EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS MEETING – 27 JUNE 2014**
SUBJECT:	**THE CLINICAL STRATEGY**
REPORT FROM:	**DIRECTOR OF STRATEGIC DEVELOPMENT & CAPITAL PLANNING**
PURPOSE:	**INFORMATION**

CONTEXT / REVIEW HISTORY
This paper presents an update of the work undertaken to date to develop a long-term Clinical Strategy and provides a high-level summary of the next steps. It also provides details of a change to the governance arrangements for the Clinical Strategy Implementation Board.

SUMMARY
Work continues to progress well on all elements of the Trust's clinical strategy programme. Eight Clinical Strategy Work Streams have now been established in order to progress further the programme and a draft timetable for the next phase has been produced. The Executive Management Team (EMT) has agreed a new governance structure combining the current Clinical Strategy Implementation Board (CSIB) with the Clinical Management Board (CMB) to form a new Clinical Advisory Board (CAB) in order to provide improved clinical engagement to the Trust's long-term clinical strategy programme, making more efficient use of the clinicians' and senior management team's time as well as streamlining decision-making processes.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES
Implementation of the agreed Clinical Strategy is key to the Trust's success in delivering on its strategic objectives.

FINANCIAL IMPLICATIONS:
Implementation of the agreed Clinical Strategy will have significant financial consequences.

LEGAL IMPLICATIONS:
None at this stage

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES (where applicable):
None at this stage

BOARD ACTION REQUIRED:

(a) to note the report and

(b) to discuss and determine actions as appropriate
CONSEQUENCES OF NOT TAKING ACTION: None at this stage

East Kent Hospitals University NHS
NHS Foundation Trust

Clinical Strategy Programme

1. Introduction

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

1.2. The Board supported the continued development and assessment of strategic plans. The drivers behind this are clear and include ensuring, as a priority, the clinical sustainability of quality services and maintaining financial sustainability over the forthcoming planning period.

1.3. This paper presents an update of the work undertaken to date to develop a long-term Clinical Strategy and provides a high-level summary of the next steps. It also provides details of a change to the governance arrangements for the Clinical Strategy Implementation Board.

2. Progress from the Clinical Strategy Work Streams

2.1. Outpatients Work Stream

The Public Consultation on Outpatient Services in East Kent has now completed. The University of Kent at Canterbury prepared its final report based on its analysis of the feedback received and the processes undertaken and this was presented to the Kent Health Overview and Scrutiny Committee on 6th June. The HOSC confirmed that they felt that the Consultation processes had been thorough and asked the Trust to update them again in September once the Trust Board and the CCGs have made their final decision.

Work is now underway to operationalise some other elements of the Outpatient Strategy including extending the working day, implementing the one-stop clinic model, and developing the use of new technologies, etc.

Divisions are working with their clinical teams to review and amend consultants' job plans to reflect the required changes which will enable the strategy to be fully implemented.

In Dover, the building work for the new Dover Hospital project is progressing well and is on track to be completed by the spring of 2015. The launch of the new Dover Hospital will be an excellent opportunity to implement many of the new ways of working which the Trust wants to roll out to all outpatient departments.

2.2. Surgical Services Work Stream

Over the past four months, a significant amount of work has been undertaken to understand the impact of centralising high-risk adult general (abdominal) emergency and elective surgery on an interim basis at Kent and Canterbury Hospital.

The detailed activity demand and capacity modelling work that has been undertaken has provided clarity about the number of patients that would be affected by centralising high-risk adult general (abdominal) emergency and elective surgery. This work has also enabled a detailed understanding of the number of patients that could be cared for as day case or by 23 hour care.

A great deal of work has also been undertaken by a number of work streams which has helped to identify the needs of ITU and critical care, inpatient ward accommodation and theatre requirements to support any future plans to centralise medium and high risk adult general (abdominal) emergency and elective surgery.

In April, at the Board of Directors meeting, it was agreed that work to centralise surgery as an interim solution should be halted. It was agreed that the centralisation of surgery could not be done safely without the necessary infrastructure in place and in the required timescales. Instead, it was agreed that the Division would implement an interim solution aimed at increasing the levels of consultant surgeon cover at William Harvey Hospital and at Queen Elizabeth The Queen Mother Hospital to provide sufficiently robust on call cover to allow services to safely remain at these two sites for the foreseeable future. Following that decision the Surgical Services Division has commenced the recruitment processes to fill the newly created posts.

It was also acknowledged that the interim solution was not sustainable in the medium term and that a centralised model was still the strategic direction of travel. Therefore, work is continuing to understand the patient pathways and clinical adjacencies associated with medium and high risk surgery.

2.3. Trauma Work Stream

The Trust secured Interim Trauma Unit status accreditation for the William Harvey Hospital in April 2013. The service has now become fully operational and has been running extremely successfully since. Work is now underway to prepare for re-accreditation, which is due to take place in September. A small project team has been set up by the Urgent Care and Long-term Conditions Division in readiness for this re-accreditation process.

2.4. Urgent Care and Long-term Conditions Work Stream

A business case for the refurbishment and expansion of each of the Emergency Departments was completed in September 2013. Unfortunately, this business case was not supported however additional revenue funding was secured by Divisions to invest in additional staffing. Work is now underway to explore alternative options to improve the use of the estate within the Emergency Departments at the William Harvey Hospital until clarity is provided over the Trust's longer-term clinical strategy.

As part of the Trust's longer-term clinical strategy programme, work has now also commenced with Emergency Medicine and the Medical Specialties to ascertain how services could be safely and sustainably delivered in the future.

2.5. Specialist Services Work Stream

Work to define the future clinical strategy for Specialist Services has begun in earnest. A Paediatric multi-disciplinary clinical stakeholder event took place in early June, which helped to clarify workforce pressures, clinical adjacency requirements and key national and local drivers underpinning the need to change how services will be delivered in the future. This work will also help the Division to shape a series of future service models as part of its longer-term clinical strategy for Specialist Services.

The Division is also now working closely with other specialties to understand their requirements too enabling a thorough recognition of the Division's future requirements.

2.6. Four additional Work Stream

Four additional work streams have been established to further develop the Trust's long-term clinical strategy programme. These additional work streams are as follows:

- Clinical Support Services the aim of which will be to ensure there is provision of the necessary clinical support services to enable the delivery of agreed models of care that are articulated by other work streams;

- Workforce and Education Work Stream main aims will be to support the Divisions in understanding the core drivers for change and the future workforce requirements for each specialty and to deliver a comprehensive long-term workforce and education plan;

- Capital Programme Work Stream aims will include undertaking site option appraisals, reviewing and prioritising capital phasing and developing and overseeing the Trust's estates development programme; and

- Communications and Engagement Work Stream main aims will include ensuring sufficient robust public, patient and stakeholder engagement is undertaken and to ensure the Clinical Strategy Programme is widely communicated.

3. New Governance arrangements

3.1. In May, the Executive Management Team (EMT) agreed a new governance structure for a number of key meetings within the Trust. It has been decided to combine the current Clinical Strategy Implementation Board (CSIB) with the Clinical Management Board (CMB) to form a new Clinical Advisory Board (CAB). The CAB will report into a newly constituted Management Board.

3.2. The new CAB will provide clinical advice to the Management Board / Quality Committee about changes to service configuration to ensure clinical effectiveness and patient safety is maintained. Secondly, it will approve all Trust-wide clinical policies in line with the Policy for the Development and Management of Organisation Wide Policies and other Procedural Documents. Thirdly, it will bring together a multi-disciplinary, senior management team of clinicians and managers to provide management oversight and support to scope, plan and deliver a transformational programme of work focused on delivering the Trust's long-term clinical strategy. The key priorities underpinning this work will include:

- improving patient safety;

- supporting care closer to home;
- where appropriate preventing admission to hospital;
- reducing length of stay and readmission rates; and
- providing efficient, effective, clinically and financially sustainable services for the next 5 to 10 years.

3.3. The CAB agenda will be held in two parts with part 1 taking the clinical lead and oversight for the Trust's longer-term clinical strategy and part 2 overseeing the clinical advice for service changes and approving policies and procedures.

3.4. The aim is that this new Board will provide greater and wider clinical engagement to the Trust's long-term clinical strategy programme making more efficient use of the clinicians' and senior management team's time as well as streamlining decision-making processes.

3.5. The Terms of Reference of the new Clinical Advisory Board are provided at Appendix 1.

3.6. Moving towards implementing these governance changes is quite a complex task and as such is not something that can be implemented quickly. The changes form part of a chain of events that run through many of the Trust's other senior Boards and Committee meetings. This move will require changes to be made to the Trust's Strategic Group meetings, Corporate Performance Management Team meetings and a will require a review of Risk Management and Governance Group meeting arrangements. It may also have an impact of the Trust's Strategic Investment Group meetings and the Executive Serious Incident Peer Group Review meetings.

3.7. It is anticipated that these changes to the Trust's governance arrangements will take place by the end of July 2014.

4. Timescales for the Clinical Strategy

4.1. Table 1 provides a summary of the timelines for the next phase of work including stakeholder engagement and formal public consultation.

	2014/2015			2015/2016				16/17
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Clinical pathways & adjacencies agreed	■	■						
Workforce planning	■	■	■					
Business case preparation		■	■	■				
Staff engagement	■	■	■	■				
Stakeholder engagement		■	■	■				
Public engagement		■	■	■				
Estates design and planning		■	■	■				
Preparation of Public consultation material			■	■				
General election				■				
Public consultation					■	■		
Independent analysis of consultation							■	
Trust Board decision								■

Table 1 Timetable for developing the plans

APPENDIX 1

TERMS OF REFERENCE

CLINICAL ADVISORY BOARD

1. CONSTITUTION

1.1. The Clinical Advisory Board (CAB) is constituted by the Management Board as the senior clinical effectiveness board of the Trust.

2. PURPOSE

2.1. CAB will provide clinical advice to the Management Board / Quality Committee about changes to service configuration to ensure clinical effectiveness and patient safety is maintained.

2.2. CAB will approve all Trust-wide clinical policies in line with the Policy for the Development and Management of Organisation Wide Policies and other Procedural Documents.

2.3. CAB will bring together a multi-disciplinary, senior management team of clinicians and managers to provide management oversight and support to scope, plan and deliver a transformational programme of work focused on delivering the Trust's long-term clinical strategy. The key priorities underpinning this work will include;

- improving patient safety;
- supporting care closer to home,
- where appropriate preventing admission to hospital;
- reducing length of stay and readmission rates; and
- providing efficient, effective, clinically and financially sustainable services for the next 5 to 10 years.

3. OBJECTIVES

PART A:

3.1. Co-ordinate the strategic direction for the clinical pathways within its scope, and will be responsible for helping reduce and alleviate any barriers across the whole health and social care system (see appendix 1 for detail).

3.2. Ensure that, at a pathway level, the impact on other pathways cross division or pan-organisation will be identified and assessed. The expectation is that this approach will facilitate the development of a fully integrated Trust-wide, longer-term clinical strategy that will be implemented over the coming 5 years.

3.3. Hold the work streams to account for delivery of their objectives but will also facilitate the required support for delivery from financial, information, prioritisation of capital and communication perspectives.

3.4. Oversee the implementation of other proposed strategic initiatives such as:

- Reduction in follow-up appointments;
- Review of non-profit making, non-mandatory services;
- Cold Orthopaedic centre;
- Location of primary care services on acute hospital sites;
- Health & Social Care Village;
- Improved internal waits and delayed transfer of care;
- Teaching Nursing homes; and
- Private patient strategic plans.

PART B:

3.5. Ensure the effective management and delivery of safe, efficient and timely services along with patient access and financial targets within a Clinical Governance framework that ensures safety of existing clinical services.

3.6. To ensure that planned service changes are reviewed effectively to minimise clinical risk, maximise patient benefits and work towards achieving the Trust's strategic direction for services.

3.7. Promote the improvement of quality healthcare by ensuring that National Institute and Clinical Excellence Technical Appraisals are implemented on time and that NICE guidance is considered and where appropriate implemented within the Trust.

3.8. Provide recommendations to Management Board in relation to modernising services in keeping with the Clinical Governance framework which lead to improvement of clinical systems, patient safety and experience.

3.9. Review and develop matters of clinical policy that affects the operation the Trust and to make appropriate recommendations to the Management Board.

3.10. To promote the leadership of the organisation through the Divisions and initiate the Team Briefing system within respective Divisions.

3.11. To promote an ethos of performance management throughout the Trust and work with our health care partners in the Community, other agencies and through the patient partnership forums.

4. MEMBERSHIP AND ATTENDANCE

PART A AND B MEETING MEMBERSHIP

Members

Clinical Members

Medical Director (Chair – Part B)
Chief Nurse and Director of Quality & Operations
Divisional Medical Director – Specialist Services
Divisional Medical Director – Clinical Support
Divisional Medical Director – Surgical Services

Divisional Medical Director – Urgent Care and Long-term Services
Divisional Head of Nursing – Specialist Services
Divisional Head of Nursing – Surgical Services
Divisional Head of Nursing – Urgent Care and Long-term Services
Divisional Head of Nursing – Clinical Support Services
Chief Executive
Divisional Director – Clinical Support
Divisional Director – Specialist Services
Divisional Director – Surgical Services
Divisional Director – Urgent Care and Long-term Services
Director of Finance, Performance & Information
Director of Strategic Development and Capital Planning (Chair Part A)

PART A ADDITIONAL MEMBERSHIP

Members

Director of Strategy and Business Development
Deputy Director of Information
Director of Communications;
Senior Strategic Development Programme Manager
Director of Estates and Facilities

PART B ADDITIONAL MEMBERSHIP

Members

Director of HR and Corporate Affairs
Deputy Chief Nurse
Associate Medical Director – Revalidation/ Deputy to Responsible Officer
Associate Medical Director – IT
Associate Medical Director – Patient Safety
Director of Pharmacy
Director of Laboratory Medicine
Head of Therapies
Director of Infection Prevention and Control
Director of Research and Development
Director of Medical Education
Chair of Medical Staff Committee or deputy
Deputy Director of Risk, Governance and Patient Safety

Attendees

CCG / GP Representative

Quorum

4.1. The intention is to reach decisions through consensus and once decisions are taken, to sustain a 'corporate position'. However, should it be necessary to vote on issues, at least 6 clinical members which must include two Divisional Medical Directors (or their deputies), two Divisional Directors' plus the Chair or Chief Executive.

4.2. If any member disagrees with the decision then their concerns should be raised at the meeting and noted within the minutes.

Attendance by Members

4.3. The Chair or the nominated deputy of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 75% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.4. Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad-hoc basis.

5. FREQUENCY

5.1. The Board shall meet monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2. The Committee has decision making powers with regard to the approval of clinical policies.

6.3. The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

6.4. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by the Committee Secretary.

7.2. Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. ACCOUNTABILITY AND REPORTING

8.1. The Board is accountable to the Management Board.

8.2. Minutes will be reported to the Management Board once they have been approved by the Chair along with exception reports as agreed by the membership of this Board.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1. The Board will provide an annual report outlining the activities it has undertaken throughout the year along with a review of its Terms of Reference.

9.2. A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

APPENDIX 1: WORKSTREAM OBJECTIVES

Surgical Work Stream

1. Consider all implications for the centralisation of elements of surgical activity and approve the capacity and demand modelling, workforce modelling, access, clinical adjacencies, patient pathways and financial implications;

2. Agree and approve future pathways for patients requiring all surgery (including breast, general and colorectal surgery) across the Trust. Objectives will include approval of capacity and demand modelling, staffing models and financial implications;

3. Agree and approve future pathways for patients requiring critical care and intensive treatment across the Trust which will include understanding and approving capacity and demand modelling, staffing models, infrastructure plans and financial implications relating to any changes to these services;

4. Work with other Divisions to understand the clinical adjacencies and dependency issues related to centralisation of high-risk surgery and the work force models to support this;

5. Ensure robust clinical engagement and patient engagement are undertaken in the planning of the patient pathways; and

6. Approve pathway plans for extended recovery to facilitate increased day surgery across the Trust. Understand the activity and financial implications for the changes from inpatient surgery to day surgery facilitated by extended recovery pathways.

Specialist Services Work Stream

1. Agree a sustainable and affordable future model of care for Obstetrics, Gynaecology, Gynae-oncology and Paediatrics for the next 5 to 10 years;

2. Define a range of options for the future configuration of all Specialist services by site. This will need to include defining what services need to be co-located with emergency surgery and other related supporting services at a “hub site”, and what services can safely be provided from other (spoke) sites;

3. Understand and approve capacity and demand modelling, staffing models and financial implications related to any future Specialist service models; and

4. Agree and approve future pathways for women’s health services, paediatric services and other Specialist services across the Trust which will support and compliment the centralisation of emergency and elective general (abdominal) surgery and financial implications; and

5. Ensure robust clinical engagement and patient engagement are undertaken in the planning of the patient pathways.

Urgent Care and Long-term Conditions

1. Agree a sustainable model of care for emergency medicine with timelines and milestones attached to achieve this;

2. Ensure robust clinical engagement and patient engagement are undertaken in the planning of the patient pathways;

3. Define a range of options for the future configuration of all Urgent Care and Long-term conditions services by sub-specialty and by site. This will need to include defining what services have to be co-located with emergency surgery and what services can safely be provided from other sites;

4. Understand and approve capacity and demand modelling, staffing models and financial implications related to any future UC&LTC models by site and by sub-specialty; and

5. Agree and approve future pathways for patients requiring access to urgent care and long-term conditions services across the Trust which will support and compliment the centralisation of emergency and elective general (abdominal) surgery and financial implications.

Clinical Support Services

1. Linked to the Estate Strategy, implement the agreed outpatients model of care (a one stop approach with the co-location of diagnostic services) at each of the selected sites in east Kent;

2. Working together with other Clinical Strategy Work Streams, ensure that there is provision of the necessary Clinical Support Services to enable the delivery of the agreed models of care that are articulated by the other divisions.

3. Ensure robust clinical engagement and patient engagement are undertaken in the planning of the patient pathways;

4. Oversee the implementation of plans to extend the working day in outpatients Monday to Saturday across the Trust; and

5. Oversee the implementation of all other elements of the agreed Outpatient Clinical Strategy including implementing the single north Kent coast outpatient site, developing the use of telemedicine and telehealth services, moving services from BHD to the new Dover Hospital, and the planned withdrawal of services from other community OPD sites.

Outpatients

1. Implement the agreed Outpatients Clinical Strategy, reducing the provision of outpatient services to fewer sites, establishing one-stop clinics, developing the use of telemedicine and telehealth services; and

2. Implement and report on the new Dover Hospital project and the decanting of services from the old hospital into the new building.

Capital Programme

1. Undertake an option appraisal of the feasibility of developing a central hub hospital on a green field site;

2. Review the prioritisation and phasing of capital programme in response to proposed pathway changes to ensure the Trust's estates infrastructure supports the Divisions' plans;

3. Develop and oversee the Trust's estates development programme to ensure that a "hub and spoke" model can be safely implemented in line with clinical needs;

4. Develop and support business cases to implement estate developments relating to the clinical strategy programme; and

5. Oversee the capital build programme to ensure facilities are delivered on time in line with operational requirements.

Workforce and Education

1. Support the Divisions and Clinical Strategy Work Streams to fully understand the core drivers underpinning the case for change including understanding the future workforce requirements for each specialty in order for the Trust to continue to deliver safe and sustainable long-term services;

2. To support the Divisions and Clinical Strategy Work Streams to deliver a comprehensive long-term Workforce and Education plan.

Communications and Engagement

1. To work with other work streams to ensure they undertake sufficient robust public and patient involvement in the development of their service plans;

2. To ensure the work of the Clinical Advisory Group is appropriately and widely communicated; and

3. To oversee the engagement processes and the Public Consultation for all proposed reconfiguration of services.