HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 13 December 2012

PRESENT:

Councillor Simmons (Chairman), Councillors Heaps, Howson, O'Keeffe, Pragnell, Rogers OBE and Taylor (all East Sussex County Council); Councillor Cartwright (Hastings Borough Council); Councillor Phillips (Wealden District Council); Councillor Davies (Rother District Council); Ms Julie Eason, SpeakUp (voluntary sector representative – non-voting)

WITNESSES:

East Sussex Healthcare NHS Trust (ESHT)
Stuart Welling, Chairman
Darren Grayson, Chief Executive
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr Andy Slater, Medical Director (Strategy)

Amanda Philpott, Director of Strategy and Provider Development, NHS Sussex and Chief Officer (interim) of Eastbourne, Hailsham and Seaford (EHS) CCG, and Chief Operating Officer (designate) of EHS CCG and Hastings and Rother CCG

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

48. APOLOGIES

48.1 Apologies for absence were received from Councillor Ungar (Eastbourne Borough Council), Councillor Merry (Lewes District Council) and Mr Dave Burke (SpeakUp).

48.2 Councillor Neil Stanley substituted for Councillor Ungar as Eastbourne Borough Council representative and Councillor Job Harris substituted for Councillor Merry as Lewes District Council representative.

49. MINUTES

49.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 30 October 2012.

50. DISCLOSURE OF INTERESTS

50.1 Councillor Tutt declared a personal, non-prejudicial interest as a member of 'Save the DGH' campaign.

51. REPORTS

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

52. 'SHAPING OUR FUTURE' – PETITION

52.1 The Chairman advised HOSC of notification of a petition organised by the 'Save the DGH' campaign in relation to the NHS decisions to be considered by the Committee. He invited the Chair of the campaign, Mrs Liz Walke, to present the petition to HOSC.

52.2 Mrs Walke made the following key points in relation to the petition:

- The campaign had always opposed the downgrading of 'core' services, and they include all emergency/unplanned care in this category.
- The petition opposing the NHS decisions had been launched on 23 November 2012 at a public meeting.
- As of 12 December 2012, 35,430 signatures had been counted on the hard copy petition, with a further 127 signatories via the campaign website and 1,209 on an e-petition – a total of 36,766.
- The response to the petition had been significantly higher than the response to the NHS public consultation and the campaign had received feedback that people were unaware of the consultation.
- The key concern of signatories to the petition was emergency access, particularly travel times, traffic congestion and the cost of travel for visitors.
- The majority of doctors in Eastbourne do not support the proposed changes.
- The NHS response to the HOSC recommendations is considered inadequate by the campaign.
- The lack of public support is evidenced by the response to the petition and, as a result, HOSC should refer the NHS decisions to the Secretary of State.

52.3 When asked to respond to concerns raised by the NHS that the wording of the petition went beyond the specific changes being proposed, thus compromising its legitimacy, Mrs Walke advised that the original wording had been changed in response to these concerns to include the word "emergency" in front of orthopaedics and general surgery. She stated that the majority of petition forms had used revised wording. Mrs Walke further clarified that the campaign group had not stated that Eastbourne District General Hospital was closing, although the campaign is concerned that the NHS decisions would have a knock-on impact on other core services.

52.4 The Chairman advised HOSC that a request had been received from Councillor Tutt to address the Committee in relation to the petition. Councillor Tutt made the following key points:

- He had not seen an equivalent response to a petition before in his experience of local politics.
- The number of signatories is significant in the context of an Eastbourne borough population of approximately 100,000, although the hospital catchment area extends beyond Eastbourne and signatories may be resident outside the town.
- The petition seeks to contest the actual proposals and the wording reflects this.
- The cross-party campaign group does not seek to protect all services but does want to retain all core services at both acute hospital sites in East Sussex.

- Eastbourne Borough Council passed a unanimous motion requesting HOSC refer the NHS decisions to the Secretary of State – HOSC Members did not participate in this vote.
- Although it is stated by the NHS that a relatively small percentage of patients will be affected, actual numbers equate to over 5,000 which is a large number.
- Based on the conflicting clinical opinions and public strength of feeling, the Secretary of State should be requested to undertake an independent review.

52.5 RESOLVED to:
(1) accept and note the petition.

53. 'SHAPING OUR FUTURE' – NHS DECISIONS

53.1 The Committee considered a report by the Assistant Chief Executive which set out the decisions reached by the NHS Sussex Board in relation to the future configuration of stroke, emergency and higher risk general surgery and emergency and higher risk orthopaedics provided by ESHT. The report also set out the NHS response to the recommendations made by HOSC in the Committee's report agreed on 30 October 2012.

53.2 Amanda Philpott and Dr Amanda Harrison presented the NHS decisions and response to HOSC recommendations, making the following key points:

- There is a common aim between commissioners and ESHT to achieve the best possible health services.
- NHS Sussex, the Clinical Commissioning Groups (CCGs) and ESHT have all committed to two thriving acute hospitals in East Sussex.
- The CCGs were united in supporting the preferred delivery options for the three services, which involve each being provided on a single site.
- Having agreed single siting, the CCGs expressed different preferences about which services should be provided from which site.
- The Outline Business Case considered by the NHS Boards reflected issues similar to those raised by HOSC, and HOSC's report was itself considered by the Boards.
- Following the decision making process a Full Business Case can now be developed, to include detailed delivery plans. This will reflect the actions arising from the HOSC recommendations.
- A multi-agency, local health economy wide programme board will oversee the delivery of recommendations and the overall Clinical Strategy, which is wider than the three services being reconfigured.

53.3 Stuart Welling thanked HOSC on behalf of ESHT for the Committee's diligence and noted that the decisions are difficult. He emphasised that the changes are part of a wider strategy which aims to provide the best possible services for all the residents of East Sussex and he welcomed that fact that a single local health economy wide view on the strategic direction for services had been achieved for the first time. He informed the Committee that a population the size of East Sussex would normally have a single district general hospital and that the Trust's strategy reflected a desire to retain a number of core services at both sites whilst also developing complementary services between sites. He viewed this approach as critical to future sustainability.

53.4 The following issues were covered in response to the Committee's questions:

53.5 **Core services**

Dr Andy Slater advised HOSC that there is no definition of 'core services' for a district general hospital. He explained the Trust view, which is that there is a need for services to treat immediately life threatening conditions such as cardiac arrest, renal failure or respiratory failure. This is the reason the Trust intends to retain accident and emergency (A&E) departments at each site. Dr Slater went to explain that orthopaedics and general surgery cases are not generally immediately life threatening and a four hour treatment window is considered reasonable in these specialties. He added that transportation of patients by the Ambulance Service is considered safe and this is evidenced by similar models of care operating safely and successfully elsewhere.

53.6 **Stroke – health inequalities**

In response to concerns about exacerbating health inequalities in Hastings by locating the stroke unit in Eastbourne, Dr Slater highlighted that a significant contributor to the higher mortality from stroke in parts of Hastings is lifestyle factors. These issues need to be addressed through public health initiatives rather than through acute treatment. Dr Slater emphasised that travel time is relevant primarily for the 12% of patients suitable for thrombolysis and in these cases the travel time is only part of the process. The ambulance service had calculated the average increase in travel time following reconfiguration to be 10-15 minutes which is not regarded as clinically significant.

In response to concerns about travel time raised in a letter from two Eastbourne consultants, Dr Slater indicated that they are not stroke specialists. He advised HOSC that stroke specialists are very clear that a single site will improve care, as evidenced in London where travel time has increased following reconfiguration. Dr Slater stated that the Trust's current inability to provide a full seven day a week service is more significant for outcomes than travel time.

Ms Philpott added that Dr Elias and colleagues from Hastings and Rother CCG had been pushing for a single site acute stroke service in order to improve quality whilst maintaining appropriate access. She confirmed that the CCG had looked closely at the Joint Strategic Needs Assessment and endorsed the plans with that knowledge.

Mr Grayson confirmed that the Trust has struggled to sustain the high quality stroke care envisaged on both sites and confirmed that the investment planned for the single unit would enable seven day a week therapy and an additional stroke consultant to be put in place.

53.7 **CCG opinion**

When asked about the differences in site preference expressed by CCGs, Ms Philpott emphasised that they had been unanimous in supporting a single site model for the three services and been unanimous in agreeing to work with the decision made by NHS Sussex on location. They had been clear that implementing the model of care was more important than their individual location preferences, which understandably reflected their geographical perspectives. Ms Philpott explained that the CCGs understood the need to work together to reach agreement on the best configuration of acute services and agreed that not all services could continue to be provided on all sites.

53.8 **Consultant views**

When asked about the divergent views amongst ESHT consultants, Dr Slater noted the clear geographical split between Eastbourne and Hastings based clinicians. He was not able to comment on the individual motivations of clinicians

in coming to their view, but noted that the development of the models of care had been led by the responsible clinicians over the past two years. Dr Slater also noted that the Chairs of the Medical Advisory Committee (MAC) at Conquest Hospital and Consultant Advisory Committee (CAC) at Eastbourne DGH had confirmed to HOSC that opportunities for consultant engagement in the process had been good. He advised HOSC that there had been constructive discussions with consultants regarding risk mitigation, but no specific alternatives, or reasons why the Trust's Clinical Strategy is unsafe, or would not deliver the quality of care intended, had been put forward.

With regard to HOSC's recommendation that the two consultant committees should merge in order to provide a single clinical view, Dr Slater reported that the MAC remained supportive of this approach and the he understood the CAC had also recently voted to support a merged committee.

Ms Philpott added that it was unlikely that complete clinical consensus would ever be achieved but that CCG GP leaders intended to work with ESHT clinical leaders to ensure a shared vision for the future of services, not a piecemeal approach. There is common ground in the desire for the best care.

53.9 **Clinical leadership**

When asked to comment on the fact that seven of the eight Primary Access Point (PAP) leads within the Clinical Strategy process are based at the Conquest Hospital, Dr Slater stressed that clinicians are employed by a single Trust, not by an individual hospital. He emphasised that the posts had been open to all applicants and appointments had been made on merit, regardless of site. His view was that it would be inappropriate to set quotas based on site and he noted that of the three Divisional Directors (above PAP lead level) two are based at Eastbourne.

53.10 **Site decisions**

Dr Harrison described the process undertaken by the Options Appraisal Panel to score each delivery option and each site option. She stressed that the Panel was not a decision making body and the outcomes of it were one part of the evidence presented to the NHS Sussex Board. The Panel's report had been fully taken into account by NHS Sussex

With regard to site, the panel had scored the Conquest Hospital slightly higher on orthopaedics and Eastbourne DGH slightly higher on general surgery, although the differences were marginal. It had been clear from the outset that these two services needed to be located on the same site. In order to inform the final decision of the NHS Sussex Board the Panel advised that further information should be provided on the view of the Sussex Trauma Network and the economic impact on the Trust of different locations. The Board took this additional information into account, alongside the Panel report and other evidence, in coming to a final decision.

53.11 **Implementation**

Ms Philpott confirmed that the CCGs have agreed to chair the Shaping our Future programme board which will oversee implementation and they will ensure that rigorous plans are in place. The Board would be very willing to return to HOSC to demonstrate progress and would be pleased to accept a HOSC representative attending meetings.

53.12 **Management savings**

Darren Grayson informed HOSC that, as part of an organisational restructure following the merger of the hospitals Trust with community services, he had reduced the running costs of the organisation by £2.9m. He advised that the Trust's management costs are now at the lower end when compared with other NHS organisations in Sussex. Mr Grayson added that there would be further back office efficiencies of 5-8% in the coming year, a higher level than expected of clinical services.

53.13 **Ambulance capacity**

In response to HOSC's recommendation that the impact of the planned reconfiguration on ambulance services be fully assessed, Ms Philpott confirmed that the CCGs were clear that they will work with the Ambulance Trust to address any additional capacity required.

53.14 **Patients affected**

Dr Slater confirmed that the estimation of around 5,000 affected patients per year is broadly correct. With regard to concerns raised in a letter from two Eastbourne consultants that the numbers said to be affected are based only on those who eventually require surgery and that actual numbers could be higher, Dr Slater advised that ESHT had based the numbers on all those the Trust believes will be required to travel. He explained that this included some who would travel for assessment but subsequently not require surgery. For general surgery, the numbers affected had been based on those attending the Surgical Assessment Unit which include patients only requiring observation, as well as those who go on to require surgery. He added that protocols with the ambulance service would ensure that patients do not travel unnecessarily.

53.15 **Travel times**

Dr Harrison acknowledged that the use of average travel times would inevitably mean that some patients actual journeys are longer and some shorter. She noted that the ambulance service had provided assurances that patients anywhere in East Sussex could be transported to a hyper acute stroke unit within 45 minutes and argued that the use of averages to inform decisions is reasonable in this context, as it enables the overall differences to be calculated.

Dr Harrison added that, other than stroke patients, the majority of patients who would be affected would not require blue light transfers. Many surgical patients see their GP before admission and the majority of orthopaedic patients are assessed by the ambulance service and can then be taken direct to the appropriate site. Dr Harrison emphasised the Trust's view that the additional travel time is a price worth paying for improved care.

53.16 **Consultant rotas**

Dr Slater clarified that whilst appointing extra consultants on both sites may temporarily shore up current services for similar cost, this would not address the fundamental structural issues threatening the sustainability of the services. He argued that bigger units would be more able to attract the necessary staff on a long-term basis.

53.17 **Quality of current services**

Dr Slater welcomed the fact that the majority of ESHT patients receive an excellent service but he pointed to too many instances where a high quality and timely service is not provided. He argued that the planned changes will enable both current and future quality challenges to be addressed.

53.18 **Petition**

Ms Philpott welcomed the fact that the initial wording at the top of the petition had been changed but expressed concern that a footnote suggested wider changes. She informed HOSC that letters had been received from members of the public expressing concern that they had been told their local hospital was closing. Ms Philpott clarified that she did not believe this was a message Mrs Walke had been communicating, but that it was clearly a perception amongst the public.

Mr Grayson added that people had asked him why he was closing Eastbourne DGH. He stressed that he would not support the closure of the hospital and that there is £30m of investment in services there currently underway which is indicative of its strong future role.

53.19 **Finance**

Mr Grayson confirmed that the necessary financial arrangements are in place to support implementation. He noted that the changes are of a larger scale than those seen in East Sussex previously but gave examples of the Trust's recent track record in meeting national targets and managing organisational change to assure HOSC of its ability to deliver.

53.20 **Communications with the public**

Mr Welling recognised the strong feelings amongst the public with regard to hospital services but highlighted the responsibility of the Trust to make corrections where it feels that facts are not presented accurately. He reminded HOSC that a full public consultation process had been undertaken and that the NHS Sussex decision had been made in the best interests of the people of East Sussex.

Ms Philpott added that decisions about the services had been finely balanced and are difficult but the CCGs were clear that the preferred models of care are the right way forward to improve care which is why they agreed to work with whatever decision was made by NHS Sussex.

53.21 RESOLVED:

(1) by a majority of 8 votes to 4 votes, that the NHS Sussex decision that ESHT acute stroke services should in future be provided only at Eastbourne DGH is in the best interests of the health service for East Sussex.
(2) by a majority of 7 votes to 5 votes, that the NHS Sussex decision that ESHT emergency and higher risk elective orthopaedic and general surgery services should in future be provided only at the Conquest Hospital is in the best interests of the health service for East Sussex.
(3) to reconvene the HOSC Task Group to provide additional scrutiny of the development of implementation plans and request that it report to the main Committee.
(4) to request a full progress report from NHS Sussex, ESHT and the CCGs in March 2013.
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The Chairman declared the meeting closed at 3.58pm