HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 15 DECEMBER 2022

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -

East Sussex County Council Members
Councillors Abul Azad, Colin Belsey (Chair), Penny di Cara, Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson (Vice Chair) and Alan Shuttleworth

District and Borough Council Members
Councillors Councillor Mary Barnes, Rother District Council
Councillor Christine Brett, Lewes District Council
Councillor Richard Hallett, Wealden District Council
Councillor Mike Turner, Hastings Borough Council
Councillor Candy Vaughan, Eastbourne Borough Council

Voluntary Sector Representatives
Geraldine Des Moulins, VCSE Alliance
Jennifer Twist, VCSE Alliance

AGENDA

1. **Minutes of the meeting held on 22 September 2022** *(Pages 5 - 18)*

2. **Apologies for absence**

3. **Disclosures of interests**

   Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4. **Urgent items**

   Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5. **NHS Sussex Winter Plan** *(Pages 19 - 40)*

6. **Reconfiguration of Cardiology Services at East Sussex Healthcare NHS Trust** *(Pages 41 - 102)*

7. **Reconfiguration of Ophthalmology Services at East Sussex Healthcare NHS Trust** *(Pages 103 - 150)*

8. **Primary Care Access and Next steps in Integrating Primary Care - update report** *(To Follow)*

9. **HOSC future work programme** *(Pages 151 - 158)*

10. **Any other items previously notified under agenda item 4**

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7 December 2022

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Next HOSC meeting: 10am, Thursday, 2 March 2023, County Hall, Lewes

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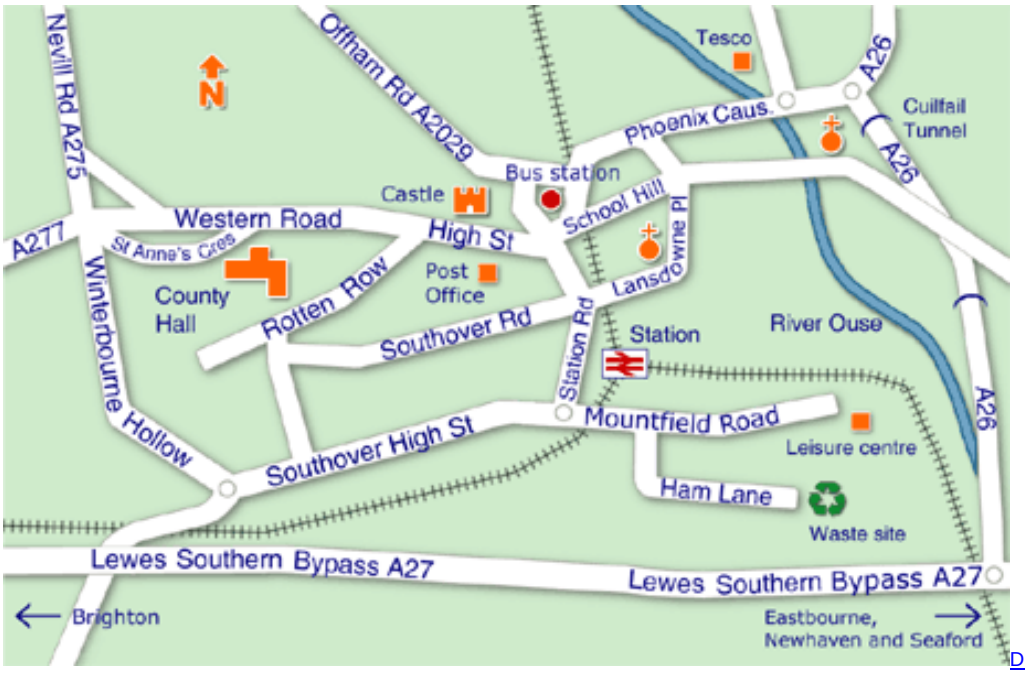

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 22 September 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); Councillor Christine Brett (Lewes District Council), Councillor Richard Hallett (Wealden District Council) and Geraldine Des Moulins (VCSE Alliance)

WITNESSES in attendance:

NHS Sussex

- Jessica Britton, Executive Managing Director, East
- Maggie Keating, Urgent and Emergency Care Programme Director

East Sussex Healthcare NHS Trust (ESHT)

- Richard Milner, Chief of Staff

Maidstone and Tunbridge Wells NHS Trust (MTW)

- Katherine Holmes, General Manager for Emergency Care

South East Coast Ambulance NHS Foundation Trust (SECAmb)

- Ray Savage, Strategic Partnerships Manager
- Matthew Webb, Director of Strategic Partnerships and System Engagement
- Rhiannon Darling, Operating Unit Manager

University Hospitals Sussex NHS Foundation Trust (UHSussex)

- Harvey McEnroe, Managing Director for UHS

Sussex Partnership NHS Foundation Trust (SPFT)

- John Child, Chief Delivery Officer at Sussex Partnership Foundation Trust
- Rachel Walker, Operational Director, CAMHS, Specialist, Learning Disability/Neurodevelopmental Services
- Dr Alison Wallis, Clinical Director - CAMHS and Specialist Services

East Sussex County Council

- Mark Stainton, Director of Adult Social Care and Health
- Alison Jeffery, Director of Children's Services

LEAD OFFICER: Harvey Winder, Scrutiny and Policy Officer

9. MINUTES OF THE MEETING HELD ON 30TH JUNE 2022

9.1. The minutes of the meeting held on 30 June 2022 were agreed as a correct record.

10. APOLOGIES FOR ABSENCE

10.1. Apologies for absence were received from:

- Cllr Mary Barnes
- Cllr Mike Turner
- Jennifer Twist

11. DISCLOSURES OF INTERESTS

11.1. There were no disclosures of interests.

12. URGENT ITEMS

12.1. There were none.

13. HOSPITAL HANDOVERS

13.1. The Committee considered a report providing an update on the work being undertaken to reduce Hospital Handover times between South East Coast Ambulance NHS Foundation Trust's (SECAmb) ambulances and the Emergency Departments (ED) of the three hospital trusts that provide services to East Sussex residents.

13.2. The Committee asked why performance at the Royal Sussex County Hospital (RSCH) was an outlier compared to other hospital trusts, particularly given conveyances to the hospital had not increased recently, and asked whether enough was being done to improve the service when compared to the number of actions being taken elsewhere.

13.3. Harvey McEnroe, Managing Director for University Hospitals Sussex NHS Foundation Trust (UHS), said UHS accepts that the RSCH continues to be an outlier in its handover performance, despite improvements in other hospitals owned by UHS. There are three reasons for this:

1. the challenges with the estate restricting the flow of patients through the ED, made worse by COVID-19 infection prevention measures restricting how the corridors are managed;

2. the increasing acuity of patients presenting at the ED via ambulance makes it more complicated to manage them, having a knock-on effect to admissions, despite the Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC) streaming off lower acuity capacity; and

3. the flow of admissions through and out of the hospital, including delays in discharging patients, has a knock on effect on the flow of patients from ambulances into the ED. The hospitals improvement programme is aiming to improve the flow of patients within the hospital, but there is a wider system issue with the number of Medically Fit for Discharge (MFD) patients waiting for discharge, which has not improved as much as other UHS-run hospitals.

13.4. There is an additional issue of the fatigue of staff following an extremely difficult winter and summer and the lingering effects of COVID-19. This limits the extent to which staff can respond to changes in the ED. He clarified they are being helped as much as possible through the process.

13.5. Harvey McEnroe explained that the Trust is developing an Urgent and Emergency Care Improvement Plan for RSCH that will set out plans to improve patient flow. The top priority for UHS is to eradicate the 60-minute handover delays and then prioritise 30-minute handovers. The relationship between the ED Team and SECAmb has dramatically improved over the past 6-8 months, in part driven by the implementation of Fit 2 Sit and the Full Capacity Protocol (which moves people out of ED to prioritise the ambulance crews), and by replacing the culture of seeing the ambulance queue as an extension of the ED and treating them as a priority. Ray Savage confirmed SECAmb is working incredibly hard with UHS to expedite handovers at the RSCH, including embedding a member of staff in the department during busy periods to assist

ED teams. He added that handovers are a system wide issue and often delays in the ED are caused by the delays in the discharge of MFD patients. Ray Savage assured the Committee the ambulance trust would continue to work with UHS in the coming months, during what is expected to be a very challenging winter, to reduce if not eliminate 60-minute handover times and then focus on over 30-minute handovers.

13.6. The Committee asked for further details on the number of MFD patients waiting for discharge.

13.7. Mark Stainton, Director of Adult Social Care and Health, said that ambulance delays are a manifestation of a system under pressure, but are not a new problem and will not be solved overnight. All organisations present at the meeting will have staffing challenges to some extent and for the East Sussex County Council (ESCC) Adult Social Care Department (ASC) it is care workers in the independent sector. The current challenge around discharge of MFD is around the availability of beds in care homes and other alternatives to residential care in the community. Whilst under pressure, there is less challenge in the non-residential care sector, as ESCC took steps to increase the volume of home care workers, including the successful overseas recruitment of over 100 home care workers from two Eastern European countries and the Far East.

13.8. Mark Stainton added that there is a need to prevent people going to hospital in the first place through admissions avoidance and prevention, and providing alternative pathways for SECAmb to ambulance conveyance, such as the rapid response community nursing service, joint community rehabilitation service, and access to GP appointments within 24 hours. There is an expected announcement of further financial support from the new Secretary of State over the winter period to support discharges.

13.9. However, funding is only part of the issue and getting people into the roles and working effectively is not something that can be achieved overnight. In addition to overseas recruitment, some of the initiatives to address the recruitment challenges include offering apprenticeships; schemes supported by the Department of Work and Pensions to provide the long-term unemployed on Universal Credit with trial employment whilst protecting their benefits for a period of a month; and working with veterans associations to offer positions to ex-military personnel seeking an alternative career.

13.10. The Committee asked what could be done to improve patient flows within hospitals.

13.11. Richard Milner, Chief of Staff at East Sussex Healthcare NHS Trust (ESHT), said the Rapid Assessment and Triage areas would be reopened (through resolving staffing issues) in Eastbourne District General Hospital (EDGH) in October and Conquest Hospital in early November. The purpose of them is to rapidly assess lower acuity patients in a separate area to free up the flow through the wider ED. Mark Stainton added that ASC staff are present in the EDs and gateway wards at ESHT and their role is, where possible, to help avoid admissions into an inpatient bed. This is achieved through the use of block-purchased home care hours, enabling the patient to receive rapid support at home.

13.12. Harvey McEnroe said UHS has a robust model of alternative support for patients who fit the criteria of admission avoidance, including the Fit 2 Sit area where patients with more moderate acuity are streamed to within the ED, creating capacity for ambulance flow into the majors area. There is also the Stream Away pathway for patients who arrive and are assessed but are not deemed to need ED treatment. He said around 8 patients a day at RSCH, 3 in Princess Royal Hospital and 6-7 in Worthing and Chichester Hospitals attend who would not

have needed to come to ED if there was something in the community to help them. UHS is continuing to work with SECAmb to develop these alternative pathways.

13.13. Katherine Holmes, General Manager for Emergency Care at Maidstone and Tunbridge Wells NHS Trust (MTW), said that in Tunbridge Wells Hospital there is a 14-bed Rapid Assessment and Treatment (RAT) area where ambulance attendances to the department are managed, avoiding the usual triage process. COVID-19 measures can make dealing with patients in a timely manner more challenging in this space, however. There is a community team in the ED that treats patients where appropriate, and a frailty department that can take direct ambulance admissions. The ED also allows SECAmb to take appropriate patients directly to the Same Day Emergency Care (SDEC) area to prevent them waiting in the ED. The Trust also works with SECAmb to analyse the cause of any 60-minute wait time breaches and takes into consideration any learning from it.

13.14. The Committee asked what the effect will be on discharge rates of patients from the new social care reforms, including the cost cap, increased eligibility rate and the assurance framework.

13.15. Mark Stainton said a report to ESCC's Cabinet on 29th September will set out the impact of the social care reforms due to come into effect in October 2023 on ESCC, both in terms of cost to cover the cap and the number of staff needed to undertake social care and financial assessments of the around 3,000 additional people likely to be eligible for subsidised care support. ESCC is in a reasonable position compared to other councils in England and the Council, in anticipation of this additional demand, has begun a comprehensive programme of preparation. This includes developing software that enables people to self-service their care accounts, with remote support from ESCC, and beginning the recruitment of the additional roles needed to create 3,000 additional care accounts. Mark Stainton said ASC already has a well-established internal quality assurance framework and welcomes the national assurance framework, from April 2023, as it will provide external validation of the work of the Department – as is already the case for the NHS and Children's Services Departments.

13.16. The Committee asked when each Trust might return to the 15-minute handover target.

13.17. Richard Milner said that there is no firm timeline for achieving this target. The purpose of developing the changes in handover practices is to build a model that is designed to reduce handover times and to monitor their impact to ensure they are the right actions and improve if not. After that point, a timeline may be developed.

13.18. Katherine Holmes said the mindset of zero tolerance to over 60-minute delays is already embedded, as at MTW all over-60 minute handovers are discussed and investigated with SECAmb.

13.19. Harvey McEnroe confirmed that the Urgent and Emergency Improvement Plan will include internal trajectories for the eradication of 60 and 30-minute handovers. All 60-minute delays are treated as a serious incident and reviewed accordingly.

13.20. The Committee asked why Conquest Hospital appeared to have longer handover delays than Eastbourne District General Hospital (EDGH).

13.21. Richard Milner said that most efforts are focussed on over 60-minute delays, which are greater in EDGH due to the type of patients seen at that ED. Due to the specialisation of the two hospital sites, more elderly and complex patients are taken to EDGH, whereas Conquest Hospital receives less complex patients and is able to treat a larger number of them in the Fit 2

Sit areas. Rhiannon Darling, Operating Unit Manager, SECAmb, said that the streaming of patients means patients who have experienced trauma are more likely to go to Conquest, and these patients are unwell but relatively non-complex. The patients taken to the EDGH, on the other hand, do not have such a clear medical pathway and on arrival the correct pathway to stream them to is not as simple or obvious as it is for someone with a traumatic injury. This means that it takes more time to diagnose and move the patient to either the SDEC or the Acute Medical Unit (AMU). Based on data from last week, the handover times were roughly the same, but Conquest has had quite a few more patients than EDGH.

13.22. Ray Savage explained that SECAmb's conveyances to hospital have generally reduced over the past two months due to new, non-conveyance pathways that are available to paramedics following assessment of a patient. Around half of patients who call 999 are treated on these non-conveyance pathways. The pathways include patients being given advice and support, or an intervention by the ambulance crew and left safely at home, or the ambulance crews call Health and Social Care Connect (HSCC) and refer the patient to community-based teams such as the urgent community response teams. The upcoming virtual wards will also mean ambulance crews can contact the clinical team who are responsible for the patient to speak to them about an alternative to conveyance. Paramedic practitioners also sit within the ambulance hubs and can speak to paramedic crews about the best course of action for a patient. Ray Savage explained that the capacity of these other services, or the time of day the intervention takes place, means that sometimes conveyance is the only option available.

13.23. The Committee asked to what extent hospital trusts are speaking with each other about sharing good practice to solve the problems at UHS.

13.24. Harvey McEnroe confirmed that UHS is eager to take system learning from other hospital trusts both directly and in collaboration with commissioners and SECAmb. The Trust is also seeking to implement national guidance with assistance from the Urgent Care Improvement scheme, with members of the national team due to attend to support the ED team shortly. He added that a lot of the good practice would need to be implemented elsewhere in the hospital, as patient flow through wards and the patient discharge process are often the causes of delays in moving patients through ED.

13.25. Jessica Britton added that there is a comprehensive whole-system programme from NHS Sussex to manage hospital admissions over the winter period and its outcome will be reported to HOSC in the new year.

13.26. The Committee RESOLVED to:

1) Note the report;

2) Request that UHS circulates via email its Urgent and Emergency Care Improvement Plan for the RSCH; and

3) Request a further report on hospital handover performance, including evidence of how trusts have worked together to make a difference, for the 29 June 2023 meeting, following the end of the winter period.

14. SOUTH EAST COAST AMBULANCE FOUNDATION NHS TRUST (SECAMB) CARE QUALITY COMMISSION (CQC) REPORT

14.1. The Committee considered a report providing an overview of SECAmb's Care Quality Commission (CQC) report findings, following a rating of inadequate in the well-led domain, and the Trust's Improvement Plan.

14.2. The Committee asked how staff are involved in the improvement plan.

14.3. Matthew Webb, Associate Director of Strategic Partnerships and System Engagement, confirmed SECAmb is absolutely listening to staff and not just transmitting to them. The Trust has now spent the last 6 months listening to staff, as it began its improvement journey last year through the 'Better By Design' programme prior to the release of the CQC report in June. Matthew Webb said that Better By Design did not address all the concerns identified by the CQC Report but demonstrated there was a recognition of the fundamental concerns and issues that needed to be addressed as an organisation. He confirmed the Trust recognises staff can contribute to each of the four improvement pillars and are helping to co-design them. There are also leadership visits being undertaken by middle managers and Board members to meet staff and listen to their challenges and concerns, as well as opportunities for staff to communicate via email with executives and receive a response to their concerns. Cultural change will take time, so in the short term ahead of winter, the Trust is aiming to ensure staff have the right toolset, resources and support to enable them to respond to patients effectively.

14.4. The Committee asked when SECAmb is aiming to exit the Recovery Support Programme (RSP).

14.5. Matthew Webb explained the Trust has worked through a number of criteria with NHS England covering how it will exit the Recovery Support Programme (RSP). It is working towards a period of 9-12 months before it will leave the RSP, at the earliest. However, a target end date is currently being agreed with NHS England and commissioners. The CQC has also issued warning notices that must be achieved by November 2022. Issues around culture, however, will likely take 24 months or more to fix.

14.6. The Committee asked why the Trust's CQC rating slid backwards to inadequate following achieving good in 2019, and asked what reassurance could be given it will not happen again.

14.7. Matthew Webb agreed that the Trust made a number of improvements between 2016 to 2019, however, it did not as an organisation maintain or sustain them. This is because at the time SECAmb developed a CQC Action Plan to rectify the issues raised by the CQC, which it treated it as a transactional plan to satisfy the CQC's warning notices. This time, however, SECAmb has developed an Improvement Plan, which is a long term plan recognising the significant journey the Trust is on not just to address the cultural issues raised by the CQC, but also to improve the quality of care it provides and develop the best support it can to staff. The Improvement Plan aims to ensure these changes are embedded and sustained over the long term.

14.8. The Committee asked whether the training for managers outlined in the Improvement Plan is sufficient and whether enough is being done to embed whistleblowing and other measures that allow staff to raise concerns.

14.9. Matthew Webb said SECAmb recognises the position it is in, including the disconnect between the board and senior leadership team and staff, but it is by no means an outlier amongst ambulance trusts in terms of the pressure it is under.

14.10. Matthew Webb said that the Trust will adopt national frameworks for the National Culture Transformation Programme and Freedom to Speak up, rather than develop its own. The Trust is working with NHS England to implement the frameworks, including developing comprehensive training that will be rolled out to staff.

14.11. Matthew Webb said the Trust is engaged with subject matter experts nationally who will deliver that training to ensure it is tailored to the needs of the staff.

14.12. The Committee asked what effect bullying culture has on staff recruitment and retention.

14.13. Matthew Webb said SECAmb is not an outlier amongst ambulance trusts in the difficulties it faces recruiting and retaining staff. He agreed it was the case, however, that the culture is not where it needs to be and more than likely it is having an impact on retaining staff. One of the four improvement pillars includes a workstream on recruitment and retention, and the Trust is focussing on the retention of staff together with recruitment, because of the difficult recruitment market. Work around retention includes understanding why people leave and what can be done to make SECAmb the employer of choice, and providing clinical staff with the opportunity for portfolio working that helps to expand their knowledge of different clinical areas.

14.14. Matthew Webb added that, whilst not responsible for the culture of the trust, a number of changes to the senior management have taken place. This includes a new Interim Chief Executive, Interim Chief Finance Officer, Executive Director for Planning and Business Development, and Chief Nursing Officer. There has been some positive feedback from staff about the visibility of the Leadership Team and the opportunities to engage with them.

14.15. The Committee asked for confirmation whether staff pay for their own training, as outlined in the CQC report, or whether there is a lack of communication about the available opportunities.

14.16. Matthew Webb said he was not aware of staff needing to pay for their training where it relates to their primary role and SECAmb, like others in sector, has a mechanism for professional development. However, the governance procedures around how staff undertake continuing professional development (CPD) was not clear, resulting in disparities and variation in staff training. The policy for CPD, including sign off and funding, is being developed as part of the Improvement Plan.

14.17. Ray Savage added that there is statutory and mandatory training for all clinicians that involves a 2-day classroom-based training session. Online mandatory training is also required for clinical and non-clinical staff. Registered clinicians must also engage in CPD in order to maintain their registration. Where the CPD is related to their role it is funded by the Trust, including some external training run by acute and community trusts. However, applications for CPD less relevant to the role may not be funded by SECAmb.

14.18. Matthew Webb argued there was a need to acknowledge that when the CQC undertook the inspection in February 2022 the country was only just transitioning from the COVID-19 response recovery. During the COVID-19, the Trust was working to the highest level of escalation an ambulance trust can operate at, REAP 4. When operating at this escalation level, there are certain actions that an ambulance trust must undertake to ensure it remains as responsive as it can for patients. This includes cancellation initially of non-mandatory training

but potentially all training for staff to make sure they can be reassigned to service delivery. This meant the feedback the CQC received would have been reflective of this period of the COVID-19 response.

14.19. Matthew Webb said the Trust has continued to operate at REAP 4 and REAP 3 during recent months and demand on the Trust is high, but statutory and mandatory training has been preserved since the Trust moved into COVID-19 recovery. This ensures that clinical and non-clinical staff have the skills they need to undertake the job to the best of their ability.

14.20. Matthew Webb added that the Trust is committed to ensuring staff receive their statutory and mandatory training, but its Improvement Plan involves doing more around the provision of CPD training and how the Trust supports its staff in undertaking it. There is also a need to ensure non-clinical staff, who do not need to undertake CPD to retain a professional registration, have the same opportunities to develop and progress.

14.21. The Committee asked whether staff-side union representation is involved in developing the four improvement pillars.

14.22. Matthew Webb said the four pillars have been informed by the CQC inspection, the key challenges and concerns identified in the NHS Staff Survey, and the feedback and intelligence of union colleagues. He added that there is a need to include staff members and their union representatives in the improvement journey and the communications and engagement plan includes opportunities for staff and union colleagues to contribute and codesign the workstreams of the four pillars.

14.23. The Committee asked for details of the current staff turnover and vacancy rates.

14.24. Matthew Webb said this information was not available to hand but could be provided to the Committee. He agreed an improvement in these two factors would be useful metrics to indicate an improvement in the culture of the Trust, however, the NHS is not in a good place currently with regards to workforce and the systemic challenges to the healthcare services.

14.25. Ray Savage added that there were still a good number of staff applying for internal development from other roles to become registered paramedics. This showed that staff were keen to work within the organisation. There is also an issue of paramedics leaving for other parts of the healthcare system, meaning they are not leaving just because they are unhappy with SECAmb but they want to broaden their clinical expertise, such as in a GP Practice.

14.26. The Committee asked how the Trust will measure its improvements.

14.27. Matthew Webb said the Trust will measure quantitative improvements via a newly developed dashboard that contains key metrics to measure significant improvement. For example, an increase in staff reporting incidents and a reduction in the number of staff coming to detriment as a result of the reporting or incident in the first place. The Trust Board is also monitoring the improvements the Trust is making on a monthly basis. The Staff survey will also show quantitative improvement, although it is not likely to be significant in the upcoming staff survey, as cultural changes take time. The themes and trends of the various listening activities undertaken by the Trust's leadership will also be reported back and listened to.

14.28. The Committee RESOLVED to:

1) Note the report;

2) Request that details of the current staff turnover and vacancy rates are circulated via email, including numbers of staff leaving to other clinical roles in the healthcare system;

3) Request a further report on the progress of SECAmb exiting RSP at its 29 June 2023 meeting;

4) Request that any future SECAmb CQC reports, and SECAmb's monthly Board assurance updates are circulated via email.

15. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

15.1. The Committee considered a report providing an update on the Child and Adolescent Mental Health Services (CAMHS) in East Sussex, including the progress being made to reduce assessment waiting times and the impact of additional investment in CAMHS on service provision and performance.

15.2. The Committee asked how young people on the waiting list are monitored and kept safe whilst they await an assessment.

15.3. Jessica Britton explained that significant resources have been prioritised locally in 2021/22 and 2022/23 to support specialist CAMHS services, particularly eating disorder services and the neurodiversity assessment pathway. There is a programme of work to understand the resources and staffing required to meet the demands of the waiting list and there will be a significant piece of work to support it.

15.4. Alison Wallis said that CAMHS is a needs-led service meaning those young people who are most unwell do get seen more quickly. This results in a number of young people who are not as high priority being on the routine waiting list. All referrals are via the Single Point of Access and Advice (SPoA) and if there is not sufficient information from the referral to prioritise the patient, the referrer, patient, or their parents will be contacted to understand how quickly they need to be seen. Alison Wallis set out some of the support provided to children and young people, and their families, once on the waiting list, including:

- SPFT sends clear information to the family about who they should contact if they become more concerned about their child;

- NHS Sussex has also commissioned AMAZE to provide navigation support for parents for the support they can give their children whilst they wait;

- SPFT sets clear expectations of the service families will receive and how CAMHS will meet them;

- If someone is concerned about the deterioration, they can contact the Duty Team that have slots available for longer consultations with the child, both over the phone or face to face;

- Families are proactively contacted every six months to see if there are any concerns or change in their child's presentation; if so, it will be reviewed;

- A lead practitioner is assigned to a young person who is waiting if there are concerns about them. The Lead Practitioner regularly contacts the child, their family and those in close contact with both, such as social workers or schools, to develop an understanding of how the child is functioning to see if there is a need to do something about that child's priority within the waiting list;

- CAMHS has multi-agency conversations with social care, schools and youth offending services to discuss how best to support a child if necessary, including an evidence-based intervention from CAMHS, or community support that can reduce their symptoms;

- Work is also underway as a partnership with a local university to develop training on how to support people with neurodevelopmental disorders in their home setting, in order to help understand how best support people whilst they are waiting.

15.5. Alison Wallis added that not all patients on the waiting list will benefit from one-to-one interventions. Some will benefit from an evidenced based transdiagnostic intervention delivered in a group that enables more targeted but fewer sessions for those who have more mild acuity.

15.6. Two new roles have been piloted to help increase the clinical capacity of CAMHS:

- administrative assistants who support clinicians by carrying out much of their administrative work and reduce the "child not brought" numbers by contacting the family the week before an appointment; and

- "sticky workers" who stay working with a specific young person to support them from an acute setting into the community, stabilise them and help them with school and other activities that support them in the community.

15.7. The Committee asked what can be done to increase the number of schools that receive support from the Mental Health Support Teams (MHSTs).

15.8. Jessica Britton said MHST is a national programme and there are national expectations on the rollout of it locally into schools. The schools targeted locally are based on an Equality and Health Inequalities Impact Assessment (EHIA) determining where funds will have best effect. Alison Jeffery, Director of Children's Services, explained the Government has outlined the number of schools that should receive MHST and there is no expectation that it will become a universal service, with the current target being 51% of schools being covered, although ESCC has lobbied for there to be funding for a comprehensive service. Funding is ring fenced and ESCC oversees the service and employs and manages the MHST staff. ESCC also employs two additional staff to work with all schools on developing a whole-school approach to the promotion of mental health.

15.9. The Committee asked what the levels of vacancies were like in CAMHS.

15.10. Rachel Walker said East Sussex CAMHS has the least recruitment challenges out of the areas covered by SPFT and the service has managed to recruit to the majority of vacancies created through the increased funding. Alison Wallis added that a retention strategy is something SPFT has spent a lot of time on and includes the new roles that will reduce administrative burden on staff, greater support for clinicians to help them feel more supported,

and CPD and a robust internal training programme for clinical and operational staff to help ensure there are opportunities for promotion and career development.

15.11. The Committee asked about the impact of the cost-of-living crisis on mental health.

15.12. Rachel Walker said there has been an increase in the number of young people not brought to appointments across all services. Work is underway to establish whether the cost of living is contributing to this, for example, whether parents cannot afford to bring their child. Whilst assessments are normally face to face, alternatives would be offered if they are not practical, such as remote consultations.

15.13. The Committee asked whether iRock would be expanded, particularly in the rural areas of the county.

15.14. Rachel Walker said she would support an expansion of iRock given its support of young people who may not need specialist interventions, but additional funding would be required. There is an increasing digital offer for young people to engage with that does not rely on geographical location and includes a recent, successful Instagram Live session on the different presentations of mental health issues like anxiety and depression, and how to cope with them.

15.15. The Committee asked how discharge rates could be improved.

15.16. Alison Wallis agreed discharge is something SPFT focuses on a lot and is very important for patient flow and the clinical outcomes of patients. CAMHS sets goals with a young person when they first meet clinicians and this is used as a point of reference that enables the review of goals with the family and young person later on, in order to show positive and sustained changes. It has been more difficult to do this consistently during COVID-19, and as a result, the length of time in the service became longer, especially as people coming into service during COVID-19 were often more unwell and in crisis – making getting them back to normal functioning more difficult. The Trust is now focusing on restoring this mechanism and focusing on discharge more widely through weekly team discussions and undertaking discharge planning during one-to-ones on clinical case load.

15.17. The Committee asked why waiting times are generally longer for people with neurodevelopmental disorders

15.18. Alison Jeffery explained that ESHT's paediatricians undertake Autism Spectrum Condition (ASC) diagnosis for 0-11 and CAMHS clinicians do ASC diagnosis for over 11s and Attention Deficit Hyperactivity Disorder (ADHD) diagnosis for the whole age range. Some of the particularly long waits that the Committee members hear about from residents are for under 11 year olds waiting for an ASC diagnosis. There is a separate NHS Sussex project to streamline the process involving all the services, but it is quite complex and the demand on the services is very high.

15.19. The Committee asked when the additional investment may result in a downward trend in the number of young people waiting for an assessment.

15.20. John Child said the peak in referrals for neurodevelopmental disorders has not necessarily been reached yet, with increased demand so far outstripping the investment in additional resources. It is therefore hard to define a date with any confidence at this point in time. Rachel Walker added that overall, for all mental health needs there had been a 27% increase in resources but 54% increase in demand. John Child said the system wide waiting time transformation programme, designed to quantify the amount of resource needed to bring

down waiting times to a clinically suitable timeframe, will hopefully provide more clarity. This should include more resources, pathway redesign, particularly around ASC diagnosis, and potentially greater outsourcing of assessment to independent sector organisations for children and young people on the waiting list.

15.21. The Committee discussed the need to make further representations on the assessment waiting times.

15.22. Alison Jeffery said the national access standards for CAMHS is a third of children who need specialist support receiving it, which the national Association of Directors of Children's Services believes is too low and would not be expected for any other condition. If the Committee wanted to lobby about funding it might also be appropriate to raise the issue of the target. John Child welcomed the approach of articulating the current levels of need, and the winter demand and cost of living crisis.

15.23. The Committee RESOLVED to:

1) Note the report;

2) Request a future report on the progress of the waiting times for CAMHS, including progress on the development of the neurodevelopmental pathway, figures for the numbers of young people waiting more than 52 weeks, and how long young people wait between assessment and the beginning of treatment; and

3) Request that the Chair of the Committee writes to the Leader of the Council requesting they undertake further lobbying through all available channels for greater CAMHS funding, highlighting the pressure on the system particularly over the upcoming winter period, and recommending an increase in the national access standards for CAMHS above the current target.

16. HOSC FUTURE WORK PROGRAMME

16.1. The Committee considered its work programme.

16.2. The Committee RESOLVED to agree its work programme.

17. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

17.1. There were none.

The meeting ended at 12.45 pm.

Councillor Colin Belsey

Chair

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

Date of meeting: **15 December 2022**

By: **Assistant Chief Executive**

Title: **NHS Sussex Winter Plan**

Purpose: **To provide an overview of the NHS Sussex Winter Plan 2022/23.**

RECOMMENDATIONS

The Committee is recommended to consider and comment on the report

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1. Background & supporting information

1.1. Winter planning is an annual requirement of the NHS to ensure that the local health and social care system has sufficient plans in place to effectively manage the capacity and demand pressures anticipated during the Winter period. The Sussex Winter Plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. The Plan period runs this year from October 2022 to April 2023.

1.2. Winter Plans are developed with input from partners across the system including local authorities, providers, commissioners and the voluntary sector. This report highlights the Sussex wide and East Sussex specific elements of the plan. It should be noted that there has been no reduction in operational pressures over the summer months and providers are entering winter with significant capacity pressures (availability of workforce and service capacity) for all organisations. The process for developing the system Winter Plan was agreed by the three place based Sussex Local Accident and Emergency Delivery Boards, and covers all service areas across health and care, including the Voluntary Sector.

1.3. A summary of the NHS Sussex Winter Plan 2022/23 is attached as **Appendix 1** for consideration by the HOSC and covers the following topics:

- *Development of the Winter Plan*
- *The Winter Operating Model*
- *The Winter Operating Delivery Plan*
    - *Aligning Demand and Capacity*
    - *Discharge*
    - *Improvements in ambulance service performance*
    - *Improving NHS 111 performance*
    - *Avoiding admission and alternative 'in hospital' pathways to improve flow*
    - *Infection Prevention and Control*
    - *Seasonal vaccination programme*
    - *Workforce*

    - *Communications*
    - *Planned Care Recovery Programme*
    - *Mental Health*
- *Enhanced Work Streams (Rapid Improvement Pathways)*
    - *Out of Hospital Urgent Care*
    - *Frailty Pathways*
    - *Discharge*
    - *High Risk Cohorts*
    - *Mental Health Crisis Resolution*
- *Local Plans – East Sussex*
    - *Acute Hospital Urgent Care Services*
    - *Admission Avoidance*
    - *Discharge*
    - *Primary Care Winter Planning*
    - *Public Health*

2. Conclusion and reasons for recommendations

2.1 HOSC is recommended to consider and comment on the NHS Sussex Winter Plan.

PHILIP BAKER
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NHS Sussex

NHS Sussex Winter Plan

Report for Health Overview and Scrutiny Committee

December 2022

Better health and care for all

1 TABLE OF CONTENTS

NHS Sussex Winter Plan....2
1.0 Introduction....2
2.0 Background....2
3.0 Development of the NHS Sussex Winter Plan....3
4.0 The Winter Operating Model....3
4.1 System Operations Centre....4
4.2 Governance....4
5.0 The Winter Operating Delivery Plan....5
5.1 Aligning demand and capacity....5
5.2 Discharge....5
5.3 Improvements in ambulance service performance....6
5.4 Improving NHS 111 performance....6
5.5 Avoiding admission and alternative 'in hospital' pathways to improve flow....7
5.6 Infection Prevention and Control....8
5.7 Seasonal vaccination programme:....8
5.8 Workforce....9
5.9 Communications....9
5.10 Planned Care Recovery Programme....10
5.11 Mental Health....10
6.0 Enhanced Work Streams (Rapid Improvement Pathways)....11
6.1 Out of hospital urgent care....11
6.2 Frailty pathways....11
6.3 Discharge....12
6.4 High Risk Cohorts....12
6.5 Mental Health crisis resolution....12
7.0 Local Plans – East Sussex....13
7.1 Local Plans – East Sussex....13
7.2 Acute Hospital Urgent Care Services....13
7.3 Admission Avoidance....14
7.4 Discharge....15
7.5 Primary Care Winter Planning....16
7.6 Public Health....17
8.0 Summary....17

NHS Sussex Winter Plan

1.0 Introduction

This report provides a summary of the overall Sussex Winter Plan. The plan spans the period from October 2022 to April 2023. The report highlights the Sussex wide and East Sussex specific elements of the plan for assurance for the Health Overview and Scrutiny Committee.

The Sussex Winter Plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. It is an annual national planning requirement and provides assurance that the system and partners have the necessary measures in place to deliver health and care for the local population.

2.0 Background

The Sussex health and care system faces an extremely challenging winter. Locally and nationally, the health and care systems are experiencing significant operational pressure across many of their services. Some patients are experiencing delays in accessing both planned and unplanned healthcare, despite the best efforts of our workforce. There has been no reduction in operational pressures over the summer months and providers are entering winter with significant capacity pressures (availability of workforce and service capacity) for all organisations.

In addition to the current pressures, we face a range of hard to quantify risks such as the potential for further waves of Covid-19, high incidence of flu cases mirroring the Southern Hemisphere, increases in respiratory illnesses and the impact of the cost of living on both our workforce and our patients.

Recognising this risk, on 12 August 2022, in the letter titled '*Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter (*B1929_Next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winte.pdf (england.nhs.uk)). NHS England described the actions they expected all systems and providers to take to increase capacity and operational resilience in urgent and emergency care ahead of winter.

Since the receipt of that letter on 12 August there have been two further national communications relating to winter. The Secretary of State for Health's 'Plan for patients', issued on 22 September (Our plan for patients - GOV.UK (www.gov.uk)), and a further communication on 18 October titled 'Going further on our winter resilience plans' (NHS England » Going further on our winter resilience plans). Both set out additional measures which systems and providers are expected to implement to improve service delivery this winter.

The NHS Sussex Winter Plan addresses the requirements of the national letters and plans, and has been built bottom up, to respond to the capacity challenges surfaced through the modelling of expected pressure for this winter. In addition to locally agreed actions to address the capacity challenges, we have established rapid improvement workstreams that are being applied across the system, led jointly by NHS Sussex executives and executives from partner organisations. These workstreams are drawing on best practice examples, to ensure people receive the right care from the right organisation at the right time and are supported to return to their normal place of residence at the earliest opportunity.

3.0 Development of the NHS Sussex Winter Plan

NHS Sussex has developed its Winter Plan in conjunction with partners to ensure that we can deliver safe and effective services for Sussex residents throughout the winter. It has been developed taking into account feedback and learning following evaluation of the Winter Plan for 2021/22.

Contributors to the Plan include:

- East Sussex Healthcare NHS Trust (Acute and Community).
- University Hospitals Sussex NHS Foundation Trust (Acute).
- Sussex and Surrey and Sussex Healthcare Trust (Acute).
- Sussex Community NHS Foundation Trust (Community).
- Sussex Partnership NHS Foundation Trust (Mental Health).
- Local Authorities (Adult Social Care, Children's Services, Public Health) and District Councils.
- South East Coast Ambulance Service NHS Foundation Trust.
- Primary Care.
- The Voluntary Sector.

The plan incorporates the requirements set out within these national communications. There are three key elements to our approach:

- The establishment of a system wide winter operating model.
- The development of our winter operational plan for delivery, incorporating the use of the National Urgent and Emergency Care (UEC) Assurance Framework – a framework developed by NHS England, designed to be a helpful tool to support Integrated Care Boards (ICBs) in managing winter pressures.
- The mobilisation of several targeted rapid improvement workstreams targeting admission avoidance and timely discharge from hospital.

These three elements are described in more detail in the remainder of this paper.

4.0 The Winter Operating Model

Considering the significant operational challenges and associated risks anticipated this winter, it is important that the system's winter operating model delivers a responsive, well-coordinated, and effective approach to delivery of the winter plan and management of surge

pressures. While our Winter plan outlines **what** it is that we intend to deliver, the Winter Operating Model describes **how** we will deliver it.

4.1 System Operations Centre

The national 'Going further on our winter resilience plans' letter issued on 18 October 2022 (BW2090-going-further-on-our-winter-resilience-plans-letter-october-22.pdf (england.nhs.uk)), sets the requirement for all systems to have in place a System Control Centre from 1 December 2022. NHS Sussex recognised the importance of having a Control/Operations Centre in supporting the management of a safe winter, and so has already instigated the establishment of its System Operations Centre (SOC) in September 2022.

The SOC went live on 3 October. The core team are supported by 'subject matter experts' (SMEs) from across NHS Sussex, including finance, nursing, medical, communications, transformation, digital, primary care, workforce, and operations. This team will co-ordinate the system response to any emerging pressures and work to help unlock issues and identify solutions.

4.2 Governance

The Winter Operating Model has a weekly cycle of system wide executive level meetings, supported by the outputs of the SOC, to ensure we have a mechanism for taking executive decisions on critical issues, in a joined-up way across system partners. Along with daily data insights there is a weekly data information pack which facilitates the monitoring and responding to emerging risks and trends.

A weekly Winter Board has been established, chaired by the ICB Chief Executive, and attended by NHS Provider CEO's, System Executives and Local Authority colleagues. The purpose of the Winter Board is to ensure we take leadership decisions in a joined-up way in response to any issues being escalated by the SOC, or through National or Regional bodies. We recognise that there will be challenging decisions to be taken over the course of this winter and the Winter Board ensures that we have a mechanism to do that in a way that considers the needs of our entire population and the needs of staff working across both health and care.

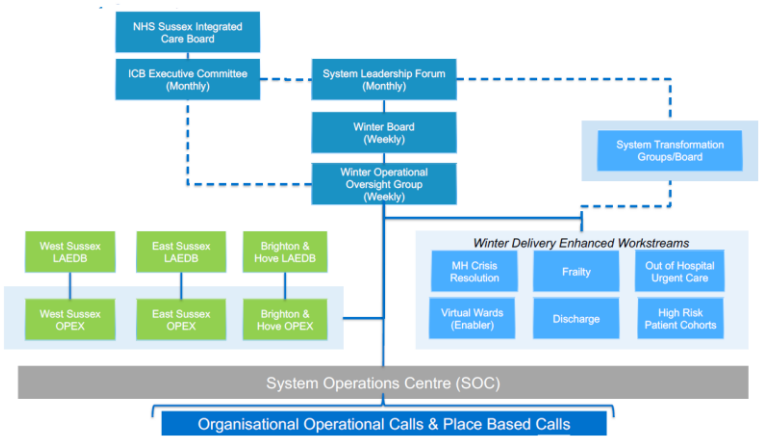


Figure 1: System Winter Governance and Oversight

5.0 The Winter Operating Delivery Plan

The NHS Sussex winter plan has been developed by building on individual provider and partner plans, and aligning with the areas covered by the NHSE assurance framework across the following core domains:

- aligning demand and capacity,
- discharge,
- improvements in ambulance service performance,
- improving NHS 111 performance,
- avoiding admission and alternative 'in hospital' pathways to improve flow,
- preparing for new Covid-19 variants/respiratory challenges,
- workforce, and
- communications.

The process for developing the system winter plan was agreed by the three place Sussex Local A&E Delivery Boards and covers all service areas across health and care, including the Voluntary Sector.

5.1 Aligning demand and capacity

The system has undertaken detailed demand and capacity modelling, informed by public health intelligence and seasonal trends, incorporating likely known pressures such as Flu and Covid, to understand the likely pressure on service capacity. Work is ongoing with UK Health Security Agency (UKHSA) to understand the potential health impact of the cost-of-living crisis so that this can also be incorporated into the modelling.

The Plan includes a range of actions being taken to mitigate the capacity risks identified by the modelling and our approach to delivering safe and effective care.
The impact of the agreed winter plan actions will be monitored through the system SOC throughout the winter period to understand whether these actions are delivering the expected impact or whether we need to increase our focus in particular areas where we continue to see pressures build or new issues emerge.

5.2 Discharge

Timely discharge is essential in supporting the right care in the right place. Discharging patients, with the right support, once they have no further need for acute medical is key to the quality of care received and ensuring a good experience for local people. It also supports improvements in flow through the hospital and a reduction in waiting times for patients in the Emergency Department (ED). This helps reduce the time ambulances may need to handover safely to hospital in a timely way and ensure people are admitted to the right wards where they receive care by the specialists they need to see.

The system has committed additional investment to fund discharge to assess pathways, supported by voluntary sector home support provision, and we are working to optimise workforce capacity through technological innovations including the implementation of a virtual care and virtual ward model.

All providers have local plans to address the '100 Day Discharge Challenge', which is a national initiative of 10 key actions to improve flow through hospitals to support timely safe and effective discharges.

A system wide workstream to further improve discharge and system flow, building upon the continual improvement programmes at place, has been established as a key area for rapid improvement focus over the winter period. Detailed process mapping and evaluation of current pathways has been undertaken to inform the programme of improvement work.

While the majority of patients will be discharged back to their own home with no further care requirements, a number of patients will need additional support from community services or social care. Consequently, the work described above is a multi-agency approach involving all health, social care and voluntary sector organisations who play a role in supporting patients to be discharged from our acute, community or mental health beds.

5.3 Improvements in ambulance service performance

Improvements in ambulance service performance are a key area of focus for this winter, with a particular focus on reducing handover delays and improving ambulance response times.

In respect of reducing handover delays, a clear system escalation framework is in place, which identifies actions for acute providers to take – if there are handover delays at the hospitals. In addition, the Sussex Winter Board has committed to significantly reduce long ambulance delays and the system escalation framework has been amended to reflect this as a key metric.

In respect of improving response times, South East Coast Ambulance Service (SECAmb) have fully implemented their 2018-23 fleet strategy and fleet requirements, in line with their current delivery model. St Johns Ambulance (Ambulance auxiliary service) are in place to support SECAmb and a Care Home line supporting direct access to NHS111CAS to reduce avoidable conveyances.

Within our system plan rapid improvement workstreams there are areas of focused work to improve the response of urgent community services, including the falls response service to reduce the number of category 3 and 4 conveyances, which will in turn improve ambulance response times.

5.4 Improving NHS 111 performance

To support the improvement in NHS 111 performance, additional investment has been made to enable SECAmb to recruit an additional 111 whole-time-equivalent call handlers, which should enable the service to ensure that 95% of calls are answered in 60 seconds and to reduce call abandonment rate to <5%. Recruitment plans are in place and progress is being regularly monitored.

Action is also being taken to improve NHS 111 in respect of Mental Health (MH) crisis response, ensuring that 24/7 MH Crisis lines are in place and integrated with NHS111. SECAmb have seven embedded MH professionals across their footprint, working in their Emergency Operations Centres (EOC) and Clinical Advisory Service (CAS), providing specialist advice and support for people with mental health concerns who access services via both 111 and 999 routes.

5.5 Avoiding admission and alternative 'in hospital' pathways to improve flow

Action to avoid unnecessary admission and alternative' in hospital' pathways to improve patient experience, ensure the right service is available to best support people, and to improve flow, is a key component of the NHS Sussex Winter Plan, with rapid improvement workstreams mobilised to focus on out of hospital urgent care and the establishment of a consistent single point of access to urgent community response services across the whole county being implemented ahead of winter. In addition, there is a focus on strengthening existing community falls response to reduce pressure on the ambulance service where no acute medical support is required, and additional action is being taken to provide preventative personalised care to individuals at high risk of hospital admissions. Further examples of admission avoidance actions include:

- Expansion of Acute Same Day Emergency Care (SDEC) pathways in acute and community services including links to acute multi-disciplinary assessment teams in emergency departments.
- A system wide clinical model for 'virtual ward' (VW) care has been agreed for patients with frailty, respiratory and heart failure conditions. There are currently 54 virtual ward beds available across Sussex and this will increase to 125 by January.
- Urgent Community Response (UCR) to deliver streamlined admissions avoidance pathways to help support people in their usual place of residence.
- Consultant access for advice and guidance to health care professionals in Community and Primary Care services to support decision making and avoid unnecessary referrals to secondary care.
- Self-management advice materials for patients.
- Long Covid services and treatment services for those particularly vulnerable to Covid are in place including supply of oximeters for at risk patients in primary care.

5.6 Infection Prevention and Control

Given the challenges identified for this winter it is critically important that we maintain the highest standards of infection prevention control across our system, and the following core prevention and control measures are in place:

- Provision of Infection Prevention Control (IPC) teams across acute and community settings.
- Daily Covid-19 monitoring.
- Established infection prevention governance monitoring and reporting.
- Specialist infection prevention support across Sussex to provide outbreak management across health and social care providers.

Additional controls being implemented across Winter 2022/23 include:

- Development of an updated Seasonal Infection Prevention Surge Plan.
- System infection prevention cell meeting weekly.
- NHS support to social care providers via local authority Public Health teams.
- Provision of additional specialist training for new infection risks identified.
- Provision of specialist FFP3 mask FIT testing to ensure compliance with National requirements.
- Mutual aid support across IPC teams such as personal protective equipment (PPE).
- Updated Respiratory Syncytial Virus (RSV) and Paediatric Surge Plan for managing increased activity in paediatrics caused by seasonal RSV.

5.7 Seasonal vaccination programme:

Ensuring that we maximise the update of both the flu and Covid-19 vaccination in eligible members of the population and our workforce ahead of winter is a key priority, ensuring that we continue to work with system partners and local communities to improve uptake in parts of our community where there is lower uptake identified.

As of 14th November 2022, 58% of the eligible East Sussex population have taken up an offer of the Covid-19 autumn booster vaccination with 79% of care home residents, 40% of healthcare workers, and 80% of over 80 year olds having taken up the offer.

To support vaccine uptake across East Sussex we are working with system partners on:

- Focused communication and engagement following the eligibility for over 50 year old age group including a media release, social media, and newsletter content.
- Developing the programme's communication and engagement plan for autumn, which has been circulated to appropriate stakeholders.
- A key area of focus continues to be ensuring clear public information about the programme, current eligible cohorts, and delivery models – who, what, how, where.
- Developing areas of focus for hyper local activity to ensure equity of uptake. A specific approach has been taken for groups, which have seen lower uptake to date

across the programme, including translated materials, work with trusted intermediaries, work through Voluntary, Community and Social Enterprise partners, and identifying community leaders to share information and gain support.

- An insight summary is being produced to have a clear understanding across the programme and at Place (e.g. East Sussex) of the insight we have on barriers, challenges and hesitancy, and operational and communication solutions needed. A survey closed on 25 September to understand current attitudes towards the vaccination programme.

As of 6 November 44% of the eligible population have taken up the offer of a flu vaccination with 69% of all 65 and over having been vaccinated. Practices and providers continue to plan and host flu clinics at practice sites. Flu vaccinations are widely available for eligible patients at community pharmacists, local vaccination centres, and practices. Plans for Mobile Vaccination Units in each area are underway to provide additional capacity for the delivery of both Covid-19 and Flu vaccination in areas showing low uptake.

5.8 Workforce

Workforce capacity over winter is an identified risk within our system plan. Therefore, whilst we have been able to increase our workforce number, it is important that we continue with recruitment and retention activity, including overseas recruitment, and ensure that processes are in place to support the health and well-being of our workforce during the winter period and beyond.

The following measures are in place to ensure that optimum workforce levels are in place.

- Robust safe staffing escalation processes in place within each provider.
- System wide mutual aid systems and processes in place to enable the sharing of workforce across providers to maintain safe staffing levels and service provision.
- Sharing of pay rates across the system.
- Assessment of staffing levels daily, and implementation of local response actions to meet shortfalls in capacity.
- New roles and ways of working are being explored, for example the virtual ward programme.
- As a system we are a vanguard nationally in a violence reduction and prevention programme to keep colleagues safe in the workplace
- Our workforce vaccination programme commenced in September to support protection of colleagues from contracting flu and covid infection in support or sickness absence position.

5.9 Communications

To support the NHS Sussex Winter Plan, a Sussex communications and engagement approach has been agreed by all system partners. This aims to provide clear information about services and how people can access the health and care they need, influence

behaviour change, maintain public trust and confidence and gain insight to support further operational solutions and responses.

The overarching approach follows the national 'Help Us Help You' campaign, and is structured over four key focus action areas:

1) Behaviour change campaigns – We will run a series of campaigns under the 'Help Us Help You' banner to signpost to services to encourage greater understanding and usage
2) Public Engagement – We will carry out targeted engagement with identified communities and groups to gain a greater understanding of their barriers/motivations to support operational interventions and delivery
3) Workforce – We will focus on specific communications and engagement with our workforce to support morale and wellbeing
4) Public confidence – We will develop a series of communications that outlines progress and issues in a honest and open way to help maintain public confidence

For each there is a focused action plan to share clear and effective communications with the public, stakeholders and patients. Materials and resources will be shared with all health and care partners, and wider VCSE and community partners to ensure wider sharing to the public and our communities.

Effective communication both with our citizens and our staff is key to ensuring that we can deliver high quality services and treat patients in the most appropriate service and setting for their needs.

5.10 Planned Care Recovery Programme

As a system, our priority is to ensure that the recovery of elective and cancer care services continues, by securing capacity across Sussex which will not be impacted by emergency admissions. This will include using mutual aid between NHS providers, use of the independent sector where necessary, and the further development of Community Diagnostic Hubs. This will help us to continue with our elective recovery plan to diagnose and treat both the most clinically urgent and those that have waited the longest.

There is a Planned and Cancer Escalation Framework which sets out the underpinning principles, key triggers, and actions at each stage of escalation to protect the continuity of planned care and cancer services.

5.11 Mental Health

Mental health services have seen a rapid increase in need, which has placed considerable pressure on the services that are available. Children and Adolescent Mental Health Services have seen particularly significant rises in need as a consequence of the pandemic.

One of the main objectives of the mental health winter plan is to reduce the number of patients having to receive inpatient support outside of the county, recognising the challenges that this creates both for the patient and their families. The plan aims to do this by:

5.11.1 Supporting better clinical decisions at the point of admission.

5.11.2 Reducing length of stay (LoS)

- Creating an Assessment / Triage Ward.
- Developing a clinically led complex case review processes.
- Tackling unwarranted variation in length of stay.

5.11.3 Reducing delays in discharging patients by:

- Maximising the use of Discharge to Assess model in East Sussex.
- Maximising partnerships across East Sussex to support discharge including supporting vulnerable patients (for example, working with our voluntary and community sector)
- Improving how we work across health and social are to assess patients' needs

6.0 Enhanced Work Streams (Rapid Improvement Pathways)

The third component of the system winter plan relates to five rapid improvement pathways, which have been agreed by the senior leadership of the Sussex Health & Care system including local authority colleagues, which are summarised below:

6.1 Out of hospital urgent care

The focus of the out of hospital workstream is to improve ambulance response times

Objectives:

- To improve access to and utilisation of community pathways including a consistent single point of access.
- Develop clear standardised referral and handover pathways into consistent admissions avoidance and other community pathways, to increase direct referrals, and reduce conveyances where appropriate.
- Identify alternative pathways to safely convey suitable patients to destinations other than Emergency Departments.

6.2 Frailty pathways

The focus of the Frailty workstream is to ensure we have clear and effective frailty pathways, including falls services in place, Sussex-wide with a focus on enhanced admission avoidance through early support and intervention in the community, in care homes and in Emergency Departments.

Objectives:

- To improve access to, and utilisation of community pathways to keep patients closer to home.
- Establish core clinical principles of frailty pathway for Sussex.
- Deliver agreed targeted actions across the Frailty Pathway.

6.3 Discharge

The focus of the Discharge workstream is to ensure full implementation of each Place's discharge plan aligned to the Sussex agreed model, delivering the 100-day discharge challenge.

Objectives:

- To evaluate and optimise the current agreed discharge model.
- To agree and establish a set of system metrics across the end-to-end pathway.
- To agree and identify the high impact areas of focus, which will deliver improvements to ensure patients who are 'medically ready for discharge' can be safely discharge in a timely way.

6.4 High Risk Cohorts

The focus of the High Risk cohorts workstream is to identify and support people who maybe at high risk of hospital admission over winter, for example people with long term conditions.

Objectives:

- To offer proactive, personalised care for individuals at high risk of hospital admissions.
- Maximise support through social prescribing link workers, health and wellbeing coaches, and care coordinators.
- Improve symptom and condition self-management.
- Increase access to a broader range of support options in their communities.

6.5 Mental Health crisis resolution

The focus of the mental health workstream is to reduce the number of patients, adults, children, and younger people who are receiving their acute inpatient psychiatric care outside of Sussex

Objectives:

- Reduce number of inappropriate out of area placements (acute psychiatric care).
- Reduce length of stay within acute adults and older adults' inpatient units.
- Reduce number of patients who are identified as medically ready for discharge and not yet able to be discharged.

7.0 Local Plans – East Sussex

All the Sussex wide elements of the NHS Sussex Winter Plan apply to all parts of Sussex. The section below provides details that are additional actions that East Sussex are taking.

7.1 Local Plans – East Sussex

Partners across health and social care have collaborated to develop detailed East Sussex place-based plans. These plans encompass our key community, primary care, acute, mental health and social care services to address the current and expected challenges in demand across the winter months, reflecting on learning from experience of last winter.

The general principles that have been agreed across East Sussex will help to support resilience across all partners to secure delivery of, and access to, health and care services.

The primary aims are to ensure patients have the right support at the right time, and in the right place to maximise reablement and minimise the risk of harm. The system is working together to help patients make best use of options such as:

- Urgent Treatment Centres at Eastbourne District General Hospital, Conquest Hospital in Hastings and Lewes Victoria Hospital
- Minor Injury Units at Uckfield Community Hospital and Crowborough War Memorial Hospital
- Urgent Community Response and Mental Health Crisis Response

Where these options can best meet the needs of local people, they provide alternatives to our Emergency Departments. The system will do all it can to support the safe and timely discharge of patients and reduce the number of patients that are currently in acute and community beds, who are medically ready to be discharged. This includes jointly agreeing and implementing additional physical and mental health, and social care support for local people as part of the national funding allocation.

Local system oversight arrangements are in place across the East Sussex health and care system partners, with senior operational arrangements in place during winter to help support the delivery of urgent and emergency care and discharge objectives. There is also fortnightly system-wide Executive oversight through the East Sussex Health and Care Executive. This is supported by a weekly East Sussex Operational Executive (Opex) to solve any escalated issues, or make timely decisions on new proposals, so that we can remain responsive and flexible throughout the winter to best support local people.

7.2 Acute Hospital Urgent Care Services – East Sussex

East Sussex residents access a range of acute emergency services mainly East Sussex Healthcare NHS Trust (ESHT) from Eastbourne District General Hospital, the Conquest Hospital (Hastings). In addition, patients in the west of East Sussex access services from University Hospitals Sussex NHS Foundation Trust - Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) sites; and patients to the north of East Sussex access services from Maidstone and Tunbridge Wells NHS Trust - Tunbridge Wells Hospital.

The emergency departments at East Sussex Healthcare NHS Trust have seen a significant drop in performance through the Covid pandemic, and other emergency departments serving the East Sussex population have experienced similar challenges. Our plans recognise the importance of improving performance in the context of anticipated winter demand. An increasing number of patients are choosing emergency departments as their first port of call with medical conditions that could often be treated in a different urgent care setting. As such, work is ongoing to improve flow to the co-located and stand-alone Urgent Treatment Centres to maximise the number of patients that can be seen there. In addition, there is close work with a remote GP provider, offering on the day appointments daily, accessible through the Urgent Treatment Centres, therefore freeing up more time for the Emergency medics to treat the seriously unwell.

The challenge to maintaining performance is also associated with an increased number of people who are ready to be discharged but are delayed, which reduces the ability to admit patients through the emergency department. Significant work on ambulance handover is taking place and has previously been reported to the HOSC.

Our local hospitals continue to work to improve flow through the organisation to support the decongestion of the emergency departments. Escalation areas are open to increase the amount of bedded capacity, with further capacity planned to come online in the peak of winter in order to maintain access and support for the local population of East Sussex.

7.3 Admission Avoidance – East Sussex

The Sussex wide enhanced work stream is developing an enhanced admission avoidance access point. The enhanced workstream is also developing the frailty response that will help support patients to remain in their own home rather than being treated in an Emergency Department. This will build on and enhance existing Urgent Community Response Services (UCR) provided by East Sussex Healthcare NHS Trust. In addition, Sussex Community NHS Foundation Trust are introducing Urgent Community Response Services in the west of East Sussex.[1] The UCR services are developing improved access and responsiveness to non-injurious falls, including supporting call outs to Care Homes. The Urgent Community Response teams are working closely with the Ambulance Trust and its crews to increase awareness of the service offer and enable direct clinician to clinician decision making to support referrals into community as an alternative to conveyance.

[1] The Urgent Community Response Service provided by Sussex Community Foundation NHS Trust will initially provide support for local people in the Lewes and the Havens areas, following which the service will expand into the Wealden area.

Our Urgent Treatment Centres (UTCs) at Eastbourne District General Hospital, the Conquest Hospital in Hastings and Lewes Victoria Hospital alongside Minor Injury Units at Uckfield Hospital and Crowborough War Memorial Hospital will help support patients if their condition is better suited to treatment in these settings.

LIVI is a remote GP service which has been commissioned to provide remote consultations to 111 patients. LIVI successfully manages the review and treatment of 70-80% of patients without the need for a face to face appointment. This avoids the patient having to attend in person, and frees up face to face capacity for those with more urgent or complex needs. Suitable patients identified in Emergency Departments will also be offered the option to return home with a pre-arranged phone appointment with one of the LIVI GP's.

Access to Same Day Emergency Care services is also being improved. A set of clinical condition criteria is being developed with each acute medical service to allow SECAmb to directly convey patients with predefined medical conditions, to acute hospital same day care units. These are patients who would benefit from the experience of an acute medical consultant, but who otherwise would have had to go through Emergency Departments, potentially leading to an unnecessary admission. This approach will enable these patients to by-pass Emergency Departments and be directed to the right clinician quickly, with the goal to treat the patient and discharge them within the same day.

Finally, we continue to work with our district and borough councils and our local voluntary and community sector to support people who are homeless or have housing difficulties, those who are more vulnerable and may need help with more complex needs and support people who need help with welfare benefits advice. We also have Safe Spaces in Eastbourne and Hastings town centres operating on Saturday nights, with voluntary sector first aid trained staff who provide support and advice to vulnerable people as part of the night-time economy, endeavouring to reduce pressure on Emergency Departments.

7.4 Discharge – East Sussex

In East Sussex there are well established discharge pathways. The majority of patients can go home with no support. However, a small proportion of patients may need social care support in order to be discharged home, or need to be discharged into either rehabilitation services or into longer term residential or nursing care. East Sussex has developed a Discharge Transformation Programme, which will support better ways of working over the coming 18 months to 2 years. Within this longer term programme, our plans focus on key improvement areas to deliver over winter including working with the voluntary and community sector, supporting vulnerable people, ensuring effective access to equipment, action to support our workforce, improving how we work together across health and social care to assess patients, ensuring effective transport to support discharge and reviewing our discharge pathways and rehabilitation services.

The East Sussex system commissions services with the Voluntary Sector who play an essential role in the local health and care system. These services are being strengthened further over the winter and provide support to patients who may need a little bit of extra help

to get home (but do not need formal support), or to help them stay at home avoiding coming into hospital where appropriate.

East Sussex will continue to prioritise Home First as a preferred discharge pathway, aligning to the strategic principle of enabling patients to return to their own homes following an acute hospital stay, wherever safe and practical, with funding going into the service for both clinical and domiciliary care capacity. As part of our winter plans, we are also increasing capacity for local people who require discharge to a dementia bed in East Sussex.

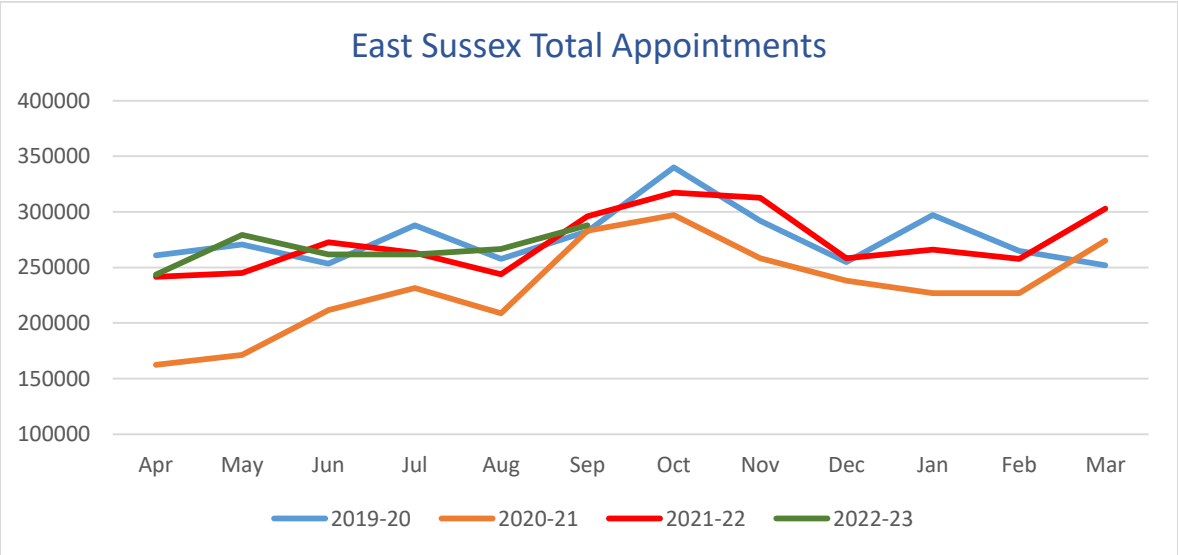
British Red Cross have been awarded a national contract by NHSE to deliver a winter surge capacity. This will increase Assisted Discharge and Home from Hospital capacity

7.5 Primary Care Winter Planning – East Sussex

The approach to this winter has been influenced by patient feedback highlighted, and the experience of last winter. A £3.3m winter fund has been made available across Sussex to ensure better access to primary care. The key areas of focus will be to increase capacity; maximise its effectiveness; and improve communication between providers and with patients as set out below:

7.5.1 Increasing capacity

The table below shows the number of GP appointments offered in East Sussex from April 2019 to September 2022. It highlights the increased number of appointments available during 2022-23 compared to 2021 and shows that the level of appointments available in 2022-23 is comparable to pre-pandemic levels.



We will use the £3.3m winter fund to deliver an additional 86,000 appointments across Sussex. This has been offered to all GP practices in East Sussex, who will therefore be

eligible for an additional £1 per head of weighted population to increase capacity. For those PCNs facing the highest inequalities in East Sussex (Hastings and St Leonards PCN and the ALPS PCN in Eastbourne), they will be eligible for an additional c.£2.37 per head of weighted population to increase capacity.

Increased roll out of the Community Pharmacy Consultation Service (CPCS) will enable GP practices to book patients with a minor illness for a same day consultation with their local pharmacy where appropriate.

We will support PCNs to recruit additional staff, including new GP Assistant, and digital and transformation roles, to ensure patients see the right clinician at the right time, rather than every patient having to go through the GP for a referral to them.

7.6 Public Health – East Sussex

The East Sussex winter plan includes ongoing joint work with Public Health. This includes the East Sussex Covid-19 and Flu Vaccination plan to maximise vaccine uptake across the whole population and reduce health inequalities and transmission of flu and Covid-19. This includes an outreach engagement plan for groups with the lowest uptake and in the areas of highest deprivation. The East Sussex Energy Partnership (ESEP) will continue to deliver its fuel poverty reduction programme actions, including the 'Keep Warm and Well in East Sussex' communications campaign. This campaign aims to ensure a consistent and co-ordinated approach to the delivery of interventions to tackle health and wellbeing issues related to cold homes, particularly for vulnerable groups. Alongside this, we will continue to offer the East Sussex Warm Home Check service. This is our year-round affordable warmth scheme which offers advice, home visit assessments, provision of small preventative measures and coordination/ installation of major heating and insulation measures (subject to sourcing of external funding) for eligible low income households. An emergency temporary heating scheme and advance cold weather community messaging system (coldAlert) is in place.

Public Health protection team and the ICB infection control teams also work closely together to prove support to the East Sussex care provider market with infection prevention control support.

8.0 Summary

There has been significant engagement from all system partners to develop a robust winter plan for the system, support local people in East Sussex to have access to the right services to support their need, and to put in place the mechanisms necessary to support delivery and respond in an agile way to pressures experienced across our services. Consequently, we are well placed both to deliver on the requirements set out in the national letters and plans issued in recent months, and to manage winter as effectively as possible with the resources available to us.

The plans set out the mechanisms through which we will remain sighted on the key issues, respond in an agile way to pressures and ensure that system leadership remains aligned on the key actions that we take.

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

Date of meeting: **15 December 2022**

By: **Assistant Chief Executive**

Title: **Reconfiguration of Cardiology Services in East Sussex**

Purpose: **To consider whether the NHS decision on changes to the future provision of Cardiology services by the East Sussex Healthcare NHS Trust (ESHT) is in the best interest of the health service in East Sussex**

RECOMMENDATIONS

The Committee is recommended to consider whether the NHS Sussex's decision as set out in paragraph 2.1 in relation to the changes to the future provision of Cardiology services by the East Sussex Healthcare NHS Trust (ESHT) is in the best interest of the health service in East Sussex.

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1. Background

1.1. On 2 December 2021 HOSC considered a report by the local Clinical Commissioning Groups (CCGs), now NHS Sussex, on the proposed changes to acute Cardiology services in East Sussex provided by the East Sussex Healthcare NHS Trust (ESHT) at the Eastbourne District General Hospital (EDGH) and the Conquest Hospital, Hastings.

1.2. Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change which would constitute a 'substantial development or variation' to services for the residents of the HOSC area. The HOSC may then make comments in response to the proposals consulted on prior to the NHS organisation's decision.

1.3. The Committee resolved that the cardiology proposals constituted a 'substantial development or variation to services' requiring formal consultation by the CCGs/NHS Sussex with HOSC.

1.4. HOSC established a Review Board to consider the evidence in relation to the proposed changes to Cardiology services in detail and prepared a report and recommendations as the Committee's response to the consultation. The Board comprised Councillors Belsey, Di Cara, Marlow-Eastwood, Robinson and Turner; the Review Board elected Councillor Robinson as the Chair.

1.5. The Review Board considered a wide range of written and oral evidence from NHS and other witnesses and agreed a draft report and recommendations. At this stage in the process the proposals included single siting some of the highly specialised interventional cardiac services, carried out in catheterisation labs, at either the Eastbourne DGH or the Conquest Hospital.

1.6. The HOSC agreed on 30 June 2022 to endorse the draft report and agreed to submit the final report to NHS Sussex (which came into being on 1 July 2022) for consideration as part of their decision making process alongside the outcome of the public consultation and the Decision Making Business Case (DMBC).

1.7. On 12 September the NHS organisations held an independently-facilitated site panel meeting to determine the preferred hospital location for the specialist cardiac services. Following consideration of all the evidence the recommended site in the DMBC for the specialist cardiac services is Eastbourne DGH. On the 11 October 2022 the ESHT Board considered the proposals in the DMBC and endorsed them. On the 2 November 2022 the NHS Sussex Integrated Care Board (ICB) agreed the proposals.

2. Supporting information

NHS Decision

2.1. The NHS Sussex ICB at its meeting on 2 November 2022 agreed to:

Approve the post-consultation Decision Making Business Case; specifically to:

- *form a Cardiac Response Team to support patients on their arrival at the Emergency Department (ED), alongside 'hot clinics' that will provide consultant-led rapid assessment at both of our acute hospital sites (all patients will benefit from these improvements).*
- *co-locate the most specialist cardiac services, needed by a small number of patients (impacting approximately 3% of patients who use these services), at Eastbourne District General Hospital. These specialist cardiac services include surgical procedures, investigations or treatments that might require access to a catheter laboratory, Coronary Care Unit or cardiology inpatient beds.*

2.2. The NHS Sussex ICB further agreed to:

- *note the consultation findings, how these have informed the Decision-Making Business Case, and how they have resulted in the post-consultation proposal;*
- *note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal, in particular as part of the site options appraisal process;*
- *note that the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population*
- *note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.*

2.3. The DMBC summary is attached as **Appendix 1** to this report. The DMBC summary provides more details of the decision and sets out the reasons for taking it and includes links to all the relevant published information. Section 4 of the DMBC summary and section 8 of the full DMBC outline how the DMBC has taken into account and responded to HOSC's recommendations.

2.4. The agenda pack of the NHS Sussex ICB meeting is available on the NHS Sussex website and also includes links to the full versions of the DMBC, Equality Health Impact Assessment (EHIA), concise Quality Impact Assessment (QIA), Public Consultation Feedback Report, Independent Site Panel report, and the Transformation Travel and Transport Review Group (TTRG) recommendations report.

Response to HOSC's recommendations

2.5. **Appendix 2** is the HOSC report submitted to NHS Sussex for consideration prior to its decision. HOSC's recommendations together with recommendations from the TTRG are set out in **Annex 1** of the DMBC summary (Appendix 1), with responses by NHS Sussex on how they plan to

meet each recommendation. In some cases, the response to HOSC's recommendation includes work across the wider NHS Sussex system.

HOSC role in considering NHS decisions

2.6. Health scrutiny regulations allow HOSC, once NHS Sussex has taken its decision, to consider whether the decision in relation to the proposed service change is in the best interests of the health service for East Sussex. In reaching its view, the Committee should take into account the evidence gathered during its review of the proposals and the responses to its recommendations.

2.7. If a HOSC does not consider an NHS decision on a substantial variation to services to be in the best interests of the health service in its area, it has the option to refer the decision to the Secretary of State for Health for review. Any referral may not be made unless a HOSC is satisfied that reasonably practicable steps have been taken to try to reach agreement with the local NHS. Thus, should HOSC consider that NHS Sussex's decision is not in the best interests of the local health service, the Committee would need to consider whether all possible steps have been taken to reach an agreement, prior to making a referral.

2.8. Any referral that HOSC makes to the Secretary of State *must* be accompanied by, amongst other things:

- an explanation of the reasons for making the referral;
- a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area; and
- an explanation of any steps that the HOSC has taken to try to reach agreement with NHS Sussex.

3. Conclusion and reasons for recommendations

3.1. The Committee is recommended to consider whether the NHS Sussex decision in relation to changes in Cardiology services as set out in paragraph 2.1 is in the best interest of the health service in East Sussex.

3.2. If HOSC determines that the NHS Sussex decision is not in the best interests of the health service, the Committee will need to consider whether or not to refer the matter to the Secretary of State for Health and to agree the grounds for such a referral. The Committee must consider whether all practicable steps to reach local agreement have been taken before making a referral.

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Decision Making Business Case Summary for Cardiology Transformation at East Sussex Healthcare NHS Trust

1 CONTEXT

1.1 NHS Sussex works in partnership with health and care organisations across Sussex as part of our Integrated Care System. Our aim is to ensure better health and care for all now and in the future. Our ambition is for every person living in Sussex to have access to the best health and care from the moment they are born and throughout their lives. We want:

- People to live for longer in good health.
- To reduce the gap in life expectancy between people living in the most and least disadvantaged communities.
- People's experience of using services to be better.
- Staff to feel supported and work in a way that makes the most of their dedication, skills and professionalism.
- The cost of care to be affordable and sustainable in the long term.

1.2 Our proposals sit within this context and focus on the improvement of hospital-based cardiology services to benefit our population in East Sussex. We want to ensure sustainable services into the future. This means that there is a focus on expanding services within local communities and recognising that for some of our more specialist services, consolidating these in one place will ensure the retention of this specialist expertise within East Sussex in a way that offers the best outcomes for local people. Our commitment to two thriving district general hospital sites, both with Emergency Departments (EDs) and a wide range of services, is supported by specialist services at one or other site in order to deliver the best outcomes for patients.

East Sussex Healthcare NHS Trust Services

1.3 East Sussex Healthcare NHS Trust has made significant improvements for patients and local residents in recent years. The Trust is rated 'good' by the CQC, with several 'outstanding' services and has ambitious plans for the future, enabling residents to access the best care in the most appropriate place: at home; in the community; or when they need to come into hospital.

1.4 As an integrated acute and community provider, an important part of the trust's five-year strategy to best meet the healthcare needs of our population is to increase and improve the care provided outside of hospital. This means being proactive in supporting the health of local residents, preventing avoidable hospital visits and stays, improving patient outcomes and experience and making better use of resources. This has helped the Trust to focus their hospitals to build on their strengths while improving how services work together across the whole health and care system.

1.5 The Trust has two acute hospital sites, Conquest Hospital in Hastings and Eastbourne District General Hospital. Both the Conquest and Eastbourne District General acute hospital sites provide urgent and emergency services, with some services already located solely or primarily at one or other of these sites. The Trust also operates services at Bexhill Hospital. Bexhill Hospital is a community-based facility with an emphasis on ophthalmology and rehabilitation services.

1.6 Eastbourne District General Hospital looks after serious stroke cases, ear nose and throat inpatients and is also home to the Trust's urology service, for which we have recently invested in a dedicated investigation suite, robotic surgery and non-invasive treatment for kidney stones. The hospital also provides for patients needing inpatient diabetes care, day case eye surgery (undertaken in the Jubilee Eye Suite) and a diabetic foot service. In addition, inpatient endocrinology beds are only at Eastbourne District General Hospital.

1.7 The Conquest Hospital in Hastings is the Trust's trauma unit and looks after emergency surgical services and complex elective surgical services, including general, vascular, gynaecology and orthopaedic surgery, and patients needing closer medical monitoring and support when giving birth. The hospital also includes paediatric inpatient services.

1.8 Both hospitals are supported by a range of clinical support services, operate 24/7 emergency departments and intensive care units (ITUs).

1.9 There is a commitment to improving hospital services at both acute sites, Conquest Hospital and Eastbourne District General Hospital. As detailed above, each hospital site has its own profile of services, and we are working to strengthen and develop these two hospitals to make best use of the resources at each site to best serve our patients; having two thriving acute hospital sites is central to this plan.

1.10 Looking further ahead, the trust's Building for our Future programme, funded as part of the government's commitment to build 40 new hospitals, will deliver a complete redesign of both our ageing hospitals, taking advantage of new technologies and improvements in healthcare to ensure that we can meet the future needs of our population.

2 INTRODUCTION

2.1 The purpose of the Decision-Making Business Case is to describe the final proposals to provide a model of care that will improve the cardiology services, their sustainability, and outcomes for the benefit of the local population. It describes the evidence base, the process for the development of the proposals, quality and equality impact assessment and details key enablers such as workforce and finance.

2.2 This summary also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.

2.3 The full Decision-Making Business Case has been published and is available to all

committee members on request. The Decision-Making Business Case is available here. It recommends one option to take forward for implementation, which, has been approved by the NHS Sussex Integrated Care Board, and is now submitted to the East Sussex Health Overview Scrutiny Committee for their consideration.

2.4 The Decision-Making Business Case follows the approved Pre-Consultation Business Case and subsequent formal public consultation and shows how all available information and evidence has been considered, together with feedback captured from the public consultation. This has informed the final proposal to transform acute cardiology services that has been developed by NHS Sussex, in partnership with the East Sussex Healthcare NHS Trust (ESHT). Subject to the outcome of the East Sussex Health Overview and Scrutiny Committee, mobilisation of the transformation proposal can begin for implementation within the timeframe outlined, by January-March 2025. Early implementation of some elements of the model may be sooner than this, in order to realise quality benefits as quickly as possible.

2.5 The document provides a summary of the context and of the case for change as outlined in the Pre-Consultation Business Case. It also provides an analysis of the feedback received from the public consultation and the consultation with the East Sussex Health Overview and Scrutiny Committee, and the updated post-consultation proposal, approved by NHS Sussex, that has been informed by the feedback received from local people and stakeholders during the consultation process.

2.6 A significant majority of respondents to the public consultation agreed with the proposal and views differed on which site should be preferred for the delivery of the most specialist services. NHS Sussex recognises the importance of access to services and has carefully and systematically analysed the consultation outcomes and balanced it with evidence that has been collected since the Pre-Consultation Business Case and in response to the consultation. This process informed NHS Sussex's considerations during the Decision-Making Business Case development process in order to ensure consultation feedback informed final proposals.

2.7 The model of care has been confirmed throughout the process as the right strategic proposal to improve acute cardiology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case.

2.8 The proposed model of care is that improvements would be made to services for all local people with the development of cardiac response teams on both sites. In addition to this, the specialist interventional services, would be located on one of the two acute sites. The carefully considered assessment of this through an independently facilitated site panel, has concluded that the proposed site should be Eastbourne District General Hospital.

2.9 The model is based on clinical best practice and national guidance and evidence, including British Cardiovascular Intervention Society, Heart Rhythm UK, National Institute for Cardiovascular Outcomes Research, the national Getting It Right First Time programme and NHS contract for specialist cardiology. Alongside local clinical engagement and leadership in the development of the model of care, it has also been reviewed by the South East Clinical Senate.

2.10 The Cardiac Response Teams in the Emergency Departments and hot clinics on both sites will provide real benefits for patients in terms of faster senior decision making, faster access to diagnostics, faster cardiology management and treatment plans, less appointments and reduced waiting times, and better patient experience and outcomes.

2.11 Alongside this, proposed specialist interventional services provision from one site supports the Trust to follow, and sustain, national guidance which recommends minimum numbers of procedures to be undertaken by clinicians to increase specialist expertise and therefore improve patient outcomes.

2.12 For those people requiring emergency specialist interventional services, it is common to travel by ambulance to a specialist unit. For example, in West Sussex patients are well served by hospitals in Brighton or Portsmouth for specialist emergency interventional cardiology.

2.13 In summary, the proposal approved by NHS Sussex, is to improve the services at both acute hospital sites through forming a Cardiac Response Team to support patients on their arrival at the Emergency Department (ED), alongside “hot clinics” that will provide consultant-led rapid assessment at both of our acute hospital sites and locate the most specialist cardiac services, needed by a small number of patients, at Eastbourne District General Hospital. These elements are interdependent as locating the specialist service on one site also enables resource to be focused on enhancing the front door offer at both sites.

2.14 The introduction this model, with a Cardiac Response Team in ED, together with hot clinics will ensure faster senior clinical input, faster assessment, treatment and diagnostics, reduced waiting times, more procedures being completed on an outpatient basis (at both sites), a higher proportion of elective procedures completed as day cases (and therefore fewer overnight stays), and fewer repeat outpatient visits.

2.15 The changes to services as a result of the proposals are summarised below:

Services that would be new to both sites

- Cardiac Response teams which will provide all front-end care, including cardiac triage, assessment, diagnostics (including radiology and pathology), prescribing, treatment and onward referral, if required. This change, from the current model of care, is that this would all be completed on the patient’s arrival to ED, rather than later in the patient’s pathway as is the process at present. This means patients will receive a faster diagnosis, reduced waiting times, reduced number of appointments required for patients and a reduced length of time patients have to stay in hospital.
- Hot clinics that will provide patients with consultant-led rapid assessment, which will also ensure faster diagnosis, reduce waiting times, reduce the number of appointments

required for patients and reduce the length of time patients have to stay in hospital.

- Some day-case procedures will be able to be completed as an outpatient procedure, rather than as an inpatient, and these will also be available from both acute sites along with all other outpatient appointments.

Services that would remain on both sites

- Outpatient services will continue to be provided at both sites, this includes new patients, follow up and monitoring appointments, treatment plan appointments and discussions, pre-surgical assessment and post-surgical follow up, and diagnostic services. There are approximately 50,000 appointments per year for these outpatient services.
- Cardiac monitoring will continue to be available at both sites, as cardiac monitors are available in multiple areas and services, not just within cardiology. The emergency department and the acute medical units / acute assessment units all have cardiac monitored beds, which will continue to be available at both sites.

Services that would change and be co-located to one acute site

- The most specialist cardiology services, which will be co-located at Eastbourne District General Hospital, and supports approximately 3,000 patients per year, including those who require catheterisation laboratories, Coronary Care Unit and cardiology inpatient beds. This would mean approximately 1,500 patients, who would have previously attended Conquest Hospital for these services, would now have their treatment provided at Eastbourne District General Hospital.

2.16 This proposal will have positive impacts for our patients improving patient experience, patient outcomes and our performance against national standards in the long term, whilst making the service more efficient and sustainable for the future, alongside positive impact for our workforce now and in the future. Our proposal to introduce Cardiac Response Teams and rapid assessment hot clinics will positively impact all cardiology patients across both hospital sites. Approximately 1,500 patients who would have previously attended Conquest Hospital for the most specialist cardiology services, will now have their treatment provided at Eastbourne District General Hospital, these patients will be variably impacted by these proposals depending on where they live, whether they are accessing the service on an emergency or planned basis and their mode of transport informed by clinical advice.

2.17 The evolution of the Covid-19 pandemic required East Sussex Healthcare NHS Trust to take steps to increase its critical care capacity during the summer months of 2020. As part of this, cardiology facilities at the Conquest Hospital were identified as required to support the response to the pandemic; meaning that the Conquest Cardiac Catheter Labs were unable to be used for cardiology procedures. The interventional service therefore had to be temporarily consolidated to Eastbourne District General Hospital.

2.18 As part of the temporary change to services due to the Covid-19 pandemic, cardiology services were also able to test out a front-end model of care in the Emergency Department; where senior clinicians were able to provide assessment and opinion to patients presenting to ED. This enabled the service to provide more timely access to expert opinion, appropriate diagnostics, and treatment; in many cases reducing the need for admission whilst also

improving the quality of care received. From this perspective of cardiology service provision, the change in provision of interventional services demonstrated the associated benefits of a front-end model.

3 CONSIDERATIONS

3.1 The Case for Change was developed by a wide range of stakeholders including clinicians, operational staff and experts by experience. It was recognised that the current service is unsustainable. We have reviewed the strategic drivers for change and the existing acute cardiology services. This led us to the following conclusions:

- Subspecialisation – cardiology has become increasingly complex and specialised, and the current configuration of services limits our effectiveness by spreading our sub-specialist workforce across sites and reducing opportunities for effective multidisciplinary team working.
- Workforce – operationally providing complete and comprehensive services that directly mirror each other on both sites is a significant workforce challenge that does not maximise the opportunities of subspecialisation and is further complicated by difficulties with recruitment and retention of the workforce. For example, East Sussex Healthcare NHS Trust's vacancy rate for specialist staff is between 10-15% (many staff work across both sites).
- Quality - performance indicators and national guidance. There are a range of performance indicators and national guidance for cardiology care, but East Sussex Healthcare NHS Trust is not currently able to consistently meet all of these due to the service's current configurations.
- Net Zero NHS - the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
- IT / Digital - it has been recognised that improvements to the digital infrastructure can benefit and support patient pathways.
- Estates and equipment - the engineering infrastructure is no longer fit for purpose, some of the catheterisation labs are due for replacement and are not operating reliably.
- Making best use of our resources - we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.
- The national Getting It Right First Time (GIRFT)1 programme reviewed the cardiology service in November 2019 making a range of recommendations including consolidating inpatient cardiology, ensuring clinicians are performing the right numbers of procedures to ensure clinical quality.

3.2 The case also considered the national picture and what the future of cardiology services looks like. This includes medical advancements in research and technology that are

[1] The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

reshaping the way in which we will deliver cardiology care. Increasing subspecialisation means that cardiologists now specialise in one or two types of treatment, rather than offering the full range, along with the development of new technologies, diagnostics and treatment options. These modernising changes reduce risk, pain and infection, and allow patients to recover more quickly, which means that many planned procedures are now done safely as day-cases, without having to stay overnight in hospital.

3.3 As a result, the Decision-Making Business Case proposed changes to a range of acute cardiology services provided by East Sussex Healthcare NHS Trust.

4 PROCESS TO DATE

Our Case for Change and developing our Pre-Consultation Business Case

4.1 Following analysis of the current service provision and the emerging future needs of local people, we developed a Case for Change that outlined the key drivers for service transformation. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about cardiology services. This initial engagement indicated several key themes as important to local people:

- Care provided
- Equality and diversity
- Access and transport
- Clinical services.

4.2 Alongside finding out what is important to local people and clinicians, we reviewed local health needs in East Sussex. This told us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We took account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in the Pre-Consultation Business Case (more detail on this can be found in the Decision-Making Business Case: Appendix 1 – Equality and Health Inequalities Impact Assessment and Appendix 2 – Equality and Health Inequalities Impact Assessment Actions). The full Equality and Health Inequalities Impact Assessment is available here.

4.3 Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services – ORS[2]) took place, during March 2021, to identify and consider a longlist of possible options for the future provision of acute cardiology services, including sites where the service would be delivered from, to appraise these options and make recommendations for preferred viable options.

4.4 Following this, and as part of our in-depth comparative analyses for the Pre-Consultation Business Case, we also reviewed quality indicators, travel analysis, the impact this transformation could have on other services (within Sussex and outside of Sussex), the impact this transformation could have on the equality and health inequalities of our

[2] Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.

population, and the financial feasibility of each option.

4.5 A Pre-Consultation Business Case was developed to make the case for change and set out the plans for a Public Consultation around the transformation of acute cardiology services at East Sussex Healthcare NHS Trust. It was approved by East Sussex CCG and East Sussex Healthcare NHS Trust, on 17 and 30 November 2021 respectively, and submitted to the East Sussex Health Overview and Scrutiny Committee on 2 December 2021 prior to formal public consultation. An independent report on the findings of the consultation has been produced and this report presents the feedback from those who participated in the consultation. This is found at Appendix 3 of the Decision-Making Business Case.

4.6 When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case we considered insight from local people and clinicians from engagement and consultation; continually assessed our developing proposals in relation to equality, health inequality and quality impact and took associated action: commissioned independent travel analysis; took account of South East Clinical Senate recommendations; were informed by feedback from East Sussex Health Overview and Scrutiny Committee; assessed proposals against the NHS Four Tests for service reconfigurations ; undertook stage one and two NHSEI assurance; and developed our proposals and associated plans in line with the Gunning Principles.

4.7 The Joint Sussex Committee reviewed the summary PCBC, together with the Equality and Health Inequalities Impact Assessment and Quality Impact Assessment and approved the case for consideration by the East Sussex Health Overview and Scrutiny Committee, following which (on 2 December 2021) East Sussex Health Overview and Scrutiny Committee reviewed the summary PCBC, together with the Equality and Health Inequalities Impact Assessment and Quality Impact Assessment and considered the proposal to be a substantial variation, and therefore asked that the programme consulted with East Sussex Health Overview and Scrutiny Committee.

Public Consultation

4.8 The formal public consultation into the proposal to transform cardiology services at East Sussex Healthcare NHS Trust began on 6 December 2021 and ended on 11 March 2022. It set out the quality improvements anticipated from the proposed transformation, together with information about the two possible sites for specialist services. Opinion Research Services (ORS), was appointed to advise on, independently manage and report on the public consultation programme of engagement with service users, their families and carers, clinicians and other NHS staff and other stakeholders. The Public Consultation Feedback Analysis report outlined that our consultation was open, accessible, and following ‘good practice’ guidelines in both the scale and the balance of elements used, and that we took appropriate action to ensure any potential impacts of the COVID-19 pandemic were mitigated throughout undertaking the consultation process. The full report can be found as an appendix to the Decision-Making Business Case at Appendix 3. The public consultation was well promoted and included virtual public meetings, stakeholder events and face-to-face listening events, and included a wide range of activities including a focus on groups identified by the Equality and Health Inequalities Impact Assessment.

4.9 A number of common themes were identified during the public consultation process. These

included:

- Travel and access, for example:
  - Older people and people with disabilities, severe clinical needs, multiple complex needs, young children, among others
  - Those from more rural areas and those on lower incomes who might have to pay for taxis to access services
  - Anyone without access to private transport, or who finds long journeys challenging or distressing
  - Staff members who have to travel further or face increased costs, which could impact their well-being
- Staff recruitment and retention, and/or job security especially at non-specialist site
- Impacts on other services, for example. South East Coast Ambulance Service (SECAmb), and concerns about infrastructure and patient transport
- Implications for cardiology patient care on other wards, for example monitoring equipment

Key actions following public consultation

4.10 Alongside public consultation, East Sussex HOSC established a Review Board to carry out a detailed review of the proposals and produce a report and recommendations on behalf of the Committee. In addition, following feedback from the public consultation regarding travel and access, we established a Travel and Transport Review Group to review our developing proposals and make recommendations. The feedback from the HOSC Review Board and the Travel and Transport Group are outlined below, followed by the recommendations and associated planned action.

Engagement with East Sussex Health Overview and Scrutiny Committee (HOSC) – HOSC Review Board

4.11 The Review Board carried out its review between April and June 2022. A full report (Appendix 4 of the Decision Making Business Case) sets out the evidence the Board considered, along with its conclusions and recommendations. The HOSC review board report is available here and the travel and transport review group report is available here. The East Sussex HOSC was presented with the Review Board's report, findings and recommendations at their meeting on 30 June 2022, where it was approved by the membership. The recommendations made by the East Sussex HOSC were as follows:

4.12 The Committee endorsed the proposed new clinical model for cardiology on 30 June 2022, including:

- Cardiology catheter labs should be single-sited;
- That both Eastbourne District General Hospital and Conquest Hospital sites are viable sites;
- There is potential for new services to improve patient care and outcomes via the 'Front Door' model and 'Hot Clinics';
- There will be better services for patients at either Emergency Department (ED) sites; and
- Other services provided at each of the hospitals will not be affected or downgraded by

the proposals for cardiology

4.13 The Health Overview and Scrutiny Committee Review Board carefully considered a range of evidence on the proposals for the reconfiguration of cardiology services in East Sussex and agreed the clinical case for change is sound and addresses the staffing challenges and future sustainability of specialist interventional cardiology services. The HOSC Review Board acknowledged that members of the public may ideally wish to see interventional services retained at both acute hospitals, but it would be in patients' best interests if such services continue to be provided in East Sussex at whichever hospital is selected. There are clear patient benefits arising from the 'Front Door' cardiac responses teams in Emergency Departments and 'Hot Clinic' models and the HOSC Review Board advised they would like to see these proposals implemented as soon as possible.

4.14 On balance, the HOSC Review Board considered the clinical considerations, patient benefits and the need to address staffing challenges, outweigh any disbenefits of the proposals in terms of increased travel. It was also considered important that access is taken into account in the development of the Decision-Making Business Case and throughout the implementation of the proposals. As part of their review, the HOSC Review Board made a series of recommendations, the key ones of which are summarised in section 4.23.

4.15 These recommendations have been taken into account and further details on how these have been considered and addressed, for our post-consultation proposal and as part of the development of the Decision-Making Business Case, can be found in section 8 of the Decision Making Business Case.

4.16 At this stage, initial actions in response to insight from the public consultation included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous Equality Health Impact Assessment actions, and the establishment of a Travel and Transport Review Group.

Travel and Transport Review Group

4.17 During the public consultation, travel and transport (public and private transport, including access and parking) were raised by many respondents as issues to be addressed. Therefore, we established a Transport and Travel Review Group to consider the issues raised.

4.18 The group was tasked with reviewing findings from the pre-consultation engagement processes, options development and appraisal processes, Equality and Health Inequalities Impact Assessment (Equality and Health Inequalities Impact Assessment), the Public Consultation, as well as independent travel analysis carried out by external consultants, and considering the conclusions to make suggestions and recommendations on possible transport solutions for those who may be affected by the proposed service change.

4.19 People responding to the consultation identified key groups who may be adversely affected by transport and travel impacts created by the proposals, e.g. some people having to travel further to see their loved ones and some staff having longer journeys to work. Alongside this, respondents made some suggestions, e.g. to work with authorities in relation to public transport, consider parking, consider financial reimbursement.

4.20 Following the review outlined above including insight from the public consultation, the Travel and Transport Review Group made several recommendations some for implementation and some for further investigation. The key actions are summarised in 4.23.

Recommendations and associated action/action plans from HOSC Review Board and Travel and Transport Review Group

4.21 The Health Overview and Scrutiny Committee Review Board and the Travel and Transport Group made a range of recommendations which have been taken into account in our final proposal and our developing draft mobilisation planning.

4.22 These key recommendations were focused on travel and transport and included providing travel support for local people; the introduction of Travel Liaison Officer at East Sussex Healthcare NHS Trust; improved communication about travel options; liaising with patients about their individual travel and access needs; supporting patients with information and processes about accessing financial reimbursement where eligible; improving information for patients about alternative transport options and exploring over the longer-term improvements to public transport; and measures to support recruitment and retention of staff.

4.23 In response to these recommendations, some have been implemented and others have been committed to and we are progressing them as this programme continues and we implement our proposals. A summary is provided below:

- The priority recommendation of the establishment of a travel and transport liaison officer has been committed to by the Trust and will be implemented alongside these proposals
- Work has taken place within the Trust to ensure information provided via its website, patient letters and patient information leaflets is clear for patients around travel, transport and access options and parking to it various sites. This work will continue to be reviewed and updated as additional actions and recommendations are addressed
- Work has taken place to ensure staff are aware of travel opportunities, such as Trust schemes, are promoted and this will be included in staff messages on a frequent basis
- Work has taken place with ICS colleagues to understand learning around travel arrangements for the recent vaccination programme
- A commitment has been made to monitor staff recruitment and retention measures and these have been included in the Key Performance Indicators (KPIs) of this programme
- As part of the upcoming communications plan, post decision, further work will take place to ensure information around the changes will be shared with our local stakeholder and population, including a Frequently Asked Questions document
- Working with Trust and primary care colleagues to ensure individual needs of patients are recognised and taken account of when booking appointment and procedures, along with clear communications to patients to raise awareness of the options available to them
- Work is in progress to compile a directory of any, and all, transport services, including community, volunteer and charity organised services, and their eligibility criteria where necessary, to which patients could be signposted
- Work with voluntary, community and social enterprise and patient representatives to ensure changes to services and facilities is co-designed
- Consideration by the Trust of a long-term travel and transport strategy

4.24 There are also a number of recommendations which are being explored by the wider Sussex system, as these do not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust, such as:

- Exploring the options for a pilot shuttle bus service
- Working with NHS colleagues on additions to the Non-Emergency Transport Service (NEPTS), such as a digital tracking element and eligibility criteria
- Working with local authority and public transport providers on and potential future services

A summary of the recommendations of the HOSC Review Board and the Travel and Transport Group and progress against these is provided at Annex 1 to this report.

4.25 Considering options and developing a preferred site for specialist cardiology

Appraisal on preferred site

4.26 Our Pre-Consultation Business Case (PCBC) outlined our intention to consult on the proposed model, alongside proposed sites for the specialist service as there was no significant information or evidence at that stage that would indicate a site preference for these. We were clear we would assess and recommend a decision based on the range of published information and evidence, together with feedback from the public consultation, any further information following publication of the PCBC and required further analysis.

4.27 This information would be used to assess each of the site options against weighted criteria that considered information from our Pre-Consultation Business Case, Equality and Health Inequality Impact Assessment, Quality Impact Assessment, and new or updated information since the public consultation. It was recognised that there will be differential impacts, benefits and risks associated with each site option.

Independently facilitated site panel

4.28 On 12 September 2022, following the close of the public consultation and the completion of analysis of consultation feedback, NHS Sussex convened an independently facilitated site panel to consider the two possible locations, Conquest Hospital in Hastings and Eastbourne District General Hospital, and to undertake an appraisal exercise aligned to five key criteria, listed below, and a number of sub-criteria that took into account issues such as population demographics, health inequalities, travel times, workforce issues, infrastructure on sites activity and finance. This is not intended as an exhaustive list, the full report from the independently facilitated site panel is contained in the report from Opinion Research Services (ORS) which is attached to the Decision Making Business Case at Appendix 7.

- Quality and Safety
- Clinical Sustainability
- Access and Choice
- Deliverability
- Financial Sustainability

4.29 The purpose of the panel was to gather views from key stakeholders on the available evidence to inform a site preference. The outcome was not, on its own, a decision on site for the location of specialist cardiology inpatient services and catheter laboratories in East Sussex. The outcome was then reviewed alongside evidence regarding clinical quality and sustainably, public health analysis, detailed financial analysis, speed of implementation, and alignment with the travel and access analysis in order to test this preference. The panel included a variety of different stakeholders to consider and discuss the evidence, provide insight and undertake indicative scoring. The stakeholders represented a balance of attendees, particularly in terms of those attendees with a strong connection to just one or other of the sites, and included:

- Patient representatives and service users
- Voluntary, community and social enterprise organisation representatives
- Cardiology service staff, including consultants, nurses and junior doctors
- Clinicians from other services, such as anaesthetics, physiology, radiology
- GP Clinical Lead
- Healthwatch
- NHS Sussex and East Sussex Healthcare NHS Trust Managers, such as senior quality, health inequalities and finance leads
- Public Health
- South East Coast Ambulance Service (SECAmb)

4.30 The panel assessed against the appraisal criteria using recognised methodology and tested the weighting of the criteria fairly evenly. The outputs from the panel are included in the Decision Making Business Case at section 9, the full report from the independently facilitated site panel is contained in the report from Opinion Research Services (ORS) which is attached to the Decision Making Business Case at Appendix 7.

4.31 The summary outputs are as follows:

- Overall, Eastbourne District General Hospital was identified as somewhat[3] better able to fulfil the criteria used to appraise the sites than Conquest Hospital, although it should be noted that both sites tended to be viewed nearly equally able to fulfil the criteria of Quality and Safety and Access and Choice.
- This view was shared by the three ‘stakeholder groups’, and by the majority of participants, i.e., those with a connection to both acute hospital sites, or neither site.
- The determining factors in reaching this outcome are that both sites tended to be broadly viewed nearly equally able to fulfil the criteria of Quality and Safety and Access and Choice by the majority of stakeholders, with a slight favour towards Conquest Hospital; but with the Eastbourne District General Hospital viewed by most stakeholders as being able to fulfil the Clinical Sustainability, Deliverability, and Financial Sustainability criteria somewhat better than the Conquest Hospital (and with a more significant margin).It is important to note, however, that there was evidence of strongly differing views among those who indicated a particular connection or affiliation to one site over the other, both in the appraisal scoring and in the way that the criteria were weighted; the group with a

connection to Conquest Hospital only favoured that site against all criteria, and vice versa for those connected only to Eastbourne District General Hospital.

- While this latter point was signalled as not necessarily impacting the decision-making process, consideration will be given to these differences in views during any post-decision consultation with stakeholders and at implementation stage.

Preferred site

4.32 We have carefully considered our equality and health inequality impact assessment and recognise the importance of supporting prevention and timely access to care and treatment through improved local services. This is addressed by this proposal which improves cardiology services for all service users and for 97% of cardiology service users, these improvements will be implemented locally at both the Conquest Hospital in Hastings, and Eastbourne District General Hospital. This, alongside improved access (shorter waiting times for treatment) in the longer term is anticipated to have a positive impact in reducing the numbers of people who will require more specialist care as they are accessing improved care assessment, diagnosis and treatment earlier on in their clinical pathway.

4.33 For those patients who require a specialist service further along their clinical pathway, in making these improvements, it is necessary to consolidate our most specialist cardiology services onto a single site – Eastbourne District General Hospital - which also will result in significantly improved clinical sustainability of the service. This change will mean that a small proportion of patients from Hastings and Rother area will travel further for these specialist services. Of those who will travel further we have considered the recognised larger deprived population in Hastings as compared to Eastbourne, noting there is also significant deprivation within Eastbourne.

4.34 Part of our population based analysis considered the potential impact on people living in our most deprived wards in Eastbourne and Hastings. Based on the percentage of people in our most deprived wards, this indicates that there is a net differential impact of approximately 300[4] people who will be affected, who would have to travel further for their most specialist cardiology care. Approximately half of these will travel by ambulance or cross-site transfer. For those patients who would previously have accessed specialist care at the Conquest for a planned procedure and choose to travel by car there will be an average increase in travel of 15 minutes [5]. It should be noted that if the service were sited in Hastings, there would also be people from our deprived communities having to travel further. This further travel for some patients has been analysed and balanced with the clinical sustainability of the specialism that will ensure a viable service for the whole population.

4.35 We have taken account of feedback from our public consultation, HOSC Review Board

[4] This is based on, of the approximately 1,500 people who use the Trust's specialist cardiology services at each site, approximately 600 people from the most deprived wards in Hastings are likely to be affected if the specialist service is at Eastbourne District General Hospital, and 300 people from the most deprived wards in Eastbourne are likely to be affected if the specialist service is at Conquest Hospital. This is based on the percentage of people in our most deprived wards who would be affected. In 2019-20, Conquest Hospital provided 1,536 interventional procedures and inpatient stays requiring a specialist cardiology bed and Eastbourne District General Hospital performed 1,630.

[5] Note, for clinical reasons patients are advised not to use public transport

recommendations and Travel and Transport Review Group recommendations to develop a package of measures to better support patients who may need support to travel to hospital as summarised in section 4.24.

Plans for implementation

4.36 This Decision-Making Business Case presents the public consultation feedback together with additional information and evidence that have been collated as part of this document's development and in response to the consultation. The purpose of the Decision-Making Business Case was to enable and support the NHS Sussex Integrated Care Board's decision-making process. The NHS Sussex Integrated Care Board met on the 2nd of November and approved the recommendations in the Decision Making Business Case.

4.37 If the post-consultation proposal is formally supported by HOSC, we would enact our implementation plan from December 2022 for full implementation in January-March 2025, although early implementation of some elements of the model may be sooner than this, in order to realise quality benefits as quickly as possible.

Decision-making

4.38 The purpose of the Decision-Making Business Case is to ensure that the proposals have been consulted upon, are clinically sound, financially viable, and in line with the improved outcomes agreed in the Pre-Consultation Business Case. At their meeting in public on 11 October 2022, East Sussex Healthcare NHS Trust noted the development of the Decision-Making Business Case, including the feedback from the public consultation; and following their review of the summary Decision-Making Business Case, endorsed the case for consideration by the NHS Sussex Integrated Care Board. Following this NHS Sussex Integrated Care Board met on the 2nd of November and approved the recommendations in the Decision Making Business Case.

4.39 The decision was determined in two parts:

- Firstly, confirmation that the case for change and pre-consultation proposals remained valid and have received support through the public consultation, and
- Secondly, which of the two sites (Eastbourne District General Hospital or Conquest Hospital, Hastings) provides the best location for the very specialist reconfigured services. This was arrived at by reviewing all the evidence that has been used to inform this Decision-Making Business Case, including our pre-consultation engagement, public consultation feedback, our Equality and Health Inequalities Impact Assessment, Quality Impact Assessment, and the independently-facilitated site panel, and in light of this Eastbourne District General Hospital as the preferred site was approved by NHS Sussex.

5 IMPLICATIONS

Financial implications:

5.1 There would be a positive financial impact on the Trust of implementing the changes outlined, this is as a result of implementing best practice and benefiting from resulting

economies of scale.

Revenue

5.2 The case shows that under co-location there will be net efficiency savings, which takes into account the cost of capital, resulting in a favourable revenue position from year 3 for the recommended option. For comparison, the Conquest option results in a favourable position by year 4, once efficiencies can be realised.

5.3 The table shows the annual surplus / deficit position for both options when compared with the do nothing option. The preferred option (5a Eastbourne) is financially favourable, with an average 400k per annum additional efficiency savings above 5b Conquest, over the 10-year period.

Heading, £000's	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
5a (Eastbourne) vs. Do Nothing	-73	-283	1,081	1,171	1,305	1,449	1,604	1,770	1,950	2,142
5b (Conquest) vs. Do Nothing	-30	-90	-355	802	927	1,061	1,205	1,360	1,527	1,706

5.4 The difference between the options is driven by lower capital investment due to less new infrastructure required, and earlier realisation of efficiencies for the preferred option due to the earlier implementation timescales.

Capital

5.5 The total capital required capital for the recommended option (5a Eastbourne) is £12.4m, with capital expenditure phased over three financial between 2023/24 and 2025/6. Full implementation of the model of care is planned from quarter 4 2024/25.

5.6 This compared to a total capital required capital for option 5b Conquest of £13.9m, with capital expenditure phased over three financial years between 2023/24 and 2025/6. Full implementation of the model of care is planned from quarter 4 2025/26.

5.7 The levels of capital outlined in this case for the recommended option can be funded within the Integrated Care System's Capital allocation, in agreement with system partners.

Legal implications:

5.8 NHS Sussex has a legal requirement under the NHS Act 2006 to ensure patients and the public are involved in service changes. Therefore, the Gunning Principles as outlined above have been followed.

5.9 This underpins the pre-consultation engagement and the public consultation processes that have been followed for this programme.

5.10 Our Pre-Consultation and Decision-Making Business Cases have demonstrated compliance with former Clinical Commissioning Group and now Integrated Care Board statutory duties.

Other compliance

Data and Privacy Impact Assessment (DPIA)

5.11 The proposal has no impact or changes to what data would be processed nor how it would be processed. There would be no new or different organisations and/or providers involved in accessing and/or sharing patient information, and no new data processing systems would be utilised. No further Data Privacy Impact Assessment is, therefore, required.

NHSE/I Five Tests for service reconfiguration

5.12 Part of the evaluation of any service reconfiguration is the demonstration that five specific areas have been considered to determine the value of the project:

1. that service users and the public are involved in the development of the proposals
2. whether any proposed redevelopment would maintain the availability of service user choice
3. demonstration of sufficient clinical evidence and clarity on the case for change
4. assurance that the proposals have the approval of local commissioners
5. relates to any proposal including plans to significantly reduce hospital bed numbers

5.13 Full consideration has been given to these points and details of which have been included in our Decision Making Business Case. In brief, the process has been clinically informed and led. Defining the vision for improved acute cardiology services across East Sussex involved a wide range of partners, these included service users, carers and their families, clinicians, including the service's workforce, and other local communities and key stakeholder organisations such as Healthwatch. Feedback collated from the pre-consultation engagement was provided to inform decision-making and a wide range of stakeholders were involved in the options development and appraisal process to ensure different perspectives could be heard and accounted for in the decisions made. There will be no reduction in bed numbers.

Quality and Safety implications

5.14 The aim of transforming these services is to deliver significant clinical improvements that will improve quality, outcomes and safety for patients.

5.15 The Quality Impact Assessment has been completed in relation to the recommended option and in conjunction with the quality team. The Quality Impact Assessment is a live document and has been re-iterated throughout each phase of the programme and shown to have positive impacts.

Equality, diversity, and health inequalities

5.16 Integrated Care Boards have a duty to reduce inequalities between patients in respect to outcomes and access and this transformation has embedded health inequality considerations into the redesign process.

5.17 A Screening Equality and Health Inequalities Assessment was initially developed, followed by a full Equality and Health Inequalities Impact Assessment taking account of feedback from ICS colleagues and NHSE/I. This Equality and Health Inequalities Impact Assessment is a live document and has been re-iterated throughout each phase of the programme. Action from this has been undertaken, is reflected in the model of care, informed our public consultation and communications and engagement delivery plan, our site panel, and our communications plan post-decision. The Equality and Health Inequalities Impact Assessment is Appendix 1 of the Decision-Making Business Case.

Patient and public engagement

5.18 Following historical informal engagement, full pre-consultation engagement took place to understand what is important to local people. The information gathered during this engagement process informed our model of care and options appraisal process.

5.19 The transformation programme has been further informed by local people through our formal public consultation process, where the proposals were broadly welcomed with overall agreement on the proposed model of care, as there was recognition for the need to make changes to address challenges and deliver improvement to acute cardiology services.

5.20 In addition, our options development and appraisal process; our independently facilitated site panel included patients and patient representatives to inform our proposals as they have developed.

5.21 The feedback was helpful and a number of common themes were identified during the public consultation process, and initial actions in response to insight from the public consultation have included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous Equality and Health Inequalities Impact Assessment actions, and the establishment of a Travel and Transport Review Group, the actions of which have been, or are currently being, taken forward as part of the programme and when informing our final Decision-Making Business Case and recommendations.

Health and wellbeing implications

5.22 The transformation of services in East Sussex is expected to improve access to care and health outcomes for our patient population, supporting the health and wellbeing agenda and reducing inequalities.

6 CONCLUSION

6.1 The process to develop these proposals has been comprehensive and the recommended model will deliver benefits for our local populations. We are proposing to improve services for the vast majority of patients who access cardiology services at both hospital sites, alongside consolidating our very specialist services onto a single site to improve clinical sustainability of these and the overall service, ensure future quality of clinical care and enable the introduction of Cardiac Response Teams and hot clinics at both sites. To make sure that the majority of patients receive good quality care close to home, outpatients, non-invasive diagnostics, cardiac monitored beds, cardiac rehabilitation and heart failure services will stay

at both hospitals or in the community. For the many patients who are referred to a consultant by their GP for non-urgent cases, they will continue to be seen in outpatient clinics, which will still be provided at both hospitals and some clinics in the community.

6.2 Through our engagement and options development and appraisal process we developed five potential model of care options. During the Pre-Consultation Business Case, and public consultation, with patients, the public and local stakeholders, the conclusion was to recommend the post-consultation proposal detailed in the Decision-Making Business Case. This is the same model of care that was appraised (as part of our options development and appraisal and pre-consultation processes) as the one that will best provide good patient experience, support improved outcomes for local people and a high-quality sustainable service, enabling the model of care to be implemented that will realise these benefits and is deliverable.

6.3 We recognise that this will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the implementation and evaluation processes to continue to understand the implications of our proposal. All new information and evidence gathered as part of an evaluation will inform how the final proposal is working.

6.4 Subject to the outcome of the East Sussex Health and Overview Scrutiny Committee's consideration as to whether the proposals are in the best interests of local people, mobilisation will begin. During any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to understand how best to provide easily accessible information to support local people and professionals about the changes, and to communicate the changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

Annex 1: Themed actions in response to public consultation and recommendations

Following the feedback from the public consultation, the HOSC Review Board and the Travel and Transport Review Group made a range of recommendations which have been taken account of as we have developed our proposals and our developing draft mobilisation planning. These key recommendations were focused on travel and transport and included providing travel support for local people; the introduction of Travel Liaison Officer at East Sussex Healthcare NHS Trust; improved communication about travel options; liaising with patients about their individual travel and access needs; supporting patients with information and processes about accessing financial reimbursement where eligible; improving information for patients about alternative transport options and exploring over the longer-term improvements to public transport; and measures to support recruitment and retention of staff.

In response to these recommendations, some have been implemented and others have been committed to and we are progressing them as this programme continues and we implement our proposals. There are also several actions/recommendations which are being pursued and/or explored by the wider Sussex system, as these do not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust. Themes, recommendations and progress updates are detailed in the table below.

Theme	Recommendations from HOSC Review Board and Travel and Transport Review Group (TTRG)	Progress update
Workforce	Further measures to support the recruitment and retention of staff are explored in collaboration across the Sussex ICS and other system partners, which address the workforce challenges of the service (HOSC)	Collaboration across the Sussex ICS is ongoing and is a continuing programme, as workforce challenges are widespread across the system and multiple services.
	Staff recruitment and retention is monitored to ensure the workforce challenges are being met and to assess whether additional measures to support recruitment and retention are needed (HOSC).	Monitoring of recruitment and retention has been built into the programme's KPI reporting to ensure we can incorporate this important element in our future evaluations to demonstrate the impact the proposed changes will have.
	Trust to ensure travel opportunities for staff, such as pool cars and salary sacrifice schemes, are advertised	This has been completed, and this information is shared with staff on a frequent basis.

	and widely known to staff (TTRG for implementation)	
Travel and Access	The Board recommended a package of travel and access mitigation measures is put in place to assist those patients who will have to travel further under the proposals, and those on low incomes or without other forms of support, including but not limited to those outlined below; the Travel and Transport Review Group recommendations are also outlined:	These have been completed, are in progress or being further explored as part of the programme timeline.
• **Travel support options including communication**	The establishment of a Travel Liaison Officer post is essential (HOSC)	The Trust has committed to this and it will be implemented as this programme is implemented.
	Trust to introduce a "Travel and Access Liaison Officer" role, possibly within PALS, who will provide patients and families bespoke support, information/advice and, if needed, arrangements to be made for around travel (TTRG for implementation)	As above.
	The communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments, etc (HOSC)	This has been completed, and this information will continue to be shared on a frequent basis via our websites, social media, patient letters, etc., to ensure patients are aware of these opportunities.
	The provision of information on the travel support available in appointment letters via a separate leaflet or information sheet in an accessible format and links to the website (HOSC).	This has been completed and will be updated as additional work around this programme and related actions progress.
	Encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services (HOSC)	This has been completed, and this information will continue to be shared on a frequent basis via our websites, social

		media, patient letters, etc., to ensure patients are aware of these opportunities.
	Trust to provide clearer parking information for people attending Bexhill (TTRG for implementation)	This has been completed and will be updated as additional work around this programme and related actions progress.
	NHS Sussex to explore the opportunities for digital tracking element when the Non-Emergency Patient Transport Services is re-commissioned, so patients have a clearer idea of when they will be picked up (TTRG for investigation).	This is being pursued and/or explored by the wider NHS Sussex system, as this does not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust.
	Following agreement of decisions, ensure all FAQs are updated to explain proposed recommendations and resolutions for these programmes (TTRG for investigation).	This will form part of our communications plan post-decision, pending the decision that is agreed. Our communications plan is a live document and is continually being re-iterated as we get closer to our post-decision/implementation phase.
• **Establishing travel needs in advance of appointment**	The CCG and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the patient pathway (HOSC)	This is being pursued and/or explored by the wider Sussex system, as this does not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust.
	Trust to include travel and transport information, hospital site map and signposting information and advice in patient letters and/or patient information leaflets (TTRG for implementation)	This has been completed and will be updated as additional work around this programme and related actions progress.
	NHS Sussex and Trust colleagues to identify when/where in a patient's pathway is the most appropriate opportunity for their individual needs to be highlighted, e.g., if a longer appointment is needed or it needs to be held at a specific time of the day due to other conditions or learning/physical disabilities, dementia, etc., and then ensure this is built in and embedded to the pathway working with key	This is being pursued and/or explored by the wider Sussex system, as this does not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust. NHS Sussex has a personalised care programme committed to embedding a personalised care approach in all pathways, including cardiology, to give people choice and control over the way their care is planned and delivered.

	stakeholders (TTRG for investigation).	The Trust's agreed Travel and Access Liaison Officer will support individual patients with this.
• **Other transport options**	Actions to improve access via other transport alternatives (e.g., development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc (HOSC)	Discussions with the local authority regarding transport alternatives are ongoing and will be included in implementation planning as appropriate.
	NHS Sussex and East Sussex Healthcare NHS Trust to investigate potential options to pilot a shuttle bus service between the Trust's hospital sites for staff and/or patients (TTRG for investigation)	The programme team will continue to assess the requirement and the feasibility of a shuttle bus as part of the implementation plan. This will be resolved ahead of go live.
	NHS Sussex to compile a directory of any, and all, local charity, and volunteer transport services that patients could be signposted to if they are ineligible for other services, such as Non-Emergency Patient Transport Services (NEPTS) (TTRG for implementation).	This is currently ongoing and will be ready prior to implementation.
	Explore details and arrangements of shuttle bus services that other Trusts have implemented.	The programme team will continue to review other Trust transportation solutions prior to implementation as part of the travel and transportation workstream.
	Explore progress of the Trust's potential plans to have an in-house patient transport service.	The programme team will continue to review other Trust transportation solutions prior to implementation as part of the travel and transportation workstream.
• **Exploring improvements to existing**	NHS Sussex and Trust colleagues to discuss potential resolutions to public transport concerns with local public transport providers (TTRG for investigation).	This work will form part of implementation plans and wider trust approach.

public transport	NHS Sussex and Trust colleagues to initiate discussions with East Sussex County Council (ESCC) and Stagecoach to investigate potential future bus provision to meet the needs of the re-configured acute cardiology services (TTRG for investigation).	Working with local authority partners, the programme team will continue to review a range of transportation solutions, including bus service improvement, prior to implementation as part of the travel and transportation workstream.
	NHS Sussex and Trust colleagues to approach ESCC to discuss how the local population's transport and travel needs could be considered as part of its Bus Service Improvement Plan (TTRG for investigation).	Working with local authority partners, the programme team will continue to review a range of transportation solutions, including bus service improvement, prior to implementation as part of the travel and transportation workstream.
• **Insight from local people and communities in implementing travel and transport action**	All decisions and recommendations taken forward will be co-designed with voluntary, community and social enterprise members who represent the patient population (TTRG for implementation).	This will form part of implementation plans, to ensure our new service is accessible and user friendly for all our local population.
	NHS Sussex to investigate learning from the vaccination programme, as travel arrangements have been arranged to support patients to get to their vaccination programmes (TTRG for investigation).	This has been completed.
• **Evaluating impact of travel and transport actions**	Trust and NHS Sussex colleagues to work in partnership with voluntary, community and social enterprise organisations and patient groups to review access to hospitals, e.g., a mystery shopper exercise, to focus on those groups highlighted in the programme EHIAs, pre-consultation engagement, options development and appraisal processes, and public consultations who have experienced access issues (TTRG for implementation).	This will form part of implementation plans, to ensure our new service is accessible and user friendly for all our local population.
• **Strategic approach**	Trust to consider drafting a long-term Trust-wide transport and travel strategy to meet all patient, carer, family, and staff needs across East Sussex (TTRG for investigation).	This is being explored by Trust colleagues, as this do not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust.

Timely implementation	Implementation of the proposals is undertaken as soon as possible, and consideration is given to mitigating the risks posed by workforce challenges and the development of other competing services to ensure no loss of services in the implementation plan (HOSC)	This DMBC sets out high level implementation plans and timescales to reflect how soon we can safely and appropriately fully implement this transformation proposal. This is to ensure we are not negatively impacting the continuity of care for our patients or services at East Sussex Healthcare NHS Trust.
Assurance on impact on other services	The Decision-Making Business Case contains assurance that other services provided at the two hospitals will not be affected by the implementation of the proposals for cardiology (HOSC)	This has been completed and assurance included in the Decision-Making Business Case.

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Scrutiny Review of the proposal to redesign Cardiology Services in East Sussex

Report by the Health Overview and Scrutiny Committee (HOSC) Review Board

Councillor Christine Robinson (Chair)

Councillor Colin Belsey

Councillor Penny di Cara

Councillor Sorrell Marlow-Eastwood

Councillor Mike Turner

June 2022

Health Overview and Scrutiny Committee (HOSC) – 30th June 2022

Scrutiny Review of the proposal to redesign Cardiology Services in East Sussex

Contents **Page**

Recommendations **3**

Background **5**

1. The proposals for the future of cardiology **6**

Current Service provision **6**

Number of patients using service 8

Case for Change **10**

Meeting national standards 10

Workforce challenges 11

Comments of the Board 12

Proposed options for reconfiguring cardiology **13**

Number of patients affected 14

Benefits of new service model 16

Benefits of the Front End Model 16

Front end model Pilot 18

Benefits of consolidation of interventional sites 18

Ambulance transfers 19

Views of ambulance trust (SECAmb) 20

Views of the Clinical Senate 20

GP views 20

Views of Healthwatch 21

Views of stakeholder groups 21

Views of staff 21

Public consultation 22

Comments of the Board 24

Issues with the new service that should be addressed **26**

Workforce challenges **26**

Comments of the Board 26

Travel and access **27**

Comments of the Board 28

Timelines for implementation and loss of specialist services **28**

Comments of the Board 29

Summary Comments **29**

Appendix 1 ..... **30**

Review Board meeting dates..... 30
Witnesses 30
List of documents considered by the Review Board 30

Recommendations

1	**The Committee endorses the proposed new clinical model for cardiology including:** - **Cardiology cath labs should be single sited;** - **that both Eastbourne DGH and Conquest hospital sites are viable sites;** - **there is potential for new services to improve patient care and outcomes via the 'Front Door' model and 'Hot Clinics';** - **there will be better services for patients at either Emergency Department (ED) sites; and** - **Other services provided at each of the hospitals will not be affected or downgraded by the proposals for cardiology.**
2	**The Board recommends:** - **Further measures to support the recruitment and retention of staff are explored in collaboration with the Sussex ICS and other system partners, which address the workforce challenges of the service.** - **Staff recruitment and retention is monitored to ensure the workforce challenges are being met and to assess whether additional measures to support recruitment and retention are needed.**
3	**The Board recommends:** **A package of travel and access mitigation measures is put in place to assist those patients who will have to travel further under the proposals, and in particular those on low incomes or without other forms of support, including but not limited to:** - **the establishment of a Travel Liaison Officer post is essential.** - **the communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments etc.** - **the provision of information on the travel support available in referral letters via a separate leaflet or information sheet in an accessible format and links to the website.** - **the CCG and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the patient pathway.** - **encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services.** - **actions to improve access via other transport alternatives (e.g. development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc.).**

4	**The Board recommends:** - **Implementation of the proposals is undertaken as soon as possible and consideration is given to mitigating the risks posed by workforce challenges and the development of other competing services to ensure no loss of services in the implementation plan.** - **The Decision Making Business Case (DMBC) contains assurances that other services provided at the two hospitals will not be affected by the implementation of the proposals for cardiology.**

Background

1. East Sussex Healthcare NHS Trust (ESHT) provides acute cardiology services for the residents of East Sussex at its two main hospital sites at Eastbourne District General Hospital (EDGH) and Conquest Hospital, Hastings, as well as cardiology rehabilitation in the community.

2. The Trust's acute cardiology services encompass interventional cardiac services, which include surgical procedures or investigations that might require an overnight or longer stay in hospital, as well as outpatients, non-invasive diagnostics, cardiac monitored beds and heart failure services.

3. East Sussex NHS Clinical Commissioning Group (CCG) – which is the responsible organisation for service reconfigurations – and ESHT undertook a review of the Trust's acute cardiology services that concluded, amongst other things, the service has workforce challenges; is not providing the nationally recommended volume of various procedures; and is not consistently meeting all of the performance indicators and national guidance for cardiology care.

4. As a result, the CCG and ESHT proposed the following changes to the acute cardiology services provided by ESHT:

- locate the most specialist cardiac services, including surgical procedures or investigations that might require an overnight or longer stay in hospital, **at one of the two acute hospitals;**
- introduce a "front door model" involving forming a Cardiac Response Team to support patients on their arrival at A&E, alongside 'hot clinics' that will provide consultant-led rapid assessment at **both acute hospital sites**; and
- retain outpatients, non-invasive diagnostics, cardiac monitored beds, cardiac rehabilitation and heart failure services **at both hospitals**, and in the community.

5. The CCG undertook a public consultation between 6th December 2021 and 11th March 2022 seeking views on the case for change, the proposed new clinical model for services and whether people preferred EDGH or the Conquest as a site for the location of the specialist cardiac services.

6. In addition to its duties to engage with the public, the NHS is required under regulations to consult with the local health scrutiny committee on any proposal that is deemed by the committee to be a substantial variation or development to existing services. As a result, representatives of the CCG and Trust attended the East Sussex Health Overview and Scrutiny Committee (HOSC) meeting on 2nd December 2021 to explain the proposed changes to cardiology services.

7. The HOSC agreed the proposals constituted a substantial variation to services requiring formal consultation with the Committee under health legislation. The HOSC established a Review Board to carry out a detailed review of the proposals and produce a report and recommendations on behalf of the Committee. The Review Board comprised Councillors Colin Belsey, Penny di Cara, Sorrell Marlow-Eastwood, Christine Robinson, and Mike Turner. The Review Board elected Councillor Robinson as the Chair.

8. The Review Board carried out the majority of its review between March and June 2022. This report sets out the evidence the Board considered, along with its conclusions and recommendations.

1. The proposals for the future of cardiology

9. Cardiology is the branch of medicine dealing with the diagnosis and treatment of heart disorders and related conditions. While there are many clinical conditions that can affect the heart in people of all ages, such as diabetes, many heart conditions are age-related; this makes cardiology services more and more important as people get older. Cardiovascular disease remains one of the biggest killers in the UK, responsible for more than a quarter of all deaths – around 136,000 each year.[1]

10. Cardiology commonly includes the diagnosis and treatment of amongst other things Angina (chest pain caused by narrowing of the coronary arteries), Arrythmias (irregular heartbeat), disease of the heart muscle, heart attack, diseases of the arteries, heart murmurs, hole in the heart, and shared care of pregnant women with heart disease. [2]

11. Cardiology is also constantly evolving with new developments in disease prevention, diagnostics and therapeutics that reshape the way in which cardiology services are delivered. These modernising changes reduce risk, pain and infection, and allow patients to recover more quickly; many planned procedures are now done safely as day-cases, without having to stay overnight in hospital. They also result in the field of cardiology becoming more complex and requiring subspecialisation, with cardiologists now specialising in one or two types of treatment rather than offering the full range of services they would have done 20 years ago. This can make recruitment of a full complement of cardiologists more challenging.

Current Service provision

12. ESHT's current cardiology department provides the following services at its two district general hospitals – Conquest Hospital and Eastbourne DGH:

- Coronary care units (CCU) for higher acuity cardiology patients, such as those with heart attacks who require continuous monitoring;
- Dedicated cardiology inpatient wards for patients who need admitting but not to a CCU;
- Three cardiac catheter laboratories (cath labs) across the two hospitals, which are examination rooms with specialist equipment used to look at how well the heart is working, diagnose problems and to provide certain types of treatment;
- Outpatient cardiology clinics (also provided once a week at Bexhill and Uckfield Community Hospitals);
- On-call 24/7 primary percutaneous coronary intervention (PPCI) service for patients suffering an acute heart attack;
- Cardiac pacemaker and diagnostic imaging services;
- Electrophysiology (EP) services that provide alternative diagnostic services via the monitoring of electrical impulses of the heart to diagnose and treat a wide variety of abnormal heart rhythms, (at EDGH only); and
- Cardiac rehabilitation and heart failure services are provided in the community.[3]

13. The number of cardiology beds across both sites is as follows:

[1] GIRFT report p.10 /PCBC p.15

[2] Cardiology presentation to the HOSC Review Board, East Sussex Clinical Commissioning Group (CCG) and East Sussex Healthcare NHS Trust (ESHT), 21st April 2022

[3] Ibid. and PCBC p.32

	EDGH	Conquest
Coronary Care Unit (CCU)	✓ 11 beds	✓ 6 beds
Recovery	✓ 12 beds	✓ 6 beds
Ward beds	✓ 14 beds	✓ 16 beds
Catheter labs	✓ 2 labs	✓ 1 lab
Advanced procedure room/pacing lab	✓ 1 room	×

[4]

14. The main emergency surgical procedure the Trust provides to treat patients who have had an acute heart attack and need who need immediate life-saving intervention is a PPCI, also known as an angioplasty. It is a procedure carried out in a cath lab used to treat the narrowed coronary arteries of the heart in patients through the insertion of a catheter balloon into the blocked artery through which a stent is inserted to keep the artery open. Patients with a suspected heart attack will be taken via ambulance directly to a cath lab to receive a PPCI, bypassing the Emergency Department (ED). National guidelines require acute trusts to provide PPCI on a 24/7 basis.

15. In East Sussex in order to offer a 24/7 service, the PPCI service is currently provided as a weekday service for acute inpatient cardiac services in the cath labs at both hospital sites, but at evening and weekends it is provided from a single site that alternates between the two hospitals. This means any emergency admissions from the community by ambulance will be to whichever hospital site is on call and South East Coast Ambulance NHS Foundation Trust (SECAmb) will be aware of which site to use. Likewise, SECAmb will transfer any inpatients who have a heart attack or patients who arrive at ED with a suspected heart attack during out of hours to the site operating the PPCI service. This out of hours service during evenings and weekends has been operating safely for some time.

16. Cath labs also provide elective (planned) Percutaneous Coronary Intervention (PCI) for patients who require stents but not as an emergency, the implantation of pacemakers, and diagnostic procedures such as angiography – measurement of the extent of the narrowing of the arteries – via a CT Scanner.

17. Under the current pathway, any patients attending the ED with chest pains or other symptoms of a heart condition would first be seen by the emergency teams, who may then consult a cardiologist for an opinion. The patient would then be admitted to an Acute Medical Unit (AMU) under the care of the acute medical doctors, but Cardiologists also attend ward rounds in order to provide specialist opinion for patients and would visit these patients on the AMU. The patient would then be transferred to a cardiac bed or be discharged for further outpatient appointments, diagnostic tests and treatment, depending on the acuity of their condition.

18. Under temporary operating arrangements introduced during the COVID-19 pandemic and again whilst the cath labs at the Conquest Hospital were closed for refurbishment, patients requiring the services provided by the cath labs, including PPCIs, travelled or were taken by ambulance to the EDGH both in and out of hours. This arrangement has now reverted back to normal.

[4] PCBC p.31

Number of patients using service

19. As outlined above, the acute cardiology services provide a mixture of non-elective and emergency care, elective and day case surgery, and outpatient and diagnostic appointments. The Review Board saw figures from ESHT showing cardiology activity across all three sites that were based on the 2018/19 year, due to the disruption caused by COVID-19 in the subsequent two years and the temporary closure of the Conquest's cath lab for refurbishment during 2020/21. The vast majority of activity is either outpatient or diagnostic appointments:

Activity	Conquest Hospital	EDGH	Bexhill & Uckfield Hospitals	Total
Non-elective (emergency/ unplanned inpatients)	1,081	909	N/A	1,990
Day Case	937	1,427	N/A	2,364
Elective (Planned inpatient procedures)	106	149	N/A	255
Outpatient/Diagnostics	21,454	26,025	1,135	48,614
Total	**23,578**	**28,510**	**1,135**	**53,223**

[5]

20. The Board also sought information on patient flows for the non-elective, day case and elective activity over the past six years (as outpatients and diagnostics will not be affected by the proposals). This showed the volume of activity remaining fairly stable across both sites except for when the cath lab at Conquest Hospital closed for refurbishment in 2021 (NB the figures for EDGH are slightly higher as they include approximately 500 Electrophysiology cases per year which are only provided at the pacing lab in the EDGH).

[5] PCBC p.34 and figures provided by ESHT, 24th May 2022

Financial Year	Conquest Hospital	EDGH	
2015/16	1,988	2,579	
2016/17	2,002	2,664	
2017/18	1,864	2,481	
2018/19	1,989	2,399	
2019/20	1,863	2,560	
2020/21	1,006	2,616	

[6]

21. Some East Sussex residents also receive cardiac care at other hospital trusts outside of the county, mainly at the hospital sites provided by University Hospitals Sussex NHS Foundation Trust in Brighton and Haywards Heath. For 2020/21, this was as follows:

Point of Delivery (POD)	East Sussex Healthcare NHS Trust	Maidstone & Tunbridge Wells NHS Trust	Queen Victoria Hospital	University Sussex Hospitals NHS Trust (East)	University Sussex Hospitals NHS Trust (West)
Day Case	1,498	95	0	474	4
Elective Inpatient	84	22	0	107	0
Emergency admission	1,353	57	0	380	0
Total	**2,935**	**174**	**0**	**961**	**4**

[6] figures provided by ESHT, 24th May 2022

Case for Change

22. As part of the Pre-Consultation Business Case (PCBC), the CCG and ESHT set out a Case for Change highlighting concerns about the long-term sustainability of being able to provide a safe and effective service in light of an ageing population and the projected increase in patient numbers. Predominantly these concerns were about meeting national standards and overcoming workforce challenges.

Meeting national standards

23. Cardiology services are required to meet a number of national and international standards that are set out in the NHS Standard Contract. The CCG and ESHT highlighted in the PCBC and in discussions with the Board that not all standards were being met. For example:

- Over 75% of PPCI should be delivered within 60 minutes of a patient's arrival at hospital. This is known as "door to balloon time"; the percentage of PPCI administered within a door-to-balloon time of 60 minutes is below 75% at Conquest, although above 75% for EDGH;[7]
- Trusts must provide 24/7 access to PPCI, which is met albeit with an alternating out of hours service;
- centres providing PPCI should treat 400 or more PPCI patients per annum but the volume is below 400 per year – Conquest Hospital was 342 in 2019/20 and EDGH was 243;[8]
- individual consultants should treat 75 PCI patients per annum (elective and emergency) but individual numbers of procedures for some clinicians on both sites are below the minimum of 75 cases per year; and
- PPCI centres must have two or more cath labs, but the cardiology department has two labs at Eastbourne and only one dedicated lab at Conquest. [9]

24. In addition, a Getting it Right First Time (GIRFT) report on cardiology was produced in November 2019 that concluded the volume of various procedures on both sites was below nationally recommended numbers and set out a number of recommendations to address this including:

- single site all elective and non-elective inpatient cardiology activity, including elective and emergency PCI, on the grounds that the low volume of procedures at each site is not sustainable in the longer term;
- Non-invasive investigations and outpatients should be provided on both sites subject to appropriate infrastructure and sufficient volumes of activity; and
- the Trust should aim to provide continuous on call consultant cardiology cover across both sites, as there is not continuous 24/7 consultant cardiology cover at Conquest when it is not on call for PPCI.[10]

25. The Board asked Professor Nik Patel, Clinical Lead for Cardiology at ESHT, if this critical mass number of procedures cannot be reached, whether services would be stopped entirely at either site. Professor Patel said that minimum numbers of activity are required for delivery of a high quality service and some sites nationally have had to stop undertaking some

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[7] Ibid.

[8] Ibid.

[9] NAPCI-Domain-Report_2021_FINAL.pdf (nicor.org.uk), p.39 and NHS Standard Contract 2013/14

[10] PCBC p,16

procedures owing to small volumes of patients. He said the Trust "100% needed the changes to happen", and that without them there will be "a much poorer service and we will not meet national guidelines"[11].

26. Alan Keys, from Healthwatch, reiterated this concern to the Board and said that failure to continue to provide specialist services in a sustainable way could eventually lead to the loss of them on both sites and the need for patients to travel outside of East Sussex to receive certain care.

Workforce challenges

27. The Board heard a number of concerns relating to the sustainability of the cardiology workforce in its current configuration, including:

- operationally providing complete and comprehensive services that directly mirror each other on both sites is a significant workforce challenge, including covering the interventional cardiology rotas, and staffing two coronary care units (CCU) and wards with the appropriately skilled staff;
- this is exacerbated by the sub-specialisation of cardiologists who, due to increased complexity and technological advances, now specialise in one or two types of treatment rather than offering the full range of 'generic' skills. This means covering all disciplines of cardiology across two sites is becoming unsustainable. For example, the service requires eleven full time equivalent (FTE) consultants for a full establishment, however the service is currently utilising three full time locums to reach this level due to difficulties in recruitment, and still has one remaining vacancy;
- there is national shortage of cardiac physiologists, as well as challenges with recruitment of trained cardiac nurses and sufficient cardiac radiographers to cover both acute sites; [12]
- there is competition for staff with Brighton and London hospitals that may be perceived to be able to offer more opportunities than locally; and[13]
- the current model prevents the Trust from providing dedicated 'front door' specialist cardiology services in ED, which evidence from other Trusts and ESHT's pilot shows can improve outcomes.[14]

28. The Review Board also saw that, despite the concerns listed above, the current service provides high quality care and services, for example:

- during discussions with the Board, Professor Nik Patel said the Cardiology service is one of the better performing in the country with both EDGH and Conquest regarded as 'Centres of Excellence' presently and are the top two hospitals regionally for expertise;
- Dr Simon Merritt, Chief of Service for Medicine, said at the same meeting that ESHT are fitting more devices such as pacemakers than Royal Sussex County Hospital (RSCH) in Brighton and that whilst not a teaching centre, the Trust is a centre of excellence;

[11] 21st April meeting

[12] Pre-Consultation Business Case (PCBC) p.36

[13] 21 April meeting

[14] This is from 21 apr powerpoint, rest is 2 dec cover report.

- The PCBC also says ESHT was recognised in a recent review for being at the forefront of district general hospital Cardiology in relation to its development of Electrophysiology services at the EDGH.[15]
- The provision of PPCI is not provided at all district general hospitals, for example, it is not provided at Maidstone Hospital;[16]
- Despite the workforce challenges, the out of hours service, which had been alternating on a two-weekly basis between EDGH and Conquest hospital, had operated well;
- The PCBC states the Trust was meeting guidelines for the maximum amount of time that it should take for a patient to be taken to a catheter lab if they are having a heart attack during these periods; and[17]
- The PCBC also showed the service had a Friends and Families Test score of between 94.8-100% for each of the cardiology services.[18]

Comments of the Board

29. The Board agrees with the view of Professor Nik Patel and Dr Simon Meritt that the current cardiology service is one of the better performing in the country. The Board also agrees, however, that the clinical case for change put forward by the CCG and ESHT is well evidenced. Workforce challenges and an inability to meet national requirements for the volume or procedures puts the sustainability of the service at risk, and changes to the service need to be made to address these shortcomings.

[15] PCBC p.31

[16] Ibid p.34

[17] PCBC p.39

[18] PCBC p.35

Proposed options for reconfiguring cardiology

30. In response to the Case for Change, the CCG and ESHT are proposing the following changes to the acute cardiology service model provided by ESHT:

- locate the most specialist cardiac services, including surgical procedures or investigations that might require an overnight or longer stay in hospital, **at one of the two acute hospitals;**
- introduce a "front door model" involving forming a Cardiac Response Team to support patients on their arrival at A&E, alongside 'hot clinics' that will provide consultant-led rapid assessment at **both acute hospital sites**; and
- retain outpatients, non-invasive diagnostics, cardiac monitored beds, cardiac rehabilitation and heart failure services **at both hospitals**, and in the community.

31. The CCG conducted a public consultation from 6th December 2021 to 11th March 2022 on the following proposals:

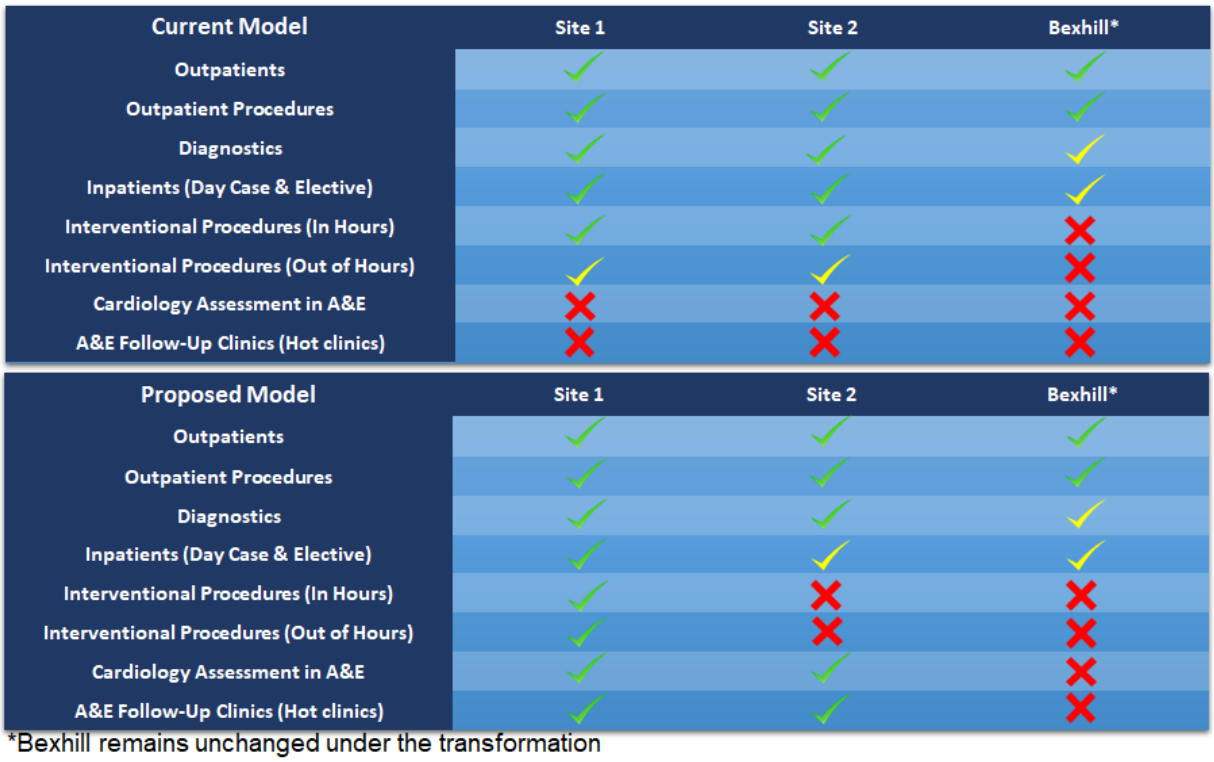
- Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services at **Eastbourne District General Hospital**, with acute outpatients and diagnostic services remaining at **both sites**; alongside establishment of Cardiac Response Team in A&E and hot clinics providing rapid assessment at **both acute hospital sites**.
- Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services at **Conquest Hospital**, with acute outpatients and diagnostic services remaining at **both sites**; alongside establishment of Cardiac Response Team in A&E and hot clinics providing rapid assessment at **both acute hospital sites**.

32. The PCBC states the CCG and ESHT do not have a preferred option for the site where cath labs and specialist inpatient services would be located. When asked by the Board, Professor Patel said the siting of the three cath labs can work at either site.[19]

33. The proposals put forward by ESHT focus on the following adult areas only: interventional cardiology pathways; inpatient pathways that require admission under a cardiac specialist; front-door pathways including ED review; and cardiac specialist opinion. The range of other services like diagnostic imaging, radiology, pathology, echocardiogram, outpatients, community services, and rehabilitation are outside of the scope of the CCG's proposals and were not considered by the Review Board.

34. The Board was provided with the following table summarising the current and proposed models:

[19] 21st April meeting



[20] Green tick = full service; yellow tick = partial service; red cross = no service.

Number of patients affected

35. The table below shows that, based on 2018/19 activity, only around 8.6% of patient activity is subject to the reconfiguration. This figure of under 10% was confirmed by Professor Patel when asked by the Board.

Point of Delivery	Number of Patients	Percentage
Outpatients	29567	54.5
Outpatient Procedures	11057	20.4
Outpatient Diagnostics	8992	16.6
Emergency / Unplanned Inpatients	1990	3.7
Planned Day Case Procedures	2364	4.4
Planned Inpatient Procedures	255	0.5
Grand Total	54225	

[21]

36. In addition, depending on which site is chosen the figure will be less, as only one site stands to close its cath labs. Under Option 5A, the following patient activity provided at the Conquest site would be moved to Eastbourne (based on 2018/19 data):

[20] 27 May presentation

[21] PCBC p.41

POD	Number of Conquest patients	Percentage of total cardiology activity
Non-elective	1,081	1.99%
Elective	106	0.20%
Day Case	937	1.73%

37. Under Option 5B, the following patient activity provided at the EDGH site would be moved to Conquest (based on 2018/19 data):

POD	Number of Eastbourne patients	Percentage of total cardiology activity
Non-elective	909	1.68%
Elective	149	0.27%
Day Case	1,427	2.63%

38. Professor Patel advised the Board that only 2% - 3% of total cardiac patients would be ultimately affected by the proposal to consolidate cath lab services on one site or another. This means that under the proposals, whichever site is chosen, approximately 1,500 patients per year will have to travel to an alternative hospital site for their elective or day case care. Non-elective, emergency patients would be taken to whichever site is chosen via ambulance.[22] Taking into account that not all emergency or non-elective activity involves PPCI, Professor Patel further clarified that only 1% of patients the Trust manages will have to move to the other site for stenting.

39. It also means, according to the CCG and ESHT, that the projected increase in population of East Sussex of 64,000 in the coming 10 years would have a minimal impact on the number of additional PPCI interventions undertaken each year at both sites, meaning population increase would not make a two site option viable.

40. The Board also sought information on where patients travelled from for non-elective, day case and elective activity over the past five years (as outpatients and diagnostics will not be affected by the proposals). This showed the volume of activity remaining fairly stable across both sites except for when the cath lab at Conquest Hospital closed for refurbishment in 2021. It also showed that the number of patients travelling to each of the hospital sites was roughly the same (excluding approximately 500 Electrophysiology cases per year provided only at EDGH, which could be relocated). This means the number of patients whose travel and access to interventional services affected by the proposed options will be approximately the same, irrespective of the site chosen. There will also be a number of patients who live equidistant from the two hospitals who will be unaffected

41. The Board heard that an emergency patient's outcomes are not determined by the distance travelled but by how quickly a patient is seen by a specialist member of staff. Either site falls within the golden hour to an hour and a half target time, between door to treatment (door to balloon) for patients in East Sussex. The CCG and Trust is confident that either site is suitable, and the model offers the best treatment option and is based on experience and evidence seen in other parts of country e.g. London. The CCG and Trust argue that having the

[22] 24 May meeting

specialist team there to see patients quickly is more important than travel time. The Trust also clarified that Electrophysiology services can be located at the selected site.

Benefits of new service model

42. The Board heard how the service model represented a clinician led and supported proposal for how the Trust can preserve the quality of its services.

43. The CCG and ESHT produced a Quality Impact Assessment to understand the impact of the proposals on Patient Safety, Clinical Effectiveness, and Patient Experience. Overall, the QIA indicates that, for each of the shortlisted options, transformation would bring about quality improvement.

44. The Equality and Health Inequalities Impact Assessment (EHIA) included in the PCBC looks at the impacts of the proposals on different sections of the local population, including those classed as having protected characteristics in the Equality Act 2010. The EHIA shows a positive or neutral impact on all protected characteristics.

45. The main changes under the model can be summarised as:

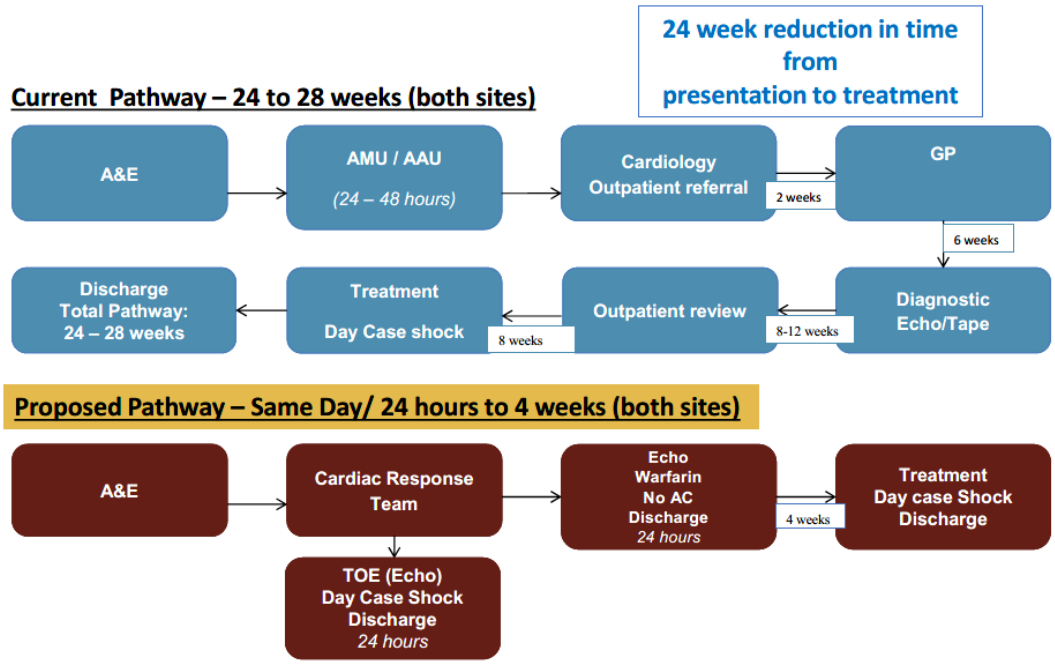
- The addition of a 'front end' model and 'hot clinics', increasing access to specialist opinion
- The consolidation of interventional services on one site.

Benefits of the Front End Model

46. Under this new model, a patient attending ED with cardiac symptoms would no longer be seen as described in paragraph 17, but instead would be streamed to a member of the front door cardiology team for physical review and/or specialist opinion. There would also be the addition of a hot-clinic – a consultant-led clinic which provides rapid access to assessment for adults with either acute or sub-acute symptoms – in which patients can be booked in for re-review quickly in the hospital after attending the emergency department rather than waiting for a GP appointment and referral. [23]

47. The CCG and ESHT provided the Board with a diagram showing how the pathway for patients arriving at the ED with Atrial Fibrillation (chest pains) would change once the front door model of cardiac response teams and hot clinics are in place:

[23] ibid



48. The Board also saw a summary of how various other cardiac symptoms would be addressed in new pathways:

Procedure	Current timescale	Proposed timescale for new pathway
High risk syncope	Up to 28 weeks	Same day
Atrial Fibrillation	Up to 28 weeks	24 hours
Shortness of breath Heart failure	Up to 9 days	24 hours – 3 days
Stable chest pain	Up to 28 weeks	24 hours – 8 weeks
Unstable chest pain	Up to 96 hours	24 hours – 48 hours

[24]

49. Both in the PCBC and in discussions with the Board, the CCG and ESHT put forward a number of benefits the new service will provide to patients and the workforce:

- the introduction of this 'front door' model and 'hot clinics' will ensure a better patient experience through faster diagnosis, reduce waiting times, reduce the number of appointments required for patients and reduce the length of time patients have to stay in hospital;
- The new model will improve waiting times and patient experience significantly – from 140 days down to 40 days waiting times for routine Cardiology investigations from presentation to treatment;
- In other hospitals where a 'front door' cardiac assessment model has been implemented in their EDs, the early cardiac specialist involvement in a patient's care often led to early and effective patient management, timely patient care and avoids admission to hospital,

[24] Presentation 27th may

therefore improving patient experience. The evidence also suggests a discharge rate of 30-40%, meaning 30-40% of patients can go home the same day.[25]

Front end model Pilot

50. The temporary closure of the cath lab at Conquest Hospital as a result of the COVID-19 pandemic allowed ESHT to test the 'front door' model during May and June 2020 by releasing senior clinicians to work in the ED alongside coronary care nurses, A&E triage nurses and Registrars in a temporary cardiac response team and creating a skeleton form of a hot-clinic at the EDGH. This allowed the trust to undertake diagnoses and tests such as Echo cardiograms on patients in the ED who otherwise would have had to be admitted for further investigations or discharged with a letter to their GP requesting a referral to an outpatient appointment.

51. When asked by the Board about the success of the 'front door' model pilot, the Trust said prior to implementation the waiting time was 129 days between referrals and appointment for treatment and post implementation of the pilot it was 39 days from presenting to treatment; a 70% improvement in treatment time.

52. The temporary closure of the Conquest Cath lab for refurbishment in late 2021 has allowed the pilot to be tested again and it has been expanded to cover out of hours. 'Hot Clinics' have been started with patients getting appointments within two weeks.

Benefits of consolidation of interventional sites

53. Also under the proposed model, all patients requiring a PPCI would be taken via ambulance to a single site where the cath labs will be located permanently, and where other interventional procedures would be performed. The CCU will also be co-located at the site along with the EP. Prof Patel confirmed to the Board that the pacing lab where Electrophysiology is conducted will also be co-located at the same site and that there will be no reduction in the number of beds.

54. The Board heard how with the evolution of cardiology imaging, MRI and other technologies, will mean other non-invasive services can be expanded at both sites. This may include CT imaging for diagnostic angiograms to assess the state of arteries, for example. Non-invasive procedures will be retained at both sites and patients will not need to go to cath labs for this type of diagnostic and imaging.

55. The advantages of a single site are:

- it will allow for the creation of flexible and resilient staff rotas, which in turn frees up the workforce to provide the 'front door' model (which the Board was informed is not possible in the current model);
- consolidating catheter laboratories will improve the care pathways and the door to balloon times. This will mean that the national target of 75% of call-to-balloon time within 150 minutes will be achievable, and access to catheter laboratories will improve;[26]
- single siting of catheter labs and developing a Centre of Excellence will offer greater opportunities for staff development, training, sub specialisation and provide attractive professional career opportunities for cardiologists by offering high level specialist work and complex procedures for heart failure patients. This will attract candidates who want the opportunity to undertake a range of specialist work, for example, a new Cardiologist has recently been recruited and the proposed new service model made it easier to bring this person on-board once they saw the vision for the service. The presence of an Electrophysiology service has also aided recruitment; and

[25] PCBC

[26] PCBC p.39

- the use of non-invasive services on both sites will allow the Trust to convert a proportion of day cases to an outpatient procedure, which means patients would be able to access their care at either hospital site, and would reduce the day case numbers needing to move by approximately 25%.[27]

Ambulance transfers

56. The Board heard that an emergency patient's outcomes are not determined by the distance travelled but by how quickly a patient is seen by a specialist member of staff on arrival. This is known as door to balloon time, which the CCG and Trust believe the single siting of interventional cardiac services will improve. The CCG and Trust are confident that either site is suitable to meet the call to door time, which is the time it takes an ambulance to deliver a patient to the hospital from the time they made a call for assistance.

57. There are three categories of patients who require ambulance transfers: those who have a heart attack in the community who can be taken directly by ambulance to the new single centre; those who have a heart attack whilst an inpatient at the hospital; and those who are stable but who require non-elective treatment within 48 hours, for example, a patient who turns up at an ED with chest pains and is admitted to an Acute Medical Unit.

58. In the event of the interventional cardiac services being moved to a single site, the number of patients who would have to travel further via ambulance from the community is **238** if EDGH is the chosen site and **217** if EDGH is chosen. This is based on patient location data for 2018/19 and equates to 4-5 patients per week. [28]

59. The number of diverts to other hospitals outside of East Sussex in the event of a single site will be around 20-24 per year. The PCBC states SECAmb is not concerned with this volume and already undertakes diverts out of hours when a single cath lab site is operating in East Sussex.[29]

60. The number of transfers for inpatient heart attacks is **69** if EDGH is chosen and **71** if Conquest Hospital is chosen. Of this number, the total who require a transfer with anaesthetist support (e.g. ITU to ITU transfers) is fewer than 10 per year.[30]

61. Non-elective patients will either be treated in the Acute Medical Unit with cardiologist supervision (as is the case now), or if they need more specialist care they will be transferred via ambulance to the interventional site within 48 hours, where the specialist cardiac beds will also be located. The PCBC says under the proposals that a total of **448** patients would require transfer after 48 hours if EDGH were chosen as the cath lab site and **212** patients would receive medical management on the non cath lab site. Conversely the figures would be **383** transfers and **207** on site management, respectively, if Conquest was the chosen site. This equates to **7-9** patients per week. [31] The Board also heard that fewer than 10% of patients presenting at ED are transferred to tertiary centres (such as the Royal Sussex County Hospital in Brighton), so the majority will be transferred within the Trust.

62. The Board heard from Professor Patel that the potential need to transfer patients under the proposed model needs to be put in the context of the numbers involved and it needs to be made clear that the current service of transferring patients to the out of hours site works well.

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[27] HOSC report 2nd Dec

[28] Pre-Consultation Business Case (PCBC) p.43

[29] PCBC p.44

[30] Ibid and 21 april minutes

[31] Pre-Consultation Business Case (PCBC) p.46

63. The impact on patients travelling to elective or day case appointments is covered in a later section in the report.

Views of ambulance trust (SECAmb)

64. The Board questioned representatives of SECAmb on their views about the proposals. The Board heard that SECAmb is fully supportive of the single site proposal, feeling it will be beneficial to patients and to the Trust itself. Some of the reasons the Trust is supportive include:

- Currently there are challenges around having two alternating sites and crews needing to check which site is active, which can add to delay. It is crucial for SECAmb to have consistency as to which site to take patients to. Single siting will be simpler for crews, with no time delays and cross checking;
- Stable patients who require cath lab services are transferred within a 48-hour period, and this target, according to SECAmb, can be achieved even when the ambulance service is busy;
- Inter facility transfers for all services are already a significant proportion of the Trust's overall work. SECAmb are looking internally at this to see if improvements can be made in the transfer service they provide; and
- In effect SECAmb has been taking patients to one site for a number of years as part of the alternating model for out of hours emergency treatment, so SECAmb has already been operating services under the proposed model.

65. The Board asked if SECAmb had a preferred site. Representatives said based on the travel analysis of existing data, there is no differentiation between sites. Either site is of benefit, and the site selected does not make any difference from a SECAmb perspective.

66. Asked whether the SECAmb would have any difficulties supporting the new service, representatives of the Trust acknowledged that there have been pressures on ambulance services nationwide causing challenges meeting ambulance response waiting times. This is, however, a much wider issue and the cardiology transformation proposals will not make a difference to ambulance response and waiting times. A pre alert system is used to provide quicker access to areas of specialism allowing for fast clinical and specialist assessment and treatment. Ambulance staff can take patients directly to the cath labs, and SECAmb is also looking to pilot the use of tele-medicine to support more direct patient pathways and quicker access.

Views of the Clinical Senate

67. The Board saw a summary of the Clinical Senate's review of the PCBC in which it highlighted benefits of the model including:

- nurse led 'front door' cardiology service have also been successfully piloted elsewhere too with impressive results reported in the literature; and
- It is likely that the new front door cardiology service will result in fewer patient journeys and fewer inappropriate investigations requiring patients to travel. Similarly reduced hospital length of stay and avoidance of unnecessary admission also reduces patient and relative/carer journeys.[32]

GP views

68. The CCG's GP Clinical Lead informed the Board that from a GP perspective 'Hot Clinics' and having senior specialist opinion at the 'front door' is very important and will result in fewer

[32] Clinical Senate report

follow up appointments and shorter hospital stays. The proposals will improve the quality of care, speed and streamlining of services, which will ultimately improve patient experience. Overall, the Board was told that GPs are supportive of the proposals.

Views of Healthwatch

69. Healthwatch East Sussex has been involved in the options appraisal process. The Board considered verbal evidence from Healthwatch East Sussex that overall the clinical arguments for the reconfiguration were strong, particularly the development of the 'front door' model, which was described as a "first class innovation". One of the benefits of consolidating PPCI procedures onto one hospital site will be a reduction in call-to-treatment times.

70. However, it was noted that call-to-treatment times are to some extent dependent on ambulance service response times, with many ambulance services experiencing service pressures. It was noted the recruitment, retention and training of paramedic staff may also have an impact on emergency cardiac patient care.[33] This was a serious concern raised by Healthwatch.

Views of stakeholder groups

71. The Board received written statements from both Friends of the Conquest and Friends of the Eastbourne DGH raising concerns about the proposals and setting out the reasons why the hospital they are associated with should be selected as the single site. These included:

- The plans to turn Royal Sussex County Hospital (RSCH) into a Regional Centre for Cardiology and Cardiothoracic Surgery and how this will impact on the services ESHT plan to provide. It would be better to maintain a flexible joint cardiac centre approach across both sites until at least until the Trust learns how the Brighton Regional Cardiac Centre is going to affect ESHT Cardiac services;
- Concerns about an aging population, especially if a significant percentage live in deprived circumstances, and how they would access acute medical care due to the difficult geography, poor transport infrastructure and deprivation across East Sussex;
- Concerns about maintaining staffing across the two hospitals, staff location and travel under the new model;
- Whether the proposals will impact general medical services and lead to a down grading of the other services provided at the hospital not selected as the interventional site;
- An acknowledgement that some centralisation of invasive more complex procedures may be necessary;
- Suggestions for siting the service based on population, ease of access and proximity to regional centres; and
- Questions on how the new service will be sustainably staffed and whether the anticipated benefits in terms of a reduction of waiting times, length of stay and the ability to provide new and more advanced medical procedures will be realised.

Views of staff

72. The Lead Nurse for Cardiology advised the Board that staff have been involved at every stage of the process and have been encouraged to and have taken part in the consultation. Small focus groups have also been convened, providing an opportunity for staff to air any concerns. Some staff are happy with the proposals, and some are more neutral in their opinion. The main issue raised by staff is the possibility of increased travel related to the changes to the site they may be working at and the consequent travel and petrol costs. There is some level of anxiousness, pending the decision to be made on which site will be chosen, but there is also

[33] 24th may meeting

excitement about the new combined services and support for them. The Board also heard that across the board there is recognition of the value of the model and staff are excited about the approach and being able to offer 'Front Door' cardiac assessment and 'Hot Clinics' on both sites. All concerns will be discussed in the final Decision Making Business Case (DMBC).

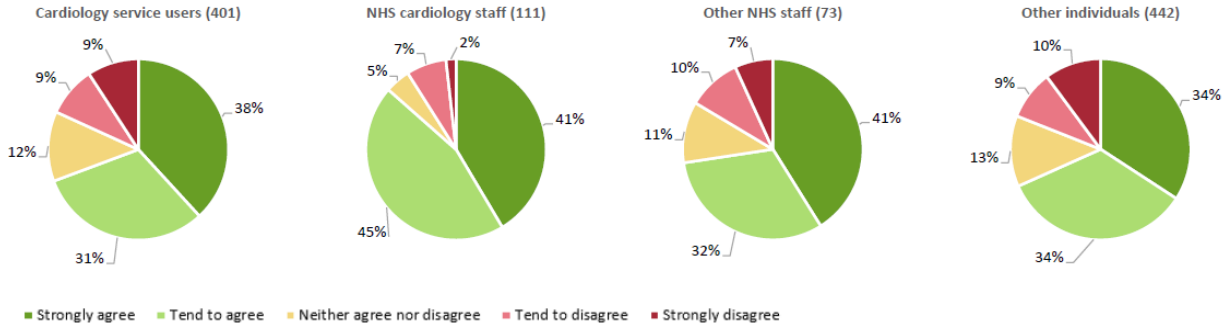
Public consultation

73. The CCG and Trust ran a public consultation on the proposals for 16 weeks from 6th December 2021 to 11th March 2022 and residents and stakeholders were invited to give feedback on both the proposed model of care and their preferred location for interventional cardiology services.

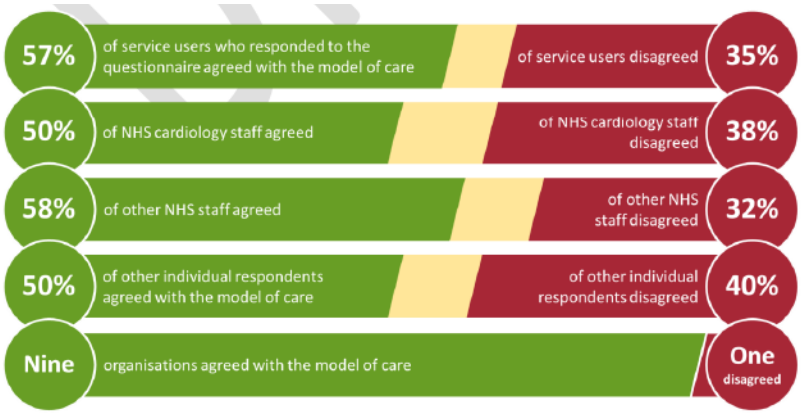
74. Opinion Research Services (ORS) provided an analysis of the consultation and the Board received a presentation summarising the findings.

75. According to ORS, the consultation had 1,067 responses including 410 cardiology service users, 112 NHS cardiology staff members, 74 other NHS staff members, and 11 responses from 10 separate organisations. The consultation also included a number of focus groups and group discussions with services users, carers and ESHT cardiology staff; in-depth interviews and engagement with service users; workshops and in-depth interviews with stakeholder organisations; public meetings, listening events, staff forums and briefings, meetings with community groups, and 'pop-up' events in public spaces.[34]

76. Despite positive feedback about current cardiology services, there was broad support for the overall need for change among all stakeholder groups responding to the consultation questionnaire:



77. There was also generally broad support for the proposed model of care for acute cardiology services among questionnaire respondents, although opinion was a more split:



[34] Presentation: Improving cardiology services in East Sussex – public consultation findings, 25th May 2022

78. People who agreed with the model, did so because of:

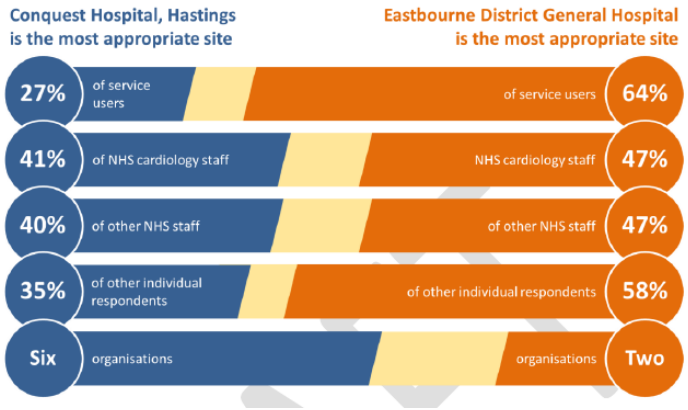
- The potential to improve efficiency and quality of care.
- The proposed introduction of Cardiac Response Teams in both emergency departments was viewed positively by service users and organisations.
- Agreement that continued access to 'local' services for most cardiology service users would be positive.
- Stakeholder organisations in particular felt that the model offered an opportunity to address current challenges and deliver a more efficient service and high-quality care for patients
- Some staff felt that the consolidation during the pandemic had provided evidence that the proposed Cardiac Response Teams would be effective.

79. Reasons for disagreement centred around:

- Concerns around travel and access for those needing to travel further to access specialist care.
- Potential negative impacts on patient outcomes in the event of treatment delays.
- The geography of East Sussex and its growing population necessitates services being provided as locally as possible over two sites.
- concerns about impacts on other services (such as the ambulance service and ED) in the event of specialist cardiology services being co-located on a single site.[35]

80. The Board heard from the CCG and Trust that they felt the reasons for disagreement had been sufficiently addressed in the development of the proposals, for example, that there are no issues with treatment delays for cardiology; only 2% - 3% of the 64,000 projected increase in population will be affected by the proposal to consolidate cath lab services on one site or another meaning a rising population will not require two sites in the future; and the ambulance service has expressed full support for the proposals. [36]

81. Most respondents expressed a preference for EDGH compared to Conquest, with some groups being more evenly split, and six of 11 organisations preferring Conquest:



82. It should be noted that the overall response to this question is influenced by the fact that there were more respondents to the consultation who were from the Eastbourne area and were expressing a preference for the hospital nearest to them, as shown below.

83. However, analysis of postcode information (where provided) indicates that most respondents were expressing a preference for their nearest hospital:

[35] ibid

[36] Minutes of 24th may meeting

37

84. Results suggest that geography has a very considerable influence on respondents' preferences (more so than stakeholder type, demographics or other characteristics such as deprivation).

85. **Respondents who favoured Conquest did so because:**

- Perceptions around unacceptable travel times for those needing to travel to Eastbourne from the east of the county (especially Rye and rural areas), while Eastbourne is located comparatively close to cardiac services in Brighton.
- The site being more centrally located within the Trust area;
- A risk of increased health inequalities (on the basis of high deprivation levels and low car ownership in Hastings).
- NHS staff members also highlighted the longstanding use of Cardiac Nurse Practitioners at Conquest Hospital, and the potential of easier expansion given the cardiology department is at ground floor level.

86. **Respondents who favoured EDGH did so because:**

- Perceptions that travel links to the site are good and/or better that those to Conquest;
- The presence of a large and growing elderly population in the Eastbourne area;
- The potential for high service demand in future as a result of ongoing building development and population growth in the area;
- Better proximity to the regional centre in Brighton;
- The opportunity to co-locate specialist cardiology and stroke services
- NHS staff members whose preference was for Eastbourne DGH tended to highlight strengths in staffing, skills and the level of facilities on the site (e.g., it has two catheterisation labs rather than one, a larger critical care unit, and interventional electrophysiology has already been centralised there).

Comments of the Board

87. The Board notes that the public consultation shows a preference for EDGH as the location of the interventional cardiology services but that this is largely because most respondents were from the Eastbourne area. All other evidence reviewed and heard by the Board suggests that both options for locating interventional services either at the Conquest in Hastings or Eastbourne DGH are viable. The Board has examined patient flow data and the impact on travel and access is approximately the same for each site. There is also no clinical preference for either site, nor is SECAmb concerned which site is chosen. The Board has some concerns about travel and access issues which are set out in the next section below.

88. The Board found that the clinical case for change is sound and is well supported by clinicians, staff, GPs and Healthwatch. The Board heard that there is a risk that if no changes are made to address the minimum case numbers needed for interventional services, some of these services may cease to be provided by the Trust in future. The Board considers that it is in patient's best interests that these services are retained in East Sussex in the future, and therefore supports the clinical case for change. The Board also heard that from the CCG's

[37] Ibid.

perspective it is important to have two thriving hospitals in East Sussex and the proposals will not have an impact on any other services.

89. The Board welcomes the creation of a 'front door' model and 'hot clinics' and hopes to see an improvement in the pathways and reduction in treatment time. If possible, the Board would like to see these aspects of the proposals implemented as soon as possible as it would appear they have the potential to improve patient care, outcomes, and experience. Consequently, the proposals have the potential to provide enhanced services at both sites from a clinical and service perspective.

90. The Board understands the public are likely to be concerned about how quickly they are going to be seen in an emergency and how easy it is to travel to an appointment. The Board heard that in an emergency patient outcomes are not determined by the distance travelled but by how quickly a patient is seen by a specialist member of staff. Either site falls within the golden hour to an hour and a half, between a patient calling and the ambulance arriving at the hospital site (call to door). The Trust is confident that either site is suitable, and the model offers the best treatment option and is based on experience and evidence seen in other parts of country (e.g. London). On the balance of evidence, it would appear that having the specialist team there to see patients quickly is more important than travel time.

91. The Board notes that outpatients' appointments will not be affected by proposals, so there will not be an impact on travel for the majority of patients. However, there will be an impact on around 3% of patients, their families, and carers who would need to travel further under the proposals to the single site for day case and elective interventional procedures, and to visit relatives admitted as an emergency.

92. Overall, the Board supports the clinical proposals, but does however maintain some concerns which are set out below.

Recommendation 1

The Committee endorses the proposed new clinical model for cardiology including:

- **Cardiology cath labs should be single sited;**
- **that both Eastbourne DGH and Conquest hospital sites are viable sites;**
- **there is potential for new services to improve patient care and outcomes via the 'Front Door' model and 'Hot Clinics';**
- **there will be better services for patients at either Emergency Department (ED) sites; and**
- **Other services provided at each of the hospitals will not be affected or downgraded by the proposals for cardiology.**

Issues with the new service that should be addressed

93. During the course of its review, the Board identified several issues that the CCG and Trust should address, regardless of which site they choose.

Workforce challenges

94. Information on staffing levels for the existing[38] and proposed service models is set out in the PCBC and is reproduced below. Year 0 of the current service provision is the provision now. Year 10 of current service provision shows how significantly the service will need to grow to deliver acute cardiology services in the future and to manage the expected demand on the service if ESHT were to do nothing. Whereas the new model will make managing that demand easier as not such a significant increase in workforce will be needed.

Current service provision (Full Time Equivalent)											
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Doctors	13.6	14.1	14.8	15.5	16.3	17.1	17.9	18.9	19.8	20.9	21.9
Nurses	147.0	154.9	163.2	191.5	202.0	213.1	224.8	237.2	250.3	264.2	278.9
Non-clinical staff	10.1	10.2	10.7	11.3	11.9	12.5	13.2	14.0	14.7	15.6	16.4

Proposed service provision (Full Time Equivalent)											
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Doctors	13.6	14.1	14.8	12.2	12.9	13.6	14.3	15.0	15.8	16.7	17.5
Nurses	147.0	154.9	163.2	158.8	167.7	177.1	187.1	197.6	208.7	220.5	233.0
Non-clinical staff	10.1	10.2	10.7	9.2	9.7	10.2	10.8	11.4	12.0	12.7	13.4

95. It would appear that addressing the workforce challenges is key to providing sustainable cardiology services in the future. The Board heard that creating a 'centre of excellence' for cardiology would be more attractive for the recruitment of all staff, allow appropriate training and supervision to develop subspecialisation, and enable flexibility in cross-subject training for the multidisciplinary team. The Trust has developed a cardiology workforce strategy for a sustainable and thriving future workforce to deliver cardiology services to local people which these proposals support.[39] This responds to the recommendations set out in the Clinical Senate report. The Board heard that ESHT has regular meetings with the Cardiology Network, and with Royal Sussex County Hospital Brighton, who have endorsed and supported the proposals, and confirmed that there are no impacts or interdependencies.

Comments of the Board

96. Although it is envisaged that creating a 'centre of excellence' will greatly assist with the recruitment and retention of specialist cardiology staff needed by the service, there appears to be no detail of what the Trust will do if the proposals fail to attract sufficient suitably qualified staff, or what will happen whilst proposals are implemented. It is understood that the proposals need to be implemented to release staff in order to provide the 'Front Door' and 'Hot Clinic' proposal. There is a risk that workforce challenges may undermine the ability to provide these services at both hospital sites.

97. The Board is concerned about whether the workforce challenges will be fully addressed by the proposals and whether sufficient staff can be attracted and retained given the potential competition with other providers. It may be possible to undertake further work in collaboration with the Sussex Integrated Care System (ICS) and other system partners to address these challenges. The Board therefore recommends that further measures to support the recruitment

[38] PCBC p.91

[39] PCBC p.87

and retention of staff are explored to address these issues, and that are capable of being put in place whilst the proposals are being implemented.

Recommendation 2

The Board recommends:

- **Further measures to support the recruitment and retention of staff are explored in collaboration with the Sussex ICS and other system partners, which address the workforce challenges of the service.**
- **Staff recruitment and retention is monitored to ensure the workforce challenges are being met and to assess whether additional measures to support recruitment and retention are needed.**

Travel and access

98. The Board understands that the proposed changes to cardiology services will only affect the travel and access of around 3% of the service's patients and their families. These will mainly be those patients undergoing interventional procedures provided in the cath labs which will be single sited either at the Conquest Hospital in Hastings or the Eastbourne DGH. It is estimated that the proposals will affect around 1,500 patients per year. Outpatients and other services will continue to be provided at both hospital sites.

99. The Board has examined postcode data over the last five years to identify where those patients who are likely to be affected are travelling from and which hospital they are using. Excluding the Electrophysiology cases which are only provided at Eastbourne DGH, approximately the same numbers of patients are travelling to each hospital. Therefore, the impact on travel and access is likely to be the same whichever hospital is chosen to single site interventional procedures. There are patients who live equidistant to the two hospital sites who will be unaffected. However, the number of patients who will have to travel further for their procedure if the proposals are implemented will be around 15-18 patients per week, and their journey time by car will increase by around 15 minutes.

100. The evidence provided by Healthwatch and the feedback from the public consultation suggests that patients and families are prepared to travel further if the quality of care is good.

101. The Board heard that a Travel and Access Group has been established to look at mitigation measures that can be put in place for those who will have to travel further under the proposals.[40] Possible measures include:

- the establishment of a Travel Liaison Officer to assist and advise patients;
- greater communication of the support available including Patient Transport Services;
- a shuttle bus between hospitals and to town centres;
- a taxi service with direct payments for those eligible;
- expanding volunteer provided services;
- exploring transport lessons learnt during the Covid-19 vaccination programme; and
- the ability to claim back travel costs on the same day for those eligible to do so.

[40] 24 May meeting

Comments of the Board

102. The Board considers that a range of mitigation measures will need to be put in place to assist those who will have to travel further under the proposed changes to the service. In particular, those people who may not be able to count on help from family and friends, or who may have fixed or limited incomes, may need additional support. The Board welcomes the proposal to establish a Travel Liaison Officer post and recommends that a package of travel and access mitigation measures is included in the Decision Making Business Case for those affected by the proposals.

Recommendation 3

The Board recommends:

A package of travel and access mitigation measures is put in place to assist those patients who will have to travel further under the proposals, and in particular those on low incomes or without other forms of support, including but not limited to:

- **the establishment of a Travel Liaison Officer post is essential.**
- **the communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments etc.**
- **the provision of information on the travel support available in referral letters via a separate leaflet or information sheet in an accessible format and links to the website.**
- **the CCG and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the patient pathway.**
- **encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services.**
- **actions to improve access via other transport alternatives (e.g. development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc.).**

Timelines for implementation and loss of specialist services

103. The Board expressed some concerns about the timescales to implement the changes once a decision is reached on the option to proceed with. The Board considered that there were real patient benefits in implementing the 'Front Door' model and 'Hot Clinics' as soon as possible, but understands that the staffing of these services is dependent on being able to implement the single siting of interventional services.

104. The Board heard that the reconfiguration proposals may take several years to implement and a more detailed implementation plan will be included in the Decision Making Business Case (DMBC). It may be possible to implement some aspects of the proposals earlier based on the experience gained during the Covid-19 pandemic. It was confirmed that capital funding is available and both sites are capable of accommodating the necessary infrastructure changes.

105. The Board understands that there are wider proposals to develop cardiology services at a regional centre in Brighton. This has the potential to impact the proposals being put forward by the CCG and ESHT and the Board is concerned that specialist staff and services may be drawn into the regional centre.

106. There is also a concern that other services at the site not chosen for the single siting of the interventional services will be downgraded. The Board has had reassurances from the CCG and ESHT that this will not be the case and thinks that it would be advisable to reiterate this point in the DMBC.

Comments of the Board

107. If agreed, the Board would like the proposed changes implemented as soon as possible in order that the benefits in patient care can be realised, and to minimise the risk to the sustainability of the service from workforce challenges and the development of other services.

Recommendation 4

The Board recommends:

- **Implementation of the proposals is undertaken as soon as possible and consideration is given to mitigating the risks posed by workforce challenges and the development of other competing services to ensure no loss of services in the implementation plan.**
- **The Decision Making Business Case (DMBC) contains assurances that other services provided at the two hospitals will not be affected by the implementation of the proposals for cardiology.**

Summary Comments

108. The Review Board has carefully examined a range of evidence on the proposals for the reconfiguration of cardiology services in East Sussex. The clinical case for change is sound and addresses the staffing challenges and future sustainability of specialist interventional cardiology services. It is acknowledged that members of the public may ideally wish to see interventional services retained at both acute hospitals, but it would be in patients' best interests if such services continue to be provided in East Sussex at whichever hospital is selected. There are clear patient benefits arising from the 'Front Door' cardiac response teams and 'Hot Clinic' models and the Board would like to see these proposals implemented as soon as possible. On balance, the Board considers the clinical considerations, patient benefits and the need to address staffing challenges, outweigh any disbenefits of the proposals in terms of increased travel. It is also important that social deprivation is taken into account in the development of the DMBC and throughout the implementation of the proposals.

Appendix 1

Review Board meeting dates

The Review Board met on:

- 28th March 2022 to agree its terms of reference and consider the CCG's proposals;
- 21st April 2022 to examine in more detail the clinical case for change contained in the Pre consultation Business Case.
- 24th May 2022 to examine stakeholder views including Healthwatch; patient flows, travel and access, and feedback for the public consultation.
- 15th June 2022 to further examine the public consultation outcomes, patient travel impacts, and consider the draft report of the Review Board.

Witnesses

East Sussex Clinical Commissioning Group (CCG)

Jessica Britton, Executive Managing Director

Fiona Streeter, Associate Director of Commissioning and Partnerships

Dr Suneeta Kochhar, GP Clinical Lead representative

East Sussex Healthcare NHS Trust (ESHT)

Richard Milner, Director of Strategy

Michael Farrer, Strategic Transformation Manager

Dr Simon Merritt, Chief of Service for Medicine

Cardiology Staff

Professor Nik Patel, Clinical Lead for Cardiology

Hazel Church, Lead Nurse for Cardiology

Kerrie Nyland, Matron CCU and Cath Labs

Rick Veasey, Consultant Cardiologist

Sharon Grain, Head of Nursing for CCU & Inpatients

Lesley Houston, General Manager Cardiovascular Services (ESHT)

SECAmb

Ray Savage Strategy & Partnership Manager SECAmb

Claire Hall, Clinical Pathways Lead SECAmb.

Healthwatch East Sussex

Alan Keys

List of documents considered by the Review Board

Documents provided to Review Board by the CCG and ESHT

Pre Consultation Business Case (PCBC) and appendices.
Travel Analysis Summary and Travel Study.
Patient flow data for the cardiology service, including postcode travel information.
Patient impact summary presentation.
Public Consultation summary and document
Public Consultation Feedback draft report (OCS). May 2022.
Recommendations for South East Clinical Senate Review PCBC for Cardiology Services for East Sussex CCG

Witness Statements

Witness statements received from the following organisations and groups.

Friends of Conquest Hospital
Friends of Eastbourne District General Hospital

Contact officer for this review:

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

Date of meeting: **15 December 2022**

By: **Assistant Chief Executive**

Title: **Reconfiguration of Ophthalmology Services in East Sussex**

Purpose: **To consider whether the NHS decision on changes to the future provision of Ophthalmology services by the East Sussex Healthcare NHS Trust (ESHT) is in the best interest of the health service in East Sussex**

RECOMMENDATIONS

The Committee is recommended to consider whether the NHS Sussex's decision as set out in paragraph 2.1 in relation to the changes to the future provision of Ophthalmology services by the East Sussex Healthcare NHS Trust (ESHT) is in the best interest of the health service in East Sussex.

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1. Background

1.1. On 2 December 2021 HOSC considered a report by the local Clinical Commissioning Groups (CCGs), now NHS Sussex, on proposed changes to Ophthalmology services in East Sussex currently provided by the East Sussex Healthcare NHS Trust (ESHT) at the Eastbourne District General Hospital (EDGH), Bexhill Hospital and the Conquest Hospital in Hastings.

1.2. Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change which would constitute a 'substantial development or variation' to services for the residents of the HOSC area. The HOSC may then make comments in response to the proposals consulted on prior to the NHS organisation's decision.

1.3. The Committee resolved that the Ophthalmology proposals constituted a 'substantial development or variation to services' requiring formal consultation by the CCGs/NHS Sussex with HOSC.

1.4. HOSC established a Review Board to consider the evidence in relation to the proposed changes to Ophthalmology services in detail and prepared a report and recommendations as the Committee's response to the consultation. The Board comprised Councillors Azad, Belsey, Brett, Robinson and Geraldine Des Moulins (voluntary and community sector representative); the Review Board elected Councillor Belsey as the Chair.

1.5. The Review Board considered a wide range of written and oral evidence from NHS and other witnesses and agreed a draft report and recommendations. The proposals provide a model of care that aims to improve the Ophthalmology services, their sustainability, and outcomes for the benefit of the local population. They include providing Ophthalmology services from two hospital sites, Bexhill and EDGH, rather than the current three locations. Forming one-stop clinics at EDGH and Bexhill and forming a diagnostic eye hub at Bexhill Hospital. Emergency and general anaesthetic surgical ophthalmology cases (including cases which require an overnight stay) will continue to be provided at the Conquest Hospital, but the outpatient and day case procedures will be moved to Bexhill Hospital.

1.6. The HOSC agreed on 30 June 2022 to endorse the draft report and agreed to submit the final report to NHS Sussex (which came into being on 1 July 2022) for consideration as part of their decision making process alongside the outcome of the public consultation and the Decision Making Business Case (DMBC). On 11 October 2022 the ESHT Board considered the proposals in the DMBC and endorsed them. On 2 November 2022 the NHS Sussex Integrated Care Board (ICB) agreed the proposals.

2. Supporting information

NHS Decision

2.1. The NHS Sussex ICB at its meeting on 2 November 2022 agreed to:

Approve the post-consultation Decision Making Business Case; specifically to:

- *locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one-stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.*

2.2. The NHS Sussex ICB further agreed to:

- *note the consultation findings, how these have informed the Decision-Making Business Case, and the post-consultation proposal;*
- *note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal;*
- *note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population;*
- *note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.*

2.3. The DMBC summary is attached as **Appendix 1** to this report. The DMBC summary provides more details of the decision and sets out the reasons for taking it and includes links to all the relevant published information. Section 4 of the DMBC summary (see in particular paragraphs 4.21 and 4.22) and section 6 of the full DMBC outline how the DMBC has taken into account and responded to HOSC's recommendations.

2.4. The agenda pack of the NHS Sussex ICB meeting is available on the NHS Sussex website which includes links to full versions of the DMBC, Equality Health Impact Assessment (EHIA), concise Quality Impact Assessment (QIA), the Public Consultation Feedback Report and the Transformation Travel and Transport Review Group (TTRG) recommendations report.

Response to HOSC's recommendations

2.5. **Appendix 2** is the HOSC report submitted to NHS Sussex for consideration prior to its decision. HOSC's recommendations together with recommendations from the TTRG are set out in **Annex 1** of the DMBC summary (Appendix 1), with responses by NHS Sussex on how they plan to meet each recommendation. In some cases, the response to HOSC's recommendation includes work across the wider NHS Sussex system.

HOSC role in considering NHS decisions

2.6. Health scrutiny regulations allow HOSC, once NHS Sussex has taken its decision, to consider whether the decision in relation to the proposed service change is in the best interests of the health service in East Sussex. In reaching its view, the Committee should take into account the evidence gathered during its review and the responses to its recommendations.

2.7. If a HOSC does not consider an NHS decision on a substantial variation to services to be in the best interests of the health service in its area, it has the option to refer the decision to the Secretary of State for Health for review. Any referral may not be made unless a HOSC is satisfied that reasonably practicable steps have been taken to try to reach agreement with the local NHS. Thus, should HOSC consider that NHS Sussex's decision is not in the best interests of the local health service, the Committee would need to consider whether all possible steps have been taken to reach an agreement, prior to making a referral.

2.8. Any referral that HOSC makes to the Secretary of State *must* be accompanied by, amongst other things:

- an explanation of the reasons for making the referral;
- a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area; and
- an explanation of any steps that the HOSC has taken to try to reach agreement with NHS Sussex.

3. Conclusion and reasons for recommendations

3.1. The Committee is recommended to consider whether the NHS Sussex decision in relation to changes in Ophthalmology services as set out in paragraph 2.1 is in the best interest of the health service in East Sussex.

3.2. If HOSC determines that the NHS Sussex decision is not in the best interests of the health service, the Committee will need to consider whether or not to refer the matter to the Secretary of State for Health and to agree the grounds for such a referral. The Committee must consider whether all practicable steps to reach local agreement have been taken before making a referral.

PHILIP BAKER
Assistant Chief Executive

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Decision-Making Business Case Summary for Ophthalmology Transformation at East Sussex Healthcare NHS Trust

1 CONTEXT

1.1 NHS Sussex works in partnership with health and care organisations across Sussex as part of our Integrated Care System. Our aim is to ensure better health and care for all now and in the future. Our ambition is for every person living in Sussex to have access to the best health and care from the moment they are born and throughout their lives. We want:

- People to live for longer in good health.
- To reduce the gap in life expectancy between people living in the most and least disadvantaged communities.
- People's experience of using services to be better.
- Staff to feel supported and work in a way that makes the most of their dedication, skills and professionalism.
- The cost of care to be affordable and sustainable in the long term.

1.2 Our proposals sit within this context and focus on the improvement of ophthalmology services to benefit our population in East Sussex. We want to ensure sustainable services into the future. This means that there is a focus on expanding services within local communities and recognising that for some of our more specialist services, consolidating these in one place will ensure the retention of this specialist expertise within East Sussex in a way that offers the best outcomes for local people. Our commitment to two thriving district general hospital sites, both with Emergency Departments (ED) and a wide range of services, is supported by specialist services at one or other site in order to deliver the best outcomes for patients.

East Sussex Healthcare NHS Trust services

1.3 East Sussex Healthcare NHS Trust has made significant improvements for patients and local residents in recent years. The Trust is rated 'good' by the CQC, with several 'outstanding' services and has ambitious plans, enabling residents to access the best care in the most appropriate place: at home; in the community; or when they need to come into hospital.

1.4 As an integrated acute and community provider, an important part of the Trust's five-year strategy to best meet the healthcare needs of our population is to increase and improve the care provided outside of hospital. This means being proactive in supporting the health of local residents, preventing avoidable hospital visits and stays, improving patient outcomes and experience and making better use of resources. This has helped the Trust to focus their hospitals to build on their strengths while improving how services work together across the whole health and care system.

1.5 The Trust has two acute hospital sites, Conquest Hospital in Hastings and Eastbourne District General Hospital. Both the Conquest and Eastbourne District General Hospital sites provide urgent and emergency services, with some services already located solely or

primarily at one or other of these sites.

1.6 Eastbourne District General Hospital looks after serious stroke cases, ear nose and throat inpatients and is also home to the trust's urology service, for which we have recently invested in a dedicated investigation suite, robotic surgery and non-invasive treatment for kidney stones. The hospital also provides for patients needing inpatient diabetes care, day case eye surgery (undertaken in the Jubilee Eye Suite) and a diabetic foot service. In addition, inpatient endocrinology beds are only at Eastbourne District General Hospital.

1.7 Conquest is the Trust's trauma unit and looks after emergency surgical services and complex elective surgical services, including general, vascular, gynaecology and orthopaedic surgery, and patients needing closer medical monitoring and support when giving birth. The hospital also includes paediatric inpatient services.

1.8 Both hospitals are supported by a range of clinical support services, operate 24/7 emergency departments and intensive care units (ITUs).

1.9 The Trust also operates services at Bexhill Hospital. Bexhill Hospital is a community-based facility with an emphasis on ophthalmology and rehabilitation services. East Sussex Healthcare NHS Trust provides ophthalmic day surgery (mainly cataract and glaucoma), outpatient clinics, wet age-related macular degeneration (AMD) services at the Dowling Unit and diabetic retinal screening from Bexhill Hospital. The site also provides short-stay rehabilitation services at the Irving Unit for patients admitted with a range of conditions and offers radiology and physiotherapy services for patients.

1.10 We are committed to improving hospital services across our sites including at both acute sites, Conquest Hospital and Eastbourne District General Hospital. As detailed above, each hospital site has its own profile of services, and we are working to strengthen and develop these to make best use of the resources at each site to best serve our patients; having two thriving acute hospital sites is central to this plan.

1.11 Looking further ahead, the trust's Building for our Future programme, funded as part of the government's commitment to build 40 new hospitals, will deliver a complete redesign of both our ageing hospitals, taking advantage of new technologies and improvements in healthcare to ensure that we can meet the future needs of our population.

2 INTRODUCTION

2.1 The purpose of the Decision-Making Business Case is to describe the final proposals to provide a model of care that will improve the ophthalmology services, their sustainability, and outcomes for the benefit of the local population. It describes the evidence base, the process for the development of the proposals, quality and equality impact assessment and details key enablers such as workforce and finance.

2.2 This summary also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement

and feedback, and finalising proposals for decision-making.

2.3 The full Decision-Making Business Case has been published online and is available to all committee members on request. The full Decision-Making Business Case is available here. It recommends one option to take forward for implementation, which has been approved by the NHS Sussex Integrated Care Board, and is now submitted to the East Sussex Health Overview Scrutiny Committee for their consideration.

2.4 The Decision-Making Business Case follows the approved Pre-Consultation Business Case and subsequent formal public consultation and shows how all available information and evidence has been considered, together with feedback captured from the public consultation. This has informed the final proposal to transform ophthalmology services that has been developed by NHS Sussex, in partnership with the East Sussex Healthcare NHS Trust (ESHT). Subject to the outcome of the East Sussex Health Overview and Scrutiny Committee, mobilisation of the transformation proposal can begin for implementation within the timeframe outlined, by December 2023 – May 2024. Early implementation of some elements of the model will be sooner than this, to realise quality benefits as quickly as possible.

2.5 The document provides a summary of the context and of the case for change as outlined in the Pre-Consultation Business Case. It also provides an analysis of the feedback received from the public consultation and the consultation with the East Sussex Health Overview and Scrutiny Committee, and the updated post-consultation proposal approved by NHS Sussex that has been informed by the feedback received from local people and stakeholders during the consultation process.

2.6 There was broad recognition for the need to make changes to address challenges and deliver improvement, and broad agreement on the proposed model of care across the public consultation feedback. NHS Sussex recognises the importance of access to services and has carefully and systematically analysed the consultation outcomes and balanced it with evidence that has been collected since the Pre-Consultation Business Case (PCBC) and in response to the consultation. This process informed NHS Sussex's considerations during the Decision-Making Business Case development process to ensure consultation feedback informed final proposals.

2.7 The model of care has been confirmed throughout the process as the right strategic proposal to improve ophthalmology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved Pre-Consultation Business Case.

2.8 The model of care sets out that services would deliver improvements for all local people with the development of one-stop clinics at both sites, Bexhill Hospital and Eastbourne District General Hospital, and a diagnostic eye hub at Bexhill Hospital. Outpatients and day case surgery that currently takes place at Conquest will be moved to Bexhill. Emergency and general anaesthetic surgical ophthalmology cases (including cases which require an overnight stay) will continue to be at Conquest Hospital: these services will not be affected by these proposals. The model is based on clinical best practice and national guidance and evidence including NHS High Impact Intervention, the national Getting It Right First Time programme, the Royal College of Ophthalmologists, NHS National Elective Care Outpatient

Transformation Programme, the College of Optometrists and the Clinical Council for Eye Health Commissioning. Alongside local clinical engagement and leadership in the development of the model of care, it has also been reviewed by the South East Clinical Senate. The one-stop clinics at both hospitals and diagnostic eye hub at Bexhill Hospital will enable a redesigned ophthalmology pathway that will increase quality of care ensuring patients are seen by the right person, in the right place, and at the right time, meaning we can better meet service standards so that patients receive care in a timely manner, meaning faster diagnosis, shorter waiting times, fewer repeat appointments for tests and therefore less travelling for patients thereby improving outcomes for local people.

2.9 The approved Pre-consultation Business Case upon which we consulted was very clear as to why Bexhill Hospital was preferred rather than the Conquest Hospital. This was detailed as part of a full options appraisal in the Pre-Consultation Business Case explaining the limitations of current theatre capacity at Conquest Hospital; ophthalmology not having clinical interdependencies that mean that it can be sited at Bexhill whilst other specialities could not; adapting the Conquest site would be prohibitively costly in terms of capital requirements; and there are physical space limitations that would make it difficult to expand and build the infrastructure required.

2.10 In summary, the proposal approved by NHS Sussex, is to improve the services at both hospital sites through forming one-stop clinics, and at Bexhill Hospital through forming a diagnostic eye hub, both of which will provide rapid assessment for patients which will reduce waiting times and the number of appointments needed. It demonstrates that we believe this is the right strategic proposal to improve ophthalmology services for the local population and is supported by stakeholders across local communities.

2.11 The proposed transformation, with the one-stop clinics and diagnostic eye hub, will make key quality improvements to the service, such as:

- enable a redesigned ophthalmology pathway that will increase quality of care ensuring patients are seen by the right person, in the right place, and at the right time
- ensure that we can better meet service standards so that patients receive care in a timely manner, meaning faster diagnosis, shorter waiting times, fewer repeat appointments for tests and therefore less travelling for patients
- provide a consultant-led model of working that efficiently utilises skill mix across the workforce and provides training opportunities
- ensure staff and expert knowledge are consolidated, allowing for improved supervision and opportunities for training and educational needs for staff who wish to upskill. Thereby, gradually improving the skills in the workforce to improve the service quality and care provided to our population.

2.12 This proposal will have positive impacts for our patients, as well as workforce, and will improve patient experience, patient outcomes and our performance against national standards in the long term by reducing waiting times alongside repeated travel for patients, whilst making the service more efficient and sustainable for the future. It also supports the wider Sussex Ophthalmology plan enabling future training and supervision from ophthalmology consultants to upskill the community Optometry workforce.

3 CONSIDERATIONS

3.1 The Case for Change was developed by a wide range of stakeholders including clinicians, operational staff and experts by experience. It was recognised that the current service is unsustainable. We have reviewed the strategic drivers for change and the existing ophthalmology services. This led us to the following conclusions:

- Quality: healthcare systems are required to minimise the risk of significant harm, through delivering timely follow-up for patients with chronic conditions. The high and growing number of these cases within ophthalmology makes this a challenge.
- Service performance: nationally, ophthalmology outpatient services are the largest of all outpatient services that people use, with East Sussex Healthcare NHS Trust seeing 18,075 new outpatients and 65,511 follow-up appointments in 2019-20[1]. The Covid-19 pandemic has impacted heavily on ophthalmology provision and this, coupled with the very high levels of need for care, has led to East Sussex Healthcare NHS Trust no longer meeting national waiting time standards.
- Growing need: It is estimated that, over the next 20 years, the need for cataract services will rise by 50%, glaucoma cases by 44% and medical retina by 20%.
- IT / Digital: making the best possible use of modern digital technology in ophthalmology services would be a significant benefit to patients, for example Electrical Eyecare Referral System (EERS)[2]. Modern technology presents opportunities to improve patient pathways and better manage the growing need for ophthalmology services. This system will improve patient safety, deliver eye care more efficiently and effectively, and facilitate other improvements for optometrists and dispensing opticians who work with hospital colleagues. This includes the development and improvement of communication, advice and guidance, feedback, shared care, discharge to primary care and supporting extended primary eye care services.
- Workforce: a census carried out by the Royal College of Ophthalmologists (RCOphth) in 2019 identifies gaps in recruitment for ophthalmologists and workforce planning, amid a predicted 40% increase in need for ophthalmology services over the next 20 years.
- Net Zero NHS: the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
- Estates and equipment: diagnosis and monitoring of ophthalmic patients is highly dependent on equipment. Much of the equipment currently used by the department across its three sites is old, which impedes the service's ability to work efficiently and effectively. There are limitations of physical space in the current service configuration limiting the capacity of the service to meet the current and growing need of the local population which contributes to challenges in meeting service standards.

[1] 2019-20 has been used throughout our Pre-Consultation Business Case, public consultation and Decision-Making Business Case as the last full year of data that was not skewed by the Covid-19 pandemic.
[2] An Electronic Eyecare Referral System is essentially shorthand for a secure, electronic system for the two-way transfer of patient and clinical data (including images) between eye care services (and with GPs).

- Making best use of our resources: we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.
- The national Getting it Right First Time (GIRFT)[3] programme reviewed the ophthalmology service in March 2018. It was recommended that:
    - Review pre-assessment clinics and review/audit coding for complex cataracts to ensure the patient pathway for cataract surgery is optimised.
    - Continue to develop health care professional staff by training and developing all members of the multi-disciplinary team, whilst utilising competency frameworks to increase the number of non-consultant clinical staff.
    - Look into using consultant-led and technician-provided virtual clinics for age-related macular degeneration (AMD) and glaucoma to improve refinement of treatment plans.
    - Review of coding practices to ensure accuracy, particularly around complex cataracts, corneal grafts, strabismus follow-ups and vitreo-retinal conditions.
    - Continue to refer to the Royal College of Ophthalmologist's "The Way Forward"[4] document to identify options to help meet demand and the Common Competency Framework to support health care professional staff development.

3.2 As a result, the Decision-Making Business Case proposed changes to a range of ophthalmology services provided by East Sussex Healthcare NHS Trust.

Covid-19 Pandemic

3.3 In response to Covid-19, East Sussex Healthcare NHS Trust had to reconfigure their hospital services to ensure they operated in a safe manner and also increased the number of beds available for Covid patients. With adult and paediatric ophthalmology services operating at a reduced level of capacity, the service was moved to operate solely from Bexhill during the first peak with particular focus on urgent services. This was also important from the perspective of infection, prevention and control and services responding to the pandemic. With its staff together at one location it enabled the department to deliver whole-team training events for its staff and learn from different ways of arranging services that had not been previously explored.

3.4 The requirement of the service to respond to the needs of local people in a different way during the early stages of the Covid-19 response, coupled with the service being temporarily consolidated on one site, led to the service working in new ways including new diagnostic pathways and virtual clinics. Feedback from the service is that working in this way has been positive, improving the working relationships of the team through improved communication, and more supervision and support for junior staff.

4 PROCESS TO DATE

Our Case for Change and developing our Pre-Consultation Business Case

[3] The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.
[4] The Royal College of Ophthalmologists, 2016, *The Way Forward*

4.1 Following analysis of the current service provision and the emerging future needs of local people, we developed a Case for Change that outlined the key drivers for service transformation. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about ophthalmology services. This initial engagement indicated several key themes as important to local people:

- Care provided
- Equality and diversity
- Access and transport
- Clinical services
- Community optometry.

4.2 Alongside finding out what is important to local people and clinicians, we reviewed local health needs in East Sussex. This told us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We took account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in the Pre-Consultation Business Case (more detail on this can be found in Appendix 1 and Appendix 2 of the Decision-Making Business Case).

4.3 Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services - ORS[5]) took place, during March 2021, to identify and consider a longlist of possible options for the future provision of acute ophthalmology services, including sites where the service would be delivered from, to appraise these options and make recommendations for preferred viable options.

4.4 Following this, and as part of our in-depth comparative analyses for the Pre-Consultation Business Case, we also reviewed quality indicators, travel analysis, the impact this transformation could have on other services within Sussex and outside of Sussex, the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.

4.5 A Pre-Consultation Business Case was developed to make the case for change and set out the plans for a Public Consultation around the transformation of ophthalmology services at East Sussex Healthcare NHS Trust. It was approved by East Sussex CCG and East Sussex Healthcare NHS Trust, on 17 and 30 November 2021 respectively, and submitted to the East Sussex Health Overview and Scrutiny Committee on 2 December 2021 prior to formal public consultation. An independent report on the findings of the consultation has been produced and this report presents the feedback from those who participated in the consultation. This is found at Appendix 3 of the Decision-Making Business Case.

4.6 When developing our options, our final draft proposals, the Pre-Consultation Business Case and Decision-Making Business Case:

- We considered the outputs from engagement and consultation with local people and

[5] Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary, and private sector organisations across the UK.

clinicians and used these to inform the Pre-Consultation Business Case and Decision-Making Business Case.

- We developed the Pre-Consultation and Decision-Making Business Cases with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We assessed the impacts of our proposals by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We commissioned an independent travel analysis to understand the impact of the proposals in this regard.
- We took into account the recommendations of the South East Clinical Senate.
- We considered opinions and insight from a number of service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.
- We were informed by feedback from the East Sussex Health Overview and Scrutiny Committee including the East Sussex Health Overview and Scrutiny Committee Review Board.
- We assessed our proposals against the NHS Four Tests for service reconfigurations.[6]
- We undertook stage one and stage two process with NHSE to assure our plans prior to public consultation.
- We developed our proposals and associated consultation plans in line with the Gunning Principles[7] to ensure that:

    - a decision would not be taken until after public consultation.
    - local people and stakeholders had information that enabled them to engage in the consultation and inform our decision.
    - there was adequate time for people to participate in the consultation.
    - we could demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
    - we could demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

Public Consultation

4.7 The formal public consultation into the proposal to transform ophthalmology services at East Sussex Healthcare NHS Trust began on 6 December 2021 and ended on 11 March 2022. It set out the quality improvements anticipated from the proposed transformation, together with the site options. Opinion Research Services (ORS), was appointed to advise on, independently manage and report on the public consultation programme of engagement with service users, their families and carers, clinicians and other NHS staff and other stakeholders. The Public Consultation Feedback Analysis report outlined that our consultation was open, accessible, and following 'good practice' guidelines in both the scale

[6] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
[7] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

and the balance of elements used, and that we took appropriate action to ensure any potential impacts of the Covid-19 pandemic were mitigated throughout undertaking the consultation process. The full report is Appendix 3 of the Decision-Making Business Case.

4.8 The public consultation was well promoted and included virtual public meetings, stakeholder events and face-to-face listening events, and included a wide range of activities including a focus on groups identified by the Equality and Health Inequalities Impact Assessment (EHIA).

4.9 Several common themes were identified during the public consultation process. These included:

- Travel and access, for example:
  - Older people and families with young children, people with significant visual impairment, particularly those with macular degeneration who require regular and frequent treatment.
  - People with other disabilities and long-term conditions or additional needs.
  - People with low incomes and from deprived communities – particularly those living in and around Hastings – and anyone without access to a private vehicle.
- Potential loss of services from Conquest Hospital.
- Buildings at Bexhill Hospital were reported to be older with poorer accessibility and facilities.
- Sufficient investment required to develop Bexhill site.

Key actions following public consultation

4.10 Alongside public consultation, East Sussex Health Overview and Scrutiny Committee established a Review Board to carry out a detailed review of the proposals and produce a report and recommendations on behalf of the Committee. In addition, following feedback from the public consultation regarding travel and access, we established a Travel and Transport Review Group to review our developing proposals and make recommendations. The feedback from the Health Overview and Scrutiny Committee Review Board and the Travel and Transport Group are outlined below, followed by the recommendations, and associated planned action.

Engagement with East Sussex Health Overview and Scrutiny Committee (HOSC) – Health Overview and Scrutiny Committee Review Board

4.11 The Review Board carried out its review between April and June 2022. A full report (Appendix 4 of the Decision-Making Business Case) sets out the evidence the Board considered, along with its conclusions and recommendations. The HOSC review board report is available here and the travel and transport review group report is available here. The East Sussex HOSC was presented with the Review Board's report, findings and recommendations at their meeting on 30 June 2022, where it was approved by the membership. The recommendations made by the East Sussex HOSC were as follows:

1. The Committee endorsed the reasons for reconfiguring ophthalmology on 30 June 2022, including:

- Clinical case for change and the potential for new services to improve patient care and experience.
- The creation of the 'Centre of Excellence' diagnostic hub, one-stop clinics, and measures to support staff recruitment and retention.

2. The Committee noted the proposed choice of the Bexhill Hospital to consolidate ophthalmology services and recommended that mitigation measures are put in place to address the concerns about travel and access to this site, such as:
   - increasing and maximising the number of on-site parking spaces at the Bexhill Hospital site.
   - ongoing monitoring of Did Not Attend (DNA) information is undertaken after implementation of the proposals to establish the reasons why patients do not attend appointments and review the travel and access mitigations in light of this information. It was reported that Bexhill Hospital had the fewest number of patients that Did Not Attend.

4.12 The Health Overview and Scrutiny Committee Review Board carefully considered the clinical case for change and the anticipated benefits for patients from the proposed service reconfiguration. The Review Board also examined the proposed choice of the Bexhill Hospital site for the consolidation of some services serving the east of the county and noted that the Bexhill site presents a number of challenges for travel and access to services based there.

4.13 On balance, the Health Overview and Scrutiny Committee Review Board considered that the proposed changes to the ophthalmology services in East Sussex are in the best interests of patients and asked that adequate mitigations to be put in place to address the travel and access issues that were identified.

4.14 These recommendations have been taken into account and further details on how these have been considered and addressed, for our post-consultation proposal and as part of the development of the Decision-Making Business Case, can be found in section 6 of the Decision-Making Business Case, summarised in 4.21 and 4.22 below. Of particular note, our Decision-Making Business Case proposal includes provision of additional car parking at Bexhill Hospital and a range of travel and transport support for local people.

4.15 At this stage, initial actions in response to insight from the public consultation included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous Equality and Health Inequality Impact Assessment actions, and the establishment of a Travel and Transport Review Group.

Travel and Transport Review Group

4.16 During the public consultation, travel and transport (public and private transport, including access and parking) were raised by many respondents as issues to be addressed. Therefore, we established a Transport and Travel Review Group to consider the issues raised.

4.17 The group was tasked with reviewing findings from the pre-consultation engagement

processes, options development and appraisal processes, Equality and Health Inequalities Impact Assessment (EHIA), the Public Consultation, as well as independent travel analysis carried out by external consultants, and considering the conclusions to make suggestions and recommendations on possible transport solutions for those who may be affected by the proposed service change.

4.18 People responding to the consultation identified key groups who may be adversely affected by transport and travel impacts created by the proposals, e.g., some people having to travel further to see their loved ones and some staff having longer journeys to work. Alongside this, respondents made some suggestions, e.g., to work with authorities in relation to public transport, consider parking, consider financial reimbursement.

4.19 Following the review outlined above including insight from the public consultation, the Travel and Transport Review Group made several recommendations some for implementation and some for further investigation. These are outlined below.

Recommendations and associated action/action plans from Health Overview and Scrutiny Committee Review Board and Travel and Transport Review Group

4.20 The Health Overview and Scrutiny Committee Review Board and the Travel and Transport Review Group made a range of recommendations which have been taken into account in our final proposal and our developing draft mobilisation planning. These key recommendations were focused on travel and transport and included providing travel support for local people; the introduction of Travel Liaison Officer at East Sussex Healthcare NHS Trust; improved parking at Bexhill Hospital; improved communication about travel options; liaising with patients about their individual travel and access needs; supporting patients with information and processes about accessing financial reimbursement where eligible; improving information for patients about alternative transport options and exploring over the longer-term improvements to public transport; and measures to support recruitment and retention of staff.

4.21 In response to these recommendations, some have been implemented and others have been committed to and we are progressing them as this programme continues and we implement our proposals. A summary is provided below:

- The programme has committed to improve car parking on the Bexhill Hospital site. This has been included in our final proposals to ensure it is implemented in line with this transformation
- The establishment of a travel and transport liaison officer has been committed to by the Trust and will be implemented alongside these proposals
- Work has taken place within the Trust to ensure information provided via its website, patient letters and patient information leaflets is clear for patients around travel, transport and access options and parking to it various sites. This work will continue to be reviewed and updated as additional actions and recommendations are addressed
- Work has taken place to update communications to ensure patients who are eligible for reimbursement of travel costs know that they are able to reclaim their expenses on arrival via the hospital cashier. The travel liaison officer will also be able to support eligible patients that are otherwise unable to travel to access this this scheme
- Work has taken place to ensure staff are aware of travel opportunities, such as Trust

schemes, are promoted and this will be included in staff messages on a frequent basis
- Work has taken place with Integrated Care System colleagues to understand learning around travel arrangements for the recent vaccination programme
- A commitment has been made to monitor staff recruitment and retention measures and these have been included in the Key Performance Indicators (KPIs) of this programme
- As part of the upcoming communications plan, post decision, further work will take place to ensure information around the changes will be shared with our local stakeholder and population, including a Frequently Asked Questions document
- Working with Trust and primary care colleagues to ensure individual needs of patients are recognised and taken account of when booking appointment and procedures, along with clear communications to patients to raise awareness of the options available to them
- Work is in progress to compile a directory of any, and all, transport services, including community, volunteer and charity organised services, and their eligibility criteria where necessary, that patients could be signposted to
- Work with voluntary, community and social enterprise and patient representatives to ensure changes to services and facilities is co-designed.
- Consideration by the Trust of a long-term travel and transport strategy.

4.22 There are also a number of recommendations which are being explored by the wider NHS Sussex system, which relate to patients who attend East Sussex Healthcare NHS Trust, such as:

- Exploring the options for a pilot shuttle bus service.
- Working with NHS colleagues on additions to the Non-Emergency Transport Service (NEPTS), such as a digital tracking element and eligibility criteria.
- Working with local authority and public transport providers on and potential future services.

A summary of the recommendations of the HOSC Review Board and the Travel and Transport Group and progress against these is provided at Annex 1 to this report.

Plans for implementation

4.23 This Decision-Making Business Case presents the public consultation feedback together with additional information and evidence that have been collated as part of the document's development and in response to the consultation. The purpose of the Decision-Making Business Case was to enable and support the NHS Sussex Integrated Care Board's decision-making process.

4.24 If the post-consultation proposal is formally supported by the East Sussex Health Overview and Scrutiny Committee, we would enact our implementation plan from December 2022 for full implementation in December 2023 – May 2024, although early implementation of some elements of the model will be sooner than this, to realise quality benefits as quickly as possible.

Decision-making

4.25 The purpose of the Decision-Making Business Case is to ensure that the proposals have been consulted upon, are clinically sound, financially viable, and in line with the improved outcomes agreed in the Pre-Consultation Business Case. At their meeting in public on 11 October 2022, East Sussex Healthcare NHS Trust noted the development of the Decision-Making Business Case, including the feedback from the public consultation; and following their review of the summary Decision Making Business Case, endorsed the case for consideration by the NHS Sussex Integrated Care Board. Following this, NHS Sussex Integrated Care Board met on the 2nd of November and approved the recommendations in the Decision-Making Business Case.

5 IMPLICATIONS

Financial implications:

5.1 There would be a positive financial impact on the Trust of implementing the changes outlined, this is as a result of implementing best practice and benefiting from resulting economies of scale.

Revenue

5.2 The case shows that under co-location there will be net efficiency savings, which takes into account the cost of capital, resulting in a favourable revenue position from year 2 for the preferred option (two sites).

£'000	Yr1	Yr2	Yr3	Yr4	Yr5	Yr6	Yr7	Yr8	Yr9	Yr10
Preferred Option vs. Do Nothing	(85)	49	232	427	658	902	1,160	1,433	1,692	1,959

Capital

5.3 The total capital required for the recommended option is £3.5m, with capital expenditure phased over two financial years between 2022/23 and 2023/24. Full implementation of the model of care is planned from quarter 3 2023/24.

5.4 The levels of capital outlined in this case for the recommended option can be funded within the Integrated Care System's capital allocation, in agreement with system partners.

Legal implications:

5.5 NHS Sussex has a legal requirement under the NHS Act 2006 to ensure patients and the public are involved in service changes. Therefore, the Gunning Principles as outlined above have been followed.

5.6 This underpins the pre-consultation engagement and the public consultation processes that have been followed for this programme.

5.7 Our Pre-Consultation and Decision-Making Business Cases have demonstrated compliance with former Clinical Commissioning Group and now Integrated Care Board statutory duties.

Other compliance:

Data and Privacy Impact Assessment (DPIA)

5.8 The proposal has no impact or changes to data that would be processed nor how it would be processed. There would be no new or different organisations and/or providers involved in accessing and/or sharing patient information, and no new data processing systems would be utilised. No further Data Privacy Impact Assessment is, therefore, required.

NHSE/I Five Tests for service reconfiguration

5.9 Part of the evaluation of any service reconfiguration is the demonstration that five specific areas have been considered to ensure best practice has been followed and affordability in terms of capital and revenue costs.:

1. that service users and the public are involved in the development of the proposals
2. whether any proposed redevelopment would maintain the availability of service user choice
3. demonstration of sufficient clinical evidence and clarity on the case for change
4. assurance that the proposals have the approval of local commissioners
5. relates to any proposal including plans to significantly reduce hospital bed numbers

5.10 Full consideration has been given to these points, details of which have been included in our Decision Making Business Case. In brief, the process has been clinically informed and led. Defining the vision for improved ophthalmology services across East Sussex involved a wide range of partners, these included service users, carers and their families, clinicians, including the service's workforce, and other local communities and interested organisations such as Healthwatch. Feedback collated from the pre-consultation engagement was provided to inform decision-making and a wide range of stakeholders were involved in the options development and appraisal process to ensure different perspectives could be heard and accounted for in the decisions made. There will be no reduction in bed numbers.

Quality and Safety implications

5.11 The aim of transforming these services is to deliver significant clinical improvements that will improve quality, outcomes, and safety for patients.

5.12 The Quality Impact Assessment has been completed in relation to the recommended option and in conjunction with the quality team. The Quality Impact Assessment is a live document and has been re-iterated throughout each phase of the programme and shown to have positive impacts.

Equality, diversity, and health inequalities

5.13 Integrated Care Boards have a duty to reduce inequalities between patients in respect to

outcomes and access and this transformation has embedded health inequality considerations into the redesign process.

5.14 A screening Equality and Health Inequalities Impact Assessment was initially developed, followed by a full Equality and Health Inequality Impact Assessment. taking account of feedback from Integrated Care System colleagues and NHSE/I. This Equality and Health Inequality Impact Assessment is a live document and has been re-iterated throughout each phase of the programme. Action from this has been undertaken, is reflected in the model of care, informed our public consultation and communications and engagement delivery plan, and our communications plan post-decision. The Equality and Health Inequalities Impact Assessment is Appendix 1 of the Decision-Making Business Case.

Patient and public engagement:

5.15 Following historical informal engagement, full pre-consultation engagement took place to understand what is important to local people. The information gathered during this engagement process informed our model of care and options appraisal process.

5.16 The transformation programme has been further informed by local people through our formal public consultation process, where the proposals were broadly welcomed with overall agreement on the proposed model of care, as there was recognition for the need to make changes to address challenges and deliver improvement to ophthalmology services.

5.17 The feedback was helpful, and a number of common themes were identified during the public consultation process, and initial actions in response to insight from the public consultation have included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous Equality and Health Inequality Impact Assessment` actions, and the establishment of a Travel and Transport Review Group, the actions of which have been, or are currently being, taken forward as part of the programme and when informing our final Decision-Making Business Case and recommendations.

Health and wellbeing implications:

5.18 The transformation of services in East Sussex is expected to improve access to care and health outcomes for our patient population, supporting the health and wellbeing agenda and reducing inequalities.

6 CONCLUSION

6.1 The process to develop these proposals has been comprehensive and the recommended model will deliver benefits for our local populations. Services will deliver improvements for all local people with the development of one-stop clinics at both sites, Bexhill Hospital and Eastbourne District General Hospital, and a diagnostic eye hub at Bexhill Hospital. Outpatient and day case surgery that currently takes place at Conquest will be moved to Bexhill. Emergency and general anaesthetic surgical ophthalmology cases (including cases

which require overnight stay) will continue to be at Conquest Hospital: these services will not be affected by these proposals. The introduction of one-stop clinics and a diagnostic eye hub will ensure faster diagnosis, reduce waiting times, reduce number of appointments required for patients to attend and repeated tests. These are key quality improvements to the ophthalmology service.

6.2 To deliver this model of care we need to bring staff together across a range of disciplines into multidisciplinary teams and the proposal enables the physical space for these staff to work together in this way. This also improves access to senior decision making and input when it is required in relation to patient care, so that patients will see the right people at the right time and repeat attendances will be reduced.

6.3 Through our engagement and options development and appraisal process we developed five potential model of care options. During the Pre-Consultation Business Case, and public consultation, with patients, the public and local stakeholders, the conclusion was to recommend the post-consultation proposal detailed in the Decision-Making Business Case. This is the same model of care that was appraised (as part of our options development and appraisal and pre-consultation processes) as the one that will best provide good patient experience, support improved outcomes for local people and a high-quality sustainable service; enabling the model of care to be implemented that will realise these benefits and is deliverable.

6.4 We recognise that this will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the implementation and evaluation processes to continue to understand the implications of our proposal. All new information and evidence gathered as part of an evaluation will inform how the final proposal is working.

6.5 Subject to the outcome of the East Sussex Health Overview and Scrutiny Committee's consideration as to whether the proposals are in the best interests of local people, mobilisation will begin. During any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to understand how best to provide easily accessible information, to support local people and professionals, about the changes; and to communicate the changes to existing services, the nature of new services and how to access them to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

Annex 1: Themed actions in response to public consultation and recommendations

Following the feedback from the public consultation, the HOSC Review Board and the Travel and Transport Review Group made a range of recommendations which have been taken account of as we have developed our proposals and our developing draft mobilisation planning. These key recommendations were focused on travel and transport and included providing travel support for local people; the introduction of Travel Liaison Officer at East Sussex Healthcare NHS Trust; improved parking at Bexhill Hospital; improved communication about travel options; liaising with patients about their individual travel and access needs; supporting patients with information and processes about accessing financial reimbursement where eligible; improving information for patients about alternative transport options and exploring over the longer-term improvements to public transport; and measures to support recruitment and retention of staff.

In response to these recommendations, some have been implemented and others have been committed to and we are progressing them as this programme continues and we implement our proposals. There are also several actions/recommendations which are being pursued and/or explored by the wider Sussex system, as these do not solely relate to ophthalmology patients who attend East Sussex Healthcare NHS Trust. Themes, recommendations and progress updates are detailed in the table below.

Theme	Recommendations from HOSC Review Board and Travel and Transport Review Group (TTRG)	Progress update
Workforce	Further measures to support the recruitment and retention of staff are explored in collaboration across the Sussex ICS, which address the workforce challenges of the service (HOSC)	Collaboration across the Sussex ICS is ongoing and is a continuing programme, as workforce challenges are widespread across the system and multiple services.
	Staff recruitment and retention is monitored to ensure the workforce challenges are being met and to assess whether additional measures to support recruitment and retention are needed (HOSC).	Monitoring of recruitment and retention has been built into the programme's KPI reporting to ensure we can incorporate this important element in our future evaluations to demonstrate the impact the proposed changes will have.
	Trust to ensure travel opportunities for staff, such as pool cars and salary sacrifice schemes, are advertised	This has been completed, and this information is shared with staff on a frequent basis.

	and widely known to staff (TTRG for implementation)	
Travel and Access	The Board recommended a package of travel and access mitigation measures is put in place to assist those patients who will have to travel further under the proposals, and those on low incomes or without other forms of support, including but not limited to those outlined below; the Travel and Transport Review Group recommendations are also outlined:	These have been completed, are in progress or being further explored as part of the programme timeline.
• **Travel support options including communication**	The establishment of a Travel Liaison Officer post is essential (HOSC)	The Trust has committed to this and it will be implemented as this programme is implemented.
	Trust to introduce a "Travel and Access Liaison Officer" role, possibly within PALS, who will provide patients and families bespoke support, information/advice and, if needed, arrangements to be made for around travel (TTRG for implementation)	As above.
	Trust to increase and maximise the number of on-site parking spaces at the Bexhill Hospital site (HOSC)	The programme has committed to improve car parking on the Bexhill Hospital site. This has been included in our final proposals within the Decision-Making Business Case (incorporating additional car parking) to ensure it is implemented in line with this transformation.
	The communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments, etc (HOSC)	This has been completed, and this information will continue to be shared on a frequent basis via our websites, social media, patient letters, etc., to ensure patients are aware of these opportunities.

	The provision of information on the travel support available in appointment letters via a separate leaflet or information sheet in an accessible format and links to the website (HOSC).	This has been completed and will be updated as additional work around this programme and related actions progress.
	Encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services (HOSC)	This has been completed, and this information will continue to be shared on a frequent basis via our websites, social media, patient letters, etc., to ensure patients are aware of these opportunities.
	Trust to provide clearer parking information for people attending Bexhill (TTRG for implementation)	This has been completed and will be updated as additional work around this programme and related actions progress.
	NHS Sussex to explore the opportunities for digital tracking element when the Non-Emergency Patient Transport Services is re-commissioned, so patients have a clearer idea of when they will be picked up (TTRG for investigation).	This is being pursued and/or explored by the wider NHS Sussex system, as this does not solely relate to ophthalmology patients who attend East Sussex Healthcare NHS Trust.
	Following agreement of decisions, ensure all FAQs are updated to explain proposed recommendations and resolutions for these programmes (TTRG for investigation).	This will form part of our communications plan post-decision, pending the decision that is agreed. Our communications plan is a live document and is continually being re-iterated as we get closer to our post-decision/implementation phase.
	Programme to monitor Did Not Attend (DNA) information following implementation of proposals to establish reasons why patients do not attend appointments and review the travel and access mitigations in light of this information (HOSC).	This will form part of our implementation, monitoring and evaluation as the programme progresses. Key Performance Indicators (KPIs) have been drafted to monitor implementation including Did Not Attend rates.
• **Establishing travel needs in advance of appointment**	The CCG and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the patient pathway (HOSC)	This is being pursued and/or explored by the wider Sussex system, as this does not solely relate to ophthalmology patients who attend East Sussex Healthcare NHS Trust.

	Trust to include travel and transport information, hospital site map and signposting information and advice in patient letters and/or patient information leaflets (TTRG for implementation)	This has been completed and will be updated as additional work around this programme and related actions progress.
	NHS Sussex and Trust colleagues to identify when/where in a patient's pathway is the most appropriate opportunity for their individual needs to be highlighted, e.g., if a longer appointment is needed or it needs to be held at a specific time of the day due to other conditions or learning/physical disabilities, dementia, etc., and then ensure this is built in and embedded to the pathway working with key stakeholders (TTRG for investigation).	This is being pursued and/or explored by the wider Sussex system, as this does not solely relate to ophthalmology patients who attend East Sussex Healthcare NHS Trust. NHS Sussex has a personalised care programme committed to embedding a personalised care approach in all pathways, including ophthalmology, to give people choice and control over the way their care is planned and delivered. The Trust's agreed Travel and Access Liaison Officer will support individual patients with this.
• **Other transport options**	Actions to improve access via other transport alternatives (e.g., development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc (HOSC)	Discussions with the local authority regarding transport alternatives are ongoing and will be included in implementation planning as appropriate.
	NHS Sussex and East Sussex Healthcare NHS Trust to investigate potential options to pilot a shuttle bus service between the Trust's hospital sites for staff and/or patients (TTRG for investigation)	The programme team will continue to assess the requirement and the feasibility of a shuttle bus as part of the implementation plan. This will be resolved ahead of go live.
	NHS Sussex to compile a directory of any, and all, local charity, and volunteer transport services that patients could be signposted to if they are ineligible for other services, such as Non-Emergency Patient Transport Services (NEPTS) (TTRG for implementation).	This is currently ongoing and will be ready prior to implementation.

	Explore details and arrangements of shuttle bus services that other Trusts have implemented.	The programme team will continue to review other Trust transportation solutions prior to implementation as part of the travel and transportation workstream.
	Explore progress of the Trust's potential plans to have an in-house patient transport service.	The programme team will continue to review other Trust transportation solutions prior to implementation as part of the travel and transportation workstream.
• **Exploring improvements to existing public transport**	NHS Sussex and Trust colleagues to discuss potential resolutions to public transport concerns with local public transport providers (TTRG for investigation).	This work will form part of implementation plans and wider trust approach.
	NHS Sussex and Trust colleagues to initiate discussions with East Sussex County Council (ESCC) and Stagecoach to investigate potential future bus provision to meet the needs of the re-configured ophthalmology services (TTRG for investigation).	Working with local authority partners, the programme team will continue to review a range of transportation solutions, including bus service improvement, prior to implementation as part of the travel and transportation workstream.
	NHS Sussex and Trust colleagues to approach ESCC to discuss how the local population's transport and travel needs could be considered as part of its Bus Service Improvement Plan (TTRG for investigation).	Working with local authority partners, the programme team will continue to review a range of transportation solutions, including bus service improvement, prior to implementation as part of the travel and transportation workstream.
• **Insight from local people and communities in implementing travel and transport action**	All decisions and recommendations taken forward will be co-designed with voluntary, community and social enterprise members who represent the patient population (TTRG for implementation).	This will form part of implementation plans, to ensure our new service is accessible and user friendly for all our local population.
	NHS Sussex to investigate learning from the vaccination programme, as travel arrangements have been arranged to support patients to get to their vaccination programmes (TTRG for investigation).	This has been completed.

• **Evaluating impact of travel and transport actions**	Trust and NHS Sussex colleagues to work in partnership with voluntary, community and social enterprise organisations and patient groups to review access to hospitals, e.g., a mystery shopper exercise, to focus on those groups highlighted in the programme Equality and Health Impact Assessment, pre-consultation engagement, options development and appraisal processes, and public consultations who have experienced access issues (TTRG for implementation).	This will form part of implementation plans, to ensure our new service is accessible and user friendly for all our local population.
• **Strategic approach**	Trust to consider drafting a long-term Trust-wide transport and travel strategy to meet all patient, carer, family, and staff needs across East Sussex (TTRG for investigation).	This is being explored by Trust colleagues, as this do not solely relate to ophthalmology patients who attend East Sussex Healthcare NHS Trust.
Timely implementation	Implementation of the proposals is undertaken as soon as possible, and consideration is given to mitigating the risks posed by workforce challenges and the development of other competing services to ensure no loss of services in the implementation plan (HOSC)	This Decision-Making Business Case sets out high level implementation plans and timescales to reflect how soon we can safely and appropriately fully implement this transformation proposal. This is to ensure we are not negatively impacting the continuity of care for our patients or services at East Sussex Healthcare NHS Trust.
Assurance on impact on other services	The Decision-Making Business Case contains assurance that other services provided at the two hospitals will not be affected by the implementation of the proposals for ophthalmology (HOSC)	This has been completed and assurance included in the Decision-Making Business Case.

Scrutiny Review of the proposal to redesign Ophthalmology Services in East Sussex

Report by the Health Overview and Scrutiny Committee (HOSC) Review Board

Councillor Colin Belsey (Chair)

Councillor Abul Azad

Councillor Christine Brett

Councillor Christine Robinson

Geraldine Des Moulins (Community and voluntary sector representative)

June 2022

Health Overview and Scrutiny Committee (HOSC) – 30th June 2022

Scrutiny Review of the proposal to redesign Ophthalmology Services in East Sussex

Contents **Page**

Recommendations **2**

Background **4**

1. The proposals for the future of ophthalmology **5**

Department of ophthalmology **5**

Reason for changing the ophthalmology service 6

Comments of the Board 7

Proposed option for reconfiguring ophthalmology **7**

Choice of site 8

Services at new facility 9

Stated benefits to patients 9

Stated benefits to staff 9

GPs Views 9

Views from Healthwatch 10

Public consultation 10

Comments of the Board 13

2. Issues with the new service that should be addressed **14**

Access and travel **14**

Comments of the Board 15

Patient choice and patient pathways **16**

Implementation timescales **17**

Staff recruitment and retention **17**

Summary Comments **18**

Appendix 1 ..... **19**

Review Board meeting dates 19

Witnesses 19

List of documents considered by the Review Board 20

Recommendations

1	**The Committee endorses the reasons for reconfiguring ophthalmology including:** - **Clinical case for change and the potential for new services to improve patient care and experience.** - **The creation of the 'Centre of Excellence' diagnostic hub, one stop clinics, and measures to support staff recruitment and retention.**
2	**The Committee notes that the proposed choice of the Bexhill Hospital to consolidate ophthalmology services and recommends that mitigation measures are put in place to address the concerns about travel and access to this site.**
3a	**The Board recommends:** **A package of measures is put in place to mitigate the travel and access impacts of the proposals on patients, families, and carers, including:** - **the establishment of a Travel Liaison Officer post is essential.** - **the communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments etc.** - **the provision of information on the travel support available in referral letters via a separate leaflet or information sheet in an accessible format and links to the website.** - **the CCG and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the patient pathway.** - **encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services.** - **increasing and maximising the number of on-site parking spaces at the Bexhill Hospital site.** - **actions to improve access via other transport alternatives (e.g. development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc.).**
3b	**The Board recommends:** **Ongoing monitoring of Did Not Attend (DNA) information is undertaken after implementation of the proposals to establish the reasons why patients do not attend appointments, and review the travel and access mitigations in the light of this information.**

4	**The Board recommends:** - **Patients are given a choice of hospital site for referral where appropriate.** - **Consideration is given to providing some specialist treatments at the Eastbourne DGH site in addition to Bexhill Hospital.**
5	**The Board recommends:** - **Detailed implementation plans are drawn up as soon as possible to facilitate the timely implementation of the proposals, once a decision is made.** - **The opportunity is taken to make early changes to services where this is possible.**
6	**The Board recommends:** - **Regular monitoring of staffing levels is undertaken post implementation to ensure the sustainability of the service.** - **Further staff recruitment and retention measures are developed.**

Background

1. East Sussex Healthcare NHS Trust (ESHT) provides ophthalmology services for the residents of East Sussex. This includes adult and paediatric ophthalmology services provided at three main centres, which are the Conquest Hospital in Hastings, the Eastbourne District General Hospital (EDGH), and Bexhill Hospital.

2. Ophthalmology is a branch of medicine and surgery that provides diagnosis, treatment and prevention of conditions that affect the eye and visual system. Many eye conditions are age-related, making ophthalmology services more and more important as people get older. Ophthalmology services commonly include the diagnosis and treatment of Age-related Macular Degeneration (AMD), Cataracts and Glaucoma.

3. East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. This means that increasing numbers of people are needing to use ophthalmology services. The changing needs of the population, the changing nature of ophthalmology care and the associated challenges in providing ophthalmology services has made the redesign of ophthalmology a key priority for East Sussex NHS Clinical Commissioning Group (CCG), - which is the responsible organisation for service reconfigurations – and ESHT.[1]

4. The CCG and ESHT are proposing following changes to ophthalmology services provided by ESHT:

- to consolidate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital;
- create one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital; and
- move outpatient appointments currently provided at the Conquest Hospital to Bexhill Hospital.

5. The CCG undertook a public consultation between 6th December 2021 and 11th March 2022 seeking views on the need to change the service, the proposed model of care, and the proposed location of ophthalmology services at Bexhill Hospital and EDGH.

6. In addition to its duties to engage with the public, the NHS is required under regulations to consult with the local health scrutiny committee(s) on any proposal that is deemed by the committee to be a substantial variation or development to existing services. As a result, representatives of the CCG and Trust attended the East Sussex Health Overview and Scrutiny Committee (HOSC) meeting on 2nd December 2021 to explain the proposed changes to ophthalmology services.

7. The HOSC agreed the proposals constituted a substantial variation to services requiring formal consultation with the Committee under health legislation. The HOSC established a Review Board to carry out a detailed review of the proposals and produce a report and recommendations on behalf of the Committee. The Review Board comprised Councillors Abul Azad, Colin Belsey, Christine Brett, and Christine Robinson and a community and voluntary sector representative, Geraldine Des Moulins. The Review Board elected Councillor Belsey as the Chair.

8. The Review Board carried out the majority of its review between March and June 2022. This report sets out the evidence the Board considered, along with its conclusions and recommendations.

[1] Pre-Consultation Business Case (PCBC) p.5/6

1. The proposals for the future of ophthalmology

9. Ophthalmology is the branch of medicine and surgery that provides diagnosis, treatment and prevention of diseases of the eye and visual system. Medical ophthalmology involves diagnosis and management of disorders affecting a person's vision. Surgical ophthalmology involves surgical procedures to correct or improve a person's vision, for example, cataract surgery.

Department of ophthalmology

10. Ophthalmology services at East Sussex Healthcare NHS Trust (ESHT) are Consultant-led and provide services for children (paediatric) and adults across three hospital sites. Paediatric services are also provided from community sites across Hailsham, Crowborough and Seaford, and these will remain as this Pre-Consultation Business Case is focussed on the provision of specialist medical and surgical ophthalmology services across East Sussex Healthcare NHS Trust's three main hospital sites, Eastbourne District General Hospital, Conquest and Bexhill.[2] The Trust also provides a Glaucoma Referral Refinement clinic, the purpose of which is to determine a patient's risk of having glaucoma.[3]

11. East Sussex Healthcare Trust's current ophthalmology service provision for adults and children is shown below[4]. This details the ophthalmology service as it currently exists.

Service/treatments, e.g.:	Conquest	EDGH	Bexhill	Community
Outpatients	✓	✓	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓	✓	✓
Monitoring/review (in person*)	✓	✓	✓	✓
Diagnostic testing	✓	✓	✓	✓
Pre- / post-operative assessment	✓	✓	✓	✓
Day surgery	✓	✓	✓	✗
Inpatient surgery	✓	✓	✗	✗
Non-elective (emergency)	✓	✓	✗	✗

*Virtual clinics have been developed during the COVID-19 pandemic, and this shift to non face to face activity will continue to be developed where clinically appropriate

12. The ophthalmology service is one of the most used outpatient services, as well as providing day case surgical procedures, and inpatient surgery. The table below[5] gives the activity levels for the service provided by ESHT from April 2019 to March 2020. It should be

[2] PCBC p.37

[3] PCBC p.38

[4] PCPB p.37, figure 7

[5] Patient flow information provided at 12 May meeting.

noted that March 2020 was impacted by the COVID-19 pandemic and Ophthalmology services were focused at the Bexhill site to ensure the Conquest and Eastbourne sites could be prioritised for acute services and COVID-19 infected patients.

Point of Delivery (POD)	Bexhill Hospital	Conquest Hospital	Eastbourne District General Hospital
Day Case	2,094	92	2,291
Elective Inpatient	0	6	21
Emergency admission	0	14	18
Outpatients	17,535	24,271	41,580
Total	**19,629**	**24,383**	**43,910**

13. Some East Sussex residents also receive ophthalmology care at other hospital trusts outside of the county.[6] For 2019/20, this was as follows:

Point of Delivery (POD)	East Sussex Healthcare NHS Trust	Maidstone & Tunbridge Wells NHS Trust	Queen Victoria Hospital	University Sussex Hospitals NHS Trust (East)	University Hospitals Sussex NHS Trust (West)	Other
Day Case	4,440	203	806	1,006	6	462
Elective Inpatient	36	3	47	101	1	15
Emergency admission	31	0	7	105	0	33
Outpatients	82,397	3,259	7,171	13,050	79	3,280
Total	**86,904**	**3,465**	**8,031**	**14,263**	**86**	**3,790**

Reason for changing the ophthalmology service

14. The East Sussex Clinical Commissioning Group (CCG) and East Sussex Healthcare Trust (ESHT) set out their concerns about the current service and why it needs to change (the case for change) in the PCBC document[7] which brings together local, regional and national requirements and drivers for change. These include:

- ***Quality*** - Healthcare systems are required to minimise the risk of significant harm, through delivering timely follow-up for patients with chronic conditions. The high and growing number of these cases within ophthalmology makes this a challenge.
- ***Service performance*** - Nationally, ophthalmology outpatient services are the most used of all outpatient services, with East Sussex Healthcare Trust seeing 18,075 new outpatients and 65,511 follow-up appointments in 2019-20. The Covid-19 pandemic has impacted heavily on ophthalmology provision and this, coupled with the very high levels of need for care, has led to the service no longer meeting national waiting time standards.
- ***Growing need*** - It is estimated that, over the next 20 years, the need for cataract services will rise by 50%, glaucoma cases by 44% and medical retina by 20%.
- ***IT / Digital*** - There would be a significant benefit to patients through ophthalmology services making the best possible use of modern digital technology, such as an Electronic Eyecare Referral System (EERS). Modern technology presents opportunities to improve patient pathways and better manage the growing need for ophthalmology services.
- ***Workforce*** - A census carried out by the Royal College of Ophthalmologists (RCOphth) in 2019 identifies gaps in recruitment for ophthalmologists and workforce planning, amid a predicted 40% increase in need over the next 20 years.

[6] Ibid

[7] PCBC p.6/7

- ***Estates and equipment*** - Diagnosis and monitoring of ophthalmic patients is highly dependent on equipment. Much of the equipment currently used by the department across its three sites is old, which impedes the service's ability to work efficiently and effectively. There are limitations of physical space in the current service configuration limiting the capacity of the service to meet the current and growing need of the local population which contributes to challenges in meeting service standards.
- The national ***Getting it Right First Time*** (GIRFT)2 programme reviewed the ophthalmology service in March 2018. It was recommended that ESHT:
    - Review pre-assessment clinics and review/audit coding for complex cataracts to ensure the patient pathway for cataract surgery is optimised.
    - Continue to develop health care professional (HCP) staff by training and developing all members of the multi-disciplinary team, whilst utilising competency frameworks to increase the number of non-consultant clinical staff.
    - Look into using consultant-led and technician-provided virtual clinics for age-related macular degeneration (AMD) and glaucoma to improve refinement of treatment plans.
    - Review coding practices to ensure accuracy, particularly around complex cataracts, corneal grafts, strabismus follow-ups and vitreo-retinal conditions.
    - Continue to refer to the Royal College of Ophthalmologist's "The Way Forward"3 document to identify options to help meet demand and the Common Competency Framework to support health care professional staff development.

15. The Review Board has also reviewed the recommendations from the Clinical Senate report on the proposals and the responses to them which have been included in the PCBC document. Amongst these recommendations the Clinical Senate makes clear that continuing with the current position, where a fragmented service is provided across three sites (i.e. the do nothing option), is not a sustainable option for the service going forward.[8]

Comments of the Board

16. The Board notes the reasons behind the proposals to change the model of care and transform the service in line with a number of local, regional, and national programmes and initiatives. It is clear that the 'do nothing' option would not be in the interests of patient care and would not address waiting times or workforce issues.

Proposed option for reconfiguring ophthalmology

17. Currently services are spread across three sites, and the proposal for the future is to locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital. The introduction of one stop clinics and a diagnostic eye hub are aimed at ensuring faster diagnosis, reducing waiting times, reducing the number of appointments required for patients to attend and repeated tests. These are key quality improvements to the ophthalmology service identified in the proposals.

18. The selection of this option followed an options appraisal process that looked at the strengths and weaknesses of four options in total. More information on this process can be found in the Pre Consultation Business Case (PCBC). Under the proposals, the range of services provided at Eastbourne DGH will remain the same and will include the provision of a one stop clinic. The key changes under the proposals are that the outpatient services currently located at the Conquest Hospital will move to the Bexhill Hospital site. Day case procedures are currently provided at Bexhill Hospital rather than the Conquest Hospital, and any inpatient

[8] South East Clinical Senate Review PCBC for Ophthalmology Services for East Sussex CCG

surgery requiring an overnight stay and emergency treatment in A&E will remain at the Conquest.

19. The Review Board heard that the proposed model provides the best opportunity to deliver high quality, safe and clinically sustainable services that also addresses the current challenges by bringing ophthalmology services together on two hospital sites. The benefits include:

- better patient experience;
- improved patient outcomes through streamlined outpatient pathways;
- a one stop service, including access to a multidisciplinary team; and
- providing sustainability of services for the future.

20. The Board questioned how the proposals will improve services. It heard evidence given by the CCG and ESHT that senior clinicians will have greater involvement in treatment plans and clinical decisions, and staff from different areas of ophthalmology would be able to work more closely together as one team enabling the service to meet national standards, guidelines and performance targets in the future. The new model will rationalise estates and equipment and align with the Sussex-wide ophthalmology Transformation Programme plan.

21. The Review Board heard evidence from a number of witnesses on the reasons for the proposed changes. This included the clinical lead for Ophthalmology, Mr Kash Qureshi, staff involved in providing the service and GP representatives in order to gain an understanding of the benefits for patients in terms of treatment, outcomes and patient experience.[9] The Board also considered evidence from Healthwatch East Sussex and submissions from the Friends of Bexhill Hospital, the Friends of Conquest Hospital and other stakeholders who responded to the HOSC Newsletter.[10]

Choice of site

22. The Board considered the reasons for the proposed location of the combined services at Bexhill Hospital and asked why Bexhill is the preferred site. The Board heard that if services stayed at the Conquest Hospital it would require an expansion of theatre space and would be more costly due to limited theatre capacity. The majority of procedures do not need to be on an acute site, so the clinical aspect of the service does not need to be at the Conquest Hospital. In addition, as the Bexhill site is a non acute site, services such as the treatment of macular degeneration were able to continue during the Covid pandemic.

23. Locating services at the Conquest was not the preferred option for a number of reasons. These included the position of the theatres which are located away from the outpatients department and the length of walk especially for elderly patients, which does not allow high patient throughput. The Conquest outpatients is not suitable for expansion to provide enhanced outpatient services needed.

24. The Board understands that the benefits of choosing the Bexhill site are that the Bexhill Hospital layout is better for patients, with the waiting areas next to the theatre, has room for expansion and allows increased patient flow. The proposals also allow for pre-assessment to be linked to the day case service as they can be done in the same location. Pre-assessment can take place on the same day as being seen, resulting in fewer appointments being needed and therefore fewer journeys for patients. This is not currently possible with the service spread across three sites and the proposals allow for a much more joined up service to be provided.

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[9] 22 April meeting

[10] 12 May meeting

This includes the creation of a multi-disciplinary team and enhanced provision of senior consultant advice and supervision.

Services at new facility

25. The Board heard that it is proposed to create a 'Centre of Excellence' at the Bexhill Hospital site which will include a diagnostic hub. These proposals include refurbished outpatients' areas and the purchase of the latest diagnostic equipment. This will allow the provision of the most technologically advanced procedures and treatment for patients, which the board understands will lead to better patient care and outcomes.

26. The Board questioned the availability of funding for the transformation proposals. It was confirmed that the Trust has the necessary capital funding in place to implement the proposals and buy new equipment. The proposals will not require an expansion of the Bexhill hospital buildings but will mean other building users will be re-located to provide the expansion space for ophthalmology. A more detailed implementation plan for the proposals will be drawn up and included in the Decision Making Business Case (DMBC).[11]

Stated benefits to patients

27. The Board heard that under the proposed model patient waiting times will be shorter, with technician led diagnostic hubs meaning fewer appointments will be needed and decisions can be made more quickly. Patients will require fewer visits for diagnosis and treatment under the new model and will be seen in a timely way due to direct supervision by consultants. The new model will improve waiting times and crucially minimise risk of sight loss due to long waiting times for referrals. The new model will provide a one stop service with diagnostics and pre operation/procedure assessment taking place in one appointment. The new model will provide capacity for clinical staff to upskill and will provide sustainability of services for the future.

Stated benefits to staff

28. The Board was told that a 'Centre of Excellence' will be good for recruitment and retention and create an attractive environment for staff. Consolidation of the sites will make a more attractive proposition when recruiting as it provides the number and level of complex cases, coupled with the right level of supervision. Consolidation of services, using staff resources to their best potential, and working in a multidisciplinary team will provide opportunities for training (e.g. on laser techniques and injections) and provide efficiencies to cover staff sickness thereby avoiding the need to cancel appointments.

29. There will be no reduction of staff numbers and currently many of the ophthalmology staff work across all three sites. Under the proposals, members of staff currently working at the Conquest will transfer to Bexhill.

GPs Views

30. The Board heard that GPs are generally positive about the proposals from a service, diagnostic, and treatment perspective. Timely access to early diagnosis and assessment, and better access to qualified ophthalmological opinion are seen as a major benefits of the proposals. It is anticipated that individual patients will require fewer follow up appointments through the use of One Stop clinics and virtual clinics, which will benefit patient experience. GPs recognise the workforce pressures and the benefits of consolidation for recruitment and retention, and the training and development of non-medical roles, which can be upskilled. There

[11] 12 May meeting

is also an opportunity to upskill community services as part of the proposals. The new model to some extent has been tested during Covid-19 pandemic with Bexhill being used as a 'cold site'.

31. The patient feedback from the pre engagement work is that people are generally happy to travel if they are receiving a senior opinion and if it involves fewer appointments. This is tempered by the issues with parking and travel at the Bexhill site. The Board heard that the overall view from GPs is the case for change is explained well. Under the new model the availability of a senior ophthalmologist is an important point which means clinical decisions can more easily be made in a single appointment. Virtual clinics are also an important element of the proposals which provides a variety of ways to access care and treatment. The proposals also provide opportunities to upskill community optometrists, who can deliver a wider range of care closer to home, which is complementary to this model.[12]

Views from Healthwatch

32. Healthwatch advised the Board that, in their view, the new model offers good quality services and an acknowledgement of the need for more space and modernisation. Healthwatch indicated that ESHT currently provides a good service, but it is overcrowded and needs more space. The challenges around recruitment are acknowledged with competition with London and hospitals within the M25 radius for suitably qualified ophthalmology staff. In this context it is important for ESHT and the CCG to provide up to date and efficient services to attract staff and to ensure a high quality of care for patients in East Sussex.

33. Healthwatch indicated that there are concerns about travel and access and there is a need to mitigate these concerns especially for people short of resources.

34. Healthwatch is supportive of the changes to ophthalmology services in East Sussex as set out in the PCBC. However, it is noted that the time taken to implement changes is sometimes slow and Healthwatch is keen to see the best quality of care being provided expeditiously for the benefit of patients in East Sussex.

Public consultation

35. A public consultation on the proposals for ophthalmology services was undertaken between 6 December 2021 and 11 March 2022, in which service users, members of the public, NHS staff members, organisations and other stakeholders were invited to give feedback on both the proposed model of care and locations for core ophthalmology services. The consultation and subsequent analysis were conducted by Opinion Research Services (ORS).

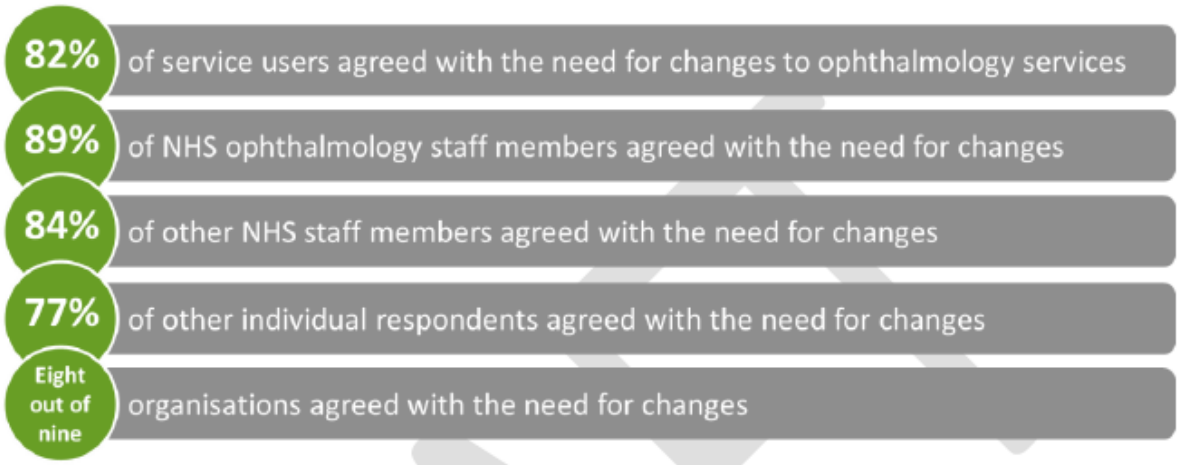
36. According to ORS, the consultation had 531 responses including 334 ophthalmology service users, 27 NHS ophthalmology staff members, 25 other NHS staff members, and 9 responses from 8 separate organisations. The consultation also included a number of focus groups and group discussions with services users, carers and ESHT ophthalmology staff; in-depth interviews and engagement with service users; workshops and in-depth interviews with stakeholder organisations; public meetings, listening events, staff forums and briefings, meetings with community groups, and 'pop-up' events in public spaces.

37. The public consultation outcomes included the following views on the need for change, the proposed model of care, and the proposed location of ophthalmology services:[13]

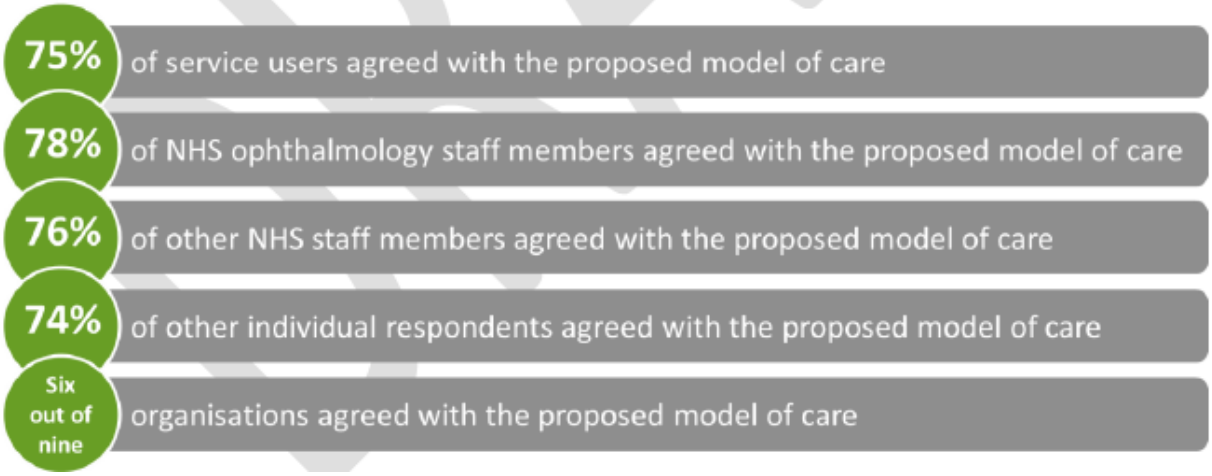
[12] 12 May meeting

[13] Presentation at 25 May meeting and ORS Public Consultation feedback draft report May 2022.

Views on the need for change – Overall, there was broad recognition for the need to make changes to address challenges and deliver improvement to ophthalmology services across the consultation feedback. There was high agreement from all stakeholder groups.

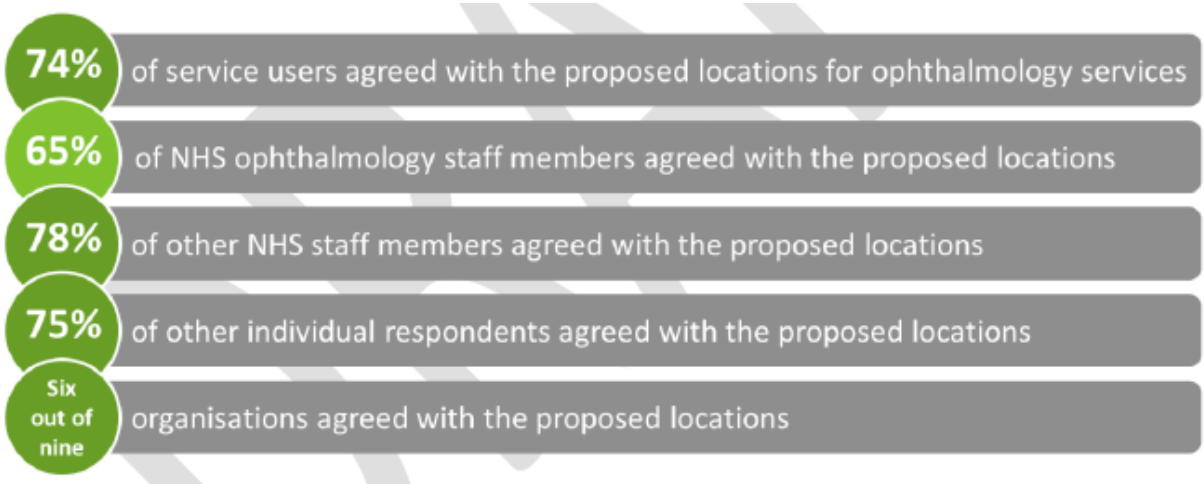


Views on the proposed model of care - There was broad agreement across the consultation feedback on the model of care. However, there were some concerns expressed by those living closest to the Conquest Hospital.



However, there were some evidence of concerns expressed by those living closest to the Conquest Hospital.

Views on the proposed locations of services - There was majority agreement across the consultation feedback on the proposal to deliver ophthalmology services from Eastbourne DGH and Bexhill Hospital in future.



However, a significant minority of respondents living closest to the Conquest Hospital (39%) disagreed with the proposed location.

38. Among those consultation participants who agreed with the proposed model of care, it was commended for:

- Aiming to speed up the referral process and reduce waiting times;
- Centralising services on two sites and introducing the 'one stop clinic' model at both sites with a diagnostic hub at one site;
- Potentially creating a 'centre of excellence' in East Sussex with a high-quality service which could attract specialist clinicians.[14]

39. Across all consultation strands, the main reasons for disagreement with the proposed model of care centred around:

- Travel and access, including longer journey times and increased costs for people from Hastings and other areas of East Sussex used to traveling to Conquest Hospital for appointments; and
- Concerns with current road access and parking at, and public transport links to, the Bexhill Hospital site. [15]

40. The most commonly suggested mitigation measures to reduce travel and access impacts, if the changes did go ahead, were:

- Increasing and improving access to patient transport services, including addressing changes to eligibility criteria which were reported to have left large numbers of people without lifts;
- Recruiting more volunteer drivers and supporting 'community bus services';
- Introducing shuttle buses between East Sussex hospital sites and to and from local train stations;

[14] ORS Public Consultation feedback draft report May 2022

[15] Ibid

- Working with local councils and public transport providers to improve public transport links to and from proposed sites;
- Providing financial support for service users who must use taxis to reach hospital;
- Introducing adequate and affordable/free parking (including additional disabled parking bays) at Bexhill Hospital and Eastbourne DGH; and
- Consult with Bexhill residents living close to the hospital who might be impacted by increased traffic and parking on residential streets. [16]

Comments of the Board

41. The Board found that the proposals for change are good, with patients being seen more quickly and having to make fewer visits. There is a convincing case that patient experience will be improved and there will be better outcomes. Getting the right processes in place for multidisciplinary teams needs to be done well, and this will be a key management responsibility in implementing the proposals. The Board notes the concerns about the time taken to implement changes in services which will benefit patients.

42. The ophthalmology consultants and staff are very supportive of the proposals to go ahead in order to be able to offer a sustainable, high quality and technically advanced service and to improve patient care and experience. Healthwatch and GP representatives considered the proposals would benefit patient care with reduced awaiting times, fewer appointments, and enhanced services, but were concerned about the inequity of access for some patients to the Bexhill Hospital site.

43. In summary, all witnesses were positive about the proposals for improvements in the service which will lead to a good quality service and increased patient care. The Board can see the potential problems with travel and access and any mitigating measures will need to be closely monitored. The Board notes there is a strength of feeling about travel and access to the Bexhill Hospital site, with a perception that it is difficult to get to via public transport and has limited parking.

Recommendation 1

The Committee endorses the reasons for reconfiguring ophthalmology including:

- **Clinical case for change and the potential for new services to improve patient care and experience.**
- **The creation of the 'Centre of Excellence' diagnostic hub, one stop clinics, and measures to support staff recruitment and retention.**

Recommendation 2

The Committee notes that the proposed choice of the Bexhill Hospital to consolidate ophthalmology services and recommends that mitigation measures are put in place to address the concerns about travel and access to this site.

[16] ORS Public Consultation feedback draft report May 2022.

2. Issues with the new service that should be addressed

44. During the course of its review, the Board identified several issues that the CCG and Trust should address. These are detailed below.

Access and travel

45. Access and travel are key issues at the Bexhill site. The Board heard from ESHT that patients will mostly travel by car or taxi to get to and from appointments. However, not everyone has family or friends who can help patients get to appointments and the situation regarding increased travel costs and affordability has changed since the PCBC was drawn up. Many people are on fixed incomes and there is a concern that those in deprived communities may not attend appointments due to these barriers.

46. It is acknowledged that the proposals may lead to patients needing to attend fewer appointments at the diagnostic hub at Bexhill. However, the difficulty of getting to this site, especially if you do not have access to a car or cannot afford a taxi, needs to be mitigated. The Board also heard concerns about the number of parking spaces available on site and the lack of frequent bus services.

47. Currently, Bexhill Hospital is served by two bus routes. Route 95 which runs 2 hourly between Bexhill and Battle via Bexhill Hospital and the Conquest. Route 98 runs hourly between Eastbourne, Bexhill and Hastings, and half hourly between Hastings and Bexhill. Neither route operates services on a Sunday. This compares with the Conquest Hospital which is served by a bus linking the hospital to the town centre and railway station approximately every 10 minutes, and Eastbourne DGH which is served by a bus linking the hospital to the town centre and railway station approximately every 5 minutes.[17]

48. These travel and access constraints will affect patients, families, and carers as well as the increased number of ophthalmology staff working at the site. With an estimated additional 18,750 outpatient visits per year[18] (taking into account the anticipated reduction in the number of appointments), there is a need to increase the amount of parking available on site for patients, people with disabilities, and staff.

49. The Board understands that a Travel and Access Group (TAG) has been established by ESHT to explore the deliverability and feasibility of a number of options to mitigate the travel and access issues at the Bexhill site. The outcomes from this work will be included in the Decision Making Business Case (DMBC) and may include:

- Creating a Travel Liaison Officer post to support patients and advise on the help that is available;
- Reviewing on-site parking provision, with a view to increasing the number of parking spaces. The Trust is confident it can fit any additional parking needed on site;
- Reviewing building and estates provision to ensure accessibility issues are addressed;
- Examining the potential of setting up a shuttle bus service;
- Looking at whether it is possible to increase work with volunteers and the voluntary sector;

[17] 12 May meeting

[18] Ibid

- Examining how transport was used during the vaccination programme to see if there are any lessons learnt that could be used; and
- Exploring whether it would be possible to pay for taxis directly for those patients that are eligible to reclaim travel costs (e.g. through a contract with taxi firms).

50. The Board welcomes these proposals and supports the proposal to create a Travel Liaison Officer post that could help and support patients with their travel and access needs, and where patients could be referred to if they needed help with travel arrangements to get to an appointment.

51. From the evidence reviewed, it is unclear to the Board whether patients are routinely asked if they need help getting to an appointment and whether information on the support that is available for travel and access is consistently made available to patients at the point of referral or when appointment letters are sent out. The Board recommends that information on travel and access support is included with referral letters, and patients' travel and access needs continue to be identified and recorded when referrals are made.

52. The Board also understands that at hospital sites where there is a cashier's office it may be possible for patients to claim back travel costs on the same day as their appointment if they are eligible to do so. For people on limited incomes this would provide a faster way of reclaiming any travel costs, and the Board considers this option should be more widely publicised to those patients who may need financial help getting to appointments.

53. The Board is concerned that some patients may not attend appointments due to the difficulty of getting to the Bexhill Hospital site. The Board has reviewed Did Not Attend (DNA) data for the ophthalmology services provided at the Conquest and Bexhill Hospitals[19]. Anecdotally the most common reason for not attending an appointment during the period covered by the pandemic was the fear of catching Covid. There was no discernible difference in recent DNA rates due to an increase in the cost of travel or cost of living. However, the Board recommends that ongoing monitoring of DNA data is undertaken after implementation of the proposals to establish the reasons why patients do not attend appointments and review the travel and access mitigations in the light of this information.

Comments of the Board

54. The Board considers that a comprehensive package of measures needs to be introduced to mitigate the impact of the proposals on travel and access. It is clear that the existing support available needs to be publicised more widely, including the eligibility criteria for free Patient Transport Services. Asking about patient travel and access needs and offering information and support at the point of referral is also vital. The Board understands the clinical administration teams currently record any travel and access needs for existing patients and this should be continued and be included in all patients' records.

55. The provision of information needs to be in accessible formats (including hard copies and large print) in a separate leaflet or information sheet for inclusion with referral letters. The Board considers that the eligibility criteria for Patient Transport Services needs to be clearly explained and more detailed clarification is required to make it easily understood. Examples should be given where a patients' condition makes them eligible.

[19] 25 May meeting.

Recommendation 3

The Board recommends:

3a. A package of measures is put in place to mitigate the travel and access impacts of the proposals on patients, families, and carers, including but not limited to:

- **the establishment of a Travel Liaison Officer post is essential.**
- **the communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments etc.**
- **the provision of information on the travel support available in referral letters via a separate leaflet or information sheet in an accessible format and links to the website.**
- **the CCG and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the patient pathway.**
- **encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services.**
- **increasing and maximising the number of on-site parking spaces at the Bexhill Hospital site.**
- **actions to improve access via other transport alternatives (e.g. development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc.).**

3b. Ongoing monitoring of Did Not Attend information is undertaken after implementation of the proposals to establish the reasons why patients do not attend appointments, and review the travel and access mitigations in the light of this information.

Patient choice and patient pathways

56. In reviewing patient flow information the Board could see that some patients, and in particular those in the west of the county around Seaford and Newhaven, were travelling quite long distances for appointments and treatment, rather than attending Brighton hospitals which are nearer. The Board examined whether patients had a choice of provider and where they go for appointments and treatment.

57. The Board heard that most outpatient appointments and diagnostic procedures can be accessed via any hospital site. However, some specialist treatments (e.g. eye injections) equipment and technicians are available only at certain hospitals (e.g. Bexhill Hospital). It was clarified that GPs will normally refer to the nearest provider and usually people would choose to travel to the nearest treatment centre. If there is a requirement for a specific treatment, there may not be a choice of provider. Referrals made by ESHT would normally be to ESHT provided services or tertiary centres where appropriate.

58. Although not part of the proposals, the Board asked whether specialist treatments such as regular injections for Age-related Macular Degeneration could be provided at Eastbourne DGH (e.g. via a weekly clinic) as well as Bexhill Hospital. This would lessen the amount of travel to the Bexhill site and improve patient experience as travelling to Eastbourne may be easier for a number of patients.

Comments of the Board

59. The Board considered that it would be beneficial for patients to be made aware of different patient pathways and where there is a choice of provider so that they can choose the hospital where they go for appointments and treatment. It was also noted that some services in

future may increasingly be available from community-based opticians, which would also increase access to services.

Recommendation 4

The Board recommends:

- **Patients are given a choice of hospital site for referral where appropriate.**
- **Consideration is given to providing some specialist treatments at the Eastbourne DGH site in addition to Bexhill Hospital.**

Implementation timescales

60. The Board notes that one of the reasons for the proposed changes to the ophthalmology service is to reduce waiting times and allow the service to meet national waiting time standards. One of the concerns expressed by Healthwatch is how quickly the proposals can be implemented, in order to benefit patients as quickly as possible.

61. The Board heard that implementation of the proposals, if agreed, can take place relatively quickly. It may be possible to change some elements of the service, in advance of others, based on the experience gained during the Covid-19 pandemic. The Board heard that capital funding is in place to implement the proposals and agreement has been sought from Friends groups to relocate donated equipment if required. A detailed implementation plan will be included in the Decision Making Business Case, but it is estimated that given the lead times it may take 12 months to complete the necessary works.

Comments of the Board

62. The Board considers that implementing the proposals quickly once a decision is made will be key to achieving the anticipated benefits for patients, staff, and recruitment and retention. Therefore, any measures that can facilitate the timely implementation of the proposals should be taken where feasible.

Recommendation 5

The Board recommends:

- **Detailed implementation plans are drawn up as soon as possible to facilitate the timely implementation of the proposals, once a decision is made.**
- **The opportunity is taken to make early changes to services where this is possible.**

Staff recruitment and retention

63. The Board heard evidence of a number of measures to recruit and retain staff including innovative training contracts and providing assistance with relocation and training expenses. There is a rolling training programme with a pre-registration year being offered in a hospital

setting which provides a training opportunity not commonly seen elsewhere. The transformation proposals also provide a basis to cross train and upskill existing staff.[20]

64. However, the Board is concerned about the impact on the sustainability of the service if the transformation fails to attract sufficient numbers of suitably qualified staff or provide the opportunities to cross train staff as envisaged. Therefore, the Board recommends that staff levels are closely monitored after the implementation of the changes to the service. If the proposals fail to attract the staff needed by the ophthalmology service, a package of additional staff recruitment and retention measures may need to be developed to tackle recruitment issues, in collaboration with system wide partners and the Sussex Integrated Care System (ICS).

Recommendation 6

The Board recommends:

- **Regular monitoring of staffing levels is undertaken post implementation to ensure the sustainability of the service.**
- **Further staff recruitment and retention measures are developed.**

Summary Comments

65. The Board has carefully considered the clinical case for change and the anticipated benefits for patients from the proposed service reconfiguration. The Board has also examined the proposed choice of the Bexhill Hospital site for the consolidation of some services serving the east of the county. The Board notes that the Bexhill site presents a number of challenges for travel and access to services based there. On balance, the Board considers that the proposed changes to the ophthalmology services in East Sussex are in the best interests of patients, but adequate mitigations must be put in place to address the travel and access issues that have been identified.

[20] 22 April meeting.

Appendix 1

Review Board meeting dates

The Review Board met on:

- 29th March 2022 to agree its terms of reference and consider the CCG's proposals.
- 22nd April 2022 to examine in more detail the clinical case for change contained in the Pre consultation Business Case.
- 12th May 2022 to examine patient flows, travel analysis and consider stakeholder views
- 25th May 2022 to consider feedback form the Public Consultation and review 'did not attend' information.
- 14th June 2022 to consider the draft report of the Review Board.

Witnesses

East Sussex Clinical Commissioning Group (CCG)

Jessica Britton, Executive Managing Director

Fiona Streeter, Associate Director of Commissioning and Partnerships

Dr Suneeta Kochhar, GP Clinical Lead representative

East Sussex Healthcare NHS Trust (ESHT)

Richard Milner, Director of Strategy

Michael Farrer, Strategic Transformation Manager

Ophthalmology Staff

Mr Kash Qureshi, Clinical Lead for Ophthalmology

Helen Peregrine, Head of Optometry

Sarah Bradbury

Sharon Ball

Jo Tucker

Healthwatch East Sussex

Alan Keys

East Sussex County Council (ESCC)

Neil Maguire, ESCC Transport Hub

List of documents considered by the Review Board

Documents provided to Review Board by the CCG and ESHT

Pre Consultation Business Case (PCBC) and appendices.
Travel Analysis Summary and Travel Study.
Patient flow data for the ophthalmology service.
Public Consultation summary and document
Public Consultation Feedback draft report (OCS). May 2022.
Did not Attend (DNA) information for the ophthalmology service.
Parking space capacity at Bexhill Hospital
Recommendations for South East Clinical Senate Review PCBC for Ophthalmology Services for East Sussex CCG

Witness Statements

Witness statements received from the following organisations and groups.

Friends of Bexhill Hospital
Friends of Conquest Hospital

Contact officer for this review:

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**15 December 2022**
By:	**Assistant Chief Executive**
Title:	**Work Programme**
Purpose:	**To agree the Committee's work programme**

RECOMMENDATIONS

The Committee is recommended to agree the updated work programme at appendix 1

1 Background

1.1 The work programme contains the proposed agenda items for future HOSC meetings and is included on the agenda for review at each committee meeting.

1.2 This report also provides an update on any other work going on outside the Committee's main meetings.

2. Supporting information

2.1. The work programme is attached as **appendix 1** to this report. It contains the proposed agenda items for the upcoming HOSC meetings, as well as other HOSC work going on outside of the formal meetings.

2.2. The Committee is asked to consider any future reports or other work items that it wishes to add to the work programme.

2.3. The Committee is also asked to consider whether to schedule any of the items listed under "Items to be Scheduled" section of the work programme for future meetings to be held later in the municipal year.

3 Conclusion and reasons for recommendations

3.1 The work programme sets out HOSC's work both during formal meetings and outside of them. The committee is asked to consider and agree the updated work programme.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Martin Jenks, Senior Scrutiny Adviser
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Health Overview and Scrutiny Committee (HOSC) – Work Programme

Current Scrutiny Reviews		
Title of Review	**Detail**	**Proposed Completion Date**
To be agreed.		

Initial Scoping Reviews		
Subject area for initial scoping	**Detail**	**Proposed Dates**
To be agreed.	To be scheduled once the reviews of Cardiology and Ophthalmology have been completed.	

List of Suggested Potential Future Scrutiny Review Topics	
Suggested Topic	**Detail**
To be agreed.	

Scrutiny Reference Groups		
Reference Group Title	**Subject Area**	**Meetings Dates**
University Hospitals Sussex NHS Foundation Trust (UHSussex) HOSC working group	A joint Sussex HOSCs working group to consider the performance of UHSussex and any upcoming issues that may be of interest to the wider East Sussex HOSC. Membership: Cllrs Belsey, Robinson and one vacancy *meetings postponed due to COVID-19.	Last meeting: 9 September 2020* Next meeting: TBC 2022
Sussex Partnership NHS Foundation Trust (SPFT) HOSC working group	6-monthly meetings with SPFT and other Sussex HOSCs to consider the Trust's response to CQC inspection findings and other mental health issues. Membership: Cllrs Belsey, Robinson, and Osborne	Last meeting: 31 October 2022 Next meeting: TBC in 6 and 12 months time
The Sussex Health and Care Partnership (SHCP) HOSC working group	Meetings of Sussex HOSC Chairs with SHCP leaders to update on progress and discuss current issues. Wider regional HOSC meetings may also take place on the same day from time to time. Future arrangements for the meeting being discussed due to changing governance of SHCP. Membership: HOSC Chair (Cllr Belsey) and Vice Chair (Cllr Robinson) and officer	Last meeting: 20 November 2020 Next meeting: TBC

Reports for Information		
Subject Area	**Detail**	**Proposed Date**
Future Car parking arrangements at Conquest Hospital	Confirmation from ESHT about the planned car parking arrangements at the Conquest Hospital under the Building for our Future programme	2022

Development of the new Inpatient Mental Health facility	A future update via email on the progress of the development of the new facility in North East Bexhill.	2022
Integrated Care Board (ICB) and implementation of the Health and Care Act 2022	A report or away day session on the new Sussex Integrated Care Board (ICB) structure and priorities, and any other impacts of the Health and Care Act 2022	Winter 2022 /Spring 2023
Training and Development		
Title of Training/Briefing	**Detail**	**Proposed Date**
Joint training sessions	Joint training sessions with neighbouring HOSCs on health related issues.	TBC
Building for Our Future	A briefing on the Building for Our Future plans for the redevelopment of Eastbourne District General Hospital (EDGH), Conquest Hospital and Bexhill Hospital developed by East Sussex Healthcare NHS Trust (ESHT)	TBC
Visit to Ambulance Make Ready station and new Operations Centre – East.	A visit to the new Medway Make Ready station and new Operations Centre for 999 and 111 services once the new centre is operational.	Autumn/Winter 2022/23
Visit to the new Inpatient Mental Health facility at Bexhill	A visit to the new Inpatient Mental Health facility due to be built at a site in North East Bexhill to replace the Department of Psychiatry at Eastbourne District General Hospital (EDGH).	TBC but likely 2024

Future Committee Agenda Items		**Witnesses**
2 March 2023		
Primary Care Networks (PCNs), Emotional Wellbeing Services and mental health funding	A report on the performance of PCNs and the future plans for primary care in East Sussex. Report to also include: • an update on the roll out of Emotional Wellbeing Services, which will be co-ordinated across PCN footprints; and • the future of mental health investment.	Representatives of NHS Sussex/SPFT/PCNs

Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser
29 June 2023		
Hospital Handovers	An update report on the hospital handover times performance, including evidence of how trusts have worked together to make a difference, following the end of the winter period.	Representatives of ICS, SECAmb and hospital trusts ESHT/MTW/UHSussex
SECAmb CQC report	A report on the progress of South East Coast Ambulance NHS Foundation Trust (SECAmb) exiting the Recovery Support Programme (RSP).	SECAmb
Child and Adolescent Mental Health Service (CAMHS)	An update report on CAMHS with particular emphasis on the progress of the waiting times for CAMHS, including progress on the development of the neurodevelopmental pathway, figures for the numbers of young people waiting more than 52 weeks, and how long young people wait between assessment and the beginning of treatment.	Representatives of NHS Sussex and SPFT
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser
21 September 2023		
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser

14 December 2023		
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser
Items to be scheduled – dates TBC		
Transition Services	A report on the work of East Sussex Healthcare NHS Trust (ESHT) Transition Group for patients transitioning from Children's to Adult's services	Representatives of ESHT
Patient Transport Service	To consider proposals to recommission the Patient Transport Service (PTS) and to consider the outcome of the Healthwatch PTS survey. *Note: provisional dependent on NHS Sussex's plans*	Representatives of lead NHS Sussex and Healthwatch
Implementation of Kent and Medway Stroke review	To consider the implementation of the Hyper Acute Stroke Units (HASUs) in Kent and Medway and progress of rehabilitation services in the High Weald area. *Note: Timing is dependent on NHS implementation process*	Representatives of East Sussex NHS Sussex/Kent and Medway ICS
Adult Burns Service	A report outlining proposals for the future of Adult Burns Service provided by Queen Victoria Hospital (QVH) in East Grinsted. *Note: provisional dependent on NHS England's plans*	NHS England and QVH
Sexual Assault Referral Centre (SARC)	A report on proposals for re-procurement of Sussex SARCs *Note: provisional dependent on NHS England's plans*	NHS England
Implications of the Health and Care Act 2022	A report or away day to consider the implications for the Committee of the Health and Care Act including the replacement of CCGs with Integrated Care Boards (ICB) and the effect of the regulations that allow the Secretary of State to intervene in local service reconfigurations on HOSC's powers to refer decisions to the Secretary of State that are not in the best interests of local health services.	Representatives of NHS Sussex and Senior Scrutiny Adviser / Scrutiny and Policy Support Officer.

	Note: date subject to release of the regulations setting out the powers of the Secretary of State to intervene on local health service reconfigurations.	