

BSUH Clinical Strategy

Board of Directors

DRAFT FOR APPROVAL

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Executive summary

Context

Brighton and Sussex University Hospitals (BSUH) is an acute teaching Trust working across two principal sites: the Royal Sussex County Hospital (RSCH) in Brighton and the Princess Royal Hospital (PRH) in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital (RACH) and the Sussex Eye Hospital, and the Haywards Heath campus includes the Hurstwood Park Regional Centre for Neurosciences.

We deliver services to local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and some specialised services for patients across Sussex and the south east of England.

In common with the rest of England the population we serve is both growing and ageing. At the same time an increasing proportion of that population is living with long-term conditions. These changes are putting significant pressure on our hospitals, particularly in urgent and emergency care.

Along with many other areas of the NHS, our current financial position is already stretched and likely to become more so as a result of this pressure. Our analysis suggests that in order to deliver a 1% operating surplus in 2018/19 we will need to deliver 4-5% a year improvements in productivity each year for at least the next five years. This will be challenging in the context of the rising costs of meeting quality standards, continuing BSUH's strong reputation for safe and high quality service provision, and meeting access standards for an increasingly older population. Additionally we must continue to provide high quality education and training via our links with our academic partners who face their own pressures.

Vision and role of BSUH

Over the last year, based on conversations with our clinicians, our patients, local partners and other stakeholders we developed our vision for BSUH. We will be:

- A provider of safe, high quality secondary and local acute services to Brighton and mid-Sussex that are integrated with services in partner agencies, financially sustainable, and responsive to the needs of the local population.
- A provider of safe, high quality, financially sustainable, tertiary services to Sussex, south-East Surrey and south-West Kent, where a Sussex-based service is in the best interests of patients
- A hub for expertise and skill in specialist provision, innovation, training and research, that supports development of clinical academic expertise and high quality networks of care across Sussex, delivered by both BSUH and partner providers

To support this vision, we will strive to achieve clinical, operational and financial sustainability. We will be:

- An organisation which achieves operational excellence to ensure it can provide safe, high quality, financially viable services
- A learning and innovative organisation whose relationship with commissioners is based on transparency and mutual respect, where priorities are aligned and the challenge of clinical and financial sustainability is shared
- An organisation which truly treats patients as both partners and co-producers and involves them closely in decisions ranging all the way from individual care choices to the future direction of the trust

Our vision is underpinned by aspirations for our clinical services. These are described below:

1. Unscheduled care

To deliver BSUH's vision of providing high quality general acute services to Brighton and mid-Sussex, as well as regional emergency care, our aspirations are as follows:

- Deliver fully on our commitment to offer a high quality Major Trauma service
- Continue to run two emergency departments one at RSCH and one at PRH, delivering seven day services, working actively with commissioners and local GPs to manage the demand for acute care, focusing on ensuring appropriate rapid access to care and integrated support with the community
- Establish PRH as a centre for supporting frail patients, starting with consolidating all fractured neck of femur work at PRH and increasing senior medical input
- Building on the Major Trauma Centre designation and specialised emergency provision already located at RSCH, establish a combined hyper-acute/acute stroke service at RSCH

2. Elective care

Our vision for competed elective services is to improve patient experience, and quality and responsiveness of service provision. We will do this by:

- Working in partnership with our commissioners as well as primary and community care providers to co-design and remodel services both within the Trust and looking to new models externally
- Challenging whether the current location of services is best for patients. Our aspiration is to provide services as locally as possible. For example, we will establish peripheral clinics for first outpatient services in high volume specialties.
- Challenging the current medical focus of service delivery and building on the use of clinical nurse specialists, therapists and others

3. Sussex-wide services and Neurosciences

Our vision is to provide high quality tertiary and extended acute services to Sussex, south-East Surrey and south-West Kent. Our aspiration is to develop a sustainable model for Sussex-based tertiary provision. Responding to the strategic intention of NHS England to move to 15 – 30 contracts for most specialist services, we intend to remain a specialist contract holder for our main tertiary services. We will need to work closely with partner providers of secondary care services in Sussex, specifically Western Sussex Hospitals NHS FT and East Sussex Healthcare NHS Trust; and with partner tertiary centres in London, to establish appropriate pathways. We will work closely with our

commissioners (CCG and NHS England) to ensure our proposals align with their aspirations for high quality services for local residents.

Specifically, we will

- Continue to develop the RSCH site as the centre for specialist work, with a few exceptions
- For renal and neurological care where a more networked model is proposed, we will aim to provide in-reach support to facilitate the provision of a wider range of speciality-led inpatient and outpatient provision at other hospitals. This model will continue to be developed and optimized for cardiac services to generate the capacity to serve a critical mass of patients requiring complex surgery
- We will continue to focus on delivering the benefits of the previously agreed network approach for vascular services and on developing a strategic partnership with Sussex Community NHS Trust for genito-urinary medicine provision, which has critical links with our well established and highly respected HIV service

We will aim to position our tertiary services strongly in the context of the emergent specialised commissioning strategy. We will also take decisions not to provide some specialised services, based on working with commissioners to assess Sussex-wide needs and best layout of provision.

4. Cancer

Our vision for cancer services is to further develop the Sussex Cancer Center and RSCH as the hub for cancer care in Sussex working with local hospitals, ensuring that our services:

- Implement the pre-existing radiotherapy strategy
- Continually improve outcomes for patient
- Are highly regarded by patients and partner agencies
- Meet or exceed quality standards;
- Serve as a hub for innovation, research and teaching

5. Obstetrics and paediatrics

Our vision is to deliver the BSUH vision of providing high quality general acute maternity and paediatric services to the population of Brighton and mid-Sussex and a wide range of extended acute / tertiary maternity and paediatric services to the population of Sussex we will:

- Enhance the services at RSCH by the further development of the full range of obstetric services including a midwife-led unit, second obstetric theatre and transitional care
- Develop the Royal Alexandra Children's Hospital as a tertiary centre for Kent, Surrey and Sussex and work with community children's services to improve patient experience and manage pressure on the paediatric emergency department and general paediatric medicine
- Develop ambulatory obstetrics and gynaecology at both PRH and RSCH, reducing antenatal attendance pressure on both labour wards

6. Support services

Our aspirations for the next five years are to:

- Give support services such as therapies, diagnostics and pathology a greater voice within strategy and service development work
- Develop strong 7-day based services where clinically appropriate, maximizing the benefits for patient flow and site capacity as well as an improvement in quality outcomes
- Find opportunities to improve the scope and efficiency of clinical support services by working closely with services in other agencies

What this means for our main hospital sites

RSCH will continue to operate a mixture of local acute services for the Brighton and Hove population, and specialist services for a Sussex-wide population including the operation of a Major Trauma Centre, with the major addition being co-located neurosurgery to support the provision of neurosurgical input to Major Trauma. The RSCH will meet the new national definition for a major emergency centre.

PRH will continue to develop its dual focus on care of the elderly and elective work, while retaining the majority of its current service provision. PRH will retain its core provision of medically-led A&E services that meet the Keogh review definition of an emergency centre, and an acute medical inpatient bed base. The consolidation of elective care to PRH will continue with moves of ENT/Max Fax and Urology.

BSUH will continue to run outpatient and ambulatory care services from a number of other sites including Hove Polyclinic, Brighton General Hospital and Lewes Victoria Hospital. RSCH-based services not requiring advanced diagnostic and inpatient facilities will increasingly look to use other estates.

Building on our academic and research strength

BSUH prospers from its links with Brighton and Sussex Medical School, the University of Sussex, the University of Brighton and Health Education England. With our academic partners the trust will prioritise the research agenda with existing strong service provision and research interests, such as in cardiology, oncology, paediatrics, renal, HIV and neurology. Teaching will remain a priority with the Trust working closely with HEE KSS to support its programmes and with BSMS to achieve its aim of remaining a top tier medical school for undergraduate teaching.

What this means for staff

Activity growth, more intensive staffing as a result of raising standards, and service developments provide significant opportunities for staff development as a result of the strategy. Demand management and productivity initiatives will also change staffing requirements.

Enablers of our clinical strategy

There are three important enablers of our clinical strategy:

- **Foundations for Success:** the Trust has committed to an internal development programme, Foundations for Success including Clinical Structure, Empowerment, Performance and Accountability and Values and Behaviours, empowering our staff in delivering high quality and sustainable care
- **IT:** the strategy will require improved information technology to be effective. BSUH is implementing an Electronic Patient Record system
- **Information:** the Trust will need to make use of information and data. We are currently refreshing our informatics strategy.

Financial implications

The Trust has forecast a £20m per year income and expenditure challenge for the next five years. The clinical strategy described above, along with existing CIP initiatives, makes a contribution to mitigating this challenge while substantially improving clinical sustainability. Further transformation will however be required.

Implementation and further developing the strategy

The majority of initiatives described in this strategy will be implemented in 15/16 with some further work to be completed in 2016/17 and 2017/18.

In parallel BSUH will need to continue to significantly improve its financial performance and maintain and improve clinical quality sustainably. The requirement to achieve 7% CIP next year and 4-5% CIP annually in the following years is achievable but not easy. The projected need for increased bed capacity across both sites will also require efficiency improvements to be made. To achieve this level of operational improvement, BSUH will:

- **Develop an internal clinical and operational transformation mechanism**, using the new clinical structure, that allows for focused, data-driven change in clinical productivity and methods of delivering care. Internal transformation is key to our clinical and financial sustainability going forward.
- In addition to the current Urgent Care Boards and existing joint work with commissioners on the Better Care Fund, BSUH will develop **a set of speciality-level work groups jointly instituted with commissioners**. The groups will focus on general acute planned care pathways and jointly agree efficiency opportunities on the basis of maintaining and where possible improving BSUH's net contribution from these services. The groups will report to the clinical transformation board.
- **Continue our clinical and operational strategy development**. We will continue to assess what additional strategic and operational changes are need to deliver our vision. We will consider further options for changes to methods of delivering care, including opportunities

for further Sussex-wide partnerships, opportunities not to provide some services which could be provided by neighbouring organisations, further opportunities for service moves within BSUH and specific options for achieving far reaching efficiency improvements across all staff groups and all cost areas.

Conclusion

The challenges facing the wider NHS are substantial and in some ways daunting – this strategy sets out how we can address these but to do so will require transformation across our services, continuing contribution from our staff, positive working relationships with our partners and continued, two-way, communication with our patients. The strategy we have developed, and our on-going clinical and operational transformation effort, together provide a path to addressing those challenges and enabling BSUH to thrive as a vibrant sustainable independent organisation delivering high quality care to its patients. However it is not a strategy that the Trust can deliver on its own. BSUH is part of a health economy and our strategy must be part of a broader effort to deliver high quality care to our communities. Our success is dependent on the success of our partners. A core part of what we do over the next five years will be to work closely with commissioners and other providers to ensure a sustainable future for the NHS across Kent, Surrey and Sussex.

1. Context

- 1.1 Brighton and Sussex University Hospitals (BSUH) is an acute teaching Trust working across two principal sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital, and the Haywards Heath campus includes the Hurstwood Park Regional Centre for Neurosciences.
- 1.2 We provide District General Hospital services to our local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.
- 1.3 Core provision of A&E, inpatient medicine and outpatient planned care is provided across both sites. In addition, the Princess Royal Hospital is our centre for elective surgery and the Royal Sussex County Hospital is our centre for emergency and tertiary care. Our specialised and tertiary services include neurosciences, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. We are also the major trauma centre for Sussex.
- 1.4 The Trusts' core market is the area for which BSUH is the nearest acute hospital provider. By local authority area this is:
- Brighton and Hove City Council (co-terminous with B&H CCG)
 - Mid-Sussex District Council (part of Horsham & mid-Sussex CCG)
 - Most of Lewes District Council (part of High Weald, Lewes and Havens CCG)
- 1.5 The outlying market includes Horsham and High Weald areas, who are served by DGHs in Surrey and Kent; the populations served by the other four Sussex CCGs, and for a limited subset of services, the populations of south-east Surrey and south-west Kent

Core population demographics

- 1.6 Within the core market, demographics vary considerably between the urban area of Brighton and Hove and the mid-Sussex/Lewes areas to the north and east. Brighton and Hove has a larger working age population, with 64% of residents being between 17 and 60 years old, as opposed to 53% in mid-Sussex and 50% in Lewes. Mid-Sussex and Lewes combined contain 47% of all residents, but 58% of residents aged 60 or over.

Brighton and Hove

1.7 Brighton's population faces typical urban population challenges. Factors identified from the local Joint Strategic Needs Assessment which are particularly relevant to the market for healthcare services include that:

- a. The proportion of people living in inappropriate housing conditions is double the national average. Hazardous drinking levels are 26% higher than the average for South-East England and higher than statistically similar areas of the UK. These trends reflect Brighton's significant homeless/itinerant communities and large areas of urban deprivation
- b. Brighton residents are less obese, participate in more sport and consume greater amounts of fruit and vegetables than the UK average.
- c. Deaths from circulatory, coronary and respiratory disease are 7 – 11% lower than both the UK average and statistically similar parts of the UK; cancer deaths are 6% higher
- d. Rates of dementia diagnosis are well below the assumed prevalence, suggesting under-diagnosis and treatment

1.8 On this basis, Brighton and Hove CCG and Health and Wellbeing Board have identified five key priorities:

- a. Cancer and access to cancer screening
- b. Dementia
- c. Emotional health and wellbeing-including mental health
- d. Smoking
- e. Healthy weight and good nutrition

Mid-Sussex

1.9 Mid-Sussex constitutes the area directly to the north of Brighton and Hove, up to the boundaries with Crawley, Kent and Surrey. The area is characterised by smaller market towns and villages, the largest of which is Haywards Heath, containing the Princess Royal Hospital.

1.10 The population is generally characterised as affluent, with low levels of smoking and high levels of physical activity. The dominant factor affecting the healthcare market is the high proportion of older residents. A third of residents are registered as having a long-term condition. This has led Horsham and mid-Sussex CCG to identify the following key priorities:

- a. Preventing people from dying prematurely
- b. Enhancing quality of life for people with long-term conditions
- c. Helping people to recover from episodes of ill-health or following injury
- d. Ensuring that people have a positive experience of care

- e. Treating and caring for people in a safe environment and protecting them from avoidable harm

Lewes

- 1.11 The Lewes District Council area is to the north-east of Brighton and Hove, covering the towns of Lewes and Newhaven, and the rural area up to the border with Uckfield. BSUH operates daycase and outpatient services from Lewes Victoria Hospital.
- 1.12 The large elderly population has needs associated with long-term conditions and general frailty, and can be isolated with poor access to infrastructure and services. Smoking rates are high, as are rates of alcohol and drug misuse.
- 1.13 High Weald, Lewes and Havens' commissioning intentions, as they apply to provision at BSUH, therefore focus on
 - a. Reducing falls
 - b. Reducing hospital admissions
 - c. Reducing health problems associated with lifestyle choices

The wider Sussex population

- 1.14 BSUH provides services for patients from across Sussex, with some provision extending into Surrey and Kent. Sussex is defined by the Unitary Authority of Brighton and Hove, and the County Councils of West Sussex and East Sussex. Surrey and Kent are defined by their respective County Councils.
- 1.15 In terms of geography, it is of note that Sussex contains very few major roads (East Sussex is the worst served, with only 20 miles of dual carriageway) and the railway infrastructure consists principally of the ends of radial lines that run into London, with coastal lines running in and out of Brighton. Because of the requirements to co-locate services, much of the specialised/tertiary provision offered by the Trust has to be located at the RSCH site, which depending on local circumstances can be 15 – 25 minutes from either of the nearest trunk roads, and is 10 – 15 minutes by car from the railway station. This means that for many service lines, journey times from the north and west of Sussex may be comparable or shorter to BSUH's competitors.

Operational, quality and financial performance

- 1.16 Performance on the unscheduled care pathway has been significantly challenged since Q3 2012/13. Occupancy of beds, particularly at the RSCH site, has been a key factor in this pressure. Performance on the scheduled care pathway was subject to very significant

improvement during 2012/13 and has been compliant for every 18 week target at speciality level throughout 2013/14.

- 1.17 The Trust has had historic challenges in achieving stated performance levels in stroke care and in the level of unplanned readmissions to hospital. However overall mortality is at or below expected levels, and VTE risk assessments, medication errors, falls and pressure ulcer rates are all low. This reflects the Trusts' strong historic focus on safety in the delivery of care.
- 1.18 The Trust has a forecast outturn position of £5.2m Surplus in 2013/14 and Financial Plans for 2014/15 and 2015/16 that deliver reported surpluses of £2.2m and £5.2m respectively. These positions deliver overall 'Continuity of Service Risk Ratings' of 3 for 2014/15 and 2015/16 i.e. meet the core requirements for a sustainable Foundation Trust application.
- 1.19 The Trust has recovered from a position of historic deficit to two successive years of reported surplus by delivery of significant growth as well as high levels of CIP performance. However, an underlying deficit remains requiring significant extra CIP delivery in 2014/15. After 2014/15, current projections indicate a typical 4 – 5% per annum cost improvement challenge, which is in line with national requirements for 4% annual efficiency gains across the NHS.

2. Vision and role for BSUH

2.1 Our vision for BSUH is articulated below.

2.2 BSUH's vision is to be a provider of safe, high quality secondary and local acute services to Brighton and mid-Sussex that are integrated with services in partner agencies, financially sustainable, and responsive to the needs of the local population.

Rationale: the majority of our capacity and resource continues to be focussed on our general acute services. Our strategy must ensure that our general acute services are of a high level of quality and meet standards such as

- providing a uniform level of inpatient emergency care across all seven days of the week, with safe and appropriate staffing levels, even where in some cases this means providing services on a single site.
- providing appropriate and accessible choices of place of birth
- providing accessible and high quality planned care services

The intentions and initiatives within our strategy will lead to us working more closely with commissioners, community providers and local government, in both planned and unplanned care. At the moment, this vision extends to acute services in outpatient and hospital inpatient settings. Whilst we do not anticipate a strategic approach of full vertical integration with GP-based primary care, we will seek opportunities for more integrated clinical decision-making with community NHS and social services.

2.3 BSUH's vision is also to be a provider of safe, high quality, financially sustainable, tertiary services to Sussex, south-East Surrey and south-West Kent, where a Sussex-based service is in the best interests of patients

Rationale: we do already, and will continue to, offer a range of more specialised services. However, we must be mindful of the commissioning drive towards greater centralisation, as well as our own capacity constraints. The key test for maintaining or extending specialist provision is therefore the test of compelling patient interest in the service being available locally as well as the proximity and accessibility of other providers of services. This drives a greater focus in, for example, sub-speciality paediatrics, than in transplantation surgery. We are also committed to providing regional specialised emergency care as the designated major trauma centre for Sussex.

2.4 BSUH's vision is to be a hub for expertise and skill in specialist provision, innovation, training and research, that supports development of clinical academic expertise and high quality networks of care across Sussex, delivered by both BSUH and partner providers

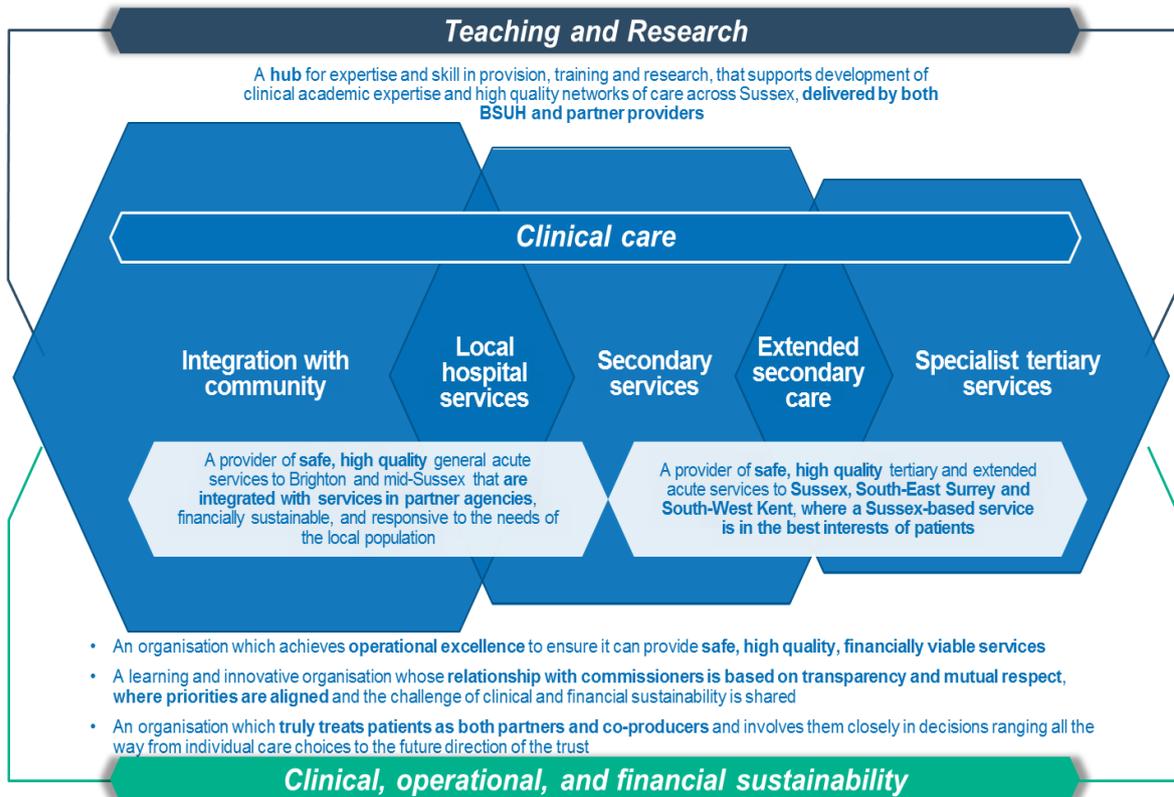
Rationale: the strength in the NHS Sussex system is in collective working. With seven acute sites serving 1.6m people, generating the scale for effective teaching, research and specialised provision in Sussex has historically offered significant challenges. BSUH cannot and should not attempt to do everything, but it can act as a hub and co-ordinating centre for a Sussex-oriented approach. In research, this means acting as a patient identification centre for trials running across multiple sites. In medical training, it means supporting locally oriented trainee rotations instead of seeing Sussex split between SW/SE London rotations. In provision, it means acting as the centre of specialist expertise, and running a small specialist bed base, that supports patients to be managed and treated via their local centres. We remain committed to BSMS as a centre of high quality, practically focused medical training and to across the board high quality training of other health professionals.

2.5 BSUH's vision is to be an organisation which achieves operational excellence, continually innovates how it delivers services and works closely and transparently with commissioners and patients to ensure it can provide high quality, financially sustainable services.

Rationale: BSUH's position as a 'fixed point' in the local NHS system gives it significant leverage in determining how local NHS services are organised. However, we respect the fact that commissioners have a statutory duty to seek quality and value for money in the services they purchase. BSUH wants to remain the provider of choice, therefore it must be proactive in seeking opportunities to work with commissioners to innovate, improve quality, lower costs and improve the patient experience, with the expectation that this is done in a way that recognises its cost base and drives sustainability.

2.6 The diagram below summarises the Trusts' vision for its clinical strategy, reflecting the vision set out above and the linkages between the groups of clinical services delivered by BSUH.

Vision for the BSUH clinical strategy



3. Vision for BSUH services

3.1 Our vision for services - unscheduled care

Internal context

- 3.1.1 BSUH provides urgent and emergency care for the populations of Brighton, mid-Sussex and Lewes, totalling 495,000 people. The Trust provides regional emergency care for 1.6m people, as the designated major trauma centre for Sussex. In addition, it is the regional centre and hub for other services with significant unscheduled care components, such as the vascular service, critical care service, paediatric services, cancer. Services are primarily delivered from the Princess Royal Hospital (PRH) in Haywards Heath and the Royal Sussex County Hospital (RSCH) in Brighton.
- 3.1.2 The urgent and emergency care services at BSUH treat 150,000 patients a year, of which 43,000 are admitted. This represents 48% of the Trusts' total income. The Trust has experienced year on year growth in urgent and emergency care attendances with 15,000 more patients projected to be treated in 2013/14 compared to 2010/11. This is a 3.4% per annum increase, only 2.2% of which can be explained by demographic growth. The Trust incurs a £2m per annum penalty for unscheduled care activity occurring above the non-elective threshold level set in 2008.

Princess Royal Hospital

- 3.1.3 PRH is a small general hospital with a 24/7 emergency department and a general inpatient medical facility, including monitored cardiac beds. The hospital serves a catchment population of approximately 240,000 and the emergency department sees 33,000 patients per year.
- 3.1.4 The emergency department performs well on access to care. However, for those patients admitted to the hospital (23% of A&E attendances convert to admissions) length of stay is high with patients staying an average of 4.7 days. Hospitals in Kent, Surrey and Sussex with a similar patient mix have a Length of Stay of 3.3 – 4.3 days.
- 3.1.5 PRH does not currently operate uniformly across the seven days of the week. Fewer senior doctors are present out of hours and over the weekend. A national study by NHS England has demonstrated that access to senior doctors is important to achieving the best outcomes for patients with mortality rates higher across the country for those patients admitted at the weekend. The site is not compliant on nationally recognised stroke standards because it fails to meet the requirements for patients to be cared for by a stroke medical team on admission and the site does not have vascular surgery or interventional radiology.

Royal Sussex County Hospital

- 3.1.6 RSCH provides general hospital care for the local population of 260,000 and emergency general surgery and orthopaedic care for approximately a further 60,000 in East Sussex. The hospital has a major emergency department (with a 35-patient capacity), a clinical decision unit, short stay ward, acute medical unit, acute stroke ward, interventional cardiology facilities and a dedicated 24/7 accident and emergency service as part of the Sussex Eye Hospital. RSCH is the designated major trauma centre for Sussex. In addition, it is the regional centre and hub for other services with significant unscheduled care components, such as the vascular service and critical care service. There is a separate Children's ED in the Royal Alexandra Children's Hospital (not discussed in this section).
- 3.1.7 Over the past five years the services at RSCH have undergone significant improvement increasing the quality and range of specialised emergency care provided. This has included improved access to acute physicians, the designation of the hospital as a major trauma centre and the introduction of interventional radiology. As a designated major trauma centre, services are regularly peer reviewed meaning that standards are checked and there is a process of continued learning and improvement.
- 3.1.8 The emergency department at RSCH is extremely busy. It has 75 ambulance conveyances per acute bed per year, which is the highest in Sussex and compares to ~50 per bed per year at surrounding sites. This has led to increasing pressure on the hospital overall, demonstrated by 98% bed occupancy against a target level of 90%, and low Friends and Family Test scores. At times RSCH is required to treat patients from its local catchment and transfer to PRH for an inpatient stay because of lack of bed availability.
- 3.1.9 Since November 2013 there has been 24 / 7 shop-floor presence of emergency physicians at the RSCH emergency department, not only for trauma calls. This level of service and approach was particularly commended in the national external peer review for MTCs by Prof. Sir Keith Porter and colleagues. This round the clock capability offers support to the PRH emergency department also, with both telephone advice and re-positioning and deployment of resources, when required.
- 3.1.10 In advance of the development of this strategy BSUH had already committed to the co-location of neurosurgery, currently provided at Hurstwood Park in Haywards Heath, with the major trauma centre at RSCH. This move will ensure the major trauma centre meets the national standards expected of such a service. This change, which will be implemented in 2014, is a significant part of the strategy for urgent and emergency care.
- 3.1.11 The strategy to 2019 must address:
- The requirement for **seven day working** at both PRH and RSCH, and compliance with emerging standards for major emergency centres and emergency centres

- The need to work in partnership with clinical commissioners and local government to **improve pathways of care**, leading to a reduction in the need for emergency care as per the principles of the Better Care Fund
- **Length of stay** should be reduced minimising the time patients need to be in hospital, enhancing their recovery and improving patient experience
- The **bed utilisation** across the Trust needs to be sustainable.

External outlook for service demand

3.1.12 To 2019 we expect to see the following trends in the demand for unscheduled care services:

- **Demographic data** shows growth rates in key emergency care specialties to be 40 - 60% higher in the PRH catchment than RSCH in the next decade due to the more rapidly ageing population in mid-Sussex (see demographic model outputs at Appendix E). We expect surgical emergencies to continue to grow in line with population demographics of 0.7% (B&H CCG) – 1.4% (H&MS CCG).
- **Demand management** in 2014/15, equating to 2.6% in non-elective admissions. Our modelling indicates that after 2015/16 and the Better Care Fund (see below), demand management should not be required in order to deliver CCG financial balance except as a result of CCG prioritisation decisions in those years and therefore is not included in our baseline modelling.
- **Pathway changes** in acute, elderly, respiratory and general medicine. CCG strategies focus on reducing the need for these services through reduced admissions. NHS England has set all commissioners the target of achieving a 15% reduction in non-elective admissions, a target that will fall disproportionately in acute, elderly, respiratory and general medicine. The Trust must consider the difficulties in achieving similar plans in previous years and the longstanding pattern of activity growth in this area. Therefore whilst the Trusts' baseline scenario assumes the achievement of CCG demand management objectives including those required for the Better Care Fund, the Trust is mindful of the impact on demand for services should these changes not occur
- As the **regional centre for specialised emergency care**, volumes will increase in line with the achievement of full major trauma centre status following the co-location of neurosurgery, resulting in a further 80 highly complex admissions per year by 2019
- The changes at East Sussex Hospital will result in increased market share at PRH and RSCH. This is expected to result in an additional 550 – 600 spells per year in general surgery and trauma, representing a further estimated £2m in gross income and an assumed marginal income benefit of £800k and driving in particular the need for a

Surgical Assessment Unit model at the RSCH to manage a higher workload of emergency general surgery patients from East Sussex.

High-level aspirations

3.1.13 In order to respond to the internal and external challenges above and to deliver BSUH's vision of providing high quality general acute services to Brighton and mid-Sussex, as well as regional emergency care, our aspirations are as follows:

- Two emergency departments delivering seven day services, working actively with commissioners and local GPs to manage the demand for acute care, focusing on ensuring appropriate rapid access to care and integrated support with the community, in line with the RCP's Future Hospitals Commission vision.
- Establish PRH as a centre for supporting frail patients. At first, a particular emphasis will be on fractured neck of femur pathway.
- Building on our specialised emergency provision, a single site combined hyper-acute/acute stroke service should be established with intensive input to patients for the first 72 hours, ensuring rapid access to diagnostics and specialist consultants.

3.1.14 Specifically, this aspiration means that we will be able to achieve the following:

- Quality: high quality care delivery based on consistent delivery of access standards in the emergency departments; compliance with 7-day working standards by April 2017 with demonstrated consistency in care via measures such as weekend versus weekday mortality
- Experience: high quality patient experience leading to the achievement of top quartile performance for relevant specialties in the *NHS friends and family test*, compared to peers
- Efficiency: reductions in admissions for acute, elderly, general medical and respiratory patients of 16 – 20%. Length of Stay for all non-elective admissions to improve by 15% and to reach best quartile for the identified peer group, in areas with specific initiatives such as stroke and fractured neck of femur.

3.1.15 To achieve this we will need to work with commissioners, primary, community and social care providers to ensure we deliver integrated services, which work together to meet a coordinated vision for urgent and emergency care with co-ordination of care around each individual patient who has a condition or number of conditions that lead to a higher risk of hospital admission. We are particularly keen to continue to develop our links with Sussex Community Trust to achieve this vision.

Description of the model of care

3.1.16 The emergency department and medical take services will be improved by:

- Partnering with primary care to ensure effective usage of urgent and emergency care where it is needed, including communication about the alternative delivery points available.
- Development of a frailty pathway: Both sites developing, with commissioners and community services, an acute elderly assessment service supported by a MDT to provide same day comprehensive geriatric assessment and admission avoidance, as well as supporting wider, community-based efforts to reduce unnecessary admission to hospital and to facilitate quicker discharge after an acute stay
- 7-day provision of physiotherapy and occupational therapy to elderly patients requiring rehabilitation ready for discharge.
- Care of patients with a fractured neck of femur being consolidated onto a single site allowing a dedicated pathway of care. A hyper-acute stroke unit will be established ensuring rapid assessment and treatment of patients suffering from a stroke
- A discharge coordination function being located on each hospital site to put in place the package of care required ensuring the safe discharge of the patient. This will require working closely with social care and community health services

Interdependencies

3.1.17 This model of care depends on the following critical interdependencies:

- The availability of a general surgical opinion to medical inpatients on both sites where required
- To support the provision of stroke care, **a full range of diagnostic and interventional services including advanced imaging and neurovascular input**. Many of these support services and diagnostics are also required by Major Trauma services.
- To support the maintenance of the major trauma centre service at the RSCH, the full range of diagnostic and co-located/networked specialties (for many of which BSUH acts as a hub), and diagnostic and other support services.

3.1.18 A full interdependency map is set out at Appendix D.

Workforce and capacity implications

3.1.19 As a result of this strategy we expect to:

- Continue the development of an acute physician workforce at the RSCH to support 7-day acute physician presence in acute medical unit
- Develop an acute/GIM consultant medical take rota at PRH that provides 7-day consultant review of new admissions with support from ward-based teams
- Institute an orthopaedic rota to see and operate on fractured hip patients if required by a decision on site location

- Institute a 7-day on site stroke consultant rota
- Develop the geriatric physician workforce to support the front door frailty service to enable access to 7 day comprehensive acute geriatric assessment

Detail on the strategic initiatives to achieve this is outlined in Appendix A.

3.2 Our vision for services – competed elective care

Internal context

- 3.2.1 Brighton and Sussex University Hospitals NHS Trust (BSUH) currently operates a very wide range of elective services from the two main sites. In order to maximise local accessibility for patients, a range of services are also provided at:
- Hove Polyclinic which provides physiotherapy, pain medicine, T&O & rheumatology (as well as elective elements of respiratory, cardiac, neurology and radiology services)
 - Lewes Victoria Hospital which provides DD surgery, gynaecology, Urology, ENT, Dermatology, pain management T&O and gastroenterology
 - Sussex Orthopaedic Treatment Centre for elective orthopaedic surgery
 - Brighton General Hospital for physiotherapy and dermatology
 - A range of smaller sites
- 3.2.2 RSCH focuses on major surgical cases for patients requiring the full range of supporting services and inpatient stays on specialist surgical wards, including cancer surgery. PRH focuses on daycase and elective patients.
- 3.2.3 The services have focused on providing high quality, responsive and efficient care. Advanced and innovative techniques are used to increase access and improve outcomes in pain management, urology, dermatology and ophthalmology services. As a consequence of these innovations, the Trust has achieved specialty-level 18 weeks compliance in all services since Q1 2013/14.
- 3.2.4 The Trust is also a regional centre for some specialities including the specialist skin multidisciplinary team and ophthalmic care via the Sussex Eye Hospital. Elective services have a strong reputation among patients and for ease of access. However, the physical capacity and quality of the estate is a limiting factor.
- 3.2.5 BSUH is able to attract high quality staff because of the training and research opportunities available. The workforce is well regarded and skilled and this in turn enhances the Trust's ability to recruit staff. We also have staff with specialist skills, for example in lithotripsy, retinal surgery and pain management.

External outlook for service demand

- 3.2.6 In the past three years, we have seen 2.2% per annum growth in elective services. However, this trend is unlikely to continue for two key reasons:
- The scale and scope of services being offered by primary and community providers is increasing, with the likely impact of flattening (if not decreasing) referrals to the Trust.

- Commissioners are adopting prime provider models, which give financial responsibility for demand management to the provider of the services. For example, local commissioners are in the process of introducing a musculoskeletal prime provider pathway model which aims develop services within a fixed financial envelope in planned musculoskeletal care (orthopaedics, pain management, rheumatology and physiotherapy) by managing referrals to consultant-led services and directing patients to other interventions. Commissioners have indicated that are keen to apply this approach to Dermatology and potentially Ophthalmology services.

3.2.7 Given these changes BSUH is planning for demand growth to be lower than demographic growth, specifically:

- In inpatient and daycase elective services we expect demand management of 1% per annum after growth
- In outpatient services we expect demand management of 2.6% per annum after growth

3.2.8 The detailed expected demand growth varies by service and is summarised at Appendix E.

High-level aspirations

3.2.9 In order to deliver BSUH’s vision of providing high quality general acute services to Brighton and mid-Sussex, our vision for competed elective services is to improve patient experience, and quality and responsiveness of service provision by:

- Working in partnership with our commissioners as well as primary and community care providers to co-design and remodel services
- Challenging whether the current location of services is best for patients. We will radically look at where services are provided and whether they really need to be on an acute site. We will explore and promote the use of other more accessible sites wherever possible, including primary care facilities. (Approximately 3000m² of space at the Brighton site is used for outpatient services and some of this could be better used by other services.)
- Challenging the current medical focus of service delivery, and achieving efficiencies by changing clinical skill mix. For example, ophthalmology nurses could be trained to provide monthly injections to treat macular degeneration.
- Selectively identifying opportunities to increase our market share including by expanding our catchment population.

3.2.10 Specifically, our aspiration means that we will be able to achieve the following:

- Quality: Move from 82% to 95% NICE pathway guidance compliance.
- Experience: Improve NHS friends and family test scores to the top quartile in each relevant specialty, and maintain performance at that level.
- Efficiency: Achieve service line net surplus in all majority-elective specialties by 2018/19.

Description of the model of care

3.2.11 To achieve our aspirations we will need to work closely with commissioners, to review our use of sites and to be able to respond swiftly and effectively in an increasingly competitive market.

Working closely with our commissioners to co-design and remodel services

3.2.12 Our commissioners tell us that they want to work with responsive providers who deliver high quality efficient services which is aligned with our own aspiration. We will therefore need to work closely with our commissioners to understand their priorities for service reviews and agree a programme of pathway reviews so that we co-design our services in line with their expectations. Our aspiration is to facilitate the shift of work to primary and community care where possible, including ceasing to do work where appropriate or providing services in community settings.

Number of sites and services delivered by site

3.2.13 It is important that good outpatient and high volume daycase provision remains available to both Brighton and Hove and mid-Sussex residents at the two main acute sites. Inpatient elective orthopaedic activity will continue at the PRH site via the main building and Sussex Orthopaedic Treatment Centre. Major inpatient specialties will continue to use the RSCH for large cases including cancer surgery except where specific moves are facilitated either to PRH or other providers. This is reliant on the urgent and emergency care component of BSUH's strategy succeeding in reducing outlying emergency surgical and medical patients in elective surgical beds.

3.2.14 However, to achieve our aspiration of providing services as locally as possible for all the population, some changes to site provision are likely:

- Inpatient urological services should move to PRH facilitating the development of a Sussex-wide pelvic cancer service (see below)
- A satellite ophthalmology clinic and operative capacity at Southlands Hospital (dependent on agreement with Western Sussex Hospitals NHS Foundation Trust)
- Peripheral clinics for first outpatient services in high volume specialties should be developed bringing services closer to patients and releasing physical capacity at RSCH
- The development of a single infusions service that entails the development of an offsite clinical infusion facility that is near to the acute site should be pursued

- 3.2.15 Further work will take place to understand the case for a potential outpatient and rapid access diagnostic hub away from RSCH. At the current time no candidate site has been identified for this development but with such a development the Trust could secure improved accessibility to patients and use of the RSCH campus for critically co-located care. However we will, via the 3Ts Full Business Case process, review the opportunities for providing increased general OPD capacity in 3Ts Stage 1 from 2019.
- 3.2.16 We will also work closely with our commissioners to understand and explore the better utilisation of primary care estate and opportunities in the community.

Responding in an increasingly competitive market

- 3.2.17 The Trust will exploit opportunities to improve market share in services that make a net contribution, where there is a clear requirement from commissioners and referring clinicians to do so. However, it is not Trust strategy to aggressively expand its borders for planned care services.
- 3.2.18 By undertaking the joint pathway reviews highlighted above, the Trust is seeking to work proactively with commissioners to demonstrate and improve the value for money and quality within current provision as well as the important financial and clinical sustainability contribution that planned services make to the Trusts' wider portfolio.
- 3.2.19 However, some competitive tendering of services will be a feature of the landscape the Trust operates in. In order to respond to tenders the Trust will need to:
- Understand the net contribution of competed elective services to the rest of the Trust via the development of improved patient level costing
 - Decide if it will be a prime provider and if so how it will manage the scale of risk involved, particularly managing clinical pathways within agreed commissioning thresholds. Decisions already made in respect of prime provider opportunities in 2013/14 may not be an indicator of the Trusts' response to future opportunities
 - Create capacity and expertise to support clinicians to develop tender responses.
 - Complete the implementation of a modern EPR system which is a requirement for competing effectively for new services

Interdependencies

- 3.2.20 Planned care services have complex co-dependencies. Most outpatient services can be delivered in a range of settings with staff scheduling being the limiting factor. Most elective specialties have a number of interventions that can be delivered in a low-risk setting, which favours the PRH site, and a smaller number of high risk cases which require the full range of co-dependencies supported at the RSCH.

Workforce and capacity implications

3.2.21 As a result of this strategy we need to make the following changes in the workforce:

- The total number of consultant PAs required for outpatient duties will reduce as other staff perform extended roles in elective pathways or where volumes of services reduce.
- New pathways will call for increased use of extended scope nursing and allied health professional roles. This will require increasing sub-specialisation in nursing and AHP positions
- The Trust will continue to pursue its academic strategy target of increasing the ratio of trainee to staff middle grades

3.2.22 At present elective services use 170 beds across the Trust. With aggregate inpatient elective demand changing by 19% in the planning period, and assuming achievement of an improvement in Length of Stay of 18% and a reduction in overall bed occupancy, aggregate bed requirement will be 180.

Detail on the strategic initiatives to achieve this is outlined in Appendix A.

3.3 Our vision for services - Sussex-wide services and Neurosciences

Internal context

- 3.3.1 In the last ten to 15 years BSUH (and its predecessor Trusts) has established itself as a medical school and high quality tertiary service provider for a number of clinical specialties. In some areas, such as neurosciences, the Brighton and mid-Sussex area had a long history of tertiary service provision. In other areas the development of tertiary provision has been relatively new and has reflected advancements in medicine and the need for specialties with expensive resources and scarce skills to operate on a single site for all Sussex patients. The result is that BSUH is the principal provider of renal, HIV, cardiac surgery and neurosurgery services in Sussex and operates as a hub provider of more specialised services for interventional cardiology, vascular surgery and neurology. GUM services are strongly linked to the HIV service although currently only provided to the core Brighton and mid-Sussex population. With the exception of neurology all of these services will be primarily based at the Royal Sussex County Hospital (RSCH) site by the end of 2014. Brighton is a designated Heart Attack Centre and growth has been seen in the primary PCI service with flows from West Sussex and depending on the final configuration of services in East Sussex the SCC will see increased patient flows from the east.
- 3.3.2 Sussex-wide services deliver renal services, GUM and HIV services, vascular services, cardiology and cardiac surgery, Neurosciences and major trauma services to patients locally and Sussex wide on a catchment of 1.6m.
- 3.3.3 Service quality in many services is demonstrably high against peers with strong outcomes in renal and HIV care. Neurosciences have a strong reputation with patients and commissioners. Patient and family satisfaction is high - 86% for neurology and 89% for neurosurgery. Research is also well embedded into service provision and BSUH benefits from its status as the Sussex training centre for many services attracting research income, academic training placements and consultants with strong sub-speciality interests.
- 3.3.4 The overall challenge for Sussex-wide services is physical capacity constraints, particularly on the RSCH site and historic challenges in successfully implementing Sussex-wide network agreements for tertiary provision. These services struggle to maximise the value of their expertise and facilities when broader pressures on inpatient capacity impact on service provision. However there are opportunities within the cohort of services to generate bed capacity through efficiency improvements. Cardiology continues to develop rapidly with interventional treatments appropriate to a group of patients who were previously deemed too high risk for operation / intervention. Non-elective cardiac patients can be admitted to RSCH or PRH and a key focus is on rapid

transfer of appropriate patients from the northern site for care under the cardiologists in line with national guidance.

- 3.3.5 The challenge for neurosciences are that the current facilities are inadequate to improve on current performance. In particular there is a high cancellation rate for elective work because of the lack of an HDU/ITU on the current site, Hurstwood Park Hospital, Haywards Heath. For neurology, the current district based service does not lend itself to coordination and planning of specialist / tertiary services. As a consequence both neurosurgery and neurology work in our current catchment is going to other providers.

External outlook for service demand

- **Growth in demand:** the outlook for service demand is growth at demographic baseline levels, with two areas of higher growth: renal and HIV services. Historic growth is at 5% HIV and renal services indicating increasing incidence of disease (3.8% in renal services and 3.4% in HIV) which is supported by national trends. Cardiac services are projected to grow significantly in demand as a function of age profile changes, new technologies permitting invasive treatment for conditions formerly only suitable for medical therapy and changes in clinical pathways for example Primary PCI. In cardiac surgery repatriation from London is the primary driver for growth.
- **The proximity of services to London** presents continual challenges in terms of developing and maintaining effective scale of provision. Registrar training rotations still principally use historic 'Thames regional' models oriented around a London centre with Brighton being at the geographical edge of the rotation. Volumes of provision are limited as the 'natural' boundaries based on travel times to the west and north mean the maximum population BSUH can serve is 1.2–1.6 million (dependent on the service).
- **Demand management** in 2014/15 in specialized services which is subject to negotiation with NHS England
- Tightening requirements by national commissioners to **co-locate highly specialised services** in order to deliver the highest and most reliable standards of care. This has already caused the Trust to plan the co-location of neurosurgery at RSCH for 2014, which is ahead of the planned redevelopment at RSCH, in order to meet major trauma centre requirements.
- NHS England are in the process of developing **a specialised commissioning strategy**. The outcome of this exercise is likely to be a significant reduction in the numbers of centres holding primary contracts for specialised provision. The implementation of this strategy is likely to require public consultation and will take several years to implement. However, BSUH needs to begin to assess the potential impact of this strategy on individual tertiary services to determine if a service is likely to be assessed to either be capable of absorbing provision from other centres or managing

a network of provision; or lose all or significant parts of a service as a result of a decision that a service needs to be centralised elsewhere.

High-level aspirations

- 3.3.6 In order to respond to the challenges above, and to provide high quality tertiary and extended acute services to Sussex, south-East Surrey and south-West Kent our aspiration is to develop a sustainable model for Sussex-based tertiary provision.
- 3.3.7 To achieve this we will need to continue to work closely with partner providers of secondary care services in Sussex, specifically Western Sussex Hospitals NHS FT, East Sussex Healthcare NHS Trust, Queen Victoria Hospitals NHS Foundation Trust and Surrey and Sussex Healthcare NHS Trust; and with partner hyper-tertiary centres in London, to establish appropriate pathways. CCG and NHS England relationships will be critical to secure acceptance and support for our proposed model of care.
- 3.3.8 We will aim to position our tertiary services strongly in the context of the emergent specialised commissioning strategy. We will also take decisions not to provide some specialised services, based on working with commissioners to assess Sussex-wide needs and best layout of provision.
- 3.3.9 Specifically, this aspiration aims to achieve the following
- Quality: continuing development of high quality standards, mitigating the impact of capacity challenges and improving opportunities that tertiary service patients receive elsewhere such as enrolment in therapeutically beneficial clinical trials
 - Patient experience: improved patient experience of BSUH services, whether at the RSCH or at other sites, with NHS Friends and Family Test scores moving to and tracking at the top quartile in relevant specialties
 - Efficiency: improved access to inpatient beds as a result of developments in other parts of the clinical strategy, leading to more revenue generating tertiary provision; more acute patients being managed off the RSCH campus with support from BSUH consultants; length of stay improving by 3% per annum across all services and moving to top quartile in target specialties

Description of the model of care

- 3.3.10 To achieve our aspirations we will need to make changes to the model of care as described below. With the exception of neurology, tertiary services will continue to be centered on the RSCH site.
- 3.3.11 The overall approach is of a **hub and spoke model** with BSUH as the hub provider for most tertiary services, but working with other providers in Sussex to provide elements of the service on a local basis.

- 3.3.12 For renal and neurological care where a more networked model is proposed, BSUH would look to provide in-reach support to facilitate the provision of a wider range of speciality-led inpatient and outpatient provision at other hospitals. This would improve local access for patients. More complex or seriously ill patients would be treated within the RSCH site. This would provide increased access to sub-specialty services, scarce skills and the most advanced equipment.
- 3.3.13 The cardiac model of hub/spoke based care is already well developed with satellite cardiology clinics throughout Sussex. Clinics are one stop with non-invasive investigations available. Patients attend the RSCH for invasive treatments / cardiac surgery. Inpatient flow is maintained by managing flow of elective and non-elective patients tightly to maximize the currently available bed base. However, formal repatriation agreements with East and West Sussex are required to facilitate the best patient experience and maintain flow, creating bed capacity to secure critical volume levels for high quality cardiac surgery provision. In very specialist services around congenital heart disease, BSUH acts as a spoke for the service run by Guys' & St Thomas NHS Foundation Trust but will develop more integrated services with community providers to manage patients with heart failure out of the acute setting.
- 3.3.14 This partnership approach continues with our focus on delivering the benefits of the previously agreed network approach for vascular services and developing a strategic partnership with Sussex Community NHS Trust for genito-urinary medicine provision, which has critical links with our well established and highly respected HIV service.

Interdependencies

- 3.3.15 This model of care depends on the following critical interdependencies including:
- Critical care, advanced diagnostic, interventional radiology and advanced pathology and pharmacy support being available 24/7
 - Co-location of specialties in line with the major trauma centre specification.

A full map of interdependencies is included at Appendix D.

Workforce and capacity Implications

- 3.3.16 As a result of this strategy we do not expect to see significant changes to the structure of the clinical workforce except where, and if, the operation of a networked model of clinical care requires the formation of a single consultant workforce. In this case BSUH would seek to work with partner trusts to reconfigure staffing on the basis of service need at that stage.

Detail on the strategic initiatives to achieve this is outlined in Appendix A.

3.4 Our vision for services - Cancer

Internal context

- 3.4.1 BSUH operates the Sussex Cancer Centre (SCC), which provides comprehensive diagnostic and therapeutic acute oncology and multi-disciplinary care. The SCC is based at the Royal Sussex County Hospital (RSCH) in Brighton, which is the hub of the Sussex Cancer Network. Breast cancer care is provided from the Park Centre in Brighton. The SCC provides services from Rye to Worthing and Brighton to East Grinstead. It covers a population of 1.3m. The SCC also employs all the oncologists working within the Sussex Cancer Network and providing care at BSUH, Western Sussex Hospitals NHS Foundation Trust (WSHFT) and East Sussex Healthcare NHS Trust (ESHT).

BSUH delivers oncology, haematology, radiotherapy, breast care and specialist palliative care to Brighton and mid-Sussex patients. Oncology services represent 6% of the Trusts' income, but patients in oncology services are referred into medical and surgical multi-disciplinary teams for on-going treatment, which constitutes a significant element of highly complex work particularly in surgical specialties.

- 3.4.2 The SCC has established strong relationships across Sussex, with partner providers, Brighton and Sussex Medical School and the patients it serves. It has several areas of unique service provision, for example nurse-led chemotherapy and the integration of level 2 haematology and specialist acute services.
- 3.4.3 However, the SCC is currently limited by poor inpatient capacity and facilities at RSCH. As a result patients are admitted under general medical consultants and cannot always access specialist oncology beds or support such as specialist palliative care input.
- 3.4.4 The development of satellite radiotherapy units in east and west Sussex has been subject to severe delays. As a consequence over 50% of SCC patients are not being treated within the national specification of a maximum of 45 minutes travel time for radiotherapy. This leads to poor uptake of radiotherapy as a treatment option. Proposals to address this were originally agreed in 2012 but units have not been established due to delays in securing an appropriate route to capital. This is now progressing with business cases being reviewed by the NHS Trust Development Authority at the time of drafting.
- 3.4.5 There are a number of development requirements within the acute oncology service including clinical nurse specialists and senior clinical cover for certain tumour sites.
- 3.4.6 SCC also needs to further develop its academic strength in cancer care which is a fundamental part of delivering quality patient care, maintaining the reputation of the service, recruiting highly skilled staff, and innovating in service delivery.

- 3.4.7 Significant investment in oncology has been anticipated in 2014/15 business planning. The strategy must seek to move the service to a sustainable income base for meeting future pressures of this type.

External outlook for service demand

- 3.4.8 To 2019 we project that growth in cancer demand will grow to reflect:

- The **demographic** baseline model shows highly variable growth for elective cancer services across geographic areas served by the SCC, ranging from 0.7% - 1.7% per annum. This is likely to accurately reflect the variable impact of population demographics on observed rates of cancer activity
- Overall cancer **incidence** will increase by 2.6% per year in line with historic growth across Sussex
- **Screening programmes**, whilst not changing overall rates of incidence, are likely to prompt increases in early intervention which may spike oncology and radiotherapy demand in a specific year.

This makes cancer a key area for demand growth amongst BSUH's services.

High-level aspirations

- 3.4.9 In order to respond to the challenges and trends highlighted above, our vision for cancer services is to further develop the SCC and RSCH as the hub for cancer care in Sussex working with local hospitals, ensuring that:

- Services continually improve outcomes for patients;
- Are highly regarded by patients and partner agencies;
- Meet or exceed quality standards; and,
- Serve as a hub for innovation, research and teaching. Our goal is to work as a Network across Sussex to provide high quality general acute cancer services, as well as selected extended acute and tertiary cancer services for the Sussex population.

- 3.4.10 Specifically, this aspiration means that we will be able to achieve the following in three key areas:

- **Quality:** Compliance with all service specifications, IOG and peer review standards; improved survival rates
- **Experience:** improved patient experience demonstrated by achieving and maintaining top quartile performance against relevant peers for all cancer services for Friends and Family Test

- Efficiency: for cancer provision in Sussex to achieve a position of net financial contribution to all SCC partner organisations, having met all appropriate service standards, with an increase of 25% of the contribution from clinical trials from 2013/14 outturn.

3.4.11 Achievement of this vision will require significant work with partner agencies and commissioners to achieve a new organisational model for Sussex cancer services. [DN more detail needed around the vision for this]

Description of the model of care

3.4.12 To achieve this we will need to make changes to the model of provision for cancer services in Sussex.

3.4.13 This would mean, in the first phase of development to the end of 2015/16, improving oncology services as follows:

- SCC to manage new outpatient oncology patients and follow-up activity across all three Trusts and their six hospitals: RSCH, PRH, Eastbourne Hospital and Conquest Hospital, (St Leonards-on-sea), Worthing Hospital and St. Richard's Hospital, (Chichester).
- Expansion of the oncology service to include the delivery of services at St. Richard's Hospital, Chichester and an enhanced presence Conquest Hospital, St Leonards-on sea
- In line with the proposed redevelopment of the RSCH site BSUH would over the long term become the main provider of oncology inpatient beds.
- BSUH, ESHT and WSHFT would continue to manage surgical oncology services, with more specialised tumour sites managed at one site ('centre of excellence' approach) to be defined and agreed with other providers. The centralisation of urological cancers currently underway is an example of this type of development and this could lead to other Sussex providers services currently provided at BSUH.
- Business cases are in progression for satellite radiotherapy centres in East and West Sussex and decant of the linacs based at the RSCH site. These centres will be BSUH-owned and run, providing outpatient radiotherapy within 45 minutes travel time for the majority of Sussex patients which is not currently available.

3.4.14 Internally, Haematology-oncology will be developed at Princess Royal Hospital. The goal of this initiative, which is closely linked to the infusion service initiative in the competed

elective service group strategy, is to ensure close-to-patient haematology -oncology access for mid- and north-west Sussex patients.

3.4.15 The second potential phase of development from 2016 onwards would focus on ensuring a complete package of cancer treatments is available locally for patients and developing partnerships at the extreme ends of the county to include. Whilst this requires extensive further discussion with our partner providers, this could include

- SCC developing to provide chemotherapy across the three partner Trusts
- SCC to establish closer links with Maidstone and Tunbridge NHS Trust and Portsmouth Hospitals NHS Trusts to share the oncology workforce to serve populations on the extreme ends of the county.

3.4.16 We have sought and received patient input into the above plans through existing patient engagement forums, such as the Radiotherapy Programme Board.

3.4.17 Simultaneous with these two phases we will ensure that the oncology unit continues to develop academically. This is fundamental to continuous improvement of quality, innovation, reputation and recruitment of highly skilled staff. Success in this will be measured by the appointment of a new Chair and two senior lecturer positions; by the subsequent retention of the post-holders; the achievement of new organizational metrics for the success of academic positions; and securing an overall net financial contribution to service provision as a result of clinical trials income

Workforce and capacity implications

3.4.18 As a result of this strategy we will see 80 PAs extra in consultant oncology resource (already employed by the Trust) being used to deliver BSUH-led services with some efficiencies in delivery to be gained by using clinical nurse specialist posts more effectively given the expanded catchment.

Detail on the strategic initiatives to achieve this is outlined in Appendix A.

3.5 Our vision for services - obstetrics and paediatrics

Internal context

- 3.5.1 At the current time, BSUH operates a comprehensive maternity service from the RSCH and PRH as well as ante- and postnatal and community midwifery services.
- 3.5.2 BSUH operates a comprehensive paediatric service from the Royal Alexandra Children's Hospital at RSCH including a stand-alone paediatric emergency department, high dependency unit, paediatric radiology, paediatric medicine and paediatric surgery. In addition, it provides a range of paediatric specialised services including paediatric respiratory medicine, cystic fibrosis, long term ventilation, diabetes and endocrinology, gastroenterology and nutrition and surgery (including ENT, trauma and orthopaedics). There is also a paediatric dentistry and orthodontics service, minor injuries unit for children at the Emergency Department at PRH and regional neonatal intensive care unit at the RSCH which hosts a regional neonatal transport service.
- 3.5.3 Services are very well regarded locally, with strong medical, nursing and midwifery expertise. Both have embedded research strategies and are well linked with the medical school and university.
- 3.5.4 The Trust delivers ~6000 babies a year and 23,000 children and young people are seen by the paediatric services. Since the establishment of the new Royal Alexandra Children's Hospital in 2007, paediatric ED, surgery and medicine have been consolidated into the RACH. The facilities provided in the RACH, as well as the service's academic links and research interests, have facilitated the development of sub-speciality and tertiary interests. However, some key growth specialties such as paediatric T&O remain single-consultant which is a risk to sustainability.
- 3.5.5 At nearly 5% the Trust has one of the highest home birth rates in the country. However, the caesarean section rate is high at 29% and has been static for some years. Brighton, in particular has a young age profile and we would expect to support more mothers to have a normal birth.
- 3.5.6 The major strategic challenge for maternity services is the lack of a co-located midwifery-led birthing unit at either RSCH or PRH, which impacts on the ability of the service to provide the best choice and experience for mothers having a normal birth. We believe the absence of such a facility has contributed to the static caesarean section rate.
- 3.5.7 Estate issues have been a significant barrier to the development of a midwifery-led birthing unit. Maternity services in particular cannot expand their bed base without changes to surgical provision, which is seeing high growth because of drivers cited elsewhere in this document.

3.5.8 Key challenges that the strategy needs to respond to are:

- Service standards, workforce availability and funding constraints have the combined effect of driving the centralisation of care into fewer but larger units in both paediatrics and obstetrics
- The national availability of middle-grade doctors is a key constraint for both obstetrics and paediatrics. Both services are moving towards models of consultant delivered services 24/7 and the development of advanced and specialised nursing roles.
- With the temporary closure of the obstetric service at Eastbourne Hospital, there is uncertainty over the future model of maternity care in East Sussex. However, we know that all proposed models include only one inpatient paediatric unit and one obstetric unit for East Sussex. Increases in paediatric and, to a lesser extent, maternity activity are likely to be sustained and may increase further.
- Securing the future of specialised services in the context of national service specifications published by NHS England. This will include identifying and supporting those which RSCH can deliver independently and working with other providers in hub and spoke models for those we cannot
- Establishing BSUH as a regional centre for training and education for all health care professionals, including through the establishment of a regional simulation centre at the RACH

External outlook for service demand

3.5.9 In total the maternity and paediatric services at BSUH represent 13% of income for the Trust.

3.5.10 The outlook is one of activity growth across all aspects of the service:

- Underlying obstetric activity growth is forecast at 0.2% (HWLH) – 0.5% (B&H) per year based on demographics.
- Demographic figures are based on 2011 data. We believe this data may understate growth due to additional housing in the mid-Sussex catchment, to allow for this the Horsham and mid-Sussex obstetric activity growth projection has been increased from 0.3% to 0.5% per annum.
- Since the temporary closure of the Eastbourne Hospital obstetric service in May 2013, we have seen activity increases of 372 additional births (projected full year effect on 2012/13 baseline). We expect this to continue with more expectant mothers opting to use BSUH. We forecast a 3% per annum market share shift to BSUH from the HWLH catchment. This is subject to the outcome of the East Sussex consultation on women’s and children’s services.
- Paediatrics is projected to grow by 0.7 – 0.9% per year with highest growth area expected to be general acute care for the catchment in mid-Sussex. Paediatric medicine and surgery is not expected to be subject to the same demand management strategies as those for adult services and thus is projected to grow faster with a higher margin.

- We expect that with the development of tertiary interests in specialised services in respiratory medicine, cystic fibrosis, long term ventilation, diabetes and endocrinology, gastroenterology and nutrition, paediatric surgery, paediatric trauma and orthopaedics, paediatric market share across Sussex (excluding Brighton and Hove) will increase by 1.5% per annum which is half the observed growth rate from the last two years.

High-level aspirations

3.5.11 Our vision is for BSUH to provide high quality general acute maternity and paediatric services to the population of Brighton and mid-Sussex and a wide range of extended acute / tertiary maternity and paediatric services to the population of Sussex.

3.5.12 Our core principles for the next three to five years are to:

- Further establish the Royal Alexandra Children’s Hospital as the leading children’s hospital in the Kent, Surrey and Sussex region, providing a range of specialised services independently and in collaboration with other specialised service providers;
- Establish the obstetric service as a tertiary service in line with the tertiary neonatal unit (fetal medicine);
- Develop innovative, efficient and sustainable local and specialised services which respond to the needs and priorities of our commissioners and partners on behalf of the women, children and young people we serve; and,
- Proactively seek the involvement of women, children, young people and their families in everything we do

3.5.13 Specifically, this aspiration means that we will be able to achieve the following in two key areas.

- Quality: safe, high quality care reflected in performance against national standards and compliance with service specifications. Long term goals are top level CNST accreditation, a C-section rate at or below the national mean rate, and MLU/ ambulatory obstetric care/ fetal medicine/ high risk obstetric service
- Experience: NHS friends and family test scores in the upper quartile for comparable units on a sustainable basis.

3.5.14 To achieve this we will need to make further developments to the model of care for both obstetric and paediatric services.

- The services at RSCH will be enhanced by the further development of the full range of obstetric services including a midwife-led unit, second obstetric theatre and neonatal transitional care. This will allow the obstetrics service to provide a

full range of perinatal care to Brighton and mid-Sussex residents. Following the successful development of these changes, BSUH will explore development of a fetal medicine service taking BSUH obstetrics onto a fully tertiary basis. BSUH will promote further development of research and clinical academic interests within the speciality

- The Royal Alexandra Children's Hospital will continue to develop as a tertiary centre for Kent, Surrey and Sussex, building resilience and capacity in tertiary and general acute services. Opportunities to develop community children's nursing will help to manage pressure on the paediatric emergency department and general paediatric medicine.
- Ambulatory obstetrics and gynaecology will be developed at both PRH and RSCH, reducing antenatal attendance pressure on both labour wards

3.5.15 We worked closely with existing maternity patient groups to develop and test our aspirations for the service and the specific planned developments.

Workforce and capacity

3.5.16 Changes that will be required in order to facilitate this strategy include:

- Continuing recruitment of midwives to maintain a 1:30 delivery ratio
- Development of 60-hour consultant presence for obstetrics at the PRH site which will require a further 8 PAs. The Trust is aware that national guidance regarding consultant presence on the labour ward may develop to require further (98 hour) or continual (168 hour) consultant presence which will be extremely challenging to deliver.
- An increase in the level of cover to paediatric general and critical care wards in order to facilitate increasing sub-specialisation and capacity for growth
- Increased use of specialised nursing roles in paediatrics to maintain compliance with specialised commissioning roles and to complement medical sub-specialisation

3.5.17 Within the change of the service from the projected number of births increases from 6000 to 6400 – 6500 and reinforces the requirement for the RSCH service to include a co-located midwifery unit from a capacity as well as a quality and choice perspective. This is a key priority for the Trust emerging from this strategy.

Detail on the strategic initiatives to achieve this is outlined in Appendix A.

3.6 Our vision for support services

- 3.6.1 BSUH has a full range of support services, which for the purposes of this document are all services providing direct care to patients admitted by other services or teams. These include Critical Care, Radiology, Pharmacy, Theatres, Anaesthetics, OT, Physio, SaLT, Dietetics, Microbiology, Pathology.
- 3.6.2 Clinical support services accrue £110m cross-charged income and cost per annum. Early involvement of all the clinical support services in discussions for business cases and delivery of all elements of BSUH Clinical Strategy has been very important. For example, the pharmacy service monitors and controls the Trust drug expenditure – currently £45m per year. There are good examples where early involvement in the patient pathway of the clinical support services which could lead to efficient use of Trust resources and lead to reduced lengths of stay. For example, early involvement of microbiology, radiology, pharmacy, OT in a patient's admission can help ensure that the right tests, medicines, diagnostics are ordered and acted on to help shape the remainder of the patient's stay.
- 3.6.3 Generally support services operate on a cross-charged basis for service line reporting purposes, meaning that there is a lack of reliable data regarding their efficiency however, many of the clinical support services do contribute to national datasets; and the patient experience within these services is reflected in the measures attributed to front-line specialties and wards. However, the sense within BSUH is of a highly capable workforce who have contributed to the development of national professional standards and with a strong track record of delivering against internal targets and large savings plans. Professional leadership and commitments to training, research and development are seen as specific strengths and utilisation of planned theatre lists is within the top decile nationally at 96.5%. Weaknesses exist around IT systems and infrastructure including aged equipment in many diagnostic services. Theatre and laboratory space is at a premium, driven by the wider constraints on BSUH's estate. Communication to clinical support services has been challenging in the past, with closely aligned services working from different divisions and the organisation's business processes being more closely configured to tariff-earning directly-admitting clinical specialties. Trends and challenges that need to be responded to are:
- The requirement for seven-day inpatient provision which will put a new focus on most of the clinical support services' provision, which in many areas has only been funded to provide inputs on a 5-day basis in the past, or with on-call availability at the weekend and varied across site
 - The drive towards rapid access to therapies and diagnostic provision for patients presenting at hospital as emergencies, in order to increase the volume of patients who can be cared for on an ambulatory basis or with a very short stay in hospital (e.g. the frailty unit/pathway initiative referenced in the unscheduled care strategy)

- Technological developments in pharmacy, pathology and diagnostic imaging leading to increasing requirements for complex and expensive equipment and increased sub-specialisation of staff
- Pressure for increasing efficiency, and a lack of capital resource, leading to further requirements to improve theatre and anaesthetic time utilization instead of developing new facilities
- The drive for integration between services supporting patients with complex needs, which could challenge the current system configuration of separate support services in acute, community, mental health and social care sectors.

Outlook for service demand

3.6.4 Looking forward, we see that demand for support services will track demand in directly admitting clinical services in the following areas:

- Demographic-driven growth will impact primarily in unscheduled care provision, where rates of underlying growth (before demand management) are up to 2.5% per annum. However, this is also the area of provision most likely to require more intensive inputs as a result of the shift to 7-day working and many demand management initiatives will require intensive demand management input, where the basis of the change in service model is to perform traditionally inpatient diagnostics in an outpatient or short stay setting
- Lower growth in elective services, as a result of both demographic trends (with a younger age profile) and expected continuing constraints in demand management. Where support services are aligned with competed elective provision, tenders and prime provider contracts can affect the outpatient provision base which uses the same workforce and provides direct income support to inpatient provision. However taking a prime provider approach can provide an opportunity for some services to develop a greater base of services in direct access/planned ambulatory care. This cannot be quantified at the current time.
- We do anticipate that shorter length of stay in acute care will for most clinical support services increase their volume of work. For example, shorter/ ambulatory-based contacts with patients will require intensive provision of therapy and diagnostic care.

3.6.5 In summary, the expectation for support services is that demand growth will track the aggregate growth across all other services.

High-level aspirations and core principles

- 3.6.6 In order to address these challenges our aspirations for the next five years are to:
- Put support services at the forefront of what we do and our approach to improving quality and operational efficiency
 - Develop strong 7-day based services where clinically appropriate, maximizing the benefits for patient flow and site capacity as well as an improvement in quality outcomes
 - Find opportunities to improve the scope and efficiency of clinical support services by working closely with services in other agencies, using the model of the Pathology Hub scheme being developed jointly with Surrey and Sussex Healthcare NHS Trust.

3.6.7 Across BSUH as a whole, a strategy for each of the clinical support services to take on wider roles (e.g. increased non-medical prescribing to improve safety and free up junior doctor time) should be planned. Clinical support services areas in this review have strong leadership and highly skilled staff who contribute significantly to the safe care of patients in BSUH. For example, the pharmacy service aims to reconcile all medicines for admitted patients within 24 hours of their admission, thus ensuring the right medicines are prescribed for patients early in their admission. The critical care outreach team are part of the rapid response service for deteriorating patients and can help to prevent admission to critical care where possible or to facilitate admission to critical care.

Detail on the strategic initiatives to achieve this is outlined in Appendix A.

4. Our strategy across our main hospital sites

4.1 BSUH operates a unified model of care across multiple sites. This allows us to offer services to a greater population catchment, and to organise our service provision in a way that both meets patient needs and benefit from economies of scale. It is our ambition and strategy to ensure that our sites support each other in delivering high quality, financially sustainable care to our patients.

The Royal Sussex County Hospital (RSCH)

4.2 The RSCH campus is situated near the seafront in Kemptown, East Brighton. The nature of the site reflects the progressive aggregation of services since the construction of the original Barry Building in 1828. The site is now surrounded by residential development on all four sides. Access by car is acceptable but parking is tightly constrained. Public transport access is via bus.

4.3 Significant infrastructure investment has been made in the RSCH campus including the Royal Alexandra Children's Hospital development, cardiac theatres, catheterisation laboratories, radiotherapy equipment, CT and MRI. This means that a number of services have to be provided wholly or partly on the RSCH site, which in turn creates a number of further co-dependencies with other specialties.

4.4 **The RSCH will maintain the majority of its current service provision as a consequence of the above strategic initiatives and further develop its focus as a Major Emergency Centre and a specialist services centre.** RSCH will continue to operate a mixture of local acute services for the Brighton and Hove population, and specialist services for a Sussex-wide population including the operation of a major trauma centre, with the major addition being co-located neurosurgery to support the provision of neurosurgical input to Major Trauma. Services planned to move away from the RSCH site will be elective inpatient urology and ENT, and the fractured neck of femur pathway. It is our aim for RSCH to meet the requirements for a Major Emergency Centre as per the Keogh review of emergency services.

4.5 This will mean that the RSCH remains an extremely busy site, especially as achieving the full specification for MTC compliance will drive increased volumes of very complex patients. However, we believe that the impact of the above moves, length of stay improvements and the Better Care Fund and related work moving into the community, will be that occupancy at the RSCH site reduces by 2% over the life of the strategy, even allowing for growth as a result of demographic and prevalence changes, and anticipated moves of services onto the RSCH site in order to meet service specifications. [In the table we need to be able to describe how we manage in 14/15 specifically.]

Driver affecting bed base numbers	Number of RSCH beds (ex. Maternity & Paediatrics)					
	2014/15	15/16	16/17	17/18	18/19	
• Total beds at start of year (current occupancy ¹)	526	553	517	515	511	
• Demand management	(13)	-				
• Better Care Fund	-	(52)				
• Service developments	Site reconfiguration	2	7			
	Growth of services	9	14	2	-	-
• Natural demand growth	11	11	11	11	11	
• Clinical strategies	Length of stay improvement	(19)	(21)	(15)	(15)	(15)
	Growth of services	10	5	-	-	-
• Sub-total: requirement at current occupancy ¹	526	517	515	511	507	
• One-off addition to achieve 90% occupancy	27	-	-	-	-	
• Total bed requirement for year	553	517	515	511	507	
• Net change in beds	27 ↑	(36) ↓	(2)	(4)	(4)	

BCF provides capacity to accommodate service growth through service developments and clinical strategies

4.6 Key to successfully achieving the vision for the RSCH will be:

- Reduced length of stay in all inpatient areas with specific reductions in key areas such as emergency surgery, vascular surgery and elderly medicine
- The delivery of a new model of care for frail older patients, with care co-ordination outside hospital leading to greater redirection away from acute services, and timely senior assessment prior to a decision to admit for those who attend the RSCH
- Tertiary specialties managing a higher caseload of specialist patients in the RSCH bed base, but supporting other providers to manage a wider casemix of patients
- The implementation of comprehensive 7-day working at RSCH
- These shifts delivering a relative re-focussing of the bed base at RSCH, away from general acute care and towards more specialist care. Where general acute patients are admitted, their length of stay will be shorter.

4.7 The below table illustrates the overall movements across the RSCH campus by speciality over the life of the strategy.

Specialty	Critical Care (L2/3)	Ward	All															
A&E	0	7	7	0	7	7	0	5	5	0	5	5	0	5	5	0	5	5
Cardiac Surgery	10	15	25	11	15	26	13	17	30	14	18	32	14	18	31	14	17	31
Cardiology	2	38	40	2	38	41	2	38	40	2	37	39	2	36	39	2	35	38
Critical Care Medicine	8	3	10	9	3	11	9	3	11	9	2	11	9	2	11	9	2	11
Digestive Diseases (Medical)	1	21	22	1	21	22	1	17	19	1	17	18	1	16	18	1	16	17
Digestive Diseases (Surgical)	6	62	68	7	64	71	7	55	62	7	54	61	7	53	60	7	51	59
Gynaecology	0	6	6	0	6	6	0	6	6	0	6	6	0	6	6	0	6	6
Haematology	0	8	8	0	11	11	0	13	13	0	15	16	0	18	18	0	20	20
HIV / Infectious Diseases	1	12	12	1	12	13	1	11	11	1	11	11	1	11	12	1	11	12
Medicine for the Elderly	1	135	136	1	135	136	1	119	121	1	118	119	1	116	117	1	114	115
Medicine Group	3	61	64	3	61	64	3	51	54	3	49	53	3	48	52	3	47	51
Oncology	0	11	11	0	11	11	0	11	11	0	10	11	0	10	10	0	10	10
Renal Medicine	1	25	26	1	25	26	2	25	26	2	25	27	2	26	27	2	26	28
Surgery Group	4	48	53	4	39	42	5	42	47	5	42	46	5	41	46	5	40	45
Trauma & Orthopaedics	1	34	35	1	34	35	1	34	35	1	34	35	1	34	35	1	34	35
Neurosurgery	0	0	0	11	16	27	11	16	27	11	16	27	11	16	27	11	16	27
SEH	0	3	3	0	3	3	0	3	3	0	3	3	0	3	3	0	3	3
Grand Total	38	485	523	42	481	523	46	447	492	47	443	490	47	439	486	48	435	483
Obstetrics / Midwife / Neonatology	29	40	69	32	40	71	35	40	76	36	39	76	37	39	75	37	38	74
RAH Medical	6.5	21.1	28	7.8	23.0	31	8.6	25.3	34	9.5	27.4	37	10.4	29.5	40	11.4	31.5	43
RAH Surgical	2.5	10.9	13	2.9	11.7	15	3.0	11.7	15	3.1	11.7	15	3.2	11.6	15	3.2	11.4	15

4.8 It is key therefore to note that the successful achievement of demand management in non-elective and particularly medical specialties is critical to sustainable safety and quality in service provision on the RSCH site.

The Princess Royal Hospital (PRH) and Hurstwood Park (HWP)

4.9 The PRH will also retain the majority of its service provision, and continue to develop its dual focus on care of the elderly and elective work. PRH will retain its core provision of medically-led A&E services that meet the Keogh review definition of an centre, (but not a major emergency centre) Emergency Centre, and an acute medical inpatient bed base. The fractured neck of femur pathway will relocate to the PRH site.

4.10 One significant area for further discussion will be the location of stroke care as a consequence of the co-dependencies of a hyper-acute stroke model with interventional radiology and vascular surgery. The consolidation of elective care to PRH will continue with ENT and Urology.

4.11 The key issue for PRH is the impact of its new medical model, improved frailty care and the Better Care Fund, on its bed base. It is projected that the PRH bed requirement reduces from the current 312, accommodated at 85% occupancy, to 240. This is based on

- reduced presentations at the PRH site via demand management in the community,
- the continuing use of the Rapid Access Medical Unit model to treat patients presenting at PRH on an ambulatory basis where an acute admission is not required
- reduced length of stay for admitted patients via more regular senior medical and therapies input

Driver affecting bed base numbers	Number of PRH beds (ex. Maternity & Paediatrics)				
	2014/15	15/16	16/17	17/18	18/19
• Total beds at start of year (current occupancy ¹)	312	302	263	258	253
• Demand management	(6)	-	-	-	-
• Better Care Fund	-	(23)	-	-	-
• Service developments					
{ Site reconfiguration	(5)	(8)	-	-	-
{ Growth of services	-	-	-	-	-
• Natural demand growth	4	4	4	4	4
• Clinical strategies					
{ Length of stay improvement	(13)	(14)	(9)	(9)	(8)
{ Growth of services	-	2	-	-	-
• Sub-total: requirement at current occupancy ¹	292	263	258	253	249
• One-off addition to achieve 90% occupancy	10	-	-	-	-
• Total bed requirement for year	302	263	258	253	249
• Net change in beds	(10) †	(39)	(5)	(5)	(4)

4.12 This change provides further opportunities for the PRH to:

- Extend its rehabilitation care offering to patients from across the BSUH catchment, providing step-down facilities to patients on other pathways. The quality benefits of this option must always be weighed carefully against the impact of conveying patients between sites and further from their home location
- With other providers, develop specialist rehabilitation services accommodating other patients
- Accommodate other community services, in discussion with Horsham and mid-Sussex Clinical Commissioning Group and in line with their infrastructure strategy
- Develop excellence in a specific pathway, to provide that service to patients from across BSUH's catchment area

4.13 The remaining inpatient service at Hurstwood Park – inpatient neurosurgery – will move to the Royal Sussex County Hospital. A number of opportunities exist to make use of the HWP estate including daycase beds and the provision of satellite haematology-oncology which will be considered as part of the Trusts' estate strategy, to be updated to reflect this work.

Other sites

4.14 BSUH will continue to run outpatient and ambulatory care services from a number of other sites including Hove Polyclinic, Brighton General Hospital and Lewes Victoria Hospital.

4.15 RSCH-based services not requiring advanced diagnostic and inpatient facilities will increasingly look to use other estates. This will mean:

- More outpatient and ambulatory care taking place in community-based locations including community hospitals and other acute hospital sites, particularly where as part of our increased engagement with commissioners on planned care pathways, there is a request from commissioners to bring clinics physically closer to patients.
- As surgical procedures progressively move from inpatient to daycase-based, greater use of theatre facilities where available on these sites for daycase work

This reflects our vision for BSUH, and particularly the RSCH, as a hub for a network of care rather than a standalone multi-speciality tertiary centre.

3Ts

4.16 The site strategy set out above re-affirms the strategic requirement for redevelopment of the RSCH site, primarily to provide high quality estate for services provided in Brighton and Hove, but also for the extension of tertiary provision. This strategic requirement is at the heart of the 3Ts business case. In particular, the capacity modelling associated with the clinical strategy exercise has reaffirmed that the overall bed capacity identified for the first phase of 3Ts is appropriate to the level of bed requirement projected for the RSCH site at the end of the strategy period.

4.17 It is also of note that NHS England specialist commissioning strategy may place further demands on the 3Ts infrastructure, if the Trust is successful in securing hub/prime contractor status for its key tertiary services.

4.18 The 3Ts case has been in development since 2007. Since this time, clinical requirements and ways of working have changed. The strategy process has identified a number of potential refinements to the 3Ts case to be considered in the development of the Full Business Case for submission in late 2014. These are:

- The prospect for inclusion of services housed in outlying buildings, currently including Ophthalmology located in the Sussex Eye Hospital;
- Accommodating further tertiary, Sussex-wide or larger catchment services which could include hosting third-party services which require access to BSUH's clinical infrastructure
- Re-examining the configuration of outpatient facilities within the building and particularly the option of providing a general use outpatient space

5. Links with our academic partners

5.1 BSUH prospers from its links with Brighton and Sussex Medical School, the University of Sussex, the University of Brighton and Health Education England.

5.2 Developing and strengthening these links is critical to the future success of the organisation. However, it is important that this is done in a way that reflects the strategic context for its clinical academic relationships:

- A historically low base of research activity. Despite growth from £3.4m since the opening of the Trusts' Clinical Investigation and Research Unit, projected research income sits at £6.4m in 2013/14, only 1.2% of total Trust income. This compares with a typical benchmark level for a medical school of 5%
- The proximity of London which acts as a 'centrifugal force' for postgraduate medical training and research, affecting the scale at which clinical academic departments, research activities and training rotations operate in Sussex

5.3 Therefore it is critical that BSUH and its academic partners take a selective and targeted approach to developing clinical academic links. The key aspects of this approach are set out below.

Research & Development

5.4 Key priorities will be aligned with existing strong service provision and research interests, specifically in cardiology, oncology, paediatrics, renal, HIV and neurology where the development of an improved model will be taken forward alongside BSMS.

5.5 Mirroring tertiary service provision developments, BSUH and BSMS will work together to develop a hub and spoke system of patient identification and enrolment for trials that supports patients treated by other providers being enrolled in Brighton-led trials, particularly where the treating consultant has a substantive or honorary post with BSUH or BSMS (the 'Patient Identification Centre' concept).

5.6 BSUH and BSMS will apply to NIHR for Clinical Trials Unit status in 2015, which will provide additional support for home grown research. A little more on this in terms of how this secures our place in research terms.

5.7 Taken together with the other elements of this strategy, this will drive 10% growth in commercial income and 25% growth in non-commercial income, taking aggregate research income to a projected £8.6m in 2018/19

Clinical academic appointments

5.8 BSUH and BSMS will establish a mechanism to plan and assess proposals for clinical academic appointments on a 'business case' basis, reflecting that

- Appointments need to be made with a clear case in terms of expanding research, meeting a commissioner requirement (whether education commissioner or service commissioner) or otherwise making a material contribution to BSMS and BSUH
- Appointments need to be co-ordinated to ensure that the case is deliverable i.e. isolated chair or senior lecturer appointments may not deliver benefits without supporting clinical fellow or academic foundation posts.
- Plans to make clinical appointments will therefore be generally expected to make a net financial contribution to BSUH whether by expanding or consolidating existing service provision, facilitating academic trainee appointments or research income

5.9 Over 10 years, we will aim on this basis to increase clinical academic appointments by 25%.

Teaching

5.10 BSUH is working with its education commissioner, Health Education England Kent Surrey and Sussex (HEE KSS) to develop a new concept of a unified, multi-disciplinary structure for Education and Knowledge. Under this concept the Trust will provide education through a multi-disciplinary framework. Educational activity for all staff will be unified, with opportunities to learn together and make better use of resources.

5.11 BSUH will support the HEE KSS goal of KSS-only specialist trainee rotations where practicable. In tangible terms, this will mean ensuring that service developments that have the opportunity of bringing specialist training wholly 'in house' are designed to include this aspiration where possible. Where not practicable, BSUH will continue to contribute placements to legacy rotation arrangements. The proportion of middle grade positions filled by trainees will increase.

5.12 BSUH will continue to promote simulation-based learning where applicable with a specific aspiration in paediatrics and other initiatives as set out in its Education and Knowledge strategy

5.13 BSUH will support BSMS's aim to remain a top tier medical school for undergraduate teaching and will work with BSMS to develop its strategy for the next five years in support of this goal

6. Workforce implications

6.1 The implication of the clinical strategy modelling undertaken is that BSUH's workforce is expected change in overall size from 6184 WTE staff in post to 5797 WTE as per the table below.

WTE	2013/14	Gross impact of productivity improvements	Staff growth to meet national requirements	Staff growth to meet local requirements	Technical changes	Activity growth to meet new demand	Service developments	2018/19 projections
Consultant	407	(79)	29	3	1	4	22	386
Junior medical	575	(112)	41	5	1	5	31	545
Nursing, midwifery & health visitors	2,141	(418)	152	18	4	38	115	2,050
Other clinical staff	729	(142)	52	6	1	13	39	697
Scientific, therapeutic, & technical	1,073	(209)	152	9	2	19	57	1,103
Non clinical staff	1,259	(246)	0	0	2	0	0	1,016
	6,184	(1,207)	425	42	11	78	264	5,797

6.2 This shows that whilst staff may be displaced as a result of productivity improvements delivered by the strategy, for example reductions in length of stay, as has been shown in the capacity modelling, delivering higher standards, responding to additional demand and new service developments will provide significant opportunities to redeploy staff. And working with our partners particularly around integration of care

6.3 Based on initial analysis of the requirements to deliver 7-day working, it has been assumed that there will be net growth in scientific, therapeutic and technical staff numbers.

6.4 This projection has been developed based on the expected changes to the paybill, based on the strategic initiatives and capacity assumptions developed above as well as an expectation of recurrent cost improvement initiatives over the five year period. It is assumed that

- cost per whole-time equivalent grows in line with expected pay inflation of 1% per year 2015 - 2019
- all workforce growth as a result of implementing the strategy occurs solely in clinical staff categories
- bed reductions affect the size of the clinical workforce, principally in nursing and therapies
- further CIP requirements fall equally across clinical and non-clinical pay categories

7. Enablers of our clinical strategy

Foundations for Success

- 7.1 BSUH's committed, skilled and experienced staff base is the key enabler of this strategy and is the organisation's principle strength.
- 7.2 The Trust has committed to an internal development programme, Foundations for Success, of which clinical strategy is one of four elements. The others are Clinical Structure, Empowerment, Performance and Accountability and Values and Behaviours.
- 7.3 The aim of this strategy is to provide clarity over the strategic direction of BSUH, in a way that can be communicated to staff and provide common purpose for the Trust leadership, thus supporting both Values and Behaviours and Empowerment, Performance and Accountability elements of the work.
- 7.4 However, for the strategy to be successful, the Clinical Structure work will be a key enabler to support delivery of the clinical strategy vision. Key considerations for the Clinical Structure work are:
- A structure that is able to support the required clinical transformation agenda within the organisation, ensuring dedicated resource is available for clinical leadership within and along key pathways of care that can drive innovation, standardisation and improved clinical productivity within these pathways
 - The case for a specific organisational base and identity for clinical support services, which was one of the key requirements identified by the service group workshops in this area

The capability to deliver the more complex commercial relationships and interactions required by the strategy, including the management of networked arrangements of provision in competed elective and Sussex-wide services, the strategic partnerships that will be required with partner providers in networks, and the strategic partnership with Sussex Community Trust for the provision of GUM services. This will include the capability to support clinicians and managers by providing patient and outcome data for all specialties in a way that is simple to access and interpret.

IT

- 7.5 BSUH is implementing an Electronic Patient Record system. Implementation of EPR has significant predicated benefits for clinical efficiency in the period 2014 – 16, which support the delivery of the clinical strategy. The Electronic Patient Record is a key component of the IT required to underpin this strategic vision and will support the transformation of clinical services. Once the EPR system is fully implemented, the scale of the 'data business unit' unit

may reduce as more colleagues can access the data they need independently through the EPR system.

7.6 EPR will support the strategy by:

- Providing improved opportunities to share and link data with community and general practice providers, facilitating provision of linked information leading to more integrated approaches to care
- Improving the availability of clinical data to support service transformation work
- Reducing clinical time spent on administrative tasks, refocusing effort on clinical activities
- Improving the linkages between legacy IT systems
- Contributing to CIPs and transformation

Information

7.7 BSUH is in the process of refreshing its informatics strategy. As part of this work, the emergent requirements for improved management information have been identified.

7.8 The most pressing requirement will be the technology to manage hub and spoke/networked provider arrangements. Specific requirements will be:

- The ability to generate and interpret management information about the size of a particular market, including tariff and non-tariff care, drug expenditure and linked non-acute services including sources of referrals.
- Management of patient flow between primary care, BSUH and other providers including via complex pathways involving multiple handoffs between BSUH and other providers

7.9 The requirement for further stretching clinical transformation with Brighton and Sussex University Hospitals will require the provision of enhanced operational benchmarking and costing information, for example patient-level costing systems that facilitate the analysis of the costs of service provision for specific patients, building on our current service-line reporting system.

8. Financial forecast

Summary

8.1 The Trust has forecast a c. £20m per year income and expenditure challenge for the following five years as highlighted in Chapter 1 of this document.

8.2 The forecast for the impact of the clinical strategy on this can be characterised in two areas:

- The impact of the model of care described in the sections above. In summary, the impact of these initiatives is to
 - significantly improve the quality and scope of service provision within BSUH
 - improve the operational capacity to deliver services
 - identify and mitigate known cost pressures from rising service standards such as the Better Care Fund and 7-day working and Keogh with a net contribution to meeting the future challenge
- Further opportunities identified for internal clinical transformation of services, the details of which has not yet been rigorously debated by clinical and operational leadership of BSUH as it was outside the scope of this strategy, but which set the agenda for future changes to BSUH models of service delivery

Income forecast

8.3 Income is forecast to change in each of the service groups as follows. This includes the Better Care Fund and the impact of demand management:

	Income				
	2014/15	15/16	16/17	17/18	18/19
Unscheduled care	-918	-8,509	1,131	1,147	1,163
Competed Elective	851	-1,185	745	754	762
Sussex wide and neuro	1,843	1,966	2,641	2,695	2,795
Cancer	3,156	1,125	1,165	1,206	1,249
Obs and Paeds	1,059	3,124	2,162	1,766	1,809
Support services	-591	383	387	392	397
TOTAL	5,400	-3,096	8,233	7,960	8,174

Expenditure forecast

8.4 Expenditure is forecast to change in each of the service groups as follows:

	Expenditure				
	2014/15	15/16	16/17	17/18	18/19
Unscheduled care	-49	-5,512	1,183	860	872
Competed Elective	1,065	-675	559	565	572
Sussex wide and neuro	442	2,007	1,984	2,057	2,096
Cancer	2,208	844	874	905	936
Obs and Paeds	1,823	1,762	1,953	302	305
Support services	-323	287	291	294	298
TOTAL	5,167	-1,287	6,843	4,984	5,079

8.5 A further estimated £3.6m is saved through bed reductions from improved Length of Stay across the clinical strategy. These reductions are primarily achieved at the Princess Royal Hospital site.

Investment requirements

8.6 The Trust has identified capital expenditure requirements of £XX over the following five years. Specific requirements within this sum to deliver the clinical strategy are as per the table below:

[TBC]

9. Implementing and further developing the strategy

Proposed phasing of the clinical strategy

9.1 BSUH recognises that the relative prioritisation of its clinical strategy initiatives has a number of interdependencies including:

- The availability of physical capacity to deliver more networked models of care and increased inpatient bed requirements, particularly on the RSCH site
- The requirement to maintain financial delivery including I&E surpluses needing investment in service delivery to be phased
- Priorities of commissioners and alignment with other providers arising from the forthcoming five-year plan development exercise in summer 2014.

9.2 The proposed phasing of the clinical strategy initiatives is therefore as follows for the current time, but subject to further development and refinement:

Strategic grouping	Clinical Strategy initiatives beginning in year		
	2014/15	2015/16	2016/17+
1 Unscheduled care	<ul style="list-style-type: none"> • Development of frailty pathway • Fractured NOF service consolidation at PRH • Requirements for royal college compliant 7/7 working • PRH acute medical model 	<ul style="list-style-type: none"> • Stroke service consolidation at RSCH 	<ul style="list-style-type: none"> • -
2 Competed Elective	<ul style="list-style-type: none"> • Lithotripsy expansion • Dermatology day surgery and MOHs • Move routine ENT surgery to PRH & repatriate major H&N to RSCH 	<ul style="list-style-type: none"> • Centralise urology at PRH • Develop ophthalmology services • Physio rehab services • Surgical assessment unit 	<ul style="list-style-type: none"> • -
3 Sussex wide	<ul style="list-style-type: none"> • Re-establish vascular clinical network 	<ul style="list-style-type: none"> • Renal networked care 	<ul style="list-style-type: none"> • -
4 Support Services	<ul style="list-style-type: none"> • Developing advanced practice roles 	<ul style="list-style-type: none"> • - 	<ul style="list-style-type: none"> • -
5 Cancer	<ul style="list-style-type: none"> • Satellite Haematology-Oncology at PRH • Development of Family History service in line with NICE guidelines • Plan A – repatriate activity and income from other Sussex Trusts 	<ul style="list-style-type: none"> • - 	<ul style="list-style-type: none"> • -
6 Obstetrics	<ul style="list-style-type: none"> • New transitional obstetric and neonatal care unit • Birthing centre and Sussex Women's Health Centre 	<ul style="list-style-type: none"> • High risk tertiary obstetrics 	<ul style="list-style-type: none"> • Regional simulation centre (18/19) • Fetal medicine (18/19)
7 Paediatrics	<ul style="list-style-type: none"> • Specialised service derogation compliance • Paediatric Trauma and Orthopaedic service development 	<ul style="list-style-type: none"> • - 	<ul style="list-style-type: none"> • Expand general paed. & critical care (16/17)
8 Neurosciences	<ul style="list-style-type: none"> • Productivity improvements (as part of 2014/15 CIP) • Neurosurgery repatriation • KSS Neurology strategy 	<ul style="list-style-type: none"> • - 	<ul style="list-style-type: none"> • -
9 Trust-wide	<ul style="list-style-type: none"> • Length of stay reduction plan • 90% occupancy rate at both sites 	<ul style="list-style-type: none"> • - 	<ul style="list-style-type: none"> • -

Implementing and further developing the strategy

Aligning with external partners

9.3 BSUH recognises that this clinical strategy represents the continuation of a process of dialogue. To date, whilst this dialogue has included commissioners, it has principally focussed on BSUH's internal clinical community.

- 9.4 BSUH is part of the Sussex unit of planning for the process of converging 5-year commissioner and provider plans by 20th June 2014.
- 9.5 The process for this is understood to be that CCGs will develop individual plans and these will be brought together to develop an overarching Sussex vision. A series of system-wide interventions will be developed along with their benefits/impacts. The impact on providers will be assessed and providers will be engaged to ensure alignment between commissioner and provider plans
- 9.6 BSUH has developed its clinical strategy on the basis that this will form a strong basis for its engagement with the five-year planning process outlined above. BSUH therefore continues to expect its clinical strategy to be refined during liaison with the CCGs.
- 9.7 Governance will be commissioner-led by the CCGs and Surrey and Sussex Area Team. BSUH continues to expect that the 3Ts Oversight Forum will be the vehicle for discussing and agreeing required changes to BSUH's strategic plans. The 3Ts Commissioner Oversight Forum includes BSUH, its three principal CCG commissioners and senior staff from the Area Team and has an established agenda based on ensuring that financial assumptions are aligned in commissioner plans, the 3Ts business case and BSUH's IBP.
- 9.8 In addition to the current Urgent Care Boards and joint work with commissioners on frailty care, linked to the Better Care Fund, BSUH will develop and report to the clinical transformation board, a programme of speciality-level work groups jointly instituted with commissioners, focussing on general acute planned care pathways and jointly agreeing efficiency opportunities on the basis of maintaining and where possible improving BSUH's net contribution from these services.

Internal clinical transformation

- 9.9 It is recognised that in order to develop the potential clinical transformation opportunities highlighted above, BSUH will need to in parallel significantly improve its operational efficiency. The requirement to achieve 7% CIP next year and 4-5% CIP annually in the following years is achievable but not easy. To achieve this level of operational improvement, BSUH will need to **develop an internal clinical transformation mechanism**, using the new clinical structure, that allows for focussed, data-driven change in clinical productivity and methods of delivering care. This group will also need to ensure that the significant clinical quality benefits envisaged within each section of the strategy, are managed and delivered alongside the financial and operational benefits.

9.10 This mechanism will support the further development of the strategy and **consideration of further options for changes to methods of delivering care in order to improve clinical and financial sustainability**, including opportunities for:

- further Sussex-wide partnerships, especially where there may be service changes due to reconfiguration. This could include opportunities not to provide some services which could be provided by neighbouring organisations or to provide them through partnership and network models
- further service moves within BSUH
- reducing length of stay further, through standardizing and innovating clinical pathways. It should be noted that the strategy already makes challenging assumptions about the length of stay improvements that can be delivered on the basis of the identified models of care and strategic initiatives
- far reaching staff productivity improvements
- improving fixed asset utilization further, including theatres and outpatient areas. This strategy assumes no growth in physical theatre capacity through the life of the strategy, meaning that growth will be delivered through increased efficiency, longer working days and 7-day weeks for planned activity
- reducing the cost of both clinical and non-clinical supplies, while preserving quality
- increasing R&D income and margin beyond the levels set out above

9.11 Our ongoing strategy development process will continue to closely involve both patients and staff. Their support for any changes that BSUH undertakes is critical to our continued success.

Conclusion

9.12 This strategy sets out how we can address some of the key challenges we face in terms of clinical and operational sustainability. This requires ongoing transformation across our services, a continuing contribution from our staff and positive working relationships with our partners.

9.13 However it is not a strategy that the Trust can deliver on its own. BSUH is part of a health economy and our strategy must be part of a broader effort to deliver high quality care to our communities. Our success is dependent on the success of our partners. A core part of what we do over the next five years will be to work closely with commissioners and other providers to ensure a sustainable future for the NHS across Kent, Surrey and Sussex.

Appendices

A – service initiatives

Unscheduled care

Initiative: Stroke service consolidation

- Goal: improved stroke service by consolidating to a single site
- Measure of success: provision of a single site TIA service and achievement of best practice tariff; sustainable achievement of all stroke performance targets; consistency in LOS for stroke patients (currently variation between RSCH and PRH)
- Key actions required:
 - Agree service and medical model and estate plan
 - Development of pre-consultation business case
 - CCG, HOSC and wider public engagement

Initiative: Fractured neck of femur service consolidation

- Measure of success: reduced length of stay for fractured neck of femur care
- Key actions required
 - Agree model of care including patient selection criteria with ambulance service
 - Agree consultation requirements with CCGs
 - CCG, HOSC and wider public engagement

Initiative: Frailty pathway development

- Measure of success: reduced admissions for cohort of patients; increased proportion of 0-1 day LOS admissions; reduced LOS for geriatric medicine patients
- Key actions required
 - Agree model of care with partners including CCGs and community providers
 - Recruit to key medical and nursing positions

Initiative: PRH medical model

- Measure of success: NHS 7-day standard compliance for all inpatient admissions at PRH; reduced length of stay for acute/GIM admitted patients

Competed elective

Initiative: development of ophthalmology services

- Goal: secure modern, fit for purpose and productive ophthalmic outpatient services at the Sussex Eye Hospital, and develop a satellite clinic and operative capacity at Southlands Hospital from 2015 onwards to maintain market share
- Measure of success: achievement of speciality-level CIP requirements through streamlining of outpatients; maintenance of market share for first output referrals in east Brighton catchment

Initiative: Increased scope and market share for dermatology services

- Goal: to create Mohs service at BSUH and to increase capacity for skin cancer related work, which is the key area of referral growth within dermatology
- Measure of success: achieving improvement in net contribution as per business cases

Initiative: movement of routine ENT/Max Fax surgical services to PRH

- Goal: increases capacity for major head and neck cases at RSCH and repatriates work currently being sent to external providers.
- Measure of success: increased income repatriation; recovery of major head and neck length of stay to acceptable levels as per speciality society audit measures
- Key actions required: space requirements to be confirmed by the site reconfiguration programme board

Initiative: development of pelvic cancer centre and centralisation of urological services

- Goal: create single Sussex-wide urological cancer centre at PRH to include all radical prostatectomies and cystectomies and maximize lithotripter utilization by East Sussex; centralize all IP surgery at PRH
- Bidding process underway for cancers led by division of surgery and urology service manager

Initiative: development of nurse-led or AHP-led clinics and one-stop models

- Goal: reduce demand in consultant clinics, mitigating the requirement for additional consultant appointments or facilitating redeployment of

resource; deliver real-terms cost reductions and pathway efficiencies to CCGs that achieve system QIPP goals whilst mitigating the risk of tendering exercises proceeding on a prime provider basis

- Measure of success: achievement of speciality-level CIP requirements; gain-share saving returned to CCGs where appropriate
- Key actions required: establishment of speciality-level bilateral dialogue with commissioners to map pathways and agree required changes

Initiative: development of peripheral clinics

- Goal: secure increased income and activity from offering close-to-patient first OP services in high volume specialties. ENT, Dermatology and Rheumatology provisionally identified
- Measure of success: increased volumes of referrals from target practices
- Key actions required:
- establish commissioner acceptance/requirement for improved access in peripheral areas. These have been identified from early discussions as being East Grinstead and Uckfield/Heathfield

Initiative: development of ambulatory care centre/models and development of central infusion service

- Goal: facilitate the use of offsite estate to provide more care in an appropriate setting and as outpatient or outpatient procedure, reducing emergency attendances, use of ward space, and inpatient stays. The model of care is confirmed for gynaecology and a business case is in progression but requires detailed development for other areas which could include venesection, ascitic taps and transfusions. The infusion service would run on a split site basis with a single managed service providing high acuity infusions on the RSCH site and low acuity infusions offsite.

Initiative: laparoscopic surgery development

- TBD

Sussex-wide services

Initiative: GUM strategic partnership with Sussex Community Trust

- Goal: maintain and improve the current genito-urinary medicine service, in the context of commissioner pressures, by a strategic partnership with Sussex Community Trust. This would maximise the benefits of aligning two existing strongly

performing services, and build a service model capable of competing to widen its service footprint in the future

- Measure of success: secure the future of GUM and sexual health services with BSUH/SCT for Brighton and Hove
- Key actions required

Agreement of Heads of Terms with SCT

Development of estate and clinical model for service

Prepare for service tender in 2015/16

Initiative: Renal care pathway integration and outreach

Development of a model of primary, secondary and tertiary renal care for Sussex by 2018/19 that:

- Manages effectively the rapid rise in demand for renal services and the future impact of current under-intervention in chronic renal disease
- Provides appropriate specialist clinical support to renal disease managed in other Sussex hospitals on an inreach model with outpatient dialysis facilities
- Reduces length of stay in the Sussex Kidney Unit at RSCH to clinically appropriate levels, securing repatriation of patients with complex general medical needs, to appropriate local hospitals
- Facilitates repatriation of patients currently going to London because of excess demand for highly acute services in Sussex

Measure of success:

- Market share for Sussex renal services, across Sussex providers, increases to cover all patients except transplantations
- Renal replacement therapy rates for Sussex rise to national median
- Increase in clinical trials enrolment

Key actions required

- Agreement of clinical pathway with all commissioners
- Cross-Sussex renal clinical leads discussion to agree response to clinical model including optimal patient flows and repatriation agreements

Initiative: re-establishment of the vascular Operational Delivery Network

Goal: introduce effective shared care between tertiary and secondary centres for vascular patients, improving local access for patients and reducing inappropriate bed utilization on the RSCH site

Measure of success: Vascular length of stay returning to specified clinically appropriate levels, typically 48 hours post-operative

Key actions: to secure agreement with spoke hospitals and agree provider wide clinical protocols to ensure the right procedures are delivered in the right place

Initiative: Relocation of neurosurgical services to the RSCH site

Goal: establish co-located neurosurgery to support major trauma centre status, supporting current service aspirations and maximizing improved co-location of services to support further developments in subarachnoid haemorrhage care.

Key actions are underway to confirm and finalise the model for this development, which is expected to be undertaken in August 2014.

Initiative: Develop a networked Sussex Neurology service

Goal: allow strategic planning for appointments and specialist tertiary clinics in neurology, facilitating repatriation of work from London and other adjacent areas taking Sussex patients. A strong networked Sussex neurology service could develop into surrounding areas outside Sussex, generating a more sustainable catchment for both neurology and neurosurgery ahead of the 3Ts development. Significant opportunities exist in expanding the patient base for clinical resource in a trial-heavy clinical speciality

Benefits: the development of planned specialist tertiary neurology services will repatriate patients and ensure improved quality and equality and standardisation in medical, nursing and AHP care

Key actions

- Establish benefits case with service and academic leads
- Facilitate Sussex-wide neurology leads dialogue, with provider CEO support, to generate options for model
- Agree with provider CEOs and commissioners, model to pursue

Cancer

Initiative: Satellite radiotherapy

- The goal of this initiative is to deliver outlying satellite radiotherapy units in east and west Sussex

- The success of the initiative will be measured by reduced travel times for Sussex radiotherapy patients and increased take-up of active treatment, which is currently limited in some cases by patients' ability to travel on a daily basis to Brighton
- In terms of key actions, business cases for both developments are being progressed. A decision is still required as to location of the unit in west Sussex
- This is being led by the division of specialised services
- Expected financial impact is cost neutral due to the high cost of capital associated with the developments

Initiative: Rebuilding academic oncology

- The goal of this initiative is to ensure that the oncology unit continues to develop academically. This is fundamental to continuous improvement of quality, innovation, reputation and recruitment of highly skilled staff
- Success will be measured by the appointment of a new Chair and two senior lecturer positions; by the subsequent retention of the post-holders; the achievement of new organizational metrics for the success of academic positions; and securing an overall net financial contribution to service provision as a result of clinical trials income

Obstetrics and paediatrics

Initiative: relocation and redesign of antenatal care

- Goal: create a standalone ambulatory women's health service with gynaecology, antenatal and postnatal care. This will improve capacity in both these services and also create physical capacity for the co-located midwife led unit
- Measure of success: creation of the MLU at the BSUH site with reduced C-section rate.
- Key actions required: confirmation of prospective location and signoff of business case; estates enablement work

Initiative: Midwife-led units

- Goal: create a co-located midwife-led unit on the RSCH site, introducing additional capacity and choice of place of birth for the BSUH catchment
- Measure of success: overall unit obstetric intervention rates at peer norm; introduction of further choice of place of birth without any increase in obstetric complications
- Key actions required: achieve space at RSCH site by delivering Sussex Women's Health Centre initiative

Initiative: High risk and tertiary obstetrics

- Goal: develop the capacity and ability to manage the full range of obstetric events, principally with the development of a second dedicated obstetric theatre and supporting rotas

Initiative: fetal medicine

- Goal: develop a fetal medicine service at BSUH. This development requires the successful achievement of improvements in capacity, maternal choice and experience as laid out above. Following the achievement of these developments, a fetal medicine model could be developed. This potential development would be at the end of the current strategy cycle and thus has not been worked up in detail at the current time.

Initiative: transitional obstetric and neonatal care:

- Goal: develop supported care for newborn babies and mothers with low levels of increased needs within existing postnatal capacity to provide care to newborn infants alongside their mother
- Measure of success: lower level of SCBU admissions and shorter length of stay with increased rates of breast feeding

Initiative: development of paediatric medicine and critical care capacity

- Goal: move paediatric staffing to a sustainable model, achieving national standards and permitting further development and expansion of specialised services without requirements for additional specialist paediatricians
- Measure of success: delivery of 18 week obligations for paediatric specialised services even with high levels of growth, without the use of extra capacity; delivery of projected service growth; delivery of high quality training and education; delivery of high quality clinical care with optimal length of stay and reduced hospital admissions

Initiative: Paediatric Trauma and Orthopaedics

- Goal: develop a fully-fledged paediatric T&O service with two consultants, repatriating all paediatric T&O care and advancing Sussex-wide market share for paediatric T&O We could explore the development of satellite operating centres in Sussex, Surrey and Kent
- Measure of success: increased market share

Support services

Initiative: 7-day working

- The Trust has undertaken a baseline analysis of its compliance with the ten NHS England 7-day working standards
- Critical requirements for delivering the standards have been identified in the provision of therapies staff for support of inpatients at the weekends; and in the use of appropriate diagnostic testing at the weekend, which whilst currently provided is typically under-utilised

Initiative: early pathway involvement

- Goal: to improve the impact of support services by bringing forward first contact with the patient; shortening length of stay, reducing errors and positively influencing the care plan
- Measure of success: Reduced medicines reconciliation errors; reduced medically fit for discharge patients in general, acute and elderly medicine
- Key actions required:
 - Business cases required to support physiotherapy elderly rehab support and development of OT capacity, leading to provision of appropriate 7-day support services input, predicated on improved performance and reduced length of stay/delayed discharges and readmissions
- To be taken forward by individual service leads

Initiative: developing advanced practice

- Goal: to utilize as effectively as possible, the skills of our staff by introducing advanced roles
- Measure of success: improved service quality and staff retention in target areas with improved unit costs
- Specific cases are required for each opportunity to be taken forward by individual service leads:
 - Advanced radiographer reporting case in process
 - Therapy radiographers aligned with Sussex Cancer Centre
 - Prescribing pharmacists

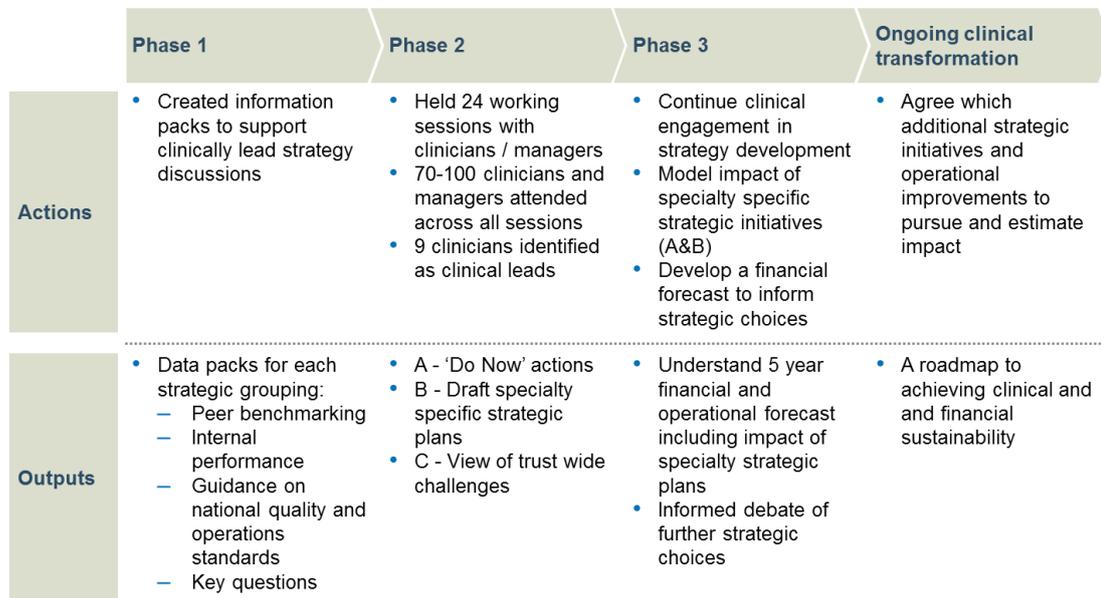
Initiative: involvement in business case process

- Goal: to ensure full consideration to support services requirements in business case consideration, including ensuring that new developments meet the support service aspects of service specifications

The support services group has also proposed to sit under a single organizational unit/directorate. This proposal will be taken up in forthcoming work on the clinical structure for the organization.

B – description of process and groups involved in developing strategy

1. The Clinical Strategy was developed in three phases as articulated in the diagram below. The finalisation of the clinical strategy document represents the conclusion of Phase 3 of the work.



2. Strategic groupings for Phase 2 were developed with a view towards the key questions which needed to be resolved in the strategy. Groupings were selected on the basis of having similar strategic challenges, rather than representing any current or future organisational form. Some specialties contributed to a number of strategic grouping discussions, particularly between unscheduled care and competed elective. The groupings and the key challenges addressed were as per the diagram below.

Strategic grouping	Challenges for strategy to address	Service lines
1 Changing Medicine ways of working	<ul style="list-style-type: none"> How do we move to 7 day working How do we Integrate with the community How should services be best configured across sites? 	<ul style="list-style-type: none"> Stroke A&E Diabetes Respiratory medicine Acute and general med Elderly med
2 Responding to the competed elective challenge	<ul style="list-style-type: none"> What should we provide? How should we compete and where should we partner? 	<ul style="list-style-type: none"> Ophthalmology & retino screen Dermatology ENT DD Rheumatology Physio Musculoskeletal Urology Oral surgery Gynae
3 Delivering truly Sussex-wide services	<ul style="list-style-type: none"> What does Sussex wide service provision look like? What networks do we need to establish? How do we work with NHS England? 	<ul style="list-style-type: none"> Renal Vascular HIV/GUM Cardiology Cardiac Surgery
4 Responding to local challenges in Obstetrics	<ul style="list-style-type: none"> How do we grow the service given the Eastbourne consultation on changed service provision? Is there potential for a Sussex-wide service? 	<ul style="list-style-type: none"> Obstetrics
5 Responding to local cancer challenges and building Sussex-wide care	<ul style="list-style-type: none"> What does Sussex wide service provision look like? What networks do we need to establish? What academic links do we need to establish? 	<ul style="list-style-type: none"> Oncology Haematology Breast care Radiotherapy
6 Advancing our paediatric tertiary options	<ul style="list-style-type: none"> What are the further tertiary growth opportunities? How would we be impacted by other changes to nearby DGH units? 	<ul style="list-style-type: none"> Neonatology Paed med Paed surgery
7 Responding to challenges in neurosciences	<ul style="list-style-type: none"> What level of ambition should there be to grow the service? What is the short and long-term vision to accommodate across both sites? 	<ul style="list-style-type: none"> Neurology Neurosurgery
8 Getting the right model for support services	<ul style="list-style-type: none"> How do support services respond to become income generating? How should we respond to risks around competition? How do services need to respond to other changes in the Trust 	<ul style="list-style-type: none"> Radiology Critical care Pathology OT Pharmacy Theatres Anaesthetics SaLT Dietetics

C – PESTLE analysis

1. The clinical strategy was developed with a view to a number of specific environmental parameters, summarised below.
2. **Political** – The NHS has significant political connotations, both locally and nationally. There is significant local history of attempted reform and cynicism about service change, particularly in mid-Sussex. Any strategy needs to be politically realisable. This does not mean avoiding any service moves but it does mean that they have to be acceptable to the local population.
 - i. Closing the Emergency Department (ED) at either RSCH or PRH (which would not be feasible from an operational or demographic growth perspective)
 - ii. Ceasing to admit acutely unwell patients to medical wards at either RSCH or PRH
 - iii. Closing the maternity unit at either RSCH or PRH, unless directed to do so by a commissioning body as part of a wider reconfiguration of maternity and paediatric services based on safe staffing levels
 - iv. Ceasing to provide any core service including those cited above but also routine surgical specialties and cancer care, without an agreed plan for re-provision by another provider
 - v. Ceasing to maintain Major Trauma Centre status at the RSCH
3. **Economic** – for the reasons above, the Trust must both continue to seek its own efficiencies, and also co-operate in system-wide efficiency improvements. The capacity constraints in the acute bed base make this a particularly pressing challenge for BSUH; whilst financially a strategy of continual growth might mitigate some of these pressures, this is operationally unviable and the future success of the Trust is dependent on lower demand for acute unscheduled care. This means that:
 - i. Strategic initiatives that require a growth in demand for beds would have to identify reductions elsewhere, or would only be actionable in a demand scenario where the bed requirement reduced significantly
 - ii. Large-scale capital investment will require changes to the 3Ts plan - as other large capital schemes are unlikely to be approved in the context of the 3Ts capital requirement
 - iii. The overall strategy should make a net contribution to meeting the recurrent 4% per year efficiency challenge
 - iv. The overall strategy should not increase the costs of like-for-like provision of services to local Clinical Commissioning Groups
4. **Social** – changes in societal expectations lead to greater demand for accessibility in service provision. Therefore it was not anticipated that any strategic initiative would lead to a reduction in the accessibility to planned elective services. This was not in any case discussed in any of the workshops

- 5. Technological** – changes were discussed in a number of specific areas including the increase in rates of survival in many serious diseases including renal disease and oncology, leading to increased long-term reliance on service provision such as dialysis. However, for a 5-year timescale the most pressing strategic constraints were perceived to be:
- i. Any strategic initiative must be consistent with current known commissioning standards and NICE guidance
 - ii. Specifically known clinical co-dependencies must be respected i.e. the requirement for certain specialties, types of intervention and diagnostic tests to be on the same site. The biggest constraint is the requirement to co-locate services that support a Major Trauma Centre which include major, bed-heavy specialties of Neurosurgery and Cardiac surgery. It should be noted that MTC status therefore places a significant strategic constraint upon BSUH's ability to move services away from the RSCH site to more accessible and central locations.
- 6. Legal** – whilst not articulated to clinical workshops, a key test for the strategy is its compliance NHS legislation and the wider law. In particular any merger, acquisition or other organisational change would require regulatory clearance.

D - co-dependencies map

To be appended separately

E – demographic model outputs

To be appended separately