East Sussex Healthcare NHS Trust

Cardiology Transformation at East Sussex Healthcare NHS Trust

HOSC Update – December 2025

1 INTRODUCTION

Background and Context

1.1 In the Autumn of 2022, following a full public consultation process, a Decision-Making Business Case (DMBC) was finalised by East Sussex Healthcare Trust (ESHT) in partnership with NHS Sussex Integrated Care Board (ICB) with the primary goal of enhancing patient outcomes through the implementation of the proposed cardiology transformation.

1.2 Specifically, the cardiology transformation proposal was to form Cardiac Response Teams to support patients on their arrival at Emergency Department (ED), alongside "hot clinics" that will provide consultant-led rapid assessment at both of our acute hospital sites and locate the most specialist cardiac services, needed by a small number of patients, at Eastbourne District General Hospital (EDGH).

1.3 The ESHT Trust Board approved the DMBC on 11 October 2022, which was followed by the approval of the ICB at their public board meeting on 2 November 2022.

1.4 Following NHS internal approval. The DMBC was submitted to the East Sussex Health Overview and Scrutiny Committee (HOSC), who endorsed the DMBC at their public meeting on 15 December 2022.

1.5 A full list of activities completed as part of the options development and appraisal process, and the full public consultation process, can be found in the original DMBC and published papers.

Purpose of this paper

1.6 This aim of this paper is to provide an update to the HOSC regarding the key actions against their recommendations made on 15 December 2022, and well as to provide additional context on the implementation plans and activities which have been undertaken since.

1.7 Please note, the recommendations made by the HOSC on 15 December 2022 followed on from a larger set of recommendations made by both the 'HOSC review Board', and the 'Travel and Transport Review Group'. These recommendations were discussed at the HOSC meeting on 15 December 2022 where a number of updates were given, and some actions had already been implemented, investigated and closed. The resulting list of HOSC recommendations were therefore distilled from this larger list, and these are the ones that are addressed directly in this paper.

2 HOSC RECOMMENDATIONS

2.1 Following the feedback from the public consultation, the 'HOSC Review Board' and the 'Travel and Transport Review Group' made a range of recommendations which have been taken account of as we have developed and implemented our proposals.

2.2 All actions have remained under review during implementation phase and have been discussed on a quarterly basis at the ICB Joint Steering Board, as part of a standing agenda item on 'Mobilisation Assurance Actions'. Following cessation of the ICB Joint Steering Board these reverted to ESHT governance forums as business as usual.

2.3 The HOSC meeting on 15 December 2022 reviewed this longlist of recommendations and considered each one in turn. Some of those actions had already been completed and closed, and some remained open. Those actions that remained open, and were supported by the HOSC, were distilled into a series of 4 recommendation made by the HOSC when endorsing our proposals on 15 December 2022. An update to each of these recommendations is provided 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.**

2.4 Rather than being a recommendation that ESHT and the ICB were required to action, recommendation 1 was an endorsement of the clinical model proposed in the Decision-Making Business Case.

2.5 Consolidation of Primary Percutaneous Coronary Intervention (PCI), Elective and Inpatient Cardiology activity has now been completed at EDGH in October 2025, following an extensive estates and construction plan. We have completed the staff consultation process and have implemented the front door model with Cardiac Response Team's supporting the emergency departments (EDs).

2.6 The front door model has allowed us to start to deliver the benefits of the model of care described during the consultation, including the provision of improved pathways avoiding lengthy discharge and referral processes via GPs in the community whilst patients wait for a Cardiology outpatient appointment, and expediting early diagnostics and treatment. This is being provided at both sites.

2.7 Diagnostics and outpatient cardiology services continue to be offered at both sites, so that cardiology patients have local access to the cardiology specialty at their nearest hospital for all cardiology care except interventional procedures and specialist inpatient stays. Cardiology opinion, and cardiac monitoring, remains available at both sites.

2.8 The impact of the new model of care has also meant that we have been able to successfully recruit to long term vacant posts, which helps reduce reliance on bank and agency, and ensure the future sustainability of the service.

2.9 We can confirm that other services at the hospitals have not been affected or downgraded as a result of the cardiology transformation. Careful effort has been made throughout implementation to ensure operational continuity throughout the extensive programme of estates reconfiguration work.

2.10 SECAmb have commented on the service received since the consolidation over the past few weeks. Specifically, they have fed back how well the model is working for receiving patients through ED, how quickly patients have been streamed to the lab when this has been required, and noted the good outcomes for patients so far.

2.11 We are currently completing an initial benefits realisation project, which will help us to understand the scale of the improvements already made, and where we should focus our efforts next.

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.**

2.12 The service is now fully recruited against its medical establishment due to the transformations plans that we have implemented. This includes recruitment to longstanding vacant consultant posts. This has reduced reliance on bank and agency and helps to safeguard the future of the service. It also aids in training and development for both medical and other groups of staff.

2.13 Staffing levels, recruitment and retention are monitored on an ongoing basis. Measures are developed in response to the monitoring of these metrics, and actions taken where required. The service continues to measure workforce metrics on a rolling basis.

2.14 As a result of the transformation programme, we have been able to meet recommendations of the Getting It Right First Time (GIRFT) report outlined in the DMBC in relation to the training of staff, and improve our performance against minimum required volumes, in order to provide a sustainable service that remains attractive to prospective medical and non-medical cardiology workforce across all sub-specialisms.

Recommendation 3

The Board recommends:

3a. A package of measures is put in place to mitigate the travel and access impacts of the proposals on patients, families, and carers, including but not limited to:

- **the establishment of a Travel Liaison Officer post is essential.**

2.15 The travel liaison officer role was intended to provide a single point of contact for patients who are experiencing difficulty in attending their appointment or arranging hospital transport.

2.16 The 'Travel liaison Officer' role has since been fulfilled by the single point of contact that is provided as part of the new Sussex wide NEPTS contract which came into effect last year. This role provides a single place where patients can call to discuss their travel arrangements and difficulties and has the benefit of being open to all hospital patients, not just those accessing cardiology services.

- **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.**

2.17 Since the consultation we have updated the advice on our Trust communications to include clearer advice on travel support and financial support for travel costs where patients are eligible. This information is now included on relevant patient letters, as well as being available on our website.

2.18 The information given has been standardised to avoid confusion, and the same information is given by the Trust as by other sources, such as by the new NEPTS service.

2.19 Where patients are eligible, patients can also receive reimbursements for travel costs whilst attending their appointment by visiting the cashier's office on site. Patients are informed of eligibility criteria and told in advance what documents they will need in order to claim back their travel expenses.

- **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.**

2.20 As above, this information is now included on patient letters and on our website, and accessible formats are available. This follows a Trustwide programme to standardise and review the information on clinic letters across the Trust, and align this with information from other sources, such as that available online on our website.

- **the CCG (now ICB) 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.

2.21 As part of communication to patients from the Trust, it is highlighted that patients can get in touch to raise any difficulties they may have in attending their appointment, and appropriate contact details are given for them to do so.

2.22 If it is a patient's first appointment, the Trust will rely on either 1) the patient getting in touch to let us know if they have particular difficulties, or 2) the information being available at the point of referral, in order for the Trust to be able to take action to assist. It is not possible or viable for the Trust to check personally with every new patient ahead of their first appointment.

2.23 However, as part of raising awareness of this issue with referrers directly, the ICB have asked referrers via identified groups (Such as at GP forum meetings) to include any travel and access requirements on their referrals when initially referring patients into the Trust. The roll out of this message was monitored at the ICB Joint Steering Board, and the message is repeated periodically.

- **encourage providers to provide clear explanations of the eligibility criteria for Patient Transport Services.**

2.24 As explained above, eligibility criteria for patient transport services have been recently refreshed and clarified as part of the new NEPTS contract. This information is available online or by phone and is aligned with the information given by the Trust. Patients can also access the single point of contact if there is any confusion.

- **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.).**

2.25 The travel and transport group investigated the feasibility of a shuttle bus, however, the conclusion was that a shuttle bus would likely not be a viable option, or serve the patients we would aim to reach, as patients do not generally travel between hospital sites for these appointments, but instead travel from their home addresses.

2.26 However, a financial viability assessment was conducted by the Trust to determine the options available for providing a shuttle bus. In every scenario the numbers of travellers required in order to make the shuttle bus service a viable and justifiable use of public funds were felt to be unachievable.

2.27 Notwithstanding the above, patients who are having difficulties in reaching their appointment for clinical or financial reasons are able to access NEPTS if they fall within the eligibility criteria.

2.28 A library of volunteer transport services was collated as part of this action by the programme team. This was then written into the NEPTS contract refresh in order to be maintained as part of the single point of access requirements. This library is now maintained and updated by the NEPTS provider.

2.29 The Trust and the ICB met with Transport managers at ESCC to discuss the transformation plans and potential improvements to transport links. Despite investigating the opportunities, the local bus improvement plan funding was not available to be used for this due to targeted plans for where the funding was needed most. However, the transport manager is cognisant of our plans, and a relationship is maintained such that the Transport manager will report back on any potential future opportunities.

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.**

2.30 Detailed implementation plans started to be drawn up immediately following approval and endorsement of the DMBC. A detailed update to these implementation plans can be found in section 3 below.

2.31 Risk posed by workforce challenges were, and continue to be, monitored by ESHT to ensure continuity of service. In reality, the work on implementing the approved transformation has had an overall positive effect on recruitment and retention which has allowed us to better manage this risk. Certainty around the future of the service provided by the approved model allowed us to focus targeted recruitment for consultants, nursing and other medical workforce.

2.32 Staff were kept up to date with the progress of implementation, and a HR consultation was launched as part of the implementation plan, which has now been completed. Redeployment opportunities were explored on an individual basis with staff where individual circumstances meant that consolidating to Eastbourne was not a preferrable option for them.

2.33 Further details on the implementation can be found in section 3 of this report, which provides a more in-depth update of the work undertaken to date.

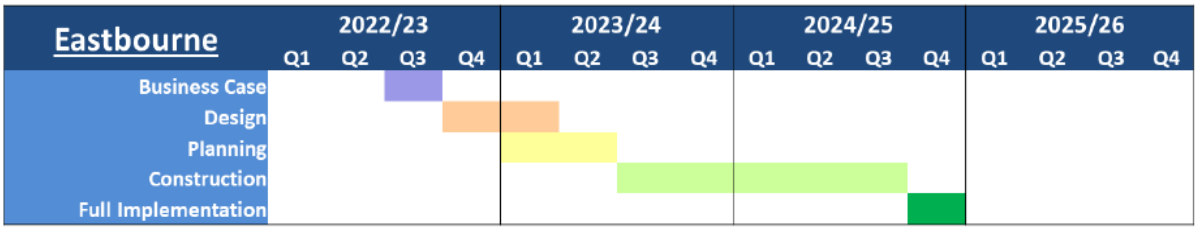
2.34 As per recommendation 1, it can be confirmed that there have been no negative impacts on the continuity or provision of other services as a result of this transformation programme.

3 IMPLEMENTATION PROGRESS

Original DMBC Implementation Timescales

3.1 An indicative implementation plan was developed as part of the DMBC process, which illustrated the ambition of the cardiology transformation plans, and provided a high-level road map for mobilisation.

3.2 The indicative implementation timescales that were given in the DMBC are reproduced below for reference.



3.3 There have been some delays to the programme following development of more detailed plans. These delays are largely due to 1) a deeper understanding of the scope of the work required at each stage, 2) emergent work which has been uncovered (such as plant work as part of the moving of wards to accommodate the cardiology footprint), and 3) difficulty with interdependencies with other estates programmes (such as aligning with plant works and fire compartmentation). There have also been some small-scale delays in general procurement and construction processes.

3.4 All delays have been raised via the risk and issues process to the ESHT Transformation Board, and the ICB Joint Steering Board, and then later through the Operational Management Group as governance changed. In all cases these committees have received assurance that all mitigating actions have been taken where possible, and all efforts have been made to minimise the impact on the timescales for realising the benefits of the model of care for our patients.

3.5 Notwithstanding the delay in implementation outlined above, the programme has progressed to the stage where it has been able to realise its original proposal to 1) offer a front end cardiac response team at both acute hospital sites, and 2) consolidate all cardiology interventional and inpatient activity at the Eastbourne site.

3.6 This has meant that, in October 2025 we were able to consolidate the specialist cardiology workforce onto the Eastbourne site, allowing us to implement the most impactful elements of our model of care. As a result, we have already started to realise some of the benefits outlined in the DMBC.

Implementation Update

3.7 Following approval to proceed to implementation, more detailed plans were drawn up, which included an estates and facilities plan, as well as operational and workforce plans.

3.8 Implementation was planned in a phased approach in order to enable the estates reconfigurations required to build and expand CCU, Recovery Unit, and Cardiac Ward spaces within the footprint at EDGH. This required a schedule of ward moves across the footprint at EDGH in order to continue to provide other specialty services without impacting patients or pathways.

3.9 The original high-level timescales in the DMBC indicated that the original estimate for full implementation was by the end of March 2025. There has been a 6-month delay in implementing the proposed model of care with respect to the consolidation of interventional services on the EDGH site. Some of the causes of the delays to the building and estates works required to enable us to achieve these timescales are given below:

- A complicated ward moves schedule was required to vacate space identified at EDGH, this was not fully appreciated at the initial stages.
- The schedule of estates refurbishments has had to be adapted to coincide with simultaneous fire compartmentation works.
- Some ward refurbishments have revealed unexpected challenges, such as plumbing and plant work requirements.
- Ward moves required closing beds behind discharges, which has been delayed by operational pressures.
- There have been some capital reprioritisations and capital slippages which have impacted on the programme timescales.

3.10 Notwithstanding the delays, we were able to consolidate the interventional cardiology service at the EDGH site in October 2025 and provide the new model of care outlined in the Decision-Making Business Case.

3.11 There is still some further work to complete in order to fully realise all the benefits of the Decision-Making Business Case, however, these have not further delayed the implementation of the key advantages of the model of care outlined in the original proposal (i.e., we have consolidated, and are providing a front door service at both sites).

3.12 The remaining work required includes estates work on East Dean ward to be completed, due January 2026. This will allow the move of the CCU to this space, freeing up the footprint to develop the build for the third Cath Lab outlined in the DMBC.

4 BENEFITS REALISATION

4.1 The new cardiology model of care outlined in the DMCB has now been implemented, with the consolidation of Primary PCI to Eastbourne District General Hospital occurring on 20 October 2025, and the move of Elective and Inpatient Cardiology activity completed on 23 October 2025.

4.2 We have also fully implemented the front door model with Cardiac Response Team's supporting both emergency departments (EDs) at Eastbourne District General Hospital, and the Conquest Hospital in Hastings, which started on 20 October alongside consolidation.

Current Improvements and Benefits

4.3 The workforce supporting specialised interventional cardiology procedures and inpatient stays has been consolidated from Conquest to the Eastbourne site. (Outpatients, diagnostics and cardiac monitoring remain available at both sites).

4.4 New rotas are in place as above which has allowed for the provision of the front end Cardiac Response Team (CRT) model, at the Conquest and the Eastbourne sites. Elements of the front door service has been provided earlier during the implementation phase where it was operationally possible to do so. With the full service being established at both hospital sites permanently since October 2025.

4.5 New cardiology pathways are now in place enabling patients to be seen promptly, and investigations initiated. Patients are also brought back to a hot clinic, rather than discharged to GP. Meaning reduced waiting times and improved access to treatment and diagnostics across both sites. The front end model is in place on both sites and hot clinics continue the EDGH site. CQ hot clinics are in development, and we are using Cardiology outpatient capacity at CQ in the interim where this is clinically indicated.

4.6 There has been an increase in MDT Working between the subspecialities within cardiology, between different staffing groups, including specialist nurses. Cardiology continues to have daily touch point calls for Cardiology between the sites.

4.7 Increased supervision and improved training for medical and nursing staff under the new model of care.

4.8 Improvement in recruitment and retention of staff. We have managed to recruit to longstanding vacancies within the cath labs, which includes the appointment of substantive consultants, meeting national minimum volumes required.

4.9 Ability to recruit and retain has in turn reduced our reliance on bank and agency staff, which reduces the cost of activity, and improves the continuity of care for our patients.

4.10 We have been able to meet the GIRFT recommendation to consolidate our service and meet minimum volumes, as noted in a review of their recommendations during a subsequent visit to the Trust in 24/25. The transformation now allows us to continue to improve against other GIRFT recommendations, focused on continued service delivery development (outside of, but enabled by, this transformation).

4.11 Positive feedback received from SECAmb, who have commented on the service received since the consolidation over the past few weeks. Specifically, they have fed back how well the model is working for receiving patients through ED, how quickly patients have been streamed to the lab when this has been required, and noted the good outcomes for patients so far.

Benefits Realisation Plan

4.12 Benefits realisation is being currently being conducted following on from consolidation onto the EDGH and can be brought back to the HOSC once completed.

4.13 With only one month having passed since implementation, the full benefits realisation that was planned for Autumn 2025 has not yet been finalised.

4.14 There are a range of key performance indicators (KPIs) that enable us to assess the performance of the new model of care, and an extensive list is shown below. We will draw on these as we update our Board.

Key Performance Indicators (KPI) Description
Admission Avoidance
Length of Stay (in Cardiology)
Length of Stay (in Medicine)
Hot Clinics Attendances
Average outpatient pathway length
Diagnostics completed as Same Day Emergency Care
Telemedicine effectiveness
Ambulance transfer category
Number of cross-site transfers
Timeliness of cross-site transfers
Inpatient PCI within 24-48 hours
Call-to-Balloon time
Door-to-Balloon time
Call-to-Door time
Adverse and serious incidents
Complaint rate
Patient experience
Elective DNA rate
Effect on staff vacancy (by staff type/area)
Effect on staff turnover rate
Increase recruitment rate (including hard to fill posts)
Improve staff retention
Improve staff satisfaction

4.15 Data sources for national audit (such as MINAP) are not yet available for the reason set out at 4.13. These will become available in the coming months and will be included in the benefits realisation that goes to our Board.

4.16 We propose sharing the Board paper details with colleagues at HOSC to demonstrate that the new model is functioning in a way that is both effective from a workforce perspective and which continues to provide quality clinical care for patients.