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

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

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

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Recommendations

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

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

Background

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

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

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

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

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

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

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

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

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

1. The proposals for the future of cardiology

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

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

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

Current Service provision

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

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

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

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

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

[3] Ibid. and PCBC p.32

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

[4]

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

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

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

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

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

[4] PCBC p.31

Number of patients using service

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

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

[5]

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

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

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

[6]

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

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

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

Case for Change

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

Meeting national standards

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

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

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

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

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

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[7] Ibid.

[8] Ibid.

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

[10] PCBC p,16

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

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

Workforce challenges

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

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

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

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

[11] 21st April meeting

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

[13] 21 April meeting

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

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

Comments of the Board

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

[15] PCBC p.31

[16] Ibid p.34

[17] PCBC p.39

[18] PCBC p.35

Proposed options for reconfiguring cardiology

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

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

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

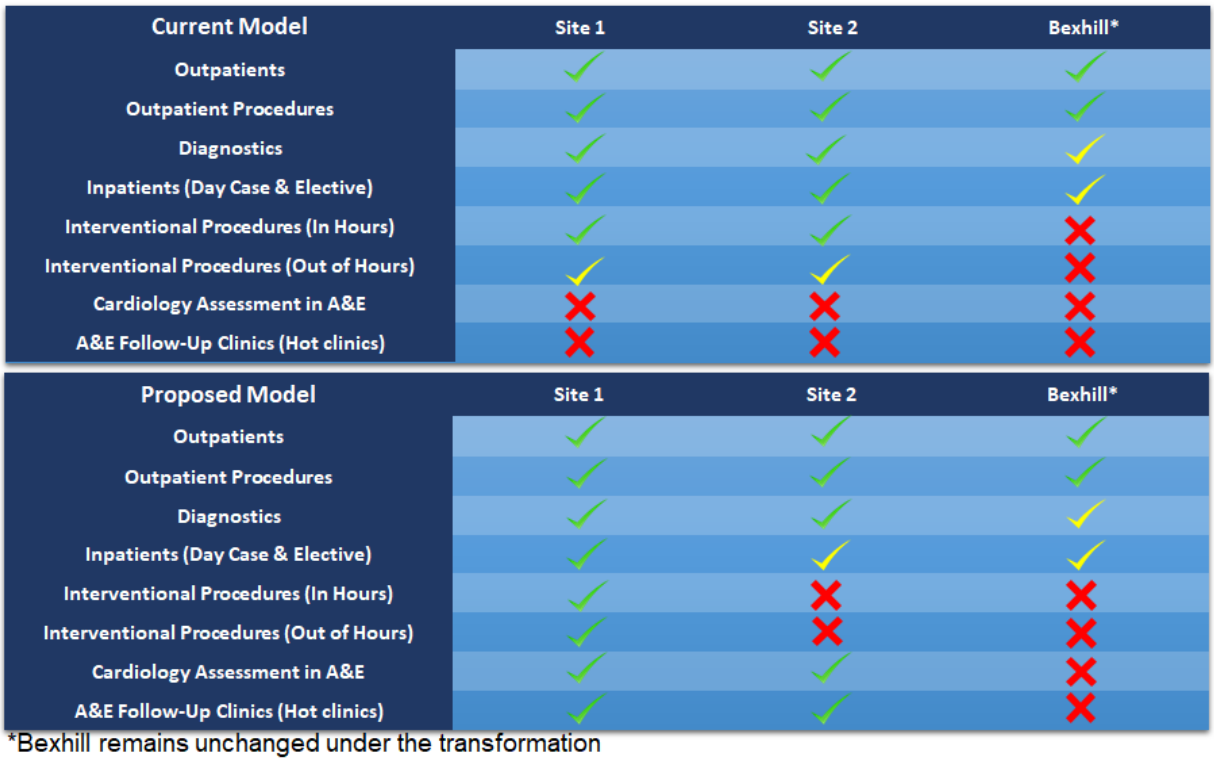
- Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services at **Eastbourne District General Hospital**, with acute outpatients and diagnostic services remaining at **both sites**; alongside establishment of Cardiac Response Team in A&E and hot clinics providing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

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

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

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

[19] 21st April meeting



Current Model	Site 1	Site 2	Bexhill*
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients (Day Case & Elective)	✓	✓	✓
Interventional Procedures (In Hours)	✓	✓	✗
Interventional Procedures (Out of Hours)	✓	✓	✗
Cardiology Assessment in A&E	✗	✗	✗
A&E Follow-Up Clinics (Hot clinics)	✗	✗	✗

Proposed Model	Site 1	Site 2	Bexhill*
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients (Day Case & Elective)	✓	✓	✓
Interventional Procedures (In Hours)	✓	✗	✗
Interventional Procedures (Out of Hours)	✓	✗	✗
Cardiology Assessment in A&E	✓	✓	✗
A&E Follow-Up Clinics (Hot clinics)	✓	✓	✗

*Bexhill remains unchanged under the transformation

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

Number of patients affected

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

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

[21]

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

[20] 27 May presentation

[21] PCBC p.41

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

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

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

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

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

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

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

[22] 24 May meeting

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

Benefits of new service model

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

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

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

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

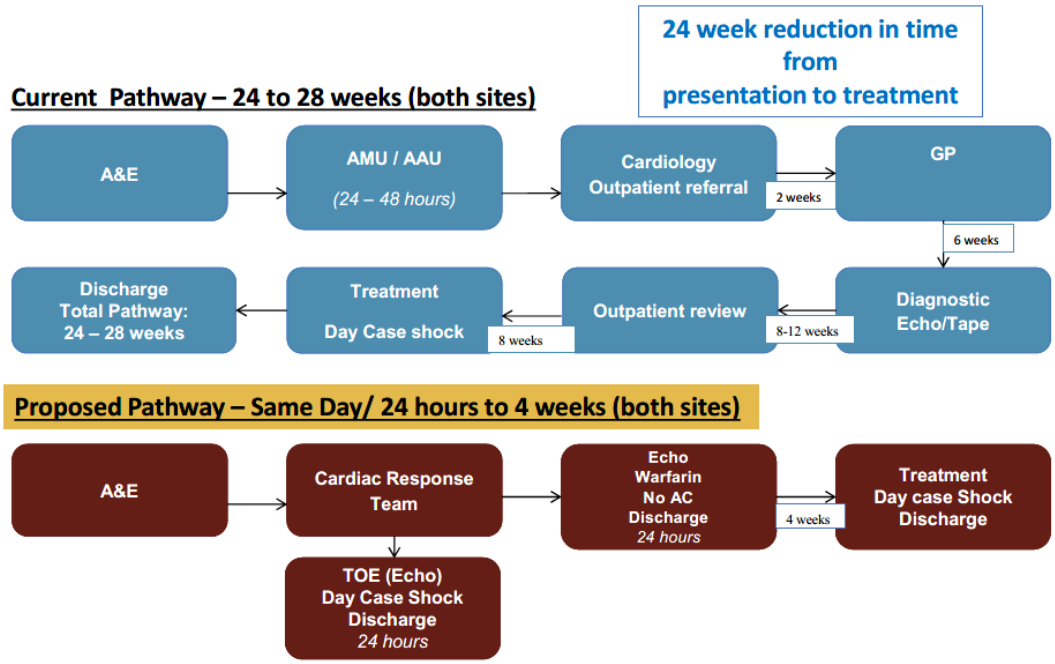
- The addition of a 'front end' model and 'hot clinics', increasing access to specialist opinion
- The consolidation of interventional services on one site.

Benefits of the Front End Model

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

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

[23] ibid



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

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

[24]

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

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

[24] Presentation 27th may

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

Front end model Pilot

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

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

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

Benefits of consolidation of interventional sites

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

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

55. The advantages of a single site are:

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

[25] PCBC

[26] PCBC p.39

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

Ambulance transfers

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

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

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

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

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

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

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

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[27] HOSC report 2nd Dec

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

[29] PCBC p.44

[30] Ibid and 21 april minutes

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

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

Views of ambulance trust (SECAmb)

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

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

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

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

Views of the Clinical Senate

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

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

GP views

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

[32] Clinical Senate report

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

Views of Healthwatch

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

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

Views of stakeholder groups

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

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

Views of staff

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

[33] 24th may meeting

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

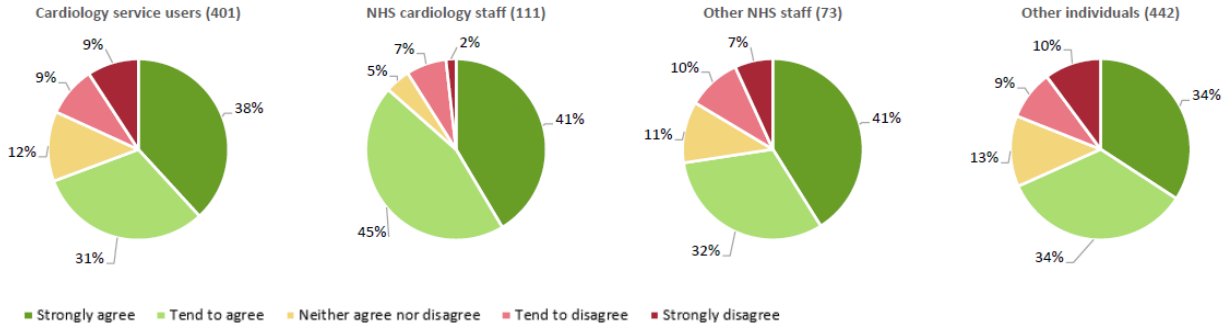
Public consultation

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

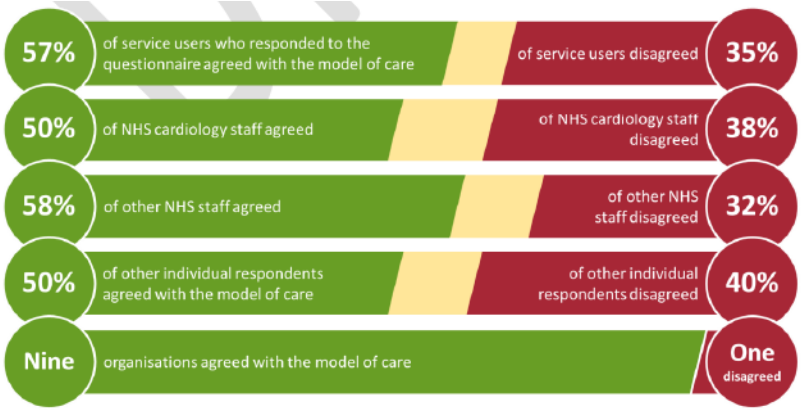
74. Opinion Research Services (ORS) provided an analysis of the consultation and the Board received a presentation summarising the findings.

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

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



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



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

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

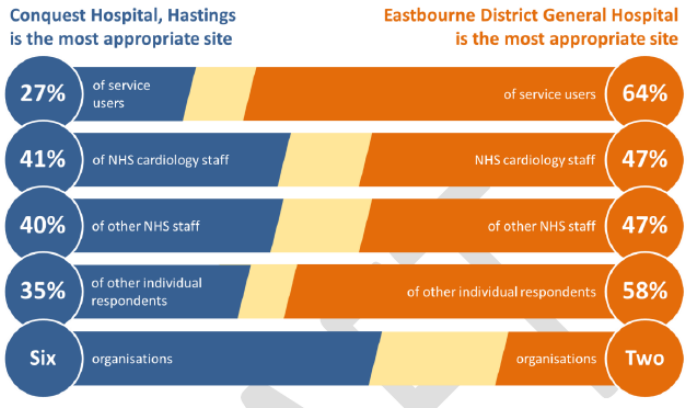
- The potential to improve efficiency and quality of care.
- The proposed introduction of Cardiac Response Teams in both emergency departments was viewed positively by service users and organisations.
- Agreement that continued access to 'local' services for most cardiology service users would be positive.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

79. Reasons for disagreement centred around:

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

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

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



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

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

[35] ibid

[36] Minutes of 24th may meeting

37

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

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

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

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

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

Comments of the Board

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

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

[37] Ibid.

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

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

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

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

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

Recommendation 1

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

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

Issues with the new service that should be addressed

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

Workforce challenges

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

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

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

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

Comments of the Board

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

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

[38] PCBC p.91

[39] PCBC p.87

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

Recommendation 2

The Board recommends:

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

Travel and access

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

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

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

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

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

[40] 24 May meeting

Comments of the Board

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

Recommendation 3

The Board recommends:

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

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

Timelines for implementation and loss of specialist services

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

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

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

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

Comments of the Board

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

Recommendation 4

The Board recommends:

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

Summary Comments

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

Appendix 1

Review Board meeting dates

The Review Board met on:

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

Witnesses

East Sussex Clinical Commissioning Group (CCG)

Jessica Britton, Executive Managing Director

Fiona Streeter, Associate Director of Commissioning and Partnerships

Dr Suneeta Kochhar, GP Clinical Lead representative

East Sussex Healthcare NHS Trust (ESHT)

Richard Milner, Director of Strategy

Michael Farrer, Strategic Transformation Manager

Dr Simon Merritt, Chief of Service for Medicine

Cardiology Staff

Professor Nik Patel, Clinical Lead for Cardiology

Hazel Church, Lead Nurse for Cardiology

Kerrie Nyland, Matron CCU and Cath Labs

Rick Veasey, Consultant Cardiologist

Sharon Grain, Head of Nursing for CCU & Inpatients

Lesley Houston, General Manager Cardiovascular Services (ESHT)

SECAmb

Ray Savage Strategy & Partnership Manager SECAmb

Claire Hall, Clinical Pathways Lead SECAmb.

Healthwatch East Sussex

Alan Keys

List of documents considered by the Review Board

Documents provided to Review Board by the CCG and ESHT

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

Witness Statements

Witness statements received from the following organisations and groups.

Friends of Conquest Hospital
Friends of Eastbourne District General Hospital

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