MAIDSTONE AND TUNBRIDGE WELLS TRUST

REPORT TO: Trust Board

REPORT FROM: Corporate Development Director

DATE: 27 August 2008

SUBJECT: Orthopaedic and surgery reconfiguration

AGENDA ITEM: 080/08

SUMMARY

The creation of a trauma centre at Kent & Sussex (K&S) and a centre for complex and cancer surgery at Maidstone hospital was approved by West Kent PCT (PCT) on 15th March 2007, subject to caveats. The Kent County Council (KCC) Health Overview & Scrutiny Committee (HOSC) opposed the decision and referred it to the Independent Reconfiguration Panel (IRP) on behalf of the Secretary of State.

The IRP supported the proposal and set out 9 recommendations in their report of 18 December 2007. A clinically-led response has produced the reconfiguration proposal contained in the attached paper, which addresses both the PCT caveats and the IRP recommendations. The proposals are subject to PCT commissioning approval (PCT Board meeting 24 July 2008) and main changes for MTW Board to note since reviewing the paper in June are:

- Insertion of a check date (January 2009) for Board to evaluate the state of readiness and confirm the actual start date
- Recognition that a detailed implementation plan should be worked up and project managed tightly. The plan to include effective communication (including perceived issues i.e. transport), change management and effective marketing with GPs
- A project management methodology and structure should be in place to ensure successful delivery
- 5 year financials have been included to show the longer term effect (positive) on trust sustainability. Linked to this the recognition that a detailed income implementation plan has to be developed that sits alongside the implementation plan and the wider clinical strategy development
- Further work on risk mitigation of activity changes and capacity suggests a multi-faceted approach that would include working with GPs to alter referral flows from K&S to Maidstone

Clinicians are concerned about the ability to recruit into some posts and the implications of the European Working Time Directive (EWTD), along with changes to UK immigration rules that have restricted the flow of some doctors into the country. However, this is a generic issue to the NHS and could be mitigated by pro-active recruitment and positive advertising as well as consideration of direct recruitment into Europe.

Fit with corporate objectives

- Provide safe quality services and experience for patients, staff and the public
- Deliver services which are efficient and productive
- Ensure the effective governance of the Trust and its services
- Ensure we are a model employer in the local community and within the NHS
- Deliver financial viability and sustainability

Risks/issues

- Reconfiguration does not take place – clinical safety is not sustainable
- Capacity at Kent & Sussex – mitigated through improving efficiency and better use of community beds
- Ability to recruit staff – affects start time and possibly the model of care
- Loss of income – can be mitigated by repatriation

Action required

1. Confirm implementation option (subject to PCT)
2. Support project management and a detailed implementation plan, check date and timetable

Maidstone and Tunbridge Wells NHS
NHS Trust

THE IMPLEMENTATION OF THE SURGICAL AND ORTHOPAEDIC RECONFIGURATION PLAN

Creating a centre of excellence for complex and cancer surgery at Maidstone Hospital and a trauma centre at Kent and Sussex Hospital

Submitted by Frank Sims, Corporate Development Director

Executive Summary
Creating a centre of excellence for complex and cancer surgery at Maidstone Hospital and a trauma centre at Kent and Sussex Hospital

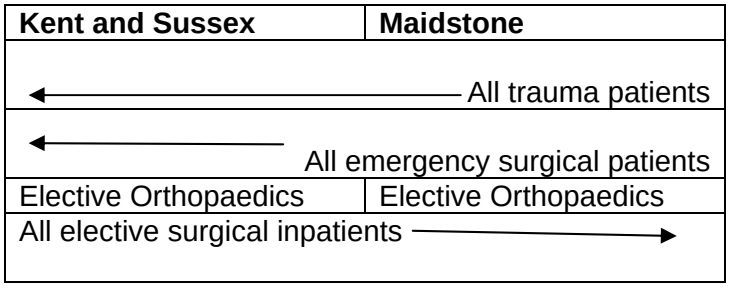
1.0 Introduction

This paper describes the interim reconfiguration (ahead of full centralisation of the trauma and orthopaedics in Pembury in 2011) which began in 2006. It was driven by clinicians to create a trauma centre at Kent and Sussex and establish complex cancer related surgery in Maidstone in response to national requirements for improving the care to trauma and emergency surgical admissions.

2.0 The Objectives

- To address the Confidential Enquiry into Peri-operative Death (CEPOD) and trauma issues
- To have a dedicated surgeon for managing emergency admissions
- To reduce the high level of elective operations cancellations
- To reduce the level of cross infection (MRSA and CDiff)
- Litigation cases:-Missed diagnosis/poor surgery
- Reduce the number of complaints in T/O and general surgery
- Reduce the time patients wait to have an emergency operation

3.0 Services to be provided



4.0 The Options

Option	Description
1	Do nothing
2	Reconfigure with on site surgical cover in Maidstone until 12mn and T&O cover until 8pm
3	Reconfigure with on site surgical cover in Maidstone until 8pm and T&O cover until 6pm.

4.1 Justification of the options

Option 1 – Do minimum	
This means the trust does not reconfigure trauma and emergency surgery and the status quo remains.	The trust will not be European Working Time Directive (EWTD) and New Deal compliant with its' junior doctor rotas. This will increase in the number of consultants and junior staff will be required in both specialties on each site. Such an increase will make recruitment impossible, as the 'pool' of doctors and the number of patients are too small resulting in the doctors seeing too few patients to maintain skills. This would lead to poorer training and eventual Royal College and Deanery de-recognition of the junior posts. It would also provide a poorer service to patients **This option does not meet the project objectives and would have a catastrophic effect on all MTW's services. It will require an estimated additional expenditure of £2.4m.**

Option 2 – The preferred option	
This means the trust will reconfigure surgery and trauma services with on site middle grade surgical cover at Maidstone until 12mn and orthopaedic middle grade cover until 8pm.	This option allows the trust to be EWTD and New Deal compliant in trauma & orthopaedics and surgery with no increase in the number of doctors in these specialties. Junior doctor training will not be compromised and Royal College recognition will not be threatened. **This option provides an optimum solution with a viable and sustainable trauma and emergency surgical service. It is the preferred option and will require an additional net expenditure £0.5m when the all new services are fully operational.**

Option 3 – Default Option (Do minimum)	
This means the trust will reconfigure surgery and trauma services with on site middle grade surgical cover at Maidstone until 8pm and orthopaedic middle grade cover until 6pm.	This option allows the trust to be EWTD and New Deal compliant in trauma & orthopaedics and surgery with no increase in the number of doctors in these specialties. Junior doctor training will not be compromised and Royal College recognition will not be threatened. **This option provides an acceptable solution with a viable and sustainable trauma and emergency surgical service. It is the default (do minimum) option as the level of on site surgical cover falls below the level deemed necessary by the physicians in Maidstone. In practical terms this means there will a greater proportion of on call cover from home rather than on site. It does not mean a surgical opinion is unavailable but that the person on call will need to travel from home to provide it. This option will require an additional net expenditure £0.4m when all new services are fully operational.**

5.0 Financial & Activity Impact of the Preferred Option

The table below provides a comparison between the 'do nothing' and the preferred option over the five year period.

	Preferred option	*Do Nothing*	*Net Saving/ (Cost)*
	£	*£*	*£*
2008/09	448,640	98,706	-349,934
2009/10	3,665,778	2,476,246	-1,189,532
2010/11	1,794,075	2,566,246	772,171
2011/12	828,615	2,566,246	1,737,631
2012/13	565,503	2,355,607	1,790,104
2013/14	565,503	2,355,607	1,790,104
TOTAL	**7,868,115**	**12,418,658**	**4,550,543**

This table demonstrates it will cost £4.5m more if the reconfiguration does not proceed.

In adopting the preferred option, further detailed work has been undertaken. The table below takes into account the loss of income, cost of implementing the preferred option, preliminary appraisal of impact of European Working Time Directive and New Deal for junior doctors in T/O and surgery and other income opportunities from the surplus capacity at Maidstone.

	Financial Implication					
	2008/09	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
	£	**£**	**£**	**£**	**£**	**£**
Income Impact						
Income from Additional Activity		1,784,803	4,734,058	6,531,454	7,057,678	7,057,678
Loss of Income	0	(2,765,778)	(3,017,212)	(3,017,212)	(3,017,212)	(3,017,212)
	0	**(980,974)**	**1,716,846**	**3,514,242**	**4,040,466**	**4,040,466**
Expenditure Impact						
Costs associated with additional Income		1,008,218	2,709,661	3,608,359	3,871,471	3,871,471
Implementation Costs:						
Theatres at K&S	-	210,639	210,639	210,639	210,639	210,639
Consultant Anaesthetists	-	52,885	57,692	57,692	57,692	57,692
Consultant Emergency	-	100,679	100,679	100,679	100,679	100,679
Junior doctors at K&S A&E	-	144,042	144,042	144,042	144,042	144,042
Radiology	-	28,536	28,536	28,536	28,536	28,536
Transport (incl non pay)	-	104,435	104,435	104,435	104,435	104,435
Ward 4 at K&S	386,140	926,737	926,737	926,737	926,737	926,737
Non Pay savings	0	(16,367)	(17,855)	(17,855)	(17,855)	(17,855)
Communication Strategy	50,000	50,000				
Project Management Costs	12,500	75,000	75,000	75,000	75,000	75,000
	448,640	**2,684,803**	**4,339,567**	**5,238,265**	**5,501,377**	**5,501,377**
Net Financial Impact (-ve is deficit)	**(448,640)**	**(3,665,778)**	**(2,622,721)**	**(1,724,023)**	**(1,460,911)**	**(1,460,911)**
MFF on additional Income	**0**	**0**	**828,646**	**895,408**	**895,408**	**895,408**
Adjusted Financial Impact after MFF	**(448,640)**	**(3,665,778)**	**(1,794,075)**	**(828,615)**	**(565,503)**	**(565,503)**

Therefore, in financial terms the preferred option provides a cheaper solution than the 'do nothing' option, which also derives no clinical benefit and would have a catastrophic impact on all clinical services.

Additional Contribution from repatriation		4.1m
Loss of Income	3.0m	
Implementation cost	1.6m	
		4.6m
Net cost to Trust per annum		**0.5m**

6.0 Timetable

The original proposal was to implement the reconfiguration of these services in October 2008. It is proposed this reconfiguration now takes place in April/May 2009 as the trust has a number of competing pressures arising from:-

- 5 month lead in for recruitment from decision to proceed in July 2008
- Capacity to deliver 18 weeks compliance by December 2008
- Winter pressures January to March 2009
- Ongoing deep cleaning programme

	2008						2009				
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
PCT Board approval											
MTW Board approval											
Agree joint communication strategy											
Staff consultation											
Complete doctors job plans											
Commence recruitment of additional posts											
Agree any changes to operational policies											
Revise major incident policy											
Scale down elective activity at both hospitals											
Revise patient admission letters											
Confirm date for reconfiguration											
Agree all SECAmb arrangements											
Move T&O and surgical emergencies											

7.0 Deliverability & Risks

In aspiring to deliver a first class service for patients option 2 remains the clinicians' preference. However, recruitment of middle grade doctors is a significant risk and therefore the trust must be pragmatic about the ability to deliver the preferred option if medical staffing recruitment to the desired level is unachievable.

If this proves to be the case, then option 3 becomes the default option in order to maintain safe clinical services in trauma & orthopaedics and general surgery.

The Human Resources (HR) business partners will work with the divisional management teams to actively make MTW an employer of choice. This will require active marketing across all disciplines using innovative recruitment methods.

A comprehensive risk management plan is in place but the four greatest risks are:-

- Unable to recruit staff (particularly middle grade medical staff)
- The plan does not proceed and the issues of critical mass are not addressed
- Bed stock inadequate at K&S – leading to capacity problems
- Loss of income and repatriated services

The plan clearly identifies the accountable officer for each of the risks, which will be monitored by the divisional management teams as the trust progresses through the implementation of this plan.

8.0 Project management

A detailed implementation plan will be project managed through the strategy steering group and to the Board via the Divisional Structure. It will include key work streams including:

- Income and marketing plan
- Communication plan
- Transport strategy
- Change management plan

9.0 Board action

A) Board is asked to give approval to option 2 as the preferred option, and option 3 as the 'do minimum'.
B) Endorse a proposed start date of April/May 2009, subject to formal review and ratification in January 2009 and for process to follow a dedicated project management methodology.