HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 30 JULY 2024

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

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

District and Borough Council Members
Councillor Dr Kathy Ballard, Eastbourne Borough Council
Councillor Mike Turner, Hastings Borough Council
Councillor Christine Brett, Lewes District Council
Councillor Beverley Coupar, Rother District Council
Councillor Graham Shaw, Wealden District Council

Voluntary Sector Representatives
Jennifer Twist, VCSE Alliance
Vacancy, VSCE Alliance

AGENDA

1. **Minutes of the meeting held on 7 March 2024** *(Pages 5 - 16)*

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. **Changes to Paediatric Service Model at Eastbourne District General Hospital (EDGH) - Update Report** *(Pages 17 - 34)*

6. **NHS Sussex Audiology Services Overview** *(Pages 35 - 42)*

7. **South East Coast Ambulance Foundation NHS Trust (SECAmb) Care Quality Commission (CQC) Inspection - Update Report** *(Pages 43 - 60)*

8. **HOSC future work programme** *(Pages 61 - 66)*

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

PHILIP BAKER
Deputy Chief Executive
County Hall, St Anne's Crescent
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22 July 2024

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Next HOSC meeting: 10am, Thursday, 3 October 2024, County Hall, Lewes

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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 7 March 2024

PRESENT:

Councillors Colin Belsey (Chair), Councillors Abul Azad, Penny di Cara, Sorrell Marlow-Eastwood and Alan Shuttleworth (all East Sussex County Council); Councillors Councillor Dr Kathy Ballard (Eastbourne Borough Council), Councillor Graham Shaw (Wealden District Council) and Jennifer Twist (VCSE Alliance)

WITNESSES:

NHS Sussex

Jessica Britton, Executive Managing Director, East Sussex

Maggie Keating, Urgent and Emergency Care Programme Director

Harvey Winder, Urgent and Emergency Care Transformation Lead

NHS England

Catherine Croucher, Public Health Consultant

Sabahat Hassan, Head of Partnerships and Engagement South East Commissioning

Natalie Hughes, Senior Transformation Delivery Manager for Children's Specialist Services

Dr Chris Tibbs, Medical Director Specialist Commissioning

Ailsa Willens, Programme Director Children's Cancer Principal Treatment Centre Reconfiguration Programme

East Sussex Healthcare NHS Trust

Joe Chadwick-Bell, Chief Executive

Dr Matthew Clark, Consultant Paediatrician, Chief of Women and Children Division

Richard Milner, Chief of Staff

University Hospitals Sussex NHS Foundation Trust

Prof Katie Urch, Chief Medical Officer

LEAD OFFICER:

Martin Jenks and Patrick Major

29. MINUTES OF THE MEETING HELD ON 14 DECEMBER 2023

29.1 The minutes of the meeting held on 14 December 2023 were agreed as a correct record.

30. APOLOGIES FOR ABSENCE

30.1 Apologies for absence were received from Councillors Christine Robinson, Sarah Osborne, Mike Turner, Beverley Coupar and Christine Brett.

31. DISCLOSURES OF INTERESTS

31.1 There were no disclosures of interest.

32. URGENT ITEMS

32.1 There were no urgent items.

33. FUTURE LOCATION OF SPECIALISED CANCER SERVICES FOR CHILDREN - PUBLIC CONSULTATION UPDATE

33.1 The Committee considered a report on the outcomes of the public consultation on the proposed future location of very specialised cancer services for children in south London and much of the South East, including East Sussex. There were two options consulted on for potential locations of the future Principal Treatment Centre (PTC), which were Evelina London

Children's Hospital in Lambeth, south London, run by Guy's and St Thomas' NHS Foundation Trust, and St George's Hospital in Tooting, South London. A decision on the future location was to be made on 14 March 2024. (*Post-meeting note: On 14 March 2024, leaders for NHS England (London and South East regions) decided that Evelina London Children's Hospital should be the future Children's Cancer Principal Treatment Centre).*

33.2 The Committee asked whether patients and families that did not qualify for non-emergency patient transport would get support in travelling from East Sussex to London.

33.3 Catherine Croucher, Public Health Consultant NHSE London, explained the national guidelines allowed there to be discretion, so provider Trusts could offer transport for patients and families who didn't meet the eligibility criteria. Both providers that had been consulted on as potential future options had committed to conduct an assessment of the transport needs of the patient group, noting the heightened needs that the particular patient cohort would have such as immunosuppression.

33.4 The Committee noted that it could be difficult and costly for residents travelling from East Sussex to travel to London, and asked how families would be supported with this.

33.5 Catherine Croucher noted that both the locations were within the London Ultra Low Emission Zone (ULEZ), while Evelina London was also in the Congestion Charge zone. Families traveling to and from London would be able to register with the hospital trust, which would mean that while ULEZ and Congestion Charge payments would be taken in the usual way, they could be reimbursed on the same day. Families would be required to register with the system and may need support with this, which would be provided by the chosen provider to help families navigate the reimbursement system.

33.6 The Committee asked whether parking and overnight accommodation would be provided at the chosen location.

33.7 Catherine Croucher responded that it was the standard model for parents to be able to stay overnight with their children when they were on the ward. Both providers had accommodation on or near their sites for wider family networks. As part of the implementation phase, consideration would be given to the likely capacity need to help ensure that accommodation facilities were fit for purpose. Both options had also committed to providing free and dedicated parking.

33.8 The Committee asked what mechanisms would be in place to ensure the operation of the service should insufficient staff agree to transfer to a new location.

33.9 Ailsa Willens, Programme Director Children's Cancer Principal Treatment Centre Reconfiguration Programme, noted that there were 170 staff at the Royal Marsden that would be eligible for TUPE (Transfer of Undertakings Protection of Employment rights) protection if Evelina London was selected for the new PTC. Staff had been engaged as part of the consultation and they had raised concerns such as increased travel costs. While a move from the Royal Marsden to Evelina London would result in increased salary weightings for staff if the service were to move, it was possible not all staff would choose to move with the service. Both providers had plans to address this potential challenge, including upskilling the current workforce and continued recruitment work. There would be detailed work once a decision had been made to ensure there was sufficient staffing and that staff needs could be met.

33.10 The Committee asked what continued consultation and engagement there would be to shape the service once a decision on the future location had been made.

33.11 Ailsa Willens confirmed that the NHS, including potential future providers were keen to continue engagement throughout the transition and implementation period, and that families and staff were keen to help shape the service. Both providers had committed to work in partnership with the current service and staff to help co-design the new service and build on what already existed. There would also be patient and family representation at governance level and throughout the transition and implementation period.

33.12 The Committee asked what recommendations had been made by other HOSCs that had declared the changes a substantial variation.

33.13 Ailsa Willens noted that two Joint HOSCs had considered the changes a substantial variation, which had provided valuable feedback that was being considered as part of the decision, and would also inform the implementation of the new service. Travel and access was an area of particular interest other HOSCs had provided feedback on. Sabahat Hassan, Head of Partnerships and Engagement South East Commissioning, added that other HOSCs had fed back positively on the way they had been engaged with throughout the process.

33.14 The Committee RESOLVED to:

1) note the report;
2) receive written confirmation on which provider was chosen; and
3) receive an update six months after implementation to hear a progress update.

34. CHANGES TO PAEDIATRIC SERVICES AT THE EASTBOURNE DISTRICT GENERAL HOSPITAL (EDGH)

34.1 The Committee considered a report by the HOSC Review Board into Changes to Paediatric Services at the EDGH, which included 13 recommendations. The Committee also considered an update report from East Sussex Healthcare NHS Trust (ESHT) outlining monitoring data of implementation.

34.2 Cllr Alan Shuttleworth, who had been a member of the Review Board, noted that he agreed with the recommendations in the report, but outlined a number of areas where he remained concerned. His concerns with the new model were:

- That the implementation of changes had been rushed and that ESHT had not sufficiently prepared for the changes, including that a number of clinical pathways were not in place from the beginning of the implementation.
- The staffing model was not sustainable, and that the number of Advanced Paediatric Nurse Practitioners (APNPs) was too low to support the new model. He therefore felt that having a paediatric consultant on-site to support APNP staff at the EDGH was critical.
- There would not be enough space following the closure of the Short Stay Paediatric Assessment Unit (SSPAU), and that would leave children without a quiet and relaxing space to be in while being treated given the new unit's proximity to the Emergency Department (ED).

- Families with planned care had not been sufficiently informed and updated on the changes being made, and more consultation with all interested groups should have been done ahead of the changes being made.
- That more patients and families would potentially need to travel from Eastbourne to the Conquest Hospital in Hastings, and that the long-term sustainability of services remaining at Eastbourne was in doubt.

34.3 Joe Chadwick-Bell, ESHT Chief Executive, thanked the Review Board for their work and comments. She noted that the points made by Cllr Shuttleworth had been responded to in the meetings of the Review Board, and that the recommendations in the Review Board's report would be responded to in full following discussions with clinicians and the ESHT senior leadership team.

34.4 The Committee asked why changes were implemented before everything necessary (such as the new unit) were in place to support the new model.

34.5 Joe Chadwick-Bell responded that there were several reasons. First was that it made it possible to put additional resource into ED, which had allowed children to be seen much more quickly than they had been previously. The beginning of January (which was when the changes were implemented) was one of the busiest times of year when more children presented to ED, so the changes had been introduced then to improve children's experience by allowing them to be seen quicker and go home quicker. There was a dedicated area for children in the ED already so having the new unit in place was not vital for providing necessary care. In an ideal world the new unit would have been in place from the start, however the Trust took the view that delaying the implementation of changes would have meant delaying an improvement in services for children. There were a very small and specific number of patients and families with planned care that were affected by the changes, and they were engaged throughout.

34.6 Dr Matthew Clark, Consultant Paediatrician and Chief of Division, added that the implementation of the changes had meant there had been a significant increase in the number of children being seen by paediatric specialists earlier, and children were spending less time in ED as a result. ESHT saw the changes as an improvement and was therefore keen to implement the changes as soon as possible. The Trust was working to produce planned care pathways and would be able to update the HOSC with these in June.

34.7 Cllr Azad thanked those who had been involved in the review, and asked whether children who were severely unwell would be treated in a separate area.

34.8 Joe Chadwick-Bell explained that within the unit there was a separate room that could be used for patients with particular needs, such as infection control or for patients with mental health issues, alongside cubicle areas where other children were seen.

34.9 The Committee asked for more detail on the post-implementation independent review of the new model.

34.10 Joe Chadwick-Bell explained that independent clinician (external to Sussex) had been identified to lead the review and was due to begin in the middle of March. ESHT would share the HOSC reports and documents with them as part of the review and the Trust hoped the review would be concluded by the end of March.

34.11 The Committee asked why ESHT felt an independent review was necessary given that HOSC had conducted a review already.

34.12 Joe Chadwick- Bell explained that it was a clinical review, led by a clinician with experience in emergency care and paediatrics, different from the type of review done by HOSC. She confirmed that it was being led by someone who had been independently identified and was completely separate from Sussex-wide health services. Although ESHT did not initially commission the review, the Trust felt it was important given the level of public interest in the issue, as well as the interest from HOSC.

34.13 The Committee asked whether there was any chance of the paediatric space being used by adults at times when ED was overrun.

34.14 Joe Chadwick-Bell confirmed that the unit would not be used by adults and was a completely separate paediatric space.

34.15 The Committee asked why all clinical pathways were not in place from the implementation of the new model.

34.16 Dr Matthew Clark explained that previously emergency and elective care had be done in the same location, which created infection control issues. Separating planned and emergency care therefore required new pathways to be created, but because of the unpredictable nature of emergency care the Trust prioritised establishing these first. Planned care pathways were now being worked up and would be shared in future.

34.17 The Committee asked how the model would be sustained if the required APNP staff were not available to work or left the Trust.

34.18 Joe Chadwick-Bell confirmed that if an APNP was not available, then a paediatric registrar would be working in ED to support the new model. That would be the staffing model going forward and was the reason that it had been possible to staff the model since implementation. Dr Matthew Clark added that he shared the Review Board's concern about recruitment, but the Trust's previous recruitment drives in this area had been successful. ESHT would continue to build the team up to ensure the sustainability and resilience of the model.

34.19 The Committee RESOLVED to:

1) agree the report of the Review Board; and
2) refer the report to East Sussex Healthcare NHS Trust for consideration and a formal response to the recommendations.

35. <u>NHS SUSSEX NON EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS)</u>

35.1 The Committee considered an update report on the re-commissioning of the Non-Emergency Patient Transport Service (NEPTS) in Sussex. NEPTS is an eligibility driven service that is a statutory obligation for NHS commissioners to provide to transport patients to and from their healthcare appointments. (*Post-meeting note: NHS Sussex has appointed ERS Transition Limited, trading as EMED Group, to be the new provider of Non-Emergency Patient Transport Services (NEPTS) for Sussex. The service is due to go live on 1st April 2025).*

35.2 The Committee asked what the lessons learnt from previous mobilisations were and what were the main areas of risk.

35.3 Maggie Keating, NHS Sussex Urgent and Emergency Care Programme Director, explained that one of the key lessons learnt by NHS Sussex had been from the procurement process, which had been far more robust and included much more market engagement than the previous procurement. The risks during mobilisation would be specific to the chosen provider, but generally they would likely be on whether the right vehicles, workforce, and technology were in place by April 2025. If a new provider was taking on the contract how the transition would be handled was another potential risk area.

35.4 The Committee asked how the performance of the new service would be monitored and whether potential issues would be spotted at an early stage.

35.5 Maggie Keating explained that there were a number of Key Performance Indicators (KPIs) as part of the contract, alongside a number of quality and safety indicators. One of the key risks when Coperforma had the contract was that it was a small organisation that delivered the core booking service and relied on a number of subcontractors to transport patients. The new contract would not be like this and, whilst subcontractors were permitted, there was a requirement for the winning bidder to have a core turnover that was sufficient that the Sussex contract would not form the majority of its activity. Harvey Winder, Urgent and Emergency Care Transformation Lead added that the minimum turnover requirement for bidders was at least double the value of the contract if they were to be considered.

35.6 The Committee asked how people would be signposted to the Single Point of Co-ordination (SPoC).

35.7 Harvey Winder explained that during mobilisation there would be an opportunity to develop ways to ensure patients were being sign-posted to the NEPTS, for example, working with acute trusts to include the NEPTS SPoC contact details in the text of patients' outpatient appointment letters (outpatient appointments account for around 80% of NEPTS journeys). If patients who use the SPoC were deemed as not eligible for NEPTS, the SPoC call handler is required under the new service model to signpost them to other schemes including those that reduced or reimbursed the cost of private travel, such as the Healthcare Travel Costs Scheme (HTCS), or to other community providers of patient transport services.

35.8 The Committee asked how those with mental health problems would be supported under the new NEPTS contract.

35.9 Maggie Keating explained that the primary mental health conveyances (journeys from the point of contact with the patient to a designated place of safety) are the responsibility of South East Coast Ambulance Trust (SECAmb) as the emergency ambulance provider, but secondary journeys (those from the place of safety to a mental health provider's care) and tertiary journeys (all other journeys including discharge and transfers of patients) of both detained and informal mental health patients would be dealt with by the new NEPTS provider Sussex Partnership Foundation Trust (SPFT), the primary mental health provider trust was currently arranging secondary and tertiary transport on an ad hoc basis using several private providers that are not under contract with the Trust, increasing costs and limiting performance monitoring. The new NEPTS would take responsibility for these cases away from SPFT, which would free up resource within the Trust, provide better value for money, and ensure mental health conveyances were monitored to the same standard as physical health conveyances through the KPIs.

35.10 The Committee asked how NHS Sussex was working to recruit volunteers given the crowded volunteer recruitment field.

35.11 Maggie Keating explained that as part of NHS Sussex's pathfinder programme it had worked closely with the East Sussex voluntary sector to understand recruitment and retention issues. The ICB worked with Havens Community Cars (HCC) on ways to boost recruitment and retention of volunteer car drivers. HCC had a local videographer produce a promotional video and a local radio studio produced a jingle. As a result of the advertisement drive, HCC successfully increased the number of volunteer car drivers and increased the number of weekly journeys by over 20%. In addition, the video was going to be shared more widely with community organisations across the country to assist further recruitment. Harvey Winder added that HCC had demonstrated it had been able to use its status as a voluntary organisation to achieve excellent value for money in purchasing the video and jingle due to the willingness of vendors to offer exclusive deals in support community good will.

35.12 The Committee RESOLVED to:

1) note the report;
2) be provided an update on which organisation had been awarded the contract by email; and
3) receive an update on the mobilisation and transition of the new contract at the June 2025 HOSC meeting.

36. UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST CARE QUALITY COMMISSION (CQC) REPORT

36.1 The Committee considered an update report on University Hospitals Sussex NHS Foundation Trust (UHSx) Care Quality Commission (CQC) inspection reports. The CQC reinspected four of UHSx's hospitals (including the Royal Sussex County Hospital (RSCH) in Brighton) in August 2023 looking at Surgery and Medicine and published the reports in February 2024. The RSCH report showed an improvement from the previous report, with the overall rating upgraded to 'Requires Improvement'. The safe and well-led domains were also rated as 'Requires Improvement'.

36.2 The Committee asked what had led to the decline in UHSx's hospitals ratings, in particular in the safety domain.

36.3 Professor Katie Urch, UHSx Chief Medical Officer, explained that the hospital ratings were not where they should be and recognised the need to improve in the safety domain, but clarified that hospitals were not inadequate or unsafe. While the majority of patients had a high quality of care, learning and change was needed. She explained that post-pandemic it was not uncommon for hospitals and Trust's to see a decline in ratings given the suspension of normal services. Re-establishing services to the regular high level and documenting and demonstrating them effectively took time after COVID-19, and there had also been a significant turnover of staff. UHSx had also had a merger which created challenges as there were different documentation processes across hospital sites. Professor Urch emphasised that the CQC had reported that the care patients received was of a very high quality and safety level, but it was demonstrating that care and providing assurance to the regulator that had led to the decline in ratings.

36.4 The Committee asked whether the Trust would have progressed sufficiently to be considered 'good' under the CQC rating system by September 2024.

36.5 Prof Katie Urch explained that providing effective documentation of the level of care would not be instantaneous, but already work had gone in to ensure good practice was being shared and delivered across different hospital sites. There had been significant work behind the scenes to implement a system that improved staff feedback systems and allow the Trust to quickly learn about issues. The CQC was very clear that the care delivered on the ground was 'outstanding', and that was very reassuring for the Trust. Speaking about the Trust's Quality and Safety Improvement Programme (QSIP) timeline and implementation, Prof Urch said progress would not stop in September, but by then there would have been substantial improvements to how the high-quality care being delivered was evidenced. The Trust was confident that the bulk of the culture and safety change work would have been implemented by September, and then it would primarily be monitoring that those improvements were being embedded. However, it was difficult to say when the CQC rating might change as the scale and regulatory of inspections had changed.

36.6 The Committee asked for more detail on the police investigation at the RSCH, and how there could be assurance of current levels of safety given the investigation.

36.7 Professor Katie Urch emphasised that the police were investigating historical allegations between 2015-2021, and the Trust was completely complying with the investigation and being as transparent as it could be. The Trust could not comment in more detail given the ongoing investigation. UHSx had commissioned and conducted reviews into neurosurgery and general surgery and found that outcomes in these departments were not an outlier in national benchmarking statistics. Quality, safety and mortality meetings had all been reviewed by Prof Urch and that had given her high confidence in the team and how it reviewed itself. General surgery had slightly lower outcomes largely due to long waiting lists at the RSCH, and the Trust was exploring how to provide safe and timely care for elective patients at other sites to reduce this wait time.

36.8 The Committee asked for more information on how the Trust was reducing emergency department (ED) waiting times.

36.9 Professor Katie Urch noted that 76% of patients waiting less than four hours in ED was the target for the coming year, but that this was not currently being delivered, with the RSCH having the longest wait times. A challenge was that the ED had too many patients who should either be on a ward or discharged, but could not be because the hospital was full or care arrangements had not yet been made. There were therefore a lot of people who no longer needed hospital care which was creating longer wait times in ED. The Trust was spending £50m on expanding the ED floor at Brighton as it was currently too small, despite being adequately staffed. The programme is phased over the next three years with initial new developments, such as a new Surgical Assessment Unit, due to open later this year.

36.10 The Committee RESOLVED to:

1) note the report; and
2) receive an update report at an appropriate time.

37. HOSC TERMS OF REFERENCE

37.1 The Committee considered a report on proposed amendments to the HOSC Terms of Reference to reflect changes brought about by updated national regulations and statutory guidance.

37.2 Cllr Marlow-Eastwood commented that she felt there should be a system in place where should the Secretary of State for Health and Social Care disagree with the HOSC and refused to call-in a service change, the HOSC should be able to appeal that decision.

37.3 Martin Jenks, Senior Scrutiny Advisor, noted that it was not yet known how the new system would operate, and explained that the statutory guidance would be reviewed after it had been in operation for a year. Cllr Marlow-Eastwood's comment, as well as any other comments on how the new system was working could be fed through the appropriate channels as part of that review of the guidance. Martin Jenks also noted that the Secretary of State's powers were expected to only be used in exceptional circumstances, and the expectation remained that Trusts and the local HOSCs should resolve disagreements locally in the first instance.

37.4 The Committee RESOLVED to endorse the amendments to the HOSC terms of reference.

38. HOSC FUTURE WORK PROGRAMME

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

38.2 The Chair noted that the Committee had been contacted by Diabetes UK, regarding the adoption of National (NICE) Guidelines that recommended extending access to flash and continuous glucose monitors by NHS Sussex. Jessica Britton, Executive Managing Director, East Sussex, agreed to provide a position update by email on this issue.

38.3 The Committee had been contacted by East Sussex Hearing regarding problems people in East Sussex are experiencing with access to audiology services. The Committee felt that this was an important area to scrutinise further and agreed to receive a report on system wide audiology pathway performance at its June 2024 meeting.

38.4 Cllr Shaw asked whether HOSC could explore successful models of hospital discharge elsewhere in the country for learning locally. Joe Chadwick-Bell explained that work was going on across Sussex exploring hospital discharge, and was happy to provide an update on the issue at a future meeting. Cllr Dr Ballard asked that virtual wards and other methods of hospital admission prevention also be part of that report.

38.5 The Committee RESOLVED to:

1) amend the work programme in line with paragraphs 33.14, 34.19, 35.12, 36.10, 38.2, 38.3, and 38.4;
2) schedule the reports on missed NHS appointments and access to NHS dentistry to its October meeting; and
3) defer the reports on Primary Care Networks and hospital handovers at the Royal Sussex County Hospital currently scheduled for its June meeting, to a later meeting.

39. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

39.1 None.

The meeting ended at 12.29 pm.

Councillor Colin Belsey

Chair

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**30 July 2024**
By:	**Deputy Chief Executive**
Title:	**Changes to Paediatric Services at the Eastbourne District General Hospital (EDGH)**
Purpose:	**To consider an update report from East Sussex Health Trust (ESHT) on changes made to paediatrics services at EDGH under the new service model, and the implementation of HOSC's recommendations from the Review of these changes.**

RECOMMENDATIONS

The Committee is recommended to:

1) **Note and consider ESHT's response to HOSC's review recommendations as set out in appendix 1 and ESHT's update report in appendix 2.**
2) **Consider ESHT's update report on the implementation of the new service model at the EDGH attached as appendix 2;**
3) **Consider the independent report on the new service model from Dr Moya Dawson which is contained as an appendix to ESHT's report; and**
4) **Identify any further information that it would like included in the December 2024 update report.**

1. Background

1.1. On 14 December 2023 the HOSC considered a report from East Sussex Healthcare NHS Trust (ESHT) on changes to the Paediatric service model at the Eastbourne District General Hospital (EDGH). Both NHS Sussex and ESHT did not regard the changes as a substantial variation to services which would require formal consultation with HOSC, and the changes were considered to be operational differences in the way in which the services are provided.

1.2. Following concerns raised by the Committee and members of the public about the changes, the HOSC agreed to establish a Review Board to examine the impact of the changes to the Paediatric service model at EDGH more closely. The implementation of changes to paediatric services at the EDGH started on 8 January 2024 and the HOSC Review took place over a series of meetings held during February 2024.

1.3. At the HOSC meeting held on 7 March 2024 the Committee considered and agreed the report of the Review Board and it's thirteen recommendations regarding the changes to the paediatric service at EDGH. The HOSC also considered an update report on the implementation of the new service model from ESHT at this meeting. The Committee agreed to submit the review report to ESHT for consideration and a formal response to the recommendations made by the HOSC.

2. Supporting information

2.1. ESHT submitted a formal response to HOSC's recommendations on 10 April 2024 and a copy was circulated to all Committee members. A summary of the HOSC review recommendations and ESHT's response to them is contained in **Appendix 1**. A full copy of the HOSC Review Board's report can be found here together with the 7 March 2024 HOSC meeting papers.

2.2. One of the HOSC recommendations was to bring an update monitoring report on the implementation of the changes to Paediatric services to the June and December 2024 HOSC meetings. As the June HOSC meeting was cancelled due to the pre-election period for the General Election, an update report is now being presented to the Committee on the operation of the new

service model. The ESHT update report on the new service is in **Appendix 2** of the report, which also contains further updates on ESHT's response to HOSC's recommendations. The Committee is asked to consider the response to HOSC's recommendations and update report provided by ESHT.

2.3. Section 2 of ESHT update report (Appendix 2) contains monitoring data regarding the operation of the new service model up until March 2024. This supporting data shows:

- The days per week with Paediatric cover in the new unit in the Emergency Department (ED), which show an increasing number of days per week that the new service is being operated (figure 1).
- There has been a small reduction in the number of children breaching the 4 hour waiting time target in ED (figure 2).
- An increasing percentage of children being seen in ED by paediatrics (figure 3); and
- There has not been an increase in the number of children needing to be transferred to the Kipling unit at the Conquest Hospital in Hastings, and the trend is a reduction from an average of 5 transfers per week to around 3 transfers a week (figure 4).

2.4. Section 3 of the report outlines the additional actions taken since April in relation to the HOSC recommendations. This includes a visit from Healthwatch and young Healthwatch; work on the new pathways for elective care for children to have food allergy and endocrine testing in the Paediatric Outpatients department; and a response to the recommendation regarding the location of the paediatric consultant managing the GP triage phone line.

2.5. ESHT have also commissioned an independent review of the new service model and have asked this review to also look at the issue of clinical (paediatric consultant) support for the new model. The independent review was undertaken by an independent paediatric consultant, Dr Moya Dawson, and a copy of her report and findings is included in an appendix to the ESHT report contained in Appendix 1. The independent review covered the following areas:

- Are the changes safe?
- Do the changes represent an improvement both in access and quality of urgent care pathways and in use of resources?
- Are the changes offer sustainable access to high quality care?
- Does the Consultant Paediatrician staffing the GP triage phone need to be permanently located at the EDGH site?

2.6 A summary of the findings of the independent review are as follows:

- The urgent care pathways that are currently in place feel safe. Children are managed by appropriately trained and skilled staff, and, where there is need, the same staff have access to appropriate senior decision maker advice over the phone – be this a consultant paediatrician or the STRS retrieval service – or in situ with the ED team.
- The ED team report feeling much better supported by having consistent paediatric support in situ rather than having to liaise – with some reported difficulty – with an inconsistent off-site team.
- The ED clinical lead reports that having paediatric support in situ also enhances emergency medicine training as, going forward, FY2 trainees will be doing a 4-hour shift with the paediatric Advance Nurse Practitioners (ANPs) daily.
- For this reason, the provision of urgent and emergency care appears to be both improved and sustainable, not only in terms of appropriate use of skilled and knowledgeable resource within the ED but also in terms of career progression and training for doctors, ANPs, paediatric nurses and Health Care Assistants (HCAs).
- The planned and elective services offered by the Paediatric team under the leadership of Dr Muhi-Iddin also feel safe. She has thought through the change process in detail and has ensured that it continues to meet the need of the children of Eastbourne and that it does not compromise on safety. Given the low numbers of children attending the Short Stay

Paediatric Assessment Unit (SSPAU) historically, the changes would also seem to be a wiser use of resource both in terms of workforce and financially.

- Addressing the HOSC board's specific recommendation that EHST permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site: within the paediatric consultant job plan, 1PA of consultant time is dedicated to triaging and managing online GP referrals and 1 PA to holding the advice phone line for both Conquest Hospital and EDGH as well as undertaking the consultant's own SPA work. These two PAs will count largely as remote direct clinical care and, as such, a) *do not* include the additional work of providing an input into the new service model and providing additional assurance to address concerns about the level of consultant presence in the hospital and b) can be safely done remotely and would not have to be permanently on site.

2.7 The overall conclusion of the independent report is that the new service model is safe, and urgent and emergency care appears to be improved and sustainable. There is also assurance around the actions taken on elective care pathways that were affected by the new service model and an undertaking by ESHT to share further details with HOSC when available.

3. Conclusion and reasons for recommendations

3.1 The HOSC is recommended to consider ESHT's response to the HOSC review recommendations, and the update information on the operation of the new service model and the actions taken in response to HOSC's recommendations. The Committee is also asked to consider the independent report and identify any further monitoring information it requires for the next update report at the December HOSC meeting.

PHILIP BAKER
Deputy Chief Executive

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<u>Appendix 1</u> – Summary of Recommendations from the HOSC Review of Changes to Paediatric Services at the Eastbourne District General Hospital (EDGH), and the response to the recommendations received from the East Sussex Healthcare Trust (ESHT).

HOSC Recommendations

	Recommendation
1	**The Board recommends that ESHT engage at an earlier stage with HOSC on any future service changes, particularly where there might be public interest in the service in question.**
2	**The Board recommends that ESHT involve staff and representative groups including Healthwatch and the East Sussex Parent Carer Forum in the design and fitting out of the new dedicated paediatric space where possible, to ensure it is child friendly, child safe and meets patients' and their families' needs.**
3	**The Board recommends that Healthwatch and Young Healthwatch be asked to visit and assess the new dedicated paediatric space and service once it has been completed.**
4	**The Board recommends ESHT investigate developing the space in the Scott Unit for facilities for planned paediatric care activities.**
5	**The Board is concerned that many of the pathways were not finalised before the new model was rolled out and recommends that ESHT finalise the outstanding planned care pathways as soon as possible and that copies of the new clinical pathways documentation are provided to HOSC once finalised and agreed with staff.**
6	**The Board recommends that additional communications are provided to parents and carers that are affected by the any of the changed pathways as a matter of urgency, so that families and their children who are regular users of the services at EDGH understand how the changes may affect them.**
7	**The Board remain concerned about having sufficient Paediatric consultant presence at the EDGH site and recommends that ESHT permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site to provide a level of consultant input into the new service model and to provide additional assurance to address concerns about the level of consultant presence in the new model.**

8	**The Board recommends that ESHT consider identifying a suitable space that could be used for children and young people presenting with mental health issues within the facilities in ED.**
9	**The Board recommends that ESHT reviews and expands the number of trainee APNP roles if possible, to provide greater resilience and assurance for the operation of new service model.**
10	**The Board recommends that ESHT promote the travel and access support that is available to patients and their families, who may be affected by changes in the new model of care, and consider the use of a Travel Liaison Officer role to support travel and access arrangements.**
11	**The Board recommends that ESHT clarifies the metrics and milestones used to determine the effectiveness of the changes to paediatric care at EDGH to HOSC and Healthwatch.**
12	**The Board recommends that ESHT provides an update report to HOSC on the operation of the new service model at the 6 June 2024 and 12 December 2024 HOSC meetings.**
13	**The Board recommends that HOSC works with Healthwatch to monitor and review the operation of the new service model.**

Response to HOSC's recommendations from the East Sussex Healthcare Trust (ESHT)

As noted in several of the responses to the recommendations, ongoing reporting to the HOSC during 2024 will continue to note the progress of this service.

Recommendation 1.

The Board recommends that ESHT engage at an earlier stage with HOSC on any future service changes, particularly where there might be public interest in the service in question

We note the request and are happy to engage HOSC at the relevant times. The CEO and HOSC Chair meet informally on a regular basis and can agree how and when services changes are bought to HOSC.

Mindful that there is no formalised definition of 'substantial variation' to services, together with ESCC and ICB colleagues we are keen to develop a range of criteria to help structure the approach as to how we collectively respond to proposed local service changes

Recommendation 2.

The Board recommends that ESHT involve staff and representative groups in the design and fitting out of the new dedicated paediatric space where possible, to ensure that it is child friendly, child safe meets patients' and their families' needs.

We are refreshing the dedicated paediatric space in the Emergency Department at EDGH to make this a welcoming space for young patients and their families as soon as possible and have involved staff in that work. To get this done quickly we've been unable to involve representative groups but will take the recommendation on board and involve these groups in future.

Recommendation 3.

The Board recommends that Healthwatch (HW) & Young Healthwatch be asked to visit and assess the new dedicated paediatric space/service once it has been completed.

We are scheduling times with Healthwatch & Young Healthwatch to undertake this work.

Recommendation 4.

The Board recommends ESHT investigate developing the space in the Scott Unit for facilities for planned paediatric care activities.

At present the routine planned care activities are taking place in Friston (Paediatric) Outpatients rather than Scott Unit.

We continue to review developing the space in the Scott Unit to ensure that we are utilising all of our Paediatric space, and we are liaising with teams around that. Understandably, feedback from staff was to ask us to allow the changes to bed in with the new model before further changes were suggested.

Recommendation 5.

The Board recommends that ESHT finalise the outstanding planned care pathways as soon as possible and that copies of the new clinical pathways documentation are provided to HOSC once finalised and agreed with staff

We agree and would suggest that these form part of the updates to the June and December HOSC meetings.

Recommendation 6.

The Board recommends that additional communications are provided to parents and carers that are affected by the any of the changed pathways as a matter of urgency, so that families and their children who are regular users of the services at EDGH understand how the changes may affect them.

We have revised our 'open access/long term patients' list. Once this is fully completed, we intend to write to all of the affected patients/families re the changes. Any current regular users of the service have already been liaised with.

Recommendation 7.

The Board recommends that ESHT permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site to provide a level of consultant input into the new service model and provide additional assurance to address concerns about the level of consultant presence in the new model

We are not in a position offer an immediate commitment without first understanding the resource and efficiency implications, as well as the views of the consultant body, given this is ultimately a clinical matter. We will discuss this with paediatric consultant colleagues for their consideration and will provide an update on our modelling of the implications at the June and December HOSC meetings. We have also asked the independent clinical review to consider the implications and need to support the clinical model of locating a consultant permanently at EDGH.

Recommendation 8.

The Board recommends that ESHT consider identifying a suitable space that could be used for children and young people presenting with mental health issues within the facilities in ED

There is a separate room that can be utilised if the young person requires somewhere calm and quiet. However, not all young people will want to be separated and may need closer supervision and therefore may want to wait within the new unit. This space will still be less crowded and more appropriate than the previous space that was shared with the adult minor injury service.

Recommendation 9.

The Board recommends that ESHT reviews and expands the number of trainee APNP roles if possible, to provide greater resilience and assurance for the operation of new service model.

We recognise the importance of ensuring we have adequate cover for the demand that we are seeing through the unit and would seek to follow Trust process if we need to increase to meet rising need/activity. In both the immediate and medium term, the rota is staffed by either an APNP or a Paediatric Medical Registrar.

Recommendation 10.

The Board recommends that ESHT promote the travel and access support that is available to patients and their families, who may be affected by changes in the new model of care and consider the use of a Travel Liaison Officer role to support travel and access arrangements.

As part of conversations with patients and their families around treatment plans, we always discuss and signpost the various support options that are available.

Recommendation 11.

The Board recommends ESHT clarifies the metrics/milestones used to determine the effectiveness of the changes to paediatric care at EDGH to HOSC and HW

As per the March paper to HOSC, we currently measure; availability of paediatric cover (7/7), paediatric activity (total number), transfers to the Conquest inpatient ward and % access to specialist paediatric opinion (EDGH).

Recommendation 12.

The Board recommends ESHT provides an update report to HOSC on the operation of the new service model at 06 June 2024 & 12 December 2024 HOSC meetings

Agreed.

Recommendation 13.

The Board recommends that HOSC works with Healthwatch to monitor and review the operation of the new service model.

We have a twelve-month forward workplan with Healthwatch, with at least two scheduled visits to the paediatric facility at EDGH.

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Update to Health Overview and Scrutiny Committee, July 2024
Paediatric Care in the Emergency Department (ED) at Eastbourne District General Hospital

1. Summary

1.1 This update report forms part of the briefings that we agreed to share with colleagues for assurance purposes following the HOSC review into the new model for paediatric care at Eastbourne District General Hospital. Another update is due in December this year.

We are pleased to report positive progress with the model for paediatric care. This update covers two broad areas:

- Supporting data from the new model.
- Additional actions undertaken following the HOSC Review recommendations.

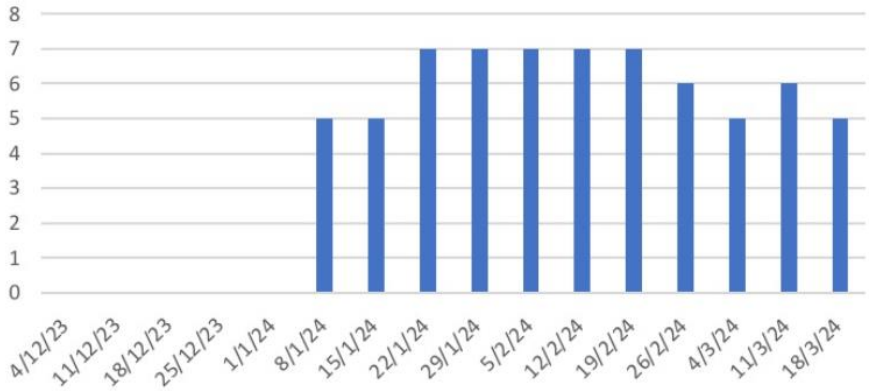
2. Supporting data

2.1 We have now had the benefit of almost five months of activity through the paediatric hub. As the graphs below indicate, we have a regular presence in ED, improving activity levels and a decreasing number of children needing referral to the Hastings site.

2.2 Figure 1 below shows that coverage has been consistently between 5 and 7 days per week. On these days, any paediatric presentation to ED where a paediatric opinion is required, has immediate access to the service. As HOSC members will recall, prior to the new model, there was no paediatric specialists in ED.

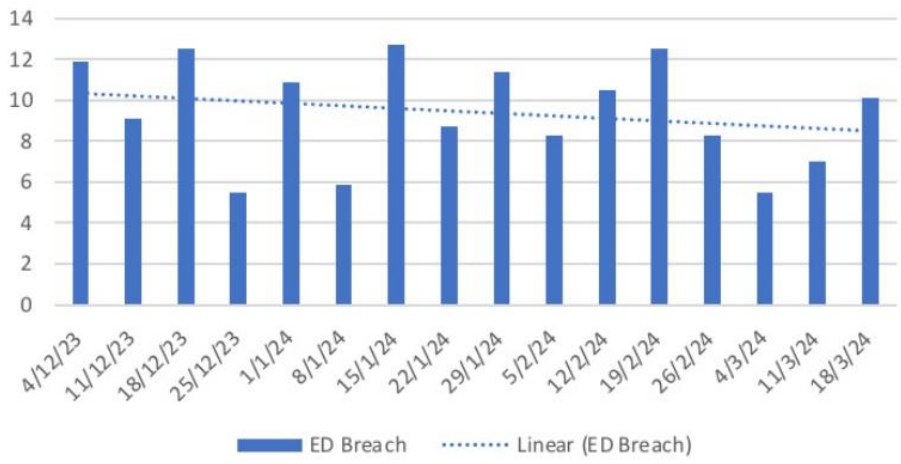
2.3 Members will recall that under the previous model, we regularly closed the assessment unit at short notice (weekends and during staff shortages) so the current model has increased access and has brought less unpredictability to the planning of staff rotas/ departmental cover.

Figure 1: Days per week with paediatric cover in the (ED) emergency department (max. 7)



2.4 Figure 2 shows that, since implementing the new model in early January, there has been a small reduction in the number of children waiting over four hours, approximately two fewer per week.

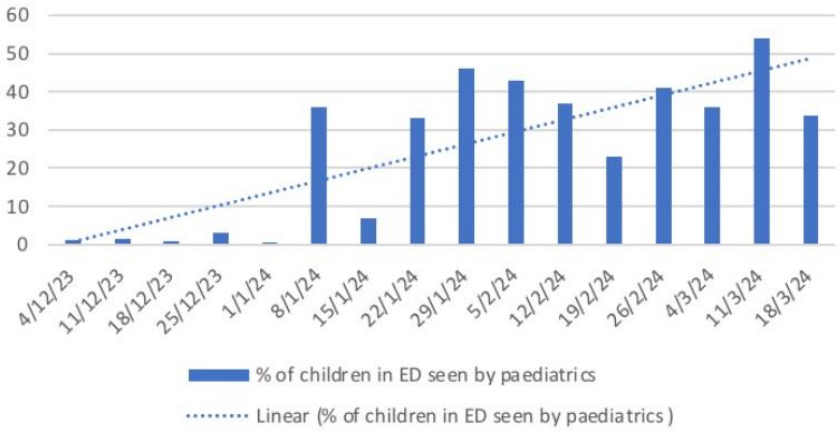
Figure 2: Numbers of children breaching the 4-hr ED standard



2.5 Members will recall that only a very small number of children (3%-4% typically need paediatric care/opinion in the ED, with the majority covered by ED nursing and/or consultant intervention) and for those who did, historically this would have taken place in another part of the site.

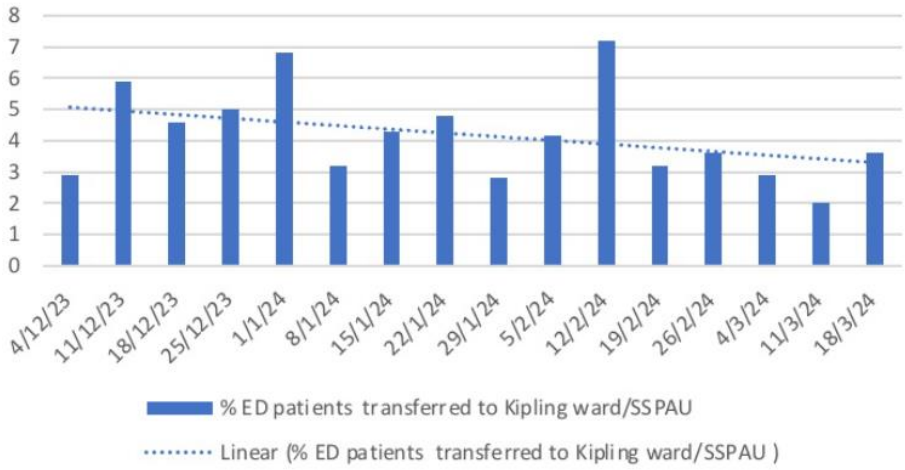
2.6 Figure 3 shows that we are seeing a steadily increasing number of children directly in ED, supporting the improvement in access to paediatric opinion that the model affords to local parents.

Figure 3: Percentage of children seen in ED by paediatrics



2.7 Members will recall that one of the concerns put forward with regard to the new model is that it would result in an increase in paediatric cases going to our Hasting site. As Figure 4 shows, this has not been borne out by the results, with the trendline showing a reducti on from an average of 5 a week to around 3 a week.

Figure 4: Numbers of children transferred for care in Hastings



3. Additional actions since April relating to the HOSC recommendations

3.1 ***HealthWatch:*** HOSC members will recall that recommendation 3 of the HOSC review requested that Healthwatch and Young Healthwatch be asked to visit and assess the new dedicated paediatric space/service, and we are happy to confirm that the Trust hosted this visit on 11 May 2024.

3.2 Feedback from the Healthwatch/Young Healthwatch visit was overwhelmingly positive. The visit was undertaken by a HealthWatch volunteer and a teenage member of Young HealthWatch. The report notes the calm environment that was out of the more frenetic pace of an emergency department. It reflected the observation that APNPs were evidently experienced and kind with the patients and the environment was clean, tidy and pleasant. Overall, the visit was positive and supportive of the new model in place, which it believes is working well.

3.3 ***Elective care:*** As per recommendation 5, although there have been no changes to elective surgery or radiology services for children at EDGH, new pathways have been developed for children to have food allergy and endocrine testing in outpatients at EDGH, and these will be shared with HOSC colleagues in due course. There are a small number of children (5) with complex needs who are currently having their elective medical care at conquest hospital.

3.4 ***Paediatric consultant base:*** Members will recall that, in response to Recommendation 7 (the location/base of the paediatric consultant managing the GP triage phone line), we agreed to commission an independent clinical review of this matter and to consider the specific question of the clinical model being supported by locating a consultant permanently at the EDGH site.

3.5 For the purposes of transparency we have included the full report from the independent paediatric consultant Dr Moya Dawson as an appendix to this update. Dr Dawson is a Consultant in Paediatric Emergency Medicine at the Oxford University Hospitals Foundation Trust, where she is the clinical Lead for Resuscitation and Chair of the Trust Resuscitation and Paediatric Resuscitation Committees. She is also the Southeast Regional Clinical Advisor for Paediatric Urgent and Emergency Care, NHS England.

3.6 Regarding the independence of the review, we would add that Dr Dawson does not otherwise know the Trust nor any members of the Paediatric service leadership nor the colleagues she spoke to on her visit. We were introduced to Dr Dawson by Dr. Vaughan Lewis, the Southeast Regional Medical Director for NHS England. Dr Dawson was not paid by ESHT for her review or visit. This is considered a feature of her role as Southeast Regional Clinical Advisor for Paediatric Urgent and Emergency Care NHS England.

3.7 With regard to the HOSC recommendation that the consultant be based permanently at Eastbourne DGH, as opposed to the current arrangement which bases the consultant at whichever site is more practical at that point: The Consultant body, including all Consultants based at Eastbourne DGH, has discussed this recommendation. Their view is that this is not necessary or beneficial at this point in time, noting that we routinely review and adapt consultant presence according to demand and population risk (e.g. viral infection patterns) across the year.

3.8 We note that Dr. Dawson's review does not suggest there would be a benefit in implementing this recommendation at this point. She notes:

"Addressing the HOSC board's specific recommendation that EHST permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site: within the paediatric consultant job plan, 1PA of consultant time is dedicated to triaging and managing online GP referrals and 1 PA to holding the advice phone line for both Conquest Hospital and EDGH as well as undertaking the consultant's own SPA work. These two PAs will count largely as remote direct clinical care and as such a) do not include the additional work of providing an input into the new service model and providing additional assurance to address concerns about the level of consultant presence in the hospital and b) can be safely done remotely and would not have to be permanently on site."

Therefore, we do not intend to implement this recommendation. We will continue to keep the amount and role of consultant presence on each site under review as we already do.

3.9 ***Future plans for paediatric services:*** As per our response to recommendation 4, we will be working with colleagues over the next six months to decide how to use the Scott Unit to further improve the quality of care we provide for children in Eastbourne.

3.10 Following recommendation 9, we have recruited two further trainees advanced nurse practitioners, when all our trainees are trained, we will have seven advanced nurse practitioners. We are developing plans for a virtual ward and primary care MDT to reduce the number of children needing to come to either of our hospitals.

3.11 As per our response to recommendation 4, we will be working with colleagues over the next six months to decide how to use the Scott Unit to further improve the quality of care we provide for children in Eastbourne.

Dr Matthew Clark
Clinical Chief of Division, Women's & Children and Sexual Health

Ms Kaia Vitler
Divisional Director of Operations, Women's & Children and Sexual Health

Appendix: Visit of Eastbourne District General Hospital on 18.3.24 by Dr Moya Dawson

I am a consultant in Paediatric Emergency Medicine based at the John Radcliffe Hospital in Oxford. I am the Trust Clinical Lead for Resuscitation, and the Chair of the Trust Resuscitation and Paediatric Resuscitation Committees. I am the lead for the RCPCH Grid and the RCEM training programmes in Paediatric Emergency Medicine at the John Radcliffe. I am the Regional Clinical Advisor for Paediatric Urgent and Emergency Care NHS England for the Southeast.

During my visit to the hospital, I was able to visit the Emergency Department including the area d edicated to paediatrics, as well as the Paediatric Outpatient Department. I had the opportunity to speak with the following staff members whom I felt gave me a broad, fair and balanced view of how acute paediatric care is delivered at EDGH. I did not feel at the time that I needed to speak to more members of staff but did make it clear that of course I would be more than happy to going forward should there be an appetite for this.

- Simon Dowse – Director of Transformation, Strategy and Improvement
- Matthew Clark - Chief of Division for Women's and Children's
- Nadia Muhi-Iddin - Clinical Lead Paediatrics
- Utham Shanker – Clinical Lead Emergency Medicine
- Kate Morrison – PANP in ED
- Joe Chadwick-Bell – Chief Executive Officer

The EDGH paediatric service sees children and young people aged 0 to 15 years included.

1. General Paediatric planned and elective services

EDGH does not have a paediatric inpatient unit but does have outpatient services, a small Paediatric Emergency Department (PED), and did have a small Short Stay Paediatric Unit (SSPAU) until recently.

The SSPAU accepted the following:

- children referred by the ED (2.5% of paediatric attendances)
- children attending for day case surgery
- children scheduled for testing such as allergy or endocrine testing
- children scheduled for blood transfusions, pamidronate infusions and shared care chemotherapy

The SSPAU number of daily attendances was low, it was closed on weekends and after 7pm.

The elective services previously provided by the SSPAU are now being provided by the OPD (allergy testing, endocrine testing), by the surgical day case unit who has allocated one day a week for paediatric elective day cases, and, for a small number of children needing transfusions, infusions and chemotherapy, by Conquest hospital.

Those children who may have been transferred to the SSPAU from PED for a paediatric review or a period of observation are now being managed in one observation bed in the PED by paediatric trained staff (see further details in Section 2).

Hot clinics for GP referrals are being accommodated in the OPD. Follow up reviews, prolonged jaundice clinics and virtual wards are currently presenting an evolving picture with details still being determined by the paediatric team.

These changes are still undergoing review to ensure safety and sustainability, and Dr Muhi-Iddin holds two-weekly meetings with her consultant colleagues to ensure this.

There are consultant paediatricians on site who work primarily in the Outpatient Department (OPD), who manage the GP referrals that are received via email and who hold the GP advice phone line.

Paediatric consultants are on call for both EDGH and Conquest Hospital, which is based in Hastings.

There are no trainees at Eastbourne DGH.

2. Paediatric Urgent and Emergency Services

The Emergency Department (ED) sees approximately 13,500 children a year aged 0-15.

Of these children, in 2022- 2023, prior to the dissolution of the SSPAU, 2.5% were transferred to SSPAU for general paediatric review, 2.3% were seen in the PED by a paediatrician, and 3.5% were transferred to Conquest Hospital for admission to the ward. Overall the acuity of presentations to EDGH is low, as all children conveyed by ambulance will be taken to conquest. The exception for this is for children who are peri-arrest or in cardiac arrest, when they will be conveyed to the closest hospital. In total, approximately 92% of children attending the PED were seen, managed and discharged by an ED doctor.

Currently the ED has a small audio-visually separate PED which runs seven days a week, from 8.00am to midnight. It includes a small bay with two chairs, a bed and a cot. This bay is used for triage as well as treatment. There is no available piped or tanked oxygen in this bay, but there is portable suction.

There is a separate room with a bed which can be used for isolation of patients or for children and young people with mental health or sensory difficulties. This room is currently awaiting renovation to make it more patient friendly and less office-like.

There is a large paediatric bay in the resus area and there is one smaller neonatal resuscitation bay with a *resuscitaire* in situ and ready for use.

Children attend the PED by registering in main reception and moving to the PED area. Here they are assessed by a paediatric ED nurse and seen and managed by a paediatric ANP, and ED middle grade or occasionally a paediatric middle grade covering the shift. Some children are streamed to urgent care.

The PED is primarily staffed by highly skilled Paediatric ANPs, paediatric nurses and HCAs. When fully staffed the PED will have 1 PANP, two nurses and 1 HCA every day.

There are currently three qualified PANPs, one who is nearly qualified, two who are training and one in her first year of training. The paediatric ANPs work from 8.30am to 9pm, they see and manage all patients during their shifts; they are fully registered prescribers and are fully IRMER registered, they have no restrictions on what they can prescribe and what imaging they can order. They, alongside the paediatric ED nurses and HCAs have the following clinical skills: venepuncture, cannulation, suturing, glueing, plastering.
The PANPs will refer to the paediatricians at Conquest Hospital should a child need admission, using the STOPP form (Safe Transfer of the Paediatric Patient).

An ED doctor will see children when the PANPs are not present in the day or at night. 25% of paediatric attendances are between 9pm and 8am the following day.

The presence of paediatric ANPS has all but obviated the need for paediatricians in the PED, but there is always an on-call paediatrician available on the phone for advice. The full ED team is also always available for help and advice.

The EDGH is supported by the South Thames Retrieval Service (STRS) in case of paediatric retrieval need, and by Kings College Hospital for trauma management. It is otherwise supported by Conquest Hospital.

3. <u>Purpose of the review</u>

1. Are the changes safe?
2. Do the changes represent an improvement both in access and quality of urgent care pathways and in use of resources?
3. Are the changes offer sustainable access to high quality care?
4. Does the Consultant Paediatrician staffing the GP triage phone need to be permanently located at the EDGH site?

The urgent care pathways that are currently in place feel safe. Children are managed by appropriately trained and skilled staff, and, where there is need, the same staff have access to appropriate senior decision maker advice over the phone – be this a consultant paediatrician or the STRS retrieval service – or in situ with the ED team.

The ED team report feeling much better supported by having consistent paediatric support in situ rather than having to liaise – with some reported difficulty – with an inconsistent off-site team.

The ED clinical lead reports that having paediatric support in situ also enhances emergency medicine training as, going forward, FY2 trainees will be doing a 4-hour shift with the paediatric ANPs daily.

For this reason, the provision of urgent and emergency care appears to be both improved and sustainable, not only in terms of appropriate use of skilled and knowledgeable resource within the ED but also in terms of career progression and training for doctors, ANPs, paediatric nurses and HCAs. This nurturing and forward-thinking environment is likely to attract high quality career seeking candidates and is also much more likely to retain staff through job satisfaction and opportunity to progress. This in turn will lead to high quality care presently and in the future.

The planned and elective services offered by the Paediatric team under the leadership of Dr Muhi-Iddin also feel safe. She has thought through the change process in detail and has ensured that it continues to meet the need of the children of Eastbourne and that it does not compromise on safety. Given the low numbers of children attending the SSPAU historically, the changes would also seem to be a wiser use of resource both in terms of workforce and financially.

Addressing the HOSC board's specific recommendation that EHST permanently locates the Paediatric consultant staffing the GP triage phone at the EDGH site: within the paediatric consultant job plan, 1PA of consultant time is dedicated to triaging and managing online GP referrals and 1 PA to holding the advice phone line for both Conquest Hospital and EDGH as well as undertaking the consultant's own SPA work. These two PAs will count largely as remote direct clinical care and, as such, a) *do not* include the additional work of providing an input into the new

service model and providing additional assurance to address concerns about the level of consultant presence in the hospital and b) can be safely done remotely and would not have to be permanently on site.

4. Looking ahead

I observed many areas of good practice and forward thinking within the PED at EDGH. I would be happy to assist in any upcoming plans for expansion or improvements to the service in the PED.

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**30 July 2024**
By:	**Deputy Chief Executive**
Title:	**Audiology service provision in East Sussex**
Purpose:	**To provide an overview of audiology service provision in the county**

RECOMMENDATIONS

The Committee is recommended to:

1) **consider and comment on the report; and**
2) **consider whether to further scrutinise any of the areas covered in the report.**

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1. Background

1.1 Audiology services are focussed on the assessment, prevention, and treatment of disorders of hearing and balance. Audiology is delivered in a variety of settings, including hospitals and in the community.

1.2 The Committee has been made aware of difficulties some people in East Sussex have in accessing primary and secondary audiological care services and at its meeting on 7 March 2024 requested a report to better understand the issue.

2. Supporting information

2.1. NHS Sussex has produced a report for the HOSC attached as **Appendix 1**. The report covers:

- Commissioning arrangements (acute and community)
- Audiology pathways, including age-related hearing loss
- Earwax services
- Issues of note, including hearing aid services, earwax removal, concerns raised by East Sussex Hearing Resource Centre (ESHRC), East Sussex Healthcare NHS Trust (ESHT) audiology and ESHRC
- Interface with Voluntary, Community and Social Enterprise (VCSE)
- Future commissioning

3. Conclusion and reasons for recommendations

3.1 The HOSC is recommended to consider the report and decide whether it wishes to further scrutinise any of the areas covered in the report.

PHILIP BAKER
Deputy Chief Executive

Contact Officer: Patrick Major, Scrutiny and Policy Support Officer
Tel. No. 01273 335133
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NHS Sussex

Provision of Audiology Services in East Sussex

Report to the East Sussex Health Overview and Scrutiny Committee: July 2024

1. Audiology Overview

1.1 Audiology services are focussed on the assessment, prevention, and treatment of disorders of hearing and balance. Audiologists and Hearing Aid Dispensers (HADs) use a range of diagnostic tests and tools to assess the functioning of the auditory system and determine the nature and extent of a patient's hearing loss or vestibular disorder. Audiologists often work closely with Ear, Nose and Throat (ENT) departments. Audiology is delivered in a variety of settings, including hospitals and in the community.

2. Commissioning Arrangements

2.1 NHS Sussex commissions audiology through both acute hospital services and community services.

Acute Audiology Services

2.2 Acute hospital-based audiology services are commissioned as part of wider acute contracts with East Sussex Healthcare NHS Trust and University Hospitals Sussex NHS Foundation Trust. These services cover everything from paediatric audiological disorders to adult patients with complex complaints such as severe tinnitus, balance disorders, hearing loss treatments such as Bone-Anchored Hearing Aids and Cochlear Implants, as well as hearing aid services for patients with severe and profound hearing loss or patients with special needs.

2.3 Our commissioning of acute audiology also includes the provision of routine hearing aids services by East Sussex Healthcare NHS Trust, from their sites in Eastbourne, Hastings and Bexhill. This hearing aids service is very similar to the community service (see paragraph 2.6), but forms part of a contract with the trust that operates to the national waiting times framework.

2.4 University Hospitals Sussex NHS Foundation Trust provide complex adult and paediatric audiology services. The Trust does not provide routine hearing aid services after the services in Brighton ceased in 2013/14 and in West Sussex in 2021/22. In these areas, services are commissioned in the community.

2.5 Surrey and Sussex Healthcare NHS Trust has not had audiology provision since 2013/14 and NHS Sussex commissions a bespoke complex audiology service in the Crawley area.

Community Audiology

2.6 Community Audiology is centred on the provision of hearing aids to patients aged 55 and above. Since 2013/14 this has been commissioned across the whole of Sussex under an ‘Any Qualified Provider’ scheme, which is open to any provider that can meet the service specification and accepts our contract terms. The range of organisations that deliver these services is diverse, spanning a mix of ‘high street’ commercial entities such as Specsavers and Scrivens, small or specialist organisations such as Hidden Hearing and Outside Clinic, an NHS social enterprise in the form of First Community Health, and a local charity in the form of Action for Deafness (formerly known as West Sussex Deaf and Hard of Hearing Association). They all provide exactly the same service to exactly the same minimum standards.

2.7 The scheme is closely monitored by the NHS Sussex commissioning and contracting teams, including regular contract monitoring meeting with each provider to review provider performance, activity, service quality, service issues, complaints and plaudits.

2.8 Since inception, there have been 5 – 6 contracted community providers, delivering the service in up to 60 - 70 locations across Sussex. The service delivered approximately 18,000 hearing aid fittings in 2023/24 and at any point in time there are typically around 50,000 patients being cared for by providers. This represents around 80% of all audiology patients.

2.9 A key feature of the service delivered by community audiology providers is a typical 3–4 weeks' timeline from referral to assessment, which often includes fitting as a one-stop function.

2.10 There are no known gaps in audiology commissioning across Sussex, including East Sussex. All age groups and patient profiles are fully commissioned for. Audiology commissioning covers the complete pathway from initial referral to treatment, follow-up and ongoing care. Hearing Aids pathways cover the entire pathway from referral through to audiological assessment, fitting, follow-up, ongoing aftercare, periodic review and re-assessment/re-fitting where appropriate.

2.11 NHS hearing aid services are one of the most widely distributed NHS services. Within East Sussex there are approximately 20 sites from which services are provided, including the 3 acute audiology service sites. Across Sussex as a whole, services are provided from around 60 sites.

3. Audiology Pathways

Age-Related Hearing Loss

3.1 Bilateral, age-related hearing loss (presbycusis) accounts for around 80% or more of all audiology referrals and, typically, the 'treatment' is provision of hearing aids. All providers deliver against a service specification and pathway that is based on a national-level specification published by the Department of Health in 2012:

- Patients are referred by their GP (who needs to ensure their ears are free of occluding wax).
- The patient is offered an assessment appointment.
- At assessment, if the patient needs hearing aids and is suited to a 'one stop' pathway, they are fitted with aids in the same attendance.
- If the patient is not suited to open fit and needs ear moulds, impressions are taken, and a fitting appointment is arranged.
- At fitting, a follow-up check is arranged for a point within the next 10 weeks or so. This is to check that the patient is adapting to using aids and, if necessary, to arrange an attendance for adjustment to the aids.
- The patient is supported with free batteries, other consumables and any other aftercare needs for the lifetime of the hearing aids.
- The provider should periodically review the patient's needs.

Other Pathways

3.2 Acute audiology pathways cover a much wider spectrum of hearing issues than age-related hearing loss, such as unilateral hearing loss, tinnitus, vertigo, hereditary hearing loss and so on. In these instances, the patient will be referred, by their GP, to either the Audiology or ENT department for investigation of their issue. The pathway from that point onwards depends on the condition. It can involve additional diagnostic tests, rehabilitative interventions, collaborations with ENT or with other teams such as Paediatrics and Speech and Language Therapy.

3.3 There is an overlap with the community pathways in so far as the acute service may also address the determined hearing issue by prescribing and fitting hearing aids. The hearing aids pathways tend to be similar to those in the community except that patients may be referred on to audiology or for hearing aid assessment consequent to referral or examination by the ENT department or following a complex audiology assessment.

4. Earwax Services

4.1 Earwax removal has historically been part of primary care (GP) provision and this continues through the NHS Sussex commissioned Locally Commissioned Service (LCS) arrangement with primary care practices. Under the current LCS, patients are either treated by their practice or, if the practice is unable to provide this service, through inter-practice referral to a different GP practice. Across Sussex, there are currently 132 practices providing ear irrigation, of which 36 also provide microsuction. For East Sussex 42 of the 52 practices offer ear irrigation and 15 offer microsuction.

4.2 Best practice for earwax removal is that patients are taken through a tiered pathway as follows:

- Self-care
- Irrigation
- Microsuction.

4.3 Under this scheme, 5,899 Sussex patients underwent ear irrigation in 2023/24 and 1508 also or alternatively proceeded to have microsuction. These figures do not include earwax removal undertaken within acute hospitals as part of an ENT attendance.

4.4 Earwax removal is a relatively simple intervention that nevertheless requires special training. The Care Quality Commission advises that “earwax removal is a regulated activity if the person and a listed health care professional both agree there is a problem that needs an intervention; and the treatment is carried out by a listed healthcare professional”. All practices in Sussex offering NHS-funded irrigation and microsuction are required to be CQC registered. Earwax removal through the LCS scheme is provided free of charge.

4.5 Many private sector organisations, such as high street optician chains, private audiologists and private hearing aid providers, offer fee-paying earwax removal including microsuction. There are several non-NHS providers offering a fee-paying service in the Eastbourne area, including East Sussex Hearing Resource Centre and many more across Sussex as a whole. The NHS is not involved with these private services and holds no information on their training, qualifications or CQC registration status.

5. Issues of note

Hearing Aid services

5.1 A factor of the AQP system is that it is market driven i.e. providers seek to provide from locations that generate higher demand. This means that rural, low-population-density areas are generally less well covered. All parts of East Sussex however are covered by domiciliary services if the patients qualify and are unable to travel to appointments.

5.2 A large proportion of patients still choose the hospital service for provision of their routine hearing aids needs. Hospital delivered services, including for hearing aids, were severely impacted by the COVID pandemic and waiting times became quite long. However, the hospital service waiting times in East Sussex have been addressed and once again comply

with national standards (6 weeks for diagnostic assessment, 18 weeks for first definitive treatment). Waiting times in the community service were also adversely affected but have been back to pre-COVID levels for more than a year.

5.3 There is a need for clear communication to support patient understanding of the services available. There is a common misconception that hearing aids have to be replaced every three years. Modern digital hearing aids can be adjusted to accommodate progressive hearing loss, up until more powerful aids are required. Most manufacturers publish an expectation that their hearing aids will last around 5 – 7 years.

Earwax Removal

5.4 As an aerosol-generating process, earwax removal by GP practices was also severely affected by COVID and suspended during lockdown. Post-COVID, practices needed to prioritise other services and access to this service was quite limited during the recovery period. However, the Locally Commissioned Service was refreshed in 2023 and, as described above, provision is now widespread with accessible to the Sussex population.

Concerns raised by East Sussex Hearing Resource Centre (ESHRC)

5.5 In March 2024 ESHRC raised a range of concerns with NHS Sussex to which we responded to, providing clarification on how earwax removal services are delivered in line with best practice guidance including NICE and the audiology pathway. We also offered to engage further with ESHRC with regard to how we might further improve signposting for patients on the audiology pathway to support services, how we might have a greater focus on prevention measures in the pathway and how we could further enhance hearing assistive equipment and staff training with regards to hearing communication within Primary Care and acute services.

East Sussex Healthcare NHS Trust (ESHT) Audiology and ESHRC

5.6 Up until recently, the ESHT Audiology department provided 1.5 days per week of audiologist support for the East Sussex Hearing Resource Centre services in Chantry House, Eastbourne. This was a long-standing arrangement wherein NHS patients would be seen, by appointment, by the NHS audiologist, who was also able to provide ad hoc support to the walk-in repairs and maintenance clinics offered by ESHRC.

5.7 ESHT has had to take the decision to relocate this role to the ESHT base at Eastbourne Park Primary Care Centre following introduction of a private microsuction service by ESHRC using the same room. This relocation was primarily related to the impact of aerosol generating procedures on NHS audiological equipment and clarity for patients around colocation of paid for services alongside NHS provision. ESHT continues to provide consumables such as batteries and tubing to ESHRC for distribution to ESHT patients on their behalf.

Impacts on the system

5.8 Community audiology was particularly impacted by the COVID pandemic, and this led to some providers re-appraising their position. Two of the smaller AQP providers terminated their NHS contracts: Hidden Hearing in mid-2022 and Sussex Health Care Audiology in mid-2023. In both instances, this necessitated NHS Sussex to manage and deliver a large-scale transfer of patients to alternative providers. NHS Sussex and providers responded swiftly to manage the safe transfer of 7000 patients to ensure continuity of care.

5.9 For the Sussex Health Care Audiology transfer, the caseload of 5,000 patients was subsequently too large for absorption by the other providers and NHS Sussex brought on board, at short notice, a new provider called The Outside Clinic. This provider specialises in domiciliary audiology but has adapted to the face-to-face model for Sussex.

5.10 While the transfer process was relatively seamless for most patients, we recognise that this was not the case for a relatively small number of people. The reasons varied by individual, from out-of-date contact information to needs for care at short notice, and NHS Sussex worked hard to address any issues that arose. Provider withdrawals from the market is an indication of fragility in the community audiology system that NHS Sussex is seeking to address.

6. Interface with Voluntary, Community and Social Enterprise (VCSE)

6.1 The acute audiology departments have a long history of working with local VCSE organisations, typically signposting patients for additional social support and in some instances providing supplies of 'spares' such as batteries and tubing to enable easier access for patients.

6.2 The community audiology sector engages with VCSE's differently. Within the range of providers, we contract with Action for Deafness, who are themselves a local VCSE and combine being one of the largest providers of NHS-funded hearing aids with extensive charitable activities in support of people with hearing loss across Sussex. First Community Health is to some extent similar, in that it is a social enterprise, and also operates on a not-for-profit basis. Equally, private companies such as Specsavers and Scrivens are both engaged at a corporate and local level with the VCSE community, from their national support of particular VCSE organisations and liaison/signposting patients and, in some instances, provision of spares and supplies in much the same way as the acutes audiology providers.

7. Future Commissioning

7.1 The introduction of AQP Audiology in 2013/14 was a ground-breaking initiative that transformed access to hearing aids services. However, the system has certain attributes that have come to the fore during recent years. Hearing Aids services require long term provider stability and continuity. Once a patient is fitted with aids, they will normally need hearing aids for the rest of their hopefully long life but more immediately, they need ongoing aftercare for these specific aids for anything up to 6 or 7 years.

7.2 An AQP system can drive a level of competition which may discourage providers from locating service points in low-density rural areas. Smaller providers may not have the resources or marketing ability of larger commercial organisations. Equally, even larger organisations can fail to secure their desired market share where there are a number of other providers operating. In 2014 one national-level company terminated their Sussex contract for this reason. Similarly, both providers who terminated their Sussex contracts in 2022 / 2023 cited low market share as one of the drivers for withdrawal.

7.3 This market fragility can be both challenging and less cost effective and NHS Sussex has been in discussion with providers, looking at different options to mitigate the risks. As a consequence, we are considering how best to develop our approach to the commissioning of these services in the coming year. This will ensure we seek to retain and improve upon those features that are most valued, such as the wide distribution of access points and short waiting times whilst enabling better transferability, through standardising the range of aids, and strengthening the quality of aftercare provision.

END

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**30 July 2024**
By:	**Deputy Chief Executive**
Title:	**South East Coast Ambulance NHS Foundation Trust (SECAmb) Care Quality Commission (CQC) Inspection Report**
Purpose:	**To provide the Committee with an overview of progress made by South East Coast Ambulance NHS Foundation Trust (SECAmb) to improve services and organisational culture as part of the Recovery Support Programme (RSP) following the CQC inspection.**

RECOMMENDATIONS

The Committee is recommended to:

1) **Note the report, and consider and comment on the contents of the report; and**
2) **Consider whether to request a further report on any of the areas covered in the report.**

1. Background

1.1. South East Coast Ambulance NHS Foundation Trust (SECAmb) provides emergency and urgent care services in response to calls from the public and other healthcare professionals across Brighton and Hove, East Sussex, West Sussex, Kent and Medway, Surrey, and parts of North East Hampshire. The Trust operates two emergency operations centres (EOC) that receive and triage 999 calls. The EOC provides ambulance dispatch as appropriate and provides assessment and treatment advice to callers who do not need an ambulance response, a service known as "hear and treat". SECAmb is also the provider of the NHS 111 service for residents in Kent and Sussex who require urgent care and advice over the phone.

1.2. The CQC conducted a focused inspection of the Emergency and Urgent Care services provided by SECAmb in March 2022 to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures. The CQC also inspected the EOC and 111 service, and inspected the well-led domain for the trust due to concerns about leadership quality and culture in the organisation.

1.3. The CQC published its inspection report on 22nd June 2022 and rated the Trust as inadequate in its well-led domain. Due to the inadequate rating in the well-led domain, the CQC recommended to NHS England that the Trust be placed into the Recovery Support Programme (RSP). NHS provider trusts placed into an RSP by NHS England must produce an Improvement Plan that includes a target timeline for exit from the RSP. NHS England must be satisfied that the agreed exit criteria have been met in a sustainable way and any required transitional support is in place before agreeing that a trust may leave the RSP.

1.4. The Committee received an update at its 29 June 2023 meeting to consider a report providing an overview of SECAmb's progress in its Improvement Journey to address the findings of the CQC report and the work being undertaken to improve services and exit the RSP. At that meeting the Committee were informed that SECAmb was continuing its Improvement Journey, developing a new Strategy for the Trust and were still working as part of the RSP. Consequently, the Committee requested an update report be brought to it at an appropriate time to provide an update on progress being made towards exiting the RSP.

2. Supporting information

2.1. SECAmb has produced a report for the HOSC attached as **Appendix 1**. The report covers the work the Trust has been doing to improve operational performance to meet NHS England (NHSE) Recovery Support Programme goals and developing a new Trust strategy. The report includes information on:

- **Performance of the 999 service.** There have been improvements in the ambulance response times for all call Categories (1, 2, 3 and 4) and has a mean response time for Category 2 under 30 minutes which is better than many other services and improvements in Category 1 response times.
- **Emergency Call Answering times.** Call answering times have improved from 47 seconds in September 2023 to 10 seconds in January 2024 against a target answering time of 5 Seconds.
- **111 Service Performance.** There have been challenges in call answering and abandonment rates, but there has been positive performance in ambulance disposition, validation, and direct referrals which consistently exceeded NHS England's national averages. The Trust has the lowest number of Emergency Department referrals and highest ambulance validation percentage.
- **Hospitals Handovers.** Overall, hours lost due to handovers have significantly decreased compared to 2022 through work with Acute Trust partners across Sussex, and improvement work is continuing in this area.
- **Urgent and Emergency Care.** New models or work have been piloted through Clinical Coordination Hubs. Pilots show early evidence of reduced conveyance to emergency departments, improved patient outcomes, and enhanced collaboration among health providers.
- **Community Provider Access to Category 3 & 4 Incidents.** Daily 'touchpoint' calls were established in 2023 which allowed community providers to view the Trust's clinical stack of category 3 and 4 incidents and discuss potential direct referrals to Urgent Community Response teams or Virtual Wards. A portal access initiative has recently been launched which allows community trusts to directly access the clinical stack of category 3 and 4 incidents through a secure web browser, enabling the Urgent Community Response team to view and self-refer incidents throughout their operational hours.
- **Improvement Journey (NHSE Recovery Support Programme).** This programme continues to guide the Trust in delivering exceptional patient care through strategic initiatives and concerted efforts which include: Enhanced Quality and Quality Improvement programmes; Responsive Care; Supportive Culture and the Culture Transformation programme; and Sustainable partnerships.
- **Strategy Development Programme.** The Trust is developing a long-term strategy aimed at delivering high-quality, equitable, and efficient care within a sustainable financial framework. This strategy also prioritises enhancing the experience of our people, supporting our partners, and committing to environmental stewardship.

2.2 The purpose of the report is to provide HOSC with further information on the Improvement Journey that SECAmb has undertaken in response to the findings of the CQC inspection report and to gain assurance that improvements have been made to the services provided by the Trust. As part of the last report to the HOSC in June 2023 the Committee were particularly keen to hear about improvements in recruiting and retaining staff and the actions being taken to improve the organisational culture and staff morale, which were seen as key to providing effective services to residents in East Sussex.

3 Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider and comment on the report and decide whether future updates are needed on any of the areas covered in the report.

PHILIP BAKER
Deputy Chief Executive

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

30 JULY 2024

SOUTH EAST COAST AMBULANCE SERVICE NHS FT UPDATE

Report from: Matt Webb, Associate Director, Strategy & Partnerships (SECAmb)

Author: Ray Savage, Strategic Partnerships Manager (SECAmb)

Executive Summary

In 2023 and into 2024, the Trust has prioritised improving operational performance, meeting NHS England (NHSE) Recovery Support Programme goals, and developing a new Trust strategy. Improving response times has been a key focus, and while some of these times still fall short of national targets, the Trust has performed better than many peers, achieving notable successes.

Looking ahead to 2024/25, the Trust will concentrate on implementing its new strategy, developing a new clinical delivery model, and continuing to enhance service quality, response times, and patient outcomes.

1. Performance 999 & 111

1.1. Ambulance services faced significant challenges throughout 2023 and into 2024, with the Trust often operating at its highest levels of escalation (Surge Management Plan [SMP] and Resource Escalatory Action Plan [REAP]), mirroring national trends.

1.2. **Response Times**

1.2.1. Category 2 (C2) Performance

1.2.1.1. The Trust achieved a mean response time under 30 minutes, outperforming several peers (Appendix A).

1.2.2. Categories 1, 3, and 4

1.2.2.1. Although these categories did not meet national targets, response times improved over the past six months and were frequently within NHS England's mean times when benchmarked against other services (Appendix B).

1.3. **Factors Improving Response Times**

1.3.1. Whole Time Equivalent (WTE) frontline staffing has been increased, providing more hours (Appendix C).

1.3.2. There have been focused efforts on managing abstractions, specifically sickness and training schedules.

1.3.3. Adhering to NHS England's protocol for Category 3 and 4 incidents to be placed into a clinical queue for validation by a senior clinician has resulted in increased Hear and Treat (H&T) rates from below 10% to 14% over six months (Appendix D).

1.3.4. Collaboration with acute hospital partners has improved ambulance handover and turnaround processes.

1.4. **Emergency Call Answering**

1.4.1. Call answer times significantly improved from 47 seconds in September 2023 to 10 seconds in January 2024 (against a target of 5 seconds) due to focused

recruitment and retention, along with the new combined Emergency Operations Centre in Gillingham, Kent (Appendix E).

1.4.2. Difficulties in maintaining workforce levels have been observed at the Trust's 'West' Emergency Operations Centre in Crawley due to local employment competition.

1.5. **111 Service Performance**

1.5.1. There have been challenges in call answering and abandonment rates, however, positive performance in ambulance disposition validation and direct referrals.

1.5.2. Despite a consistent call volume from June to November 2023 and a seasonal uplift in December, the service fell short of the 95% target for calls answered within 60 seconds, partly due to a 20% gap in Health Advisor WTEs (Appendix F).

1.5.3. High levels of clinical contact, reduction in ambulance dispositions, and high Direct Access Booking rates have consistently exceeded NHS England's national averages, with the service recognised as having the lowest number of ED referrals and highest ambulance validation percentage (Appendix G).

2. Handover

2.1. **Engagement with Acute Trust Partners**

2.1.1. The Trust continues to work with acute Trust partners across Sussex to manage ambulance handover delays and improve crew turnaround times. Strategic engagement with the Integrated Care Board (ICB) aims to enhance patient flow through hospitals and into community services. Overall, hours lost due to handovers have significantly decreased compared to 2022 (Appendix H).

2.2. **Key Hospitals for East Sussex**

2.2.1. Conquest Hospital

2.2.2. Eastbourne District General Hospital

2.2.3. Royal Sussex County Hospital

2.2.4. Tunbridge Wells Hospital

2.3. **University Hospitals Sussex Update**

2.3.1. In December 2023, University Hospitals Sussex provided an update on efforts to reduce handover delays at the Royal Sussex County Hospital, including challenges related to estates and patient discharge. Phase one of the acute floor reconfiguration is a 12-month project, expected to be completed by summer 2024.

2.4. **ECIST Support and Joint Improvement Group**

2.4.1. NHS England's Emergency Care Intensive Support Team (ECIST) has supported reviews at RSCH. The Joint Improvement Group, with representatives from RSCH and SECAmb, meets fortnightly to address day-to-day operational challenges.

2.5. **Flow Improvement Workshop**

2.5.1. A recent workshop at the Royal Sussex County Hospital, attended by health and social care partners from Sussex, focused on enhancing short and long-term strategies to improve patient flow, particularly in the Brighton and Hove area.

3. Urgent and Emergency Care – Clinical Coordination Hubs

3.1. **New Models of Working**

3.1.1. The Trust has been piloting multidisciplinary Integrated Urgent Care hubs in Kent, supported by ambulance Advanced Paramedic Practitioners and clinicians from Urgent Community Response (UCR), acute, mental health, and primary care services.

3.2. Pilot Hubs

3.2.1. East Kent (Ashford) Hub: This 'pre-dispatch' model focuses on 999 calls coming into the Trust with real-time assessment and coordinated clinical responses.

3.2.2. West Kent (Maidstone) Hub: This 'post-dispatch' model contacts ambulance crews at the patient's side to provide a coordinated clinical response and identify appropriate referral pathways if ED transport is not necessary.

3.3. Early Results

3.3.1. Both pilots show early evidence of reduced conveyance to emergency departments, improved patient outcomes, and enhanced collaboration among health providers.

3.4. Evaluation and Expansion

3.4.1. A working group of Subject Matter Experts (SMEs) is reviewing the success and sustainability of the hubs, ensuring alignment with the Trust's strategic direction and the ICB's Joint Forward Plan. Discussions are underway with the ICB and partner providers to develop similar hubs across Sussex to support resilience in Winter 2024/25.

4. Community Provider Access to Category 3 & 4 Incidents

4.1. Daily Touchpoint Calls

4.1.1. The Trust, in collaboration with commissioners, NHS England, and community partner providers, established daily 'touchpoint' calls in 2023. These calls allowed community providers to view the Trust's clinical stack of category 3 and 4 incidents and discuss potential direct referrals to Urgent Community Response teams or Virtual Wards. While successful, the 30-minute window limited the approach's full potential.

4.2. Portal Access Initiative

4.2.1. Building on the success of the touchpoint calls, the Trust recently launched a portal access initiative. This allows community trusts to directly access the clinical stack of category 3 and 4 incidents through a secure web browser, enabling the Urgent Community Response team to view and self-refer incidents throughout their operational hours.

4.3. Expansion and Impact

4.3.1. Sussex was the first ICS to go live with portal access, followed by Kent, Surrey, and Northeast Hampshire.

4.3.2. This initiative enhances the ability to provide timely and appropriate support for patients in the right setting.

5. Improvement Journey (NHSE Recovery Support Programme)

5.1. Programme Overview

5.1.1. The Trust's Improvement Journey Programme began in 2022 following Care Quality Commission reports published in July and October. This programme

continues to guide the Trust in delivering exceptional patient care through strategic initiatives and concerted efforts.

5.2. **Key Improvements**

5.2.1. Significant improvements have been made across key areas of the organisation:

5.2.1.1. Enhanced Quality and Responsiveness

5.2.1.2. Supportive Culture

5.2.1.3. Sustainable Partnerships

5.3. **Strategic Pillars**

5.3.1. Quality Improvement

5.3.1.1. QI has been widely applied across existing practices and new pilots. Through 2023/24.

5.3.1.2. Initiatives include future-proofing medicines management, responding to patient feedback, and robust risk identification to foster a proactive response culture and continuous improvement.

5.3.2. Responsive Care

5.3.2.1. Patient safety remains paramount throughout the Trust.

5.3.2.2. Operational Efficiency: Optimised on-scene time, expanded remote response capabilities, and improved dispatch processes and resource allocation to enhance responsiveness has strengthened the trust and reliability of our services.

5.3.3. People and Culture

5.3.3.1. The Culture Transformation programme continues to promote a culture of openness, transparency, and accountability.

5.3.3.2. Comprehensive leadership development training and empowerment of leaders is fostering improved trust and respect.

5.3.3.3. A focus on wellbeing and professional development, zero tolerance for poor behaviours, and encouraging staff to voice concerns ensures a supportive working environment.

5.3.3.4. There has been significant progress in the Trust's speak-up culture, strengthened by the Freedom to Speak Up (FTSU) framework and enhanced training.

5.3.3.5. Improvements within the NHS Staff Survey 2023 were noted in person-centred care (+8%), motivation (+5%), and willingness to speak up about concerns (+8%) (Appendix J).

5.3.3.6. The Trust is a signatory on the NHS Sexual Safety Charter.

5.3.3.6.1. As a signatory, the Trust has committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.

5.3.3.6.2. We aim to implement the 10 principles during Q1.

5.3.4. Sustainability and Partnerships

5.3.4.1. Prioritising frontline care and reducing carbon footprint is being achieved through resource optimisation:

5.3.4.2. The Trust remains committed to patient-centric pathways and collaborative partnerships, working with ICS partners.

5.3.4.3. A new Five-Year Plan outlines a trajectory toward delivering sustainable, high-quality care, ensuring a clear future direction.

6. Strategy Development Programme

6.1. Overview

6.1.1. In early 2023, the Trust embarked on developing a long-term strategy aimed at delivering high-quality, equitable, and efficient care within a sustainable financial framework. This strategy also prioritises enhancing the experience of our people, supporting our partners, and committing to environmental stewardship.

6.2. Guiding Principles

6.2.1. Clinical Leadership and Patient-Centred Approach: The strategy has been co-designed with our patients, people, and partners, and grounded in evidence and practical implementation.

6.3. Strategy Programme Phases

6.3.1. Phase 1: Diagnose & Forecast

6.3.1.1. The Trust has worked to understand the current environment, challenges, and stakeholder perspectives, anticipating future needs to build a compelling case for change.

6.3.2. Phase 2: Generate Options & Prioritise

6.3.2.1. In Q3 (2023/24), strategic options were formulated and evaluated, with the Trust Board selecting the preferred strategic direction based on robust evaluation criteria.

6.3.3. Phase 3: Deliver & Evolve

6.3.3.1. This phase further developed the selected strategic option, identifying required capabilities; establishing delivery and evaluation structures to ensure ongoing relevance and success.

6.4. Commitment to Engagement

6.4.1. Engaging with our people, patients, and partners to inform the clinical direction, diagnostic assessments, and integrated care systems' strategic priorities has been fundamental.

6.5. Case for Change

6.5.1. Population growth, ageing, and complexity of health conditions will lead to a 15% growth in patient demand over the next five years.

6.5.2. The existing service model is insufficient to address these challenges, adversely impacting patient outcomes and staff well-being.

6.5.3. Maintaining the status quo is unsustainable, requiring an unrealistic workforce expansion. Radical change is therefore essential for future-proofing services and safeguarding patient and staff welfare.

6.6. Strategic Options and Selection

6.6.1. Extensive engagement has supported the Trust’s understanding of key issues and co-designing the three strategic options.

6.6.2. Preferred Strategy Direction (February 2024):

6.6.2.1. Addresses diverse patient needs with tailored end-to-end care.

6.6.2.2. Promotes effective collaboration with health and care partners, positioning the Trust as a system leader in UEC.

6.6.2.3. Empowers staff with the necessary skills, support, and career opportunities.

6.6.2.4. Builds on existing strengths for a radical yet achievable service model change.

6.7. **Next Steps**

6.7.1. The implementation stage (2024/25) involves:

6.7.1.1. Executing the strategic delivery framework with a refined vision and defined outcomes.

6.7.1.2. Detailing plans for workforce development, digital innovation, clinical design, and a clear execution roadmap.

6.7.1.3. Officially unveiling the new strategy in the first quarter of 2024, marking a new era of service excellence and sustainability.

7. Patient Safety Incident Response Framework

7.1. **Framework Launch**

7.1.1. In January 2024, the Trust implemented NHS England's Patient Safety Incident Response Framework (PSIRF).

7.2. **Framework Objectives**

7.2.1. PSIRF replaces the current Serious Incident Framework, enabling the Trust to develop more effective responses to patient safety incidents. The primary aim is to enhance learning and improve patient safety.

7.3. **Leadership and Oversight**

7.3.1. A newly created senior position, the Deputy Director for Patient Safety and Care, heads the PSIRF team, ensuring dedicated leadership and oversight.

8. Recommendations

8.1. **The committee is requested to:**

8.1.1. Note the update provided.

8.1.2. Provide comments and feedback on the contents of the report.

Lead Officer Contact

Ray Savage, Strategic Partnerships Manager (SECAmb)

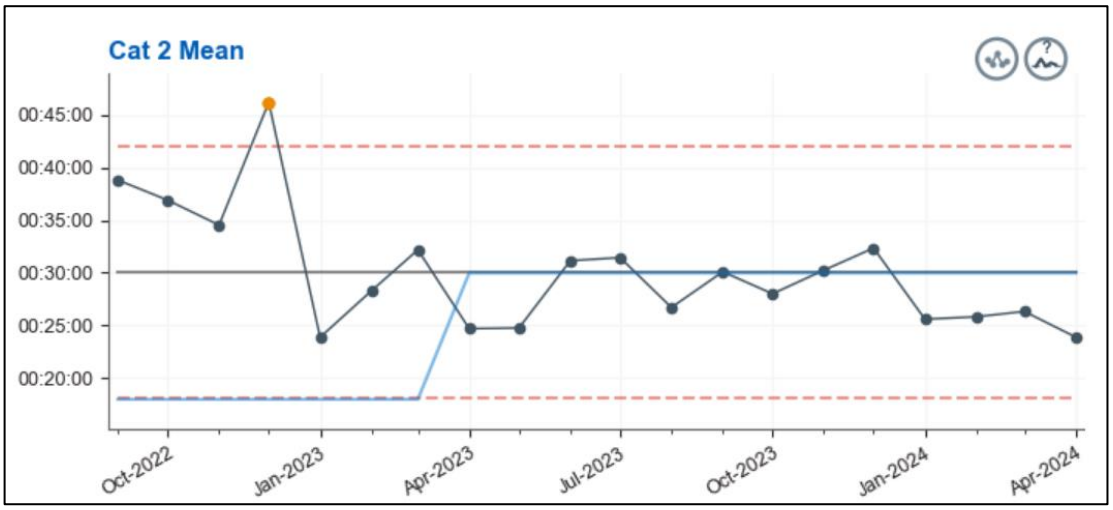
Background papers

None

Appendices

Appendix A

Category 2 Performance - Mean



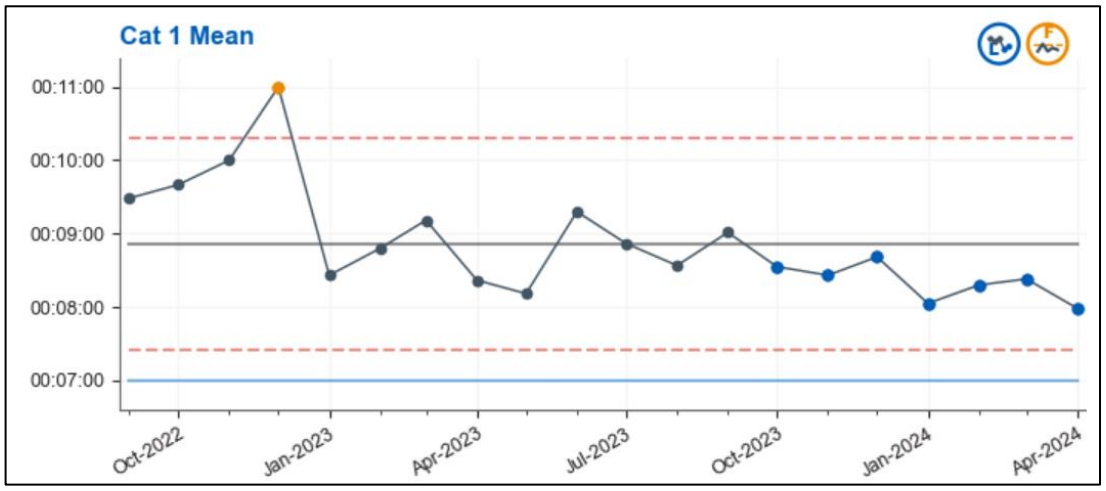
National Ambulance Quality Indicators – March 2024

	C2	Mean
	England	00:33:50
1	North West	00:24:22
2	South East Coast	00:26:20
3	Yorkshire	00:29:28
4	Isle of Wight	00:30:24
5	South Central	00:31:49
6	West Midlands	00:33:01
7	London	00:33:11
8	North East	00:33:20
9	East of England	00:39:06
10	East Midlands	00:43:06
11	South Western	00:45:54

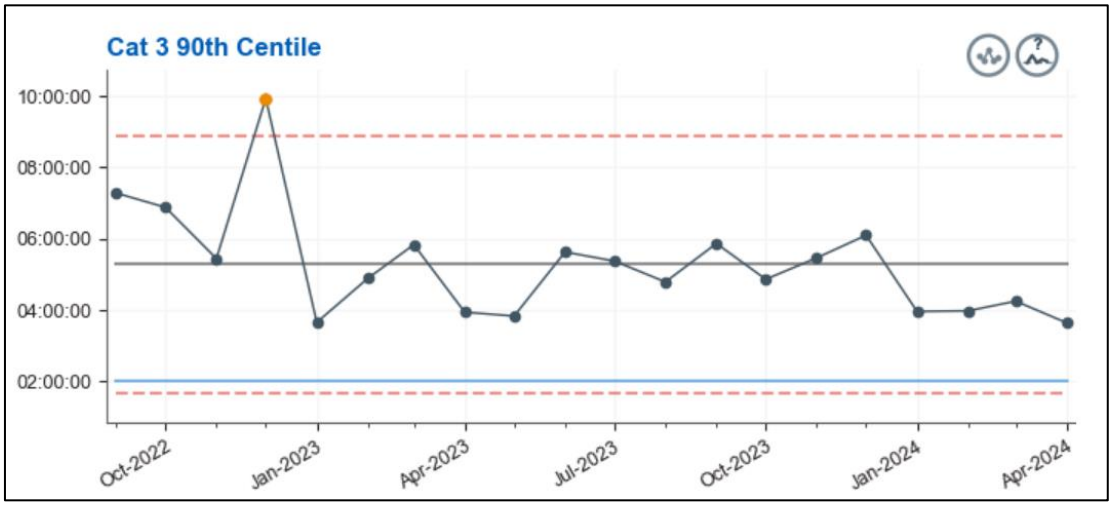
	C2	90th
	England	01:11:51
1	North West	00:48:32
2	South East Coast	00:52:44
3	South Central	01:02:30
4	Yorkshire	01:05:52
5	North East	01:07:35
6	Isle of Wight	01:08:31
7	West Midlands	01:13:01
8	London	01:14:05
9	East of England	01:24:10
10	East Midlands	01:31:19
11	South Western	01:36:54

Appendix B

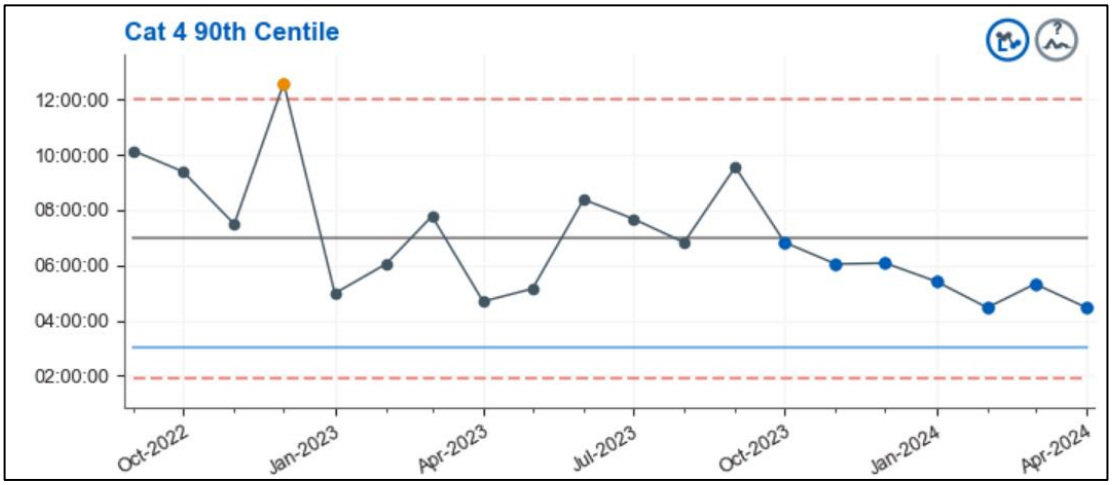
Category 1 Performance - Mean



Category 3 Performance – 9oth Percentile



Category 4 Performance – 90th Percentile



National Ambulance Quality Indicators – March 2024

	C1	Mean
	England	00:08:20
1	North East	00:06:58
2	London	00:07:11
3	North West	00:07:56
4	Yorkshire	00:08:07
5	West Midlands	00:08:14
6	South East Coast	00:08:23
7	South Central	00:08:38
8	East of England	00:08:49
9	Isle of Wight	00:09:07
10	East Midlands	00:09:13
11	South Western	00:09:53

	C1	90th
	England	00:14:48
1	London	00:12:14
2	North East	00:12:18
3	North West	00:13:16
4	Yorkshire	00:14:01
5	West Midlands	00:14:31
6	South East Coast	00:15:30
7	South Central	00:15:36
8	East Midlands	00:16:25
9	East of England	00:16:28
10	Isle of Wight	00:17:21
11	South Western	00:18:28

	C3	Mean
	England	02:03:47
1	London	01:05:48
2	Isle of Wight	01:18:04
3	Yorkshire	01:31:48
4	North East	01:41:07
5	North West	01:55:08
6	South East Coast	01:55:18
7	East of England	01:57:18
8	South Western	02:09:32
9	South Central	02:42:05
10	West Midlands	02:53:47
11	East Midlands	03:00:33

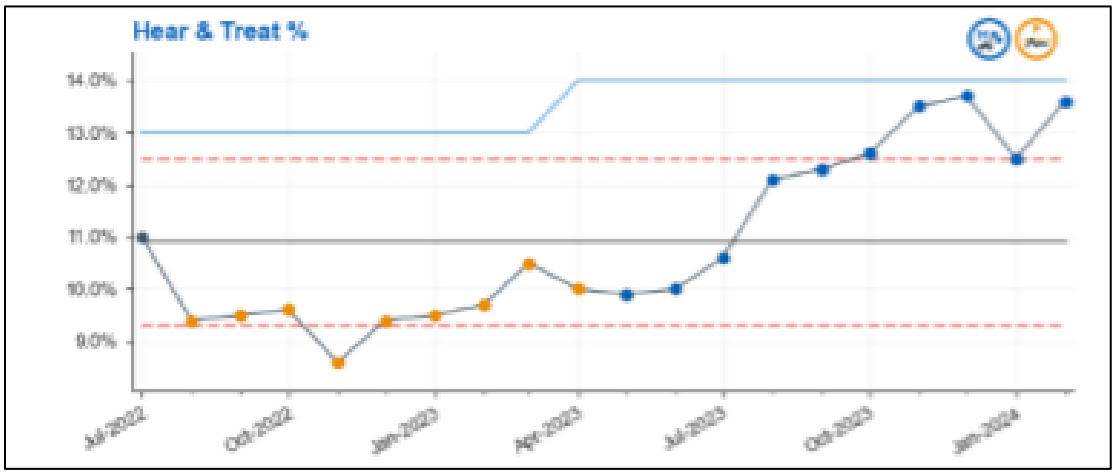
	C3	90th
	England	04:52:42
1	London	02:42:55
2	Isle of Wight	03:01:06
3	Yorkshire	03:22:46
4	North East	03:49:43
5	North West	04:10:23
6	South East Coast	04:14:30
7	East of England	04:32:13
8	South Western	05:33:13
9	South Central	06:12:13
10	East Midlands	07:07:24
11	West Midlands	07:30:30

	C4	Mean
	England	02:29:48
1	Yorkshire	01:37:15
2	North East	01:37:44
3	London	02:00:43
4	Isle of Wight	02:04:28
5	North West	02:22:40
6	South East Coast	02:23:49
7	East of England	02:42:18
8	East Midlands	02:44:04
9	South Western	02:48:55
10	South Central	03:29:03
11	West Midlands	03:41:22

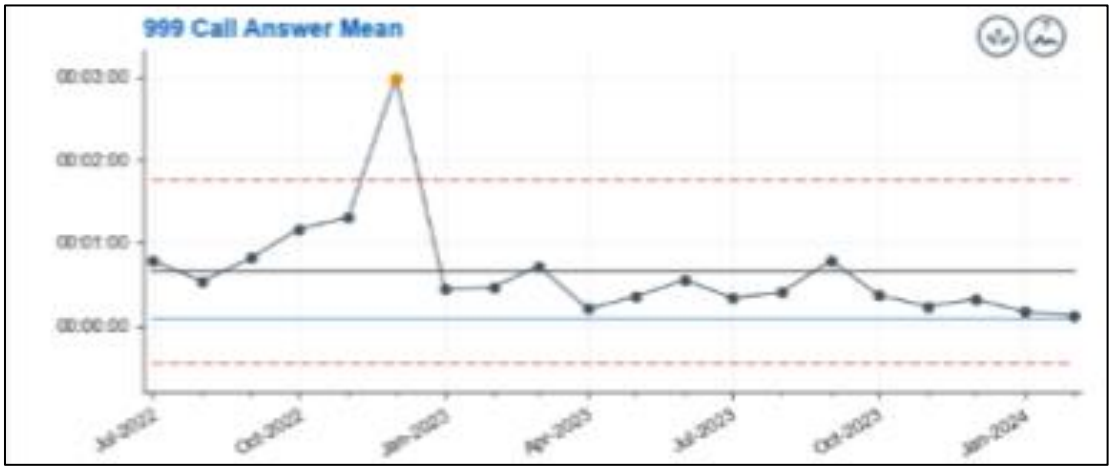
	C4	90th
	England	06:02:39
1	Yorkshire	03:34:40
2	North East	03:46:03
3	London	04:05:39
4	Isle of Wight	04:17:48
5	South East Coast	05:19:21
6	North West	05:32:43
7	East Midlands	06:19:37
8	East of England	07:24:13
9	South Western	07:51:06
10	South Central	08:22:27
11	West Midlands	11:15:08

Appendix C – 999 Frontline Hours Provided

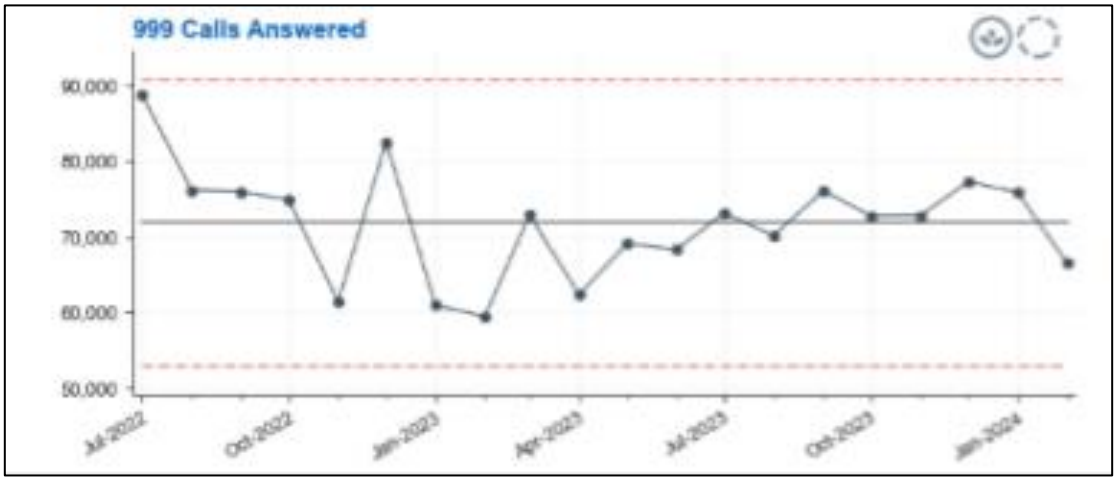
Appendix D – Hear and Treat



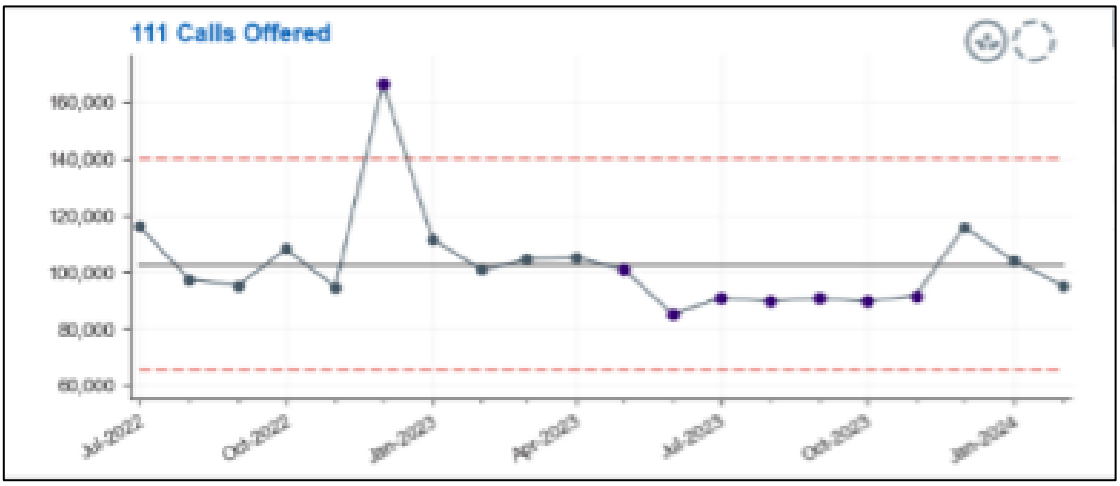
Appendix E – 999 Call Answering – Mean



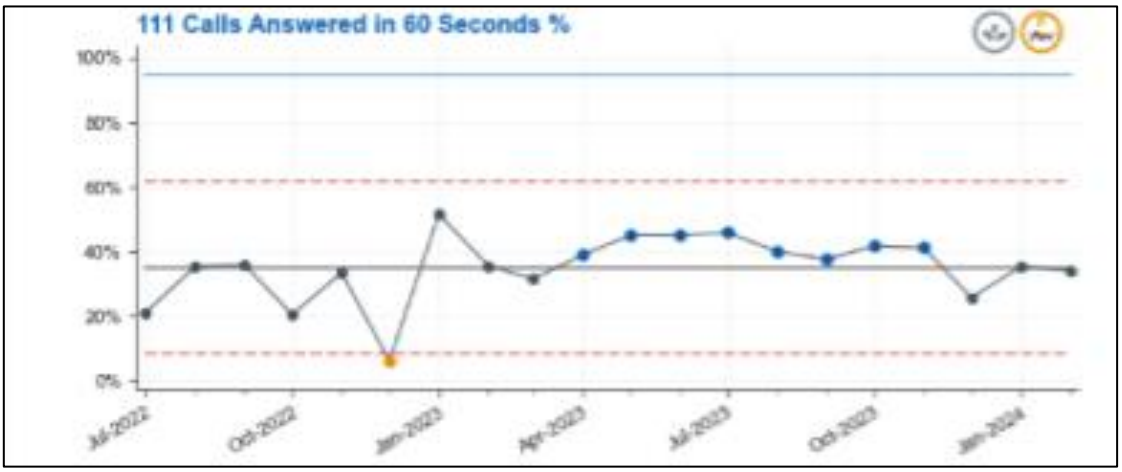
999 Calls Answered



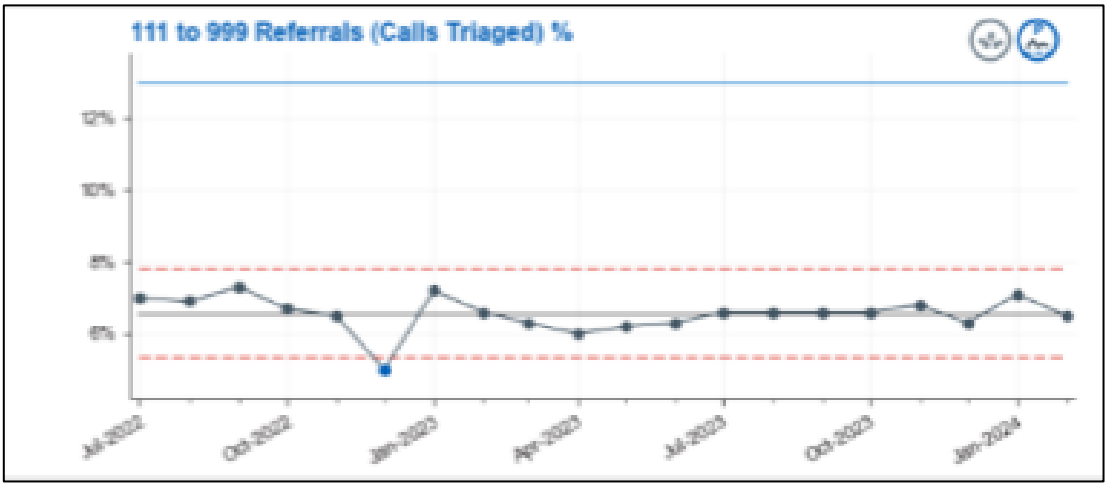
Appendix F – 111 Calls Offered



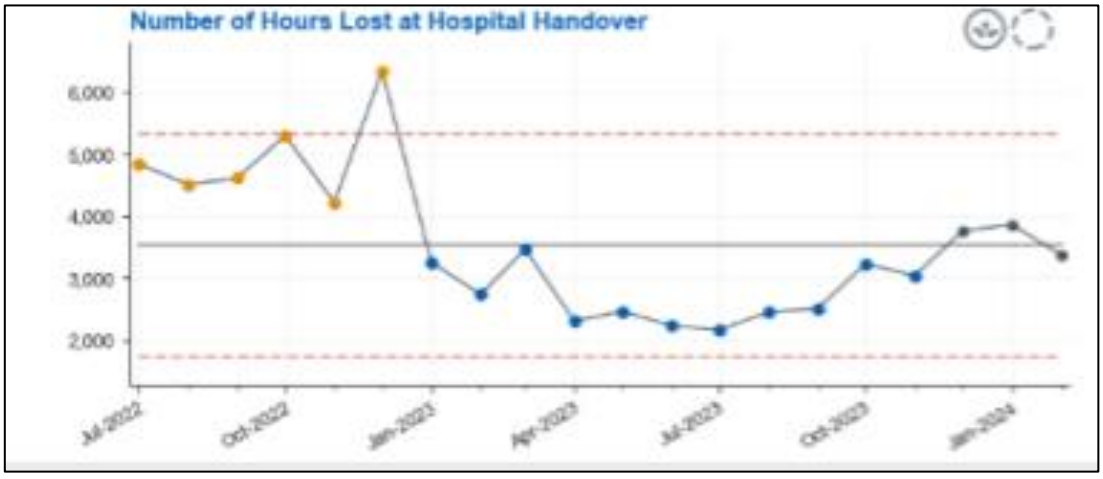
111 Calls Answered in 60 Seconds



Appendix G – 111 to 999 Referrals

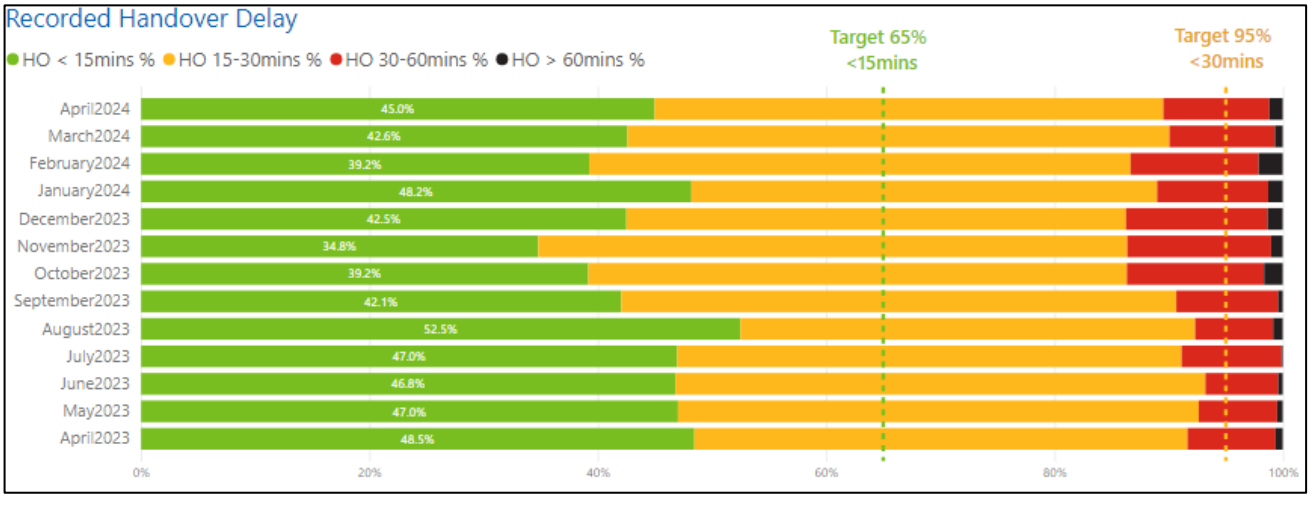


Appendix H – Number of Hours Lost at Hospital Handover

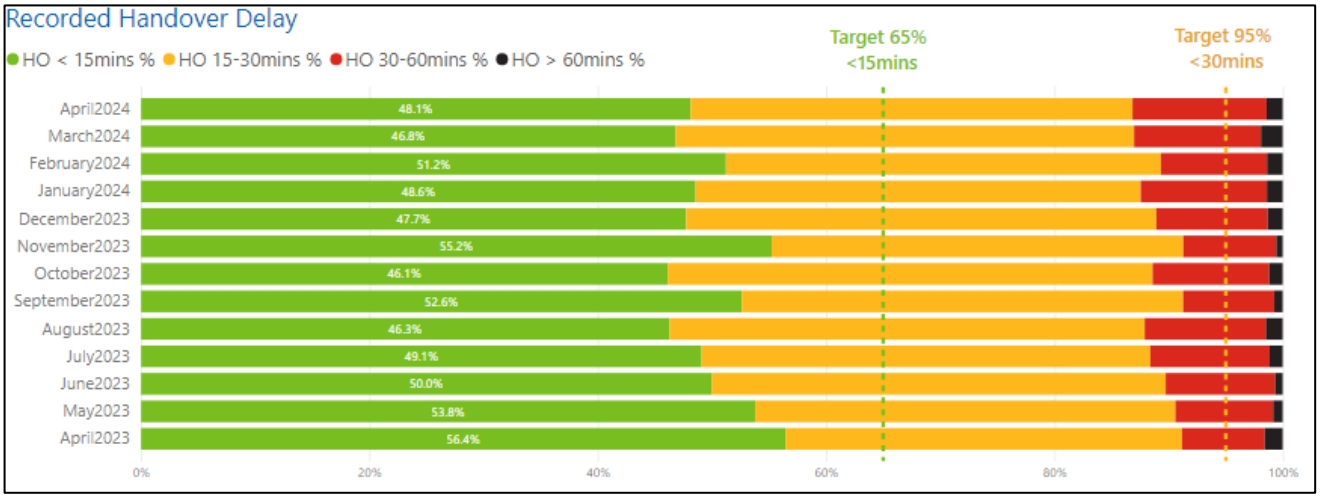


Appendix I – Hospital Handover Delays – April 2023 to April 2024

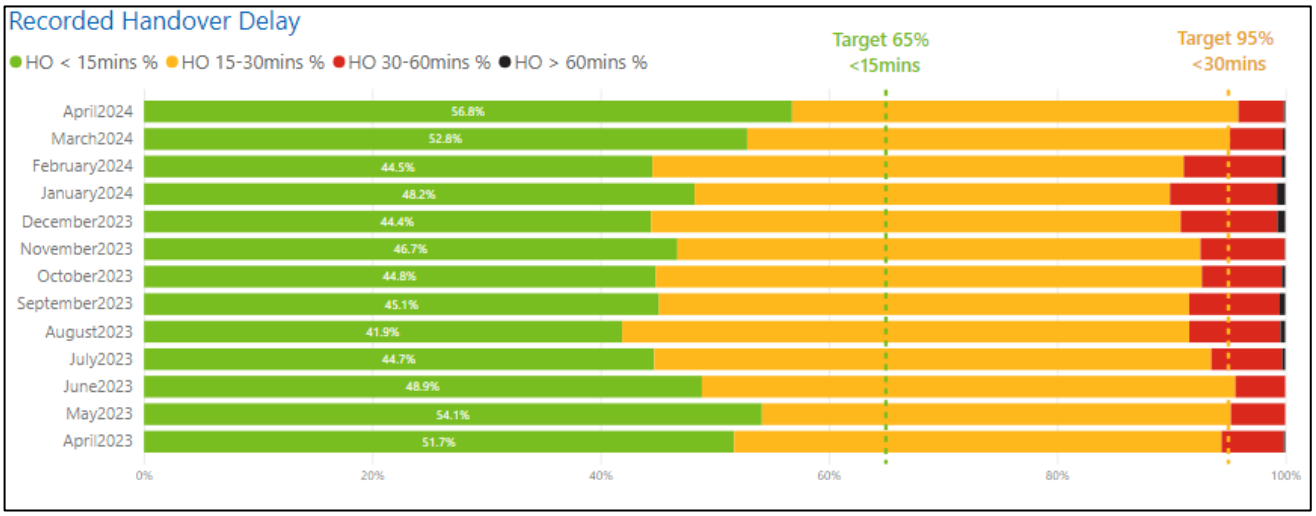
Conquest Hospital



Eastbourne District General Hospital

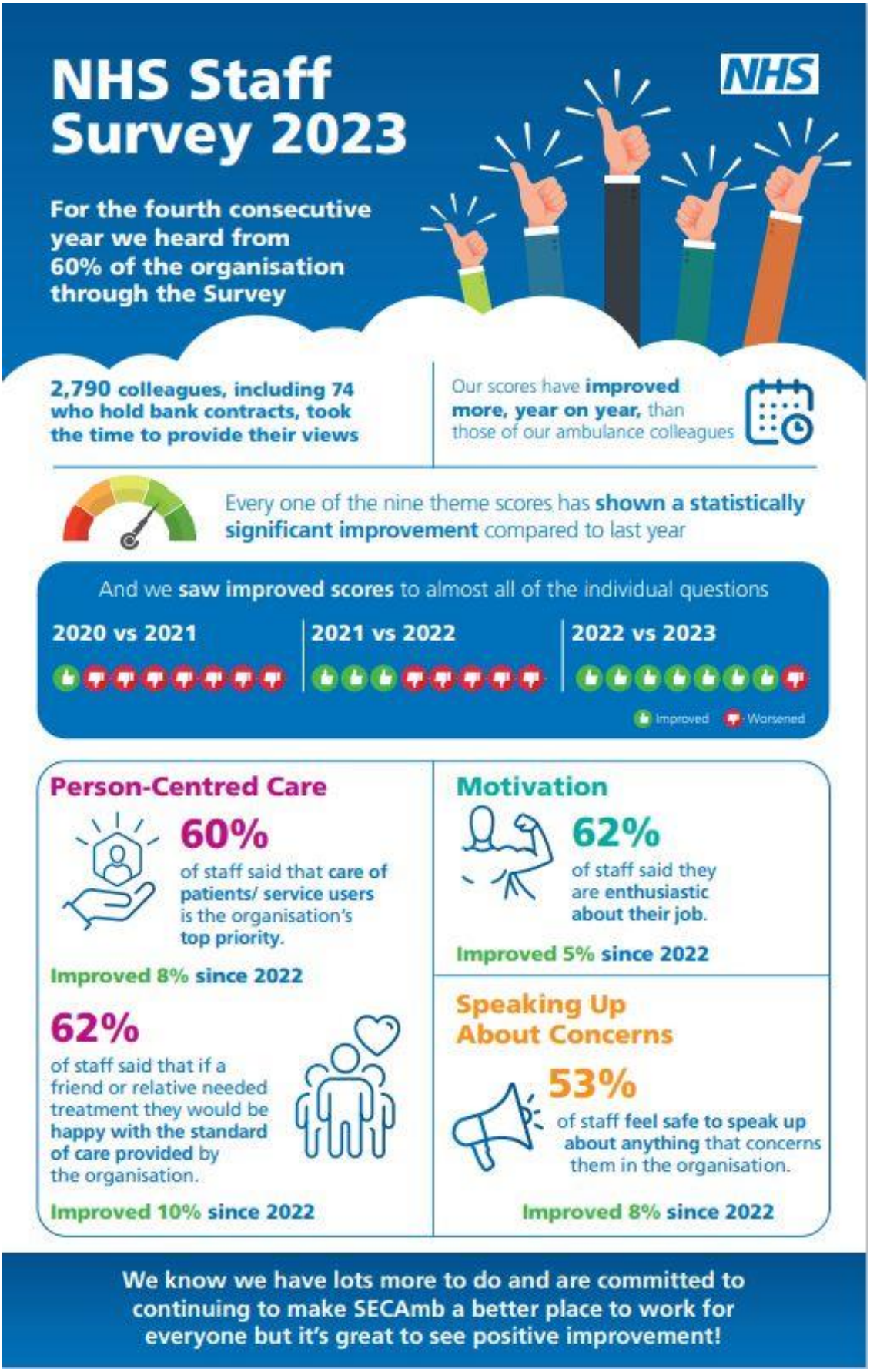


Tunbridge Wells Hospital



Royal Sussex County Hospital

Appendix J – NHS Staff Survey 2023 – Highlights



Health Overview and Scrutiny Committee (HOSC) – Work Programme

Current Scrutiny Reviews		
Title of Review	**Detail**	**Proposed Completion Date**
To be agreed	To be agreed	

Initial Scoping Reviews		
Subject area for initial scoping	**Detail**	**Proposed Dates**
To be agreed.	To be scheduled.	
List of Suggested Potential Future Scrutiny Review Topics		
Suggested Topic	**Detail**	
To be agreed.		

Scrutiny Reference Groups		
Reference Group Title	**Subject Area**	**Meetings Dates**
Sussex Partnership NHS Foundation Trust (SPFT) HOSC liaison group	Regular informal meetings with SPFT and other Sussex HOSC Chairs and Vice Chairs to consider the Trust's work and other mental health issues. Membership: Cllrs Belsey and Robinson	Last meeting: 31 October 2022 Next meeting: September 2024
Reports for Information		
Subject Area	**Detail**	**Proposed Date**
Inappropriate behaviour of NHS staff	Following media reports that there were national problems with inappropriate staff behaviour in the NHS, to provide a briefing on the extent of the issue in East Sussex and what is being done to address problems if they were known to exist.	2024
Training and Development		
Title of Training/Briefing	**Detail**	**Proposed Date**
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 2024
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 2025

Future Committee Agenda Items		Witnesses
3 October 2024		
Access to Primary Care Services – GPs and Primary Care Network (PCN) services	An update report on the working being undertaken to improve access to GP services and appointments in East Sussex, including Primary Care Network (PCN) performance and services provided, including enhanced hours services.	Representatives of NHS Sussex.
Access to NHS Dentistry Services	An update report on the progress being made to improve access to NHS Dentistry services in East Sussex following the delegation of commissioning responsibilities from NHS England to NHS Sussex.	Representatives of NHS Sussex / NHS England SE. Healthwatch East Sussex.
Missed NHS appointments	A report on missed NHS appointments across East Sussex, the causes of these, and work being done to mitigate them.	Representatives from NHS Sussex
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
12 December 2024		
NHS Sussex Winter Plan	A report on the NHS Sussex Winter Plan 2024/25 and associated risks covering the preparations that are being made for the coming peak demand winter season.	Representatives from NHS Sussex, ESHT and other Trusts
Paediatric Service Model, Eastbourne District General Hospital (EDGH)	To receive a further update report on the implementation of the changes to paediatric services at EDGH and to consider East Sussex Healthcare Trust's (ESHT) implementation of the recommendations from HOSC's Review of the changes to paediatric services.	Representatives from ESHT
UHSx CQC report and Hospital Handovers at Royal Sussex County Hospital (RSCH)	To receive an update report on University Hospitals Sussex NHS Foundation Trust's (UHSx) response to the August 2023 CQC inspection report (with a particular focus on the actions being taken at Royal Sussex County Hospital on patient safety), and a further update on the improvements being made to tackle hospital handovers and ED waiting times at the RSCH.	Representatives from UHSx and SECAmb

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
6 March 2025		
Ophthalmology Transformation Programme	An update report on the implementation of the ESHT Ophthalmology Transformation Programme including the development of services at Bexhill Hospital and the implementation of HOSC recommendations on transport and access measures made as part of the review of these transformation programmes	Representatives of ESHT and NHS Sussex.
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		
Hospital Discharge and Admission Prevention	To receive a report on the work being undertaken to improve hospital discharge including the models being elsewhere, and the work on virtual wards and other measures to prevent hospital admissions.	Representatives of ESHT and NHS Sussex.
Non-Emergency Patient Transport Service (NEPTS)	To receive an update report on the implementation and mobilisation of the new contract for Non-Emergency Patient Transport Services (NEPTS) in Sussex. *Note: Report to by scheduled for June 2025.*	Representative from NHS Sussex.
Cardiology transformation Programme	An update report on the implementation of the ESHT Cardiology transformation Programme including the transport and access recommendations and measures made as part of the review of this transformation programme. *Note: Timing is dependent on ESHT implementation timescales.*	Representatives of ESHT and NHS Sussex.
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

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 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
Specialised Children's Cancer Services – Principal Treatment Centres (PTCs)	To receive an update report from NHS England, London and South East on implementation of the changes to the Specialised Children's Cancer Services – Principal Treatment Centre located in south London which serves East Sussex. *Note: timing of the report will be dependent on the implementation of the changes which are not due until 2026 at the earliest.*	NHS England, London and South East

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