EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS – 27 JUNE 2014**

SUBJECT: **OUTPATIENT CONSULTATION**

REPORT FROM: **DIRECTOR OF STRATEGIC DEVELOPMENT AND CAPITAL PLANNING**

PURPOSE: **AGREEMENT AND FINAL DECISION POST CONSULTATION**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

In June 2013, the Out-Patient Clinical Strategy (OPCS) Full Business Case was presented to the Strategic Investment Group (SIG) and in November 2013 was endorsed by the Trust 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 East Kent Hospitals University Foundation Trust (EKHUFT) in the consultation process.

The outcome of the consultation is to be discussed following engagement with the Kent Health and Overview Scrutiny Committee (HOSC). The final decision on the outcome of the consultation will be informed by an independent analysis of the process undertaken by the University of Kent which was commissioned by Kent and Medway Commissioning Support (KMCS) and is attached as Appendix 1.

SUMMARY:

This paper provides an overview of the Outpatient Consultation and the decision making process.

The key proposals in the consultation were:

a. to reduce the number of facilities used for out-patient clinics from 15 to 6;

b. to offer a wide range of services across most specialities including diagnostic support;

c. to 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;

d. to increase the number of people who are within a 20 minute drive of out-patient services;

e. to invest in the clinical environment to support high quality clinical services and an improved patient experience;

f. to develop a one-stop approach more widely than is currently seen in services;

g. to expand the use of technology to reduce follow up appointments and support patients, monitoring their progress at home or in Primary Care; and

h. invest £455,000 in extending / modify public transport routes provided by Stagecoach.

An option appraisal process has been undertaken to identify a preferred site for the North Kent Coast. The Investment Benefit Scoring model was used for this work and the final scores can be seen in Appendix 2.

The University of Kent was employed to independently analyse the consultation responses. The Kent HOSC was asked to endorse the public consultation as an

appropriate process.

At the HOSC meeting on June 6th it was recorded "that in our recommendation the appreciation of the Committee of the hard work that the Trust has put into the consultation and that the comments of the members of the HOSC be considered and taken into account."

The main issues raised included:

- NHS monies being spent on Stagecoach public transport improvements;
- use of voluntary sector transport;
- increased journey times for patients in the Deal area;
- concerns about the previous Dover consultation undertaken by the PCT; and
- the capacity available on the six sites to meet growing demand.

The HOSC member who attended the option appraisal informed the HOSC on June 6th that she was impressed and surprised by the thoroughness of each appraisal.

The HOSC confirmed that they felt the consultation had been thorough and asked the Trust to update them again in September once the Trust Board and the NHS Canterbury and Coastal CCG have made a final decision.

A full copy of the HOSC minutes are attached at Appendix 3.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

The Trusts Annual Objective 2 (2013/14) states:

AO12: Agree with Commissioners and consult with the public to implement a sustainable clinical strategy which will in particular meet the standards for emergency surgery; look to provide a trauma unit; ensure the availability of an appropriately skilled workforce; provide safe sustainable services with consideration of access for patients and their families and visitors.

Agree and implement following consultation the future provision of Outpatient services across the Trust, reducing the number of outpatient sites from 22 to 6 whilst continuing to provide local access (within 20 minutes) to OPD services. Extend the working day for OPD services, increasing the use of one-stop clinics and exploring the use and viability of telemedicine and telehealth. Commence the build of the new Dover Hospital. Understand the estate requirements at each of the other trust's sites to deliver the new models of care.

FINANCIAL IMPLICATIONS:
Detailed in the business case which has been approved by the Board.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
Consultation process has been independently analysed.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
N/A

BOARD ACTION REQUIRED:

The Trust Board is asked to support the:

a) implementation of new ways of working in an outpatient setting i.e. to introduce and increase appropriate levels of the one stop approach to clinics and patient management to extend the working week from 0730 to 1900 Monday to Friday – introduce Saturday morning sessions and expand the use of assistive technology to support access in GP surgeries, other community settings and in peoples own homes.

b) investment of £455,000 into the extension of public transport links.

c) reduction of specialist acute outpatient clinics from 15 sites down to 6 sites to enable more local access for east Kent patients (an increase from 70.1% to 83.5% of patients) across the patch. This move will also allow access to a much wider number of specialties on these 6 sites.

d) choice of EVMC as the centralised site for specialist acute outpatient services on the north Kent coast.

e) Intent of NHS C&C CCG to develop community hubs/networks that will enable the appropriate transfer of GP/community led outpatient services into other settings beyond the 6 site model being adopted by EKHUFT.

CONSEQUENCES OF NOT TAKING ACTION:
The Trust strategic objectives would not be met including; providing safe sustainable services with consideration of access for patients and their families and visitors.

Progress report on the Outpatient Consultation in east Kent

Trust Board
June 2014

1. Introduction

1.1. In June 2013 the Out-Patient Clinical Strategy (OPCS) Full Business Case was presented to the Strategic Investment Group (SIG) and in November 2013 was endorsed by the Trust 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 East Kent Hospitals University Foundation Trust (EKHUFT) in the consultation process

1.2. The outcome of the consultation is being discussed following engagement with the Kent Health and Overview Scrutiny Committee (HOSC). The final decision on the outcome of the consultation will be taken by the Trust Board taking consideration of the independent analysis of the process undertaken by the University of Kent which was commissioned by Kent and Medway Commissioning Support (KMCS), (Appendix 1)

2. Background

2.1. The Trust currently operates a comprehensive range of general 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 general outpatient and diagnostic services from the Royal Victoria Hospital Folkestone (RVH) and Buckland Hospital Dover (BHD).

2.2. The Trust also delivers general outpatient services from a number of community hospital sites which includes; 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.

2.3. In addition to the above 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.

2.4. The Clinical Strategy's key principles are based on improving the Trust's out-patient services and improving access for the local population. They included:

a. improved patient access based on local postcodes;
b. each site offering a broad spectrum of specialities;
c. a 20 minute travel time for patients by car to their clinic appointment;
d. a reduction from 15 sites to 6 sites;
e. an extended working day to offer a greater choice of appointment times;
f. a one stop model to reduce the follow up attendances and improve efficiency;
g. introduction of telemedicine to reduce face to face contacts for some patients;
h. scope the potential for increasing income by attracting patients currently being referred to other Trusts in Kent;
i. to ensure outpatient facilities are fit for purpose and upgraded where necessary; and

j. implementation of speciality specific criteria i.e. 5 hour sessions for the Surgical Division.

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

a. to reduce the number of facilities used for out-patient clinics from 15 to 6. The Trust's five sites and one site on the North Kent Coast;
b. to offer a wide range of services across most specialities including diagnostic support;
c. to 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;
d. to increase the number of people who are within a 20 minute drive of out-patient services;
e. to invest in the clinical environment to support high quality clinical services and an improved patient experience;
f. to develop a one-stop approach more widely than is currently seen in services;
g. to expand the use of technology to reduce follow up appointments and support patients, monitoring their progress at home or in Primary Care; and
h. invest £455,000 in extending / modify public transport routes provided by Stagecoach.

2.6. Services delivered from Deal Hospital were not included as they have previously been consulted on as part of the re-build of Dover Hospital.

3. The option appraisal process

3.1. The Trust 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%. (Appendix 2)

3.2. The scoring was undertaken for each of the four potential north Kent coast sites in February 2013. The merits of the sites were considered and discussed by the team. Each section is weighted and the scores were calculated. On initial appraisal the Estuary View Medical Centre (EVMC) site achieved the highest score and was therefore put forward as the preferred north Kent site.

4. The consultation process

4.1. 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 will be consulted by the Trust about out-patient services whilst Canterbury and Coastal CCG agreed to partner the Trust in the process.

4.2. 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 took place on 13 March 2014.

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

a. advertisements in December and January were placed in local papers and online via the Kent Messenger newspaper group across east Kent;

b. two BBC Radio Kent interviews;

c. news items on BBC South East and Meridian at launch and subsequently on 13 March 2014 covering the second public meeting at Herne Bay;

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

e. 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;

f. 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;

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

h. 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;

i. 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;

j. 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

k. 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.

4.4. 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.

4.5. This was followed by an 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.

4.6. At the Faversham, Deal and Herne Bay 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, chaired by the Chief Executive, was held and was 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.

4.7. 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.

4.8. 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.

4.9. Responses to the consultation were logged and sent to independent researchers from the University of Kent who collated and analysed the information. A total of 273 online surveys have been submitted, 259 paper surveys have been received as well as a number of petitions and several stakeholders have sent in written submissions.

5. Findings of the Consultation

5.1 There was a low overall engagement in percentage terms of the east Kent population. In terms of 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.

5.2 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 public meeting.

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

5.4 The reduction of sites and acknowledgement of the pressure to reconcile services generated some agreement but some concerns were raised about the proposed reduction. Public transport and access were the two main reasons for concern.

5.5 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 were:

a. an inaccurate measure of the car parking capacity at Herne Bay in the initial assessment process;
b. investment and alterations in Community Hospital sites since the first visits in 2013; and
c. the lack of consideration of demographic data.

6. Further Option Appraisals

6.1 In light of the concerns expressed during the Consultation on April 1st 2014 the Trust and NHS Canterbury and Coastal Clinical Commissioning Group re-visited the four potential sites being considered for the sixth clinical site on the north Kent coast.

6.2 To re-assess the community hospitals, the visiting team from EKHUFT needed information from NHS Property Services who own the three community hospitals at Faversham, Herne Bay and Whitstable. Site plans and building options were requested.

6.3 Following these site visits there was a second option appraisal on April 22nd 2014 with a team including EKHUFT, HOSC, and the C&C CCG.

6.4 NHS Property Services did not return the information required in time for this appraisal so a third meeting was arranged for May 29th. NHS Property Services subsequently sent information on Herne Bay hospital only, leading to the conclusion that Faversham and the Whitstable & Tankerton Hospitals are not suitable for refurbishment to meet the required standard. The sequence of events and communication with NHS Property Service continued over several months.

6.5 The chronology of contact with NHS Property Services is outlined below:

- NHS Property Services was approached first on 8th January 2014 and asked for information on the three Community Hospitals owned by them in Faversham, Whitstable and Herne Bay. They were specifically asked about room availability and suitability. No information was received ready for the pending Public Consultation meetings but no information was received.

- On 31st January EKHUFT's CEO and Chairman visited the Herne Bay Hospital where they met the Chair of the League of Friends and the staff from NHS Property Services. The facilities were discussed and the possible proposals to improve the site for EKHUFTs use. Some site plans were received for Herne Bay hospital but with no clear proposals for where building work could be undertaken to make the area fit for practice.

- On 13th March 2014 a meeting was held with NHS Property Service staff to consider the details for all three sites and the output of this meeting was confirmed in a telephone conference the next day between the Property Services Area Manager, Surrey, Sussex, Kent and Medway, and EKHUFTs CEO. A letter was sent from the Trust the following day confirming in writing details of the information requested.

- On April 1st a team from EKHUFT visited the three community hospital sites and also Estuary View Medical Centre to review the accommodation as concern had been raised at the public consultation meetings. This helped to assess any changes made to the sites since the initial visits the previous year. A further telephone conference on 4th April requested building plans, costs, and lease details from NHS Property Services in time for the second option re-appraisal on April 22nd 2014.

- The second option appraisal was arranged for the morning of April 22nd and NHS Property Services was asked to send all relevant details the week before. Unfortunately the information to allow full scoring didn't arrive and therefore the scores for Herne Bay Hospital were considered but without any detail of how the site could be adapted.

- Relevant information finally arrived from NHS Property Services on May 2nd.

6.6 A third option re-appraisal was held on May 29th 2014. Some concerns were raised by EKHUFTs estate experts on the costs suggested in the initial proposals and a subsequent revision was later sent by NHS Property services with adjusted costs. A rental cost estimate was also received. NHS Property Services also informed the Trust that capital costs were indicative and subject to future Business Case approval which gave no certainty as to the financial costs of the proposals and timescales around the implementation.

6.7 No information was received on NHS Property Services views on Whitstable and Tankerton or Faversham hospital feasibility, the length of tenure for a lease agreement, or clarity on meeting timescales to expand services in November 2014.

6.8 The final scores are presented in Appendix 4 which confirms Estuary View Medical Centre as the Trust's preferred site.

6.9 There are 15 parameters within the Investment Benefit Scoring Model and EVMC scored higher than Herne Bay on 11 of these. There was equal scoring on three and Herne Bay scored higher on one.

- The parameter that scored Herne Bay higher than EVMC was the equitable section. A specific paper was received by the group outlining the options that looked at the demographics, population and housing growth across the three coastal towns. Whilst Whitstable had a larger elderly population proportionally than either Herne Bay or Faversham, Herne Bay was more deprived and had a larger population numbers and relevant growth than Whitstable or Faversham
- The three parameters that scored equally were timely, EBITDA, best use of resources.

In summery these scores did not impact on the overall weighted score or change the overall outcome score.

6.10 Estuary View Medical Centre remains the highest scoring site at 93 out of 100.

7 CCG Views

7.8 NHS C&C CCG has confirmed that they support the underlying principal of the outpatient consultation; the reorganisation of outpatient services to offer improved access, quality and cost effective provision to its whole population. The CCG has taken a listening role through the consultation process and has agreed that the key messages were:

a. support for the Trust's vision to centralise specialist outpatient services onto one site;
b. a need to review the criteria used to assess suitability for the north Kent site;
c. the CCG were of the opinion that they supported supporting specialised outpatients in a single location while at the same time working with communities, GPs and other stakeholders, as part of the Community Services review, to identify services that should be available in all towns; and

d. specific consideration should be given to Care of the Elderly services, along with support for GP led outpatients (as currently being proposed for Deal Hospital).

The CCG recently concluded an extensive review of community services in both Canterbury and Coastal and Ashford CCGs. A letter outlining the CCGs plans for hub/network work programme is attached in Appendix 5.

8 Recommendation

8.1 The Trust Board is asked to support the;

a. implementation of new ways of working in an outpatient setting i.e. to introduce and increase appropriate levels of the one stop approach to clinics and patient management and to extend the working week from 0730 to 1900 Monday to Friday – introduce Saturday morning sessions and expand the use of assistive technology to support access in GP surgeries, other community settings and in peoples own homes.

b. investment of £455,000 into the extension of public transport links.

c. reduction of specialist acute outpatient clinics from 15 sites down to 6 sites to enable more local access for east Kent patients (an increase from 70.1% to 83.5% of patients) across the patch. This move will also allow access to a much wider number of specialties on these 6 sites.

d. choice of EVMC as the centralised site for specialist acute outpatient services on the north Kent coast.

e. intent of NHS C&C CCG to develop community hubs/networks that will enable the appropriate transfer of GP/community led outpatient services into other settings beyond the 6 site model being adopted by EKHUFT.

Appendix 1

CHSS
University of Kent
Centre for Health Services Studies

CONFIDENTIAL DRAFT (v1)

Evaluation of the Outpatients consultation in East Kent.

Jenny Billings, Reader in Applied Heath Research

Dr Sarah Hotham, Research Associate

Linda Jenkins, Public Health Specialist

April, 2014

Commissioned by:

Kent and Medway Commissioning Support

Appendix 1 (cont/d)

Centre for Health Services Studies

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 £1 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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Appendix 1 (cont/d)

Contents

Appendix 1 (cont/d)

Appendix 1 (cont/d)

List of figures

Appendix 1 (cont/d)

List of tables

Appendix 1 (cont/d)

Introduction

CHSS undertook to support Kent and Medway Commissioning Support (KMCS) 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 spectrum of services on each site.

CHSS has provided methodological support to the consultation process, run focus groups and carried out quantitative and qualitative analysis of the information gathered during the consultation period (December 2013 to March 2014). 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 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 (OP) 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 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 Cottage Hospital (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

Appendix 1 (cont/d)

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, are 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 concentrating services on six sites;
- To offer a wider range of outpatient services across all specialities including diagnostic support;
- 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;

Appendix 1 (cont/d)

The consultation process

East Kent Hospitals University NHS Foundation Trust spent two years developing their proposals for improving outpatient services across east Kent. They 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 for extra public meetings to be held.

The consultation process used a range of means to involve people through public meetings, focus groups, online and paper surveys, by attending local meetings and using social media to elicit people's views. There were various ways for people to respond via a dedicated telephone line, email and website. 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. They were also available at focus groups, public meetings and patient meetings or events that the Trust and engagement team were invited to attend.

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 OP services. 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

Appendix 1 (cont/d)

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 rate was: 41 telephone enquiries, 54 emails and letters, 273 online and 205 paper completed surveys. Two petitions were presented with 776 signatures in total, 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. All of the responses received have been recorded and collated by the University of Kent within this report.

Survey analysis

One way of giving views to the consultation was responding to a survey (see Appendix A). This was a pull-out section of the widely distributed consultation document, and it could also be completed online from the consultation website. In this section the response to the survey is described in terms of the number completed, demographics of who responded and how they heard about the consultation, levels of agreement/disagreement with consultation questions and any factors associated with these and, the nature of the comments written in.

Number of responses and response rates

From the launch of the consultation in early December 2013 up to the end of March 2014, 478 people completed the survey part of the consultation, with 205 returning the pull-out paper surveys and 273 completing online. The paper response rate was low (less than 2%) given that over 16,000 consultation documents were distributed. 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 on the paper survey forms was good in terms of the number of people who completed each question within the survey. Over 95% giving their gender, age and postcode and the slightly lower proportion not stating their ethnicity were all signs of a good quality survey and response. The main consultation questions were similarly well completed on paper returns. Although for the online surveys, the demographics and how people heard about the consultation were completed to the same level, the main consultation

Appendix 1 (cont/d)

questions and comments were answered by a lower percentage (74-84%) online. As the questions did not seem to be sensitive ones, or 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 have automatically 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 who were carers (11%) was the same for both methods of responding. People completing the survey online also tended to be younger with more aged 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 general public, but did include more older people which may account for the higher numbers with long-term conditions and disabilities.

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). 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.

Appendix 1 (cont/d)

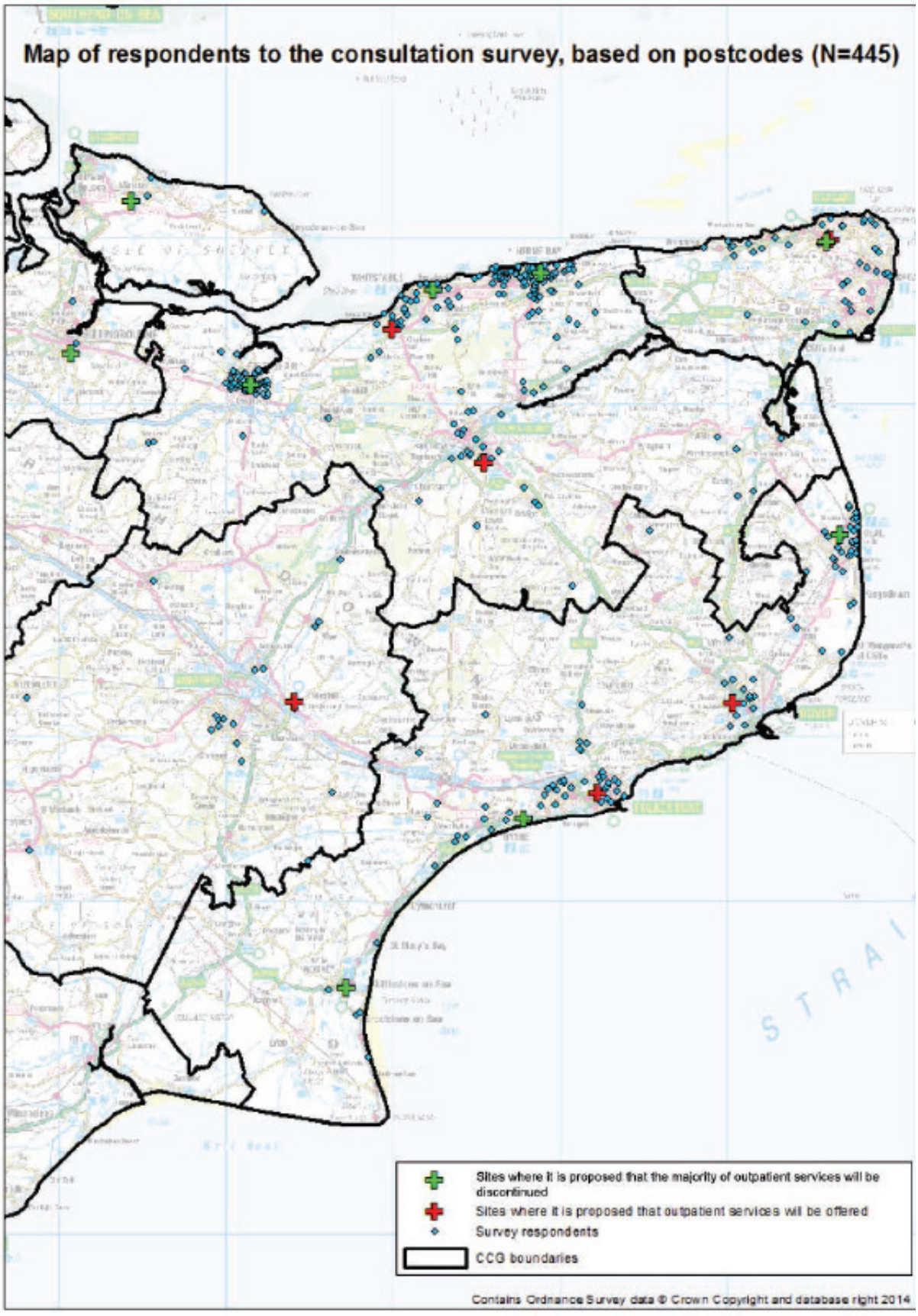
Looking at the CCG catchment area in which people live, the greatest numbers of replies were from Canterbury & Coastal (282 or 59%) and South Kent Coast (112 or 23%) CCGs, with considerably fewer from Thanet (41 or 8.6%), Ashford (21 or 4.4%) and Swale (5 or 1.0%) CCGs. People were allocated to a CCG using the postcode they gave.

Within the two main CCGs 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 the towns most affected by the proposals, with 235 from Faversham, Whitstable and Herne Bay (ME13, CT5, CT6), and 43 from Deal and Sandwich (CT14, CT13). The first part of the postcode was considered sufficiently accurate for the purposes of this analysis to identify the towns where people lived.

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 and social media (29%), reading a newspaper (23%) or from searching online (10%). Respondents using both survey formats had also heard about the consultation were through friends or family (12%). 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.

Appendix 1 (cont/d)

Figure 1 Map of where respondents to the consultation survey live



Appendix 1 (cont/d)

Levels of agreement with consultation questions and comments

There were seven key consultation questions or statements in the survey presenting 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 different sub-groups of the public. The sub-groups were chosen to separate the views according to how affected people might be by the proposals. For example, people living close to the major areas of proposed changes in services (in the most affected CCGs or towns), and people who are likely to be heavier users of outpatient facilities (with health problems or over 75). Although a big overlap might be expected between the 'heavier users' this was not the case, as 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, so both groups have been retained in the analysis.

There were also five open-ended questions in the survey, which were not always completed but nevertheless generated around 1500 comments. 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 three-quarters of the paper surveys to give a flavour of what was written in. The qualitative results section analyses comments made during other parts of the consultation and the survey comments have also been incorporated there.

In selecting noteworthy results for the consultation process, high levels of disagreement with the key consultation statements have been included, with a threshold of 20% or more disagreeing, and also where there was a 5 or more percentage point difference between sub-groups' responses as these were likely to be statistically significant variations. 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'.

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

Although the majority (62%) agreed with this, a substantial 27% disagreed. Disagreement rose for the people living in the most affected areas (49% in Deal/Sandwich and 36% in

Appendix 1 (cont/d)

Faversham, Whitstable and Herne Bay) 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). Likewise levels of disagreement were lower for people aged 75 and over (16% disagreed). Even for consultation survey respondents who did not live 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

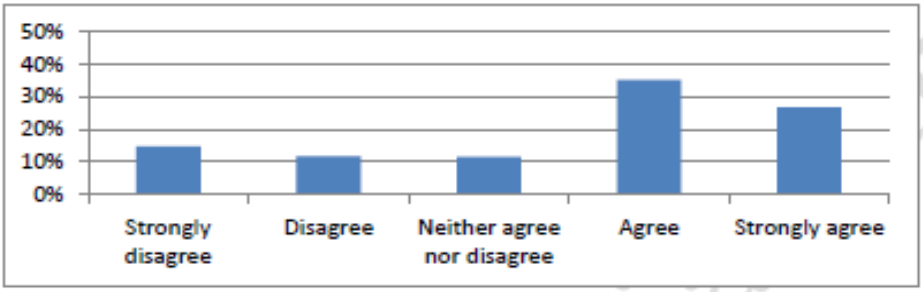


Figure 3: Consultation question 1 - Faversham/Whitstable/Herne Bay respondents

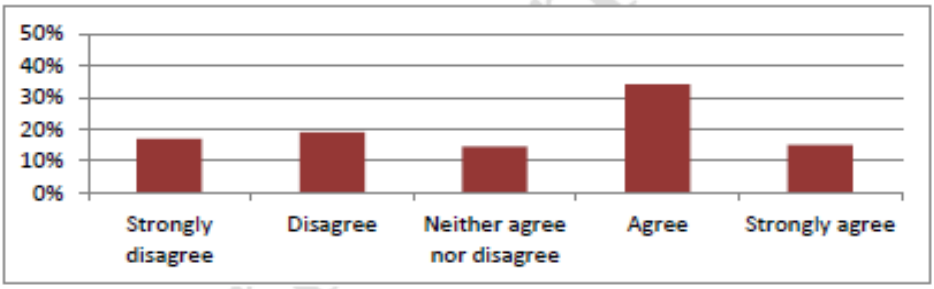
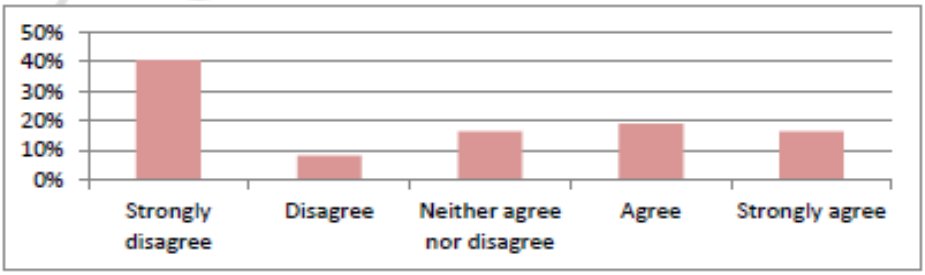


Figure 4: Consultation question 1 - Deal/Sandwich respondents



Appendix 1 (cont/d)

Figure 5: Consultation question 1 - Respondents not living close to major changes

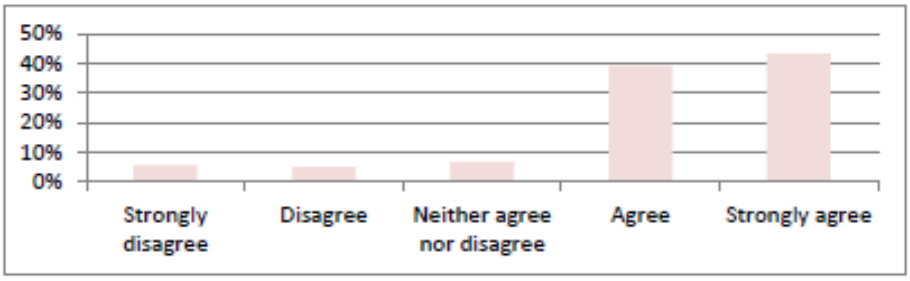


Figure 6: Consultation question 1 - Respondents with disabilities, long-term conditions or are carers

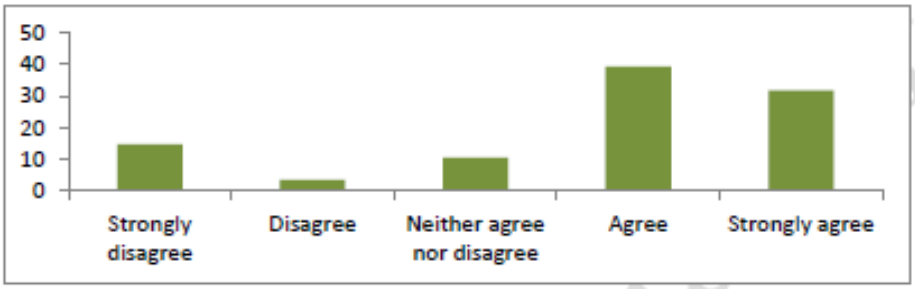
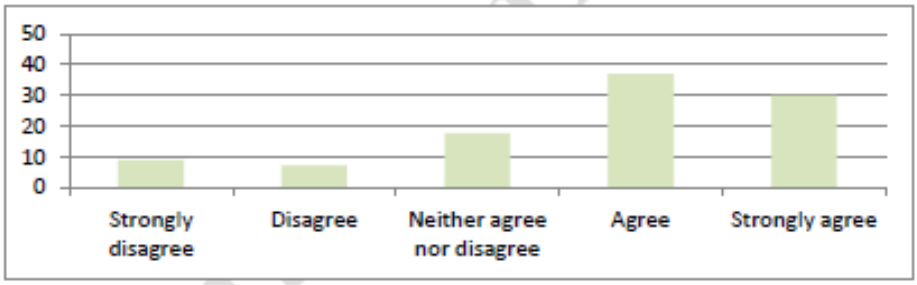


Figure 7: Consultation question 1 - Age 75+ respondents



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

There was general agreement with this statement (84% agreed and 9% disagreed) and this did not vary by CCG or for people with disabilities, long-term conditions or who were carers. Fewer survey responders in the Deal/Sandwich area (71%) agreed with the advantages of extended opening hours, and 16% disagreed. There was least disagreement (3%) with this statement from people aged 75 and over, and from those living in less affected areas.

Appendix 1 (cont/d)

Figure 8: Consultation question 2 - All respondents

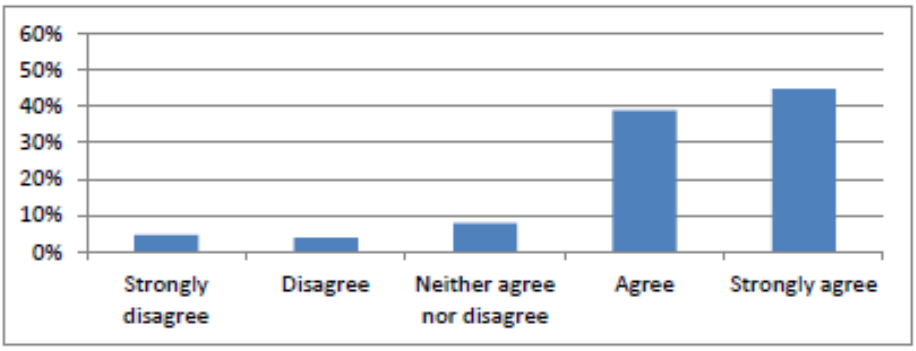


Figure 9: Consultation question 2 - Deal/Sandwich respondents

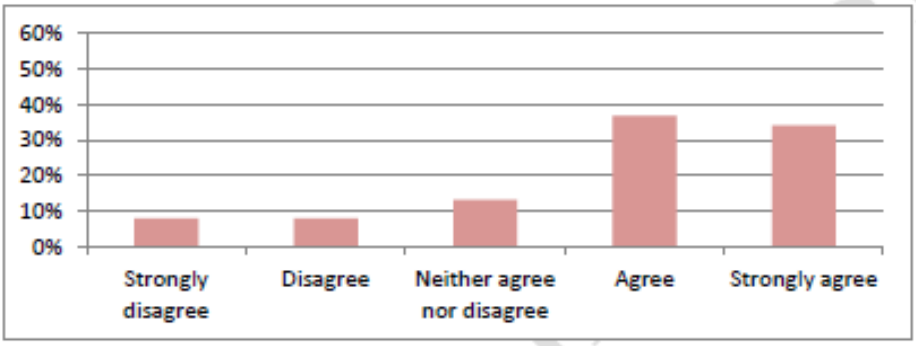
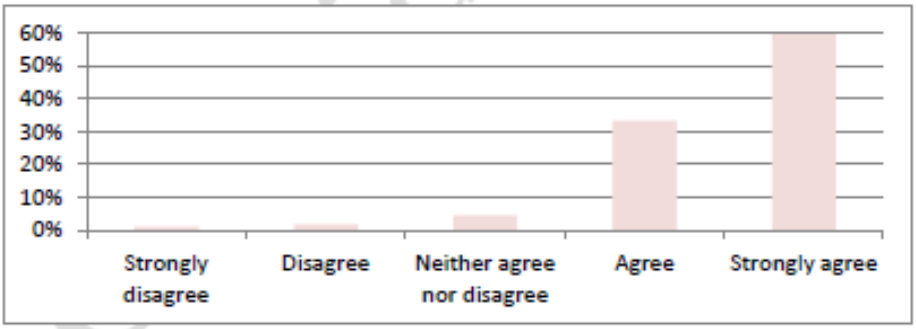


Figure 10: Consultation question 2 - Respondents not living close to major changes



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

Only 54% agreed and nearly a third (33%) disagreed with this statement overall, and this increased to 40% of survey respondents living in Canterbury & Coastal CCG, and those replying online. As many as 31% of people aged 75 years and over did not agree with the 20 minute drive pledge, as well as 24% of people living in South Kent Coast CCG, and 24% of

Appendix 1 (cont/d)

survey responders who had disabilities, long-term conditions or were carers. Around half living in the affected areas disagreed with the 20 minute pledge, with 45% in Faversham, Whitstable and Herne Bay, and 54% in Deal/Sandwich clearly unhappy with the consultation process making this assertion about access to outpatient clinics. Survey respondents who did not live in 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.

Figure 11: Consultation question 3 - All respondents

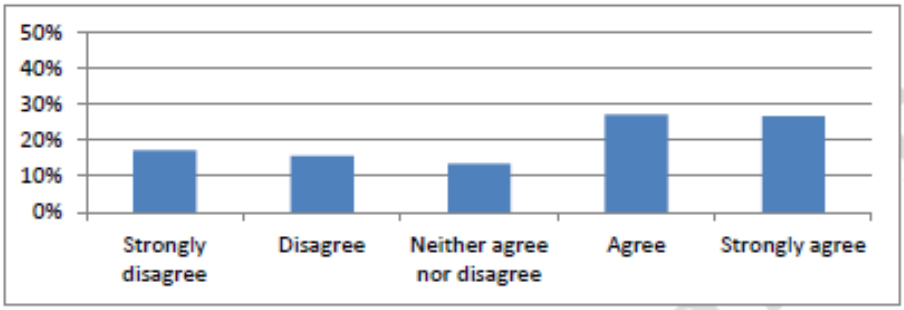


Figure 12: Consultation question 3 - Faversham/Whitstable/Herne Bay respondents

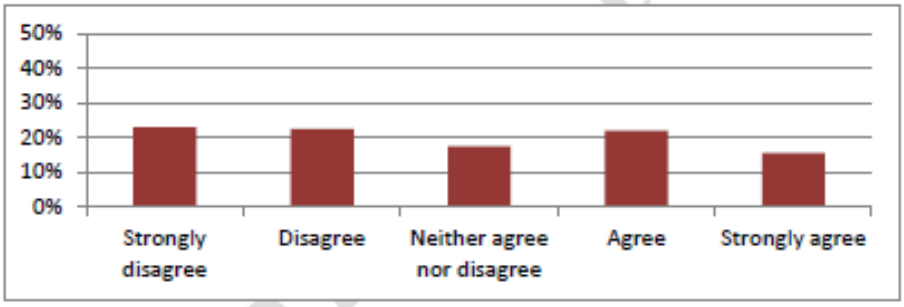
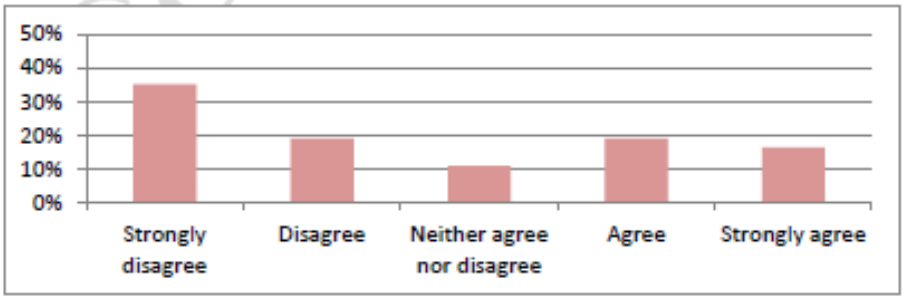


Figure 13: Consultation question 3 - Deal/Sandwich respondents



Appendix 1 (cont/d)

Figure 14: Consultation question 3 - Respondents not living close to major changes

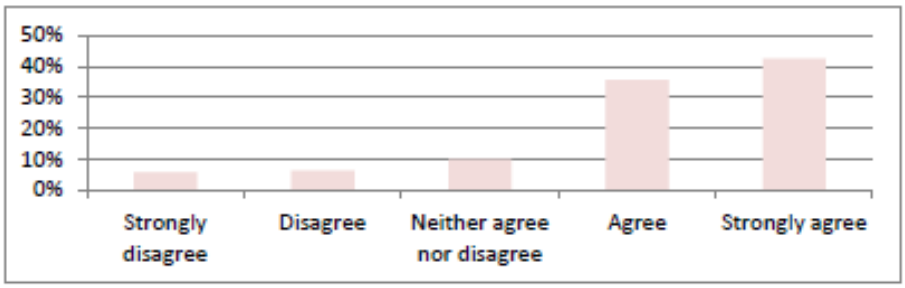


Figure 15: Consultation question 3 - Respondents with disabilities, long-term conditions or are carers

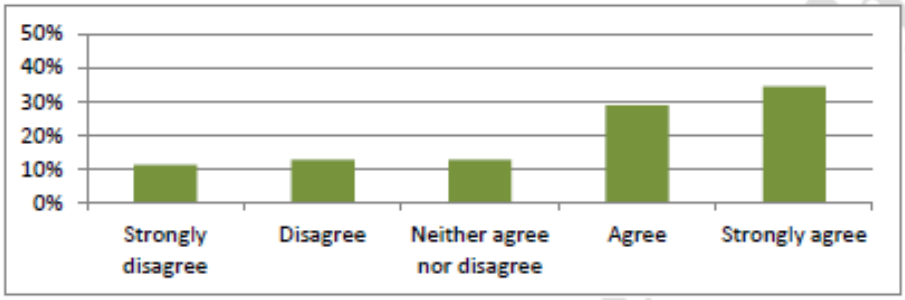
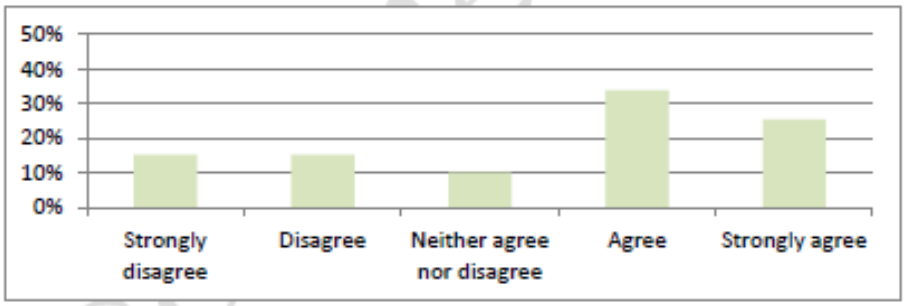


Figure 16: Consultation question 3 - Age 75+ respondents



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

There was agreement with this statement from 64%, with 20% neither agreeing nor disagreeing and 16% disagreeing. This varied little by CCG, the specific towns affected or for people most likely to use outpatient services.

Appendix 1 (cont/d)

Figure 17: Consultation question 4 - All respondents

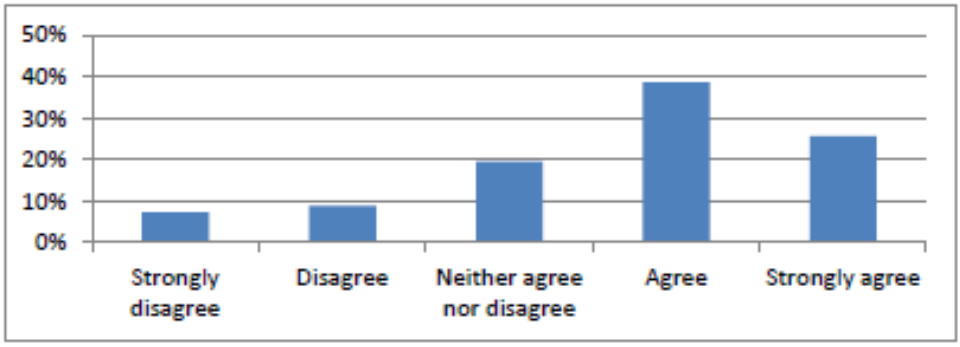
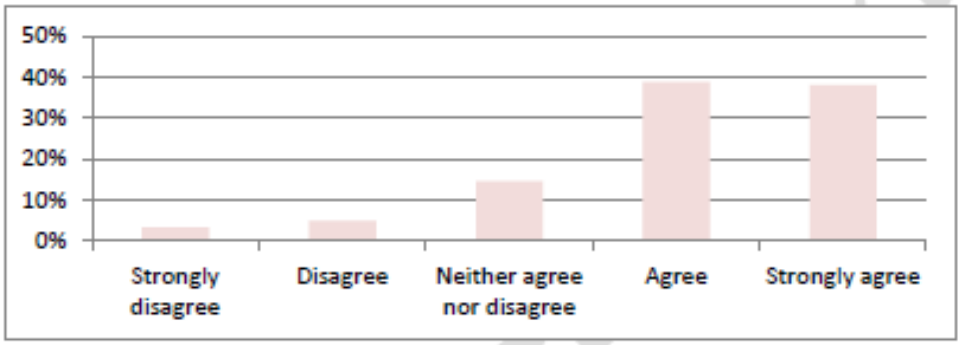


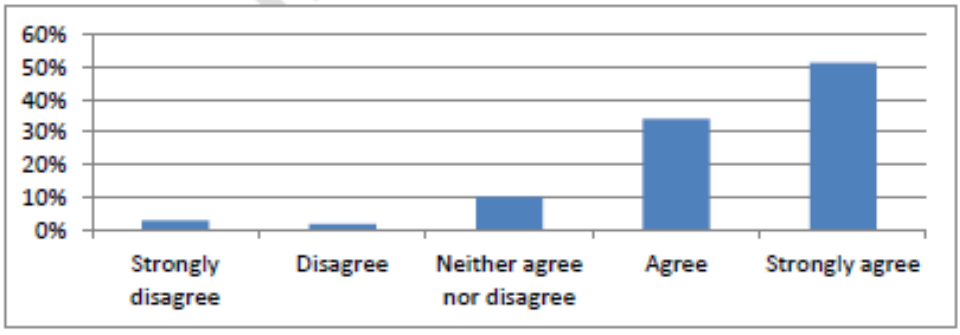
Figure 18: Consultation question 4 - Respondents not living close to major changes



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

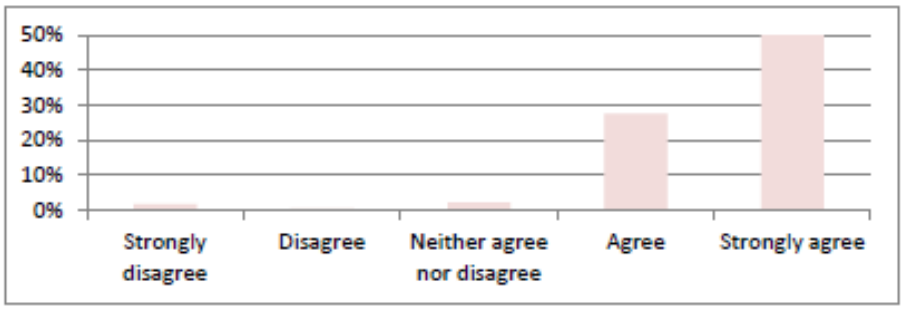
Overall 85% agreed and very few disagreed with this statement (4%).

Figure 19: Consultation question 5 - All respondents



Appendix 1 (cont/d)

Figure 20 Consultation question 5 - Respondents not living close to major 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). There were also comments about specific services such as in Margate and closing a fracture clinic.

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. See Table 1.

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

There were fewer comments, and these focused on issues like making greater use of public transport, and for specific people and services, making efficient use of resources and developing other facilities. See Table 1.

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.

Appendix 1 (cont/d)

There were also critical views on the use of NHS resources and the consultation process. See Table 1.

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

There was general agreement with this statement (73% agreed and 14% disagreed), 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. 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.

Figure 21: Consultation question 10 - All respondents

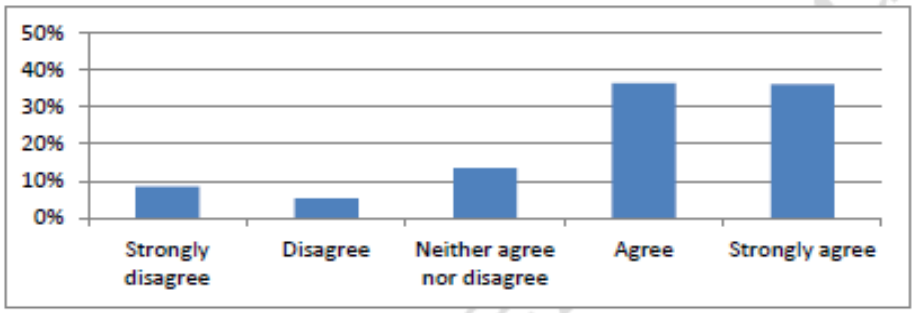
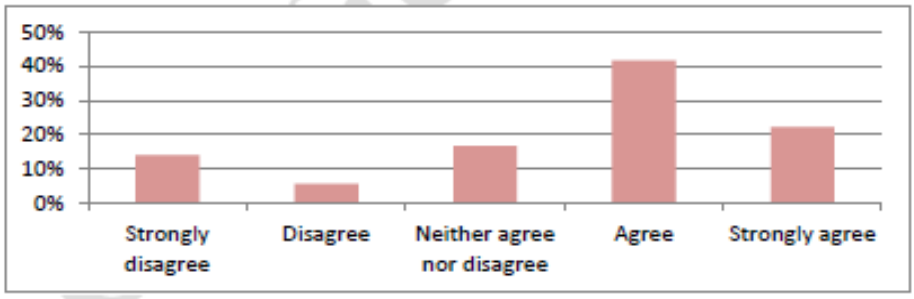
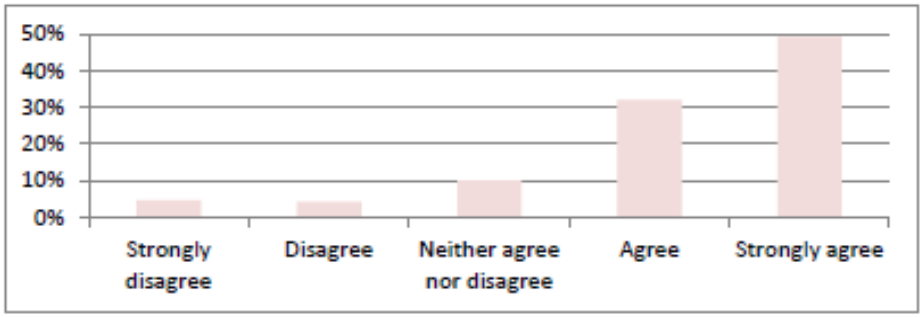


Figure 22: Consultation question 10 - Deal/Sandwich respondents



Appendix 1 (cont/d)

Figure 23: Consultation question 10 - Respondents not living close to major 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?

Although 62% agreed, as many as a quarter (25%) disagreed with this statement and opposition was much greater for survey responders living in Deal/Sandwich (55% disagreed of the 33 people who replied). The percentage against expanding the one-stop approach also increased in other areas: to 30% in Canterbury & Coastal CCG, 34% in Faversham/Whitstable/Herne Bay, and 32% among online responders. Although 73% of those with disabilities, long-term conditions or who were carers went along with this statement, 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. For people who did not live in areas most affected by the consolidation of sites, 9% did not support an expansion.

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.

Appendix 1 (cont/d)

Figure 24: Consultation question 11 - All respondents

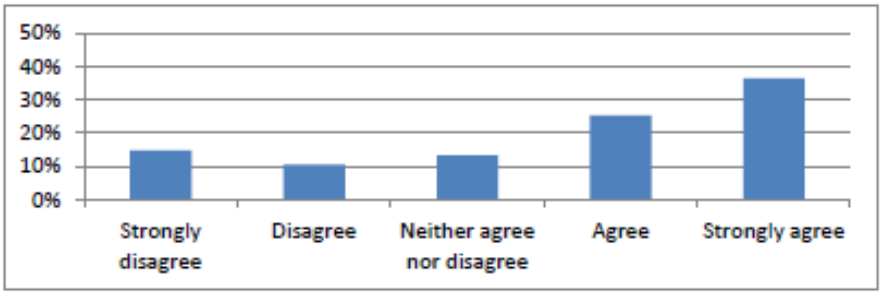


Figure 25: Consultation question 11 - Faversham/Whitstable/Herne Bay respondents

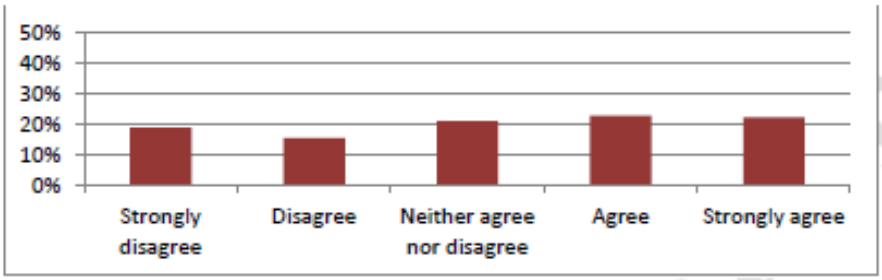


Figure 26: Consultation question 11 - Deal/Sandwich respondents

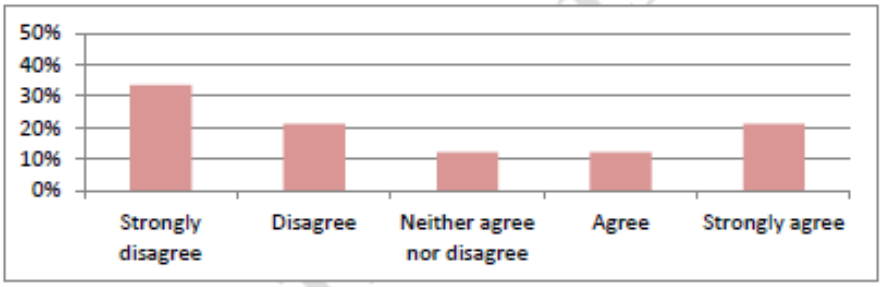
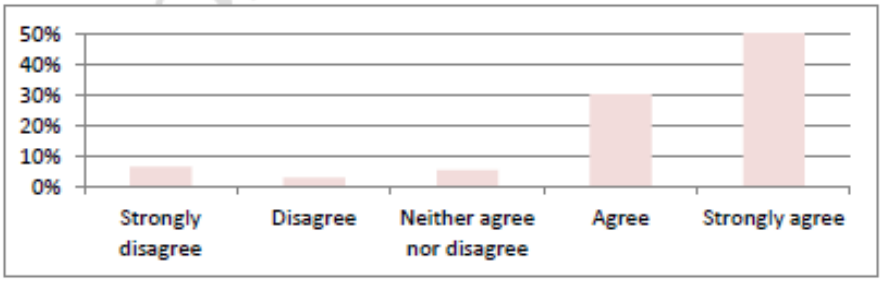


Figure 27: Consultation question 11 - Respondents not living close to major changes



Appendix 1 (cont/d)

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

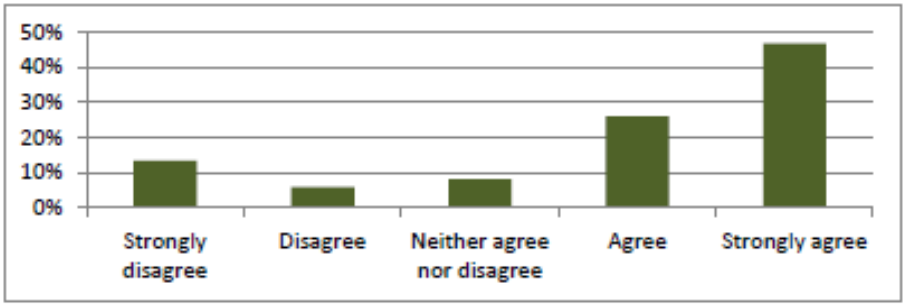
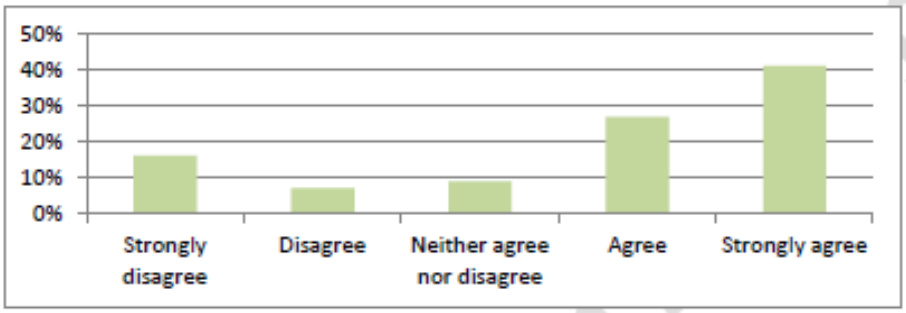


Figure 29: Consultation question 11 - Age 75+ respondents



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 concept would work. It was also the place where people wrote their final comments covering the whole consultation and often repeating comments they had already made (See Table 1 categorising survey comments).

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

Compared to the ticked box questions in the survey, the comments written on the paper survey returns gave the impression of more deep-seated and widespread concerns about the consultation changes (see Table 1). About a half of the comments voiced doubts or concerns about how well the proposed changes would work, and around one third thought the changes would make things worse. Comments in favour were in the minority and these were

Appendix 1 (cont/d)

predominantly about the improved facilities that would come from consolidation on to six sites, the choice of Estuary View, and expanding the on-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 on-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 criticisms of the consultation process and whether it would have any effect on decisions being made.

Key points from the survey

The overall response rate was low given widespread publicity and the number of consultation documents handed out. Less than 500 completed the survey out of a population of 700,000- this gives an indication of the levels of either opposition or ambivalence to the consultation documents and process.

There was an uneven survey response with most people taking part coming from Canterbury & Coastal CCG and South Kent Coast CCG, and within Canterbury & Coastal CCG there was a heavy bias towards the views of Faversham, Whitstable and Herne Bay residents.

There was overall support for all the key consultation questions, but for some of them there were substantial proportions of people who disagreed with the consultation statements. The most contentious parts of the survey were the overall concept that access would be improved by providing a greater range of services from each location (Q1), that access would be improved by increasing the number of people within a 20 minute drive of a fully equipped outpatient centre (Q3), and expanding the one-stop approach (Q11). The greatest opposition on the three most contentious survey questions came from people living in areas affected by the proposed changes (i.e. people living in Deal/Sandwich and Faversham/Whitstable/Herne Bay). Survey respondents from Deal/Sandwich were also more opposed to the suggestions that access would be improved by extending opening hours (Q2) and the trust could make better use of technology in people's homes (Q10).

Appendix 1 (cont/d)

In contrast to the levels of agreement on the tick-box questions, the comments on the survey forms were much less positive, and raised many concerns and doubts about the proposals effect on aspects of future outpatient service.

The survey showed overall support for the changes, but with a considerable number and range of concerns, alongside some pockets of highly critical people.

Table 1: Distribution of paper survey comments

Appendix 1 (cont/d)

2nd digit	3rd digit		1st digit coding of comments			1 the changes will be an improvement 2 the changes will make things worse 3 I have comments, doubts or concerns																		
			q6			q7			q8			q9			q12			totals				N of comments			% 2nd digit
			1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	all	1	2	3	
1 Access	1 journey: distance, time, cost			1	2	1	10	3		4	2		4		1	1	2	2	20	9	31		-	*	
	2 ease of using public transport			3	3		6	2		5	6		4	3			2	0	18	16	34		-	**	
	3 ease of using car									1	1							0	1	1	2				
	4 for specific people (older, without car, etc)			1	2		6	1		2	4		1	1				0	10	8	18		-	*	
	5 for a specific service, eg Margate, fracture clinic			1	8		1	1			4						1	0	2	14	16			**	
	6 for people in Deal/Sandwich area			1	1		3	1		1							1	0	5	3	8		-		
	7 for people in Herne Bay/Faversham area			2	1		4			2	1		3				2	0	11	4	15		-		
	8 for other specific areas, eg Lydd			1	3		1	2										0	2	5	7			*	
	9 other access			1	2			1		1	1		1	1				0	3	5	8			*	32%
3 Facilities	1 proposed changes in services		1	4	1	26	11	3	2	3	2	27	6	3	5	6	1	61	30	10	101	+++	---	**	
	2 parking space and charges				3		2				1		3	1		1	1	0	6	6	12		-	*	
	3 clinic capacity, seating						1			1	1		2				1	0	4	2	6				
	4 other developments suggested	*			3									1				0	0	4	4				
	9 other facilities	*			3						3			1				0	0	7	7			*	30%
4 Quality of service	1 communication and co-ordination, incl booking and test res				16						3							0	0	19	19			**	
	2 delays and waiting times			1	10		1	2			1		2	1	1	2	2	1	6	16	23		-	**	
	3 one-stop clinic		1		1			1							10	1	8	11	1	10	22	++		**	
	4 patient choice									1								0	1	0	1				
	5 patient rather than provider-orientated						4										1	0	4	1	5				
	6 overall service				2		2									1		0	3	2	5				
	9 other service quality				1												1	0	0	2	2				18%
5 Use of NHS	1 efficiency			1			2			1	3	1		1		1	2	1	3	8	12			*	
	2 use of non-NHS premises						1				3	1		2				1	1	5	7			*	
	9 other resource use			1	3		1				2		2	2				0	4	7	11			*	7%
6 Miscellaneo	1 views on the consultation	*			3			2						3			5	0	0	13	13			**	
	2 views on change being needed			6	4		3			2			2	1		2	1	0	15	6	21		-	*	
	3 views on developing other facilities	*			1						3			3				0	0	7	7			*	
	4 views on better ways of working	*			4				1		1			1		1	3	1	1	9	11			*	
	9 other miscellaneous	*			1									1			1	0	0	2	2				13%
	Sub-totals		2	24	78	27	57	21	3	24	42	29	30	25	17	16	35	78	151	201	430				100%
	Question totals		104			105			69			84			68			430							
	% distribution		2%	23%	75%	26%	54%	20%	4%	35%	61%	35%	36%	30%	25%	24%	51%	18%	35%	47%					
	* - some will only have first digit=3																								

Appendix 1 (cont/d)

Table discussion analysis

Table discussions were held as part of the consultation events. At five of the consultations (Deal and both events in Herne Bay & Faversham) the audience was deemed too large to effectively run these small 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.

The table discussions enabled people to break out in to smaller groups and reflect on the proposals in more depth. In these groups, the questions from the consultation survey were asked and feedback obtained via the Likert questions and free text comments. This Likert data was completed by the group facilitator (e.g., Trust employee, KMCS representative) and represented 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.

As with the survey questions, responses were scored from 1 = 'seriously disagree' to 5 = 'strongly agree'; hence higher scores are indicative of a more positive response. Seven Likert questions were asked and the results from these questions are detailed below in Table 2. The Mean values suggest that overall people were in agreement with most of the proposals put forward. Access to an outpatient's clinic within a 20 minute car journey was the question that elicited the lowest overall Mean response.

Appendix 1 (cont/d)

Table 2. Descriptive statistics for Likert data at table discussions

Question	N	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

Qualitative analysis

Introduction

To gain an in depth understanding of the public reaction to the proposals set out in the consultation, responses across 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 generated at the 12 public consultation events and subsequent table discussions (6 of the 12 events), four focus groups run by the CHSS , six focus groups run by KMCS, 54 letters and emails, and comments provided in the survey. Data from the focus groups was recorded and transcribed in full. In the consultation events and table discussions, written notes were made at the time by representatives of KMCS and subsequently forwarded to the University of Kent.

Appendix 1 (cont/d)

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 PPGs across the SKC, Thanet, Canterbury & Coastal, and Ashford to offer the opportunity of participating in a focus group. Subsequently the University of Kent ran four focus groups with Mencap in Deal, Dover Disability Group, an ESOL class in Dover, and the mental health support group Thanet SpeakupCIC. These focus groups typically ran for 1 hour and followed a guide developed by University of Kent and KMCS (see appendix B).

KMCS also ran an additional six focus groups with Locality Groups in Dover and Shepway, Stoma Support Group 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 their plans for the new Dover.

The data generated from these sources is presented in four parts, reflecting the main areas of covered by the consultation: measures for improving outpatient services, reduction of sites, choosing the North Kent site, and future improvements. Within each part, 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.

Within this part, the four proposed improvements, as set out in the consultation, were discussed:

1) To increase the range of services;
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

Views on a number of proposed improvements were sought. The first improvement focused on increasing the range of clinical outpatient services that, going forward, would be available

Appendix 1 (cont/d)

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. It was also recognised that having outpatient services spread out across numerous sites may not be the best utilisation of resources- consolidating these, and the equipment used, 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)

Appendix 1 (cont/d)

"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 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)

Appendix 1 (cont/d)

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 won't 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.

"If you're trying to get anywhere on a Sunday and using public transport it's a bit of a different matter." (Margate: Focus group)

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

The need to consider transport restrictions was highlighted as a potentially barrier for people attending early outpatient appointments.

iii) Implementation concerns

This theme encompassed a number of concerns raised regarding the practicalities of extending the service. 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

Appendix 1 (cont/d)

did not know it was available. You need to make an effort ensure receptionists inform people." (Dover: Consultation Q & A)

However, 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 numbers of patients at each site is to increase.

"If they go ahead with these closures, it's the only way they can… They have to extend it because the amount of people that are going to turn up to different clinics they are going to need extended hours. They'll probably even have to start looking at Sundays."(Dover: Focus Group)

"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 OP care within a 20-minute drive of a fully equipped OP 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.

Appendix 1 (cont/d)

"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)

"Well, yeah, and 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:

Appendix 1 (cont/d)

".....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)

"(20 minute drive) Not been tested by "actual" journeys." (Dover: Consultation Q & A)

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

Appendix 1 (cont/d)

"You are planning to spend ½ mil 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 money allotted 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, making the environment more welcoming.

Then 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 investigating 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. Parking came across in both table discussions at some of 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 to be moved. Finally, regarding staff, various improvements were offered, mainly from the table discussions, and focused on increasing staff numbers, staff training and enhancing the staff-patient relationships (e.g., information about staff in the clinic).

Appendix 1 (cont/d)

Although in general this proposal was positively received, alongside these views 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.

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.

Agree with the proposal

Responses gathered from a number of the table discussions, focus groups and survey comments indicated a degree of 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 comments)

"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)

Appendix 1 (cont/d)

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- while acknowledging the need to consolidate resources there were concerns expressed about how the reduction 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)

Disagree 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 noted across all forums of feedback 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.

Appendix 1 (cont/d)

"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 appointment, have to wait for buses - 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, and in letters/email received and in focus groups held in Margate and Shepway. 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. Concerns emphasised the difficulty people living in this area already have in terms of transport and accessing healthcare- by closing outpatient services in Hythe and New Romney this population could be further disadvantaged.

"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)

Appendix 1 (cont/d)

Furthermore, 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 was expressed about how the proposed changes could affect this 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, ill, 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.

Elderly

Response from the 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)

Without a car

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

Appendix 1 (cont/d)

"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)

Another example of this concern was expressed in the Herne Bay consultation; comments were made 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)

Ill health

The focus group in Margate with SpeakupCIC – 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 at a detriment 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) Patient transport

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

Appendix 1 (cont/d)

".....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 OP 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 the University of Kent and KMCS, and finally letters and emails sent by members of the public.

Points used to compare

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) Agree 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. People not directly affected by the choice of the North Kent coast site (i.e., Dover and Folkestone) also commented that they felt the appraisal covered the key points.

ii) Disagree with points used

However, although support for the points used was noted in some discussions, the majority of comments provided to this question reflected a number of concerns. These concerns were voiced at consultation events in Herne Bay (across both events), Faversham (across both events), Whitstable, Canterbury, and Margate. Furthermore, comments made in the table

Appendix 1 (cont/d)

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 collected from these sources highlighted a number of key criticisms. First, letters received from Herne Bay residents, alongside responses expressed at the consultation events in Herne Bay, suggested the facilities at QVMH had been incorrectly evaluated. For example, the description 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. A similar view was also expressed in one of the table discussions in Canterbury.

"..... 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, the appraisal of car parking was also criticised. Views expressed in the consultation events and focus groups highlighted the opinion 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 OP services are available, people felt OP services could be increased using current facilities. The

Appendix 1 (cont/d)

example was given of Newton Place Surgery, which was not included in the appraisal, but was highlighted as having available clinic rooms.

Finally, 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 WTH 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. Finally, concerns were 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

Alongside feedback on whether points used as comparators were useful and accurate, the consultation and focus groups also provided an opportunity for the public to suggest other points to be 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.

Appendix 1 (cont/d)

For example, a number of letters received from 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

Appendix 1 (cont/d)

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 OP service provision in Faversham and Ashford.

iii) Ownership of estate

A final minor suggestion 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 received 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 include disabled facilities, baby changing, toilet facilities, and current staffing levels.

Appendix 1 (cont/d)

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 OP 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 OP 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)

Appendix 1 (cont/d)

"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 the 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." (Herne Bay: Letter 4)

In conjunction with these concerns, 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 OP services at this site, the current car park would be sufficient.

Appendix 1 (cont/d)

"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 of comment 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 had either 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,

Appendix 1 (cont/d)

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-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)

One-stop approach

The Trust would also like to develop a 'one-stop' approach. 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.

Appendix 1 (cont/d)

"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 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

Appendix 1 (cont/d)

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.

Appendix 1 (cont/d)

"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)

Reflections on consultation process

Governmental guidance on consultations published in October, 2013 provides a code of practice to help policy makers make the right judgements about when, with whom and how to consult. The governing principle 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 forms of consultation (e.g., public meetings, focus groups, surveys) rather than reverting to only a written form. With this in mind, the current outpatient's consultation meets this recommendation as various informal avenues were offered to the public to enable them to engage with consultation. 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.

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)

Appendix 1 (cont/d)

"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, 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'*

Appendix 1 (cont/d)

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)

Appendix 1 (cont/d)

Summary of main points

- In considering the data and subsequent conclusions drawn, it is important to note two key aspects. First, regarding the survey responses, there was a low overall engagement in percentage terms. Second, as people were able to offer their feedback in various forms (e.g., consultation Q & A, table discussions, via surveys, letters, and focus groups) 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.

- In terms of the improvements detailed in the consultation, overall the proposal to extend opening hours and improve the range of outpatient services was received well, with little opposition voiced in the consultation events and focus groups.

- The proposal to increase the number of people within a 20-minute drive of an outpatient's clinic received an 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 the20-minute criteria and the focus on drive time- not on public transport journey times.

- The reduction of sites generated some agreement and acknowledgement of the pressure to reconcile services; however, the predominant feeling expressed across all forums of feedback was concern about the proposed reduction. 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 host. 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 the demographics of the areas involved.

Appendix 1 (cont/d)

- There was also 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 utilisation of new technology and the one-stop approach was viewed in the consultations and focus groups with positive, but cautious feelings about how these changes would be implemented. However, responses from the survey suggested reduced support for one-stop clinics.

References

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

Appendix 2

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

KENT COUNTY COUNCIL **Appendix 3**

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, 6 June 2014.

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

ALSO PRESENT:

IN ATTENDANCE:

UNRESTRICTED ITEMS

44. East Kent Outpatients Services: Consultation Update
(Item 6)

Simon Perks (Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs), Liz Shutler (Director of Strategic Development & Capital Planning, East Kent Hospitals University Foundation Trust), Rachel Jones (Director of Business and Strategy Development, East Kent Hospitals University Foundation Trust) and Marion Clayton (Divisional Director, Surgical Services, East Kent Hospitals University Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Shutler introduced the item and proceeded to give a presentation which covered the following key points:

- The Trust's justifications for change
- Consultation and engagement process
- Feedback from patients
- Outpatient Services Strategy
- The six proposed Outpatients sites
- Option appraisal for the North Kent site
- Next steps - decision-making at the EKHUFT and CCG boards

(2) The Chairman asked Miss Harrison to comment on the optional appraisals which she attended on behalf of the Committee on 22 April and 29 May. Miss Harrison observed that she had been impressed and surprised by the thoroughness of each appraisal. The final option appraisal in May was held following the receipt of information from NHS Property services.

(3) Mr Inett was also invited to comment. He explained that Healthwatch Kent had been working with the Consultation Institute; they had been using the consultation as a test case to look at their role as a critical friend. The focus of the consultation by the Trust had been on Landsley's four tests for service

reconfiguration. Mr Inett highlighted that if there was a legal challenge, the Gunning Principles would be applied instead. One of the Gunning Principles was that consultation must take place when the proposal was still at a formative stage. Mr Inett requested additional information regarding the public's involvement in option development. He also sought clarification about the support for six outpatients' clinics (question 7 on page 59 of the agenda pack) and the involvement of minority groups in focus groups. Mr Inett commented that the consultation focused on the North Kent site and that Healthwatch had been made aware of concerns from the public regarding the effectiveness of the one stop shop process. Healthwatch Kent was looking at one stop shops across the country. Healthwatch Kent were meeting with the Trust to discuss issues in detail.

(4) Ms Shutler responded to the comments and questions raised by Mr Inett. It was explained that the six sites were modelled technically looking at patients, travel times and demographics of the local communities. Patient and professional representatives were on the working group which developed the outpatients' strategy; patient surveys and public stakeholder meetings were also held. Concerns had been raised by elderly groups about the time appointments would take and facilities at the one stop shop. The Trust stated that giving more power to patients to book appointments would improve the flow and patient experience. The Trust commissioned the University of Kent to undertake the focus groups; the outcomes of these focus groups were detailed in the report. During the consultation period, the Trust was able to talk to other minority groups including the Nepalese community in Hythe. Ms Shutler indicated that she could provide further details to Mr Inett at their meeting.

(5) Members of the Committee then proceeded to ask a series of questions and made a number of comments.

(6) Members raised concerns about the Trust's investment of £455,000 to extend and modify public transport routes provided by Stagecoach. It was explained that the Trust had been in lengthy discussions with Stagecoach about additional services; Stagecoach had not been willing to look at additional routes without additional funding. The majority of the funding would be going to Stagecoach to provide additional routes. Details of voluntary sector transport services would be made available to patients in their information pack when booking appointments. In relation to a specific question about transport links in Deal and Walmer; it was acknowledged that the number of buses which run from Deal to Buckland Hospital per hour would be doubled. There was also a proposed route from Whitfield to Buckland Hospital which would run on to Deal, Sandwich and the QEQM Hospital. The Trust acknowledged the need to improve and invest in public transport; at present 80% of the Trust's patients travel by car to their outpatient appointments. The Trust was working with the current patient transport service provider to improve their response rate.

(7) A Member enquired about the quality of communication with patients. As part of the outpatients' consultation, patient administration services had been reviewed. The Trust had found issues with communication with patients and was looking to improve this aspect of their service. It was confirmed that letter writing had not been outsourced to a foreign company; letters were written by Trust staff locally.

(8) A Member expressed concerns that patients in Deal would have an increased journey time to outpatients' services as set out in the proposals. It was explained that under the proposals the number of patients from Deal, who would be able to access care within the time frame, would increase. Residents in Deal generated 30,000 outpatient appointments a year, a third of these appointments (10,000) took place in Deal Hospital. 90% of appointments at Deal Hospital were follow-up appointments; patients would not access their entire pathway at the hospital.

(9) The Member raised a further concern that the residents of Deal had been misled in a previous consultation regarding Buckland Hospital and the service provision in Deal. It was explained that the consultation being referred to was a consultation on service provision in Dover which was led by East Kent Primary Care Trust in 2006. The consultation document looked at three options for outpatient services: services being provided as close to home as possible in a GP surgery or in a central Dover location; moving services from community to acute hospitals; and maintaining services at all sites including at Deal Hospital. The majority of respondents chose option G1 – providing services as close to home as possible in a GP surgery or in a central Dover location. Ms Shutler stated that she felt that this was a very clear consultation exercise. As a result of the 2006 consultation, East Kent Hospitals University Foundation Trust invested £23 million to develop a new hospital at the Buckland site.

(10) A number of comments were made about the consultation events, patient mobility and the capacity of the proposed system. The Trust offered to provide the Committee with data regarding outpatients accessing patient transport services. It was acknowledged that capacity was currently underutilised. Under the proposals, the working day would be extended which would increase the utilisation of the buildings and enable patients a greater choice of appointments. The workforce would be maximised and provide a more efficient service as staff would not be required to drive to 15 different sites. The Trust had forecasted demographic growth as part of future proofing and was confident the service would not be over capacity in the future.

(11) The Trust asked in their report for the Committee to 'agree that the public consultation process has met the required standards as set out in the Health and Social Care Act'. The Scrutiny Research Officer was asked to provide guidance on the recommendation. She explained that the legal duty to consult local authority health scrutiny bodies was distinct from the separate duties in the NHS Act 2006 (as inserted by the Health and Social Care Act 2012) on Trusts, CCGs and NHS England to involve service users in the development of proposals for service change; and it was important that the two duties were not confused or conflated. She stated that a recommendation, asking the Trust and CCG to take on board the comments made by Members during the meeting, would be more appropriate.

(12) RESOLVED that:

(a) The Committee records its appreciation of the hard work the Trust has put into the consultation.

(b) The comments made by Members of the HOSC are considered and taken into account.

(c) The Committee asks for a return visit in September when a final decision has been taken.

Appendix 4

The final scores are in two versions below as there is no clarity from NHS Property services on the likely funding source.

The financial impact on the Trust of an assumed increase in rental to recover the capital outlay by NHS Property services and the 2nd version assumes that the capital outlay is fully covered by a charitable donation to NHS property services.

In Summary, the outcome of version one (rental increase to cover capital outlay) is in the table below.

BENEFIT CATEGORY	WEIGHTING	Estuary View	Faversham	Herne Bay	Whit & Tank
QUALITY BENEFITS	30	25	10	23	9
COMMERCIAL BENEFITS	40	40	18	33	20
STRATEGIC FIT	30	28	10	24	10
OVERALL WEIGHTED SCORE	**100**	**93**	**38**	**80**	**38**

In summary, the outcome for version two (charity funding capital) is in the table below. The impact includes those changes in version one except the revised financial scoring to reflect the reduced cost and financial risk if the charity fund the capital outlay. HB overall total weighted score rises to 83 from 80.

BENEFIT CATEGORY	WEIGHTING	Estuary View	Faversham	Herne Bay	Whit & Tank
QUALITY BENEFITS	30	25	10	23	9
COMMERCIAL BENEFITS	40	40	18	36	20
STRATEGIC FIT	30	28	10	24	10
OVERALL WEIGHTED SCORE	**100**	**93**	**38**	**83**	**38**

Appendix 5

Canterbury and Coastal
Clinical Commissioning Group

Liz Shutler
Director of Strategic Development and Capital Planning
East Kent Hospitals University NHS Foundation Trust

SENT BY E-MAIL

Brook House
John Wilson Business Park
Reeves Way
Chestfield
Whitstable
Kent CT5 3DD

Tel: 01227 795024
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16 June 2014

Dear Liz

Outpatient Consultation

Following the conclusion of the consultation on your proposals for the future design of outpatient services in east Kent, and in advance of our respective organisations taking decisions on the outcome of that consultation, I thought it would be helpful to set out our expectations of the further work CCGs will be undertaking with our communities, specifically those of Faversham, Whitstable and Herne Bay.

You will know that we have recently concluded an extensive review of community services in both Canterbury and Coastal and Ashford CCGs. From this we have conceived a community hub/network approach that has been shared with the CCG 'town teams'. We see the development of these community hubs or networks as a major component of our commissioning effort over the next three years and we are establishing a work programme, led by a programme director jointly working with Kent County Council to take this work forward. Following the success of our work with residents, local councillors and GPs in Faversham on the development of a new service specification for the MIU at the Cottage Hospital we intend to establish similar groups in Whitstable and Herne Bay to help us in the design of future community, primary care and social care services in these towns. This is an approach we will be rolling out across both CCGs.

You will know, following the meeting of members of respective Boards/Governing Bodies, that we had hoped to hold initial meetings of these groups in the three towns mentioned above before the end of June. It has not proved possible to mobilise these meetings within that timescale, however we are currently setting up initial engagement events with the support of Sara Warner and we will confirm the details of these events.

I anticipate that once we have the town groups established they will be considering what services are required locally to meet the defined needs of their population and what service delivery is possible within the financial and clinical resources available. It is my expectation that these discussions will, in a number of instances, identify how services that are currently provided by EKHUFT on an outpatient basis might become part of the service offer in a community hub/network.

Cont'd

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I am sure that these groups will wish to work with provider organisations, including yourselves, as they develop their thinking and I will be encouraging them to work closely with you on services that may change as a result of the implementation of your new outpatient service design to ensure continuity of service wherever this is appropriate.

Please let me know if there is any further information about this programme of work that it would be helpful to have at this stage.

Yours sincerely

Simon Perks
Accountable Officer
NHS Ashford CCG
NHS Canterbury and Coastal CCG