Submission from 'Save the DGH' group

Summary of current situation

The local NHS has gone out to public consultation on their plans to single site General Surgery, Orthopaedics and Stroke services. They are also possibly planning to single-site Maternity and Paediatrics, going to public consultation later. Added to which although they have said A&E will not be downgraded, it is anticipated that either Eastbourne DGH or The Conquest will become a Trauma unit with the other site being downgraded.

The local NHS say there is need for these proposals to improve the service they designed with the flaws they are now saying result in the need to single-site some of them. Why can't the changes being considered on single sites be provided on both sites? Why can't the specialist doctors travel between sites? If it is a small number of patients affected, why such a drastic change which could see recruitment of clinical staff on the downgraded site very difficult? There is no doubt that with modernisation, change is needed. However, we believe that this can be achieved by reconfiguration of services on BOTH sites allowing core services to be kept on BOTH sites.

The congestion on the A259 between Hastings and Eastbourne is notoriously bad and the services which are proposed to single-site are those you need in an emergency.

In 2002 Eastbourne District General Hospital and the Conquest Hospital at Hastings merged to become East Sussex Hospitals Trust now named East Sussex Healthcare Trust, when it took on Community Services in 2011. The reason to merge in 2002 was a management one to save money (on management and admin) promising NOT to remove any patient services from either hospital.

ESHT problems for the last 10+ years.

- Finances awful
- Payments by results – Quality standards and care not well managed so financial targets not achieved.
- Because financial and quality targets not achieved cannot provide services as they now can't afford them.
- Why no 24/7 service? Evenings/ weekends?
- Reputation of always threatening to downgrade/reconfigure services has caused difficulty in recruiting doctors. Also good staff have left.
- In future will be difficult to recruit doctors to the unit which has been down-graded.
- Patients (and GP's) living outside Eastbourne and further afield less likely to opt for ESHT if service with history of quality issues etc and have already 'lost' patients to other providers (Horder Centre, Princess Royal etc).
- No point moving specialist treatment for the few at the expense of local consultant treatment for the many.
- Emergency situations need urgent attention and most of these should be dealt with at the local hospital reducing travel times and delay to treatment enabling access for patients and family.

- There is no reason why all emergencies should not be treated urgently, with better bed management, resulting in less cancelled operations on both sites. Are more beds needed? Beds re-opened?
- No evidence to say that bigger units have better outcomes or provide better care
- Specialist treatment will nearly always result in additional travel but should only be required by less than 5% of local population and networked between the local hospital and Specialist hospitals such as Brighton to ensure priority is given to networked hospital patients.
  Note: Hastings and Eastbourne are not specialist hospitals and will not provide specialist treatment such as given at Brighton. Consultation documentation misleading.
- Specialist hospitals have waiting lists so patients could be waiting for transfer from the new single-sited unit over 20 miles away from family with a transfer journey to specialist unit longer (ie. Hastings to Brighton as opposed Eastbourne to Brighton).
- No mention in any consultation document which refer to the needs/ wishes of those visiting their loved ones in hospital. 35 mile journey to endure every time they visit and neither hospital is anywhere near a train station.
- Many patients will be elderly, given the demographics, and often their visitors will be elderly too and in many cases won't be able to travel at all or will only be able to infrequently.
- Discharge arrangements for patients very difficult if not in nearest local hospital delaying discharge. Also aftercare likely to be disjointed or very much reduced. Community staff raised concerns at all PAP stage 4 meetings.
- Need more ambulances. Cost included?
- Smaller hospitals can cost more but efficiencies can be obtained eg. Quality targets met, often more popular with patients and public, onset of symptoms to treatment times reduced and in line with national standards, staff not travelling between sites etc. etc. Advantages far outweigh disadvantages!
- Cottage hospital instead of a DGH?

In 2008 the then Secretary of State for Health stopped the downgrading of the consultant-led Maternity unit at Eastbourne DGH to a midwife-led unit. Main reason – A259 and local geography. It has not changed in fact congestion is worse!

Do these drastic proposals save money? Of the £100million savings needed at East Sussex Healthcare Trust (ESHT), these changes will contribute £4.4million!! Where will the other savings be made? Before any downgrading or removal of any core service, reconfiguration and modernisation should be looked at on both sites separately and together, like for like, to see if possible, but must include full robust financial data showing <u>all the other savings</u>.

Thinking outside the box!!
ESHT has had problems since merging in 2002 and has never been able to fund the services which have always been provided and are essential for patients and the future of our county. Problems have not improved since merging and so what about de-merging the hospitals. This needs to be fully investigated.

Liz Walke
Chair of the Save the DGH Campaign & Eastbourne Borough Council Hospital Champion

HOSC - For information

The numbers are impressive. Eastbourne DGH treats 350-400 hip fractures per year, delivers over 2000 babies and has 2000 admissions per year due to falls.
Where are they going to go?

Here are a few scenarios:-

Mrs x is expecting their first child. She goes into labour at the new midwife-led unit at DGH. After a few hours, the midwife realises that the baby has a problem (eg its heart rate). Unfortunately there is no obstetrician on duty any more for DGH to deliver the baby. She has to go to Conquest. Luckily there is an ambulance crew nearby, but even so, by the time they have got her onto their trolley, onto the vehicle, blue light journey in labour straight to delivery theatre, meets obstetrician and is got ready for a Caesarean, one hour has passed. The baby makes a poor effort at breathing. Later, his learning difficulties and poor coordination are put down to the delay in birth.
The compensation the couple get isn't enough for the extra care he needs.

Mrs y is 85, found on the floor by her carer, dehydrated. Taken to DGH, she gets some fluids. Then it is noticed that she has broken her hip. Unfortunately, there is no team to operate on these at DGH at the weekend any more. An ambulance takes her to Conquest, where she can't get her operation for a few days because other people with fractures were also sent there before her. Her neighbours can't visit and she is frightened of going home.

8-year old z come to DGH after falling off a trampoline. Her arm is bent. Unfortunately the surgeons at DGH aren't allowed to operate on children anymore because there aren't any children's beds. She has to go to Brighton. Her mum is a single parent and has to arrange a neighbour to look after her other child. They can't go home as the operation is quite late in the day. They go to DGH for xrays, but the arm needs another operation, so they have to go back to Brighton.

Also: it can be difficult, especially with older people, to work out what is wrong. And it takes time to examine and get test results back. ESHT plan to keep medicine on both sites, but lots of people may be transferred many hours (or days) later, delaying care (which makes outcome worse).

What about

- travel times?
- transferring with fractures or when sick?
- resulting discharge problems?
- domino effect on services?

Other Options

Could HOSC ask/ demand the local NHS for the following to be explored?

1) Proposal to demerge the two hospitals. First criteria to keep core services. Then build on what you need to do to provide these. Proposal to create centres of excellence where numbers and service appropriate eg. Stroke. This would then make Trust attractive to specialist consultants and medical staff needed where previously have had difficulty recruiting.
2) Proposal to demerge the two hospitals and build closer protocols by networking with tertiary hospitals to ensure rapid access to specialist treatment reducing wasted bed days waiting and quicker discharge.
3) If DGH's too small to be sustainable as single Foundation Trust hospitals, then merge with nearest Tertiary unit

All above options with proviso of ensuring that core services kept at both of the Acute hospitals ie. Eastbourne DGH & The Conquest at Hastings.

NOTES FROM MEETING WITH GAVIN BOYLE CHIEF EXECUTIVE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST 19TH JANUARY 2012
VINCENT ARGENT & RICHARD BOOTH

EXECUTIVE SUMMARY

Core services can be retained if the desire and will exists. Starting from the premise that core services are the key offering to the local community, it is then just a question of how to achieve that goal. Yeovil fights to create surpluses from other sources to support core services and structure themselves to minimise the costs of providing all services. Gavin Boyle was an impressive individual with energy and vision who thinks outside the usual NHS box.

In terms of Foundation Trust Status, the strategy adopted to cope with the funding issues to maintain core services is a mindset; an ethos. It requires an understanding of accountability to the local community and a rigour of approach in the handling of the funding issues. The strategy and actions adopted by Yeovil are by Gavin's reckoning, all possible within a conventional NHS Trust. It just requires a state of mind. Perhaps the conversion to Foundation Trust status is the enabler which can bring about this state of mind. Perhaps the key lays in the recruitment of the right Chief Executive.

DETAILED NOTES

- Introductions – VA & RB working with Stephen Lloyd on options for health provision in Eastbourne & East Sussex

- Yeovil had financial problems up to 2003/04 – gradually recovered financial position so that by 2006 it could convert to Foundation Trust in 2nd wave

- Yeovil is about half size of Eastbourne. It has an annual income of £106.5m (ES NHS Trust £360m), 2200 staff (7500 ES), serves a population of 185,000 (500,000 ES), has 345 beds (1023 ES)

- It is therefore a small hospital but provides the core services of obstetrics, paediatrics, maternity, acute surgery, acute medicine including E M (A & E)

- It has near neighbours of Taunton & Somerset NHS Hospital (29 miles), Dorchester County & Exeter General Hospital (21 miles) & Exeter (49 miles)

- How has Yeovil survived pressure to merge or be acquired? By providing other answers.

- Answer 1.
    - The ethos is that core services are essential to the local community but they do not generate a surplus. Core services are not sustainable in isolation because the national tariffs generally are not high enough for these services. (The extent of the loss changes year on year as the national tariff for each service changes).
    - The hospital undertook and continues to undertake an analysis of its portfolio of services so that it balances the losses made by core services with profits made on other services. It has even developed a clinical specialism to sell to other hospitals to make a profit.

- Answer 2.
    - Partnership. The hospital is not sustainable in isolation.
    - An appreciation that the hospital is part of the town not simply part of the NHS. It is the third largest employer in Yeovil and hence a key player in the local community. Links with the community are therefore key. The hospital is a member of the chamber of commerce. The chief executive regularly meets local employers and funds from those firms assist the hospital develop its infrastructure and hence its services. Currently the hospital is raising £2.4m for re-development of its 42 year old Womens' Hospital Unit under a banner of "Flying Colours" is involving the local business community to assist.
    - For certain services it has created network links with the other local hospitals mentioned above. For example:
    - an E M (A & E) consultant has been on secondment from Exeter because of short term recruitment issues;
    - Pathology. The path service to local GP's made a profit but the hospital cases made a loss as more complicated. Whilst retaining path labs at Yeovil and Taunton & Somerset, these two hospitals have set up a new lab on an M5 site to handle their more complex path issues. This shares the costs for more complex cases. They hope to add other hospitals as partners hence the choice of the M5 site.
    - Pharmacy. Joint bid with Boots for community pharmacy services (e.g. prisons etc) and won contract away from Lloyds.
    - Sterile Services Dept offers services to outside parties such as doctors, dentists etc in Somerset & Dorset. The cost of a new state of the art unit is effectively paid by this external income.
    - Redevelopment of onsite staff accommodation to another adjacent site will free up a large areas for re-development which will be undertaken with a private developer. The Trust as the ability to borrow but has no borrowing currently. Some borrowing may be considered as the project will generate income which in turn will assist in the repayment of any debt. A Housing Association delivered the new accommodation.
    - Lots of meeting with the other hospitals to build up relationships with them so they are prepared to work together.
    - Retaining key staff. Many senior managers have been with the Trust for long periods of time and hence provide stability and continuity. The Trust recognises its intellectual capital e.g. by retaining all their student nurses even when there were seemingly too few places at that moment in time. They know that there will be leavers and it is better to have someone who learned in the organisation than pay to recruit someone at this level from outside.

- Answer 3.
    - Staff and team management & attitude.
    - "Icare" - effective COMMUNICATION, positive ATTITUDE, RESPECT for patients, carers and colleagues, and an ENVIRONMENT that is conducive to care and recovery. Borne out of a clinical complaint, the system involved training all staff over an 18 month period about respect & caring, setting up weekly monitoring through simple questions about the items that if they went wrong could cause issues with immediate allocation of resource to any department with a potential weakness. Links quality agenda and staffing agenda. Indicative of a clinically led organisation.
    - Clinical led management at a practical level. For example the head nursing officer heads the procurement committee and is able to challenge consultants on the use of cheaper alternatives which a non clinical manager could not.

- Equipment library. An area where commonly used items of equipment are returned to after every use rather than standing awaiting use on wards. This has reduced the number of items required (e.g. pumps), enables maintenance to be undertaken immediately as required whilst always having a stock of items available ready for use.
- Staffing management. Though staff are allocated to departments, there is a system in place which allows staff with common skills to be shared between departments when required by pressure of work (e.g. theatre nurses). This has significantly reduced agency & bank staff costs.
- A can do approach. For example, to keep within guidelines as to timescales for release of patients, the systems may highlight the need for a few extra hours of work to be required on a Saturday. The income loss through breaching the guideline outweighs the additional wage cost. They have systems which recognise such issues, short communications channels to allow the matter to be taken up at clinical level and the willingness of staff to do the extra hours.
- Accessibility of chief executive and directors to clinical staff. Staff ideas for changes and savings are encouraged, listened to & taken on. The pharmacy idea above came from within the hospital from seeing an advert.

- Answer 4.
  - Keeping the commissioning body close. Obstetrics was a worry as the numbers are not high. The relationship with the PCT is key to taking a long term view. The risk of removal of the service has been mitigated by the quality of the service. This in term leads to awards & accolades making it difficult for the PCT to make a change. The womens' service combines a number of related activities including breast surgery which is a profit generator and hence helps supports losses. (Breast surgery is normally part of general surgery).

IMPORTANT POINTS VINCENT ARGENT JULY 2012

1. Towns such as Eastbourne and Hastings require essential core services at their local hospital.
2. Withdrawal of core services would make Eastbourne the most disadvantaged town in the UK with the worst population access factor (size of population x distance to core services).
3. The A259 between Eastbourne and Hastings is one of the most congested in Europe and 9th most dangerous in the UK.
4. Eastbourne ' Accident and Emergency ' would be downgraded to a Minor Injuries Unit as it would not fulfil the TARN (national Trauma Audit Research Network) criteria for a Trauma Unit or the Sussex Trauma Managed Clinical Network criteria.
5. A great deal of emergency surgery is obstetrics and gynaecology. These would have to be single sited contrary to the IRP concerns about access and safety. It can be far more efficient to co-locate elective and emergency orthopaedics and general surgery. ESHT has not implemented the recommendations of the 2008 IRP Report
6. The Total Transfer Time from Eastbourne to Hastings is about 94 minutes. This is the 'down time'. This far exceeds the acceptable safety limits for many interventions e.g. emergency Caesarean section.
7. The Optimum Stroke Thrombolysis time (onset of symptoms to needle) is 90 minutes and not 4.5 hours. If single-sited at Hastings, all Eastbourne patients would fall outside the optimum time.
8. The Regional Hyperacute Stroke Unit could be in Brighton with co-located neurosurgery and neurosciences and vascular surgery and endovascular interventional radiology with thrombolysis stroke units in Eastbourne and Hastings.
9. There is no evidence that larger units are safer for the great majority of standard emergencies. The CQC Report showed decreasing quality standards with increasing size of units.
10. The people of the Eastbourne area are fully committed to the maintenance of essential core service in both Eastbourne and Hastings. Eastbourne Borough Council, the Eastbourne Business Community, the Churches and Services Organisations all support the need for modernised networked essential core services.
11. Eastbourne consultants realise that the proposed changes are a disaster.
12. It can be done. Yeovil is an example of an outstanding financially stable Foundation Trust which is fully committed to maintaining the essential core services as its fundamental goal.
13. ESHT has not implemented the recommendations of the 2008 IRP Report.

Eastbourne should be given the chance to run its own hospital and services with an option to demerge.