HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 26 July 2012

PRESENT:

Councillor Simmons (Chairman), Councillors Heaps, Pragnell, 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); Councillor Davies (Rother District Council); Mr Dave Burke, Hastings and Rother Counselling Service; and Ms Julie Eason, East Sussex Advice Plus (voluntary sector representatives)

WITNESSES:

East Sussex Healthcare NHS Trust
Darren Grayson, Chief Executive
Dr Amanda Harrison, Director of Strategic Development and Assurance
Jayne Black, Assistant Director of Strategic Development
Gary Bryant, Deputy Director of Finance

NHS South of England
Helene Feger, Associate Director of Communications and Engagement

Campaign Groups
Liz Walke, Chair of Save the DGH campaign
Margaret Williams, Chair of Hands off the Conquest campaign
Vincent Argent, Clinical advisor to Save the DGH

South East Coast Ambulance Service NHS Foundation Trust
Geraint Davies, Director of Commercial Services
James Pavey, Senior Operations Manager
Matt England, Clinical Quality Manager

Clinical Commissioning Groups
Dr Martin Writer, Chair of Eastbourne, Hailsham and Seaford CCG
Dr Matthew Jackson, Vice-chair of Eastbourne, Hailsham and Seaford CCG

NHS Sussex
John O'Sullivan, Project Director – Strategic Finance

East Sussex County Council/NHS Sussex
Jane Thomas, Consultant in Public Health

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

8. APOLOGIES

8.1 Apologies for absence were received from Councillors Howson and O'Keeffe, and Ms Janet Colvert, Local Involvement Network representative.

9. MINUTES

9.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 19 June 2012.

10. DISCLOSURE OF INTERESTS

10.1 There were none.

11. REPORTS

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

12. 'SHAPING OUR FUTURE' – HOSC EVIDENCE GATHERING PROCESS

12.1 The Committee considered a report by the Assistant Chief Executive which set out the planned approach to the Committee's evidence gathering process and highlighted key documentary evidence.

12.2 In addition to the formal evidence gathering meetings outlined in the report, the Chairman advised that HOSC Members would also receive an information pack each month containing any additional representations received from stakeholders. This pack would also be made available publicly on the HOSC website.

12.3 RESOLVED to:
(1) note the documentary evidence within the appendices; and
(2) agree the planned evidence gathering process.

13. 'SHAPING OUR FUTURE' – PERSPECTIVE FROM NHS SOUTH OF ENGLAND

13.1 The Committee welcomed Helene Feger, Associate Director of Communications and Engagement from NHS South of England, the Strategic Health Authority (SHA).

13.2 Ms Feger highlighted the following points about the role of the SHA in quality assuring locally developed proposals for service change:

- Engagement and consultation is a key part of the accountability framework when service change is proposed, and forms part of the 'four tests', introduced by the Secretary of State in July 2010, with which proposals must demonstrate compliance.
- The SHA ensures that the National Clinical Advisory Team (NCAT) and the Department of Health Gateway team are engaged and undertake the necessary reviews before proposals are able to go out to consultation.
- The SHA uses a readiness framework which requires the local NHS to set out the case for change, business case, local engagement undertaken and a range of other factors. This framework takes account of the 'four tests'.
- Proposals are tested via a series of challenge sessions which cover issues such as clinical leadership, benefits to patients and engagement. A range of SHA staff contribute to the assurance process including nursing, medical, finance and communications/engagement representatives.
- Plans do not go forward until the SHA has agreed they meet the required standards.

13.3 Ms Feger responded to questions from the Committee, covering the following areas:

13.4 **SHA view on the proposals**
Ms Feger confirmed that the SHA had found the Shaping our Future proposals to be coherent. She explained that the assurance process is iterative and there should be a dialogue between the SHA, NHS Sussex and East Sussex Healthcare NHS Trust (ESHT) regarding the case for change and anticipated benefits. Areas needing further development had been identified earlier in the process and further work was undertaken. The SHA had given approval to progress to consultation on the basis of readiness to move on to this stage. However the proposals are currently at Outline Business Case stage and further development would be expected at Full Business Case stage, for example on issues such as workforce.

13.5 **Patient choice**
When asked how the SHA had assessed compliance with the Secretary of State's test relating to patient choice, Ms Feger acknowledged that this was challenging. She highlighted that the proposals predominantly affect emergency services rather than elective, where choice is more significant. She argued that the proposals develop choice for patients through changes such the ability to see a senior specialist sooner and the development of community services to increase choice in relation to long term care.

13.6 **Clinical engagement**
Ms Feger indicated that the SHA regarded clinical engagement in the development of the proposals as strong, with clinical leads and divisional directors engaged from the outset. She acknowledged that not all Trust clinicians are signed up to the plans but understood that work was ongoing to discuss their concerns.

Ms Feger confirmed that the SHA was aware of a letter from the Consultant Advisory Committee at Eastbourne District General Hospital (DGH) raising concerns about the Clinical Strategy and indicated that it was primarily orthopaedic consultants at Eastbourne DGH who had raised questions, which was understandable. She explained that the SHA looks at the level and source of support for the proposals and had found there to be significant support for the proposed reconfiguration in all three service areas, whilst acknowledging the need for additional work with orthopaedic clinicians.

13.7 **SHA role in decision making**
Ms Feger explained that the SHA would be engaged in ongoing discussion with NHS Sussex and ESHT regarding the progress of the consultation and would look at the analysis of consultation responses and the proposals put forward and give views to the Board.

13.8 RESOLVED to:
(1) note the comments of NHS South of England.

14. 'SHAPING OUR FUTURE' – PERSPECTIVE FROM CAMPAIGN GROUPS

14.1 The Committee welcomed Liz Walke, Chair of Save the DGH campaign, Vincent Argent, clinical advisor to Save the DGH and Margaret Williams, Chair of Hands off the Conquest campaign, and considered the written submissions made by each group which were attached to the agenda.

14.2 Mrs Walke highlighted the following views and concerns of the Save the DGH group:

- The proposals had not been led by doctors working within the services - such as stroke and orthopaedic consultants – and none of them agree with the plans. Although they agree improvements are needed, they argue that many of the problems are outside of their control and, in respect of stroke, they are only tasked to provide a five day a week service.
- Surgery is an urgent service where time to access care matters.
- The proposals are financially motivated but the estimated saving is only £4.5m when £100m savings are required. The campaign group has not been able to obtain costings by site from ESHT.
- All patients using the services, and their relatives and friends, are affected. Many are elderly and don't like travelling outside their home town.
- The campaign agrees that recruitment is an issue, but the Trust has a poor track record in this regard for various reasons such as offering temporary contracts and poor reputation.
- The campaign is concerned that there would be a 'domino effect' - if some services were not provided from one site, then others would follow.
- Travel times should be the most important factor and emergency treatment should be provided closer to home rather than further away, particularly as the A259 is regarded as one of the worst roads in Europe.
- In terms of stroke, 2million brain cells are lost every minute and treatment is needed as soon as possible and in a certain time limit. Eastbourne DGH acts straight away.
- The Trust's approach is wrong – the core services are the emergency services which should be at the heart of the hospitals.
- The Trust should de-merge. Consultants in Hastings and Eastbourne have very different ways of working. There are smaller hospitals elsewhere, so it can be achieved.
- The overwhelming public opinion is that core services should be kept at both hospitals.

14.3 Mr Argent added the following points in support of the campaign group's position:

- It is not correct to say that there would be no change to Accident and Emergency (A&E) services as an A&E department cannot be designated a trauma unit without emergency surgery and orthopaedics on site, according to the Sussex Trauma Network. So the A&E department without these services would be a Minor Injuries Unit or Local Emergency Hospital, effectively a downgrading of the department.
- In relation to stroke, the Shaping our Future document mentions a time window for treatment of 4.5 hours but national guidance and the product guidance for the thrombolysis drug cite an optimum time of 90 minutes from the onset of symptoms, with 4.5 hours as the upper limit and little benefit seen by this point. 90 minutes is hard to achieve.
- The Sussex Stroke Network has no overall strategy for the location of services. A hyper acute stroke unit should be co-located with neurosurgery and endovascular and interventional radiology, therefore would need to be located at the Royal Sussex County Hospital in Brighton where these services are available. Eastbourne should have an acute stroke unit in order to achieve the 90 minute thrombolysis target.
- Emergency surgery is not undertaken after 9pm at night unless necessary. The bulk of surgery after 9pm is paediatric and obstetric/gynaecology related. If emergency surgery is located at one site it is therefore almost certain that

obstetrics and gynaecology will follow. The proposals are therefore more drastic than they appear.

14.4 The Save the DGH representatives responded to questions on the following topics:

14.5 **Trust de-merger**
When asked how a de-merger of the Trust would address the issues which had been highlighted, Mrs Walke argued that it would enable core services to be provided at each hospital. The hospitals would focus on profitable services to subsidise core services.

Mrs Walke indicated that a merger of Eastbourne DGH with Brighton and Sussex University Hospitals NHS Trust could be considered as an alternative if a stand alone Trust was not viable, as accessing specialist services in Brighton was more appropriate than accessing some services in Hastings and then potentially requiring onward transfer to Brighton. However, she acknowledged that Eastbourne GPs and clinicians are not supportive of this option due to concerns that Brighton would dominate. The campaign group's preference is therefore for a stand alone Foundation Trust for Eastbourne with merger with Brighton as the second choice.

14.6 **Save the DGH representativeness**
Mrs Walke argued that Save the DGH covers most of the population and includes representatives such as the Bishop of Lewes, Churches Together, each local political party, the Chamber of Commerce and a retired GP. She indicated that the campaign had collected 5000 signatures in support of an alternative option in relation to a previous consultation on maternity services, but this had been counted as a response from a single group.

14.7 **Recruitment**
Mrs Walke argued that the recruitment problems experienced by ESHT are self-made due to a perception that it is a troubled trust. She highlighted the attractions of East Sussex as a place to live and expected that two individual hospital trusts would be able to attract top applicants.

Mr Argent added that middle grade doctors undertake a significant amount of service delivery, especially out of hours, and they are particularly hard to recruit. The view of the Royal Colleges is to move towards a consultant delivered service. He argued that ESHT should recruit more consultants to alter the ratio.

14.8 **Views of stroke consultants**
Mrs Walke indicated that she had spoken to a senior stroke and she stated that the consultant had not supported the proposals.

14.9 **Travel and transport measures**
Mr Argent suggested that NHS bodies should work closely with transport planners to make radical changes to the transport infrastructure to reduce transit times.

14.10 **NCAT report**
Mrs Walke responded with surprise to the National Clinical Advisory Team's support for the proposals and questioned whether they knew the full detail of the proposals or whether they had visited the services in question. She also

expressed concern about the accuracy of information in the consultation document.

Mr Grayson clarified that the NCAT representatives had visited the units and spoken to clinicians.

14.11 **Domino effect**
Mr Argent clarified his earlier statement that paediatrics would almost certainly need to be co-located with emergency and higher risk general surgery on one site due to the need for surgery on children e.g. to treat fractures.

14.12 **Quality of services at Eastbourne DGH**
Mr Argent indicated that services would benefit from investment and improvement and suggested that the Sussex Stroke Network should be asked for views on the improvement required. He suggested that this is a common issue for district general hospitals and smaller hospitals, such as the Princess Royal Hospital in Haywards Heath, have stroke units. Mr Argent highlighted the potential to use a telemedicine link to a hyper acute stroke unit.

14.13 Mrs Williams highlighted the following points on behalf of the Hands off the Conquest group to supplement her written submission:

- The two campaign groups are united in their position.
- The group had contacted the Local Medical Committee and local branch of the British Medical Association who had replied but had not commented on the proposals.
- The group has concerns about information within the consultation document and believe it should be withdrawn and the process restarted. She listed a number of specific concerns about statistics quoted in the document.

14.14 Mrs Williams agreed to supply HOSC with a written summary of the group's detailed concerns about data cited in the consultation document so that HOSC could request a response from the NHS.

14.15 Mrs Williams responded to questions on the following topics:

14.16 **De-merger**
Mrs Williams confirmed that Hands off the Conquest are in favour of a de-merger of the Trust. She indicated that the residents surrounding each hospital are loyal and know the hospital staff will be loyal to them and work in their best interest. The group is uncertain about a potential merger of the Conquest Hospital with another Trust, which would depend on the ability of the Conquest to operate as a stand alone Trust. She argued that a stand alone Trust would eliminate access issues.

14.17 **Recruitment**
Mrs Williams argued that a de-merged Trust would find it easier to recruit and highlighted the attractions of the area. She pointed out that the Trust had been able to recruit five obstetric consultants after the previous consultation on maternity services had ended, and suggested that recruitment is possible if approached in the correct way.

14.18 **Views of consultants at the Conquest Hospital**

When asked about indications that Hastings consultants are supportive of the proposals, Mrs Williams suggested that clinicians are wary of speaking out due to concerns about their jobs, and therefore she was not able to comment on their views.

14.19 **NCAT report**
When asked to comment on the conclusions of the NCAT report, Mrs Williams highlighted that the NCAT representatives are clinicians from outside the area and she doubted their familiarity with the local travel issues, such as the A259.

14.20 **Changes to elective services**
HOSC referred to the suggestion in the Hands off the Conquest group's submission that changes to elective services could be accepted but not emergency. Mrs Williams stated that the group understands the pressures on the Trust and the need for some change, but that emergency services should remain local, in both hospitals, to serve the large area covered by the Trust.

14.21 RESOLVED to:
(1) note the comments of the campaign groups.
(2) request a summary of the Hands off the Conquest group's concerns about data in the consultation document and to request a response from the NHS.

15. 'SHAPING OUR FUTURE' – PERSPECTIVE FROM THE AMBULANCE SERVICE

15.1 The Committee welcomed Geraint Davies, Director of Commercial Services, James Pavey, Senior Operations Manager and Matt England, Clinical Quality Manager from South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

15.2 The SECAmb representatives responded to questions on the following topics:

15.3 **Handover times**
Mr Davies informed the Committee that the need to improve handover times at A&E departments had been recognised and a new policy had just been introduced. Work is ongoing with ESHT to improve data capture on handover times and to improve liaison between ambulance crews and A&E staff. Mr Davies added that the proposed service changes would enable crews to take patients to a specialist site and that telemetry can be used to send advance information to hospitals about the patient's status.

Mr Pavey added that SECAmb would plan for the impact of the service changes and have managed similar changes elsewhere in the Trust's area. Resources can be applied to meet demand and there have been discussions with commissioners to ensure this is met.

15.4 **Impact on SECAmb**
Mr Pavey explained that the impact on ambulance resources would relate to extended journey times rather than additional patients and that the precise impact would need to be assessed once a service configuration was agreed. He advised the committee that the extension to journey times would be a matter of minutes rather than hours and this may be offset by gains elsewhere. Mr Pavey acknowledged that there would be a cost to any additional ambulance resources which may be required to support the

changes. However, he argued that by taking the patient to the right place at the right time their recovery would be quicker, making it a better use of NHS resources overall.

Mr Davies confirmed that SECAmb would calculate the impact on job cycle times based on the preferred service configuration in order to identify the impact on ambulance resources for discussion with commissioners. Mr Davies assured HOSC that SECAmb would have the debate about resource implications with commissioners and indicated that commissioners had previously supported extra resources to mitigate the impact of reconfiguration on the ambulance service.

15.5 **Diagnosis**

Mr Pavey explained that ambulance crews do not necessarily seek to diagnose a patient, but rather to identify the possible problem(s) in order to access the appropriate care. He cited the example of abdominal pain which is a complex issue where crews would err on the side of caution regarding the appropriate place to take patients. In Haywards Heath a patient with these symptoms would not be taken to the Princess Royal Hospital as they do not accept surgical emergencies, they would be taken directly to Brighton. He indicated that this system of decision making is well tested and based on evidence gathered over a long period of time.

With regard to stroke, Mr Pavey advised the Committee that diagnosis using the FAST (Face, Arm, Speech, Time to call 999) test is relatively straightforward and has a high degree of accuracy. He indicated that, although the changes would make some difference to SECAmb, the evidence that that taking patients to the right place is beneficial to their outcome is the overriding factor. Mr Pavey told HOSC that he was extremely comfortable with this methodology which he viewed as tried and tested.

15.6 **Self-presenting patients**

Mr Pavey agreed that there is always the possibility of patients self-presenting at the ‘wrong’ site for their condition, despite campaigns to improve recognition of conditions like stroke, but he indicated that it is a small number of people. Mr England assured HOSC that if a patient arrives at, for example, a minor injury unit with a stroke or a heart attack requiring primary angioplasty, SECAmb treats the call from the unit with the highest priority and dispatches a blue light response as if the patient was in any other location.

When asked to clarify the arrangements for patients in Seaford, Mr Pavey explained that they would be taken to the nearest hospital with the relevant facilities for their condition, which already happens for trauma and primary angioplasty. He confirmed that Seaford is well within the 45 minute (trauma) and 90 minute (stroke) travel times to Brighton.

15.7 **Benefits of two sites**

When asked whether it would be preferable to retain services on two sites, Mr Pavey acknowledged that the public view hospitals as a place of help. However, he would focus on where they can get the best help and best outcome. He told HOSC that evidence suggests there is a need for a critical mass of patients in order to support the necessary expertise required in hospitals for certain conditions and that the specialist site model works best for patient outcomes.

15.8 **Response times**

Mr Pavey confirmed that SECAmb consistently meets the national required standard of response within 8 minutes for 75% of category A calls. He advised the Committee that this target would become more challenging from April 2013 when category A would be divided into two levels and 80% of the most life-threatening calls would be expected to receive a response in 8 minutes.

Mr Davies clarified that SECAmb is commissioned to meet targets at the level of the previous PCT boundaries and that performance will be at different levels in different areas as the data is disaggregated to lower levels.

15.9 **Stroke treatment**

Mr Pavey confirmed that ambulance crews cannot administer thrombolysis as they do not have the technology to diagnose whether the stroke is caused by a clot or a bleed. If such technology was developed, SECAMb would want to be the first Ambulance Trust to adopt it. Mr England explained that the crew would manage the symptoms and alert the receiving hospital. Around 10-15% of FAST positive patients will be suitable for thrombolysis and the hospital decides suitability. The crew's role is to get the FAST positive patient to the place they can get the right care as soon as possible.

Mr England advised HOSC that a 5.5 hour window (recently extended from 4.5) had been agreed by the Sussex Stroke Network in terms of thrombolysis treatment, and the age limit on use of the drug had also been removed. The 5.5 hours is intended to comprise 1 hour pre-hospital stage and 4.5 hour in hospital phase.

15.10 **Effectiveness of protocols**

Mr Davies was able to cite examples of protocols agreed with other Trusts where certain services are not provided at all hospitals and SECAmb identifies and takes patients to the correct location. These include a stroke protocol in Kent, the protocol between the Princess Royal Hospital and the Royal Sussex County Hospital which operates successfully based on clinical need and an agreement between Pembury and Maidstone hospitals, again based on the type of need.

Mr Davies highlighted that similar models to that being proposed in East Sussex were already running elsewhere nationally and locally, based around networks of services. These arrangements had been used to address similar challenges to those ESHT is facing. Mr Davies assured the Committee that SECAmb had a responsibility to provide the safest environment for patients and would challenge colleagues in Trusts on the clinical evidence supporting proposed service configurations where necessary.

Mr England advised HOSC that SECAmb builds in safety measures to support such protocols, such as a clinical support desk to provide additional advice to crews. In terms of protocols, Mr England stressed the need for clarity based on a 24/7 pathway, rather than arrangements based around 9-5 with different pathways out of hours.

15.11 **Traffic congestion**

Mr Pavey argued that traffic congestion is a problem everywhere and is not an issue restricted to East Sussex or the A259. He added that ambulances can use blue lights to by-pass more difficult traffic and that the planned Bexhill

to Hastings link road may help in the future. Mr Davies offered to supply data on areas covered within a 45 minute travel time to hospital and a matrix showing how SECAmb can cover the whole area. He also agreed to supply information on total transfer times, including loading and unloading time.

15.12 **Location of ambulances**
Mr Davies explained the Trust's system to strategically locate vehicles at different locations at different times of day, based on analysis of demand. As the 8 minute response target begins from the time the call is made (rather than answered) it is critical to have ambulances in the best possible location. The Trust's strategy is based around central make ready depots which clean and maintain vehicles, surrounded by a network of response posts. This is a development from the traditional ambulance station model which was less flexible. A make ready depot already exists in Hastings and one is being developed in Polegate.

15.13 **Engagement**
Mr Davies confirmed that SECAmb had been engaged in the redesign of emergency care at ESHT.

15.14 RESOLVED to:
(1) note the comments of the South East Coast Ambulance Service NHS Foundation Trust.
(2) request further data on travel and transfer times from the Trust.

16. 'SHAPING OUR FUTURE' – PERSPECTIVE FROM CLINICAL COMMISSIONING GROUPS

16.1 The Committee welcomed Dr Martin Writer and Dr Matthew Jackson, Chair and Vice-Chair of Eastbourne, Seaford and Hailsham Clinical Commissioning Group (CCG). Dr Writer and Dr Jackson confirmed that they were representing the views of all three CCGs covering East Sussex.

16.2 Dr Writer highlighted the following reasons why the CCGs support the proposals for service change:

- The CCGs recognise that the two hospitals are struggling to deliver best practice services and GPs have been involved in the Clinical Strategy review which identified the need for reconfiguration of three services.
- The changes are based on best clinical evidence and discussion amongst clinicians. The reconfiguration will deliver a much higher standard of care.
- Although there will be longer travel times for some patients, they will receive quicker, higher quality care and will recover more quickly.
- The reconfiguration of stroke care in London has been successful despite concerns about increased travel time. ESHT stroke services are disappointing, only recently meeting thrombolysis targets and not offering the seven day a week service which a single unit could provide, which would improve outcomes. Investment is available for extra capacity but is not possible to recruit the necessary staff in the current set-up.
- Similar benefits can be achieved in general surgery and orthopaedics. Patients are not assessed quickly by a senior decision maker. In the proposed model there will be dedicated staff and theatre time. People may have to travel further but they will get treatment more quickly.
- Although there is a perception that travelling further leads to worse outcomes there is clear evidence, such as from trauma centres, that the right care gives better outcomes even if it is further away.

- CCGs believe these are compelling arguments for GPs and commissioners who want to see the best patient outcomes.

16.3 The CCG representatives responded to questions as follows:

16.4 **NCAT report**
Dr Writer confirmed that he had been interviewed by NCAT, despite not being listed in their draft report, and that he supports the NCAT conclusions.

16.5 **Community services**
Dr Writer argued that the provision of both community and acute services by ESHT presents an ideal opportunity for integrated services. Rehabilitation is an important part of the strategy and CCGs are confident that they can work with ESHT to strengthen services for people at home or on discharge from hospital. CCGs are also confident that the anticipated reduced lengths of stay in hospital can be achieved. Dr Writer indicated that CCG concerns focus on the fact that the community side of ESHT is still bedding in, with inevitable changes arising from the integration of these services into the organisation leading to some movement and unsettling of staff.

Dr Writer indicated that CCGs are working to ensure ESHT can deliver the necessary investment and improvement in community services. If the Trust can't deliver, or services are not of a high enough standard, CCGs may need to look at alternative provision and have the option to put services out to tender. However, the CCGs have confidence in ESHT and any alternative would be a long way off. Dr Writer confirmed the CCGs' awareness of the concerns regarding investment in community services and their importance to the strategy.

16.6 **Health inequalities**
Dr Jackson emphasised that the reconfiguration primarily affects a small number of acutely ill patients who would generally receive an ambulance response. He does not therefore believe that the changes would disadvantage particular social groups but, as commissioners, CCGs would look at the impact across the area, working with Public Health.

16.7 **Views of GPs and consultants**
When asked whether the CCG views are shared by the wider GP community, Dr Jackson assured HOSC that the CCG leadership had worked closely and extensively with their member practices on the approach to working with ESHT on the Clinical Strategy. There had been unanimous support to work with the Trust on the process. Dr Jackson acknowledged that this did not mean all GPs fully support the specific proposals, but there may be an ongoing need to build understanding of the proposals. Dr Jackson confirmed the CCG view that there is a compelling body of evidence that the proposals will improve care of the small number of patients affected. He had not seen compelling evidence to the contrary so was unsure where any colleagues who opposed the plans obtained their evidence from.

Dr Jackson confirmed his awareness of the views expressed by the Eastbourne DGH Consultant Advisory Committee and assured HOSC that no similar level of concern had been expressed by GPs. He stated that CCGs had worked closely with clinical leaders at both hospitals and had reached consensus on the clinical evidence.

16.8 **Ambulance service capacity**

Dr Jackson assured the Committee that CCGs would look at the position regarding any new needs across the board to ensure funds are allocated where needed as part of the commissioning cycle. Dr Writer highlighted the need to recognise the challenging financial context but emphasised that these proposals are about quality rather than finance. He was not able to give a financial commitment without knowing the specific costs but gave an assurance that needs would be discussed with SECAmb and factored into commissioning decisions.

16.9 **De-merger/Yeovil model**

Dr Writer indicated that he had discussed the Yeovil Trust model, cited as an example of a successful smaller Trust by Save the DGH campaign, with Mrs Walke. His view, informed by having previously worked in nearby Taunton, is that Yeovil and Eastbourne are not similar. Yeovil is looking to share stroke services and will not deliver the same standard as would be provided by ESHT under the proposed model. Dr Writer also stated that Eastbourne DGH would not be viable as a stand alone Trust so would have to merge with the Brighton Trust. If this route was taken, he was very confident that they would remove services from Eastbourne, leaving it as a cottage hospital. Dr Writer argued that the two hospitals in East Sussex are sustainable if they work closely together and integrate some services.

16.10 **Domino effect**

Dr Jackson argued that fears of a domino effect on other services were based on a misconception that a large amount of activity would be moving to one site from the other. He stressed that it is a small number of very sick patients who would be affected and this is where there is a need to concentrate expertise and case mix in one place. Dr Jackson highlighted that over 90% of admissions are medical, remaining on both sites, so he does not believe there will be a domino effect. There may be activity travelling in both directions with each site specialising in different areas.

16.11 **Financial drivers**

Dr Jackson indicated that services must be sustainable and able to live within their means – in this sense money is a factor in any service redesign.

With regard to achieving the stroke best practice tariff, Dr Writer estimated that ESHT could meet part of the required pathway in the current configuration but not the required therapeutic input, which is the main benefit for most patients as only a small percentage are suitable for thrombolysis.

16.12 **Maternity and paediatrics**

Dr Writer confirmed that these specialties were being looked at through Sussex Together. The CCGs had been keen to include them in the local review but this large piece of work across Sussex could not be completed in time. He argued that if East Sussex had gone ahead with locally developed options there would have been a risk that these may not fit with a wider strategy developed for Sussex as a whole. Dr Writer expressed his confidence that there are no critical interdependencies with other services and that maternity and paediatrics could be provided on either site. He did not know what the outcome of Sussex Together would be, but anticipated that it could be radical.

16.13 RESOLVED to:

(1) note the comments of the Clinical Commissioning Groups.

17. 'SHAPING OUR FUTURE' – FINANCIAL PERSPECTIVE

17.1 The Committee welcomed Darren Grayson, Chief Executive, Gary Bryant, Deputy Director of Finance and Dr Amanda Harrison, Director of Strategic Development and Assurance from East Sussex Healthcare NHS Trust (ESHT) and John O'Sullivan, Project Director – Strategic Finance from NHS Sussex. The Committee considered a report provided by ESHT which was attached to the agenda.

17.2 **Level of financial detail**
When questioned by HOSC on the level of detail in the Trust's report and whether it fulfilled the requirements in the Treasury's 'Green Book' guidance, Mr Grayson stated that the figures had been put together through the standard NHS process and had been signed off by the finance teams of the Trust, NHS Sussex, the SHA and Department of Health Gateway team. He highlighted that more detail is contained within the Trust's pre-consultation business case which is publicly available and the report provided to HOSC represented a summary of this. Mr Grayson emphasised that the Trust did not seek to mislead or obfuscate and argued that the Gateway team would not have approved the progression of the process if this had been the case. He acknowledged that the proposals were currently at pre-consultation business case stage and would need to go through the more detailed Outline Business Case and Full Business Case stages before investment decisions could be finally agreed.

Mr Bryant confirmed that the Green Book requirements referred to the Outline Business Case and Full Business Case stages of the process which had not yet been reached. These later stages included the completion of a cost-benefit analysis

17.3 **Accuracy of estimated savings**
Mr Grayson acknowledged that the pre-consultation business case, which is produced at this early stage of the process, is necessarily based on assumptions about the future which could change. The Outline Business Case and Full Business Case stages will develop the modelling and give a final picture of anticipated savings. Full Business Case stage would not be reached until 2013, but Mr Grayson was of the view that the modelling undertaken so far was in line with best practice.

Dr Harrison highlighted the balance the Trust was trying to strike between working up sufficient detail to enable meaningful consultation but without progressing so far that the appearance may be of a decision already made. She argued that it was important for consultation to be able to influence the decision, and the later stages of the work on the agreed option. Dr Harrison also highlighted the extent of the work which would be required to fully develop the agreed option and advised HOSC that it would not be a good use of resources to carry out this level of extensive work on all options as some would not be chosen for implementation.

With regard to the potential need for additional ambulance resources, Dr Harrison clarified that there would not be a need for additional air ambulance capacity as the patients affected would not be transported in this way.

17.4 **Role of the Irvine Unit**

Mr Grayson indicated that, although the Trust had committed to expanding the Irvine Unit in Bexhill as a rehabilitation service, there was no possibility of developing the unit to provide acute stroke services as the necessary range of support services would not be available at a community hospital.

17.5 **Audacious goals**

Mr Grayson clarified that the NHS Sussex audacious goals are commissioning intentions, but that the whole local health economy is committed to them and they had been factored into the pre-consultation business case. He suggested that a lot could be done by the health and social care system to reduce admissions, for example providing additional support to care and nursing homes, especially in relation to dementia. Mr Grayson explained that the goals have a set of plans underpinning them and represent the way in which the local health economy will deliver government savings requirements.

17.6 **Capital availability**

Mr Bryant advised HOSC that the Trust has a number of options for accessing the necessary capital to deliver the proposed reconfiguration, including Trust reserves, government loan, loan from the market or accessing public capital (although this is unlikely). He indicated that the Trust is in ongoing discussion with the SHA about these options and the capital was not secured at this stage.

Mr Grayson clarified that the Trust did not intend to pursue a Private Finance Initiative (PFI) scheme. He advised the Committee that the most straightforward way to access capital was for the Trust to achieve a surplus but the Trust would not be able to generate a surplus without making changes to services. Mr Grayson stated that the Trust's future capital plan includes an indicative £30m to deliver reconfiguration but it is not possible to go any further until an option is agreed for implementation. He indicated that the Trust has SHA and commissioner support to make capital available.

Mr Bryant confirmed that the estimated revenue costs of the capital spend had been included in the overall Trust financial strategy, based on a public sector loan source, but had not been specifically listed against each of three options in the report.

17.7 **Source of savings**

HOSC questioned Trust representatives about the reductions in staffing, beds, outpatient clinics and theatre time outlined in the report as the source of the anticipated savings from reconfiguration. Dr Harrison clarified that stroke care is currently provided by two wards which also provide care to other patients and it is all the care provided by these wards which the current figures are based on. For the proposed future stroke configuration, figures had been based on the optimum number of staff to provide specialist stroke care, whilst factoring in reduced length of stay. She added that reductions in outpatient clinic activity for general surgery and orthopaedics relate to commissioning intentions under the audacious goals.

When asked why management savings did not appear to be included, Dr Harrison stated that the Trust had made significant savings on management costs across the organisation as a whole so these had not been apportioned to specific clinical areas. The staffing costs within the three clinical areas

affected by the proposals are primarily clinical, with minimal management overheads.

17.8 **Balance of savings**
When asked how the Trust would deliver the remaining £74m savings requirement over and above the savings estimated from the Clinical Strategy, Mr Bryant advised that this level of savings requirement is not unique to ESHT. All NHS organisations are expected to deliver a similar level each year and he expressed confidence that the Trust could deliver.

Mr O'Sullivan confirmed that this level of savings is not unique to ESHT and there is a common need across Sussex to improve quality and use resources more effectively. This is being approached through the Sussex Together programme which brings together all commissioners and providers to redesign services in line with best practice. Mr O'Sullivan indicated that the NHS had reached the limit of what is achievable through a year on year 'salami slicing' approach and there is now a need for service redesign to meet future challenges given the national financial situation. He stressed that the clinical basis for redesign is paramount and the financial element is to ensure redesign contributes to financial sustainability.

17.9 RESOLVED to:
(1) note the financial information presented by East Sussex Healthcare NHS Trust and NHS Sussex.
(2) arrange for HOSC representatives to meet with Trust finance representatives to further review the financial aspects of the proposals.

18. 'SHAPING OUR FUTURE' – PUBLIC HEALTH PERSPECTIVE

18.1 The Committee welcomed Jane Thomas, Consultant in Public Health for NHS Sussex/East Sussex County Council and considered her report highlighting key public health issues to consider, which was attached to the agenda.

18.2 Ms Thomas responded to questions on the following topics:

18.3 **Health inequalities**
Ms Thomas confirmed that health inequalities exist between different groups in East Sussex. She indicated that an area of concern from a public health perspective would be the impact of the proposals on visitors/relatives of patients due to challenges accessing the hospitals by public transport. Journeys by public transport could be up to 1.5 hours. The joint strategic needs assessment (JSNA) for East Sussex identified that a relatively high proportion of households in the county do not have access to a car. There is also some evidence that people on Job Seeker's Allowance are less likely to have a driving licence.

Ms Thomas suggested that ESHT would need to take account of the impact on visitors and consider whether any mitigating measures could be put in place such as travel vouchers or improvements to public transport. She clarified that for patients themselves the impact would be reduced as most emergency patients would be travelling by ambulance.

18.4 **Impact of visitors**
When questioned on evidence of any impact on patient outcomes from receiving visitors, Ms Thomas highlighted the benefits of family members being able to provide information about the patient to staff and possible

reduced stress levels for the patient, although the evidence on this is unclear. There is a lack of research in this area and it is possible that a patient not receiving visitors may not see any impact on their recovery. Ms Thomas also highlighted the importance of family members being able to visit patients at the end of their lives.

Although visitors may have a positive impact, Ms Thomas argued that there must be a balance with clinical quality as the most important factor for recovery is meeting national targets for best practice care, such as those outlined in the national Stroke Sentinel Audit.

18.5 **Cost shifting**
Ms Thomas suggested that the cost-shifting mentioned in her report could include costs of additional ambulance resources shifting to commissioners, or costs of travel shifted onto patients or visitors. She advised HOSC that some estimation could theoretically be made but it would be a calculation based on assumptions.

Ms Thomas indicated that any potential impact on household incomes from the forthcoming national welfare reforms would also need to be considered.

18.6 **Air pollution**
In terms of the potential for additional road travel, Ms Thomas suggested that the impact on air pollution should be taken into account, particularly as this is included in the national public health outcomes framework.

18.7 RESOLVED to:
(1) note the comments of the Public Health representative.

The Chairman declared the meeting closed at 1.45pm