HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 19 June 2012

PRESENT:

Councillor Simmons (Chairman), Councillors Heaps, O'Keeffe, Rogers and Taylor (all East Sussex County Council); Councillor Ungar (Eastbourne Borough Council); Councillor Merry (Lewes District Council); Councillor Cartwright (Hastings Borough Council); Councillor Phillips (Wealden District Council); Ms Janet Colvert, East Sussex LINk representative, and Ms Julie Eason, East Sussex Advice Plus (voluntary sector representative)

WITNESSES:

East Sussex Healthcare NHS Trust
Darren Grayson, Chief Executive
Dr Andrew Slater, Medical Director (Strategy)
Dr Amanda Harrison, Director of Strategic Development and Assurance
Jayne Black, Assistant Director of Strategic Development

NHS Sussex
Sarah Blow, Interim Chief Operating Officer (East Sussex)
Amanda Philpott, Director of Strategy and Provider Development
Jessica Britton, Head of Governance and Assurance
Catherine Ashton, Programme Director – NHS Sussex/ESHT

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

1. CHAIRMAN'S BUSINESS

1.1 The Chairman welcomed Councillor Andrew Cartwright as the Hastings Borough Council representative on HOSC.

2. APOLOGIES

2.1 Apologies for were received from Councillors Davies, Howson and Pragnell and from Mr Maurice Langham, East Sussex Seniors Association.

2.2 The Committee also noted apologies from Stuart Welling, Chairman of East Sussex Healthcare NHS Trust.

3. MINUTES

3.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 8 March 2012.

4. DISCLOSURE OF INTERESTS

4.1 There were none.

5. REPORTS

5.1 Copies of the reports dealt with in the minutes below are included in the minute book.

6. EAST SUSSEX HEALTHCARE NHS TRUST CLINICAL STRATEGY – PROPOSALS FOR SERVICE CHANGE

6.1 The Committee considered a report by the Assistant Chief Executive which set out the proposals from NHS Sussex and East Sussex Healthcare NHS Trust for changes in the provision of health services in East Sussex arising from the Trust's Clinical Strategy.

6.2 The Chairman invited the Trust's Medical Director, Dr Andrew Slater, to present the proposals to reconfigure acute stroke care, emergency and higher risk general surgery and emergency and higher risk orthopaedic services. Dr Slater highlighted the following points:

- The Trust's aim in relation to stroke care is to be amongst the top performers nationally, rather than simply meeting minimum standards. Currently performance is only average.
- Proposals for general surgery would enable the separation of teams working on elective and emergency cases. Currently, the rotas for the relatively small number of surgeons on each site require them to be available for emergency cases whilst also carrying out a list of planned operations, resulting in delays and cancellations.
- Although there are a larger number of orthopaedic surgeons, there are similar challenges as in general surgery, and particular issues regarding availability of operating theatre time.
- The Trust intends to invest in accident and emergency (A&E) services on both hospital sites, including increasing the number of consultants so that senior doctors see emergency cases as early as possible.
- As the three services proposed for reconfiguration represent a small proportion of hospital activity, the vast majority of patients will see no change to their service, except an improvement in quality through implementation of the wider Clinical Strategy. Overall, 7% of all inpatient care will be affected by the proposed reconfiguration and less than 1% of all patients using the two acute hospitals.
- The Trust recognises that a small number of patients and their families will be required to travel further but believes that the improved quality of care will provide recompense for this.

6.3 The following points were made in response to questions from the Committee:

6.4 **Higher risk surgery**
When asked to define 'higher risk' surgery, Dr Slater explained that this applies to cases where the surgeon has identified a risk that the patient may need to return to the operating theatre for further surgery following the original operation. Surgeons would assess the risk for each patient before operations took place.

6.5 **Options for consultation**
Dr Harrison clarified that a single option would be put forward for consultation on stroke services (creation of a dedicated acute and hyper acute unit on one site). For general surgery there would be two options – firstly, that emergency

and higher risk inpatient planned surgery be concentrated on one site (preferred) and secondly that emergency and all inpatient planned surgery be located on one site. Options for orthopaedics would be as for general surgery, with the addition of a third option – emergency and inpatient surgery on both sites.

6.6 **Seven day a week staffing**

Dr Slater explained that a key aim of the proposals was to provide the same level of care seven days a week. This requires a certain level of staffing which is not currently available on each site and would be hard to recruit to, given the specialist skills required. By consolidating services on one site, he argued, existing staff could be better utilised and it would be easier for the Trust to attract specialist staff to fill gaps.

Dr Harrison confirmed that modelling had been undertaken to identify the required staffing for reconfigured services. The majority of posts could be filled by existing staff, some of whom would be required to move from their current base. She anticipated that a centralised service would be more attractive to consultants due to the increased number of patients they would see. It would not be possible to employ extra consultants on both sites to cover a seven day service as the number of patients would not justify it.

6.7 **Quality and outcomes**

Dr Slater cited the reconfiguration of stroke services in London as an example where consolidation of services onto fewer sites had led to improved quality of care and patient outcomes. He stated that the average length of stay in London's stroke units had reduced from 14 to 10 days, the percentage of patients receiving thrombolysis had increased from 3% to 15%, 100% now received scans in the target time and it had been estimated that 400 patients had survived as a result of the new configuration. He anticipated similar benefits should a single specialist stroke unit be created in East Sussex.

6.8 **Long term viability of hospitals**

Dr Slater assured the committee that the proposals would not affect the long-term viability of the hospitals. He reiterated that the proposals affect less than 1% of patients using the hospitals and that the Trust was investing in core services at both sites such as A&E and acute medicine. Other services such as diagnostics, intensive care, day surgery, outpatients and lower risk inpatient surgery were all intended to remain on both sites.

Mr Grayson added that there is a general consensus that the model of district general hospitals is no longer appropriate and it is necessary for hospitals to look at more creative ways of working together. He indicated that the main driver for change is clinical viability and if there was no change it would be likely that standards would slowly deteriorate. He argued that making changes is key to ensuring a viable future for the hospitals.

6.9 **Maternity and paediatrics**

Dr Harrison confirmed that the interdependencies with obstetric and gynaecology and paediatric services had been examined. Some links had been identified with general surgery. However, the interdependency is not critical and the Trust is confident that arrangements can be put in place to provide surgical input for the small number of cases needing it. Both Dr Harrison and Mr Grayson confirmed that any decision made on the reconfiguration of the three services currently being considered would not

prejudice any future decision on the configuration of maternity and paediatric services.

Ms Philpott explained that the NHS Sussex-led programme 'Sussex Together' is examining issues of best practice, choice and workforce in maternity and paediatric services across Sussex. The outcome of two recent independently chaired workshops involving clinicians and patient representatives had been an agreement that there is a case for change to ensure safety and sustainability. A group has now been tasked with identifying options which would respond to the challenges. A progress report is expected in July, with the outcomes expected in September/October 2012. HOSCs will be asked to consider whether any proposed options constitute substantial change in due course. Ms Philpott confirmed that Sussex Together was not a decision making process and that decisions would remain with local Clinical Commissioning Groups to ensure appropriateness for local populations.

6.10 **Site selection**

Dr Harrison described how the location of any reconfigured services would be determined using the same five criteria used to assess options. These had previously been shared with HOSC. However, it was anticipated that the two criteria 'access and choice' and 'deliverability' would be the focus in determining location as the other criteria were thought to be broadly neutral between the two sites. The weighting of the criteria had been agreed by the Trust and NHS Sussex Boards, following engagement, and the location options would be scored against the criteria. Views expressed through the consultation process would help inform the scoring.

6.11 **Financial sustainability**

Mr Grayson confirmed that the financial analysis underpinning the Clinical Strategy would be made available. He emphasised that the Trust needs a strategic approach to addressing the savings required over the next few years. The Clinical Strategy is a part of this, contributing £35m-£40m towards the total of £105m savings required, but ongoing efficiency savings are also required. The three services being consulted on contribute approximately £8m-£9m in savings.

Ms Philpott added that financial sustainability across Sussex is being addressed through Sussex Together which is responding to changing need in the context of a static budget. She indicated that the Trust's Clinical Strategy sits within the context of the wider health economy financial strategy.

6.12 **Clinical engagement**

Ms Blow confirmed that GPs from the Clinical Commissioning Groups (CCGs) had been very involved through the development of the Clinical Strategy. They had worked on the development of options and identification of preferred options for each primary access point. The CCG Boards had discussed the proposals with member practices and had supported putting forward the proposed reconfiguration of services for consultation. The CCGs view the strategy as an opportunity to get the East Sussex health economy into a more sustainable position.

Mr Grayson assured the Committee that the Clinical Strategy work had been high profile within the Trust and several hundred staff had attended engagement events. The work on individual primary access points had been clinically led and involved doctors, nurses, therapists and other stakeholders.

Specific events had been organised for consultants to inform and involve them in the work. Mr Grayson acknowledged that some consultants at Eastbourne District General Hospital had expressed concerns, in contrast to consultants at the Conquest Hospital who had expressed support. He indicated his desire to work towards a more united view through ongoing discussion and noted that the Eastbourne consultants had expressed their support for any changes which would bring clinical benefits.

6.13 **Quality of community services**

Ms Blow assured HOSC that commissioners monitor the quality of community services through contracts and ongoing performance management. She added that while there was no current intention to put community services as a whole out to tender, any new provider would be required to meet relevant standards.

6.14 **Travel and access**

Dr Harrison confirmed that a travel and access analysis was being undertaken and this included looking at risks. National evidence on time windows for patients to access care was being examined. There is evidence that if patients can access a high quality service within a reasonable time period (e.g. 4.5 hours for stroke), they achieve better outcomes. The primary impact of increased travel would be on carers/relatives as most patients would be transported by ambulance. However the expected reduced length of stay in hospital as a result of the improved service would offset the impact to a certain extent. The travel analysis would be made available to HOSC and to the public during the consultation period.

Mr Grayson agreed that access does not only relate to distance but also to ability to travel. People on lower incomes tend to have less access to private transport. He indicated the Trust's wish to develop a sophisticated understanding of different aspects of access and to reflect ability to travel, including public transport.

Public interest

Mr Grayson acknowledged that the proposed service changes would attract a high level of public interest. A parliamentary debate organised by the MP for Eastbourne reflected this. He highlighted the role of local leaders in supporting an informed debate about what is best for patients.

6.15 RESOLVED to:

(1) Agree that the service change proposals set out in appendix 1 of the report constitute 'substantial variation' to health service provision requiring statutory consultation with HOSC under health scrutiny legislation.

(2) Agree that HOSC will undertake a detailed review of the proposals from July to October 2012 in order to prepare a report and recommendations.

7. <u>EAST SUSSEX HEALTHCARE NHS TRUST CLINICAL STRATEGY – PUBLIC CONSULTATION PROCESS</u>

7.1 The Committee considered a report by the Assistant Chief Executive which outlined plans for the public consultation process on service reconfiguration proposals arising from the Clinical Strategy.

7.2 Jessica Britton, Head of Governance and Assurance at NHS Sussex presented the plans to HOSC and the following issues were covered in response to the Committee's questions:

7.3 **Attendance at local groups/events**
Mr Grayson confirmed that the Trust, in conjunction with NHS Sussex, would respond to requests to attend meetings of local organisations as far as possible. It would be important to provide the right speakers for different events and there may be constraints on availability as services must continue to be provided.

Ms Britton confirmed that key voluntary sector organisations would be receiving the offer of a presentation/discussion at one of their meetings.

7.4 **Meetings for local representatives**
Ms Britton confirmed that arrangements were being made for a meeting for local politicians of all tiers in each district and borough area in response to a suggestion from the HOSC Task Group.

7.5 **Consultation timescale**
Mr Grayson confirmed that the consultation timescale would not be extended due to the need to make decisions in a timely way.

7.6 **Flexibility of the process**
Ms Britton assured the Committee that it would be possible to make changes to aspects of the consultation process as feedback was received, for example altering the structure of events or the information available. The Consultation Advisory Group being established would assist with this. However, it would not be possible to fundamentally change the process once it had begun. Ms Philpott added that the intention was to respond to what people are saying during the process and use this to enrich the debate.

7.7 **Marketplace events**
Ms Britton confirmed that there would be a minimum of five marketplace events open to the general public and there is likely to be seven in total. These will be spread out during the consultation period, based on feedback from previous engagement which indicated people may wish to attend an event both early and later in the process. The timing of the events would be focused before and after the main August holiday period.

7.8 **Geographical coverage**
Ms Britton confirmed that the consultation programme was designed to ensure it would reach all parts of the county. Marketplace events would be held in each district/borough area and the focus groups and deliberative event would include a range of people from across East Sussex. Communications about the consultation would also cover the whole county.

7.9 **Social media**
Ms Britton confirmed that, as well as electronic feedback options on the consultation website, there would be a Twitter feed and a Facebook page where people could discuss the proposals.

7.10 **Representativeness of responses**
Mr Grayson indicated the Trust's wish to hear from the front-line of communities, not just the most vocal. He indicated that consideration would need to be given as to how representative different voices are.

7.11 **Harder to reach groups**
Ms Britton acknowledged that some groups can be harder to reach and that these can include groups with a high need for health services. She indicated that the consultation would be made as accessible as possible, but that where groups did not wish to engage directly, engaging via community workers and representative groups had been found to be effective. For example, the NHS would work with older people's forums and networks who are best placed to reach out to the wider community of older people, including those who are more isolated.

7.12 **Clinical Commissioning Groups**
Ms Blow confirmed that CCGs would be involved in consultation events alongside East Sussex Healthcare Trust staff. Although many GP practices have Patient Participation Groups these tend to focus on the quality of general practice and are less involved in wider health issues. However, she agreed that CCGs would look at how to tap into their views.

7.13 RESOLVED to:
(1) Welcome the inclusion of suggestions made by the HOSC Task Group in the consultation programme.
(2) Stress the importance of hearing the voices of harder to reach groups.

The Chairman declared the meeting closed at 4.30pm