Agenda Item 5

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**8th March 2012**
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.**

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, September and November 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 (PAPs): 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 its future success.

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 . Since the conclusion of the review, work on maternity services has been taken forward in the same way as the other PAPs.

1.4 The Trust has indicated 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.

1.5 In November 2011, HOSC agreed in principle that proposed changes constituting service reconfiguration would be considered 'substantial development or variation' to services requiring formal consultation with the Committee under health scrutiny legislation.

2. Progress update

2.1 Since November 2011, the work to develop and evaluate specific options for delivering the proposed model of care for each service area has continued. This work has been led by a stakeholder group for each PAP, including ESHT clinicians and other staff, key patient groups, commissioner representatives and others. These groups undertook an initial assessment of the full list of options for each PAP (presented to HOSC in November) in order to narrow these down to a

shorter list which may be viable to implement. Further work is now being undertaken to fully evaluate the remaining delivery options.

2.2 The Trust has now also moved into a new phase of work, 'Integration', which brings the PAPs together and looks at their interdependencies. Some PAPs are closely linked, meaning that changes to one service area would have knock-on effects on another. Groupings of those services which are interdependent in this way have been identified. This enables combinations of options from the different PAPs to be put together to form potential 'scenarios'. These scenarios will set out what services would look like at the main hospitals if the particular combination of options was implemented. It is anticipated that a range of scenarios assessed to be viable to implement will form the basis of consultation.

2.3 The Trust has provided a detailed report (appendix 2) on progress since November. 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 present and discuss the report.

3. HOSC Task Group

3.1 In September 2011, HOSC agreed to establish a Task Group to provide extra oversight and scrutiny by the Committee of the remaining key phases of the strategy development. This group, comprising Councillors Davies, Merry, Phillips, Simmons (Chairman) and Ungar has met monthly since October 2011. The Task Group's Terms of Reference and notes of the meetings have previously been circulated to HOSC Members.

3.2 The Task Group has considered a number of key issues since the last report to HOSC. These include:

- The development of the delivery options for each PAP – the Task Group has considered and commented on the process of developing and evaluating the range of options.
- The interdependencies between PAPs and the development of scenarios.
- The development of options appraisal criteria.
- The Sussex Together programme led by NHS Sussex, which is looking at opportunities for collaboration and co-ordination between providers of NHS care across Sussex in key service areas. The Task Group has considered the alignment of this work with the Clinical Strategy.
- The engagement of stakeholders in the strategy development process. Three Task Group Members attended a major stakeholder event held by ESHT on 23rd January 2011.

3.3 It is intended that the Task Group will continue to meet monthly until the start of consultation. The Group will be able to provide additional HOSC oversight of plans for the consultation process itself, as well as the ongoing development of service change proposals.

4. Care Quality Commission reports

4.1 In February 2012 the Care Quality Commission (CQC) published the reports of their follow-up inspections of Eastbourne District General Hospital (DGH) and the Conquest Hospital, undertaken in September 2011, following inspections undertaken earlier in 2011. The reports have previously been circulated to HOSC Members. The latest reports indicate that the Trust is now compliant with the required standards across a number of outcomes where CQC had previously highlighted major or moderate concerns. However, improvement is still required in relation to four outcomes at Eastbourne DGH and four outcomes at the Conquest.

4.2 The statement issued by the Trust's Chief Executive in response to the reports indicated that, *"the improvements required in the quality of care at the Trust will take time to deliver and require large scale cultural and service change…. Our improvement programme is inextricably linked with the development of our Clinical Strategy: Shaping our Future which will set out how we should deliver high quality services in the future"*.

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Appendix 1

Glossary of Acronyms

The following acronyms are used in Appendix 2

BSUH	Brighton and Sussex University Hospitals NHS Trust
CCG	Clinical Commissioning Group
CRES	Cash releasing efficiency savings
EHRIA	Equality and Human Rights Impact Assessment
EIA	Equality Impact Assessment
EOL	End of Life
ESHT	East Sussex Healthcare NHS Trust
FT	Foundation Trust
GP	General Practitioner
IM&T	Information Management and Technology
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
LHE	Local Health Economy
MSK	Musculo-skeletal
MTW	Maidstone and Tunbridge Wells NHS Trust
OD	Organisational development
PAP	Primary Access Point
pPCI	Primary Percutaneous Coronary Intervention (also known as primary angioplasty)
SCBU	Special Care Baby Unit
T&O	Trauma and orthopaedics

Appendix 2

East Sussex Healthcare NHS
NHS Trust

Clinical Strategy

HOSC Meeting

8th March 2012

Agenda

1. Introduction & Objectives

2. Clinical Strategy Context & Approach

3. Outputs from Primary Access Points Stage 4 Informing Integrated Stage 1 (January – March 2012)

4. Trust Performance Baseline & Strategic Modelling update

5. Next Steps

1. Introduction and Objectives

- Present the approach taken from January 2012 for the clinical strategy and the remaining stages of the process through to 1 April, and beyond
- Review the current shortlist of delivery options arising from the Primary Access Point workgroups in Stage 4
- Review the integrated scenarios (grouped delivery options), taking into account the clinical interdependencies and likely scale of change
- Understand the next phase of the work required, including the emerging requirements for Public Consultation

2. Clinical Strategy Context and Approach

The Trust needs to enter the next financial year with a clear strategic plan for the next five years, which drives implementation of clinically and financially sustainable models of care, aligned with annual business planning and the Trust's target outcomes. The Clinical Strategy will deliver this through the following workstreams:

Integration Stage 1 - to identify and evaluate scenarios that incorporate Primary Access Point delivery options across the organisation, recognising interdependencies between PAPs and other Trust services

Strategic Modelling - to analyse "top-down" and "bottom up" scenarios using the integrated model and baseline developed for the Trust. This will be used to evaluate alternative proposals and delivery options. As the strategy moves into implementation the model will be used as a Performance Management tool

Developing impact assessments: conducted through the following -

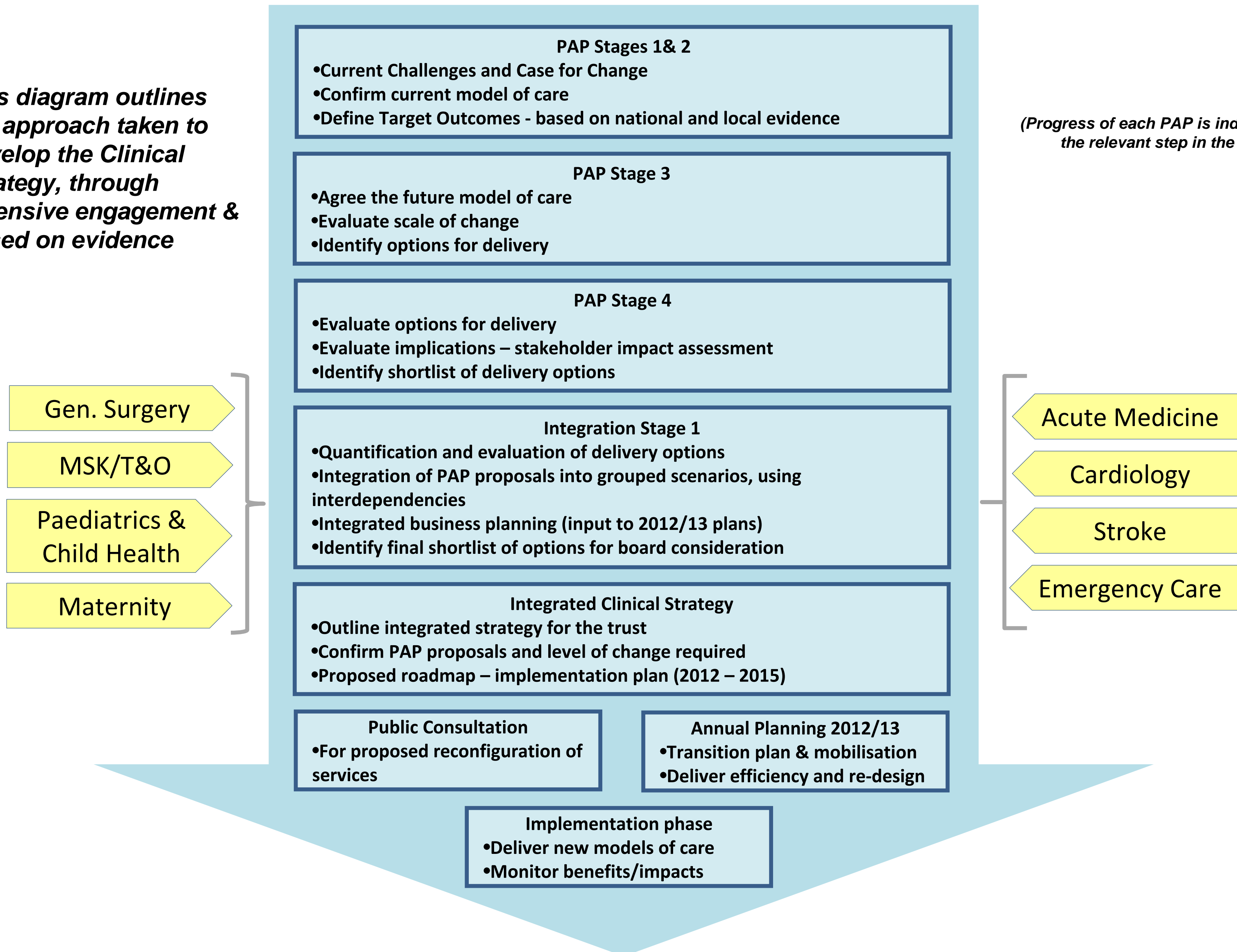
- **Corporate workstreams :** Finance, IT, Estates, Workforce, Communications
- **National Strategy Impact Group:** incorporating Long Term Conditions, Dementia, Carers & EOL
- **Clinical Support Services and Therapies:** including diagnostics, pharmacy and critical care
- **Community Redesign Group:** supporting shift of care to Community where appropriate and improving access to community services, both NHS and social care

Communications and engagement - delivery options and assessment criteria are being developed through detailed engagement. The engagement is structured so that we can undertake an options appraisal using clear criteria and with a full understanding of the potential impact e.g. through EIA, and the outputs from the groups described above. Formal consultation will be undertaken where required

Integrated business planning - to combine the clinical strategy with financial, contract and quality planning and organisational development so that there is one, coordinated, communicated and resourced plan to drive the Trust forward.

Strategic Development Approach – Primary Access Points

This diagram outlines the approach taken to develop the Clinical Strategy, through extensive engagement & based on evidence



(Progress of each PAP is indicated against the relevant step in the process)

Our current phase of work is Integration Stage 1 (Jan – March 2012)

There is an important shift from conceptual proposals in previous stages to developing the detailed quantification and evidence needed to evaluate the current shortlist of options and provide input to the 2012/13 Annual Business Plans for the trust. The key outputs for this phase are outlined below:

Detailed quantification by Primary Access Points of 'shifts' in resource and capital requirements for remaining delivery options

Integration of PAP proposals

- agree the grouping of PAPs related by interdependency
- identify and evaluate the PAP scenarios relating to the remaining delivery options and interdependencies

Strategic Modelling

- analyse "top-down" and "bottom up" scenarios using the integrated model and baseline developed for the trust, as input to options appraisal

Complete second cut of PAP delivery options

- by application of appraisal criteria, strategic modelling, impact assessments, EHRIA, evaluation of Trust scenario proposals

Integrated business planning

- combine the clinical strategy with financial, contract and quality planning and organisational development so that there is one, coordinated, communicated and resourced plan to drive the Trust forward. This will include integration with CRES.

Board assurance of content and process for strategy development will continue

Options Appraisal Criteria

Access and choice

- How does the option meet the current and future needs of the local population as defined by the JSNA
- How does the option contribute to the provision of choice including choice of service, procedure/treatment or place of care
- What is the impact of the option on access for those who will need to use the service including opening times, travel times, availability of public transport
- What are the risks to access and choice

Quality and Safety

- What is the clinical evidence base for the option
- How does the option support the delivery of the agreed model of care
- How will the option enable the trust to meet quality standards
- How will the option impact on patient safety
- How will the option impact on patient experience
- What are the quality and safety risks associated with the option

Deliverability

- How much will it cost to deliver the option including project management, IM&T, estate and start up costs both capital and revenue
- Can the option be delivered within an appropriate timeframe
- Is there the capacity and capability to implement the option
- Can we recruit, train and retain required staff within an reasonable timeframe
- What are the risks to delivery
- What are the risks and benefits of delivering this option for other services within the Trust and in the LHE

Clinical sustainability

- Will the option support integration with social care/LHE
- Will the option enable the delivery of clinically effective services as well as clinical excellence/ innovation now and in the future
- Does the option allow for appropriate flexibility of capacity and staffing now and in the future
- Will we be able to recruit, train and retain appropriate staff to deliver the option now and in the future
- Do the GP commissioners / commissioning intentions support the option
- What are the clinical sustainability risks associated with the option

Financial sustainability

- Is the option deliverable within contract income
- Does the option make effective use of resources including staff, beds, theatres
- Does the option enable the Trust to optimise the balance between income and cost
- How will the option impact on productivity
- How will the option impact on performance
- Does the option help us manage market/competitive risk
- What are the financial risks associated with this option

Dependencies for the integrated Clinical Strategy

The delivery options developed during by Primary Access Points have been informed by the following:

Other Trust initiatives

- Alignment to CRES for financial baseline and performance projections
- OD and proposed impacts through 2012/13
- Quality Programme
- 18 weeks – impact on projections for activity/bed utilisation
- Other services that can deliver savings

External dependencies

- Networks
- Sussex Together
- CCGs – emerging commissioning intentions
- Other Trusts (e.g. BSUH, MTW)

3. Outputs from Primary Access Points Stage 4 informing Integration Stage 1 (January – March 2012)

- Delivery options developed through engagement; interdependencies identified
- Identification of how delivery options can be delivered through:
  - efficiency and productivity
  - redesign
  - reconfiguration
- First review of delivery options using assessment criteria completed
- Integration with other Trust functions continues
- Equality and Human Rights Impact Assessments undertaken for all Primary Access Points
- Board Assurance for this stage completed
- Internal and external engagement continues

Delivery Options – outcome of first review (Page 1 of 3)

MSK/ Trauma & Orthopaedics	(Type of change)
Option 1- No Major Change – developing and improving services on both sites	Efficiency & productivity/redesign
Option 2- Single site elective and trauma – collocated on single site	Reconfiguration
Option 3- Elective on both sites and single site trauma	Reconfiguration

Paediatrics and Child Health	
Option 1 - No Major Change in terms of reconfiguration	Service redesign
Option 2 - Concentrating Specialist Services	Reconfiguration
Option 3 - No inpatients	Reconfiguration
Option 4 - Paediatric Assessment Units	Reconfiguration

Cardiology	
Option 2 – Joint new model of care on both sites – alternating site pPCI	Redesign
Option 4 – Joint new model of care on both sites – single site pPCI	Redesign/ reconfiguration for PCI service

Delivery Options – outcome of first review (Page 2 of 3)

Stroke	(Type of change)
Option 2 - One hyper acute and Acute unit (co-located) and community bed rehab	Reconfiguration
Option 3 – Two hyper acute and Acute units (co-located) and increased community bed rehab	Redesign

General Surgery	
Option 2 – Separate emergency and elective sites (low risk with overnight stays)	Reconfiguration/redesign
Option 3 - Separate emergency and elective sites (low risk with no overnight stays)	Reconfiguration/redesign

Maternity	
Option 2 – Consultant led unit on one site and Midwifery led unit on the other site	Reconfiguration
Option 2a - Consultant led unit on one site and Midwifery led unit on the other site. As Option 2 but with a community midwifery led unit	Reconfiguration
Option 5 - Midwifery led services on both site, supported by Consultant led units.	Efficiency & redesign
Option 5a - As Option 5 but with community midwifery led unit	Efficiency & redesign
Option 7 - Consultant led with integrated Midwifery care on both sites	Redesign
Option 7a - As Option 7 with a community midwifery led unit	Redesign

Delivery Options – outcome of first review (Page 3 of 3)

Emergency Care	**(Type of change)**
Option 1 – No change (efficiency & productivity changes only)	Efficiency & productivity
Option 2 – Site 1- Emergency Care Centre and Site 2- Trauma unit	Redesign/Reconfiguration
Option 6 – Site 1 - Emergency department and Site 2 - Trauma unit	Redesign/Reconfiguration

Acute Medicine	
Option 2 – Acute Medicine take on both sites	Redesign

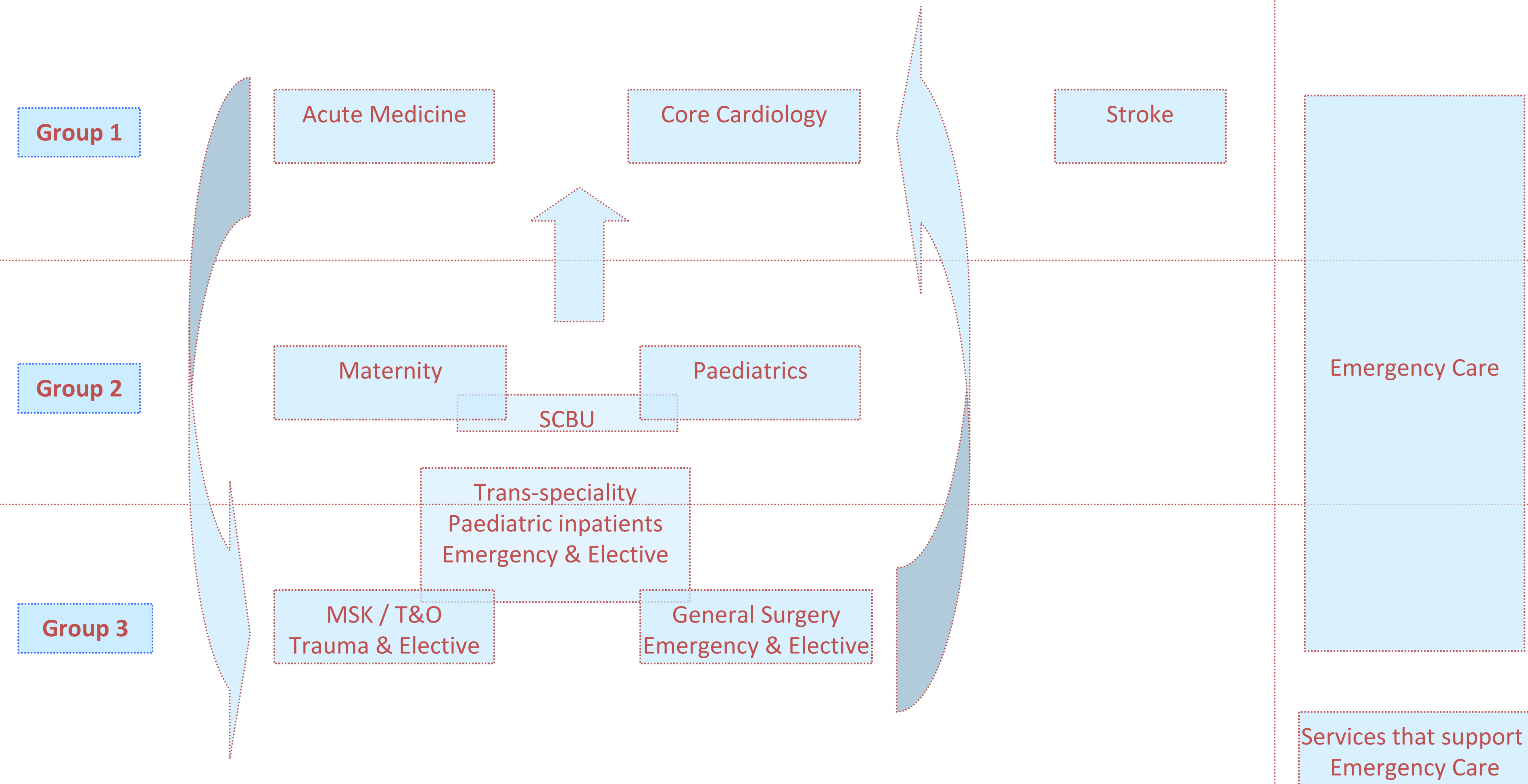
Delivery Options requiring review of viability
Output of Stage 4 (Page 1 of 2)

PAP	Option
MSK/T&O	Option 4: Trauma on both sites – single site elective (Reconfiguration)
	Option 5: Alternate site for out of hours trauma (Reconfiguration/redesign)
	Option 6: Single site Trauma out of hours (Reconfiguration/redesign)
Acute Medicine	Option 1: No change (efficiency and productivity)
	Option 3 : Single site acute medicine (Reconfiguration)
	Option 4: Increase use of community hospitals (Redesign)
Paediatrics & Child Health	Option 0: No Change – status quo
Maternity	Option 1: Networked solution: Two consultant led units and both with midwifery led care (Redesign/Reconfiguration)
	Option 3: Networked midwifery led units (Reconfiguration)
	Option 4: New build in a central location
	Option 6: Modified Status Quo (efficiency and redesign)

Delivery Options requiring review of viability
Output of Stage 4 (Page 2 of 2)

PAP	Option
Cardiology	Option 1: No change (Efficiency & productivity)
	Option 3: Single site acute cardiology (Reconfiguration)
General Surgery	Option 1:No major change (efficiency and productivity)
	Option 4: Single site all general surgery (high and low risk) (reconfiguration)
Emergency Care	Option 3 Hybrid: Site 1 full 24/7 Emergency Dept and Site 2 Emergency Dept for some hours
	Option 4: Single site full emergency dept (Reconfiguration)
	Option 5: Emergency Care Centres on both sites (Reconfiguration)
Stroke	Option 1: Status Quo (Efficiency & productivity)
	Option 4 No hyper acute units and increased community bed rehab (Redesign/ reconfiguration)
	Option 5 - Two hyper acute and Acute units (one hyper acute unit not open after hours) and increased community bed rehab

Primary Access Point Groupings– emerging view of clinical interdependencies



During Integration Stage 1, we will be exploring the clinical interdependencies as part of the evaluation of remaining delivery options to assess viability within the integrated trust services

4. Trust Performance Baseline & Strategic Modeling update

The strategic model supports the following objectives, in line with the development of the integrated Clinical Strategy:

- Ensure common understanding of the Trust's projected financial baseline and current performance
- Analyse underlying Trust dynamics (activity, demand, staffing etc)
- Assist with quantification of PAP delivery options
- Identify size, nature and timing of performance gap to be addressed by the Trust and the impact of the Clinical Strategy
- Quantify alternative scenarios to enable the Trust to forward plan more effectively (top down scenarios)

Currently the focus is on modelling the PAP delivery options and top-down scenario analysis, to support the Trust board's decision making process ahead of 1 April

5. Next steps

- Ongoing review of all options against the appraisal criteria and production of an evidence base that supports this
- Consideration in detail of opportunities for delivering options – for example networking arrangements with other Trusts for staffing or for providing a clinical pathway
- Consideration in detail of the impacts of implementing each option for community provision and other health and social care providers
- Clinical and Gateway review in preparation for consultation

- KEY DATES AND ACTIVITIES:
- 28th March ESHT Board consideration of Clinical Strategy and outline delivery proposals
- April/May – consideration of which delivery proposals represent significant service change
- May/September – Public consultation
- September/November – ESHT and NHS Sussex Board decisions on options following consultation plus HOSC review of decisions

Combined focus required to drive FY 2012/13

The business planning process needs to bring together a number of critical strands over the next three months. For services requiring consultation, the true implementation picture will not emerge until after the consultation process has concluded.