Health & Social Care
Policy & Scrutiny Sub Committee

Acute Service Redesign (ASR) Update

19 March 2018

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The CCG Governing Body recommendation – 1st February 2018

- On 1 February 2018 the IoW Clinical Commissioning Group (CCG) Governing Body approved the blueprint for the future configuration of acute services to meet the needs of local residents based on the recommendation made by the Isle of Wight Local Care Board (LCB)
- The proposal identified:
  - The optimal level of acute services to be retained 'On Island' (approximately 89% of current activity) to provide maximum local access in a sustainable configuration;
  - A proportion of higher acuity/more complex activity (11%) to be transferred to mainland providers where better outcomes can be ensured;
  - The need to maximise the repatriation of activity back to the Island for routine planned care services to deliver a net reduction in the overall patient journeys across the Solent (by approximately 500 per annum) in recognition of the strong and consistent feedback from local stakeholders and the public on the impact of cross-Solent travel
- The CCG recommendation also addressed the concerns of clinicians regarding the safety risks of transferring activity and the deliverability concerns of mainland providers by making the decision contingent on further work to develop the proposals by:
  - Defining the workforce integration requirements by focusing on the key specialties where change is most required
  - Ensuring that any changes to capacity and the future critical care model will only be undertaken where they are matched by the actual changes to the pathways
  - Including the need to define and ensure that a credible and seamless transfer and retrieval system is in place

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Next steps in developing the proposals

- The CCG recommendation provides a clear direction of travel for the future configuration of acute services to meet the needs of Island residents over the next decade
- However, the proposals need to be further developed and refined before they can be subjected to formal external Assurance and then Public Consultation through:
  - Further **stakeholder and public pre-consultation engagement:** more intensive work to engage with local residents to discuss the recommended proposals to ensure that the work to refine and develop the proposals continues to reflect the views of local people
  - Accelerating the development of the **Community Services Review:** prioritise implementation of the community and out of hospital model to **flatten projected growth** in demand for acute services by 3.5% per annum.
  - Developing the preferred **acute services configuration proposal**: work with the Sustainability and Transformation Partnership (STP) and mainland partners to agree solutions to deliver the IW's blueprint and address the workforce and activity challenges by:
    - Hampshire & Isle of Wight (HIOW) Urgent & Emergency **Inter Hospital Transfer Pathways** – rapid operational improvement of transfer arrangements and agree a stabilisation, transfer and retrieval model
    - Solent Acute Alliance (SAA) **Workforce and Pathway Resilience** – to develop the service models and workforce arrangements to deliver the transfers in activity and support the key IW services where change is most required
    - IW **Digital Maturity** – to develop digital alternatives to reduce the need for IW residents to travel across the Solent for face-to-face outpatient attendances

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Impact on timelines

- The work to refine and develop the agreed service models and workforce arrangements to implement the agreed ASR blueprint is contingent on the commitment and engagement of mainland providers and the STP
- This is now decided in principle, and our partners have agreed to work with us and invest sufficient time to develop shared solutions within the agreed framework. The aim is that this work should be completed by **30th June 2018**
- As a result, it is unlikely that the detailed proposals that will enable us to move into the **programme assurance** phase of the work will be completed until the summer
- At this point, the refined acute and community service review proposals will be drawn together as an overall local care plan reconfiguration proposal which will then be subject to the NHS England led external programme assurance process
- Programme assurance can take around 6 months (or longer where key concerns are identified), which means it is now unlikely that we will have the authority to move to formal **Public Consultation** until early 2019

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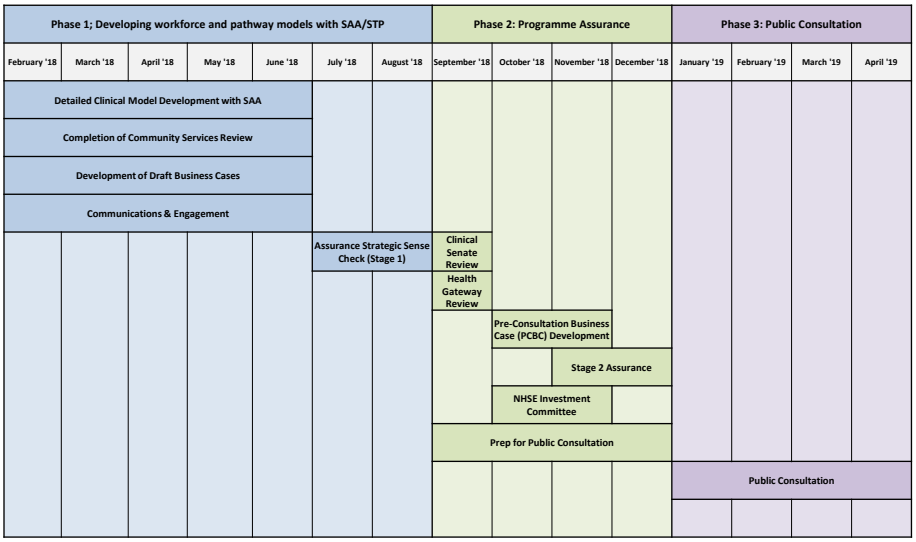
Proposed Timelines for 2018/19



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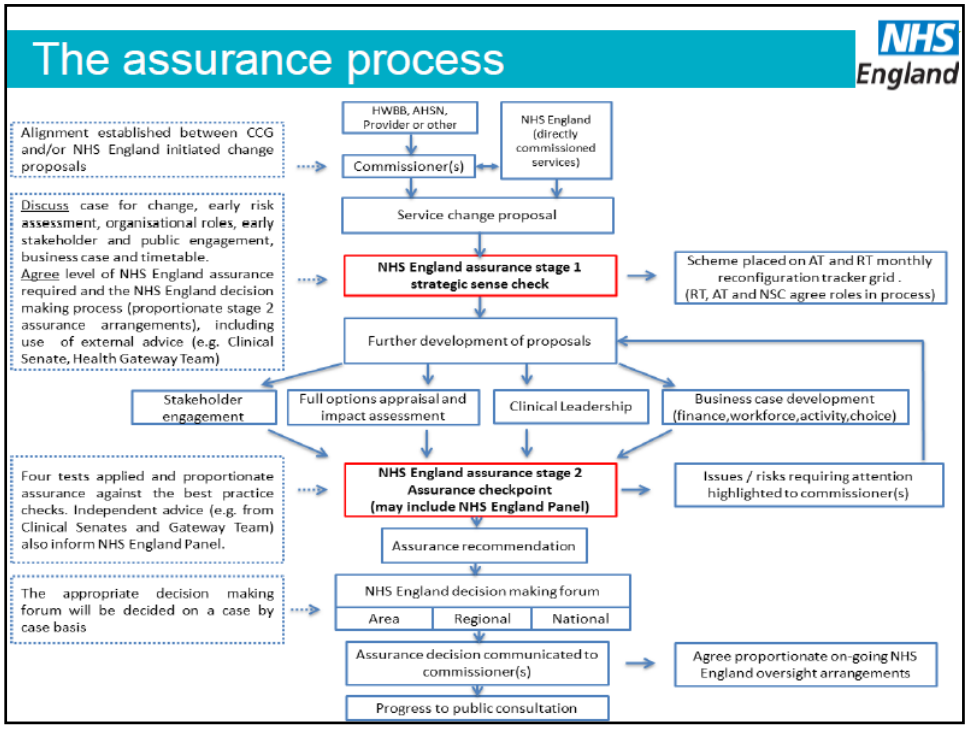
APPENDICES

Appendix 1: Programme assurance requirements - Leading Large Scale Service Change

- It is the statutory responsibility of service commissioners (Isle of Wight Clinical Commissioning Group and NHS England), to commission health services that reflect the needs of the population of the Isle of Wight
- The service reconfiguration process has several phases from identifying the case for change, setting the strategic context, developing the options for change, recommending an option, seeking NHSE Assurance, consultation and then implementation
- It is driven by the need to demonstrate from an early stage that a proposal satisfies national NHS requirements known as the **four key tests** and that it is affordable in capital and revenue terms. These requirements are set-out in *NHS England's Planning, Assuring and Delivering Service Change for Patients* (October 2015) and are:
  1. Strong public and patient engagement
  2. Appropriate availability of choice
  3. Clear clinical evidence base
  4. Clinical support
- NHS England has recently introduced a further test as part of an extension of test three (a clear clinical evidence base) to ensure patients will continue to receive high quality care, where hospital bed closures arise from proposed major service reconfigurations
- NHS organisations in the future will have to show that significant hospital bed closures are subject to the established four key tests, and demonstrate further tests of deliverability, affordability and value for money, before NHS England will approve



Appendix 2: Patient transport and the impact of travel

- The recommended option takes very seriously the concerns of clinicians regarding the safety risks of transferring activity to the mainland and as a consequence the decision is contingent on further work to rapidly improve current operational arrangements governing **inter-hospital transfers** and to develop a credible and seamless **transfer and retrieval system**
- The preferred option will see an increase in the number of hospital transfers but with a net reduction in overall patient journeys by reducing the need for IW residents to travel to the mainland for routine/planned care
- These proposals have been presented to the IWC Cross Solent Operators Group (19th February 2018) where it was agreed to work with ferry companies to:
  - Provide more data on total health/care related journeys (to include family and carers)
  - Review & improve transport advice to patients, carers and family including advice on best value journeys, tailored transport options to and from ferry terminals to/from destination mainland hospitals

	Current Baseline	Preferred Option
Hospital transfers (NHS funded)	976	4,730
Self funded journeys (inc. repatriation)	34,713	30,441
Total patient journeys	**35,689**	**35,171**
Net impact (patient journeys)	**0**	**(518)**

Total patient journeys

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Appendix 3: Centre for Public Scrutiny (CfPS) reconfiguration questions

The CfPS has devised 10 question that all services looking to reconfigure should able to answer:

1. What is the case for change and what is driving the proposed need to change?
2. What assumptions underpin the proposed reconfiguration?
3. How robust are the financial projections of the proposed change?
4. Have the proposals been externally reviewed and tested and are they compliant with legislation and policy? E.g. the secretary of states reconfiguration tests and NHS patient care test?
5. How have service users and the wider community been involved in the co-production of the proposed changes so far and how have the proposals changed as a result?
6. How will the local community be consulted about the changes and is the consultation plan robust, clear and effective. E.g. how will a final decision on the changes be
7. How have the potential positive outcomes been quantified and what are the timescales for the realisation of these benefits?
8. What are the negative or unintended outcomes of the proposed changes and how will these be recognised and managed?
9. Which groups will be most affected by the changes, has an equality assessment been completed and what is the quality of this analysis?
10. How will commissioners, patients and the public know if the reconfiguration has been successful?

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1. What is the case for change and what is driving the proposed need to change?

The Isle of Wight faces a unique set of challenges in delivering care to the same standards expected across England's NHS. As a small island there are diseconomies of scale and national workforce shortages can have a greater impact on local services. It is not always viable to have specialist services on the Island when the numbers of people accessing them are small and our staff would not maintain the levels of skill required to deliver them appropriately. The cost of maintaining the range of acute services needed is often higher than other parts of the mainland where hospitals can share resources. For example, the Island's population is around half of that normally needed to sustain a traditional district general hospital. Furthermore, our population has a proportionately much higher number of older people than other parts of the country.

The key challenges facing the Isle of Wight's acute services are as follows:

- A growing **elderly population** with changing healthcare needs that are placing greater and new demands on services. Around 25% of our population is aged over 65, and while the total population is predicted to remain relatively stable, the proportion of older people will increase to around 30% by 2025 with the biggest rises amongst the very elderly
- There is **variable quality** in acute hospital based care, particularly for more specialist services and some national quality standards are not being met. As a result, local residents do not always experience the same outcomes as patients across the country
- There are **shortages of health and care staff**, including specialist consultants, which means it is difficult to ensure there are enough staff available, especially when care is needed at all times (i.e. 24 hours a day and 7 days per week)
- There is a growing **financial challenge** - the Isle of Wight Clinical Commissioning Group is estimated to be £19m (10%) above its target funding allocation and the Isle of Wight Council is also under extreme financial pressure. The Isle of Wight NHS Trust has a current financial deficit of £18.8m which is forecast to grow to £23.6m by 2022/23 (assuming the delivery of year-on-year system efficiencies in line with national planning assumptions)
- As the NHS nationally moves to deliver more services in larger units, the Island's current configuration of acute services will be **unsustainable**; current difficulties maintaining staff rotas and delivering the levels of activity needed to maintain a sufficient scale of services will lead to further unplanned service changes if action is not taken now

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2. What assumptions underpin the proposed reconfiguration?

The assumptions on which the successful implementation of the ASR proposals are:

- Close integration and partnership working with the Solent Acute Alliance to explore the best solution to deliver the Island's workforce and activity challenges including addressing the concerns of mainland partners about the deliverability of an integrated and flexible workforce.
- St Mary's continuing to work towards meeting its Quality Improvement plans
- Prioritise the implementation of the community and out of hospital model to ensure the effective delivery of our overall Local Care Plan vision, in particular alignment with the Community Services Redesign project

In addition, following the recommendation by the CCG Governing Board on 1 Feb 2018, the following caveats were added:

- Defining the workforce integration requirements by focusing on the key specialties where change is most required
- Ensuring that any changes to capacity and the future critical care model will only be undertaken where they are matched by the actual changes to the pathways and activity.
- This will include the need to define and ensure a credible and seamless transfer and retrieval system is in place.
- Seek the leadership of the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) and our Regulators, to support and facilitate as a matter of urgency the work required on the workforce and pathway changes

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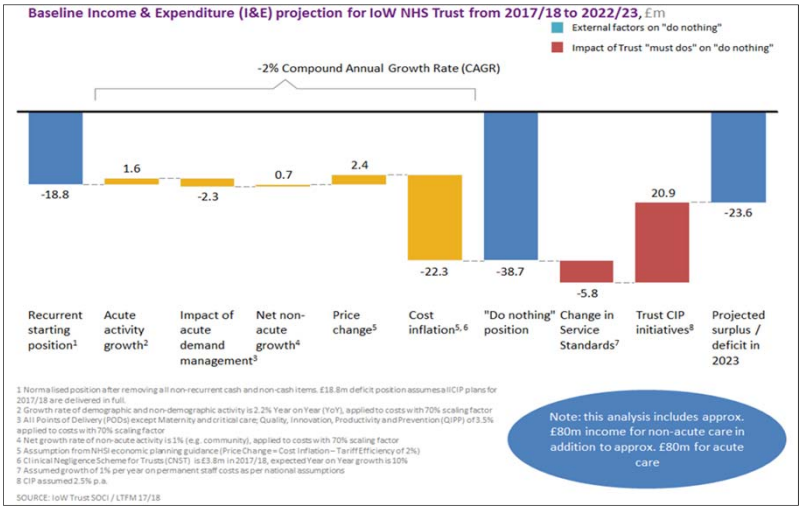
3. How robust are the financial projections of the proposed change?

- The **baseline financial analysis** shows that the Trust's recurrent starting deficit in 2017/18 of £18.8m is projected to increase to £23.6m by 2022/23, in spite of assuming the delivery of challenging year-on-year system efficiencies (including acute demand management programmes of 3.5% p.a. to flatten projected growth in activity and provider Cost Improvements of 2.5% p.a). This is reflected in Option 1 'Current state/business as usual'



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3. How robust are the financial projections of the proposed change (cont)?

- The Finance Group **concluded that Option 4 would deliver the best value for money** (£80.6m, 30 year NPV or **c£4.9m per annum**). However, it must be noted that the annual financial benefit is only marginally better than that of Options 2 and 3 and that a further financial assessment will be made during the next, more detailed phase of the work. Given the above, whilst affordability and value for money must be considered, the difference between option 4 and that of 2 and 3 is alone, not material enough to be the basis for the final decision.

Affordability impact (£m)

Options	1	2	3	4	5
Transition costs	0	0	-1.2	-2.1	-4.1
Total system net Capital costs	-4.1	-4.1	-7.3	-21.8	-54.4
Net impact on providers income and expenditure in 2022/23	-0.1	3.5	3.6	4.9	1.3
Net impact on NPV [1] to the system, comparing to do nothing	-6.8	65.7	63.6	80.6	-7.5

1 Net Present Value (NPV) – Accountancy technique that compares the cost of the capital investment with the benefit delivered on a day to day running costs over a 30 year period.
SOURCE: Reconfiguration model; Trust baseline data

- *Note: Under Option 5 financial benefits from consolidating services are consumed by the high costs of transport & capital cost of re-providing the beds.*

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4. Have the proposals been externally reviewed and tested and are they compliant with legislation and policy? E.g. the secretary of states reconfiguration tests and NHS patient care test?

Initial planning and design work for the ASR project has been performed in collaboration with healthcare consultancy firms KPMG and McKinsey's, the latter playing a lead role in designing the options presented to the Local Care Board. Such collaborations clearly demonstrate external testing and influence on this process. In fact it was actually NHSE who having reviewed the initial ASR proposals, recommended we work with McKinsey's, following their successful reconfiguration work with Dorset.

In addition, we have had helpful challenge and honesty from the Medical Directors at the Solent Acute Alliance Trusts, as well as the STP. We have had a "Critical Friend" in the shape of the Wessex Clinical Senate and been guided by their experiences well as welcoming their continued advice. Our Medical Director has begun an engagement process with the relevant Royal Colleges in order to ensure that any proposed service reconfiguration align with and meet their protocols.

The CCG has actively provided external scrutiny throughout the process, particularly in relation to the IoW Local Care Plan, of which this project forms a major part.

Planning is already underway for the next phase to ensure that ASR satisfies all forms of scrutiny particularly that of NHSE including their Sense Checks.

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5. How have service users and the wider community been involved in the co-production of the proposed changes so far and how have the proposals changed as a result?

To date, Patients Council and HealthWatch IW have been closely involved, and Community Action Isle of Wight facilitated at over 50 separate community discussions. In general, feedback from these discussions consistently focused on two key themes: transport and travel, and communications. In relation to transport/travel this included issues of cost, patient and family and carer health and wellbeing, distance, access and discharge arrangements. For communications, the issues related to communications between professionals and patients, between Clinicians and GP's, and between hospitals including issues of transfer of patient records and notes, and problems with appointments, such as scheduling and delays to treatment.

As a result of the feedback received, the work has expanded to include a detailed travel impact assessment to ensure that there is clear information available to describe the changes needed under any preferred option, including numbers of journeys, costs and the time needed to make any additional journeys.
In addition, as a direct result of these meetings, the decision has been made to establish a Patient Transport sub-group where patients can directly feed into the process. This sub-group will involve the 3 ferry operators and patient representatives, and will address directly the concerns that have been raised, and aim to find practical solutions.

The opportunity for further informal engagement and formal consultation with both public and staff has been made clear throughout this stage of the process. Plans are currently being finalised to ensure that this engagement with the public is extended during the next phase of the process up to and including consultation. In addition, a range of materials will be developed that can be tested and shaped with the different user groups before the formal period of consultation.

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6. How will the local community be consulted about the changes and is the consultation plan robust, clear and effective. E.g. how will a final decision on the changes be made

The local community has already been engaged as described in a previous slide, and the plan is to increase this engagement considerably over the next stage of the project.

We are still in the process of drafting the consultation plan, and would welcome the opportunity to share it with the Policy and Scrutiny committee for their input.

Once the NHSE Sense Check has been completed, and approval given to proceed, then a full public consultation will take place. The consultation period will run for a minimum of 12 weeks, followed by three months of post-consultation considerations which will be factored into the decision making business case.

The Final decision will be made by the CCG Governing Body, following the outputs of the full public consultation.

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7. How have the potential positive outcomes been quantified and what are the timescales for the realisation of these benefits?

There is a three-five year implementation plan but where short-term changes are required on the grounds of clinical safety, changes will be implemented more quickly. Where this is the case, the rationale for these changes will be clearly explained and the Committee will be briefed. The main proposals under consideration are;

Long Term

- Implementation of changes (if approved to go ahead) including safe and seamless transfer of patients.
- Increase in access to better quality specialist care and expected outcomes
- Plan to become Centre of Excellent for Dementia / Frailty.
- This position could make us more attractive to potential future staff as we share our knowledge and experience with the rest of the country and demonstrate that the IOW is ahead of the curve with regards our aging population

Short Term

- Repatriation of appointments to reduce patient journeys
- Increased use of Digital IT to aid communication and reduce unnecessary patient travel
- Guidance for how to travel to Southampton / provision of Helpline etc
- Closer links with the Solent Acute Alliance (SAA)

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8. What are the negative or unintended outcomes of the proposed changes and how will these be recognised and managed?

- Based on the travel impact analysis, it is clear that in order to receive services that can assure better outcomes, there will be a greater need for patients with higher levels of acuity to travel to the mainland. This will require improved inter-hospital transfer systems to be put in place and a safe and effective transfer and retrieval service to be developed with appropriate transport/conveyancing. The HIOW-STP are leading this work involving the main providers, external experts and transport providers (including the air ambulance and Coast Guard)
- IW acute services will need to ensure that they are resilient to deal effectively with periods of adverse weather which may impact on safe/timely cross-Solent transfers. (e.g. using digital / remote access for mainland advice and support)
- A key risk is that we ensure our staff are supported through the change process and that the many opportunities for their development that will result from the changes are highlighted as well as addressing the possible negative impact. It will be important to ensure that staff don't 'vote with their feet' as there will be the need for expanding workforce to deliver the IW's overall care model
- The quality of the questions and issues raised through the public, staff and stakeholder engagement has continued to identify a range of multiple risks that is helping to ensure that the widest possible range of issues are addressed as part of this process
- Clinical Senate and Health Gateway interactions during phase 2 will help to uncover any unintended outcomes, which will be addressed if identified.

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9. Which groups will be most affected by the changes, has an equality assessment been completed and what is the quality of this analysis?

The ASR process has been formed around achieving the best possible outcomes by making appropriate yet required trade-offs. These trade-offs generally involve sacrificing local care delivery for improved clinical and operational outcomes.

An Equality Impact assessment has not yet taken place, but will be completed in the next stage of the work. This work will include groups that, at this stage of the process, are considered to be potentially more likely to be affected by service changes such as the transfer of services off-Island and those already involved in cross-Solent travel for treatment.

Required work:
Once clinical and workforce models are more clearly defined, an analysis of the impacts will be performed providing a much clearer picture of the potential outcomes of the recommended changes on each of the acute services. With this information it will be easier to assess the impact of the recommended changes on equality.

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10. How will commissioners, patients and the public know if the reconfiguration has been successful?

- As an outcome of the Public Consultation a Decision Making Business Case (DMBC) will be submitted to the CCG Governing Body for approval of the final reconfiguration option
- This will set-out a detailed analysis of the outputs of the Consultation and make a final set of recommendations informed by the process
- The DMBC will also include a detailed Benefits Realisation Framework which will set out the system and public metrics by which the success of the reconfiguration will be measured, assessed and regularly reported

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