# East Sussex Healthcare NHS Trust (ESHT) and NHS Sussex's Clinical Strategy (June 2012): public health briefing for the Health and Overview Scrutiny Committee (HOSC), East Sussex County Council

## 1. Introduction

### 1.1 East Sussex public health department

The public health department in East Sussex works with a wide range of statutory and non-statutory organisations. The department aims to provide services and advice to improve population health and reduce health inequalities.

### 1.2 Health in East Sussex

Generally, health in East Sussex is comparatively good. Mortality per 100,000 from stroke, in those over 65, is in line with the average for England; within East Sussex it is highest in Hastings. Hospital admissions due to falls are higher than the England average (Joint Strategic Needs Assessment (JSNA), 2011: 19, 21).

The gap in life expectancy between the best and worst-off areas of East Sussex is currently 15 years. There are significant areas of deprivation in East Sussex. In Hastings and Eastbourne – 32% and 29% of households, respectively, are on low incomes; that is, less than 60% of national median income (JSNA Scorecard, 2011: 61). In East Sussex, 22 out of 327 LSOAs (lower layer super output areas) are amongst the most deprived 10% of LSOAs in England. Of these, 15 are in Hastings, five in Eastbourne and two in Rother.

The health service must have regard to the need to reduce inequalities between people with respect to the benefits that they can obtain from the health service (Health and Social Care Act, 2012).

### 1.3 The role of the public health department in the ESHT clinical strategy

From a public health perspective, we would seek reassurance that changes will not further disadvantage groups with lower life expectancy and that wider social implications have been taken into account. Our actions were that:

- as part of the strategy review, representatives of the public health department were invited as external stakeholders to provide advice to the eight primary access points (PAPs). Representatives also attended two stakeholder events and the clinical strategy programme board
- the public health directorate ensured that the management consultants employed by ESHT and the staff working directly on the project were made aware that they could draw on public health expertise for relevant data. Specialist public health advice was provided on issues to take into account when looking at wider impacts and equity considerations. (Key data regarding patient numbers and finance was best provided internally by ESHT and was not available from the public health directorate)

- data provided by public health was contained in the pre-consultant business case and has not been reproduced in this paper

- advice was also provided by public health on transport, including transport for visitors and issues to take into account in commissioning a transport review.

HOSC has already met and questioned representatives of EHST about the clinical strategy. In this report, we provide further points for HOSC to consider in their scrutiny and recommendations regarding the EHST clinical strategy.

## 2. Summary of issues for the HOSC to consider from a public health perspective

### 2.1 Potential risks and benefits to patients resulting from delays in access to, and use of, pooled specialist services

The clinical areas in question are within emergency care and, therefore, ambulance services will need to be available for patient transport. It will be important for the HOSC to clarify risks, and potential inequities, with experts in the relevant clinical fields identified for change and with the ambulance service.

It should be noted that outcomes for different medical and surgical emergencies vary in their dependence on quick access and access to specialist services. The three areas chosen by ESHT appear to be the most suitable for the reconfiguration proposed – see, appendix 1, notes 1 & 2 (for example, Nicholl, 2007; Norton, et al, 2012 a; Fraser, et al, 2012).

In some clinical areas a clear minimum number of procedures is set out for individual surgeons and others to undertake within a given period of time (Norton, 2012 b.: 41). In the areas covered by the ESHT review this is not so strongly the case and the numbers do not appear to require the merger of departments on this basis. Nevertheless, clinical opinion does favour a degree of specialisation (Palmer, 2011: 11). The money saved by merger can be redirected into patient care in the form of changing skill-mix and staff rotas. And, therefore, improvements in care can be gained in this way. In addition, currently the tariff makes additional payments for improved stroke care (appendix 1, notes 1 & 3). From our involvement in the PAP discussions, it would seem that improvements in care are most likely to result from these financial savings and not necessarily always from the increased experience gained by consolidated departments (also, ‘2020delivery’, 2010).

*Questions for the HOSC to consider:*

- Has a sufficient diversity of clinical advice in relation to quality improvements from reconfiguration been provided?

- Is the trust ensuring that the changes proposed will not adversely affect the health of the most disadvantaged?

- What strength of evidence does EHST have that recruitment of staff will be easier (following Fulop, et al, 2002)?

- Given patient capacity issues at ESHT, will any other services or functions be disadvantaged at the site that expands (Gaynor, et al, 2012: 4)?

- Does the assessment of financial benefit take into account all significant factors ('2020delivery', 2010: 2)?

- How will the changes be evaluated over the long-term?

**2.2 Visitors' access to the hospital**

The significant area that raises concerns from a public health perspective relates to access for visitors. This is an issue that assessments of clinical outcomes may not focus on, but from the perspective of patient and population benefits it is an important area. Patients with serious and often life-threatening emergency conditions will want loved ones near them. Equally, relatives and friends will want to visit patients.

The public health department has provided ESHT with data on deprivation and car access across the relevant geographical areas. We have made suggestions for the EHST-commissioned transport review to investigate, including: costs of taxis, public and private transport; access to blue badge parking; Hospital Friends services; journey times; ice on road at Conquest; qualitative data on experiences.

While savings can be made by the NHS through economies of scale, it is important to recognise cost-shifting to other economic areas. Cost-shifting will be experienced differently by different sections of society (see for example, Posnett, 1999). This can be mitigated by like-for-like provision directed at individual visitors (for example, improved public transport to hospitals, direct or voucher funding for travel, improved visitor accommodation and good access to parking), or, population-based payment-in-kind payback (for example, economic strategies benefiting lower-income groups).

*Questions for the HOSC to consider:*

- Are the travel times and costs for visitors acceptable? How has this been assessed (Norton, 2012, a)?

- As the NHS strives to work more efficiently and to delivering better quality care, what can be done to mitigate cost-shifting to lower income groups in particular?

**2.3 Sustainable healthcare**
Given the relationship between climate change and population health, it is important that HOSC seeks assurance on the carbon off-setting of additional road travel (Naylor and Appleby, 2011; Zander, et al, 2012). At the time of writing, clarification on additional ambulance costs had not yet been obtained.

*Questions for the HOSC to consider:*

- What steps have been taken to mitigate any identified increase in carbon emissions?

**3. Summary**
The ESHT clinical strategy needs to be based on the population's health needs and not adversely impact on health inequalities.

The areas of focus in this paper have been as follows:

- in relation to patient access and quality of care, we see the main benefits as resulting from any increased efficiency of hospital provision and subsequent reinvestment into patient care

- of concern is the impact on visitors, and, in particular, visitors from below-average income groups. The mitigation of impact on this diffuse group is an important issue for consideration by the HOSC

- in addition, the impact of any increased road use should be taken into account.

## 4. References


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## Appendix 1

## Notes

**1. Emergency care**
Improved care in specialist centres needs to be balanced against increased travel time. In urgent non-specialist care - for example, “patients in anaphylactic shock, choking, drowning or having acute asthma attacks need urgent care that would be the same wherever it is provided. For these patients, there may be a detriment in having to travel increased distances.” (Nicholl, J et al, 2007: 667).

For stroke services, initial evidence from London shows improved standards of care and outcomes where services have been concentrated into 8 hyper-acute units. Funding was boosted to support this process and improved performance is currently associated with increased tariff payments (Fraser, 2012).

**2. Stroke standards**
National standards for stroke are assessed annually in the Royal College of Physicians’ Sentinel Audit. A range of standards are covered for care at different stages in the stroke pathway. East Sussex Healthcare NHS Trust has recently improved its compliance with standards. However, there have been ongoing breaches, such as: those meeting criteria to receive brain imaging within 1 hour; patients with suspected stroke admitted directly to a specialist acute stroke unit and assessed for thrombolysis; access to specialist therapies.

**3. Tariff**
Tariffs are nationally standardised payments for procedures delivered. They are based on a process of averaging cost-data provided by all NHS trusts. In the past, in some specialties, predicting tariff payments for forthcoming financial years has been difficult.

In theory, subsidising emergency care through planned care should not generally be required. But, in practice, there are various reasons why emergency and elective tariffs might be under and overstated, respectively.

Work is underway to devise a method of providing additional payments to specific geographical areas that have extra costs, for example, PFI schemes www.monitor-nhsft.gov.

**4. Choice**
Choice of hospital for elective treatment is not relevant to the ESHT clinical strategy. However, from a health inequalities perspective, it is of note that different population groups have different perspectives on what they want from ‘choice’ (Curtice and Heath, 2009). The views of lower income groups and older people are informed by increased concern over accessibility.

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