‘Delivering our Future’

Healthwatch Kent’s report on public engagement for East Kent Hospitals University NHS Foundation Trust

April-May 2015

Prepared and submitted by

Healthwatch Kent

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Contents

Executive summary

East Kent Hospitals University NHS Foundation Trust (EKHUFT) commissioned Healthwatch Kent to undertake community engagement activities seeking public feedback on their current services and to raise awareness of the need to review how services are delivered in the future.

Healthwatch Kent adopted a number of different methods to engage with the public, visiting 23 organisations and community groups across East Kent, distributing over 5500 Speakout Forms and holding nine listening events across East Kent.

Awareness raising activities contacted 792 organisations and community groups across East Kent and approximately 900 individuals. At the time of writing this report 1019 people have contributed their thoughts, experiences about current hospital services and ideas as to how it could be improved for the future. East Kent has a population of approximately 700,000 people and therefore this sample is 0.1% of the population. However, public polling guidance proposes that a random sample of 1000 people can be robust enough to infer trends in the general public's opinions with a margin of error of 3%.

The key findings are:

- 63% of all comments received from the public were of a positive nature.
  This highlighted the following areas; general all round good service (61%), polite staff (19%) and improvements in waiting times (10%).

- 37% of all comments received from the public were of a negative nature.
  The top four areas were; appointments (31%), dissatisfaction in levels of care (17%) poor communication (12%) and issues regarding A&E (11%).

- People attending the events, universally reported a positive response to the content of the presentation and to the honesty and knowledge with which it was delivered. *'It was very concise, highly informative and extremely useful'*.

- Everyone engaged in the process both from the events and in the wider community expressed recognition that current services were under huge pressure.
- 100% of people supported the need to change something in order to improve current services and there was a general acceptance that '*as an organisation and a population, we have some choices to make'*.
- Strong public view that East Kent hospitals cannot work in isolation and that the concept of 'Tiers of Care' is a useful model to help this conversation.
- Strong public preference for more services to be based within Primary care or community settings, with support for specialist services remaining within an acute hospital setting.
- Universal support for the concept of an alterative pathway for frail and elderly people.

Recommendations

- That a series of 'focus groups' involving the public and other statutory providers, such as CCGs and KCC explore, examine issues and areas of service identified within this report.
- That community engagement activities continue, furthering the reach into the community and involving people in more focused discussions about issues raised in this report.
- That a second round of meetings are arranged across East Kent to ensure the public have opportunities to be involved in the ongoing discussions about future services.
- To develop a glossary of acronyms for use in future engagement processes.
- That a patient group is formed to work with East Kent hospitals regarding the appointment system improvement plan.

Background

As specialists in engaging and talking with communities, Healthwatch Kent was commissioned by East Kent Hospitals NHS Foundation Trust to review current public engagement activities, building relationships with the community of East Kent in order that people were engaged in conversation about how future healthcare service may look in East Kent.

Healthwatch Kent undertook the following activities;

- Building stronger and wider links for East Kent hospitals with the public and organisations representing communities in East Kent.

- Raise awareness of current pressures on services, the 5 to 10 year strategy and seek the public's views on current service provision with suggestions for improvement or change.

- Ensured that the first stage created a pool of people, who can be indentified to work in focus groups and future option development processes. Furthermore by generating interest within local community groups, develop potential for further community reach within localities and client groups as a method of reaching areas of the community that may be highlighted in future Equality Impact Assessments. This will build robustness into the future engagement and consultation process.

- Acted as a critical friend regarding the engagement, public process and advised on how communications are delivered.

- Organised and invited public/stakeholders to nine localised events (Ashford, Canterbury, Dover, Faversham, Hythe, Margate, Romney Marsh, New Romney and Tenterden) to raise awareness of the case for change and capture feedback from patients/carers about the current service, including suggestions for what could be improved.

Communication and Engagement activities

Working with East Kent hospitals, Healthwatch Kent designed an engagement strategy and action plan[1] to inform the engagement activities.

This was informed by:

- Local demographic and health inequality information
- East Kent Hospital's identified 'high volume' user groups
- A review of East Kent Hospitals public and patient engagement work, identified areas of the community and user groups that required an outreach approach

In this first phrase of public engagement the key objective was to extend the reach into the widest possible pool of stakeholders and communities.

The strategy ensured that engagement events facilitated the inclusion of community service providers, groups and individuals. At the same time providing opportunities to engage with those most likely to use hospital services, as well as actively seek to hear the views of smaller diverse groups within the community.

The strategy developed a range of mechanisms to create meaningful engagement opportunities with patients and public within East Kent.

Face to face community visits

Healthwatch Kent volunteers visited 22 community groups, meetings and day services. This included minority groups, women's groups, mother and baby groups, disability groups and older peoples groups. They used a core set of questions to facilitate a conversation about people's experiences using hospital services.

- What was your overall impression of the service you received?
- Is there anything that could have been improved?
- Are you interested in hearing more from East Kent Hospitals?

As part of the interview process, people were asked to complete a demographic profile form and to provide the first part of their postcode.

Community Champions

Healthwatch Kent talked to organisations that work with defined service user or ethnicity groups. It developed arrangements for them to 'cascade' information to their members and or clients. In addition to act as a contact point to ensure views were fed back into the engagement programme.

Public events

Healthwatch Kent engaged the wider general public by canvassing opinions at Gateways and public libraries in East Kent and a day at the University of Kent Campus in Canterbury, as students were identified as a group that are not traditionally engaged with East Kent Hospitals.

[1] Engagement Strategy and Action Plan – March 2015, Healthwatch Kent

Speakout Forms

Healthwatch Kent has a generic Speakout Form that invites members of the public to share their experiences of health and social care in Kent. People were also asked to provide their postcode as part of our monitoring. Two versions of this Speakout Form were created for this public engagement programme.

In order to reach parents with young children 3500 Speakout Forms were distributed via school book bags that invited comment about 'What hospital services have you and your children used in the last 12 months?' These were placed in book bags of pupils at 11 primary schools across Ashford, Canterbury, Shepway, Thanet and North Kent.

1250 Speakout forms were placed in outpatient departments across East Kent Hospitals.

750 Speakout forms were sent out to community groups, voluntary organisations and handed out at public events.

Desk based awareness raising

Organisations and groups were contacted by email and phone as well as though network sites, newsletters and cascade systems. An awareness raising email was sent out to organisations, community groups and individuals, promoting the 9 events as well as enclosing the Speakout Form and encouraging people to cascade distribution through their networks.

As a result of attending various community group meetings and projects Healthwatch Kent promoted that the way healthcare is delivered in East Kent needs to change in the future to approximately 900 people. Of these, 508 people chose to talk to Healthwatch Kent about their experiences and contribute their thoughts about the future.

In total 792 individual agencies and community groups were contacted directly, with a further reach beyond this via cascade mechanisms. A mix of organisations were contacted, including advocacy, minority ethnic groups, care homes, carers organisations, disability groups, family centres, gypsy and traveller groups, homeless organisations, learning disability groups, community maternity and baby services, mental health organisations older peoples community groups, transgender and young people groups and Patient Participation Groups.

Over an 8 week period, a total of 431 Speakout forms have been returned, this equates to an 8% response rate. 11% of these came from the book bag engagement activity.

Findings of the public engagement activities

In total, the various engagement activities resulted in a total of 1019 people contributing their thoughts and experiences about current hospital services and ideas on how healthcare could be improved for the future. This formed a pool of data that was reviewed for themes.

Profile of Respondents

99% of the 508 people who were interviewed identified their gender, with 59% of respondents being female. Rates for full completion of the monitoring form was lower (71%) so the tables below are only indicative of the demographic profile of people who were interviewed in the wider community engagement events.

Ethnicity	% of respondents
English/Welsh/Scottish	72%
Irish	1%
Other White background	1%
White and Asian	2%
Indian	2%
Other Asian	6%
Caribbean	1%
Other	15%

Table 1. Respondents Identified Ethnicity

First Language	% of respondents
English	68%
Other	23%
British Sign Language	9%

Table 2. Respondents identified first language

Age	% of respondents
Under 25 years	3%
25-39 years	12%
40-49 years	12%
50-59 years	14%
60-69 years	17%
70-79 years	22%
80 years and over	20%

Table 3. Respondents identified age

5% of respondents identified themselves as carers for another person and 8% of people identified themselves as disabled. This included registered blind, deaf, physical disability and learning disabilities.

Geographical spread of public engagement feedback

Feedback has been received from each postcode area within East Kent. The table below shows the percentage volume of feedback from each area. A full breakdown of postcode areas can be found in Appendix 1.

Postcode	% of respondents
CT12	14%
CT10	11%
CT19	9%
CT21	8%
CT20	6%
CT17, CT18	5% each
CT16	4%
TN29, CT2, CT15,	3% each
ME12, TN28, TN25, TN24, TN23, CT14, CT9, CT1	2% each
CT4, CT5, CT6, CT7, CT8, CT11, CT13, TN26, TN30, ME10, ME13	1% each
CT3, TN17, TN27, ME9, ME1, ME5, ME7, ME8, ME17	2 or less responses

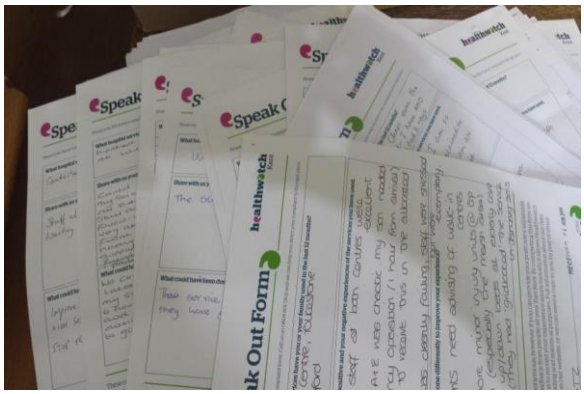
Table 4. Respondents identified postcode

Thematic review of public engagement feedback

Positive feedback

63% of the comments received from the public were of a positive nature.

Overall satisfaction



The majority of people (61%) expressed that they were generally happy with the whole service. This ranged from comments such as '*it was a first class service'*, to '*it was ok considering the pressure the staff are under*'. When asked what could be improved further, the most common response was '*get more staff*' or '*the government to give them more money'*, but one respondent had a more light hearted suggestion of *'classical music, champagne and lobster themidor!'*

Staff

The second cluster of positive comments (19%) focused around the staff working across the hospital. There was no clear pattern identifying any particular area within the wider hospital services. Staff were praised as *'pleasant', 'polite', 'helpful'* and treating people with *'utmost respect'*.

Appointments and waiting times

Another cluster of comments (10%) themed around improvements in waiting times and the appointment system. People commented that waiting times had reduced, or that the

experience of waiting was improved *'there was a delay but I was offered tea or coffee'*. Others commented that their appointments had run smoothly and that in outpatient clinics '*things have improved greatly*'. More detailed feedback commented that '*text reminders work well'.*

Quality of care received

5% of the positive feedback acknowledged the quality of care that was received in hospital. The majority of these comments, thanked staff, some by name, the sentiment being expressed by this comment '*I can't thank then enough, nothing was too much trouble*'. Others expressed how they felt they had been '*treated with respect, courtesy and dignity'*. Mention was made of staff taking time to explain treatment plans and questions around diagnosis fully. One person cited '*they took time to encourage me to try different snacks'* during a period of appetite loss during an inpatient stay.

Environment

The final 5% of positive feedback was in relation to the '*clean, tidy and hygienic'* hospital environment and in-patient food, '*I was knocked sideways by the menu choice'*.

Negative feedback

37% of all comments received from the public were of a negative nature and covered a wide range of issues.

Appointments and waiting times

The single biggest area of dissatisfaction was 'Appointments' (31%). Within this theme there were clusters of topics, the most frequent being the length of time taken to get an appointment, not receiving an appointment or having an appointment cancelled. One comment conveyed something many people had said '*the centralised appointment system is failing and it not acceptable'*. Another frequently made comment is illustrated by these two quotes '*I have given up trying to rearrange my appointment after 3 cancellations over 9 months*', '*I think that I have been pushed to the back of the queue for treatment'*.

A second issue in the 'appointment' theme is that of arriving for an appointment and experiencing long delays, or being told that your appointment has been cancelled. Some people told of situations where appointment reminder letters are sent after the appointment was cancelled, leaving them confused about whether to attend or not. Subsequent attempts to reach bookings by phone to clarify the situation were unsuccessful.

An area of dissatisfaction has emerged from certain groups within the community regarding issues regarding translation and how this impacts on their ability to attend appointments, respond to changes in appointment times and/or dates plus the anxiety about translators being available at the appointment.

The final aspect of the 'appointment' theme is that aappointment times do not take account of peoples travel requirements to reach hospital. Individuals explained how this impacted on them personally; *'I travelled for 7 hours, to attend a 10 minute appointment'. 'I am 94 and need to get 3 buses to get to the hospital, my appointment was too early'*.

Improvements suggested by the public included;

- *'Why can't we have appointments at the nearest hospital?'*
- '*Could there be a system of confirming that BSL interpreter has been booked, as we are always unsure and this adds to anxiety'.*
- '*Our community does not have English as our first language and we have difficulties expressing our symptoms and often miss appointments because we do not understand letters or phone calls that change appointments. Could you set aside certain times for appointments or clinics when we know that a community translator will be available and we can 'walk in'*?
- *'Buy a clock for Folkestone waiting area'*
- *'After work clinic time to reduce time off work?'*
- *I would like a way to test my INR at home…it would make my work easier to plan, my boss happy and reduce people in the clinic*

Quality of care received

17% of public feedback comments received created a theme around dissatisfaction in the levels of care that they had received.

Within this theme, there is a clear element (57%) of feeling '*pushed from pillar to post'*, being on a '*Conveyor belt'* that results in feelings of '*they don't care'* or '*they are not bothered*'. This feeling is further demonstrated by comments such as '*you don't know who you are talking to with the staff*' and '*patient respect need improving dramatically'*; with someone suggesting a key improvement for this would be '*a smile'*.

Within certain groups; young mums, disabled people and older people, there was a thread of comments reflecting a sense of feeling '*talked down to' , 'I am not a chid''*.
A person with Parkinson's, wrote *'I may have a lack of expression but the mind is still fine, treat us as intelligent people'*. A few parents of young children commented that '*they need to listen to parents more'.*

23% of people suggested that they were losing faith in the hospital services, ranging from strong comments such as '*I do not trust the consultants to tell the truth'* to '*I just felt my condition was not being taken seriously'*. A number of comments reported experiences of '*no pain relief*' being offered on the ward, with a similar number of people reporting not having access to water, or '*no one seems to take responsibility for making sure they eat in hospital*'.

Improvements suggested by the public included;

- *'Bring back bedside manner training'*
- *'Let family help on wards, i.e. moving family members in and out of bed for the toilet.'*
- *'Close the consultation room door'*

Levels of communication

12% of public feedback highlighted levels of '*frustration*' with difficulties in communications.

Areas of frustrations as an inpatient include staff not keeping patients aware of their treatment, *'left me on a trolley for 8hrs but no one told me they were looking for a bed for me''* as well as staff not being available, *'It can take a long time to get staff to talk to you in the ward'.*

The greatest source of frustration is the breakdown in communication between staff and across departments and agencies.
'They don't seem to be able to talk to each other internally'
'I get mixed messages from professionals'
'The report on my biopsy not received after a month, so next appointment was unable to discuss anything meaningful'
'My GP seems to have problems accessing the results'
'You are told, 'The GP will tell you', but he says nothing'

Communication was the key concern raised by people for whom English is not a first language, including the Nepalese, Roma and Deaf communities, was about the lack of translation services. They report that this has a significant impact on them.
'Can't describe our symptoms and seek referral to hospital'.
'In A&E the Dr delayed medical attention until my daughter arrived to sign for me'.
'I was expected me to communicate in writing whilst I was having a heart attack''.
'I was 6 days on a ward and did not have access to an interpreter'.
'I was told I must use my child as an interpreter'.

Improvements suggested by the public included;

- *'Could you use tele-services for interpreters in emergency or on wards?'*
- *'Could you train / recruit staff with basic BSL'*

<u>Accident & Emergency</u>

11% of feedback raised issues about Accident and Emergency services.

The major themes within these comments were the length of wait time, with a particular cluster of views from parents who highlighted the difficulties and stresses of waiting with sick children for long periods. The volume of people using A&E and the demands on staff were acknowledged but people expressed dissatisfaction in elements of their care such as *'they were so busy they were unable to perform an emergency operation within the recommended 1 hour'.*

A few people (6) mentioned the difficulties presented in finding transport home after an ambulance admission.

Improvements suggested by the public included;

- *'More information on waiting times'*
- *'More information on where else we could go to get the help we need'*
- *'Minor injuries is under-utilised, can more be done locally?'*

Maternity and young children

8% of comments reflected experiences of people using maternity services and bring young children into hospital.

Comments regarding maternity had two strands;
The first regards the environment in delivery units, with '*broken equipment'* and '*bloodied rooms'* and the second about the '*lack of time to make bond with baby'*, '*relax after birth'* and being '*rushed through to bath like being on conveyor belt afterwards'. 'As a first time mum they could have been more helpful and caring by just taking time to listen to my concerns and questions'.*

Comments regarding paediatric services focused on waiting time for child assessment centre and in A&E. 14% of people within this theme reported that they felt staff had not listened to them *'we know our children'* with one respondent feeling that '*the nurse made personal judgements about my parenting skills'*

Improvements suggested by the public included;

- *'More time with midwives to develop practical skills, feeding bathing etc'*
- *'More midwife led units'*
- *'Localised maternity services'*

Environment and equipment

7% of comments raised issues with lack of or inferior equipment including hearing aids, lenses, wheelchairs and pillows. Others talked of broken equipment including epidural machines and call buzzers.

Improvements suggested by the public included;

- *'Car parking'*
- *'Heating could be turned down and save money'*
- *'Blue badge parking'*
- *'Parking permit if in hospital for surgery'*
- *'Vending machine on the wards profits to hospital'*
- *'TV and wifi, 'extras' to be paid for by patient'*
- *'Subtitles for the TV for deaf and heard of hearing'*

Discharge

5% of comments clustered around the theme of discharge from hospital. The first of two strands were about medication '*medication not available….had to get from chemist when I felt really ill'*, or the change in continuity of tablets moving from home to hospital and back again.
The second strand related to '*no information about when they will discharge you'* and the time taken *'It took Dr three hours to write a discharge letter'.*

Improvements suggested by the public included;

- *'Make sure all checks are completed before discharge'.*
- *'Need more staff to help us get ready to leave hospital, packing and such'.*

The final themes that came from the public engagement feedback were raised by less than 20 people.

- The volumes of people (4%) using the hospital services and the identified shortage of consultants and staff *'I was told by the Consultant that there was only one Dr covering the whole department and that was why the appointment had taken so long, a whole year'*
- Issues about care of people with Dementia and end of life care (3%). '*Why did my partner keep going up to the hospital for appointments when he was dying?'*
- Concern about people with Mental Health needs getting appropriate care in A&E and on general wards were raised by 2% of comments

Listening Events

In total, 80 people attended the nine listening events held around East Kent and contributed their reactions to the presentation made by East Kent Hospitals and their thoughts at the table top discussions.

8 of the nine listening events had an inspector from the Care Quality Commission (CQC) present as part of their preparation for a second inspection at East Kent hospitals in July 2015.

Some members of the public had not heard of the Care Quality Commission but reported that having an inspector at the event and hearing about what they do had been really useful.

Profile of Respondents

90% of the 80 people who attended completed and returned a monitoring form.
65% of people attending were female and 35% were male.

Ethnicity	% of respondents
English/Welsh/Scottish	88%
Irish	6%
Other White background	1%
White and Black Caribbean	1%
Other Asian	3%
Caribbean	1%

Table 5. Respondents Identified Ethnicity

First Language	% of respondents
English	97%
Other	3%

Table 6. Respondents identified first language

Age	% of respondents
Under 25 years	8%
25-39 years	5%
40-49 years	15%
50-59 years	12%
60-69 years	24%
70-79 years	26%
80 years and over	10%

Table 7. Respondents identified age

24% of respondents identified themselves as carers for another person and 24% of people identified themselves as disabled.

Geographical spread of public engagement feedback

People attended the listening events from the postcodes identified below.

23 of the 34 postcodes were represented.

The table below shows the percentage volume of feedback from each area.

Postcode	% of respondents
CT16	16%
CT5	10%
TN29, ME13	6% each
TN28, TN23	5% each
CT1, CT2, CT9, CT19, CT20, CT21, TN30, ME10	4% each
CT4, CT6, CT7 CT10, CT17, TN24, TN26,	2% each
CT8, ME11	1% each
ME12, ME9, TN25, CT18, CT15, CT14, CT13, CT12, CT11, CT3	none

Table 8. Respondents identified postcode

Questions during and after the presentation

A range of questions were asked of East Kent Hospitals, during and directly after their presentation. A full record of these can be found in Appendix 2, but some themes emerged which will be useful to consider in planning future engagement activities.

The most commonly asked questions focused on how the service currently operates and areas of performance highlighted within the CQC report. People sought clarity on how possible changes to hospital services might fit within the wider context of healthcare across East Kent.

There were also a number of questions asked about how the national and political picture for healthcare had an impact upon East Kent Hospitals.

Recent media coverage had led many of the public attending thee events to understand that hospital closure was the *'hidden agenda'*. People asked East Kent hospitals about these recent stories and there was some expressed relief *'that the Trust are still willing to talk to us and that we are still working out **what** rather than **where**'*.

A final few questions started to explore what the next steps of this process might be and how the Trust would let people know what was happening.

The public's response to the presentation about the pressures EKHUTF face.

The overall response to the presentation was acceptance that the situation presented by East Kent hospitals did require positive action to address the predicted impact on future services. Feedback from groups was that they felt they thought that they had been '*fairly well aware of the pressures facing EKHUFT but the presentation helped to add the details'*, with other saying '*Not everyone knows about the work being done behind the scenes to try and make improvements'.*

There was a feeling that the presentation gave those attending a better understanding of where they might start having a conversation with East Kent hospitals and that it was *'pleasing that despite rumours, the "what" was going to happen was still being discussed and also that this was not influenced by the "where" at this stage'* and that '*It is good to hear that the Trust are open to discussions'.*

The most commonly raised issue was that of integration. People were '*completely supportive of trust's need to change but they need to address contextual issues too'. 'We all need to see the pressures EKHUFT talk about in terms of wider issues and not just about services'.*

A second stream of comments reflected the public's frustrations with '*management*' and in particular citing possible cost savings in reducing perceived wastage across healthcare, in terms of medication and equipment. 'T*he packets had not been opened but I was told they will be thrown away anyway, what a waste'*.

A third thread of comments focused on the leadership of East Kent hospitals, with people questioning levels of pay, role and function of Board members, '*top heavy*' management layers and accountability.

The final cluster of comments talked about the issues raised in the presentation about staffing. Recruitment problems, retention and training were recognised to be wider national problems but there were some suggestions that working practice and employment contracts should be reviewed. One group suggesting '*if we spend money training doctors, it should be in their contract that they have to stay in the Trust for a certain number of years'.* The dependence upon agency staff was talked about at many tables, the implications of this and the challenge to offer jobs that rival '*agency staff's freedom of not being tied to a particular hospital'* and '*earning more money than if they were directly employed'*.

Reaction to the concept of 'tiers of care'

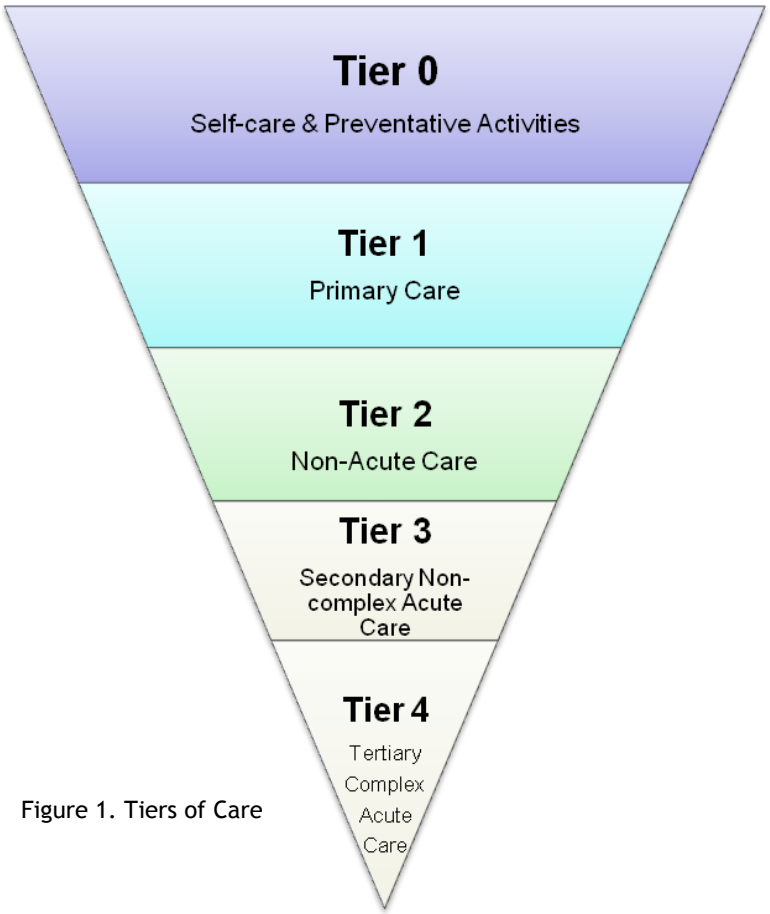


Figure 1. Tiers of Care

The model of the 'tiers of care' was well received. '*The model is good and easy to understand and should be used in all forms of public engagement'*.

There was also an '*assumption that services get more expensive*' as you travel through the tiers and people suggested that '*some context'* would be useful.

Many people suggested that the model be expanded to include detail about volumes of patients within each tier, and what services are currently offered within each tier.

It was felt that this would enable the public to engage in a more informed was and have a greater contribution.

The issue of integration was the main focus of conversation. People felt that any conversation about the tiers of care, '*needs hospitals, district nursing, post acute care, therapists, social workers and GPs'* taking part and that '*integration is an easy word, but in reality it is much harder'.*

Many people mentioned current '*differences in what services were available or what you could expect to receive*' across East Kent and '*it was suggested that there was a need to ensure standards of care were the same across practices'*. It was felt that this would allow '*consistency, so that you know what to expect at each centre*' and enable education so that '*when you not use them on a regular basis you still know what to expect'*.

Public thoughts about services that could be best delivered at a local level, in lower tiers of care.

'Ideally we would like everything local' captures the overwhelming support to review what services could be offered more locally, creating capacity within acute hospitals for services that need to remain based there. Again there was acceptance that *'need to be more communicating between GPs for this to work well'*.
Some conversations focused on the potential value within the voluntary sector to support care in lower tiers, with some questioning '*why are the voluntary sector not utilised fully, is this because they are not seen as medical model and therefore not trusted?'*

Many people said that they felt they needed to be aware of the CCG commissioning strategy for voluntary sector providers to further this area of conversation.

Tier 0

There was a lot of discussion at the tables about the range of things that would fall into the Tier 0, with many suggestions about areas of self care, preventative measures and public education.

Suggestions for Tier 0 included;

- *'Better promotion and advertising of what service we already have'*
- *'More Care plans and carers input into Tier 0'*
- *'Health promotion, 1st Aid training / CPR in schools'*
- *'Education for the public – what healthcare they can access, when and how'*
- *'Capacity building within local communities to take on more health social care preventative work in the community'*
- *'Greater, more effective levels of communication, using traditional and digitally based methods'*
- *'A centralised 'brand' for health and social care information with distribution at wider range of places across the community, local papers or supermarkets'*
- *Those working in the community need to be 'cross trained' so that wider awareness of 'trips and slips' and life style issues. People are too careful about what they say these days'*
- *'Community navigators from Challenge fund, GP can direct people to these navigators who have a wider knowledge of community services and links, peer support groups etc'*
- *'More patient support group/ peer support'*
- *'Community services to support people at home'*

Tier 1

When talking about Tier 1 services, many people raised the problem of getting a GP appointment and '*inconsistency across GP practices and what you can get locally'*. The idea of primary care or community settings delivering a wider range of services was universally welcomed.

It was suggested that building in *'rotation training'* for nurses, Drs and support staff to work across primary, community and acute hospital locations could be of great value.

Suggestions for Tier 1 included;

- *'Diabetes nurses are often not in the community, so I have to go to the hospital, I would prefer to see them in the community'*
- *'Pharmacists already have some powers, but these are not used and could be more widely publicised. – How could this be done?'*
- *'Greater use of voluntary sector provision for social and emotional support of patients and careers'*
- *'Minor surgery in GPs'*
- *'Increase range of counselling and self help options'*
- *'Social services and schools liaison'*
- *'Walk in centres for minor accidents'*
- *'Foot care'*
- *'Blood tests'*
- *'Ordering repeat prescriptions remotely is great, but not all rural surgeries have this facility'*
- *'Could GP hubs, within community networks, have specialist nurses?'*
- *'Muscular skeletal service including OT and physio'*
- *'24 hour monitors e.g. cardiac, blood pressure, being fitted'*
- *'A mental health nurse to visit regularly'*
- *'Access points for homeless people or rough sleepers – they have no fixed address so cannot register with a GP'*
- *'Support for carers, when registering at a GPs, to have a checklist that identifies carers'*
- *'Could pain control clinics be mobile?'*
- *'Rheumatoid services'*
- *'Dementia clinics, diagnosis and support for families, with links to information via community services'*
- *'Choose and book – should GPs promote this more, it does take longer to activate but could someone in the GP proactive be trained to help with patients booking online?'*
- *'Pacemaker, checking batteries'*
- *'Urine infections, renal function tests'*
- *'Ophthalmology'*
- *'Dermatology clinics'*
- *'Outpatients booking - volunteer role to liaise?'*

Tier 2

Conversations around Tier 2 were primarily based around people's understanding and experience of minor injury units (MIU).

However, some tables talked about maternity services within their tier, but there was a wider acknowledgment that *'young people find barriers to accessing some services such as mental health, pregnancy and maternity'* and that this may need further discussion with these clients groups.

Suggestions for Tier 2 included;

- *'Blood tests and x-rays'*
- *'More walk in services would help relieve pressure on A&E and GP surgeries*
- *'More information telling people where they (MIUs) are and when to use them'.*
- *'Midwife lead units co-located with hospital services, as they offer a more relaxed environment'.*
- *'Local ultrasound services'*
- *'More local ante natal clinics and post natal support with first baby and parental learning'.*
- *'Breast feeding council, could be used more if hospital referred to them, there is not enough time in hospital to support mothers bonding'*
- *'Worked with a group of young adolescent recently – shocked to find that referrals to CAMHS can take from 18months to 2 years to be seen – this is a real issue and could affect a young person's life forever'*
- *'Could physiotherapy take place in sport centres, build a more social inclusive model, like falls groups'.*

Public thoughts about services that could be best delivered at specialist units, in higher tiers of care.

People reported that they felt least able to talk meaningfully about what services should remain in the higher levels of care as they did not feel they had enough information to know what was currently within this tier and knock on effects of moving services from a hospital location to a community location.

There was however a high level consensus about some principles relating to higher levels of care;

- A "one stop" process to prevent people coming back and reduce the number of follow ups.
- That services became '*more risk adverse the higher up the scale you go'* and resulted in a greater range and number of medical interventions
- That personalised care plans would allow '*people with long term conditions to manage and pre plan appropriate entry points back'* into higher levels of care when needed. But that the information '*systems needed to ensure that this data travelled with the patient'.*

Transport to centralised services was the major area of discussion across tables. People talk of the need for family and friends to be able to visit loved ones in hospital and some told personal stories of not having the money for the cost of the train / bus fare. This was balanced by the recognition that '*when you are really ill being in a specialist hospital is good, but families who want to visit may have to travel a long way*'.

Some proposed a review of transport arrangements across healthcare, '*lots of minibus's are sitting empty for the day once they have brought people into the day centre. Could a community package of utilising all the various minibus be created*?'

Suggestions of services within higher tiers of care included;

- *'Mental health services'*
- *'Stroke services'*
- *'High grade acute services such as heart attack'*
- *'House complex equipment and specialist staff'*
- *'Heart, brain and emergency surgery should continue to go to Kings despite the 2 hour travel, the outcome for the patient is better'*
- *'Kidney services'*
- *'Rather than keeping people in hospital they could be discharged back to their own home with a 'buzzer' support service'*
- *'GP's in a hospital foyer is a really good idea to filter people'*

Public's thoughts about services that EKHUFT could stop delivering

In general tables were in favour of specialist hospitals for certain issues and conditions and that it already happened. Again there was a sense that people did not have enough information to have a more informed view on this.

However there were a number of suggestions about things that could be challenged;

- *'People are often told by a consultant following surgery to contact them again if there are any problems – this cant happen as you have to be re-sent via the GP'*
- *'Treating those that visit the country looking for free health care'*
- *'Keeping people in hospital when they don't need to be there. Alternatives need to be found'.*
- *'Children's services maybe too cautious – an alternative venue to A&E could be useful for observations rather than in the acute setting'*
- *'Cosmetic surgery – this should cover medical cases only i.e.: reconstruction following an operation to remove cancer'*
- *'Consultants that have private clinics – does the NHS subsidise these operations in terms of buildings and equipment?'*
- *'People that go abroad to have cheaper operations – if it goes wrong they expect the NHS to fix it and pay for it – these patients should have to pay'*
- *'There was a pilot to start planning discharge at 'point of entry', this would help reduced time people are in hospital'*
- *'There are too many MIU around East Kent coast'.*
- *'Could pre op assessments be done in the community?'*
- *'Could primary care or MIU remove catheters etc, rather than going to see consultant?'*

Public's thoughts about services that EKHUFT could start delivering

The idea of a teaching Nursing home, as suggested in the presentation was universally supported, as a '*great idea'* and an '*incredibly good idea'*. People likened it to the '*old fashioned cottage hospitals*', being more '*like convalescent homes*'. Many people stated that they did not feel that there were sufficient '*Step up and Down beds'*.

People also saw how these units could offer training opportunities for staff whilst providing '*Care that older people want being more local and not in a hospital setting'*, as '*Community hospitals and the main hospitals work very differently in terms of culture'.*

The theme of innovation and a greater use of technology was consistent across nine events with an appetite to explore this area further and find out more about what plans East Kent hospitals and others within health services had to make greater use of technology.

Suggestions made at the tables included;

- *'Appointments should be made on line – make greater use of technology'*
- *'Telemedicine for follow up consultation appointment'*
- *'Online medication prescriptions'*
- *'Greater use of telemedicine, outpatients, diagnosis, appointments'*
- *'Talking to a doctor virtually could be a way forward'*
- *'The younger generation will use technology more often, if they have a health question they tend to Google it'*
- *'Deaf people will soon be able to use video conferencing to get a signer for them'*
- *'Paramedics often wear cameras so that the images can go back to a hospital doctor for a diagnosis'*

Finally, a number of tables suggested that any new model should be built around current public behaviour rather than trying to change behaviour. '*If people are using local A&E departments to get help and advice quickly, then we should look at how we can adopt this to be more efficient rather than try to fight it and get people to change'*.

Public's suggestion for consideration at this stage

Thoughts about what else East Kent hospitals need to be considering at this stage could be divided into internal and external facing issues.

External facing issues

The clearest view of the public was that East Kent hospitals needs to be talking to Primary Care providers and the Clinical Commissioning Groups at this stage to look for '*joined up solutions to the challenges of the future.*'

Other suggestions for consideration at this stage were;

- *'Mental health, to ensure other specialist services are also working to support hospitals, as they are the final 'place of safety'. Could there be an alternative pathway for mental health that is an alternative place of safety?'*
- *'Needs of rough sleepers to access health services'*
- *'End of life care'*

Internal facing issues

- *'A Kent wide recruitment drive to attract people to live and work in Kent.'*
- *'Information sharing, patient data and choices needs to travel with the patient'*
- *'Translation services in minority languages to help with misunderstanding of appointments.*
- *'East Kent hospitals could employ BSL signers direct and join this up with CCGs and GPs to make a bigger team to cover all health services'*
- *'Pharmacy in hospital closed at lunchtime and creates delays in discharge; medication is a big blocker of discharge.'*

- *'Coordination of discharge is needed, medication, transport, discharge team, nursing staff to have time to be the coordinators of all this.'*
- *'Data sharing, information doesn't travel from GP to hospital with you, e.g. prescribing practice and vice versa. Particular issue regarding DNR, in emergency admission, this information is not instantly available to A&E staff'* it *'needs to travel at the click of a button'*
- *'Possible charge for not keeping appointment'*
- *'Serious investigation into the possible role and function of volunteers within hospital settings, supporting ward based activities'*
- *'Advertise where minor injuries are and hours etc so that each visitor to A&E is made aware of alternative paths'*

Next steps in Public engagement

Communication

- To maintain a mailing list of people who have expressed an interest in receiving updates about the process and to ensure updates are sent at each step.
- EKHUFT to develop a page on their website where people can find out information about the process, including copies of relevant reports and other useful documents.
- Share this report with other statutory agencies to aid a joined up approach, including but not limited to; Clinical Commissioning Groups, Kent Community Health Trust, Social Services at Kent County Council, and Kent and Medway Partnership Trust
- Share this report with Care Quality Commission to inform them before their next inspection of East Kent Hospitals

Taking forward the conversation with patients and the public of East Kent

It is proposed that a number of different methods of ensuring high levels of public engagement are developed at this next stage.

<u>Focused Discussions</u>

To create a series of focused discussions looking at particular issues, splitting the wider picture into smaller 'bite size' chunks.

Purpose of the focused discussions will be to:

- Have input from East Kent hospitals in relation to the topic to provide the public with context and background, allowing more informed discussions.
- Bring together diverse groups of people with an expressed interest in the topic area and create space for exploring a patient journey in relation to the topic.
- Allow groups to define what would be acceptable and unacceptable in terms of the patient journey and for these to start to inform the development of a 'public scorecard' that can be to evaluate future option development.

The areas proposed for Focused Discussion are:

1. Older patient's journey exploring the idea of teaching nursing homes and learning from existing pilot schemes.

2. Integration with primary care and community services
   - including learning from CCG developments such as Community Networks, and voluntary sector innovations.
3. Patient journey through A&E front door, including journeys for Minor Injury Units and Paediatrics. With a focus on journeys for children and people with mental health needs.
4. Patient Journeys in End of Life and Palliative Care
5. Patient Journeys in maternity services
6. The Patient Journey for Stroke, a Kent wide perspective
7. The Patient Journey for Stroke, a Kent wide perspective.

Wider Public engagement regarding the focused discussions

As well as the face to face focused discussions groups it is proposed that EKHUFT and Healthwatch Kent continue to visit community groups, Patient Participation Groups and public events to pose key questions that relate to the themes identified within the focused discussions.

The aim of this will be;

- To ensure the widest possible range of people are involved in thinking about topics in a more focused way.
- That groups who have been identified by an Equality Impact Assessment exercise per subject area, but who might not attend a focused discussion are involved, their views sought and their suggestions and contributions are included.

A series Update Meetings

To bring feedback from the focused discussions to the wider public in a series of update meetings across East Kent.

Purpose of update meetings is to:

- 'Test' wider public reaction to the thoughts and suggestions of public representatives that have been involved in the focused discussions.
- Create transparent process of building public ideas and views, which will then inform option development.
- Create opportunities for statutory stakeholder involvement in the public engaging and ideas building stages.

These Update meetings will be promoted in a range of ways including;

- In person via direct contact with community groups and organisations.
- On websites and in direct email mailings.
- Local media.
- Network organisations.

Appendix 1 Community engagement feedback by postcode

This table shows the number of postcodes identified by people either from SpeakOut Forms, face to face community visits or attending a listening event. Response rate for this monitoring was 69%.

CT1	Canterbury (south and city centre)	**15**
CT2	Canterbury (north), Harbledown, RoughCommon, Sturry, Fordwich, Blean, Tyler Hill, Broad Oak, Westbere	**20**
CT3	Wingham	**2**
CT4	Chartham, Bridge	**9**
CT5	Whitstable, Seasalter, Tankerton, Chestfield, Swalecliffe, Yorkletts	**12**
CT6	Herne Bay, Herne, Broomfield, Greenhill, Eddington, Beltinge,Reculver	**10**
CT7	Birchington-on-Sea, St Nicholas-at-Wade, Sarre, Acol	**6**
CT8	Westgate-on-Sea	**8**
CT9	Margate, Cliftonville, Burchington	**16**
CT10	Broadstairs, St Peters	**67**
CT11	Ramsgate	**5**
CT12	Northwood, Minster-in-Thanet, Cliffsend, Monkton, Manston	**85**
CT13	Sandwich, Eastry, Woodnesborough, Great Stonar,Richborough	**6**
CT14	Deal, Walmer, Kingsdown, Ringwould, Sholden, Great Mongeham, Worth, Ripple, Tilmanstone, Betteshanger	**14**
CT15	Alkham, Lydden, Eythorne, St Margaret's at Cliffe, Elvington	**19**
CT16	Whitfield, Temple Ewell	**35**
CT17	River	**36**
CT18	Hawkinge, Lyminge, Etchinghill, Capel-le-Ferne, Densole,Newington	**32**
CT19	Folkestone (north), Cheriton	**61**
CT20	Folkestone (south), Sandgate	**40**
CT21	Hythe, Saltwood, Lympne, Postling, Newingreen, West Hythe, Westenhanger	**52**
TN17	Cranbrook, Goudhurst, Benenden, Frittenden	**1**
TN23	Ashford (town centre), Kingsnorth, Singleton	**19**
TN24	Willesborough	**17**
TN25	Challock, Wye, Stowting	**14**
TN26	Bethersden, Hamstreet, Shadoxhurst, Woodchurch	**9**
TN27	Headcorn, Biddenden	**2**
TN28	New Romney, Greatstone-on-Sea, Littlestone-on-Sea	**16**
TN29	Lydd	**26**
TN30	Tenterden, Wittersham	**7**
ME9	Sittingbourne, Teynham, Iwade and Rural	**1**
ME10	Kemsley, Milton Regis	**9**
ME11	Queenborough, Rushenden	**1**
ME12	Isle of Sheppey, Minster, Sheerness, Eastchurch	**12**
ME13	Faversham, Boughton under Blean, Selling and rural area	**12**
ME1	Rochester, Burham, Wouldham	**1**

ME5	Walderslade, Blue Bell Hill, Lordswood Luton	**1**
ME7	Gillingham, Rainham, Hempstead	**1**
ME8	Rainham, Twydall	**2**
ME17	Hollingbourne, Hucking, Harrietsham, Lenham, Boughton Monchelsea, Linton, Coxheath, Chart Sutton, East Sutton, Langley, Kingswood, Sutton Valence	**1**

Appendix 2 Questions asked in response to EKHUFT presentation

Current services, improvement plans and what the future might be

Q. *You said that the current hospital situation is not sustainable anymore. But there have always been 3 hospitals, why is it now unsustainable?*

A. Its not about closing buildings but about re-gigging what services sit within each of the buildings and how they are delivered. It is unlikely that each of the current hospitals will look exactly as they do now but we can't say at this stage what they will offer. That is what we want to talk to you about. We want to understand the public's priorities and on what are they prepared to compromise.

Q. *If you start to take some of the specialist roles from the hospital, don't you risk fragmenting the services and making jobs unattractive for current and future staff?*

A. We need to maintain a working environment that attracts and keeps staff. We need to make sure our conversations with patients and public start to consider the impacts and compromises in light of the quality and sustainability of healthcare across East Kent as well as the working environments. This will be a complex process but we want to involve the public at each step to help us get it right.

Q. *If primary care take up some specialized areas of work, will the funds be transferred back from the hospital to GPs? GPs can't meet the appointment demands that they face now, so how will they cope of more demand is placed upon them?*

A. Primary Care is facing the same workforce pressures that we are. It is timely to undertake a detailed review of the whole system to identify the most efficient and effective ways of delivering care for people in East Kent. This will include looking at how and who delivers services as well as how they are funded.

Q. *What and where are 'One stop Shops'?*

A. One stop shop is the Outpatient model to which we aspire. They are designed to allow us to reduce appointments and create opportunities for getting consultations, diagnostic tests, and treatment plan all in one appointment. For surgical patients it will also include pre assessment and agreement of operation date.

We have previously agreed that we will provide outpatient services at six sites: WHH, K&CH, QEQM, Buckland Dover, RVHF (Folkestone) and Estuary View in Whitstable.

Q. *How many Minor Injury Units (MIU) are there in East Kent and where are they?*

A. There are 7 Minor Injury Units across East Kent. They are provided by different organisations. There are currently MIU's in Folkestone, Dover, Faversham, Canterbury, QEQM, Whitstable, Ashford and one recently closed in Dymchurch.

It is cheaper for someone to be seen in a MIU than in A&E.

Q. *What are Multi Specialty Community Providers (MCPs)?*

A. This is a new care model outlined by the NHS in which GP group practices expand, provide longer patient hours, and bring in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. These practices are intended to shift the majority of outpatient consultations and ambulatory care to out-of-hospital settings.
We know that increasing access to GPs reduces pressure on the hospitals. For example, some funding made available by the Prime Minister (Prime Minister's Challenge Fund) has paid for a GP service in Folkestone to be open 7 days a week – since this has been accessible we have seen a reduction in the number of presentations from that area at Ashford A & E.

Q. *How can you expect to get organised for such changes in the future when you can't manage current administration? Your appointment system is so bad. How will you get the fundamental things in order before embarking on change?*

A. We have set and are monitoring targets on the time a new appointment is made but did not set targets on the timing of issuing repeat appointments. We now see that there is a need to establish targets in these areas too and monitor them.

Q. *How are you addressing the 'bullying' culture that the Care Quality Commission (CQC) highlighted in their last report?*

A. We have had a substantial change in Board members, a new Chief Executive and Head of Human Resources along with new policies, but this kind of change takes time to reach all levels within an organisation as big as ours. The CQC are returning for another inspection in July and they will make a judgment on what they see.

Q. *I have been told that Canterbury Christchurch are accepting more nursing students than they have course places for.*

A. East Kent hospitals have promised every nurse that qualifies a job. We predict our staffing requirements and know that we will be able to offer a place to all current nursing students. However the issue is much wider, nursing is now a degree qualification and some students use this as a stepping stone to another career. The international demand for nursing staff has increased competition. We are competing with other countries for trained staff, America even offer packages that include 4 free flights home every year!

Q. *I worked in the NHS and have always heard the same issues regarding staff retention. How can we deliver services if we can't keep the staff?*

A. If all organisations within the health economy see the workforce as a whole, perhaps we could we use it differently. The public demand a greater degree of joined up working, could we make jobs different, share staff, reduce front line interagency tensions and improve job satisfaction?

Could we offer greater opportunities for working across different sites, different agencies and different specialties that would provide staff challenges and development opportunities with job security that would rival the current benefits of agency working?

Q. *How can people be better educated to use A&E appropriately?*

A. There are a range of reasons why people come into A&E, when there might have been alternative ways for them to receive the treatment they required. Only 20% of people attending A&E actually need the specialist services A&E provide.

The Minor Injury Departments within A&E are the busiest across all three hospital sites. We also have a large number of frail elderly and people requiring non acute care that could be better served in an alternative way.

Q. *How will you address peoples need to travel to hospitals, including those that can't afford public transport?*

A. Transport is an issue for our patients and we have heard that it is one of the most important issues to people in terms of how services in the future might look. We will make sure that transport is included in the range of checks that we will use to evaluate any options that are developed.

The wider healthcare picture – in East Kent

Q. *What are Clinical Commissioning Groups (GGGs) doing re preventative care, i.e. putting money into sport and other activities to keep people fit and healthy?*

A. The CCG would need to answer that question.

Q. *What is percentage of services that are now commissioned from the private sector by each CCG?*

A. The CCG would need to answer that question.

Q. *Romney Marsh has had a 'walk-in' centre close recently. If this is something that we think is useful in keeping people out of hospital and meets the healthcare needs of people in the Romney Marsh, how can we make sure that we get it open again?*

A. South Kent Coast CCG is the CCG with responsibility for Romney Marsh and they commission the services that are delivered. There is no new money going into the system so the CCG have to balance the demands and needs of people across the area.

Joined up services 'Integration'

Q. *Can we ever achieve joining up health and social care services?*

A The time is now right for a more integrated approach as all services are in the same boat. We need to think about how we can share the resources that are available across organisations to the best effect.

Q *Why don't the hospitals link more with domiciliary care, as nurses are all trained to level 3 and beyond? We have a duty to hold a bed for someone for 2 weeks, so we need to work together to get the person back out of hospital.*

A. We need to explore alternative pathways for older people that offers them a more appropriate place of treatment than A&E. Going into hospital starts a very medical pathway. The challenge is to work more collaboratively and allow innovation across service providers. We welcome these discussions at this stage to help identify possible opportunities for innovation.

Q. *Are you talking to Social Services?*

A. Historically we have not worked well together, but there has been a change and we are now working closer together. There are lots of pilots now taking place looking at how we can improve the way we all work.

These events are helping to inform us of a different set of questions to ask colleagues in Social Care.

The wider healthcare picture – nationally

Q. *What is the tariff and how does it work?*

A. The tariff is a national rate set by the government for activities across the NHS. For example the tariff awards East Kent hospitals an amount per operation that includes appointments from the time of referral, pre op consultations, pre med, the operation, any prosthetics required and post operative care costs. But the current tariff rate doesn't cover the full costs. This is a national problem. Monitor, the sector regulator for health services in England is currently negotiating with Government on behalf of Foundation Trusts.

Q. *Do local authority planning department have to consider the impact of housing developments on current healthcare facilities? It already takes up to 2 weeks to get a GP appointment, or queue outside from 7:45 am to get an emergency appointment. How can we make sure that new housing developments don't put more pressure on existing GP services?*

A. CCGs and the Local Authority sit on Health and Wellbeing Boards in each area and this is the kind of issue at which they look. The CQC also reviews issues around waiting times for appointments as part of GP inspections.

Q. *Current government plans forecast further cuts to the social care budget. How will this impact on the hospitals?*

A. A&E is the 'back stop' for healthcare services in this country. When people can't get their health needs addressed they know that they will get to see someone at A&E. Social care services have an important part to play in keeping people well both physically, emotionally. This is why it is so important that we start to work more closely with social care to look at how the whole health and social care provision in East Kent can deliver quality services together.

Public engagement and future consultation process

Q. *How are you making sure you talk to as many people as possible, as there aren't many people here at these meetings?*

A. We are working with Healthwatch Kent who are visiting community groups and encouraging people to get involved in the conversation with us about the future of healthcare services in East Kent. As the processes continues we will be ensuring that we reach further into local communities as well as maintaining contact with voluntary sector organisations and other representative groups.

Q. *How will you manage public expectations?*

A. Through an ongoing transparent public engagement process, with clear timeframes and identified steps. We are visibly identifying that staying the same is not an option. By working together with the public we can determine jointly what future healthcare in East Kent can look like.

Q. *What is the timeframe for this process?*

A. We are currently in the first phase and listening to people's thoughts about current services. We would like to start to involve patients and the public in more focused discussion and we will then look at what themes are emerging. We don't anticipate starting any formal consultation on future options until the end of this year.

Q. *It's nice that you are asking what we think, but it all comes down to budgets, so have we really got a choice anyway?*

A. We are asking people what they want and on what they would be prepared to compromise to inform how we can design services for the future to meet the majority wishes and needs. Everyone can contribute to this process, but not everyone will get everything that they want

Q. *To be involved in these conversations we need to understand how the budget works in the bigger picture, i.e. there will be certain things like cleaning and staff costs that need to be in place. How much information can you share with us about the different financial models and its impacts on ideas that we might have?*

A. As options start to develop we will be building costings for them and then be able to share this with people to further the debate.

Recent media coverage

Q. *The recent article in the paper had a lot of detail and digital images of the model as well as identifying a possible site for new hospital. How could they have this information if the option has not been developed?*

A. Kent County Council plans 30 years ahead for the possible needs of the population and the Local Plan does set aside some areas of land for healthcare development. There is an identified piece of land near the A2 in the local plan. We need to decide WHAT we want and then WHERE we want it. We have been looking at models of care and centralisation is one of a range of concepts. Underlying all this is the need to provide safe quality services that are staffed with appropriate numbers of trained staff. At this stage no one is talking about sites. Any future model of care will need to take account of the volume of traffic and alternative pathways that can reduce demands on high pressure services.

Q. *Could you close some of the hospitals?*

A. We are not planning to close any hospital sites, but to review what services might be better delivered more locally. These are the conversations we now want to have with you, 'what would you like to see locally and what needs to remain in current hospital site'?

Q. *When can we start to talk about the detail of what might be offered in the three main hospitals in East Kent?*

A. The conversation starts today, by starting to explore what the people of Kent would like to see delivered locally, what groups of the community such as the elderly, might benefit from an alternative pathway