approach.

Overall summary of the consultation

- Following widespread publicity, and a large number of consultation documents being handed out, the response of 478 completed surveys was in line with expectations and

commensurate with other similar consultations. Twelve consultation events across east Kent were attended by approximately 1,330 people. Response rates and attendance levels indicate a considerable level of public interest and engagement with the consultation process.

- As evaluators, we consider the scope of the consultation to be wide spread, with efforts made by the Trust and KMCS to engage with numerous organisations to a) publicise the consultation and b) gather feedback from a diverse population; thereby meeting the benchmark of public and patient engagement as stipulated by 'the four tests'.

- The Trust has also received formal support for the proposals from local commissioning groups; thereby meeting the benchmark of support as stipulated in by 'the four tests'. Furthermore, the strategy for Outpatients has been a collaborative process between the Trust and clinicians in each speciality; hence, the Trust has also met the benchmark under the criteria for clarity of clinical evidence base.

- People were able to offer their feedback in various forms (i.e., consultation Q & A, table discussions, via surveys, letters, and focus groups). The variety of forums in which feedback could be made is viewed as a positive aspect of the consultation. Regarding analysis of the feedback generated via these forums, we cannot rule out the possibility of duplication. For example, in principle, someone may have attended the consultation event and voiced their view, completed the survey, and written a letter, but the evaluation team would not be able to establish this.

- Feedback from consultation events suggests there was a degree of criticism about how the options appraisal was presented (i.e., accuracy of the information) and the criteria used in the assessment. The Trust have responded to this feedback and offered to re run the options appraisal, confirming that demographic criteria and access via public transport will be included in the new options appraisal.

- The Trust also responded to a feedback from the public during the consultation period. This responsiveness was demonstrated in a number of examples. First, in

recognition of views expressed on public transport access to outpatient services, the Trust to offer a £500,000 investment in public transport provision. Second, the content of presentation provided at the consultation events changed to reflect public feedback (e.g., inclusion of slide to clarify NHS structure, travel provision in all areas). Finally, the Trust ran additional consultation meetings in Herne Bay and Faversham to accommodate members of the public who were not able to attend the first meeting. These examples illustrate the emphasis the Trust made in public engagement and reiterates the conclusion that the benchmark for patient and public engagement under the 'four tests' was met in the Outpatients consultation.

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Ritchie, J., & Spencer, L. (2002). Qualitative data analysis for applied policy research. In M. Huberman & M. B. Miles (Eds.) *The qualitative researcher's companion (pp.*305-329). London: Sage Publishing

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Item 7: Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals University NHS Foundation Trust.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The Health Overview and Scrutiny Committee considered the development of East Kent Hospital University Foundation Trust's (EKHUFT) clinical strategy on three occasions. These were:

- 3 February 2012
- 12 October 2012
- 7 June 2013

(b) A number of 'key drivers for change' behind their clinical strategy review were identified by the Trust and this report provides additional information on Emergency Surgery Standards.

2. Emergency Surgery Standards

(a) In previous reports submitted to the HOSC, EKHUFT identified two publications as being key policy and service drivers underpinning the clinical strategy review.

(b) The first publication identified is a report by the Association of Surgeons for Great Britain and Ireland (ASGBI), *Emergency general Surgery: The Future.* This 'Consensus Statement' was produced as a result of a conference in February 2007. Some of the main points made in the conclusion are as follows:

- There is wide variation in the quality of emergency general surgery (EGS).
- EGS is one of the most common reasons for admission to a surgical bed in Britain.
- All Trusts which receive emergency general surgical admissions should have a named surgeon responsible for the clinical leadership of this service.

- Emergency admissions should have dedicated resources and senior surgical personnel readily available.
- There must be a clear and identifiable separation of delivery of emergency and elective care.
- Timely access to diagnostic services (particularly radiology), interventional radiology and emergency theatre time is necessary.
- The assessment, prioritisation and management of emergency general surgical patients should be the responsibility of accredited General Surgeons.
- The largest component of the emergency general surgical case-mix is gastrointestinal.
- ASGBI recognises the case for regional trauma centres.
- It is clear from trends within the specialty and training that separation of vascular surgery from general surgical practice in the UK is inevitable. Similar arguments apply to breast surgeons.

(c) In a later document, *Issues in Professional Practice, Emergency General Surgery*, the following explanation of the term 'general surgery' is provided:

"General surgery is a historical term, the spread of which currently includes gastro-intestinal surgery, endocrine surgery, torso trauma and hernia surgery. In some hospitals, breast, transplant and vascular surgeons still undertake some general surgery and may contribute to EGS, although these disciplines are increasingly separate. This separation has been driven by a desire for improved outcomes through specialisation, although neither the provision of specialist on-call cover nor the impact of withdrawal of manpower from EGS has been cleanly resolved."

(d) The other publication is the Royal College of Surgeons of England produced document *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*. This had the aim of providing information and standards on emergency surgical service provision for both adult and paediatric patients. This was published in February 2011.

(e) The report explains that an emergency surgical service is not one that simply operates out of hours. Instead, six elements are outlined:

1. Undertaking emergency operations at any time, day or night.

2. The provision of ongoing clinical care to post-operative patients and other inpatients being managed non-operatively, including emergency patients and elective patients who develop complications.

3. Undertaking further operations for patients who have recently undergone surgery (i.e. either planned procedures or unplanned 'returns to theatre').

4. The provision of assessment and advice for patients referred from other areas of the hospital (including the emergency department) and from general practitioners. For regional services this may include supporting other hospitals in the network.

5. Early, effective and continuous acute pain management.

6. Communication with patients and family members/others providing support.

(f) For most surgical specialties, providing emergency surgical care works out to around 40-50% of the workload. This varies according to the speciality; for example, in neurosurgery over half the admissions are non-elective and account for 70-80% of the workload.

(g) A number of reasons for changing the way emergency surgical care is delivered are given:

- "Patients requiring emergency surgery are among the sickest treated in the NHS.

- Outcome measurement in emergency surgery is currently poor and needs to be developed further.

- Current data show significant cause for concern – morbidity and mortality rates for England and Wales compare unfavourably with international results.

- It is estimated that around 80% of surgical mortality arises from unplanned/emergency surgical intervention.

- The NHS has to reduce its costs significantly over the coming years – savings can only be delivered sustainably through the provision of high quality and efficient services. The higher complication rate and poorly defined care pathways in emergency surgery (when compared to elective surgery) offer much greater scope for improvement in care and associated cost savings.

- The reduction in working hours for doctors and the focus on elective surgical care has changed the level of experience and expertise of trainees when dealing with acutely ill surgical patients.

- Patients expect consultants to be involved in their care throughout the patient pathway.

- Evidence from a survey of general surgeons indicated that only 55% felt that they were able to care well for their emergency patients.

- At least 40% of consultant general surgeons report poor access to theatre for emergency cases."

(h) The report is not prescriptive as to which model of care should be adopted, and the bulk of the report consists of describing the standards underpinning unscheduled surgical care applying to both paediatric and adult patients.

(i) A subsequent publication, *Emergency General Surgery* published by the Royal College of Surgeons (RCS) and the Association of Surgeons of Great Britain and Ireland (ASGBI) in August 2013 set out proposals to improve the care provided to emergency general surgery patients. The RCS and ASGBI recommend that:

- "NHS England should establish a strategic clinical network for emergency general surgery to oversee the delivery of safe and efficient care.

- Best practice tariffs should be developed to reward the delivery of high quality emergency general surgical services.

- Surgical treatment of acutely ill patients must take priority over planned, elective surgery when necessary.

- Services must be consultant-led and senior doctors must be involved throughout the patient's care. The seniority of the surgeon involved in the operation must match the clinical need of the patient.

- There should be a greater focus on the outcomes of care, with improved resources for audit and review of practice. Outcomes should be in the public domain".

3. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from East Kent Hospitals NHS University Foundation Trust.

Background Documents

Agenda, Health Overview and Scrutiny Committee 3 February 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3977&Ver=4

Agenda, Health Overview and Scrutiny Committee 12 October 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3983&Ver=4

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Progress report on the Interim Centralisation of Adult High Risk and Emergency General Surgery in east Kent.

Kent Health Overview and Scrutiny Committee
June 2014

1. Introduction and Background

Over the past two years the Trust has been reviewing its surgical clinical strategy to ensure the continued safe provision of surgical services. As a result of this work, a number of options have been produced, which aim to deliver safe and sustainable surgical services for the future. These options will be subject to formal public consultation later next year.

The aim of this paper is to update the HOSC on the current and future position of adult high risk general (abdominal) emergency and high risk elective surgery at EKHUFT.

In late 2012, the Trust invited the Royal College of Surgeons (RCS) to review it's surgical services. As part of this it was recognised that a negative consequence of the current on call model is that, due to skill mix, there may be multiple and potentially significant delays for patients on an emergency general surgical pathway and emergency treatment may be being provided by inappropriately skilled surgeons.

The Trust subsequently delivered a program of work to improve general surgical services and implement a model of care to support current service provision. However, at the end of 2013, the Surgical Services Division informed the Trust's Executive Team and Trust Board of Directors of the need for urgent action due to an emerging serious clinical risk in general surgery. This increased risk was driven by workforce changes, specifically the balance between gastro intestinal and non-gastro intestinal surgeons, substantive consultants and locum filled posts and, linked to that, access for patients to substantive consultant decision making. All of these factors increased the risk of poor patient care, experience and outcomes. This was of particular concern at the WHH.

As a result, on 14th February 2014, the Trust Board agreed to test the feasibility of an interim centralisation of adult high-risk general (abdominal) emergency and high risk elective surgery at the Kent and Canterbury site from May 2014.

2. Progress

Whilst the General Surgeons supported centralisation as the strategic end point, they were concerned that about the timescales for implementation and have supported us to find a safe interim solution to maintain services, in the short to medium term, at WHH and QEQM.

In addition, the Trust's own work showed that a move to a centralised service by May had some considerable challenges in terms of capacity, in particular critical care capacity and resilience on the K&C site.

The interim solution is to ensure a rota of eight gastro-intestinal surgeons will be available to manage emergency care at both the WHH and QEQMH. This would ensure the removal of non-GI surgeons (i.e. breast and endocrine surgeons) and recruitment to the current locum posts.
Importantly this means that all eight consultants at each site will support the emergency rota and thereby enable two consultants (rather than one), to manage the emergency activity.

This will increase significantly the access to consultant led decision making including the ability to offer this at evenings and weekends.

This solution is not sustainable in the long term for a number of reasons. Firstly, it is the Trust's ambition to move to a 24hour, seven day a week consultant delivered service. Delivering this ambition from two sites is not achievable because of workforce availability, further sub specialisation and the affordability of delivering the expected quality outcomes of our commissioners and the public.

3. Board Decision

At its April Board meeting, the Board was asked to confirm that the centralisation of adult high risk general (abdominal) emergency and elective surgery remained the long term solution. The Board of Directors recognises that this will need to be subject to further public engagement and consultation. The Board therefore also approved moving to the interim solution described above.

The current expected timeline for full implementation of the interim model with substantive posts is September 2014. The Trust has already gone out to advert for a total of two consultant posts and has had a positive response in terms of applications, with interviews set for June. A further four posts will be advertised in July / August to deliver a full establishment of consultant cover.

In addition the current GI consultants are also formally supporting non GI consultants whilst they are on call. As a result of these changes the Trust can confirm that the agreed interim solution has reduced the serious clinical risk identified in late 2013.

Item 8: Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 31 January 2014 the Health Overview and Scrutiny Committee received an update from the Kent and Medway NHS and Social Care Partnership Trust (KMPT).

(b) At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that the Committee thanks its guests for their attendance and contributions today along with their answers to the Committee's questions, and asks for a return visit within six months to give an update on the transformation programme with particular reference to safeguarding and dementia.*

(c) Consideration of this item has been changed from a verbal to a written update, on the request of the Chairman, due to the number of items on the Agenda. If the Committee wish for a substantive debate on this item, this can be arranged for a future meeting.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the report.

Item 8: Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia (Written Update)

Background Documents

Agenda, Health Overview and Scrutiny Committee, 31 January 2014
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5394&Ver=4

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Safeguarding Children Case Conference Attendance

"Case conferences are life changing events for children and their families".

Kent and Medway NHS and Social Care Partnership Trust (KMPT) fully recognise the importance of case conferences and the impact on children and their families. Attendance at case conferences has been a focal point for the Organisation over the past year and we have been working hard with staff to ensure their compliance at these meetings; both in terms of attendance and provision of reports. There is clear governance around this agenda, with case conferences playing a key part in our Quality Account and monitoring mechanisms via the Trust wide Safeguarding Group, the Patient Safety Group and the Quality Committee of the Trust Board.

Current position

Across Kent, the named nurses work collaboratively with the case conference administrators and receive copies of all invitations to attend a case conference. The named nurses will make contact with the relevant care-coordinator and support them to attend or to write a contributory report (where families are known to us). As a Trust we recognise that case conferences are life changing events for the families involved and we will endeavor to attend if we are involved with those families. Non-attendance is reported to team managers to prompt them to discuss the issue with practitioners in supervision.

Review case conferences tend to be booked well in advance however they are currently the least well attended. This is driven by a number of factors such as the service user having been discharged from services or hasn't engaged. The safeguarding team is working to mitigate these factors and continues to impress upon staff the importance of maintaining involvement when there are potential risks to a child(ren).

During quarter 4, 2013/14, attendance compliance increased from 56% (Q3) to 78%. Whilst shy of the 80% target, the progress made has been positive and must now be enhanced and sustained.

Plans for improvement

The 2014/15 Quality Account sets a challenging target of 100% attendance at conferences where the family is known to KMPT.

The safeguarding team have a number of actions planned to help achieve this:

- Working with the case conference administrators to improve the timeliness and accuracy of meeting notification and in ensuring Named Nurses consistently receive copies of invitations.
- Where possible the Named Nurses will complete reports when a Care Coordinator is unable to and they will provide a report for any client that has been discharged within 6 months of the conference on request.

Author: Cecelia Wigley, Head of Safeguarding, Kent and Medway Partnership Trust

- Care Coordinators are reminded to involve the Named Nurses when they receive an invite; involvement from the named nurse will aid the Care Coordinator when they produce the report and attend the conference.
- Named Nurses will continue to spend time with teams, being accessible to Care Coordinators and providing support to those who may be anxious about attending conferences.
- Specialist child protection supervision will be available to better engage frontline staff with the conference process.
- The support of the safeguarding champions is an additional resource that helps both the safeguarding teams and the frontline staff. The champions meet quarterly to maintain knowledge and to ensure they are confident in taking key messages back to the workplace.
- All training promotes the importance of information sharing through case conferences, professionals meetings and use of the Common Assessment Framework (CAF).
- The Trust wide Safeguarding Group receives regular updates, allowing the executive lead for Safeguarding to hold Service Lines within the Trust to account. Service Lines also have regular discussions at their directorate governance meetings.

Improving Dementia Services

Across the health and social care economy in Kent and Medway organisations have been working to increase the integrated provision of community based services for older people with dementia. Strategic developments have focussed upon prevention and early intervention, delivery of care closer to home, promoting continuous improvements of community based services and reducing the reliance upon in-patient beds and other forms of 24-hour care.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) have been working closely with colleagues from other organisations and key stakeholders to develop Health and Social Care Integrated Projects (HASCIP) across Kent and Medway. The goal is to ensure that efficient and responsive services are co-ordinated and delivered in conjunction with partners in the Local Authority, Kent Community Healthcare Trust (KCHT) and primary care.

KMPT are transforming the way in which older adult services are delivered. This includes functional and organic presentations in both community and acute settings. The Transformation Programme includes individual and local developments, as well as strategic transformation.

Some examples of local developments are:

- Early diagnosis for Dementia – KMPT have an aligned Mental Health practitioner for every GP practice in Kent to support Primary Care to access Secondary Mental Health Dementia Services.
- GP training – KMPT have developed a GP training programme for Dementia. This programme has an on-line training module that all GPs will be able to access and a follow up bespoke training session delivered at locality level by the local Consultant Psychiatrist.
- Memory Assessment Services and MSNAP accreditation – all localities have joined MSNAP as affiliate members and are at various stages, from preparing for assessment to achieving excellent.
- Admiral Nursing across Kent remains proactive in working with families and carers of people with Dementia
- Dementia Pledge objectives – KMPT is part of the Kent Dementia Action Alliance and have made pledges as part of the action plan, these include access to our memory assessment services and our involvement of users and carers.
- Engaging Service Users – we have an active user forum called ‘Forget Me Nots’. The forum members represent the Trust at various local and national events. Examples of recent engagement include the participation in the Dementia Friendly Communities workshop at Christ Church University and approval of new leaflets for the Trust memory assessment services
- Engagement in the Kent Pioneer programme – KMPT are actively involved at both strategic and operational level in their programme.
- National / Industrial research contributions – recent research contributions include use of music therapy to reduce aggression on inpatient units and potential participation in Kent Surrey Sussex wide research and participation in IDEAL research project.

KMPT have an Older Adult Transformation Board which is accountable for the delivery of the strategic planned developments:

Community Services Re-Design across Kent and Medway

The Community Services re-design is at the development stage and delivery of the project is to be negotiated and agreed, both within KMPT and with Partners. The anticipated changes will deliver the following benefits:

- Improved access to services for users and carers
- A more seamless service with streamlined clinical pathways
- Improved patient experience
- Efficiencies in working practices
- Improved relationships and reputation with partners and key stakeholders

Older Adult Safe and Secure In-Patient Services (OASSIS – East Kent)

The OASSIS project is at the design stage and KMPT are working with industry colleagues to deliver the building infrastructure of the first phase of the OASSIS project. The completion of a new 16 bedded unit on the St Martins site in Canterbury is scheduled for April 2016. The OASSIS project will deliver the following benefits:

- Inpatient capacity to cater for the projected population
- Provision of older adult inpatient services from centres of excellence.
- Improved outcomes, resulting in reduced length of stay and improved delayed transfers of care.
- Fit for purpose accommodation which enables safe care and recovery
- Access to therapeutic interventions across extended hours
- 24 / 7 dementia crisis service
- Retention of highly qualified, expert and motivated staff
- Increased capacity of the Home Treatment Service
- Continued engagement in national research

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Adult Mental Health Inpatients Services Review (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway NHS and Social Care Partnership Trust.

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 9 March 2012 the Health Overview and Scrutiny Committee at Kent County Council determined that the proposals for a review into adult mental health inpatient services in Kent and Medway constituted a substantial variation of service. On 27 March 2012 the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council made the same decision. In line with the regulations, The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) met to consider this topic. It met on the following dates:

- 3 July 2012
- 13 February 2013
- 19 March 2013
- 30 July 2013

(b) The work of the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) into the Adult Inpatient Mental Health Services Review concluded at its meeting of 30 July 2013 with the following recommendation:

The Committee supports the NHS proposals and asks that the report and recommendations of the independent report commissioned by the JHOSC be presented to the CCGs when they are asked to consider the next steps set out in the NHS briefing paper on p.21 of the Agenda. In particular, the Committee asks for, in line with the independent report:

- *A significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution/home treatment and a small number of additional acute beds*
- *A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites*

- *An action plan to be prepared within three months to be overseen by NHS England and Kent County Council and Medway Council Health Overview and Scrutiny Committees.*
- *Regular monitoring of performance to be undertaken in light of experience as changes progress.*

(c) The JHOSC will not meet again on this topic having concluded this review.

(d) The Health and Adult Social Care Overview and Scrutiny Committee at Medway Council subsequently referred the issue to the Secretary of State.[1] The Secretary of State then asked the Independent Reconfiguration Panel (IRP) to conduct an initial review and report back to the Secretary of State. The IRP concluded that the referral was not suitable for full review. The Secretary of State agreed with the IRP's initial assessment in full and agreed the implementation programme should be allowed to proceed as soon as possible.

(e) In line with the final recommendations of the JHOSC, and the HOSC Forward Work Programme, the Kent HOSC considered the implementation programme at its meeting of 31 January 2014. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED That the Committee thanks its guests, notes the good progress made and looks forward to a written update within six months.*

4. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the report.

Background Documents

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, 3 July 2012
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=4918&Ver=4

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, 13 February 2013
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5155&Ver=4

[1] http://democracy.medway.gov.uk/mgAi.aspx?ID=8599

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, 19 March 2013
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5183&Ver=4

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, 30 July 2013
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5337&Ver=4

Agenda, Health Overview and Scrutiny Committee, 31 January 2014
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5394&Ver=4

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Kent and Medway NHS
NHS and Social Care Partnership Trust

TRANSFORMATION PROGRAMME

HIGHLIGHT REPORT
MAY 2014

Version:	1.0	**Status:**	Draft	**Date of report:**	12/05/14
Reporting Officer:	Ivan McConnell	**Report completed by:**	Rheanna Mitchell	**Reporting to:**	HOSC

1. Introduction: Transformation Programme overview

At KMPT our aim is to ensure that the **service user is at the centre of everything we do**. Our vision is to provide …

"Excellent care personal to you, delivering quality through partnership. Creating a dynamic system of care, so people receive the right help, at the right time, in the right setting with the right outcome."

Our major challenge is to move away from traditional models of service delivery and implement evidence based integrated care pathways with the service user at the heart, whatever the team, professional or agency providing the care. We want to ensure that:

We **get the basics right**.
We deliver **improved access** through collaboration and delivery of integrated services.
We deliver a **recovery** focussed model of care.
We deliver **excellence and innovation** in our services.

There are a number of service developments planned which will support this transformation:

The **Inpatient Programme** will facilitate high quality inpatient care in safe, purpose-built accommodation and access to appropriate staffing (24 hours a day, 7 days a week). We will bring together our expertise into three clinical communities which will deliver demonstrable clinical excellence across the range of services provided. Improved partnership working between CRHT teams and inpatient wards will help increase access to treatment at home.

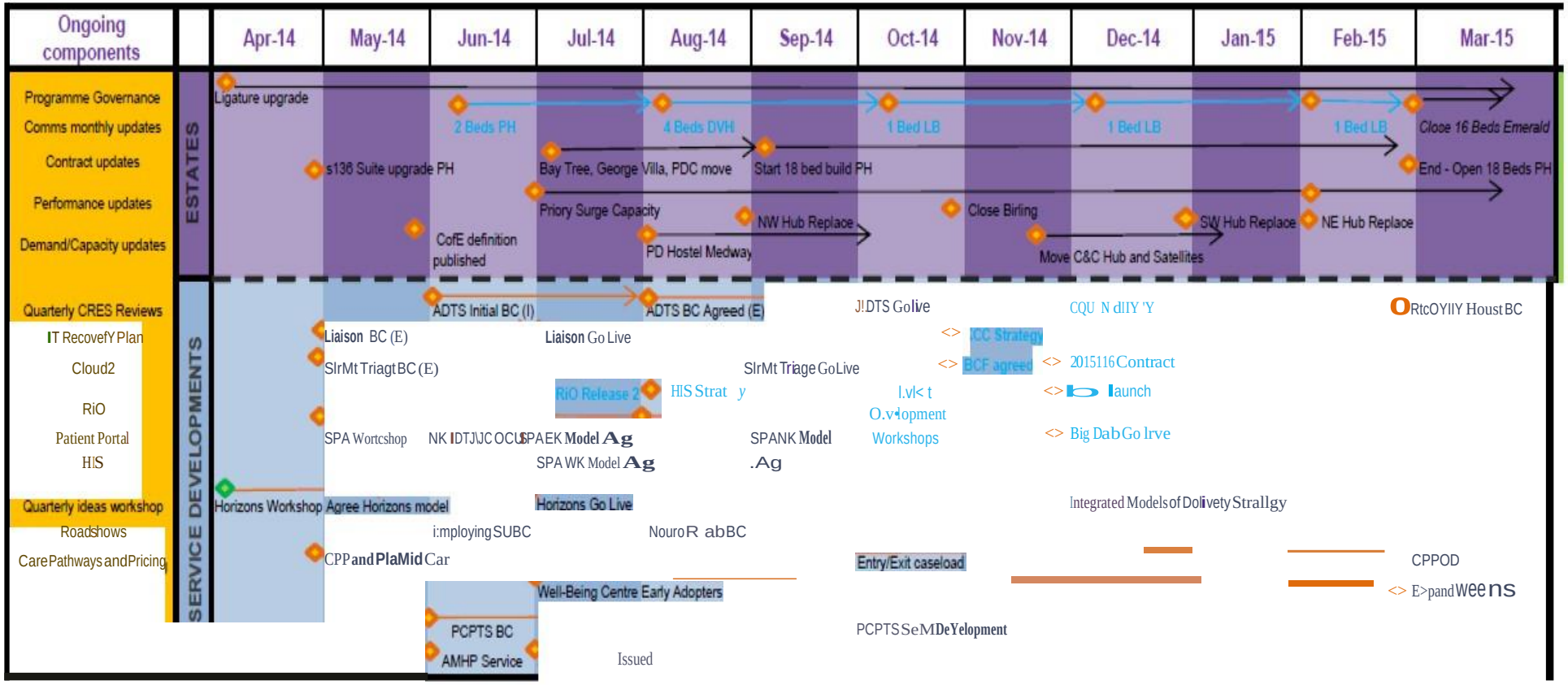
The **Urgent Care / Crisis Programme** will enable the development from a bed based service to a responsive, accessible and modern service. We will provide an improved urgent response, with timely access to assessment and choice about how acute care is provided, with services delivered in the least restrictive manner. Alternatives to admission, delivered in partnership with a range of organisations, will reduce the demand for inpatient beds.

The **Planned Care Programme** will provide a skilled workforce that can effectively and efficiently deliver high quality assessments and interventions on the care pathways that we are contracted to provide . Effective caseload management will be driven by the Recovery ethos and will give clarity about roles and remits for each profession. Hub sites will be transformed into Wellbeing Centres and provide holistic recovery focussed care within environmentally healing and ecologically sustainable buildings.

The **Integrated Care for Older Adults Programme** will address the mental health needs of people who are being treated primarily for physical health problems. With our partners we will provide a 'collaborative' response, developing a multi disciplinary and centralised approach to access via referrals units. It will enable timely discharge from secondary mental healthcare, with ongoing and seamless support available in primary care.

There are three overarching change work streams which will support and influence the delivery of these programmes; Single Point of Access, Embedding care pathways and Integrated Models of Delivery. All service developments are guided by the aims of the clinical strategy and are underpinned by enablers including Organisational Development, Finance / Commercial, Estates, IT, Communications / Engagement and R&D.

2. Milestone plan



3. Highlight report

The table below provides a headline summary of the work that we have undertaken to date and are proposing on our transformation programme.

PROJECT / SCHEME	PROGRESS THIS MONTH	FORECAST ACTIVITY NEXT MONTH	DEPENDENCIES
Increased inpatient capacity	• *DVH* refurbishment works commenced. • *Priority House* (existing ward) additional room works commenced. • *Little Brook* additional works approved • *Emerald* (new ward) initial design approved. Plans include management of transport arrangements, in partnership with Experts by Experience and the PET.	• Work completes July 2014. • Works completes June 2014. • Tenders developed • Design contractor selected and appointed. • Packs for users and carers will be enhanced in terms of travel information and support available and all sites will display posters	• On going commissioner support in relation to additional capacity created • External signage is dependent on highways agencies. KMPT is awaiting a response from them about the potential to improve signage to hospital.
Personality Disorder Therapeutic House	• *Recruitment:* House manager and Specialist MH Practitioner in post, with admin staff appointed. • Operational policy drafted. • Meetings held with CRHT and CMHT to agree interface protocols. • Proactive engagement with the	• *Recruitment:* Band 7 and Band 4 recruitment to continue. • Operational Policy and protocols, to be approved by the Trust. • Complete and jointly agree the local protocols on management of violence;	• KMPT agreement regarding staffing ratios for PD Therapeutic House. • CQC decision on the type of registration required for the PD Therapeutic House. • Securing recurrent funding post pilot.

	police and developing protocols around management of security and violence. • Pro-active engagement with local residents.	security of the building; management of anti-social behaviour; lone working; medicines management • Complete building works and installation of anti contraband/ minimal ligature windows.	
Crisis Accommodation / Recovery Accommodation	• High level PID outlining potential future service developed. • Identification of potential partners and key stakeholders.	• Planning phase continues and includes: ○ Engage with potential partners ○ Scope models used nationally ○ Develop model and business case	• Commissioner support • Support from potential partners • Resources (estate and staffing)
OASSIS	• Strategic Outline Case for Phase One (re-location of Cranmer Ward, St. Martins) approved. • Design stage to be progressed • OASSIS Project Board met with Kier/ Devereux to progress design appraisal	• Clinical Users Group to reconvene and progress Schedule of Accommodation and design for OBC sign off.	• Availability of clinical staff to engage with process • CUG / Devereux to agree a design that maintains quality and existing revenue / workforce.
Street Triage	• Pilot and review completed • Service secured funding and the business case is now being developed	• Implement agreed model	• Ongoing joint working • Agreed Finance and Commissioner support
Liaison Psychiatry	• Business case developed to ensure delivery of 24/7 services across Kent and Medway	• Approve Business Case and implement.	• Finance • Commissioner support

Acute Day Treatment Service	• Scope models and examples of best practice.
	• Explore potential sites to provide ADTS.
	• Visited lead centre
		• Planning phase continues and includes:
		  ○ Scope models used nationally
		  ○ Develop model and business case to include base to deliver service from and transport plan
			• Identification of suitable estate to deliver service.
			• Commissioner support to ensure service can be developed and is sustained.
			• Resources

Caseloads Project	• *Definitional stage:*
	  ○ Completed PID and workplan
	  ○ Identified benefits
		• Approve at Programme Board
		• Workshop to progress point of entry efficiencies
		• Demand / capacity analysis
			• Workforce project
			• Single Point of Access
			• IM&T Strategy

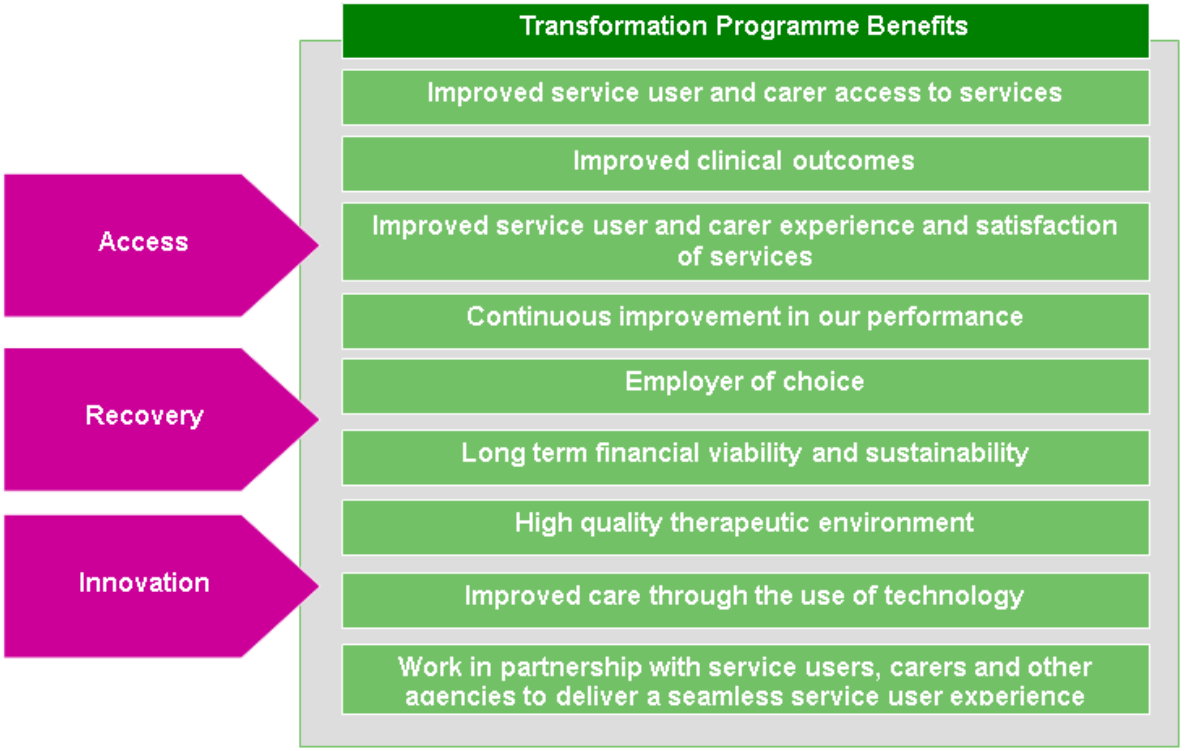
Workforce Project	• *Definitional stage:*
	  ○ Completed PID and workplan
	  ○ Identified benefits
		• Approve at Programme Board
		• Engage with Embedding Care Pathways workstrreams
			• Care Pathways and Pricing
			• Caseloads project
			• Cross Service Line workforce plans

Well-Being Centres Project	• *Definitional stage:*
	  ○ Completed PID and workplan
	  ○ Identified benefits
		• Approve at Programme Board
		• Agree early adopter sites for Recovery College approach
			• Centres of Excellence
			• Estates Strategy
			• IM&T Strategy

Review and redesign of Community Services for Older People	• Options appraisal completed in 2013, to be refreshed to reflect 2014/15 CQUIN and contract. • Workshop held in May for Urgent Care & Crisis Pathway for OPMH • Project Board provides overarching framework for delivery of revised arrangements for Urgent and Crisis	• Complete refreshed PID reflecting development of two work streams for OPMH community redesign • Project management/support arrangements to be agreed	• Cross Service Line workforce plans • Commissioner support

	response as well as reconfigured clinical pathway for clusters 18 and 19.		
Single Point of Access	• Identified clinical lead and approach to implementation • Workshops planned with commissioners and GPs, to build on learning from events held in 2013.	• Complete workshops • Develop implementation plan	• Commissioner support. • Telephony infrastructure.
Embedding Care Pathways	• Developed detailed implementation plan for 'business as usual' approach in 2014/15. • Engagement will key parties to agree the approach to management of Care Pathways and Pricing.	• Implement performance management using CPP data and framework. • Launch Care Pathways internally and engage with staffing groups.	• Communication and engagement. • Information Management.
Integrated Models of Delivery	• Identified options for improving Horizons schemes and held internal / external workshops	• Agree and implement Horizons option • Demand / capacity analysis for Rehabilitation Services	• Support and partnership working with KCC and existing housing providers.

4. Summary of Benefits



The transformation programme adopts a structured benefits approach that:

- Gives clarity to the objectives of our transformation programme
- Provides opportunities to engage our key stakeholders in a benefits led discussion
- Promotes a culture of continuous improvement by focusing on improving clinical outcomes.
- Allows us to track delivery and celebrate our successes
- Helps us to learn from experience

The success of the programme will be dependent upon us having systems, controls and processes in place which allow us to identify the benefits of each service development and provide us with assurance that these are being achieved.

A comprehensive benefits register was approved by the Finance and Resource Committee in April 2014. A system to populate the metrics with data, which will allow us to track progress, is being developed and we will be able to report on this from June 2014 onwards.

Item 10: Kent Community Health NHS Trust: Community Dental Services (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Kent Community Health NHS Trust: Community Dental Services (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent Community Health NHS Trust.

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) Kent Community Health NHS Trust requested the opportunity to bring the attached report to the attention of the Committee.

(b) In March 2014, Kent Community Health NHS Trust informed the Committee of proposed changes to the gum disease clinic in Deal and the community dental service at Folkestone Dental Clinic, subject to consultation with patients and staff. Details of the consultation were circulated to Members of the Committee on 10 March 2014.

2. NHS Dental Services - Overview

(a) NHS dental services are provided in primary care and community settings, and in hospitals for more specialised care. NHS England directly commissions all dental services for the NHS. There are over a million patient contacts with NHS dental services each week.

(b) Dentists working in general dental practices are independent providers from whom the NHS commissions services. They are responsible for whom they employ within their own dental teams and for the management of their practices. It is common for dental practices to offer both NHS-funded and private services.

(c) The NHS in England spends around £3.4bn per year on dental services; the value of the private market is estimated at £2.3bn per year.

(d) 21 Dental Local Professional Networks have recently been established across England to promote a strategic, clinically informed approach to

the planning and delivery of dental services that reflects the needs of local populations.

(e) Adult patients make a financial contribution for receiving dental care from the NHS unless they meet certain exemptions. There is a 3-band fixed charge for primary care treatment depending on the care provided by the dental practice. The dental charges system contributed £653m to the NHS budget last year.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the report.

Background Documents

NHS England, *Improving Dental Care and Oral Health - A Call To Action*, February 2014
http://www.england.nhs.uk/wp-content/uploads/2014/04/imprv-oral-health-info.pdf

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1 May 2014

Background: Kent Community Health NHS Trust (KCHT) informed Kent County Council's Health Overview and Scrutiny committee in March 2014 that it intended to make some changes to its community dental service and outlined its plans to gain feedback from patients and staff. There were two proposals, this paper explains the proposals and the way forward.

Proposal 1: To move the specialist gum disease service from Deal to the Trust's dental clinic at Dover Health Centre. The advantages of this move were improved access to people with disabilities and staff and patients benefitting from a wider dental team which would not have been possible if the service remained at Deal.

- The Deal clinic is on the first floor and there is no lift. This means patients with mobility difficulties can't use the service.
- The clinic is only open one day a week – in Dover it is a five days a week service.
- There is better parking and public transport links in Dover.

More than 90 per cent of patients who attend this specialist clinic are not local to Deal but travel from all over east Kent for their appointment at the Deal clinic. Only nine per cent of the patients seen at Deal live locally.

People living in Ashford, Shepway and Canterbury will have a shorter journey and there are more public transport links and better car parking at Dover.

Proposal 2: To move the community dental services provided at Folkestone to clinics at Ashford, Dover and New Romney which have more modern and spacious facilities including a waiting area and large disabled access lift. The service is provided for patients who need special care. 74 per cent of patients who are initially assessed at this clinic are referred on to another clinic site because they require treatment under sedation or general anaesthetic.

- This change will reduce the number being referred on to another dentist or clinic site and they will need fewer appointments.
- A significant proportion of patients will be able to receive their care and treatment at a clinic closer to their home.
- Two of the alternative clinics are on the ground floor and have good parking and transport links, the third clinic is located on the 1st floor and has a lift
- Patients will have a choice of clinic depending on where they live and what treatment they need, as well as any additional needs.
- Staff and patients will benefit from a wider dental team

Of the patients that attend the clinic, 50 per cent of patients are not local to Folkestone, while 40 per cent of all patients travel from Ashford to the clinic for their treatment.

Feedback from patients:
Letters were written to over 300 patients describing the proposed changes and providing the contact details of the Trust Customer Care Team for future information or feedback on the changes. The team received 15 calls from patients, these were enquiries about future appointments and timescales.
A local resident spoke to the local media in Folkestone and two comments were received via Facebook against the changes.

A letter was also received from a local residential home as the service would be further away from that home.

Feedback from staff:
The views of staff were sought at the same time as patients. A small number of staff suggested closing the Deal and New Romney clinics and using the equipment to update Folkestone.

Outcome: Having considered the feedback it was decided that the advantages of both proposals on patient care and staff development outweighed the small minority of people who would have to travel further.

As a result of patient and staff feedback, the service has obtained a list of all the voluntary patient transport schemes available and will include these details in with letters to patients, as well as information on how they may be able to claim help with their travel costs if they meet eligibility criteria. If a patient is housebound, the service already provides a domiciliary service at the patient's home.

Communications plan: The dental service will be contacting all its patients to advise them of where their future appointments will be held. The service will select the clinic that is closest to where they live, but will also give them the choice as to whether or not they would prefer to travel a little further to retain their current dentist, although for some patients they will continue to see the same dentist.

The changes will take place during the next three months.

Dr Mark Johnstone
Clinical Director of Dental Services
Kent Community Health NHS Trust.
T: 01622 211943

Item 11: Child and Adolescent Mental Health Services (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Child and Adolescent Mental Health Services (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Secretary of State for Health.

It is a written update only and no guests will be present to speak on this item.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The Health Overview and Scrutiny Committee initially considered Child and Adolescent Mental Health Services (CAMHS) in Kent on 31 January 2014.

(b) At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that this Committee write to the Secretary of State to ask him to assess the adequacy of the current CAMHS service in Kent and that the CCG be asked to identify an outstanding trust to assess improvements that can be to made in the way in which the Sussex Partnership Trust is carrying out the Kent and Medway CAHMS contract and to report back to this Committee.*

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(c) The reply from the Secretary of State for Health is attached.

(d) On 11 April 2014 the Committee considered updates provided by NHS West Kent CCG and Sussex Partnership NHS Foundation Trust. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) this Committee continues to be concerned for the CAMHS service in Kent and recommends that the commissioning of this service is investigated by KCC and West Kent CCG.

  (b) West Kent CCG be asked to give due regard to the recent KCC Select Committee on Commissioning.

(c) *West Kent CCG and Sussex Partnership colleagues be invited to the Committee meeting in 6 months' time and the CCG submit two monthly update reports to the HOSC.*

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the report.

Background Documents

Agenda for the Health Overview and Scrutiny Committee, 31 January 2014, https://democracy.kent.gov.uk/mgAi.aspx?ID=27048

Agenda for the Health Overview and Scrutiny Committee, 7 April 2014 https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5396&Ver=4

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Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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Robert Brookbank
Chairman
Health Overview and Scrutiny Committee
Kent County Council
Sessions House
County Hall
Maidstone, Kent
ME14 1XQ

29 APR 2014

Dear R. Brookbank,

Thank you for your letter of 16 April, about access to Child and Adolescent Mental Health Services (CAMHS) in Kent. I am sorry you did not receive a response to your original letter of 5 February, and please accept my apologies if this was as a result of the Department.

I was sorry to read of the concerns expressed by you in relation to the provision of CAMHS in Kent.

Given the nature of the concerns raised by you, Departmental officials have made enquiries with the local NHS.

I am informed that clinical commissioning groups (CCGs) in Kent are aware that there have been delays in some areas for routine assessments and treatment using particular clinical interventions. This has been a consistent issue. With regard to Tier 4 services (specialist day and inpatient units), I understand that the contract for these services was retendered in 2012, with Sussex Partnership NHS Foundation Trust (SPFT) being awarded the contract for them. Since then, SPFT has been working to improve the service, with some success – cutting waiting times of up to 18 months (in September 2012) to an average of 8 weeks by January 2014.

However, I am told that this success in bringing down waiting times for initial assessments has led to a backlog of young people who require further treatment, which has in turn been exacerbated by difficulties in recruitment. NHS England's Surrey and Sussex Area Team has put in place an interim CAMHS case manager who has oversight of the pathway of care for all Tier 4 placements in the Kent and

Medway area, and works closely with the CAMHS case managers in other area teams to ensure that issues with local services can be addressed. I understand that this is already having a positive impact on the overall quality of care for young people.

With regard to waiting times for Tier 2 and 3 services (community-based services), I am informed by NHS England that Kent and Medway Area Team is aware of the concerns that have been raised by Kent County Council HOSC and by Mr Greg Clark MP. I further understand that the Area Team convened a CAMHS Partnership Summit in December, which brought together commissioners, providers, third-sector and other organisations to discuss their experiences. As you are aware, the outcomes of this summit were shared at a Kent County Council HOSC meeting on 31 January, at which the other concerns surrounding Tier 2 and 3 CAMHS were also discussed.

Finally, I understand that NHS England's Kent and Medway Area Team are encouraging Kent County Council HOSC to consider the whole pathway provision from Tier 1-4 to get a fuller picture of mental health services for children and young people, including Kent County Council-commissioned services for Tier 1, and specialist Tier 4 services commissioned by NHS England and provided by South London and Maudsley NHS Foundation Trust.

I am told that SPFT and local CCGs are keen to hear the views of the council. Therefore, should you have any further concerns, I would encourage you to contact Mr Dave Holman at the following address:

Mr Dave Holman
Head of Mental Health Programme Area and Sevenoaks Locality Commissioning
Wharf House
Medway Wharf Road
Tonbridge TN9 1RE

Telephone: 01732 376091
Email: dave.holman@nhs.uk

I hope this reply is helpful.

Yours sincerely

Jeremy Hunt

JEREMY HUNT