Agenda Item 5

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**15th September 2011**
By:	**Assistant Chief Executive**
Title of report:	**East Sussex Healthcare NHS Trust – Clinical Strategy**
Purpose of report:	**To update HOSC on progress with the development of the Trust's Clinical Strategy**

RECOMMENDATIONS

HOSC is recommended:

1. **To consider and comment on progress with the development of the strategy.**
2. **To consider the issues arising in terms of patient and public involvement and scrutiny as set out in section 4.**

1. Background

1.1 East Sussex Healthcare NHS Trust (ESHT) is a major provider of health services for the residents of East Sussex. It is the main provider of acute hospital care for the county, including the two main hospital sites in Eastbourne and Hastings. From April 2011 the community health services previously managed by the East Sussex Primary Care Trusts (PCTs) transferred to the Trust. These include services such as health visiting, district nursing, community rehabilitation and community hospitals.

2. Clinical Strategy development

2.1 ESHT is in the process of developing a clinical strategy, known as *'Shaping our Future'*, which aims to set out the future direction which will be taken by the Trust, taking into account the national and local context. It is intended to support the organisation in taking a consistent and coherent approach to developing and reconfiguring its services over the next five years.

2.2 In March 2011 HOSC considered the Strategic Framework (stage 1 of the strategy) which sets out the Trust's vision, mission, aims, objectives and priorities. In June 2011 HOSC received an initial report on the development of the Strategic Delivery Plan (stage 2). This Plan will include detailed financial and service planning to identify how the Trust will deliver the priorities set out in the Strategic Framework, including the degree of change which will be required.

2.3 The process of developing the Strategic Delivery Plan has continued throughout the summer. The process has involved the development of preferred models of care across eight primary access points: A&E; acute medicine; general surgery; cardiology; stroke; trauma and orthopaedics; paediatrics and maternity. These services, many of which are interdependent, represent 80% of the Trust's current income and are integral to the future success of the Trust.

2.4 In May 2011 the Trust announced that the maternity aspect of this work would be undertaken through an independently led review of maternity services. Whilst part of the overall strategy development, this review has some additional features such as an independent Chairman, external project manager and external clinical input. The outcomes of this review, which concludes later in September, are intended to feed into the clinical strategy.

2.5 The Trust envisages that the sort of change emerging from the clinical strategy will fall into three categories:

- Increasing operational efficiency and effectiveness

- Service redesign – changing the care pathway experienced by patients
- Service reconfiguration – changing the service model, such as where or whether a service is provided in the future.

3. Progress update

3.1 ESHT has provided an update on the development of the Strategic Delivery Plan - attached at appendix 1. For each of the eight primary access point services this includes a summary of:

- The proposed change from the current service model
- The reasons why change is required
- The anticipated benefits of the change
- What may be required to achieve the delivery of the preferred service model

3.2 The next steps in the process focus on identifying specific options for delivering the proposed model of care for each service area through a process of engagement with stakeholders, key patient groups, clinicians and others. The intention is then for options to be narrowed down to those which would be viable to implement. This process is expected to be completed by December 2011.

3.3 Stuart Welling, Chairman, Darren Grayson, Chief Executive, and Dr Amanda Harrison, Director of Strategy, from ESHT will attend the HOSC meeting to discuss the Trust's report.

4. Patient and public involvement and scrutiny

4.1 NHS organisations have a duty to involve patients and the public in the development of proposals for change in an appropriate and proportionate way. It would be expected that any major changes proposed would be subject to public consultation. HOSC has a role in considering how effectively patients and the public have been involved. The Committee may wish to explore how the engagement undertaken to date has informed the models of care which have been developed and how the next stage of engagement will ensure patient and public involvement in the development of options for change.

4.2 NHS organisations also have a separate duty to consult the relevant HOSC(s) on any proposals for 'substantial development or variation' to services. Although there is no definition of 'substantial' it is suggested in national guidance that HOSCs and the NHS might want to consider issues such as: the number of patients affected and how intensive their use of the service may be; the impact on patients and carers in terms of access; and whether the proposal involves a significant shift in the way a service is provided. When options for change have been fully developed, HOSC will need to consider, in conjunction with the Trust, whether any of the proposed options constitute potential 'substantial' change which will require this type of formal, statutory, consultation with the Committee.

4.3 The identification of any 'substantial' change proposals requiring consultation with HOSC will inform the Trust's decision (in conjunction with commissioners) on whether proposals will require public consultation. It is generally accepted practice that proposals considered 'substantial' by HOSCs are likely to require public consultation.

4.4 Although options for change are not yet fully developed HOSC may wish to give early consideration to the factors which may indicate whether a proposed change is considered to be 'substantial' change. The Committee will be able to take a firm view at a later date when proposals are more fully developed. HOSC may wish to be informed or engaged in other aspects of the strategy implementation, but on an 'informal' basis, rather than through a statutory consultation process.

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Clinical Strategy

HOSC

15th September 2011

Guiding Principles for the Clinical Strategy - Incorporating Lansley's 4 tests

The Clinical Strategy will:

- **Achieve the Trust's target objectives and promote patient choice**
  - Services that meet the needs of the local population – aligned to the JSNA
- **Be clinically led**
  - Active involvement from a wide range of clinicians with clear clinical leadership
  - Models of care with broad clinical support
  - Aligned to commissioning intentions with support from GP Commissioners
- **Be evidence based**
  - Models of care supported by clinical evidence
  - External perspective for independent challenge and validation
- **Be developed through engagement**
  - Public and patient engagement to ensure delivery of patient-centred care models
  - External and internal communications
- **Enable the provision of integrated services**
  - Key integration and interdependencies understood
  - Links made to network strategies
  - An"end to end" view of the model of care, including services in the community and third parties
  - Informs Trust's strategy for IT, Estates and Workforce

Communications and engagement activities have been running alongside the clinical strategy approach:

INTERNAL

- General staff sessions presented by Executive across multiple sites
- CEO Consultant and staff meetings
- Robust communication strategy for staff engagement, including presentations to Divisional teams and specialties
- Testing hypothesis of cases for change via email and meetings
- Workshops open to cross section of staff at all grades to contribute to the development of:
  - target outcomes based on clinical, national, and local evidence,
  - the gap analysis and
  - new models of care
- Strategy web site and email address gives opportunity for feedback fed back to working groups with feedback collated by strategy team shapingourfuture@esht.nhs.uk
- Core themes being developed through feedback

EXTERNAL

External stakeholders and agencies

- Multiple attendance at workshops with GP's, commissioners, Adult Social Care, voluntary and external organisations e.g. carers/hospice
- Presented to cross section of organisations and groups e.g. ESCC, End of Life Board, Carers partnership Board
- Stakeholders events – 8th September 2011

Patients and the Public

- Focus groups to determine what is most important to patients and public
- Access for feedback via web site
- Participation in workshops to help determine outcomes to be achieved, development of models of care
- Stakeholder mapping exercise completed to establish next steps to ensure engagement in each stage of the process
- Presented at disability and equality groups to secure engagement and support involvement

The development of clinical strategy proposals has centred around eight Primary Access Points (PAPs)

- A&E
- Acute Medicine
- General Surgery
- Cardiology
- Stroke
- T&O
- Paediatrics
- Maternity

These 8 PAP services :

- are integral to the future success of the Trust – critical interdependencies
- represent over 80% of the Trust's income today
- have escalating demands and increasing activity
- are a focus for improving and sustaining quality

Acute Medicine

PROPOSED CHANGE

- **Consultant led,** 12 hours/day 7 days/week – assessment and triage on arrival to hospital of patients by a senior decision maker to ensure rapid formulation of diagnosis and plan
- **Aim for "decide and admit",** rather than "admit to decide". Patients staying <72 hours should stay in medical assessment unit to ensure no time lost in handover or decision-maker delay
- **Rapid access to specialist care** – inpatient or outpatient
- Identify those who do not need acute care and redirect to the most **appropriate place** for their needs
- **Redesign pathways** grouping patients with similar expected length of stay(can usually be determined on admission) or by severity of condition.
- **Work collaboratively** with primary care and other agencies to reduce demand :
  - inappropriate attendances
  - avoidable admissions
- Increase and develop **ambulatory care** pathways

WHY CHANGE?

Currently the Trust sees the following:

- 80% emergency admissions stay < 7days (42% < 2) and represent 25-30% of bed-days
- 15% stay 7-21 days and represent 40% of bed-days
- 5% stay > 21 days and represent 30-35% bed-days
- There is time of day mismatch between admission and discharge

This can result in:

Backlog

- Patients remain in MAU longer than necessary/A&E flow compromised/
- Patients not always admitted to most appropriate ward
- Delayed decisions and increased handoffs

Additional costs

- overtime, locum, agency to support the demand /opening additional beds/ wards due to backlogs in the system.

Impact on quality

Poor patient experience

Acute Medicine

BENEFITS

- earlier involvement of consultants in decision making
- timelier diagnosis
- better use of resources
- more patient-centred care
- reduced mortality
- improved patient safety,
- Improved patient experience and satisfaction
- Appropriate placing of patients to meet their needs
- Elimination of medical outliers
- More appropriate lengths of stay

DELIVERY

- Review of processes to increase operational efficiency and productivity
- Development of ambulatory units
- Redesign of pathways from pre admission, admission to discharge working closely with GPs, primary care and other external agencies through the Urgent Care Network.
- Increase the number of short stay assessment beds and reduce in patient bed requirement
- Redesign of workforce skills and practice

A&E

PROPOSED CHANGE

- **Initial rapid assessment** and triage on arrival to hospital of patients by a senior decision maker to ensure rapid formulation of diagnosis and plan
- Stream patients to most appropriate area for their needs
- **Fast track** 'life threatening & emergency specialty patients' through to specialist areas
- Stream emergency patients requiring **admission** through to MAU/SAU's (cohorting patients by LOS)
- Stream emergency patients requiring **assessment** following rapid diagnostic and treatment, supported to either go home +/- support (HIT Team, ASC, Mental health)
- **Minor patients** to be assessed by ENP service and referred to most appropriate pathway for patients needs e.g. home, primary care, HIT team
- Provision of trauma care in trauma unit linked to major trauma centre

WHY CHANGE?

- Rapid assessment by senior decision maker ensures streaming of patient to the most appropriate area for their needs.
- Streaming of patients to specialty areas improves mortality and patients outcomes e.g. cardiac patient to CCU, Stroke patient to specialist unit
- Patients currently remain in A&E longer than necessary
- A&E flow is compromised due to delays in assessment and decision making
- Patients not always admitted to most appropriate ward
- Delayed decisions and increased handoffs increases LOS
- Recruitment, training and retention of medical staff is challenging in some specialties

A&E

BENEFITS

- Enables Trust to deliver improved performance against service standards
- Increase use of ambulatory care
- Reduces unplanned re-attendance rates
- Reduces total time in A&E
- Reduces the number of patients who leave without being seen
- Improves patient satisfaction and experience
- Reduces time to initial assessment and time to treatment
- Ensures consultant/senior decision maker sign off for specific conditions
- Supports improvements in privacy and dignity for patients
- Reduces rates of inappropriate admissions
- Supports other specialty pathways for delivery of care
- Appropriate placement of patients reduces outliers
- Improved training for medical and nursing staff

DELIVERY

- Review of processes to increase operational efficiency and productivity
- Development of ambulatory care and enhanced ENP service
- Redesign of pathways from assessment to admission to discharge working closely with medical/surgical specialties and collaborative working with external agencies
- Scale of change is dependent of the impact of other specialties and their models: including acute medicine, paediatrics, trauma, general surgery, stroke

Paediatrics / Child Health

PROPOSED CHANGE

Health & Wellbeing

- Implement full Healthy Child Programme (5-19 yrs)

Integrated Comm. Nursing service (24/7)

- Admission avoidance – range of options
- Continence/epilepsy/oncology/diabetes
- Shift of care from inpatient acute provision to community/home settings where appropriate

Ambulatory Care

- Development of Ambulatory Care provision in community settings (24/7, 365 days)
- Paediatric nurse practitioner led/ use telemedicine

Assessment of acutely ill children

- In A&E admitted when required with increased emphasis on ambulatory care

Emergency surgery

- Triaged and provided by appropriate clinical expert

Inpatient care – for some conditions:

- Heart failure – intensive observation/feeding
- Infection – 48 hour observation/intravenous treatment

Long Term Conditions

- Integrated multi-disciplinary team service
- Transition planning with adult care

WHY CHANGE

Full Healthy Child Programme

- Range of preventative services
- Safeguarding issues identified early

Integrated Community Nursing Service providing:

- Equitable service across East Sussex
- Proactive care for children with Long Term Conditions
- Range of admission avoidance measures
- Extended hours to 24/7

Ambulatory Care

- Assessment taking place as close to where they child lives as possible

Acute Paediatric Care

- Children with more acute conditions can be treated in Ambulatory settings and supported to stay at or closer to home

Long Term Conditions

- Transition between children's and adult services well managed for young people with Long Term Conditions

Paediatrics / Child Health

BENEFITS

- Supporting children to stay at home and live their lives fully by providing appropriate care in appropriate place at appropriate time.
- Equitable service across East Sussex according to need
- Reduce the risk of harm, neglect and improve emotional wellbeing of vulnerable children.
- Clear pathways and information for children, young people and their families
- Clear pathways and information for referrers

DELIVERY

•Ambulatory care provision to be developed to undertake assessment.

•Shift of care from acute to community through service redesign

•Operational efficiencies can be made through ensuring consultants only see those patients that need to see a consultant

•Inpatient bed numbers required to be determined.

•Service reconfiguration could be required if significantly fewer beds are required than current provision.

Trauma & Orthopaedics

PROPOSED CHANGE

- Dedicated protected orthopaedic beds
- MSK triage, assessment and treatment in community referral
- Enhanced Recovery for all patients (elective & trauma)
- Ortho-geriatrician provision for complex cases with co-morbidities
- Increase rates of day surgery
- Improve access to rehab / non-weight bearing beds. Rehab for all regardless of age
- Further develop Trauma Assisted Discharge
- Introduce ward based social workers/ pharmacists
- Level 2 trauma provision

WHY CHANGE?

- Reduce medical/trauma outliers
- Reduce operations cancelled on the day
- Reduce surgical site infections
- MSK only refer to acute if clinically necessary
- Emergency patients seen in a timely manner by most Senior Decision maker
- Collaborative discharge planning from admission (or pre-admission) by TADs/ADs/ Living at Home etc assessing at admission
- Level 2 trauma provision linked to major trauma centre at BSUH

Trauma & Orthopaedics

BENEFITS

- All operations performed in a timely manner - fractured NOF within 36 hrs (Best Practice)
- Reduce rates of surgical site infections
- Ortho-geriatrician will reduce readmission rates, improve patient experience, reduce LOS, and attract Best Practice Tariff
- Patients seen in most appropriate clinic by most appropriate person – so consultants only see those they need to see and emergency patients seen in a timely manner by senior decision maker
- Peri-operative mortality/morbidity rates minimised

DELIVERY

- Options for delivery are interdependent with A&E, Paediatrics, General Surgery and Acute Medicine
- Operational efficiencies can be achieved through;
  - Improving the process for accessing rehab and non-weight bearing beds in the community
  - improving processes in outpatients, theatres and use of all beds
- Service redesign will be required to
  - Introduce protected dedicated orthopaedic beds
  - Introduce community based MSK,
  - Reduce LOS for emergency & elective
- Reconfiguration may be required
  - Dependent upon the outcome of the NHS SEC decision re Level 2 Trauma provision

Maternity

PROPOSED CHANGE
(based on the draft recommendations of the independent reviewers – not yet agreed by the Maternity Review Board)

Introduction of a new model of care that includes:

1 Midwifery led care – for women without risk factors

2 Consultant led – shared care with midwives and other specialists

3 Specialist Tertiary Care – for those with significant risk factors

Neonatal Care

- Introduce Transitional Care for newborns in a ward environment supported by midwives
- Develop a Level 1 SCBU with strict criteria (according to BAPM standards)

WHY CHANGE?

- National guidance focuses on normalising pregnancy (non-medical) wherever possible
- Continuous medical and social risk assessment throughout pregnancy and if no risk factors then no need to see an obstetrician(32%)
- Midwifery led care provided at home or in 'home-like' settings
- For women with minor medical problems or risk factors medical involvement most commonly through 'shared care' between midwife and obstetric team.
- Less than 1% women in East Sussex are likely to need to be delivered in Specialist/ Tertiary Centres

Neonatal Care

- Transitional care would support delivery of maternity services and release capacity on SCBU
- Clear criteria for admission into and transfer out of East Sussex. This would reduce the current transfer rate of babies to Level 2 and 3 units within the network.

Maternity

BENEFITS

- Normalises birth and improves women's experience
- Improved choices re access and type of antenatal care and type of care and place of delivery
- Specialist care (e.g. diabetic women) can be concentrated to allow better cooperation between specialists, introduction of joint clinics (e.g. cardiac problems)
- Reduce unplanned events through provision of enhanced risk assessment
- Early detection and treatment of high risk mothers and babies leading to long term health outcomes

DELIVERY

- Operational efficiencies include
  - Skill mix review and role redesign including education and training for Maternity Support Workers and for Midwives
  - Promotion of multi-disciplinary team working
  - Developing extended roles for midwives
- Service redesign will be required to introduce equitable midwifery led provision
- Potential for reconfiguration – not yet determined

General Surgery

PROPOSED CHANGE

Dedicated surgical assessment provision
- Consultant led / nurse led discharge

Dedicated ring fenced surgical beds

Increase day surgery rates

Elective / emergency separated to provide
- Emergency assessment by senior decision maker
- Dedicated beds, staff, theatres
- Emergency team

Provide core services over long hours e.g. providing theatres from – 08.00 – 20.00 including weekends

Enhanced Recovery Assessment Service involved early

Vascular
- Seen by trained vascular specialist / use of vascular research nurses

Cancer
- Improve access to flexible sigmoidoscopy / colonoscopy
- Laprascopic surgery to become the norm for colorectal cancer

WHY CHANGE?

- Emergency patients to receive rapid initial assessment by senior staff
- Better utilisation of beds and theatre capacity to match demand will reduce LOS

Elderly Patients
- consultant physician available for all elderly patients
- Improve treatment of patients with co-morbidities
- Those with non specific abdominal symptoms to be assessed by experienced doctor to exclude surgical pathology
- Improved access to rehabilitation

- **Day surgery** to be provided in Uckfield, Bexhill, EDGH, Conquest to meet British Association Day Surgery targets
- To reduce LOS
- To improve patient experience through better understanding of what is expected at each stage of the pathway (ERAS)
- Rapid assessment by colorectal cancer MDT

General Surgery

BENEFITS

- Reduces number of cases cancelled on day of operation (2010-11, 224)
- Reduces number of surgical site infections
- Reduce LOS and improve discharge
- Improves care of elderly patients by providing physician
- Early and continuous pain management
- Less invasive surgery – where appropriate
- Achievement of Best Practice Tariffs
- Delivery of 18 weeks and contracted activity

DELIVERY

Options for delivery are interdependent with critical care, anaesthetics, diagnostics, elderly care (and many more)

- Operational efficiencies can be achieved through improving processes to;
  - Make better use of theatres
  - Match capacity to demand to increase utilisation of beds
  - Reduce LOS for emergency & elective
- Service redesign will be required to:
  - Introduce dedicated surgical assessment unit
  - Introduce dedicated protected surgical beds
- May be options for reconfiguration

Cardiology

PROPOSED CHANGE

- **24/7 cardiac triage team** with a two hour response time with access to rapid diagnostics and cardiac specialist opinion through telemedicine.
- **Development of an acute cardiology triage provision** with rapid access to cardiology team for management and diagnostics.
- **Coronary angiography within 72 hours** (NSTEMI patients)
- **Emergency admissions to come directly to** cardiology triage/ cardiology ward/ CCU
- **Counselling and support** for patients and families in primary care who require devices.
- **To have a fully integrated pathway** covering the acute and community pathway
- **Echocardiogram within 2 weeks** of referral.
- **Suspected HF should be streamed to Acute Triage Unit** for rapid specialist opinion and appropriate diagnostics.
- **Cardiac rehabilitation** to be available to those patients able to participate.

WHY CHANGE?

- To achieve best clinical practice
- Patients seen in a timely manner by most Senior decision maker
- Early intervention improves patient outcomes
- Delayed decisions and increased handoffs increases LOS
- Ensure specialist provision can be delivered within national standards
- Streaming of patients to specialty areas improves mortality and patients outcomes
- Improve both primary and secondary prevention by working across the patient pathway

Cardiology

BENEFITS

- Able to improve outcomes against national standards
- Timely movement of patients to specialist units improves patient outcomes
- Reduction in LOS
- Improved support to patients and families in community
- Improved operational efficiency

DELIVERY

Options for delivery are interdependent with A&E and Acute Medicine

- Operational efficiencies can be achieved through;
  - improving processes in admission and use of all beds
  - Early intervention
- Service redesign will be required to
  - Introduce 24/7 cardiac triage team
  - Introduce Angiography in 72 hours
- Reconfiguration may be required to achieve all of these goals but will be dependant on A&E and Acute Medicine.

Stroke

PROPOSED CHANGE

- **Admit directly to a specialist acute stroke provision** if a suspected stroke.
- **Admit to acute stroke provision all patients with symptoms of TIA** not completely resolved within 1 hour at time of assessment
- **Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission** and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.
- **Brain imaging within 1 hour of arrival at the hospital** if patients meet any of the indications for immediate imaging.
- **Minimum of 45 minutes of each active therapy** that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it.
- **Fully integrated early supported discharge and community team** working alongside the acute service to enable optimal flow for re-enablement of the patient
- **Patients should be transferred to the service with the lowest level of complexity** as soon as possible, at each stage of the pathway

WHY CHANGE?

- To achieve all NICE standards
- Streaming of patients to specialty areas improves mortality and patients outcomes
- Delayed decisions and increased handoffs increases LOS
- There is not a true 24/7 Speciality Stroke Rota
- There is not a 24/7 thrombolysis service meeting the Sussex Stroke Network Service Specification
- LOS is high 21 days, target 7 days
- Direct admission to specialist acute stroke provision not occurring
- Increase of stroke specialist to support 24/7 Speciality Stroke Rota
- 7 day a week rehabilitation
- Access to Early Supported Discharge from the outset and at each stage of the stroke pathway

Stroke

BENEFITS

- Able to improve outcomes against national standards
- Timely movement of patients to specialist units improves patient outcomes
- Reduction in LOS
- Dedicated stroke rota
- Improved support to patients and families in community
- Access to Early Supported Discharge from the outset and at each stage of the stroke pathway

DELIVERY

- Options for delivery are interdependent with A&E and Acute Medicine
- Operational efficiencies can be achieved through;
  - Improving the process for accessing rehab in the community
  - improving processes in admission and use of all beds
- Service redesign will be required to
  - Introduce dedicated stroke beds
  - Reduce LOS
  - Introduce direct access to imaging
  - Introduce telemedicine
- Reconfiguration may be required to achieve all of these goals but will be dependant on A&E and Acute Medicine.

Next Steps

Further engagement:

- Identify options for delivering the proposed model of care
- Identify key groups and representatives to work with – equality impact assessment
- Develop options appraisal criteria
- Narrow option to those which are viable prior to identifying a requirement for formal consultation in consultation with the HOSC – by December 2011