ACUTE SERVICES REDESIGN

Patient Council

13 March 2017

Background

1. The Isle of Wight NHS Trust is currently failing to deliver on many fronts, is under scrutiny from its regulators and is disadvantaging patients.

2. It has undergone several **service reviews** but struggled to enact the recommendations, partly as a result of the processes not being internally owned or clinically led.

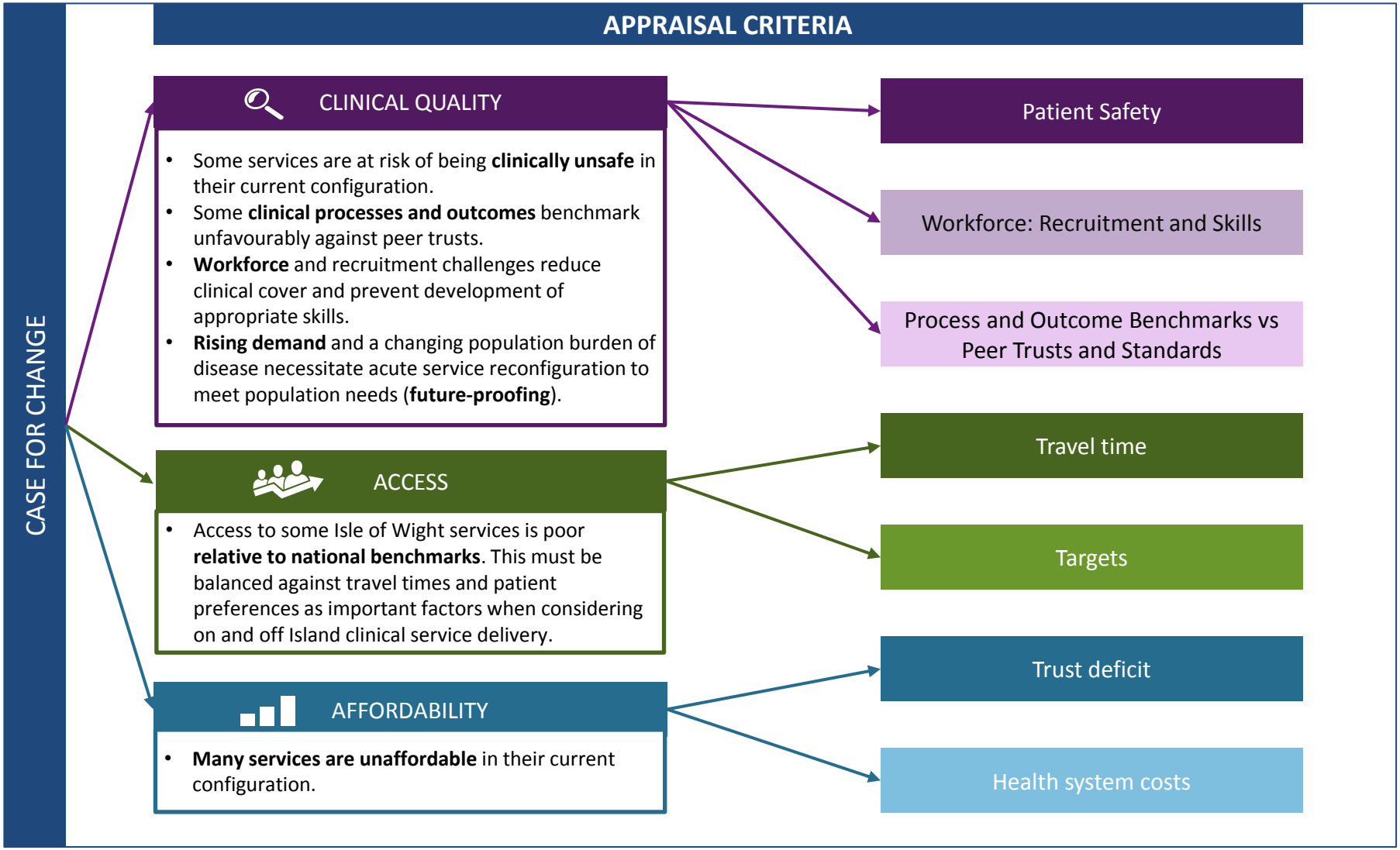
3. The recommendations of previous reviews have failed to recognise the unique circumstances of the island

- Sizable population only few miles off the South Coast
- Several days per year when it is geographically isolated
- **Two** easily accessible large hospitals who share our off-island services

4. STP Clinical Reviews have been halted pending the **Acute Services Redesign**

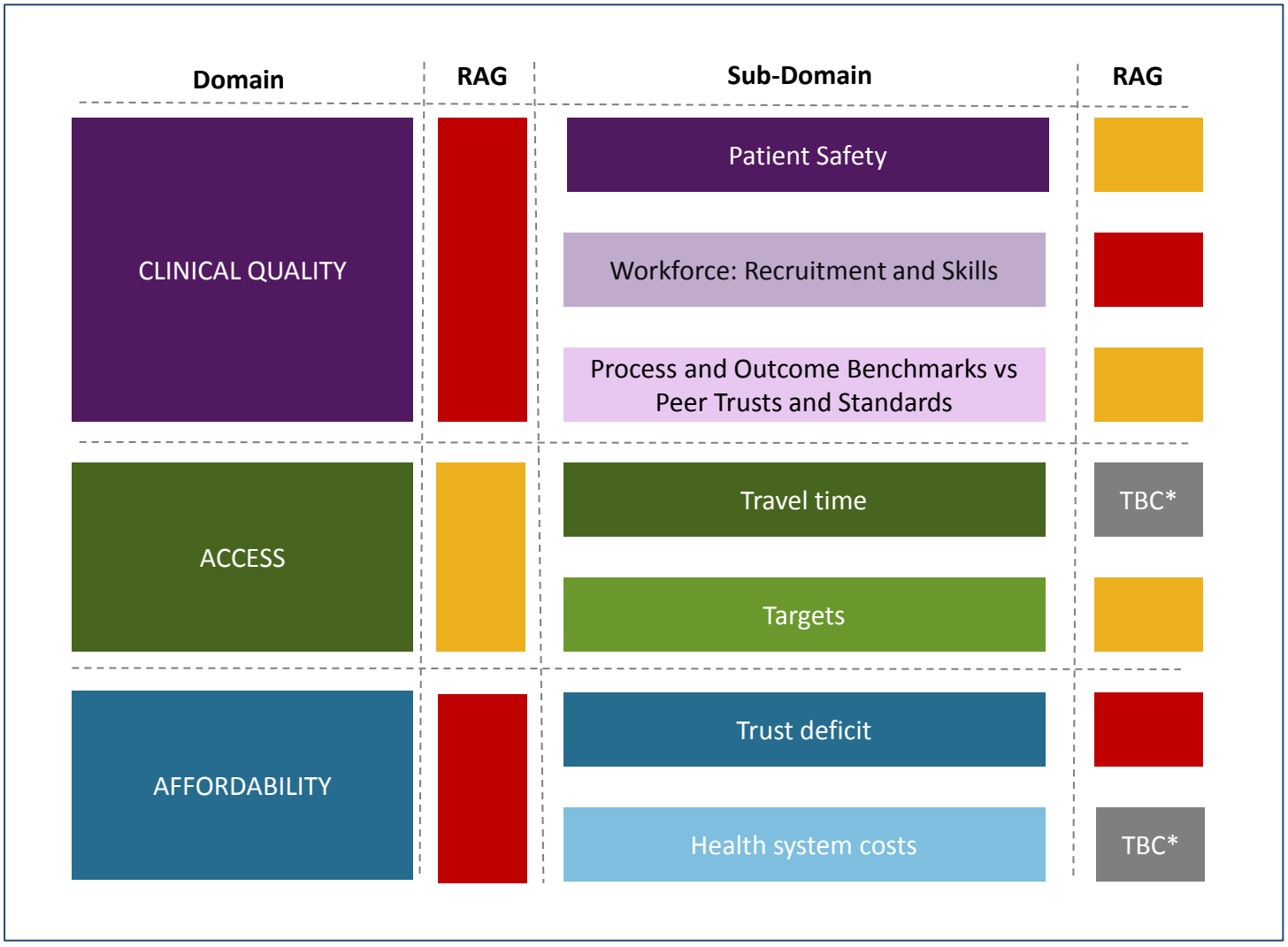
- Clinically lead with project support
- The desired outcome is to define what sustainable services look like for the island

CASE FOR CHANGE FOR ACUTE SERVICES



SUMMARY OF THE CASE FOR CHANGE FOR ACUTE SERVICES

SIGNIFICANT CHALLENGES IN ALL DOMAINS



** Domain in itself not a case for change parameter, but domain will be relevant to include for scoring against for potential redesign options.*

Key Issues

The **unique island setting** requires a careful consideration of patient safety when requiring a service reconfiguration that involves patients transfers.	The provision of **off-island services** need to take account of the willingness and ability of another provider to take on the extra activity.	The provision of **in-reach services** need to take account the additional costs of a **mobile workforce**	The provision of **community services** requires a trained and available workforce

PHASE 1: ACTIVITIES CONDUCTED

WEEK 1 Jan 30th	WEEK 2 Feb 6th	WEEK 3 Feb 13th	WEEK 4 Feb 20th	WEEK 5 Feb 27th	WEEK 6 Mar 6th
PROJECT STAGES					
Draft Service Model Framework		Clinical Scrutiny	System Leaders Scrutiny		Approval & Dissemination
OUTPUT					
TARGET OPERATING MODEL					
PROJECT GOVERNANCE & CLINICAL LEADERSHIP					
Weekly ODG 2nd Feb	Steering Group 9th Feb	Weekly ODG 16th Feb	Weekly ODG Input & Challenge Workshop 23rd Feb	Weekly ODG 2nd Mar	Trust/CCG/ASR Project Team Pre-meeting 6th Mar
		NHSi / NHSE Escalation 15th Feb			Steering Group 9th Mar
		Trust Leadership Committee 16th Feb			
CONTINUOUS INPUT FROM KEY STAKEHOLDERS					
Trust Clinical Senate 3rd Feb	SWCH CBU	CSCD, AUCC, MED CBU Meetings		Surgery Workshop 27th Feb	HMSC 6th Mar
	ENT & Ophthalmology Pre-meeting	ASR Comms & Engagement		Medicine Workshop 27th Feb	
	HMSC 6th Feb	GP Clinical Exec 16th Feb		Clinical Reference Group (CRG) 2nd Mar	
	SAA MDs Conference Call 8th Feb	SAA MDs Conference Call 15th Feb	SAA MDs Conference Call 22nd Feb		

TARGET OPERATING MODEL OPTIONS:
'AS IS' SERVICE CONFIGURATION IS NOT SUSTAINABLE

- The consultant body is strongly in agreement with the assertion that 'no change' (TOM 1) is **not an option**.
- Thus 2 target operating models (TOMs) have been developed that define a **range of potential options** to reconfigure each service to achieve sustainability, where some services may require more radical choices than others.
- For each individual speciality, redesign options need to fall within the range established by Target Operating Models 2 & 3

AS IS	RECONFIGURATION	SIGNIFICANT RECONFIGURATION
1 Target operating model 1	2 Target operating model 2	3 Target operating model 3
As-is: No change to current service offer or method of delivery	**Collaborate:** Increase the amount of collaborative working both internally and with external partners e.g. shared pathways, workforce, capacity sharing	**Re-scope:** Revise the level of service provision e.g. repatriation of activity from off-island, reduction in service and /or access
	Transform: Redesign of clinical pathways to enhance delivery and efficiencies e.g. exploring new models of care, 'top-of-licence' workforce models	**Transfer:** Cease delivery of a service / speciality and transfer to other providers

No change in service configuration is not an option.

The range within which solutions can be found to achieve service sustainability.

CLARIFYING THE PURPOSE OF THE TARGET OPERATING MODEL AS OUTPUT OF ASR PHASE 1

The Target Operating Model…	The Target Operating Model is not…
• …is a list of **potential solutions** for how the acute services could change.	• …the **final blueprint** for acute service delivery.
• …is a **range of potential options** for each service to achieve sustainability, where some services may require more radical choices than others.	• …a **binary choice** between the two target operating models for all services.
• …sets **the overall direction** for achieving individual speciality sustainability in phase 2.	• …a **prescription** of the target operating model on the speciality level.
• ... takes into account **affordability** ensuring that potential solutions improve the financial position of the trust and/or system.	• …**a solution** to the entire trust and/or system wide deficit. • …a description of the **cost improvement programmes** that will be required to meet the financial deficit.

TARGET OPERATING MODEL OPTIONS

KEY ACUTE SERVICES	REVISED TARGET OPERATING MODEL 2: **RECONFIGURATION**	REVISED TARGET OPERATING MODEL 3: **SIGNIFICANT RECONFIGURATION**
	TRANSFORMATION OF SERVICE SCOPE AND DELIVERY	**(PARTIAL) TRANSFER OF SERVICE DELIVERY**
A&E (EMERGENCY MEDICINE)	• Service transformation with a focus on admission avoidance and rapid transfer to alliance partner.	• 24/7 GP led urgent care centre. • Rapid transfer through emergency service to mainland providers as required.
ACUTE MEDICAL INTAKE	• Re-designed ambulatory care provision to support 24h ambulatory care with in-reach support from medical specialties.	• No acute intake. • Day case medical treatment and diagnostics. • Outpatient medical services.
ACUTE (ADULT) SURGICAL INTAKE	• Cease some elements of elective / emergency surgical activity. • Joint appointments to secure viable rotas to maintain on-call services.	• No acute intake. • Day case surgical treatment and diagnostics. • Outpatient surgical services.
ADULT CRITICAL CARE (INTENSIVE CARE)	• Flexible ICU/HDU bed numbers and staffing with an improved local network.	• Close critical care unit. • Option to retain HDU beds for stabilisation and transfer purposes.
CARDIOLOGY (NON-INTERVENTIONAL)	• In-reach support to MAU and ambulatory care. • Service reconfiguration with focus on collaborative working models.	• Outpatient cardiac rehabilitation unit. • Day case medical treatment and diagnostics. • Outpatient medical services.
ACUTE STROKE UNIT	• Redesign of stroke treatment protocols enabling rapid transfer of hyperacute patients suitable for intervention.	• Transfer of all hyper- acute patients through emergency services to mainland.
CONSULTANT LED OBSTETRIC SERVICES	• Movement from a Level 3 to Level 2 NICU service with concomitant redesign of obstetric protocols ensuring patients are treated at the right place and the right time.	• Midwifery led obstetrics unit. • High-risk pregnancy managed through in-reach services with off-island delivery. • Rapid transfer through emergency services to mainland providers as required.
ACUTE (NON-SPECIALISED) PAEDIATRICS AND PAEDIATRIC SURGERY	• 12 hour paediatric assessment unit co-located with inpatient ward with reduced bed base.	• Paediatric urgent care • No paediatric surgery emergency service. • Rapid transfer through emergency service pathways to mainland services as required.

The range within which solutions can be found to achieve service sustainability.

My life a full life

NEXT STEPS – PHASE 2

W5 Feb 27th	W6 Mar 6th	W7 Mar 13th	W8 Mar 20th	W 9 Mar 27th	W10 April 3rd	W11 April 10th	W12 April 17th	W13 April 24th	W14 May 1st	W15 May 8th
Project Stages										
	Steering Group 9th March	Weekly ODG 16th March	Weekly ODG 23rd March	Weekly ODG 30th March	Weekly ODG 23rd March	Steering Group 13th April	Weekly ODG 20th April	Weekly ODG 27th April	Weekly ODG 4th May	Steering Group 11th May
Urology 27th Feb 14:00 – 16:00	Haematology (1) 8th March 12:30 – 14:30 SP	Urology (TBC) 13th Mar 09:00 – 11:00 MP	Obs & Gynae (1) 20th March 14:00 – 16:00 SP	ENT (2) 31st March 09:00 – 11:00 MP	Specialty Medicine (2) 4th April 15:0 0– 17:00 MP	Obs & Gynae (2) 10th April 14:00 – 16:00 SP		ENT (3) 24th April 14:00 – 16:00 SP	Specialty Medicine (3) 3rd May 14:30 – 16:30 MP	Obs & Gynae (3) 8th May 14:00 – 16:00 SP
Testing Framework with Urology	GI (Cancer) Surgery (1) 8th March 14:30 – 16:30 SP	Specialty Medicine (1) 14th March 10:00 – 12:00 MP	Anaesthetics (1) 22nd March 12:30 – 14:30 SP	Haematology (2) 29th March 11:00 – 13:00 MP	Paediatrics (2) 5th April 12:30 – 14:30 SP	Anaesthetics (2) 12th April 12:30 – 14:30 SP	ASR Workshop Testing Event 20th April	Haematology (3) 26th April 12:30 – 14:30 SP	Paediatrics (3) 3 May 12:30 – 14:30 SP	Anaesthetics (3) 10th May 12:30 – 14:30 SP
	Acute Medicine (1) 10th March 14:00 – 16:00 MP	Paediatrics (1) 15th March 12:30 – 14:30 SP	Radiology (1) 22nd March 14:30 – 16:30 SP		Ophthalmology (2) 3rd April 14:00 – 16:00 SP	Radiology (2) 12th April 14:30 – 16:30 SP		GI /General (Cancer) Surgery (3) 26th April 14:30 – 16:30 SP	Ophthalmology (3) 2nd May 14:00 – 16:00 SP	Radiology (3) 10th May 14:30 16:30 SP
		Ophthalmology (1) 13th March 14:00 – 16:00 SP		Acute Medicine (2) 28th March 14:30 – 16:30 MP	Orthopaedics (2) 5th April 14:30 – 16:30 SP			Acute Medicine (3) 25th April 14:30 – 16:30 MP	Orthopaedics (3) 3rd May 14:30 – 16:30 SP	
Clinical Reference Group – 2nd March		Orthopaedics (1) 15th March 14:30 – 16:30 SP	Trust Leadership Committee – 23rd March	Clinical Reference Group – 30th March	GI (Cancer) Surgery (2) 7th April 09:00 – 11:00 MP					Clinical Reference Group – 11th May
		ENT (1) 17th March 14:00 – 16:00 SP								

PHASE 2 ASR: INDIVIDUAL SPECIALTY REVIEWS (ISR) OVERALL METHODOLOGY

The same method and outputs as phase 1

- A case for change, TOM options and appraisals will be produced for the highest volume (group of) pathways (top 3-5) in the speciality.

12 specialties are included

- There will be 3 meetings held per ISR (36 meetings in total).
- Specialities to be reviewed: *Urology, ENT, Acute Medicine, Speciality Medicine, Gastro-intestinal & General Surgery, Radiology, Anaesthesiology, Haematology, Obstetrics & Gynaecology, Paediatrics, Ophthalmology and Orthopaedic Surgery.*
- ISR participants will include speciality clinical leads, operational leads and nursing and quality leads with input provided from the Isle of Wight CCG, Solent Acute Alliance Partners and GP representatives.

Patient voice representation

- <u>Proposal:</u>
  - Patient voice to be explicitly considered in Meeting 1 of the ISRs through an agenda item discussing patient experience as it pertains to each speciality and through a discussion on patient experience when defining core services offered by specialities.
  - A HealthWatch volunteer to attend ISR Meeting 2 to represent patient voice.
  - Representatives at the ASR workshop testing event (20th April) from HealthWatch, Community Action, People Matter, the Isle of Wight youth council and the 3 locality town and parish councils.

PHASE 2 ASR: MEETING PLAN

ISR MEETING 1 8-22ND MARCH

- Meeting Attendees:
  - Clinical leads, operational Lead, nursing and quality lead.
- Activities and Outputs
  - Review phase 1 output and place ISR within the scope of the TOMs.
  - Validate data packs and ISR case for change.

ISR MEETING 2 28TH MARCH -12TH APRIL

- Meeting Attendees:
  - Clinical leads, operational lead, nursing and quality lead, GP representative, SAA representative, patient voice champion.
- Activities and Outputs
  - Identify the decisions, resources, co-dependencies and enablers required to resolve sustainability issues in the delivery of core services (answer the case for change).
  - Map proposals for the future core service offering against phase 1 TOMs.
  - Develop high level implementation plan for speciality redesign through RACI (responsible, accountable, consulted, informed) matrix.

ISR MEETING 3 24TH APRIL – 12TH MAY

- Meeting Attendees:
  - As for meeting 3.
- Activities and Outputs
  - Final phase 2 output consensus and sign off by participants.

PHASE 3 PROJECT PLAN

W16 May 15th	W17 May 22nd	W18 May 29th	W19 June 5th	W20 June 12th	W21 June 19th	W22 June 26th	W23 July 3rd	W24 July 10th

PROJECT STAGES

Implementation Planning

OUTPUT

Implementation plan including public consultations business case – developed with stakeholders

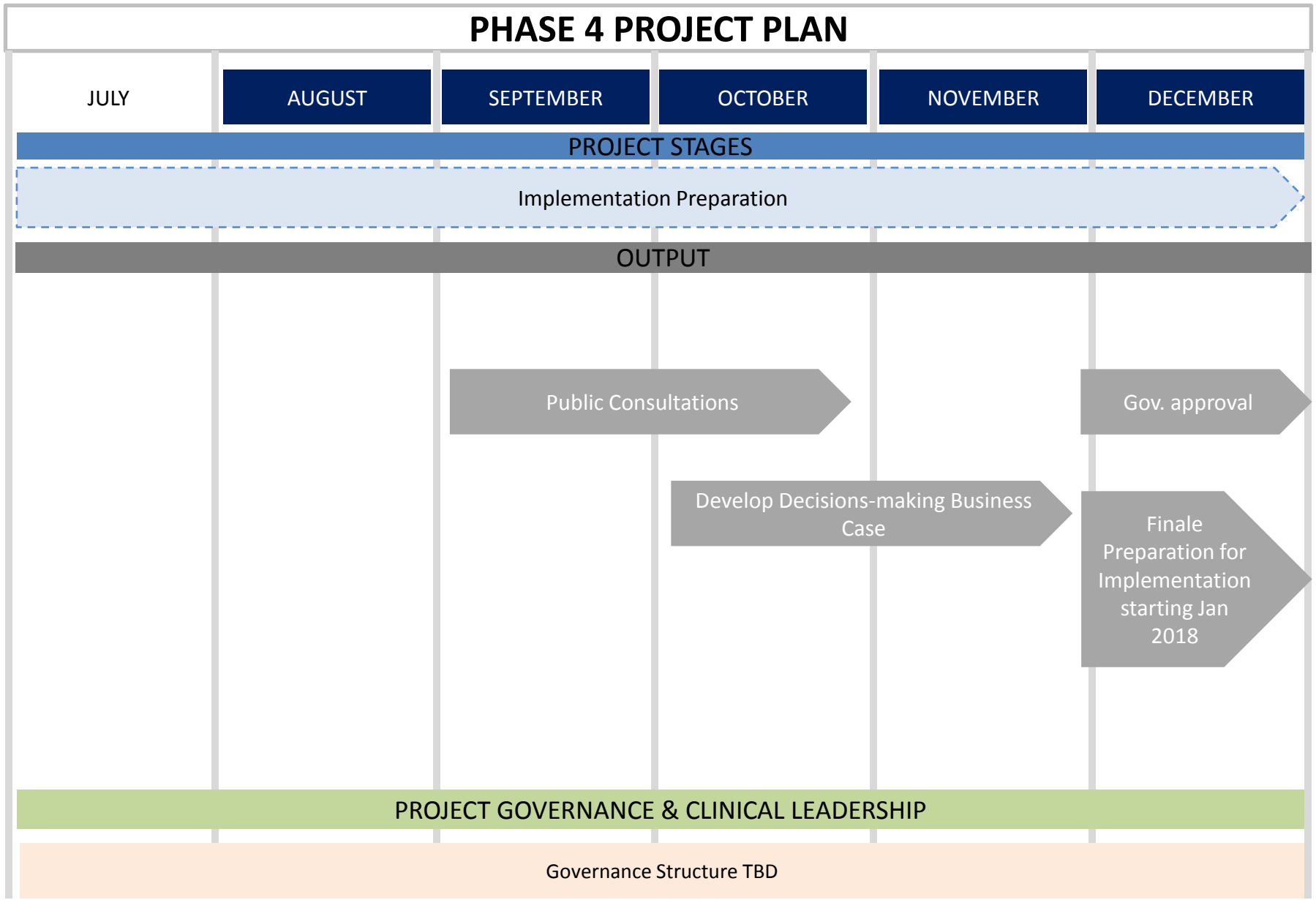
Targeted public engagement involvement

Consultation Strategy

PROJECT GOVERNANCE & CLINICAL LEADERSHIP

W16 May 15th	W17 May 22nd	W18 May 29th	W19 June 5th	W20 June 12th	W21 June 19th	W22 June 26th	W23 July 3rd	W24 July 10th
Weekly ODG 18th May	Steering Group May 25th	Weekly ODG June 1st	Weekly ODG June 8th	Weekly ODG June 15th	Weekly ODG June 22th	Steering Group June 29th	TBD	
	Sign-off Phase 2 Blueprint					*Placeholder Phase 2 Sign-off*		

PHASE 4 PROJECT PLAN



ASR Project Governance