HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 4 October 2012

PRESENT:

Councillor Simmons (Chairman), Councillors Howson, O'Keeffe, Rogers OBE and Taylor (all East Sussex County Council); Councillor Ungar (Eastbourne Borough Council); Councillor Cartwright (Hastings Borough Council); Councillor Phillips (Wealden District Council); Councillor Davies (Rother District Council); Mr Dave Burke and Ms Julie Eason, SpeakUp (voluntary sector representatives)

WITNESSES:

East Sussex Healthcare NHS Trust (ESHT)
Ms Imelda Donnellan, Consultant Surgeon and Primary Access Point Lead
Jayne Cannon, Head of Nursing and Governance
Mr Oliver Keast-Butler. Consultant Orthopaedic Surgeon and Primary Access Point Lead
Katey Edmundson, Head of Nursing for Orthopaedics
Dr Andrew Leonard, Clinical Lead - Acute and Emergency Medicine
Dr Amanda Harrison, Director of Strategic Development and Assurance
Stuart Welling, Chairman
Darren Grayson, Chief Executive
Dr Andy Slater, Medical Director (Strategy)

Brighton and Hove University Hospitals NHS Trust
Dr Iain McFadyen, Chief of Trauma, and South East Coast Trauma System Medical Director

Sussex Trauma Network
Dr Paul Wallman, Clinical Director
Kate Parkin, Manager

South East Coast Ambulance Service NHS Foundation Trust
James Pavey, Senior Operations Manager

Conquest Hospital Medical Advisory Committee
Dr David Walker, Chair

Eastbourne District General Hospital Consultant Advisory Committee
Dr Neil Sulke, Chair
Mr Andrew Armittage, Vice Chair
Ms Scarlett McNally, Consultant Orthopaedic Surgeon

NHS Sussex
Amanda Philpott, Director of Strategy
Catherine Ashton, Programme Director (NHS Sussex/ESHT)

Clinical Commissioning Groups
Dr Matthew Jackson, Clinical Chief Officer, Eastbourne, Hailsham and Seaford CCG

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

31. APOLOGIES

31.1 Apologies for absence were received from Councillors Heaps and Pragnell (ESCC) and Councillor Merry (Lewes District Council).

32. MINUTES

32.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 13 September 2012, subject to noting that apologies had been given by Cllr Howson.

33. DISCLOSURE OF INTERESTS

33.1 There were none.

34. REPORTS

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

35. ‘SHAPING OUR FUTURE’ – HOSC EVIDENCE GATHERING PROCESS

35.1 The Committee considered a report by the Assistant Chief Executive which set out the progress with the Committee’s evidence gathering process and highlighted key documentary evidence.

35.2 RESOLVED to:
(1) note the documentary evidence within the appendices; and
(2) note the progress of the evidence gathering process.

36. ‘SHAPING OUR FUTURE’ – GENERAL SURGERY PROPOSALS

36.1 The Committee welcomed: Ms Imelda Donnellan, Consultant Surgeon and Primary Access Point Lead and Jayne Cannon, Head of Nursing and Governance from East Sussex Healthcare NHS Trust.

36.2 Ms Donnellan introduced the Trust’s proposals for reconfiguring emergency and higher risk elective general surgery services. Key points included:

- All Trust departments had been asked to identify strengths and weaknesses in relation to best practice.
- There is a need to consider emergency and elective care separately, and to consider different types of elective surgery which can range from urgent cancer surgery to procedures for conditions which are not life-threatening.
- Emergency patients should be prioritised but this is not always currently the case
- General surgery at ESHT is a relatively small department with 10 consultant general surgeons – six at Eastbourne and four at the Conquest Hospital. This team does provide 24/7 cover for emergencies but it is at some expense to elective patients as the cover arrangements lead to cancellations and delays.

- These issues have been considered, alongside outcomes and national standards which suggest there is a need for a consultant delivered service with separate emergency and elective workload. New evidence from Europe was also taken into account. There are many drivers for change.
- Emergency and higher risk patients should be kept together and there are requirements in relation to a properly staffed Surgical Assessment Unit with the aim of speeding up diagnosis.
- In a larger department it may be possible to achieve these aims by restructuring job plans or merging rotas, but this is not possible with a smaller team, hence the proposal to bring together emergency and higher risk surgery on a single site.
- The Trust's proposals include dedicated theatre time, appropriate staffing and post-operative care. It would be possible to develop staff experience and specialisms and training of junior doctors would improve through increased exposure to emergency cases.
- The strategy for general surgery must be seen in the context of the whole Trust Clinical Strategy.

36.3 Ms Donnellan responded to questions on the following issues:

36.4 **Capacity**

Ms Donnellan assured the Committee that emergency theatres already exist on each site, but they are only scheduled to be used for half of each day. The proposal is to extend this to provide an emergency surgery list from 8am to 8pm on the single site. The aim is to operate during daylight hours wherever possible, as this is best for patients. There would also be a separate all day list for orthopaedic surgery. These arrangements will mean that emergency surgery will not cut across elective surgery workload. Ms Donnellan confirmed that theatres are routinely cleaned between each procedure so there would not be an issue with a single site emergency theatre being closed for cleaning. However, if the theatre was out of service for some reason it would be possible to use the elective theatre for emergency cases.

36.5 **Views of surgeons**

Ms Donnellan indicated that the general surgeons are in agreement with the plan for emergency surgery, but there is a desire for assurances from management regarding delivery of the planned bed capacity and other needs, together with assurances regarding the future of the site without emergency surgery. She stressed that the general surgery plans had attempted to build in the support needed to reassure colleagues in other specialties regarding the availability of surgical opinion on the second site. This takes the form of a resident on call surgeon of a suitable level to be able to provide a specialist surgical opinion.

36.6 **Continuity of care**

When asked if continuity of care would be affected by the planned rotation of surgeons between sites, Ms Donellan agreed that there would need to be a different way of working based on teamwork and formalising current arrangements for surgeons to pair up to cover leave.

36.7 **GP referrals**

Ms Donnellan assured the Committee that the ability for GPs to speak to a member of the surgical team regarding a referral would be unaffected as there will always be a team on call. There should in fact be an improved response due to the increased availability of consultants.

36.8 **Surgical input to A&E**

Ms Donnellan indicated that a middle grade surgeon would be on call for the A&E department at the hospital without emergency surgery as is the case currently. They would be able to discuss cases with the on call consultant. Decisions regarding the need to transfer patients to the emergency surgery site if admission is required would be clinically based. Ms Donnellan suggested that in these cases a transfer would be in the best interests of the patient as they will be in a place with the systems and staff in place to treat them. She confirmed that minor issues could be managed in the observation area of A&E as they are now. The only concern would be if patients requiring surgical review were admitted to various wards around the hospital. Ms Donnellan indicated that a robust tracking process would need to be in place.

36.9 **Surgical review of inpatients**
Ms Donnellan confirmed that there would be no change to how reviews of inpatients referred by other specialities would be carried out on the site without emergency surgery. Surgeons would be on site for other duties as now. The best arrangements for managing these reviews are currently being considered.

36.10 **Link to gynecology**
Ms Donnellan assured HOSC that the gynaecology department at the site without emergency surgery would be able to obtain a consultant opinion during the daytime in the same way as current practice. If a need arose at night the surgery team would be pre-emptively alerted and there would be surgeon availability to assist. Further planning will be undertaken to formalise this.

36.11 **Contingency arrangements**
Ms Donnellan did not foresee any significant risks from centralising services on one site in terms of the availability of alternative facilities if the emergency site was affected by an incident of some sort. She indicated that there is flexibility at both hospitals to adapt to ward closures and elective procedures could be cancelled if necessary in order to continue emergency surgery. There would have to be an incident of a major and extraordinary nature to cause significant problems. Ms Cannon indicated that a possible situation could be an infection control incident on the surgical assessment unit, and confirmed that this unit could be reprovided on other wards if necessary.

36.12 **Royal College standards**
Ms Donnellan accepted that the Royal College cannot prescribe a minimum rota as it must be left to local needs. She had spoken to the National Clinical Advisory Team to clarify that the pre-consultation business case had referred to a specified 1:8 rota in error. However, Ms Donnellan argued that the Royal College standards are clear about how onerous a rota should be depending on the level of activity. She indicated that ESHT would not qualify as a low volume Trust, where more flexibility is possible, and that the Royal College had raised concerns about the 1:6 and 1:4 rotas currently in place. 1:8 is considered the minimum requirement in order to deliver a rota compliant with the European Working Time Directive and this is what is planned under the proposed single site emergency surgery service. Ms Donnellan stressed that the rota requirements are only one aspect of the case for change in general surgery.

36.12 **Nursing perspective**
Ms Cannon confirmed that she supported the proposed changes from a nursing perspective.

36.13 RESOLVED to:

(1) note the comments of the general surgery representatives.

37. ‘SHAPING OUR FUTURE’ – ORTHOPAEDICS PROPOSALS

37.1 The Committee welcomed: Mr Oliver Keast-Butler, Consultant Orthopaedic Surgeon and Primary Access Point Lead and Katey Edmundson, Head of Nursing for Orthopaedics from East Sussex Healthcare NHS Trust (ESHT).

37.2 Mr Keast -Butler introduced the Trust’s proposals for orthopaedic surgery by making the following points:

- Approximately 2000 fractures are operated on each year on an inpatient basis across the two hospital sites so around 1000 patients would have their operation on a different site under the proposals. The plans would also affect some additional patients who are assessed as emergencies but subsequently do not require surgery.
- Major trauma is a very small proportion of the department’s work and there has been a significant drop since the Sussex Trauma Network went live from April 2012, as most major trauma cases are now taken directly to Brighton.
- The bulk of the workload is fractures in elderly patients with other health conditions.
- The department currently performs quite well against national standards, particularly Eastbourne in terms of meeting the national best practice tariff.
- The Conquest Hospital has struggled to recruit an orthogeriatrician, whereas one is already in place at Eastbourne. This is reflected in the service available. 43% of cases at the Conquest meet best practice criteria, compared to 80% at Eastbourne. It would be possible to improve the levels if a second orthogeriatrician could be recruited.
- There is difficulty providing all the required staff seven days a week, for example, providing cover when the single orthogeriatrician is on leave. If two of these consultants worked together on a single site it would be possible to cross-cover, providing the service all year.
- It has also not been possible to provide physiotherapy and occupational therapy seven days a week which increases patients’ length of stay.
- Some roles previously carried out by doctors can in future be undertaken by staff such as pharmacists and nurse practitioners.
- It will be more difficult to recruit good quality middle grade doctors in future. Recruitment and training issues must be addressed.
- Minimum numbers are needed to staff a rota – the strategy enables a consultant to be on site every day to perform or supervise surgery. Currently, there is less than a 50% chance of a consultant being allocated to a list. This will become more of a problem as it becomes harder to recruit good quality middle grade doctors.
- The aim of the proposals is to bring together all inpatient care on one site. Pooling staff can increase the number of specialists available for complex cases.
- The quality of care provided by hospitals will be compared by commissioners and there is a need to deliver better quality than competitors.
- The changes are controversial and some consultants are not happy with the plans. There is a need to present a balanced view of the evidence and be honest about quality.

37.3 Mr Keast-Butler and Ms Edmundson responded to questions on the following issues:

37.4 **Continuity of care**

Mr Keast-Butler highlighted various models used by different trusts to provide continuity of care through a team approach. Pembury Hospital offers a seven day a week consultant ward round in contrast to the more fragmented care offered at ESHT, where patients don't necessarily see a consultant every day due to current working patterns. He indicated that the proposals will ensure daily ward rounds by a consultant and orthogeriatrician which will ensure better cover, even through patients may not be followed up by the surgeon who carried out the operation.

37.5 **Differences between hospitals**

Mr Keast-Butler explained the current differences between orthopaedic services at the two hospital sites. There are significant disparities in staffing such as the orthogeriatrician, four additional therapy staff and trauma co-ordinator at Eastbourne. However, the Conquest has a consultant allocated to all trauma lists in contrast to 55% consultant allocation at Eastbourne. Mr Keast-Butler argued that the plans attempt to take forward the strengths from both sites. He acknowledged that it would be ideal to bring both sites up to the best standards of each, but said this would be unrealistic given the significant resources which would be required and issues regarding sufficient workload.

37.6 **Clinical concerns**

Mr Keast-Butler suggested that the root of concerns amongst some clinicians was the desire to deliver the best practice model on both sites. He also acknowledged that there would be some inconvenience for patients and staff in travelling between sites. However, Mr Keast-Butler indicated that the plans are making the best of available resources and he cited the example of clinicians at Pembury who were initially unhappy but appreciate that a better service is now being provided and want to work in that environment.

37.7 **Weekend cover**

In response to a question about cover at weekends under the proposed model, Mr Keast-Butler outlined how arrangements could be streamlined with a more predictable workload on a single site. He explained how operating lists could be made more efficient and the proportion of operations undertaken by consultants or with a consultant on site could be increased.

37.8 **Transfers**

When asked about the risks of extended or additional transfers to patients with fractures Ms Edmundson outlined the care provided immediately by paramedics such as pain relief and immobilisation. She acknowledged that additional travel is not ideal but argued that the benefits of fast, excellent care on arrival outweigh the disadvantages. She described the current situation as 'hit and miss' as patients may have a long wait in A&E. Mr Keast-Butler stressed the diagnostic accuracy of paramedics, with all but two hip fractures being correctly identified prior to attendance at A&E during a three month period. He acknowledged that there could be some patients taken to the 'wrong' site who subsequently require transfer and some patients who will be taken to the emergency site and subsequently turn out not to require surgery.

37.9 **Winter pressures**

Mr Keast-Butler acknowledged that there had been big increases in emergency orthopaedic demand during recent icy winters. He explained that the plans aim to cope with expected peaks in demand but that the option to cancel elective surgery in a crisis remained. Peaks and troughs had been considered when planning bed capacity and these calculations are still being refined. Mr Keast-

Butler accepted that it is not possible to truly ringfence surgical beds in a hospital which can experience unexpected peaks in medical admissions. However, he outlined the strict criteria which could be put in place for accepting medical patients on surgical wards, such as infection control measures which would effectively 'microbiologically ringfence' beds.

37.10 **Different clinical views between hospitals**
Mr Keast-Butler welcomed healthy competition between consultants which can improve services, but he indicated that historical bolstering of services had led to disparities between hospitals. He emphasised the need to move beyond separate site working to operate as a single department, building on existing cross-site meetings. He indicated his hope that clinicians would agree that consultant delivered care is beneficial and his view that change is achievable, whilst accepting that there will be impacts in terms of additional travel because it is not possible to achieve the desired standard of care on two sites.

Ms Edmundson gave a view based on her experience of working at both sites. She indicated that the basic care is very similar but that consultants and nurses at each hospital had built up different practice over time and there had been historical differences in funding which have had to be addressed. Ultimately, the aims in terms of quality of care are the same and all consultants want consultant-delivered care. Ms Edmundson indicated her view that the proposals are best for patients in the long term.

37.11 **Impact on site without trauma unit**
Mr Keast-Butler acknowledged that if it was perceived that the site without emergency surgery was declining it would be hard to recruit, but he argued that this can be addressed by rotation of staff between sites so that they experience the full breadth of the service. Ms Edmundson stressed that A&E would remain in place at both sites and that orthopaedics is only a proportion of its work. She added working in a trauma unit does not appeal to all staff and that there would be opportunities to develop the remaining specialisms such as day surgery.

37.12 **Discharge**
Ms Edmunson confirmed that the strategy required the assisted discharge schemes in place would continue and be further developed and arrangements would be put in place for the teams to work within the wards in the mornings and outreach into patients' homes in the afternoon. She confirmed that a link would be put in place from the emergency site to the community around the site without emergency surgery. Plans include the continuation of local outreach and its expansion to cover the whole county.

37.13 RESOLVED to:
(1) note the comments of the orthopaedic representatives.

38. IMPACT OF PROPOSALS ON EMERGENCY CARE AND PROVISION OF TRAUMA UNITS

38.1 The Committee welcomed: Dr Andrew Leonard, Clinical Lead - Acute and Emergency Medicine at ESHT; Dr Iain McFadyen, Chief of Trauma at Brighton & Hove University Hospitals NHS Trust (BSUH) and South East Coast Trauma System Medical Director; Dr Paul Wallman, Clinical Director and Kate Parkin, Manager from the Sussex Trauma Network, and James Pavey, Senior

Operations Manager from South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

38.2 The representatives answered questions on the following issues:

38.3 **A&E workload**

Dr Leonard gave a breakdown of A&E activity at ESHT: of 120,000 annual attendances approximately 80% are acute medicine, 15% minor injuries and the remaining 5% comprises surgery, mental health and other cases. This breakdown is the same at both sites.

38.4 **Impact on A&E**

Dr Leonard indicated that the proposed reconfiguration of services would have a minimal impact on A&E. There would be a need to transfer a maximum of 15 patients per day from the site without emergency surgery and acute stroke but actual numbers are likely to be significantly lower as most would go directly to the host site by ambulance. Dr Leonard assured the Committee that if patients were to self-present or be brought to the wrong site by ambulance there are A&E clinicians competent to diagnose and stabilise patients.

38.5 **Trauma unit status**

Dr McFadyen explained that the function of a trauma unit is to rapidly assess a major trauma patient and decide on the best ongoing management, which is usually transfer to the major trauma centre. It is the speed of clinical assessment and diagnostic capacity which are key.

Dr McFadyen indicated that indications from London (which had longest experience with an active trauma network) were that there had been no measurable impact on A&E departments which had not been designated as trauma units. This may relate to the fact that major trauma patients represent less than 0.3% of A&E admissions, therefore their absence is very unlikely to destabilise a unit. He also confirmed that there had been no measurable impact on recruitment and retention of staff at these units. Dr McFadyen suggested that this could be because major trauma cases tend to soak up resources and therefore can impact negatively on the care of other patients whilst staff are assembled into a major trauma team. This is less of an issue in larger hospitals with more staff, but in most hospitals staff are taken from other duties to respond to major trauma. It can be possible to see improvements in other areas when major trauma is not accepted so any negative impact may be offset by this.

38.6 **A&E staffing**

Dr Leonard indicated that the A&E unit at the site without emergency surgery would be almost imperceptibly different due to the low numbers (around 9 per day) of surgical patients who would no longer be attending. He stated that staffing would be very similar and the department would appear just as busy. There would be access to surgical and other specialty input for patients if required.

38.9 **Ambulance cover**

Mr Pavey explained how ambulance resources are moved to meet demand by hour and by day. There would need to be a discussion with commissioners regarding the impact of reconfiguration on ambulance capacity. Mr Pavey confirmed that SECAmb are able to plan for any scenario as long as the expected activity is clear and that any issues are not insurmountable.

Mr Pavey confirmed that paramedics already provide care for patients en route to hospital and their skills are being extended, with roles such as critical care paramedic being introduced.

38.10 **Clinical views**
Dr Leonard indicated that acute medicine clinicians support the proposed approach but there is a degree of uncertainty until it is implemented. Some concerns have been raised but these had been answered by the Primary Access Point leads.

38.11 **Intensive care and anaesthesia**
Dr McFadyen assured the Committee that these services had not been destabilised by changes in arrangements for major trauma. He referred to the configuration operated by BSUH and other trusts where emergency surgery is located on one site only. In his experience there can be risks where the basis is a simple/complex split, as there could be knock on effects on out of hours capacity to care for other patients. Where the configuration is based on a higher/lower risk split, as in ESHT's proposals, the second site retains the ability to do complex work but in a planned, lower risk way and the other site performs similar complexity of work but in a higher risk and unplanned way.

Dr Leonard emphasised that acute medicine would remain on both sites and changes to its design which had recently been successfully introduced at the Conquest would be introduced at Eastbourne. The new model mandates access to intensive care and clinical input out of hours. He agreed with Dr McFadyen that the planned split in activity is the correct approach.

38.12 **Trauma Network transfer arrangements**
Trauma Network representatives were asked whether it is acceptable for a patient located more than 45 minutes travel time from the major trauma centre to initially travel in the opposite direction to a trauma unit for stabilisation, before transfer back to the trauma centre via the original location. Dr Wallman advised the Committee that this already occurs and increased movement of patients would be expected in a Trauma Network. He explained that there is clinical operational support available to SECAmb, both from their dispatch centre and the major trauma centre, to assist in decision making. The decision may be to travel straight to the trauma centre even if this is over 45 minutes, or to transfer initially to a nearer trauma unit if stabilisation is required, even if this is in the opposite direction. The key impact on patient outcome is access to the definitive care required and going to a location not equipped to offer the necessary trauma care initially increases mortality.

Mr Pavey concurred that taking patients to the right place is critical in a life threatening situation. He explained that this is usually a relatively easy decision and a decision aid is available to paramedics to ensure a swift judgement can be reached. If the decision is to take a patient to a trauma unit rather than the trauma centre the likelihood of onward transfer being needed is relatively low, as a good initial decision has been made and the trauma unit is likely to meet the needs of these patients. He advised HOSC that this system had been operating well since its introduction in April 2012.

38.13 RESOLVED to:
(1) note the comments in relation to A&E and the Trauma Network.

39. ACCESS, TRAVEL AND TRANSPORT

39.1 The Committee welcomed Dr Amanda Harrison, Director of Strategic Development at ESHT; Catherine Ashton, Programme Director for NHS Sussex/ESHT and James Pavey of SECAmb.

39.2 The representatives responded to questions on the following issues:

39.3 **Ambulance handovers**
Mr Pavey acknowledged that there can be pressures in the system which impact on the speed of ambulance handovers at hospitals. He outlined the protocols in place which are based on 15 minutes to hand over the patient and 15 minutes for the crew to complete activities – a total of 30 minutes turnaround time. This is monitored and there are screens in A&E where the handover point is agreed between paramedics and A&E staff and logged. Mr Pavey added that there can be times when a longer handover period is appropriate for clinical reasons.

Mr Pavey indicated that SECAmb also records job cycle times which include the whole job from call to being available for a new call. This averages 70 minutes and is the unit used to plan ambulance resource needs.

Dr Harrison added that ESHT had undertaken monitoring of A&E handover times and these had reduced at the Conquest Hospital since the new model for acute medical admissions had been introduced. This model will be introduced at Eastbourne Hospital where there are currently more delays. Mr Pavey outlined the escalation process in place if handover times increase so that the Trust can take additional action to resolve it. He confirmed that the situation had improved at the Conquest Hospital since the changes had been introduced.

39.4 **Ambulance travel times**
Mr Pavey advised HOSC that average travel times to hospital by ambulance are available but these are of limited value give the wide variety of original locations. He stated that the average travel time between the two hospitals is 38 minutes, which is based on actual data at all times of the day. Mr Pavey advised that there is no specific time available for a hospital to hospital transfer including pick up and drop off but a job cycle time of between 1 hour 20 minutes and 2 hours would be expected. Ambulances can use blue lights to negotiate traffic when necessary but the majority of patients do not require a blue light transfer to hospital as they have already been treated by paramedics.

Dr Harrison emphasised the importance of focusing on what the difference would be between the current and proposed configuration. Any patient transfers to hospital now would include pick up and drop off time. It is therefore only the travel time itself which would change for some patients.

39.5 **Accuracy of estimated travel times**
HOSC highlighted concerns raised by some patients and stakeholders regarding the accuracy of travel times cited in the travel study commissioned by ESHT. Dr Harrison advised the Committee that the data had been produced independently using standard travel modelling which is based on isochrone techniques. She stressed that it is the same information available to local authorities and other bodies when undertaking planning. She also highlighted that the travel time bands used are based on average times within the area and time period covered.

39.6 **Consultants on call**
When asked whether the proposed reconfiguration would impact on the ability of some consultants to access the hospital within required on call response times

Dr Harrison stated that the precise impact would not be known until a configuration was agreed. Any impact on individual members of staff would be subject to consultation with them. The impact may be beneficial for some staff. Dr Harrison added that the Trust had begun to look at potential mitigating actions such as a shuttle bus for staff.

Dr Andy Slater, the Trust's Medical Director (Strategy) indicated that the 10 mile or 30 minute rule which is sometimes quoted is historical. Different specialities have different requirements regarding the availability of consultants out of hours. He indicated that if a patient requires immediate life saving treatment this is currently and would in the future be carried out by the experienced middle grade doctors resident on call as it would be impractical for a consultant to reach the hospital in the required timespan from any distance. The primary role of the consultant on call is to advise, often by phone, and to provide further assistance after a patient has been stabilised. A pragmatic approach to consultant access will therefore be taken. Dr Slater indicated that if a consultant is required to be on call to a hospital too far away then on site accommodation will be provided by the Trust. Ultimately the Trust cannot set requirements as to the home base of staff as it is a matter of personal choice.

39.7 **Risk assessment**
Dr Harrison stated that, in terms of risk assessment, the Trust had focused on what would change if the preferred options were implemented. A travel study had been commissioned and the Trust had worked with transport planners at the County Council on this. For example, the County Council had advised that the A259 is classified as a medium risk road.

Dr Harrison indicated that there is very little definitive information available on required or optimum times for access to treatment. The available data and risks have been examined and the clinical view (including from the National Clinical Advisory Team) is that the trade-off between travel time and clinical benefit is worthwhile. Dr Harrison emphasised that travel is only a small, but important, part of the whole clinical pathway that ensures the best clinical outcomes are achieved. She assured the Committee that the Trust would work with SECAmb to minimise and manage the impact.

39.8 RESOLVED to:
(1) note the comments regarding access, travel and transport.

40. VIEWS FROM HOSPITAL CONSULTANTS

40.1 The Committee welcomed Dr David Walker, Chair of the Conquest Hospital Medical Advisory Committee (MAC), Dr Neil Sulke and Mr Andrew Armitage, Chair and Vice Chair of the Consultant Advisory Committee (CAC) at Eastbourne DGH and Mrs Scarlett McNally, Consultant Orthopaedic surgeon who is also a council member of the Royal College of Surgeons.

40.2 Dr Walker summarised the views of the MAC in relation to the proposals:

- The vast majority of consultants at the Conquest believe that reconfiguration is essential to maintain and improve quality and efficiency.
- A survey of the consultant body had demonstrated support for reconfiguration from all but two respondents if resources were unlimited and all but one respondent when taking into account limited resources.

- It is recognised that services cannot be replicated on both sites if quality improvements and savings are to be achieved.
- There is concern that if the Trust does not make changes proactively, change may later be foisted upon the organisation resulting in worse decisions being made.

40.3 Dr Walker advised the Committee of his role on the Royal College of Physicians Committee looking at the future hospital. Through this he is well aware of national developments such as the move towards consultant delivered services and catchment populations of 500,000 for hospitals. He responded to questions on the following issues:

40.4 **Separate committees**

Dr Walker indicated that a majority of the Conquest MAC had decided over a year ago that the Committee should merge with the CAC at Eastbourne DGH. A meeting had been held with Dr Sulke and the Trust Chief Executive and Chairman to discuss this but Dr Sulke felt at the time that the Committees should remain separate whilst reconfiguration was under consideration, in order to give each hospital a voice. Dr Walker suggested that there are advantages and disadvantages to having separate Committees.

40.5 **Sustainability of services**

When asked about the sustainability of other services at the Conquest if the three being considered for reconfiguration were to be located at Eastbourne, Dr Walker said that the key issue is access to a senior opinion on the second site, for example where medical patients require a surgical opinion. He indicated that, if a senior opinion is guaranteed then the changes are not problematic as patients can be transferred for surgery if required. He added that procedures would need to be in place to manage patients presenting at the 'wrong' site.

40.6 **Capacity**

Dr Walker indicated that there is space available at the Conquest Hospital as three wards had been closed following earlier service developments. He was not able to comment specifically on theatre capacity but suggested that management would need to make appropriate capacity and resources available in order to implement the changes successfully.

40.7 Dr Sulke presented the views of the CAC on the proposed changes:

- The CAC is aware of the need to change and supports large parts of the wider Clinical Strategy including redesign of acute medicine, reducing lengths of stay and working with primary care.
- However, the CAC does not support the preferred options for reconfiguration.
- Consultants had been fully engaged in the Primary Access Point process and there had been meetings with the Chief Executive and Chairman.
- CAC cannot accept that the preferred options represent an improvement in the quality of care and believe that the core services must be provided at both sites to serve all East Sussex patients.
- A survey of the Eastbourne consultant body demonstrated that 97% do not support the Clinical Strategy in its entirety. The vast majority also opposed the specific proposals for general surgery and orthopaedics.
- Views on stroke were more mixed and there was significant support for reconfiguration. However, the survey had been conducted before a negative response from Dr Conrad, lead stroke physician at Eastbourne, had been circulated and this may have influenced views, particularly in terms of time to access acute care.

40.7 Mr Armitage explained that, as an orthopaedic consultant, he had been involved in the Clinical Strategy process for the past two years representing the views of orthopaedic staff at Eastbourne. He made the following points:

- The orthopaedic Primary Access Point group looked at all options against the criteria and the two site option (option 1) had scored best for access and choice and quality and safety. Option 3 scored least on these points, so it was surprising to see it emerge as the preferred option.
- Orthopaedic staff had responded during July raising a number of concerns about the preferred option and information in the consultation document.
- The Chief Executive and the Director of Strategic Development had agreed that the case study in the consultation document is not reflective of the service currently received by Eastbourne DGH patients.
- The Chair of Eastbourne, Hailsham and Seaford Clinical Commissioning Group had said that the case for reconfiguration of orthopaedic services is 'debatable'.
- Orthopaedic staff believe that option 1 is the best way to deliver care.

40.8 Dr Sulke and Mr Armitage responded to questions on the following issues:

40.9 **Separate Committees**

Dr Sulke stressed that departments already work cross-site e.g. cardiology. There have also been joint meetings of the MAC and CAC which have discussed the proposals. However, the Commitees had never discussed a formal merger proposal and a two thirds majority of the CAC would be required to agree a merger, which Dr Sulke considered unlikely in the current context.

Mr Armitage stated that the difference in opinion is not a site issue. He suggested that there is agreement on the desire for consultant delivered care but different views on how to achieve that.

40.10 **Trust de-merger**

Dr Sulke was not aware of consultant opinion on a proposal which had been put forward by local campaign groups for the Trust to demerge. He put forward the view that there are both benefits and downsides of scale. The key aim should be the provision of core services and the CAC feels these should be available at both sites. Whilst seeing the potential benefits of a single unit, Dr Sulke expressed concern about the interdependencies between services.

40.11 **Alternative proposal**

When asked whether consultants had any alternative proposals which would meet the required standards Dr Sulke indicated that the CAC had limited resources to put forward an alternative strategy but have put forward some proposals. The focus of the CAC is on protecting core services and Dr Sulke suggested that there may be more flexibility in terms of the structure of elective services. The CAC is also keen to optimise the interface with primary care and suggests that a massive management restructure is needed alongside clinical changes.

Mr Armitage added that orthopaedics is not a loss making service and that, although recruitment can be difficult, the Trust currently has excellent trainees and people want to work in good units such as those at ESHT. He acknowledged that the lack of a second orthogeriatrician is a problem but suggested the recruitment difficulty is due to uncertainty. Mr Armitage stressed that the issues had not been ignored by the CAC and that there are ways of delivering option 1 cost effectively.

When asked for the timescale in which the CAC would put forward their proposals, Dr Sulke indicated his desire for consultants to work with the strategy team as some have proposals which could be quite radical. However, Dr Sulke indicated that he had received further comments on the initial proposals from consultants and they are still being discussed. He suggested that it would not feasible for the CAC to produce a plan of equivalent depth to the Trust's proposals but he would be willing to work with the strategy team to develop proposals.

40.12 **Stroke proposals**

When asked to clarify the CAC position regarding stroke care, Dr Sulke stated that the response from consultants to the survey had indicated almost a 50/50 split in opinion. However, the subsequent response of the lead stroke physician had provided further information which describes the service very differently to the consultation document. This document could be made available to HOSC.

40.13 Mrs McNally advised the Committee that she is a Council member of the Royal College of Surgeons and had discussed her points with the president of the college:

- The Royal College standards for unscheduled surgical care document had been described by the Trust as the primary driver for change.
- The pre-consultation business case had suggested that this document specified the need for a 1:8 rota as a minimum and that it was therefore necessary to merge the existing two general surgery rotas. This is incorrect as the standards document does not mention a 1:8 rota.
- Patient diagnosis is not always clear and can change over time as test results are received and the patient's condition develops. There are issues regarding access to surgery for medical inpatients who develop a need.
- Most hospital beds are full of elderly medical patients and there is no approved model for a service delivered by middle grade surgeons without a consultant available to assess the patient within 30 minutes and operate as needed.
- The aim of the Royal College with regard to separation of emergency and elective care relates to co-location of all emergency patients presenting to different teams. The quote within the consultation document is from a 2007 document and has changed in the updated 2011 document.
- The number of patients affected is not just those requiring operations but also many others who require surgical opinion.
- The seven day working group of the Academy of Medical Royal Colleges (which Mrs McNally sits on) has stated that different models will be needed for rural areas where travel is difficult.
- The overall intention of the college is to increase consultant input rather than rely on unsupported middle grade doctors.
- The National Clinical Advisory Team report comments on the limited number of clinicians they were invited to meet on their one day visit and does not mention the safety issues of patients travelling for a surgical opinion.

40.14 Mrs McNally, Dr Sulke and Mr Armitage responded to questions on the following issues:

40.15 **Ability to express views**

Dr Sulke confirmed that he has been representing the views of the consultant body to management rather than a personal position. He indicated that Trust management had encouraged full engagement and had been fairly open. The CAC had been listened to and there had been no obstruction.

Mrs McNally indicated that it had been uncomfortable to question a policy which had been in development for some time. There had been opportunities to participate in the Primary Access Point process but orthopaedic staff had only seen the preferred option at around the same time it was made public. They had been surprised given that this option did not score as well as others in the fourth meeting. Mrs McNally added that there had been a lack of response from management to her concerns and she did not feel that her comments had been taken account of. Finally, she felt that statements that the changes are not about money were incorrect as savings seem to be a driver.

40.16 **Engagement**
Dr Sulke indicated that some CAC Members had felt ignored at engagement meetings. His view was that people were listened to but that the strategy team gave a different view. Mr Armitage added that there had been a debate over orthopaedics for several years and there are clearly two different views within the Trust. He confirmed that he had been engaged throughout and listened to, but had an opposing view.

40.17 **Impact of orthopaedic proposals on patients**
When asked about the impact on patients of increased journey times Mr Armitage stated that there would be no impact if the quality of care was the same, although an extended journey time is not ideal for a patient with a broken hip for example. He highlighted the impact on families and the benefits of visitors for patients, such as reduced confusion. Mr Armitage also indicated that arrangements to discharge patients can work at a distance from their community but are not as good. He added that continuity of care would be affected if patients were not followed up by the same surgeon and, although this could be addressed through working in teams, it may impact on professional responsibility.

40.18 RESOLVED to:
(1) note the views of the hospital consultants.
(2) request copies of the results of surveys undertaken by the CAC and MAC
(3) request a copy of the Eastbourne lead stroke physician response
(4) request a copy of the response of the orthopaedic staff.

41. 'SHAPING OUR FUTURE' – NHS SUSSEX AND EAST SUSSEX HEALTHCARE NHS TRUST

41.1 The Committee welcomed: Amanda Philpott, Director of Strategy at NHS Sussex; Dr Matthew Jackson, Clinical Chief Officer of Eastbourne, Hailsham and Seaford Clinical Commissioning Group, Stuart Welling, Chairman, Darren Grayson, Chief Executive, Dr Amanda Harrison and Dr Andy Slater, Medical Director (Strategy), all of ESHT, and Catherine Ashton, Programme Director, NHS Sussex/ESHT.

41.2 Mr Welling made the following reflections on issues which had emerged during the consultation process:

- There is very little true integration of services between the two hospitals and the Board will continue to encourage the formation of a single medical committee which could present a single voice from the consultant body.
- The provision of health and social care for the whole of East Sussex must be considered. The Trust does not only serve the residents of Eastbourne and Hastings.

- Services cannot be sustained in their current format and the options are based on the best advice from leading clinicians.
- The Board will reflect on the independent National Clinical Advisory Team report which presented clear recommendations.
- The direction of travel nationally is towards increased concentration of services in order to deliver the best possible care. In this context it would be illogical, unnecessary and unviable to split ESHT into three parts as has been suggested – two acute hospitals and the community services. This would also lead to loss of opportunities to provide integrated services across acute and community settings. Larger NHS organisations are looking at merger.
- He thanked HOSC for its deliberations and gave an assurance that the ESHT Board will consider the consultation outcomes and all options at a meeting on 15 November 2012, before making a recommendation to NHS Sussex.

41.3 Dr Slater made the following observations:

- The proposals are absolutely about sustainable quality care. The Trust does not provide high quality care consistently and must address this within the resources available.
- The Trust is making the minimum change needed to provide a viable way forward and is looking forward to future pinch points in order to plan for the future. Services may be just managing now but will suffer in the future.
- seven day working is key – there is currently unacceptable variation. To achieve this there is a need to increase staff resources which is both challenging and costly.
- There is a need to change the way doctors work. Continuity of care can be provided through team working rather than through one consultant, and there is not currently continuity for all patients.

41.4 Mr Grayson added the following points:

- There is a distinction between evidence and opinion, and the views of other bodies are important, such as the National Clinical Advisory Team.
- Change is difficult but ESHT has a shared responsibility with commissioners to achieve financially and clinically sustainable services.
- The current reconfiguration proposals are a modest part of the overall Clinical Strategy.
- Some services moved a few years ago without a clear process of change. For example, ear, nose and throat, urology, complex haematology and out of hours ophthalmology have moved from Conquest to Eastbourne. These changes were undertaken with little engagement but the Conquest hospital continued to thrive. The Trust is trying to achieve a better managed process of change.
- The proposals have been generated by the clinical leads and clinicians have been empowered in a much greater way than previously.
- Opposing views have been heard but there needs to be an alternative proposal. An early draft proposal does not seem viable as it includes alternating site emergency surgery which would not be acceptable to the Trust.
- Both patient safety and the sustainability of ESHT over the next few years are at stake. Without change there is a risk of a failure situation such as that seen in South London.

41.5 Speaking on behalf of NHS Sussex, Ms Philpott made the following points:

- The commissioning role is to make best use of resources for safe and sustainable care.
- Finance cannot be ignored. NHS inflation is well above budget increases and resources are tight.

- There is a commitment to two viable hospitals, building on areas of high quality and improving where necessary.
- There is a need to learn from the network approach which is based on the principles of local care where possible, a pathway approach, avoiding duplication and making best use of the clinical workforce.
- There is a desire to ensure service changes occur in response to clearly agreed plans rather than, as sometimes has happened, in response to a crisis.
- The NHS Sussex Board will take account of views from HOSC, ESHT and Clinical Commissioning Groups, plus the outcome of public consultation and the options appraisal panel, and will decide on 23 November 2012 on both the model and site. There will be no delay as there is a need to move forward after an 18 month process.

41.6 Dr Jackson added the following points on behalf of the Clinical Commissioning Groups:

- There has been an open process throughout.
- Clinical Commissioning Group representatives have been invited into the Trust and there has been openness about the evidence.
- There is a need for a planned way forward in financially difficult times.

41.7 The NHS representatives responded to questions as follows:

41.8 **Clinical support**

When asked about the differences in view between Clinical Commissioning Group GPs and some Trust clinicians Dr Jackson suggested that the Clinical Commissioners look at the whole system issues and the complex economic and wider environment. They have also taken a wider view beyond Eastbourne and Hastings. He indicated that their view is based on clarity that change must happen, an increasingly challenging financial environment and the need for a united view across East Sussex to avoid confusion.

Dr Jackson confirmed that all GPs had supported involvement in the strategy process. There is not 100% agreement on the proposals as the issues are complex and there are differing views from the consultant committees. However, he views the strategy process as robust and is clear that decisions are yet to be made, with the involvement of Clinical Commissioning Groups.

41.9 **Financial viability**

Mr Grayson indicated that a comprehensive financial analysis of options had been undertaken for the pre-consultation business case and further work would be carried out at outline and full business case stages, once a decision had been made. He highlighted ESHT's poor record of requiring financial support in eight out of the 10 years of the Trust's existence. This support from commissioners will not be available in the future and the strategy is a step forward to provide services in an affordable way.

Mr Grayson described the administration process the Trust would go into if the Clinical Strategy is not delivered and the 45 day period within which administrators would decide the future of services without consultation.

Ms Philpott highlighted that Clinical Commissioning Groups are working on improvements across pathways which are primarily about developing community and primary care rather than acute care. In this context there will be pressure for all acute trusts to manage within a smaller financial envelope and there will be ongoing difficult negotiations between commissioners and the Trust.

41.10 **Information available to Boards**
Ms Philpott highlighted the complexity of the issues the Boards would need to consider and the fact that there would never be unanimity of clinical view given the inevitable subjectivity involved in making judgements. However, the best available evidence would be made available and consideration is being given to areas where the Boards may require additional information. They will take account of outline timelines for implementation in relation to both acute and community changes. NHS Sussex has taken legal advice in order to meet its public equality duty and in relation to the process.

41.11 **Options appraisal process**
Dr Harrison clarified that the Boards will receive the outcomes of the options appraisal panel alongside the reports on public consultation, the HOSC report and a report from ESHT and NHS Sussex. The appraisal panel undertakes the scoring of options against criteria based on supporting information, most of which is already in the public domain such as the pre-consultation business case and travel study. The panel is not a decision making body and so will not receive the other reports. The panel membership is available on the consultation website.

Mr Grayson stressed that the ESHT Board is open minded and some arguments are finely balanced. He also indicated that no presumptions had been made about site selection, despite assumptions made by others regarding the favouring of the Conquest. The Board will consider a number of factors including the consultation outcomes, finances, access evidence and safety.

Dr Harrison clarified that if a new option is put forward it would be developed as far as possible and included in the process. However, most possible options had been considered earlier in the Primary Access Point process.

41.12 **Decision making**
Mr Grayson confirmed that, ultimately, judgements would be made by the Boards who are the decision makers. He stressed that the Trust had always been open and encouraged people to produce proposals to improve quality and efficiency. He indicated that finance is a significant issue but the guiding principle is about making services safer.

41.13 RESOLVED to:
(1) note the comments of NHS Sussex, Clinical Commissioning Groups and East Sussex Healthcare NHS Trust.

The Chairman declared the meeting closed at 2.45pm

18