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

Date: **18 September 2014**

By: **Assistant Chief Executive**

Title of report: **'Shaping our Future' – East Sussex Healthcare Trust (ESHT) Clinical Strategy update**

Purpose of report: **To consider an update on the reconfiguration of the Trust's stroke, general surgery and orthopaedic services.**

RECOMMENDATIONS

HOSC is recommended to consider the Trust's progress with regard to the reconfiguration of these services.

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 undertook a detailed review of the proposals from July to 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 £30m in capital funding to support implementation of the reconfiguration plans and the wider Clinical Strategy, 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 (TDA), 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.

1.7 In September 2013 the Trust advised HOSC that the FBC would be considered by the Trust Board in October and, subject to approval, would then be considered by the TDA Board in early 2014. The Trust had made interim service change arrangements for the acute stroke service, which was centralised at Eastbourne Hospital in July 2013. Interim plans to consolidate general surgery services at the Conquest Hospital were in development, with a view to moving services by December 2013. The Trust indicated that the move of orthopaedic services would not take place until 2014, as it would await the outcome of the FBC process.

2. Progress reports

2.1 ESHT's general surgery services were reconfigured as planned in December 2013. The following updates are appended to this report:

- Appendix 1 is a post-implementation review conducted by the Trust following the consolidation of emergency and higher risk elective general surgery onto the Conquest Hospital site. This presents the opportunity to review the extent to which the anticipated benefits of change have been delivered.
- Appendix 2 provides an overview of the Trust's current performance against key indicators on stroke services.
- Appendix 3 is an action plan showing progress against HOSC's recommendations for stroke, general surgery and orthopaedics.

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East Sussex Healthcare NHS
NHS Trust

EMERGENCY AND HIGHER RISK GENERAL SURGERY

POST IMPLEMENTATION REVIEW

1 INTRODUCTION

In December 2013 the Trust reconfigured emergency and higher risk surgery services by centralising these services at the Conquest Hospital. Lower risk General Surgery provision has continued at EDGH acute site, Eastbourne DSU and Uckfield Hospital.

This transfer was informed by the Trust's Clinical Strategy (2012) that proposed changes to the delivery of acute stroke, higher risk and emergency general surgery and higher risk orthopaedic surgery. The strategy document articulated the drivers behind the surgery reconfiguration, namely the need to reduce on the day cancellations; to address the lack of specialist care of elderly patients, and to provide better access to emergency care.

The service reconfiguration would meet these objectives via the following:

- An optimal assessment model of care with senior decision makers present across the whole week increasing the level of ambulatory and short stay activity that would provide better patient outcomes;
- More efficient use of staffing and bed utilisation;
- Separate emergency and elective theatre lists that would allow the Clinical Unit to balance emergency and elective capacity with Consultant availability and within the current bed stock configuration.

The reconfiguration was completed over the weekend of 14th / 15th December and the new service commenced at the Conquest Hospital on 16th December. At the same time, the new Interventional Radiology suite at the Conquest was commissioned providing a new, state of the art facility.

The benefits gained following the transfer of General Surgery included:

- Sustainable consultant rota;
- Reduced trained nurse vacancies;
- 7-day senior medical cover;
- Elective and emergency split of medical duties to allow faster access to emergency theatres.

1.1 Consultation

The changes to the provision of ESHT's provision of General Surgical services were agreed following a comprehensive local public consultation that took place in 2012. The basis for the changes involved the need to make ongoing improvements in patient safety and the quality of care provided to patients.

- views were sought from the doctors and nurses working for the Trust;
- independent clinical advice was provided by the National Clinical Advisory Team who supported the need to make the changes proposed.

Following the consultation, the proposals for the changes were reviewed by the East Sussex County Council's Health Overview and Scrutiny Committee who agreed that they were in the best interests of local people.

1.2 Changes to the General Surgery service

There has been little change in the way ESHT provides the majority of planned operations or outpatient appointments, with patients continuing to be seen at EDGH in the majority of cases.

Where there has been a change to location, some patients have been required to make different travel arrangements for getting to the Conquest Hospital for admission, discharge and for some out patient appointments.

The local Clinical Commissioning Groups, the HOSC and the Trust all supported the view that the positive impact that the changes would have on improving safety and the quality of care for patients by ensuring they were seen by senior clinicians as soon as possible, shortening the amount of time spent in hospital and providing concentrated clinical expertise on a single site balanced the impact of additional travel.

2 QUALITY OF PATIENT CARE & EXPERIENCE

2.1 Pathways

Pathways for the transfer of patients by SECamb to the Conquest site were developed pre-transfer and have been successfully implemented. Monthly data is analysed and reported by SECamb in joint meetings with the Trust. The small number of inappropriate patient transfers originally noted post transfer of services has significantly decreased to negligible levels. Unfortunately it has not been possible to quantify this as South Coast Ambulance NHS Foundation Trust (SECAmb) have not been able to provide data to the Trust in relation to any change in the numbers of journeys between the two acute sites.

There is ongoing close liaison with A&E teams regarding the transfer of high risk surgical patients and feedback is provided to the Clinical Unit (CU) on any patients whose destination is deemed to be at variance from the agreed pathway. Again numbers of patients varying from agreed pathways has reduced considerably but this continues to be monitored.

2.2 Non-elective Admissions

On average ESHT has seen a decrease of non-elective General surgical admissions by approximately 8 patients per week.

The postcode data shows approximately 6 of the 8 reduction a week are from areas to the west of Eastbourne. It was identified during the consultation period that patients in these areas would be in the Brighton catchment area following the

implementation of these changes. These numbers are in line with those predicted at the time of consultation. (Appendix 1 and 2).

The benefits identified in the clinical strategy have partly been delivered through the establishment of a Surgical Assessment Unit at the Conquest Hospital with the aim of ensuring rapid senior medical review prior to a decision to admit or discharge the patient. The following table highlights the number of patients on both sites who were admitted directly via SAU. (*Ward data*)

LoS	2013 (Jan-Mar)	% split to total	2014 (Jan-Mar)	% split to total	
>5 days	272	29%	207	18%	
3 to 5	167	18%	188	16%	
0 to 2	507	53%	778	66%	
	946		1173		+24% on 2013

The pattern of activity in SAU has changed as anticipated with (i) an increase in admissions to the unit and (ii) a reduced LoS indicating improved pathway management.

2.3 Outliers

The percentage of General Surgery patients on General Surgery wards have increased since transfer and the percentage of medical and other surgical outliers on General Surgery wards had decreased since transfer. This is also an indication of improved pathways. (Appendix 3).

2.4 Cancelled Operations

The number of General Surgery cancelled ops have reduced from 16 during Apr-Jun 2013 to 8 in the period Apr-Jun 2014 a further reduction has been seen in July 2014. This is a result of improved management of non elective admissions and theatre capacity meaning that elective bed management is more predictable and less subject to impact from non-elective demand. In addition the provision of dedicated emergency theatre time on a seven day a week basis has ensured that the treatment of emergency cases has not impacted on elective scheduling.

2.5 Interventional Radiology

Interventional Radiology services are recognised as being able to improve quality, safety and productivity while delivering the highest quality care with comparable or better outcomes for patients, shorter lengths of stay and fewer major complications. (*National Imaging Board, 2009*).

In line with the transfer of high risk General Surgery cases the Conquest Hospital a new state of the art Interventional Radiology Suite was commissioned and a 24/7 service is now provided. A predicted benefit of the service change was an increase in the volume of patients receiving Interventional Radiology treatments. This has been demonstrated including an:

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- increase of vascular angioplasty for ischaemic legs; on average 3 – 5 cases per week are now performed versus none prior to the transfer. The increase in IR cases has allowed for a significant reduction in the surgical alternatives such as bypass surgery thus allowing patients to be treated with gold standard technology and reducing lengths of inpatient stay for patients and better outcomes;
- an increase in the number of colonic stents as an alternative to surgery for colonic tumours which are performed both in and out of hours. This has reduced the number of surgical procedures required per patient with bowel cancer from 2 surgical procedures to one, reducing the length of the treatment programme and reduced lengths of stay with better outcomes (10-15 cases per quarter);
- an increase in demand for abdominal drain insertion either under ultrasound or CT for acute abdominal sepsis. The number of cases has increased at Conquest from approximately 2 per week to 3-4 per week. This group of patients would either have previously required surgery or if they had been unfit for surgery, there would have been no alternative interventional treatment available for them.#

Further developments in Interventional Radiology will be possible in the future as there is now a sufficient volume of patients and demand for interventions.

2.6 Elective treatment targets

The focus of the General Surgery move was to improve the quality of care provided to emergency surgical patients and to centralise elective high risk activity. The volume of surgical activity undertaken on each of the two sites has been reviewed alongside work on theatre capacity and efficiency. This has supported the delivery of an accelerated 18 week recovery programme that aims to clear the backlog of the longest waiting elective patients across the organisation by November 2014 in line with commissioning intentions and national guidance. Improvements in length of stay as noted above have contributed to the delivery of this plan.

3 GOVERNANCE & MONITORING ARRANGEMENTS

All relevant risks, complaints and SIs are discussed at a number of fora which include the General Surgery Governance and Audit meetings, Nursing Quality Review meetings and at relevant ward meetings. Actions from these meetings are managed by the appropriate individual.

There have not been any emerging themes and consequently no amendments have been required to the model of service delivery as a result of negative patient experience.

Robust governance and associated processes are in place to review risks raised and complaints raised in relation to the service and these have been in place both pre- and post-transfer: the Surgical Audit and Governance meeting takes place bi-monthly and the Quality and Review meetings take place every 5 weeks. Actions arising from these meetings are managed by identified individuals. Risks are reviewed by the Clinical Unit management team every 5 weeks.

3.1 Significant Incidents

June – December 2013: 2 SIs raised
January – June 2014: 1 SI raised

In line with Trust policy and practice Root Cause Analysis has been performed on all of the SIs reported during this period. The SI that occurred following reconfiguration was not found to be attributable or directly related to the reconfiguration in December 2013.

3.2 Incidents reported via DATIX

- June – December 2013: 223 incidents reported
- January – June 2014: 180 incidents reported

3.3 Complaints

- June – December 2013 – 18 complaints raised
- January – June 2014 – 28 complaints raised.
  Of these two were specifically related to the re-provision of services away from EDGH to the Conquest.

Analysis of complaints is undertaken as a routine and reported at Board level. This analysis has not shown any variation in the themes or nature of complaints following the reconfiguration.

3.4 FFT

The outcome of the Family and Friends Test pre / post move has shown no change with the Net Promoter Score remaining stable at 60%.

3.5 Elderly care review

The clinical strategy identified as an objective an improvement in the levels of specialist care for elderly patients. It had been anticipated that the Elderly Care Physicians would attend daily ward rounds in surgery to enhance the specialist care available to these patients. This is being developed through the introduction of a revised medical model that is being introduced across the Trust. In the interim Elderly Care Physicians are available for consultations as and when required.

3.6 Mortality and morbidity review

Following the transfer there have been improvements in the way the General Surgical team work across sites. The General Surgeons now have a joint monthly Morbidity and Mortality Meeting held on the second Friday of every month and an Audit and Governance meeting bi-monthly.

The Colorectal Multi-disciplinary Meeting is now a unified weekly meeting as recommended by peer review. Junior doctor teaching is established and there is a weekly timetabled teaching session.

3.7 Nurse training

The Head of Nursing and Ward Matrons have developed a new training package incorporating study days for all ward staff to fulfil the educational needs. This training package improves clinical effectiveness by targeting key skills required by teams in each of the CU areas.

4 STAFFING

4.1 Medical Staffing

The reconfiguration of General Surgery was intended to address key concerns around medical staffing at all grades, improve adherence to the Surgical Models of Care recommended by the Royal College of Surgeons and provide a 7 day week Consultant delivered service.

The Consultant on call rotas of 1:4 at Conquest and 1:6 at EDGH prior to transfer were not sustainable. Following the move a 1:10 rota is now in place The Consultant and Registrar / Middle Grade rota is based on a four day week and a three day weekend.

When on call for emergencies, the Consultant, Specialist Registrar, CT and FY1 doctors do not have any other 'planned elective' activity and are therefore available to attend emergency patients. This is in line with the originally agreed models.

Medical staffing arrangements are reviewed regularly and adjusted as required.
For example feedback from the junior doctor (FY1) and nursing staff prompted the establishment of a ward based Registrar / Middle Grade Surgeon to be rostered to cover the two General Surgical wards (De Cham Ward and Gardner Ward) on a Monday to Friday basis to provide continuity of care and be readily available to train, supervise and support more junior doctors. This has been in place since May 2014.

Recruitment to some posts continues to be an ongoing issue. There are currently some vacancies in middle and junior grades. This is in line with other Trusts across the country. However a number of appointments have been made recently and recruitment efforts are ongoing and showing signs of improvement. Feedback from trainees has also been positive.

4.2 Nurse Staffing

Prior to the transfer the General Surgical nursing team had 23 trained nurse vacancies. This was putting pressure on the service and the team required regular cover from agency staff;

- Since the transfer, trained nurses have been recruited to the Trust through a well established nurse recruitment process thus reducing the need for agency staff and improving continuity of care;
- The current vacancy position has improved significantly in the CU with trained vacancies now down to 6 WTE;

- Specific adverts to fill these vacancies have now been placed and the CU is confident this will attract more applicants into General Surgery.

5 PHYSICAL ENVIRONMENT

As part of the development to support the transfer, the physical accommodation was upgraded. Staff have advised that they are happy to have moved into the newly refurbished units. Patients have also commented positively on the improved environment.

6 FUTURE DEVELOPMENTS

In the original Clinical Strategy submission, the office area adjacent to SAU (used by pre-assessment and waiting list team) was identified for use by General Surgery. The CU still wishes to co-locate services into this area, to bring all staff into one area and promote team working.

The CU would like to establish a Minimally Invasive Integrated Theatre as a replacement of an existing theatre. This would provide a state of the art environment for performing laparoscopic abdominal and pelvic surgery. This could also be used for the teaching and training of surgeons and nursing staff and it could be linked to the postgraduate education centre should the department wish to run enhanced teaching sessions. A business case for this development will be compiled by the Clinical Unit.

10 CONCLUSION

The reconfiguration and move was implemented successfully as planned in December 2013. The **benefits** anticipated in the original case for change have and continue to be delivered. Arrangements are in place for the ongoing monitoring of these improvements and any necessary adjustments to pathways and working practices will be made in conjunction with partners to ensure these are maintained and where possible further enhanced.

The **risks** to the service continue to be around recruitment and retention of appropriately graded staff to continue to meet the demands of the service and these are being mitigated by regular advertising and interviewing and filling posts with locum staff as required.

Appendix 1

General Surgery – non-elective admissions

Source: Business Intelligence Team, ESHT

Prior to the transfer of services, it was anticipated that some General Surgery activity would be lost, primarily to Brighton.
This was approximated to be 1.2 patients per day (8.4 per week).

Table 1

Week Commencing	General Surgery non-elective admissions		
	2014	2013	Difference
06-Apr	78	84	-6
13-Apr	69	98	-29
20-Apr	82	96	-14
27-Apr	78	102	-24
04-May	88	92	-4
11-May	80	96	-16
18-May	69	95	-26
25-May	80	75	5
01-Jun	72	82	-10
08-Jun	80	77	3
15-Jun	85	77	8
22-Jun	91	78	13
Total	952	1052	-100
Weekly Ave	**79**	**88**	**-8**

Table 1 shows the number of admissions per week Apr-Jun 20134 compared to Apr-Jun 13. On average this represents a total ESHT decrease of non-elective General surgical admissions by approximately 8 patients per week.

The postcode data shows approximately 6 per week of the 8 reduction are from the Brighton catchment area (Seaford, Lewes, Newhaven, Peacehaven, Brighton and Uckfield):

Table 2

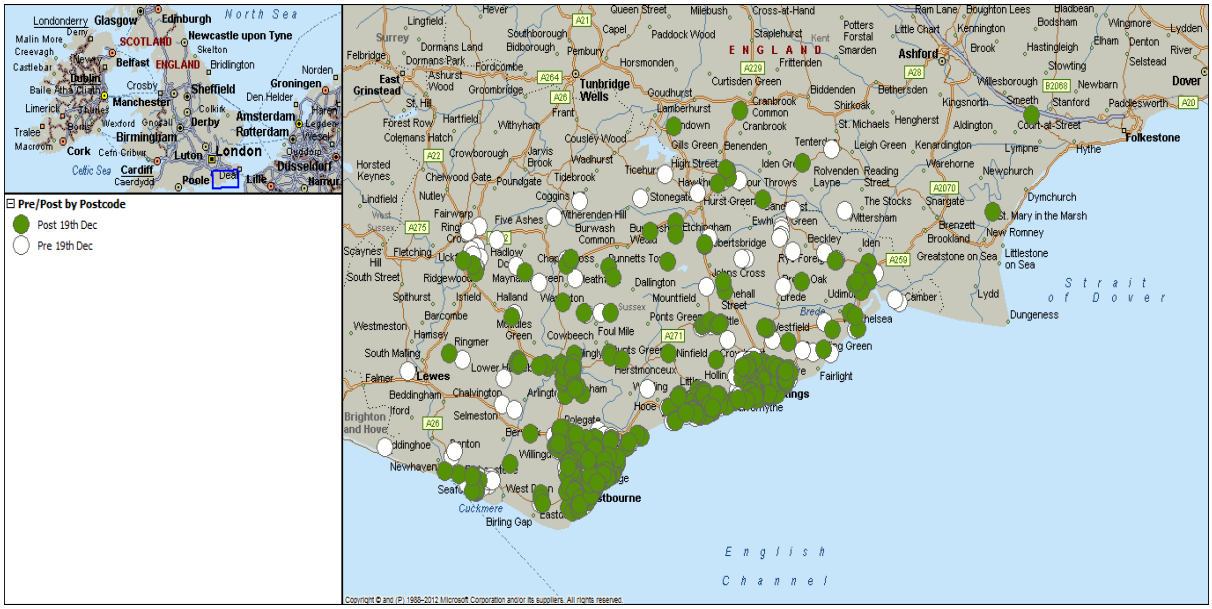
Postcode	General Surgery admissions (Apr-Jun)			Ave per week		
	2014	2013	Difference	2014	2013	Difference
Total	952	1052	-100	79	88	-8
Brighton Catchment	22	91	-69	2	8	-6

This would suggest the impact on ESHT & consequently BSUH is nearer 6 patients per week and not the approximated 8.4 patients agreed prior to the move.

Appendix 2

Emergency Activity (Mapping)

Source: Business Intelligence Team, ESHT



Green: pre-December
White: post- December

Appendix 3

General Surgery – outliers

Source: Business Intelligence Team, ESHT

The percentage of General Surgical patients on General Surgical wards has increased since transfer and the percentage of medical outliers and other non-general surgical outliers have dropped since transfer.

	Jan-Mar13	% Pts on GS Wards	Jan-Mar14	% Pts on GS Wards
General Surgery	1502	76.6%	1491	81.2%
Urology	40	2.0%	7	0.4%
Breast Surgery	56	2.9%	58	3.2%
Vascular Surgery	29	1.5%	28	1.5%
T&O	72	3.7%	54	2.9%
ENT	1	0.1%	4	0.2%
Ophthalmology	6	0.3%	3	0.2%
Medical	**254**	13.0%	**191**	10.4%
Total	**1960**	100.0%	**1836**	100.0%

Stroke Performance 2014/15

Previous to 2014/15 the Trust were measured against Accelerating Stroke Indicators (ASIs).

There were 4 main ASIs that the trust was contractually managed against. Each had a target standard.

1. ASI 2: Admission to Stroke Unit within 4 hours. Target; 90%
2. ASI 3: 90% of total stay on Stroke Unit. Target: 80%
3. ASI 4a: CT Scan within 1 Hour. Target; 50%
4. ASI 4b: CT Scan within 24 hours. Target 100%

ASIs were discontinued during 2013/14.

From April 1st 2014, ESHT has been contractually managed against the Sentinel Stroke National Audit Programme (SSNAP) Indicators.

SSNAP information is uploaded directly by the service/clinician into a web portal. It is not sourced in any way from the Trust's data warehouse.

The main SSNAP indicators are shown below together with the current provisional trust performance. SSNAP release final performance figures quarterly and normally 2 months following the end of the quarter. Trusts are able to draw down provisional reports to give an indication of recent performance.

SSNAP is not based on target standards. SSNAP does not document any targets. It provides a National average and shows Trust performance against that average. Note that in the below table below July's Thrombolysis performance is based on one eligible patient who missed the target standard by 6 mins.

ASI	Domain	Indicator	National	Apr-14 Month 1	May-14 Month 2	Jun-14 Month 3	Jul-14 Month 4
	Scanning	Median Clock Start to Scan time (mins)	78	35	38	32	24
ASI 4a	Scanning	% Scanned within 1 hour of Clock start	43.20%	78%	65.79%	78.95%	73.91%
	Scanning	% Scanned within 12 hours of Clock start	86.10%	100%	94.74%	100%	100%
	Stroke Unit	Medican Clock Start to First Stroke Unit (mins)	218	151.5	121	165	114
ASI 2	Stroke Unit	% Admitted to Stroke Unit within 4 hours	57.80%	84%	81.58%	78.95%	91.30%
ASI 3	Stroke Unit	At least 90% Stay on Stroke Unit	82.30%	92%	92/11%	89.29%	82.61%
	Thrombylisis	% Thrombylised within 1 hour of Clock Start	55.50%	44.44%	33.35%	80%	0.00%
	Specialist Assessments	Swallow Screen within 4 hours	65%	74.47%	58.82%	74.07%	82.61%
	Specialist Assessments	Formal Swall assessment within 72 hours	80.90%	56.76%	70.83%	57.89%	44.44%
	Occupational Therapy	Median minutes per day OT	40	30	35	30	30
	Physiotherapy	Median minutes per day of PT	32	30	30	30	30
	SALT	Median minutes per day of SALT	30	30	38	30	30
	Mult-Disciplinary Working	% receiving OT Assessment within 72 hours	87.70%	56.82%	57.14%	84.52%	95.24%
	Mult-Disciplinary Working	% receiving Physiotherapy Assessment within 72 hours	94.10%	84.44%	87.10%	89.36%	90.48%
	Mult-Disciplinary Working	% receiving SALT Assessment within 72 hours	80.30%	40%	55.56%	35.29%	57.14%
	Mult-Disciplinary Working	% Rehab Goals set within 5 days	82.50%	82%	68.42%	77.19%	69.57%

APPENDIX 3

Clinical Commissioning Groups and East Sussex Healthcare NHS Trust (ESHT)
Action Plan: HOSC recommendations on stroke, general surgery and orthopaedics reconfiguration

Updated August 2014

This is a condensed version of the full action plan. It summarises the main actions taken since December 2012 in response to each of the HOSC recommendations, and areas where further action is required/ongoing to fully implement the recommendations. It is intended to support HOSC's ongoing scrutiny of the implementation of the agreed reconfiguration of services by enabling focus on outstanding issues.

HOSC recommendation		***Key action taken since Dec 2012***	***Further action ongoing/required***
Stroke			
1	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.	• Second scanner installed at EDGH and contingency plans in place for failure of individual scanners • 1 hour scan performance currently over target (52.5% July 2013 against 50% target) • New stroke pathway in place. • Protocols agreed with A&Es and SECAmb. • Trust monitoring performance in stroke care through SSNAP (Provisional data for 2014 Q1 and 2013/14 attached at Appendix 1)	• None
2	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.	• 5 day therapy service in place as part of current arrangements. • Some agency staffing – recruitment underway for permanent staff. • All patients receive 6 month multi-disciplinary review – outcomes recorded on SSNAP database as above.	• Funding for 7 day therapy service included in FBC and submitted to TDA – ESHT awaiting outcome.

HOSC recommendation		*Key action taken since Dec 2012*	*Further action ongoing/required*
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.	• Early Supported Discharge (ESD) service in place in EHS and H&R CCGs and built into new service. • Irvine Unit (Bexhill) expanded to 18 beds as planned. • Rehab demand and response monitoring in place. • Patient outcomes monitored by commissioners using SSNAP.	• For patients receiving care at other Trusts, HWLH CCG has developed a business case with options to develop the community neuro-rehab service or focus on a community stroke rehabilitation service. This will be progressed as part of the CCG's review of community services.
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.	• Draft end of life care (EOLC) pathways developed for consideration by EOLC Board. • EOLC commissioner met with stroke lead to co-ordinate. • Family areas included in plans within FBC	• Pathways work is being taken forward through EOLC Board. This is an on-going part of core business
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.	• New pathway developed and agreed. Patient information has been shared with the Programme Board.	• Further review and revision of information is ongoing. Involvement of patients and carers is sought in ongoing development
General surgery and orthopaedics			
6	Commissioners and ESHT should ensure the following safeguards are in place on the site without emergency surgery: • Access to a senior surgical opinion 24/7 • Formalised and well communicated procedures for other specialties to access a surgical review	• Implemented in December as part of the reconfiguration • General surgery staffing plan agreed by all consultants – includes access to surgical opinion and	• None other than on-going (commissioner) quality monitoring arrangements in place as part of core business. Monitored

HOSC recommendation		*Key action taken since Dec 2012*	*Further action ongoing/required*
	• Contingency plans for patients with unforeseen immediate need for surgery • Clear protocols with the ambulance service, including for transfer of patients requiring emergency surgery.	relevant protocols. • Pathways agreed with SECAmb • Outcomes against key benefits set out in 3 month review	through Clinical Quality Review Group.
7	ESHT should undertake further work to identify co-dependencies with other specialities, such as obstetrics and gynaecology, and further modelling to specify the number of patients affected. This work should be used to set out a clear plan to ensure appropriate access to surgical input is available on the non-emergency site.	• Complete as above • Decision on future of Maternity services made	• None other than on-going (commissioner) quality monitoring arrangements in place as part of core business
8	ESHT should put in place alternative escalation procedures to manage sudden peaks in medical admissions, to avoid the use of surgical beds. It would also be important to have fully implemented planned improvements to acute medicine on the site hosting the centralised surgical services, in order to support improvement bed management, prior to implementation.	• Organisational Resilience and Capacity plan in place for 2014/15 and reflects service changes. • Changes to acute medicine in place at Conquest and EDGH. Further work underway on revised medical model across the Trust	• None other than on-going (commissioner) quality monitoring arrangements in place as part of core business
9	Discharge procedures should be reviewed to reflect the fact that patients, carers and families may need to make more complex travel arrangements if they have been treated further from home.	• Discharge procedures have been changed to reflect arrangements. All discharges continue to be planned on individual requirements. • Review of transport information (see below)	• None other than on-going (commissioner) quality monitoring arrangements in place as part of core business
10	'Accessibility plans' should be developed for each acute hospital in order to take a strategic approach to maximising access to each site and to identify all potential mitigating actions to reduce the impact from increased travel if services are reconfigured. These should include the Trust's plans in areas such as: • working with transport planners to maximise public transport access	• Patient and public access group established – including voluntary groups • Patients are offered the earliest possible or closest to home appointment and patients are informed how they can change appointments if necessary	• Communications and improved information work on-going as part of core business.

HOSC recommendation		*Key action taken since Dec 2012*	*Further action ongoing/required*
	• working with community transport services and volunteer services to support access, particularly for the most vulnerable • making appointment systems more flexible and offering greater choice • parking policy, including disabled parking • staff travel, including the use of alternatives to the car • access for those with mobility restrictions or other disabilities • publicising availability of help with travel costs through NHS schemes and national schemes such as free bus passes for older people • maximising the access of visitors to patients	• Trust continues to host site specific transport working groups with local partners • Trust and CCG input into ESCC transport consultation • Advice sought from transport consultant. • ESHT website pages re travel revised and improved. • New leaflet developed. • Communications plan for travel information being developed. • Planning undertaken re appointment systems. • Parking policy reviewed against latest government guidance all requirements met • Disabled access audits reviewed. • Staff travel plan in place • Access implications of building works included in FBC.	
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.	• 2010 feasibility study reviewed – still assessed as poor value for money. • Temporary arrangements ceased due to poor uptake.	• Ongoing feasibility study required • ESCC to ensure public transport strategy takes account of reconfiguration changes
12	ESHT should consider measures to mitigate the impact of reduced access for visitors such as: • Use of telephone contact with families/carers to ensure	• Addressed through ongoing work on personalised care planning. • Specific stroke volunteering	• Ongoing review in conjunction with partners

HOSC recommendation		*Key action taken since Dec 2012*	*Further action ongoing/required*
	staff are aware of patient needs/preferences • Increased use of volunteers to provide psychological and practical support to patients • Increased flexibility in visiting arrangements/hours • Improved advice to visitors on how they can best support their loved one, whether this is through visits or in other ways such as providing information on needs and preferences.	programme with Stroke Association. • Family areas incorporated into plans within FBC.	
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.	• Monitoring has indicated changes are in line with those anticipated • Task Group noted that increases in activity may be offset by decreases elsewhere. • The CCGs reflected changes in activity in the contract with SECamb for 2013/14 and 2014/15.	Ongoing assessment and arrangements for change part of the normal contract discussions.
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.	• MAC and CAC agreed merger in principle but yet to be implemented. • Cross-Trust Clinical Leaders Group established as part of ESHT governance. •	• None (not within ESHT gift to merge CAC and MAC)
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.	• Established by CCGs – first met in May 2013. • The work of this group will move into the East Sussex Better Together Programme.	• None
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	• Incorporated into work on East Sussex Better Together with full	• The commissioning intentions for 2015/16

HOSC recommendation		*Key action taken since Dec 2012*	*Further action ongoing/required*
	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.	public engagement • Care Design Groups (commissioners and providers) are currently reviewing service specifications for a range of community services. • Ongoing work led by Community Redesign Group and Integrated Care Network • Major integration programme due to be launched by NHS and Adult Social Care – East Sussex Better Together. • Early Supported Discharge built into new stroke pathway in EHS and H&R CCGs.	will reflect our plans for commissioning community health services. • Within the ESBT framework, HWLH CCG is undertaking a targeted review of community services as a priority; patient flows to providers outside of East Sussex are central to this. A full programme of stakeholder engagement is included. • HOSC and Adult Social Care Scrutiny Committee to set up joint working group to scrutinise progress in this area in more detail.
17	An integrated, partnership approach to the development of community services should continue to be taken by Clinical Commissioning Groups, Adult Social Care and ESHT. Plans must recognise: • the impact of earlier discharge and reduced admissions, in terms of impact on carers and increased reliance on means-tested social care. • the need for additional support for more vulnerable residents and those in more deprived areas, as these groups are less likely to have access to support networks and resources to support their care. • the importance of clear pathways between local services, such as intermediate care and rehabilitation teams, and single sited acute services, if these are implemented.		
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.	• Stakeholder event held. • Patient and public access group established. • ESHT stakeholder advisory group continues to meet. • The CCGs have held extensive stakeholder engagement events which include these discussions.	• None with specific relation to original reconfiguration of stroke, general surgery and orthopaedics. • On-going engagement, including through East Sussex Better Together.
19	A clear set of quality indicators should be agreed and monitored before, during and after implementation by Commissioners, ESHT and HOSC. These should be able to demonstrate how	• Benefits realisation indicators developed and included in FBC and	• Ongoing monitoring of indicators after service

HOSC recommendation		*Key action taken since Dec 2012*	*Further action ongoing/required*
	patient experience and outcomes have been impacted by changes to services and demonstrate whether the anticipated financial impact of changes is being realised.	submissions to TDA. • Indicators include patient experience and finance measures. • Each CCG regularly reviews quality and access in the cases relying on these services where they are available.	changes.
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.	• Agreed CCGs chaired Programme Board	• None

Acronyms

CAC – Consultant Advisory Committee
CCG – Clinical Commissioning Group
EDGH – Eastbourne District General Hospital
EHS – Eastbourne, Hailsham and Seaford
ESD – Early Supported Discharge
ESHT – East Sussex Healthcare NHS Trust
FBC – Full/Final Business Case
H&R – Hastings and Rother
HOSC – Health Overview and Scrutiny Committee
HWLH – High Weald Lewes Havens
MAC – Medical Advisory Committee
SECAmb – South East Coast Ambulance Service NHS Foundation Trust
SSNAP – Sentinel Stroke National Audit Programme
TDA – NHS Trust Development Authority