Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**30 October 2012**
By:	**Assistant Chief Executive**
Title of report:	**Shaping our Future – HOSC response**
Purpose of report:	**To consider HOSC's draft report in response to the Shaping our Future consultation process.**

RECOMMENDATIONS

HOSC is recommended to:

1. **Agree the report attached at appendix 1.**
2. **Agree to forward the report to the Chairs of NHS Sussex, East Sussex Healthcare NHS Trust and East Sussex Clinical Commissioning Groups for their Boards' consideration and to request a response to HOSC's recommendations.**

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) orthopaedics

1.2 The proposals were set out in a public consultation document available from www.esht.nhs.uk/shapingourfuture. The public consultation process ran from 25 June to 28 September 2012.

1.3 In June, HOSC determined that the proposed changes constitute potential '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.

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. This includes consideration of HOSC's report.

2. HOSC evidence gathering process

2.1 Three Committee meetings were arranged between July and October to enable HOSC to seek a range of views on the proposals from key stakeholders.

2.2 The 26 July meeting focused on cross-cutting issues and views, including finance and perspectives from the Ambulance Trust, Clinical Commissioning Groups, Campaign Groups, Public Health and the Strategic Health Authority. The 13 September meeting focused on the proposals for stroke care, perspectives from the voluntary sector, and looked at how community

health and social care services were being developed to support changes in acute care. The 4 October meeting focused on proposals for general surgery and orthopaedics and how these would impact on emergency care. In addition, the meeting heard views from the consultant committees at each of the two acute hospitals, further considered travel and access, and discussed points emerging during the consultation with representatives of ESHT, NHS Sussex and the Clinical Commissioning Groups.

2.3 In addition to verbal and documentary evidence considered at the meetings, any unsolicited written submissions received by HOSC were collated monthly into supplementary information packs which were circulated to Committee Members and published on the HOSC website www.eastsussexhealth.org.

3. HOSC response

3.1 HOSC's draft report is attached at appendix 1.

3.2 The report aims to:

- Summarise the evidence heard by the Committee, in particular highlighting the different viewpoints expressed by different stakeholders.
- Highlight HOSC's observations regarding major issues and key points which have emerged from the process.
- Make recommendations for the Boards of NHS Sussex, ESHT and the Clinical Commissioning Groups to consider when making their decisions.

3.3 It is intended that the report will provide the Boards with additional insight into the issues they need to consider when coming to a view on the proposals, particularly from a patient and public perspective. The report and recommendations also highlight where further work may be needed prior to the implementation of any preferred option, and how it may be possible to mitigate some of the concerns expressed to a certain extent.

4. Next steps

4.1 When HOSC's report has been agreed, it should be made available to the NHS Boards who will be coming to a view on the proposals during November, with the final decision being made by the NHS Sussex Board at a meeting on 23 November.

4.2 The decision of NHS Sussex will be reported to HOSC at the Committee's next meeting on 13 December, along with the NHS response to HOSC's recommendations. At this point HOSC will need to consider whether the decision is in the best interests of health services for the local area.

SIMON HUGHES
Assistant Chief Executive, Governance and Community Services

Contact Officer: Claire Lee
Tel No: 01273 481327, Email: Claire.lee@eastsussex.gov.uk

October 2012

Better health and wellbeing *for all*

East Sussex Health Overview and Scrutiny Committee

DRAFT response to:

'Shaping our Future'
Consultation on stroke, general surgery and orthopaedic services

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Preface

This report represents the formal response of East Sussex Health Overview and Scrutiny Committee (HOSC) to NHS Sussex and East Sussex Healthcare NHS Trusts' consultation 'Shaping our Future'. This relates specifically to proposals to reconfigure stroke, general surgery and orthopaedic services.

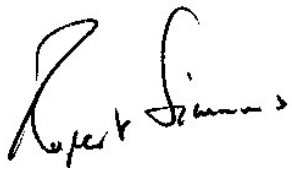
HOSC's response is based on an extensive process of gathering both written and verbal evidence from a wide range of stakeholders. The Committee has made every effort, within the inevitable time and resource constraints, to hear the full range of perspectives and arguments and to properly consider all information which has been submitted to us.

The planning of health services is a complex balance between access, clinical quality and resources. There is no easy answer and any service configuration will be a compromise between these factors. Ultimately, the focus must be on achieving the best possible health outcomes for everyone in our county and that is HOSC's aim.

The Committee's role has been to take an independent, balanced look at the proposals from a lay person's perspective and to make observations based on the evidence available to us. At times, we heard completely opposing views and these are reflected in our report. HOSC has attempted to weigh up these different points of view and to consider where and how it may be possible to address concerns.

HOSC makes a number of recommendations for commissioners and the Trust to consider when making their decisions and we look forward to receiving their response. The Committee will consider the response and the decisions made in due course.

I would like to thank all the witnesses who made time to attend HOSC meetings and contribute their views and expertise, those who made written representation to us, and all those who observed meetings to hear the discussion. I would also like to thank the Committee Members for the time and effort they have put into understanding and questioning the complex issues we have been asked to consider.



Councillor Rupert Simmons

Chairman

East Sussex Health Overview and Scrutiny Committee

East Sussex Health Overview and Scrutiny Committee response to 'Shaping our Future' – consultation on stroke, general surgery and orthopaedic services

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Background

1. Over the past two years East Sussex Healthcare NHS Trust (ESHT) has been developing a Clinical Strategy known as 'Shaping our Future'. The strategy sets out the future direction for the Trust's services, taking into account the national and local context. The Clinical Strategy is based on preferred models of care across eight service areas: emergency care; acute medicine; general surgery; cardiology; stroke; trauma and orthopaedics; paediatrics and maternity. These services, many of which are interdependent, represent 80% of the Trust's current income and are integral to its future success.

2. A number of potential delivery options were identified for each service area, which were then assessed to determine which could be taken forward as potentially viable ways to deliver the service in the future. Potential delivery options entailed varying levels of change to the way the service is currently delivered which can be categorised as follows:

- Increasing operational efficiency and effectiveness
- Service redesign – changing the care pathway experienced by patients
- Service reconfiguration – changing the service model, such as where or whether a service is provided in the future.

3. In June 2012 HOSC considered proposals for reconfiguration in three service areas. The proposals, put forward by NHS Sussex (the local cluster of Primary Care Trusts) in conjunction with ESHT and the emerging Clinical Commissioning Groups, involve reconfiguration of these specific services:

- Acute stroke care
- Emergency and inpatient elective (planned) general surgery
- Emergency and inpatient elective orthopaedic surgery

4. 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.

5. For acute stroke care, only one option has been put forward from the original list of delivery options:

- Option 2: creation of a hyper acute/acute stroke unit on one site.

6. For general surgery, two options have been put forward from the original list:

- Option 2 (preferred): emergency and higher risk inpatient surgery on one site with lower risk inpatient surgery on the second site. Outpatients and day surgery remain on both.
- Option 3: emergency and all inpatient surgery on one site. Outpatients and day surgery remain on both.

7. For orthopaedics, three options have been put forward from the original list:

- Option 1: no change to configuration – some productivity and efficiency improvements
- Option 2: emergency and all inpatient surgery on one site. Outpatients and day surgery remain on both.
- Option 3 (preferred): emergency and higher risk inpatient surgery on one site with lower risk inpatient surgery on the second site. Outpatients and day surgery remain on both.

8. 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 general surgery and orthopaedic surgery are interdependent and therefore must be located at the same hospital. This hospital would be the Trust's designated trauma unit.

9. Recognising the significance of the proposed changes, and following discussion with the Health Overview and Scrutiny Committee, NHS Sussex and ESHT agreed to undertake a public consultation process. The proposals were set out in a pre-consultation business case and a public consultation document. The public consultation process ran from 25 June to 28 September 2012.

10. 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.

Role of the Health Overview and Scrutiny Committee

11. Health Overview and Scrutiny Committees, or HOSCs, were established under the Health and Social Care Act 2001 with a remit to review and make recommendations about health services and health issues on behalf of local people. East Sussex HOSC comprises a mix of East Sussex County Councillors, District and Borough Councillors and voluntary sector representatives. A full list of current HOSC members is attached at appendix 1. HOSCs are independent of the NHS but work with local NHS organisations to improve health services.

12. NHS organisations are required to consult formally with the HOSC when they have under consideration a proposal for a 'substantial development or variation of services'. In such cases, the HOSC responds to the NHS, based on the evidence available to it, focusing on two key questions:

- Is the Committee satisfied with the content of the NHS consultation process and that sufficient time has been allowed?
- Is the NHS preferred way forward in the best interests of the health service for people in the area affected?

13. At the HOSC meeting on 19 June 2012, the Committee decided that the proposals represented a potential 'substantial variation' to current services requiring formal consultation with the Committee.

14. In order to respond to NHS Sussex and ESHT the Committee initiated a programme of three main evidence gathering meetings on 26 July, 13 September and 4 October 2012. A wide variety of witnesses were interviewed by the Committee and a wide range of written evidence considered, both as part of formal agendas and in the form of supplementary information packs containing correspondence received by HOSC during the process. A further meeting on 30 October considered a report on the public consultation responses and the consultation process. A full list of witnesses and documentary evidence is attached at appendix 2. The minutes of each meeting are available on the HOSC website www.eastsussexhealth.org .

15. HOSC set out to take a balanced approach to evidence gathering, hearing views from all perspectives and the full range of arguments being put forward on the proposals. HOSC Members come from a variety of backgrounds and are not health service experts or clinicians. They are intended to represent an informed public and patient perspective and draw on the views of those involved in planning and providing services as well as representatives of the public. The focus of the Committee is on protecting, and where possible improving, health outcomes for the population of East Sussex.

16. This report summarises the arguments heard by the Committee, together with issues and recommendations for ESHT, Clinical Commissioning Groups and NHS Sussex to consider when taking the proposals forward and making decisions.

HOSC Findings

Stroke services

The proposals

17. NHS Sussex and ESHT put forward a single option for the future of the Trust's acute stroke care service which proposes a single hyper acute and acute stroke unit at one of the two main hospitals, replacing the existing wards used for stroke care at each site. The key reasons given for this proposal are:

- to provide a consistent 7 day a week service, particularly therapy and TIA (mini-stroke) services, which are currently available only Monday to Friday.
- to make it easier to attract specialist staff, notably stroke consultants and therapists
- to improve speed of access to scanning and thrombolysis (clot-busting drugs) when patients arrive at hospital
- to separate the acute phase of care from the rehabilitation phase – the current wards provide a mix of both, which is not regarded as best practice
- to provide access to psychology and neuropsychiatry for stroke patients, provision of which is currently inadequate or non-existent

18. It is argued that the Trust would be unable to deliver a service meeting these standards on both sites as the number of stroke patients seen each year would not support the staff and facilities required.

19. In 2011/12, ESHT provided inpatient care to 773 stroke patients and 360 TIA patients. A proportion of these patients (depending on their original location) would have had to travel further to hospital if a single stroke unit had been in place. It is estimated that the number of patients who might have to travel further if a single unit is established would be 7 or 8 per week.

20. A saving of £853,000 has been estimated over the period 2013/14-2016/17 if a single unit is implemented. This particularly relates to anticipated reductions in the length of time patients stay in hospital, based on them receiving more therapy earlier in their treatment and being discharged earlier to rehabilitation. They would also be expected to spend less time in community inpatient rehabilitation and/or be able to return home with support at an earlier stage.

21. These changes enable the number of acute beds to be reduced and associated staffing changes to be made, particularly a reduction in the nursing staff required. However, increases are anticipated in some staff groups, notably doctors and therapists. It should be noted that comparisons between the current bed numbers and staffing in the stroke wards and the proposed single hyper acute/acute unit are problematic due to the presence of non-stroke patients in the current wards.

22. The provision of inpatient rehabilitation beds is planned to increase from 12 to 18 at Bexhill Hospital's Irvine Unit which, combined with anticipated reductions in length of stay, is expected to alleviate the waiting list for the Unit.

23. NHS Sussex and ESHT anticipate that the proposed changes will enable the Trust to meet key stroke targets, a number of which it does not currently deliver. Linked to this is the ability for the Trust to achieve the stroke best practice tariff, which will deliver additional income to support the service.

Key issues

24. The following key issues emerged in relation to the proposals for stroke care:

Quality of current stroke services

25. HOSC was aware of a long history of concerns regarding the quality of the ESHT stroke service, having undertaken a scrutiny review on the topic in 2008/9. In addition, a peer review in 2010 highlighted significant ongoing issues and in November 2011 commissioners issued a notice requiring improvements in performance due to ongoing failure to meet key targets.

26. These issues were highlighted in the pre-consultation business case, which cited poor performance against key indicators. However, concerted efforts by the Trust, overseen by a Stroke Improvement Board, had resulted in significant improvements in the first quarter of 2012/13, as the consultation on proposed reconfiguration began.

27. These improvements raised the question of whether the proposed reconfiguration represented the only or best way to provide a high quality service, or whether the improvements seen could be sustained and developed at both hospitals for the future. Whilst acknowledging the efforts made, both commissioners and the Sussex Stroke Network expressed a clear view that the improvements would not be sustainable in the long term and represented a 'sticking plaster' solution. They also highlighted that the improvements related to a few key targets only, and that ESHT would find it hard to deliver against a range of other quality indicators without change. Some opponents of the proposals acknowledged the need for improvements, but suggested that additional investment and increased use of telemedicine could be alternative ways to address concerns.

Access to thrombolysis

28. Thrombolysis (clot-busting drugs) is a treatment estimated to be suitable for around 10-15% of stroke patients. By rapidly breaking down a blood clot which is restricting blood flow to the brain it can have a significant impact on a patient's recovery. Its use is controlled by certain parameters, particularly related to the time since the onset of stroke symptoms, and it must be administered by trained staff following a CT scan. Thrombolysis is currently available at both of ESHT's main hospitals on a 24/7 basis, although the consultation document states that it is 'not always as quickly as we would like', and HOSC heard that the level of staffing support for the treatment is currently below the optimum, particularly at weekends.

29. It is access to thrombolysis (for the 10-15% of patients who could benefit) which is the primary time-critical element of stroke care and the key driver for hyper-acute care (the care provided immediately after a stroke). Concerns were expressed to HOSC that the establishment of a single unit would lengthen the time taken for some patients to access the treatment and therefore impact on patients' chances of recovery.

30. There has been confusion over the time window within which thrombolysis drugs can be administered. The consultation document cites a 4.5 hour window from onset of symptoms, but a window of 5.5 hours specified by the Strategic Health Authority has also been quoted. Some units have been cited as using a window of up to 6 hours. These differences may well reflect the fact that knowledge about the treatment is evolving and its use is gradually being extended as practice develops.

31. As well as the upper time limit, the question of an 'optimum' time has been raised with HOSC. An optimum of 90 minutes was quoted by campaign groups, and the aim for treatment to be available as quickly as possible was confirmed by the regional clinical lead for stroke. However, clinicians were keen to emphasise the need for a balance between rapid access to thrombolysis and the quality of the ongoing care available, particularly therapy support, for all patients, including those for whom thrombolysis is not an option.

32. Modelling by South East Coast Ambulance Service, based on actual cases over a three month period, showed that the average journey time to hospital would have increased by 10-13 minutes if a single unit had been in place (variation depending on location of the unit). Their view was that the benefits of improved care in a single unit would outweigh disadvantages of the additional travel time. The Ambulance Service and commissioners also highlighted that patients would be taken to the nearest hospital with an acute stroke unit and this may be outside East Sussex.

33. Opponents of the proposal highlighted the significant increase in travel time for those living nearest the hospital without the hyper acute unit, and the disadvantage this would present in their access to thrombolysis, and therefore their potential recovery, particularly as the treatment is currently available at both sites. They viewed the proposed reconfiguration as a backward step in this respect.

Recruitment

34. ESHT told HOSC that they had experienced difficulties in recruiting specialist stroke staff to the current units, particularly an additional stroke consultant and specialist therapy staff. A single unit, they argued, would attract staff who wanted to work in an environment with other specialist staff, providing best practice hyper acute care. The ability to shape such a unit would, they believed, be attractive to such staff, who are in relatively short supply. This view was supported by commissioners and the Sussex Stroke Network, although based on anecdotal feedback rather than specific evidence of recruitment to hyper acute units.

35. Opponents of the reconfiguration suggested that it is the uncertainty over the future of the service, and the Trust's wider challenges and reputational issues, which impact on its ability to recruit staff. Examples of successful recruitment to other specialties were cited, suggesting that it is possible if approached correctly. The attractiveness of East Sussex as an area to live and work was highlighted.

36. Some gaps in staffing are linked to resources rather than inability to recruit. ESHT's proposals include an intention to increase medical and therapy staff to national best practice levels. They argue that it would not be possible to increase staffing to these levels on both sites due to availability of funding and a lack of patients to justify the levels.

Access to specialist services

37. Around 2% of stroke patients will need access to additional specialist services such as endovascular or neurosurgery. In Sussex these are provided by the Royal Sussex County Hospital in Brighton.

38. It was suggested by some opponents of the proposals that a true hyper acute unit required on site access to these services and so Brighton should take on this role, with ESHT's hospitals retaining lower level, acute units. The Sussex Stroke Network confirmed that this is not the case. A hyper acute unit does, however, require a protocol regarding access to these services and clear arrangements for transfer. It was suggested that an ideal transfer time would be 1 hour, but otherwise as near as possible to this.

Stroke service reconfiguration in other areas

39. The consultation document cites experience in London, where stroke services were recently reconfigured to create eight hyper acute units providing thrombolysis. Initial data had been positive in terms of a significant increase in use of the treatment and improved outcomes. HOSC noted that the data is preliminary and yet to be published or peer reviewed. The differences in local geography and likely travel times were also highlighted. Trust clinicians emphasised that the London data was one factor in developing the preferred model locally, and not a key driver. They also highlighted differences between the proposed structure of services in East Sussex and the London model.

40. A further reconfiguration in the Bournemouth area was cited as an example of successful centralisation of hyper acute care. However, again, it was too early to provide published data. It is also difficult to make comparisons between areas with different local circumstances.

Capacity

41. The Trust's proposed acute bed numbers take account of estimated reductions in length of stay, 85% average occupancy, relocation of inpatient rehabilitation to the Irvine Unit and loss of some patients to other Trusts. Some concern was expressed to HOSC about the planned bed reductions and whether this would provide sufficient capacity in a single unit. The difficulty of comparison with the current wards which have a different case mix was noted but HOSC is also aware that the proposed bed numbers are based on estimates, particularly regarding improved length of stay. If a single stroke unit was created, close monitoring would be required to ensure that the assumptions made are being achieved and therefore the number of beds sufficient. In addition, effective bed management would be critical to ensure current issues with non-stroke patients occupying stroke beds and, equally, stroke patients being distributed onto non-stroke wards, are not perpetuated.

42. ESHT offered reassurance regarding scanning capacity at a single site, given that the introduction of a second CT scanner is planned on both sites. As well as providing capacity, this would offer back-up if one scanner failed. It was also argued that containing stroke demand to one site would make it easier to manage.

Rehabilitation

43. Provision of appropriate inpatient and community rehabilitation services is critical to the service model. The plans include an increase of six beds at the Irvine Unit (from 12 to 18), taking into account anticipated reduced lengths of stay. Early supported discharge teams are already in place to in-reach to acute units and the Irvine Unit but these need to be expanded to cover 7 days a week.

44. Generic and specialist community rehabilitation is in place, including recent integration with social care teams. The consistency of specialist stroke rehabilitation across the county is unclear given that ESHT is not commissioned to provide this in the Lewes, High Weald and Havens area and that additional funding received for the Hastings and Rother and Eastbourne areas is non-recurrent. Consistent access to community stroke rehabilitation is key, not just from an equity perspective, but also in terms of supporting the proposed model which anticipates significant reductions in acute and community inpatient lengths of stay. Confidence in the support available in the community is important for public confidence in the model, and is particularly relevant for those who will be in a caring role for stroke patients returning home earlier in their recovery.

Access for visitors

45. Access is covered in more detail later in this report, as it is relevant for all the proposed changes. However, it is important to note that access for visitors was considered particularly important for stroke patients who could be confused, disoriented or unable to speak. In such cases, visiting family members or carers may be able to act as advocates for the patient's needs or provide practical assistance such as feeding.

Clinical views

46. The case for change was presented to HOSC by the stroke lead at the Conquest Hospital, who is also the overall lead for stroke within the Clinical Strategy. Clinicians at the Conquest Hospital have also given their overall support for the proposed changes in a poll conducted by the Medical Advisory Committee.

47. The views of clinicians at Eastbourne with regard to stroke are less clear. A survey conducted by the Consultant Advisory Committee had yielded split opinion with a slight majority against the reconfiguration. The Chair of the Committee advised that the poll had been taken before the stroke consultant, who had previously publicly supported the plans, had written a consultation response opposing them.

48. Senior Trust clinicians including the Medical Director and Divisional Director for Emergency Care, supported the plans. Clinical leads for the Sussex Stroke Network also spoke in support of points made by the Trust, and GP representatives of Clinical Commissioning Groups strongly supported the proposed changes, arguing that improved quality of care would outweigh disadvantages in terms of access.

HOSC conclusions – stroke services

49. HOSC makes the following observations regarding the proposed changes to stroke care:

- Despite the best efforts of staff, the current ESHT stroke services are not satisfactory and improvements are needed.
- Patients should not be disadvantaged by having a stroke at night or at the weekend.
- Access to thrombolysis is important and time-critical, but will only be suitable for 10-15% of patients. The creation of a single unit would increase the journey time to thrombolysis treatment for some patients which could have some impact on the benefit of the treatment.
- Additional travel time and cost for some visitors/carers to a single acute unit is likely to impact negatively on their access to the patient. This may be offset to a certain extent by reduced lengths of stay in hospital.
- The importance of visitors is particularly apparent for stroke patients who may experience disorientation and/or speech problems.
- There is an urgent need to increase therapy and other specialist staffing support to meet best practice levels and to provide a seven day service. This is critical to achievement of the strategy.
- There is a need to provide access to psychological support for stroke patients.
- There is a need for consistency in access to community stroke rehabilitation for residents in all parts of the county, including those accessing acute care at other Trusts (which is likely to increase if a single unit was created).
- Proposed bed numbers in both acute and community settings are calculations based on certain assumptions. The capacity of the Irvine Unit in particular would need to be closely monitored as any delay in patients accessing the unit would have a knock-on effect to the hyper acute unit and therefore impact on achievement of the overall model of care. The Irvine Unit may need to be enhanced if capacity issues emerge.
- Although the emphasis has rightly been on optimising recovery, there will be some patients who are unable to recover and there is a need for any reconfigured service to have appropriate end of life policies and procedures in place. Access for families at end of life is important.

General surgery services

The proposals

50. NHS Sussex and ESHT have put forward two options for the provision of general surgery:

- Option 2 (preferred): emergency and higher risk inpatient surgery on one site with lower risk inpatient surgery on the second site. Outpatients and day surgery remain on both.
- Option 3: emergency and all inpatient surgery on one site. Outpatients and day surgery remain on both.

51. Both involve the consolidation of emergency surgery on one of the two main hospital sites. Option 3 involves also locating all planned inpatient surgery at this site, whereas option 2 involves the centralisation of only higher risk planned surgery, including major cancer surgery.

52. Because both options involve the provision of emergency surgery at one site, this site would become the Trust's trauma unit, which provides a supporting role to the area's major trauma centre in Brighton within the Sussex Trauma Network.

53. The key reasons given for the proposed consolidation of services on one site are:

- To provide faster assessment of emergency surgical patients by senior doctors
- To reduce cancellations by providing dedicated surgeons and theatre time for planned operations and separate resources for emergency patients
- To increase rates of day surgery
- To reduce infections by ringfencing beds for surgical patients
- To provide an out of hours emergency surgery team to provide care overnight and at weekends
- To offer better care for the elderly through providing input from a specialist physician.

54. It is argued that the consolidation of emergency care and its separation from planned operations will enable a dedicated team to provide a prompt response to emergency patients, with more consultant input. This would mean doctors would not be called away from elective work, causing it to be delayed or cancelled.

55. These changes, together with extension of Enhanced Recovery after Surgery schemes, it is argued, will reduce the amount of time patients need to spend in hospital. Both options also involve increasing the use of less invasive techniques as surgeons have more time dedicated to elective work and can develop their skills.

56. ESHT states that it is not possible to provide the new model described on two sites because a large number of additional staff would be required and the number of patients would not justify this, particularly in the context of an estimated reduction in surgical activity over the next 5 years. The current teams of surgeons on each site are described as small and changes to vascular surgery arrangements, it is argued, will add to difficulties sustaining the on-call rota.

57. In 2011/12, ESHT undertook 4,936 emergency operations and 1,505 planned inpatient operations. If either of the two options was implemented it is estimated that around 2,400 emergency patients per year would have to go to a different hospital than the one they go to now. In addition 219 patients would have to move sites for planned operations under option 2 and around 750 under option 3. This equates to 41-62 patients per week potentially travelling further (dependent on location of the service).

58. As well as the difference in the number of elective patients required to travel under the different options, there are other pros and cons such as increased choice but higher costs to retain surgical cover on the second site with option 2. Under option 3 there would be some greater economies of scale as all overnight surgical stays would be on one site, but greater impact on capacity and initial investment required on the single site.

59. With option 2 a financial saving of £3,120,000 is anticipated by 2016/17, compared to £3,759,000 under option 3. Savings are associated with achieving reductions in patients' length of stay and reductions in beds and staff linked to this, plus efficiencies from a single site.

Key issues

60. The following key issues emerged in relation to the proposed changes to general surgery:

Emergency access to surgery

61. Opponents of the proposals raised concerns about the additional journey times some patients would experience if emergency surgery was located on one site. The need for prompt treatment was emphasised, which supported the view that emergency surgery is a core service which should be offered by a local hospital. The likelihood of patients requiring transfer from the non-emergency site if a surgical need emerges was also highlighted. These views were based on concerns about safety, discomfort and inconvenience associated with increased travel.

62. Trust lead clinicians argued that journey time is only one aspect of access to prompt care. The improved access to consultants, who would not be occupied with planned operations, was highlighted as a key benefit of the proposed model, which could result in faster assessment and treatment when patients arrive at hospital. They argued that this would offset increased journey times to a certain extent.

63. South East Coast Ambulance Service cited the example of the Princess Royal Hospital in Haywards Heath which does not take surgical cases. Any patients identified as potentially requiring surgical input have, for several years, been taken directly to Brighton. It is, however, very likely that some patients who do not turn out to need surgery will be taken to the emergency surgery site as paramedics are rightly cautious when making an initial assessment.

Access to surgical opinion

64. The risk of patients self-presenting at the Accident and Emergency (A&E) department of the 'wrong' site was raised as a concern. In addition, the need for a surgical opinion to be available to inpatients of other specialties, such as gynaecology, was highlighted as an issue, including in the report of the National Clinical Advisory Team. Consultants at the Conquest Hospital had also stressed the importance of access to a senior surgical opinion for medical patients at the site without emergency surgery.

65. The clinical lead for general surgery gave assurances to HOSC that the proposals included access to surgical opinion for other specialties and A&E. Out of hours this would be provided by a middle grade doctor with access to a consultant on-call. In hours there would be surgical teams on site carrying out elective work who would have time available to review patients referred by other specialties. The clinical lead suggested that these arrangements would need to be formalised to work smoothly and inspire confidence in colleagues. Arrangements for tracking patients requiring surgical review admitted to various wards would also need to be in place.

66. The National Clinical Advisory Team raised potential recruitment issues associated with the proposed middle grade on call arrangement. However, they also proposed that enhancing the hospital at night team to provide suitable cover could be a suitable alternative approach if necessary, subject to further analysis of needs. Concerns about reliance on a middle grade doctor for out of hours cover were raised by Eastbourne consultants and it was suggested that this goes against the shift towards consultant delivered care.

Royal College standards

67. The pre-consultation business case draws significantly on national standards for emergency surgery published by the Royal College of Surgeons. Meeting these standards is cited as a key driver for the centralisation of emergency surgery and its separation from planned operations.

68. There was some dispute over how these standards had been interpreted, particularly in relation to the expected rotas setting out how often each consultant is required to be on-call. The frequency of on-call commitments will depend on the number of consultants available to participate in the rota at each hospital and standards influence how onerous the on-call requirements are expected to be.

69. The pre-consultation business case had cited a specific rota requirement, said to be taken from the Royal College standards, which ESHT would not be able to meet with the current configuration and staffing levels. The lead clinician acknowledged that the standards did not in fact specify a rota and an error had been made in quoting an exact number. However, she told HOSC that Royal College representatives had, when visiting the Trust, expressed concerns about the current rotas and ESHT had been expected to address the issue. She added that the rota cited in the pre-consultation business case is the minimum required for compliance with the European Working Time Directive and it would not be possible to meet these requirements in the current configuration.

70. The opposing view, from a Trust orthopaedic surgeon and Royal College Council member, was that the standards had been interpreted too rigidly and did not represent such a strong driver for reconfiguration. She suggested that there is increased flexibility for hospitals with a lower volume of work and that the College's intention regarding separation of emergency and elective care was based on co-location of emergency patients from all specialties. However, the clinical lead told HOSC that ESHT was not a lower volume Trust in relation to general surgery so the level of flexibility suggested did not apply.

Ringfencing beds

71. Doubts have been raised about the Trust's true ability to protect surgical beds in a hospital which may still experience substantial peaks in medical admissions and therefore be required to place these patients in surgical beds. This is important as, if it were to occur, the risks of cancelled operations and infections are potentially reintroduced. In fact, it was suggested to HOSC that an influx of medical patients is the main reason for cancellations now, rather than the conflicting demands on surgeons. Bed management has previously been an area highlighted for improvement, including in a Care Quality Commission report of 2011.

72. The Trust could not guarantee that these 'breaches' of the ringfence will not happen in such circumstances, but argued that the consolidation of, particularly emergency, surgical patients on one site makes the workload more even and manageable. In addition, it was suggested that improvements from the wider Clinical Strategy, for example, in the assessment and management of acute medical patients, would have an impact on the Trust's ability to better manage patient flows and therefore contain medical patients in medical wards.

Consultant access to emergency hospital

73. Concerns were expressed regarding the need for consultants on-call to be able to reach the hospital within 30 minutes. Opponents of the proposals pointed out that this may not be feasible for consultants living nearer to the non-emergency site.

74. The Trust's Medical Director assured HOSC that accommodation would be available on site for those who required it when on-call but noted that the Trust could not dictate where staff chose to live. He also indicated that immediate life saving treatment would need to be given by doctors at the hospital at the time, as it is now, as any travel time would be too long in these circumstances.

Continuity of care

75. The possible impact on continuity of care under the new model was raised with HOSC, in that a patient may be followed up by a different surgeon from the one who carried out the original operation. The clinical lead acknowledged that the model was based on a new type of team working, with a group of colleagues taking responsibility for patients rather than an individual. Existing issues with continuity in the current configuration were highlighted, if the designated doctor was not at the hospital for any reason. Continuity of care is considered important from the patient's perspective.

Staffing

76. The difficulty in sustaining on-call rotas was highlighted in evidence from the clinical lead, as mentioned above. She indicated that, although 24/7 emergency cover is provided, it impacts on the care provided to patients expecting planned operations due to the conflicting demands on consultants. It was argued that, whilst larger surgical departments may be able to split the work between consultants, ESHT's smaller teams needed to merge to provide a single on-call rota, separate from the planned workload.

77. Concerns about the impact on doctors' skills or training at the non-emergency site were raised. Some opponents of the proposals expressed doubts over whether doctors would be attracted to working in this environment. Evidence from the clinical lead suggested that this would be addressed through the rotation of staff between hospitals, and that training of junior staff would be enhanced though increased exposure to emergency cases.

78. ESHT's proposals include increased input from a physician specialising in elderly care. This is particularly relevant for elderly surgical patients with other health conditions which could add complications or delay to their care and is an important contributor to the predicted reductions in length of stay.

Clinical views

79. The lead clinician assured HOSC that the general surgical team is in agreement with the overall model for emergency care, but wished to have assurances from Trust management regarding some of the detail such as bed capacity and the future of the non-emergency site. She also recognised the need for colleagues in other specialties to be reassured about access to surgical opinion on the non-emergency site. The lead nurse for surgery confirmed her support for the plans.

80. Polls of the consultant bodies at the two hospitals yielded almost diametrically opposed views – consultants at the Conquest hospital generally supporting the overall plans whereas those at Eastbourne overwhelmingly opposed the plans. GP representatives from Clinical Commissioning Groups supported the plans, and clinical representatives from the Ambulance Trust did not raise concerns and cited examples of similar arrangements in place elsewhere.

HOSC conclusions – general surgery

81. HOSC makes the following observations in relation to the plans for general surgery:

- There is scope to improve the organisation of elective and emergency surgery.
- In reality the complete ringfencing of surgical beds may be challenging due to pressures from medical admissions, particularly given the ambitious plans to reduce admissions which may not be achieved.
- Given the reduction in surgical beds envisaged it would be particularly important to ensure these beds are not compromised by peaks in medical admissions and to ensure that requirements regarding mixed sex accommodation and infection control could be met.
- If a site was not providing emergency surgery it would be critical to ensure access to a senior surgical opinion 24/7 to review cases in A&E and medical inpatients.
- Retaining inpatient elective general surgery at both sites would be beneficial in terms of on site access to surgical review if a site was not providing emergency surgery.
- Planned reductions in surgical admissions and lengths of stay are ambitious and it is possible that they may not be fully achieved. Flexibility is required so that additional bed capacity can be made available if demand is higher than envisaged.
- Contingency plans for managing an unforeseen immediate surgical need on the site without emergency surgery, particularly out of hours, need to be clarified.
- It is important that continuity of care is provided by the service as a whole, not necessarily by an individual surgeon.
- There are challenges in terms of the sustainability of consultant rotas.
- Input from specialists in the care of the elderly is particularly relevant in East Sussex given the demographic profile of the population.

Orthopaedic services

The proposals

82. NHS Sussex and ESHT have put forward three options for the future provision of orthopaedic services:

- Option 1: no change other than efficiency improvements, services remain on two sites
- Option 2: one site provides all emergency and inpatient orthopaedic surgery and would be the trauma unit. Both sites provide outpatients and day case surgery.
- Option 3 (preferred): one site provides all emergency and higher risk surgery and would be the trauma unit. The second site retains lower risk inpatient surgery. Both sites provide outpatients and day case surgery.

83. The key reasons given for consolidation of emergency and higher risk orthopaedic surgery, which have some similarities with general surgery, are:

- To provide early assessment of emergency orthopaedic patients by senior doctors
- To provide improved out of hours emergency orthopaedic care overnight and at weekends
- To reduce infections and cancellations by ringfencing beds for surgical patients, thus reducing the risk of cross-infection from medical patients placed in surgical wards
- To offer better care for the elderly through providing orthogeriatrician input to all relevant patients, which is currently only available at Eastbourne
- To increase efficiency and capacity, enabling the Trust to undertake planned operations within 18 weeks – currently some patients have to go elsewhere which means a loss of income to ESHT
- To improve therapy provision to enable patients to be discharged earlier.

84. It is argued that concentrating staff on one site would improve quality by enabling staff to develop skills in larger teams and would reduce cancellations by separating teams dealing with emergencies and planned operations. It is also planned to extend early supported discharge arrangements to enable more patients to return home sooner.

85. Unlike general surgery, there are enough surgeons currently to provide appropriate on-call cover. The main driver in orthopaedics is reducing delays and cancellations and providing enough bed and theatre capacity to treat patients within the 18 week national standard.

86. Although option 1 is included, the consultation document cites a number of disadvantages of retaining emergency and higher risk surgery on two sites. These include inability to create specialist units, difficulty attracting specialist staff such as orthogeriatricians and significant ongoing costs of maintaining staff on two sites. The consultation document makes it clear that this option is not favoured.

87. Key differences between options 2 and 3 are the number of patients needing to travel further and differences in cost. In 2011/12 the Trust undertook 2,510 emergency orthopaedic operations and 2,761 planned inpatient operations. Under option 2, it is estimated that around 1,250 emergency and 1,350 elective patients would have to go to a different hospital. Under option 3 this would be around 1,350 emergency patients and 129 elective patients. This equates to 25-28 patients per week who might need to travel further than they do now.

88. All options are expected to generate savings over the period to 2016/17: £574,000 from option 1, a significantly lower level than the £5,591,000 from option 2 and £4,789,000 from option 3. These are associated with achieving reductions in patients' length of stay and reductions in beds and staff linked to this, plus efficiencies from a single site.

Key issues

89. The following key issues emerged in relation to the proposals for orthopaedic services:

Quality of current services

90. Orthopaedic staff at Eastbourne hospital expressed concern that the consultation document did not reflect the good standard of care already provided at the hospital. They highlighted aspects of the proposed model which are already being provided at Eastbourne and innovative ways of working which had been recognised nationally. For them, the proposed reconfiguration could represent unnecessary change to a successful service.

91. It was acknowledged by the clinical lead that ESHT's orthopaedic service currently performs relatively well against national standards, particularly at Eastbourne. However, he highlighted the Conquest hospital's unsuccessful attempts to recruit an orthogeriatrician, contributing to an unequal service between the two hospitals, and the gaps in service at Eastbourne at weekends or when this doctor (a specialist in care of the elderly) is on leave. It was argued that concentrating emergency and complex cases on one site would attract a second orthogeriatrician and enable the two clinicians to provide cover for each other.

92. Opponents suggested that it was uncertainty regarding the future of the service which was affecting the recruitment of a second orthogeriatrician.

Staffing

93. As well as orthogeriatrician input, historical differences in staffing arrangements and levels between the two hospitals were highlighted, such as disparities in therapy staff and the level of consultant supervised surgery. The lack of a seven day a week therapy service, which increases patients' length of stay in hospital, was also emphasised by the clinical lead. He recognised that ideally these disparities would be rectified by recruiting additional staff to both sites, but viewed this as unrealistic given resource constraints. Instead, it was argued that pooling staff and inpatient care on one site would increase the number of specialists available for complex cases.

94. The national direction of travel towards increased consultant input and the likely future shortage of middle grade doctors were further reasons given for consolidating services. The existing number of consultants is seen by the Trust as relatively high and the preferred option includes a reduction of two or three consultants but an increase from one to two orthogeriatricians and a doubling of the Trauma Assisted Discharge team complement from four to eight. A significant reduction in nursing staff is also envisaged in the preferred configuration.

Continuity of care

95. As with general surgery, it was acknowledged that a different model of working would be required, with ongoing patient care supervised by the team as a whole rather than the individual consultant carrying out the original operation. One view was that this is detrimental to continuity of care and impacts on professional responsibility. The clinical lead argued that care is currently fragmented and the proposed consolidation of services on one site would enable better oversight by the consultant team as a whole and provide orthogeriatrician input to all relevant patients.

Travel and transfers

96. Concerns were expressed by opponents of the proposals about the impact of additional travel time and potential transfers of patients with fractures between sites– for example elderly patients with broken hips who, they argued, would suffer additional discomfort. The lead orthopaedic nurse acknowledged that additional travel is not ideal, but argued that the quality of care and prompt treatment once patients arrived at the designated emergency site would justify the inconvenience. Both ESHT and Ambulance Trust representatives described their ability to immobilise fractures and provide pain relief prior to transfer.

97. A review of patients over a three month period had shown that the ambulance trust had successfully identified all but two hip fractures prior to arrival at A&E, which would have enabled paramedics to take these patients directly to the emergency orthopaedic site. However, it was acknowledged that a minority of patients may be not be diagnosed, be taken to the other site in error and subsequently require transfer. In addition, some patients would be unnecessarily taken to the emergency site and a fracture or the need for surgery subsequently ruled out.

98. The Vice-Chair of the Eastbourne Consultant Advisory Committee (an orthopaedic surgeon) indicated that increased journey times would have no impact if the quality of care is the same, but suggested that extended journeys were not ideal for patients. He also highlighted the negative impact on access for families and the benefits of visitors to patients.

Ringfencing of beds

99. It was acknowledged that icy conditions such as those seen in recent winters could create significant peaks in demand for emergency orthopaedic services. It was accepted that, in a crisis situation, planned operations would still have to be cancelled in order to prioritise emergencies. However, it was argued that normal peaks and troughs in demand have been taken into account in calculating bed numbers.

100. The clinical lead acknowledged that it was never possible to truly ringfence surgical beds in a hospital which may experience an unexpected peak in emergency medical admissions. However, he outlined criteria which could be put in place regarding medical patients admitted to surgical wards such as MRSA screening to minimise risk of cross-infection.

Discharge

101. Concerns were expressed about the impact on discharge arrangements if patients received care away from their local acute hospital. Effective discharge arrangements are particularly important to patients and carers. The Eastbourne Consultant Advisory Committee suggested that, although arrangements from a distance can work, they are not as good as those organised more locally.

102. HOSC was assured by ESHT that the proposed model of care incorporated maintaining and extending the assisted discharge and outreach schemes in place within orthopaedic services. This included arrangements to link to community services in the area surrounding the non-emergency site.

Clinical views

103. The most vocal opposition to proposed reconfiguration appeared to be in relation to orthopaedic services. This was concentrated amongst staff in Eastbourne, which may be linked to the higher standard of care already provided in the hospital. This could make any potential benefits of change less clear. The Vice-Chair of the Consultant Advisory Committee also indicated that the service did not make a financial loss, another potential reason why the need for change was being questioned. A poll of Eastbourne consultants by the Consultant Committee indicated overwhelming opposition to reconfiguration.

104. In contrast, the view of Conquest consultants in a similar poll was overwhelming support, which may be linked to the more apparent need for improvements in the model of care for orthopaedics within that hospital.

105. The clinical lead for orthopaedics recognised that clinicians would prefer to be able to deliver the improved emergency and planned services on both sites so that patients and staff did not have to travel. However, he emphasised the need to work as a single Trust-wide department to deliver an improved overall model within available resources. The lead nurse for orthopaedics suggested that clinicians had common aims in terms of consultant delivered care, but different views on how to achieve this. She was of the view that the preferred option would be best for patients in the long term.

106. GP representatives of Clinical Commissioning Groups supported the proposals and representatives of the Ambulance Service expressed confidence that they could support the preferred configuration.

HOSC conclusions – orthopaedic services

107. HOSC makes the following observations in relation to the proposals for orthopaedic services:

- The differences in service between the two hospitals, and the level of service currently offered in Eastbourne was not clear in the consultation document
- Improved orthogeriatrician input is beneficial for elderly orthopaedic patients
- There is a need to reduce disparities in service between the two sites and ensure that the best aspects of care currently provided are available to all residents of East Sussex
- In reality the complete ringfencing of orthopaedic beds may be challenging due to pressures from medical admissions, particularly given the ambitious plans to reduce admissions which may not be achieved.
- Given the reduction in orthopaedic beds envisaged it would be particularly important to ensure these beds are not compromised by peaks in medical admissions.
- It is important that continuity of care is provided by the service as a whole, not necessarily by an individual surgeon.
- There may be additional challenges in organising discharge arrangements at a distance and it is important to patients and carers that these operate effectively.
- The level of opposition to reconfiguration amongst Eastbourne orthopaedic staff may present challenges in terms of implementation of any change

Cross-cutting issues

108. A number of cross-cutting issues emerged as clear themes during HOSC's review of the proposals.

Emergency care

109. ESHT's provision of emergency care in its Accident and Emergency (A&E) units was reviewed as part of the overall Clinical Strategy process. Proposals for change focused on redesign only, with A&E units remaining at both main hospital sites. The proposed reconfiguration of stroke, emergency general surgery and orthopaedics does, however, mean that these patients would not be taken by ambulance to the A&E department at the hospital without these services. Because emergency general surgery and orthopaedics are required services for a trauma unit, this also means that the A&E department at the hospital without emergency surgical services would not be a designated trauma unit within the major trauma network.

110. Opponents of reconfiguration argued that the impact on A&E at the second site would be significant, potentially amounting to a 'downgrade', and the loss of trauma unit status would have repercussions on the hospital. Concerns focused on the knock-on effect on supporting services such as on-call anaesthesia and intensive care, and whether clinicians and other staff would be attracted to working in a department which does not take surgical or major trauma cases. Concerns that patients may self-present at the 'wrong' A&E have been mentioned above and, in addition, some emergency physicians at Eastbourne expressed doubt over whether modelling had captured the full extent of patients who may be affected by the proposed changes.

111. HOSC heard that less than 5% of A&E attendances are for surgical problems and 0.3% are for major trauma. ESHT's clinical lead for acute and emergency care assured HOSC that the impact on A&E would be minimal given that 95% of attendances are acute medicine or minor injury patients. He also expressed confidence that A&E clinicians would be able to stabilise any patients arriving at the wrong site prior to onward transfer. It was estimated that a maximum of 15 patients per day would require transfer but actual numbers were likely to be significantly less as the ambulance service would take most patients directly to the correct site.

112. The role of trauma units is to support the major trauma centre (located locally in Brighton) by providing assessment and stabilisation of patients, often before they are transferred to the centre. Major trauma patients (those with multiple, severe, usually life-threatening injuries) within approximately 45 minutes journey time of Brighton would be taken directly there, meaning that a trauma unit within East Sussex would take a minimal number of patients. Within the public debate there appeared to be some confusion with orthopaedic trauma – more routine fractures – which would be treated by ESHT emergency orthopaedic services. Trauma unit status is not relevant for these less serious injuries.

113. With regard to wider impact on A&E departments and hospitals without trauma unit status, the Sussex Trauma Network pointed to London experience which had shown no discernable impact. In fact they highlighted the heavy resource implication of major trauma and the reduced disruption to a range of services if these cases are not accepted, particularly in smaller hospitals with smaller staff teams.

114. HOSC received assurances regarding the ability of one A&E to take the relatively small number of additional emergency surgical patients each day. However, concerns have been raised regarding delays in ambulance handovers at A&E, particularly in Eastbourne. ESHT and the Ambulance Service described how these were being addressed both at point of handover and in the way acute medical patients are managed within the hospital. The redesign of emergency care and acute medicine under the wider Clinical Strategy, which includes improved triage arrangements and earlier assessment by senior clinicians, aims to improve patient flow through more rapid diagnosis and decision making. These changes have only been partially implemented at this stage. Instances of delayed handover need to be reduced, both as a quality of care matter and if the benefits of proposed new models of care are to be maximised.

Access, travel and transport

115. Access, particularly travel times and transport arrangements, are a significant concern to the public in relation to the proposed reconfiguration. The primary concern relates to delays in accessing urgent treatment, particularly for stroke care (discussed above) but also for emergency surgery. The secondary, but still significant, concern relates to access for families and carers to visit loved ones when in hospital. This is a particular issue given that the services under consideration primarily affect older people, whose carers and spouses may also be elderly.

116. The accuracy of travel times quoted in a travel study commissioned by NHS Sussex and ESHT was questioned in the light of day to day experience. Frustration was expressed that data had been produced by an external company without actual experience of local travel circumstances. Opponents of the proposals also highlighted traffic concerns on the main A259 route between the two hospitals and raised issues about the safety record of the road. It was not possible, however, to provide alternative robust data and ESHT stressed that the travel study was produced by a specialist company, based on the best information available. It was noted that the planned Bexhill to Hastings link road, which has recently received the go-ahead, may help alleviate travel difficulties on the A259 to some extent.

117. The majority of patients affected by the proposed changes would be travelling by ambulance to hospital. South East Coast Ambulance Service expressed confidence in their ability to transfer patients to hospital in a timely way, and stated the view that the quality of care available from single sited services would compensate for additional journey time. They cited similar arrangements in place elsewhere in the south east to by-pass some hospitals in order to transfer patients to more specialist care further away. It was recognised that additional journey times would have an impact on ambulance resources. The Ambulance Service had not yet calculated this impact and commissioners would not commit to additional resources in the absence of this information.

118. The proposed changes may also have an impact on community and voluntary sector transport providers. There may be increased demand from both patients and visitors and further work could be undertaken with providers to understand the potential effect and to consider how this could be addressed.

119. The challenging local geography and transport links were recognised by all parties. However, different views were taken on the appropriate balance to be struck between the importance of access and the importance of organising care in an optimal way. Those supporting the proposals emphasised the benefits of the proposed model of care, the speed of treatment on arrival at hospital and the fact that it would not be possible to achieve all of these benefits with staff spread across two sites. Opponents focused on speed of access to the hospital, the confidence patients have knowing that they can access a place of assistance quickly, the potential discomfort and inconvenience of additional travel and concerns about safety.

120. A disadvantage of the proposals agreed on by all parties is the negative impact on access for those visitors who would be faced with increased travel time, increased complexity of journeys by public transport and increased costs. The question is whether this impact can be justified by benefits of the proposals to patient care and outcomes.

121. The value of visitors to patients was highlighted, as was the desire of families to see their loved one receive the best possible care. ESHT and NHS Sussex suggested that the impact would be offset to a certain extent by anticipated reductions in the average time patients would spend in hospital. This meant, they argued, that whilst families may be travelling further, they would be required to make a reduced number of journeys, with patients receiving rehabilitation at an early stage of their recovery, closer to home.

122. There is a differential impact on families/visitors according to the location of services (varying public transport links), the resources available to them (access to a car and ability to fund increased travel costs) and ability to travel (e.g. time availability, frailty). These factors, which may be linked to age and/or levels of deprivation, would need to be taken into account when making decisions about service configuration and location of any consolidated services.

123. Service reconfiguration would also have an impact on staff, some of whom may be required to work in a different location from their current base, or who may be required to rotate between sites. ESHT indicated that staff would be consulted on any personal impact and that mitigating actions, such as a shuttle bus between sites, were under consideration.

Finance

124. The significant financial challenges facing ESHT and the wider local health economy formed part of the backdrop to the consultation. The Trust is required to save £104million over a five year period. The overall Clinical Strategy is estimated to contribute £32m in savings, with the remainder achieved through efficiency savings of around 4% per year. The three services proposed for reconfiguration are estimated to contribute £8.5m with £4.2m specifically due to the single site elements. One-off investment of between £13.5-£30m could be required for building and alterations required to implement single sited services. This cost is seen as an 'invest to save' measure – i.e. an initial outlay to deliver a more financially sustainable model for the longer term.

125. ESHT and NHS Sussex emphasised the clinical factors driving the reconfiguration plans, and these were confirmed by the National Clinical Advisory Team report. However, all agree that the financial context is another key factor given the required savings, and the lack of resources to invest in services across two sites.

126. ESHT provided financial modelling of the preferred options within the pre-consultation business case and further breakdowns of each option were provided at HOSC's request. These provided a picture of the estimated savings but it was acknowledged that, at this stage of the process, calculations are based on assumptions which could change. Although it can be frustrating that certain details are not available at consultation stage, HOSC understands that further levels of financial detail will be developed through the outline business case and full business case stages which any agreed option would go through before implementation. In particular, the completion of a cost-benefit analysis at these stages would be important.

127. The financial modelling takes into account the impact of commissioning intentions which include a planned reduction in activity in acute hospitals. This incorporates 'audacious goals' set by NHS Sussex which include a 15% reduction in emergency admissions to hospital. Such reductions, if achieved, will impact on the number of patients treated by the hospitals and therefore the income received by the Trust. Evidence from Clinical Commissioning Groups and NHS Sussex confirmed that the plans for services had taken into account their intentions and were viewed as affordable for commissioners as well as meeting the Trust's financial requirements. It was also clear that additional financial support for the Trust, over and above normal income for patient care, would not be available in future years as it had been in the past.

128. Costs which have not yet been factored in are the precise revenue costs of the capital needed to implement changes (this is unclear until preferred configurations and locations are determined) and the potential costs to commissioners of additional ambulance capacity, which would be subject to negotiation between the Ambulance Service and Clinical Commissioning Groups.

129. The wider economic impact of the proposed reconfiguration was raised, in terms of the impact on the local economy of changes to hospital services in one location. Although an economic assessment would not be carried out until the latter stages of the process, ESHT emphasised the relatively small proportion of overall hospital activity which could change location.

Community services

130. Implementation of the overall Clinical Strategy is dependent on the ability to reduce admissions, reduce length of stay and discharge patients home promptly and with appropriate support. These objectives require the necessary support from community health and social care services. As a provider of community, as well as acute, health services ESHT has significant opportunities to overarch and enable pathways of care, but working with partners in primary care and social care is critical.

131. The planned reductions in acute activity are ambitious and some doubts have been raised about their achievability. Public support for the proposed changes will be influenced by the level of confidence that community services will be in place to support the shift away from care in acute hospitals. In order to provide a level of confidence, HOSC received reports on the development of integrated health and social care community services. These provided assurances that some changes were already being put in place, but equally highlighted that there is much more to be done to support effective implementation of the Clinical Strategy.

132. Evidence presented to HOSC suggested that plans are in place for the development of community services but their achievement is dependent on savings being achieved in acute care which will enable both ESHT and commissioners to invest in alternatives. For patient and carer groups the achievability of this strategy was a key concern.

133. Another critical issue for patient and carer groups is the effectiveness of discharge and liaison arrangements with local community services, particularly when acute care is provided further from home and not from their closest acute hospital. Community health staff may have knowledge about individual patients which could be harder to communicate to a more distant acute service. Effective connections between local services such as intermediate care and rehabilitation teams and the proposed single sited acute services are seen as essential.

134. The potential impact on Adult Social Care was raised, and the potential for ‘cost-shifting’ between sectors. This was recognised as a risk, but one that was being addressed through the development of integrated services and whole health and social care community working. Adult Social Care managers told HOSC that there was no obvious alternative approach.

135. The potential impact on patients and families of receiving more healthcare at home as opposed to in hospital is important to recognise. There may be increased reliance on means tested Adult Social Care as opposed to free at point of use NHS care. There may also be an increased burden on carers as patients return home earlier. However, the benefits of the home environment and patients’ preference for this are well known in most cases (although this may not always be the case for the more vulnerable or those with difficult home circumstances).

136. HOSC was assured that East Sussex residents receiving acute care at other Trusts would be able to access ESHT community services in the same way as those treated at ESHT acute sites.

Health inequalities

137. The provision of acute services is not the primary way to influence health inequalities. However, it is important that proposed changes do not exacerbate inequalities. The Equality Impact Assessment undertaken by NHS Sussex and ESHT highlights that the primary negative impact of the proposals is on access. It also highlights differential impacts on access depending on population characteristics in different areas and groups, and the importance of identifying any mitigating actions which could be taken.

138. The claimed benefits of the proposed reconfiguration would also need to be taken into account. If the improvements in patient outcomes claimed were to be achieved, these could have a positive impact on health and quality of life which would need to be set against negative impacts.

139. HOSC received an assurance from NHS Sussex that legal advice was being sought to ensure that Public Equality Duties were met.

Clinical leadership

140. ESHT had ensured, early on in the Clinical Strategy development process, that clinical leads were identified for each service area under review. Other clinicians and staff had been given the opportunity to participate in the development of models of care and options. GPs representing the emerging Clinical Commissioning Groups also actively participated in this process to ensure that their commissioning intentions were reflected.

141. Despite this engagement, stark differences in clinical views are apparent, particularly between clinicians based at the Conquest and Eastbourne Hospitals. The public has significant respect and trust in the view of clinicians on what constitutes best care for patients. It is therefore hard for people to make judgements on the merits of proposals when clinicians have divergent views. Indeed it causes widespread confusion amongst the general public when the majority of hospital consultants are unable to come to a professional agreement on best practice. Such confusion does nothing for trust in local health services.

142. It is unclear whether the differences are based on different interpretations of the same evidence, perceptions of where services would be more likely to be located, differences in the current services between the two sites or other factors. There was certainly evidence of considerable pride where innovative and high quality services had been developed, such as within orthopaedics, or where considerable hard work had been put in to improve care with limited resources, such as in stroke services. It is understandable that those involved wish to protect these achievements, and to avoid unnecessary inconvenience for patients and their families.

143. The Local Involvement Network expressed doubt as to whether consultants opposing the proposals are entirely motivated by the clinical best interests of patients across the Trust area. HOSC noted that reconfiguration would require changes in working patterns and additional travel which may not be easy or popular. It is possible that the proposed staffing reductions may also be of concern. It was not possible or appropriate for HOSC to investigate the extent that the proposals would impact on individuals' personal circumstances but it is likely that clinicians who have worked for the Trust for some time have developed personal and professional arrangements linked to their hospital base, such as commuting arrangements or private practice, which would be disrupted.

144. HOSC is mindful that all those currently involved in providing the services have the potential to be personally affected and it is probably inevitable and understandable that this influences views to a greater or lesser extent. However, it would be beneficial to patients and the public for clinicians to agree and present a Trust-wide view on the future of services rather than a view from each hospital. The requirement to develop a Trust-wide approach would encourage clinicians to balance the perspectives of both hospitals and focus on patient outcomes. This point was backed up by the National Clinical Advisory Team report which noted the culture of two separate hospitals within the Trust and emphasised the need for Trust-wide working. Written evidence from the Local Involvement Network on behalf of patients and the public also stressed this view.

145. The views of those leading the provision of services were only one clinical perspective presented to HOSC. GPs representing Clinical Commissioning Groups have spoken strongly in favour of the preferred options. All three Groups have agreed and presented a united view on the proposals, despite covering different parts of the county, which has offered the public and HOSC clarity from the perspective of clinicians who will be leading the commissioning of services from April 2013. They have recognised that there may be individual GPs with different views but HOSC has not been made directly aware of any opposing views from primary care clinicians.

146. HOSC also received the report of the National Clinical Advisory Team which supported the changes and the endorsement of the Strategic Health Authority, with input from their medical and nursing directorates, was noted. Clinicians representing stroke and trauma networks spoke in support of specific elements of the proposed service models. Clinical representatives from South East Coast Ambulance Service raised no objections to the proposed options and quoted similar examples elsewhere.

Impact on other services

147. Opponents of the proposed changes raised concerns about a ‘domino effect’ on other services, suggesting that it is likely that further services will be reconfigured onto one site if the current proposals are implemented, particularly obstetrics and paediatrics. They feared for the future viability of the hospital not providing a full range of, particularly emergency, services.

148. This vision was strongly disputed by ESHT, NHS Sussex and Clinical Commissioning Groups, who each publicly made a commitment to maintaining two viable hospitals in East Sussex. Their vision was for the hospitals to each provide the services which serve the majority of patients, including acute medicine and A&E, outpatients and day surgery, with some lower volume services shared between the two. These shared services would not necessarily all be located at one of the two hospitals, although there will be interdependencies between some services which require co-location.

149. HOSC is aware that the future of maternity services is under review as part of a Sussex wide programme. ESHT has given public assurances that the location of emergency surgical services would not pre-determine the location of obstetric or paediatric services should these be subject to future reconfiguration.

HOSC conclusions – cross-cutting issues

150. HOSC makes the following observations in relation to the cross-cutting issues which have been considered:

151. Emergency care:

- It was unhelpful to the public that the impact of the proposals on A&E provision and significance of trauma unit status was overstated by some parties. However, confusion over the terminology relating to trauma was a factor.

- HOSC does not believe that the proposals would have a significant impact on A&E provision at a hospital without emergency surgery provision, providing that appropriate contingency plans are in place to manage immediate surgical needs. More needs to be done to assure the public on this point.

152. Access, travel and transport:

- The major focus of public concern relates to travel and transport for both patients and visitors. Some reassurance could be offered by taking action to address or mitigate the issues raised as effectively as possible.
- Whilst HOSC acknowledges the limitations on available travel data, the experiences of witnesses suggest that estimated journey times are optimistic.
- If the services were provided on one site there would be a negative impact on access for visitors. This needs to be considered against evidence related to quality of care and impact on patients' length of stay in hospital.
- People without access to a car, on low income, or where public transport is more difficult would be particularly affected by the proposed changes. More could be done to understand the impacts and identify any mitigating actions which may help.
- The impact on ambulance capacity is not yet clear and would need to be fully assessed in order to agree how it would be resourced. It is critical that this impact is recognised if delays in accessing emergency care are to be avoided.
- The potential for increased demand on community transport providers has not been recognised and more work would be required to understand and address this.
- It will be important for the NHS Sussex Board to take into account the impact on access for populations experiencing health inequalities and those with an older age profile as part of the decision making process.

153. Finance:

- Further financial information, including a cost-benefit analysis, will need to be made available to the Boards of ESHT and commissioning organisations during the outline and full business case stages and before final approval is given to implement any preferred option. This information should be made publicly available.

154. Community services:

- Investment in community services is critical to the achievement of the Clinical Strategy. The planned investment is welcome but high risk, and is dependent on the achievement of savings in acute services. Public confidence would be affected if planned improvements to community services were not delivered alongside any reconfiguration of acute services.
- The achievability of planned reductions in acute activity is not clear and flexibility will need to be retained in the acute hospitals in order to respond if demand exceeds plan.
- Despite the risks inherent in the proposed shift from acute to community care, there is no obvious alternative way to respond to increased demand and reduced resources and it is in line with the national direction of travel. Progress will need to be closely monitored and investment rigorously focused on schemes with clear evidence of impact.
- There is a need to maximise the potential of ESHT's status as an integrated acute and community Trust by developing clear pathways which include effective discharge arrangements and transition to community services, taking into account the fact that patients may not be receiving acute care at their nearest acute hospital.

155. Clinical leadership:

- Clinicians within ESHT must take a Trust-wide view of the future of services in order to focus on achieving best outcomes for all patients served by the Trust.
- Clinicians and staff would need to be prepared to work more flexibly in the future if the proposals were to be implemented.

156. Impact on other services:

- The relatively small proportion of hospital activity affected by these proposals mean they would be unlikely to fundamentally destabilise any hospital which would not provide emergency surgery and orthopaedic services or acute stroke care.

Consultation

Public consultation process

157. Overall, feedback on the consultation process, and pre-consultation engagement was broadly positive. The addition of a pre-consultation engagement phase with stakeholders had been warmly welcomed by HOSC and the benefits of it were evident in terms of the increased involvement of patient and carer representatives, stakeholders and staff, which built a stronger foundation for the public consultation phase.

158. Patient representatives largely commented favourably on the opportunities they had to be involved and the openness of ESHT throughout the process. Key stakeholders such as the Clinical Commissioning Groups, the Ambulance Service and Adult Social Care assured HOSC they had been able to participate in the development of proposals and the consultation process.

159. Most ESHT staff interviewed by HOSC also acknowledged that there had been many opportunities to be involved in the process and to give views on proposals, even where these views had been in opposition to the Trust's preferred options, although one consultant had felt uncomfortable challenging the proposals.

160. Some voluntary sector representatives informed HOSC they felt there had been insufficient opportunities to discuss the impact of the proposals and, specifically, how they could be implemented.

161. The consultation process largely followed a standard format but a relatively new approach to public events was taken. These were organised in the form of a 'market place', with stands offering information on the various services and issues and staff from ESHT and NHS Sussex available to talk informally with attendees. The value of ensuring senior, particularly clinical, NHS representatives were on hand to discuss the proposals at these events was evident and HOSC welcomes the efforts made to ensure this was the case as far as possible.

162. The market place events appear to have been well received and offered the public opportunities for a tailored one-to-one conversation in contrast to the more traditional public meeting format which can be intimidating to some people. Where these events were scaled down to be feasibly run in shopping centres this may have over-simplified the questions to which people were asked to respond. However, the trade-off is the ability of these locations to reach more people, including those who may not attend a specific event.

163. ESHT and NHS Sussex responded positively to suggestions from HOSC such as extending the consultation period beyond the usual 12 weeks to allow for summer holidays and organising events for local politicians from all tiers of local government. HOSC also emphasised the need to engage harder to reach groups and was pleased to note specific focus groups were organised to engage with target audiences.

164. The consultation document, both in full and summary form, was widely distributed, and supplementary information was made available on the ESHT website for those who wished to read it. Some people struggled with the language and content of the consultation document, which is perhaps to some extent inevitable given the complexity of the issues in question.

165. There were some regrettable errors and some lack of clarity in data used within the document. Although important, HOSC does not believe that the discrepancies materially impact on the overall arguments for or against reconfiguration. They do, however, impact on the public's confidence in the accuracy of the document. HOSC welcomes the efforts of members of the public in bringing these errors to its attention and welcomes the action taken by NHS Sussex and ESHT to publicise the errors and the correct data.

166. HOSC had suggested prior to the consultation that the document should be open about the financial context within which the Trust and local health economy is operating and include information about the financial implications of proposals. The consultation document included very little financial information and this may have fuelled different perceptions regarding underlying financial motives. Financial information was available in the pre-consultation business case available on the consultation website but this would not be accessible for many people.

167. The representativeness of case studies within the document has also been questioned and they may in some respects have overstated the differences between the current and future models. The accuracy of the portrayal of current services, particularly orthopaedics, has also been criticised. It is important that consultation documents are balanced and realistic otherwise they risk being viewed as a sales pitch rather than an open minded exploration of the issues.

168. As with any consultation, there are a number of learning points to bear in mind for future exercises of this type:

- The importance of pre-consultation engagement must be recognised and replicated in future change processes. There is potential for future engagement to be enhanced even further which would be worthwhile in terms of supporting a positive public consultation process.
- Consultation documents must be balanced and open about all the issues driving change, including finance. They must promote genuine discussion and debate to avoid being seen as leading.
- More time should be allocated to checking data and factual information used in consultation documents prior to publication – this should include review of a final draft by a panel of clinicians from affected services and a panel of patient representatives.
- A plain English summary document should be tested with members of the public who have not had any involvement in development of proposals to ensure readability prior to publication.
- Meetings with local politicians are welcome but should be held earlier in the consultation period, with more notice given of dates and more consultation on the appropriate timing to maximise attendance. Better informed elected representatives could have helped both inform and engage residents in the debate.
- Additional consideration should be given to communication and consultation with residents who receive acute services primarily from other Trusts. It is necessary to explain how the proposed changes are of interest to them and to tailor consultation activities to their perspective and level of interest.
- It is regrettable that misleading information relating to the proposals was placed in the public domain. This may have impacted on people's ability to make an informed response to the consultation. It is HOSC's view that all interested parties and the media have a responsibility to foster an informed and balanced debate, raising concerns responsibly and focusing on achieving the best care for all residents of East Sussex.
- Engagement with the voluntary and community sector should include opportunities to discuss practical impacts of proposals and their implementation, as there may be an effect on services provided by the sector which should be recognised.
- There are lessons for Clinical Commissioning Groups in terms of the importance of building relationships with the public and stakeholders from the outset through openness and honesty in order to support trusting conversations about difficult issues.

169. Some of the above points could be addressed by ensuring a longer lead in time from the finalisation of proposals for change to the start of consultation. HOSC recognises that time pressures will always be a factor, but undue haste in preparing consultation documents and organising consultation activities can create problems which could have been avoided.

Consultation with HOSC

170. HOSC was engaged in the Clinical Strategy development process for over 18 months prior to the start of formal consultation. For approximately 9 months in the lead-up to consultation a Task Group of five HOSC Members provided additional oversight and scrutiny to the process of developing proposals for change and provided observations, alongside the Trust's progress reports, to meetings of the full Committee.

171. This level of engagement was significant and HOSC welcomes the openness of the Trust in sharing information early and proactively with the Task Group and the Committee. This approach should be maintained for any future change proposals and should be emulated by other NHS organisations.

172. HOSC has been largely satisfied with the response of NHS Sussex and ESHT to the Committee's suggestions during the process and the response to requests for information and attendance at meetings. However, there were a few specific points where HOSC's input could have been more effectively taken into account, for example regarding the inclusion of financial information in the consultation document.

Consultation outcomes

173. Brief summary of overall views expressed in response to the public consultation to be added.

Recommendations

174. Having considered the evidence available to the Committee, HOSC makes the following recommendations for the ESHT Board, Clinical Commissioning Groups and NHS Sussex Board to consider when making decisions.

Stroke services

Recommendation 1

If a single stroke unit is created, ESHT should take all possible measures to maximise speed of access to thrombolysis once a patient arrives at hospital, with a view to offsetting additional travel time. ESHT should aspire to surpass current requirements regarding the proportion of scans undertaken within one hour and robust contingency plans must be in place if one scanner is out of use.

Recommendation 2

If a single stroke unit is created, commissioners and ESHT must ensure that seven day intensive therapy and treatment services are in place from the outset as this has been a key promise to the public and would be critical to achieving improved patient outcomes.

Recommendation 3

Commissioners should review access to community and inpatient stroke rehabilitation across East Sussex to ensure consistency across the county, particularly for patients receiving acute care at other Trusts given that demand would increase if the proposed reconfiguration was implemented. The capacity of rehabilitation services to meet need should be closely monitored as a shortage will have significant knock on effects on acute stroke services' ability to support improved bed management.

Recommendation 4

Commissioners and ESHT should ensure that any reconfigured service meets end of life standards contained within the Stroke Network integrated service specification. The impact of extra travel time for families should be recognised – for example, providing improved information for families on a patient's prognosis where possible, or providing improved facilities for visitors spending lengthy periods at hospital.

Recommendation 5

If a single stroke unit is created, a clear and understandable patient pathway for stroke should be developed to demonstrate to patients and the public what they can expect from the reconfigured service, from prompt assessment and treatment on arrival at hospital to how patients will be transferred to community services closer to home.

General surgery and orthopaedic services

Recommendation 6

If emergency surgery is consolidated on one site, commissioners and ESHT should ensure the following safeguards are in place on the site without emergency surgery:

- Access to a senior surgical opinion 24/7
- Formalised and well communicated procedures for other specialties to access a surgical review
- Contingency plans for patients with unforeseen immediate need for surgery
- Clear protocols with the ambulance service, including for transfer of patients requiring emergency surgery.

Recommendation 7

If emergency surgery is consolidated on a single site, ESHT should undertake further work to identify co-dependencies with other specialities, such as obstetrics and gynaecology, and further modelling to specify the number of patients affected. This work should be used to set out a clear plan to ensure appropriate access to surgical input is available on the non-emergency site.

Recommendation 8

If the proposed reconfiguration is implemented, ESHT should put in place alternative escalation procedures to manage sudden peaks in medical admissions, to avoid the use of surgical beds. It would also be important to have fully implemented planned improvements to acute medicine on the site hosting the centralised surgical services, in order to support improvement bed management, prior to implementation.

Recommendation 9

If the proposed reconfiguration is implemented discharge procedures should be reviewed to reflect the fact that patients, carers and families may need to make more complex travel arrangements if they have been treated further from home.

Cross-cutting issues

Recommendation 10

'Accessibility plans' should be developed for each acute hospital in order to take a strategic approach to maximising access to each site and to identify all potential mitigating actions to reduce the impact from increased travel if services are reconfigured. These should include the Trust's plans in areas such as:

- working with transport planners to maximise public transport access
- working with community transport services and volunteer services to support access, particularly for the most vulnerable
- making appointment systems more flexible and offering greater choice
- parking policy, including disabled parking
- staff travel, including the use of alternatives to the car
- access for those with mobility restrictions or other disabilities
- publicising availability of help with travel costs through NHS schemes and national schemes such as free bus passes for older people
- maximising the access of visitors to patients

Recommendation 11

If the proposed reconfiguration of services is agreed, a feasibility study should be undertaken to consider the introduction of a regular shuttle bus between the two hospital sites, for staff, patient and visitor use, to include the impact on parking arrangements.

Recommendation 12

If the proposed reconfiguration of services is agreed, and particularly if a single stroke unit is created, ESHT should consider measures to mitigate the impact of reduced access for visitors such as:

- Use of telephone contact with families/carers to ensure staff are aware of patient needs/preferences
- Increased use of volunteers to provide psychological and practical support to patients
- Increased flexibility in visiting arrangements/hours
- Improved advice to visitors on how they can best support their loved one, whether this is through visits or in other ways such as providing information on needs and preferences.

Recommendation 13

If the proposed reconfiguration of services is agreed, the impact on ambulance capacity should be fully calculated and a plan for resourcing this agreed between commissioners and South East Coast Ambulance Service before changes are implemented. This should include the impact on patient transport services, demand for which may increase.

Recommendation 14

The Medical Advisory Committee at the Conquest Hospital and the Consultant Advisory Committee at Eastbourne District General Hospital should merge into a single Clinical Advisory Committee in order to provide ESHT, Commissioners, patients and the public with a Trust-wide clinical view on sustainable and best practice future provision of Trust services.

Recommendation 15

A local 'clinical senate' should be put in place by Clinical Commissioning Groups and ESHT to improve liaison between Trust consultants and GP commissioners, to foster joint work on the development of sustainable acute services and build clinical consensus. Appropriate links should be made to the regional Clinical Senate and Clinical Networks.

Recommendation 16

Commissioners and ESHT should jointly publish and regularly update a clear timeline showing planned developments in community health services, in order to give confidence to patients and carers that these services are developing alongside changes in acute care. This timeline should reflect access to these services for residents whose acute provider trust is outside East Sussex.

Recommendation 17

An integrated, partnership approach to the development of community services should continue to be taken by Clinical Commissioning Groups, Adult Social Care and ESHT. Plans must recognise:

- the impact of earlier discharge and reduced admissions, in terms of impact on carers and increased reliance on means-tested social care.
- the need for additional support for more vulnerable residents and those in more deprived areas, as these groups are less likely to have access to support networks and resources to support their care.
- the importance of clear pathways between local services, such as intermediate care and rehabilitation teams, and single sited acute services, if these are implemented.

Recommendation 18

If the proposed reconfiguration of services is agreed, further work should be undertaken with voluntary and community sector organisations to improve understanding of the impact of service changes and to address issues arising from the implementation of changes.

Recommendation 19

If the proposed reconfiguration of services is agreed, a clear set of quality indicators should be agreed and monitored before, during and after implementation by Commissioners, ESHT and HOSC. These should be able to demonstrate how patient experience and outcomes have been impacted by changes to services and demonstrate whether the anticipated financial impact of changes is being realised.

Recommendation 20

NHS Sussex should clearly set out arrangements for accountability for decisions relating to the ongoing development or implementation of proposed changes after the abolition of Primary Care Trusts in March 2013.

Appendix 1: Committee Membership

East Sussex County Council:

Councillor Rupert Simmons (Chairman)

Councillor David Rogers OBE (Vice-Chairman)

Councillor Carolyn Heaps

Councillor Philip Howson

Councillor Ruth O'Keeffe

Councillor Peter Pragnell

Councillor Barry Taylor

Eastbourne Borough Council:

Councillor John Ungar

Hastings Borough Council:

Councillor Andrew Cartwright

Lewes District Council:

Councillor Elayne Merry

Rother District Council:

Councillor Angharad Davies

Wealden District Council:

Councillor Mrs Diane Phillips

Co-opted Members (non-voting)

Julie Eason, SpeakUp (voluntary sector representative)

David Burke, SpeakUp (voluntary sector representative)

Janet Colvert, Local Involvement Network (LINk) representative – to August 2012.

Officer support

The Committee is supported by Claire Lee, Scrutiny Lead Officer.

Additional support for this review was provided by Paul Dean, Scrutiny Manager, Simon Bailey, Democratic Services Officer, Hannah Matthews, Democratic Services Assistant and Harvey Winder, Scrutiny Support Officer.

Meeting dates

19 June 2012

26 July 2012

13 September 2012

4 October 2012

Appendix 2: Sources of evidence

Witnesses

HOSC would like to thank all the witnesses who provided evidence in person:

19 June 2012

East Sussex Healthcare NHS Trust

- Darren Grayson, Chief Executive
- Dr Andrew Slater, Medical Director (Strategy)
- Dr Amanda Harrison, Director of Strategic Development and Assurance
- Jayne Black, Deputy Director of Strategic Development

NHS Sussex

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

26 July 2012

East Sussex Healthcare NHS Trust

- Darren Grayson, Chief Executive
- Dr Amanda Harrison, Director of Strategic Development and Assurance
- Jayne Black, Deputy Director of Strategic Development
- Gary Bryant, Deputy Director of Finance

NHS South of England

- Helene Feger, Associate Director of Communications and Engagement

Campaign Groups

- Liz Walke, Chair of Save the DGH campaign
- Margaret Williams, Chair of Hands off the Conquest campaign
- Vincent Argent, Clinical Advisor to Save the DGH

South East Coast Ambulance Service NHS Foundation Trust

- Geraint Davies, Director of Commercial Services
- James Pavey, Senior Operations Manager
- Matt England, Clinical Quality Manager

Clinical Commissioning Groups (CCGs)

- Dr Martin Writer, Chair of Eastbourne, Hailsham and Seaford CCG
- Dr Matthew Jackson, Vice-Chair of Eastbourne, Hailsham and Seaford CCG

NHS Sussex

- John O'Sullivan, Project Director – Strategic Finance

East Sussex County Council/NHS Sussex

- Jane Thomas, Consultant in Public Health

13 September 2012

East Sussex Healthcare NHS Trust

- Dr James Wilkinson, Divisional Director – Medicine and Emergency
- Dr Mohammed Rahmani, Stroke Consultant and Primary Access Point Clinical Lead
- Jenny Darwood, Clinical Service Manager – Stroke
- Jayne Boyfield, Associate Director of Integrated Care
- Jayne Black, Deputy Director of Strategic Development
- Flowie Georgiou, Associate Director of Urgent Care

Sussex Stroke Network

- Julia Buck, Stroke Network Manager
- Dr David Hargroves, Strategic Health Authority Clinical Lead
- Dr Rajen Patel, Network Clinical Lead

Clinical Commissioning Groups (CCGs)

- Dr Roger Elias, Chair of Hastings and Rother CCG
- Sarah Blow, Interim Chief Operating Officer

NHS Sussex

- Alistair Hoptroff, Programme Lead for Stroke and Long Term Neurological Conditions

East Sussex County Council

- Imran Yunus, Strategic Commissioning Manager, Adult Social Care (ASC)
- Beverley Hone, Assistant Director (Strategy and Commissioning), ASC
- Mark Stainton, Assistant Director (Operations), ASC

Voluntary and Community Sector

- Alan Keys, Chair – East Sussex Local Involvement Network (LINk)
- Sandra Field, Regional Head of Operations – Stroke Association
- Kate Davies, Chair – East Sussex Seniors Association (ESSA)
- Jennifer Twist, Chief Executive – Care for the Carers

4 October 2012

East Sussex Healthcare NHS Trust

- Ms Imelda Donnellan, Consultant General 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 Andrew Slater, Medical Director (Strategy)

Brighton and Sussex University Hospitals NHS Trust

- Dr Iain McFadyen, Chief of Trauma, and South East Coast Trauma System Medical Director

Sussex Trauma Network

- Paul Wallman, Clinical Director

- Kate Parkin, Network Manager

South East Coast Ambulance Service NHS Foundation Trust

- James Pavey, Senior Operations Manager

Conquest Hospital Medical Advisory Committee

- Dr David Walker, Chair

Eastbourne DGH Consultant Advisory Committee

- Dr Neil Sulke, Chair
- Mr Andrew Armitage, Vice Chair
- Mrs Scarlett McNally, Consultant Orthopaedic Surgeon

Clinical Commissioning Groups (CCGs)

- Dr Matthew Jackson, Vice-Chair of Eastbourne, Hailsham and Seaford CCG

NHS Sussex

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

Documentary Evidence

Item	**Date noted**
Shaping our Future: East Sussex Service Reconfiguration – Proposals for Service Change, *East Sussex Healthcare NHS Trust (ESHT)*	19 June 2012
Shaping our Future: East Sussex Service Reconfiguration - Public Consultation Process, *NHS Sussex*	19 June 2012
Travel and Access Report pertaining to 'Shaping our Future' strategy document, *NHS Sussex/ESHT*	26 July 2012
Final report of the National Clinical Advisory Team (NCAT), *NCAT*	26 July 2012
Submission from 'Save the DGH' group, *Save the DGH*	26 July 2012
Documentation from Hands off the Conquest group, *Hands off the Conquest*	26 July 2012
The Clinical Strategy: the financial case for change, *ESHT*	26 July 2012
Public health briefing, *NHS Sussex/East Sussex County Council*	26 July 2012
A consultation conundrum, *Hands off the Conquest*	13 September 2012
Shaping our Future – consultation document figures, *NHS Sussex/ESHT*	13 September 2012
Notes of meeting to discuss financial aspects of the proposals, *HOSC*	13 September 2012
Case for change: stroke services (extract from the pre-consultation business case (PCBC)), *ESHT/NHS Sussex*	13 September 2012
Extracts from the NHS South East Coast Integrated Stroke Care Pathway Specification, *Sussex Stroke Network/Kent Cardiovascular Network/Surrey Heart and Stroke Network*	13 September 2012

Community Services for Adults and Older People, *ESHT*	13 September 2012
Community Services: Adult Social Care perspective, *East Sussex County Council*	13 September 2012
ESHT Clinical Strategy Review LINk report to HOSC, *East Sussex Local Involvement Network (LINk)*	13 September 2012
Written submission - The Stroke Association, *The Stroke Association*	13 September 2012
Report from East Sussex Seniors Association (ESSA) meeting in response to Shaping Our Future, *ESSA*	13 September 2012
Case for change: general surgery (extract from the PCBC), ESHT/*NHS Sussex*	4 October 2012
Case for change: musculoskeletal (MSK) and orthopaedic services (extract from the PCBC), ESHT/*NHS Sussex*	4 October 2012
Equality Impact Assessment (EIA) (extract from the PCBC), ESHT/*NHS Sussex*	4 October 2012
The role of the major trauma network in Sussex and how this differs from orthopaedic trauma, *ESHT*	4 October 2012
Travel and Access Report pertaining to 'Shaping our Future' strategy document (updated version), *NHS Sussex/ESHT*	4 October 2012
Travel data provided by South East Coast Ambulance Service NHS Foundation Trust, *South East Coast Ambulance Service NHS Foundation Trust*	4 October 2012
Shaping our Future' – Closing the consultation, *NHS Sussex/ESHT*	4 October 2012

Supplementary information

HOSC received a significant amount of correspondence from interested parties during the consultation process. All representations received were circulated to HOSC Members during the evidence gathering process in the form of four supplementary information packs. These packs are available to view on the HOSC website www.eastsussexhealth.org, as are all HOSC agenda papers and minutes.

Contact officer: Claire Lee (Scrutiny Lead Officer) Telephone: 01273 481327
E-mail: Claire.lee@eastsussex.gov.uk