Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**20 June 2013**
By:	**Assistant Chief Executive**
Title of report:	**East Sussex Healthcare NHS Trust Clinical Strategy**
Purpose of report:	**To consider progress towards implementing reconfiguration of the Trust's stroke, general surgery and orthopaedic services. To receive an update on implementation of temporary changes to maternity and paediatric services and to consider progress towards developing proposals for the long term future of these services.**

RECOMMENDATIONS

HOSC is recommended to:
1. request that the Clinical Strategy Task Group continues to provide close scrutiny of the implementation of reconfiguration in stroke, general surgery and orthopaedics;
2. request that the Task Group expands its role to incorporate oversight of the development of longer term proposals for maternity and paediatrics on the Committee's behalf; and
3. request a further progress report in September 2013.

1. Background – stroke, general surgery and orthopaedics

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'*:

- 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 undertook a detailed review of the proposals from July-October 2012 and prepared a report, including 20 recommendations, which was agreed by the Committee on 30 October 2012. The report is available from the HOSC website www.eastsussexhealth.org.

1.3 In November 2012 the Board of NHS Sussex (the Primary Care Trust cluster), as the then commissioner of services, decided that:

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

1.4 In December 2012 NHS Sussex and ESHT sought HOSC's support for the decisions. They also presented the NHS response to HOSC's 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.

1.5 In March 2013 HOSC received a report from ESHT on progress towards the implementation of the service changes and action against HOSC's recommendations. The Full Business Case (FBC), required to gain final approval for implementation of the plans, was in development, with the intention that it would be considered by the ESHT Board in June 2013. Implementation of the service changes was planned for autumn 2013.

2. Background – maternity and paediatrics

2.1 ESHT's Clinical Strategy incorporates a number of other Primary Access Points (PAPs) or service areas, two of which are maternity and paediatrics. These two services are very closely interlinked and the development of plans for both services was informed by a maternity review in 2011, undertaken as part of the wider Clinical Strategy development process. Following this

review, the Trust had reached the stage of having agreed preferred 'models of care' and having identified a range of potential delivery options, which include potential service reconfiguration.

2.2 Alongside the ESHT strategy development, a pan-Sussex project, 'Sussex Together' has been considering the provision of maternity and paediatric services across the entirety of Sussex (East, West and Brighton and Hove) over the past 18 months. Further development of the ESHT Clinical Strategy for these services has been on hold, pending the outcomes of this wider work.

2.3 On 8 March 2013, an extraordinary meeting of the ESHT Board was called to consider safety issues relating to the Trust's maternity and paediatric services. This followed a review of the services by the National Clinical Advisory Team (NCAT) on 4 January 2013. The NCAT review was carried out at the Trust's request due to concerns which had been raised internally. NCAT made specific recommendations to the Trust in their final report of February 2013, including a recommendation to consolidate some aspects of services onto one site as soon as possible.

2.4 The ESHT Board decided that consultant-led obstetric services, emergency gynaecology and inpatient paediatric services should be temporarily located only on the Conquest Hospital site, with a midwife-led unit for low risk births and a daytime paediatric assessment service retained at Eastbourne DGH. Other services including the Crowborough Birthing Unit, elective gynaecology, outpatient and community services are unaffected. Changes were implemented on 7th May 2013.

2.5 The ESHT Board also agreed that proposals for the long-term future of the services should be brought forward for consultation within 18 months from the date of the Board decision. The development and consultation process on long-term proposals will be led by the Clinical Commissioning Groups (CCGs) who took on commissioning responsibilities in April 2013.

2.6 NHS organisations are required under health scrutiny legislation to consult HOSC when considering a proposed 'substantial development or variation' of services unless *"they believe a decision has to be taken on an issue immediately because of a risk to the safety or welfare of patients or staff"*. HOSC was informed of the reasons why the temporary changes were considered necessary on urgent clinical safety grounds at its meeting on 21 March 2013. Any decisions on permanent changes to service configuration are subject to the usual consultation requirements.

3. Progress reports

3.1 A report from ESHT (**appendix 1**) outlines the work underway to implement the agreed reconfiguration of stroke, general surgery and orthopaedics. The report highlights a delay to the production of the FBC in order to meet requirements of the new NHS Trust Development Authority, the body now responsible (since April 2013) for overseeing NHS Trusts and agreeing their requests for capital funds. This delay will impact on how the service reconfiguration progresses. Annex 1 of appendix 1 provides a progress report against each of the HOSC recommendations.

3.2 A second report from ESHT (**appendix 2**) provides an update on the implementation of temporary changes to maternity and paediatric services.

3.3 A report from the CCGs (**appendix 3**) updates HOSC on the development of proposals for the long term future of maternity and paediatric services. This outlines the 'clinical consensus' which has recently emerged from the Sussex Together project, and plans for a pre-consultation engagement process to begin imminently.

3.4 Darren Grayson, Chief Executive, Dr Andy Slater, Medical Director (Strategy), Dr Amanda Harrison, Director of Strategy and Lindsey Stevens, Head of Midwifery from ESHT, plus Dr Martin Writer and Dr Matthew Jackson from Eastbourne, Hailsham and Seaford (EHS) CCG and Catherine Ashton, representing EHS and Hastings and Rother CCGs, will present the reports.

4. HOSC Task Group

4.1 In December 2012 HOSC agreed to reconvene its Clinical Strategy Task Group in order to provide additional scrutiny of the implementation of service reconfiguration. Since the last HOSC meeting the Group has met once, on 6 June. A short note outlining issues discussed is attached at **appendix 4**. It is recommended that the Group continues to meet regularly to scrutinise progress.

4.2 As the development of plans for the future of maternity and paediatric services is now entering a pre-consultation engagement phase, it is also recommended that the Task Group's remit expands to provide additional oversight of this process on HOSC's behalf.

SIMON HUGHES
Assistant Chief Executive

Contact Officer: Claire Lee
Tel No: 01273 481327

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 'Shaping our Future': implementation of the ESHT Clinical Strategy**
Date	**For consideration by HOSC on 20th June 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 and implementation of the wider Clinical Strategy** **To provide a progress report on response to the HOSC recommendations.**

1. Introduction

East Sussex Healthcare Trust's (ESHT) 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.

Throughout 2011 and 2012 ESHT, along with key stakeholders, 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 then NHS Sussex Board unanimously agreed to the creation of a specialist centre for stroke services on Eastbourne District General Hospital (EDGH) 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. Implementation Planning Update.

From January 2013 implementation 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, specifically in light of the non-delivery of commissioners' demand/activity reduction plans for 2012/13
- 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 Primary Access Points (PAPs) as well as the all other services run by the Trust

3. Progress of PAPs

All three reconfiguration PAPs, as well as the three other PAPs where service change will be delivered through redesign (Cardiology, Adult Acute Medicine and the Emergency Departments), have worked hard throughout the first part of this year to develop their implementation plans for their services, including working with other interdependent services to determine the full impact of the proposed changes. This work has formed the basis of the detailed implementation plans at an individual service level, as well as the overarching implementation planning needed to co-ordinate the whole operational picture for the Trust for the next two years. The plans are now in the final stages of development, meaning that the clinical services could now move into a delivery phase.

4. Corporate Workstream Development

Other supporting workstreams were established in January 2013, and the work from these workstreams has now been linked into the implementation plans at an individual service level. This includes such things as medical records, diagnostic imaging, housekeeping and porterage.

5. 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 as well as being a key member of the External Stakeholders Advisory Group.

6. Full Business Case Development

Since December 2012 the Trust has been working to develop the Full Business Case (FBC) for the reconfiguration of stroke, emergency and high risk general surgery and emergency and high risk orthopaedic surgery that supports the delivery of our Clinical Strategy. Work commenced on the development of the FBC as per the Treasury Green Book Guidance.

Because the Trust and local commissioners wanted to ensure that the public consultation leading to this decision considered all possible options, detailed site specific implementation plans and capital costing did not form part of the OBC. The decision to site stroke services at Eastbourne DGH and emergency and high risk general surgery and emergency and high risk orthopaedic

surgery at Conquest Hospital was not made until the consultation had concluded and the views gathered during the consultation could be considered as part of the decision making process.

Since the decision was made the Trust has been working on the detail of the capital scheme required to support the agreed service reconfigurations. In order to develop the FBC fully it is necessary for both the clinical and estates impact of the proposed changes to be understood. It was anticipated that the FBC would be submitted to the Trust Board on 5th June for the final internal approval of the service changes and their associated costs. This is required before the Trust makes an application for a capital loan.

However, the impact that changes in the NHS system would have on the process for access and allocation of capital were not anticipated in December when we began the process of FBC development. Following the publication of the NHS Trust Development Authority (TDA) Accountability Framework it is now clear that the capital loan application will need to be submitted to them for agreement. We are in the process of agreeing with the TDA the level of detail required to support this application and ensure that it can proceed as rapidly as possible.

Unfortunately this means that there is likely to be some delay in agreeing and delivering the capital scheme required to fully support the implementation of our reconfiguration plans. Therefore we are currently developing the options for delivering the required service change as rapidly as possible taking the above approval process into account. This includes consideration of options for phasing of service change and for temporary estates solutions that will allow us to deliver the service benefits from consolidation but do not require extensive capital development.

The Trust is determined that these service changes, which will bring clinical benefits to patients, are delivered as soon as possible but is not prepared to compromise on patient safety at any stage. We have been meeting with the clinical and nursing leads of these three services and others that are directly impacted by the proposed changes so that they are fully involved in the development of any short term options. This will allow us to determine the full implications for staff and patients and to ensure we can maintain the quality of services. We will need to consider the risks of each option and in particular we need to ensure that we are able to operate safely through the winter.

7. Updated HOSC Action Plan

This is attached at annex 1 for reference.

HOSC action plan – ESHT updated 06.06.13 Appendix 1, Annex 1

	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	Protocols agreed MONITOR POST IMPLEMENTION OF SERVCIE MOVE.	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 commence in Radiology (-10 mins)	G
		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%	G
		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 appraisal 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	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								procedures, should one 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	Associate Director Urgent Care/General manager Stroke Servcies	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	General manager Stroke Services	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 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.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	Associate Director urgent Care General Manager Strokes Services CCG leads	Senior Operations group via Community redesign and integrated network Board		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 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.	A
		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/ CCG	Flowie Georgiou	ASI 2	Ongoing	Ongoing review against Stroke improvement action plan through the quality and contracting 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.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	General Manager and Head of Nursin Stroke Servcies Deputy Director of Nursing ESHT E Sx. EOLC programme Manager	Medical Director for governance- chair end of life programme Board	Monitor and review 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 management. Lead commissioner has met with Stroke lead, this work will now be incorporated in the EOLC Programme Board worrstream.	A
		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	Ongoing with estates designs.	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.	G
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 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	G

	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 management and guidance for SECAmb crews.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								Initial meeting in February Secamb meeting with all clinical leads for Pathways sign May 2013	
		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 order to support improvement bed management, prior to implementation.	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-configuration in 2013, transitional escalation plan will need to be agreed across the Divisions and at Trust CME.	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		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 Deputy Chief Associate Directors. Operating Officer (Ops)	Senior Operations Group	Ongoing development through the implementation phases with the clinical Services,	DON overseeing discharge planning review. Though T&F group led by the ADNs.	A
		9.2	Develop information for patients & families	Deputy Director of Nursing	Chris Craven	Director of Nursing in short term task and finish group	Ongoing development through the implementation phases with the clinical Services,	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**	George Melling Commercial Director	Delivery Programme Board	Ongoing with estates design work and within the commercial Division.	Work has commenced. T&F group set up .by Assistant Director of Facilities 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**	Stuart Barnhill John Kirk	Delivery Programme Board	Ongoing	**1. ESHT Healthy Transport Group meets quarterly with reps from Borough/County Councils, Stagecoach, employers, staff, local pressure groups. Low level green travel issues – walking, cycle routes, public transport, incentives. NOT strategic.** **2. Good quality travel info on ESHT website – bus and rail links, Community Transport sites, Info boards on acute sites.** **Actions** **1. Seek agreement that ESHT resources are insufficient to**	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								scope and publish a 5 year strategy. **2. Engage service of a Transport Strategist** **3. Confirm likely demand – pt episodes, clinic numbers, catchment areas, travel distances/needs** **4. Review existing bus services across the EB/Bexhill and Hastings Boroughs** **5. Improve link with Stagecoach, Community Transport Operators and Southern Rail**	
		10.3	Working with community transport services and volunteer services to support access, particularly for the most vulnerable	**Assistant Commercial Director, Facilities**	Stuart Barnhill John Kirk	Delivery Programme Board	March 2013	**Current** **1. ESHT website has links to 16 Community Transport sites and networks.** **2. ESHT has 60 Volunteers Services registered – Age Concern, Help the Aged, various local village groups etc.**	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								Actions **1. Develop 5 year strategy to identify demand and to further develop the above** **2. Comms – further publicise community and volunteer services e.g. main reception HT events, include info on all pt correspondence, additional info boards, pc in main receps linking to travel operator sites for timetable info. Further develop ESHT website**	
		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 has reviewed implications for OP appointment modelling and how patients can access OP appointments at most convenient site.	G
		10.5	Review and where appropriate update the parking policy, including disabled parking	**Assistant Commercial Director, Facilities**	Mark Paice	Delivery Programme Board	March 2013	**1. Parking Policy is fit for purpose.** **Action** **1. Review as required with input from the Transport Strategist**	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		10.6	Staff travel, including the use of alternatives to the car	**Assistant Commercial Director, Facilities**	Mark Paice	Delivery Programme Board	March 2013	**Current** **1. Working HT Plan is sufficient – ¼ staff meetings, link to Occ Health (Fit 4 Work Life) Projects, car share packages, tax free cycle purchase, free cycle training, free cycle repairs, shop discounts, subsidised bus travel, cycle travel claims, enhanced cycle storage/shelters, roadshows/events.** **Actions** **1. Review HT plan in line with Transport Strategy** **2. Continue to promote staff incentives** **3. Continue to monitor travel movements by conducting 2 yearly ESCC Travel Surveys.**	G
		10.7	Access for those with mobility restrictions or other disabilities	Head of equality , diversity and human rights	Jourdain Duraiaj	Delivery Programme Board	March 2013	Access audits undertaken for both acute sites. Autumn 2012. To be reviewed in light of services changes. This is now agreed.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		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**	Stuart Barnhill John Kirk Comms Departments	Delivery Programme Board	Ongoing – refresh of publicity initiatives already in place.	Refresh publicity already done in previous years, especially on web site and on ESHT sites in clinical areas	A
		10.9	Maximising the access of visitors to patients	**Assistant Commercial Director, Facilities**	Stuart Barnhill John Kirk	Delivery Programme Board	March 2013	Embedded within any estates planning process in terms of parking, disabled access, dedicated parking spaces,	G
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**	Stuart Barnhill John Kirk	Delivery Programme Board	Working with transport plannr expert to scope study requirements	**Current** **1. Simple feasibility undertaken in 2010 for a Mon – Fri 0800 to 1630 service, not public holidays from EDGH via Bex to Conquest. Return every 2 hours. 35 seats, public use permitted, free for staff. £65k pa. Cost for a improved service likely to be around £250k p.a** **2. Car Parks – oversubscribed and full at peak times.**	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								Action **1. Confirm demand, pt episodes, clinics, volumes** **2. Scope likely tender with Transport Strategist and Procurement.** **3. Identify any acute land that can be converted to parking, subject to planning.**	
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	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		12.2	Increased use of volunteers to provide psychological and practical support to patients	Deputy Director of Nursing in short term task and finish group	Chris Craven	Senior Operations Group	March 2013	There is an ongoing programme of 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.	G
		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 space requirements on the two sites.	G
		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 are 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	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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.	G
		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 Clinicnas tasked Governing Body	March 2013	Planning impact of activity shifts has has commenced	A
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

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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 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.	16.1	Publish a timeline of planned developments in community health services	Chief operating Officer. Lead Commissioner within PCT/ CCG	Richard Sunley Flowie Georgiou Paula Smith	SoF Programme board	March 2013	This action will be linked in with the existing Community Redesign group and the Integrated Care Network annual workplan.	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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: a) the **impact of earlier discharge and reduced admissions**, in terms of impact on carers and increased reliance on means-tested social care. b) 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. c) the importance of clear **pathways** between local services, such as intermediate care and rehabilitation teams, and single sited acute services, if these are implemented.	17.1	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 the Integrated Care Network annual workplan.	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
		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

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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 CCG	Alice Webster Jessica Britton	SoF Programme Board Senior operations group	March 2013	A table of benefits realisation has been prepared which includes patient experience. ESHT have also developed a patient experience strategy and this will be lead by a clinical manager who provide regular updates	G
		19.2	improvements in patient outcomes	Medical Director- Governance Lead Commissioner within 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 benefits	A

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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.	20.1	NHS Sussex to provide details of 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.	Chief Operation Officer EHS & H&R CCGs and Interim Accountable Officer EHS CCG	Amanda Philpott	SoF Programme Board Senior operations group	Jan 2013	Verbal update to Programme Board on 11th Feb 2013. Statement to be circulated with minutes	G

Appendix 2

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 interim strategy for maternity and paediatrics**
Date	**For consideration by HOSC members on 20th June 2013**
Purpose and Timeframe	**To update progress made by ESHT with regard to the interim reconfiguration of maternity and paediatrics**

1. INTRODUCTION

1.1 Following the decision made by the Trust Board on 8th March 2013, to temporarily reconfigure maternity and paediatric services on the grounds of safety, an implementation programme was set up. Implementation plans were established with an intended 'go live' date of 7th May 2013. Planning involved internal and external engagement and scrutiny including from the Clinical Commissioning Groups, other local provider Trusts, South East Coast Ambulance service and others.

1.2 Detailed project plans were developed to cover estates and infrastructure changes, policy development, staff consultation and engagement and provision of information to local primary care clinicians and members of the public.

1.3 Plans are in place for the ongoing monitoring of the service and the report below details for each specialty the events that occurred to support the 'go live' and in the weeks following. Changes will be made to operational policy and procedure in response to outcomes from monitoring and any issues identified.

2. MATERNITY and NEONATES

2.1 **The move**

A robust time line for the move was developed and supported the changes over the weekend leading up to the 7th May. This included:

- Friday 3rd May - the consultants undertook a ward round to review every ante-natal inpatient to ensure they had an individual care plan that took account of the pending move
- Monday 6th May - removals of equipment from maternity, Special Care Baby Unit (SCBU) and children's ward commenced with three large removal vans. All midwifery managers worked to ensure that the removals did not impact on the clinical work and that Murray, the ante-natal ward and day care, were set up for the next day

- Monday 6th May from 19.30 all high risk admissions booked to Eastbourne District General Hospital (EDGH) were asked to attend the Conquest to ensure that they did not need to be transferred in labour
- Tuesday 7th May 07.15 operation of high risk consultant-led service at Conquest and midwifery led unit (MLU) at EDGH commenced
- There were no babies in SCBU so specialised neonatal transfer was not required

2.2 **New ward areas**

Changes made to support the reconfigured provision include:

- Frank Shaw ward is now postnatal and has 19 beds with a 5 bedded transitional care unit
- Murray ward is the new antenatal ward with 8 in patient beds, a 6 bedded induction of labour (IOL) bay and day care
- The total beds for maternity now total 32 but there is the ability to flex up using both the IOL bay and the day care in very busy times
- Murray ward has also been converted to provide the ante-natal clinics (re-located form Frank Shaw). This ensures a smooth management for all ante-natal women in their pathway.

2.3 **Activity**

2.3.1 Up to the 22nd May seven babies had been born on the MLU site and there have been two home births. All of the women have been very happy with the care they received and have made positive comments in the media and on social network sites. One mother describing the birth as the "best experience of her life."

2.3.2 The consultant-led unit has been busy. On the day of go live there were a total of 14 babies delivered over the 24 hours. Generally, we would expect between 9 and 10 babies a day. 50% of these were Eastbourne women all of whom were very happy with the care they received. Levels of activity have been as predicted and therefore higher than previously experienced by either unit. However there have been no incidents or issues in respect of patient care.

2.3.3 Staff working in the consultant-led unit at Conquest report that it 'feels' very different and particularly note that they are enjoying working in a busy vibrant area. Midwifery staffing has been good with good supervisory support from the minimum of two band 7 midwives on each day along with supervisory support from ward matrons.

2.3.4 The additional consultant presence (now at 72 hours) is very obvious with the consultant visible on the labour ward until 2100 hours. The doctor support is much improved with the Registrar always available and supported by a Senior House Officer (SHO).

2.3.5 There have been no Serious Incidents (SIs) since the move. The occurrence of a birth before arrival whilst the parents were travelling to the Conquest Hospital received wide publicity and has been subject to a full investigation. Lessons learnt from this event have been incorporated into operational practice. Whilst babies born before arrival or without assistance of a midwife (BBA) are not common they do happen. Last year 39 babies booked for delivery at the Trust were born either en-route to hospital or unplanned at home before the assistance of a midwife arrived.

2.3.6 Initial data from Brighton shows there has been some impact on activity. In April 2013 they delivered 7 women (all from Seaford). This compares with April 2012 when they delivered 2 women from the ESHT area (1 from Heathfield and 1 from Seaford). Up to the 15th May 2013 they had delivered 6 (1 from Eastbourne and 5 from Seaford). In May 2012 they delivered 2 women (both from Seaford). Arrangements are in place to continue monitoring any impact on services at Brighton.

2.3.7 There have been low levels of SCBU activity since the service changes. The transitional care unit opened on Monday 20th May with three babies cared for in this area to date. Transitional care offers extra support for babies who do not require full SCBU support but who need a little more care than can be given by midwives on the postnatal ward. This includes babies who require, for example, antibiotics, naso-gastric feeds or phototherapy. Having a transitional care bay will ensure that the 12 cots on SCBU are kept free for those babies who need more intensive nursing.

2.3.8 Arrangements are in place for neonatal checks to be undertaken within the Short Stay Paediatric Assessment Unit (SSPAU). The Trust is working towards training midwives to undertake these checks and is currently reviewing the training programmes available and the length of time required to complete them. Some of the EDGH consultant paediatricians have offered to support this training.

2.4 Plans for the future

2.4.1 Promotion of the Eastbourne Midwifery Led Unit

The Trust is seeking to ensure that the maternity services it provides meet the needs of local women in East Sussex. As part of this there are plans for the ongoing promotion of the MLU as a viable option for low risk mothers who live in the area and further afield, for example Hastings and Brighton women. Local community midwives are giving appropriate information to women on their options and are encouraging low risk women to come to the unit for a tour and to talk to the MLU midwives about the birth options available there. Open days are also being held for pregnant women and their families with the support of women who have used the service. In addition, one of the matrons from the Eastbourne MLU and the matron from Crowborough have had

an abstract accepted at the national annual birth conference in July. They will be presenting the work that was undertaken between the two sites to support a safe service change.

2.4.2 **Improvements to neonatal services**

Plans are in place to further develop the transitional care service by offering support in the community that will allow mothers and babies to be discharged earlier from SCBU. This service may also be able to support babies who are being discharged home from tertiary centres and prevent the need for them to be repatriated to the Conquest SCBU.

3. GYNAECOLOGY

3.1 Arrangements were put in place for all gynaecology emergencies requiring admission to be admitted to Mirrlees ward at the Conquest from the morning of 7th May.

3.2 A middle grade doctor supports the elective inpatient gynaecology service at EDGH and assesses emergency gynaecology referrals from A&E or GPs from 0830 – 2100 weekdays and from 0900 – 1300 at weekends. Outside of these hours cover for elective inpatients is provided by the urology SHO on-call from 1300 – 2100 at weekends and by the Hospital at Night team overnight.

3.3 **Activity**

From 7th May – 12th May there were 7 admissions and from 13th May – 19th May there were 11 admissions to Mirrlees from the Eastbourne area. There have been no serious incidents or concerns raised within gynaecology. On three occasions reviews of admissions and transfers have highlighted that alternative referral routes could have been used and updates to operational processes have been made to reflect this.

4. PAEDIATRICS

4.1 **The move**

4.1.1 In developing the operational policies that support the agreed service change the Trust sought external advice from Maidstone and Tunbridge Wells NHS Trust (MTW) and Brighton and Sussex University Hospitals Trust (BSUH), both of whom have been operating similar service configurations for paediatric services for some time. The operational policy was based on that currently used by MTW. Elements of the discussions that supported the development of the policy were facilitated by Dr Ryan Watkins, Consultant Paediatrician at BSUH and Clinical Lead for Paediatrics in Sussex. The draft policy was discussed and disseminated widely with comments being sought from a broad range of clinicians and managers. The consultant

paediatricians at EDGH participated in this process and have raised a number of issues that are being addressed as the policy and implementation plan are further developed. As would be expected, arrangements are in place for ongoing review and amendment of the policy in response to monitoring of its effectiveness in operation.

4.1.2 The policy makes specific provision to ensure that the transition from a two site inpatient paediatric service to a single site service is being managed safely including:

- Ensuring consultant on call rotas are appropriate. No change from the previous on call commitment is required and arrangements are in place to provide consultants who currently live more than the required travel distance from the Conquest site with accommodation when they are on call. This arrangement for on call accommodation is identical to that being adopted by the consultant obstetricians.
- When the SSPAU is open at EDGH it is supported by a middle grade and a consultant.
- Provision is in place for paediatric support for A&E at EDGH when the SSPAU is closed. Wherever possible this role is provided by a consultant/Certificate of Completion of Training (CCT) holder and in all cases since 'go live' on 7th May the doctor undertaking this role has been a specialist registrar as a minimum.
- Arrangements are in place for telephone handover when consultant job plans currently prevent them from being on site at the Conquest Hospital at the time of handover. Consultants have been invited to discuss a review of their job plans in order to move to ensuring consultant presence at handover.
- In common with MLUs across the country the operational principles and practices at the MLU on the EDGH site are the same as those for a home birth.

Women are advised on the risks of choosing to give birth in an MLU and are aware that clinical support other than that provided by the attending midwives will not be available. The MLU only accepts bookings from women considered to be low risk. Should complications occur for mother or baby during labour or after birth arrangements will be made to transfer the woman and/or baby to a consultant-led unit and/or an inpatient paediatric unit as appropriate. This will, in cases of a life threatening emergency, be via a 999 ambulance call. This policy is identical to that in operation at the Crowborough Birth Centre.

- In addition to the above, and in recognition of the fact that the MLU at EDGH is located within an acute hospital, it has been agreed that in those cases where the patient is in cardiac arrest or peri-arrest a call will be made to the hospital resuscitation team after a 999 call has been made. Provision has been made in the MLU for appropriate drugs and equipment to be available to support the resuscitation of a mother or neonate in this situation prior to ambulance arrival and transfer.

- The operational policy details arrangements for the safe transfer of children between sites. The Trust has purchased additional safety equipment to support transfer as this was not already available as standard in ambulances across the region. This equipment includes baby pods, pedimates and car seats and therefore provides for the safe transport of children of all ages and weights. The policy also supports clinical decision making on how a child requiring transfer between sites is transferred and who accompanies them. This may include transfer accompanied by a paramedic ambulance crew or a member of nursing staff. The policy also covers transfer to a tertiary centre where transfer is managed by the paediatric retrieval team who attend from the tertiary centre. The policy addresses situations where a doctor is required to support transfer arrangements, although experience shows that where a doctor is required this is usually for children requiring tertiary transfer and retrieval.
- The operational policy contains detail on the roles and responsibilities of the paediatric doctor in A&E. Direct supervision of this doctor is provided by the A&E lead consultant who is happy that the arrangements are robust. The doctor has access to the on call consultant at the Conquest for clinical advice.
- The Trust asked the Sussex Clinical Lead for Paediatrics to review the operational policy with respect to considering whether further action should be taken to address the concerns raised. His view was that the Trust's policy was appropriate and the actions taken were reasonable and proportionate. He noted that discussion on the detailed operation of the policy required the engagement and involvement of all consultants.
- As noted above there were no babies in SCBU at EDGH on 7th May. In addition none of the inpatients on Friston required transfer to Kipling and all being discharged from the ward within the operating hours of the SSPAU.

4.2 **Activity**

4.2.1 14 patients were admitted to the inpatient ward from the Eastbourne area in the first week of operation of the reconfigured service either via the SSPAU or direct GP referral (data is currently being collated for week two). The number of inpatient beds occupied at midnight since the 7th May has varied with 16 being the highest and four the lowest bed occupancy.

4.2.2 The number of patients attending the SSPAU at EDGH was 78 in the first week and 97 in the second. Of these 49 and 41 respectively attended for booked medical care, 7 and 16 attended for booked surgical care and 22 and 40 attended for emergency care following A&E or GP referral. The numbers of patients transferred between the SSPAU and an inpatient ward was 6 in the first week and 7 in the second.

4.2.3 In A&E the paediatric middle grade doctor who is present overnight has had very few children to review but has ensured that they involve the A&E staff in reviewing the children to aid in increasing their awareness and skills.

4.2.4 There have been no serious incidents, incidents resulting in harm or near misses in either paediatric service since 7th May. There have been some events that have required careful review and discussion to ensure the operational policy is being correctly applied with respect to specific individual clinical needs and circumstances. These include:

- One baby brought appropriately to A&E at EDGH for rapid stabilisation before being admitted to the SSPAU for observation. It was agreed following a period of observation that the baby should be admitted to the Conquest Hospital. The baby was transferred via a paramedic ambulance accompanied by the mother, the ambulance crew and a nurse. Following discussion between consultant paediatricians it was agreed that a doctor was not required to support the transfer although one was available had they been needed.

- Two children requiring isolation for an infectious disease were taken to Worthing Hospital because there were no isolation cubicles available at either the Conquest Hospital or BSUH. The decision where to take these children was made using standard operational policies that predate any change in configuration. The number of isolation cubicles available has been reduced through this change from eight to four with five to be available once building works complete next month. Work is underway to ensure that cubicles are utilised effectively and that options for cohorting are taken where appropriate. Although the previous usage of isolation cubicles was analysed in order to inform the number of cubicles provided post reconfiguration, demand for cubicles has always been unpredictable. Therefore, policies and procedures that enable Trusts to manage demand and clinical requirements across the system in this way have always been required and utilised regardless of configuration.

- Monitoring has also identified the requirement to change the operational policy from that in place on the 7th May in one respect. The policy had required all responses to 999 calls that resulted in the conveyance of a child to take the child directly to the Conquest Hospital unless there was considered to be an immediate life threatening emergency when the child would be taken to EDGH A&E or to Brighton. Following the transfer of a child with a minor injury (a cut finger requiring one stitch) the policy has been amended to ensure children with minor injuries are treated as locally as possible.

4.3 **Plans for the future**

The ward currently has 21 beds (including 9 cubicles) with the ability to expand to 27 by utilising the current SSPAU space. Building work is due to commence in about 2 weeks time to double the size of the SSPAU and provide an additional cubicle for isolation of emergency attendees, this will ensure that if the 27 beds are required SSPAU activity is not affected.

5.0 CONCLUSION

Provision of a single site option for high risk obstetrics, inpatient paediatrics, the Special Care Baby Unit (SCBU) and emergency gynaecology has ensured the Trust is able to address the risks to safety that were present in the previous configuration and offer a safer service to women, patients and children and their families.

Increased consultant presence, and therefore supervision of junior doctors, and increased band 7 midwife presence to supervise junior midwives are now in place. This will support actions to address common themes identified from Serious Incidents (SIs) that occurred prior to the temporary reconfiguration, including of lack of supervision and poor communication.

Appendix 3

Title of report	Developing options for sustainable maternity and paediatric services in East Sussex
Purpose	To provide the East Sussex HOSC with an update on progress and timescales for the next steps of the Sussex-wide review, and the development of sustainable maternity and paediatric services in East Sussex
Authors	Catherine Ashton, Associate Director of Strategy and Whole Systems EHS and H&R CCG and Caroline Huff, Clinical lead, Sussex Collaborative Delivery Team.
Date	For discussion at the East Sussex Health overview and scrutiny Committee on 20th June 2013

1. Summary

Since April 2012 the clinical leaders from across Sussex, supported by the Sussex Collaborative Delivery Team (SCDT), have developed two Clinical Reference Groups; Children and Young People, and Maternity and Newborn. These groups examined the evidence base for the services that are provided and then undertook a gap analysis (examining the gaps between what is currently being provided and the clinical consensus). This will enable a consistent review which will then inform a strategy for the development of those services across Sussex.

The clinical case for change which has been developed by the Clinical Reference Groups will be published by the end of June 2013. The Clinical Commissioning Groups (CCGs) in East Sussex will then launch a period of local public engagement, so that people are able to discuss and understand the case for change, reflect on what this means for local women and children and can inform models of care and potential delivery options. If the delivery options signal significant change then we would expect to undertake public consultation in the autumn of 2013.

The process and timescales for developing the case for change were agreed and supported by all Trusts and CCGs including East Sussex Healthcare Trust (ESHT) and the three East Sussex CCGs (PCTs prior to April 2013) in April 2012.

The requirement for a temporary reconfiguration of maternity and paediatric services on the grounds of safety, made by ESHT in March 2013 and implemented in May 2013, has not impacted on these agreed timescales, but they have brought a clear focus on the need to find sustainable service models in East Sussex within the next 18 months. The clinical consensus and case for change, which has been developed over the past year, will enable us to build upon a solid foundation in the wider engagement with the public and stakeholders in the coming months.

2. Developing the clinical consensus and evidence base.

Clinicians from ESHT, Western Sussex Hospitals NHS Trust (WSHT), Brighton and Sussex University Hospitals NHS Trust (BSUH), Surrey and Sussex NHS Trust (SASH), Sussex Partnership Foundation Trust (SPFT), Sussex Community NHS Trust (SCT) and the Clinical leads from the Sussex CCGs were involved in the review and reached consensus on the evidence base in March 2013 with agreed sign off by Trust and CCG Leads in May 2013.

The Maternity Services Liaison Committees (MSLC) were involved in discussing the clinical consensus and, in addition, a project was completed on reviewing the views of service users from recent Trust surveys as well as conducting semi-structured interviews with service users. These findings were incorporated into the consensus.

3. Key Findings of the Maternity and Newborn Clinical Reference Group

The Sussex CCGs, Surrey and Sussex Area Team and Sussex Trusts, along with East Sussex County Council joint maternity and paediatric commissioners met on 22nd May 2013 to review the key findings of the gap analysis and agree the next steps in gaining agreement on strategic direction.

The key messages presented by the Maternity and Newborn Clinical Reference Group were that the case for change supports what clinicians and commissioners in East Sussex have been saying: there is a pressing need to change maternity services at East Sussex Healthcare Trust (ESHT), ensuring that the impact on paediatric services, other critical co-dependent clinical services and co-dependent organisations (BSUH, WSHT and SASH) are considered in the process. We need to continuously review the standards of care across Sussex as maternity services respond and adapt to new pressures, particularly the impact of service changes from within and outside Sussex (e.g. the possible reconfiguration of services in Epsom). Key areas that evidence the case for change in East Sussex include:

3.1 Numbers of births

There is a threshold of 2500 births, below which the sustainability of the service should be scrutinised more closely due to the additional challenges of maintaining safety and quality. The most efficient sized unit is in the region of 4000 – 5000 births per year. Above this threshold the workload and frequency of obstetric emergencies are sufficiently high to require the service to be equipped and staffed to deal with

concurrent emergencies. This includes the ability to simultaneously run two obstetric operating theatres, which requires employing an additional team of obstetric, theatre and anaesthetic staff. The incremental rise in medical staff required to maintain quality and safety in large units should be considered when assessing the sustainability of services strategically. The services below 2500 births per year were at Princess Royal Hospital, Eastbourne District General Hospital and the Conquest Hospital.

Table1: numbers of births 2011/12 by Trust and site

WSHT- St Richards	2771
WSHT- Worthing	2851
BSUH- Royal Sussex County Hospital	3587
BSUH- Princess Royal	2422
SASH-East Surrey Hospital	4465
ESHT- Eastbourne DGH	1949
ESHT- Conquest Hospital	1804
ESHT-Crowborough Birth Centre	243

3.2 Recruitment of staff

Although all Trusts had difficulties recruiting middle grade staff, ESHT had experienced particular difficulties and low trainee numbers. All Trusts were meeting the required consultant presence on the labour ward hours. No Trusts were achieving the pledge of 1:1 care in labour. ESHT were the only Trust to achieve the expected mother: midwife ratio but reported difficulties in temporary recruitment of midwives to back-fill maternity absence. Heavy use of bank staff at the Conquest (150 hours/month) and Crowborough (80 hours/month) was also reported.

3.3 Serious Incidents

ESHT had significantly more Serious Incidents in 2012-13 than other providers in Sussex

Table 2: serious incidents by Trust 2012/13

WSHT	3
BSUH	4
SASH	2
ESHT	16

3.4 Internal diverts and closures due to insufficient staff and no beds in 2012/13

Maternal transfers are a key indicator on the Trust dashboard with a goal of 0 transfers. They usually occur if the unit has no capability to provide the necessary care for the mother or child if complications occur. ESHT had the highest number of maternal transfers in Sussex.

Table3: Closures, Diverts and maternal transfers by Trust 2012/13

	Closures	Diverts	Maternal transfers to another hospital
WSHT	0	50	9
BSUH	9	63	5
SASH	3	0 (no internal divert option)	n/a
ESHT	1	57	36

4. Key Findings of the Children and Young People Clinical reference Group.

The key messages presented by the Children and Young People Clinical Reference Group were that there are significant opportunities to improve services provided to children at home, school or in the community and reduce their dependence on hospital services for acute care. This will require increasing the confidence, knowledge and experience of GPs, increased access to community children's nursing and the design and implementation of integrated care pathways, personalised care plans and family education. In return, this will reduce hospital based activity and encourage reconfiguration, thereby also addressing current and future workforce challenges and the need to develop centres of excellence.

A Sussex-wide collaboration is needed to guide this process and the establishment of networked primary care, community children's services, Short Stay Paediatric Assessment Units, children's A&E services and inpatient paediatrics. The case for change for Sussex children's acute services at this time would be to meet Royal College of Paediatrics and Child Health (RCPCH) standards and address the medical workforce challenge, or to reflect the critical co-dependency of neonatal care with any proposed changes to maternity services. It was suggested that greater collaboration is needed between primary and secondary care on the development of services.

The gap analysis showed variable access to children's nursing services, variable access to specialist advice for GPs and GPs experience and knowledge base of acute paediatrics, lack of consistent pathways, anomalies in data collection hampering scrutiny and variation in meeting Royal College Standards.

5. Actions to deliver sustainable maternity and paediatric services

- The Sussex Collaborative Delivery Team will support the rapid development of a set of core standards for maternity and paediatrics based on the clinical consensus and services across Sussex will be commissioned against these.
- The pace of change will be different across Sussex, but it was agreed, for the reasons mentioned earlier, that all organisations involved in the Clinical Reference Groups will support East Sussex CCGs as the pioneers for this work.

- The engagement process has already begun, with independent research with service users conducted for the clinical and service users' consensus, along with initial discussions with key stakeholders on the engagement plan. CCGs will ensure that local people are able to discuss and understand the case for change and can inform models of care and potential delivery options; this will involve target work with those people who will be impacted by service change or who have recent experience of the services.

.

Catherine Ashton
Associate Director of Strategy & Whole System Working
Eastbourne, Hailsham & Seaford and Hastings & Rother CCGs
June 2013

HOSC Clinical Strategy Task Group

Report to HOSC meeting 20 June 2013
The Task Group has met once since the last HOSC meeting on 21 March 2013. Below is a summary of the two key issues considered at the meeting.

Implementation update
The key issue considered by the Task Group was the delay to production of the Full Business Case (FBC) and the likely knock on effect on the timetable for service moves. The Group raised a number of issues and suggested that HOSC may wish to explore these further with senior Trust representatives at the meeting on 20 June. Key issues were:

- The NHS Trust Development Authority's increased requirements for FBCs, whether these could have been anticipated and how they differ from the previous regime under the Strategic Health Authority.
- Potential options for interim/temporary delivery of service change without access to the full capital funds and how these would differ from original plans.
- The level of capital funding needed for these specific changes, whether this differs from earlier estimates, and potential sources of funding.
- How any delays to service change will be communicated to the public and how this may be interpreted.
- Communications to staff within the affected services, and whether prolonged uncertainty could create instability.
- The impact of any delay on achieving planned quality improvements.

Community Services
HOSC had requested that the Task Group examine progress with the development of community services in more detail. This relates to HOSC recommendation 17 which highlighted the importance of these services in supporting the strategy for acute services, and the need for public confidence in the development of community services.

The group received a presentation from Adult Social Care and ESHT which outlined how integrated community services are being developed, what has already been achieved and what is planned. The work is being led by the multi-agency Integrated Care Network and Urgent Care Network.

Representatives stressed that the shift from acute to community services, and the integration of health and social care, is a long term journey on which progress has been made, but there is a long way to go. The need to increase the scale and pace of change was also highlighted.

The Task Group agreed to return to this issue and request a progress report in 6 months time.