HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 30 June 2022

PRESENT:

Councillors Colin Belsey (Chair), Councillors Abul Azad, Penny di Cara, Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson and Alan Shuttleworth (all East Sussex County Council); Councillors Councillor Mary Barnes (Rother District Council), Councillor Richard Hallett (Wealden District Council), Councillor Mike Turner (Hastings Borough Council), Geraldine Des Moulins (VCSE Alliance) and Jennifer Twist (VCSE Alliance)

WITNESSES:

Amy Galea, Chief Primary Care Officer, NHS Sussex

Jessica Britton, Executive Managing Director, East Sussex Clinical Commissioning Group

Richard Milner, Director of Strategy, Inequalities & Partnerships, East Sussex Healthcare NHS Trust

Michael Farrer, Strategy, Innovation & Planning Team, East Sussex Healthcare NHS Trust

LEAD OFFICER:

Harvey Winder, Policy and Scrutiny Officer

1. MINUTES OF THE MEETING HELD ON 3 MARCH 2022

1.1 The minutes of the meeting held on 3rd March 2022 were agreed as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Cllr Christine Brett and Cllr Amanda Morris.

3. DISCLOSURES OF INTERESTS

3.1 There were no disclosures of interest.

4. URGENT ITEMS

4.1 There were no urgent items.

5. RECONFIGURATION OF CARDIOLOGY SERVICES AT EAST SUSSEX HEALTHCARE NHS TRUST

5.1 The Committee considered a report seeking agreement of the HOSC Review Board's report on NHS proposals to reconfigure cardiology services in East Sussex.

5.2 **The Committee asked for an outline of the next steps that would be taken before NHS representatives return to the HOSC with the final decisions for cardiology and ophthalmology.**

5.3 Jessica Britton, Executive Managing Director of East Sussex Clinical Commissioning Group (CCG), explained that, should the HOSC agree the Review Board's report and submit it to NHS Sussex (which replaces the CCG from 1st July), there are a few activities that will take place. NHS Sussex will produce for both cardiology and ophthalmology a Decision Making Business Case (DMBC), which builds on the Pre-Consultation Business Case (PCBC) and will be informed by both the analysis of the public consultation and the HOSC recommendations, stating how the NHS will respond to the HOSC recommendations. In addition, for cardiology, the DMBC will be preceded by a site options appraisal, which is an extensive process to determine which of the two proposed sites would best deliver the outcomes agreed for the interventional element of cardiology. The DMBC will then be agreed through NHS Sussex's governance process culminating in the Integrated Care Board (ICB) meeting on 7th September. The HOSC will then consider whether the ICB's decision is in the best interest of health services locally at its meeting on 22nd September [Note: the Committee has been subsequently advised that the decision will be reported to HOSC meeting on 15th December].

5.4 Michael Farrer said that the Trust and CCG are in the process of drawing up a detailed implementation timeline as part of the DMBC, in consultation with the Trust's Estates and Finance Teams. The intention is to implement the decisions, subject to endorsement by the HOSC, as soon as possible and in the right way for patients.

5.5 **The Committee asked for clarification whether the impact on patient flows from the north of East Sussex (the High Weald area) as a result of the decision by Kent & Medway CCG to centralise interventional cardiology services provided by Maidstone and Tunbridge Wells NHS Trust (MTW) to Maidstone Hospital has been considered by the CCG.**

5.6 Jessica Britton said that the impact of the MTW reconfiguration would feed into the options appraisal. Michael Farrer confirmed that patient flow modelling for patients in the north of the county had already been undertaken and the CCG and Trust were aware of the decision by MTW and the Kent and Medway CCG to move interventional cardiology services to Maidstone Hospital. Michael Farrer said that the CCG and Trust is confident that the changes to

patient flows for patients in the north of the county would be negligible. He clarified that MTW does not provide Primary Percutaneous Coronary Interventions (PPCIs) at either of its sites – either in the current or future configuration – so the emergency patient flows for patients in the north of the county would not change and they will continue going to the sites that they would have done previously. The pathways for non-elective (patients who arrive in the Emergency Department) living in the north of the county would remain unchanged, as the MTW model provides services for these patients on both sites. This means patients can continue to go to Pembury Hospital's ED where onward care would then be arranged. Outpatient and diagnostics appointments at both sites would also remain unaffected. The only changes would be to elective and day-case patients, who may have to now travel further to Maidstone Hospital, but most likely for one or two procedures in a lifetime. He said it is unlikely patients would opt to receive these elective procedures from ESHT once under the care of MTW consultants, however, any patients who did elect to travel to ESHT could be absorbed by the Trust using existing capacity.

5.7 **The Committee asked why retaining two cardiology sites was not an option and whether the New Hospitals Programme rebuild of the Eastbourne District General Hospital (EDGH) would mean that site should be chosen as the interventional cardiology site.**

5.8 Jessica Britton said the proposed model was clinically driven by the cardiology service to deliver the best possible health outcomes for local people and was not resource driven. The proposals account for changes in staffing models, particularly in relation to the effect of specialisation on recruitment. The Executive Director said the site options appraisal would take into account a wide range of factors including population profile, consultation feedback, and deliverability of the changes on either site. The DMBC would make clear how each of these important factors have been balanced against each other.

5.9 Michael Farrer said that retaining all services on both sites was considered during the options development workshops, but it was quickly discounted as a viable option because a key clinical driver of the change is to provide sufficient training to staff. The staffing requirements of two sites and the fact that the population is not sufficient for two sites to both undertake the recommended volume of procedures means there is not enough capacity to provide the training needed to deliver the best quality of outcomes for patients. By consolidating interventional cardiology onto one site, however, the Trust can provide the volume of procedures and levels of supervision necessary to deliver sufficient training.

5.10 Richard Milner explained that the Department for Health and Social Care's (DHSC) definition of a new hospital was not necessarily the same as the NHS definition. The DHSC guidance includes refurbishment and expansion of existing sites as a new hospital, in addition to building brand new hospitals from scratch. He said that the Trust did not have a preferred site for interventional cardiology and that this would be identified through an objective review of the weighted evidence across a number of parameters for both sites. Richard Milner further added that the higher number of preferences for EDGH as the cath lab site reflected the higher number of responses from the Eastbourne area and this would be balanced as part of options appraisal.

5.11 **The Committee asked how consultation results would be weighted against other factors.**

5.12 Jessica Britton explained that public consultations are incredibly useful but that, within the context of an engagement that aims to reach as many people as possible, the CCG only hears back from people who have chosen to respond. The themes and trends of the public consultation responses are taken into account alongside other factors, but there is not a mathematical weighting assigned to the consultation results compared to these other factors. The consultation analysis also recognises that the volume of residents responding in any particular area is not the same as the issues and themes feedback raised in the consultation responses, which require careful consideration.

5.13 **The Committee asked when the Travel and Access Group will submit its findings, whether they will be accepted in full, and when they may be implemented, for example, the appointment of the travel liaison officer.**

5.14 Jessica Britton confirmed the findings of the Travel and Access Group will be in the DMBC. The implementation of the recommendations will vary in length depending on what they are, with those that can be implemented quickly done so as soon as possible. Michael Farrer added that travel and access is a Trust-wide programme and in many cases the Trust will want all patients to benefit from these changes, not just cardiology and ophthalmology patients.

5.15 Michael Farrer said the travel and liaison officer will be recruited to as soon as possible subject to the approval of the DMBC. There are a number of different avenues of support available already for patients, so a key role of the travel and liaison officer will be to connect and signpost those patients to existing services. This post will also be able to escalate more complex personal circumstances to an appropriate level.

5.16 **The Committee asked who is on the Travel and Access Group and whether the existing services available have the capacity to support additional patients with their travel arrangements.**

5.17 Michael Farrer said the Travel and Access Group membership included patient and public representatives, Healthwatch, South East Coast Ambulance NHS Foundation Trust (SECAmb), PTS representatives, and ESHT community representatives.

5.18 Michael Farrer confirmed the Trust is looking at the capacity of existing services. The work will also feed into the recommissioning of the Patient Transport Service (PTS) that is due imminently, including around the capacity of that service to meet demand. He said there is capacity to signpost patients to these services and that the metrics of the service will be monitored during the pilot phase to ensure patients are able to access the transport services they need.

5.19 Two members of the Committee made the following comments against the Review Board's recommendations:

- Cllr Alan Shuttleworth welcomed the proposed front door model and retention of non-invasive cardiac services on both sites but said the proposed model should provide interventional cardiology services on both sites too, ensuring there was a complete service mirrored on both sites. If this was not possible, then Eastbourne District General Hospital (EDGH) should be the site for the cath labs for a number of reasons including better access for patients, including those in the High Weald area; the population profile; the preference for it as the site in the public consultation; and the fact it is due to be significantly rebuilt under the New Hospitals Programme.

- Cllr Mike Turner expressed his opposition to single-siting cardiology cath labs on the grounds that the he believed the proposals contained a number of uncertainties.

5.20 The Committee RESOLVED by nine votes to one to:

1) agree the report and recommendations of the HOSC Review Board attached as Appendix 1; and

2) agree to refer the report to NHS Sussex for consideration as part of its decision making process.

6. RECONFIGURATION OF OPHTHALMOLOGY SERVICES AT EAST SUSSEX HEALTHCARE NHS TRUST

6.1 The Committee considered a report seeking agreement of the HOSC Review Board's report on NHS proposals to reconfigure ophthalmology services in East Sussex.

6.2 **The Committee asked whether the proposed changes would help address the waiting lists for consultations and procedures in ophthalmology**.

6.3 Richard Milner said that a key aim of the Trust this financial year is to reduce the waiting list across all specialities and not just ophthalmology. This will involve reducing the backlog of outstanding appointments caused by COVID-19 whilst also managing additional new appointments based on clinical need. This can be achieved in part by optimising the available medical workforce to see more patients, and one of the key aims of the ophthalmology proposals is to increase capacity of the existing workforce by concentrating them on two sites. In addition, there is a wider ophthalmology transformation programme across NHS Sussex to train community ophthalmologists to enable people to receive ophthalmology care in the high street, where appropriate. By consolidating the acute service, ESHT will be able to free up its consultant ophthalmologists to train some of the community ophthalmologists. This will not only increase capacity and help reduce the backlog but will also improve patient outcomes by allowing them to be treated earlier, quicker and closer to home.

6.4 **The Committee asked for further details on the expansion of available parking at Bexhill Hospital as part of the proposals.**

6.5 Michael Farrer said the Travel and Access Group's remit included looking at the opportunities for increased parking at the Bexhill Hospital site. He said that the CCG and Trust know that the additional number of ophthalmology patients attending the site, based on an increase of eight patients per hour for the clinics, will equate to 10 additional parking spaces. The Trust is confident it can absorb that number of spaces on the site, however, that is a minimum number, and the Trust is exploring with its Estates Team options for further expansion of parking on the site. The parking details will be included in the DMBC.

6.6 **The Committee asked whether data for 'did not attend' patients would be collected to understand what barriers there were for patients attending.**

6.7 Michael Farrer said the CCG and Trust fully agreed with the HOSC Review Board's recommendation around collecting 'did not attend' (DNA) data. At the moment, the Trust systems do not allow the collection of DNA data, as the patients did not attend an appointment to be asked that question. The Trust does, however, follow up DNAs to make sure they rebook their appointment and are not discharged back to their GPs, and there is an opportunity then to have a conversation about why they did not attend and to record that reason. Anecdotally, the reason people did not attend is not because they physically could not get to the Bexhill site, for example, during the pandemic when services were single-sited at Bexhill, there did not appear to be an increase in the number of DNAs for travel and access reasons. Patients in fact appeared happier to attend the site, as it was away from the acute sites where COVID-19 was more prevalent.

6.8 Michael Farrer confirmed there is a Trust-wide programme being developed on how DNA data is collected and how it is monitored. This programme is aimed at identifying and mitigating any adverse reasons for patients not attending. It is likely this will involve the collection of DNA data through periodic audits of DNAs when there appears to be an increase in the number of them, rather than systemically recording the reasons for each DNA as it happens. He said DNA data will be included in the metrics to measure the success of the ophthalmology service in the future.

6.9 **The Committee asked whether the reasons for a DNA could include the patient forgetting the date of their follow up appointment if it is booked too far in advance.**

6.10 Michael Farrer explained that for many eye conditions, a patient will be on the Trust's books for life. Depending on the severity of their condition, there may be a need for a patient to attend an appointment every 3, 6 or 12 months. Consequently, appointments are often booked 12 months or more in advance. ESHT has a system in place to remind patients of these longstanding appointments; patients are reminded via letter closer to the appointment date and may also receive a text message reminder if they stated that as a preferred contact method. Michael Farrer said the data shows this system works quite well, as patients frequently called the ophthalmology service during the pandemic to delay their appointments, showing they were

aware of the dates. There has been some feedback from patients not receiving their notifications and the Trust is working to update contact details that may become out of date due to the longevity of the patient's contact with the service.

6.11 **The Committee asked whether patients may be referred for treatment in community ophthalmologists.**

6.12 Michael Farrer said that independent sector ophthalmologists like SpaMedica are commissioned to complete a lot of high volume, low complexity work, whilst ESHT will perform the more complex cases. Patients at the point of referral should be given a choice of where to go, and those with less complex needs will often be happy to be referred to the independent sector if the wait times are shorter than at NHS facilities.

6.13 **The Committee asked whether there is scope to provide outreach surgeries periodically in more rural settings for treatments such as macular injections.**

6.14 Michael Farrer said that the Trust's philosophy is to provide its services as close to the patient as possible, wherever possible. The pan-Sussex community ophthalmology training programme, therefore, is aiming to help provide greater ophthalmology care closer to patients. Conversely some services require specialist skills or equipment or have fewer patients using the service. The best way to provide a quality service in this instance is from a specialist site where there is sufficient staff to run it properly and maximise training and clinical capacity; and high utilisation rates from patients to ensure equipment is not sitting dormant for long periods of time. Macular injections, for example, are offered on the Bexhill site only because they are a very specialist procedure requiring specialist training and equipment within a mini-theatre setting where air flow is monitored, due to the invasiveness of the procedure. The other estates do not have suitable space for the procedure, nor is there sufficient staff or demand from patients to offer it elsewhere. If an increase in demand did occur, however, the Trust may review its position.

6.15 **The Committee asked whether there will still be the staff and skills onsite at the Conquest Hospital to conduct emergency eye procedures after the reconfiguration.**

6.16 Michael Farrer confirmed the emergency pathways are not changing as part of the reconfiguration, with particularly complex cases remaining at the Conquest Hospital. This includes specialist eye surgery for patients who require an anaesthetic and therefore need to use the Conquest's main theatre and anaesthetist teams; and people who require an overnight stay in a surgical ward using a shared care arrangement with the surgical team and an ophthalmologist, due to their underlying conditions or high-risk characteristics. These two cohorts of patients amount to less than 100 patients per year and around half a theatre list per month.

6.17 Michael Farrer clarified there is no eye trauma unit at the Conquest ED, so eye trauma patients will continue to use the current pathway and go to the nearest centre at the Royal Sussex County Hospital (RSCH) in Brighton, which is a safe, robust and well embedded

pathway. Ophthalmology is currently delivered at the Conquest ED largely via ED consultants themselves using on-call ophthalmologist support to aid their decision making. The community-based minor eye condition clinics that patients are referred to for urgent non-emergency cases will also continue as before.

6.18 **The Committee asked how the Trust will provide information on patient choice and travel and access arrangements to the Bexhill Hospital in accordance with the Review Board's recommendations.**

6.19 Michael Farrer said that the Trust is developing a Trust-wide communications plan. This includes updating the website to make sure it is accessible in multiple languages, with Google Translate having gone live in the last couple of months. The Trust will signpost people to its website for information wherever possible, including in its referral letters and leaflets.

6.20 Michael Farrer explained that the CCG instructs referring organisations (GP practices) to offer patient choice at the point of referral. Whilst the Trust is not responsible for referrals, it will remind people as often as possible about patient choice and will put the information on its website. Jessica Britton added that the CCG works with GP practices in relation to patient choice. Any feedback the CCG receives on its communications is used to improve future communications. Both Jessica and Michael welcomed the HOSC Review Board's recommendation.

6.21 Michael Farrer also said that a Sussex-wide plan is being developed to improve the quality of patient referrals by offering patients earlier access to the opinion of an ophthalmologist to see whether a further appointment is appropriate or not.

6.22 The Chair thanked Jessica Britton, Richard Milner and Michael Farrer for giving their time to support the two review boards.

6.23 The Committee RESOLVED to:

1) agree the report and recommendations of the HOSC Review Board attached as Appendix 1; and

2) agree to refer the report to NHS Sussex for consideration as part of its decision making process.

7. ACCESS TO GP PRACTICES IN EAST SUSSEX

7.1 The Committee considered a report providing an overview of access to GP surgeries and appointments following the Covid-19 pandemic, including the challenges Practices are facing in returning services to pre-Covid levels and changes in working practices.

7.2 **The Committee asked when the number of available appointments will recover to pre-pandemic levels.**

7.3 Amy Galea explained that the data showed the number of available appointments has now returned to pre-pandemic levels. What has changed, however, is that individual practices are now operating virtual appointments alongside face-to-face appointments. This has advantages to some parts of population, but others still prefer face to face appointments. The CCG is working with Practices to understand what the right balance and mix of appointments could be for their practice list, which varies from practice to practice due to the demographic makeup of their lists.

7.4 Amy Galea added that the CCG is trying to understand the reasons why people are making GP appointments. The data shows half the appointments patients make are for the same day they contact the GP practice. This suggests there is unmet demand, if half the patients have to wait longer. It is also necessary to understand whether people who have a same day appointment need to have it on the same day, or whether it is less urgent. The healthcare needs of callers are being assessed as part of a piece of work being undertaken with some practices in Sussex. In addition, the CCG is working with ESHT to understand why some people are using the ED on the same day they have a GP appointment later in the day.

7.5 In addition to this work, Amy Galea said a pilot has begun in Brighton & Hove involving a team of healthcare workers either going to people's homes or locations like a town hall to offer primary care services. This is designed to benefit people who may not want or be able to access a GP practice. If successful, it may be rolled out across Sussex.

7.6 **The Committee asked for clarification how the needs of the 50% of patients who do not receive a same day appointment can be served.**

7.7 Amy Galea clarified that whilst half of patients who call the practices are not getting a same day appointment, it is not necessarily the case that they all wanted to have one that day. Similarly, patients who did receive a same day appointment may not have needed one but were able to get through and book one. Furthermore, not all practices have the facility to book patients ahead and require patients to call up each day until they get an appointment for that day, which is unproductive for both the individual and practice.

7.8 Amy Galea said there is currently no way of measuring the telephony systems to understand in a systemic way why people requested an appointment on the day and whether the reason they did was appropriate or not. The CCGs are working to understand these issues across the 161 practices in Sussex and will produce a multi-year improvement strategy called "Next Steps on Integrating Primary Care" that will be agreed by the successor organisation, NHS Sussex, in September. Amy Galea added that the CCGs are already working with those GP practices that are known to have acute issues with same day appointments and their service offer generally and these will be resolved quicker than less acute practices. The Executive Director of Primary Care clarified that four of these are in East Sussex.

7.9 **The Committee asked how people who are hard of hearing can receive virtual appointments, for example through Teams using subtitles, when practices only offer over the phone or face-to-face appointments.**

7.10 Amy Galea said the technology does exist to provide this service and some practices do offer it. The CCG is focussed on reducing the variation of the virtual offer available to patients that exists across practices. This includes establishing the eHub that offers video call facilities to GP practices that sign up to it. The CCG is also working with Healthwatch on how the service offer could be more sensitive to people with differing needs, such as the neuro-diverse and hard of hearing, and those who struggle with using technology.

7.11 **The Committee asked whether there are alternatives to booking appointments over the phone, for example, online bookings.**

7.12 Amy Galea said the work to improve the virtual offer to patients includes exploring the more widespread use of online booking, which currently does not happen across all practices in Sussex and forms part of the eHub offer.

7.13 **The Committee asked whether continuity of care with the same GP could be improved.**

7.14 Amy Galea explained that continuity of care needs to be considered within the context of the increasing number of patients with complex needs and the development of the GP workforce into multi-disciplinary teams of healthcare professionals. This means patients will no longer solely rely on seeing a GP and will instead increasingly being seen by the right kind of healthcare professional based on their need, for example, seeing mental health practitioners when presenting with anxiety or depression. This is not just because lack of growth of GP numbers, but also in recognition that the type and complexity of cases coming to GP practices could be better served by other parts of the GP team.

7.15 **The Committee asked for more details of the eHubs, including where they were situated, how they were staffed, why take up was not at 100%, how GP practices would be made to sign up to it, and how GP practices would advertise them to patients.**

7.16 Amy Galea explained eHubs work across a cluster of GP practices within a geographic area. The eHub integrates the back office functions of these practices virtually to provide a unified offer for patients, so that they are able to call up or book online using the eHub systems rather than the ad hoc systems used by the individual practices. The eHubs will require an additional new workforce to staff. They have been adopted by 30 practices in East Sussex rather than the whole of the county in order to pilot different ways of running them over the next six months. Once the data from this period has been collected and reviewed, they should be rolled out across Sussex during the next financial year 23/24. From the perspective of patients, eHubs will result in better opportunities to book online and carry out video consultations; whilst for GP practices, it will enable them to manage demand on any single day in a different and more robust way.

7.17 Amy Galea said the CCG cannot require GP practices to adopt video consultations or online bookings, however, some may not offer these services as they have not recognised the benefits they have delivered elsewhere – both to patients and to the practices themselves – for

example, they may not recognise that the online and telephone lists are not separate lists of patients that require further resources to meet the needs of, but are the same list trying to access services in different ways and offering both can increase the practice's capacity.

7.18 **The Committee asked where GP practices are offering screening services such as Health Checks again, and whether eHubs might benefit health checks.**

7.19 Amy Galea explained that in order to meet the demands of the pandemic, deliver virtual appointments and then deliver the vaccine programme, national guidance required GP practices to deprioritise routine health checks. GP practices are now restoring health checks using national incentives and they should be back to pre-COVID-19 activity levels soon. As part of the future work around Primary Care Networks (PCNs), NHS Sussex will expand on the work some practices – such as the Hastings PCN – have done with Public Health Teams and the voluntary and community sector to offer more comprehensive, early health checks, such as monitoring different vital statistics in people who might be at risk of developing conditions later in life.

7.20 The Executive Director of Primary Care said it is hoped the eHubs will improve all services, as it is a way of better managing the demand a practice receives on any single day and allows the practice to plan for activities in a more managed way.

7.21 **The Committee asked what the effect recruiting additional roles such as paramedics has on other areas of healthcare, particularly the ambulance trusts.**

7.22 Amy Galea agreed there is a risk that creating new roles moves people around the NHS without increasing workforce numbers. In response, once established, NHS Sussex will review the workforce across the whole of Sussex to help ensure that when one area puts in place an initiative such as this it does not move healthcare workers away from another area and put it at risk.

7.23 **The Committee asked what reasonable adjustments would be made for people who struggle with technology to access online or video consultations.**

7.24 Amy Galea agreed a one size fits all approach to accessing GP practices will not work and that GP practices will need to have an offer that responds to different people's needs and preferences, however, this offer needs to be realistic and deliver a service that meets these different needs whilst operating within the resource restrictions that are in place.

7.25 **The Committee asked what could be done to reduce the length of time people spend on the phone.**

7.26 Amy Galea agreed waiting on the phone is a frustrating process and GP practices need to be sensitive to the concerns people have about waiting. It is, however, a common phenomenon in many industries where people often make contact via phone. In GP practices it is also often due in part to the limitations of the software package they purchased to handle calls.

7.27 **The Committee asked whether the start time of 8am could be amended particularly help single parents, and whether any feedback from these groups has been sought.**

7.28 Amy Galea said the CCG regularly uses feedback from communities to help shape its work. The Next Steps on Integrating Primary Care strategy will set out how NHS Sussex plans to help improve the 8am call up process and improve the offer to patients generally, including those such as single parents who work parttime or fulltime and may struggle to call at 8am.

7.29 The Committee RESOLVED to:

1) agree to consider a future report on primary care access at the 15th December meeting; and

2) agree to consider the Next Steps on Integrating Primary Care strategy at the 15th December meeting.

8. HOSC FUTURE WORK PROGRAMME

8.1 The Committee considered its work programme.

8.2 The Committee RESOLVED to agree the work programme subject to the addition of the following items:

1) the addition of a report on SECAmb's response to the Care Quality Commission (CQC) report at the 22nd September meeting;

2) agree that the Chair, Vice-Chair and Cllr Hallett meet with relevant officers to discuss the Crowborough Minor Injuries Unit.

The meeting ended at 12.05 pm.

Councillor Colin Belsey

Chair