Agenda Item 6

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**24 November 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 provisionally agree which aspects of the emerging clinical strategy proposals are likely to constitute 'substantial development or variation' to services requiring formal consultation with the Committee.**

1. Background

1.1 East Sussex Healthcare NHS Trust (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.

1.2 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 and September 2011 HOSC received reports on the ongoing development of the Strategic Delivery Plan (stage 2). This process has involved the development of preferred models of care across eight primary access points: emergency care; 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.

1.3 In May 2011 the Trust announced that the maternity aspect of this work would be undertaken through an independently led review of maternity services. This review concluded in September 2011 with the agreement of a future model of care for maternity and related services. The full report of the review has previously been circulated to HOSC Members and is available on the Trust's website www.esht.nhs.uk .

1.4 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.

2. Progress update

2.1 Following HOSC's consideration of the proposed models of care for each of the primary access points in September, the models were agreed by the ESHT Board later that month.

2.2 The next stage in the process, currently underway, is to identify 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.

2.3 The Trust has provided a detailed report (appendix 2) on progress with this stage. This covers the identification of options, the development of the criteria which will be used to assess and 'shortlist' options and details of the stakeholder engagement which has informed this work. A glossary of acronyms used in the report is attached at appendix 1 for reference. Darren Grayson, Chief Executive and Dr Amanda Harrison, Director of Strategic Development and Assurance from ESHT will attend the HOSC meeting to discuss the report.

2.4 In September, HOSC agreed to establish a Task Group to provide extra input from the Committee during the options development phase. This Group, comprising Councillors Davies, Merry, Phillips, Simmons (Chairman) and Ungar met on 24th October and 18th November to consider the process of identifying options, the development of a set of criteria for assessing the options and the engagement being undertaken to inform the process. The Task Group's Terms of Reference are attached at appendix 3 and notes of the meetings have previously been circulated to HOSC Members.

3. Patient and public involvement, consultation and scrutiny

3.1 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 and consulted by the NHS.

3.2 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.

3.3 The Trust's report at appendix 2 provides an initial assessment of the proposals for change likely to emerge. HOSC needs to consider whether any of the proposed options constitute potential 'substantial' change which will require formal, statutory, consultation with the Committee. In order to take a consistent view across all primary access points HOSC may wish to consider the three levels of change described in paragraph 2.4 above and whether, for example, proposals for service reconfiguration are likely to represent 'substantial' change.

3.4 As the identification and shortlisting of options is not yet complete, any view HOSC gives now will be provisional. The Task Group will be in a position to monitor whether any significant changes to the proposals during the remainder of the process may impact on HOSC's view and advise the Committee accordingly. It is important to note that HOSC can also be informed or engaged in other aspects of the strategy implementation which are not considered to be substantial change, but on an informal basis through the Committee's ongoing work programme, rather than through a statutory consultation process.

3.5 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.

SIMON HUGHES
Assistant Chief Executive

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Appendix 1

Glossary of Acronyms

The following acronyms are used in Appendix 2

AHP	Allied Health Professional
ANLS	Advanced Neonatal Life Support
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CRES	Cash releasing efficiency savings
CSS	Clinical Support Services
CT	Computerised Tomography (type of scan)
EIA	Equality Impact Assessment
EoL	End of life
ES	East Sussex
ESS	East Sussex Seniors
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare Trust
EWTD	European Working Time Directive
FT	Foundation Trust
GP	General Practitioner
HDU	High Dependency Unit
IT	Information technology
ITU	Intensive Treatment Unit
LHE	Local health economy
LINk	Local Involvement Network
LOS	Length of stay
LTC	Long term condition
MSK	Musculo-skeletal
NH	Newhaven
NSIG	National Strategies Impact Group
OD	Organisational development
OOH	Out of hours
PAP	Primary Access Point
pPCI	Primary Percutaneous Coronary Intervention (also known as primary angioplasty)
SCBU	Special Care Baby Unit
T&O	Trauma and orthopaedics
TBC	To be confirmed

Clinical Strategy

HOSC

24th November 2011

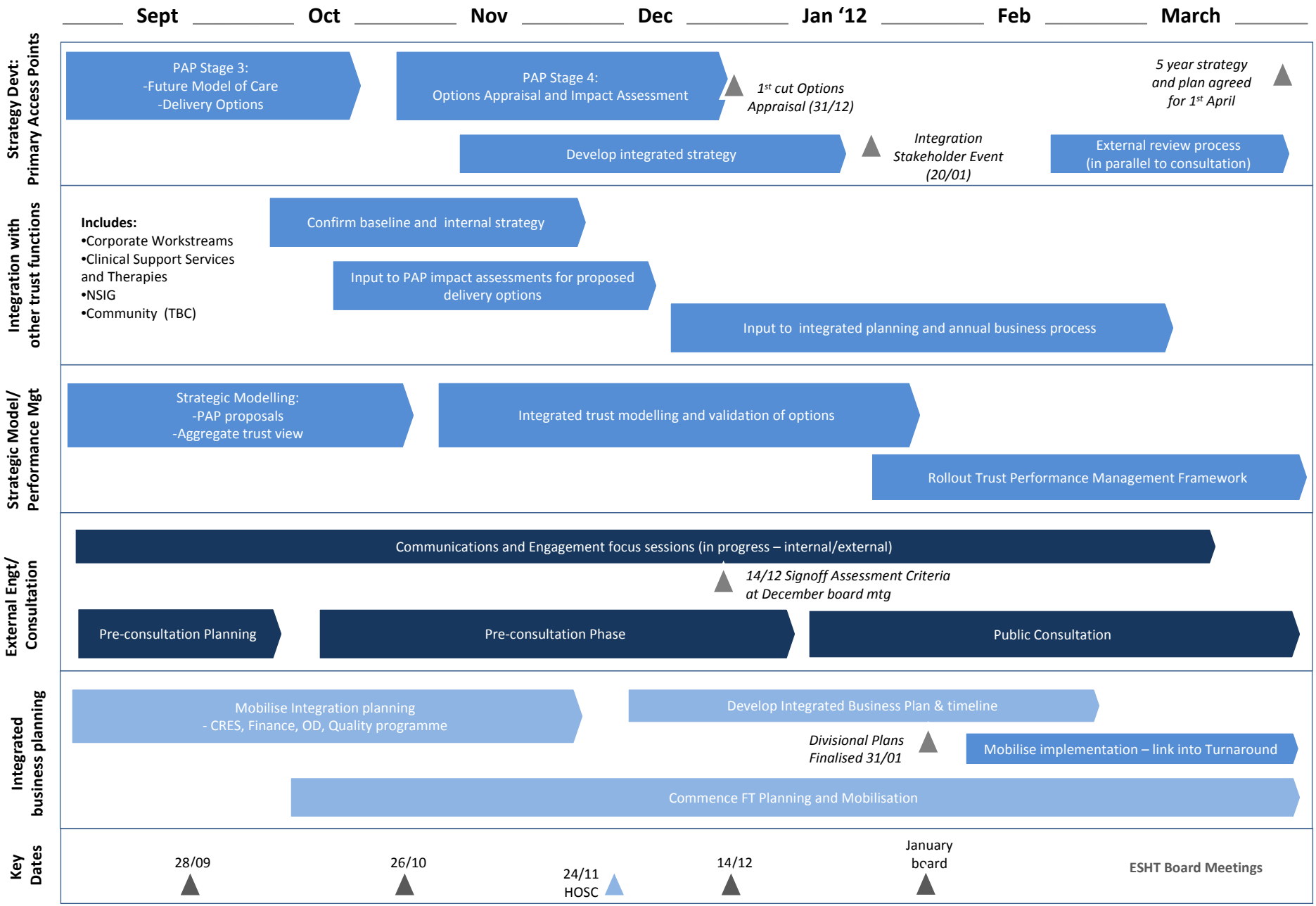
Progress to Date

- Establishment of Trust aims and objectives
- Identification of eight Primary Access Points (PAPs) - 80% of Trust's income and activity

    - **Acute Medicine**
    - **Emergency Care**
    - **Muscular Skeletal, Trauma and Orthopaedics**
    - **Paediatrics and child Health**
    - **General Surgery**
    - **Cardiology**
    - **Stroke**
    - **Maternity**

- Development of new models of care, through engagement and based on evidence
- Identification of interdependencies

Clinical Strategy High Level Plan (September 2011 – March 2012)



Clinical Strategy – Pre Consultation phase

DELIVERY OPTIONS

- Development of delivery options through internal and external engagement
- Change emerging from the clinical strategy falls into three categories:
    - Increasing operational efficiency and productivity
    - Service redesign – changing the pathway experienced by patients
    - Service reconfiguration – changing the service model, such as where or whether a service is provided in the future

Delivery Options

- Work commenced in November, following the development of the new models of care, to identify **all** delivery options for the 8 PAPs

- The following delivery options are draft and continued discussions are taking place through internal and external engagement to develop these further and ensure they represent the full scope of potential options

MSK Trauma and Orthopaedics

OPTION 1- No change

- No Change to current configuration of services.
- Improvements in efficiency and productivity and some redesign through :
- Streamlining trauma pathway from Emergency care to ensure early senior medical review.
- Streamlining elective pathways to reduce length of stay and increase early discharge and care at home
- Expert Senior medical care for complex cases and for the elderly
- Ring fenced elective beds on both sites
- Increase in day case surgery procedures and increase use of day case facilities to attain national best practice
- Enhanced triage through muscular Skeletal Service. Outpatients at community and main hospitals sites
- Increased utilisation of community rehab beds and enhanced community support service for early discharge

Delivered by:
Efficiency productivity/Redesign

OPTION 2 - Single site both elective (Major joint replacements) and trauma

- Single site both elective (Major joint replacements only) and trauma
- Streamlining trauma pathway from Emergency care to ensure early senior medical review.
- Streamlining elective pathways to reduce length of stay and increase early discharge and care at home
- Ring fenced elective beds on both sites
- Increase in day case surgery procedures and increase use of day case facilities to attain national best practice
- Enhanced triage through Muscular Skeletal Service. Outpatients at community and main hospitals sites
- Out patients on both sites
- Higher utilisation of community rehab beds and enhanced community support service for early discharge
- Enhanced provision of preventative services

Delivered by: Reconfiguration

MSK Trauma and Orthopaedics

OPTION 3 - elective on both sites and single site trauma

- Both sites elective , Single site trauma –
- Develop into a ‘super’ trauma unit reflecting county wide network proposals
- Streamlining trauma pathway from Emergency care to ensure early senior medical review.
- Enhanced triage through Muscular Skeletal Service. Outpatients at community and main hospitals sites
- Streamlining elective pathways to reduce length of stay and increase early discharge and care at home
- Ring fenced elective beds on both sites
- Increase in day case surgery procedures and increase use of day case facilities to attain national best practice
- Higher utilisation of community rehab beds and enhanced community support service for early discharge
- Enhanced provision of preventative services

Delivered by: Reconfiguration

OPTION 4 – Trauma on both sites – single site elective

- Both sites trauma, Single site elective (spinal and joint replacements)
- Increase in day case surgery procedures and increase use of day case facilities to attain national best practice
- Streamlining trauma pathway from Emergency care to ensure early senior medical review.
- Streamlining elective pathways to reduce length of stay and increase early discharge and care at home
- Ring fenced elective beds on both sites
- Higher utilisation of community rehab beds and enhanced community support service for early discharge
- Enhanced triage through Muscular Skeletal Service. Outpatients at community and main hospitals sites
- Enhanced provision of preventative services

Delivered by: Reconfiguration

MSK Trauma and Orthopaedics

OPTION 5 - Alternate site for out of hours trauma

- Alternating sites for trauma Out of Hours (by week)
- Current configuration of elective services on both main sites
- Increase in day case surgery procedures and increase use of day case facilities to attain national best practice
- Trauma provision to be provided alternating sites by week. Streamlining trauma pathway from Emergency care to ensure early senior medical review.
- Enhanced triage through Muscular Skeletal Service. Outpatients at community and main hospitals sites
- Enhanced provision of preventative services

Delivered by: Reconfiguration/redesign

OPTION 6 - Single site Trauma out of hours

- Single site Out of Hours trauma
- Current elective and trauma services will be continued to be provided on both sites' in hours'
- One site only to provide Trauma service after hours. Streamlining trauma pathway from Emergency care to ensure early senior medical review.
- Increase in day case surgery procedures and increase use of day case facilities to attain national best practice
- Higher utilisation of community rehab beds and enhanced community support service for early discharge
- Enhanced triage through Muscular Skeletal Service. Outpatients at community and main hospitals sites
- Enhanced provision of preventative services

Delivered by: Reconfiguration/redesign

Paediatrics and Child Health

OPTION 1 - No Change to current service

- Providing two acute sites for emergency and elective patients. Community paediatrics.
- Efficiency and productivity improvements through:
- Streamline quick access to senior medical assessment and review for referrals from Emergency Care or GP
- Enhance use of community services to support children and families within their homes
- Enhance community services to safeguard vulnerable children
- Enhanced community services to minimise poor outcomes through prevention and early intervention
- Full Healthy Child Programme (0-19 years)

Delivered by: Efficiency & productivity

OPTION 2 - Concentrating Specialist Services

- Assumes two main sites for assessment, but one inpatient site co-located with one neonatal site.
- Increase community and decrease acute resource
- Maintains day case and outpatients services locally
- Centralises specialist services into one area
- Emergency assessment by senior staff (decide to admit, not admit to decide)
- Development of increased ambulatory care and specialist community nursing service to support child and family at home
- Full Healthy Child Programme (0-19 years)
- Enhanced specialist nursing roles
- 24 hour nurse support
- Maintenance of day cases (one site or two)
- Outpatients on both sites

Delivered by: Reconfiguration

Paediatrics and Child Health

OPTION 3 – No acute inpatient services at either site. All directed to other surrounding acute Trusts

- Development of expertise in stabilisation and transfer (out of area) for inpatient care
- Work with primary care to increase the competence, confidence of GPs, Paramedics, AHPs to assess, diagnose and treat acutely ill children at home
- Emergency assessment by senior staff (decide to admit, not admit to decide)
- Development of increased ambulatory care and specialist community nursing service to support child and family at home
- Enhanced community provision for preventative and early intervention
- Full Healthy Child Programme (0-19 years)
- Enhanced specialist nursing roles
- Maintenance of day cases (one site or two)
- Outpatients on both sites

Delivered by: Reconfiguration

Cardiology

OPTION 1- No Change to current configuration of services

- No Change to current configuration of services
- Current model provision on both sites to support acute medicine. Alternating weekly sites for OOH Ppci

Delivered by : Efficiency and Productivity

OPTION 2 - Joint new model of care on both sites – alternating site pPCI

- Joint new model of care delivered on both sites for core cardiology services. Enhanced community services . Triage straight to specialist assessment and opinion.
- Alternating OOH pPCI
- Streamlining trauma pathway from Emergency care to ensure early senior medical review and triage to cardiology.
- Enhanced community and primary care provision to support prevention and integrated discharge
- Rapid access to diagnostics 24 hrs

Delivered by: Redesign

Cardiology

OPTION 3 – Single site acute cardiology services.

Enhanced community model for long term conditions and End of Life

- Centralisation of services and expertise
- Enhanced community and primary care services to prevent admissions and readmissions and improve discharge
- End of life care for heart failure patients (Iron transfusion at home)

Delivered by: Reconfiguration

OPTION 4 - Joint new model of care on both sites – single site pPCI

- Streamlining trauma pathway from Emergency care to ensure early senior medical review and triage to cardiology.
- Enhanced community and primary care provision to support prevention and integrated discharge
- Rapid access to diagnostics 24 hrs

Delivered by: Redesign/ ?reconfiguration for PCI service

Stroke

OPTION 1 - No Change to current configuration of services.

- Two acute hyper acute units.
- Community bed provision

Delivered by: Efficiency and productivity

OPTION 2 -One hyper acute unit and community bed rehab

- 1 hyper acute unit
- Community bed rehab provision
- Enhanced community integrated early discharge

Delivered by: Reconfiguration/ redesign

Stroke

Option 3 – Two hyper acute units and increased community bed rehab

- Hyper acute units on both sites
- Primary prevention and stroke awareness
- Community rehab bed provision (East & West – Specialist Stroke)
- Enhanced integrated early community discharge
- Slow stream rehab beds (possibly in NH with therapy input)

Delivered by: Redesign

Option 4 – No hyper acute units

- No Hyper acute units on either site
- Primary prevention and stroke awareness
- Community rehab bed provision (East & West – Specialist Stroke)
- Enhanced integrated early community discharge
- Slow stream rehab beds (possibly in NH with therapy input)

Delivered by: Redesign/reconfiguration

General Surgery

Option 1 – No major change

- No major configuration changes to services
- Efficiency changes – no reconfiguration of space/wards/theatres/recovery rooms
- Surgical ring fenced beds (emergency / elective)

Delivered by: Efficiency and Productivity

General Surgery

Option 2 – Separate hot and cold sites (cold with overnight stays)

Split emergency (trauma/emergencies/major elective cases) to one hot site and / Elective (day case/routine) to the cold site

Hot site

- Supported with diagnostics (CTs, X rays etc); ITU, HDU, recovery areas in theatre
- Major cancer cases carried out on hot site
- Streamlining surgical emergencies from Emergency care to Surgical assessment to ensure early senior medical review and treatment.
- Expert Senior medical care for complex cases and for the elderly

Cold site (with overnight stays)

- Day case / routine procedures only (no emergency admissions)
- Out patients carried out local to patients
- Increase in day case surgery procedures and increase use of day case facilities on multiple sites to attain national best practice
- Streamlining elective pathways to reduce length of stay and increase early discharge and care at home.
- Ring fenced elective beds on both sites
- Enhanced recovery

Delivered by: Reconfiguration/redesign

General Surgery

Option 3 - Separate hot and cold sites (cold with no overnight stays)

Split emergency (trauma/emergencies/major elective cases) to one hot site and / Elective (day case/routine) to the cold site

Hot site

- Supported with diagnostics (CTs, X rays etc)
- ITU, HDU, recovery areas in theatre
- Supported with diagnostics (CTs, X rays etc); ITU, HDU, recovery areas in theatre
- Major cancer cases and overnight stays carried out on hot site
- Streamlining surgical emergencies from Emergency care to Surgical assessment to ensure early senior medical review and treatment .
- Expert Senior medical care for complex cases and for the elderly

Cold site – day case only

- 8.00 – 6.00 presence – senior decision maker 'opinion' out of those hours
- Day case / routine procedures only (no emergency admissions)
- Out patients carried out local to patients
- Increase in day case surgery procedures and increase use of day case facilities on multiple sites to attain national best practice

Delivered by: Reconfiguration/redesign

General Surgery

Option 4 – single site hot and cold
Single site both emergency and elective services

- Increase in day case surgery procedures and increase use of day case facilities on multiple sites to attain national best practice
- Centralisation of expertise and resources
- Supported with diagnostics (CTs, X rays etc); ITU, HDU, recovery areas in theatre
- Streamlining surgical emergencies from Emergency care to Surgical assessment to ensure early senior medical review and treatment .
- Expert Senior medical care for complex cases and for the elderly
- Enhanced recovery
- Out patients carried out local to patients

Delivered by: Reconfiguration

Maternity

Option 1 - Networked solution: Two consultant led units and both with midwifery led care

- **High risk unit** that provides care to all women with risk factors. Consultant cover, all the middle grades, level 1 SCBU and transitional care. Midwifery led care available and embedded within a network for secondary/tertiary care
- **Low risk obstetric unit**. Midwifery led care with consultants available either daytime only, and on call for emergency caesarean/ instrumental delivery. Extended role training for Midwives e.g. Ventouse extraction. Transitional care on the ward.

Delivered by: Reconfiguration/redesign

Option 2 - Consultant led unit on one site and Midwifery led unit on the other site

- **Midwifery led unit**–stand alone home from home facility. Women selected according to strict criteria. Midwives fully trained in advanced neonatal life support (ANLS). Outpatient to continue the same but with no on call / availability for consultant labour ward presence. Transfer to consultant led unit as required.
- **Consultant led –** as the high risk unit above

Delivered by: Reconfiguration

Maternity

Option 3 - Networked midwifery led units

- **Networked midwifery led units** – stand alone units supported by a network of consultant led units outside of ESHT for high risk women. No consultant led unit within in East Sussex
- **Midwifery led unit** – as above. Supported by a network of consultant led units outside of East Sussex for the high risk population. Decision taken about intra partum transfer and direct admission at onset of labour would be taken account of, and be sensitive to, the distance and time to travel to consultant unit

Delivered by: Reconfiguration

Option 4 - Women's services in a central location.

- New build in a central location - to accommodate all obstetrics, gynaecology, midwifery, and neonatal activity on one site

Delivered by: Reconfiguration

Maternity

Option 5

- Midwifery led services on both site, supported by Consultant led units

Delivered by: Redesign

Option 6

- Modified status quo

Delivered by: Redesign

Emergency Care

Option 1 - No change

- 2 emergency departments with same level of service provision

Delivered by: Redesign

Option 2 – Site 1 Emergency Care Centre Site 2: Enhanced trauma unit

- Development of emergency care centre model
- Emergency care departments on both sites
- One site enhanced trauma unit facility

Delivered by: Redesign

Emergency Care

Option 3 – Hybrid of 2 and 3

- Hybrid model
- Two departments
- One site operating as full 24/7 emergency department
- Other site normal full emergency service for defined period of time in the day. OOH becomes emergency centre model

Delivered by: Redesign

Option 4 – Single site full emergency dept

- Single site full Emergency department. Enhanced integrated preventative and discharge services
- Single emergency department
- One site operating as full 24/7 emergency department

Delivered by: Redesign

Emergency Care

Option 5 – Emergency Care Centres on both sites

- Development of emergency care centre model. Departments on both sites. No trauma unit facility

Delivered by: Reconfiguration

Acute Medicine

Option 1 – No change

- Improvements through redesign of patient pathways

Delivered by: Efficiency and productivity

Option 2 – Acute Medicine take on both sites

- Senior clinician assessment and streaming (decide to admit, not admit to decide)
- Both sites – acute medical emergency takes
- Increased % patients with short LOS, decrease % patients with extended LOS
- Enhanced community preventive and discharge integrated services
- Increase % of ambulatory care patients
- Enhanced roles of 'geriatricians' for complex patients and support to community model
- Early diagnostics
- Adult social care
- Mental Health support
- **AHPA** to support specialist team

Delivered by: Efficiency and productivity

Acute Medicine

Option 3 – single site acute medicine

- Single site acute medicine
- Enhanced community preventive and discharge integrated services
- Increase % of ambulatory care patients

Delivered by: Reconfiguration

Clinical Strategy – Pre Consultation phase

OPTIONS CRITERIA AND APPRAISAL

- Currently, developing criteria through internal and external engagement

- **Options appraisal and impact assessment** - to identify how the future model of care and proposed delivery options may affect internal and external stakeholders and to evaluate options recognising challenges, dependencies and sequencing

- We will evaluate and align preferred options for implementation across the organisation, recognising challenges, dependencies and sequencing etc.

- Equality Impact Assessments will be completed in November for all 8 PAPs

- Design of options appraisal to be completed by 1st December

- 1st cut of delivery options, using criteria by the 31st of December

Options Appraisal Criteria (draft so far)

Access and choice (20%)

- Meets needs of local population (older people, vulnerable, seldom heard groups) EIA – specific elements in here
- Contributes to the provision of choice of service, procedure/treatment or place of care
- Ease of access (travel times, public transport)
- Evidence of stakeholder engagement in proposals

Quality and Safety (25%)

- Clarity on clinical evidence based
- Support from GP commissioners / commissioning intensions
- Access to prompt specialist assessment
- Able to meet CQC quality and safety standards
- Demonstrates patient safety and experience

Workforce (10%)

- Ability to recruit, train and retain staff
- Able to meet requirements of professional bodies
- Able to flex capacity and capability
- Adheres to workforce standards e.g. EWTD

Clinical sustainability (20%)

- Clinical case convincingly described in sufficient detail
- Capacity for integration with social care/LHE
- Clinical risk measures – service specific
- Interdependencies on other services (e.g. clinical support services / other PAPs, EoL, LTCs) managed
- Ability to deliver clinical excellence and innovation
- Demonstrates high quality clinical performance

Financial affordability (25%)

- Ability to operate within tariff/budget
- Financial risk measures (to be added)
- Capital costs – *do we have these?*
- Value for money *(need a methodology)*
- Makes best maximum use of resources, staff, beds, theatres etc
- Demonstrates productivity performance
- Demonstrates value for money across all services and achieve financial stability

Clinical Strategy – pre-consultation phase

Pre-consultation engagement

- to ensure that delivery options and assessment criteria are developed with full engagement.

- The engagement has been structured so that we can undertake an options appraisal using clear criteria and with a full understanding of the potential impact

- Pre-consultation Communications and Engagement plan developed and implemented 1st October – 31st December 2011

Developing delivery options engagement activity

Groups	Number
Consultants meetings October and November	70
Nursing & Allied Health Professionals x 2 workshops	150
Primary Access Point meetings x 8 in October and November (including ESHT, CCG, LINK)	172
Carers and ES Disability Assn/LINk	25
Rye Community Hospital	30
Divisions within ESHT (cascade) and ESCC and NHS Sussex (cascade)	Ongoing
Campaign Groups and specialty voluntary sector groups	Nov-Dec

Developing appraisal criteria engagement activity

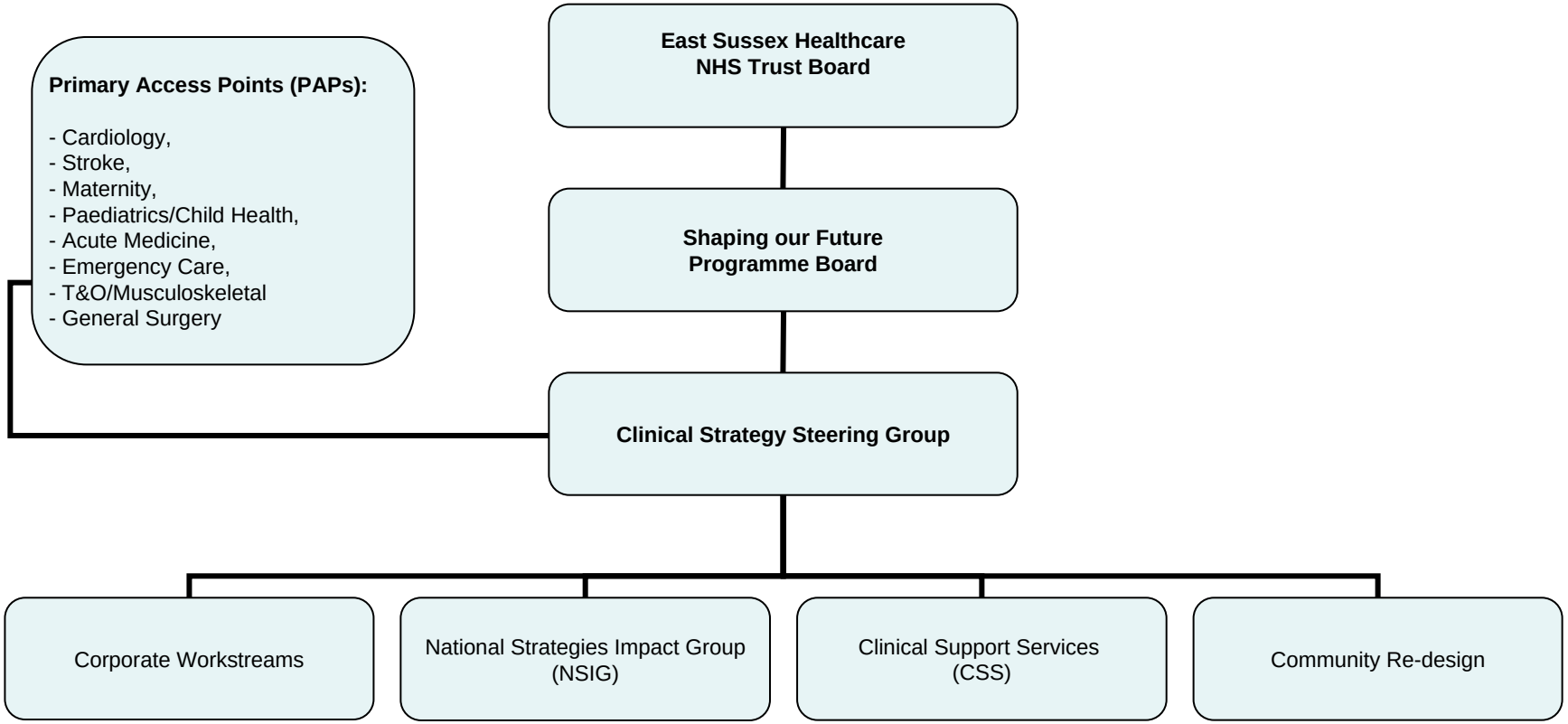
Groups	
Nursing & Allied Health Professionals	2&10 Nov
Primary Access Point stage 4 meetings	Nov - Dec
Improving Life Chances Board	21 Nov
Focus Groups	21&22 Nov
Equality Steering Groups & EIA impact assessments	November
Carers Health & Wellbeing Action Group & specialist voluntary sector groups	Nov- Dec
Clinical Commissioning Groups	Oct - Nov
Mail shots to members and ESS	November

Clinical Strategy – Pre Consultation phase

Integration with other trust functions –

- **Corporate workstreams :** Finance, IT, Estates, Workforce, Communications
- **National Strategy Impact Group:** incorporating Long Term Conditions & EOL, Dementia etc
- **Clinical Support Services and Therapies:** including diagnostics, pharmacy and critical care
- **Community redesign group-** including demands on community teams and beds

Shaping our Future
Governance structure



Next Steps

- Developed an integrated strategic model for anaylsing the impact of the clinical strategy from a Trust wide perspective

- Ongoing work with HOSC working group

- Increasingly working closely with NHS Sussex and CCGs as we move towards formal consultation and implementation

- Commenced planning for consultation phase – EIAs will be fed into the process and we are working with HOSC to agree timelines

East Sussex
Health Overview and Scrutiny Committee

Task Group – East Sussex Healthcare Trust (ESHT) Clinical Strategy
Terms of Reference

Role of the group: To provide additional input, on behalf of HOSC, to the Trust's process of options development and engagement during the period leading up to the start of formal consultation with the committee and the public on any proposals for substantial change to services.

Specifically:

- To assess whether stakeholders, including representatives of patients and the public and GP commissioners, have been appropriately involved in the process of options development and assessment.
- To assess whether a full range of options for delivery has been developed on the basis of robust evidence and with appropriate leadership by clinicians.
- To assess whether the criteria for assessing options are appropriate, based on good evidence and reflect the overall objectives of the Clinical Strategy and the interests of patients.
- To provide advice to the Trust on how the process of engagement and options development could be improved, from HOSC's perspective.
- To provide feedback and make recommendations to HOSC as required.

The group is not intended to:

- take decisions on behalf of HOSC.
- participate in the assessment/shortlisting of options.

Agendas and notes:
Agendas, papers and notes of the meetings will be circulated to all HOSC Members and will be made publicly available via the HOSC website.

Task Group Membership:
HOSC Members Cllr Angharad Davies, Cllr Elayne Merry, Cllr Diane Phillips, Cllr Rupert Simmons, Cllr John Ungar

Officer support:
Claire Lee, Scrutiny Lead Officer, East Sussex County Council, will provide officer support to the Task Group including co-ordination of agendas, note taking and advice on HOSC's role and health scrutiny legislation.

Jayne Black, Deputy Director of Strategic Development, will be the primary point of contact at ESHT for the Task Group and will lead the input from the Trust perspective.