HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 26 June 2025

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PRESENT:

Councillor Colin Belsey (Chair), Councillors Abul Azad, Sorrell Marlow-Eastwood, Steve Murphy and Alan Shuttleworth (all East Sussex County Council); Councillor Kara Bishop (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Christine Brett (Lewes District Council) and Councillor Terry Byrne (Rother District Council)

WITNESSES:

**East Sussex Healthcare NHS Trust (ESHT)**

Simon Dowse, Director of Transformation, Strategy & Improvement

**NHS Sussex**

Wendy Young, Director of Acute Services Commissioning and Transformation

Danny Leach, Deputy Head of Acute Services Commissioning and Transformation (Non Elective)

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

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

Dr Suneeta Kochhar, Clinical Director

**East Sussex County Council**

Mark Stainton, Director of Adult Social Care and Health

LEAD OFFICER:

Patrick Major

1. MINUTES OF THE MEETING HELD ON 6 MARCH 2025

1.1 The minutes of the meeting held on 6 March 2025 were agreed as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Councillor Sarah Osborne (Councillor Steve Murphy substituted), Councillor Christine Robinson, Councillor Graham Shaw, Jennifer Twist and Emma McDermott.

3. DISCLOSURES OF INTERESTS

3.1 There were no disclosures of interest

4. URGENT ITEMS

4.1 There were no urgent items.

5. NHS SUSSEX WINTER PLAN 2024/25 - REVIEW AND EVALUATION

5.1 The Committee considered an update and evaluation report on the NHS Sussex Winter Plan. The Winter Plan set out how the local health and social care system plans to effectively manage capacity and demand pressures anticipated during the Winter period and ran from 1 November 2024 to 31 March 2025. The plan was developed against demand and capacity modelling for each of the key workstreams, and the outcomes have been evaluated against the objectives. This review identifies key areas of improvement to be incorporated into planning for Winter 2025-26.

5.2 **The Committee asked what the barriers to discharging patients from hospital were and how capacity can be developed in the community to receive people out of hospital.**

5.3 Ashley Scarff, Director of Joint Commissioning and Integrated Care Team Development NHS Sussex, responded that managing hospital discharge was a system-wide issue, requiring collaboration between all system partners. NHS Sussex have been working with partners to develop consistency in their approach to discharge; there was a correlation between the ability

to discharge ‘No Criteria to Reside’ (NCTR) patients and bed occupancy levels, so this work is ongoing.

5.4 Mark Stainton, Director of Adult Social Care and Health, East Sussex County Council, clarified that NCTR refers to patients that no longer had a medical criteria to reside in hospital, but there are multiple reasons why people might need to remain in hospital longer than necessary. A number of NCTR patients have multiple and complex needs, including cognitive needs, so multiple agencies are engaged to safely discharge them. Significant capacity exists in the home care market, but bedded care placements were more limited and more complex needs made discharge into bedded care more complicated. While much work went into preventing people needing to go into hospital in the first place, there was also work done with hospital trusts to map patient journeys through hospital, particularly where they had an extended length of stay, to locate where they encounter barriers to discharge and address these ahead of time. While there had been a sustained improvement in the number of patients waiting for discharge, there was still a lot of progress needed.

5.5 Simon Dowse, Director or Transformation, Strategy and Improvement, East Sussex Healthcare Trust (ESHT) added that bed occupancy numbers could be misleading as what mattered from a hospital operational perspective was whether the right beds were available to meet patient need. This fluctuated day to day and multi-agency discharge events (MADE) had been successful in improving intra-day bed occupancy levels. The trust continues to work with community based bed capacity and the social care sector to improve flow of people. ESHT were also conducting analysis of its own processes to manage patients’ movement as quickly as possible.

5.6 **The Committee asked how Integrated Care Board (ICB) savings plans will impact this capacity next winter.**

5.7 Ashley Scarff clarified that the ICB was having to make savings in the cost of running the organisation, which is separate to its commissioning budget. The savings plans may impact the ICB’s management capacity as opposed to the capacity of service provision.

5.8 **The Committee asked how ESHT will improve Emergency Department (ED) waiting times.**

5.9 Simon Dowse responded that ESHT EDs had been performing well since the end of winter, despite a continued increase in the number of attendances. Waiting times depend on a number of factors, including arrival times for patients and their volume, the ability to avoid conveying patients that attend EDs, and the ability to move people to other settings in the hospital. The developments undertaken as part of the winter plan did improve waiting times, and the Trust would have faced more challenges meeting those targets over the winter had these developments not been in place, due to the impact on bed occupancy. There was a high degree of excess demand this winter as a result of high levels of flu, COVID-19, RSV and norovirus, which would have been difficult to predict ahead of winter. ESHT was exploring options to improve bed occupancy and increase escalation capacity in the future, which directly impacted on ED performance. Further work to increase use of virtual wards, development of integrated care teams to reduce demand, and realigning capacity within the hospital for peak times would also help improve ED performance.

5.10 **The Committee asked what efforts were being made to target vulnerable and high-risk populations for vaccination for winter 2025-26.**

5.11 Rachael Kramer, Deputy Director of Emergency Preparedness, Resilience and Response, NHS Sussex, responded that an independent review of vaccination scheme success was undertaken by the primary care team. This identified key areas of focus to target people that are vulnerable and harder to reach for vaccinations for winter 2025-26. As well as targeting vulnerable people, the ICB worked with providers to improve staff vaccinations rates. In the coming winter, this would begin much earlier and more would be provided on-site to increase uptake. Rachael clarified that staff who were eligible to receive vaccinations for medical reasons and did so from their GP or other providers were not counted in the statistics in the report, so the overall figures of staff vaccination levels may be higher.

5.12 Dr Suneeta Kochhar, Clinical Director NHS Sussex, responded that reaching vulnerable groups is key to prevention, and that further work was being undertaken to reach vulnerable populations, including outreach and quiet clinics and bringing care closer to the community. It will also be necessary to increase staff vaccination rates by making them more accessible to staff, to reduce absences and maintain capacity in the winter months.

5.13 **The Committee asked for clarification on the definition of a 4-hour versus 12-hour ED waiting time, and when 12-hour waiting times were likely to be in line with targets.**

5.14 Simon Dowse explained that the clinical target for a four-hour waiting period was for a patient to have left the emergency department (either discharged or taken to their next place of care) within four hours of them first having registered as attending ED. However, the 12-hour waiting period refers to the time to move people safely from the ED into a suitable bed in the hospital after the decision to admit has been made, and this relies on bed occupancy. ESHT was working to address the bed occupancy challenge and reduce the number of patients over the 12-hour clinical target with the ambition of reaching zero.

5.15 **The Committee asked how ESHT can speed up prescriptions to expediate discharge and reduce the number of No Criteria to Reside (NCTR) patients.**

5.16 Simon Dowse responded that although having prescription medications ready has been identified as something that can delay the discharge process on the day, due to its reliance on pharmacy capacity and Doctor sign-off, this is not one of the larger barriers to discharge. Work was underway to improve ESHT's internal processes to pre-plan, identify and prepare medication for individual patients in advance of discharge in hospital pharmacies, to expediate their discharge.

5.17 **The Committee enquired about the location of the vaccination sites in Hastings that had a low uptake over winter 2024-25, and where these might be moved to for winter 2025-26 to reach the greatest number of vulnerable people.**

5.18 Dr Suneeta Kochhar responded that although she did not have the specific locations, clinics were often located in areas of deprivation and worked with voluntary, community and social enterprise (VCSE) organisations to try to increase vaccination rates. There were also outreach clinics, including GP home visits to deliver vaccinations, which although only reached a small number of people, was important for getting the most vulnerable vaccinated. In some areas there was a level of vaccination fatigue, with people choosing not to opt in to the vaccination programme, explaining the lower level of uptake.

5.19 **The Committee noted challenges in accessing primary care and asked how pathways into same-day emergency care and virtual wards were being improved to prevent patients attending ED.**

5.20 Simon Dowse confirmed that same-day emergency care and virtual ward delivery was being expanded, so the capacity for these would increase in the future. Simon recognised that the route into same-day emergency care and virtual wards needed to be streamlined, and the communication around these pathways improved; this was being investigated by the Trust.

5.21 Suneeta Kochhar responded that virtual wards could be seen as alternatives to in-patient bedded care, and they have significantly increased capacity in wards recently. Access to virtual wards can be relatively straightforward but relies on initial access to primary care. ESHT worked closely with hospice teams, community and district nursing teams to coordinate care outside of hospital.

5.22 **The Committee asked whether unused wards (such as James Ward after it closed) could be used to increase bed capacity in future years, and what happens to staff when wards close.**

5.23 Simon Dowse explained that ESHT had escalation wards which could be opened to increase capacity as needed, although remedial work had meant the Trust had to close these wards in summer. For winter 2025-26, ESHT was planning to identify its escalation capacity, and this would be budgeted for and staffed accordingly. The impact on staff is minimised when wards close, as vacancies are available in other wards and staff are consulted so that they can have a voice in deciding where they will be redeployed. In some cases, the Trust could see a benefit as redeploying staff could reduce the need for Bank and temporary staff, which both improves quality of care and reduces costs.

5.24 **The Committee asked why ESHT had one of the highest proportions of NCTR patients in the country and whether ESCC had a statutory duty to provide support for people with NCTR.**

5.25 Mark Stainton responded that the statutory duties of Adult Social Care are set out in the Care Act 2014 which largely relate to assessing and meeting eligible need. Many NCTR patients do not have any Care Act needs, but the Council has a duty to support those that do. There are varying levels of care that patients may need after they are discharged: people may need support like equipment, housing support or care; they may require reablement or assessment before discharge; or they may need more complex bedded care like hospice or community care to be arranged. The figures are particularly high in East Sussex due to the nature of our older population, an increasing number of people with complex needs, and safeguarding concerns preventing discharge. Capacity in the ICB, ESHT and ESCC also impact discharge rates, as increased activity and complexity increase workloads. The system overall faces challenges, including those of staff recruitment and retention, which places further pressure on the ability to discharge. The system received support from the national Discharge Support Oversight Group (DSOG), but that challenges for the system meant that even with this support there were difficulties in identifying solutions.

5.26 **The Committee noted that 18,500 staff received vaccinations over the winter plan period and asked what percentage of staff that represented.**

5.27 Rachael Kramer confirmed that 43% of ESHT staff received a flu vaccination over the winter 2024-25 period, and 14% had a COVID-19 vaccination through the staff vaccination

programme. Though, the number of staff who received vaccinations may be higher if staff received them outside of the staff vaccination programme, such as through their GPs.

5.28 **The Committee asked whether there is a team in the NHS that works to discharge people while waiting for longer term social care arrangements.**

5.29 Ashley Scarff responded that there are multi-faceted aspects to discharge from hospital, and Transfer of Care Hubs (ToCHs) based in hospitals operate as a multi-disciplinary team to facilitate patients moving through the system. Discharge teams work with Adult Social Care and other system partners to discharge and make best use of resources, but it remains a challenge.

5.30 **The Committee asked whether the GP practices that did not sign up to the multi-disciplinary teams could be identified, and what can be done to ensure all practices sign up in the future.**

5.31 Rachael Kramer responded that information on the practices not signed up could be provided outside of the meeting, but that the success of the programme in winter 2024-25 provides an incentive for further practices to engage with the multi-disciplinary teams in the coming year. Ashley Scarff added that through working with Integrated Community Teams, multi-disciplinary teams are able to identify populations with complex and compound needs and enables the system to affect wider health and wellbeing, focused on neighbourhood health.

5.32 Suneeta Kochhar added that in areas where GP practices did not engage with the multi-disciplinary teams, this was usually due to workforce capacity. These practices are undergoing engagement with the Trust so that they can join next winter.

5.33 **The Committee asked how ICB savings proposals will impact delivery of primary and secondary care.**

5.34 Ashley Scarff clarified that ICB savings relate to the reduction of its organisational running costs. Separately the ICB, working with system partners, needs to identify savings in commissioning services due to the rising costs of demand and technology. In finding efficiencies, the organisation will need to ensure the system maintains the ability to provide care and meets the needs of the local population in the best way that it can.

5.35 The Committee expressed concern about the rate of uptake for vaccinations, and whether the NHS could consider bulk vaccination programmes for future years.

5.36 The Committee RESOLVED to:

1) Note the report; and

2) Request an update on the Winter Plan 2025/26 at the December 2025 HOSC meeting.

## 6. NON-EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS)

6.1 From 1 April 2025, following a procurement process run by NHS Sussex, ERS Transition Limited, trading as EMED Group, has been the provider of Non-Emergency Patient Transport Services (NEPTS) for 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. The Committee considered an update report on the mobilisation of the new contract for NEPTS in Sussex.

6.2 **The Committee asked whether there have been changes to the eligibility criteria for NEPTS with the new provider, as some residents had been unable to access the service.**

6.3 Wendy Young, Director of Acute Services, Commissioning and Transformation NHS Sussex confirmed that the criteria for NEPTS is determined nationally, though there is some variation in how local areas interpret and apply it. In Sussex approximately 90% of NEPTS requests that are filed are accepted, compared to much lower rates of acceptance in areas like Surrey. Where there had been a lack of capacity, the system was working with the new provider to identify and fill gaps in transport. She clarified that if patients don't meet the criteria, the provider has links to the VCSE sector and can direct them to organisations for assistance.

6.4 **The Committee asked if there is a 2-week limit for patients when booking in advance of appointments, and how appointment information is considered as part of capacity planning.**

6.5 Wendy Young responded with concern that patients had reported that they had not been able to book NEPTS in advance of their appointments. She confirmed that the issue would be investigated to ensure the ability to book further in advance was included within the service, and that this would be taken as an action from the meeting. It was important that patients who have been waiting a long time for appointments can have reassurance in their transport being booked further in advance. Wendy also agreed to verify that failed booking data was captured where appropriate.

6.6 **The Committee asked what information is available to patients about NEPTS and similar resources in the VCSE sector, and what the routes to accessing the service are.**

6.7 Danny Leach, Deputy Head of Acute Services, Commissioning and Transformation NHS Sussex, responded that extensive promotion among staff and patients had been undertaken at all hospital sites to raise awareness of the new service. He confirmed that appointments can be made online as well as via telephone, to make accessing the service as broad as possible. He clarified that where multiple cancellations are made, the system is reviewing eligibility of patients for unutilised NEPTS to free up capacity for those that need it.

6.8 **The Committee asked what reminders are sent to patients about their booked transport.**

6.9 Danny Leach responded that there is a reminder process in place, but there was further work to be done to ensure that the reminders are effective to mitigate future cancellations.

6.10 **The Committee asked if there have been any changes in the number of people accessing the service compared to the previous provider.**

6.11 Danny Leach confirmed that there had been no recent changes to the eligibility criteria for NEPTS. Capacity for the service had been modelled by EMED from previous years' activity levels; from the data gathered for April 2025, the rate of activity is similar to usage under the previous provider.

6.12 **The Committee asked what is being done to reduce cancelled, delayed and missed journeys, and how capacity was managed at peak times.**

6.13 Wendy Young responded that cancelled journeys are driven largely by hospitals' capacity and changes to appointments, but the system was working with both the hospital and the provider to ensure that capacity and demand for NEPTS are aligned.

6.14 Danny Leach added that there had been initial issues with appointment data, but the provider worked to resolve these quickly. Part of the reason for this was data being received from different providers. There had been some variation in types of journeys, and EMED have been working to train staff and equip them for these changes. The vehicles for the new provider are malleable and can adapt to patients' needs and criteria on arrival if needed.

6.15 The Committee noted challenges that had previously existed with NEPTS provision and emphasised the importance of NHS Sussex addressing issues arising quickly and effectively. Wendy Young confirmed that the ICB was mindful of previous issues, which was part of the reason for having a longer mobilisation period than was usual, and that a very active approach to monitoring the service was being taken. Danny Leach added that the involvement of Healthwatch and provider Trusts had been an important for designing the new contract

6.16 The Committee RESOLVED to:

1) Note the report; and

2) Request a short update on NEPTS at a future meeting.

## 7. HOSC FUTURE WORK PROGRAMME

7.1 The Committee received a verbal update from Ashley Scarff about changes to NHS England, the Department of Health and Social Care, and changes to the ICB. NHS Sussex will be merging with NHS Surrey, to form one ICB covering two health and care systems.

7.2 The Committee requested to receive a regular update from NHS Sussex, to report back on progress and changes within the ICB. The Committee requested that this update include metrics for performance and areas for improvement in key areas of interest, so it can be used to inform the future work programme.

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

7.4 The Committee RESOLVED to:

1) Receive a regular update from NHS Sussex;

2) Schedule the reports on Access to Primary Care Services and the Children and Young People Mental Health update to its September meeting; and

3) Defer the full reports on the HOSC Review of the Provision of Audiology Services in East Sussex and Paediatric Service Model at Eastbourne District General Hospital, currently scheduled for its September 2025 meeting, and instead receive a short update on these items.

8. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

8.1 None.

The meeting ended at 12.10 pm.

Councillor Colin Belsey

Chair