Delivering Our Future

1. Introduction

1.1 This purpose of this paper is to describe to the Trust Board progress from the work stream over the last month. Work has also been ongoing around the likely consultation process and some re communications around the timing, of the consultation process are also highlighted in the report.

2. Background

2.1 In January 2014, having undertaken a strategic review of the Trust's clinical services, the Trust Board identified a clear direction of travel for the organisation over the next five to ten year period.

2.2 The Board supported the continued development and assessment of strategic plans that moved the Trust towards a single emergency and high-risk hospital. It was proposed that this facility would be supported by a network of local base hospital sites that would maintain access to a wide range of core diagnostic and treatment services and drive as many services as possible to continue to be delivered locally.

2.3 The drivers behind this are clear and include, as a priority, ensuring the clinical sustainability of quality services alongside the maintenance / return to financial sustainability over the five year planning period.

2.4 Engagement events and dialogue with trust staff, clinicians, CCGs and GPs has helped to formulate the ideas to date and will continue until end of March 2015 so as to refine the Trust's plans.

3. Progress from the Clinical Strategy Work Streams

3.1 Outpatients Work-Stream

Mobilisation of the out-patients clinical strategy continues with the Divisions now preparing for extended working days, one-stop clinics and the changes to job plans to allow for a change of working practices as outlined within the strategy. Engagement with the Divisions is good but data requested from the Divisions has been delayed due to operational pressures and there are concerns that job planning is not as advanced as it should be if the Trust is to implement extended working days from April.

Architects have been appointed to assess the changes required for the main site outpatient departments at Margate, Canterbury and Ashford hospitals in line with the strategy. Their proposals are currently under review by the Divisions. A meeting with stakeholders has been arranged to review these further.

The building work at Estuary View Medical Centre is now complete and clinics commenced from this facility on 26th January 2015. There has been a minor issue with PACs but this issue is in the process of being resolved.

The Buckland Hospital project is progressing well but the construction company are reporting delays of one month. Handover and commissioning is now May 8th 2015. There will then be a two week deep clean process before the process of decanting services from the old building begins on Monday 15 June. Approximately 150 users have visited the site to see their new areas for the first time. There are more visits arranged throughout March.

3.2 Surgical Services Work Stream

The three options for surgery have now been proposed, with Option 3 being the division's preferred option:

Option 1	
Hub site:	All emergency surgery and all high-risk elective inpatients will attend the hub, 24/7
Base site(s):	A full range of day case surgery will be provided but there will be no emergency surgery service and no inpatient surgery provided

Option 2	
Hub site:	All high-risk emergency surgery will attend the hub, 24/7. All high-risk elective surgery will be undertaken at the hub
Base site(s):	Low-risk emergency surgery will be provided together with a full range of day case surgery. Low-risk inpatient elective surgery undertaken

Option 3	
Hub site:	All emergency surgery will attend the hub, 24/7. All high-risk elective surgery will be undertaken at the hub
Base site(s):	A full range of day case surgery along with Low- to medium-risk inpatient elective surgery undertaken (approx 80%). No Emergency Surgery.

Over the last month a great deal of work has been undertaken to analyse the demand for surgical specialties and to understand the capacity required to deliver those services. The work has enabled the Team to understand in real detail what level of surgical activity could be undertaken in the future for each of the three options outlined above. The analysis, which is in the process of being finalised, will outline what level of surgical activity will be provided at a base site

and what activity needs to be centralised onto a High-risk and Emergency hub hospital site.

The findings of this detailed analysis, together with a summary of the assumptions underpinning the demand and capacity modelling, were shared with the Clinical Advisory Board at its meeting on 11th March 2015. The CAB agreed that the Trust should focus on Option 3 as the preferred option for surgical services although it was recognised that further refinement of the services' specifications will be required.

The pathway modelling for emergency and elective surgery has been completed. The Team now is focussing on finalising the workforce requirements for each of the options and on completing the theatre and bed capacity requirements.

3.3. Specialist Services Work Stream

The Women's & Children's Steering Group continues to meet and has good attendance. The Task and Finish Groups for Women's Health and Child Health are now established and they are progressing their tasks.

For Paediatric services, the initial three options that were originally produced have now been reduced to two options for the future model:

- A central acute hub for all inpatient paediatric activity with two base sites;
- Two hub sites for all inpatient paediatric activity with a base site in-between (i.e. stay as we are).

The models of care for Paediatrics for both the Emergency and High-Risk Hub and base site have been agreed and the group has completed their analysis of the activity demand data. The forecast capacity required for the future Emergency and High-Risk Hub and base site model has still to be been agreed.

A detailed analysis of the nursing staff required for the Emergency and High-Risk Hub and Base sites has been undertaken. Work is now underway to look at the Medical and Consultant requirements for this model.

The Women's Health Task and Finish Group has agreed their model of care for the Emergency and High-Risk Hub and base site models although further detailed work needs to undertaken to agree the future models of care for midwifery services. The two options for the future of Women's Health services are as follows:

- A central acute hub for all inpatient activity with two base sites;
- Two hub sites for all inpatient activity with a base site in-between (i.e. stay as we are).

Work is still underway to define the demand and therefore the capacity required (beds, theatres, workforce, etc.) to deliver the model. This is planned to complete by the end of March.

3.4 Urgent Care and Long-term Conditions Work Stream

Operational pressures have made progress slow through January and February as clinical and operational priorities have had to take precedence.

Focus has been on the emergency department activity, the clinical flows and the capacity required to deliver this activity. Discussions with A&E team have taken place to understand high-level model of a single A&E with an Integrated Urgent Care Centre (IUCC) provided on the base sites. Work has also been concluded to analyse the data for A&E and on the modelling of potential pathways for patients from the front door of the hospital through to admission or discharge.

Rheumatology pathways have been mapped with clinicians from both primary and secondary care. This included a model to divide activity into a "tiers of care continuum" (self-care through to secondary care) with discussion of what can be done where, and an analysis of the activity that would be affected.

The next steps are for the Divisions to share their emergency pathways through A&E with other divisions so that a unified model can be produced for all specialties and to agree the activity data modelling widely.

3.4 Ambulatory Care Work Stream

The Ambulatory Care Work stream has now been formally established and the Group's membership, governance and terms of reference have been agreed.

Work will initially focus on improving the understanding of specialty activity, establishing universal coding, setting KPIs, and securing an appropriate environment with sufficient workforce for ambulatory care services. It has been agreed that direct ambulance admissions will be piloted at QEQMH.

3.6 Clinical Support Service Work Stream

This work stream is dependent on the clinical divisions describing their service models and negotiating their demands based on the geographical spread of certain specialities.

The CSS Division will liaise with the other work streams to ensure good communication and ensure interdependencies are clear.

The Division is also cognisant of the fact that consideration must be given to clinical support services when planning the Trust's long-term strategy to ensure this does not compromise the overarching clinical strategy.

The Division has described the strategy, business development, market assessment and workforce implications for each department and is working to ensure all necessary clinical adjacencies are considered. The specialty plans that are being amalgamated into a CSSD overarching plan include:

- Pharmacy
- Out-patients
- Therapies
- Radiology
- Pathology

The Division will review services these including finances, risk registers and 5 year implementation strategy plans as part of their work.

3.7 Workforce & Education Work Stream

Several steering group meetings have taken place. The Group has worked on the assumption that the base sites would have Day Surgery, OPD clinics, Ambulatory Care, 23 hour low risk surgery, planned surgical procedures and lower-risk activity. The Group will now look at the workforce requirements for each of the base site options described in section 5 below.

A medical skills matrix has been compiled that describes the competencies and skills required for a base site options including the provision of out-of-hours nursing-led teams. Further work will be undertaken to review the skills required by other clinical groups to underpin the clinical strategy.

HR Business partners are now working with their respective divisions in developing their workforce action plans. This will be cross-referenced with the HEKSS Urgent and Emergency Care Framework.

3.8 Estates and Facilities Work Stream

Following the Board's approval of the proposals to progress the establishment of a partnership with Kent County Council (KCC) a number of sessions have been held with KCC to determine early works and the resources needed. A proposed governance structure for new partnership will be presented to the Board at its April meeting.

A team has been established to look at making the necessary estates infrastructure improvements within the Trust's A&E departments following the Trust's CQC inspection.

Work has also progressed to establish an off-site ICT Support Service hub in Ashford. The licence to occupy the facility has been signed and moves are scheduled to take place later in March.

Work has also been concluded to evaluate a range of possible options for the use of the vacant Arundel unit at the WHH. This work concluded that one floor of the three-storey building should be used to accommodate a range of Ambulatory Care services including chemotherapy, pre-assessment, hot and cold ambulatory care services and vascular assessment clinics. The remaining two floors of the building would remain central to the plans to develop a Private Patient Unit, until a final decision on this matter is made at the May Trust Board.

3.9 Communications and Engagement Work Stream

In January, a Delivering our Future newsletter was published providing staff with updates and feedback of the work to date. A number of staff listening event were held at WHH and at QEQMH where staff views were recorded.

The Director of Strategic Development and Capital Planning will continue to offer to meet staff in wards and on departments on specific sites during March and April.

4. The requirements for Public Consultation

4.1 In December, the Trust's Strategic Development Team sought legal advice from Capsticks Solicitors on the requirements for a formal public consultation exercise to support the development of the Trust's long-term clinical strategy.

4.2 Under section 242 of the Health and Social Care Act (2006), NHS bodies have two separate legal duties to consult about the way the NHS is operating and about proposed changes. The duties focus on consulting:

- patients and the public; and
- the local authority Health Overview and Scrutiny Committee (HOSC).

Consulting patients and the public

4.3 The legal requirements for public consultations require that any proposed service changes be outlined in sufficient detail so that the public can fully understand how services will be affected at each individual hospital site and therefore how the public's access to services may change.

4.4 Capsticks view was that a formal public consultation exercise could be undertaken outlining the proposed model of care alongside the different site-based options, which would need to include detailed substance relating to the impact of each particular option.

4.5 The National Health Service Act (2006) states that NHS bodies must consult with the NHS and the local authority's HOSC before making any significant changes to services. Failure to consult would leave the NHS body open to a challenge by way of Judicial Review.

4.6 In relation to temporary changes to health services driven by clinical safety concerns, there have been differing views in the past as to whether or not consultations are required for these. The National Health Service Act (2006) and subsequent case law[i] goes some way to clarifying this requirement

although it remains an area of some uncertainty. NHS bodies must consider whether they need to consult, even if a change is only temporary or is driven by genuine clinical concerns.

4.7 Public consultation is not required for every minor or temporary change in the way a hospital functions or in the way services are provided. However, if there is any significant change in the way that local health services are provided, even if that change only applies for a few months, it is possible for patients to argue that there was a duty to consult the public and patients under section 242 before the changes are brought into effect.

4.8 Consequently, a withdrawal of acute medicine from K&CH (even if it is only planned to be withdrawn for a few months) would require a formal public consultation before any enabling works can be implemented.

Consulting the HOSC

4.9 The Trust and the CCGs attended the Kent County Council's Health Overview and Scrutiny Committee (HOSC) meeting in January 2015. At the meeting a joint presentation was made detailing the latest position. As part of the presentation the Trust informed the HOSC that it intended to commence formal public consultation in June 2015 on its plans to reconfigure acute services in East Kent.

4.10 The Trust and the CCGs have made a commitment to keep KCC HOSC informed of progress over the coming months.

4.11 It is vital that the local CCG Commissioners work closely with us on developing the consultation documents. The Trust has agreed with both CCGs that they would wish to consult jointly with us on the proposals.

4.12 It is also really important that NHS England is fully involved and endorses the case for change and any potential service reconfiguration options.

5. Timescales

5.1 The Trust continues to engage with key stakeholders in its long-term clinical strategy and this will continue through to the 30th March 2015 (the date of the dissolution of Parliament). Any formal engagement exercise needs to have been completed prior to the period of Purdah (the period of time immediately

before elections or referendums when specific restrictions on the activity of civil servants are in place).

5.2 The general election must have concluded and the new government established before the Trust can continue with any stakeholder engagement or any formal public consultation for its clinical strategy.

5.3 In light of this constraint, and following reflection of the amount of work still required to prepare the organisation for a formal public consultation exercise the proposed timescales for consulting on the clinical strategy is now September 2015.

6. Conclusion

6.1. The Board is asked to note the progress of the work streams and the proposed changes to the consultation date to September 2015

[i] A significant example of such case law is *R (on the application of Morris) v. Trafford Healthcare Trust (2006) EWHC 2334 (Admin)*