East Kent Hospitals University NHS
NHS Foundation Trust

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

CLINICAL STRATEGY: UPDATE

1. Introduction

1.1 East Kent Hospitals University NHS Foundation Trust (EKHUFT) has earned its enviable record for safety and performance by its continued search for improvement and better results for patients. As we strive to achieve the best for people in East Kent and whilst we recognise that our staff work extremely hard to deliver a safe and high quality service, we know that we can do better.

1.2 Although we achieve good outcomes for patients, we need to continue to improve. We recognise that improved treatments require improved facilities and we need to ensure that we make the best use of the resources that we have. The Trust like every NHS Trust in the country is expected to plan services to make them sustainable, drive efficiency and deliver high quality care.

1.3 As part of this improvement process the Trust has been working on developing a clear strategy for its clinical services, since the end of 2010.

1.4 The process began with discussions with our clinicians and other stakeholders, to draw on their knowledge and experience of advancements in treatments, technologies and standards and that has shaped the current thinking around the Trust's Clinical Strategy.

1.5 At this stage we have not taken any decisions or ruled anything in or out and we are seeking to establish the viability of the suggestions that have come forward from our clinicians.

1.6 That being said, we cannot promise that everything will stay the same for ever. Advances in technology and science will lead to change over a period of time.

2. Purpose of paper

2.1. The purpose of this paper is to provide the members of the Health Overview and Scrutiny Committee with an update from the latest thinking relating to the Trust's Clinical Strategy that have resulted from our discussions as we continue to engage with staff and other stakeholders across the health economy.

2.2. It also summarises the activities that have taken place to date as part of the initial communication and engagement phase which was launched at the end of October 2011 and highlights how we plan to engage further with staff and other external stakeholders so that we can further test the validity of the ideas so far.

3. The key policy and service drivers behind the work

3.1 The key policy and service drivers that have led the Trust to undertaking a Clinical Strategy review are the following:

a. Recent publications from both the Association of Surgeons for Great Britain and Ireland (ASGBI) *"Emergency General Surgery: The Future"* and the guidelines from the Royal College of Surgeons (RCS) on *"Standards for Emergency Surgical Care"* outline that outcomes for patients requiring out of hours surgery i.e. at night and at weekends, are relatively poor, as opposed to those treated during "normal" working hours on weekdays.

4. Aim of the review and key principles

4.1 As work has progressed on the Clinical Strategy Review, key themes have emerged around quality of care, patient safety, financial pressures, trends in care provided by primary care (GP surgeries), community services and location of services.

4.2 As part of this review all the services provided by the hospital were examined and taking account of the emerging themes, the Trust agreed some principles. Relating to our vision for services in East Kent these were:

a. The highest priority for the Trust is "emergency care". This means that patients, who are cared for and/or treated in our hospitals as an emergency, receive high quality, safe care every day of the week, around the clock.

b. The Trust also provides a wide range of other clinical services across its five hospitals and it was also agreed that there needed to be a clear strategy for "planned care" and specialist services. The Trust wants to ensure that if a patient needs a referral to hospital for care or treatments, for example (for an operation or for investigations) they would be happy to "choose" one of our hospitals to treat and look after them.

c. The geography of East Kent and the current pattern of service provision also dictate the need to develop improved community services, in line with national best clinical practice. The Trust also wants to increase the types of care and treatments that it can provide for patients as either daycase procedures or in short stay facilities as opposed to inpatient care.

4.3 In agreeing these principles it was recognised that services need to be clinically safe, affordable and provide equity of access for patients and their families. So our current focus is on areas that we know we need to change and improve:

a. Planned Care
b. Outpatient Care
c. Emergency Care (across all specialties)
d. Trauma Care

5. Details of current service provision and performance in the areas being explored

5.1 The following section outlines the current service provision and performance in the areas being looked at. As part of this work the Trust has agreed the following. The Trust will continue to:

a. provide emergency medical services from all three of its acute sites; WHH at Ashford, KCH at Canterbury and the QEQMH at Margate. This will require on site general surgical support;
b. provide acute inpatient care of the elderly services from the WHH, KCH and the QEQMH;
c. provide inpatient acute services for gynaecology and paediatrics from the WHH and the QEQMH;
d. provide acute inpatient fractured hip (neck of femur) and non complex trauma services from the WHH and the QEQMH; and
e. take into account the recommendations from the Royal Colleges, particularly the Royal College of Surgeons.

5.2 So taking note of these agreements the "Case for Change" for specific clinical areas is as follows:

Short Stay Care – Reasons for change

5.3. We recognise that patients spend considerable time within hospital and waiting for care. This time could be better spent if care were provided in other ways; day care; ambulatory care and short stay admissions.

So what might it look like?

5.4. In line with best practice nationally we need to treat 70% of all unexpected admissions as "short stay" or be discharged within one day. This type of care could utilise both hospital and community facilities. To help us achieve this we are exploring new and innovative ways to use technology to deliver medical services and we are looking at different ways of treating over forty clinical pathways.

Outpatients - Why do we need to make changes?

5.5. The Trust recognises that its outpatient department (clinics) are the front window of its clinical services and first impressions which form part of the patients experience are made around choice, quality, patient safety, privacy and dignity. We acknowledge that a number of our outpatient facilities need modernising so that they provide a welcome environment for our patients and relatives and importantly, support the proposed new models of care.

5.6. Currently we provide outpatient services from 22 sites across East Kent. We have acknowledged that the ways in which the clinics are currently organised are not providing the best service to our patients.

5.7. Although there is a large number of geographical areas where we run clinics we know that we still have a fair number of patients travelling more than 20 minutes drive time for their hospital clinic appointment and patients are often required to visit multiple sites for their assessment and treatment and "***we think our patients deserve better".*** We also know that only a few specialities are offered from some of those sites.

So what might it look like?

5.8. We want to provide a wider range of services across six sites and ensure that over 90% of patients can access outpatient services within a 20 minute drive time. We also want to improve diagnostic and treatment facilities that will allow for a "one stop clinic" approach and maximise the use of clinics by providing early evening clinics as well as possible clinics on a Saturday morning which will better meet the needs of our population. To support this work we plan to rebuild the facilities at Dover to provide up-to-date, modern facilities.

5.9. We plan to, over the next few years, improve our other four outpatient facilities. We are already improving our appointment systems. We want to try the new technology available that will allow us to communicate with GPs and patients directly preventing, where appropriate, an appointment for a hospital visit. We want to discuss this more widely with the public to make sure that we get this right and we will, of course, have to discuss this with staff groups who will potentially be asked to work differently. Finally we will have to link this with other planned changes to ensure that there is the best use of professional staff time.

5.10. One outstanding area is the location of the site for the North Kent Coast. Work continues to assess the opportunities for this location.

5.11. The Trust is also looking at opportunities to expand other forms of care, such as radiotherapy and is discussing whether we could extend this in East Kent to the QEQMH site. In addition, our focus is to extend where possible, specialist emergency outpatient services such as ophthalmology to new sites, again such as QEQMH.

Emergency Paediatrics – What do we want to improve?

5.12. We want to prevent children having to wait unnecessarily in an Emergency Department (ED). If they do arrive in an ED, we want to make sure that they are seen in a child-friendly environment with an assessment by child trained nurses and doctors. We need children to be seen rapidly as their conditions can change quickly and we need fast, expert decisions, especially at peak times of the day.

What might it look like?

5.13. By introducing a "GP hotline to a paediatric consultant" we will ensure access to direct clinical settings. We want to introduce this as soon as we can. We also want Paediatric doctors (consultants and middle grades) and nurses to be allocated to the ED, during peak activity hours and alongside this we want to create a dedicated Children's Emergency area as part of the ED.

Emergency Gynaecology - **What do we currently provide?**

5.14. Currently many women regularly attend the ED and then are referred to the Gynaecological team to be seen in the early pregnancy service the next day. There are three early pregnancy clinics on three sites, WHH, QEQMH and KCH. If women attend the ED, they may have to wait a long time because the doctors are responsible for providing cover to the Maternity for (labour ward) and Gynaecological services.

So how might it look like in the future?

5.15. The aim is for women to avoid the ED altogether, except for out-of-hours and if clinically unstable. By providing a combined early pregnancy / emergency gynaecology service during core activity hours at the WHH and the QEQMH seven days a week and by maintaining the early pregnancy service at KCH, we believe that women will have direct access to the care they need. We also have plans to extend the current emergency gynaecology service at the QEQMH and launch the same service at the WHH.

Emergency Medicine - What happens now?

5.16. We all recognise that patients need to see expert doctors and nurses as soon as possible. At the Trust many patients can be referred direct to the Clinical Decisions Unit (CDU) which is managed by the Acute Physicians who are the specialist doctors who are able to effectively manage many patients in emergency medicine.

5.17. Within our Emergency Department we have difficulties recruiting consultants and middle grade doctors and the Emergency Care Intensive Support Team (ECIST) has stated that we need to provide a consultant led service, providing strong leadership for 16 hours each day at both the WHH and the QEQMH sites.

What might it look like in the future?

5.18. Our plan is to develop a model so that we have a consultant led service 7 days a week between 8 am and midnight.

5.19. Additional consultants would need to be recruited to the Trust and rotated between the WHH and the QEQMH.

5.20. Nurse consultants will provide additional support to the clinical teams and further enhancements to the current service would be met by the further extension of the GP service (Integrated Urgent Care Centre) and the maintenance of the Emergency Care Centre Model with Acute Physicians.

5.21. The suggested improvements for Emergency Medicine are supported by the Royal College of Emergency Medicine and it is believed that it will address the recruitment issues.

Surgery – Reasons why we need to change

5.22. The increase in sub-specialisation means we can no longer rely on some surgeons to provide general surgical emergency services. For example, vascular surgeons no longer form part of the general surgical rota and a question has arisen as to how appropriate it is for breast surgeons to continue to work on the general surgical emergency service.

5.23. We also believe that junior doctors should not be unsupervised when making major decisions in emergency pathways. With small teams of general surgeons at two sites, a consultant is not always available in an emergency and this may cause delays for some patients.

5.24. General Surgery emergency services are currently delivered from two acute sites (WHH and the QEQMH).

How might it look in the future?

5.25. Emergency care is the Trust's highest priority and we need to ensure consultants deliver medium and high-risk surgery appropriately and with the best possible outcome. This means having dedicated general surgery teams without conflicting duties.

5.26. The options that have come forward to date that deliver these aspirations are modelled on a ***"Hub and Spoke"*** principle.

5.27. In this instance:

a. ***"HUB****" is a Centre for medium and high risk colorectal and general surgical cases. This means that one team of general surgeons would be available every day and night with consultant led decision making and involvement in all complex cases; .*

b. ***"SPOKE"*** *would mean that Consultants are on site Monday to Friday during normal working hours. Weekends and out-of-hours general surgical advice would be provided by the resident middle grade doctors.*

The suggested location options are shown in table one and are as follows:

Table One

Option 1	*Hub WHH – 1 spoke at QEQM; assumes KCH remains largely unchanged.*
Option 2	*Hub at KCH – 2 spokes; WHH and QEQM*
Option 3	*Hub QEQM & WHH (continue as now but increase workforce to meet improved professional standards and service improvements).*

6. Trauma Services

6.1. Evidence shows that survival rates and recovery for patients suffering major trauma are improved if patients receive immediate treatment and transport to a specialist centre.

6.2. The Kent and Medway Critical Care Trauma Network has indicated that they would wish to develop three trauma units in Kent - at Pembury, Medway and WHH, Ashford. EKHUFT has responded by making it clear that it is not in the best interests of the whole community to redesign part of the emergency services in isolation and is not therefore intending to make any decision regarding trauma until it concludes its overarching Clinical Strategy.

6.3. We need to consider the provision of major trauma in our clinical strategy and it will need to be provided from a site with a trauma team.

7. Stakeholder Engagement Events and Key Findings from Events that have taken place to date

7.1 On the 27 October 2011 EKHUFT launched the initial engagement and communication process for the Trusts Clinical Strategy Review, highlighting the emerging themes and key drivers for change.

7.2 At the launch a series of presentations to the hospital staff across the main hospitals sites was undertaken. This was followed by an afternoon session with the Clinical Commissioning Groups (CCGs) and GPs in East Kent.

7.3 Since January 2012 the Trust has undertaken a series of engagement presentations to help ensure wider engagement amongst key stakeholders. These included:

a. CCG Board meetings and CCG consortia meetings;
b. The East Kent Commissioning Federation – Whole System Delivery Group;
c. HOSC;
d. Local Borough Councils (Thanet and Ashford);
e. Council of Governors;
f. Hospital League of Friends (QEQMH);
g. MPs;
h. Staff Committee and presentations at the Trust's Chief Executive Forum; and at the
i. Patient Group at QEQMH (Urgent Care and Long Term Conditions Division)

7.4 Following the CCG / GP Stakeholder Engagement Event which was held on 25 July 2012, which was attended by GP leaders from Ashford, C4G (Canterbury), Thanet and Swale CCGs, it was clear that they were vital to the process. Both parties agreed and said they were committed to work in partnership to jointly agree any short and long term strategies for a sustainable future.

7.5 There were three key actions that were jointly agreed by all participants:

a. A commitment to establish a Group to reflect on the longer-term needs and to examine and build up what this might look like for the health economy for the sustainable future.

b. A commitment to establish a small group to reflect on the current meeting structures to ensure that they are ***"fit for purpose***" for the long-term. From these groups it is paramount that the objectives and outputs are consistent and also take account of the vision and any future strategies for the long term. Confirmation has now been given that the current meeting structure is "fit for purpose".

c. To meet with the East Kent Commissioning Federation (and Swale CCG) and the local National Commissioning Board (NCB) to identify a new radical approach to engagement, so that a wide array of key stakeholders across Kent are engaged in the process.

8. Plans for further strategy development and engagement

8.1 As an iterative part of the engagement process the Trust is now developing the second phase of its engagement process and will meet again with staff and other key stakeholders to share the latest thinking. It is planned that phase two of the engagement process will continue to take place over the next few months.

8.2 The next steps are to:
a. test our plans with the long term commissioning plans; and to
b. take independent advice from the Royal College of Surgeons on the surgical options and appropriate clinical adjacencies (a visit from the RCS is due in late November).

9. Timeline of the Process

9.1 Timelines will need to be agreed with the CCGs. It is anticipated that in the event of public consultation this can only take place in 2013 after the Trust and the East Kent CCGs have had the opportunity to engage with stakeholders across the health and social care economy.