Agenda Item 5

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**26 July 2012**
By:	**Assistant Chief Executive**
Title of report:	**Shaping our Future – HOSC evidence gathering process**
Purpose of report:	**To set out the planned approach to the Committee's evidence gathering process and to highlight key documentary evidence providing context for this meeting.**

RECOMMENDATIONS

HOSC is recommended to:

1. **Note the documentary evidence within the appendices and raise questions with witnesses as appropriate during the evidence gathering process.**
2. **Note the planned evidence gathering process and make any comments.**

1. Background

1.1 In June 2012 HOSC considered proposals for the reconfiguration of three services arising from the East Sussex Healthcare NHS Trust (ESHT) Clinical Strategy, known as *'Shaping our Future'*. The proposals, put forward by NHS Sussex in conjunction with ESHT and the emerging Clinical Commissioning Groups, involve reconfiguration of these specific services:

- Hyper acute and acute stroke care
- Emergency and higher risk elective (planned) general surgery
- Emergency and higher risk elective (planned) orthopaedic surgery

1.2 For each of these services the preferred option is to provide the service from one acute (main) hospital site only. The two acute hospital sites, which both currently provide the above services, are Eastbourne District General Hospital (DGH) and the Conquest Hospital in Hastings. There is no recommendation as to the preferred site for the location of the services and the Trust has indicated that they could be provided at either site. However, emergency and higher risk general surgery and orthopaedic surgery are interdependent and therefore must be located at the same hospital.

1.3 The proposals are set out in full in a public consultation document available from www.esht.nhs.uk/shapingourfuture . Copies have been circulated to all HOSC Members. The public consultation process began on 25 June and closes on 28 September 2012.

1.4 The final decision on any change to the configuration of services will be made by the Board of NHS Sussex as the body which exercises statutory responsibility for the commissioning of services until April 2013. The NHS Sussex Board will be informed by the views of the Clinical Commissioning Groups, who will take over commissioning responsibilities from that date, and the view of the ESHT Board. Decisions will be made following consideration of the outcomes of the consultation process.

2. HOSC's role

2.1 In June, HOSC determined that the proposed changes constitute 'substantial variation' to services, requiring formal consultation with the Committee under health scrutiny legislation. HOSC agreed to undertake a detailed review of the proposals from July-October 2012 in order to prepare a report and recommendations based on evidence gathered from a range of sources. HOSC's

report will taken into consideration by decision makers, alongside the public consultation response and other evidence.

2.2 HOSC's role focuses on consideration of two key questions:

- Are the proposals in the best interests of health services for East Sussex residents?
- Has consultation with HOSC, and with the public, been undertaken appropriately?

3. HOSC evidence gathering process

3.1 Four Committee meetings have been arranged between July and October to enable HOSC to seek a range of views on the proposals from key stakeholders and to agree a report summarising the Committee's findings. The planned structure of these meetings is set out in the table below, although this will need to be flexible as the process progresses.

Date of meeting	***Theme/focus***
26 July 2012	• Cross-cutting issues e.g. travel and access, finance • Views from key stakeholders
13 Sept 2012	• Stroke care • Community services (capacity to support changes to acute care)
4 Oct 2012	• Orthopaedics • General surgery • Links to emergency care • Further views from key stakeholders (oral and written)
30 Oct 2012	• Outcome of public consultation • Review of consultation process • Consideration of HOSC's report

3.2 A range of stakeholders will be invited to attend each meeting to aid the Committee's understanding of the services subject to change and the potential impact of the proposals. It will be appropriate for some attendees to provide written reports in advance of the meetings where additional information would be helpful to support discussion.

3.3 To make most effective use of HOSC's time, some further stakeholders will be invited to submit written comments to the Committee for consideration at the 4 October meeting. However, this will be limited to ensure that HOSC does not duplicate the public consultation process. A report summarising responses to the consultation, which the NHS has commissioned from an independent analyst, will be available for the Committee's consideration later in October.

4. Documentary evidence

4.1 In addition to discussion with key stakeholders, there are a range of key documents which may be helpful to the Committee's consideration of the proposals. This includes national guidance and specific local reports. Documents which are relevant to the meeting theme will be attached to the agenda to support the discussion.

4.2 The following documents are attached to provide general additional context to the discussion with attendees at this meeting:

- Appendix 1: Travel and access study summary report, provided by ESHT/NHS Sussex
- Appendix 2: Draft report of the National Clinical Advisory Team (NCAT), with a covering report provided by ESHT

4.3 Written submissions specific to individual agenda items are attached separately.

SIMON HUGHES
Assistant Chief Executive, Governance and Community Services

Contact Officer: Claire Lee Tel No: 01273 481327

East Sussex Healthcare NHS
NHS Trust

Report to:
East Sussex Health Overview and Scrutiny Committee (HOSC).

Date: 26 July 2012.

By:
Amanda Harrison- Director of Strategic Development- East Sussex Healthcare Trust (ESHT).

Title of Report:
Travel and Access Report pertaining to 'shaping our future' strategy document

Purpose of Report:
To highlight the issues associated with travel and access that will be considered during the option appraisal process outlined in the 'shaping our future' strategy document

Introduction:
East Sussex Healthcare Trust commissioned a report from an independent specialist travel and access research company, who were asked to provide information on patient and public access to hospitals, based on the proposals outlined in the 'shaping our future' strategy document.

Travel and Access

1.0 Introduction

We want people in East Sussex to get the right care at the right time in an environment that is designed to meet their specific needs. Currently services at Eastbourne District General Hospital (DGH) and Conquest Hospital in Hastings are failing to provide excellent care for every patient. People are not always seen by specialists as early as they should be. Too many planned operations are being cancelled too often. Hospital staff work incredibly hard to provide high quality services to patients, but we know that with some important changes to the way things are organised we can do much better.

We are already making improvements to the quality and safety of many services in East Sussex. However, we believe some services need more significant change. Stroke, general surgery and orthopaedic services are currently organised in a way that means we cannot provide the best possible care for local people.

The proposed changes will mean the majority of patients would continue to receive services at the hospital of their choice, most often the site closest to their home. About 7% of all in-patients may need to go to a different hospital, which is about 3,500 people a year; but this may not always be further away depending on where they are admitted from. The majority of patients admitted to stroke, emergency surgery and emergency orthopaedics are likely to travel by ambulance and a few by car. Carers and visitors will use both cars and public transport.

Under the proposed changes:

	The number of patients who **might** need to travel further per week if the service is sited at Eastbourne DGH	The number of patients who **might** need to travel further per week if the service is sited at Conquest Hospital
Stroke	7	8
Emergency and high risk in-patient general surgery	38	56
Emergency and high risk in-patient orthopaedic surgery	22	25

The preferred options for stroke, emergency general surgery and emergency orthopaedics would mean that routine and planned care would continue to be provided at both Eastbourne DGH and Conquest but emergency and high risk inpatient care would be delivered from a single site only. The interdependencies associated with these services mean that emergency care for general surgery and orthopaedics would

need to be located on the same site. Stroke services do not need to be co-located in this way.

We recognise the importance that patients and their visitors place on the time it takes them to travel to hospital.

We have commissioned an independent specialist to undertake research on travel times to local hospitals including those outside of East Sussex. The objectives of the independent research were to:

- Evaluate travel time and the impact of single siting some services at either Eastbourne DGH or Conquest.
- Evaluate impact for patients and visitors.
- Model the journey time to the nearest hospital.

The journey times measured were to the following Acute hospitals:

- Eastbourne (DGH)
- Hastings (Conquest)
- Brighton (The Royal Sussex County Hospital - RSCH)
- Tunbridge Wells (Pembury Hospital)

We included travel times to other hospitals as we already know that people who live on the northern and western boundaries of the county are more likely to use hospitals in Brighton and Tunbridge Wells. To the west of the county patients will also access the hospital in Ashford. The Princess Royal Hospital in Haywards Heath does not provide emergency surgery or emergency orthopaedics so we have not included it in this analysis, but we know that patients living in the north west of the county may already utilise it for other services. The data that is used is taken from a number of sources which take into account speeds on both major and minor roads, which are then validated against a recognised mapping system.

We will work with stakeholders during the consultation to gather more information on the impact that increased travel times might have. This will include meeting with the local authority to discuss public transport and the impact that the newly approved Bexhill bypass might have in the future.

The research has incorporated the following factors[1]:

Mode / Period /Factor	Patients	Visitors
Mode:		
Car	✓	✓
Blue Light	✓	
Public Transport		✓
Journey period		
7.00-9.00am	✓	✓
2.30-4.30 pm		✓
6.00- 8.00pm		✓
Geodemographic groups		
All residents	✓	✓
Deprivation	✓	✓
Car ownership	✓	✓
Age	✓	

Data	Description	Source
Road Network	Ordnance Survey Mastermap Integrated Transport Network (ITN)	Ordnance Survey provided via Multi-Client Contractor Licence (MCCL)agreement
Public Transport Network	Traveline data covering East Sussex, Kent, Brighton & Hove and West Sussex	National Public Transport Data Repository: http://data.gov.uk/dataset/nptdr
Origins (journey start points)	Codepoint data covering East Sussex	Ordnance Survey via MCCL agreement
Destinations (journey end points)	Four hospital sites used in the study	East Sussex NHS Healthcare Trust provided the list.
Geo-demographic data	Population, car ownership and Index of Multiple Deprivation data	Office for National Statistics (ONS) mid year population estimates 2010 Census 2001 (Nomis)

Car Ownership data from: http://www.nomisweb.co.uk/ An advanced query was used to extract car ownership data as LSOA level for East Sussex.

2.0 Who might be disadvantaged by increased travel times?

The majority of patients who require stroke services, emergency surgery and emergency orthopaedics are likely to be aged over 65 so we know we need to understand the impact of increased travel times for this population. We also know that people who are more deprived are likely to feel the impact of increased public transport costs or fuel costs more than others. Again we have tried to recognise the impact on this group in particular.

Ambulance times are generally faster than car times. Diagnosis, stabilisation and, in some cases, treatment starts once the ambulance staff reach the patient. Therefore key times for the ambulance service are about the time that it takes to reach the patient, not how long it takes to get them to a hospital. Reaching every patient quickly is a priority for the ambulance service, so their highly trained staff can support the patient and liaise with the hospital to ensure they are ready for the patient's arrival.

3.0 Travel time by car:

Population and travel times by car

Total number of East Sussex population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 30 minutes by car	All ages	65+
Current configuration	505,131	118,671
If services were sited at Conquest- Hasting	395,851	82,464
If Services were sited at Eastbourne DGH	401,958	98,038

Total % of East Sussex population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 30 minutes by car	All ages	65+
Current configuration	98%	98%
If services were sited at Conquest	70%	68%
If services were sited at Eastbourne DGH	78%	81%

- The data tells us that currently 98% of over 65 year olds can access one of the four hospitals we identified by car within 30 minutes.
- The data tells us that if we single site our services at Hastings then 68% of over 65 year olds can access one of the four hospitals we identified by car within 30 minutes.
- The data tells us that if we single site our services at Eastbourne then 81% of over 65 year olds can access one of the four hospitals we identified by car within 30 minutes.

Index of Multiple Deprivation (IMD) and Health IMD

The IMD combines a number of indicators that cover a range of economic, social and housing issues to give a single deprivation score. It allows different areas to be ranked and measured according to their level of deprivation. The IMD 2007 score is based on 38 indicators grouped in seven domains: income; employment; health deprivation and disability; education, skills and training; barriers to housing and services; crime; and living environment. Each domain's contribution to the overall score is weighted differently, with income and employment deprivation weighted the most. Health IMD is a sub set of IMD. The health domain combines four indicators about a range of health issues to give an overall score for the level of health deprivation experienced in a small area. The indicators used in this domain are: Years of Potential Life Lost (YPLL); Comparative Illness and Disability Ratio; Measures of acute morbidity, derived from Hospital Episode Statistics; The proportion of adults under 60 suffering from mood or anxiety disorders based on prescribing, suicide mortality rate and health benefits data.

Index of Multiple Deprivation and travel times by car

Total numbers of deprived population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton RSCH) or Tunbridge Wells (Pembury) in 30 minutes by car	IMD	Health IMD
Current configuration	105,003	107,461
If services were sited at Conquest	74,055	69,702
If services were sited at Eastbourne DGH	54,570	54,989

Top 20% most deprived population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 30 minutes by car	IMD	Health IMD
Current configuration	99%	100%
If services were sited at Conquest	70%	65%
If services were sited at Eastbourne DGH	51%	51%

- The data tells us that currently 99% of the most deprived population in East Sussex can access one of the four hospitals we identified within 30 minutes by car.
- The data tells us that if we single site our services at Hastings then 70% of the most deprived population in East Sussex can access one of the four hospitals we identified within 30 minutes by car.
- The data tells us that if we single site our services at Eastbourne then 51% of the most deprived population in East Sussex can access one of the four hospitals we identified within 30 minutes by car.

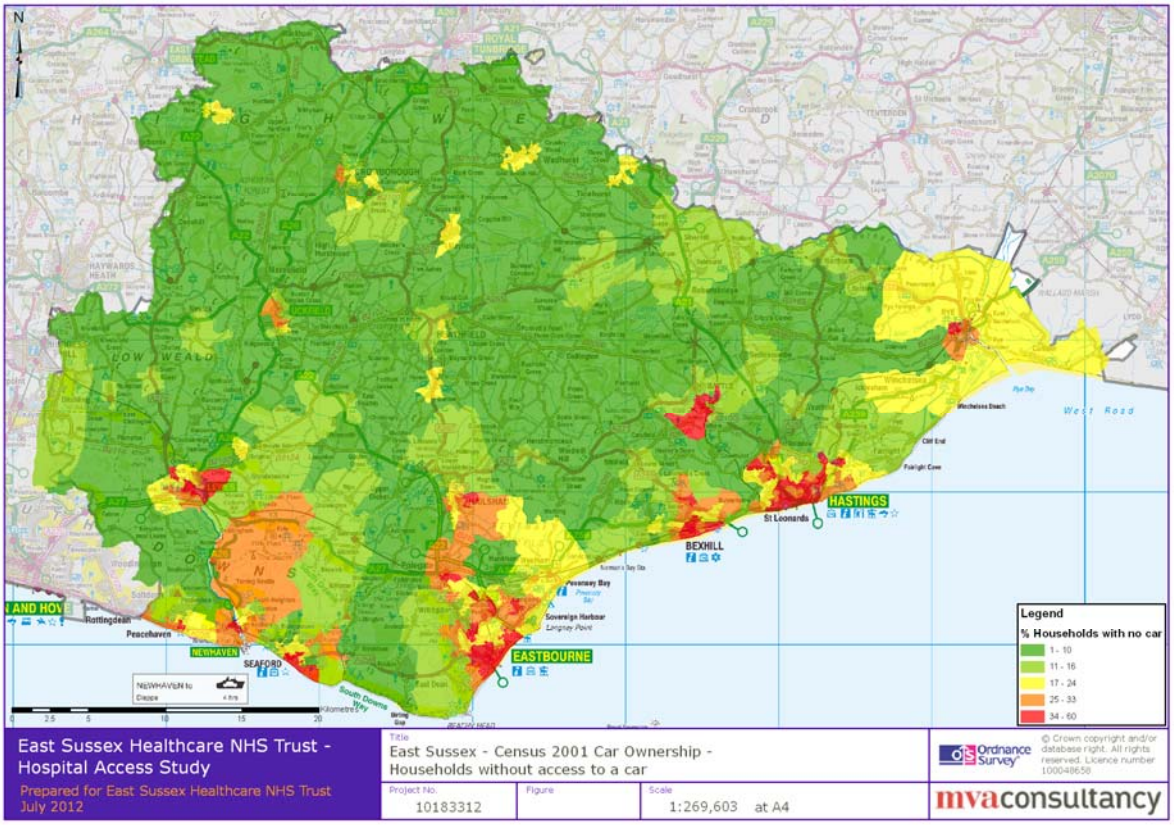
Car ownership threshold travel times

Households in East Sussex that have access to a car that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 30 minutes by car	
Current configuration	210,739
If services were sited at Conquest	148,755
If services were sited at Eastbourne DGH	165,782

% of households in East Sussex that have access to a car that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 30 minutes by car	
Current configuration	98%
If services were sited at Conquest- Hasting	69%
If services were sited at Eastbourne DGH	77%

- The data tells us that currently 98% of households in East Sussex that can access a car can travel to one of the four hospitals we identified within 30 minutes by car.
- The data tells us that if we single site our services at Hastings then 69% of households in East Sussex that can access a car can reach one of the four hospitals we identified within 30 minutes by car.
- The data tells us that if we single site our services at Eastbourne then 77% of households in East Sussex that can access a car can travel to one of the four hospitals we identified within 30 minutes by car.

Map 1: This map shows the % of households within East Sussex who do not have access to a car. The red areas identify where a higher % of households do not have access to a car.



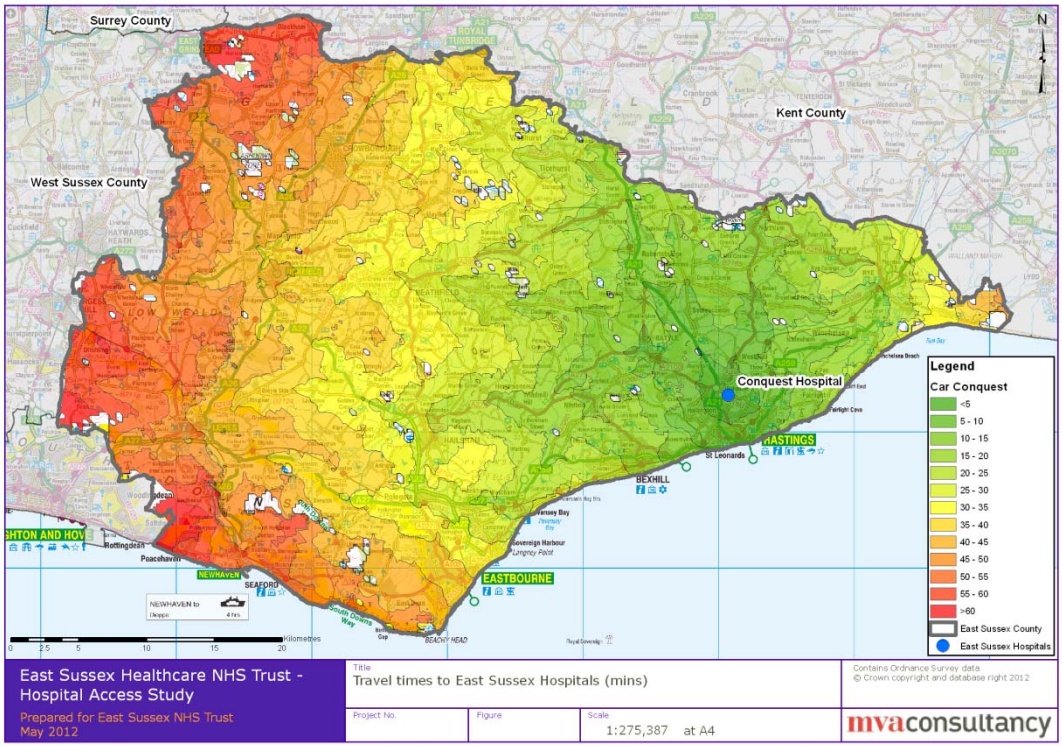
Households with access to a car in East Sussex	Number of households	% of households in East Sussex that have access to a car
Eastbourne	40,819	46%
Hastings	37,611	44%
Lewes	39,758	46%
Rother	38,218	46%
Wealden	58,214	40%

- The data tells us that between 40 and 46% of households in East Sussex have access to a car

Travel times by car to Eastbourne DGH and Conquest

The following maps show the likely travel times by car during the morning peak period to each site from all parts of East Sussex. Travel times by ambulance will be slightly shorter than this. The green areas identify a short travel time moving through to red which show a longer travel time.

Map 2: Travel times to Conquest by car 7am-9am



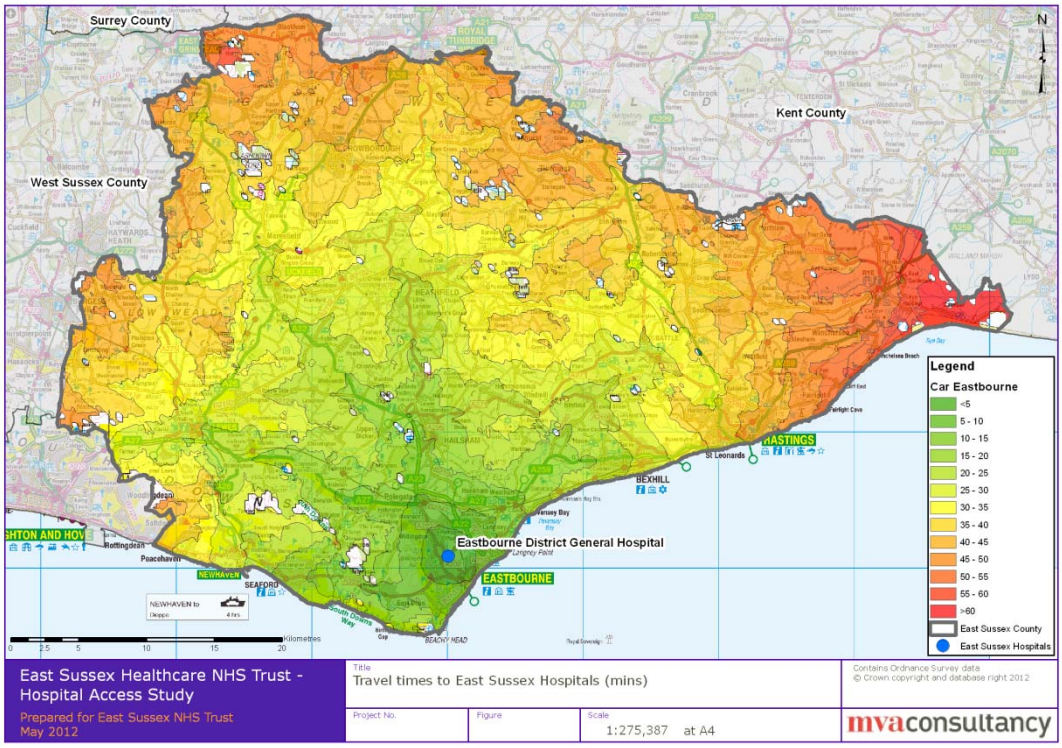
Travel times if services are single sited at Conquest

If services are single sited at the Conquest, travel times are unchanged for patients and their visitors who live in Hastings and its environs to the north and east of Hastings and in the west as far as Bexhill.

For patients who live in and around Eastbourne, travel times could increase by up to 40 minutes if services are sited at Conquest.

For patients who live in Seaford, Newhaven and points north of this, travel times to Conquest might be an hour or more. Many of these patients will already be using hospitals in Brighton or Tunbridge Wells as Eastbourne is not their closest hospital.

Map 3: Travel times to Eastbourne DGH by car 7am-9am



Travel times if services are single sited at Eastbourne DGH

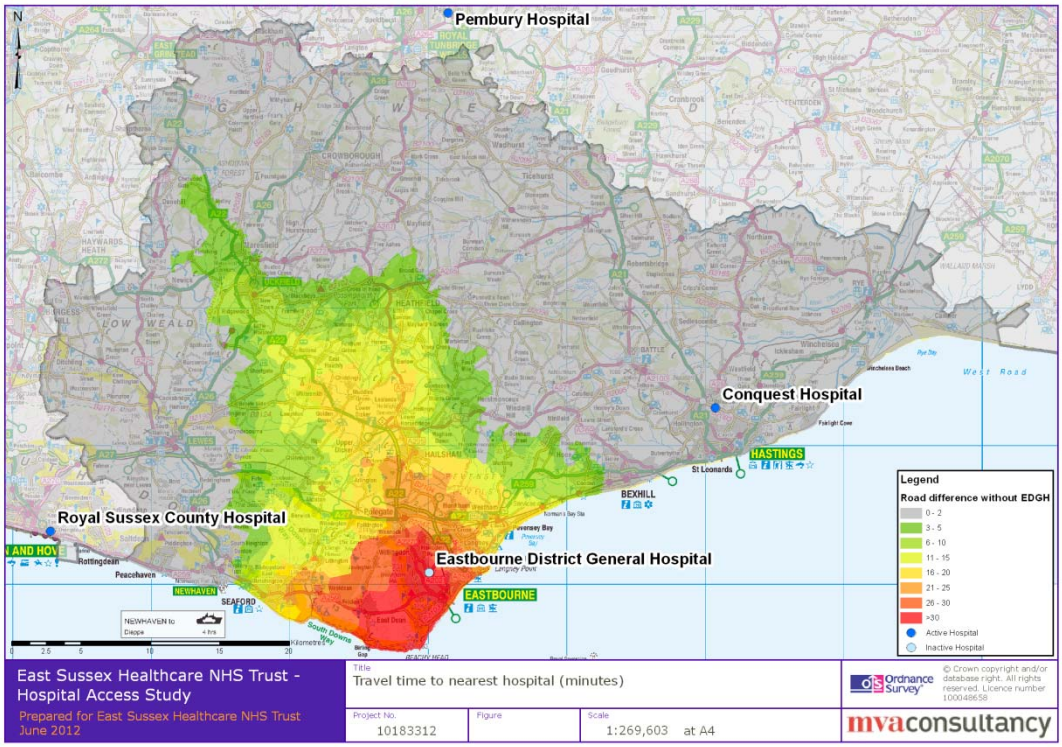
If services are single sited at Eastbourne DGH, travel times are unchanged for patients and their visitors who live in Eastbourne and its environs, to the north and west of Eastbourne and in Bexhill.

For patients who live in and around Hastings, travel times to Eastbourne DGH could be up to 50 minutes. This is the group of patients whose travel times to hospital would be most affected. From Hastings, alternative acute hospitals in Tunbridge Wells and Ashford would have similar travel times of 50 minutes.

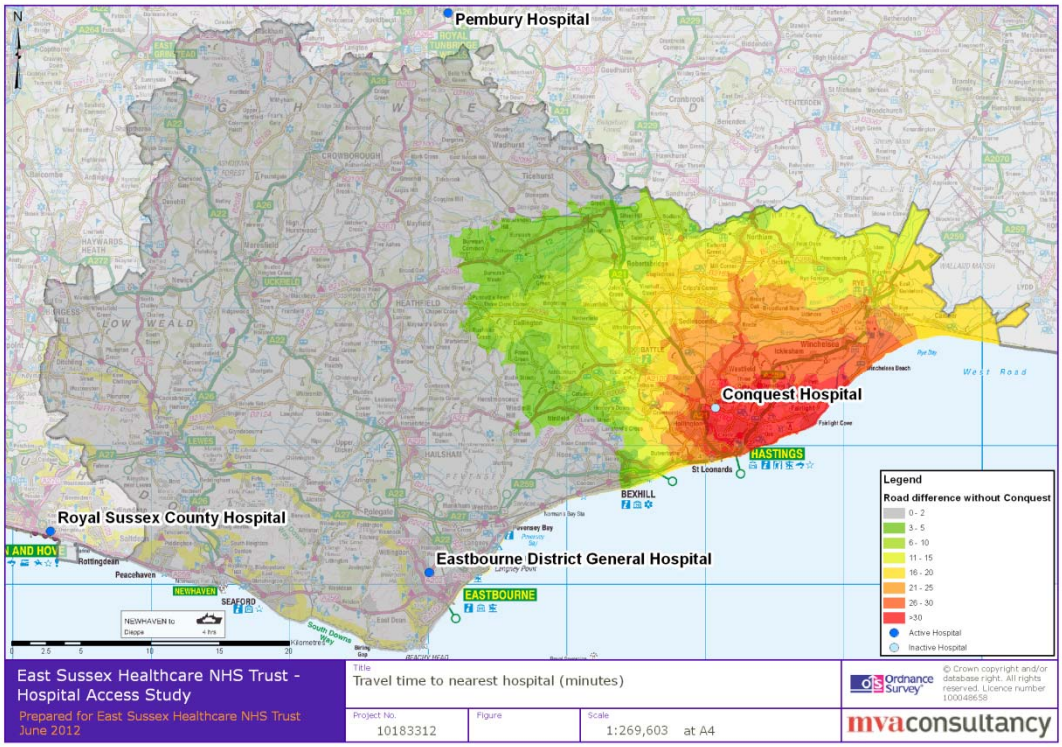
For patients who live in the far east of the county, travel times to Eastbourne DGH would be an hour or more. Some of these patients will already be using the hospital in Ashford.

For people living in the northern boundaries of the county it is likely they are already travelling to Tunbridge Wells as Eastbourne is not their closest hospital.

Map 4: Difference in travel time for patients requiring emergency or higher risk surgery, emergency or higher risk orthopaedics or stroke services by car if those services are not available at Eastbourne DGH.



Map 5: Difference in travel time for patients requiring emergency or higher risk surgery, emergency or higher risk orthopaedics or stroke services by car if those services are not available at Conquest.



4.0 Travel time by public transport (based on 3pm -5pm)

Population and travel times

The tables below show the travel times for the East Sussex population for all ages and specifically for those over 65 years old.

Total number of East Sussex population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 60 minutes by public transport	All ages	65+
Current configuration	431,430	102,482
If services were sited at Conquest	266,777	62,339
If services were sited at Eastbourne DGH	361,651	87,250

% of East Sussex population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 60 minutes by public transport	All ages	65+
Current configuration	85%	86%
If services were sited at Conquest	54%	54%
If services were sited at Eastbourne DGH	72%	75%

- The data tells us that currently 86% of over 65 year olds can access one of the four hospitals we identified by public transport within 60 minutes.
- The data tells us that if we single site our services at Hastings then 54% of over 65 year olds can access one of the four hospitals we identified by public transport within 60 minutes.
- The data tells us that if we single site our services at Eastbourne then 75% of over 65 year olds can access one of the four hospitals we identified by public transport within 60 minutes.

Index of deprivation and travel times

The following tables show the travel times and the impact on the population in terms of deprivation:

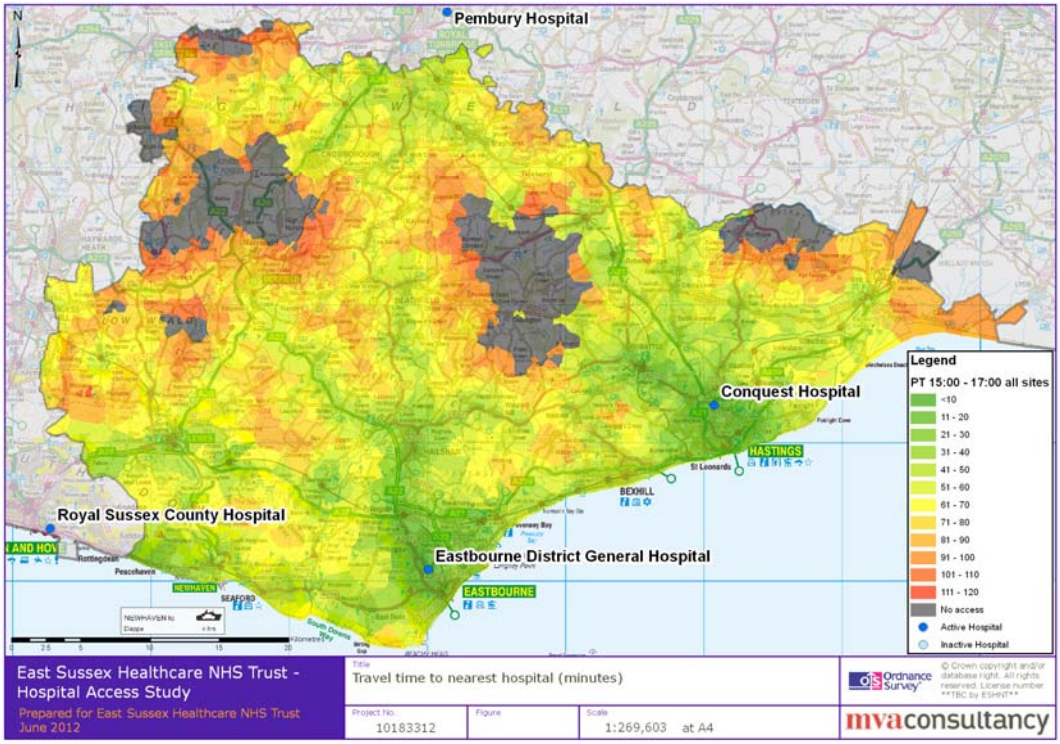
Top 20% most deprived population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 60 minutes public transport	IMD	Health IMD
Current configuration	102,916	107,382
If services were sited at Conquest	69,288	55,668
If services were sited at Eastbourne DGH	87,903	79,824

Top 20% most deprived population that can reach one of Eastbourne (DGH), Hastings (Conquest), Brighton (RSCH) or Tunbridge Wells (Pembury) in 60 minutes by public transport	IMD	Health IMD
Current configuration	97%	100%
If services were sited at Conquest	65%	52%
If services were sited at Eastbourne DGH	83%	74%

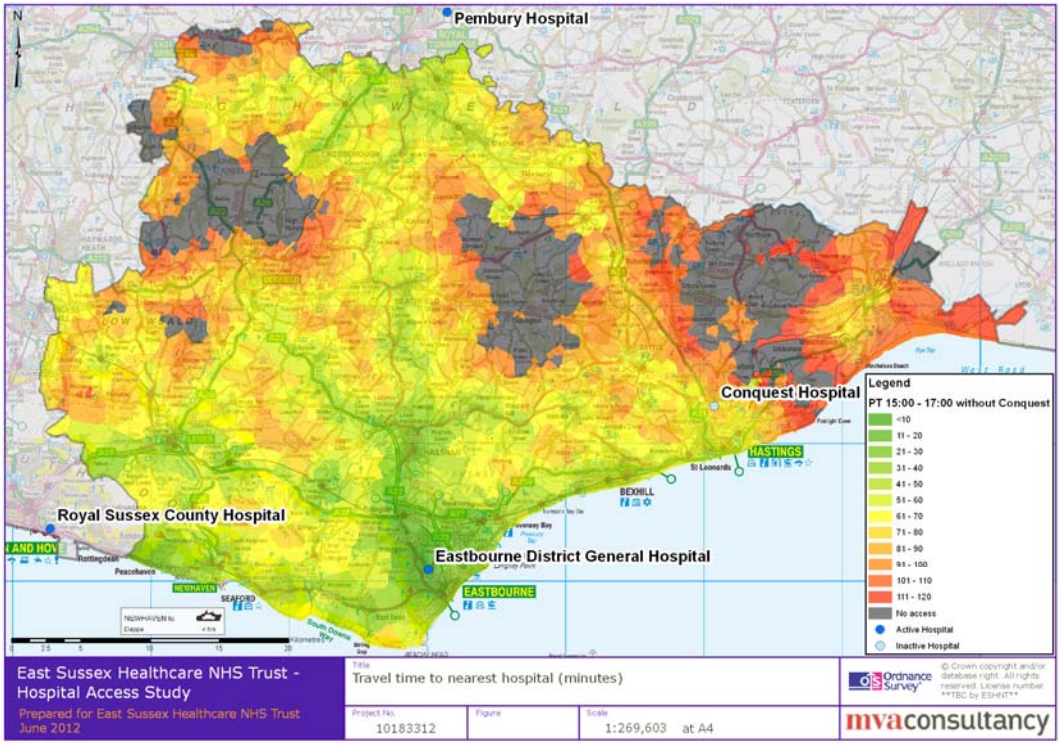
- The data tells us that currently 97% of the most deprived population in East Sussex can access one of the four hospitals we identified within 60 minutes by public transport.
- The data tells us that if we single site our services at Hastings then 65% of the most deprived population in East Sussex can access one of the four hospitals we identified within 60 minutes by public transport.

- The data tells us that if we single site our services at Eastbourne then 83% of the most deprived population in East Sussex can access one of the four hospitals we identified within 60 minutes by public transport.

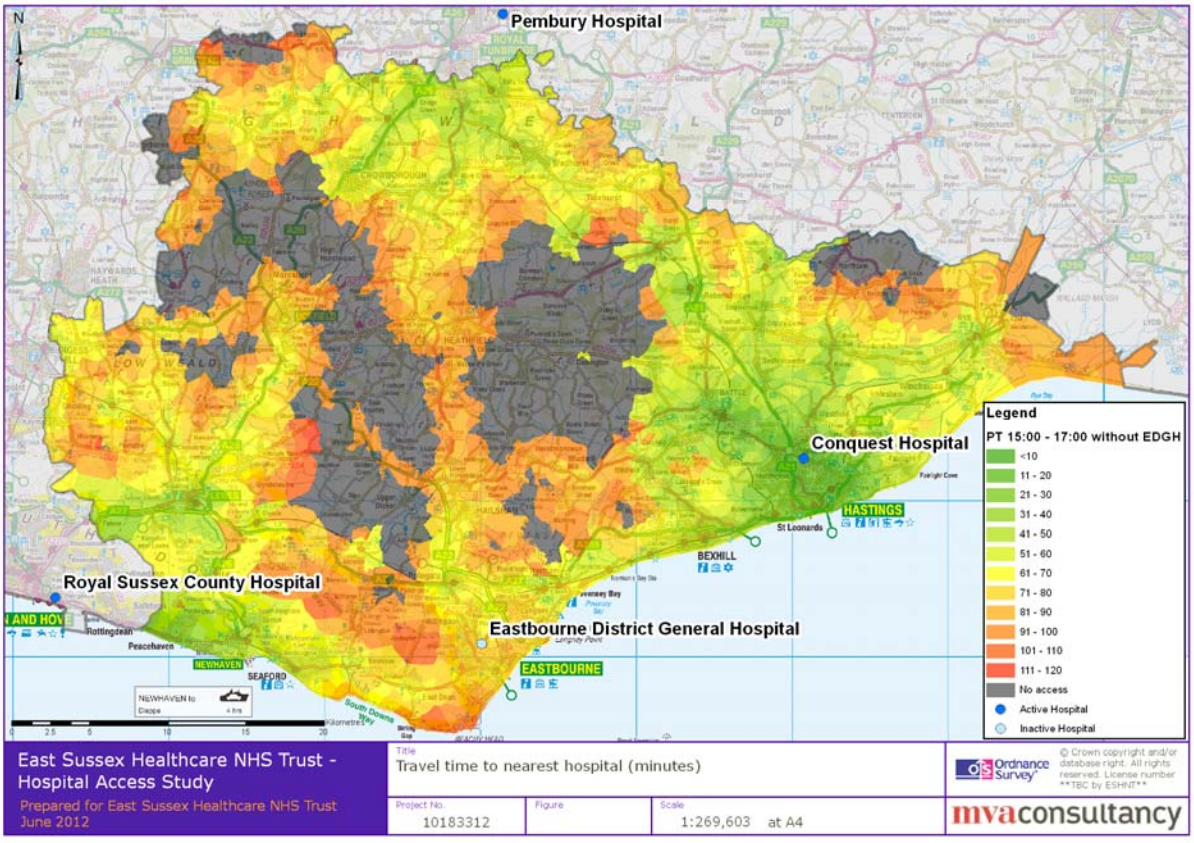
Map 6: This map shows access by minutes to Eastbourne DGH, Conquest, Brighton (RSCH) and Tunbridge Wells (Pembury) by public transport between 3pm and 5pm. There are some areas in the county that cannot access any of these 4 hospitals within two hours.



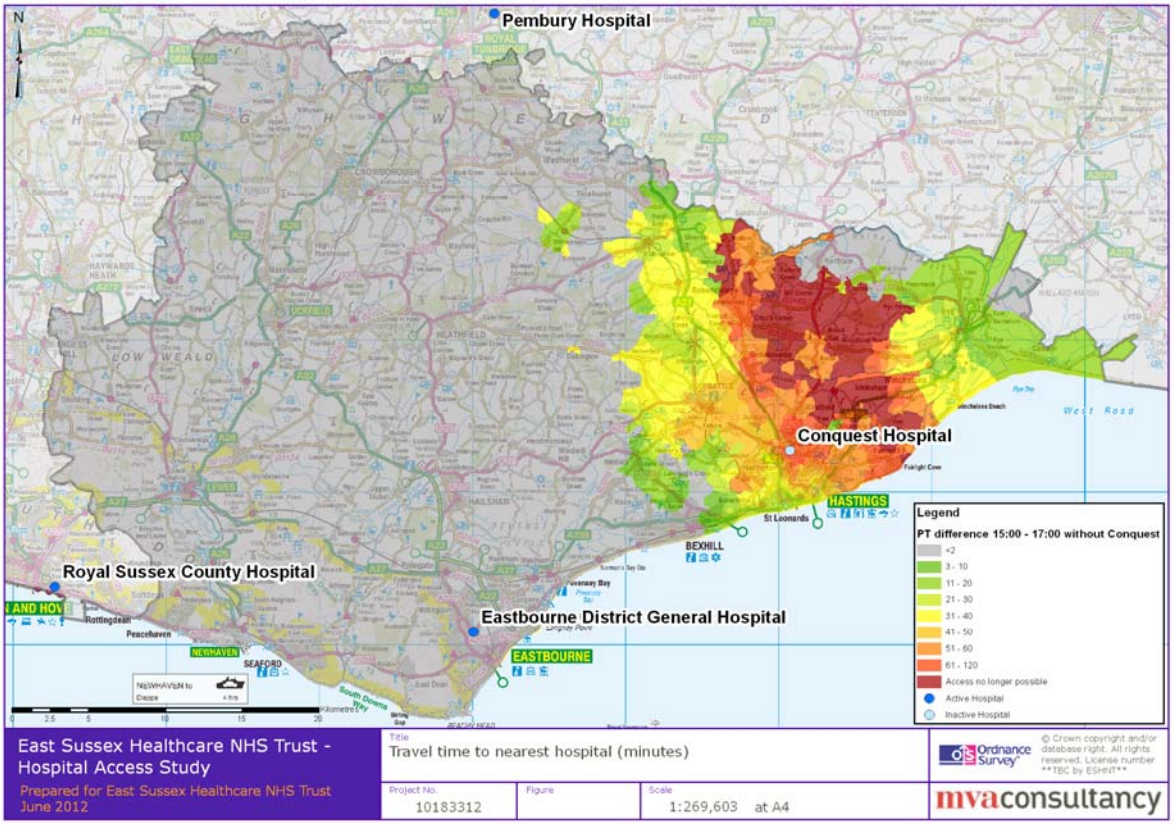
Map 7: This map shows how long it would take to travel by public transport between 3pm and 5pm to Eastbourne DGH, Brighton (RSCH) and Tunbridge Wells (Pembury) if services were not sited at Conquest.



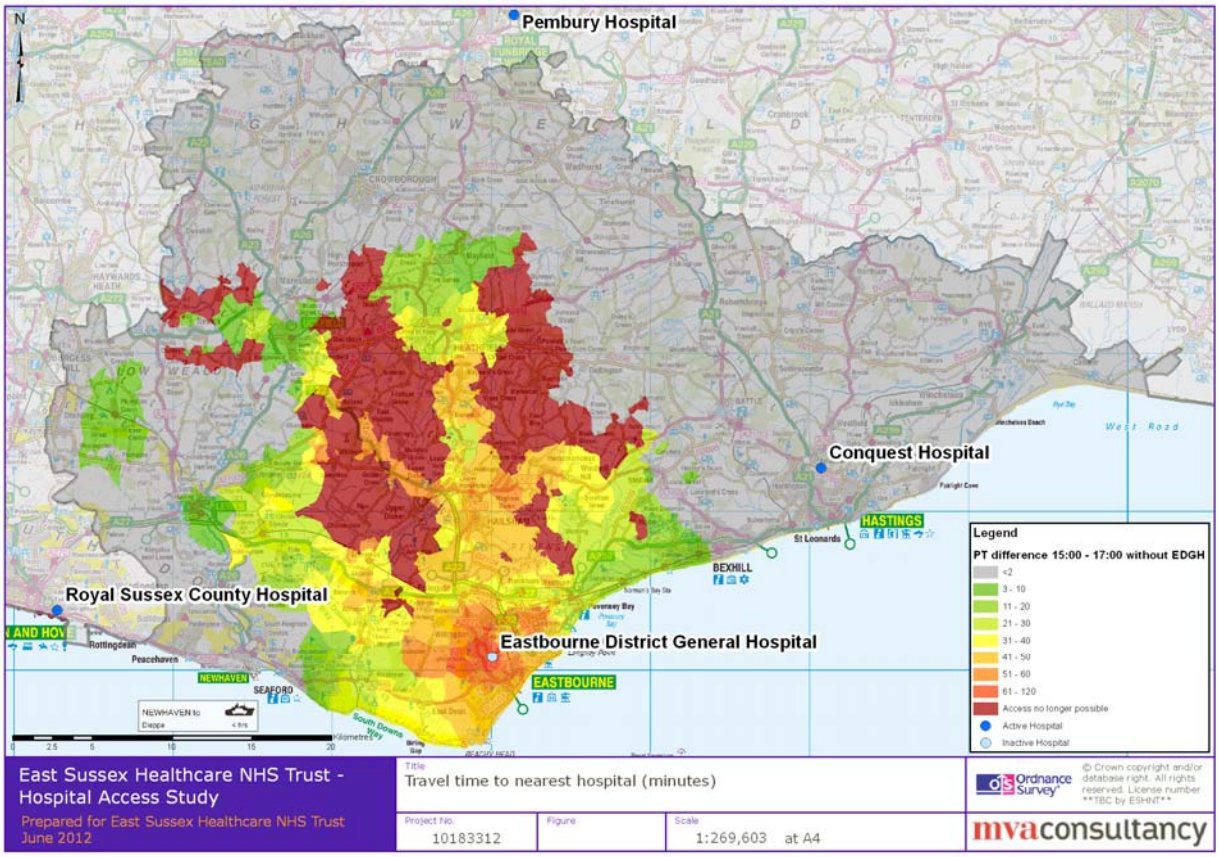
Map 8: This map shows how long it would take to travel by public transport between 3pm and 5pm to Conquest, Brighton (RSCH) and Tunbridge Wells (Pembury) if services were not sited at Eastbourne DGH.



Map 9: This map shows the areas that would have an increased travel time or for whom travel by public transport would not be possible to hospitals in Tunbridge Wells, Brighton or Eastbourne. The grey areas show that travel times would be the same or up to a two minute increase, through to red areas where public transport would not be available.



Map 10: This map shows the areas that would have an increased travel time or for whom travel by public transport would not be possible to hospitals in Tunbridge Wells, Brighton or Hastings. The grey areas show that travel times would be the same or up to a two minute increase, through to red areas where access on public transport between 3pm and 5pm would not be possible.



Conclusion:

It is clear that travel times will increase if the proposed case for single siting for stroke, emergency and high risk general surgery and emergency and high risk orthopaedics is accepted. Travel times will increase for a small number of patients who require those specific services.
It is important to recognise that for a significant proportion of the East Sussex population neither Eastbourne DGH nor Conquest is their nearest hospital and they are likely to be accessing services in West Sussex, Kent and Brighton and Hove. When considering the additional travel time for patients this should be viewed as the additional time it would take to get to any hospital that would provide these services, not only those provided by East Sussex Healthcare Trust.

During the consultation will be continuing to explore the data provided by the independent consultancy and will be ensuring that the impact of change on travel times is recognised in the decision making process. The potential impact on travel times will also be discussed with the local authority so we might understand the impact of the recent planning approval of the Bexhill bypass and the planning of public transport routes.

East Sussex Healthcare NHS
NHS Trust

Report to: East Sussex Health Overview and Scrutiny Committee (HOSC).

Date: 26 July 2012.

By: Amanda Harrison- Director of Strategic Development- East Sussex Healthcare Trust (ESHT).

Title of Report: Final Report from National Clinical Advisory Team (NCAT) on the case for change identified in the 'shaping our future' strategy document

Purpose of Report: To present the final report provided by NCAT the on the clinical case for change outlined in the 'shaping our future' strategy document and to outline the action plan.

Introduction:

The National Clinical Advisory Team was asked to provide clinical assurance to the proposed reconfiguration emerging from Shaping Our Future- Clinical Strategy for East Sussex Healthcare Trust. The review took place on the 28th May 2012 and was lead by Dr Chris Clough- chair of NCAT and Ms Denise Chaffer- Director of Nursing NW London. The NCAT team interviewed key stakeholders at both Eastbourne District General Hospital and the Conquest Hospital in Hastings.

NCAT reviewed the clinical case for change and spoke with key clinicians about the proposed models of care. They explored engagement with the local LINKS. In their conclusions NCAT strongly supports the case for change and supports the models of care proposed for stroke, general surgery and orthopaedic services.

Recommendations and action plan:

NCAT Concern/Recommendation	Actions
The Trust needs to describe the clinical strategy and clinical model proposed in simple terms	PCBC (pre-consultation business case) revised since NCAT visit and Case for change simplified – no further action
The Trust needs to describe the whole care pathway in detail; for example would stroke patients be repatriated nearer home post their acute episode for rehab?	PCBC revised since NCAT visit and the models of care describe the care pathway
The Trust needs to address the co-dependency of making these changes, for example obstetrics, interventional radiology, and agree a safe model of out-of-hours access to senior clinicians (to the site where emergency surgery is not sited) and describe the plan for this	After further clarification with Dr Clough from NCAT the Trust has sought to identify the risks for obstetrics and gynaecology if general surgery is not on site. Further work will be undertaken throughout the consultation period to ensure that the risks and mitigations of the implementation of any change in the configuration of emergency general surgery are addressed and that these will be set out in the documents that will support final NHS Board decision making and subject to a further review by NCAT.
There is a pressing need to address the challenge facing paediatrics and maternity services. The Trust and PCT agree a way forward for paediatrics and Maternity services.	A Sussex-wide initiative, aimed at reviewing maternity and paediatric services across East Sussex, Brighton and Hove and West Sussex, will build on the work that has already taken place locally to improve these services. We all have a shared responsibility to ensure our maternity & newborn and paediatric services: - reflect advances in best practice that give patients the highest possible quality of care, and - are sustainable in the long-term. A pan Sussex Board has been established the Sussex Maternity, Children, Young People and Families Network Board.
The project team responds to NCAT concerns as above and produces an action plan within two weeks	Communication has been ongoing with NCAT and this action plan has been shared with them
Prior to public consultation further work needs to be done to model the activity these changes will lead to, and to ensure that appropriate patient pathways will be put in place subsequent to the changes, supported by appropriate inpatient facilities and workforce	PCBC revised since NCAT visit and activity modelling for the preferred options have been outlined in the document
The Trust continues to operate with a culture of two separate hospitals. Strong clinical leadership is required to bring the clinical staff together. There should be one clinical strategy and one management system Further work on clinical engagement is required to achieve this.	Clinical engagement is ongoing- particularly with regard to the clinical strategy. The Trust has an Organisational Development programme in place that will also address these issues.

To: NHS South

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East Sussex Healthcare Trust
NHS Sussex

Date of visit: 28 May 2012

NCAT Visitors: Dr Chris Clough, Chair NCAT, Consultant Neurologist
Ms Denise Chaffer, Director of Nursing, NW London

In attendance Mr Malcolm Stewart, Medical Advisor SHA

1. Introduction

1.1. NCAT was asked to provide clinical assurance to the proposed reconfiguration emerging from the Shaping Our Future clinical strategy by NHS Sussex PCT and provider trust – East Sussex Healthcare Trust in expectation of going to public consultation in June. The previous week the proposals had been reviewed by Gateway and given amber status. The NCAT visitors interviewed key stakeholders at Eastbourne District Hospital and subsequently later in the day visited the Conquest Hospital in Hastings to review those facilities. See appendix 1 for list of attendees and documents reviewed.

2. Case for change and background

2.1. Eastbourne District Hospital and the Conquest Hospital Hastings are the two main providers for the population of East Sussex. They merged in 2002 to form a single trust and subsequently took over the running of community services in 2010 to form a single, vertically integrated trust – East Sussex Healthcare Trust.

2.2. The Trust faces a number of challenges, with a requirement to save £104 million over the next 3 years of which £45m needs to be identified within this year, this from an overall income of about £160 million. In order to do this the Trust and PCT has embarked on developing a clinical strategy – Shaping Our Future – which has identified £35m as a recurrent saving and a component of this will be found from reconfiguration - £9-10m. These plans are affordable to commissioners and supported by them. There is a history of financial problems

in the previous 15 years, the Trust only has broken even on two occasions and has needed multiple bail-outs.

2.3. Whilst there are pressing financial concerns, there are significant clinical drivers for the case for change. Despite the merger of the two hospitals 10 years previously, there has been very little integration of services and the two hospitals have largely run as separate entities, providing similar acute services. In the case of stroke, this has meant the continuance of two small units neither of which are meeting the national guidelines for high quality stroke care. Whilst certain departments are strong, eg cardiology at Eastbourne, and orthopaedics, the Trust has not been able to respond to changes in clinical practice. Workforce issues have been a problem, and are expected to put further pressures on service sustainability. For instance, in the case of general surgery, there are still two separate rotas – 6 consultants at Eastbourne Hospital, 4 at the Conquest – and these are supported by separate middle grade surgeons and separate SHO/Foundation trainee rotas. Many of the middle grade doctors are Trust doctors and there has been difficulty in recruiting to this grade and ensuring high quality appointments. Orthopaedics have similar problems delivering a high quality service on both sites. In particular there is lack of ortho-geriatric cover which may mean patients are inappropriately in hospital and not receiving the rehabilitation care they require post-operatively to enable them to go home quickly..

2.4. The Shaping Our Future clinical strategy is a broad strategic document for the Trust and PCT which, it is hoped, will bring down demand and the need for inpatient beds. The reconfiguration has focused on three areas, stroke, general surgery and orthopaedics, where it is clear there are significant clinical advantages to bringing these services together and redesigning them across both sites. NCAT has been asked to look at the model of care rather than decide on which site – Conquest v Eastbourne – is most appropriate. It is intended to go out to public consultation on the following three proposals:

1 Acute stroke services concentrated on one site

2 Acute surgery concentrated on one site, the other site to continue with elective surgery

3 Acute orthopaedics to be focused on one site, the other site to continue with elective orthopaedic surgery

There has been pressure from the shadow Clinical Commissioning Group to consider other reconfiguration options concerning paediatric and maternity services, but it was felt that further consideration of these services should await the deliberations of the pan-Sussex paediatric review. Nevertheless NCAT was interested to hear about the present paediatric and maternity services at the Trust, and the challenges they faced.

3. Views expressed on the day of the visit

3.1. The region is concerned that there has been no activity planning within the document submitted, and whether the planned activity will fit with commissioning intentions.

3.2. Other than some ad hoc arrangements, there has been no genuine clinical collaboration between the two hospital sites within the Trust, and prior to the new Chief Executive being appointed in 2010, there was no evidence of any strategic planning. There have been two failed attempts to achieve foundation trust status. The Trust is hoping to reapply in October-November this year.

3.3. The merger with community services in 2011 gave the opportunity to completely restructure the organisation last year.

3.4. There have been three key drivers to these changes, services are not as safe as they should be and are vulnerable. Secondly the Trust does need to save money; it has chronic financial problems and has needed several bail-outs over the last 10-15 years. It needs to save £104m over the next 3 years. Lastly these plans are fundamentally about clinical sustainability. The single site option would require a new build and has been ruled out as being completely unrealistic. The alternative model of one acute hospital and the other hospital becoming a community hospital, as has been proposed by the GPs in the past, would not deliver our clinicians or our local population, and the local population wouldn't stand for it.

3.5. Despite the two hospitals coming together 10 years ago, there are still two medical advisory committees, one for each site.

3.6. Clinical engagement started from a very low point and it has taken over the last year to find the clinical leaders these changes require. It would be fair to say there is more nervousness at Eastbourne about these changes, as they can see the logic of placing more acute services at the Conquest because of the geographical situation of the Conquest, and its more needy population.

3.7. The movement of acute surgery to one site will also mean that higher risk surgery will be performed on this hotter site too because of the need for surgical out of hours cover.

3.8. The Trust doesn't see the requirement for stroke to be on the same site as surgery, as there don't appear to be any significant co-dependencies. Presently we are seeing about 700 strokes a year, and are not expecting to see a significant change in patient flows as a result of these changes. Although presently the Trust does perform vascular surgery, we are now part of the Brighton network and the expectation is that complex vascular surgery, including carotid endarterectomy, will be performed at Brighton. Whilst we have significant numbers of radiologists at both hospitals, we are not clear on the requirements for interventional radiology, and what this might mean for our work force.

3.9. Presently the stroke service has 9 consultants on the thrombolysis rota and have good telemedicine support to be able to deliver thrombolysis on both sites. During the day there is one stroke consultant at Eastbourne, and when he is not available his duties are performed by a Trust doctor. There are two stroke doctors at Conquest Hospital. Thrombolysis rates are about 5-6%, there has been a recent improvement in access to CT scanning with 100% patients scanned within the first hour now. There has been difficulty in recruitment of stroke doctors which is due to the nature of the present service. There are have difficulties maintaining middle grade rotas, and are having to use a lot of agency staff. In the worst case scenario a patient presenting to one hospital with a stroke requiring transfer to the other hospital would mean a delay in treatment of

about 45 minutes. The expectation is that, with the appropriate protocol for ambulances, most patients will present to the hospital with the stroke unit.

3.10. The orthopaedic service is not as good as it could be. Presently an ortho-geriatrician covers both sites, and this is not satisfactory. There are 8 middle grade staff at one hospital and 7 at the other. Whilst there are a number of trainees, it is planned for a 20% reduction in trainees nationwide, hence there is a continuing requirement for Trust doctors and these can be of variable quality and difficult to find. Bringing the services together would mean developing one site as an orthopaedic centre with a consultant-led service. There would be advantage to the other site delivering elective surgery, but we recognise that it still wouldn't be possible to protect those beds. Further discussions with the ambulance service are necessary to agree how this would operate, and there need to be agreed clinical pathways.

3.11. The surgical services are having increasing problems in maintaining separate rotas for the two hospitals. These problems will be even worse when the vascular surgeons, who are dually accredited, retire in the next few years. If a single acute surgical site could be created with a dedicated consultant led and delivered service, surgeons could be solely dedicated to an on call service, and not have to do clinics at the same time, as is the situation at the moment. A single acute site would help create a sustainable middle grade trainee rota and have less reliance on the non training grade. It is presently the intention to continue to have a middle grade on call at night at the non-acute site. If there were post-operative problems at the non-acute site out of hours, the expectation is those patients would either have to be taken by ambulance to the acute site for operation or, in rare cases, the consultant would go to the non-acute site, which would mean opening up the theatres out of hours.

3.12. Day surgery rates could be improved, but there is a problem with medical outliers at both hospitals, even day beds have been occupied by medical outliers.

3.13. With obstetric and gynaecology services on both sites, there will be a continuing requirement for surgical assistance. This should mostly be within office hours

but out of hours we would expect consultant to consultant referrals. This should not be a problem if we move to the new model.

3.14. A move to a model for the non-acute site where there was no out of hours surgical cover on site would mean looking carefully at the case mix and need for return to theatre.

3.15. The clinical commissioning groups fully support these changes. Clearly something needs to be done. These are the start of the changes required, not the end of them.

3.16. In an ideal world there would be have one big hospital but the CCGs want to see two sustainable hospitals and core to this will be the continuance of acute medical admissions at both sites. New services such as the radiotherapy coming to the Eastbourne site will be helpful.

3.17. Overall there are about 140,000 attendances at the emergency departments at both sites. Presently there is no front-end triage/ urgent care centre run or commissioned by primary care.

3.18. Where acute surgery is placed should not influence the future decision making about maternity and paediatric services. There are intentions to get independent risk assessments of our paediatric and maternity services as it is recognised that there are problems in recruiting paediatric middle grade doctors and presently problems with recruitment to midwifery. Lastly the deanery has given recognition to an obstetric anaesthetist training post, but in view of the low number of interventions, this recognition is not guaranteed in the future.

3.19. LiNKS has been fully involved with these changes. They are very strongly supportive of them as they think the stroke services certainly should have better outcomes by merging the two services.

3.20. LiNKS don't think there has been enough work done in communicating with the media and others, and the Trust needs to tell a better story about these

changes. The public is more likely to accept these changes if it is recognised that, once the acute stroke care has been delivered, patients would move to a hospital or other services closer to their home.

3.21. It would be helpful to have better clarity about public transport arrangements between the two sites, presently these are appalling with long travel times.

3.22. LiNKS will continue to probe concerns about the ambulance services in the South East and would need reassurances about the ability of the ambulances to get patients to the new services within the thrombolysis time.

3.23. The local GPs think that stroke services presently are a bit dismal and were lambasted by an external review. Putting the services together has got to be a win:win.

3.24. GPs feel similarly about the orthopaedic and surgery services. There have been a number of near-misses, and we have to work at creating a single site for these services.

3.25. The two CCGs will work together to help support these changes. We would like to see more changes, particularly in the areas of paediatrics and maternity.

4. **Discussion**

4.1. The proposals as outlined presently are very limited but we did recognise this was part of an overall strategy, and the importance of keeping the public on board as the Trust moves forward to create sustainable, safe and affordable services. We think it makes eminent sense to bring the stroke services together. Presently these are two small services which are not meeting national standards. Whilst the facilities themselves are housed in modern buildings, the main problem is a lack of a workforce of sufficient size and expertise. Bringing the two units together should make a significant difference in putting stroke services on a more secure and sustainable footing. Further investment may well be needed, in particular to ensure there is the right level of nurse specialist and therapy support.

4.2. The most important thing for stroke services is that they are based within an acute hospital with links to the full range of medical services. Often patients will be elderly, with multiple co-morbidities such as diabetes and heart disease. Hence there need to be clear links with medical services. We think the model of care is a good one, and it is possible that either site could be selected as the acute stroke centre. There are already network arrangements in place so that those stroke patients who need more specialist care, for instance neurosurgery, vascular surgery, can be transferred to the appropriate hospital (Hurstwood Park or Brighton). The arrangements for vascular surgery are changing and will need to be clear and explicit in future so that patients requiring urgent carotid endartarectomy can be transferred in a timely way. This will need the development of appropriate protocols with the receiving hospital and good relationships within the network for ease of communication etc. We agreed with the Trust there is no certain linkage between the stroke services and where the acute surgery services are placed. It is possible that stroke services could be on one site and acute surgery on the other site.

4.3. We think it makes sense for the surgical services to come together. It was surprising to us that this has not already taken place, and it was symptomatic of the problems the Trust has had over the last 10 years, bringing the two hospitals together. Indeed we were surprised not to meet all the clinicians together in a single room, it would have been helpful to have met more surgeons and other clinicians from both sites together rather than use teleconferencing facilities. These proposals will require that teams from both sites will meet regularly together. We were surprised to also hear that the hospitals were still running two separate medical advisory committees. Clinical staff at both sites need to recognise they are now within a single organisation, and must work together to achieve solutions across both sites to some of the difficult challenges ahead of them. Whilst there was some evidence of working together, largely these were two separate hospitals working to their own agendas.

4.4. Presently the surgical rotas are not sustainable and we completely agreed with the consultant surgeon who spoke to us about the future challenges when the vascular surgeons become dedicated to their own specialty and leave general surgery. There is a pressing need to get ahead and merge these services to

create a single acute surgical site. This should have a positive impact on quality if, as expected, there will be better access to senior decision makers, ie the consultants, and when on call they are dedicated to the on call and not expected to have clinics at the same time.

4.5. Surgery will still be performed on the non-acute site, but this will need to be planned elective surgery. We were surprised to hear that the present plan is to continue to have a middle grade doctor on call out of hours on the non acute site as we think this would merely perpetuate the current problems with recruiting surgeons of a sufficient calibre to work in this way. We would expect that, if the appropriate patients were identified for surgery on this site and there were protocols and monitoring in place, the Hospital at Night team should provide safe supervision of these patients. Further work needs to be done about this, looking at the case mix and return to surgery figures, to ensure this could be a safe solution to the non-acute site. For instance it may be necessary to enhance the competencies and numbers of staff within the Hospital at Night team, particularly if orthopaedics is to be similarly covered.

4.6. We feel the Trust needs to do further work on the co dependency of out of hours emergency surgery and obstetrics. It did not appear that this has been discussed in detail , risk assessed and a safe contingency plan agreed

4.7. The same considerations need to be given to other co dependant services eg interventional radiology

4.8. The arguments for emergency surgery do apply to the changes for orthopaedics. Patients will receive a better service if the orthopaedic surgeons can concentrate on one site in providing a consultant led and delivered acute orthopaedic service, but again more work needs to be done in looking at the activity, case mix and patient flows. Everybody needs to be clear about the patient pathways. We think that this substantial piece of work needs to be done urgently, and agree with the SHA that the Trust needs to be clear about its activity modelling, and which patients will go where; this will need to be supported by the appropriate bed base. There is an opportunity here for the Trust to develop a protected surgical cold site service. There are considerable advantages in this for patients receiving planned surgery in that the beds can be used more efficiently, there will

be fewer cancellations on the day of operation and better screening of patients so there are fewer issues of hospital acquired infection. We think the Trust should take this opportunity to look more clearly at this hot/cold site alternative.

4.9. There is a need for a clearer clinical strategy for both sites, it is not possible to view these services in isolation, as each change will inevitably impact on other services. Workforce pressures in areas such as critical care and anaesthetics may lead to similar issues in staffing intensive care units.

4.10. Whilst presently it is not the intention of the Trust to go out to consultation on paediatric and maternity services, we do think there is a pressing concern about the continued safety and sustainability of these services. Whilst we have not looked in detail at activity or governance issues of the present service, during our visit we did hear that there were significant workforce pressures for paediatrics and the maternity services. These are two small services, again which are working separately from each other. We would think it unlikely that a paediatric inpatient unit is required at both hospitals in view of the size of population and changing demographics. We would suggest that there is an urgent strategic review of paediatric services to ensure that there is a safe and sustainable future. We did hear a point of view expressed whether there was a case for a paediatric inpatient service at all in the Trust. We would expect that, in order to support maternity services, a 24/7 on site paediatric presence is required somewhere within the Trust. Our initial thoughts were that the Trust should look at other models, perhaps retaining one inpatient paediatric site, with a paediatric assessment unit on the other site. Additionally there are two small maternity units here without adjacent midwife-led birthing units. Whilst within East Sussex there is a standalone midwife birthing unit, numbers of deliveries are small and the sustainability of that unit has been questioned. A more strategic look at maternity services is required, as there are challenges here of workforce sustainability and the need to respond to the paediatric challenges; maternity services do need to be supported by an appropriate level 1 neonatal unit, and this will require on site 24/7 presence of staff with the competencies to resuscitate the flat, blue neonate.

5. Conclusions

5.1. NCAT strongly supports the clinical case for change. We do not think necessarily there is an issue of on-site co-dependency of obstetrics/gynaecology and acute surgery but the Trust clinicians need to explain clearly how obstetrics and gynaecological emergencies which have surgical complications will be addressed on the non-acute site.

5.2. NCAT can support the model of care proposed for stroke, general surgery and orthopaedic services.

5.3. Prior to public consultation further work needs to be done to model the activity these changes will lead to, and to ensure that appropriate patient pathways will be put in place subsequent to the changes, supported by appropriate inpatient facilities and workforce.

5.4. The Trust continues to operate with a culture of two separate hospitals. Strong clinical leadership is required to bring the clinical staff together. There should only be one clinical strategy and one management system. Further work on clinical engagement is required to achieve this.

5.5. There is a pressing requirement to address the challenges facing the paediatric and maternity services.

6. Recommendations

6.1. The Trust needs to describe the clinical strategy and clinical model proposed in clear simple terms so that the public understands what clinical services are available at each hospital.

6.2. The Trust needs to describe the whole care pathway in detail, for example would stroke patient be repatriated nearer home post after acute episode for rehabilitation?

6.3. The Trust needs to address the co-dependency issues for obstetrics/gynaecology so that clinical pathways are clear and agreed by all.

6.4. The project team responds to NCAT's concerns as above and produces an action plan with two weeks.

6.5. The Trust and PCT agree on a way forward for paediatric and maternity services.

Appendix 1

People met

Darren Grayson	Chief Executive
Andrew Leonard	Acute/Emergency Medicine CU and PAP Lead
Imelda Donnellan	General Surgery CU and PAP lead
Conrad Athulathmudali	Consultant – Stroke
James Wilkinson	Divisional Director Urgent Care and Chest Physician
Oliver Keast-Butler	Orthopaedics CU /PAP lead
Javid Rahman	Stroke C/U and PAP Lead
Elena Mucci	Geriatrician and stroke physician
Neil Sulke	Chair Consultants Advisory Committee (Consultant Cardiologist)
Andy Slater	Medical Director
Sarah Blow	Chief Operating Officer, East Sussex CG
Amanda Harrison	Director of Strategic Development and Assurance
Geoff Leece	LiNK
Alan Keys	LiNK
Ivy Elsey	LiNK

Documents Reviewed

Received in advance

- Shaping our Future Programme Board – Minutes of meeting 20-4-12
- Draft document - Preconsultation stakeholder engagement dated 16-5-12
- Clinical Strategy – presentation to Board 11-4-12

Received on the day

- Shaping Our Future Clinical Strategy – Draft version 3.1
- Position statement from the HAR EHS Boards