HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 11 December 2025

PRESENT:

Councillor Colin Belsey (Chair), Councillors Abul Azad, Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson and Alan Shuttleworth (all East Sussex County Council); Councillor Mike Turner (Hastings Borough Council) and Emma McDermott (VCSE Alliance)

WITNESSES:

East Sussex Healthcare NHS Trust (ESHT)

Simon Dowse, Director of Transformation, Strategy and Improvement (via Teams)

Mike Farrer, Head of Transformation, Strategy and Improvement (via Teams)

Chris Hodgson, Director Estates and Facilities (via Teams)

Richard Milner, Chief of Staff (via Teams)

Alys Morris, Consultant General and Colorectal Surgeon (via Teams)

Professor Nik Patel, Senior Consultant Cardiologist (via Teams)

Andrew Strevens, Chief Finance Officer (via Teams)

NHS Sussex

Rachael Kramer, Deputy Director of Emergency Preparedness, Resilience and Response

Dr Stephen Pike, Deputy Medical Director

Ashley Scarff, Director of Joint Commissioning and Integrated Care Team Development (East Sussex)

Sussex Partnership Foundation Trust (SPFT)

John Child, Chief Operating Officer

East Sussex County Council (ESCC)

Mark Stainton, Director of Adult Social Care and Health (via Teams)

LEAD OFFICER:

Patrick Major

18. MINUTES OF THE MEETING HELD ON 18 SEPTEMBER 2025

18.1 The minutes of the meeting held on 18 September 2025 were agreed as a correct record.

19. APOLOGIES FOR ABSENCE

19.1 Apologies for absence were received from Councillor Sam Adeniji, Councillor Kara Bishop, Councillor Christine Brett, Councillor Terry Byrne, Councillor Graham Shaw and Jennifer Twist.

20. DISCLOSURES OF INTERESTS

20.1 There were no disclosures of interest.

21. URGENT ITEMS

21.1 There were no urgent items.

22. NHS SUSSEX WINTER PLAN 2025/26

22.1 The Committee considered a report on the NHS Sussex Winter Plan 2025/26. The Winter Plan sets out how the local health and social care system planned to effectively manage the capacity and demand pressures anticipated during the Winter period. The Winter Plan is both a Sussex-wide plan and a whole-system health and social care plan, recognising the needs of the local population. The Winter Plan 2025-26 reflected on lessons learned from winter 2024-25 and other system pressures. The plan included: progress to date; key risks impacting services provision; preparation and performance of elective and non-elective services; a staff wellbeing focus; continued focus on discharge and admission avoidance; plans for seasonal illness including infection control and vaccination plans; and key system performance measures and monitoring. Identified from learning in winter 2024-25, the system would continue to focus on patient discharge, flow, vaccination and supporting the workforce.

22.2 The Committee asked what the current status of flu cases was in East Sussex.

22.3 Richard Milner, Chief of Staff, East Sussex Healthcare NHS Trust (ESHT), responded that although ESHT sites had observed a spike in the rate of flu and Respiratory Syncytial Virus (RSV) cases recently, this was not uncommon and not unplanned for. Communications were being deployed to encourage staff and patients to wear face masks in high volume areas and minimise face-to-face meetings, to promote a safer environment and manage the spread. The flu was not causing concern from an operational management perspective, but ESHT were investing in planning and prevention, to keep staff and patients safe over the winter period.

22.4 The Committee asked what the system was doing to promote vaccination, including in the workforce, schools and the wider population.

22.5 Rachael Kramer, Deputy Director of Emergency Preparedness, Resilience and Response, NHS Sussex, responded that the flu vaccination uptake in East Sussex was at 57% of the target population (those that are eligible for vaccination). The ICB was doing a range of communication work in the lead up to Christmas to promote vaccinations, including advertorials in Sussex World, weekly newsletters online, messaging from the Chief Nurse advocating vaccination, advertisements on bus stops (particularly those in Hastings), and a social media Q&A with Lewes District Council leaders. The ICB aimed to increase staff flu vaccination uptake by a minimum 5% across all NHS Trusts in East Sussex, which was being addressed by offering staff bookable clinics, delivering vaccinations on wards directly to staff via roving vaccinators. An informal community of practice was developed with the support of the ICB to support staff to get vaccinated and address challenges, such as with the booking system, sharing best practice and mutual support to improve vaccination rates.

22.6 The Committee noted that the plan highlights the need for timely discharge to improve patient flow in hospitals, and asked what capacity Adult Social Care (ASC) has to support timely discharge.

22.7 Mark Stainton, Director of Adult Social Care, East Sussex County Council (ESCC), responded that patients are often discharged to the independent sector market, which provides both home care and bedded care. There was a block contract in place and good market supply in the home care market to ensure timely discharge, but while market supply for bedded care was good, it could be difficult to source for patients with complex needs or in specific areas. In these circumstances, the Discharge to Assess process would be used. ESCC employ 70 ASC staff in hospitals and around hospital discharge, so are well-resourced to support this. However, staff find that patients with higher and more complex needs, like cognitive impairments and mental capacity issues, would have a longer discharge process, due to needing to undertake capacity assessments and best interest decisions. ESCC were working with ESHT to reduce the number of assessments needed in hospital by introducing a Trusted Assessor Approach, whereby long-term assessments would be conducted in individual's homes, or in a Discharge to Assess bed.

22.8 The Committee asked why there are fewer touchpoint calls between ESHT and ESCC compared with West Sussex County Council and Brighton and Hove City Council.

22.9 Mark Stainton clarified that quick touchpoint calls were conducted on Mondays, Wednesdays and Fridays but were only one point of contact across the system. ESCC were in daily contact with ESHT at a senior level throughout the winter period and had made a local decision that Tuesday and Thursday calls were unnecessary due to their existing close working relationship. However, this was constantly being assessed and if officers decided that more contact was needed, the calls could be increased as appropriate.

22.10 The Committee requested vaccination figures for Royal Sussex County Hospital and Princess Royal Hospital, for residents for whom these hospitals are closest.

22.11 Rachael Kramer answered that the current rate of flu vaccination uptake in Brighton and Hove was 49%.

22.12 The Committee asked what work was being undertaken to increase virtual ward (VW) capacity, and what work was being undertaken to improve information sharing in relation to patients with complex needs.

22.13 Richard Milner responded that increasing VW capacity was important to increasing capacity by reducing length of stay and improving patient flow, as maximising community and VW bed space can be used to support discharge from hospital. System planning and hospital planning for winter 2025-26 were focussed on mapping capacity and the proportion of it in acute sites, and how to maximise community space and virtual wards. He confirmed that the Trust

were also working with the voluntary sector and looking to utilise Joint Community Rehabilitation (JCR) and Urgent Community Response (UCR) to increase community bed base.

22.14 Simon Dowse, Director of Transformation, Strategy and Improvement ESHT, added that the Trust employ several methods to increase VW capacity. This included increasing resources to the Home First team (a UCR team providing discharge care) temporarily over the winter period to give a large block of capability to discharge patients into supported care. He clarified the difference between Home First and VWs was that people ill by definition were admitted to a virtual ward, but that patients discharged into Home First were people who may not qualify for a social care package but might need additional support for a short period of time. The Trust were working with Primary Care through the neighbourhood health programme to identify and support people with a high risk of being admission to hospital to stay at home, which would increase hospital capacity further.

22.15 Ashley Scarff, Director of Joint Commissioning and Integrated Care Team Development NHS Sussex, added that South East Coast Ambulance (SECAmb) were integral to the development of the Winter Plan 2025-26. SECAmb were ensuring that they had adequate staff in place will help the system to manage spikes in demand by building capacity and ensuring that ambulances are released to respond as soon as possible to emergencies.

22.16 The Committee asked what system is in place to support residents with complex needs that live alone and may have difficulties communicating their medical needs.

22.17 Dr Stephen Pike, Deputy Medical Director, NHS Sussex, responded that NHS Sussex had launched a proactive care scheme, to be focussed on complex and frail patients, and risk stratify them, ensuring that emergency services had access to a summary of patient's care records.

22.18 John Child, Chief Operating Officer Sussex Partnership Foundation Trust (SPFT) added that SECAmb had access to a 'Blue Light Line' service, for SPFT patients with complex cognitive needs such as dementia. This enabled them to contact SPFT to seek medical advice for patients if needed. SPFT were piloting a VW service for patients with acute dementia needs that would be otherwise admitted to inpatient services, to support them to remain at home.

22.19 The Committee asked what the criteria for flu and COVID vaccinations was for Winter 2025-26, and whether this applies to residents with mental health needs.

22.20 Dr Stephen Pike responded that at risk groups are identified based on national criteria set by the Joint Committee on Vaccination and Immunisation (JCVI). Residents aged over 65 are eligible for flu vaccinations, and residents over 75 are eligible for the COVID vaccination, and other criteria include residents with compromised immunity. This wouldn't apply to residents with mental health needs, unless they have separate complex needs, but residents can receive their vaccination privately if they do not meet NHS eligibility criteria, for a small charge. He noted that due to the new flu variant, many East Sussex residents were receiving private immunisations from the community pharmacy.

22.21 The Committee asked how many residents aged under 65 are admitted to hospital due to serious flu, noting that it would be beneficial to vaccinate everyone.

22.22 Dr Stephen Pike responded that the current strain of flu was one that hadn't arisen for a while, which meant that herd immunity to the strain was low. The criteria for vaccination is determined nationally with consideration to cost effectiveness, so although offering the vaccination to younger people would greatly improve herd immunity and reduce the community carrier rate, this was not possible under the current framework. There was also an issue of stock availability: NHS Sussex ensured they had sufficient stock for all those eligible in the health

system, but there have been shortages for those outside of the eligibility criteria trying to access private immunisations.

22.23 The Committee asked how many No Criteria to Reside (NCTR) patients were currently in East Sussex hospitals, and what was being done to manage their routes out of hospital and reduce NCTR numbers.

22.24 Ashley Scarff responded that discharge is a key part of system flow. Work took place daily across the system to identify challenges in discharging individuals and to remove barriers to get patients discharged as soon as it is safe and appropriate to do so, but the health and social care system faced significant challenges, so the ICB was working to maximise resources.

22.25 Rachael Kramer responded that the number of NCTR patients changes daily, but the latest figures showed 148 NCTR patients in ESHT hospitals. The system had just conducted a Multi-Agency Discharge (MADE) event for community services, which involved examining patients in community care, whether their care was appropriate, and whether they could be moved to care elsewhere in the system. She reported that they had already seen the number of NCTR patients reduce due to this, and the aim of the event was to reduce the worst of the system pressures before the peak of the winter period.

22.26 Mark Stainton added that Transfer of Care Hubs, which are multi-agency hubs located in the hospital, were in operation for Winter 2025-26, and staff on these hubs worked on a patient-by-patient basis to manage patients' discharge. There was a well-established process for managing discharges and factors that might delay discharge included housing or family concerns, safeguarding concerns, and concerns about mental capacity. Staff would focus on patients with longer Length of Stay or Delayed Discharge as part of their processes, but a core challenge for ASC remained the high proportion of older people in the county, presenting a challenge of many patients with very complex needs. ASC conducted preventative work to support people from being admitted to hospital, as well as a wider drive to encourage healthy lifestyle in the long term, so that people live healthy lives for as long as possible.

22.27 Richard Milner reassured the committee that NCTR patients were discussed daily amongst staff to find routes out of hospital. Staff employ models such as moving patients out of acute hospital settings and into more appropriate community care; MADE events, for example, help encourage patient flow and ensure that care is appropriate. This was in conjunction with patient safety events for staff, to ensure that if patients should remain in hospital, that their care is clinically appropriate to their needs and safe.

22.28 John Child confirmed that resource capacity within mental health services impacted the ability of trusts to ensure patient flow, especially where patients have complex needs. Demand and capacity issues are also experienced by mental health services, so working with clinicians was important to the Trust to make the best use of available resources. He added that often the language of productivity wasn't appropriate for clinicians, language around patient safety and patient outcomes often works better to engage them to deliver outcomes.

22.29 The Committee RESOLVED to:

1) note the report; and
2) receive a feedback report in June 2026.

23. ESHT CAPITAL WORKS PROGRAMME

23.1 The Committee considered a report on the ESHT Capital Works Programme, which sets out the major works in ESHT sites as well as hospital equipment and ongoing repairs to infrastructure. Chris Hodgson, ESHT Director of Estates, introduced the report, highlighting the

now-operational Sussex Surgical Centre (SSC) and it's attached endoscopy unit; the cardiology programme; the refurbishment of the thrombolysis (East Dean) ward at EDGH; upgrades to radiology at the Conquest site; and £10.3m in grant funding for the upgrade of infrastructure such as electrical and ventilation systems and fire compartmentation on sites.

23.2 The Committee noted residents' concerns about the need for repairs, especially to the roof, at Conquest Hospital, asked what proportion of the £10.3m grant funding was planned to be allocated across hospital sites.

23.3 Chris Hodgson responded that the funding was planned to be split across all three sites, and that repairs to the roof at Conquest Hospital were significant and ongoing; £350,000 had been spent in 2025 on repairs to the roof. The roof needed to be replaced, but funding so far had been insufficient to carry out a full replacement. Additionally, the majority of electrical infrastructure repairs would be conducted at the Conquest site, due to the way equipment is distributed throughout the site. There was not a large discrepancy in spending between EDGH and Conquest Hospital, but EDGH occupied an older site than Conquest, which meant more repairs were required. Andrew Strevens, ESHT Chief Finance Officer, noted that the £10.3m had been distributed between EDGH and Conquest Hospital, and exact figures could be provided to the Committee outside of the meeting.

23.4 The Committee asked what the impact of delays to the New Hospitals Programme has been on service provision at EDGH.

23.5 Chris Hodgson explained that ESHT is part of a number of replacement hospitals through the New Hospitals Programme, which is managed by the Department of Health and Social Care. The new hospital at EDGH was in Wave 2, which will now not commence until 2037, leaving a number of years to allocate that funding. The original plans involved all three hospital sites, but EDGH was at greatest risk due to the age of the site. This was the reason for securing critical infrastructure risk funding to repair the site, using ESHTs own funds and national funding. £750m was being allocated nationally over for four years for the programme, and they were confident this funding could be secured in future years also.

23.6 Andrew Strevens clarified that the £750m of national funding had been allocated across 7 regions nationally, and that the allocation for the South East was around £150m. Within the funding, ESHT were given indicative allocations of expected funding per hospital, as well as expected funding for critical infrastructure risk. The estates team had drawn up a 10-year plan in terms of the infrastructure that needs to be replaced and modified, which would be used as a basis for placing funding bids.

23.7 The Committee noted from previous site visits to Conquest Hospital, a number of tiles missing from the ceiling, and commented that this impacts patients' perceptions of care.

23.8 Chris Hodgson responded that ongoing works on fire compartmentation meant it was necessary to keep the ceilings open longer than expected. Other works were being carried out, such as a new system for oxygen supply being installed, but that they would be replaced as soon as possible and there were plans in place to do so.

23.9 The Committee RESOLVED to:

1) note the report; and
2) receive a written briefing for circulation containing further developments, information about digital infrastructure, and a breakdown of project spending.

24. RE-PROVISION OF UCKFIELD DAY SURGERY UNIT

24.1 The Committee considered a report regarding ESHT's proposals for changes to the Uckfield Day Surgery Unit (DSU), including whether this change represents a 'substantial variation' to services, requiring a consultation with HOSC. Simon Dowse introduced the report, which highlighted the reasons for the proposals, including only being able to support local anaesthetic on site, progression in day surgery services, some activities no longer requiring surgery or being offered in other settings, and some NHS pathways no longer being supported. ESHT conducted a review of the site and found that: there were limited opportunities to increase utilisation of the unit; significantly more of the services provided at Uckfield DSU could be provided at EDGH, with the same capacity; 88% of patients using Uckfield DSU lived closer to EDGH or Conquest Hospital were travelling across county to access the site; and that moving the DSU to acute sites would have a beneficial impact on waiting times.

24.2 The Committee noted a correction to the covering sheet to the report, which reads:

'The Day Surgery Unit (DSU) delivers approximately 13% of ESHT's overall day surgery activity'.

And should instead read:

'The DSU activity contributes approximately 13% of Trust activity at the site'.

Uckfield DSU contributes a total of approximately 1.2% of Trust overall elective activity.

24.3 The Committee asked what the impact of the service reprovision would be for staff employed at Uckfield DSU.

24.4 Mike Farrer responded that focus groups were conducted with staff throughout the pilot scheme and there were a mixture of views among staff wishing to relocate to acute sites or continue working at Uckfield. However, staff recognised the benefits for patients that were shown during the pilot and understood the reasons for the move. Staff were on temporary redeployment and were keen for the process to be concluded as soon as possible. ESHT were in contact with staff regularly to find appropriate permanent positions for all staff from Uckfield DSU and were not seeking to reduce staffing levels.

24.5 Alys Morris, Consultant General and Colorectal Surgeon ESHT, confirmed that work had been undertaken to try and increase activity on site at Uckfield DSU, however it had not been possible to make maximum use of the facility. The Getting it Right First Time (GIRFT) programme requires that procedures are conducted in the appropriate settings and the DSU only being equipped for local anaesthetic limited the surgeries that could be carried out on site. Most patients would be more appropriately treated in procedure rooms or the Sussex Surgical Centre (SSC).

24.6 The Committee asked if patients were able to elect to receive treatment at other non-ESHT sites such as Princess Royal or Royal Sussex hospitals.

24.7 Simon Dowse confirmed that the service could be accessed wherever it was available, but that this should be discussed between patients and their GP when the referral is made for treatment.

24.8 The Committee asked how local and national guidance about bringing services closer to the local community is being applied in this context.

24.9 Richard Milner confirmed that while the 10-Year Health Plan emphasised moving services closer to communities, this is only for services that are most appropriately delivered at that level. This does not relate to DSU activity, as day surgery is not appropriate for a community setting. He highlighted important work that could be moved into the vacated unit to

supply local people with health services, that would be more appropriate to a community setting than day surgery.

24.10 The Committee asked what the financial implications of the relocation of the DSU were.

24.11 Simon Dowse responded that the implications would be complex due to NHS income and funding models. Income would increase slightly in relation to lists due to increased capacity resulting in higher activity levels, but this depended on contracting for elective services and how the SSC was optimised. There would be future savings of around £200,000 per annum for ESHT, once their lease terminated on the vacated unit, but the cost of the lease would remain in the healthcare system in Sussex.

24.12 The Committee asked if the ICB planned to mothball the vacated unit, or if it had potential to be used as a neighbourhood health facility in the future.

24.13 Ashley Scarff responded that there were a lot of national strategies and changes that could impact the future of the unit. The ICB had worked closely with ESHT and recognised the case for change, as the provision of day surgery had changed over the years and only 43 people per year would be impacted by the reprovision. As the cost of the lease would remain in the system, the ICB would look to utilise all community assets by filling the unit. National strategy was developing a trajectory towards community health, such as with the development of Integrated Community Teams. The ICB were working to assess the sustainability of potential new services placed in there and the staffing required.

24.14 The Committee asked what the transport and access options are for people who are less mobile.

24.15 Mike Farrer responded that Non-Emergency Patient Transport Service (NEPTS) is open for transportation for patients who require assistance accessing their appointments, the same as at other NHS sites in the County. The full information about services, including voluntary services and the reimbursement scheme for transport were available online and could also be accessed through the Single Point of Contact; information about NEPTS was distributed to patients on their appointment letters and could be found on brochures on site.

24.16 The Chair commented that the relocation of the DSU seemed like a more efficient and cost effective method of working, and the reprovision seemed to have improved outcomes for patients during the trial period.

24.17 The Committee discussed how ESHT could change their practices regarding service reconfiguration. They requested that future service changes should have a consultation with staff, residents and the VCSE sector; more clarity should be given to patients; the equalities data and Equality Impact Assessment (EQIA) should be provided to the HOSC, to see the impact on vulnerable people; and requested that the HOSC be involved earlier in the process of service reconfiguration.

24.18 The Committee RESOLVED to:

1) Agree that the proposed changes to Uckfield Day Surgery Unit did not constitute a substantial variation to health service provision requiring statutory consultation with HOSC under health scrutiny legislation;
2) to receive a copy of the EQIA for this service re-provision; and
3) to receive a copy of the post-implementation review in 2026, after this has been conducted by ESHT.

25. NHS SUSSEX UPDATE

25.1 Ashley Scarff provided an update from NHS Sussex regarding national and local changes to the NHS, including some service changes. This included the following updates:

- Following the decision to merger NHS Sussex and Surrey Heartlands from April 2026, the new Chair of the ICB and Chief Executive were appointed from 1 October and the first public joint board meeting between NHS Sussex and Surrey Heartlands had been held.
- There will be a national funding mechanism in place to facilitate the redundancy scheme resulting from the merger, and in line with other ICBs, voluntary redundancy was being offered to staff. A further redundancy programme would take place following the merger in April 2026.
- The ICB were reviewing planning and commissioning intentions for 2026-27, including the localisation of the 10-year plan for health.
- The ICB were moving from a 12-month planning cycle to a 5-year planning cycle, to make more strategic plans for the medium-term.
- NHS England had published its Strategic Commissioning Framework, which clarified the remit of the ICB in its reduced capacity, and the increasing role of providers in commissioning services.

25.2 The Committee asked for an update on Integrated Community Teams and on the merger of the South East Coast Ambulance Service (SECAmb) and the South Central Ambulance Service (SCAS).

25.3 Ashley Scarff responded that an update regularly is given to the East Sussex Health and Wellbeing Board about Integrated Community Teams, so information about this was in the public domain. He added that SECAmb would likely want to be involved with any future updates to the HOSC about changes to their service.

25.4 The Committee asked if the voluntary redundancies would be frontline or back room staff.

25.5 Ashley Scarff responded that the ICB is largely not a frontline workforce, but frontline capacity was being ringfenced by the ICB where appropriate to protect those jobs that did exist where possible. The ICB did not anticipate frontline job losses, this would likely be in management and back room staff.

25.6 The Committee expressed concerns about future staff losses impacting working relationships with the ICB and asked how the ICB was ensuring continued engagement with the VCSE sector.

25.7 Ashley Scarff responded that the ICB have been holding vacancies for a number of months to downsize in a more managed way. The ICB were assembling an executive team and assessing its underpinning structure but remained committed to engaging locally. He confirmed that some touchpoints might change, and that the VCSE sector would still be able to engage with providers and Integrated Care Team leaders to continue engagement with the health system.

25.8 The Committee asked how the ICBs capacity for engagement with scrutiny might look in the future.

25.9 Ashley Scarff responded that the ICB and NHS commissioning were undergoing significant changes, that had been determined nationally, which would change the ICBs

functions and responsibilities. This included a potential increased role of the Department of Health/NHS England in oversight of the performance of providers. The Strategic Commissioning Framework was recently published, which sets out those roles and provides more clarity to the ICB. The ICB were taking care to ensure that during these changes they were maintaining their responsibilities and capacity within their reduced resources.

25.10 The Committee RESOLVED to:

1) note the verbal update; and
2) receive an update on neighbourhood health centres, and the merger of SECAmb and SCAS under this item at the next meeting.

26. CARDIOLOGY TRANSFORMATION AT EAST SUSSEX HEALTHCARE TRUST

26.1 The Committee considered a report providing an overview of progress made by ESHT on the implementation of the Cardiology Transformation programme, including in relation to the recommendations made by the Committee in its review conducted in 2022 and the response from that. Mike Farrer noted that there had been some small delays to the implementation of the programme, which was complicated by ward moves, but the cardiac response teams had been put in at both sites, and the programme was doing very well operationally.

26.2 Cllr Mike Turner raised concerns that patients weren't able to access the stroke centre at Conquest Hospital, to be stabilised before being transferred to EDGH, and asked how ESHT were ensuring that residents were being treated as soon as possible to prevent conditions from worsening.

26.3 Professor Nik Patel, Senior Consultant Cardiologist ESHT, responded that it would be in patients' best interest to access the stroke unit at EDGH, as this is a Centre for Excellence. In an emergency, if a patient is unstable, it is imperative that residents must go to their local A&E, where patients can then be transferred to EDGH if needed; a pre-screening call would be conducted to assess if it is appropriate to transfer stroke patients from other hospitals to the stroke centre at EDGH. The ICB were working on a pan-Sussex model of care for a single stroke service, whereby a stroke physician would instruct and deliver treatment using AI and telemedicine. He added that NICE guidelines advise that patients go to a stroke centre as soon as possible for treatment, and to go to the closest A&E if the patient is unstable. He confirmed that he was not aware of any issues in the community-to-Eastbourne pathway.

26.4 The Committee requested to be provided with information regarding the distance travelled by patients to access the service and asked how transport information was provided to patients who lacked internet access.

26.5 Mike Farrer confirmed that transport information was provided on letters to patients, as well as a phone number that could be contacted for support, in addition to the existing information on the website.

26.6 Professor Nik Patel added that the pathway for cardiology remains predominantly the same, as acute heart attacks remain directed to either Trust site. Around 200 patients are transferred to the single site at EDGH per year for angioplasty, 50% in hours and 50% out of hours. ESHT have found that staff have been engaged in delivering the transformation programme, and since 27 October 2025, 425 patients have been admitted to specialist cardiac teams at Conquest Hospital, with a response rate of less than an hour. Of those patients, around 11% (approximately 50) were discussed for transfer to EDGH for either assessment or procedure.

26.7 Cllr Mike Turner asked if ESHT had any plans to introduce thrombectomies to EDGH.

26.8 Professor Nik Patel responded that the procedure for stroke is always thrombolysis followed by thrombectomy, and patients will be transferred to a centre that conducts that procedure. Very few surgeons were able to conduct thrombectomies, due to the complexity of the surgery and expertise required, and therefore were only conducted in a select few centres nationwide. The nearest centre was located at Royal Sussex County Hospital in Brighton, which was open 24-hours on weekdays and there were plans in place for it to be open 24/7 in the next year. Local services in Eastbourne and Hastings would not be able to deliver these in the short-term, due to the national training and resource requirement for cardiologists to go through a rigorous training programme to conduct thrombectomies, but that expertise was being built. In the meantime, there were centres in London open 24/7 for thrombectomies, for cases of emergency.

26.9 The Committee asked if any monitoring was put in place for people missing appointments, and whether this might be impacted by factors such as rurality, deprivation or digital exclusion.

26.10 Professor Nik Patel confirmed that 95% of procedures remained the same, as outpatient facilities were not moved to EDGH. Only elective procedures, which comprised around 1-2% of cardiology activity, were moved sites.

26.11 Mike Farrer clarified that it was unusual for patients to not show for elective cardiac procedures, but that the Trust did conduct Did Not Attend (DNA) assessments for patients across services in the Trust. This involved assessing which groups were likely to DNA and reviewing patient feedback through the Patient Advice and Liaison Service (PALS), to ensure that no group was being disadvantaged. Richard Milner added that the data for DNA rates and waiting times could be sorted into different categories of patient (such as by gender, age, and social deprivation), to understand the groups at most disadvantage and understand the barriers to accessing appointments. The Trust would be engaging with the VCSE sector to discuss barriers to access.

26.12 The Committee RESOLVED to:

1) note the report; and
2) conclude scrutiny of this issue.

27. HOSC FUTURE WORK PROGRAMME

27.1 The Committee discussed the items on the future work programme.

27.2 The Committee RESOLVED to:

1) Schedule a report on NEPTS to its meeting on 5 March 2026;
2) Schedule a report on the new Neighbourhood Mental Health teams to a future meeting; and
3) Receive an update on the SECAmb CQC report as a written report via email.

28. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

28.1 None.

The meeting ended at 12.18 pm.

Councillor Colin Belsey

Chair