Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**12 September 2013**
By:	**Assistant Chief Executive**
Title of report:	**East Sussex Healthcare NHS Trust Clinical Strategy**
Purpose of report:	**To consider progress with implementing reconfiguration of the Trust's stroke, general surgery and orthopaedic services.**

RECOMMENDATIONS

HOSC is recommended to:
1. request that the Clinical Strategy Task Group continues to provide close scrutiny of reconfiguration of stroke, general surgery and orthopaedics;
2. request a further progress report in November 2013.

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'*:

- 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 access to capital funding to support 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.

1.6 In June 2013 HOSC received a further progress report from ESHT which advised the Committee of a delay to the production of the FBC in order to meet additional requirements of the new NHS Trust Development Authority, the body responsible (since April 2013) for overseeing NHS Trusts and agreeing their requests for capital funds. This delay was expected to impact on how the service reconfiguration progressed.

2. Progress reports

2.1 A report from ESHT (**appendix 1**) outlines progress since June towards implementing the agreed reconfiguration of stroke, general surgery and orthopaedics.

2.2 The report highlights progress in developing the FBC since June and the intention for it to be considered by the Trust Board later in September 2013, prior to consideration by the NHS Trust Development Authority.

2.3 The report also outlines the current state of play with each of the three services. In summary:

- Stroke services have been centralised at Eastbourne DGH since 22 July 2013. The desired accommodation and layout will, however, not be fully achieved as planned until full capital funding is available. Further staff recruitment is also necessary to fully deliver the planned service model.
- Plans to centralise the relevant aspects of general surgery at the Conquest Hospital are at an advanced stage with the move expected to take place in November 2013. Again, the accommodation, supporting facilities and layout will require further work when capital funds become available in order to fully deliver the planned service model.
- The centralisation of emergency and higher risk elective orthopaedic services at the Conquest Hospital will be delayed until 2014, after the release of capital funding.

2.4 Annex 1 of appendix 1 provides a progress report against each of the HOSC recommendations.

2.5 Darren Grayson, Chief Executive, Stuart Welling, Chairman and Dr Andy Slater, Medical Director (Strategy) from ESHT will present the report to HOSC. Amanda Philpott, Acting Accountable Officer/Chief Operating Officer, Eastbourne, Hailsham and Seaford/Hastings and Rother Clinical Commissioning Groups (CCGs) will also be in attendance from a commissioner perspective. Amanda chairs the Shaping our Future Programme Board, the partnership group which oversees the Clinical Strategy implementation.

3. HOSC Task Group

3.1 HOSC's Clinical Strategy Task Group provides additional scrutiny of the implementation of service reconfiguration and delivery of action against HOSC's recommendations. Since the last HOSC meeting the Group has met twice, on 25 July and 6 September. The Task Group has particularly focused on the new arrangements for stroke care and on how HOSC's recommendations with regard to transport and access have been taken forward. It is recommended that the Task Group continues to meet regularly to scrutinise progress.

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East Sussex Healthcare NHS
NHS Trust

Appendix 1

To	**East Sussex Health Overview and Scrutiny Committee**
From	**East Sussex Healthcare NHS Trust**
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 12th September 2013**
Purpose	**To outline the progress made by East Sussex Healthcare Trust (ESHT) with regard to the proposed reconfiguration of stroke, general surgery and orthopaedic services in East Sussex To provide response to the recommendations made by East Sussex HOSC on 'Shaping our Future'**

1. Introduction

ESHT'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.

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 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. Implementation Planning Update.

Stroke Services

Stroke services were reconfigured on the 22nd July 2013. From this point, the hyper acute and acute unit have been based at the Eastbourne District General Hospital (EDGH), and the Bexhill Irvine Unit stroke rehabilitation beds increased from 12 to 18. The Egerton Stroke Unit at the Conquest continued to care for patients until the first week in August, at which point all patients from that unit had been discharged or transferred.

Staffing of the Eastbourne unit is now robust, with some staff transferring from Conquest to EDGH and others being recruited into vacant posts.

An immediate priority has been to improve the therapy inputs to stroke patients, and provide an improved five day stroke therapy service. This required current staffing vacancies at both EDGH and Bexhill to be filled with locum staff whilst recruitment is underway into vacancies. The Trust is moving towards a seven day service for therapy, and this is included in the Full Business Case for the Clinical Strategy,

The Trust is continuing to advertise for suitable stroke consultants to deliver the required level of substantive consultant cover. Interim measures utilising existing consultant staff from Care of the Elderly services remain in place pending the appointment of the new consultants.

The Trust has concentrated on improving the skill-mix of the nursing staff with stroke competencies, and a 24 hour stroke specialist nurse rota is in place to support the Emergency Department and receive patients on their arrival. South East Coast Ambulance Service provides advance notice of the conveyance of patients who are FAST positive and the proactive approach that is now taken to the management of these patients from their arrival at the hospital is having positive benefits..

The monthly data demonstrates that there is an average of 24-26 stroke admissions a week with an approx 50/50 spilt of patients from Eastbourne and Hastings area. This is as anticipated.

Since the 22nd July there has been a total of four patients from Hastings and Rother area who have been taken to the William Harvey Hospital in Ashford, Kent following a stroke. All these patients have been repatriated back to ESHT following agreed clinical protocols and pathways.

The Accelerating Stroke Improvement Measures (ASI) data for the month of July (latest validated data) shows improvements:-

- 90% of a patient's stay is in a dedicated stoke unit –
  achieving 89.7% against a target of 80%

- Direct admission to a stroke unit
  achieving 80% against a target of 90% - an increase of 5% on the previous month.

- Access to brain imaging in 24 hours
  achieving 100% against a target of 100%

- Access to brain imaging within 1 hour
  achieving over 50% against a target of 50%.

ASI Performance Overview

Monthly Performance

		M01	M02	M03	M04
ASI Type	Target	Apr	May	Jun	Jul
ASI 1: Preventable Stroke	**60%**				
ASI 2: Direct Admission to Stroke Unit	**90%**	65.1%	69.2%	75.9%	81.0%
ASI 3: 90% Acute Stroke Care (ESHT)	**80%**	61.1%	76.3%	86.8%	89.7%
ASI 3b: 90% Acute Stroke Care (Vital Signs)	**80%**	61.2%	76.6%	87.1%	89.1%
ASI 4a: Access to Brain Imaging (1H)	**50%**	42.9%	59.4%	61.8%	52.5%
ASI 4b: Access to Brain Imaging (24H)	**100%**	95.2%	100.0%	98.2%	100.0%
ASI 5: High Risk TIA	**60%**	71.4%	80.0%	82.8%	67.4%
ASI 9: Access to and availability of ESD (Early Supported Discharge) Services	**40%**	23.3%	19.0%	22.0%	18.0%

ASI 9: Access to Early Supported Discharge Services. This has shown a dip in July and the full reasons for this are being investigated. A full review of the service reconfiguration will be undertaken after three months, with a focus on the patient experience and performance against the ASIs.

3. Progress of other Primary Access Points (PAPs)

Detailed planning is now underway to reconfigure general surgical activity within the Trust, with the emergency and high risk general surgical activity being delivered from the Conquest Hospital from the autumn of this year. Low risk elective in patient surgery will continue to be provided at the Eastbourne site, along with surgical outpatient services for the local population. Upgraded Interventional Radiology equipment must be available at the Conquest before the surgical services can reconfigure, and the installation of this equipment is part of the detailed project plan. At the point that emergency general surgical activity moves to the Conquest site, the Trust will have only one Trauma Unit, which will be at the Conquest Hospital. This is in line with the Trauma Network requirements.

Planning for the move of emergency and high risk orthopaedic activity will commence in the New Year, but it is not anticipated that this service will

actually be reconfigured until summer 2014. This is so that the Trust can maintain sufficient inpatient capacity over the peak winter period, and not have that capacity disrupted by ward moves and building work. The three East Sussex CCGs are aware of the planned timescale and are supportive of the need to maintain the winter capacity within the acute hospitals.

4. 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 Clinical Strategy Delivery Group, overseeing implementation planning

5. Full Business Case (FBC) Development

The Trust Board will receive the Full Business Case to support the capital loan application for the estates developments required to support the implementation of the Clinical Strategy on September 25th.

It is anticipated that submission of the FBC to the NHS Trust Development Authority (TDA) will follow on immediately from that Trust Board.

The Trust has been linking closely with the TDA in the last two months to ensure the FBC is developed in line with the latest guidance.

Underpinning the FBC development are detailed plans for the estates reconfigurations that will see the PAP clinical services and related support services developed into their permanent locations on the two acute sites.

6. Updated Action Plan

This is attached for reference at annex 1.

HOSC action plan – ESHT updated 28.08.13 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.	• Service move complete. Review at three months	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	G
		1.3	Agree contingency plans when scanner out of use	Associate Director for Integrated Care	Paula Smith/Ian Bourns	ESHT Senior Operational Group	Scanner on site August	Second scanner installation in track	G
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		Seven day working is already in the therapies redesign plan, Recruitment is now underway for outstanding therapy posts and the FBC completes the investment picture for all therapy requirements.	G

HOSC Action Plan – Stroke Services
Jane Darling- Strategy Implementation ESHT

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		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)	G
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	CCG leads	Ashley Scarfe HWLH CCG	Urgent and Integrated Care Programme Boards.	April 2014	Work is progressing by Commissioning to determine the local service specification and delivery solutions that will enable improved rehabilitation care, including early supported discharge, for HWLH stroke patients WHO are discharged from hospitals outside of East Sussex. Direct dialogue with those acute providers is on-going. Rehab demand and response monitoring in place through ICAP.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		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,	G
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 Nursing Stroke Services Deputy Director of Nursing ESHT E Sx. EOLC programme Manager	Medical Director for governance-chair end of life programme Board	Ongoing reviews through EOLC programme Board.	ESHT EOLC group to monitor the specifics. 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 workstream.	G
		4.2	Review facilities and support for families visiting	Head of Nursing for Stroke	Lucy Scragg	Deputy Director of Nursing to support if required.	Ongoing with estates designs for consolidated unit at EDGH.	Accommodation schedules for all estates designs to take account of likely visitor, family, carer requirements.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	Sandra Field Lucy Scragg	Senior operations group	Pathway Complete		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	October 2013	General Surgery management team meeting with SECAmb regional Operational lead to agree pathway management and guidance for SECAmb crews. Initial meeting in February SECamb meeting with all clinical leads for	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								Pathway sign off 3rd April. More detailed work being undertaken through September/October 2013 as detailed reconfiguration plans are developed for GS service moves.	
		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	October 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	Reviewed and completed September 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	Reviewed September 2013	As above	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	COO	Pauline Butterworth, Deputy COO, Operational planning.	Senior Operations Group And CME	At point of service moves.	Winter planning for East Sussex and ESHT is underway, and escalation plans will reflect the service changes.	G
		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	COO	Pauline Butterworth/Andrew Leonard	Senior Operations Group And CME	Summer 2014 to agree final accommodation changes in the EDs and Acute medical Assessment areas.	Ongoing implementation of model of care and revision of accommodation as described in the FBC.	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 – should be under regular review as part of normal business	Travel information to be available on the wards with staff signposting patients and carers to relevant information and support.	G
		9.2	Develop information for patients & families	Deputy Director of Nursing	Chris Craven	Director of Nursing in short term task and finish group	Ongoing – should be under regular review as part of normal business g	As above, and linked to the review of transport information being undertaken.	G

	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.	Access group established which will have patient and public representatives. Construction phases are required to consider impact on access for patients and public at a site level, and forms part of normal estate planning process.	G
		10.2	Working with transport planners to maximise public transport access	**Assistant Commercial Director, Facilities**	Stuart Barnhill John Kirk	Delivery Programme Board	ONGOING	**ESHT Healthy** Current 1. ESHT Healthy Transport Group meets quarterly with reps from Borough/County Councils, Stagecoach, employers, staff, local pressure groups. Remit is to influence and support staff travel Low level green travel issues – walking, cycle routes, public transport, incentives. NOT strategic. 2. ESHT website – all pages have been revised and changes continue to be made. Improved information relates to bus and rail links, Community Transport sites, Cycling and Walking, Voluntary Transport Services.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
								3. A poster/leaflet has been created, based on the above and will go for printing and circulation across the region. 4. Travel Advisor/Consultant engaged to provide strategic advice and marketing/communications support. Strategic communications plan should include: • Multi faceted approach • Identifying channels • Partnership working with operators • Improved website functionality and content • Targeted communications and promotional material • Training	
		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	ONGOING	Patient Travel and Access Group met at the Conquest Hospital, involved stakeholders and it was agreed that there is a need for this group to engage a wider groups of stakeholders – operators, patient groups, clinical reps, voluntary and community groups. The group should represent the whole county and have a focussed and challenging remit so that external groups feel that they are fully valued and engaged.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		10.4	Making appointment systems more flexible and offering greater choice	General manger for Outpatients	Maureen Blunden	Senior Operations Group	COMPLETED	Planning has been undertaken	G
		10.5	Review and where appropriate update the parking policy, including disabled parking	**Assistant Commercial Director, Facilities**	Mark Paice	Delivery Programme Board	COMPLETED	1. Parking Policy is fit for purpose. Action 1. Review as required with input from the Transport Strategist	G
		10.6	Staff travel, including the use of alternatives to the car	**Assistant Commercial Director, Facilities**	Mark Paice	Delivery Programme Board	ONGOING	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. Review HT plan in line with Transport Strategy Continue to promote staff incentives Continue to monitor travel movements by conducting 2 yearly ESCC Travel Surveys.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		10.7	Access for those with mobility restrictions or other disabilities	Head of equality , diversity and human rights	Jourdain Duraiaj	Delivery Programme Board	ONGOING	Access audits undertaken for both acute sites. Autumn 2012. To be reviewed in light of services changes. This is now agreed.	G
		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 publicity already done in previous years, especially on web site and on ESHT sites in clinical areas	G
		10.9	Maximising the access of visitors to patients	**Assistant Commercial Director, Facilities**	Stuart Barnhill John Kirk	Delivery Programme Board	ONGOING	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 planner 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	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	COMPLETED	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
		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	COMPLETED	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	COMPLETED	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

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		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	COMPLETED	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
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	2013/14	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	2013/14	Planning impact of activity shifts has commenced	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	Clinical leaders Group being established which will sit within the ESHT governance structure. This grouping with encompass Clinical Leaders from across the Trust to give the clinicians a clear role in the Trust planning and decision making	G
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.	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

HOSC Action Plan – Crosscutting Issues
Jane Darling- on behalf ESHT Programme Delivery Board.

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
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	ICN ANNUAL WORKPLAN 2013/14	This action will be linked in with the existing Community Redesign group and the Integrated Care Network annual workplan.	G
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:	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	ICN ANNUAL WORKPLAN 2013/14	Integrated Care Network annual workplan.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
	- the **impact of earlier discharge and reduced admissions**, in terms of impact on carers and increased reliance on means-tested social care. - the **need for additional support** for more vulnerable residents and those in more deprived areas, as these groups are less likely to have access to support networks and resources to support their care. - the importance of clear **pathways** between local services, such as intermediate care and rehabilitation teams, and single sited acute services, if these are implemented.	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	ICN ANNUAL WORKPLAN 2013/14	Integrated Care Network and Programme Board.	G
		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	ICN ANNUAL WORKPLAN 2013/14	Integrated Care Network and Programme Board	G

	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	ONGOING ENGAGEMENT	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	COMPLETED	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 Now included in FBC and submissions to TDA.	G
		19.2	improvements in patient outcomes	Medical Director- Governance Lead Commissioner within PCT/ CCG	David Hughes Jessica Britton	SoF Programme Board Senior operations group	CVOMPLETED	A table of benefits realisation has been prepared which includes improvement in patient outcomes. Now included in FBC and submissions to TDA.	G

	Recommendation		Action required	Lead	In Post	Monitored by	Timescale	Update	Rag rating
		19.3	financial benefits	Director Finance ESHT Director Finance Joint CCGs	Vanessa Harris John O'Sullivan	SoF Programme Board Senior operations group	September 2013	Now included in FBC and submissions to TDA.	G
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	COMPLETED	Verbal update to Programme Board on 11th Feb 2013. Statement to be circulated with minutes	G