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

Date: **21 March 2013**

By: **Assistant Chief Executive**

Title of report: **Shaping our Future – Progress Report**

Purpose of report: **To consider progress towards implementing decisions made by NHS Sussex in relation to the 'Shaping our Future' proposals for reconfiguration of stroke, general surgery and orthopaedic services provided by East Sussex Healthcare NHS Trust.**

RECOMMENDATIONS

HOSC is recommended to:
1. Consider and comment on progress.
2. Request a further progress report in June 2013.

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1. Background

1.1 In June 2012 HOSC considered reconfiguration proposals for 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 (CCGs), involved reconfiguration of these specific services:

- Acute stroke care
- Emergency and higher risk elective (planned) general surgery
- Emergency and higher risk elective orthopaedics

1.2 HOSC agreed that the proposed changes constituted 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 based on evidence gathered from a range of sources. HOSC's report was agreed by the Committee on 30 October 2012 and is available from the HOSC website www.eastsussexhealth.org .

1.3 In November 2012 the Board of NHS Sussex, as commissioner of services, decided that:

- ESHT acute stroke services should in future be provided only at Eastbourne District General Hospital.
- ESHT emergency and higher risk elective orthopaedic and general surgery services should in future be provided only at the Conquest Hospital.

1.4 The NHS Sussex Board was informed by the views of the CCGs, who will take over commissioning responsibilities from April 2013, and the view of the ESHT Board. It also took into consideration the outcomes of the consultation process, including HOSC's report and recommendations.

1.5 In December 2012, NHS Sussex and ESHT sought HOSC's support for the decisions taken. They also presented the NHS response to HOSC's 20 recommendations, all of which were accepted. HOSC agreed, by majority vote, that the reconfiguration of these services is in the best interests of the health service for residents of East Sussex and could therefore proceed to implementation.

1.6 NHS Sussex and ESHT subsequently informed HOSC that they had received notice of intention to pursue a Judicial Review from lawyers acting on behalf of 'Save the DGH' campaign group. However, this action is now understood to have been withdrawn.

2. Progress report

2.1 A summary progress report has been provided by ESHT (appendix 1) outlining the work underway to implement the agreed reconfiguration of services. The work is overseen by the multi-agency Shaping our Future Programme Board, chaired by the Chief Operating Officer of Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs, Amanda Philpott. Cllr Davies attends this Board on behalf of HOSC in order to maintain a detailed overview of progress.

2.2 Implementation is subject to development and approval of a Full Business Case (FBC), building on the Outline Business Case already approved by the Trust and NHS Sussex Boards.

2.3 Appendix 2 details progress in implementing the NHS response to HOSC's recommendations, in the form of an updated action plan.

2.4 Darren Grayson, Chief Executive and either Richard Sunley, Chief Operating Officer or Jane Darling, Deputy Chief Operating Officer from ESHT, together with Amanda Philpott, representing East Sussex CCGs, will attend HOSC to discuss the reports.

3. HOSC Task Group

3.1 In December 2012 HOSC agreed to reconvene the Committee's Clinical Strategy Task Group in order to provide additional oversight and scrutiny of the implementation of the changes on the Committee's behalf.

3.2 This group met on 8 February and 11 March 2013 to scrutinise specific aspects of the implementation process. A short report summarising the issues considered by the Task Group is attached at appendix 3. HOSC may wish to suggest specific issues for the group to consider in more detail.

3.3 Progress in relation to the NHS response to HOSC's recommendations is a standing item on Task Group agendas. As HOSC's representative on the Programme Board, Cllr Davies is able to provide feedback on the work of the Board in order to highlight issues the Task Group may wish to consider in more detail, and to avoid duplication.

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	APPENDIX 1
To	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
From	**Richard Sunley. Chief Operating Officer and Deputy Chief Executive– East Sussex Healthcare Trust (ESHT).**
Subject	**Update on the recommendations made by East Sussex HOSC on: 'Shaping our Future'** **Consultation on stroke, general surgery and orthopaedic services and implementation of the Clinical Strategy**
Date	**For Consideration by HOSC members at the meeting on the 21st March 2013**
Purpose and Timeframe	**To outline the progress made by ESHT with regard to the proposed reconfiguration of stroke, general surgery and orthopaedic services in East Sussex.** **To provide an update on the response to the recommendations made by East Sussex HOSC on 'Shaping our Future'**

1. Introduction

East Sussex Healthcare Trust's Clinical Strategy, Shaping our Future, has been developed to ensure that the Trust is able to deliver sustainable healthcare services for its local population and respond to national and local requirements to improve patient safety, patient outcomes and service quality and to meet standards. Through this overarching strategy the Trust has sought to ensure it can deliver bold and radical change that reflects the changing needs of patients, the rapid development of clinical practice in a new era of financial austerity that requires services to be efficient and cost effective.

Over the past 18 months ESHT, along with key stakeholders, have, through the eight Primary Access Point (PAP) workgroups, developed and agreed models of care and the options for delivering these models from this. The following areas were identified as requiring reconfiguration in order to provide the agreed models of care:

- Stroke
- General Surgery
- Orthopaedics

Following a careful review of the evidence and the recommendations of ESHT and the local Clinical Commissioning Groups (CCGs), the NHS Sussex Board unanimously agreed to the creation of a specialist centre for stroke services on Eastbourne DGH site, and a specialist centre for emergency and high risk

general surgery and emergency and high risk orthopaedics on the Conquest Hospital site in Hastings.

2. Governance

Following the HOSC meeting on December 13th 2012, ESHT reviewed and approved a revised internal governance structure to support implementation of the service reconfigurations, with implementation being led through the operational management team. This governance structure also provides for an improved link between future strategic developments and operational management.

Senior personnel in NHS Sussex and ESHT have continued to work closely on developing stakeholder engagement and communication programmes through the implementation period. This partnership working will continue during transition to CCGs and onwards to ensure an oversight of the key HOSC recommendations.

The Shaping our Future Programme Board has now revised its terms of reference to reflect the change from strategic development to operational implementation and therefore is tasked with providing assurance that implementation is progressing according to plan. A member of the HOSC is now an invited member of this Board.

The HOSC Task Group has now reconvened and meets monthly to explore in more detail key areas of interest for the HOSC which to date have included how we may best monitor patient experience and other quality indicators. This group reviews progress of the action plan drawn up in response to the HOSC recommendations.

3. East Sussex Clinical Senate

HOSC recommendation 15 was the establishment of a local Clinical Senate which is also reflected in the new governance structure.

4. Early Implementation

From January 2013 implementation has focussed on the necessary confirmatory processes as below:

- Reconfirming that the models of care remain appropriate
- Establishing whether activity and workforce assumptions in the Outline Business Case (OBC) required updating.
- Ensuring that financial and activity assumptions were appropriately linked to the long term financial modelling and Trust Development Agency submissions.
- Ensuring that the commissioning intentions for 13/14 did not impact significantly on the models of care or activity assumptions.
- Complex option developments for the estates remodelling for the six remaining PAPs as well as all other services run by the Trust

5. Progress of PAPs
In January 2013 all six PAPs established implementation delivery groups which are led by clinical leads, heads of nursing and general managers for the relevant service. The remit of these groups is to ensure that clinical pathways, processes and protocols are established for patient safety and the quality of service as well as ensuring the appropriate workforce and estate infrastructure is provided to meet the needs of their services.

Each of these groups has been tasked with developing and maintaining their own implementation action plans and risk registers. These are monitored and supported as required through the senior operational group which is chaired by the Chief Operating Officer (COO). The office of the COO will maintain the overarching implementation plan which pulls together all operational site changes (PAP and non PAP developments) for the year ahead.

6. Corporate Workstream Development
Other supporting workstreams have also been established so that all corporate infrastructure changes are incorporated into the plans for the service changes e.g. medical records, facilities, transport etc.

7. Full Business Case (FBC) Development
Work has commenced on the development of the FBC as per the Treasury Green Book Guidance but the confirmatory processes and implementation planning as above have necessarily needed to feed into the FBC.

It was planned to present the FBC to the ESHT Board in March 2013. However, recent urgent decisions regarding the delivery of maternity services will delay this because the ward areas identified in the early reconfiguration plans are now likely to be utilised as a priority for obstetric in-patient capacity.

The planning for implementation is continuing, but now has to take into account the short term relocation of maternity services as a priority. Revised timescales will be discussed and agreed as a matter of urgency.

8. Patient Experience
ESHT is ensuring that its patient experience programme is at the heart of the reconfiguration of services and the Deputy Director of Nursing is on the Senior Operational Group overseeing implementation planning.

10. Updated Action Plan
This is attached for reference.

Appendix 2

HOSC action plan – ESHT updated 12.3. 2013

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
Stroke Services									
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.	1.1	Develop internal protocol to maximise speed of access to thrombolysis.	Stroke Clinical Unit lead Emergency Dept lead	Javid Rahmani Andrew Leonard	Stroke performance indicators. * ASI 3	Draft for approval to Clinical Management Executive (CME) January 2013. For assurance by Shaping our Future (SoF) Programme Board	New protocols being agreed with the Emergency Departments. These will be signed off by the clinical leads of Stroke and Emergency Care, after final discussions with SECAmb. • SECAmb will be pre-alert stroke nurses of patient arrival • Stroke nurse to be at ED door to greet patient and assess • Working up plans for Radiology hot reporting (-8 mins) • Looking to see if thrombolysis can	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								commence in Radiology (-10 mins) •	
		1.2	Agree and monitor % scans undertaken within one hour Improve on national target of 50%	Diagnostic Clinical Unit lead Radiology Manager	Graham Rayner Christian Kasmeridis	Stroke performance metric ASI 4a	Target milestones agreed January 2013. Draft for approval to CME January 2013. For assurance by SoF Programme Board	Already monitored in ASIs Performance above 50% now, though only commissioned to achieve 50%	A
		1.3	Agree contingency plans when scanner out of use	Associate Director for Integrated Care	Paula Smith/Ian Bourns	ESHT Senior Operational Group	Draft options appriasial for approval to CME March 2013. For assurance by SoF Programme Board	Two scanners on each of the acute sites need to be in place before the stroke services can single site. Plans for the second scanner at EDGH are in progress, and may require a transitional plan for a mobile unit to provide resilience for emergency work, Radiology business continuity plans put emergencies before elective procedures, should one	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								scanner be non-operational for any period of time.	
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.	2.1	ESHT to work closely with commissioners to develop 7 day therapy services	Associated Director for Integrated Care Lead Commissioner within PCT/ CCG	Jayne Phoenix Alistair Hoptroff – Lead Commissioner for Stroke	Senior Operations group	Implementation plan March 2013	Seven day working is already in the therapies redesign plan, Recruitment is now underway for outstanding therapy posts	A
		2.2	Develop robust monitoring and reporting of patient outcomes of service	Associated Director for Integrated Care Lead Commissioner within PCT/ CCG	Jenny Darwood Alistair Hoptroff – Lead Commissioner for Stroke	Senior Operations group ASI 3 ASI 2 ASI 9 ASI 4a ASI 5 First SNAP Data from April 2013	Implementation plan March 2013	Monitored through the national Stroke database (SNAP) this went live in ESHT in December 2012, but will take 6 months for data to be rich enough to be meaningful. Each patient will have a 6 month MDT review (and the stroke association are participating in this review process), and SNAP records the outcomes at an individual	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								patient level. We anticipate this will be producing meaningful outcome data by the autumn of this year. This is in line with other Trusts, and MDT coverage is ahead of other Trusts because we have partnered with the Stroke Association MDT assessors.	
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.	3.1	To develop and implement plans to ensure consistency across county for stroke rehabilitation	Associate Director for Urgent Care Lead Commissioner within PCT/ CCG	Flowie Georgiou Alistair Hoptroff – Lead Commissioner for Stroke	Senior Operations group via Community redesign and integrated network Board	Implementation plan March 2013	Currently no ESD service commissioned for Lewes and havens, and Lead Commissioner working through service specification with that group. Rehab demand and response monitoring in place through ICAP. We have	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								commenced more detailed look at the total demand for slow stream rehab. In addition to the requirements for stroke, ESHT needs to determine the full picture of rehab requirements to support ESHT and network plans for patient pathway management and reductions in length of stay across a range of specialities. A strategy for delivery of rehab in totality would then ensure the most efficient use of all resources.	
		3.2	ESHT to work with commissioners and have robust reporting and monitoring in place to achieve patient outcomes	Associate Director for Urgent Care Lead Commissioner within PCT/	Flowie Georgiou Alistair Hoptroff – Lead	ASI 2	Ongoing	Ongoing review against Stroke improvement action plan through the quality and contracting	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
				CCG	Commissioner for Stroke			routes already in place. Currently monitored against ASIs, but these will be replaced by SNAP from April 2013. We will shadow run ASIs in the first 6 months at least for consistent monitoring.	
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.	4.1	Review and ensure implementation of agreed model of care which includes standards for end of life.	Director of Nursing Lead Commissioner within PCT/ CCG	Alice Webster Kay Muir	Medical Director for governance-chair end of life programme Board	Implementation plan by February 2013. outcomes reviewed bi monthly at Programme Board	ESHT EOLC group to monitor the specifics. CSM for stroke now set up range of meetings of meetings in ESHT and community to review EOLC pathways. Draft pathways to go to the next EOLC Board Meeting Work with palliative care teams to commence particularly on out of area pathway	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								management. Lead commissioner has met with Stroke lead, this work will now be incorporated in the EOLC Programme Board worrstream.	
		4.2	Review facilities and support for families visiting	Head of Nursing for Stroke	Chris Craven	Deputy Director of Nursing in short term task and finish group	Implementation plan by March 2013	Now in place in terms of the planning with the Estates department and planning for the new unit. Other services may also require this facility, so estates planners looking at possible solutions for rest rooms and quiet areas.	
5.	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	5.1	Develop clinical pathway information for stroke patients and their families	Stroke Clinical Unit lead/ Head of Nursing. Lead Commissioner within PCT/ CCG	Jarvid Rahmani Jenny Darwood Alistair Hoptroff –	Senior operations group	Pathway Complete by March 2013	In progress, being led by Stroke Management team. Developing Posters and leaflets for patients and carers, and the communication	

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								departments will also support messages in the community about service reconfigurations (developing the communication strategy from the consultation process to implementation) The Stroke Association and patient experience groups will be involved in the review of any information	

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
General Surgery & Orthopaedic Services									
6	Safeguards need to be 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.	6.1	Confirm level of senior cover available to provide surgical opinion on lower risk site	Clinical Unit Lead for General Surgery	Imelda Donnellan	Senior Operations Group	Implementation plan March 2013	Staffing plan for Gen Surgery agreed with all Consultants. Middle grade cover at EDGH will provide for senior decisions making and advice. All medical staffing plans relating to re-configured services will need to be signed off by the medical directors prior to the FBC going to the Trust Board.	G
		6.2	Develop agreed procedure and protocol for accessing surgical opinion	Clinical Unit Lead for General Surgery	Imelda Donnellan	Senior Operations Group And CME	Implementation plan March 2013	AS above. The plan includes how to access Consultant opinion as well.	G
		6.3	Agree and develop protocol for unforeseen immediate need for surgery	Clinical Unit Lead for General Surgery	Imelda Donnellan	Senior Operations Group And CME	Implementation plan March 2013	As above	G
		6.4	Agree protocols for surgical admissions with SECAmb	Clinical Unit Lead for General Surgery	Imelda Donnellan	Senior Operations Group And SoF Programme Board And CME	March 2013	General Surgery management team meeting with SECAmb regional Operational lead to agree pathway	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								management and guidance for SECAmb crews. Initial meeting in February Secamb meeting with all clinical leads for Pathway sign off 3rd April	
		6.5	Agree and protocols for treat and transfer of patients requiring emergency surgery	Clinical Unit Lead for General Surgery	Imelda Donnellan	Senior Operations Group And SoF Programme Board And CME	March 2013	AS above.	G
7	ESHT should undertake further work to identify co-dependencies of general surgery 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.	7.1	Carry out in depth analysis of co dependencies and activity numbers for FBC	General Manager for General Surgery	Jane Farrow	Medical Director for Strategy	January 2013	Plans now in place for access to surgical input	G
		7.2	Develop agreed procedure and protocol for accessing surgical opinion and for unforeseen immediate need for surgery (as in recommendation 6)	Clinical Unit Lead for General Surgery	Imelda Donnellan	Senior Operations Group And CME	March 2013	As above	G
8	Develop 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	8.1	Development of robust contingency plans to ensure surgical bed capacity	Deputy COO (Operations)	Pauline Butterworth	Senior Operations Group And CME	March 2013	Transitional bed modelling has been based on medical patient occupancy of 85%. In addition through the period of re-	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
	order to support improvement bed management, prior to implementation.							configuration in 2013, transitional escalation plan will need to be agreed across the Divisions and at Trust CME.	
		8.2	Review the model of management of acutely unwell patients currently provided at Hastings in order to further develop on the Hastings site and implement on the Eastbourne site	Associate Director urgent Care + director of Emergency Care	Flowie Georgiou+= Andrew Leonard	Senior Operations Group And CME	March 2013	Senior Consultant from Conquest to work at EDGH from WC January 28th. All system to be reviewed and medical staffing plan to support EDGH MAU being developed by the Clinical lead to ensure processes and infrastructures are equivalent on both sites.	G
9	Review discharge procedures to reflect that patients, carers and families may need to make more complex travel arrangements if they have been treated further from home.	9.1	Establish robust discharge processes to provide care closer to home as soon as possible	Deputy Director of Nursing	Chris Craven	Senior Operations Group	March 2013	DON overseeing discharge planning review. Though T&F group led by the ADNs.	AA
		9.2	Develop information for patients & families	Deputy Director of Nursing	Chris Craven	Director of Nursing in short term task and finish group	March 2013	Being considered in the T&F group as above	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
Crosscutting Issues									
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. Develop robust 'accessibility plans' These should include: Access policies Transport Estates Equality & Diversity Access Audits	10.1	To coordinate a number of work streams and actions that focus on accessibility and produce an accessibility plan	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	Work has commenced. T&F group set up .by DCOO to ensure theses aspects of accessibility to services is planned for.	A
		10.2	Working with transport planners to maximise public transport access	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	As above	A
		10.3	Working with community transport services and volunteer services to support access, particularly for the most vulnerable	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	As above.	A
		10.4	Making appointment systems more flexible and offering greater choice	General manger for Outpatients	Maureen Blunden	Senior Operations Group	March 2013	OP General Manager now looking at implications for OP appointment modelling and how patients can access OP appointments at most convenient site.	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		10.5	Review and where appropriate update the parking policy, including disabled parking	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	Car Parking Policy dated May 2012; version number and issue number 2012156 V1.1 – refers	G
		10.6	Staff travel, including the use of alternatives to the car	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	Trust Healthy Transport Plan 2006	G
		10.7	Access for those with mobility restrictions or other disabilities	Head of equality , diversity and human rights	Jourdain Duraiaj	Senior Operations Group	March 2013	Access audits undertaken for both acute sites. Autumn 2012. To be reviewed in light of services changes	A
		10.8	Publicising availability of help with travel costs through NHS schemes and national schemes such as free bus passes for older people	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	T&F group set up .by DCOO to ensure theses aspects of accessibility to services is planned for.	A
		10.9	Maximising the access of visitors to patients	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	T&F group set up .by DCOO to ensure theses aspects of accessibility to services is planned for.	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
11.	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.	11.1	A feasibility study to be undertaken to consider the introduction of a regular shuttle bus between the two hospital sites, for staff, patient and visitor use.	**Assistant Commercial Director, Facilities**	Mark Paice	Senior Operations Group	March 2013	T&F group set up .by DCOO to ensure theses aspects of accessibility to services is planned for.	A
12.	ESHT should consider **measures to mitigate the impact of reduced access for visitors** such as:	To mitigate reduced access by reviewing:							
		12.1	Use of telephone contact with families/carers to ensure staff are aware of patient needs/preferences	Deputy Director of Nursing in short term task and finish group	Chris Craven	Senior Operations Group	March 2013	This is fundamental to the personalised care planning being implemented and the services that are being single sited are being given priority in guidance development. This is being overseen by the DoN	A
		12.2	Increased use of volunteers to provide psychological and	Deputy Director of Nursing in	Chris Craven	Senior Operations Group	March 2013	There is an ongoing programme of	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
			practical support to patients	short term task and finish group				development with our own ESHT volunteers. We are now developing a specific programme with the Stroke Association to give specific training and work along side our volunteer groups.	
		12.3	Increased flexibility in visiting arrangements/hours	Deputy Director of Nursing in short term task and finish group	Chris Craven	Senior Operations Group	March 2013	Being reviewed at a service level dependent upon clinical environments and patient needs, but also being built into the personalised care planning. If families travel from a distance they will be accommodated in visiting. Family areas being planned into the new	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								space requirements on the two sites.	
		12.4	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.	Deputy Director of Nursing in short term task and finish group	Alice Webster	Senior Operations Group	March 2013	Again, this is fundamental in individualised, personal care plans. These should be developed with the family and carers as well as the patient, and agree the information required and access for follow up information DoN overseeing this process	A
13.	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.	13.1	Calculate impact on ambulance capacity, including patient transport services	Chief Financial Officer (ESH and H&R CCG)	John O'Sullivan	SoF Programme Board Joint CCG Governing Body	March 2013	First meetings with SECAmb to share activity profiles set up. Detailed analysis to come from that work.	A
		13.2	Agree plan for resourcing extra ambulance capacity with commissioners	Chief Financial Officer (ESH and H&R CCG	John O'Sullivan	SoF Programme Board Joint CCG Relevant	March 2013	Planning impact of activity shifts has has commenced	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
						Clinicnas tasked Governing Body			
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.	14.1	Set up single Clinical Advisory Committee	Chair of Consultants Advisory Committee at Eastbourne Chair of Medical Advisory Committee at Hastings	Neil Sulke David Walker	ESHT Trust Board	March 2013	Discussion with the chairs of the two committees has been widened to discussion with the whole consultant body working towards a merger of the two committees.	A
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.	15.1	Establish a local 'Clinical Senate'	Medical Directors ESHT Medical Directors CG Chairs	Tbc Roger Elias & Martin Writer	NHS Sussex / Sussex Together	April 2013	First meeting is scheduled for 1st May 2013	G
16.	Commissioners and ESHT should jointly publish and regularly update a clear **timeline showing planned**	16.1	Publish a timeline of planned developments in community health services	Chief operating Officer.	Richard Sunley Flowie	SoF Programme board	March 2013	This action will be linked in with the existing	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
	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.			Lead Commissioner within PCT/ CCG	Georgiou Paula Smith			Community redesign group and taken forward through this forum.	
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	17.1	Review impact of earlier discharge and reduced admissions on carers and social care provision	Associate Director of Strategy and Whole systems working Associated Director for Integrated Care	Catherine Ashton Dr Hugh McIntyre	SoF Programme Board Senior operations group	March 2013	This action will be linked in with the existing Community redesign group and Integrated Care Network and will be taken forward through this forum.	A
		17.2	Review the options for providing additional support to the most vulnerable	Associate Director of Strategy and Whole systems working Associated Director for Integrated Care	Catherine Ashton Dr Hugh McIntyre	SoF Programme Board Senior operations group	March 2013	This action will be linked in with the existing Community redesign group and Integrated Care Network and will be taken forward through this forum.	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
	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.	17.3	Develop pathways between local services and acute services	Associate Director of Strategy and Whole systems working Associated Director for Integrated Care	Catherine Ashton Dr Hugh McIntyre	SoF Programme Board Senior operations group	March 2013	This action will be linked in with the existing Community redesign group and Integrated Care Network and will be taken forward through this forum.	A
18.	**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.	18.1	Consult with voluntary and community sector organisations to understand and address issues arising from services changes	Associate Director of Strategy and Whole systems working Deputy Chief Operating Officer	Catherine Ashton Jane Darling	SoF Programme Board Senior operations group	March 2013	A stakeholder event has agreed to continue with this advisory group during implementation of the clinical strategy and to agree ongoing engagement. Jointly lead by CCGs and ESHT	G
19.	A clear set of **quality indicators** should be agreed and monitored before, during and after implementation by Commissioners, ESHT and HOSC.	Develop agreed set of indicators to demonstrate:							
		19.1	patient experience	Director of Nursing. Lead Commissioner within PCT/ CCG	Alice Webster Jessica Britton	SoF Programme Board Senior operations group	March 2013	A table of benefits realisation has been prepared which includes patient	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								experience. ESHT have also developed a patient experience strategy and this will be lead by a clinical manager who provide regular updates	
		19.2	improvements in patient outcomes	Medical Director- Governance Lead Commissioner within PCT/ CCG	David Hughes Jessica Britton	SoF Programme Board Senior operations group	March 2013	A table of benefits realisation has been prepared which includes improvement in patient outcomes.	G
		19.3	financial benefits	Director Finance ESHT Director Finance Joint CCGs	Vanessa Harris John O'Sullivan	SoF Programme Board Senior operations group	June 2013	Finance Directors advised and they will be discussing and producing a paper on quality indicators. The development of the FBC will also describe financial benifits	A
20.	NHS Sussex should clearly set out arrangements for **accountability for decisions**	20.1	NHS Sussex to provide details of arrangements for accountability for	Chief Operation Officer EHS &	Amanda Philpott	SoF Programme Board	Jan 2013	Verbal update to Programme Board on 11th	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
	relating to the ongoing development or implementation of proposed changes after the abolition of Primary Care Trusts in March 2013.		decisions relating to the ongoing development or implementation of proposed changes after the abolition of Primary Care Trusts in March 2013.	H&R CCGs and Interim Accountable Officer EHS CCG		Senior operations group		Feb 2013. Statement to be circulated with minutes	

Appendix 3

HOSC Clinical Strategy Task Group

Report to HOSC meeting 21 March 2013

The Task Group has met twice since the last HOSC meeting on 13 December 2012. Below is a summary of key issues considered at each meeting.

8 February 2013
As this was the first meeting of the reconvened group the agenda comprised an overview of developments, issues arising and discussion of areas the Group wished to focus on in more detail. Key points discussed were:

- Timescale and process for developing the Full Business Case
- Governance arrangements for the implementation process
- Planning for implementation, including the role of Primary Access Point (PAP) implementation groups and the importance of providing certainty regarding implementation timescales as soon as possible, particularly for affected staff.
- Arrangements for monitoring the quality of services during transition and on an ongoing basis.
- Progress with delivering against HOSC recommendations and the importance of recommendations being delivered before, or alongside, implementation (as appropriate)
- Discussions underway between the Ambulance Service and commissioners regarding the impact of reconfiguration on ambulance capacity.

11 March 2013
This meeting focused on three specific areas

- **Communications** – the Task Group considered a draft implementation communications plan focused on ESHT staff and key stakeholders. It was noted that a separate communications plan would be developed to cover patients and public.
- **Benefits realisation** – The Task Group considered a draft set of quality/performance indicators for each of the PAPs. The intention is for these to be monitored before, during and after implementation in order to check that the anticipated benefits of change are being realised. The Group recommended the addition of further indicators of patient experience, potentially through patient feedback mechanisms which would enable concerns or issues to be identified and addressed during the transitional period and beyond.
- **Progress against HOSC recommendations** – the updated action plan was considered on an 'exception' basis. This will be a standing agenda item.

Cllr Rupert Simmons (Chairman)