EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 14th December 2021 commencing at 09:30 via MS Teams

AGENDA			Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Hero of the Month award		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 12th October 2021	A	Chair	
4.	Matters Arising	B		
5.	Board Committee Chair's Feedback 5.1 Quality and Safety (Q & S) Committee 5.1.1 Q & S Terms of Reference 5.2 People and Organisational Development Committee 5.3 Audit Committee 5.4 Strategy Committee 5.5 Finance and Investment Committee	C	Committee Chairs	
6.	Chief Executive's Report	D	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Integrated Performance Report Month 7 (October) 1. Quality and Safety 2. Our People – Our Staff 3. Access and Responsiveness 4. Financial Control and Capital Development	Assurance	E	CND MD COO CPO CFO	1015 - 1115
8.	Learning from Deaths Q1	Assurance	F	MD	

STRATEGY

					Time:
9.	Cardiology and Ophthalmology	Assurance	G	DS	1115 - 1130

BREAK

GOVERNANCE AND ASSURANCE

					Time:
10.	Mortuary Security Assurance	Assurance	H	CND, MD	1145 - 1215
11.	Annual Reports for noting: • Workforce Disability Equality Standard • Guardian of Safe Working Hours • Safeguarding • Complaints • Nursing Establishment	Information	I	Various	
12.	Disciplinary Procedure	Assurance	J	CPO	

ITEMS FOR INFORMATION

				Time:
13.	Meeting Dates for 2022	K	Chair	1215 - 1230
14.	Use of Trust Seal	L	Chair	
15.	Questions from members of the public (15 minutes maximum)		Chair	
16.	Date of Next Meeting: Tuesday 8th February 2022		Chair	

Steve Phoenix

Chairman 2nd November 2021

Key:	
Chair	Trust Chair
CEO	Chief Executive
ACS	Acting Company Secretary
CND	Chief Nurse and DIPC
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DEF	Director of Estates and Facilities
DS	Director of Strategy
CFO	Chief Financial Officer
CPO	Chief People Officer
MD	Medical Director

Hero of the Month Awards

Meeting information:		
Date of Meeting:	14th December 2021	Agenda Item: 1.3
Meeting:	Trust Board	Reporting Officer: Steve Phoenix, Chair

August 2021

Karen Aldred, Service Administrator for the Community Bladder and Bowel Team

Karen was nominated by Tracey Perkins, Senior Bladder and Bowel Nurse who said: "During the Covid pandemic many of the community bladder and bowel team were redeployed to different areas of the Trust. This meant the team who were left were dealing with the many phone calls from anxious patients and family members who had concerns about the supply of products, or anxious about how Covid was affecting them. Through this time Karen worked with colleagues to support these patients, often going the extra mile to help someone or prompt me to call a particularly distressed person.

"Karen has also been key in reviewing how administration is going to look in the future for the clinical team. She has been working with her managers to review pathways and new ways of working. This is challenging at the best of times but this is straight after all the working changes of the last 18 months.

"There are many unsung heroes hidden away working hard, and without their dedication, clinicians wouldn't be able to do their work. Without Karen's dedication, many patients would have suffered and her reassuring voice has brought a lot of comfort to people so they know that someone cares."

September 2021

1. Trust-wide Research Team

The team was nominated by Janet Sinclair, Cardiology Senior Research who said: "The team have worked above and beyond gathering all of the data of every patient admitted to our hospitals from the start of COVID-19 and delivered this information back to Public Health England within tight timelines.

"The team helped with the Recovery study, a ground breaking study which has played a key role in helping very ill patients and staff over the last 15 months throughout the UK.

The team have also cared for 240 members of staff over the last year with the Siren study taking Covid swabs and bloods for Antibodies and monitoring results.

"We are a small team but everyone has pulled together, often working well over their normal hours including holidays and weekends within their own time. The team have helped each other and shown much compassion and support throughout this difficult time.

I am one of the lead nurses of this team and am very proud of the leadership we have and every team member for everything they have given both professionally and personally."

2. Tracie Hazel and Martinha Kirk, EME Equipment Library – Eastbourne DGH

The Team was nominated by Simeon Beaumont, EME Manager who said: "Equipment librarians at Eastbourne, Martinha Kirk and Tracie Hazel have worked above and beyond during the last month as the Trust has been exceptionally busy. Despite the increase in activity they have managed to meet every single equipment request, including visiting clinical areas to re-issue equipment where it was needed, therefore improving our patient's clinical outcomes. They are true super heroes of the Trust and regularly clock up over 20,000 steps in their shifts to provide the equipment where and when it is needed."

October 2021

Tania Winchester, Emergency Department - Conquest

Tania's first nomination read: "Tania has worked in the ED for 25+ years and is a valued, respected and loved member of the team. Tania is based in the Sister's office and over the years has put up with our highs, lows, rants and tears. Along with her day to day role, she has been an agony aunt to so many of us, she always listens and nothing is ever too much. She is kind and caring, with a great sense of humour.

She organises all of our training and accommodates all of our individual needs perfectly. Not only does she demonstrate all of the Trust values, but she is the perfect example of how they should be applied by all ESHT staff."

Her second nomination read: "Since I started my new role in ED a couple of months ago, Tania has been my point of contact with numerous emails and face to face questions. She always has a smile on her face, is willing to help and nothing is too much for her. She has worked in the ED for 29 years and she still seems just as enthusiastic and helpful as I'm sure she was when she first started. I can't thank her enough."

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 12th October 2021 at 09:30 video conference via Microsoft Teams

Present: Mr Steve Phoenix, Chairman
Mrs Joe Chadwick-Bell, Chief Executive
Mrs Tara Argent, Chief Operating Officer
Mrs Vikki Carruth, Chief Nurse & DIPC
Mr Paresh Patel, Non-Executive Director
Mr Damian Reid, Chief Finance Officer
Dr David Walker, Medical Director
Mrs Nicola Webber, Non-Executive Director

Non-Voting Directors:
Mr Steve Aumayer, Chief People Officer
Mrs Amanda Fadero, Associate Non-Executive Director
Mr Chris Hodgson, Director of Estates and Facilities
Mr Richard Milner, Director of Strategy, Inequalities & Partnerships
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Mr Peter Palmer, Acting Company Secretary
Mr Josh Graham, Assistant Company Secretary (minutes)
Ms Liz Walke

061/2021 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting.

2. Apologies for Absence
Mr Phoenix advised that apologies for absence had been received from:
Ms Lynette Wells, Director of Corporate Affairs
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Karen Manson, Non-Executive Director

062/2021 **Declarations of Interest**
In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chair noted that no potential conflicts of interest had been declared.

063/2021 **Minutes**
The minutes of the Trust Board meeting held on 10th August 2021 were considered and agreed as an accurate record. The minutes were signed by the

Chair and would be lodged in the Register of Minutes.

064/2021 **Matters Arising**

There were no matters arising from the meeting on 10th August 2021.

065/2021 **Board Committee Chair's Feedback**

i. Audit Committee

Mr Patel reported that the Audit Committee had met on 23rd September.

The results of the EPRR self-assessment were presented and it was noted that the Trust had complied substantially with the required standards. This was validated by an independent peer review and represented a significant achievement given the operational climate of the Covid-19 pandemic.

A presentation was made by the Digital team on their progress in complying with recommendations made by internal auditors. A further update would be provided in January to the Committee on the actions which remained outstanding.

Mr Patel noted a reduction in the number of tenders and waivers being made and work was ongoing to continue this positive trend.

An update on Information Governance was also heard in September, which reported that work had begun to ensure compliance with the new Data Security and Protection Toolkit (DSPT). Assurance was given that all necessary measures would be implemented by the deadline of June 2022.

Internal auditors presented three draft reports. Outcomes of reasonable assurance were given to audits of Covid risk assessment and overseas recruitment, and an outcome of limited assurance was given for the audit of workforce strategy and remote working.

The Board noted the report.

ii. Finance and Investment (F&I) Committee

The paper was taken as read and Mrs Webber invited questions from the Board. Mrs Kavanagh asked whether a risk relating to the Estates team's ability to undertake improvements whilst the Trust was operating at close to full capacity had been added to the risk register'. Mr Hodgson advised that each of the critical risks on the register were due to be reviewed but a separate entry had not yet been made. A number of Estates related risks were already on the register and these were reviewed on a monthly basis. Mr Reid added that capacity remained a challenge but pleasingly the Trust had been awarded further capital based on bids for the second half (H2) of the financial year, with work needing to be completed in-year. Mr Phoenix noted this would provide a good opportunity to develop the process and control improvements the Trust

was targeting. Mr Reid agreed and advised he would meet with Mr Hodgson following the meeting to review areas which could be strengthened.

The Board noted the report.

iii. Strategy Committee

Mr Milner explained that the most recent Committee meeting had focused on the development of the Trust's clinical strategy. This work was being undertaken in conjunction with Chiefs of Service and operational leads, and some Non-Executive Directors had been involved with shaping strategic objectives. He anticipated that the strategy would be completed in December 2021.

The Board noted the report.

iv. Quality and Safety (Q&S) Committee

Mrs Fadero confirmed that the Committee had last met on 16th September and advised that the agenda had been reshaped to reflect the five key domains which the CQC focused on in its work.

Mrs Fadero emphasised that the Infection Prevention and Control (IPC) BAF was an important document in overseeing how IPC risks were being mitigated and would be closely monitored moving into winter.

The TIAA Assurance Review of Maternity Services was presented and offered reasonable assurance. The main area of weakness identified in the audit related to the provision of a full complement of medical staffing across all hours of each week but mitigating actions were in place to ensure that high quality, safe care was offered to patients.

The Quality Account priorities for the following year were being reviewed and an update would be presented to the Board in a future meeting. Good progress with Getting it Right First Time (GIRFT) actions been made with visits to the Trust restarted following a pause during the pandemic. It was agreed that the Excellence in Care programme should continue and Mrs Fadero confirmed she had spoken with Executives about next steps in terms of prioritisation within transformation goals.

Mrs Fadero reported that the Safer Staffing report had been presented, highlighting the staffing challenges caused as a result of escalation capacity being used on a regular basis. This was being monitored by Q&S and People & Organisational Development (POD) Committees. Mrs Webber suggested it would be helpful if drivers of demand within escalation areas could be assessed and asked whether this knowledge could then be used to ascertain exactly what human resourcing was required. Mrs Fadero advised that this was being explored and pre-Covid capacity had been considered to help establish appropriate metrics.

A programme of work addressing CQC self-assessment had begun. Mrs Fadero noted that some associated actions had not yet been completed. Mrs Webber asked how important these areas were judged to be and whether a timeline was in place around their closure. Mrs Carruth explained that she was in the process of reconsidering each of the nine actions individually. They would then be brought back to the next Committee meeting and closed if it was agreed reasonable assurance could be evidenced.

The Board noted the report.

066/2021 **Board Assurance Framework (BAF)**

Mr Palmer reported that the BAF had been reviewed by all sub-committees of the Board in November, with the exception of POD which had been cancelled.

The target ratings for all areas of the BAF had been reviewed and updated with the appropriate executives.

Due to the reduction of capital available within the Trust during 2020/21, the score for BAF 7 had increased from 12 to 16. All other areas remained the same as in the previous quarter.

The risk rating of 16 for BAF 8 had been highlighted in the F&I Committee by Mr Hodgson. A six facet survey of Trust Estates would take place to assess associated risks. The outcome of this survey could potentially lead to the score for this area being revised in the next quarter.

The Board reviewed and noted the Corporate Risk Register and Board Assurance Framework.

067/2021 **Chief Executive's Report**

Mrs Chadwick-Bell summarised the Trust's priorities for the remainder of the year as follows:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Recovery of services, and building on the lessons learned during the pandemic with a focus on transformation
- Achieving key access standards in our Emergency Departments and Cancer Services
- Delivering the Trust's financial position for 2021/22 and driving through efficiencies
- Playing a proactive role in the Sussex Integrated Care System (ICS) and Place, focussing on local health outcomes and addressing health inequalities
- Maintaining a high standard of care, and continuing to meet the needs

of patients with Covid

She highlighted the following risks to meeting these objectives:

- Short planning cycles providing a level of uncertainty
- Sustained demand at the front door and high bed occupancy
- Ongoing pandemic and potential flu-related challenges
- Leadership capacity to cover the range of priorities and still focus on strategy and moving towards an Outstanding CQC rating
- Loss of Covid funding

Mrs Chadwick-Bell noted that activity levels within the Trust remained high. Within the past few weeks, operational guidance for H2 (Oct 2021 to March 2021) had been received, and work was ongoing to review the impact on the Trust, with trajectories being submitted and bids submitted against the targeted recovery fund. Funding had recently been awarded for a number of supportive schemes and further details would be clarified over the coming weeks. In summary, revenue and capital projections for the coming six months were positive.

Mrs Chadwick-Bell reported that the Trust continued to deliver in the mid to upper quartile compared to other organisations nationally, but some areas were under more significant pressure. More patients were presenting at the front door, which in turn was affecting elective care activity. Four additional wards had also been opened: three at Eastbourne and one at Conquest.

Following a system workshop with clinical leaders across East Sussex around how to better deliver urgent care in periods of heightened demand, a new front door model had been devised and would be implemented moving forward.

The Trust had submitted a bid for funding for community diagnostic hubs, which would expand diagnostic capacity for radiology and echocardiography. Endoscopy capacity had also been increased. Mrs Chadwick-Bell explained that a reimagining of community services programme had been developed. Rapid community response teams had been expanded and increased support was being provided to care homes.

Mrs Chadwick-Bell outlined the Trust's capital plans up to March 2022, but noted that some of work may not be completed until the next financial year:

- An expanded A&E at Conquest. This had been completed and would open in the week beginning 18th October 2021
- An extended A&E at Eastbourne, which was due later in the year
- Expansion and improvements to critical care units both at Eastbourne and Hastings
- A new ultrasound area at Eastbourne which would improve the pathway for patients with breast cancer and reduce the number of different appointments. This was due at the end of October 2021.

- Additional capacity for paediatric outpatients at Eastbourne and a new facility at Edgerton Road
- A dedicated day surgery unit at Eastbourne which would support the continued recovery of elective services and be opened by the end of March 2022
- Changes to respiratory wards to improve use of the space to support infection control recognising the ongoing pandemic

Mrs Chadwick-Bell praised staff for their ongoing efforts and dedication to patient wellbeing. Special tributes were made to:

- Simon Purkiss, Head of Communications, who had retired after 28 years with the Trust
- Jane Purkiss, Head of Nursing within the CHIC division, who also retired recently
- Janet Garrood, Access and Bookings Coordinator, who recently celebrated 50 years of service within the NHS and remained in her role.

Mrs Fadero thanked Mrs Chadwick-Bell for her overview of the capital schemes and the focus on staff wellbeing. In response to a question from Mrs Fadero on development of place within community services, Mrs Chadwick-Bell confirmed that the Trust continued to work well with place as part of a wider integrated care system. Conversations continued with local authorities and health visiting teams about how community services could be further improved. Mrs Chadwick-Bell advised that she was also due to meet with the Director of Adult Social Care within East Sussex to explore further opportunities for collaboration.

Mr Phoenix noted that a further update on place in East Sussex was anticipated on the new ICS chair and leadership team began their roles. Mr Milner added that the Trust was also due to receive a presentation from the NHS Confederation in relation to place.

The Board noted the Chief Executive's Report.

068/2021 **Integrated Performance Report Month 5 (August)**

i. Quality & Safety

Mrs Carruth confirmed that the number of Covid-positive patients within the Trust continues to be around 30. Some ongoing challenges remained in terms of pathways, as well as the need for strict infection prevention and control. Some acquisitions within the Trust occurred due to asymptomatic patients, some of whom were unvaccinated, being admitted with an initial negative Covid-19 test. Unfortunately, some patients and visitors had not complied with requirements to socially distance and wear a face covering. This had at times proved challenging for staff and Mrs Carruth noted that it increased risk in terms of the Trust's hierarchy of controls.

There had sadly been an increase in hospital onset of clostridium difficile. In the year to date, 39 cases had been recorded against the Trust's self-imposed target of no more than 50. However, September had seen a decrease in cases reported and there was optimism that this trend would continue. Post-infection reviews were underway. A visit had recently taken place from NHSI/E infection control colleagues, which had been very supportive and positive.

The Trust maintained a proactive reporting culture. 827 of the 856 ESHT incidents reported were considered to be either 'no harm' or 'low harm' and this was better than the national average.

There was a slight increase in Category 2 damage from pressure ulcers, which was potentially linked to ongoing workforce challenges. A review of acuity and dependency data indicated a steady increase over time of high-dependency patients. These patients were at greater risk of experiencing malnutrition, falls and pressure damage. Frail patients would often need support from two or more members of staff for daily care.

34 complaints had been received by the Trust during August. There was no change to the top three categories of complaint: care; communication and; patient pathways. There was still significant challenge around response times, especially for divisional teams, against a backdrop of increasing capacity and pressures.

The Trust's Friends and Family Test scores continued to be highly positive. From over 1,740 responses in August across Inpatients, A&E and Maternity, 99% of those completing the Inpatients survey would recommend the Trust, against the July national average of 94%. The A&E score was 89% against the national average of 76%. Maternity scored 99% against a national average of 93%. It was pleasing to note the highest scoring questions from the test related to patients being treated with kindness and having their pain well-managed. 16 negative responses out of the 208 had been received by A&E in August, most of which related to long waiting times. One negative response had been received out of the forty surveys for Maternity, which was due to pain relief. Outpatient scores were very positive overall.

August and September had been challenging from a workforce perspective, especially in terms of demand. Fill rates for nursing, including care hours per patient day, dropped again and staffing was stretched. Skill mix and registered nurse ratios were also impacted. However, work was ongoing to ensure safety for patients and support for colleagues.

In relation to the 'care hours per patient' data, Mrs Webber asked which escalation areas were open during May. Mrs Carruth noted that escalation capacity would be opened and closed as required, even outside of the Covid pandemic. This transience meant that it was difficult to use national calculation tools to capture metrics such as care hours per patient or fill rates. The pandemic had led to the additional capacity being fully opened all the time, which had impacted upon the overall fill rate. Mrs Webber asked whether the

data could be used to inform conversations about patient safety and associated requests for additional staffing which were brought to Committees. Mrs Carruth noted that the median average given for the Trust and the wider NHS accounted for a large amount of variance between different wards and departments. Even within wards, there was a split between registered nurse hours and care support worker hours. Discussions had taken place with Heads of Nursing and Associate Directors of Nursing about providing a more granular level of detail in reporting, which would provide greater assurance that staff were being deployed in the most effective way.

Mrs Webber suggested that team stability could be included in fall data to identify if there was any correlation. Mrs Carruth agreed to raise the suggestion with the Falls Prevention group.

Mrs Fadero asked how assurance could be given that the right plans were in place around staffing over the challenging winter period to ensure safe care. Mrs Carruth anticipated that the care quality dashboard, which was being developed, would help provide assurance.

ii. Mortality

Dr Walker explained that two mortality indices were tracked: the Summary Hospital Mortality Indicator (SHMI) and the Risk Adjusted Mortality Index (RAMI). The SHMI had increased from 96 to 98 in the last period, but over the same period the RAMI decreased. Crude mortality had fallen over the timeframe in question.

Investigation of the data had highlighted that the increased mortality largely related to the Conquest site, which had a higher SHMI than Eastbourne, despite the RAMIs being almost identical. The depth of coding had been reviewed and had been found to be greater at the Eastbourne site than Conquest. Much of this coding related to palliative care, and roughly twice as much was in place at Eastbourne compared to Conquest. SHMI included a change for palliative care code whereas RAMI did not. Dr Walker advised this was a potential explanation for the disparity between the indices.

Dr Walker noted that despite the SHMI having gone up, ESHT remained significantly below the national average. The RAMI also provided a strong level of assurance about mortality in the Trust.

Mrs Kavanagh highlighted that mortality had been flagged as an area of concern on the balanced scorecard, and Dr Walker noted that this was due to the comparison of the reading to that in the previous year. Both months were well below the national average. Mrs Chadwick-Bell explained that extensive discussions about the IPR and balanced scorecard had taken place between Executives.

iii. Access, Delivery & Activity

Mrs Argent explained that the demand in Emergency Departments (ED) had increased to a around 10% higher than 2019/20 activity levels. Usual seasonal decreases in demand had not materialised in 2020/21. Ambulance attendances were also at a high level, causing increased pressure on the Trust. Furthermore, bed occupancy levels remained significant and this was in part due to supporting front door services.

Mrs Argent outlined the plan which had been developed to respond to challenges faced by the Trust's EDs:

- Remote consultations at the front door, where remote GP consultants would review patients on arrival at ED. If appropriate, patients would be sent home immediately with a booked GP appointment.
- Digital streaming, which would provide a safe and consistent approach to streaming through the E-Consult system at the front door by signposting towards the right services and help to protect the ED from surges.
- Increasing Urgent Treatment Centre (UTC) capacity. A bid to improve the UTC had been approved, which would allow UTC opening hours to be extended. UTCs would provide rapid assessment and triage for all ED patients.
- Expanding gateway access, which would help referrals to other specialities to be processed rapidly and ensure many patients did not need to remain in ED for their triage

Mrs Argent advised that the Trust and local health system were operating at the highest Operational Escalation Level (OPEL) and as a result business continuity had been initiated. A bid to develop urgent community response work as part of the Winter Plan had been submitted. Approval had been granted to increase two hour rapid response provision in the community. The possibility of making discharge lounges open 24 hours a day had also been explored, as well as linking these facilities in with the Trust's discharge hubs.

Mrs Argent advised that although the term 'escalation wards' was widely used to describe additional capacity provision, 'winter surge wards' was a more appropriate description. True escalation would be over and above this known increase in bed requirements. The surge wards were already open.

The Trust had submitted its anticipated elective recovery for H2; during H1, trajectories had been broadly achieved. Revised operational planning guidance had been provided for H2 and a new target of achieving 89% of 2019/20 clock stops had been set, marking a change from the 95% of 2019/20 activity goal which had been set for H1. A paper would be produced once the submission had been ratified.

The five keys areas for recovery had been identified as:

- Theatre utilisation. The Trust would continue to monitor throughput and activity. Some sessions would be moved between sites to maintain the target levels.
- Patient Treatment List (PTL) management. The PTL size as of 30th September 2021 would need to be the same, or lower, than in March 2022 for the target to be met. Various waiting list initiatives were being evaluated to maximise throughput.
- Digital technology to drive efficiencies in clinic utilisation. This would take the form of an automated programme to accurately manage templates and in turn reduce the number of hospital-initiated cancellations.
- Diagnostic capacity. Insourcing of endoscopy capacity would continue. The Trust would procure new echocardiogram (ECG) units to help support delivery of elective treatment.
- Provision of beds. A portion of the elective capacity would be ring-fenced to retain throughout. Furthermore, a protected day surgery unit was in development.

Mrs Argent confirmed that the Trust system had been working around an 'over 104' wait as a key metric in provision of cancer services. ESHT was the only Trust in the region to have delivered against the externally mandated target in this area. The 85% self-imposed Trust target was however not achieved. Mrs Argent explained that this was in part linked to the high levels of complexity with some patient cases. The first of the main priorities for recovery of cancer services would be reducing the time for a first face-to-face or intervention with a patient to four days from an average of seven days, speeding up pathways.

Over the past five months, the Trust had averaged 84-89% of patients being discharged on 'pathway zero' (patients who come in and go home to the same destination without any need for further ongoing intervention). There would be a continuing focus on work that could be undertaken to reduce length of stay before patients were ready for discharge. This would involve further embedding of the Trust's criteria to reside, consultant peer length of stay reviews and improvement of digital management through Nervecentre, as well as ensuring that patients (and their families) understood their anticipated pathway throughout their time with the Trust.

Rapid response and discharge teams were being aligned to assess bed occupancy. An assessment by adult social care at this 'discharge to assess' stage would ensure any necessary ongoing support was in place before the patient left hospital. Engagement with pharmacy teams would facilitate patients developing a sense of ownership and understanding of their medication regime. This would help them to be ready for discharge as soon as possible and feel greater confidence in the process.

The 'EHST at Home' scheme would continue to be piloted over winter, which provided more care to patients within their own homes, where appropriate, under direct ESHT supervision. Mrs Argent outlined an example of one patient, who received twice daily visits and support with IV lines, and how this had saved in the region of 18 hospital bed days. Discussions with external companies were ongoing to provide a care bridge expansion of the Trust's crisis service, as was implemented in the previous winter.

Mr Patel thanked Mrs Argent and asked whether initiatives such as GP Consult

were also being deployed at a primary care level. Mrs Argent confirmed that GP forums and foundations were being engaged to ensure cohesion across the system. GP Consult was live in primary care. The Trust had championed the Livi system, which was now being expanded to a Sussex-wide solution. Mrs Chadwick-Bell added that where good practice was identified, efforts were being made to develop shared models. Other Trusts were planning to adopt ESHT's UTC approach, for instance.

Mrs Webber acknowledged that a good level of assurance had been provided that the front end initiatives described would be able to provide a step change in performance levels, and commended the innovative approaches. She asked whether a similar impact could be made for medically ready for discharge (MRD) patients without an ICS-level response. Mrs Argent acknowledged that some aspects were not wholly within EHST's control, but pilots such as the ESHT at Home programme could help embed 'virtual wards' and accelerate discharge for some patients. Reducing length of stay would support recovery of elective activity so was a priority for the organisation.

Mrs Fadero emphasised the value of a collective winter plan with all system partners, based on shared assumptions around flow from hospital sites into the community. Mrs Agent advised that a workshop was scheduled for 18th October to sign off the system-wide winter plan.

iv. Workforce

Mr Aumayer reported that strong recruitment was being made into the Trust and high levels of interest in roles confirmed its status as an enticing place to work, although underlying turnover rates remained relatively flat.

Levels of sickness had stayed continued at a similar level during the previous twelve months but these were a higher level than was being targeted. The latest data available since the report was published indicated a reduction in overall sickness,, which, in combination with the end of the summer holiday period, had led to an increase in staff availability.

Numbers of nurses and healthcare assistants (HCA) within the Trust were at their highest ever level. Colleagues continued to undertake bank shifts. However, escalation wards, high acuity and MRD patients were adding to pressures. Mr Aumayer noted that a recruitment drive to staff escalation areas was underway.

Operational excellence was highlighted as a key priority, which meant ensuring optimal utilisation of the workforce and maximising its availability. Rota management support was being provided to senior nursing teams to facilitate delivery of this objective supported by weekly meetings.

Efforts were being made at a system-wide level to establish how organisations could best support each another and achieve a greater level of resilience. This included EHST proving support to smaller non-NHS and charitable organisations (such as hospices) to recruit staff from a wider pool of candidates by searching internationally. System-level workforce planning and mobility would further reinforce areas in need.

Mr Aumayer confirmed that the Trust's Covid vaccination hubs had now reopened for booster injection, as well as flu vaccine provision. A roving flu immunisation campaign was also operating.

The staff survey had been opened, and staff response rates were above anticipated levels based on the previous year. Levels of mandatory training compliance were at their highest ever level of 89.9% against a 90% target.

v. Finance

Mr Reid confirmed that breakeven would be achieved for the first six months of the financial year. A small contingency would be brought forward into H2, but he anticipated a greater level of financial challenge for H2. Income continued to deliver beyond target by £5.6M and the Trust remained in receipt of Elective Recovery Fund (ERF) revenue, albeit at a reduced level. The cost of staffing had increased due to recruitment into winter surge wards, which had not yet been built into establishment.

Mr Reid noted that the cost of drugs was increasing, along with certain diagnostics costs. Medicine and core services were also highlighted as areas of increase. As in previous recent years, there was some reliance on agency workers to fulfil certain areas.

There had been some success in delivering the Trust's efficiency plan and achieving the target of £10M in savings remained in sight. However, Mr Reid clarified this would not necessarily be a full efficiency, and in part would come from being better able to avoid cost overspends. Mr Reid acknowledged that the Trust was unlikely to receive ERF funding in H2 that was comparable to that obtained during H1. The move to 89% clock stops as the new key metric was significant and assessment was ongoing about how best to invest and obtain funding in order to meet the target.

There had been high level confirmation of funding being made available for specialities including pathology and radiology, and these projects were being progressed rapidly to ensure they were delivered within year. Changes to staffing establishment were close to being finalised and Mr Reid advised this would provide a clearer staffing baseline once completed.

The capital plan would evolve slightly due to the additional allocations coming through. Mr Reid confirmed it was a normal expectation that some activity would continue into the following financial year and this was also true for 2020/21 in a way that was proportionate with the scale of the plan. Mr Reid reported that he and Mr Hodgson were working on a set of measures to ensure the plans remained on target, which would include quantifying and reporting of any risks to their delivery.

Mrs Webber asked for an update on the Cost Improvement Programme (CIP), and Mr Reid confirmed that identified savings remained the same as those seen at the recent F&I Committee Meeting. Additional plans were being drafted and expected to be developed during the following month.

The Board noted the IPR Report for Month 5 and actions in place.

069/2021 **Winter Plans**

Mrs Argent noted that the Winter Plan was being presented to the Board prior to going to the Q&S Committee as a result of operational pressures. She explained that overall bed base during periods of stability was 352 beds at Eastbourne and 384 at Conquest. A number of beds had been added as part of the planning cycle to accommodate 'red' and 'green' Covid patient pathways. Some schemes used to manage discharges earlier in the year were coming to a close, and these had been accounted for. It was anticipated that Eastbourne would require 408 beds for winter and Conquest would need 415.

In Eastbourne, Devonshire Ward was already opened and would remain so as part of winter surge planning. Glynde would also remain open to address the shortfall between usual requirements and enhanced winter levels. An additional four beds had been added to Crisis Response and this would be reviewed based on outcomes of bids to see if further mitigations could be implemented. The bridging service, previously known as Care Bridge, had been reinstated and would serve to further bolster crisis response. Once these initiatives were fully implemented, a gap of 37 beds would remain at Eastbourne. This would be addressed by working closely alongside system partners and the throughput acceleration schemes previously outlined.

Mrs Argent acknowledged that Conquest had less scope for increasing the bed base. Some bays in Murray Ward were being repurposed to address the shortfall as part of the winter surge. As at Eastbourne, Crisis Response would be extended at Conquest. A gap of 30 beds had been calculated for the Conquest site.

Mrs Argent explained that analysis by the Trust and ICS around the gaps was aligned. Redirecting anticipated admissions from the hospital into ESHT at Home wards and managing discharge profiles would be crucial. Flow within community settings would also be closely managed. Mrs Argent added that providing security, quality and safety were at the forefront of all winter planning. Winter plans aimed to minimise movement of staff and patients to achieve the best possible care experience.

Mrs Webber asked for clarification as to whether it was admission growth or the baseline that been adjusted. Mrs Argent advised that admission growth had increased but length of stay had not fluctuated significantly. She emphasised that the updated numbers were felt to be realistic. Reducing length of stay would be a critical factor towards easing operational pressures. Mrs Chadwick-Bell added that the methodology being used had been brought in four years before and tested robustly, so the plan was felt to be secure and within normal parameters. The Trust was broadly in a similar position to 2019/20 despite the current MRD challenges and risks were mitigated. Overall, the average length of stay was less than in the previous year.

Mrs Webber checked whether the baseline included all the regular beds as well as the surge areas already open, or whether it was just derived from normal capacity. Mrs Chadiwck-Bell explained that the starting point was determined

by how many beds were projected to be required at any given stage in the year, meaning it was not built on top of core capacity. Activity and length of stay were the main inputs to this calculation.

Mr Patel asked whether the model accounted for the potential surge in flu cases which some analysts had predicted, noting that last year flu cases would have been much lower than in other years. Mrs Argent acknowledged that the Trust had not been provided with modelling around expected flu levels and as such 2019/20 was taken as the basis. However, the need to separate patients who were infectious had been considered, which was why 'red' and 'green' flow was built into planning. Any new intelligence received would be fed into modelling.

Mrs Fadero noted that staff had experienced a very challenging 2019/20, and that winter would provide a further challenge. She asked how staff were generally feeling and coping. Mrs Argent reported that additional staff were being recruited to establishment, rather than through bank or agency, to help provide continuity of care and teams. This continuity of teams was welcomed by staff who had previously undergone a period of consistent change and uncertainty. Some temporary staffing would be required to fill gaps on occasion but care would primarily be delivered by established workforce. Mrs Chadwick-Bell added that the Trust was now employing more staff than ever before and sickness levels were not higher than during 2019/20. Access to temporary workforce was also greater.

Mrs Fadero commended the Trust's winter planning approach and took assurance from the plan to build establishment for the surge wards.

In relation to funding for the winter plan, Mr Reid confirmed that capital had been secured as part of H2 for crisis response and some community elements that had been requested. Funding for the three additional wards had yet to be confirmed but this process was ongoing.

The Board noted the Winter Plan

070/2021 **Learning from Deaths Q4**

Dr Walker highlighted a significant increase in deaths seen during Q4, with 726 deaths reported primarily due to the pandemic. This was a large increase over the number of deaths seen in Q4 of previous years. The Trust's medical examiner system had been implemented and was working effectively. This had led to reviews being completed for 714 of the 726 deaths.

During Q4, three deaths had been identified as being possibly avoidable, each linked to Covid in some way. It had been challenging to determine how avoidable the deaths were, given the unprecedented volume of patients at some stages during the pandemic and the difficulty in quantifying the impact of high levels of staff sickness.

Mrs Webber asked about the levels of mortality for patients with identified learning disabilities, as these did not form part of the main dashboard. Mr Walker confirmed that deaths for this group were also higher in Q4 than the previous quarter. Almost all deaths were reviewed through an external process and Dr Walker advised that Covid was the key factor in the increase. A national concern had been raised early in the pandemic where some Covid-positive patients with learning difficulties were inappropriately marked as 'do not resuscitate' (DNR). There was no evidence from data that this had been the case at ESHT, although some learning-disabled patients with Covid had marked as DNR but they had multiple comorbidities which made resuscitation impossible.

The Board noted the report.

071/2021 **Annual Reports for Noting**

i. Health and Safety

Mrs Carruth noted that the paper had been brought for assurance and information. It had been formulated through extensive conversations within the Health and Safety Steering Group and the Q&S Committee.

Mrs Carruth thanked staff for their efforts in what had been an extraordinary year. She also gave thanks to Jenny Newbury, who gave particular support around Covid risk assessments alongside the Infection Prevention and Control team.

The Board noted the report.

ii. Infection Control

The paper was taken as read. Mrs Carruth again thanked all teams within the Trust, including those within the community, as well the local population.

The Board noted the report.

iii. **Organ Donation**

Dr Walker thanked Dr Judith Highgate (Organ Donation Lead), who had written the report. He was noted that the Covid pandemic had made organ donation more challenging, due to increased pressures on intensive care units and the organs of Covid-positive patients being unsuitable for donation. Nonetheless, seven organ transplants were able to take place.

Dr Walker highlighted a request made within the report to roll over donor recognition funds (determined by the number of patients put forward for organ donation) from one year to the next. The amount each year was variable and relatively small, so it was hoped allowing these funds to accumulate would enable larger scale projects. This had happened for the previous year but it

was requested this process become routine. Mr Reid explained there was greater financial flexibility at the end of the previous financial year compared to the current one. A conversation would be held in a different forum to assess whether funds could be brought forward.

The Board noted the report.

072/2021 **Use of Trust Seal**

In response to a question from Mrs Webber about Sealing 72 (Lease agreement for building at Egerton Park, Bexhill), Mr Hodgson confirmed this related to a diagnostics hub for the paediatrics community team.

The Board noted the use of the Trust Seal.

073/2021 **Questions from Members of the Public**

Mr Phoenix noted that a number of questions had been received from Mr Campbell and these would be responded to by the Trust in writing.

A question had been received from Ms Burt, asking when visiting restrictions would end. Mrs Carruth noted that the Trust had never banned visiting at any stage, despite the challenging context of the past year. Visiting restrictions were regularly reviewed and varied between different areas of the Trust. Unfortunately, some visitors were unvaccinated, or refused to comply with mask wearing requirements and social distancing. Mrs Carruth confirmed that there were no plans to further ease restrictions over the winter period. However, the Trust would continue to do all that was safely possible to accommodate visitors. Virtual visiting initiatives were in place for when in-person visits could not occur. Mrs Chadwick-Bell added that communication between wards and families around visiting was very important. Safety of staff, patients and visitors remained the utmost priority and so restrictions would likely remain in place until at least Spring.

Ms Burt also asked whether the pressures on NHS staff during the Covid pandemic had impacted upon the quality of care patients received. Mrs Carruth acknowledged that the second wave of Covid in particular had caused significant challenges to the Trust. Transmission rates had been extremely high within the local community at the time and the national vaccination programme was in its infancy. Despite the best efforts of staff and every possible mitigation being implemented, the fact that many within the workforce were redeployed to the frontline meant that certain services had needed to be suspended. Staff were also negatively impacted by the situation and so everything possible was being done to support the Trust's workforce in moving forward positively. Many of the quality indicators were now recovering.

Mrs Chadwick-Bell added that workforce stress generally came through being unable to deliver the care they would like under enormous operational challenges, rather than staff not being in a position to deliver good care

because they were stressed. Mr Aumayer noted there had been a substantial campaign to deliver support for the workforce in the time and place of need, including placing mental health first aiders on wards ensured help could be given to those in need without delay.

A question was asked by Mrs Walke about availability of crisis response beds for mental health in light of Sussex Partnership moving out of the Trust. Mrs Chadwick-Bell gave assurance that patients presenting with a need for a mental health bed would be provided with one, in line with Sussex Partnership protocols. If a patient could not be discharged to a place of safety, then they would remain in the care of the Trust, either in A & E or on a ward. It was anticipated that there would be sufficient capacity even after Sussex Partnership relocated.

Mrs Walke enquired what was being done to support patients with limited access to or knowledge of technology as more NHS communications were now being delivered digitally. Mrs Chadwick-Bell confirmed that addressing inequalities was a major priority for the Trust, and the provision of any current or future services would never consciously disadvantage any member of the public. Mrs Carruth added that telephone contact was still used extensively alongside more modern solutions and communications were always tailored to each patient's needs.

Mrs Walke sought assurance that the Midwife Led Unit (MLU) would remain open in Eastbourne throughout winter. An update on the status of the planned maternity hub was requested. Mrs Chadwick-Bell advised that the unit remaining open could not be guaranteed, especially in the event of staffing issues. In that situation, a risk assessment would be used to determine the best course of action. However, there were no plans to close the unit. Regarding the maternity hub, Ms Chadwick-Bell confirmed it formed part of the Trust's BFF and transformation plans.

Mrs Walke also asked what plans there were for improving transport links across the two main acute sites, given that some services operated exclusively from one or the other. Mrs Chadwick-Bell noted that as part of the Trust's BFF planning there would be assessment of the number of people travelling between acute sites for treatment. An informed decision could then be made once the scale of need was clear.

Mrs Walke suggested that staff awards and patient story segments be included on Trust Board agendas moving forward. Mrs Chadwick-Bell confirmed that staff awards continued to be given and confirmed updates on these would be shared with the public in future meetings. Mr Aumayer added that 'Hero of the Month' awards were a regular discussion point at Executive Director meetings. Furthermore, the 'Pride of ESHT' annual celebration event was due to take place in the coming months to recognise some of the incredible work done within the Trust. Thank you note cards had also been made available throughout the Trust to provide immediate positive feedback. It was noted by Mrs Chadwick-Bell that patient stories were a standing item within the Quality

and Safety Committee. Mrs Carruth added that bringing some of these stories to the Public Board would be considered.

It was proposed by Mrs Walke that the one visit per day policy should be more widely publicised as there were still people unaware of the restrictions, and perhaps more allowances could be made. Mrs Carruth recognised that placing limits on visiting was challenging for all connected to the Trust. However, it was essential at this time that bays on wards were not crowded and sufficient ventilation be achieved. Visits had the potential to be conducted outside at a considerably lower risk level during suitable weather.

Mrs Walke asked whether the next Board meeting would be conducted in person rather than via MS Teams. Mr Phoenix confirmed that the December and February meetings would be hosted virtually again but the policy was under regular review.

074/2021 **Date of Next Trust Board Public Meeting**

The next Trust Board Public Meeting would take place on Tuesday 14th December 2021 at 0930-1230 via MS Teams.

Signed ……

Position ……..

Date ……

Matters Arising

Meeting information:	
Date of Meeting: 14th December 2021	Agenda Item: 4
Meeting: Trust Board	Reporting Officer: Steve Phoenix, Chair

There were no matters arising from the meeting held on 12th October 2021.

Quality and Safety Committee

Terms of Reference

1. Purpose

The Trust Board has resolved to establish a committee of the Board to be known as the Quality and Safety Committee (the Committee). The main duties of the Committee, on behalf of the Board, taking account of best practice are to;

- Ensure that the organisation's culture and values support innovation, learning, scrutiny and challenge
- Ensure that systems and processes are in place to support effective decision making, based on sound evidence and patient, public, staff and professional experience
- Ensure that structures and systems are in place to support continuous improvement of services and that services are of a high quality, are safe, efficient, effective and deliver a positive staff and patient experience
- Ensure that risks to quality and safety are reviewed regularly and that systems and controls are in place to ensure mitigation, that risks are current and reflect the context and feel of the organisation and the system

2. Responsibilities

Assurance

- Seek assurance that patients, staff and other key stakeholders are actively and effectively engaged in quality and safety issues and that the mechanisms for seeking and responding to feedback from staff and patients are robust and effective
- Seek assurance that recommendations emerging from national NHS quality and safety reports are considered and implemented as appropriate
- Review the Trust risk register and Board Assurance Framework (BAF) to identify relevant quality and safety risks and seek assurance that appropriate management action has been taken to manage and mitigate these risks, reporting any gaps in control or assurance to the Board
- Review the Trust's key quality metrics to seek assurance that areas of underperformance are identified and that appropriate quality improvement actions are taken to deliver the measurable improvements required
- Monitor and review the systems and processes in place in the Trust in relation to Infection Prevention and Control and to review progress against identified risks to reduce healthcare acquired infections.
- Receive reports and assurances (including those from internal and external audit) that the Trust's Quality Governance Structure is being effectively operated and agree any amendments to the strategy prior to recommending these to the Board for approval.

Improvement

- Seek assurance that the Trust's Quality Improvement Programme addresses key areas of concern & risk, is being delivered in a timely way and that there is an evidence base for the effectiveness of the plan & the delivery of the required quality improvements
- Seek assurance that effective management processes are in place that ensure the Trust has taken appropriate action and shared learning in response to relevant national and local reports, guidance and reviews to improve the safety and quality of care.
- Review themes and trends that occur in patient and staff feedback, patient safety & quality data, clinical audit, complaints, Claims and Inquests, patient safety and serious incidents. Seek assurance that actions are in place and that learning is being embedded.
- Monitor the programme of external visits and reviews and have oversight of the progress in implementing actions and shared learning. To receive a highlight report and minutes from the Patient Safety and Quality Group and from all other groups that report into the Committee

Other Activities

- To receive exception reports for Health and Safety and seek assurance on the actions to be taken and identified learning shared across the organisation.
- Monitor the Trust's Quality Accounts and ensure effective consultation with stakeholders takes place and to monitor the delivery of the quality targets.
- Receive a six monthly review of Quality Impact Assessments in relation to cost improvement programmes, for assurance that a robust process is in place and that unintended consequences are identified, mitigated and monitored.
- The Committee will work with other Committees within the organisation whose work can provide relevant assurance to the Quality and Safety Committee's own scope of work; in particular this will include the Finance and Investment Committee and the Audit Committee.

3. Membership and Attendance

The Committee and the Committee Chair will be appointed by the Chair of the Trust Board. Members of the Committee shall be:

Core Membership

 Two Non-Executive Directors one of whom will be the Committee Chair
 Chief Operating Officer
 Medical Director
 Chief Nurse
 Director of Corporate Affairs
 Head of Governance
 Chief People Officer
 Assistant Medical Director (also deputises for Medical Director)

 Director of Strategy, Improvement and Innovation
 Chief Pharmacist
 Deputy Director of Nursing (also deputises for Chief Nurse)
 Assistant Director of Nursing and Quality for each Division
 Head of Nursing (Conquest or EDGH) for the Emergency Departments
 Head of Nursing, Core Services Division

Chiefs of Division, while not members, will be invited on a rotational basis and to address specific agenda items.

4. Quorum
Quorum of the Committee shall be four members, at least one of which must be a non-executive director. Core members are expected to attend all meetings. In their absence a fully briefed deputy must attend and will count towards the quorum.

5. Frequency
Meetings shall be held every month and at such other times as the Chair of the Committee shall require. Work plans will detail the reports to be taken at each meeting.

6. Authority
The Committee is authorised by the Trust Board to review any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employers are directed to cooperate with any requests made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee may establish sub-committees or working groups if this would support it in achieving its objectives.

7. Reporting arrangements and subcommittees
Minutes of the Committee meetings shall be formally recorded by the Secretary to the Committee and submitted to the Trust Board. The Chair of the Committee shall present a short written summary of each Committee meeting to draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the statement on internal control and by exception as and when necessary.

The Committee shall undertake a self-assessment of its effectiveness annually.

The committee has the following subcommittee reporting into it:

Patient Safety and Quality Group

These Terms of Reference shall be reviewed by the Committee and proposed revisions considered by the Trust Board on at least an annual basis.

People and Organisational Development (POD) Committee Executive Summary 18th November 2021

Introduction
Since the Board last met a POD Committee meeting was held on 18 November 2021. A summary of the items discussed at the meeting is set out below.

Review of Action Tracker
The outstanding items on the action tracker were reviewed and further updates would be provided at the next meeting.

Workforce Report
An update was provided on the workforce report highlighting that the Emergency Department (ED) remained challenged across the Trust driven by high levels of ED attendance and multiple "Medical Ready to Discharge" (MRD) patients. The ability to be able to forecast and plan against need had improved significantly enabling these challenges to be managed appropriately.

Staff Vaccination Hubs
Hubs for Covid Booster and Flu remain open working alongside community hubs to ensure that all staff have access to vaccination services. Roving flu clinics also in place to offer maximum uptake.

Winter Sparkle Programme
The aim of the "Winter Sparkle" programme was to be as efficient as possible around discharges, flows and working in different ways. Alongside this, a number of opportunities had been put in place to recognise and thank staff for their continual support at this very challenging time.

Highlights
- The recruitment team held a re-set week focussing on start dates; achieved 125 booked start dates in one week.
- 44 International nurses to commence in post in December with further cohorts planned in the New Year.
- A number of activities planned for Disability History Month.
- Staff attendance at the HSJ Awards; nomination of 2 awards.

Steve Aumayer expressed his thanks and congratulations to Jacquie Fuller, who had been an amazing member of the HR team for 30 years. Jacquie commenced in post as a crèche assistant to her current post of Staff and Wellbeing Manager.

The Guardian of Safe Working Hours (GOSWH)
An update was provided of the GOSWH report covering the 244 new intake of Doctors in Training (DiTs) who joined the Trust between the period of August to October 2021. Traditionally a higher number of Exception Reports (ERs) are received as trainees settle into their new roles and departments during induction.

Overall DiT are still underreporting by ERs. This is clear from feedback generated by the trainee representatives at their relevant post local faculty group meeting where more concerns are generated regarding rotas, rota gaps and intensity of work. Some of the reasons behind the underreporting have been highlighted in the trainee survey answers. The GoSWH team are sharing the outcome, action points and recommendation with the current trainees directly and with supervisors via Local Faculty Group meetings.

Leadership Development
An update was provided outlining Leadership Development during the pandemic and the importance of moving forward to the 'new normal' at all levels.

During the pandemic, the Organisational Development Team have been responsive to the needs of individuals and teams by developing a range of high quality, accessible, bitesize development opportunities to support our leaders during a very challenging time.

Like many other organisations there has been an increase in the use of virtual learning through MS Teams as well as continuing with some face to face training particularly for teams at times to suit their own needs.

It was recognised that moving into the 'new normal' would continue to be extremely challenging to everyone but especially to Leaders who will be dealing with the secondary stressors following the pandemic- operational pressures, no real opportunity for all colleagues in the NHS to pause leading to fatigue and in some areas low morale.

Apprenticeships
An update was provided on apprenticeship activity.

Key focus:

- Apprenticeship activity continues to grow in the Trust and there are currently a total of 188 employees on a range of apprenticeship programmes.
- Working with Henley Business School the Trust commissioned a comprehensive Leadership BMA Programme for Senior Leaders from Band 7 and above.
- FYI Leadership programme:
- 15 FY1 doctors commenced programme in July 2020, 13 remain
- 17 new FY1 doctors commenced programme in August 2021
- Clinical Apprenticeship programmes in place.

Challenges:

- Continue to support a number of clinical and non-clinical employees on apprenticeship programmes with breaks in learning for a variety of reasons.
- Funding - The ongoing challenge with the adoption of the apprenticeship programme is the lack of being able to use the Levy to support salary backfill that can be used to support services who wish to develop their staff using the apprenticeship pathway.

Future priorities:

- Develop robust career pathways to support development of staff through the apprenticeship routes to support service transformation.
- To continue to increase the number of existing staff accessing approved apprenticeships.
- Continue to work with the ICS to develop and support the implementation of programmes that will work across the healthcare pathway.
- Continue to maximise full use of the Apprenticeship Levy and ensure that there is sufficient funding to cover End Point Assessments.

Miranda Kavanagh
Chair of POD Committee
November 2021

Audit Committee Report – 25th November 2021

The Audit Committee last met on the 25th November.

Capital Programme Review
Recommendations following the recent Capital Programme Review were presented to the Committee, along with updates and actions from the Trust. The Audit Committee would monitor the actions being undertaken by the Trust, and an update would be presented at January's Committee.

Review of Declarations of Interests, Gifts, Hospitality, Sponsorship and Ex Gratia Payments
It was noted that these declarations were now submitted through the NHS Electronic Staff Record system. Since moving to the new system, compliance had risen from 58% to 70% for decision making staff of Band 7 and above. Declarations were reviewed and escalated to Executives when required. It was suggested that a requirement to declare could be stipulated within job specifications for all staff, including those below Band 7. Mandatory online training for staff was another proposed mitigation. This would be coupled with proactive monitoring as part of the work plan.

Data Quality
A report was presented around ongoing work to assess and ensure the quality of data used within the Trust. It was noted that a finalised report would be submitted in around March 2022. It was suggested there may be scope for greater use of digital solutions that would reduce the degree to which data was manually processed.

Tenders and Waivers
27 waivers had been issued in the year to date, compared to 26 in the previous year. Two retrospective waivers were implemented. The first of these was in relation to Frencon Construction and the second was for an audit of the Hospital Sterilisation and Decontamination Unit (HSDU) by SGS (an accreditation body).

Review of Losses and Special Payments
Most of the losses reported related to drugs but the overall amount was less than it had been in previous years. Some drugs needed to be kept for emergency situations, despite it being unlikely they would be used. The cost of these then had to be written off when they reached the expiry date.

Information Governance Toolkit Update
Confirmation was received that the Data Security and Protection Toolkit (DSPT) work was expected to be ready for submission in June 2022. The Trust's Information Governance Lead and Data Protection Officer reported two information governance (IG) breaches. One had since been closed with the Information Commissioner's Office and the other was awaiting feedback. More incidents had been reported by staff than over the same period in the previous year. Board members would need to ensure that their IG and data protection training was up to date in order to meet with audit requirements.

Internal Audit Progress Report
Three summary reports had been issued since the previous meeting. There were two outcomes of reasonable assurance and one of limited assurance (around remote working).

Status of Internal Audit Recommendations
The main focus of ongoing recommendations was the IT continuity audit. It was agreed that some risks could be moved onto the risk register and removed from the recommendation tracker.

External Audit Report
It was confirmed that ESHT would have a dedicated external audit team for 2022. This would help to ensure a short turnaround on audit queries.

Anti-Crime Specialist (ACS) Service Progress Report
It was noted that the Trust's Head of Procurement had agreed to take on the role of Counter Fraud Champion for ESHT. A contract management review would take place, which would be considered alongside diligence checks on suppliers to see whether there were any areas of high risk within the Trust. A recommendations tracker had been implemented.

Paresh Patel
Chair – Audit Committee

Strategy Committee Summary – October 2021

The Strategy Committee last met 28th October. The key points from which were as follows:

BFF
The Committee reinforced the need to ensure digitisation was embedded as part of the ESHT transformation plans. It was also reported that the clinical strategies for Cardiology and Ophthalmology would be considered at HOSC in December.

ICS
Support was given to the ICS strategy of developing common source data rich environments to inform patient need based on analytics. This is developing but will not be a quick win.
The Committee stressed the need to ensure that service reform should include third sector/voluntary organisation. It was noted that in terms of engagement our community services were already active.

MSK
The Committee was keen to support service delivery and influence further development to improve patient experience and clinical outcomes.

Accessibility
It was reported that EDS2 have, or are developing, four key goals to focus on patient engagement to ensure accessible services and these would be scrutinised at POD.

Digital Strategy
It was reported that there are 3 bids in progress to build digital maturity at Acute, Mental Health and Community and at ICS level. ESHT is deeply involved in these, which gives assurance on fit with our strategic goals.

Clinical Strategy
An update on progress was presented, with the Committee noting the importance of workforce development, Health and Well-being and Patient Empowerment.

Jackie Churchward-Cardiff
Chair – Strategy Committee

Chief Executive Report

Meeting information:			
Date of Meeting:	14th December 2021	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell, CEO

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

Introduction

As always, I would like to start with a big thank you to our staff, who continue to work tirelessly and with compassion to look after our patients through our community, urgent and planned care services, but also those who work in corporate areas to support their colleagues.

The Trust remains busy as we see increased urgent activity, but also continue to ensure we can treat our cancer and elective patients. As we move into winter we aim to continue all of our services and where we can undertake more out-patient and elective work, and we will do that through increasing productivity but where people are happy to with extra sessions as teams are keen to work to reduce waiting lists which built up in the earlier stages of Covid.

Whilst ensuring our services remain safe, there will be a greater focus on reducing our financial run rate and efficiency. The financial arrangement for the second half of the year are signalling a likely deficit position, which we are working across Sussex providers and the ICS to mitigate. There are opportunities to mitigate further with additional activity although this is challenging at this time of year and we are awaiting confirmation of further national monies to support our winter wards, extended community services and extra elective activity.

Colleagues will give more detail in the integrated performance report about how this impacts, quality, our workforce, performance and finance.

We are delighted to announce that we have been selected for some new initiatives

1) We will be one of 4 national pilots, introducing a new clinical system which will;

- Enable consultants, schedulers, and data quality teams to clean, validate, and manage Trust waitlists from a shared source of truth.

- Ensure Data quality issues are automatically flagged to the relevant user groups, providing clean and up-to-date waitlists.
- Enable clinicians to conduct reprioritisation by providing a systematic way to track surgical waitlists, and action the reprioritisation of patients on the waitlist.

2) Electronic Patient Record (EPR)

Our bid to NHSX for funding to support the implementation of an Electronic Patient Record (EPR) was successful. The programme is being badged as "Digital Aspirant Plus" and means we will be given £250,000 to support the development of a business case and the procurement phase, with the aim of awarding the contract by December 2022. We will then receive 50% funding for the cost of the system and implementation, with the Trust required to match fund the remaining 50%.

The EPR will provide a single system where all patient information will be recorded digitally and securely, replacing several paper and digital systems currently used in the Trust. This will give clinicians quick and easy access to the information they need at any time of day or night, reduce paperwork and repetition and free up time to spend with patients. It will also remove the need for patients to repeat the same information to different members of staff and improve the overall patient experience by providing care that is smoother, safer and more patient-centred.

Key Areas of Risk and Focus

- Covid numbers have increased in recent weeks and safety and care continues to be our priority
- Greater focus on reducing our financial run rate and reduce the likely financial gap
- Embedding our UTC model and flow direct to ambulatory and assessment services in order to reduce pressure in our emergency departments and optimise same day care
- Reducing our length of stay in our acute hospitals and optimising flow and pathways within our community services, aim to return to 2019/20 length of stay as a minimum
- Focus on completing elective treatments 'clock stops' in line with the national requirements as a minimum of 89% compare to 19/20, aiming for 94%
- Recognising 4 hour performance is challenged nationally, aim to be an upper quartile provider
- Deliver our capital programme and key schemes

Integrated Care System and Partnerships

The Integrated Care System (ICS) will transition to the Integrated Care Board (ICB) from 1 April 22 and will become a legal entity known as NHS Sussex. The new Chair has been announced and we are glad to welcome Stephen Lighfoot into the role. The CEO recruitment is complete, but appointments have not yet been announced, although this is due imminently. The ICB will be responsible for the oversight of the NHS across Sussex although providers retain the sovereignty and accountability through the Chief Executive and Board.

We will continue to develop collaboration of providers across Health and Care at the East Sussex level to ensure we develop and organise services with a focus on inequality and population health.

Winter Sparkle

As already noted, winter will be challenging for us, however by working together across the organisation there are some areas which if we focus we believe we can make some improvements and these largely focus one ensuring we embed processes which focus on right care, right place, right time. These are not new, but need some fresh focus over the coming weeks, the aim is to reduce the need to reduce bed occupancy, which in turn reduces the extra capacity and the need to move staff to cover areas away from their usual place of work, we aim to reduce the number of patients who no longer require care in our acute beds and this is a perfect opportunity to build in

some of the new clinical models being developed within our Building for our Future Transformation Programme.

However, we equally want to prioritise the wellbeing of our staff and ensure through this time we focus on how our colleagues are feeling and we have a few treats lined up along the way in the lead up to Christmas.

The Board and other senior leaders will be more visible across the Trust and in some cases will be 'back to the floor' supporting colleagues in their day to day work.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period October 2021 (Month 7)

Content

East Sussex Healthcare NHS Trust

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4.	Our People – Our Staff - Recruitment and retention - Staff turnover / sickness - Our quality workforce - What our staff are telling us?	
5.	Access and Responsiveness - Delivering the NHS Constitutional Standards - Urgent Care - Front Door - Urgent Care – Flow - Planned Care - Our Cancer services	
6.	Financial Control and Capital Development - Our Income and Expenditure - Our Income and Activity - Our Expenditure and Workforce, including temporary workforce - Cost Improvement Plans - Divisional Summaries	
7.	Ensuring Our Future - Our Business Plans - Our Business Cases / Cases for Change	

East Sussex Healthcare NHS Trust

About our IPR

- Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (2021/22), is being delivered.
- Throughout our work we remain committed to delivering and improving on:
  - Care Quality Commission Standards
    - Are we safe?
    - Are we effective?
    - Are we caring?
    - Are we responsive?
    - Are we well-led?
  - Constitutional Standards
  - Financial Sustainability in the long term plan
- Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.
- Detailed data can be found within the IPR Data Detail (appendix A).

Our AMBITION is to be an outstanding organisation that is always improving
Our VISION is to combine community and hospital services to provide safe, compassionate and high quality care to improve the health and well-being of the people of East Sussex

Balanced Scorecard

East Sussex Healthcare NHS Trust

Key Metrics

Safety	Target / Limit	Last month	This Month	Variation	Assurance
Patient Safety Incidents	M	985	1037	Common Cause	
Serious Incidents	M	6	4	Common Cause	
Never Events	M	0	0	Improvement	
Falls per 1,000 bed days	5.5	5.5	7.1	Common Cause	Inconsistent
Pressure Ulcers, grade 3 to 4	0	2	1	Common Cause	Inconsistent
MRSA Cases	0	0	0	Improvement	Consistently Hit
C diff cases	<5	7	1	Common Cause	Inconsistent
MSSA cases	M	1	2	Common Cause	
RAM	94	85.6	84.7	Common Cause	Consistently Hit
SHM (NHS Digital monthly)	0.99	0.99	0.97	Common Cause	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	89%	89%	Common Cause	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	80%	83%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last month	This Month	Variation	Assurance
Complaints received	M	40	38	Common Cause	
A&E FFT Score	M	90%	94%	Common Cause	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	100%	98%	Common Cause	
Out of Hospital FFT Score	M	99%	98%	Common Cause	
Outpatient FFT Score	M	98%	99%	Common Cause	

Our Performance	Target / Limit	Last month	This Month	Variation	Assurance
A&E 4 hour target	>95%	75.3%	73.9%	Concern	Consistently Missed
A&E Non Admitted	M	82.9%	81.8%	Concern	
A%E 12 hour from Arrival	M	285	330	Concern	
UTC 2 hour	>98%	65.5%	62.6%	Concern	Consistently Missed
Cancer 2ww	>93%	96.0%	97.4%	Common Cause	Consistently Hit
Cancer 62 Day	>85%	71.8%	76.2%	Common Cause	Inconsistent
62 day Backlog	M	139	156	Common Cause	
104 day Backlog	M	32	34	Improvement	
RTT under 18 weeks	>92%	76.2%	75.1%	Common Cause	Consistently Missed
RTT 52 week wait	0	61	50	Common Cause	Consistently Missed
RTT Total Waiting List Size	36,833	36,833	37,005	Concern	Inconsistent
Overdue P2	M	221	244	Common Cause	
CHIC within target wait time	M	88.7%	83.8%	Common Cause	
Diagnostic <6 weeks	<1%	17.5%	17.7%	Common Cause	Consistently Missed

Our People	Target / Limit	Last month	This Month	Variation	Assurance
Establishment (WTE)	M	7,577.9	7,910.8		
Vacancy Rate	<5%	6.3%	9.2%	Common Cause	Inconsistent
Staff Turnover	<9.9%	10.1%	10.5%	Concern	Inconsistent
Retention Rate	>92%	92.5%	92.5%	Common Cause	Consistently Hit
Sickness - Absence % (rolling 12 mths)	<4.5%	5.1%	5.2%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	18.6	19.1	Concern	Consistently Missed
Staff Appraisals	>85%	73.2%	73.3%	Concern	Consistently Missed
Statutory & Mandatory Training	>90%	89.2%	89.1%	Improvement	Consistently Missed

Our Recovery	%19/20 Agreed	Last month	Var	%19/20 Agreed	This Month	Var
Total Outpatients	95%	106%	11%	95%	105%	10%
New Outpatients	95%	105%	10%	95%	104%	9%
Follow UP Outpatients	95%	109%	14%	95%	109%	14%
Elective Daycase	95%	99%	4%	95%	95%	0%
Elective Inpatients	95%	76%	-19%	95%	77%	-18%

Our Productivity	Target / Limit	Last month	This Month	Variation	Assurance
4 hour theatre sessions	M	496	461	Improvement	
Average Cases per 4 hour session	M	2.5	2.4	Improvement	
Clinic run rate	M	80.5%	82.4%	Improvement	
Non Face to Face Outpatients	>25%	30.4%	28.2%	Concern	Consistently Hit
Elective Length of Stay	2.7	3.0	2.7	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	4.3	4.2	Common Cause	Inconsistent

East Sussex Healthcare NHS Trust

Executive Summary

- Our standards in Quality and Safety remain consistently high. With falls, pressure ulcers and incidents all remaining within control limits. We continue to listen to our patients through FFT and complaint routes to understand what is important to our patient, what we can improve on and to share recognised good practice.
- The 4 hour standard for ED averaged at 73.9% for October. This places us 40th overall in the country out of 119. Although not where we would want to be, we are above average nationally and are continuing to invest in our Emergency Departments; financially and from a service improvement perspective. Recognising that front door demand has changed, we have audited and reviewed our demand, and now recruiting to a new structure to support the 4 hour target. We are also working with our digital team to introduce new systems to aide an improved and more efficient patient experience.
- Our cancer performance continues to improve. Achieving the 28 day faster diagnosis again in October and improving our overall 62 day performance whilst reducing the 104 day backlog. There is an increase in cancer referrals and this will continue to remain a key focus for the Trust to manage these referrals and ensure patients are seen in line with national guidance.
- For our elective programme, the national operational planning guidance for H2 has changed. Trusts are asked to baseline the number of completed pathways achieved in 2019/20 and work towards achieving 89% of this in H2 of 2021/22. In October, the Trust achieved 78% against the 89% target. However, given that the guidance was only published on 30th September, it was accepted that we could not adapt our booked activity in time to refocus towards the H2 ask. There is a risk to delivery of the elective programme in the coming months, both from a financial and workforce perspective. Which the Trust will continue to work towards and ensure patients are waiting well. But it should be recognised that the aforementioned are limiting factors to delivery.
- Our challenge to be able to discharge patients who are medically ready is still very much a focus but we continue to work with our system partners to address this. Although there has been an overall decrease in LoS, this is principally seen in those patients whom we are discharging to home address and with no increase / requirement for additional support.
- We have increased our workforce to deal with the increased demand and pressure and it remains a daily focus to try and ensure we have sufficient staffing to meet the growing and changing demand. However, this will impact on our finances as we have to fill some gaps at short notice with temporary / agency staff. To support our elective recovery and emergency care demand. The Trust is using 498 (7%) more staff than in 19/20.
- Income is broadly in line with plan, variance is driven by ERF and H1 pay award to date
- Our pay cost variance has increased driven by the inclusion of £4.3m of pay award back pay. And temporary staff costs are £22.4m YTD
- Non-pay costs now exceed budget mainly driven by tariff excluded drugs and devices above plan however, some of this is offset by higher tariff drug income.
- A net risk of £7.5m has been identified; Against mitigations of £5.8m, suggesting that based on current information, the Trust will face significant challenge to deliver a balanced position
- Covid position continues to support the trusts overall financial position with an effective YTD contribution of £10.9m (£16.8m income).

Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

East Sussex Healthcare NHS Trust

Quality and Safety

			Author(s)
Quality and Safety **October 2021 data**	**COVID - 19** The prevalence of COVID in the local population was (and is) increasing with a higher rate in parts of East Sussex (and in the over 60 years age group) than the national level. The highly infectious delta variant is still the dominant strain. 70% of all positive inpatients were fully vaccinated. There were three outbreaks of COVID during the month. **Infection Control** The revised limits for the alert organisms were published in August. The limit of CDI was exceeded in the first two quarters of the year but was below the self imposed limit in October with 3 cases attributed to ESHT against a limit of 4.There is no evidence of an outbreak. **Incidents** • 4 SIs were reported in October and incidence remains within normal variation • Challenges remain in completing SI investigations and reports within 60 days **Pressure Ulcers** Overall rates remain within control limits within common cause variation. One category 3 pressure ulcer was reported and RCA investigation is underway. **Falls** 1 x severity 3 fall at Rye Intermediate Care with an overall considerable increase there under review. Significant additional capacity still open (80-100 beds) impacting on nurse staffing levels with resources still very stretched. Hot spot areas identified with evidence of staffing challenges and high acuity/dependency.	**Patient Experience - Complaints/Friends & Family Test (FFT)** Teams continue to work through the backlog of complaints from wave 2 with ongoing challenges to response times. FFT submissions still remain lower than pre-COVID but with recommendation rates ranging between 94.05% and 99.11% for A&E, Inpatient areas, Maternity and Outpatients. It is hoped that a digital option for FFT will be available by December which will give patients the option to provide feedback in other ways. **Nursing & Midwifery Workforce** The requirement for significant amounts of additional capacity has continued through October (and Nov) and patient admissions due to COVID-19 have increased. This continues to impact on nurse staffing levels on a daily basis. Additional health and well-being support has been put in place. System benchmarking and sharing of safer staffing methodology for nursing to ensure consistency across Sussex is underway. The next ESHT Nursing Establishment Review for 2021/2022 data collection began on the 1st November and will conclude on 26th November with the aim to complete the review in Q4. Fortnightly Healthroster support sessions are now being held with senior Divisional nurses to ensure safe/optimum staffing levels. **Mortality** Both SHMI and RAMI indices of mortality remain better than peers. Both SHMI & RAMI have decreased this month and RAMI remains in the top quartile across NHS England Acute Peers. Work is ongoing with investigations into depth of coding and other areas to improve the accuracy of SHMI.	 **Vikki Carruth** Chief Nurse and Director of Infection Prevention & Control (DIPC)  **David Walker** Medical Director
Actions:	Review of falls at Rye IC.		

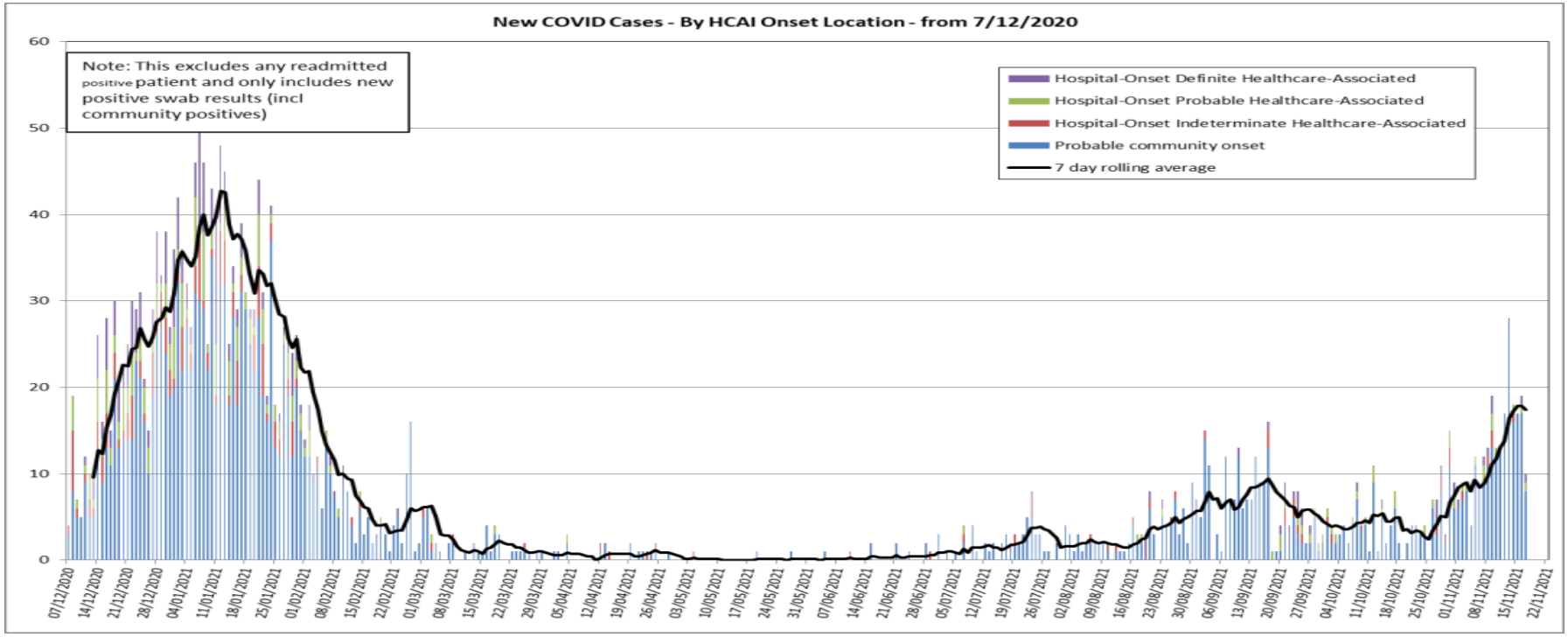
COVID-19

East Sussex Healthcare NHS Trust

Quality and Safety

Prevalence

The rate of COVID in parts of East Sussex was/is greater than the England rate. Prevalence of COVID in the local community was/is increasing. As at the 15th of November Hastings had a positivity rate of 457/100,000 compared to the England prevalence of 354/100,000 and Rother and Wealden were also higher than national prevalence. In addition the number of people over 60 years old testing positive in Hastings (304/100,000) and Rother (252/100,000) was significantly higher than the overall England level of 183/100,000 and the reason for this is currently unclear.



Outbreaks and Serious Incident Investigations

On 30/09/21 Tressell ward was closed due to a relatively small outbreak of COVID. On 23rd October 2021 a more significant COVID-19 outbreak was declared on Devonshire ward and Seaford ward was closed on 30/10/21 due to a small outbreak. All are subject to full RCA and SI investigations. There is no evidence to suggest any lapses in care and sources are most likely thought to be patients or visitors with some patients incubating Covid on admission with an initial negative result subsequently testing positive later on. Not all patients are fully vaccinated and not all are compliant with PPE and IPC guidance/requirements for various reasons. The vaccination status of visitors is unknown and again compliance with PPE and IPC is variable despite staff challenge/support.

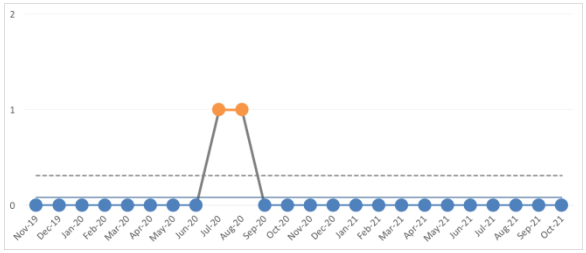
Safe Care - Infection Control (non COVID)

East Sussex Healthcare NHS Trust

Quality and Safety

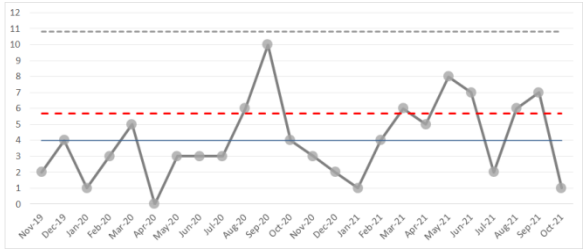
MRSA cases

Target: 0
Variation: Normal
Current Month: 0



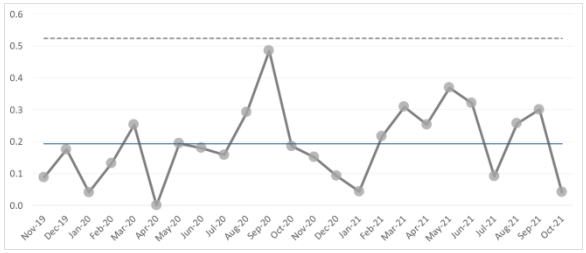
CDIFF cases

Limit: 5.66
Variation: Normal
Current Month: 1



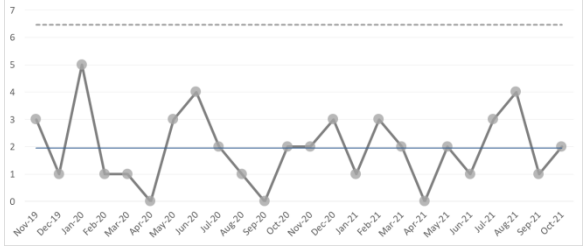
CDIFF per 1000 bed days

Monitoring
Variation: Normal
Current Month: 0.4



MSSA

Monitoring
Variation: Normal
Current Month: 2



Author: Lisa Redmond – Head of Infection Control & Deputy DIPC

MRSA bacteraemia (MRSA)
There were no attributable MRSA bacteraemias reported in October.

Clostridium Difficile Infection (CDI)
For the month of October, ESHT reported 3 cases of CDI against the internal monthly limit of 4. Of these 3 cases, one was reported as a HOHA (Hospital Onset Healthcare Associated), and 2 cases were reported as COHA (Community Onset Healthcare Associated). Post infection reviews are underway. There is no evidence that cases are related in time and place, or represent an outbreak. There is an increase nationally but no clear data yet as to why.

MSSA bacteraemia
In October the trust reported 2 hospital attributable MSSA bacteraemias. One case was found to be Hickman line related in a complex patient receiving Total Parental Nutrition (TPN). It was assessed as possibly unavoidable as the patient was frequently off the ward. The line was later removed and the patient was treated with antibiotics. The second case was of an unknown cause and the patient received antibiotics.

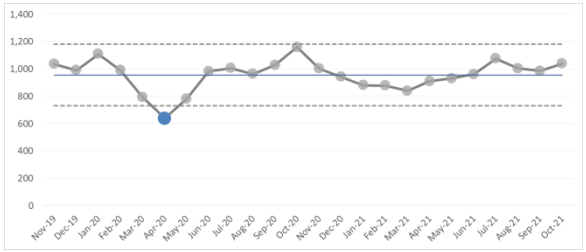
Safe Care – Incidents

East Sussex Healthcare NHS Trust

Quality and Safety

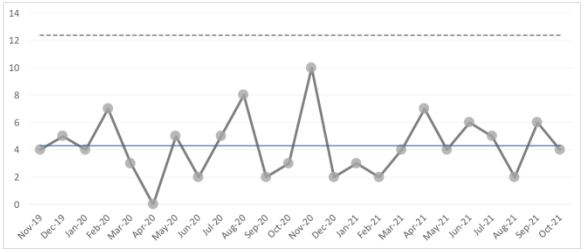
Patient Safety Incidents
(Total Incidents ESHT *and Non ESHT*)

Monitoring
Variation Normal
Current Month: 1038



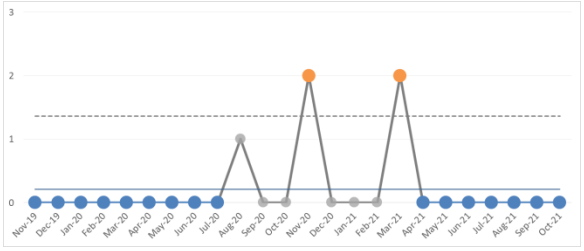
Serious Incidents (SIs)
(Incidents recorded on Datix)

Monitoring
Variation: Normal
Current Month: 4



Never Events
(Incidents recorded on Datix)

Monitoring
Variation: Normal
Current Month: 0



Author:	**Lisa Forward – Head of Governance**
Status Report	Of the **890 ESHT only** incidents: 629 x severity one, 245 x severity two, 15 x severity three, 1 x severity four and 0 x severity five. **Top three locations** : • Patient's Home (68) • Emergency Dept CQ and Emergency Dept EDGH (40 each) • Administration (34) Top categories remain Slips/Trips/Falls with 169 incidents, (increase), Medication incidents with 124 (increase) and Diagnosis and Diagnostic Services with 93 (decrease). There were 4 SIs reported in October: • 1 x baby requiring transfer to another hospital for cooling (HSIB investigation) • 1 x paediatric Safeguarding case • 2 x COVID-19 outbreaks meeting SI criteria
Challenge & Risk:	The number of **open SI** investigations continues to increase. The implementation of the Patient Safety Incident Response Framework (PSIRF) is a concern, particularly in relation to training and education for staff. At present, there is not the capacity to deliver training or capacity for staff to attend.
Actions:	The internal process for SI and Amber reports has been adjusted to streamline review and sign off. Ongoing raising of awareness through presentation of the PSIRF at appropriate meetings. Previous gap analysis against the short and medium term priorities for PSIRF. Actions to be reviewed and an update provided to Quality and Safety Committee in December.

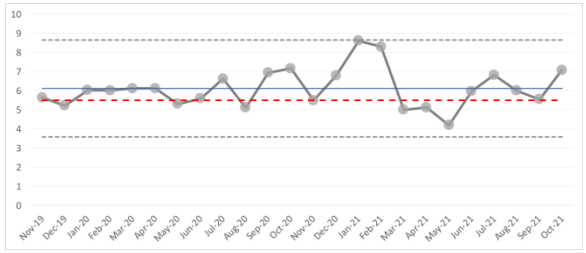
Safe Care – Falls

East Sussex Healthcare NHS Trust

Quality and Safety

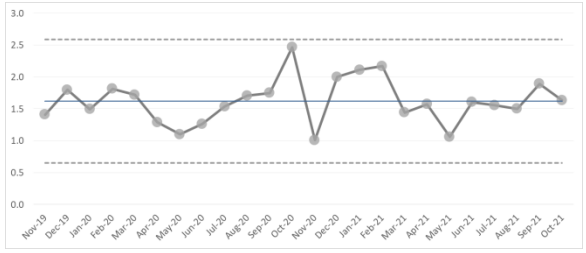
Total Falls Per 1000 bed days

RCP National Average: 6.6
(RCP – Royal College of Physicians)
Internal Stretch: <5.5
Variation: Normal
Current Month: 7.1



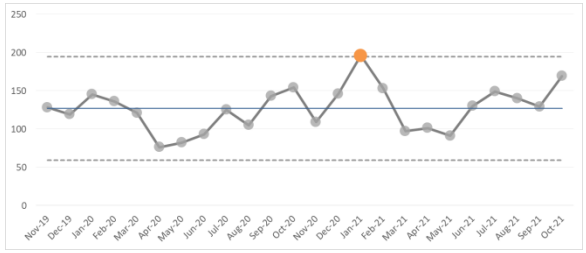
Falls with Harm Per 1000 bed days

Monitoring
Variation: Normal
Current Month: 1.6



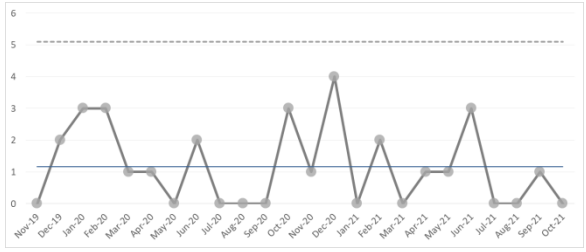
Total Falls

Monitoring
Variation: Normal
Current Month: 169



Major or Catastrophic Falls

Monitoring
Variation: Normal
Current Month: 0



Author: **Hazel Tonge – Deputy Director of Nursing**

Status Report

Recent months have continued to be very challenging due to ongoing pressures with significant new additional and escalation capacity open of circa 70 -100 beds. To ensure safety and support continuity, substantive areas continue to deploy staff to the new areas whilst recruitment continues. Despite best efforts, it is not always possible to backfill, leaving many gaps at times with reduced ratios and skill mix.

1 x severity 3 fall at Rye Intermediate Care

Top locations :

- Irvine Unit (17)
- Devonshire Ward (14)

Challenge & Risk:

The significant additional capacity and impact on nurse staffing is likely to have an impact on falls especially for higher risk patients many of whom require enhanced observation (1:1 care) or two staff to help with mobility and personal care.

Actions:

- Recruitment underway for new areas and existing vacancies with attempts to reduce escalation capacity - 30 beds plus at EDGH proving challenging.

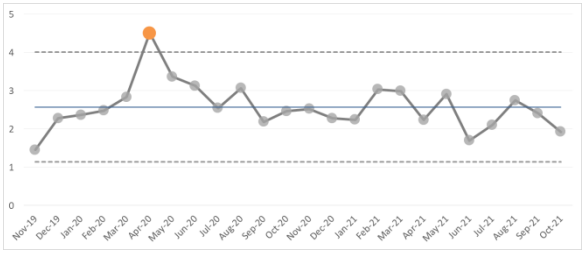
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

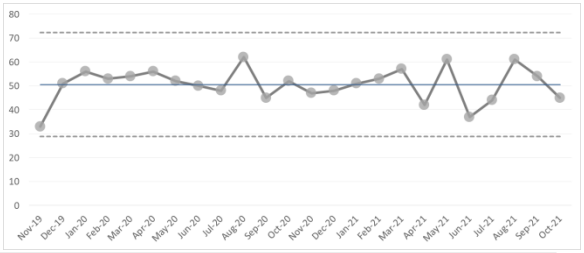
Pressure Ulcers (PUs) Per 1000 bed days (Grade 2,3,4)

Monitoring
Variation: Normal
Current Month: 1.93



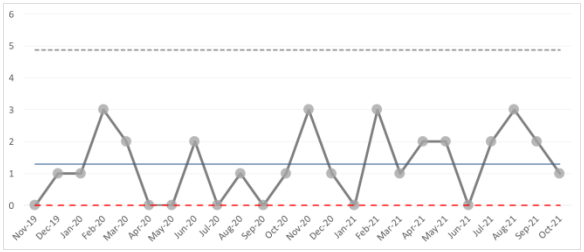
Pressure Ulcers Category 2 (inpatient and community)

Monitoring
Variation: Normal
Current Month: 45



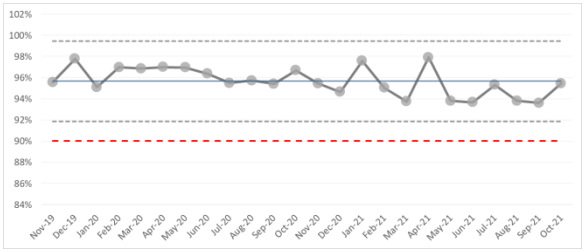
Pressure Ulcers Category 3&4

Monitoring
Variation: Normal
Current Month: 1



Pressure Ulcers Assessment Compliance

Target: 90%
Variation: Normal
Current Month: 95.5%



Author:	**Tina Lloyd, Assistant Director of Nursing - Corporate**
Status Report	A total of 45 category 2 PUs were reported in October 2021 Despite the increase in bed numbers and occupancy, the total number and rate of PUs reported remains within expected control limits which is a credit to ward staff. One category 3 PU was reported this month on an inpatient ward at the Conquest hospital with a RCA underway. Of those audited, the compliance of patients with completed PU assessments is 95.5%. The Pressure Ulcer Review Group continue to oversee incidents to determine if any contributory lapses.
Challenge & Risk:	This report may change in the future due to reassessment/validation of damage that may deteriorate/change after the reports are extracted each month. This occurs because the Datix system is live and subject to change as skin damage is subject to ongoing clinical review and validation.
Actions:	The Pressure Ulcer Review Group (PURG) continues to review the root cause analyses relating to pressure damage.

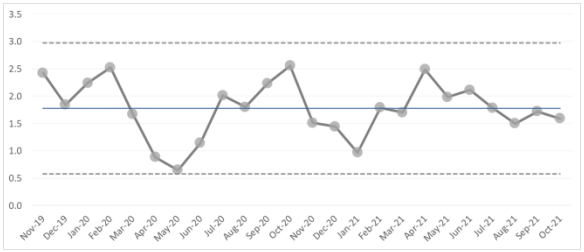
What patients are telling us?

East Sussex Healthcare NHS Trust

Quality and Safety

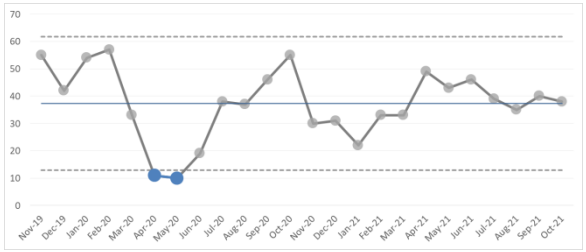
Author: **Amy Pain- Patient Experience Lead**

Complaints Received per 1000 bed days



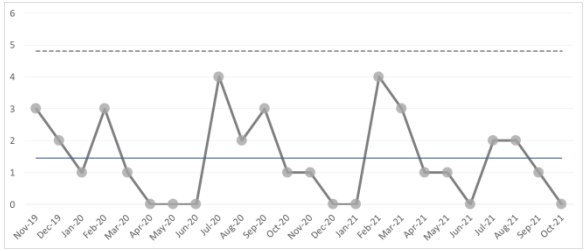
Monitoring
Variation: Normal
Current Month: 1.7

Complaints Received



Monitoring
Variation: Normal
Current Month: 38

PHSO contacts



Monitoring
Variation: Normal
Current Month: 0

Status Report

There were 104 open complaints at the end of October, a reduction compared to 120 at the end of September.

In October, the **top three primary complaint subjects** were:

- 'Standard of Care' (19)
- 'Communication' (7)
- 'Patient Pathway' (5)

Top complaint locations:

- Outpatient Departments combined totalled 7 (CQ =4, EDGH =3) with Orthopaedics x4 and Neurology, Gen Surgery and Paeds all x1
- Emergency Departments totalled 6 (CQ =3, EDGH =3)
- Acute Assessment Unit (3)

The remaining complaints were spread over a further 19 different locations.

No **PHSO** contact with the Trust in October.

Reduction of 12% with 578 **PALS** contacts.

In October compliance with the **three day acknowledgment** standard for new complaints was 100%.

Compliance with complaint **response rates** deteriorated due to ongoing operational and clinical pressures, with the Trust regularly in Business Continuity. The 35 (working) day rate was at 9%, whilst the 50 day rate was 17%, giving an overall response rate of 10%. An additional 6 month fixed term Complaints Officer post was proposed to support the divisions but is not going ahead due to financial pressures.
The November position has improved with huge efforts from all involved in the process.

4 complaints were **reopened** in October 2021 as complainants were unhappy and/or had additional questions/concerns.

On a positive note the trust received 2,078 **compliments** in month versus 39 complaints.

Challenge & Risk: There remains a caseload of overdue, open complaints as a result of COVID wave 2 and the ongoing operational pressures.

Actions: Ongoing monitoring and discussions in divisional IPRMs and at Q&SC.

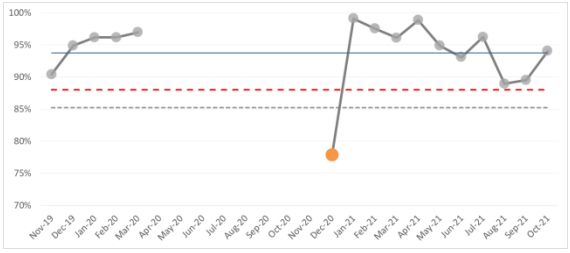
What patients are telling us?

East Sussex Healthcare NHS Trust

Quality and Safety

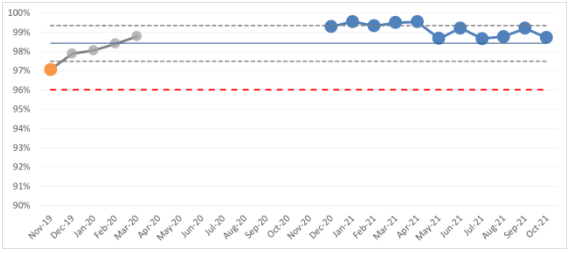
F&FT – A&E Score

Target: 88%
Variation: Normal
Current Month: 94.0%



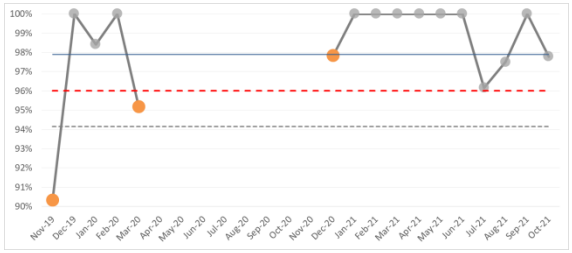
F&FT – Inpatient Score

Target: 96%
Variation: Improvement
Current Month: 98.7%



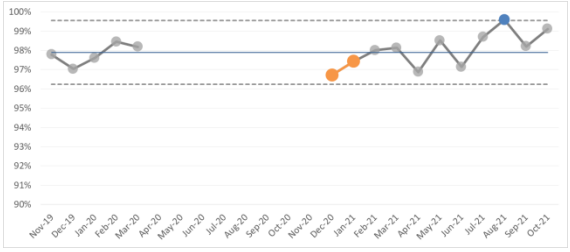
F&FT – Maternity Score

Target: 100%
Variation: Normal
Current Month: 97.8%



F&FT – Outpatient Score

Monitoring
Variation: Normal
Current Month: 99.1%



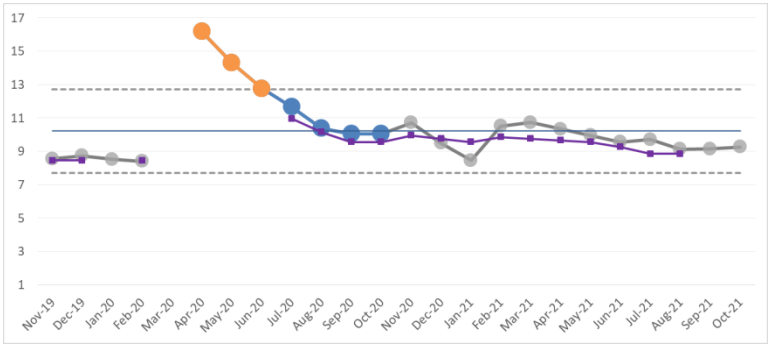
Author:	**Amy Pain - Patient Experience Lead**
Status Report	The **total number** of FFTs returned in October was **2,322** , which was an increase compared to September's 2,116. As with complaints, **response rates** are challenged by ongoing operational challenges; Inpatients 27.67%, A&E 0.78% and Maternity 36.59%). Maternity saw their response rate increase by 18.97% compared to September (17.62%). The **positive recommendation rates** for October, compared to the most recent data released by NHSE (September) were all higher than the national average as follows: **ESHT** Inpatient - 98.71%% (national average in September 94%) A&E - 94.05% % (national average in September 75%) Maternity - 97.78% % (national average in September 92%) The **top scoring questions** were: • Were you always treated with kindness? 99.05% (631responses) • Did all staff have a smiling and friendly approach? 98.42% (634 responses) • Did you feel the staff responded appropriately to any questions or concerns you raised? 98.08% (626 responses) The **lower scoring questions** were: • Do you know who to contact if your condition deteriorates? 88.63% (598 responses) • Were you given enough notice about when you were going to be discharged from hospital? 93.63 % (612 responses) • Did you feel involved in decisions about your discharge from hospital? 93.68 % (617 responses)
Challenge & Risk:	Both A&E's continue to face considerable pressures with crowding at times and longer waits.
Actions:	Continue to work towards offering FFT via a digital platform in addition to paper.

Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

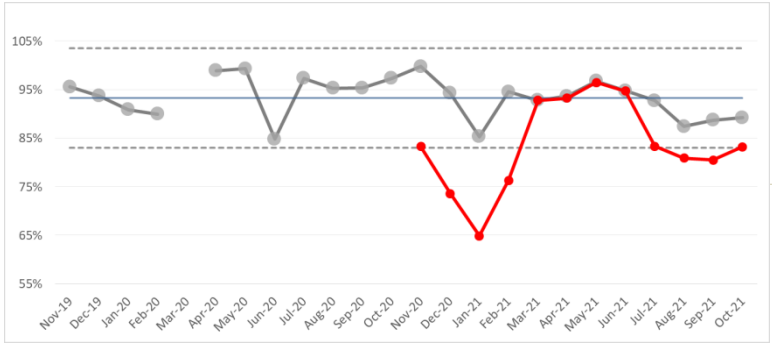
Quality and Safety

CHPPD (Trust)



Care Hrs Per Patient Day National Median: 8.4 (August 2021)
Variation: Normal
Current Month: 8.8

Staff Fill Rate (total)



Target: 100%
Variation: Normal
Current Month: 89.2%
Incl. escalation: 83.2%

Author: **Angela Colosi, Assistant Director of Nursing - Corporate**

Status Report

Care Hours per Patient Day (CHPPD*)
August's Model Hospital benchmark data shows peers at 8.2 and national median at 8.4 with ESHT at 8.7. ESHT's CHPPD shows a stable trend with overall rate of 8.8 in October. Ward level breakdown is discussed in the Safer Staffing report at PSQG with variation across wards and units. Higher Dependency areas skew the overall average with 19 areas less than 8 in Oct and the lowest at 5.6.

*CHPPD is calculated by dividing the actual hours worked by the number of patients in beds at midnight

Staff Fill Rate
89.2% was October's fill rate against the budgeted establishment for nursing with 10 areas at less than 80%. Additional capacity remained opened for medical patients on Devonshire, Glynde, Polegate, Egerton, Murray and occasionally an extra bay on Seaford.

The fill rate including the escalation areas was 83.2% (red line), indicating that substantive nurse staffing levels were stretched to care for a greater number of medical patients. Some shifts were filled with temporary staff where available. The data shows the increased and sustained demand for medical beds since June 2021, and the increased number of staff required to safely care for those patients.

Actions:

- Health and well-being initiatives continue for staff
- Recruitment to community posts and substantive positions on Glynde and Devonshire have begun but are proving difficult to fill
- Additional snacks and refreshments have been provided by the Health and Well-Being team for ward staff
- 17 International Nurses are arriving on 26th November 2021 with a further 23 in December 2021
- Additional hours have been sourced for our Clinical Facilitators to further support ward staff

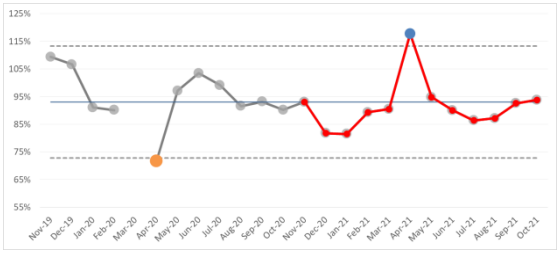
Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

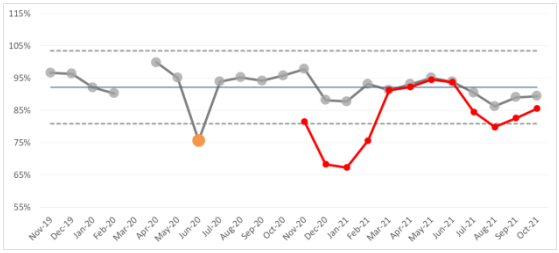
Staff Fill Rate (Bexhill)

Target: 100%
Variation: Normal
Current Month: 93.8%
Incl. escalation: 93.8%



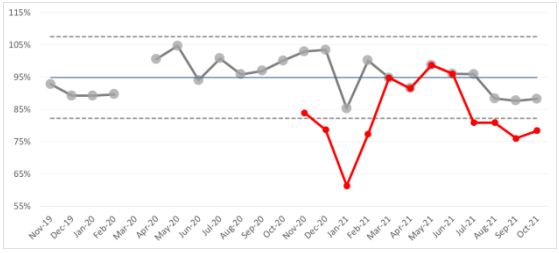
Staff Fill Rate (Conquest)

Target: 100%
Variation: Normal
Current Month 89.4%
Incl. escalation: 85.6%



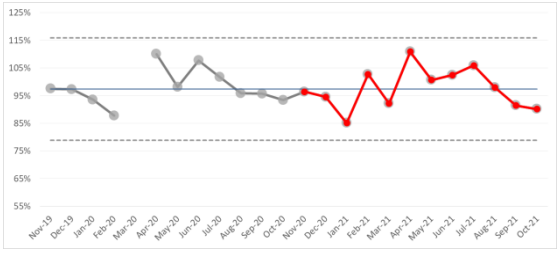
Staff Fill Rate (Eastbourne DGH)

Target: 100%
Variation: Normal
Current Month: 88.2%
Incl. escalation: 78.4%



Staff Fill Rate (Rye Memorial)

Target: 100%
Variation: Normal
Current Month: 90.1%
Incl. escalation: 90.1%



Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report	Fill rates at Bexhill have remained stable during October. Rye have seen a slight decrease but remain within common cause variation. There are no escalation beds at either community hospital now as they are funded for the full occupancy of beds (54 and 19 respectively) to facilitate rehabilitation and care of patients who are non weight bearing. EDGH and Conquest acute hospital data shows the impact of the significant number of extra beds. They show a reduced fill rate (red line) against the established template as substantive staff are distributed to safely care for those patients in new surge/escalation areas.
Challenge & Risk:	With the workforce so stretched, it is very difficult for staff to be able to undertake all of the clinical and non clinical elements of care. As staff will always prioritise direct patient care it may mean that other duties are not fulfilled such as complaints, RCA investigations, some elements of documentation and certain aspects of flow/discharge. This also impacts on the HoNs and ADNs and other members of the divisional leadership teams. The daily deployment of nurses to other wards is having an impact on morale and willingness of some staff to work extra shifts as they are moved from their base ward.
Actions:	• The twice daily staffing meetings continue in order to ensure safe care and service delivery, and shared risk management and decision making across the divisions. • The Professional Nurse Advocate national programme has begun that trains individuals to facilitate restorative clinical supervision • Fortnightly workforce support sessions are being held (chaired by the CNO and CPO) with senior Workforce and Divisional nurses to ensure optimum staffing levels through HealthRoster compliance

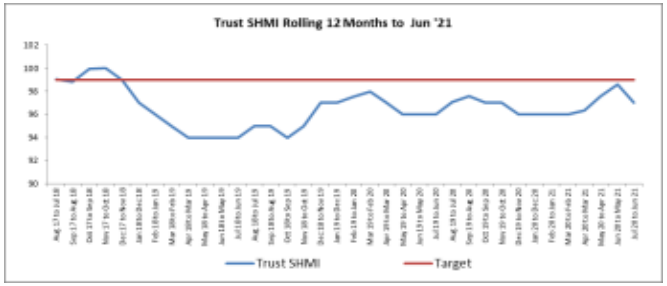
Effective Care - Mortality

East Sussex Healthcare NHS Trust

Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

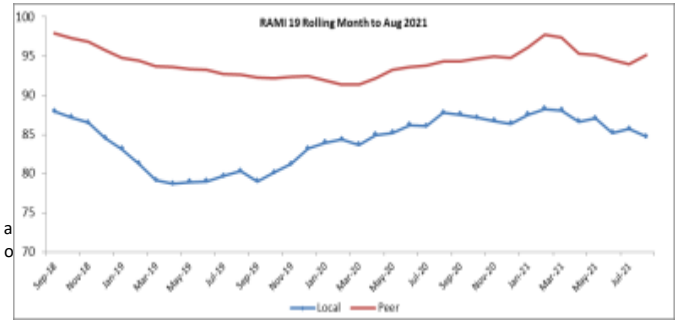
Summary Hospital Mortality Indicator (SHMI)

Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



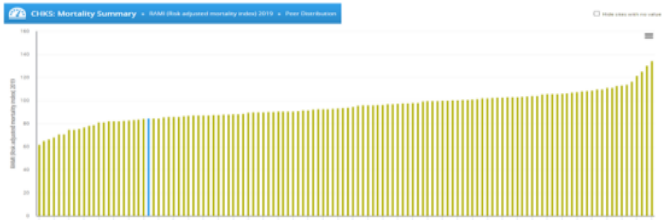
- SHMI – July 2020 to June 2021 is showing an index of 0.97. SHMI is higher at Conquest and investigations are ongoing to try to understand the difference between the sites.
- RAMI 19 without confirmed or suspected Covid-19 – September 2020 to August 2021 (rolling 12 months) is 85 compared to 88 for the same period last year. August 2020 to July 2021 was 86.
- RAMI 19 was 79 for the month of August and 80 for July. Crude mortality without confirmed or suspected covid-19 shows September 2020 to August 2021 at 1.38% compared to 1.61% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 65% for September 2021 deaths compared to 71% for August 2021 deaths.

Risk Adjusted Mortality Index (RAMI) – without confirmed or suspected Covid-19



There are:
47 cases which did not fall into these groups a
20 cases for which no CoD has been entered o
selected.

RAMI Peer Distribution without confirmed or suspected covid-19



RAMI v Peer

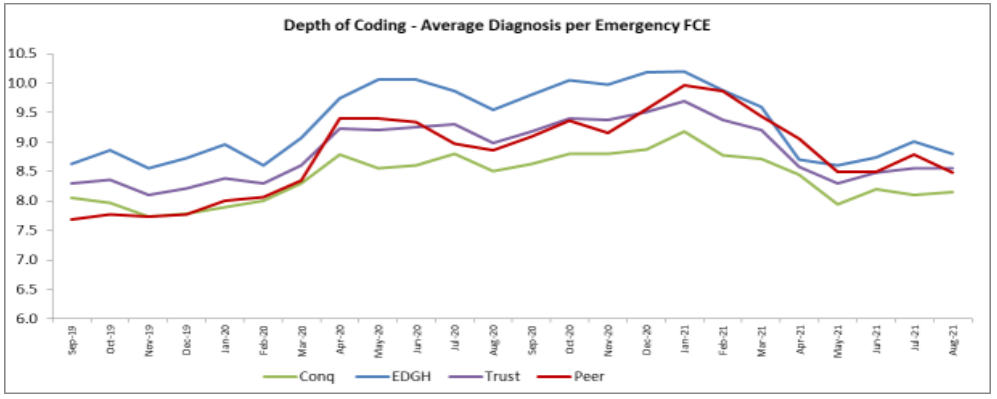
This shows our position nationally against other acute trusts - currently 23/124

***October 2021 Main Cause of In-Hospital Death Groups (ESHT)**

Sepsis/Septicaemia	26
Pneumonia	17
Cancer	14
COVID-19	8
Heart Failure	6
Cerebro-vascular Incident	5
Chronic Obstructive Pulmonary Disease (COPD)	4
Liver Disease	3
Acute Kidney Injury (AKI)	2
Myocardial Infarction (MI)	2
Atrial Fibrillation (AF)	1
Community-acquired Pneumonia	1
Hospital-acquired Pneumonia	1

There were 8 COVID -19 related deaths in October and 15 in September.

There are:
47 cases which did not fall into these groups and have been entered as 'Other not specified'.
20 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.



Work is ongoing to understand the differences between the sites and why depth of coding has declined in recent months

Our People – Our Staff

Recruitment and retention
Staff turnover / sickness
Our quality workforce
What our staff are telling us?

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Appraisal** compliance has increased by 0.1% to 73.3%	**Annual turnover** has increased by 0.4% to 10.5%, reflecting 661.8 fte leavers in the rolling 12 months **Vacancy rate** has increased by 2.9% to 9.2%. **Current vacancies** are showing as 691.67 ftes **Annual sickness** has increased by 0.1% to 5.2% and **Monthly sickness** has increased by 0.2% to 5.7%. **Mandatory Training** rate has reduced by 0.1% to 89.1%	 **Steve Aumayer** Chief People Officer

Overview:

Performance remains challenged across the Trust due to the abnormal levels of activity. This continues to be driven through high levels of ED attendance and multiple "Medically Ready to Discharge" (MRD) patients within the Trust. These not only create additional activity, and stretch staffing, but also affect flow, our medical outliers and therefore the efficiency with which colleagues can deliver care. We have more staff than ever before but they are stretched further.

Substantive staff numbers increased once again within the month, but increasing turnover in October meant that despite the 109.3 starters the net impact is just 12.3 WTEs. The Trust turnover rate in month was 0.4% up on the previous month at 10.5% (1% above where it sat in March 21 and 0.1% above previous year). One of the noted reasons for leavers is end of fixed term contracts. If we remove those planned leavers our turnover rates reduce to 9.9% for this year and 9.2% for previous year showing an increase of 0.7%. This clearly needs to be an area of focus. Our vacancy rate has increased in month by 2.9% due to an increase of 281.1 FTEs largely due to increased funding of the emergency care pathway.

Whilst our substantive workforce numbers have shown an upward trend for 22 of the past 24 months, our reliance on temporary workers remains high due to activity although in October it has reduced slightly for the first time in 7 months. The reduction applies to all staff groups with the exception of Scientific Staff and AHPs. Fill rates remain a challenge because of volume of requests but the bank continues to grow with over 200 colleagues currently in the pipeline.

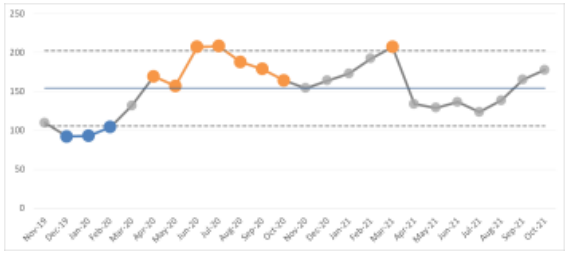
Sickness levels remain a concern with 6 months of increases in monthly sickness and average sick days per FTE. Although at the time of writing this report levels appear to be dropping slightly again. Anxiety, Stress and Depression whilst still the predominantly identified reason for absence has now reduced for 3 consecutive months and typical winter reasons are increasing as would be expected.

Our staff vaccination hubs for COVID booster vaccinations and flu are open and working alongside community hubs to ensure that all staff have access to vaccination services. We are also running roving flu clinics to ensure maximum uptake. The announcement of mandatory vaccination requirements will create a new set of challenges and risks for us and we await full guidance from NHSI on the requirements.

Workforce – Contract type

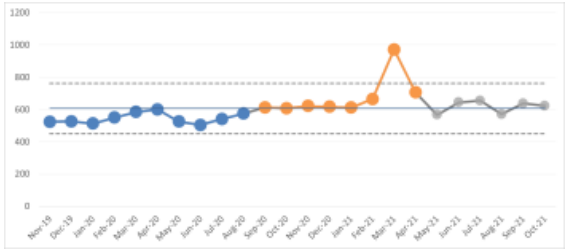
East Sussex Healthcare NHS Trust

Agency FTE Usage



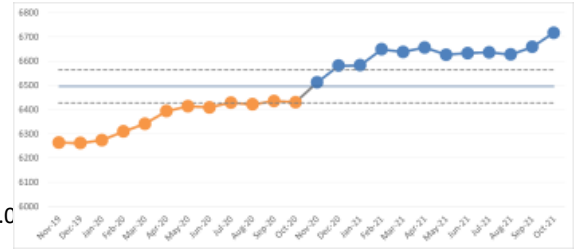
Current Month: 177.7

Bank FTE Usage



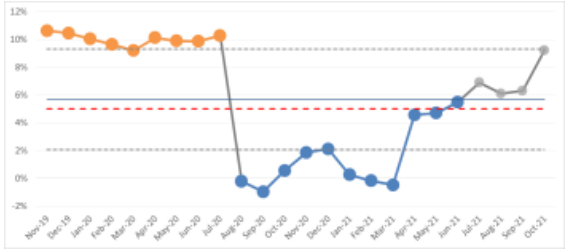
Current Month: 622.2

Substantive FTE Usage



Current Month: 6,717.0

Vacancy Rate



Target: 5%
Current Month: 9.2%

Author: Jenny Darwood

Status Report

Substantive usage increased by 58.9 fte, bank usage reduced by -15.0 ftes whilst agency fte usage increased by 12.3 ftes. Vacancy rate has increased by 2.9 to 9.2%. This is due to an increase in the substantive fte of establishment of 281.8 ftes largely due to the increased H2 funding for the Emergency Care pathway.

Demand for temporary workforce has stabilised at c.22,000. A reduction in requests have been seen in all workgroups with the exception of Scientific staff and AHPs. Supply of staff has remained static at 13,500 shifts equating to 800 fte supply. Temporary workforce supply remains stable. The Trust bank continues to be the main supplier of temporary staff and provides 80% of the filled shifts

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	69.3	68.0	48.7	89
Reg Nurse	284.7	265.8	107.9	78
Addit Clin Serv	299.4	105.9	61.4	56
AHP	18.2	72.7	36.0	57
Prof, Sci, Tech	-3.6	10.6	3.0	76
Healthcare Scs	3.8	12.0	15.6	72
A&C	3.7	81.2	39.3	42
Est & Ancillary	13.4	30.6	20.6	85
Trust	**691.6**	**645.1**	**332.5**	**69.4**

Challenge & Risk:

Due to increase in leavers and additional funding there is an increase in Nov for Registered Nurse requests for Emergency Departments and Critical Care areas. Escalation Wards remain a pressure for TWS and has contributed to the increase in agency use within the nursing group. Nov requests are increasing in specialist areas which command a higher agency rate. If a supply is found a further increase in agency expenditure will be seen within these areas.

There is a risk to TWS in being able to respond to a further surge in demand as the supply of temporary staffing has stabilised for the past 6 months despite the engagement of new suppliers and on-going recruitment campaign. Insufficient agency supply to meet request demand will reduce % fill.

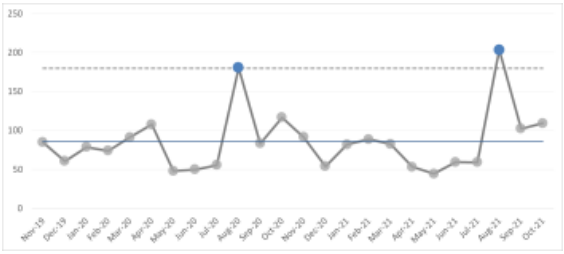
Actions:

TWS runs an active recruitment campaign with 221 applicants in our pipeline.. Working in conjunction with recruitment and divisions to co-ordinate temporary and substantive staff campaign with specialist framework agencies.

Workforce - Churn

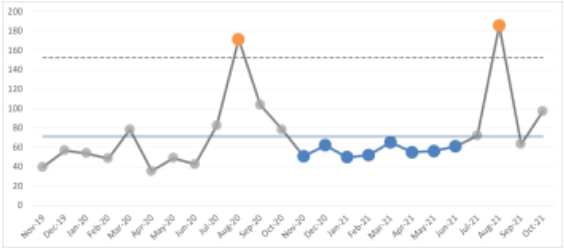
East Sussex Healthcare NHS Trust

Starters FTE



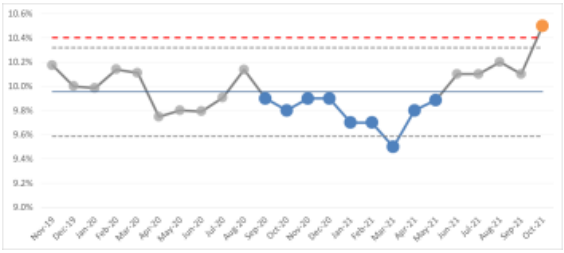
Current Month: 109.3

Leavers FTE



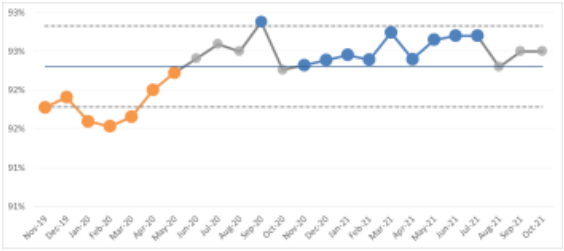
Current Month: 97.0

Annual Turnover Rate



Target: 9.90%
Current Month: 10.5%

Retention Rate



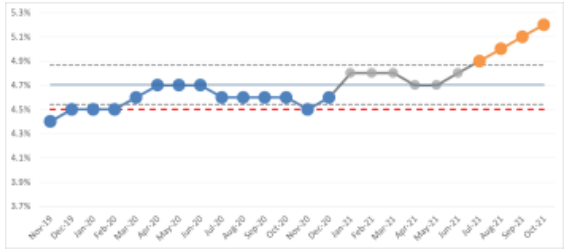
Target: 92%
Current Month: 92.5%

Author:	David Moulder & Greig Woodfield
Status Report	The Trust starters & leavers monthly net total as at Oct 21 is +12.3 with 109.3 starters fte and -97.0 leavers fte. Over the last 12 months there was 1,028 fte starters & 868.8 fte leavers giving a net increase of 159.2 mainly showing in the nursing staff group. The Trust turnover rate has increased by 0.4% to 10.5%. There were 661.8 fte leavers in the previous 12 months. The Trust Retention rate (i.e. % of staff with at least one year's service) was unchanged at 92.5%.
Challenge & Risk:	Staff peak retirement usually occurs in December of March however we may see an increase in this due to Covid pressures. Covid Travel restrictions continue to effect some International travel which impacts on overall Trust Time To Hire. International candidates still currently required to quarantine for 10 days. Some delays still with visa applications at source countries due to volumes. Despite success with continued targeting of "hard to recruit" posts, areas of focus remain e.g. Consultants for various posts; Cardiology,, Acute Medicine, Respiratory and Care of the Elderly. Recruitment activity focused around Escalation wards, Theatre ODPs. Sonographers, Dietitians and Community Nurses.
Actions:	There is a strong pipeline of international nurses, 144 arrived since Oct 20. A further two cohorts (44) of Nurses are due end of Nov and beginning of Dec. Planned intakes for remainder of 2021/22. Continued campaigns with external recruitment agencies to provide Sonographers and Theatre ODPs. Hard to recruit medical posts with Medacs and other additional agencies, as required. Targeted phased approach to filling medical posts continues with direct applications remaining strong . Major campaigns for CHIC UTC and Emergency Medicine underway/due to start. New Recruitment Attraction webpage launched, with initial activity centred around CHIC.

Workforce - Sickness

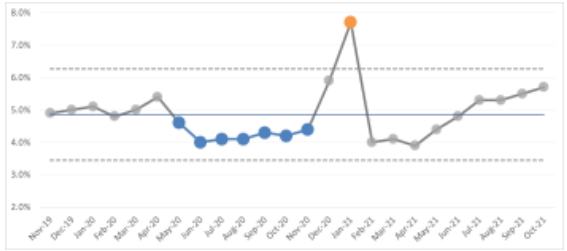
East Sussex Healthcare NHS Trust

Annual Sickness



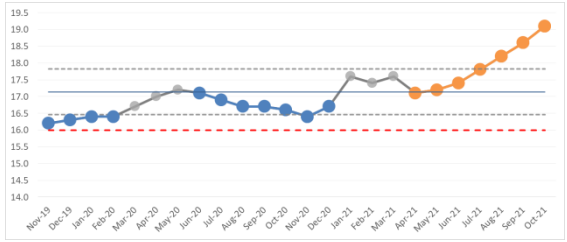
Target: 4.5%
Current Month: 5.2%

Monthly Sickness



Current Month: 5.7%

Average sickness Days per FTE



Target: 16
Current Month: 19.1

Author:	David Moulder, Julie Hales
Status Report	Although monthly sickness % for October has increased this month by 0.2% to 5.7% and is higher compared to last year, we have started to see sickness trending downwards since 2nd week in October (11% downward trend). Total staff reported as absent due to Covid sickness as at 11th Nov was 23 (compared to a peak of 237 on 22nd Jan). Overall, there were 339 staff absent due to all types of sickness, compared to a peak of 540 (also on 22nd Jan). There were 65 staff absent on isolation, (of which 21 are able to work), This figure peaked on 15th Jan at 378 staff absent. Sickness averages is 19.1 days per fte compared to pre-Covid was average 16.4 absent sick days lost per fte.
Challenge & Risk:	Monthly sickness rate continues to increase and is at its highest since the pandemic peak in Jan 21. It is 1.5% higher than the rate for Oct 20 and 1.2% higher than the rate for Oct 19. Annual sickness rate is the highest it has been for the last 2 years but this reflects wave 2 within this time period so not unexpected
Actions:	Whilst sickness absence is managed within the policies, focus is also on identifying other reasons that absence may increase ,such as annual leave, due to staff not being able to take this during the half term. Managers will be helped to plan their schedules further in advance, including reporting on all outstanding annual leave still to be booked until end of leave year OD interventions supporting areas of high stress such as key work with teams around values and utilising the TRIM practitioner role along with mental health first aiders. Work continues with understanding the impact of the HWLB interventions and the potential reduction in stress and anxiety.

Workforce - Sickness

East Sussex Healthcare NHS Trust

Author: David Moulder; Julie Hales

Status Report

Anxiety/Stress/Depression

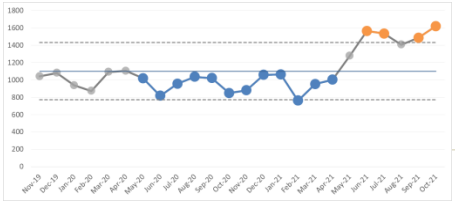
Back Problems

Chest & Respiratory Problems

Cough, Cold & Flu

Gastro-intestinal Problems

Other MSK problems



Reason	fte Days Lost +/-		Total fte Days Lost
Anxiety, stress & depression	▼	-59.8	2,086.4
Back problems	▼	-146.1	514.8
Chest & respiratory	▲	+456.6	1,566.2
Cold, cough & flu	▲	+745.8	1317.4
Gastrointestinal	▼	-229.6	648.2
Other MSK problems	▲	+132.5	1,619.8
Other reasons	▲	+67.4	4.308.0
All reasons	▲	+966.8	12,060.8

Challenge & Risk:

It is anticipated that compliance with the booster and flu vaccine would support a reduction in absence with seasonal flu and in longer term Covid. Following the return to schools and reduction in restrictions, however, we have seen an increase in seasonal illness such as cold, cough and flu and chest & respiratory illnesses (not all of which are Covid).

Actions:

The continued decrease in anxiety and stress illnesses (third consecutive monthly drop) reflects the ongoing Health & Wellbeing initiatives being promoted within the Trust.

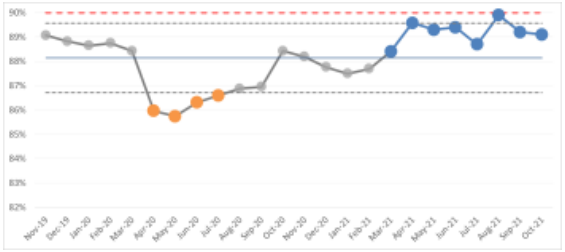
OH continue to review reasons for MSK and appropriate support ensuring compliance with Manual Handling training. There is currently a focussed MSK initiative to support staff.

Workforce - Compliance

East Sussex Healthcare NHS Trust

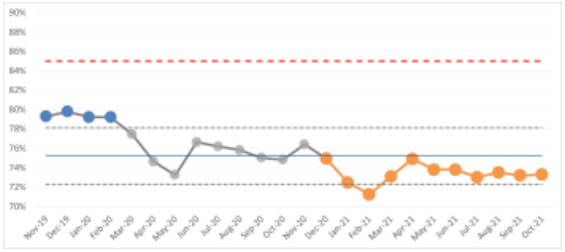
Our People – Our Staff

Mandatory Training Compliance



Target: 90%
Current Month: 89.1%

Appraisal Rate



Target: 85%
Current Month: 73.3%

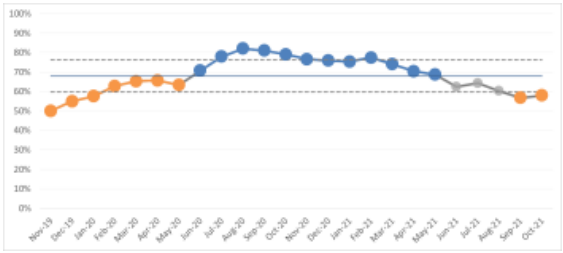
Author:	Dawn Urquhart
Status Report	Core Skills Training compliance decreased again slightly by 0.1% to 89.1%. This reflects the significant operational pressures that have existed over the last few weeks in the Trust. The number of staff who DNA training (clinical) also increased again, marginally, in Oct from Sept and continues to be monitored . Appraisal compliance, however, did increase slightly by 0.1% to 73.3% Future developments will now focus on the development of an e-appraisal tool and process together with a Talent Management alignment that will support and embed career pathways with the purchase of the new Education Learning Management System (LMS). The Vaccinator Hubs on both sites are due to close on 19th Nov.
Challenge & Risk:	Whilst we are continuing to provide additional Induction capacity to support recruitment initiatives, there is a risk that we will not be able to implement more blended approaches to learning as is being advocated by HEE. Operational status of the Trust (including future Covid outbreaks) with the subsequent pressures on service infrastructures and care pathways could impact negatively on future compliance capability.
Actions:	The Training Directory has been kept up to date and is available on the Intranet. The New LMS is to begin implementation project phase this month. Additional staff from TWS have been recruited using HEE funding to support Healthcare Support Worker induction including working alongside new staff when they start in the workplace.

Workforce – Job Planning

East Sussex Healthcare NHS Trust

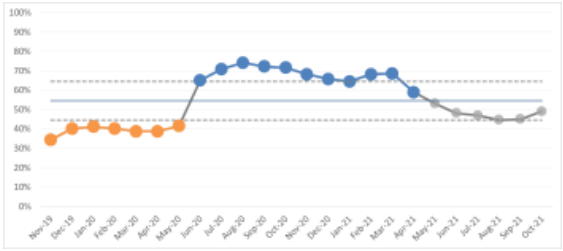
Consultant eJob-Planning Fully Approved Rate

Current Month: 58.1%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 49.0%



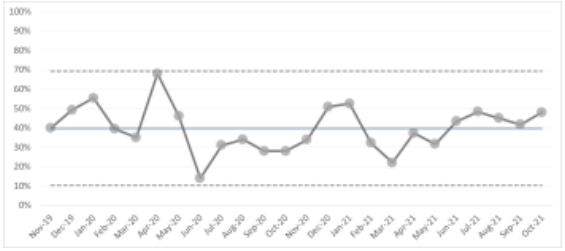
Author:	Joanne Penfold;
Status Report	The overall medical job plan approval rate is 56%, an in crease of 3%. 147 of 253 Consultants have a completed eJob Plan (58.1%) and 50 of 102 SAS Doctors have a completed eJob Plan (49.0%).
Challenge & Risk:	Operational pressures are impacting on Service Managers, Specialty Leads and Medics having the time to review job plans. Medicine, WCSH & DAS have all improved their signed off rate, while Core Services has decreased.
Actions:	Of the 158 not yet signed off, 68 are in discussion and 90 are within the sign-off stage, with 15 of these remaining at the 2nd sign off stage (Clinical Lead / Chief). HR implementation of job planning to embed the system has been completed however the emphasis and ownership of the approval rates in each division sits with the clinical Lead. The eJob Planning team has reduced to one analyst who is supporting training and technical system challenges along with reporting and insight for Trust reports. The Trust is aiming for a 90% compliance rate to uphold NHSI Levels of Attainment Level 2. .

Workforce – Roster Completion

East Sussex Healthcare NHS Trust

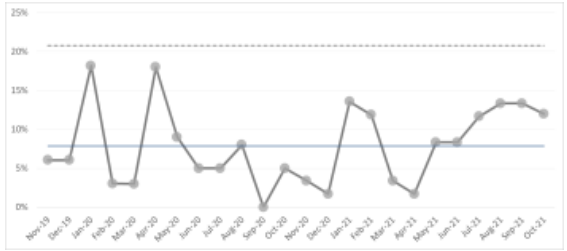
6 week Nursing Management Roster Approval Rate

Current Month: 48%



8 week Nursing Management Roster Approval Rate

Current Month: 12%



Author:	Penny Wright
Status Report	Roster approval for 6 weeks continues to improve as new models and insight is shared with the operational leads. For the roster starting on 4th Oct, 48% of rosters had been approved at 6 weeks before the go live date which is a 6% improvement on the previous month, whilst 12% had been approved at 8 weeks prior to commencement which is a slight reduction of 1%. .
Challenge & Risk:	There are opportunities to improve effective planning to in turn drive efficient deployment of staff. Lower roster approval rates are linked with late requests for TWS support. This means probability for filling shifts becomes lower and has implications for patient safety and staff morale.
Actions:	New workforce planning tools have been designed to support effective planning of rosters in a timely manner. These will be embedded in the divisional IPR reviews and supported by Corporate Nursing and HR. The new Nursing Deployment dashboard has been shared with senior nurse leaders and is regularly updated. . Further self-serve bite size training modules are currently being piloted in the operations to ensure that we improve the quality of roster planning with practical guidance. There will also be a programme designed to link effective planning and efficiently deploying rosters with staff wellbeing due in Oct/Nov.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

Diagnosing and treating our patients in a timely way that supports their return to health

Summary

East Sussex Healthcare NHS Trust

Access and Responsiveness

	Positives	Challenges & Risks	Author
Responsive	**Cancer 28 day FDS:** The Trust delivered 75% for Faster Diagnostic Standard (FDS) for the second month running. Which demonstrates that the focused effort on clearing the backlog and putting us in a sustainable position to meet this standard has proven effective	**ED Performance:** The Trust delivered 76.1% against a target of 95% in October placing the Trust 40th in the country. Similar to elective inpatients, the challenges the target are the constraints to inpatient flow: high bed occupancy; escalation wards open, workforce challenges and an increased overall LoS which is due to the current pressures in the social care market limiting our ability to discharge medically fit patients; and the acuity of patients continuing to remain higher than pre-covid levels. **Elective Recovery:** The Trust has received the operational planning guidance for the second half of the year H2. There has been a change in the way that the target has been set, moving from a % of 19/20 activity to a % of 19/20 clock stops. In October, as a Trust we are reporting 78% of clock stops against the 89% ask. **Escalation Wards:** In October, we were regularly using our escalation beds (80 @EDGH and 14 @ Conquest) to support flow. However, this comes with its own workforce and financial challenges to maintain this level of bed capacity. **Cancer 62 day standard:** Although we achieved the 28 day FDS in Cancer, the Trust remains challenged to deliver the 62 day standard. This is in part, due to our reliance on tertiary centres for some diagnostics and treatments. As well as this, we have seen a continued increase in demand. **Cashing Up:** Although this is an ongoing challenge for the Trust to keep up to date, there will be more of a focus on this process as we look to stop clocks in a timely manner in month. With over 5,000 outstanding at any given time, this is an area we will need to focus on moving forward. **Workforce:** Impact on H2 delivery and resulting increase in the number of cancellations. And the need to rebook patients within 28 days	 **Tara Argent** Chief Operating Officer

Actions:

- Implementation of LIVI
- Recruit to new urgent care model
- Reinvigorate 642 meetings and manage the closure of 2 theatres on the Conquest site from 22nd November for planned estates works

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

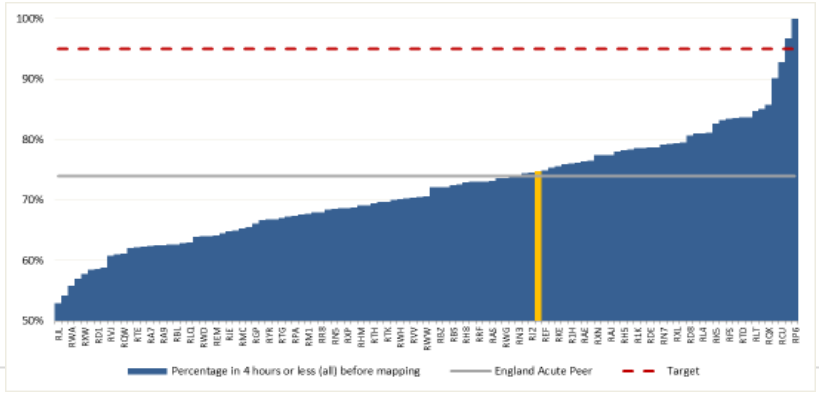
*NHS England has yet to publish all October 2021 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

October 2021 Peer Review

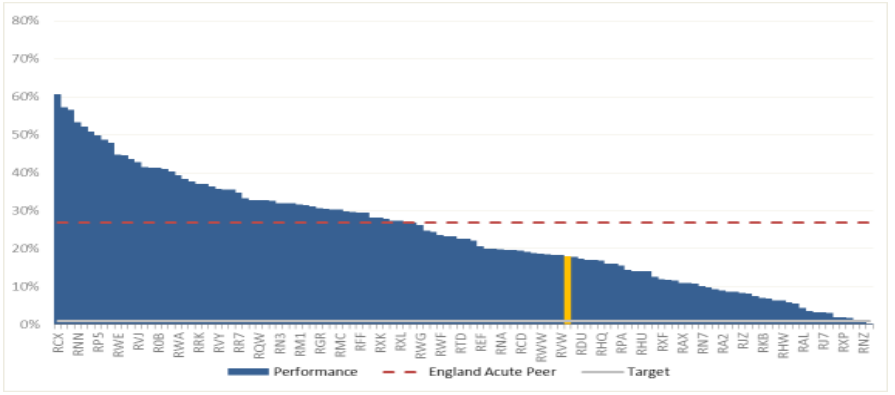
National Average: 73.90% ESHT Rank: 40/113



Planned Care – Diagnostic Waiting Times

September 2021 Peer Review*

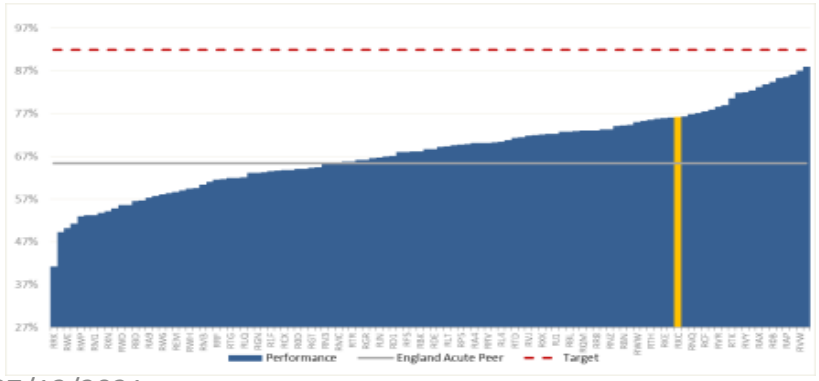
National Average: 26.8% ESHT Rank: 46/122



Planned Care – Referral to Treatment

September 2021 Peer Review*

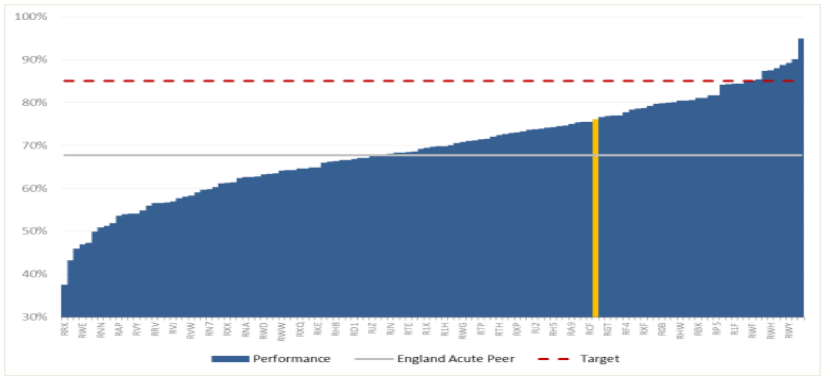
National Average: 65.4% ESHT Rank: 20/112



Cancer Treatment – 62 Day Wait for First Treatment

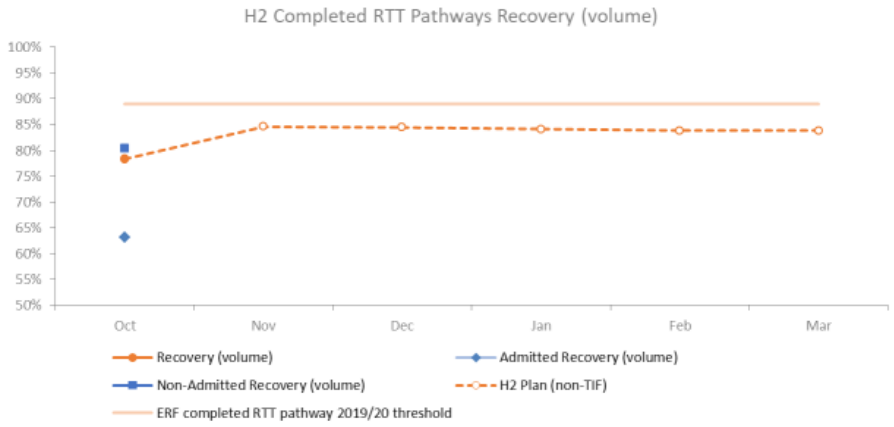
September 2021 Peer Review*

National Average: 67.7% ESHT Rank: 35/123



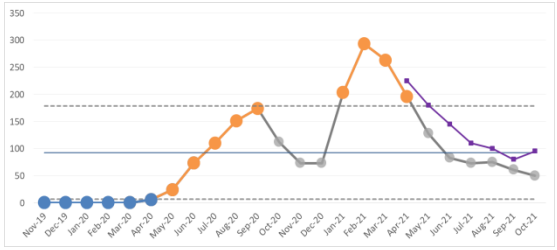
Planned Care – H2 Recovery KPIs

East Sussex Healthcare NHS Trust



RTT 52 Week Waiters

Target: 0
Trajectory: 95
Current Month: 50



The Trust continues to deliver against the recovery trajectory for patients waiting over52 weeks remaining the best performing Trust in Sussex.

With continued workforce pressures, demand on beds and patient flow production planning becomes more challenging to meet the changing demand.

Weekly PTL meetings review patients waiting for treatment at specialty level detail and discuss with booking and theatre teams, looking at the capacity gaps and the clinical prioritisation of patients. PTL meeting enable us to have grip and control of our waiting list management.

The ask for H2 is to deliver 89% of clock stop activity against a 2019/20 baseline, a trajectory has been submitted however this has been compromised by the change in demand on the hospital sites and pressures experienced on patient flow. There are mitigating actions being developed and implemented to improve the Trust data which may go some way to improve our reported position.

Although Patient Initiated Follow Up (PIFU) numbers steadily increase month on month, there is still more work to be done to ensure we are increasing the number of PIFU pathways to deliver and maintain the required 800 conversions to PIFUs per month needed to achieve the H2 target. The Outpatient Transformation team are undertaking target work with specialties to support this.

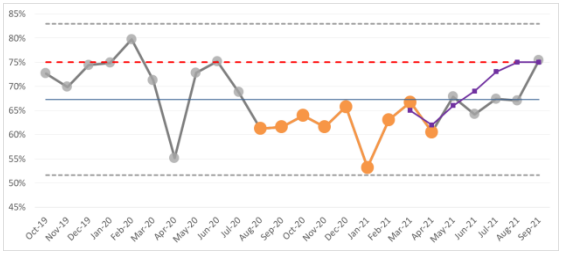
Planned Care – H2 Recovery KPIs

East Sussex Healthcare NHS Trust

Access and Responsiveness

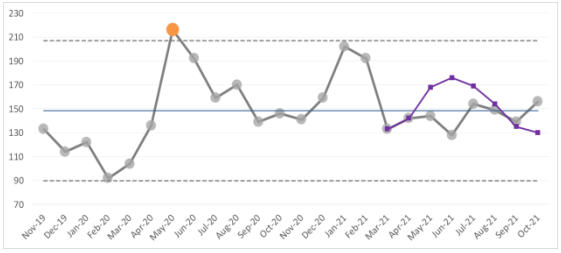
28 Day FDS(Faster Diagnosis Standard)

Target: 75%
Trajectory: 75%
Current Month: 75.4%



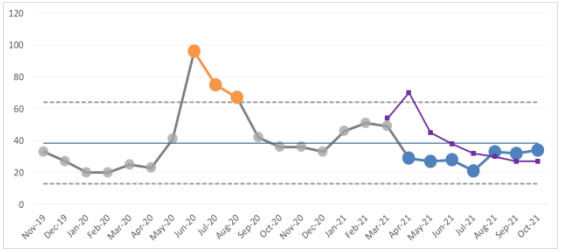
Cancer 62 Day Backlog

Target: Monitor
Trajectory: 130
Current Month: 156



Cancer 104 Day Backlog

Target: Monitor
Trajectory: 27
Current Month: 34



October has seen the Trust deliver the 75% target for the Faster Diagnosis Standard (FDS) for the second time since the target came into effect. This is a significant achievement for the Trust. The delivery of this target should support an improvement in the 62 day target over the coming weeks and contribute to an improvement in the DM01 diagnostic target.

Patient choice; demand for diagnostic procedures ; a reliance on tertiary centres for certain cancer pathways; and an increase in referrals through the summer months has impacted on delivering against trajectory for October for both 62 and 104 day backlogs. All >104 day waiters are reviewed weekly by the senior leadership team to ensure that actions are taken and these patients will continue to be closely monitored so as to recover our position.

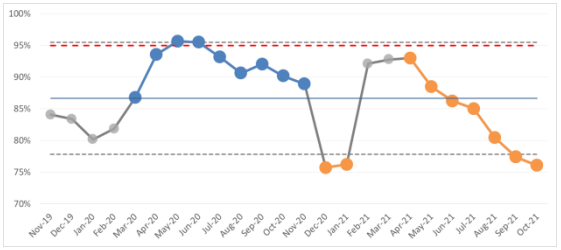
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

Access and Responsiveness

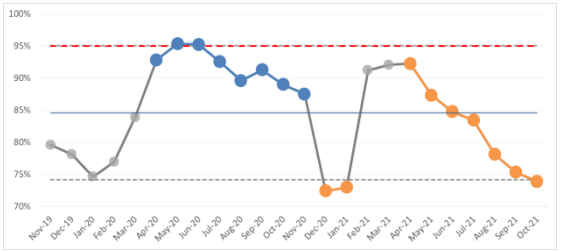
A&E Performance
(Local System)

Target: 95%
Current Month: 76.1%

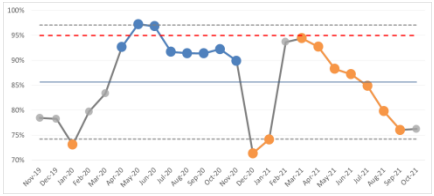


A&E Performance
(ESHT Total Type 1 & 3)

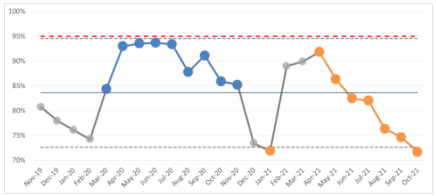
Target: 95%
Current Month: 73.9%



CONQ

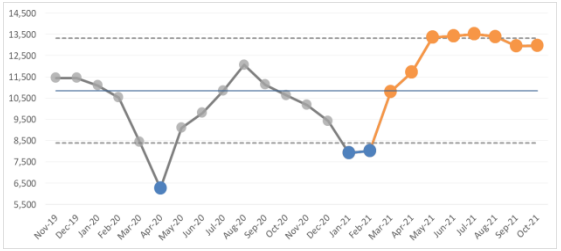


EDGH



A&E Attendances
(ESHT Total Type 1 & 3)

Target: Monitor
Current Month: 12,976



Due to the urgent care demand and acuity of patients needing admission outstripping the ability to discharge patients the trust has seen a decrease in performance against the national 4 hour urgent care metric. It should be acknowledged that this decline in performance is mirrored across the UK and the region.

Despite decrease in performance ESHT remain above the national average and have increased national ranking from 43/114 to 40/114.

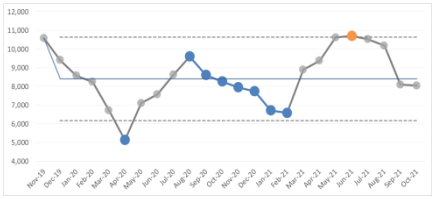
Exit block remains a significant issues across both sites but most notably at EDGH, however this is also an evolving issues at the Conquest site.

Access to gateways remains difficult, either due to the need to separate red and amber pathways, or as a result of flow being compromised. The continued decreased in non-admitted performance correlates with an increasing LoS in the department. The focus is to improve the flow at the front door with improved utilisation of the Urgent Treatment Centre (UTC) and Same Day Emergency Centre (SDEC), the Trust is also working with the system to deliver digital solutions to support diverting appropriate patients to booked appointments reducing the need to wait/be seen in the ED setting.

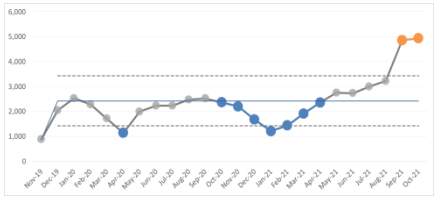
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

ESHT Total Type 1

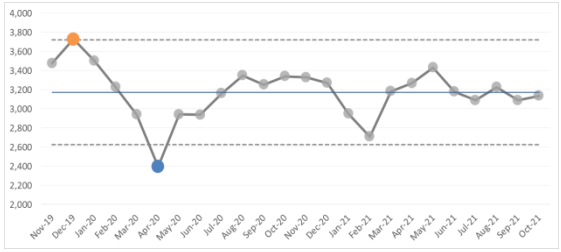


ESHT Total Type 3



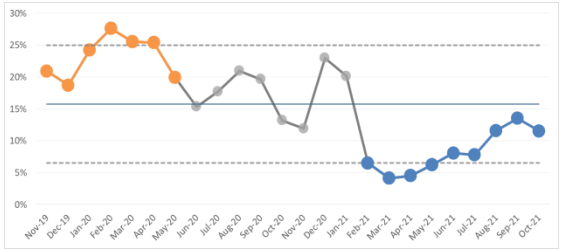
Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,135



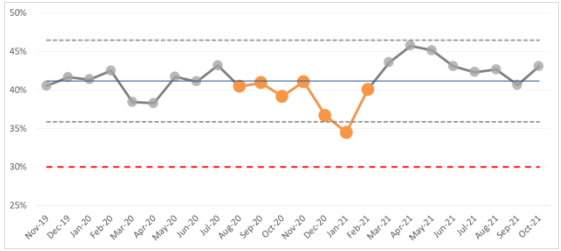
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 11.5%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 43.1%



Type 3 attendances have increased as appropriate patients are treated through the UTC this has resulted in a reduction in type 1 performance recorded which is an accurate reflection of how the patients are seen and treated.

Conveyances continue at broadly the same level seen over the last quarter however handover delays have decreased from the previous month in the main due to flow issues.

Immediate handover continues to apply pressure and both sites are working hard to meet the new national regulation.

Access to non ED locations for SECAmb remains limited this will be a focus going forward working on pathways and criteria to support this going forward.

To address challenges, the Trust is working on

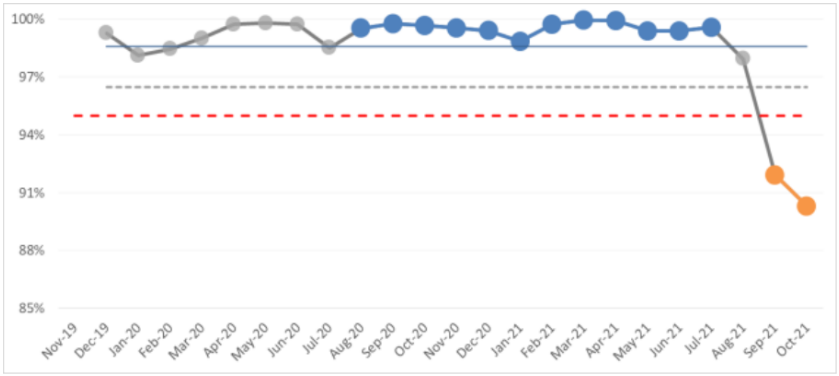
- Recruitment and retention plans, including working with TWS.
- Daily reviews of performance with night teams to capture lessons learnt.
- LIVI to go-live in November to help meet UTC demand.
- Continued focus on ambulance handovers.
- Continual monitoring of all metrics.
- Initial focus to remain on 4hr standard, but if not achieved then focus on moving patients within 6hrs from arrival to avoid “delay related harm”.

Urgent Care – UTC

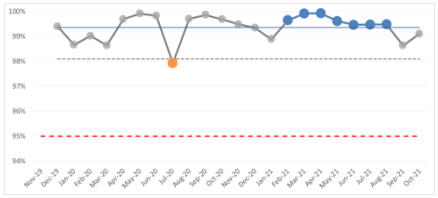
East Sussex Healthcare NHS Trust

UTC 4 hour standard
(Visit complete within 4 hours)

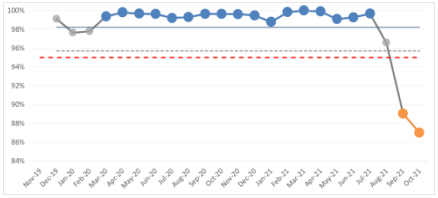
Target: 95%
Current Month: 90.3%



CONQ



EDGH



A continued decreased in UTC wait time performance is expected as a result of the workforce constraints and physical space available. A business case for the UTC has been submitted to the ICS to fund the UTC correctly which will allow the Trust to increase its establishment and recruit substantively reducing the reliance on locum support.

The ED capital works are in the process of being handed over which will elevate the pressure being experienced with space to deliver the services at CQ.

Actions for ED / UTC Gateway:

- Increasing substantive workforce
- Exploring non-GP workforce
- Implementation of digital solutions – LIVI and e-consult
- Redirection of patients to bookable slots in local walk in centres or to other health providers .e.g. optometrists and pharmacies

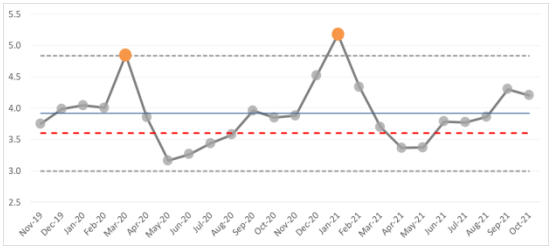
Patient Care- Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

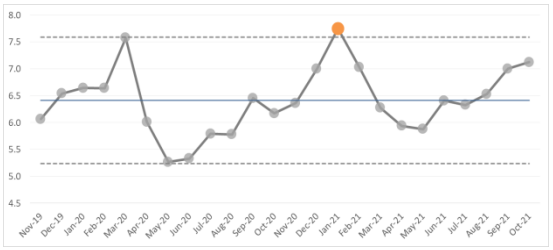
Non-elective Length of Stay (Acute)

Target: 3.6
Current Month: 4.2



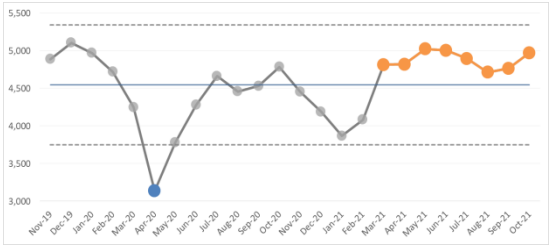
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 7.1



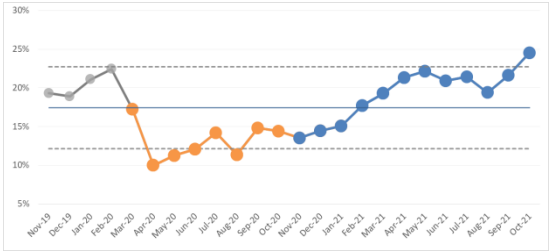
Non Elective Spells

Target: Monitor
Current Month: 4,970



Medical Non Elective Admissions (% SDEC)

Target: Monitor
Current Month: 24.5%



The Trust has seen a slight reduction in its overall length of stay in October. This is mainly in the Pathway Zero category (discharging to home address and with no increase / requirement for additional support). The Trust continues to strive to deliver over 80% of P0s being discharged successfully.

Throughout October, the Trust continues to see an increased pressure on acute admissions and patient flow, along with patients presenting with a higher acuity.

Additional escalation has been in place on both sites for a number of months. This is to increase the bed base to support the additional activity although it should be noted that this places additional pressure on the workforce and overall patient flow. Bids for external funding to support recruitment to the escalation areas has been submitted which will support our substantive workforce and improve our patient experience in these areas. The Trust has also employed more locum Doctors assistants (qualified Drs) to current vacancies to support the clinical teams and discharging of patients

It is not only the Trust that is experiencing these issues and the resourcing challenges the care market is experiencing challenges with recruitment and retention which is impacting on the availability and timeliness of packages of care (delivery and capacity) . As a result discharges to D2A/Intermediate care beds and nursing homes are being delayed and this is having a direct impact on the Trust's overall average LoS.

Good patient flow through both the Trust and the system as a whole is key to ensuring that patients are seen and treated in a timely manner, and cared for in the appropriate setting. As part of the Trust's 'Winter Sparkle' initiative, there are a number of projects that focus on flow in order to assist the challenges faced during the coming winter period and also to address longer term sustainability.

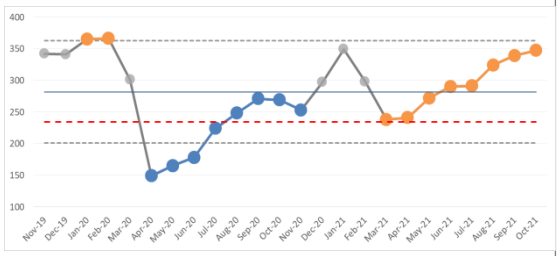
Patient Care - Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

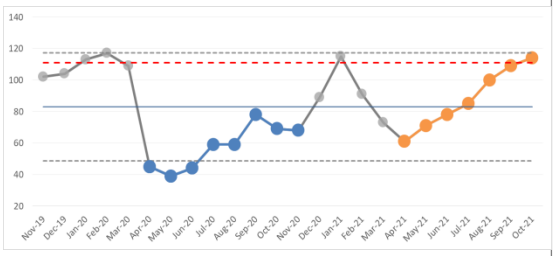
Adult inpatients in hospital for 7+ days (Acute)

Target: Monitor
Current Month: 347



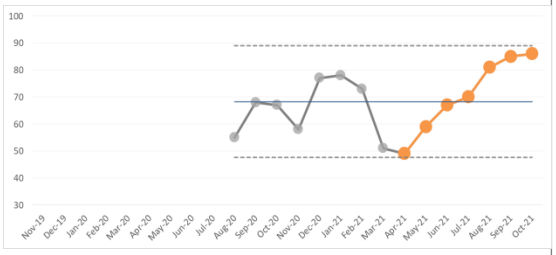
Adult inpatients in hospital for 21+ days (Acute)

Target: Monitor
Current Month: 114



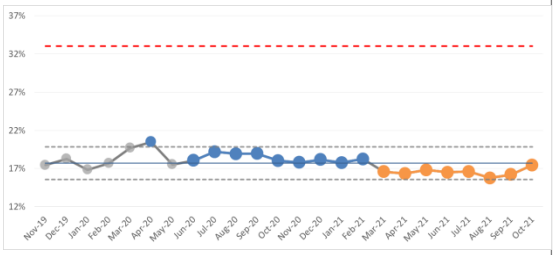
MRD on Pathways 1-3

Target: Monitor
Current Month: 86



Patients discharged before midday %

Target: 33%
Current Month: 17.4%



There has been a continued increase in LoS for patients waiting over 7 and 21 days , this will be an initial focus for the Winter Sparkle campaign being undertaken in November/December.

Patients on Pathway 1 are taking longer to be discharged from the point that they no longer meet the criteria to reside, this is as a result of the current pressures on the care market limiting capacity for discharges.

Patients on Pathway 2 discharge are being delayed into community rehabilitation beds due to the increase demand of patients who are requiring bedded rehabilitation and also the complexity of those cases. These delays and lack of flow also impact on delivery of services at the front door . Patients on Pathway 3 requiring care home placements have remained a similar LoS as September, although this is still an area of concern as we head into winter. We continue to work with our system partners to ensure that we maintain flow and reduce the LoS in the acute setting.

Increase in LoS from the point that a person doesn't meet the criteria to reside to actual discharge , places additional pressure on bed capacity and can lead to further deconditioning of the patient.

Actions under consideration :

- Increasing same day discharge by supporting the continued increase in capacity for Crisis Response service
- System wide review on community rehabilitation beds to ensure capacity meets both volume and complexity of demand-In progress.
- Working with the system partners on winter and 12- 18 month Discharge Plan to support current pressures.
- Process map the P1's from Pre-MRD to MRD recommending streamlined pathway.
- Report the number of patients that do not meet the criteria to reside daily – of which MRD will be a subset
- Recruit a Winter Director for Nov-Feb with an option to extend to April if needed

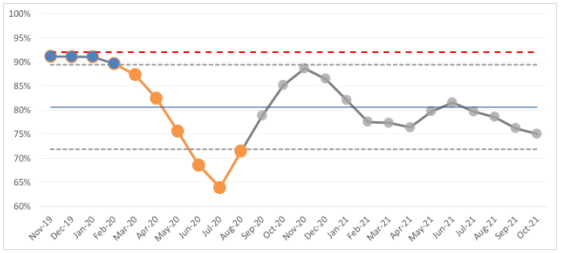
Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

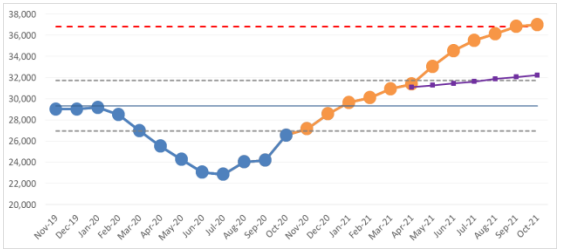
RTT Incomplete Standard

Target: 92%
Current Month: 75.1%



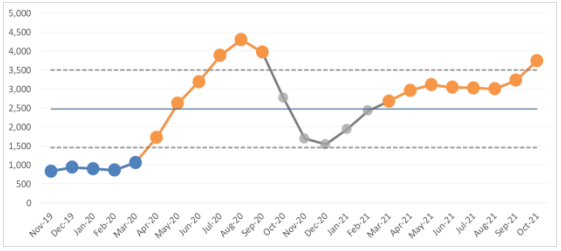
RTT Total Waiting List Size

Target: 36,833 (Sep-21)
Trajectory: 32,230
Current Month: 37,005



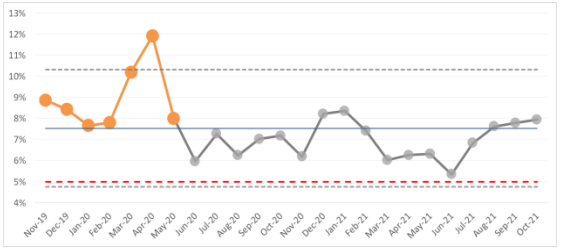
RTT 26 Week Waiters

Target: Monitor
Current Month: 3,742



Cancellations On The Day (Activity %)

Target: 5%
Current Month: 7.9%



Although RTT 18 weeks is still a constitutional standard no NHS Trust is being actively measured against this currently, however the Trust is placed 20th in October.

Our waiting list size continues to increase above trajectory and our current activity and productivity levels would suggest that we will see this trend continue, although at a slower rate over the next few months.

Cancellations on the day continue to increase due to workforce challenges which results in reduced theatre capacity. The Trust prioritises the delivery of capacity for trauma and CEPOD, as well as cancer and urgent cases. Cancellations have robust clinical intervention and oversight at a senior level to ascertain what patients are clinically appropriate to postpone. Patients that are cancelled on the day are always rebooked within the required 28 days, with patient agreement.

Access to procedures is based on individual patient need, whilst considering the need of the overall waiting list. To identify patient need, all patients on the admitted waiting list are prioritised according to the Royal College of Surgeons classifications P1-6. This allows the Trust to also manage the patients that have been waiting >26 weeks working to reduce the backlog. We remain the only Trust on the region to have no patients waiting >78 weeks.

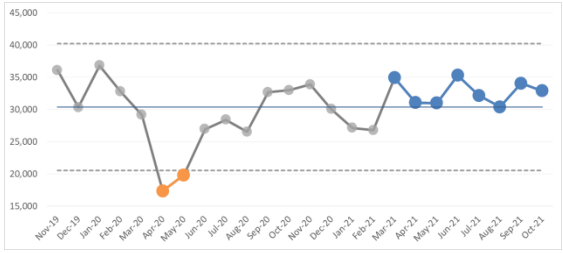
Planned Care – Outpatient Delivery

East Sussex Healthcare NHS Trust

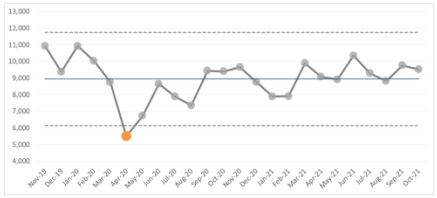
Access and Responsiveness

Outpatient Total Activity
(New and Follow-up)

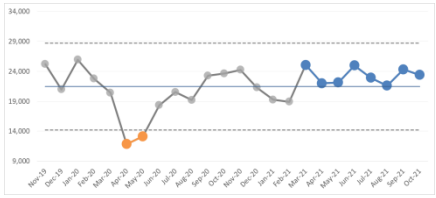
Target: Monitor
Current Month: 32,898



New

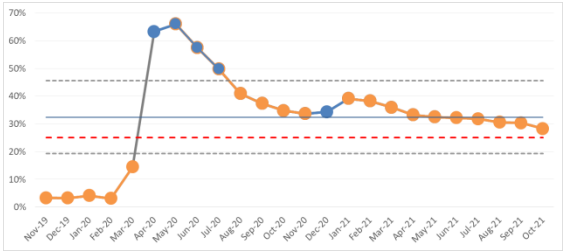


Follow-up



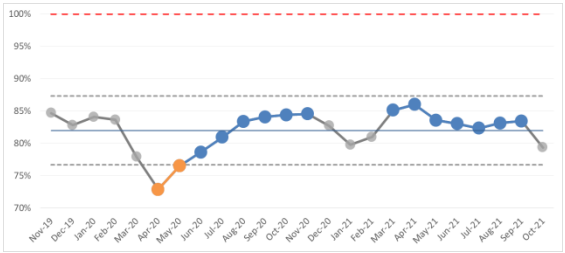
Non Face to Face Outpatients Activity
(Activity %)

Target: 25%
Current Month: 28.2%



Outpatient Utilisation
(Consultant and nurse led Clinics)

Target: 100%
Current Month: 79.3%



October saw a slight decrease in the number of patients seen in Outpatients, but this was still a higher than expected activity level, with ESHT delivering 104% against 19/20 outpatient activity .

To ensure that we deliver the operational planning guidance for the second half of the year and maximise our capacity, outpatient utilisation remains a key focus along with the timely cashing up of clinics to ensure 'clock-stops' are identified early.

We continue to deliver over 25% of our outpatients virtually. Whilst we have the highest virtual activity numbers in the system we are adopting a balanced approach to ensure pathways are not protracted as a result.

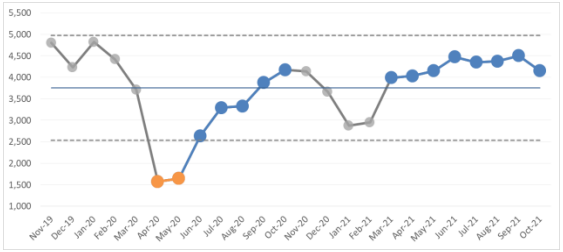
Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

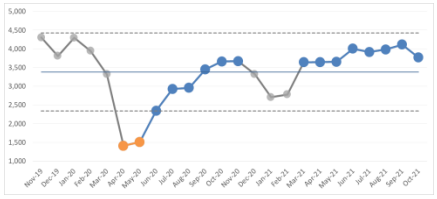
Access and Responsiveness

Elective Spells
(Day case and Elective IP)

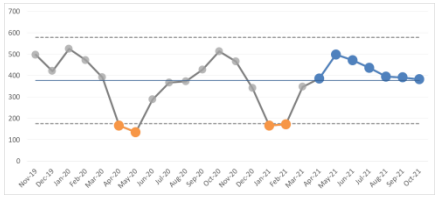
Target: Monitor
Current Month: 4,149



Day case

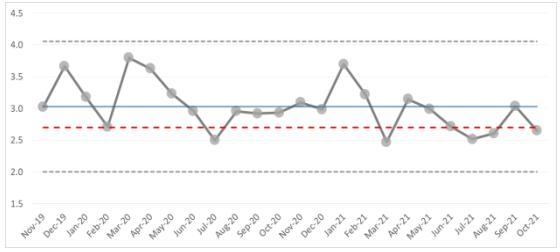


Elective IP



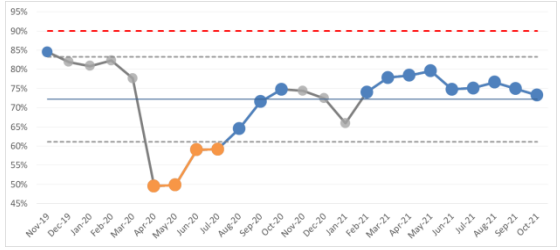
Elective Average LoS
(Acute)

Target: 2.7
Current Month: 2.7



Theatre Utilisation

Target: 90%
Current Month: 73.2%



The Trust delivered 94.8% of day case activity against the 19/20 baseline and 79.7% of elective ordinary activity. The continued increase in non-elective activity and high bed occupancy across both acute sites remains a challenge in matching 19/20 activity and will be monitored closely in view of the H2 priorities.

Divisions continue to work hard to balance priorities and ensure elective activity is maintained whilst dealing with other pressures.

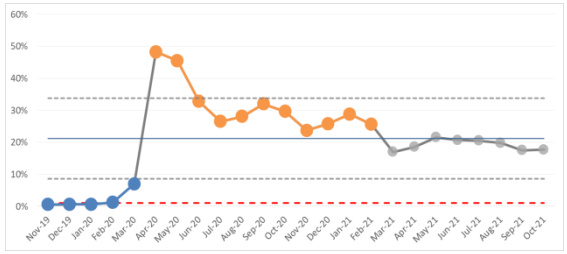
Our elective average LoS is inline with target days of 2.7. Although there is a decrease in elective admissions teams have worked hard to support timely discharges.

Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

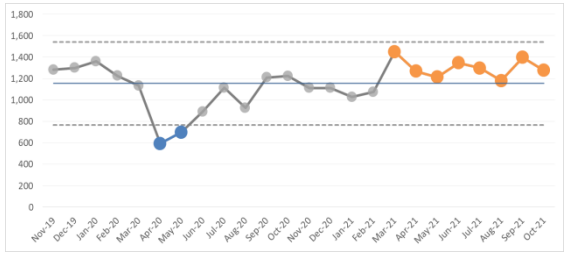
Diagnostic Standard

Target: < 1.0%
Current Month: 17.7%



Endoscopy Demand
(Waiting List Additions)

Target: Monitor
Current Month: 1,276



Our DM01 position has improved again in October and we would anticipate this trend to continue collectively across the modalities.

We have continued to see an increase in activity above the 19/20 baseline. This has helped to improve the cancer Faster Diagnosis position. Although seeing continuous improvement in the DM01 standard there is still more work required to reach the 99% compliance target.

There continues to be an increased demand for patients with a high suspicion of cancer and urgent tests, meaning that diagnostic teams are prioritising capacity to meet demand, which is resulting in certain modalities' recovery trajectory being slower than others. Work to deliver the Community Diagnostic Centre (CDC) commences in November and this should help address the wait for routine diagnostics and see the DM01 position improve. CDCs will also enable our Acute diagnostic teams to concentrate on the more complex and clinically urgent diagnostics.

Non Obstetric Ultrasound remains challenged in terms of workforce nationally and the department continues to try and recruit substantively for sonographers. Work is ongoing to try and provide additional capacity where possible with insourcing lists.

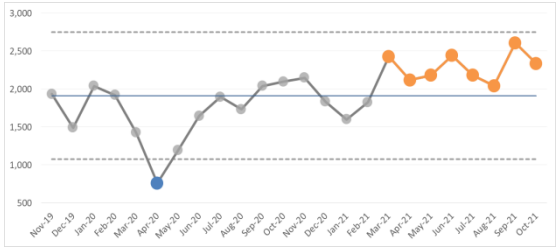
Cardiology has slightly improved it's DM01 position and this will further improve with additional insourcing for echocardiograms which is due to start in December.

Cancer Pathway

East Sussex Healthcare NHS Trust

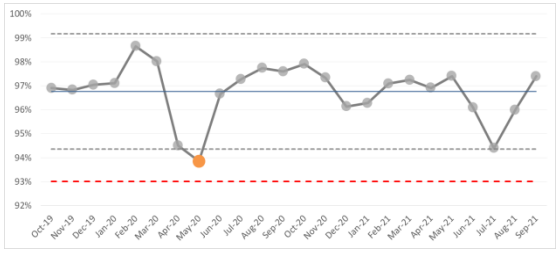
Two Week Wait Referrals

Target: Monitor
Current Month: 2,333



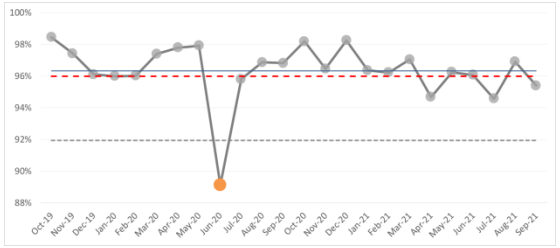
Cancer 2WW Standard

Target: 93%
Current Month: 97.4%



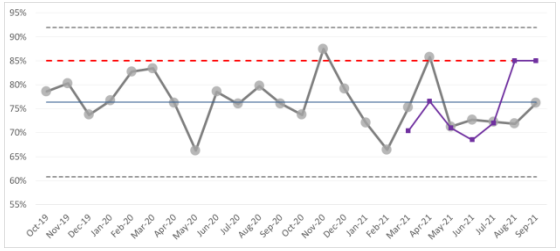
Cancer 31 Day Standard

Target: 96%
Current Month: 95.4%



Cancer 62 Day Standard

Target: 85%
Trajectory: 85%
Current Month: 76.2%



The divisions continue to work to reduce the backlog for the number of patients waiting over 62 and 104 days.

Focused weekly PTL meetings continue to support tumour stream specific PTL meetings ensuring patients are treated in a timely manner.

The delivery of the 28 day FDS standard is pivotal to us achieving the 62 day standard for our patients. The Trust delivered the FDS target for the first time in September and has again delivered in October. Diagnostic delays create a risk to 62 day delivery.

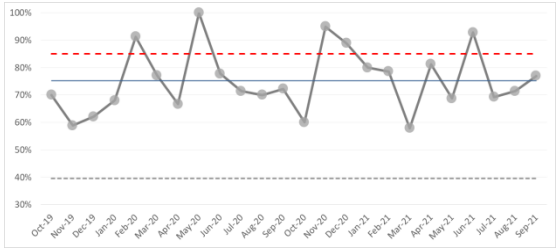
The risks to delivery :

- Increased 2ww referrals (highest number recorded in September 2021 (by date of decision to refer)
- Histology capacity and turnaround times
- Radiology and Endoscopy demand outstripping capacity
- Oncology outpatients
- Complex patient pathways
- Patient choice – delays
- Staff shortages – vacancies and sickness
- Increasing covid prevalence in the community , patients having to isolate
- Delays in patients seeking treatment in primary care setting

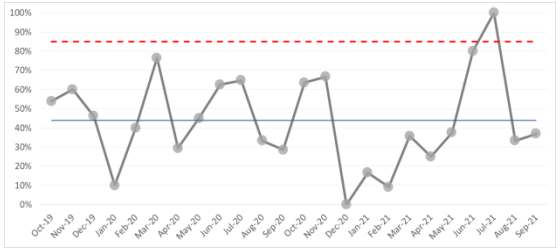
2WW Referral to First Treatment 62 Days

East Sussex Healthcare NHS Trust

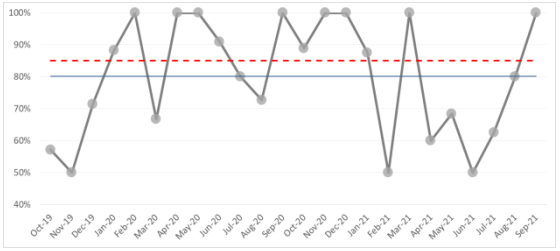
Breast



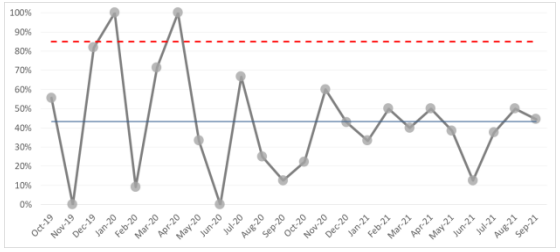
Gynaecology



Haematology



Head & Neck



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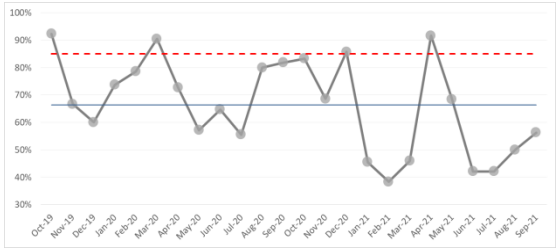

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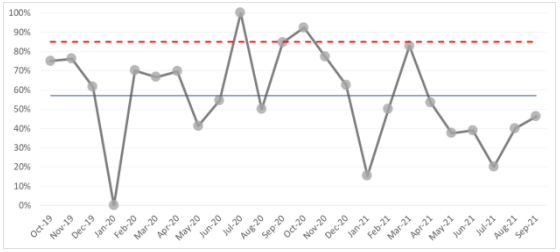
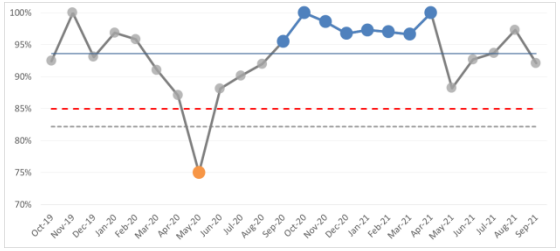
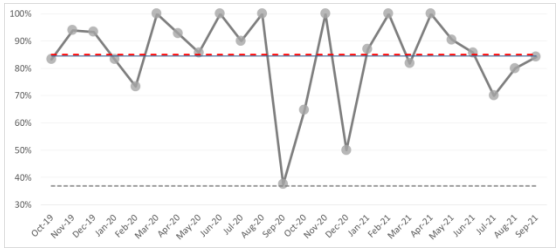


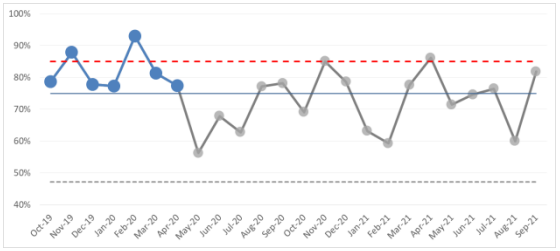
Skin



Upper GI



Urology



Rolling monthly reported positions by Tumour Site, Target: 85%

Financial Control and Capital Development

Our Income and Expenditure

Our Income and Activity

Our Expenditure and Workforce, including temporary workforce

Cost Improvement Plans

Divisional Summaries

We will use our resources economically, efficiently and effectively
Ensuring our services are financially sustainable for the benefit of our patients and their care

Contents

East Sussex Healthcare NHS Trust

(1) Due to the reallocation of covid costs and into core spend in M5 as well as some other significant one-offs in the last couple of months as well as backdated pay award expected to occur in M6 the run rate analysis is not considered helpful at present in the absence of a detailed forecast. We will re-introduce this analysis alongside a forecast in coming months when the position is more stable.

Exec summary

East Sussex Healthcare NHS Trust

	RAG	YTD actual (£m)	YTD var (£m)	Commentary
Income	G	316.8	7.3	• Income is broadly in line with plan, variance is driven by ERF (see below) and H1 pay award
ERF (inc. above)	G	9.0	5.4	• ERF income if £5.4m ahead of plan, amount earned has reduced significantly in the last couple of months (only £0.3m earned in M6) due to increased baseline and falling activity.
Pay	R	(201.1)	(8.6)	• Pay cost variance has increased from £4.0m adverse last month to £9.0m – driven by the inclusion of £4.3m of pay award back pay. • Temporary staff costs are £22.4m YTD • The Trust is using 498 (7%) more staff than in 19/20
Non-pay	R	(108.2)	(4.3)	• Non-pay costs now exceed budget mainly driven by tariff excluded drugs and devices above plan by £2.3m, some of this is offset by higher tariff drug income.
Covid	G	(3.9)	5.6	• Covid position continues to support the trusts overall financial position with an effective YTD contribution of £10.9m (£16.8m income).
Surplus/deficit	A	(1.2)	0	• The in-month deficit is £1.2m, it should be noted that the M7 ledger closed whilst negotiations around the H2 position, particularly funding, was on going with the ICS, the final planning position is proposed to be a balanced plan and therefore we would expect to recover this over the rest of the year. This is set out in more detail in the H2 planning paper.
Efficiency	R	4.4	0.1	• Full year identified efficiency is £11.6m against an indicative plan of £14.7m (£10.1m previous target plus £4.6m – contingency £3m and income recovery £1.6m - see H2 planning paper). Whilst the gap to year end target has reduced to £3.1m, the H2 requirement is based on run-rate reductions. As such this has been rated as red.
Capital	A	11.0	0.8	• Capex of £11.0m is £0.8m behind plan, given the overplanning margin this is not considered a significant issue at this point. • Current forecast is to spend £42.4m against a plan of £45.1m, a £2.7m slippage against the overplanning margin of £4.6m, leaving a residual overplanning amount of £1.9m
Risk & Mits	R	n/a	n/a	• We have identified £7.5m of net risk (after probability weighting – to present a reasonable worst case) against mitigations of £5.8m suggesting that based on current information the Trust will face very significant challenge to deliver a balanced position.

Income and Expenditure

East Sussex Healthcare NHS Trust

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Act	Plan	Var	Act	Plan	Var
Income						
Contract income	35,643	35,993	(349)	261,078	255,931	5,146
Divisional	5,505	5,522	(16)	25,560	28,864	(3,304)
ERF	-	-	-	9,010	3,567	5,443
Covid - block	2,407	2,407	-	16,514	16,514	-
Covid - variable	819	819	-	4,686	4,686	0
Total Income	**44,374**	**44,740**	**(366)**	**316,847**	**309,562**	**7,285**
Operating Expense						
Pay						
Permanent	(25,392)	(28,047)	2,655	(174,674)	(181,021)	6,347
Temporary	(4,249)	(1,698)	(2,551)	(26,474)	(11,487)	(14,987)
Total pay	**(29,641)**	**(29,745)**	**104**	**(201,148)**	**(192,508)**	**(8,640)**
Non-pay						
Drugs	(1,049)	(1,087)	38	(7,198)	(6,717)	(481)
Pass through drugs	(3,596)	(3,644)	49	(26,829)	(24,212)	(2,617)
Clinical supplies	(3,825)	(3,235)	(591)	(22,513)	(20,404)	(2,110)
Purchased services	(1,260)	(841)	(418)	(7,319)	(5,614)	(1,705)
Finance costs	(1,894)	(2,078)	184	(13,258)	(14,545)	1,288
Other	(3,114)	(3,830)	716	(31,125)	(32,483)	1,358
Total non-pay	**(14,737)**	**(14,715)**	**(22)**	**(108,242)**	**(103,975)**	**(4,267)**
Covid exp - block	(336)	(619)	283	(3,930)	(9,553)	5,623
Covid exp - variable	(819)	(819)	-	(4,686)	(4,686)	-
Total Expense	**(45,533)**	**(45,898)**	**365**	**(318,006)**	**(310,723)**	**(7,283)**
Surplus/(Deficit)	**(1,158)**	**(1,158)**	**(1)**	**(1,159)**	**(1,161)**	**2**
Memo:						
WTE (worked)	7,512	7,911	(399)	7,430	7,538	(108)

I&E position

The in-month deficit is £1.2m, it should be noted that the M7 ledger closed whilst negotiations around the H2 position, particularly funding, was on going with the ICS, the final planning position is proposed to be a balanced plan and therefore we would expect to recover this over the rest of the year. This is set out in more detail in the H2 planning paper.

Income

- YTD favourable income position £7.3m driven by:
  - of ERF from months 1 to 6 being £5.4m ahead of plan, amount earned has reduced significantly in the last couple of months due to increased baseline and falling activity;
  - the effect of the back dated pay award for H1 of £4.3m included in contract income; partially offset by
  - Divisional income under-performing due to the impact of COVID on the Trust's ability to bill for third party rents, car parking and other services provided.
- M7 income is below plan by £349k however this is driven by tariff excluded drugs & devices income performing lower than plan.

Expense

- The Trust has a YTD £8.6m adverse pay position, this has reduced from £9.0m in M6 of which £4.3m driven by the back dated pay award.
- Underlying overspend is due to the Trusts reliance on temporary staffing solutions to deliver the elective recovery and increased emergency care levels that are currently being delivered.
- WTE usage is significantly below plan, as set out in the appendix to the M5 report the use of agency and bank is therefore driving the overspend on pay.
- The £4.3m adverse non-pay variance is due to the increased effort in delivering the elective recovery, increased emergency care activity and the costs of delivering health care under a COVID regime.
- In month non-pay is in line with plan, driven by clinical supplies and purchased services being £0.6m & £0.4m adverse respectively (due to recognising costs for outsourced reporting from H1 which had not previously been accrued) off set by other costs being £0.7m favourable.
- Covid block expenditure is £3.9m which is £5.6m better than plan with Covid Block Income recognised at £16.5m meaning there has been an effective contribution of c£10.9m YTD.

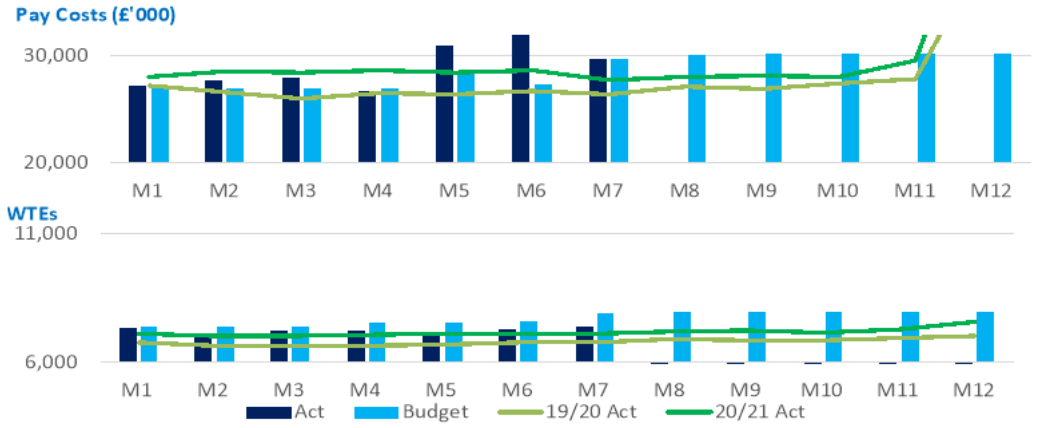
Pay costs

East Sussex Healthcare NHS Trust

Pay analysis

All staff	Pay costs (£'000) - In Month					WTE				
	Act	Var	PY	YTD var	YTD ave	Act	Var	PY	YTD var	YTD Ave
Medical	(7,710)	(733)	*(6,489)*	(3,198)	(7,195)	820	21	*725*	21	790
Nursing	(12,036)	737	*(10,604)*	1,776	(11,776)	3,420	(476)	*3,082*	(274)	3,352
AHP	(4,061)	143	*(3,680)*	159	(3,991)	1,107	(19)	*1,008*	(6)	1,090
Admin	(3,431)	49	*(3,327)*	(170)	(3,540)	1,293	(7)	*1,212*	7	1,291
Other	(2,404)	(106)	*(2,332)*	(7,479)	(2,409)	769	(18)	*772*	(21)	742
Total	**(29,641)**	**90**	**(26,433)**	***(8,911)***	**(28,912)**	**7,408**	**(498)**	**6,798**	***(273)***	**7,264**

Temporary	Pay costs (£'000)					WTE				
	Aug	Sep	Oct	PY	YTD	Aug	Sep	Oct	PY	YTD Ave
Bank	**(2,006)**	**(1,552)**	**(1,475)**	**(1,270)**	**(9,969)**	**400**	**429**	**452**	***424***	**427**
Medical	(693)	(468)	(574)	(352)	(2,881)	32	39	36	*28*	31
Nursing	(554)	(342)	(405)	(250)	(2,088)	66	70	86	*39*	61
AHP	(97)	(90)	(112)	(124)	(694)	16	16	21	*27*	19
Admin	5	156	32	(25)	(375)	14	12	12	*1*	15
Other	-	-	-	-	-	-	-	-	-	-
Agency	**(1,339)**	**(744)**	**(1,059)**	**(751)**	**(6,038)**	**129**	**138**	**154**	***95***	**126**
Locum	**(1,723)**	**(1,269)**	**(1,410)**	**(1,034)**	**(8,748)**	**110**	**91**	**107**	***81***	**104**
WLI	**(260)**	**(238)**	**(298)**	**(49)**	**(1,881)**	**25**	**22**	**23**	***9***	**25**
Total Temp	**(5,328)**	**(3,803)**	**(4,242)**	**(3,105)**	**(26,637)**	**664**	**679**	**736**	***610***	**681**



Note: Due to the impact of Covid, the 19/20 equivalent has been used as the prior year comparator with inflation applied

Pay analysis

- Note the costs and WTE's exclude those included in covid costs.
- M7 pay costs are in line with budget, however withing that medical overspent by £0.7m in month and the spend was £0.5m higher than the average in M1-6. This was offset by nursing which underspend by £0.7m.
- Overall the in month spend of £29.6m is £3.2m higher than inflation adjusted 19/20 comparator with covid costs over and above that.
- YTD all staffing groups other than nursing & AHP's are overspending. Nursing underspending due to the significant increase in the budget for H1 & H2 and recruitment lagging behind this.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive. A more detailed analysis is set out demonstrating this was included in the M5 finance report.

PY comparison

- Pay (£) is overall is above the inflation adjusted 19/20 and 20/21 comparator although the underlying related activity trends are quite dissimilar (covid and non-covid). The spike in month five is caused by the reallocation of covid costs and M6 from pay award.
- When compared to 19/20 in particular costs are materially higher in 21/22.
- WTEs continue to be higher in 21/22 than in 19/20. Oct 21 when compared to 2019 has 9% more WTE (498), driven mainly by nursing (338), AHP (100), Medical (95) & admin (81).

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month			Ytd –M7			Full Year					Schemes
	Plan	Actual	Var	Plan	Actual	Var	Target	Rec	NR	Total	Gap	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	#
Medicine	1	1	-	662	662	-	1,948	44	653	697	(1,251)	4
Emergency Care	0	0	0	0	0	0	538	-	2	2	(536)	1
DAS	80	89	9	850	882	32	2,273	409	1,451	1,860	(413)	10
Core Services	42	39	(3)	209	230	21	1,695	670	97	767	(928)	14
CHIC	34	34	-	508	508	-	1,056	362	305	667	(389)	4
WCSH	(306)	18	324	419	419	-	997	13	914	927	(69)	5
Estates & Facilities	33	33	-	1,019	1,019	-	823	358	904	1,261	439	3
Corporate	17	33	16	519	585	66	806	222	612	833	27	23
Trust wide	171	171	-	171	171	-	4,590	1,590	3,000	4,590	-	2
Total	**73**	**418**	**345**	**4,356**	**4,474**	**118**	**14,725**	**3,668**	**7,937**	**11,605**	**(3,120)**	**66**
Movement from last month	*(1,534)*	*(877)*	*657*	*72*	*418*	*345*	*4,590*	*2,050*	*2,801*	*4,851*	*259*	*13*

Overview

- The Divisions have delivered £0.4m in month 7 and £4.5m YTD, (including the ERF over-performance)
- The in month variance is positive, due to the removal of the 20/21 Maternity CNST scheme that is not going to be received and the scheme There are small over-achievements for DAS this is due to the increased SEES activity and vacancy slippage in Corporate.
- The YTD variance is largely due to the increased SEES activity and vacancy slippage in Corporate.
- The target for the year is £14.7m, £11.6m has been identified, including £3m contingency and £1.6m income recovery. The remaining gaps stands at £3.1m.
- There is a high proportion (68%) of non-recurrent schemes, this is expected during a transition back to BAU working patterns, with budgeting and the funding regime making it hard to recognise items (such as the ERF over-performance) as recurrent.

Risks

The main risks to delivery are:

- Impact on delivery of a further wave of COVID-19; and
- The H2 target needs to be a run-rate reduction; and
- Sufficient time and capacity for division to develop and implement savings plan in an uncertain environment; and
- Less than 5 months left to identify and deliver the £3.1m gap.

Next Steps

- Work with the divisions to develop robust plans for the rest of the year, targeting run-rate reductions;
- Exploit benefits using Model Hospital and Model Health System and GIRFT benchmarking, including Gateway documents and MH highlight reports as well as Corporate benchmarking which is due to be published Q3/Q4.

Capital

East Sussex Healthcare NHS Trust

SCHEME	TRUST LEAD	YTD			Full year			RAG
		Plan £'000	Actual £'000	Var £'000	Plan £'000	F'cast £'000	Var £'000	
Fire Compartmentalisation	EST	605	460	(145)	1,250	1,250	-	
Backlog Maintenance	EST	2,088	2,189	101	6,996	5,996	(1,000)	
Cath Lab Replacement CONQ	EST	214	116	(98)	1,315	1,315	-	
ED and DSU - EDGH	EST	125	3	(122)	2,200	1,750	(450)	
Emergency Department CONQ	EST	1,475	1,886	411	2,549	2,549	-	
Medical Equipment	EME	220	878	658	1,527	1,177	(350)	
Paediatrics	EST	70	-	(70)	200	200	-	
Respiratory Ward - Westham	EST	88	5	(82)	250	500	250	
Respiratory Ward - Baird	EST	88	5	(83)	250	50	(200)	
Energy Centre EDGH/CONQ	EST	357	387	30	535	535	-	
BFF Enabling/Transformation	EST	1,982	1,403	(579)	4,694	4,694	-	
ICU Covid-19 adaptations	EST	140	1	(139)	400	200	(200)	
Triple Breast	EST	200	34	(166)	200	200	-	
Temporary Accommodation	EST	1,156	986	(170)	1,423	1,423	-	
Digital	DIG	1,820	1,246	(574)	3,800	3,800	-	
Minor Capital	FIN	630	817	187	1,400	1,400	-	
Reserves and Unplanned Urgents	FIN	338	-	(338)	750	500	(250)	
Other	FIN	218	419	201	218	218	-	
Donated	FIN	-	154	154	-	-	-	
Original planned Capital		**11,812**	**10,988**	**(824)**	**29,957**	**27,757**	**(2,200)**	
Digital Aspirant/Transformation	DIG	-	-	-	1,600	1,600	-	
Seed Aspirant - EPR	DIG	-	-	-	250	250	-	
Digital Pathology - PathNetwork 7	DIG	-	-	-	2,075	2,075	-	
Community Diagnostics Centre	EST	-	-	-	1,787	1,587	(200)	
Radiology Imaging Network	DIG	-	-	-	1,321	1,321	-	
Cyber Security	DIG	-	-	-	250	250	-	
ICS Digital - Shared Care Record	DIG	-	-	-	3,750	3,750	-	
Robotic Process Automation (TIF)	DIG	-	-	-	150	150	-	
E-Triage (TIF)	DIG	-	-	-	407	407	-	
Da Vinci Robot (TIF)	THE	-	-	-	700	700	-	
Upgrade Theatres (TIF)	THE	-	-	-	1,400	1,120	(280)	
CT Scanner (TIF)	RAD	-	-	-	550	550	-	
Diagnostics Equipment (TIF)	RAD	-	-	-	885	885	-	
Additional Capital		**-**	**-**	**-**	**15,125**	**14,645**	**(480)**	
Capital Position		**11,812**	**10,988**	**(824)**	**45,082**	**42,402**	**(2,680)**	
Headroom/(Overplanning) Margin					**(4,583)**	**(1,903)**		

RED: Reasonable chance of 25% slippage or 250k on individual scheme whichever is smaller
Amber: Reasonable chance of 10% slippage or 100k whichever is smaller
Green: Less than 10% chance of slippage
Blue: Scheme complete

Capital

- The planned Capital resource limit (CRL) for 2021.22 is £24.2m. This is made up of internally generated depreciation of £16.7m and additional external funding expected to be received in year (£7.5m).
- The forecast CRL totals **£40.3m** and includes additional funding of £16.2m (including agreed overspend offset with another ICS provider - £15.1m without).
- The total capital plan is now expected to be **£45.1m** with an overplanning margin of £4.6m.
- Consideration is being given to deferring the carpark to later in next year due to the commitment on Trust internal capital it would place on next years programme and the likely delay in BFOF means this is less urgent.
- The capital position at the end of month 7 totals **£11.0m** of actual expenditure. This compares to the revised plan of £11.8m with a **slippage of £0.8m**.
- The YTD spend represents a relatively low proportion of spend. However a number of schemes are now progressing with a bit of a hiatus as the implications of the audit have played through.
- The current forecast shows a predicted **variance of £2.7m underspend** against plan, resulting in a **£1.9m overspend** against capital resource limit. Our expectation is that as we continue the forecasting exercise in December that this will reduce further, although it is possible with the direction construction costs are moving that this may increase – which will require us to consciously slip the timeline on some projects.
- The biggest risks to delivery of the capital plan relate to some of the recent allocations (CDC and the laminar flow theatres), the DSU and EDGH ED may also be challenging to deliver by 31 March.

Balance Sheet

East Sussex Healthcare NHS Trust

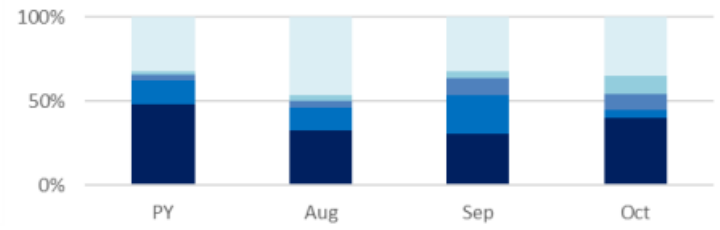
Trust Balance Sheet

	Aug	Sep	Oct	Change
	£'000	£'000	£'000	£'000
Non-current assets	**256,813**	**257,149**	**258,740**	**1,591**
Inventories	6,651	5,291	5,611	320
Trade and other receivables	25,707	25,421	17,697	(7,724)
Cash and Cash equivalents	53,072	49,420	54,018	4,598
Current Assets	**85,430**	**80,132**	**77,326**	**(2,806)**
Trade and other payables	(48,549)	(44,257)	(41,509)	2,748
Other liabilities	(3,399)	(2,821)	(6,392)	(3,571)
Current Liabilities	**(51,948)**	**(47,078)**	**(47,901)**	**(823)**
Non-current liabilities	**(5,226)**	**(5,226)**	**(5,226)**	**-**
Total assets employed	**285,069**	**284,977**	**282,939**	**(2,038)**

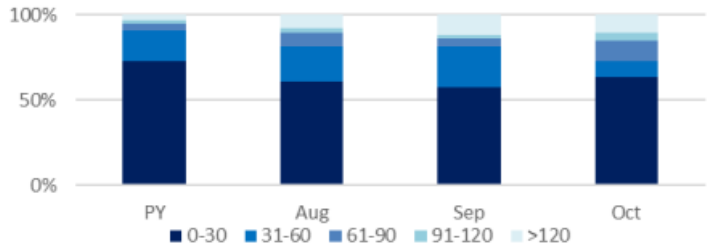
BPPC

Trade	90.7%	91.0%	91.9%	0.9%
NHS	99.4%	99.4%	99.5%	0.0%

Trade receivables Ageing



Trade Payables Ageing



Balance sheet

- The balance sheet shows a broadly consistent position overall with the previous month (as would be expected with a break even I&E position), total assets deployed have reduced driven by the in month deficit.
- There have been a number of movements relating to timing of payments (e.g. trade payables and receivables).
- The Trust continues to hold very significant cash balances.

Trade Receivables

- The sales ledger balance at the end of October is £4.8m which is a decrease on the previous month of £0.1m.
- The number of invoices on the sales ledger at the end of the month has increased by 28 to a total of 1,504.
- The ageing profile remains broadly similar to the previous month, the total debt owed to the Trust aged over 30 days has reduced from 695 to 60% however at the other end of the profile debt over 90 days has increased from 36% to 46%. However, most of the debt owed to the Trust is from other NHS bodies and therefore there is a low risk of non-recovery.

Trade Payables and Better Payment Practice Code (BPPC)

- BPPC performance has improved again in October and is a result of the on-going work of the financial services team to increase performance, particularly around non-NHS payables.
- A decrease in month of £0.6m on the creditor position reducing the purchase ledger total to £6.7m. There has however been an increase in the number of invoices on the purchase ledger system to 5,280 from 4,473.
- 85% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.

Risks and mitigations

East Sussex Healthcare NHS Trust

The risks and mitigations set out below are aligned to the H2 system planning submission and highlight the very significant level of risk facing the Trust to deliver on the H2 plan of breakeven.

	Gross value £'000	Risk adjusted %	Net value £'000	Description
H2 Efficiency Programme	4,736	40%	1,894	Trust plan is predicated on delivery of £4.7m of efficiency compared to H1 run rate. Reducing expenditure by that qunatum in four months remaining will be extremely challenging
CCG income disputes	1,590	60%	954	The plan includes £1.6m of additional income from CCGs for historical services commissioned outside the block. The CCG has yet to agree to pay for these and refused in H1 on the grounds of affordability.
Funding assumptions	9,573	40%	3,829	The Trust has assumed a funding support for a number of items which help address the financial gap largely relating to bids against national funds. These have not yet been confirmed and even if they are may require incremental activity over and above existing plans which would add further cost
Additional cost pressures	2,060	40%	824	General risk for 1% of H2 forecast expenditure. The most signficant risk being WTE utilisations as excluding covid are c400-500 budgeted WTE above used, if these are filled then it will increase costs faced
Total Risk	**17,960**		**7,502**	
ESHT contingency contribution	2,648	80%	2,118	Fair share (population basis) allocation of capacity fund to meet NEL pressures
Fair Share Capacity Funding	3,080	40%	1,232	ESHT has contributed £3.1m to ICS contingencies which are currently not allocated
ICS contingency	12,232	20%	2,446	Deployment of residual ICS capacity
Total mitigation	**17,960**		**5,797**	

Mortality Report – Learning from Deaths: 1st April 2017 to 31st June 2021

Meeting information:	
Date of Meeting: 14th December 2021	Agenda Item: 8
Meeting: Trust Board	Reporting Officer: Dr David Walker, Medical Director

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSI/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The attached report on "Learning from Deaths" follows the requirements set out in the Care Quality Commission review. The mortality database is designed to reflect this process and has also been updated to incorporate the Medical Examiner review process which commenced at the Trust on September 1st 2020. All cases referred by the Medical Examiners for further scrutiny, are highlighted to divisions and are discussed at specialty Mortality and Morbidity meetings.

The current "Learning from Deaths" report details the April 2017 – June 2021 deaths, recorded and reviewed on the mortality database.

The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process, in order to mitigate any risk.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

N/A

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board are requested to note the report. "Learning from Deaths" reports are required on a quarterly basis.

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard June 2021-22

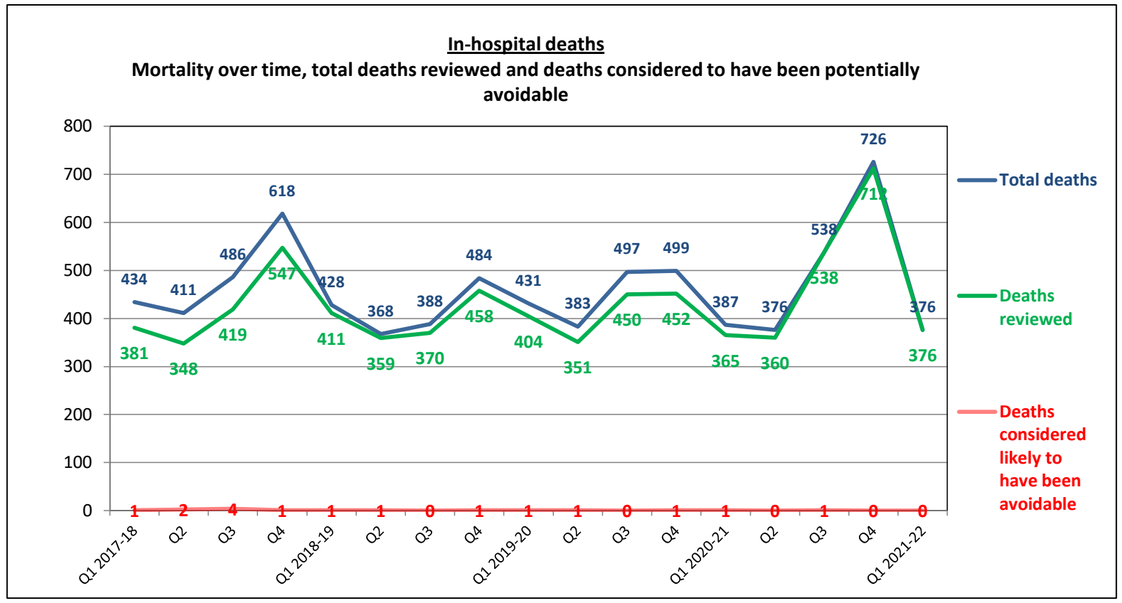
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 08/11/2021)

Total number of in-hospital deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities)

Time Series:	Start date	2017-18	Q1	End date	2021-22	Q1

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
128	128	128	128	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
376	726	376	712	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
376	2027	376	1975	0	2



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	100.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	100.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%

Data above is as at 08/11/2021 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 4 care concerns expressed to the Trust Bereavement team relating to Quarter 1 2021/22 deaths, none of which were taken forward as a complaint.
Complaints - Of the complaints closed during Quarter 1 2021/22 which related to to 'bereavement', none have an overall care rating of 'poor care' on the mortality database.
Serious incidents - There were four severity 5 Serious incidents reported in Q1 2021/2022, two of which related to ward COVID outbreaks.
As at 08/11/2021 there are 529 April 2017 - June 2021 deaths, still outstanding for review on the Mortality database.

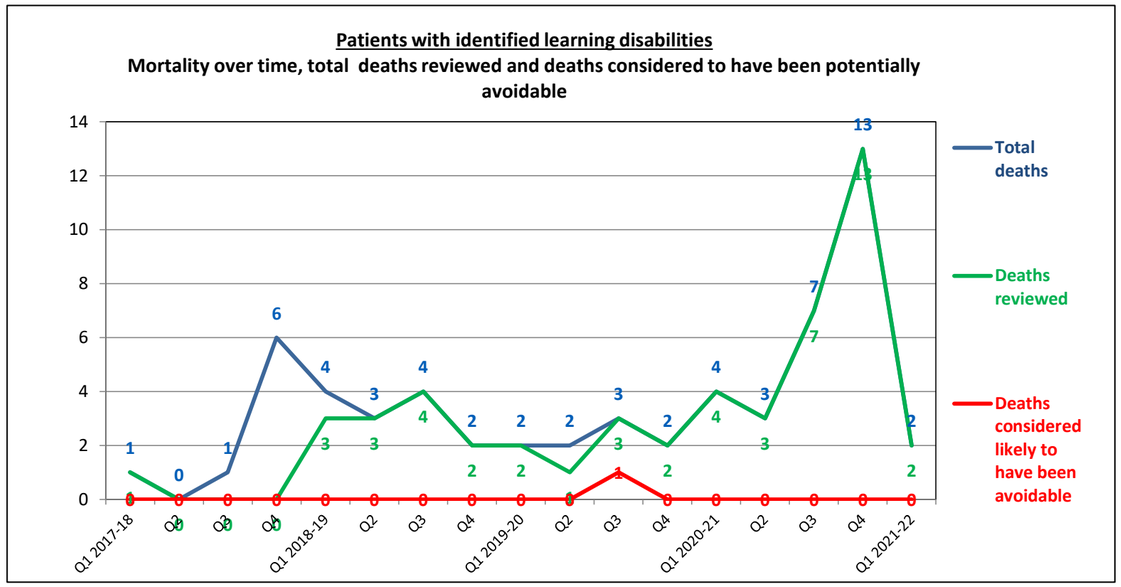
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 08/11/2021)

Total number of deaths, deaths reviewed and deaths deemed avoidable for patients with identified learning disabilities

Time Series:	Start date	2017-18	Q1

End date	2021-22	Q1

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	1	1	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	13	2	13	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	27	2	27	0	0



The LeDeR (learning disability mortality review) programme is now in place and the deaths of patients with a learning disability are being reviewed against the new criteria externally. Feedback from these external reviews is now being received by the Trust.
These deaths are also reviewed internally by the Acute Liaison Nurse for Learning Disabilities, who enters the review findings on the mortality database.

Cardiology and Ophthalmology Transformation Programmes

Meeting information:			
Date of Meeting:	14 December 2021	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer:	Richard Milner, Director of Strategy

Purpose of paper: (Please tick)			
Assurance	☐	Decision	☒

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state: NHSE/I, Clinical Senate, GPs, MPs, Healthwatch, SECAmb (a full list of stakeholders can be found within the PCBC)			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

On 30 November 2021 the Trust Board met to fulfil the process requirement of reaffirming our commitment to the proposals relating to cardiology and ophthalmology service transformation. We have included as appendices all the documents that were provided to the Board ahead of our decision on 30 November. These documents were also considered by ICS colleagues at the Joint Sussex Committee (JSC) in reaching its decision on 26 November.

The Trust Board having reaffirmed its commitment to the proposals, it also agreed its support for the proposals going forward to Health Overview and Scrutiny Committee (HOSC), and that HOSC would decide whether the proposals constituted a 'substantial variation' to the existing model of provision. The support of this Board echoed the JSC support for the proposals.

As per the process, with both provider and other ICS board-level support agreed, the joint presentation to HOSC took place on 02 December. HOSC determined that both of the service transformation proposals constituted "substantial variation" from the existing model of care and so a formal consultation would be needed for both services.

We are working with our colleagues in the Sussex system to understand the precise phasing of the consultation and the associated governance requirements. Formally, the consultation with the public commenced on 06 December 2021 and will conclude on 11 March 2022. The public-facing documents and further details on engagement events will be co-ordinated through the website. ESHT has also made staff formally aware of the consultation, although informally many have kept themselves aware of progress to date through colleagues and wider networks.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Prior to the decision of the Trust Board on 30/11/21, papers covering the ophthalmology and cardiology transformation had been discussed in a range of forums. These are summarised below:

- Joint Sussex Committee (JSC), 17.11.2021
- Joint Steering Group, 21.10.2021 – Endorsed PCBC and proposal ahead of JSC / Trust Board
- CCG EMT Meeting, 25.10.2021 – Approved PCBC & proposal for submission to JSC.
- NHSE/I Stage 2 Assurance, 14.10.2021 – Approved PCBC and proposal for public consultation
- Deep Dive Presentation, 06.09.2021 – Programme / PCBC Overview and Q&A
- F&I Strategy, 26.08.2021 – Transformation Update Papers – Progress Against Plan
- Trust Board, 13.04.2021 – Programme Update Post Initial Presentation at HOSC
- HOSC, 04.03.2021 – Programme Update Paper to HOSC
- NHSE/I Stage 1 Assurance, 29.01.2021 – Approved Case for Change/Strategic Sense Check
- F&I Strategy, 26.11.2020 –Transformation Update – Timeline & Case for Change (Pre-NHSE/I Stage 1)

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to:

1) Note the 30 November Board reaffirmation of support for the transformation proposals
2) Note the 02 December HOSC decision that the two transformation proposals constitute a "significant variation" from the current operating model
3) Acknowledge the ongoing work with ICS colleagues to determine the consultation roadmap and implications for ESHT during this timeframe

Mortuary & Body Store Assurance

Meeting information:			
Date of Meeting:	14th December 2021	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Chief Nurse and Medical Director

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	Yes.

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

All health trusts have been asked to review mortuary access and post-mortem activities following revelations last month regarding the case of David Fuller, a hospital electrician employed at a Trust in Kent. In addition to murder and sexual assault some years ago, the case also involves the sexual assault of deceased patients in a mortuary setting.

The NHS wrote to all trusts asking for mortuary access and post-mortem activities to be reviewed against current guidance. An independently chaired review is already underway into exactly what occurred at the trust in question, which will report into the Health Secretary and the Health Secretary has also asked the Human Tissue Authority (HTA) for advice on whether changes are required to existing regulations.

A letter dated Oct 12th 2021 was sent to all NHS trust chief executives, ICS leads and directors of estates from Mark Cubbon, Interim Chief Operating Officer for NHS England and NHS Improvement (NHSE/I) regarding mortuary and body store facilities.

In the letter NHSE/I requested that Boards of organisations with either a mortuary or body store ensure they are compliant with existing guidance, and take additional steps as set out in this letter. ESHT has mortuary facilities/body stores at both EDGH and Conquest hospitals.

The Human Tissue Authority (HTA) is the regulator which oversees the licensing and inspection of post-mortem facilities, including security arrangements. All Trusts were asked to undertake a review of the HTA guidance and take steps to assure their Boards that they are compliant.

NHSE/I required all Trusts with either a mortuary or body store to urgently review their practices and ensure the following four actions are implemented:

1. **Ensure all access points to the mortuary or body store are controlled by swipe card**

security access. Where this is not immediately possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access.

Response

- Swipe card access is in place on most doors at Conquest mortuary and is restricted. The other doors are key operated and restricted.
- Keys are in place at EDGH and are restricted.
- Only authorised persons are permitted to enter the mortuary. Identification is checked for anyone requesting access, including for viewing purposes with the lead visiting relative.
- Working hours access is managed by the mortuary team. All non-mortuary staff sign in unless they are admitting a patient.
- During the admission process 24/7 the professionals sign the admission documentation, therefore providing details of the date, times and professionals involved.
- Out of hours access is mortuary staff, porters and Coroners/police contracted funeral directors (named personnel only). All out of hours access staff are trained and competency assessed annually.
- Porters admit patients who have died on a ward routinely and only allow access and accompany ambulances, police arriving with the ambulances, and non-contracted funeral directors admitting with British Transport Police.
- The Coroners/police contracted funeral directors (CPJ Field) admit community deceased only and can only access the fridge room areas and toilet. They do not permit anyone else entry other than the police officers and/or coroners officers who attend the scene. Records are held of photographic identification and DBS checks are in place for these personnel. Anyone not trained is not permitted entry. There is regular communication with the company manager.
- There is a contract in place with East Sussex County Council which highlights the expectations of community admissions and personnel on site covering CPJ Field. Review meetings are held three times a year.
- The On-Call mortuary APT's are contacted if anyone else requires access including other Trust staff or NHSBT tissue services.
- Maintenance staff may ask for admission to access fuse boards and they should be accompanied throughout their visit. If this is to look at mortuary equipment the On-Call APT must be called in and attend to accompany them.
- Annual security audit undertaken to ensure area is secure.
- Documentation is held on QPulse and within the mortuary on security, access, visitors, training, competencies and HTA license requirements.
- All mortuary documentation is removed from the fridge room area as soon as the deceased patients are registered onto the electronic system. This is only accessible by the mortuary team.
- Swipe card access to be fitted at EDGH with additional access points being added at Conquest.
- Maintenance team to be reminded that there is no access out of hours unless accompanied by a porter or On-Call APT throughout the visit.

2. **There must be effective CCTV coverage in mortuary areas and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and mental health support may be required to support staff to undertake this task.**

A subsequent letter on letter on 3rd November 2021 clarified that trusts should:

"Ensure there is effective CCTV coverage, monitoring access to and from mortuary areas. CCTV data should be reviewed, alongside swipe card data, by an appropriately trained and authorised individual to audit access".

Response:

- CCTV is in place on most doors and entrances at Conquest, with coverage of remaining doors being put in place, ideally with images available in the main security offices.
- CCTV is in place on some doors and both entrances at EDGH, with coverage of remaining doors being put in place, ideally with images available in the main security offices.
- CCTV covers all areas where the deceased patients are held except the post mortem rooms, however the entrance to these is covered.
- The fridges/freezers are all covered by CCTV and are not double ended.
- The monitors are located and managed by the mortuary team in a secure area and password protected. Regular checks of the footage are made.
- Fortnightly review of CCTV which will be documented.
- Annual review with security adviser/manager.

3. **A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area.**

Response:

- There was already a documented risk assessment process in place, however a more thorough assessment and detailed report has since been carried out on each site and will now be reviewed annually.

4. **Ensure there is consistent application of appropriate levels of DBS checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract. Employers are required to pay attention to the security features of a DBS certificate.**

Response:

- The Trust has a *Disclosure and Barring Policy* in place to ensure that new and existing staff (including permanent, fixed term, TWS Bank, volunteers, students and agency staff) are suitable to work in 'regulated activity' working with children or vulnerable adults. The policy also gives guidance to ensure compliance with the DBS Code of Practice, the Data Protection Act 1998 and the Recruitment of Ex-Offenders.
- All staff eligible for a DBS are checked on appointment. Existing staff moving to new areas that have not been checked at the appropriate level are required to have a DBS check. There is a 5 yearly rolling programme in place to carry out retrospective checks for all staff requiring a DBS. This is carried out by the Recruitment department.
- Any contractors supplied via the Bank working at the Trust are also required to have a DBS.
- Contracted funeral directors all have current DBS checks with information on file including photo ID.
- Mortuary manager has agreed with HR that mortuary staff will be added to the high risk group and have DBS checks every three/five years according to Trust high risk staff group. This has been done with immediate effect.

In addition to these four points the Trust was also asked to review mortuary and body store practices against the HTA Code of Practice, specifically parts A and B. An internal review has shown no areas of immediate concern. The HTA are due to visit ESHT in February 2022 and any recommendations for improvement will be acted upon.

It should be noted that HTA guidelines cover all hospital departments, not just the mortuary. The governance structure is set out in the guidance and requires there be a named Licence Holder (Dr

David Walker), a Designated Individual (Michele Elphick, ADO for DAS Division) and departmental Designated Leads. These roles and role holders will be reviewed again once the HTA inspection has All health trusts have been asked to review mortuary access and post-mortem activities following revelations last month regarding the case of David Fuller, a hospital electrician employed at a Trust in Kent. In addition to murder and sexual assault some years ago, the case also involves the sexual assault of deceased patients in a mortuary setting.

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7. **A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area.**

Response:

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certificate.

Response:

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The Trust responded to each of these points through a NHSE/I web portal by the deadline on 16th November 2021 and is awaiting feedback.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Trust Executives on 8th November 2021.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

Trust Board is asked:

1. To review the evidence in response to each of the above actions and confirm that they are satisfied that the appropriate responses have been taken to date;

2. Asked to note the upcoming HTA inspection visit in February 2022; and to

3. Agree that future updates regarding mortuary and body store processes and guidance should be reported to the Quality & Safety Committee along with an action plan as required.

Workforce Disability Equality Standard

Meeting information:			
Date of Meeting:	14th December 2021	Agenda Item: 11.1	
Meeting:	Trust Board	Reporting Officer:	Steve Aumayer

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☒

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:	BAME Staff Network, Workforce Equality Group		
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This report informs the Trust Board on the 2021 data baseline and progress with regards to the Workforce Disability Equality Standard (WDES), and can be viewed alongside the WDES Action Plan.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Various groups are involved in the actions for the WDES plan, including the People & Organisational Development (POD) Committee, WDES Task and Finish group (Dis)Ability staff network.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The committee is asked to note and accept the contents of the data for submission.

Gain assurance from the attached WDES Action Plan that the actions will be progressed and the leads are committed to delivering results within the agreed timescales.

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE TRUST WDES ACTION PLAN 2021				
1. Diversity Declarations Project				
Action	**By Who**	**By when**	**Outcome expected**	**Update**
1.1: Blind copy email sent to all staff with diversity detail missing on ESR	Workforce EDI Team	December 2021	Staff self-disclose their details on ESR Reduce the unknown Disability declaration rates to 25%	**Completed.** New data will be produce in January 2022 Phase 2 reminder emails will be sent out
1.2 Information on pay slips encouraging staff to update Diversity information	Workforce EDI Team Payroll Team	January 2022	Staff self-disclose their details on ESR Reduce the unknown Disability declaration rates to 25%	**Dec 2021** Message sent to salaries to include disclosure information on December payslip
1.3 Paper copies of diversity detail sent to staff to complete and send back to up-load on ESR	Workforce EDI Team Workforce Information Team	March 2022	Declaration rates reduced to 10%	To commence in February 2022 waiting for phase 1 to complete
2. Bullying and Harassment				
Action	**By Who**	**By when**	**Outcome expected**	**Update**
2.1: Ensure that there is a (Dis)Ability Staff Network member on the Violence and Aggression Sub-group	Workforce EDI Lead (Dis)Ability Staff Network	December 2021	Co-production of process and benefit to Disabled Staff	**Nov 2021** Waiting for the new People Experience manager to start
2.2: Include incidents relating to Disability on Datix	Training Department Organisation Development	December 2021	Achieve Public Sector Equality Duties	**Completed** Business Case approved to draw

	Team			information from ESR and PAS to Datix. Protected Characteristics now included on Datix
2.3 Encourage more staff with and without Disability to report incidents on Datix	Violence and Aggression – Sub Group Disability Staff Network	January 2022	More incident reporting and richer data relating to incidents	**Nov 2021** Protected Characteristics field needed to be included on Datix
2.4 Power & Resilience training for Disabled staff	Workforce EDI Team and Health Promotion	December 2021	More staff with a disability feel empowered to speak up and report incidents	**Completed** Resilience training took place in Summer network meeting
3. Engagement & Wellbeing				
Action	**By Who**	**By when**	**Outcome expected**	**Update**
3.1: Advertise the (Dis)Ability Staff network through recruitment and a Communications campaign	Workforce EDI Team Staff Network Recruitment Team	February 2022	Increased membership to the staff network	**Nov 2021** Staff network promoted through Disability History Month Recruitment element partially started
3.2 Compassionate Check-ins for staff with a long term health condition or illness	Health and Wellbeing team	During Winter pressure months	Staff engagement for Disabled staff and a platform for raising	**Nov 2021** Dates and key staff to be

			concerns so that staff with a long-term health condition or illness feel supported.	confirmed
3.4 Raising the profile of Disabilities through events such as Disability History month and Diversity Dialogue sessions	Workforce EDI Team (Dis)Ability Staff Network	31 December 2021	Better understanding of Disabilities across the trust.	**Nov 2021** A range of events and awareness raising has been planned for Disability History month. Guest speaker, Quiz, Diversity Dialogue and promotional videos
4. Explore an Asset Register for Reasonable Adjustments				
Action	**By Who**	**By when**	**Outcome expected**	**Update**
4.1: A scoping exercise to include Facilities and Estates, IT Department, Procurement team Operational HR and the Occupational Health team	WDES Task and Finish Group	January 2022	Better use of equipment for staff with a long-term health condition or illness	**Nov 2021** Partially started initial conversations with key stakeholders .
4.2: Currently teams and Divisions pay for Reasonable Adjustments in the workplace. Develop a budget forecast for a 5 year period Review if a centralised	Workforce EDI Team WDES Task and Finish Group Finance Charitable Funds	January 2022	A better understand of cost related to Reasonable Adjustments	**Nov 2021** Dependant on 4.1

asset register would be cost effective? Cost Benefits vs Charitable Funds				
4.3: Explore options for equipment accommodation	Facilities & Estates & IT Department	January 2022	Sufficient space to store large equipment	**Nov 2021** Dependant on 4.1
4.4. Explore the Department and resources required to own the register	WDED Task and Finish Group	January 2021	Clear process an flow chart on equipment	**Nov 2021** Dependant on 4.1
4.5: Paper to POD and other committees on the Reasonable Adjustment Asset Register	Workforce EDI Team	March 2022	Option to agree the process	**Nov 2021** Dependant on 4.1 – 4.5
	5. Recruitment and Leadership			
Action	By Who	By When	Expected Outcome	Update
5.1 Wording for all recruitment to include; Disabled candidates are encouraged to apply as underrepresented at ESHT	Recruitment Team	December 2021	More staff with a disability or long-term health condition apply for roles	**Nov 2021** Website and recruitment paperwork need to be up-dated
5.2 Commission an audit from application to short-listing around disabled staff.	Recruitment team Disability staff network	March 2022	Understand a) How many candidates applied under the guaranteed interview scheme b) Any reasonable adjustments made at interview c) The likelihood of application to shortlisting	**Nov 2021** Due to winter pressures not yet started
5.3 Ensure that all leadership programmes and	Training Departments OD Department	Ongoing	More participation from Disabled staff	**Nov 2021** All programmes

opportunities are advertised through the (Dis)Ability Staff Network	Apprenticeships		and better opportunities for development	are
5.4 Monitor learning and development attendance by disability status at the Equality Meetings	Training Departments OD Department Apprenticeships	31 December 2021	Ensure there are no barriers for disabled staff accessing courses and development programmes	Nov 2021

For a copy our SMART Objectives delivery plan please email: esht.workforceinclusion@nhs.net

Guardian of Safe Working Hours Annual Report

Meeting information:	
Date of Meeting: 14th December 2021	Agenda Item: 11.2
Meeting: Trust Board	Reporting Officer: Dr N Muhi-Iddin and Mr W Yousef

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☒

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS AND ISSUES RAISED BY THE REPORT

All doctors in training are on the 2016 Contract TCS. There are a total of 244 doctors allocated to the Trust by HEE for the Academic year the 1st August 2020 to the 31st of July 2021.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

- To be reviewed by the Trust board following the POD meeting
- To be shared at the next LNC meeting including the trainee representatives
- Part of the report may be shared with HEE KSS Guardian of safe working Network group.
- Relevant parts of the meeting could be shared ant the Local academic board meeting and relevant LFG meeting with clinical and educational supervisors.
- Actions or outcomes may be fed back to DiT Trainee representatives

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

1. The Guardian of safe working hour's team thanks the Clinical Supervisors for their support of their trainees over the last challenging and busy year. As a rule, ERs have been acted on in a timely manner. In the last quarter there have been a number of delays in reviewing and assigning an action to exception reports. This response should happen within 7 days of submission of the exception report so that Doctors are compensated appropriately.

   There has not been an increase of ERs in the last quarter. The delay may be due to annual leave taken during the summer, or supervisor workload. This means that ERs are reviewed instead by the GoSWH and relevant issues not discussed with supervisors. Occasionally some supervisors will not engage with exception reporting for a number of reasons.

   This issue has been and will be will be raised by the team at the coming LFGs and the LAB meetings and DME.

2. Exception reporting is a system that has now been in place for 5 years and its aims for safeguarding patient safety and DiT wellbeing is widely known. However non-compliant workload, missed breaks and additional hours worked and still underreported. Many trainees are still uneasy submitting a report

for fear of negative repercussions from supervisors and senior staff. The guardian team has had recent feedback directly from Take 5 meeting to that effect. Some past negative experiences have been in previous trusts with lasting effects however, the Guardian team seek a statement of reassurance and support from the Trust board to all trainees that the trust fully supports the Trainees to submit ERs in keeping with their TCS and act on any grievance a trainee may raise with concern following discouragement or unfair denial of authorisation.

3. More DiT are now uncomfortable in asking of compensatory payment or TOIL for additional hours worked. This is due to the feeling of unfairness towards colleagues who are not able to exception report as they are not employed on the same contract but may also be working additional unpaid hours. Trust doctors/LAS/SAS. Several Trusts nationally and regionally have opted to allow a modified system of exception reporting for other medical staff. This issue has been raised and discussed by the guardian team in the last couple of years. ESHT has opted not to change the current system.

   The GoSWH has received reassurance that other Trust employed staff members have in place a system to request compensation in TOIL or payment when working beyond their scheduled hours due to workload, unforeseen rota gap necessary safe patient handover. ESHT has appointed a Trust grade doctor lead and an SAS Lead. The guardian team seek reassurance form the board that the pathway and procedures for all medical staff are made clear, simple and widely accessible.

4. Every DiT rotation, the Guardian administrator enter the names of the Educational Supervisors and Clinical Supervisors into the Exception reporting system; DRS4. There has been a challenge to obtain significant number of those data prior to the start of the rotation. This results in delay in providing DiT with log in details and losing out in submitting Exceptions reports against their TCS. It is not very clear who should provide that information. The Guardians are asking divisional leads to identify staff within each department to provide those names to the Guardian administrator in good time prior to the start of the rotations.

Safeguarding Annual Report 2020 to 2021

Meeting information:	
Date of Meeting: 21 October 2021	Agenda Item: 11.3
Meeting: Trust Board	Reporting Officer: Vikki Carruth, Chief Nurse

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The Annual Safeguarding Report provides retrospective information around the key points that arise from national and local safeguarding guidance and incidence. The report provides an update of progress of these key points and Safeguarding responsiveness. The report includes the annual work plan for 2020-2021 to provide assurance that actions are in place to address statutory reporting as well as being responsive to risks. This year's report was is reflective of the challenges that occurred in safeguarding amidst the pandemic, which had an impact on both the governance structure of the ESHT Safeguarding team and the broader context of Safeguarding:

Key Achievements in Safeguarding 2020 - 2021 by various colleagues and teams

- The Safeguarding Team have continued to support all the Divisions with Safeguarding issues throughout the Pandemic even in surges.
- Safeguarding holistic *'Think Family'* training was relaunched as virtual webinar offer, to ensure that mandatory level 3 safeguarding continued throughout the pandemic. There has been continued interest shown in this presentation by other health trusts within the country, one of whom contacted the ESHT Safeguarding team following a recommendation by the CQC.
- The Named Doctors have facilitated a programme of peer training with Paediatric colleagues.
- The Safeguarding team and Named Doctors have embedded Royal College guidance regarding the management of perplexing cases with a bi-monthly forum to discuss complex cases with the relevant key staff.

- The team have worked with Occupational Health to develop pathways to support staff that are experiencing Domestic Abuse which increased during the pandemic and various lockdowns with some very significant cases.
- A Domestic Abuse rapid assessment tool has been developed to support staff to discuss domestic abuse, this has been uploaded to Nerve Centre for use within the Emergency departments and also has been adopted by Occupational Health,
- The Safeguarding Transition Specialist Nurse is now working with children from the age of 13 to 25 to ensure that work undertaken is both preventative and proactive; the practitioner moreover dovetail's with the broader trust transition team to ensure a cohesive service.
- The Safeguarding Transition Specialist has implemented the Healthy Teen Minds *'We can talk'* project which is designed to support staff in their conversations with young people.
- The team continue to develop and refine safeguarding governance systems and processes ensuring increased collaborative working with clinical and operational teams.
- Multi-disciplinary work has been undertaken with the CCG, Sussex Partnership, East Sussex Children's Social Care to consider how information can be shared with school when a child accesses health care as a result of an overdose.
- The team have worked to raise the profile of Deprivation of Liberty Safeguards as a precursor to the forthcoming changes to Liberty Protection Safeguards. Both the Head of Safeguarding and the Named Nurse for Adults are part of a Sussex wide LPS steering group.
- Supported the implementation of the mandatory Female Genital Mutilation Information System (FGM-IS) in maternity.
- Maternity Safeguarding Midwives continue to raise the profile of domestic abuse. They work closely with maternity staff supporting strategies to enable them to discuss the issue of domestic abuse with all pregnant women during their antenatal and postnatal care.
- The team worked closely with the Women's and Children's Division and Urgent Care to address concerns regarding the experiences of patients with Mental ill-health, specifically through audit, including a review of the risks on the Trust Risk Register and development of a more robust process of monitoring the patients that are referred to Child and Adolescent Mental Health and Children's Social Care database (GDPR compliant).
- The team have continued to provide a Safeguarding Supervision offer throughout 2020/2021, in Adult and Child Specialist areas, specifically the teams which have managed self-neglect and complex caseloads, the mode of delivery however altered to a virtual offer and has been well received.
- Contribution to ESSCP Quality Assurance Subgroup in monitoring and evaluating the effectiveness of the work carried out by board partners by contributing to 2 multiagency audits (injuries to infants and young children and domestic abuse)
- ESHT have contributed to the ESSCP Learning and Development sub group to consider the multi-agency training programmes going forward that are in line with current themes.
- ESHT safeguarding have worked alongside the Women's' and Children's division and the Emergency Departments to complete and take forward action from the Joint Targeted Area Inspection.
- Whole team meetings have occurred monthly to share best practice and learning in both adult and child cases.
- The weekly child risk meeting is multidisciplinary with representation included from Children's social care practitioners, CAMHS and the under 19 Substance misuse service

- The maternity safeguarding team has begun to provide targeted training/updates regarding domestic abuse, trafficking, forced marriage and modern slavery to the maternity day unit and early pregnancy clinic.
- The National Maternity Safeguarding Network together with The Centre for Child and Family Justice Research at Lancaster University are currently undertaking a piece of work exploring women (and families) who have their babies removed at birth due to care proceedings. Part of this work is exploring the trauma by an informed approach of gifting the women and their baby, a box filled with small keepsakes and memories. The ESHT maternity safeguarding team is working closely with this national group and this idea was implemented at ESHT in 2019.
- Since the introduction of Baby Boxes at ESHT, maternity safeguarding has provided approximately 40 boxes. The team are now offering both parents a Baby Box rather than one for each couple.
- Safeguarding supervision is offered to all midwives and maternity support workers annually and to the community maternity team quarterly. Safeguarding supervision will develop over the next fiscal year to include quarterly supervision to specialist midwives and the maternity day assessment unit.

Throughout 2020/2021 ESHT has supported changes in practice as a result of learning from Safeguarding Case Reviews (SCR's) including;

- Working alongside the CCG to develop pathways for the sharing of Safeguarding referrals with health partners such as GP's
- Working alongside STAR and clinical staff to develop pathways for vulnerable people using substances and alcohol (Adult C and a Domestic Homicide Review).
- Safeguarding learning will inform the work underway regarding discharge planning (Adult C -Safeguarding Adult Review)
- In three Domestic Homicide Reviews in 2020-2021 a lack of routine inquiry was a theme; a rapid assessment tool has been developed to support staff to enquire about Domestic Abuse.
- A Serious Case Review (Child T) highlighted risks associated with vulnerable children who transition from child to adult health and social care services. An innovative multiagency project is now being piloted where high risk complex safeguarding cases with long term medical needs are now jointly supervised by both ESHT and the Local Area Safeguarding team.
- Maternity services are improving practice in relation to the return of mother and baby hand held notes postnatally.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

PAG - Chaired by the Chief Nurse
Safeguarding Operational Committee - Chaired by the Head of Safeguarding
Safeguarding Strategic Group – Chaired by the Chief Nurse
Quality & Safety Committee – 21 October 2021

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE COMMITTEE)

1. Support with implementation and delivery of the actions outlined in the safeguarding work plan for 2020-2021 (see appendix 1)

2. Support the Safeguarding Teams contribution to the work undertaken by the Safeguarding Boards and the dissemination of learning and actions from presentations, case reviews and safeguarding audits.

Annual Complaints and Patient Advice and Liaison Service (PALS) Report 2020-2021

Meeting information:	
Date of Meeting: 14 December 2021	Agenda Item: 11.4
Meeting: Trust Board	Reporting Officer: Vikki Carruth, Chief Nurse

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This report meets the reporting requirements detailed in regulation 18 of the Local Authority Social Services and NHS Complaints Regulations (2009). Please noted the global Covid-19 pandemic was declared in March 2020 and is ongoing.

Headlines:

- The Trust received **365** new complaints across all services in 2020/21; this compares with 583 in 2019/20 and 558 in 2018/19.
- The Trust acknowledged **100%** of new complaints within three working days.
- There were **32** complaints reopened in 2020/21; reduction on 2019/20 (n=58) and 2018/19 (n=83).
- The Trust's compliance with published complaint response timescales fluctuated during 2020/21; the average overall compliance rate for 2020/21 was **34%**.
- There were **64** overdue complaints at the end of 2020/21; the most overdue complaint was 77 working days.
- PALS contact rate dropped by **9%** compared to 2019/20 (2020/21 n=6,123 and 2019/20 n=6,737) despite closing to face-to-face (walk in) contacts as part of COVID infection management measures.
- The Trust received **11** enquiries and 7 case outcomes from the Parliamentary and Health Service Ombudsman (PHSO) in 2020/21.

Positive developments which have occurred in 2020/21 within the complaints handling process:

- Digitised complaint records;
- Supported Divisions with timely and helpful reports on the status and progress of complaints;
- Detailed weekly updates to named Executive;
- Maintained a high and quality standard of complaint responses;
- Changes to the complaint signing process to make it more efficient;
- Continually sought to improve the complaint handling process, and gained feedback from staff on how to further improve this; and
- Maintained a fully operational PALS provision.

Summary of actions to be taken in 2021/22 that have been identified this year and plan to be implemented during 2021/22 to improve complaint handling:

- Review and approve Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model);
- Complete the move to DatixWeb from RichClient;
- Review training provided to staff in relation to complaint handling (explore online training available);
- Survey our staff about how they experience the complaint handling process;
- Reinstate our post complaint survey; and
- Complete the self-assessment against the new NHS Complaints Standards Framework in preparation for the launch in March 2022.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality and Safety Committee – 18 November 2021

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE COMMITTEE)

To receive the report.

Nursing Establishment Review 2020/2021 (Recommendations for 2021/2022)

Meeting information:		
Date of Meeting:	14th December 2021	Agenda Item: 11.5
Meeting:	Trust Board	Reporting Officer: Vikki Carruth, Chief Nurse & DIPC Contributor(s) Angela Colosi ADN Corporate

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSE/I/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

- Presentation of the outcomes from the Nursing Establishment Review (NER) 2020/2021 for the wards referred to within this report in the 4 clinical divisions.
- In August 2019 the NER suggested an increase of 30 FTE which was approved. Therefore the agreed funded FTE for those wards in August 2019 was 1,337 FTE with a plan to recruit from Jan 2020. **The Dec budgeted FTE is proposed as the baseline for comparison against this latest NER.**
- The Covid19 Pandemic began in Feb 2020 declared by the WHO in March as a global Pandemic. In Sept 2020 the data collection for the NER process began as per plan and as in previous years. However with Covid the Trust footprint was very different due to IPC precautions and the need to separate patients and staffing in many areas with some double running and a number still having to do so. Activity and acuity were very distorted on that basis.
- This latest NER recommends that the FTE required to deliver safe and effective care for ward establishments is 1,457.08 FTE as described in the paper and shown in Fig 1 in the Divisional Summary table.
- Due to the concern that 2020 was anomalous due to Covid, options are provided with a **suggested option recommending an increase for Cookson Attenborough to run as a 24 hour seven day elective ward at an additional cost of £503k. The F&IC is asked to approve this investment.**

- Given the complexity and scale for Urgent Care and Cardiology Services, updated business cases are urgently required so details are not included in this review as out of scope.

- There is a necessity to focus on education and training if we are to retain staff and ensure well-being

- The need to focus on new roles now and in the future when planning the workforce is key.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

- Finance and Investment Committee
- Executive Directors Meetings

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

That the Trust Board members acknowledge the contents of this report and note that the investment request has been approved by the Finance and Investment Committee (28 October 2021). To also note that with regard to the other recommendations in the report, these will be taken forward for discussion by the Executive Team.

Disciplinary Procedure

Meeting information:			
Date of Meeting:	14th December 2021	Agenda Item: 12	
Meeting:	Trust Board	Reporting Officer:	Steve Aumayer, Chief People Officer

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

A review of Disciplinary Procedures has taken place to ensure alignment with the recommendations and guidance arising from our 'lessons to identify' review of the imperial incident. Please see attached documents:

- Letter to Chairs and Chief Executives
- Learning Lessons
- Action Plan

The ESHT ratified Disciplinary Procedure is available to view on the Trust Website; please follow link below and then select Corporate Governance.

Corporate Publications and Statements – East Sussex Healthcare NHS Trust (esht.nhs.uk)

2. REVIEW BY OTHER COMMITTEES

University Sussex NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Sussex Community NHS Foundation Trust
East Sussex Healthcare NHS Trust
Queen Victoria Hospital NHS Foundation Trust

3. RECOMMENDATIONS

To inform the board that the ESHT Disciplinary Procedure is now available to the public.

East Sussex Healthcare NHS Trust

Disciplinary Procedure

Document ID Number	43
Version:	V4.0
Ratified by:	Policy Ratification Group.
Date ratified:	09 November 2021
Name of author and title:	Chloe Allistone, HR Advisor
Date originally written:	February 2012
Date current version was completed	September 2021
Name of responsible committee/individual:	Chief People Officer, Human Resources
Date issued:	17 November 2021
Review date:	November 2024
Target audience:	All staff,
Compliance with CQC Fundamental Standard	Good Governance
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	Policy for Safeguarding Allegations Against Staff Exclusion from Work Guidelines Protocol for Parallel Criminal and Disciplinary Investigations Anti-Fraud Bribery and Corruption Policy Violence and Aggression Policy Professional Registration Policy Disclosure and Barring Service Policy Pay Procedure Interests, Gifts, Hospitality and Sponsorship Policy Performance Improvement Procedure Attendance Management Procedure Grievance Procedure Anti-Harassment and Bullying Policy

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V3.0	December 2016	Clare Hammond, HR Manager	Review and refine processes	Re-formatted re-write of procedure
V4.0	April 2021	Chloe Allistone, HR Advisor	Periodic Review	Introduction of Just Culture principles including Investigation checklist & Staff Support Checklist Introduction of agreed outcome

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Operational HR		May 2021
Workforce Policy Partnership Group		June 2021

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

1.1 The Trust is committed to ensuring that acceptable standards of conduct and behaviour are expected from all staff; in line with the Trust's values and we are committed to helping people improve and learn from mistakes. This policy and procedure is designed to ensure a fair, systematic and consistent approach is taken when an employee's behaviour or action is in breach of workplace rules and falls short of the expected standards.

1.2 The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. An objective and prompt examination of the issues and circumstances should be carried out to establish whether there are truly grounds for a formal investigation and/or formal action. Would training for the employee, support, guidance or informal management be more appropriate and productive?

1.3 This procedure embeds a "Just Culture" approach to managing concerns, which can be seen as an environment where equal emphasis is put on accountability and learning, and one that when an adverse event occurs the instinctive approach is to ask "what went wrong?" rather than "who is to blame?"

1.4 Where an employee's ability to do their job is affected by a lack of skill or knowledge, or ill health, this will be managed by following the Performance Improvement Procedure or the Attendance Management Procedure

2. Purpose, Rationale, Principles & Scope

2.1 This procedure is intended to help maintain those standards and to ensure fairness and consistency when dealing with allegations of misconduct.

2.2 Minor conduct issues can usually be resolved informally by the line manager. This procedure sets out the informal steps and also the formal steps to be taken if the matter is more serious or cannot be resolved informally.

2.3 This procedure applies to all employees regardless of length of service. It does not apply to Temporary Workforce Services (Bank), agency workers or self-employed contractors.

2.4 This procedure does not form part of the contract of employment and it may be amended at any time following the usual process for changing procedures.

3. Definitions

Disciplinary Standards describe the types of conduct that warrant disciplinary action and are listed in Appendix B. This is a guide and not an exhaustive list.

Responsible Officer – senior divisional manager who reviews the outcome of the Pre-Investigation checklist and determines if formal investigation is required. NB not to be confused with the role of Case Manager in regard to medical and dental staff.

Investigating Officer – identified by the Responsible Officer to undertake a formal investigation into the allegations

Hearing Chair – Independent manager not previously involved in the process to chair disciplinary hearing

4. Accountabilities and Responsibilities

4.1 All colleagues are expected to behave in a manner that promotes good relations with other colleagues and are expected to present a professional image to the general public, patients/service users, relatives and carers.

4.2 All colleagues are responsible for ensuring they are aware of this procedure.

4.3 Managers must consider how they can support any colleague involved in this process. The following list gives examples of adjustments that may need to be considered. This list is not exhaustive.

- Consideration of any disability, e.g. access to rooms, larger font paperwork
- Consideration of carers responsibilities, e.g. timing of meetings
- Consideration of any health requirements, e.g. sickness, Occupational Health Advice
- Translation services

5. Procedures and Actions to Follow

5.1 Employee Support

5.1.1 Being subject to allegations of misconduct can be very upsetting and stressful for the member of staff and other colleagues affected. Managers will use the Staff Support Checklist to ensure that support is identified (Appendix H).

5.1.2 Investigating Officers are responsible for maintaining communications and will make every effort to ensure the member of staff being investigated receives regular progress updates on any investigation until the matter is concluded.

5.1.3 Where there are concerns about an employee's health or wellbeing, Occupational Health advice will be obtained.

5.1.4 Members of staff, including those who are involved as witnesses, will have access to Carefirst and can obtain information on support services available via the Occupational Health and Wellbeing, Supporting the Emotional Wellbeing of Staff extranet page.

5.2 Assessment of allegations

5.2.1 Allegations of misconduct will be carefully assessed by the relevant line manager, with HR advice, to decide if the matter can be managed informally where possible or whether there are grounds for further investigation and/or formal action.

5.2.2 The line manager will carry out initial fact finding, without unreasonable delay and should ensure that they have explored all of the issues where possible, being certain of the veracity of any facts and meet the member of staff to establish their version of events. The line manager may also meet with other relevant individuals to get a good understanding about what has happened.

5.2.3 What is the difference between 'fact finding' and a 'formal investigation?

Establishing Facts (Informal)	Investigation (Formal)
Line Manager	Case Investigator appointed
Gathering information/facts surrounding the issue/complaint that have given rise to concern – readily available e.g. documentary records such as timesheets/written statements	Investigation is directed by established and agreed terms of reference
The individual concerned has been made aware informally that there is an issue	Individual notified formally by the Responsible Officer (RO) of formal proceedings that will take place
Issue is known about by local team manager(s)	Case discussed with the RO
No notice is required i.e. no invite to formal meeting; no right of representation	Right to notice to prepare following notification of formal invite to meeting in writing
No right of representation	Right of representation applies
Progress managed locally	Progress monitored by RO
Not following a formal process	Action in line with disciplinary process

Prior to an investigation commencing the line manager will review the information gathered and complete the Pre-Investigation Checklist (Appendix F) before the Responsible Officer makes a decision to commence any formal investigation.

5.3 Informal Action

5.3.1 One of the main aims of this procedure is to promote a supportive workplace culture where concerns about conduct or behaviour are dealt with informally and directly with those concerned wherever possible.

5.3.2 It is good practice for managers to deal with issues of minor misconduct informally. In many cases, an informal conversation between a manager and the member of staff will be sufficient to address any issues and identify if there are any prevailing contributory factors.

5.3.3 The line manager will discuss any concerns regarding the member of staff's conduct and behaviour directly with them in an environment that is conducive to discretion and confidentiality. In some cases it may be appropriate for additional training, coaching and advice may be offered to the member of staff. When there are concerns about conduct, line managers will talk to the member of staff, as soon as possible, normally within a few days. The line manager should facilitate a conversation that is two-way, offering opportunity for the staff member to discuss and talk through the issue. If any scope for development or improvement is identified as a result of this the manager should provide constructive and honest feedback to the employee considering how best to support them in achieving this.

During this discussion the line manager will:

- Make the member of staff aware of the nature of the concern about their conduct or behaviour
- Advise the member of staff of the standard of conduct expected
- Support the member of staff to improve by agreeing standards and behaviours that need to be attained within a set timeframe
- Agree a period of review

- Complete a file note summarising the details of the conversation. A copy will be given to the member of staff and a copy will be retained by the line manager. If the member of staff's conduct has improved and is sustained the file note will be disregarded after a period of 12 months.

5.3.4 Should the concerns persist the line manager will review and give consideration to whether formal action under this policy should be invoked.

5.4 Formal Action - Investigations

5.4.1. When a misconduct issue is alleged to have occurred and before any disciplinary hearing is held, the matter will be investigated. The Responsible Officer will review the outcome of the Pre-Investigation checklist and confirm if the investigation is to proceed.

5.4.2 In some cases of alleged misconduct, it may be necessary to relocate or exclude the staff member from work while the investigation(s) or disciplinary procedure (or both) are carried out. If excluded the staff member should not visit Trust premises or contact any Trust staff or patients unless authorised to do so by the manager (or line manager's manager), or in the case of a medical emergency. Exclusion is not considered to be disciplinary action. During the period of exclusion the Investigating Officer will maintain regular contact with the excluded member of staff, in order to keep the member of staff informed of any progress in the investigation. The Investigating Officer will agree with the member of staff what will be reasonable contact for the duration of the exclusion. See Exclusion from Work Guidelines for further information.

5.4.3 The Investigating Officer should make all efforts to complete the investigation within 6 weeks of appointment and submit their report to the Responsible Officer within a further five days. In cases where it is not possible to complete the investigation within 6 weeks, the Investigating Officer must inform the Responsible Officer about this and outline an update on the investigation, who will then communicate the new timescales to the member of staff.

5.4.4 Should the member of staff under investigation have concerns regarding the timeframe for the investigation they should raise their concerns with the Responsible Officer.

5.4.5 The Trust's Counter Fraud team are responsible for investigating allegations involving Fraud Bribery and Corruption, in accordance with procedures documented in the NHS Anti-Fraud Manual issued by the NHS Counter Fraud Authority. The investigation will be conducted in line with the Trust's Anti-Fraud Bribery and Corruption Policy, which outlines the process for criminal investigation by the Counter Fraud Service (CFS), and in conjunctions with HR as outlined in the Trusts Protocol for Parallel Criminal and Disciplinary Investigations.

5.5 Agreed Outcome

5.5.1 Where the facts of the allegation are not in dispute, the member of staff has accepted the allegations against them and the allegations do not constitute gross misconduct where dismissal is a potential outcome; an agreed outcome process can be considered.

Appendix I details the agreed outcome process and this must be considered by the Responsible Officer with the full agreement of the individual and their Trade Union Representative or workplace colleague. The HR Department will support the Responsible Officer in this process.

If either the Responsible Officer or the staff member concerned does not accept an agreed outcome or level of sanction offered, the formal disciplinary process will be followed.

5.6 Disciplinary Hearing

5.6.1. The Responsible Officer will identify an independent manager, not previously involved in the process, to Chair the Disciplinary Hearing. A professional member of the Human Resources Department will be appointed to serve as Secretary to the Hearing Chair. The role includes ensuring the administrative aspects of the hearing are carried out and to advise the manager hearing the appeal on relevant employment law and good practice.

5.6.2 The member of staff will be given written notice of the hearing, including sufficient information about the alleged misconduct and possible consequences to enable them to prepare at least 10 working days prior to the hearing. The member of staff will be given copies of relevant documents and witness statements.

5.6.3 With the agreement of all parties and on the instruction of the Hearing Chair, the secretary to the Chair will make an electronic recording of the Disciplinary Hearing to ensure an accurate account of the hearing is made. The use of any other form of electronic recording or listening device, including mobile phones at meetings, without prior agreement is strictly prohibited and may be subject to further disciplinary action.

5.6.4 The member of staff has a right to be accompanied at the hearing by a trade union representative or a workplace colleague, to act as a companion.

5.6.5 If the member of staff refuses twice or is unable to attend a meeting the Chair may make a decision in their absence based on the evidence provided.

5.6.6 The member of staff should let the Hearing Chair know as early as possible, but no later than 5 working days before the hearing if there are any relevant witnesses they would like to attend the hearing or any documents or other evidence they wish to be considered.

5.6.7 The Hearing Chair will inform the member of staff in writing of the decision, usually within 5 working days of the hearing.

5.7 Disciplinary Action and Dismissal

Sanctions include the following;

a) **Stage 1: First written warning.** Where there are no other active written warnings on a staff member's record, they will usually receive a first written warning. It will usually remain active for six months.
b) **Stage 2: Final written warning.** In cases of further misconduct where there is an active first written warning on a staff member's record, they will usually receive a final written warning. This may also be used without a first written warning for serious cases of misconduct. The warning will usually remain active for 12 months.
c) **Stage 3: Dismissal or other action.** Member of staff may be dismissed for further misconduct where there is an active final written warning on their record, or for any act of gross misconduct. Examples of gross misconduct are given in section 5.8.

   We may consider other sanctions short of dismissal, including demotion or redeployment to another role (where permitted by the contract), and/or extension of a final written warning with a further period of review

   Additional action as result of being issued with a disciplinary sanction: If a first or final warning is issued, the member of staff will not be awarded a pay increase on the pay step date whilst the sanction is still live. The Chair of the hearing will ask the line manager to action this. In those situations the manager should initiate a pay step

review meeting before the expiry of the warning, and if all other requirements have been met, the member of staff will progress to the next pay step effective from the date after the warning expires.
In addition to the issue of a final written warning the following actions may be appropriate:

- Transfer to another department/location/site
- Demotion or downgrading without pay protection
- Change of shift or working pattern

5.8 Appeals

5.8.1 The staff member may appeal in writing to the Chief People Officer, stating the full grounds of appeal, within 10 working days of the date on which the decision was sent or given to the staff member.

5.8.2 The appeal letter should include all documents in support of the appeal, although the staff member may submit further documents up until a minimum of 5 working days before the date of the appeal hearing. Any documents submitted outside of this timeframe may not be considered. The appeal document and any supporting documents are considered to be the member of staff's statement of case.

5.8.3 An appeal meeting will be held, normally within 10 working days of receiving the appeal. This will be dealt with impartially by a more senior manager or Non-Executive Director who has not previously been involved in the case. The staff member will have a right to bring a companion; the companion may be either a trade union representative or a colleague.

5.8.4 A professional member of the Human Resources Department will be appointed to serve as Secretary to the manager hearing the appeal. The role includes ensuring the administrative aspects of the hearing are carried out and to advise the manager hearing the appeal on relevant employment law and good practice.

5.8.5 The staff member will be given copies of relevant management response documents, 5 working days before the appeal hearing.

5.8.6 The final decision will be confirmed in writing, usually within 5 working days of the appeal hearing. There is no further right of appeal.

5.8.7 In cases of appeal against a dismissal, the date of which the dismissal takes effect will not be delayed pending the outcome of the appeal hearing.

5.9 Gross Misconduct (Appendix B)

5.9.1. Gross misconduct will usually result in dismissal without warning, with no notice or payment in lieu of notice (summary dismissal).

5.9.2 The following are examples of matters that are normally regarded as gross misconduct:

a) theft or fraud
b) physical violence (see appendix G) or bullying
c) deliberate and serious damage to property
d) serious misuse of the Trust's property or name

e) deliberately accessing internet sites containing pornographic, offensive or obscene material
f) serious insubordination
g) unlawful discrimination or harassment
h) bringing the Trust into disrepute
i) serious incapability at work brought on by alcohol or illegal drugs in accordance with the Substance Misuse Policy
j) causing loss, damage or injury through serious negligence
k) clinical misconduct/compromise of patient safety
l) a serious breach of health and safety rules
m) a serious breach of confidence

This list is intended as a guide and is not exhaustive; further details can be found at Appendix B.

5.10 Referral to External Bodies

Depending on the allegations, where an employee is registered with a professional body, such as registered nurse, midwife, or other, the regulatory body may be notified. This decision will be taken by the most senior professional lead from the Division, in conjunction with the relevant professional lead for the Trust such as ADN, Chief Pharmacist, Lead AHP etc. All referrals will be logged and overseen by the Lead nurse for workforce. See Professional Registration Policy for more details.

Where allegations concern the safeguarding of children of vulnerable adults, the Trust Safeguarding Lead must be notified without delay. See Policy for Safeguarding Allegations Against Staff.

The Trust has a legal duty to refer to the Disclosure and Barring Service if a member of staff has been removed from a regulated activity, see Disclosure and Barring Service Policy for more details.

Where appropriate, investigations by the counter fraud team, or other agencies, such as police or social services, may be carried out separately from investigations under this procedure. The Trust will give full cooperation and in these circumstances the Trust will only delay carrying out internal investigations following the disciplinary procedure where absolutely necessary. See Anti-Fraud Bribery and Corruption Policy and Protocol for Parallel Criminal and Disciplinary Investigations.

Where cases include serious personal data breaches likely to result in a risk to the rights and freedoms of data subjects, the Trust has a legal duty to report such cases to the Information Commissioners Office within 72 hours via the Trust's Data Protection Officer.

5.11 External Advice

Employees are able to access further guidance on employment issues from the following bodies;

The Advisory, Conciliation and Arbitration Service **(**Acas**)** - Acas | Making working life better for everyone in Britain

Citizens Advice - Citizens Advice

6. Equality and Human Rights Statement

6.1 An Equality and Human Rights Impact assessment has been carried out and is documented in appendix A.

7. Training

7.1 Please refer to the Induction and Mandatory training policy and the Training Needs Analysis.

7.2 On-line guidance of the policies referred to in this policy can be found via the Extranet Page or the Human Resources Department.

8. Data protection

8.1 When managing employees under the Disciplinary Procedure, the Trust processes personal data collected in accordance with its Data Protection Policy. Data collected from the point at which the Trust commences action under the procedure is held securely and accessed by, and disclosed to, individuals only for the purposes of managing their performance. Inappropriate access or disclosure of employee data constitutes a data breach and should be reported in accordance with the organisation's Data Protection policy immediately. It may also constitute a disciplinary offence, which will be dealt with under the Trust's Disciplinary Procedure.

9. Monitoring Compliance with the Document

Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
No. and level of sanction per year -– including agreed outcomes	Head of Operational HR	Selenity	Annual	Trust Board	HR SMT	HR SMT
Staff with protected characteristics	Head of Operational HR	Selenity	Annual	POD	HR SMT	HR SMT

10. References

- Employment Rights Act 1996
- Employment Relations Act 2004
- Employment Act 2008
- Protocol for Parallel Criminal and Disciplinary Investigations http://nww.esht.nhs.uk/finance/cfs/
- Advisory, Conciliation and Arbitration Service (ACAS) Acas | Making working life better for everyone in Britain - NHS Improvements Dido Harding letter 24 May 2010 with guidance relating to the management and oversight of local investigation and disciplinary procedures
- NHS Resolution "Being Fair – Supporting and Just and Learning Culture for staff and patients following incidents in the NHS Being fair report - NHS Resolution

Appendix A – EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

Due Regard, Equality & Human Rights Analysis

Title of document: Disciplinary Procedure
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc. All staff
Please include a brief summary of intended outcome: To help maintain those standards and to ensure fairness and consistency when dealing with allegations of misconduct.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	Yes	Section 4.3,
	• Disability (including carers)	Yes	Section 4.3,
	• Race	Yes	Section 4.3,
	• Religion & Belief	Yes	Section 4.3,
	• Gender	Yes	Section 4.3,
	• Sexual Orientation (LGBT)	Yes	Section 4.3,
	• Pregnancy & Maternity	Yes	Section 4.3,
	• Marriage & Civil Partnership	Yes	Section 4.3,
	• Gender Reassignment	Yes	Section 4.3,
	• Other Identified Groups		
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**		Section 4.3,
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	Section 4.3,	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	Section 4.3,	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	Section 4.3,	
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected**	Section 4.3,	

	characteristic and those who do not" as per the Equality Act 2010?	
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	Section 4.3,
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	WPPG
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	Section 4.3,

Appendix B
EAST SUSSEX HEALTHCARE NHS TRUST

DISCIPLINARY STANDARDS

Disciplinary standards and procedures are produced to ensure that you are aware of the standards of conduct expected of you and the type of conduct that will warrant disciplinary action including summary dismissal.

The following list has been drawn up to enable you to know and understand the types of conduct that will warrant disciplinary action and describe the Trust's approach to issues of staff misconduct but should not be regarded as exhaustive or complete

1 Examples of conduct warranting disciplinary action

1.1 Failure to knowingly carry out duties satisfactorily.
1.2 Failure to obey reasonable instructions.
1.3 Acts of insubordination.
1.4 Failure to comply with the Infection Control Policy.
1.5 Persistent failure to wear ID badge(s) or adhere to dress codes.
1.6 Failure to administer drugs in accordance with NMC guidelines.
1.7 Persistent bad timekeeping.
1.8 Unauthorised absence without good reason.
1.9 Unauthorised or inappropriate use of NHS property.
1.10 Smoking within Trust premises.
1.11 Using offensive language.
1.12 Other actions considered a breach of good conduct and/or likely to bring the Trust into disrepute.
1.13 Failure to provide an efficient, safe and high quality service with concern and respect for the feelings and well-being of other employees, patients and visitors.
1.14 Failure to observe the Trust internal policies.
1.15 Failure to follow the correct procedure for dealing with the media.
1.16 Inappropriate use of the internet.
1.17 Making malicious complaints under the Dignity at Work or Whistle blowing Policy.
1.18 Serious or persistent breach of Trust values.

2 Examples of Conduct Warranting Dismissal

2.1 There are in addition, certain types of conduct which are considered so serious as to constitute 'gross misconduct' and to warrant dismissal with no previous warnings and no notice or pay in lieu of notice.

2.1.1 **Dishonesty/Fraud**

(a) Unauthorised possession or use of Trust property. E.g. removing Trust property from site. This includes property belonging to patients, visitors or other member of staff or installation of unauthorised software.

(b) Deliberate falsification of records or the deliberate attempt to obtain money from the Trust by false pretences or from a member of the public in the course of official duties. This includes misrepresentation of entitlement to expenses or allowances; overtime or mileage claims

(c) Falsification or misrepresentation of timesheets or clock cards.

(d) The unauthorised receipt of money, goods, favours or hospitality in respect of any service rendered.

(e) Giving or receiving a bribe in the form of a financial or other advantage to encourage the recipient to perform their functions improperly.

(f) Undertaking paid or unpaid employment whilst claiming sick pay from the Trust or whilst on suspension from duty.

(g) Any deliberate action that causes financial loss to the Trust.

2.1.2 **Failure to Disclose an Interest**

(a) Any action which is contrary to the Trust's Standing Orders or Standing Financial Instructions.

2.2 **Assault**

2.2.1 Any assault or attempt to cause injury (including verbal assault) upon a patient member of the public, or other employee that takes place on Trust premises or whilst on duty, including threats of serious assaults.

2.3 **Bullying and Harassment**

2.3.1 Any uninvited, unwelcome or unreciprocated behaviour of a sexual or social nature which is offensive to the person involved and causes that person to feel threatened, humiliated or embarrassed, or which compromise the protection of whistleblowers.

2.3.2 Any acts of harassment or discriminating behaviour so as to prejudice the health, safety and well-being of staff or others.

2.3.3 Serious breach of the Dignity at Work Policy.

2.4 **Gross Carelessness**

2.4.1 Any actions, or failure to act, which threatens the health or safety of a patient, member of the public or another member of staff on Trust premises or which may bring the Trust into disrepute.

2.5 **Malicious Damage**

2.5.1 To Trust property or to the property of patients visitors or staff.

2.6 **Being Unfit for Duty**

2.6.1 Through the effect of, for example, drink or drugs (subject to the recommendations within the Substance Misuse Policy) or by being asleep on duty when not appropriate.

2.6.2 Failure to report any contagious or infectious disease or any other hazard which may endanger the health of other staff, patients or visitors.

2.7 **Breach of Contract**

2.7.1 Conduct or behaviour which may render continuation of employment impossible or undesirable.

2.7.2 Action which results in loss of trust and confidence in the employee's capacity to continue to be employed by the Trust.

2.7.3 Breach of statutory requirements, e.g. Prevention of Illegal Working, Loss of Professional Registration, etc.

2.7.4 Conviction under court proceedings or cautions which in the opinion of the Trust renders the employee unsuitable to continue the duties for which they are employed.

2.7.5 Unauthorised possession, custody or control of illegal drugs on the premises.

2.8 **Confidentiality/Unauthorised Disclosure of Information**

2.8.1 Failure to keep safe all personal information in relation to patients, their relatives or staff members

2.8.2 Breach of trust or misuse or unauthorised disclosure of any confidential information or data, documents or information relating to individual patients, members of staff, or affairs of the Trust.

2.9 **Intentionally Making False Statements**

2.9.1 Falsifying documents, for example when incidents or accidents are being investigated, or when applying for employment, transfer or promotion, or in connection with medical examinations relating to the Trust.

2.9.2 Failure to disclose a previous conviction under the Rehabilitation of Offenders Act in securing employment with the Trust.

2.9.3 False Qualifications , false identity or immigration documentation or right to work and reside documentation

3 Special Rules

3.1 Breach of departmental rules/codes (e.g. concerning safe handling of dangerous substances, radiological safety or operation of machinery).

4 Statutory Registration

4.1 Certain staff are required by law to be registered with a particular body. If such registration or membership lapses or is cancelled the Trust will take immediate action to terminate the contract of employment of the members of staff concerned. See Professional Registration Policy.

5 Loss of Driving Licence

5.1 Staff employed in posts for which there is a contractual requirement for the possession of a valid driving licence must inform their supervisor/manager if that licence is withdrawn for any reason. Failure to do this may result in summary dismissal. Where a person who is employed in such a post loses his licence their contract of employment may be terminated. Alternative working arrangements or employment will be considered in such cases but will be offered in the following circumstances only:

5.1.1 When alternative work arrangements may be made without detriment to the Trust's purpose and its patients and other staff members
5.1.2 Where a suitable alternative vacancy exists at the material time.
5.1.3 When the circumstances of the case merit such an offer being made.

6 Fraud

6.1 Where there is a conduct issue that involves a matter of Fraud, Bribery or Corruption or financial impropriety, the Trust will notify the Trusts Counter Fraud Service and a counter fraud investigation may take place as outlined in the Trust's Anti-Fraud Bribery and Corruption Policy. If there are possible grounds for disciplinary action the Trust will carry out its own investigation and hearing under this disciplinary procedure.

7 Professional Bodies

7.1 Employees who are subject to standards of performance/behaviour of professional bodies (e.g. NMC, GMC,HCPC, CSP) are reminded that the Trust has a duty to report instances of sub-standard performance or conduct to the appropriate body as well as carrying out its own investigation and taking disciplinary action in appropriate cases.

8 Independent Safeguarding Authority

8.1 Employees are reminded that the Trust has a duty to report safeguarding concerns in relation to children or vulnerable adults to the Independent Safeguarding Authority.

9 Criminal Offences Outside Employment

9.1 As part of the usual pre-employment checks all staff, where appropriate, will have had a Disclosure carried out by the Disclosure and Barring Scheme (DBS) prior to appointment. If an employee fails to disclose a caution or conviction which appears on a DBS Disclosure, an investigation will be carried out by Trust Auditors which may result in disciplinary action being taken.

9.2 Any employee who is arrested on any charge or served with a summons on a criminal charge whilst employed by the Trust must inform his supervisor/manager as soon as practicable.

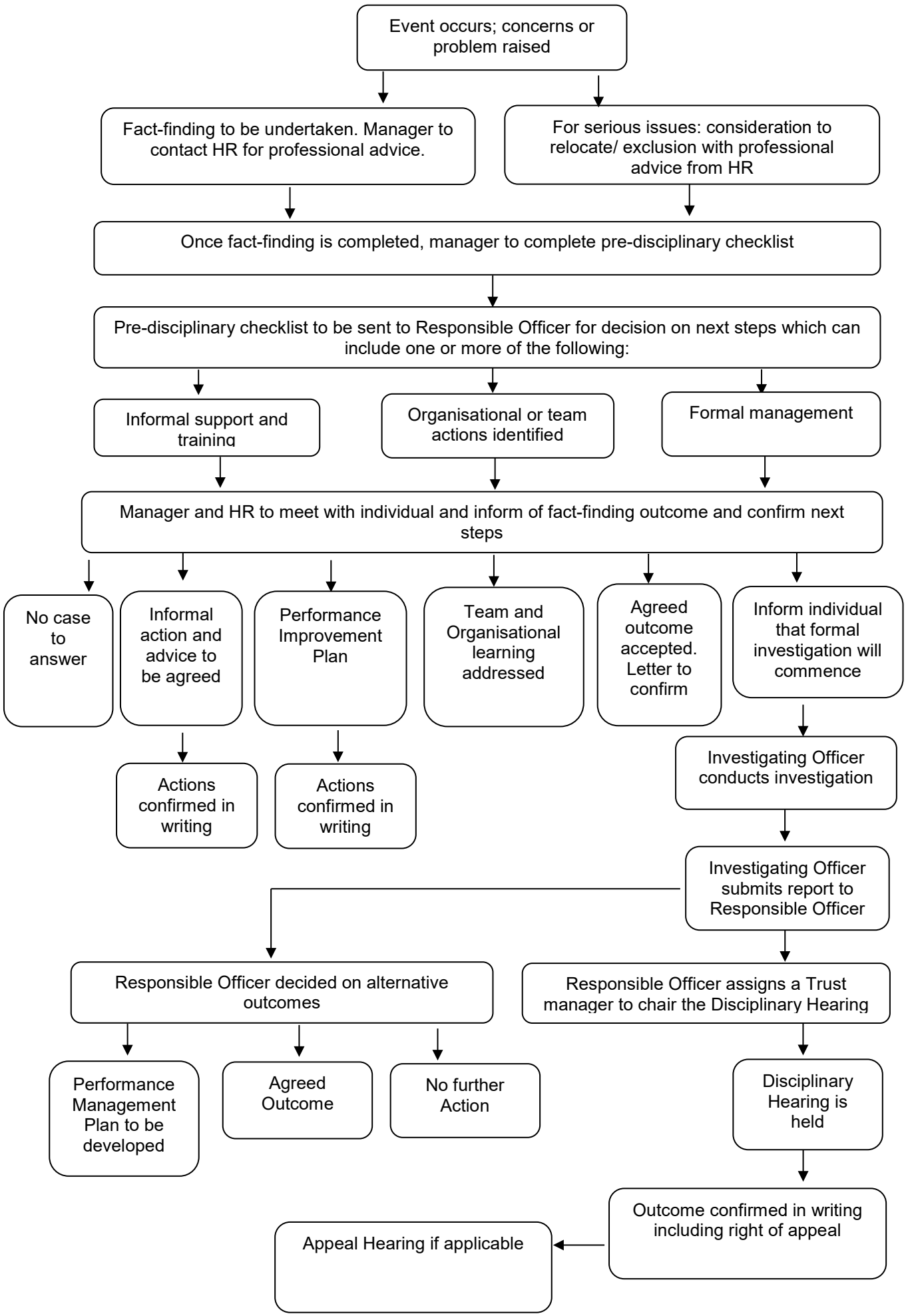
9.3 Criminal offences/alleged offences outside employment shall not be treated as automatic reasons for dismissal. The main consideration will be:

9.3.1 whether the offence brings into question the employees suitability for their work, or
9.3.2 whether it is unacceptable to other employees or patients or
9.3.3 whether the Trust's reputation could be brought into disrepute if the employee were to remain employed by the Trust or
9.3.4 Whether the employee did not declare the offence within a reasonable timescale of incurring it.

9.4 It is stressed, however, that each case will be considered on its merits and that there is no general rule that requires the automatic dismissal of a member of staff who is alleged to have committed an offence outside of employment.

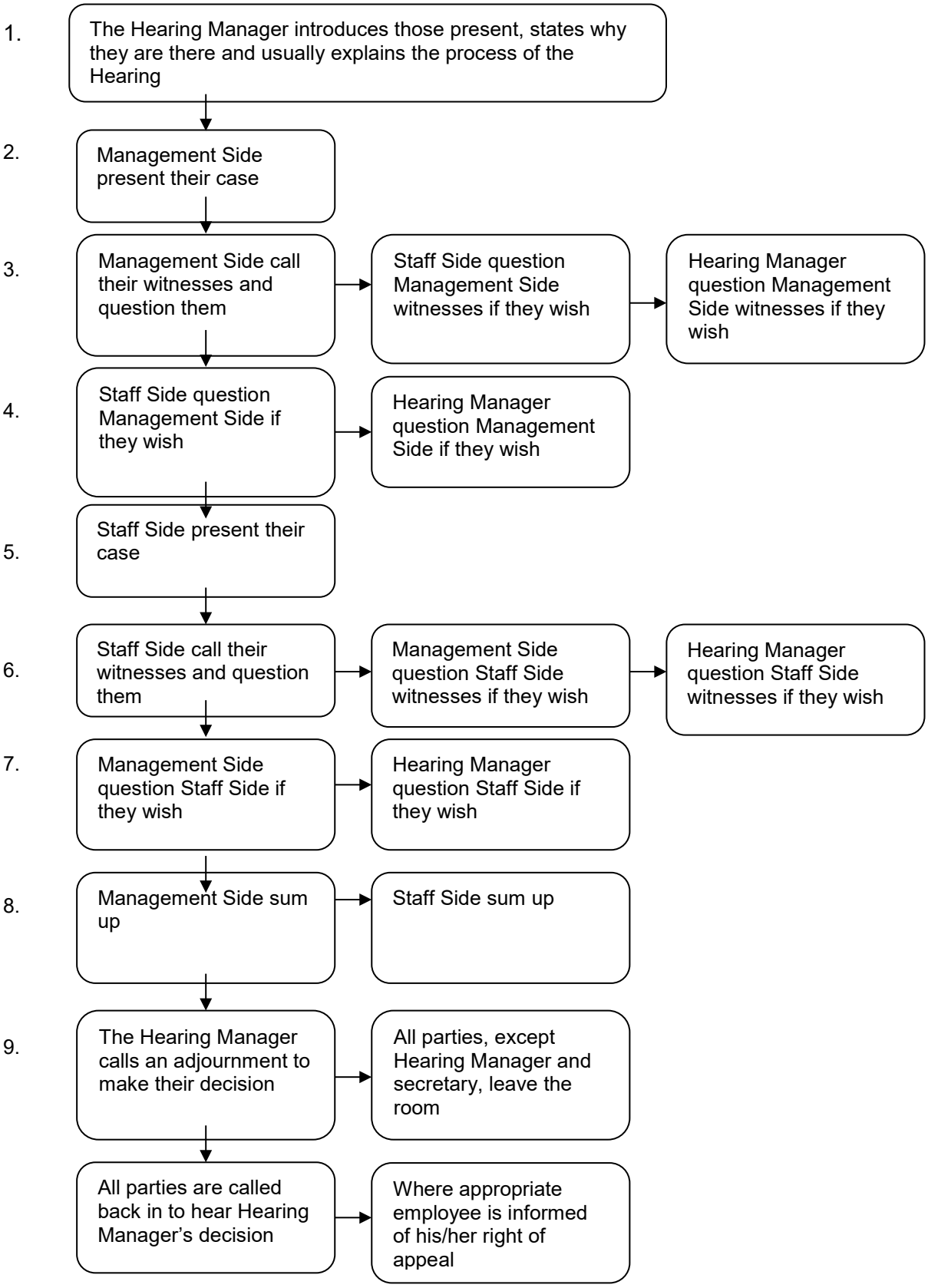
Appendix C

Disciplinary Flowchart



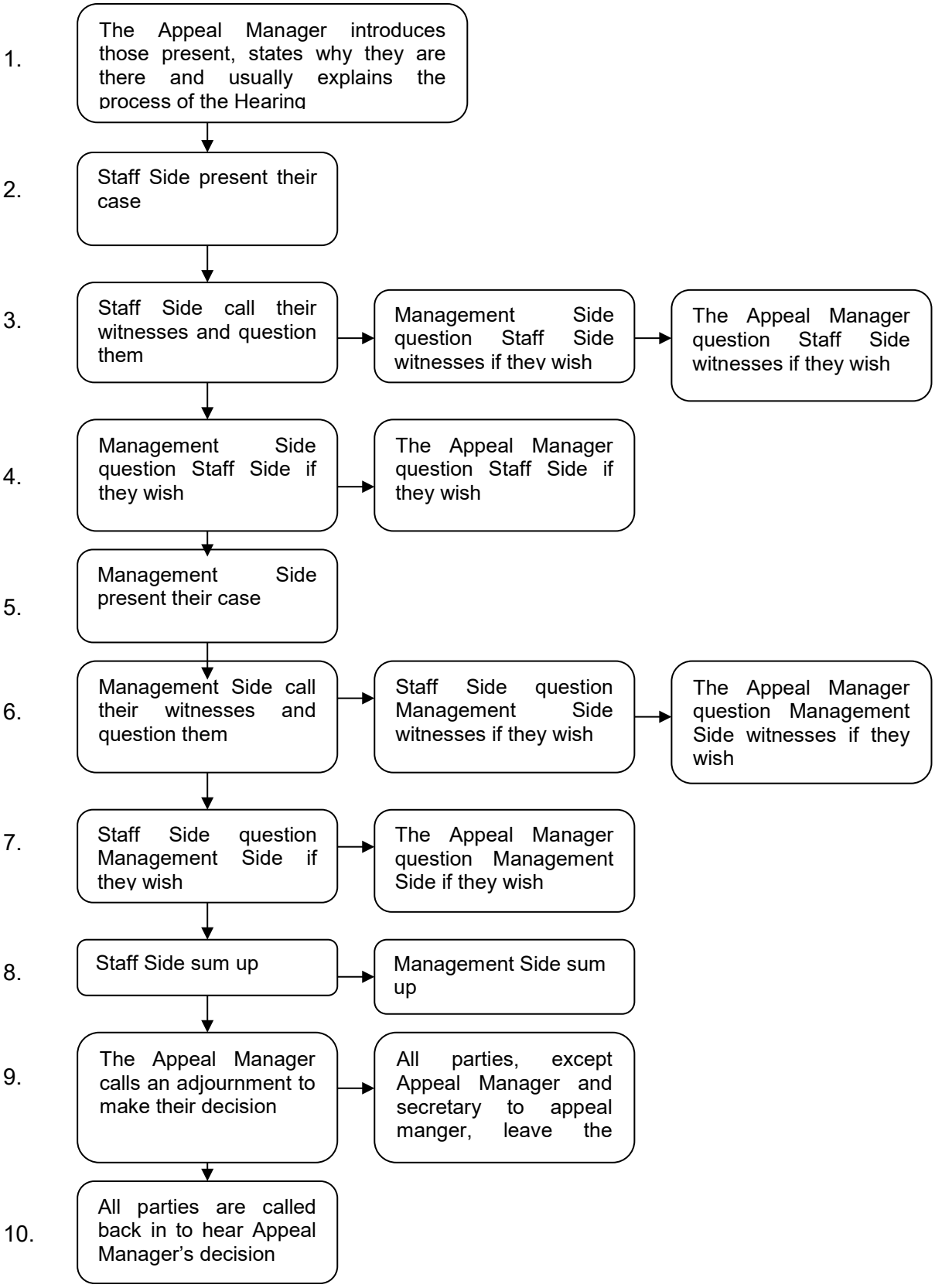
Appendix D

Process of a Disciplinary Hearing



Appendix E

Process of an Appeal Hearing



Appendix F

Pre - Disciplinary Investigation Checklist

As we seek to build on a 'Just Culture' in the organisation, a pre-disciplinary investigation checklist has been developed to mitigate against any 'rush to judgement' when entering staff into a formal process. This checklist is to be used by the investigating officer **BEFORE** a decision to formally investigate an employee or worker and once complete must be sent to the HR representative supporting the investigation.

Employee/Worker Name:	Click here to enter text.	**Role:**	Click here to enter text.
Line Manager Name:	Click here to enter text.	**Team/service:**	Click here to enter text.
Area of work:	Click here to enter text.	**Division:**	Click here to enter text.
Date of incident	Click here to enter text.	**Location:**	Click here to enter text.
Reason for possible investigation:	Click here to enter text.		

As a result of using the checklist, it is envisaged that issues are addressed appropriately prior to escalation which will improve overall employee well-being, reduce cost of absence, improve employee relations, the reputation of the Trust and reduce the cost of management time.

Have you asked yourself the following questions before making a decision to formally investigate the individual concerned?

1: Deliberate Harm Test

1a. Was there any intention on the part of the employee or worker to cause harm? ☐ Yes ☐ No

** If yes, follow Trust guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, safeguarding and referral to police and investigation in accordance with disciplinary processes. Wider investigation is still needed to understand how and why patients/staff were not protected from the actions of the individual.*

Additional Comments: Click here to enter text.

2: Health Test

- 2a. Are there indications of substance abuse? ☐Yes ☐ No
- 2b. Are there indications of physical ill health? ☐Yes ☐No
- 2c. Are there indications of mental ill health? ☐Yes ☐No

**If yes, please follow appropriate Trust guidance including Care First/Occupational Health referral.*

Additional Comments: Click here to enter text.

3: Foresight Test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

☐Yes ☐ No

3b. Were the protocols/accepted practice workable and in routine use? ☐Yes ☐ No

3c. Did the individual knowingly depart from these protocols? ☐Yes☐ No

**If no to any of above - Action singling out the individual for a conduct investigation is unlikely to be appropriate; the patient safety /staff incident investigation should indicate the wider actions needed to improve safety .These actions may include, but not be limited to, the individual.*

Additional Comments: Click here to enter text.

4: Peer Test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances? ☐ Yes ☐ No

4b. Was the individual missed out when relevant training was provided to their peer group? ☐Yes ☐ No

4c. Did senior members of the team fail to provide supervision that normally should be provided? ☐Yes ☐ No

**If yes to any of the above - Action singling out the individual for a conduct investigation is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.*

Additional Comments: Click here to enter text.

5: Mitigating Circumstances

5a. Were there any significant mitigating circumstances? ☐Yes ☐ No

**If yes, action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.*

Additional Comments: Click here to enter text.

6: Vulnerable Adult/Child

6a. Does the incident that has occurred involve vulnerable adults/children? ☐Yes ☐No
**If yes, please ensure that the Safeguarding checklist is completed and that you have discussed with Safeguarding Team.*

Additional Comments: Click here to enter text.

7: How well do you think you have reacted to the situation?

- 7a. Do you feel that you have managed this situation in a fair and consistent manner? ☐ Yes ☐ No
- 7b. Did you make the employee aware of the concern during your fact-finding meeting?☐ Yes ☐ No
- 7c. Have you taken into account the answers to 2a, 2b or 2c applies? ☐ Yes ☐ No

8: How open have you been in taking an overview of the activities and Impact?

- 8a. Have you positioned praise or blame? ☐ Yes ☐ No ☐Neither -as far as I am aware
- 8b. Have next steps been discussed with the employee? ☐ Yes ☐ No

9: Trust Values and disciplinary policy

9a. Given that our Trust Values and disciplinary policy emphasises improvement and learning, not punishment, have you taken reasonable informal steps to resolve your concerns regarding this issue or similar issues leading up to this one, prior to considering a disciplinary investigation? ☐Yes ☐ No

Issues Previously Discussed: Click here to enter text.

10: Outcome of fact-finding meeting

10a From the information gathered during the fact-finding exercise and based on the information above, what action should follow:

- ☐Formal investigation meeting
- ☐ Performance Improvement Plan to be implemented
- ☐Meeting of concern

- ☐No case to answer

If an Investigation is required please complete the following:

Investigating officer:	Click here to enter text.
HR Contact:	Click here to enter text.
Keeping in Touch/ Support:	Click here to enter text.

Have you got any pre-booked annual leave within the next 6 weeks?	☐Yes	☐No
Have you got capability to undertake this investigation within 6 weeks?	☐Yes	☐No
Have you informed your line manager of the need to undertake this investigation?	☐Yes	☐No

Once completed please send to your Human Resources Representative.

SAFEGUARDING CHECKLIST

Where a serious incident has occurred which involves patient/s and/or staff, the checklist below must also be completed.

	SAFEGUARDING CHECKLIST	COMMENTS
1.	Is this a safeguarding issue?	
2.	Has the Service Director confirmed that this is a safeguarding issue?	
3.	Have the Safeguarding Team been informed?	
4.	Does a LADO referral need to be done?	
5.	Has the Service Director informed the police?	
6.	Has the patient/s and/or staff, been allocated a named contact for support and follow up?	
7.	Do other patients and/or staff need to be contacted? If so, who will lead on this process? How will staff be notified?	
8.	Has the CQC been informed by the Service Director?	
9.	Has the issue been referred to ISA by the Service Director?	

10.	Is a Datix required? If so, who will complete the Datix?	
11.	Has the case been discussed with the professional lead and consideration given to referral to the NMC or other professional body?	
12.	Has an internal safeguarding lead been identified for the case?	

Appendix G

Violence and Aggression

1.1 Violence and Physical Assault is “The intentional application of force against a person or another without lawful justification, resulting in physical injury or personal discomfort” Source: Physical Assault Definition contained within Directions to NHS Bodies November 2003.

1.2 Aggression (non-physical assault) is “The use of inappropriate words or behaviour causing distress and/or constituting harassment”
Source: Non-Physical Assault Definition contained within Directions to NHS Bodies November 2003.

In order to ascertain if a non-physical assault occurred, staff need to recognise what aggressive and assertive behaviours are and then make a judgement to determine what behaviour is being exhibited.

- Aggression - The person being aggressive will have a total disregard for the other person's interests or position. Aggressive behaviour has the result of the other person feeling hurt, belittled, controlled or humiliated. Source: Violence and Aggression Policy (including Red/Yellow card system).

- Assertiveness - A person is honest, direct and stands up for themselves in such a way that does not intimidate, belittle or leave the other person feeling violated. Source: Violence and Aggression Policy (including Red/Yellow card system).

For further information please refer to the Violence and Aggression Policy (including Red/Yellow card system).

APPENDIX H

Staff Support Checklist

This checklist should be used to ensure that staff are provided with timely and appropriate support and that a record of actions taken is kept.

This form should be completed as appropriate (at the outset of the process and revisited on at least one further occasion) and retained by the manager until the matter is at an end. A copy of checklist should be forwarded to the HR Dept. so that it may be used for the annual audit process.

Employee name	
Job title	
Manager name	
Date completed	

	SUPPORTING STAFF	**Initial support**	**Follow-up**
		Date	
1.	Has a 'Buddy/Mentor' been offered, identified and agreed?		
2.	Has the staff member been signposted to Care First?		
3.	Was a referral to Occupational Health & Wellbeing discussed with the employee? give details, dates etc		
4.	Has other support been offered to the employee? Yes / No If yes, detail any support taken up. *Include any considerations given for staff with protected characteristics and the impact any action may have e.g. disability, race; where necessary seek advice from ESHT Workforce Human Rights & Equality lead.*		
5.	Has a copy of the procedure been provided to the employee and the process explained?		

Manager Signature	**Date**
Employee Signature	**Date**

ACTIONS
Copy of completed form given to employee
Original Form to be filed in staff member's file
Copy of completed form sent to Human Resources

APPENDIX I

Agreed Outcomes

Note: It is not appropriate to use agreed outcomes in cases of gross misconduct where dismissal is a potential outcome.

When managers make Agreed Outcome agreements they must be able to make the decision without having it overridden by a more senior colleague.

If, at the end of an investigation into a potential disciplinary issue, the employee accepts all the allegations made against them then there is no need to automatically proceed to a disciplinary hearing. The facts of the allegation are not in dispute and the employee has accepted their fault. What needs to be determined therefore is the level of sanction to be applied.

Agreed outcomes are only appropriate where both parties are agreeable to the process. If either the employee or their representative is unhappy with a proposal of an agreed outcome, then the normal disciplinary process must be followed.

Where there is agreement to an agreed outcome as being the acceptable way forward for both parties, the following principles should be followed:

Both parties must be in agreement to proceed in this way.
This decision is final and there should not be a later referral to a disciplinary hearing or appeal on this issue.

The relevant Responsible Officer with the authority to issue the disciplinary sanctions must be aware of and agree to the proposal for an agreed outcome.

Agreed outcomes can only be considered for cases where dismissal is not a likely outcome.

Cases must not interfere with, or compromise ‘due process’, e.g. audit.

A meeting should be held at which both parties (i.e. employee and their representative and the Responsible Officer) will be present, together with an HR Representative. The line manager may or may not be present but must be aware of the fact that the meeting is taking place.

At the meeting, all information relevant to the allegation(s) or complaint(s) must be available and both parties must have a full opportunity to discuss all the issues, in accordance with the normal principles of natural justice that every employee has the opportunity to freely state their case.

The meeting can be adjourned and reconvened at any time if, for example, there is a need to obtain further information.

The employee will be required to sign a letter of acceptance within 7 calendar days; referred to as ‘the cooling off’ period. If the individual wishes to withdraw from the agreed outcome process the Responsible Officer will make the decision whether or not a full Disciplinary Hearing is necessary.

In the event that the employee does change their mind, then the normal disciplinary process will be followed.

Following the meeting and ‘cooling off’ period the Responsible Officer will write to the employee to confirm the disciplinary sanction and get their written agreement to the outcome (see standard letter Appendix I).
The disciplinary sanction issued, and accepted by the employee, will have the same status as those obtained via a hearing, except that there will be no recourse to an appeal.

All relevant documentation, including a record of the meeting, must be retained in the usual manner on the personal file, with copies sent to Human Resources and the Trade Union/Professional Association representative.

Learning lessons to improve our people practices

Meeting information:			
Date of Meeting:	25th July 2019	Agenda Item: 11.6	
Meeting:	POD	Reporting Officer: Jo Gahan – Head of Operational HR	

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This report provides a summary of the HR improvement work in relation to disciplinary investigations which address the NHS Improvement guidance on 'Learning lessons to improve our people practices.' (Appendix A)

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

N/A

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Committee is asked to note the contents of this report provide assurance that actions have been developed to ensure review of current processes, training, guidance and methods used to investigate workplace incidents and recommendations for improvement are in progress.

To note the improvement work undertaken to date as detailed in the report.

EXECUTIVE SUMMARY

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure at a London Trust which culminated in Amin's summary dismissal on the grounds of misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry, the findings which were reported to the employing Trust and NHSi in August 2018. The report concluded that in addition to serious procedural errors Amin was treated very poorly and his mental health was severely impacted.

Subsequently NHS Improvement established a 'task and finish' advisory group to consider whether the failings identified in that case were unique to the Trust or more widespread across the NHS and what learning could be applied.

The findings and recommendations/guidance have subsequently been communicated to NHS Trusts by Baroness Harding in her letter 'Learning lessons to improve our people practices' (Appendix A).

Report

1. Findings of the Advisory group

The findings of the 'task and finish' group identified several key themes which proved common in other cases in the NHS. Primarily:

- Poor framing of concerns and allegations
- Inconsistency in the fair and effective application of local policies and procedures
- Lack of adherence to best practice guidance
- Variation in the quality of investigations
- Shortcomings in the management of conflicts of interest
- Insufficient consideration and support of the health and wellbeing of individuals
- An over reliance on the immediate application of formal procedures rather than consideration of alternative responses to concerns.

2. 'Learning lessons to improve our people practices' – letter from NHSi - Additional guidance relating to the management and oversight of local investigation and disciplinary procedures (Appendix A).

In summary, the recommended actions for HR are as follows (See Appendix B for Action Plan):

1. **Adhering to best practice**
   Guidance documents for Investigating Officer, Commissioning manager, Witness and Staff member are being developed by HR signposting relevant best practice guides from GMC, NMC and ACAS.

   A 'Pause and Review' checklist is being developed for use at the outset of an incident to ensure principles of a 'Just Culture' and the Incident decision tree' are applied.

2. **Applying a rigorous decision making methodology**
   Ensuring reference to above guidance, best practice guides and the 'Pause and review' process is adhered to.

3. **Ensuring people are full trained and competent to carry out their role**
   Investigation training was carried out in April 2016 and May 2017 at which a total of 97 managers and supervisor staff were trained; a new round of investigation training is being commissioned for 2019 with the view of targeting new managers.

   A review is being undertaken of available Equality & Diversity and Unconscious Bias training for Investigators, Commissioning Managers and HR staff is being carried out in conjunction with the Equality and Diversity lead to ensure all are competent before involvement in investigations.
   A programme of internal HR learning sessions are scheduled monthly throughout 2019 and include Investigations and Disciplinary Hearings as topics for ongoing learning throughout the HR team.

   HR managers and Advisors are continually coaching and guiding managers involved in a process.

4. **Assigning sufficient resources**
   Commissioning managers will ensure the allocation of an investigator to a case is considered in the light of capacity/planned leave etc.

   Delays and exceptions to agreed deadlines within the process will be highlighted and escalated to Divisional Directors and HR in line with the guidance for Investigations, staff are kept updated on progress and informed of any delays promptly by a named person agreed at the outset.

5. **Decisions relating to the implementation of suspensions/exclusions**
   A review of the Trust's suspension guidance is currently being carried out to include clear responsibilities for keeping in touch with those on suspension.

6. **Safeguarding people's health and wellbeing**
   Support for staff has been increased and now includes Care First – the new employee assistance programmes in addition to usual mechanisms to support of an allocated buddy, line manager, OH and where relevant Trade union support. This support is clearly communicated from the outset of the process and detailed in the guidance documents, template letters and conversations with staff.

7. **Board-level oversight**
   The POD Committee is updated quarterly through the Employee relations report which provides assurance that workforce incidents and complaints have been managed, investigated and acted upon in accordance with Trust Policies, within appropriate timescales, and that any learning is shared and policies amended where required.

3. CQC Feedback and improvement

Key issues being worked on as part of the ongoing HR improvement agenda are:

- timeliness of process
- keeping in touch and feedback

Consistent and timely application of the policies ensure that staff are treated fairly and consistently improves staff engagement, morale and productivity and the Trust will be viewed as a good practice employer. Failure to apply the policies correctly will result in inconsistencies in the treatment of staff, low staff engagement and ultimately litigation against the Trust, which has financial and reputational consequences.

Time taken and staff confidence in HR to resolve issues was a matter raised by the CQC and we are committed to ensuring that we continuously listen to staff involved in the processes to improve the experience for them.

The HR team are undertaking an improvement project to address the matters raised which include:-

- A review of policies and procedures with the Trusts legal advisors has taken place, procedures have been simplified and this has reduced time scales
- We have listened to the experiences of staff who have been suspended and aim to suspend only as a last resort for as shorter time as possible
- Reinforcing keeping in touch arrangements and occupational health support for staff subject to investigations
- An action plan is continuously being worked on in HR to set out smarter ways of working such as telephone interviewing
- Process mapping the investigation procedure to identify blockers
- Defining the roles of commissioning manager and case investigator
- HR Team have been trained in improvement methodology and are working with the Trust Improvement Team to reduce time taken
- Increase mediation and case management capability within the Trust
- 'Courageous Conversations' being worked up to assist managers with resolving low level conflict in their teams
- A pilot is being launched to address 'Poor Behaviours' aimed at teams signing up to a behaviours charter and empowering managers to tackle issues
- Signposting new managers to their HR advisory team

- Investigating the purchase of a case management system which will RAG rate and highlight outstanding actions for each case
- Re-launched Liveflo on-line advice for managers regularly updated in line with changes in policy
- Ensuring conflict resolution and relevant skills to manage staff are embedded in the induction of new managers
- A dedicated HR Assistant is allocated to each case to ensure consistency with administration and regular contact with the staff member
- Working closely with Speak Up Guardian to address issues before they develop into formal complaints
- Commissioning of investigation training to improve the availability and quality of investigators.

4. Conclusion

The implementation of the above learning and recommendations will ensure staff involved in an investigation and/or disciplinary process, are treated fairly, consistently and in line with our Trust values.

The formal process can be stressful and demoralising for staff. Working with the Engagement Team to ensure the agenda within the Trust Behavioural Framework is embedded in the management of staff throughout the Trust, HR work is focused on targeting managers to achieve early informal resolution.

The HR team are also working intensively on supporting areas of service change and ensuring staff are appropriately managed through these processes.

RECOMMENDATION

This report is to provide assurance that the Trusts processes for disciplinary investigations have been reviewed and where shortcomings have been identified relevant learning and best practice applied to improve the experience and outcomes of staff involved.

To undertake improvement work as detailed in the report and action plan.

Report date: 12 July 2019

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trusts and NHS foundation trusts chairs and chief executives

23 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's recommendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Investigation Process review and recommendations

Action Log – Updated 24th June 2019

Item	Recommendation	Action	Lead	Timescale	Position	RAG Status
1.	Adhering to Best Practice	• Gather input for improvements to the investigation process from– mgrs, HR, staff involved in process, recommendations from the Imperial College Healthcare NHS Trust AA case investigation, best practice guidance documents – ACAS, NMC, GMC, Just Culture, Incident decision tree. • Incorporate guidance and recommendations from NHSi 'Learning lessons to improve our people practices'.	**CS**	**30/06/19**	Complete	
2.	Applying a rigorous decision-making methodology	Review processes/roles and responsibilities and ensure Guidance documents completed for: • Staff member • Witness • Investigating Officer • Commissioning Manager Create flowcharts/checklists where relevant	**CH/MR/CS**	**30/08/19**	In progress	
3.	Ensuring people are fully trained and competent to carry out their role	• Ensure current training material is updated with amendments and published. • Review list of trained Investigation managers. • Commission refresher training for HR staff and Mgrs. • Ensure all relevant documents e.g. Letters, guidance docs, checklists etc. are reviewed, amended, saved on the HR Shared folder and published on the Intranet, via Live Flo with changes. • Ensure the list of trained IO's and CM's is up to date and new managers are trained.	**CS/MR** **All HRM's** **CS/JG** **CS/SG/CH** **CS/SG/CH**	**30/08/19** **30/06/18** **30/10/19** **30/08/19** **30/10/19**	Ongoing Completed In progress In progress Ongoing	

Item	Recommendation	Action	Lead	Timescale	Position	RAG Status
4.	Assigning Sufficient resources	• Commissioning managers to ensure allocation of investigator to a case is considered in the light of capacity/planned leave etc. Delays and exceptions to agreed deadlines within the process should be highlighted and escalated to Divisional Directors and HR in line with the guidance for Investigations. • Pause and Review checklist implemented – incorporating questions asked on page 2 of 'Learning lessons to improve our people practices' letter for current and all new cases. Staff are kept updated.	**All Commissioning managers** **All staff – HR and managers**	**Ongoing** **30/08/19**	Ongoing In progress	
5.	Decisions relating to the implementation of suspensions/exclusions	• A review of the Trust's suspension guidance is currently being carried out to include clear responsibilities for keeping in touch with those on suspension.	**CH**	**30/09/19**	In progress	
6.	Safeguarding people's health and wellbeing	Ensure sources of support are in place for staff subject to investigation and clearly communicated: • Buddy – seek and compile list of volunteers to be buddies • OH support • Trade Union • Care First – employee assistance programme • Guidance documentation	**CS/JH**	**Ongoing**	Ongoing	
7.	Board Level oversight	The POD Committee is updated Quarterly through the Employee relations report which provides assurance that workforce incidents and complaints have been managed, investigated and acted upon in accordance with Trust Policies, within appropriate timescales, and that any learning is shared and policies amended where required.	**JG**	**Quarterly**	Ongoing	

Meeting Dates for 2022

Meeting information:		
Date of Meeting:	14th December 2021	Agenda Item: 13
Meeting:	Trust Board	Reporting Officer: Steve Phoenix, Chair

The Trust Board will meet in 2022 on the following dates:

08/02/2022	Public Board	0930-1230
	Private Board	1300-1500
12/04/2022	Public Board	0930-1230
	Private Board	1300-1500
14/06/2022	Public Board	0930-1230
	Private Board	1300-1500
09/08/2022	Public Board	0930-1230
	Private Board	1300-1500
11/10/2022	Public Board	0930-1230
	Private Board	1300-1500
13/12/2022	Public Board	0930-1230
	Private Board	1300-1500

Use of Trust Seal

Meeting information:			
Date of Meeting:	14th December 2021	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Chair

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The purpose of this paper is to provide an overview of the use of the Trust Seal between 4th October 2021 and 7th December 2021.

Sealing 74 – Sectra Limited, 13th October 2021
Agreement for Picture Archiving and Communication System (PACS) and Archive Solution.

Sealing 75 – Johnson and Johnson Medical Ltd, 3rd November 2021
Agreement for orthopaedic prostheses for a four year period.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Not applicable.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note the use of the Trust Seal since the last Board meeting.

East Sussex Healthcare Trust

Ophthalmology transformation: executive summary pre-consultation business case

Joint Sussex Committee

Date:	November
Version:	1
Name of originator/ author:	CCG Programme Team

Contents

Executive Summary

1.0 Purpose

The purpose of this Pre-Consultation Business Case is to describe the wide engagement to date in communicating the drivers for change, reviewing all possible options to transform ophthalmology services provided by East Sussex Healthcare NHS Trust to deliver the best possible care for local people. The Pre-Consultation Business Case includes the available information and evidence that has supported the development of a model of care, an analysis of possible options to deliver this model of care, and it proposes preferred viable options to transform ophthalmology services.

This Pre-Consultation Business Case recommends to the East Sussex CCG (via Joint Sussex Committee delegated authority) one option to take forward to public consultation and, if approved by the CCG, to submit to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this constitutes substantial variation to services and that they would like the CCG to consult with them on this.

The full pre-consultation business case and associated document including the Equality and Health Inequality Impact Assessment, Quality Impact Assessment, the pre-consultation engagement report and options development and appraisal reports will all be available and published on the CCG websites.

2.0 Context

In 2019, the NHS Long Term Plan was published outlining the ambition that the NHS will increasingly be: more joined-up and coordinated in its care; more proactive in the services it provides; and more differentiated in its support offer to individuals, with the aim being that population health would be improved through coordinated service planning and delivery[1].

In alignment with the Sussex Health and Care Partnership, in 2019 the East Sussex system - East Sussex Clinical Commissioning Group (CCG), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership Foundation NHS Trust (SPFT), developed its' East Sussex Health and Care Plan. This built on improvements over recent years including:

- A comprehensive and co-ordinated range of preventative services
- Ongoing development of community health and social care services
- Strong whole system performance
- An Integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system wide basis for the benefit of our population.

[1] NHS Long Term Plan, 2019

3.0 Our population

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. Within this, many people live their later years in ill-health, often with more than one long term condition. This means that increasing numbers of people are needing to use local health and care services that are not always designed to support the growing numbers of local people needing their support. This increase in need is being felt within the system across Sussex and locally, with significant increases in people needing ophthalmology services in recent years. The system needs to reflect on how best to meet these changing population needs, recognising the needs of people living in areas of deprivation, and to rethink how we deliver an equitable service that can ensure the best health outcomes for our population, and can adapt to the challenges of the future, and represents good value.

The recognition of the changing needs of the population, the changing nature of ophthalmology care and the associated challenges in providing ophthalmology services has made the redesign of ophthalmology a key priority for East Sussex system. Our overall objectives are to:

- improve health, experience and quality of care
- improve the overall sustainability of health and social care services.

Delivering financial sustainability will also contribute to delivering these broader objectives.

4.0 Case for Change

We have reviewed the strategic drivers for change, the existing ophthalmology services for children and adults and the availability of other relevant existing and new services. This led us to the following conclusions:

- Quality: Healthcare systems are required to minimise the risk of significant harm, through delivering timely follow-up for patients with chronic conditions. The high and growing number of these cases within ophthalmology makes this a challenge.
- Service performance: nationally, ophthalmology outpatient services are the largest of all outpatient services that people use, with East Sussex Healthcare Trust seeing 18,075 new outpatients and 65,511 follow-up appointments in 2019-20. The Covid-19 pandemic has impacted heavily on ophthalmology provision and this, coupled with the very high levels of need for care, has led to East Sussex Healthcare Trust no longer meeting national waiting time standards.
- Growing need: It is estimated that, over the next 20 years, the need for cataract services will rise by 50%, glaucoma cases by 44% and medical retina by 20%.
- IT / Digital: there would be a significant benefit to patients through ophthalmology services making the best possible use of modern digital technology, such as an Electronic Eyecare Referral System (EERS). Modern technology presents opportunities to improve patient pathways and better manage the growing need for ophthalmology services.
- Workforce: a census carried out by the Royal College of Ophthalmologists (RCOphth) in 2019 identifies gaps in recruitment for ophthalmologists and workforce planning, amid a predicted 40% increase in need over the next 20 years.

- The national Getting it Right First Time (GIRFT)[2] programme reviewed the ophthalmology service in March 2018. It was recommended that:

    - Review pre-assessment clinics and review/audit coding for complex cataracts to ensure the patient pathway for cataract surgery is optimised.
    - Continue to develop health care professional (HCP) staff by training and developing all members of the multi-disciplinary team, whilst utilising competency frameworks to increase the number of non-consultant clinical staff.
    - Look into using consultant-led and technician-provided virtual clinics for age-related macular degeneration (AMD) and glaucoma to improve refinement of treatment plans.
    - Review of coding practices to ensure accuracy, particularly around complex cataracts, corneal grafts, strabismus follow-ups and vitreo-retinal conditions.
    - Continue to refer to the Royal College of Ophthalmologist's "The Way Forward"[3] document to identify options to help meet demand and the Common Competency Framework to support health care professional staff development.
- Net Zero NHS: the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
- Estates and equipment: diagnosis and monitoring of ophthalmic patients is highly dependent on equipment. Much of the equipment currently used by the department across its three sites is old, which impedes the service's ability to work efficiently and effectively. There are limitations of physical space in the current service configuration limiting the capacity of the service to meet the current and growing need of the local population which contributes to challenges in meeting service standards.
- Making best use of our resources: we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.

As a result this Pre-Consultation Business Case proposes changes to a range of ophthalmology services provided by East Sussex Healthcare NHS Trust.

5.0 How we developed our proposal

Following analysis of the current service provision and the emerging future needs of local people, we developed a 'Case for Change' that outlined the key drivers for service transformation. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about ophthalmology services. This engagement has indicated several key themes:

- Care provided
- Equality and Diversity
- Access and transport
- Clinical services
- Community optometry.

[2] The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.
[3] The Royal College of Ophthalmologists, 2016, *The Way Forward*

Alongside finding out what is important to local people and clinicians, we have reviewed local health needs in East Sussex. This tells us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We have taken account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in this Pre-Consultation Business Case (more detail on this can be found in Appendix 1 - Equality and Health Inequality Assessment).

Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services - ORS[4]) took place, during March 2021, to identify and consider and refine possible options for the future provision of acute ophthalmology services, to appraise these options and make recommendations for preferred viable options.

Following this, and as part of our in-depth comparative analyses for this pre-consultation business case, we have also reviewed quality indicators, travel analysis, the impact this transformation could have on other services (within Sussex and outside of Sussex), the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.

6.0 The process of assurance

When developing our options, our final draft proposals, and this Pre-consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[5]
- We have developed our proposal and associated consultation plans in line with the Gunning Principles[6] to ensure that:
    - a decision will not be taken until after public consultation
    - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
    - there is adequate time for people to participate in the consultation
    - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

[4] Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.
[5] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
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- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.

7.0 Our proposal

We are proposing to locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.

The introduction of one stop clinics and a diagnostic eye hub will ensure faster diagnosis, reduce waiting times, reduce number of appointments required for patients to attend and repeated tests. These are key quality improvements to the ophthalmology service.

To deliver this model of care we need to bring staff together across a range of disciplines into multidisciplinary teams and the proposal enables the physical space for these staff to work together in this way. This also improves access to senior decision making and input when it is required in relation to patient care so that patients will see the right people at the right time and reducing repeat attendances.

To help develop this Pre-Consultation Business Case we have engaged with local people and stakeholders. Our next step is to seek further feedback through a formal and public consultation process with local people and with the East Sussex Health Overview Scrutiny Committee. We will gather this feedback and comments and consider and respond to these before we make the final decision on the future of East Sussex Healthcare NHS Trust's ophthalmology services.

If this Pre-Consultation Business Case proposal is approved by the CCG, and East Sussex Health Overview Scrutiny Committee consider that the proposal constitutes a substantial variation to services and should therefore be subject to consultation, then this process will begin in December 2021.

Through our engagement and options process we developed 5 options. The conclusion from our options appraisal is a proposal to take forward one option for formal consultation with patients, the public and local stakeholders. This is the option that has been appraised as the one that will best provide good patient experience, support improved outcomes for local people and a high-quality sustainable service that enables the model of care to be implemented that will realise these benefits and is deliverable.

We currently provide services from three sites: Eastbourne District General Hospital, Conquest Hospital, Hastings, and Bexhill Hospital. This proposal seeks to consolidate activity from Conquest Hospital to Bexhill (from three sites to two) and to continue the provision at Eastbourne to deliver the model of care. Bexhill Hospital is 6.6 miles from the Conquest Hospital, and both are outside of the Hastings town centre. The activity in the scope of this proposal relates only to outpatients and Day Cases at the Conquest Hospital.

The proposed transformation, with the one stop clinics and diagnostic eye hub, will make key quality improvements to the service, such as:

- enable a redesigned ophthalmology pathway that will increase quality of care ensuring patients are seen by the right person, in the right place, and at the right time.

- ensure that we can better meet service standards so that patients receive care in a timely manner, meaning faster diagnosis, shorter waiting times, fewer repeat appointments for tests and therefore less travelling for patients.
- provide a consultant-led model of working that efficiently utilises skill mix across the workforce and provides training opportunities
- ensure staff and expert knowledge are consolidated, allowing for improved supervision and opportunities for training and educational needs for staff who wish to upskill. Thereby, gradually improving the skills in the workforce to improve the service quality and care provided to our population.

This option will have positive impacts for our patients, as well as workforce, and will improve patient experience, patient outcomes and our performance against national standards in the long term (by reducing waiting times alongside travel for patients), whilst making the service more efficient and sustainable for the future. It also supports the wider Sussex Ophthalmology plan enabling future training and supervision from ophthalmology consultants to upskill the community Optometry workforce.

The national and regional/local transformation of ophthalmic services, together with the demands inherent in meeting future standards and the challenging aspects of a fragmented service and workforce, mean that doing nothing means that there will be increasingly poor and fragmented access to ophthalmology services for local people. The other options were not taken forward as they either scored poorly as part of the options appraisal process, involve aspects of ophthalmology services that are out of scope for this programme of work, or are not viable following thorough financial and activity-based analyses, as part of this Pre-Consultation Business Case.

In addition, the options appraisal process showed there was a clear preference across all stakeholder groups for a combination of Eastbourne District General Hospital and Bexhill Hospital sites provision under Option 2. Combinations of site provision that included Conquest Hospital were least favoured.

Over time, as part of the longer-term vision to continue to improve ophthalmology services, we will consider the needs of the following ophthalmology service provision at East Sussex Healthcare NHS Trust (e.g. pre/post op cataract pathway, glaucoma referral refinement) alongside enhanced service provision in the community, provided by local optician practices, across East Sussex

However, at this current point the significant opportunity available to the system to transform ophthalmology services, providing one stop clinics and a diagnostic eye hub is key. Longer term service consolidation, delivered in alignment with the Sussex-wide Ophthalmology Transformation programme would also enable improved joined up service provision across community and hospital settings, consolidating staff and resources to best serve the local population. This is not the subject of these proposals and if plans are developed into the future, these would be subject to further engagement.

These options (described in more detail in Section 8) will have positive impacts for our patients, as well as workforce, and will improve our ability to meet service standards and patient outcomes in the long term, through a more efficient service and one that is more sustainable for the future.

We will continue to work with local people and stakeholders to understand the implications of our proposal through the consultation process. This will include working with local people and stakeholders to understand how best to provide easily accessible information to support local people and professionals about the proposed change.

We recognise that this will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the consultation process to understand the implications of our proposal. All new information and evidence gathered as part of a consultation will inform a final proposal.

Once a decision is reached, during any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to communicate any changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

8.0 Recommendation

It is recommended that the East Sussex CCG (via Joint Sussex Committee delegated authority):

- **approve the proposals and endorse the recommendation that these should be subject to formal public consultation**
- **agree that the decision of the CCG should be submitted to the East Sussex Health Overview and Scrutiny Committee, to consider if they would like the CCG to formally consult with them on the proposals**

East Sussex Healthcare NHS Trust Transformation of Ophthalmology Services

Summary Report for: Health Overview Scrutiny Committee

Date:	December
Version:	1
Name of originator/ author:	CCG Programme Team

Contents

1.0 Background

Improving ophthalmology health outcomes is a key priority area for the Sussex Health and Care Partnership (SHCP).

On 4th March 2021, East Sussex Clinical Commissioning Group (ESCCG) and East Sussex Healthcare NHS Trust (ESHT) presented early draft proposals for a change in the way that ophthalmology services are provided in East Sussex to the Heath Overview and Scrutiny Committee. At that meeting East Sussex HOSC confirmed that any proposals that include a relocation of current ophthalmology services will likely constitute a substantial variation in services and will require a formal consultation.

A pre-consultation business case has now been prepared that builds on the early draft proposals and this has been supported by NHS England and NHS Improvement as part of an assurance process.

At its meeting on Tuesday 30 November 2021, members of the East Sussex Healthcare NHS Trust Board are invited to review and consider the pre-consultation business case (PCBC) for the re-configuration of ophthalmology services, endorse the proposals and agree that the CCG commences a consultation process with the East Sussex Health Overview and Scrutiny Committee (HOSC), and agree that the proposal should be subject to formal public consultation. It has also been considered and approved, in principle pending approval from ESHT, by the Joint Sussex Committee at its meeting on Wednesday 17 November 2021.

The full pre-consultation business case and associated documents, including the Equality and Health Inequality Impact Assessment, Quality Impact Assessment, the pre-consultation engagement report and options development and appraisal reports, will all be available and published on the CCG website. The PCBC Executive Summary is provided as Annex 1 to this report together with our plans for consultation which are set out in Annex 2.

2.0 The Proposal

Our proposal is to locate ophthalmology services at two hospitals, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital. This means:

- There would be no change to activity at the Eastbourne site.
- The activity provided at the Conquest site would move to Bexhill. However, the activity that would be moved will only relate to outpatients and day cases. This equates to:

POD	Number of Conquest patients	Percentage of total ophthalmology activity
Outpatient First Appt	7,113	8.08%
Outpatient Follow Up	17,158	19.50%
Day Case	111	0.13%

NB: this data is based on pre-covid data. Number of appointments does not accurately reflect number of patients, as many patients attend multiple appointments.

- Bexhill is 6.6 miles from Conquest.
- Both Conquest and Bexhill are outside of the Hastings main population centre.

- The proposed pathways would reduce the number of appointments that individual patients need to attend due to one-stop clinics, faster diagnostics and senior decision making. Patients who move would need to attend an alternative site, but may need to attend less often.
- The proposal does not affect unplanned or emergency care, the pathway for which is not changing.
- Emergency and General Anaesthetic surgical cases (including cases which require overnight stay), would continue to be delivered at Conquest Hospital.
- The below table shows the current (Pre-Covid) percentage split of outpatients and day case activity across the three sites:

Percentage Activity split per site and by point of delivery (Pre-Covid)			
POD	**Bexhill**	**Conquest**	**Eastbourne**
Outpatient First Appt	5.3%	39.3%	55.4%
Outpatient Follow Up	25.4%	26.3%	48.3%
Day Case	46.2%	2.4%	51.4%

- Moving Conquest activity to Bexhill would allow us to avoid fragmentation of the service and implement redesigned pathways to increase quality of care and efficiency (including High Volume Low Complexity work), provide one-stop clinics, and provide a consultant led (as opposed to delivered) model of working that efficiently utilises skill mix and training opportunities.
- This change also enables the wider Sussex Ophthalmology plan, as training and supervision from the East Sussex Healthcare Trust consultant body support upskilling the community Optometry workforce.

The introduction of one stop clinics and a diagnostic eye hub will ensure faster diagnosis, reduce waiting times, reduce number of appointments required for patients to attend and repeated tests. These are key quality improvements to the ophthalmology service.

Over time, as part of the longer-term vision to continue to improve ophthalmology services, we will consider the needs of the following ophthalmology service provision at East Sussex Healthcare NHS Trust (e.g. pre/post op cataract pathway, glaucoma referral refinement) alongside enhanced service provision in the community, provided by local optician practices, across East Sussex

3.0 How we developed our proposal

We have worked with patients, their families and carers, wider public and stakeholders, alongside our clinical teams and local GPs throughout the development of this programme, specifically engaging in how we have:

- set out the case for change for the reconfiguration and consolidation of the current ophthalmology services delivered at the East Sussex Healthcare NHS Trust (ESHT) in the context of a wider programme of transformation and improvement
- described the agreed clinical model for acute cardiology services in the context of the Trust's wider service provision and wider national and local drivers
- worked with stakeholders to inform, develop and evaluate viable options for the redesign of acute cardiology services in East Sussex.

All information gathered in the pre-consultation phase has shaped the development and selection of the shortlisted options and feedback has provided a rich source of information which has been used to further shape and refresh the Pre-Consultation Business Case (PCBC), Equality and Health Inequality Impact Assessment (EHIA), and Quality Impact Assessment (QIA).

This PCBC describes our case for change, needs assessment, engagement process, development of options, and sets out the scope of the shortlisted options for reconfiguration and modernisation and the associated costs, risks and benefits.

4.0 The process of assurance

When developing our options, our final draft proposals, and this Pre-Consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequality Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[1]
- We have developed our proposal and associated consultation plans in line with the Gunning Principles[2] to ensure that:
    - a decision will not be taken until after public consultation
    - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
    - there is adequate time for people to participate in the consultation
    - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.
- We have engaged extensively with NHS England and Improvement (NHSE/I) and completed a rigorous NHSE assurance process in relation to the proposal and our consultation and engagement plans.

A Quality Impact Assessment (QIA) has been completed and scored highly in terms of a positive impact on safety, experience and effectiveness. The QIA will continue to be developed as the proposals progress to ensure that quality and safety considerations are built into the outcome.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
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The Programme has also completed an Equalities and Health Inequalities Impact Assessment (EHIA). The EHIA concludes that the proposed changes will have a positive impact on service users with protected characteristics. The EHIA also indicated that through the design and location, there may be an opportunity to reduce health inequalities through these proposals. The EHIA is a live document and will continue to be developed with the proposals.

5.0 Conclusion

This proposal represents an opportunity to significantly improve ophthalmology services in East Sussex. The CCG and ESHT welcome the opportunity for wider engagement through public consultation, and look forward to engagement with and feedback from the HOSC.

Travel

East Sussex Healthcare NHS Trust Ophthalmology Services Transformation

Pre-Consultation Business Case

2 November 2021

Table of Contents

1. Executive Summary

The purpose of this Pre-Consultation Business Case is to describe the wide engagement to date in communicating the drivers for change, reviewing all possible options to transform ophthalmology services provided by East Sussex Healthcare NHS Trust to deliver the best possible care for local people. The Pre-Consultation Business Case includes the available information and evidence that has supported the development of a model of care, an analysis of possible options to deliver this model of care, and it proposes preferred viable options to transform ophthalmology services.

This Pre-Consultation Business Case recommends to the East Sussex Governing Body one option to take forward to public consultation and, if approved by the Governing Body, to submit to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this constitutes substantial variation to services and that they would like the CCG to consult with them on this.

Context

In 2019, the NHS Long Term Plan was published outlining the ambition that the NHS will increasingly be: more joined-up and coordinated in its care; more proactive in the services it provides; and more differentiated in its support offer to individuals, with the aim being that population health would be improved through coordinated service planning and delivery[1].

In alignment with the Sussex Health and Care Partnership, in 2019 the East Sussex system - East Sussex Clinical Commissioning Group (CCG), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership Foundation NHS Trust (SPFT), developed its' East Sussex Health and Care Plan. This built on improvements over recent years including:

- A comprehensive and co-ordinated range of preventative services
- Ongoing development of community health and social care services
- Strong whole system performance
- An Integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system wide basis for the benefit of our population.

Our population

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. Within this, many people live their later years

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in ill-health, often with more than one long term condition. This means that increasing numbers of people are needing to use local health and care services that are not always designed to support the growing numbers of local people needing their support. This increase in need is being felt within the system across Sussex and locally, with significant increases in people needing ophthalmology services in recent years. The system needs to reflect on how best to meet these changing population needs, recognising the needs of people living in areas of deprivation, and to rethink how we deliver an equitable service that can ensure the best health outcomes for our population, and can adapt to the challenges of the future, and represents good value.

The recognition of the changing needs of the population, the changing nature of ophthalmology care and the associated challenges in providing ophthalmology services has made the redesign of ophthalmology a key priority for East Sussex system. Our overall objectives are to:

- improve health, experience and quality of care
- improve the overall sustainability of health and social care services.

Delivering financial sustainability will also contribute to delivering these broader objectives.

Case for Change

We have reviewed the strategic drivers for change, the existing ophthalmology services for children and adults and the availability of other relevant existing and new services. This led us to the following conclusions:

- Quality: Healthcare systems are required to minimise the risk of significant harm, through delivering timely follow-up for patients with chronic conditions. The high and growing number of these cases within ophthalmology makes this a challenge.
- Service performance: nationally, ophthalmology outpatient services are the largest of all outpatient services that people use, with East Sussex Healthcare Trust seeing 18,075 new outpatients and 65,511 follow-up appointments in 2019-20. The Covid-19 pandemic has impacted heavily on ophthalmology provision and this, coupled with the very high levels of need for care, has led to East Sussex Healthcare Trust no longer meeting national waiting time standards.
- Growing need: It is estimated that, over the next 20 years, the need for cataract services will rise by 50%, glaucoma cases by 44% and medical retina by 20%.
- IT / Digital: there would be a significant benefit to patients through ophthalmology services making the best possible use of modern digital technology, such as an Electronic Eyecare Referral System (EERS). Modern technology presents opportunities to improve patient pathways and better manage the growing need for ophthalmology services.
- Workforce: a census carried out by the Royal College of Ophthalmologists (RCOphth) in 2019 identifies gaps in recruitment for ophthalmologists and workforce planning, amid a predicted 40% increase in need over the next 20 years.

- The national Getting it Right First Time (GIRFT)[2] programme reviewed the ophthalmology service in March 2018. It was recommended that:

    - Review pre-assessment clinics and review/audit coding for complex cataracts to ensure the patient pathway for cataract surgery is optimised.
    - Continue to develop health care professional (HCP) staff by training and developing all members of the multi-disciplinary team, whilst utilising competency frameworks to increase the number of non-consultant clinical staff.
    - Look into using consultant-led and technician-provided virtual clinics for age-related macular degeneration (AMD) and glaucoma to improve refinement of treatment plans.
    - Review of coding practices to ensure accuracy, particularly around complex cataracts, corneal grafts, strabismus follow-ups and vitreo-retinal conditions.
    - Continue to refer to the Royal College of Ophthalmologist's "The Way Forward"[3] document to identify options to help meet demand and the Common Competency Framework to support health care professional staff development.
- Net Zero NHS: the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
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- Making best use of our resources: we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.

As a result this Pre-Consultation Business Case proposes changes to a range of ophthalmology services provided by East Sussex Healthcare NHS Trust.

How we developed our proposal

Following analysis of the current service provision and the emerging future needs of local people, we developed a 'Case for Change' that outlined the key drivers for service transformation. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about ophthalmology services. This engagement has indicated several key themes:

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- Equality & Diversity
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- Clinical services

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- Community optometry.

Alongside finding out what is important to local people and clinicians, we have reviewed local health needs in East Sussex. This tells us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We have taken account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in this Pre-Consultation Business Case (more detail on this can be found in Appendix 1 - Equality and Health Inequality Assessment).

Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services - ORS[4]) took place, during March 2021, to identify and consider and refine possible options for the future provision of acute ophthalmology services, to appraise these options and make recommendations for preferred viable options.

Following this, and as part of our in-depth comparative analyses for this pre-consultation business case, we have also reviewed quality indicators, travel analysis, the impact this transformation could have on other services (within Sussex and outside of Sussex), the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.

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When developing our options, our final draft proposals, and this Pre-consultation Business Case:

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  - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
  - there is adequate time for people to participate in the consultation
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- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.

Our proposal

We are proposing to locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.

The introduction of one stop clinics and a diagnostic eye hub will ensure faster diagnosis, reduce waiting times, reduce number of appointments required for patients to attend and repeated tests. These are key quality improvements to the ophthalmology service.

To deliver this model of care we need to bring staff together across a range of disciplines into multidisciplinary teams and the proposal enables the physical space for these staff to work together in this way. This also improves access to senior decision making and input when it is required in relation to patient care so that patients will see the right people at the right time and reducing repeat attendances.

To help develop this Pre-Consultation Business Case we have engaged with local people and stakeholders. Our next step is to seek further feedback through a formal and public consultation process with local people and with the East Sussex Health Overview Scrutiny Committee. We will gather this feedback and comments and consider and respond to these before we make the final decision on the future of East Sussex Healthcare NHS Trust's ophthalmology services.

If this Pre-Consultation Business Case proposal is approved by the CCG, and East Sussex Health Overview Scrutiny Committee consider that the proposal constitutes a substantial variation to services and should therefore be subject to consultation, then this process will begin in December 2021.

Through our engagement and options process we developed 5 options. The conclusion from our options appraisal is a proposal to take forward one option for formal consultation with patients, the public and local stakeholders. This is the option that has been appraised as the one that will best provide good patient experience, support improved outcomes for local people and a high-quality sustainable service that enables the model of care to be implemented that will realise these benefits and is deliverable.

We currently provide services from three sites: Eastbourne District General Hospital, Conquest Hospital, Hastings, and Bexhill Hospital. This proposal seeks to consolidate activity from Conquest Hospital to Bexhill (from three sites to two) and to continue the provision at Eastbourne to deliver the model of care. Bexhill Hospital is 6.6 miles

from the Conquest Hospital, and both are outside of the Hastings town centre. The activity in the scope of this proposal relates only to outpatients and Day Cases at the Conquest Hospital.

The proposed transformation, with the one stop clinics and diagnostic eye hub, will make key quality improvements to the service, such as:

- enable a redesigned ophthalmology pathway that will increase quality of care ensuring patients are seen by the right person, in the right place, and at the right time.
- ensure that we can better meet service standards so that patients receive care in a timely manner, meaning faster diagnosis, shorter waiting times, fewer repeat appointments for tests and therefore less travelling for patients.
- provide a consultant-led model of working that efficiently utilises skill mix across the workforce and provides training opportunities
- ensure staff and expert knowledge are consolidated, allowing for improved supervision and opportunities for training and educational needs for staff who wish to upskill. Thereby, gradually improving the skills in the workforce to improve the service quality and care provided to our population.

This option will have positive impacts for our patients, as well as workforce, and will improve patient experience, patient outcomes and our performance against national standards in the long term (by reducing waiting times alongside travel for patients), whilst making the service more efficient and sustainable for the future. It also supports the wider Sussex Ophthalmology plan enabling future training and supervision from ophthalmology consultants to upskill the community Optometry workforce.

The national and regional/local transformation of ophthalmic services, together with the demands inherent in meeting future standards and the challenging aspects of a fragmented service and workforce, mean that doing nothing means that there will be increasingly poor and fragmented access to ophthalmology services for local people. The other options were not taken forward as they either scored poorly as part of the options appraisal process, involve aspects of ophthalmology services that are out of scope for this programme of work, or are not viable following thorough financial and activity based analyses, as part of this Pre-Consultation Business Case.

In addition, the options appraisal process showed there was a clear preference across all stakeholder groups for a combination of Eastbourne District General Hospital and Bexhill Hospital sites provision under Option 2. Combinations of site provision that included Conquest Hospital were least favoured.

Over time, as part of the longer-term vision to continue to improve ophthalmology services, we will consider the needs of the following ophthalmology service provision at East Sussex Healthcare NHS Trust (e.g. pre/post op cataract pathway, glaucoma referral refinement) alongside enhanced service provision in the community, provided by local optician practices, across East Sussex

However, at this current point the significant opportunity available to the system to transform ophthalmology services, providing one stop clinics and a diagnostic eye hub is key. Longer term service consolidation, delivered in alignment with the Sussex-wide Ophthalmology Transformation programme would also enable improved joined up service provision across community and hospital settings, consolidating staff and resources to best serve the local population. This is not the subject of these proposals and if plans are developed into the future, these would be subject to further engagement.

These options (described in more detail in Section 8) will have positive impacts for our patients, as well as workforce, and will improve our ability to meet service standards and patient outcomes in the long term, through a more efficient service and one that is more sustainable for the future.

We will continue to work with local people and stakeholders to understand the implications of our proposal through the consultation process. This will include working with local people and stakeholders to understand how best to provide easily accessible information to support local people and professionals about the proposed change.

We recognise that this will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the consultation process to understand the implications of our proposal. All new information and evidence gathered as part of a consultation will inform a final proposal.

Once a decision is reached, during any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to communicate any changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

Recommendation

It is recommended that the East Sussex CCG :

- **review and consider the Pre-Consultation Business Case for the Transformation of Ophthalmology Services delivered by East Sussex Healthcare NHS Trust**
- **approve the proposals and endorse the recommendation that these should be subject to formal public consultation**
- **agree that the decision of the Governing Body should be submitted to the East Sussex Health Overview and Scrutiny Committee, to consider if they would like the CCG to formally consult with them on the proposals**

2. Introduction

2.1. Background to this proposal

With advances in medicine and treatment, changing health and care needs and new developments influencing wider society, we have to continually move forward so that we have a health and care system that is fit for the future. In East Sussex, the NHS and county council have been working closely together over recent years, alongside wider partners, to improve population health and wellbeing and reduce health inequalities to deliver the right services, in the right places at the right time.

Thanks to this work we are seeing more treatment, care and support being delivered where people want it – in their own homes or locally in their community. This shift in the way we provide health and care means that many people are avoiding hospital altogether. And when they do need planned or urgent hospital care they are able to see clinicians and receive treatment more quickly and spend fewer unnecessary days in hospital with better support when they go home.

We work together in the context of the wider Sussex Health and Care Partnership bringing together the health and care organisations across the Sussex Integrated Care System who serve over 1.7 million people at a cost of £4 billion per year. The Sussex Health and Care Partnership has agreed its vision for 2025. A vision where people live for longer in good health. A vision where the gap in healthy life expectancy between people living in the most and least disadvantaged communities will be reduced. A vision where people's experiences of using services will be better and where staff feel supported and work in a way that makes the most of their dedication, skills and professionalism. A vision where the cost of health and care will be affordable and sustainable in the long term.

In 2019, the NHS Long Term Plan was published outlining the ambition that the NHS will increasingly be: more joined-up and coordinated in its care; more proactive in the services it provides; and more differentiated in its support offer to individuals, with the aim being that population health would be improved through coordinated service planning and delivery[7].

In alignment with the Sussex Health and Care Partnership, the East Sussex system - East Sussex Clinical Commissioning Group (CCG), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership Foundation NHS Trust (SPFT), developed its' East Sussex Health and Care Plan in 2019. This built on improvements over recent years including:

- A comprehensive and co-ordinated range of preventative services
- Ongoing development of community health and social care services
- Strong whole system performance

[7] NHS Long Term Plan, 2019

- Integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system wide basis for the benefit of our population.

Our East Sussex Health and Care Plan (2019) outlined plans for the next three to five years focusing on the transformation priorities we need to deliver jointly as a health and social care system, to meet the future health and care needs of our population; priorities for programmes of change covering prevention, community, urgent care, planned care and mental health and our plans to work with Primary Care Networks, the voluntary and community sector and others to support delivery of a "new service model for the 21st century"[8] grounded in the needs of our local population. The plan also describes the local implications for workforce planning, IT and digital and estates. We have refreshed our local plan for 2020/21 to ensure we continue this work, whilst recovering access to services that have been impacted by the Covid-19 pandemic. This ensure a focus on:

- Population health management using public health principles
- Health inequalities
- Transformation of clinical pathways and health and social care service models
- Primary care
- Priorities for social care and housing, and other services related to delivering outcomes for our community
- Operational issues and pressures

East Sussex CCG is responsible for commissioning healthcare services for our patient population, with the majority of acute and community services being commissioned from East Sussex Healthcare Trust. The Trust is one of the largest organisations in East Sussex, employing over 7,000 staff and providing acute hospital and community health services. East Sussex Healthcare Trust provides services across three main sites in East Sussex; Conquest Hospital in Hastings, Eastbourne District General Hospital, and Bexhill Hospital. Some activities are also undertaken at small satellite sites across East Sussex. In early 2020, East Sussex Healthcare Trust received an overall CQC rating of Good, with Eastbourne District General Hospital and Bexhill Hospital rated as Good, and Conquest Hospital rated as Outstanding. Most people in the north and west of East Sussex receive community services from Sussex Community NHS Foundation Trust, and their acute services from University Hospitals Sussex East (in Brighton and Haywards Heath previously Brighton and Sussex University Hospitals NHS Trust), Maidstone and Tunbridge Wells NHS Trust (predominantly from their Pembury site) or East Sussex Healthcare Trust (from Eastbourne District General Hospital).

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. Within this, many people live their later years

[8] NHS Long Term Plan Implementation Framework(July 2019) a copy can be found here

in ill-health, often with more than one long term condition, leading to an increasing need and pressure on health and care services and resources. This increase in need is being felt within the system across Sussex and locally, with significant increases in people needing ophthalmology services in recent years.

Ophthalmology is a branch of medicine and surgery that provides diagnosis, treatment and prevention of conditions that affect the eye and visual system. While there are many clinical conditions that can affect the eye and its surrounding structure in people of all ages, many eye conditions are age-related, making eye health (ophthalmology) services more and more important as people get older.

Our system needs to reflect on the changing population needs, modernisation in approaches to care and technology developments, to rethink how we deliver an equitable service that represents value, can meet future increases in need, and ensures the best health outcomes for our population.

Historically, the ophthalmology department at East Sussex Healthcare Trust has provided services to local people that met national standards including compliance against the 18 week Referral to Treatment standard and the service has received positive feedback from Friends and Family. However, the steady growth in need is making it more difficult, each year, to maintain this service quality.

Following the impact of Covid-19 on the provision of services since March 2020, East Sussex Healthcare Trust is working to restore current service provision.

The recognition of the changing needs of the population, the changing nature of ophthalmology care and the associated challenges in providing ophthalmology services has made the re-design of ophthalmology a key priority for the East Sussex system. Our overall objectives are to improve health, experience and quality of care and improve the overall sustainability of health and social care services. Delivering financial sustainability will contribute to delivering these broader objectives.

This Pre-Consultation Business Case outlines the current ophthalmology services; the key drivers for change that indicate a re-design is required; the pre-consultation engagement that has taken place; along with proposed options to deliver ophthalmology services in the future. It also outlines the processes that will be followed to agree a preferred option for delivery.

2.2. Our engagement

The CCG is committed to involving local people in all stages of our work, including the development of our proposals for how acute ophthalmology services can best provide high quality treatment, care and support for local people and meet increasing local population need. We have worked to gather insight from local people into the patient journey and experiences of accessing ophthalmology services in order to inform service change and potential public consultation. To enable wider public/stakeholder feedback, our plans and supporting information have been publicised via social media, the Sussex Health and Care Partnership website, and

our Engagement HQ platform. We have also ensured Healthwatch has been fully involved in the work so far and have included patients, patient champions, and Healthwatch as part of our options appraisal process.

GP engagement has been sought through attendance at all GP locality forums across East Sussex, providing presentations about the ophthalmology transformation programme work to date with opportunities for questioning and clarification at the time of presentation and post-presentation. Presentation to Primary Care Network Clinical Directors and individual locality forums ensured wide GP representation that has informed this work.

This work was positively received, including feedback with regards to the importance of communication with the public about the proposals and what they might mean in terms of how services would be accessed.

Primary care colleagues expressed interest in harmonisation of Locally Commissioned Services for ophthalmic diseases, such as glaucoma as well as development of integrated ophthalmology pathways across the local area to support patients from primary to secondary care. Whilst outside the scope of this Pre-Consultation Business Case, as these developments progress their relationship with ophthalmology services will be considered.

Additionally, the Trust has undertaken internal engagement to ensure clinicians delivering interdependent services (such as, paediatrics, neurology) have had an opportunity to review the proposals to consider how any proposed changes may impact across interdependent services. Following this engagement, interdependent services have confirmed that they are supportive of this programme.

2.3. Key duties for consideration

It is important that, as we develop proposals for change, we ensure this takes account of the needs of local people in relation to protected characteristics and health inequalities, in a way that responds to the diverse needs of the population. In relation to this there are key duties that the CCG must have due regard to as outlined below.

In line with the Health and Social Care Act 2012, the CCG is mindful that it must have due regard to:

- reducing inequalities between patients with respect to their ability to access health services;
- reducing inequalities between patients with respect to outcomes achieved for them by the provision of health services.

As such, consideration has been given to a wide range of information about the CCG's population including issues such as deprivation, ability to access services, demographic trends and patterns of service use. This evidence has informed the development of our proposals to ensure that local people continue to have access to high quality, safe and sustainable services to meet their needs.

These duties have been considered as part of our process in developing this proposal, supporting clinical and financial sustainability across our local system and supporting the delivery of a wide range of services within our local community.

In addition, in order to fulfil our public sector equality duty under Section 149 of the Equality Act 2010, the CCG has undertaken an Equality and Health Inequalities Impact Assessment. This is to ensure that the impact of our proposals is understood and that there is no adverse impact on any particular group of individuals (of protected characteristics and groups who may be most impacted by health inequalities) and to identify actions to mitigate any identified impact where necessary. This is described in more detail in Section 10.2.

3. Strategic context – national drivers for change

Nationally policy makers are clear that NHS services need to continue to transform to support best outcomes for people and address improved population health and well-being[9]. This section outlines standards and quality of services we want to ensure we deliver for ophthalmology services and the ways in which ophthalmology service delivery is changing.

Nationally, ophthalmology services account for just over 8% of all outpatient appointments, with ophthalmology referrals to hospital eye services rising by over 12% from 2013-14 to 2019-20[10]. National forecasting indicates that this increase in need is set to rise further, particularly in an ageing population.

While nationally millions of patients every year benefit from high-quality care, those working within ophthalmology services recognise the impact of growing need on the timely provision of care. Consultant ophthalmologists specialise in different disease areas, for example; glaucoma, medical retina and ocular plastics. There is a national shortage of ophthalmology consultants[11], particularly in glaucoma, as well as for ophthalmic nurses and optometrists, both of which are essential and important resources within ophthalmology departments. This national shortage means that the ophthalmology workforce has not grown in line with the growing need for services and with advancements in diagnosis and treatments for conditions that require regular and timely attendance to hospital to prevent permanent sight loss, ophthalmology departments are experiencing challenges with capacity.

3.1. NHS Long Term Plan

In January 2019, the NHS published its Long-Term Plan. The Long Term Plan sets out the need to modernise current service provision across all care types, including elective care services.

The NHS Long Term Plan also has a key focus on developing Integrated Care Systems (ICSs), between Primary, Community and Secondary services, as well as local authorities, to join up the planning and delivery of services to improve population health by:

[9] https://www.england.nhs.uk/publication/transforming-elective-care-services-ophthalmology/
[10] Getting It Right First Time, 2019, *Ophthalmology GIRFT Programme National Specialty Report*
[11] https://www.rcophth.ac.uk/2019/01/new-rcophth-workforce-census-illustrates-the-severe-shortage-of-eye-doctors-in-the-uk/

- Being more proactive, joined up, coordinated and differentiated in the services we provide and how we offer support to patients
- Using technology to enable us to redesign clinical pathways and supporting health and care staff to deliver joined up services
- Improving the role of prevention and reducing health inequalities
- Tackling workforce shortages and supporting staff

There are also key focuses on improving the digital interfaces between care settings, and a drive to move away from the traditional outpatient models of care.

3.2. Getting It Right First Time (GIRFT)

Getting It Right First Time[12] (GIRFT) is a national NHS England/Improvement programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data driven evidence base to support change. The programme draws on national and international best practice. A Getting It Right First Time programme across East Sussex Healthcare NHS Trust is in progress, and the trust medical director leads this. A Getting It Right First Time review of ophthalmology was undertaken in March 2018, and the recommendations are summarised below. Implementation of the transformation proposals in this Pre-Consultation Business Case would enable East Sussex Healthcare Trust to achieve these and associated recommendations:

- Review pre-assessment clinics and review/audit coding for complex cataracts to ensure the patient pathway for cataract surgery is optimised.
- Continue to develop health care professional (HCP) staff by training and developing all members of the multi-disciplinary team, whilst utilising competency frameworks to increase the number of non-consultant clinical staff.
- Look into using consultant-led and technician-provided virtual clinics for age-related macular degeneration (AMD) and glaucoma to improve refinement of treatment plans.
- Review of coding practices to ensure accuracy, particularly around complex cataracts, corneal grafts, strabismus follow-ups and vitreo-retinal conditions.
- Continue to refer to the Royal College of Ophthalmologist's "The Way Forward"[13] document to identify options to help meet demand and the Common Competency Framework to support Health Care Professional staff development.

3.3. NHS England's National Elective Care Outpatient Transformation Programme

Ophthalmology was one of the first specialties to benefit from the NHS England Elective Care Transformation Programme[14] (ECTP). The ECTP is a NHS England initiative which focuses on identifying opportunities to transform services at pace.

[12] Get it Right First Time, 2017, *Ophthalmology National Report*
[13] The Royal College of Ophthalmologists, 2016, *The Way Forward*
[14] NHS England, 2019, *Elective Care Transformation Programme: Ophthalmology*

In early 2019, the programme published an ophthalmology handbook, drawing on best practice to provide practical guidance on changes to service delivery. The handbook and case studies look at streamlining investigations and diagnostics, utilising virtual clinics and diversifying the workforce to better manage rising need.

In October 2020, NHS England also produced an ophthalmology roadmap that sets out what systems can do now to scale up solutions to safely restore eye care services, following the Covid-19 pandemic, to minimise and prevent irreversible sight loss for patients, and also transform the way we deliver services going forward.

The five opportunities the roadmap sets out are:

1. Implement integrated eye care pathways across primary, secondary and community care
2. Implement risk stratification and failsafe processes to reduce the risk of patient harm
3. Implement remote consultations for all appointments where possible and safe to do so
4. Implement virtual diagnostic clinics for all appointments where possible and safe to do so
5. Implement patient-initiated follow-up (PIFU) care where appropriate

3.4. The Royal College of Ophthalmologists (RCOphth)

The Royal College of Ophthalmologists (RCOphth) published *The Way Forward*[15] in 2016, a major analysis of the provision of ophthalmology services. The report details options to help meet current and future demand for ophthalmology services across four main sub-specialities; Cataract, Glaucoma, Medical Retina (encompassing macular degeneration and diabetic eye disease) and emergency eye care.

The Royal College of Ophthalmologists has also produced some guiding principles to support providers of ophthalmology services to ensure a safe and efficient process for outpatients[16]; of most relevance in this context is that there should be a range of review options available depending on clinical risk, optimising use of the full multidisciplinary team, including non-medical clinical staff-led clinics, virtual clinics, telephone reviews, and use of community and primary care settings, as appropriate.

3.5. The College of Optometrists

The College of Optometrists is the professional body for Optometrists. It qualifies the profession and delivers the guidance, development and training to ensure optometrists provide the best possible care.

The College's five year plan aims to champion the role and expertise of optometrists, support them to achieve excellence in their practice, and enable them to develop their skills and

[15] The Royal College of Ophthalmologists, 2016, *The Way Forward*
[16] The Royal College of Ophthalmologists, 2018, *Ophthalmology outpatients: safe and efficient processes*

careers. It sets out priorities for the next five years and is built upon four pillars of immediate, medium and long term activity as outlined below:

1. Defining and inspiring excellence in optometry
2. Enabling optometrists to maximise their skills and develop their careers
3. Representing and amplifying the expert voices of optometrists
4. Embedding insight and evidence at the centre of the profession

Many optometrists deliver extended primary eye care services, outside of their national contract for sight testing. These services include:

- Adult Low Vision
- Children's Vision (Paediatrics)
- Covid-19 Urgent Eyecare Service (CUES)
- Glaucoma Referral Filtering and Monitoring
- Healthy Living Optical Practice (HLOP) Framework
- Integrated Cataract (pre/post-operative)
- Maculopathy Referral Filtering and Monitoring
- Minor Eye Conditions Service (MECS)
- Medical Retina Monitoring (Hydroxychloroquine)
- People with Learning Disabilities

The Local Optical Committee Support Unit (LOCSU) has developed template clinical pathways for various eye conditions, which Local Optical Committees (LOCs) and commissioners can use as a basis for local extended primary eye care services.

3.6. The Clinical Council for Eye Health Commissioning (CCEHC)

The Clinical Council for Eye Health Commissioning[17] (CCEHC) has been set up to bring together representatives from multiple professional bodies, to provide collective input to policy-makers, commissioners and providers. An example is its' Systems and Assurance Framework for Eye health (SAFE), which aims to help commissioners develop a more strategic and consistent approach to service planning.

The Clinical Council for Eye Health Commissioning 2019 report; *Priorities for Delivering the NHS Long Term Plan*[18] sets out a number of ways in which the redesign of eye health pathways can support the delivery of the NHS Long Term Plan:

- Including eye health in the development of Integrated Care Systems (ICSs) and their operating infrastructure for networked care, governance, quality assurance and health information

[17] The Clinical Council for Eye Health Commissioning, 2018, *Systems and Assurance Framework*
[18] The Clinical Council for Eye Health Commissioning, 2019, *Priorities for Delivering the NHS Long Term Plan*

- Re-design of services to allow specialist outpatient care to prioritise diagnosis and active management and treatment
- Establish IT connectivity across primary, community and secondary care to enable continuity of patient care

3.7. Net Zero NHS

With the NHS being responsible for 6.3% of England's total carbon emissions, and 5% of its total air pollution[19], there is increasing pressure for health services to be delivered in ways that are environmentally sustainable. This has led to an NHS Plan outlining how the NHS will tackle what has been described as a climate healthcare emergency, with the aim of making the NHS 'net zero' by 2050[20].

Committing to reaching net zero by 2050 means significantly reducing our carbon emissions within the UK through looking at pharmaceuticals, estates, procedures and travel. The NHS Long Term Plan is clear on its goals to reduce the burden of unnecessary travel within the NHS, encouraging service delivery to happen virtually where appropriate, and locally where patient attendance is required. With 17% of the NHS' carbon emissions being attributed to patient and public travel, it is evident that there is great scope for improvement.

With the UK as a whole committed to reducing greenhouse gas emissions by 34% in 2020 and 80% by 2050, sustainable changes in service models are required to reduce healthcare related carbon emissions in line with wider national targets. As a result, we need to pay due attention to the carbon impact of service redesign and new models of care at a local level, focussing on projects that will improve efficiency from a carbon and cost perspective, while maintaining and improving the quality of care received by patients.

Although some improvement can be made by increasing efficiency at the operational level (for example, through use of energy-efficient technologies) this alone is unlikely to be sufficient. The scale of the challenge suggests a fundamental transformation in service models will be needed, so the transformation of this service presents an opportunity to work towards the Net Zero NHS goal. Potential areas of consideration for carbon reduction during transformation include the number of sites services are offered from, the locations of those sites in relation to the population they serve and redefining criteria for face-to-face and virtual appointments, especially where the overall quantity and mileage of journeys can be reduced and optimised, including in relation to the workforce. It is likely that transformed service models would adopt environmental sustainability as a core value, akin to equity or accessibility, with meaningful mechanisms to monitor and hold the system to account for its environmental performance. These proposals offer improvements through the likely need for fewer appointments across the

[20] NHS England, 2020, *Delivering a 'Net Zero' National Health Service*

clinical pathways described and therefore a reduced need for repeated appointments and related travel.

East Sussex Healthcare Trust's Building for our Future (BFF) programme[21] will transform the environment in which we provide care for patients in East Sussex. This transformation programme is not directly dependent on Building for our Future but will be aligned to it to ensure that changes made inform, and are informed by, the wider Building for our Future plans. Together these programmes will be a complete redesign of our ageing hospitals, taking advantage of new technologies and improvements in healthcare to ensure that we can meet the future needs of our population. The estates implementation of any transformation in the service will be delivered in harmony with East Sussex Healthcare Trust's Building For our Future programme.

Our approach to achieving net zero emissions will be iterative and adaptive and aims to continuously improve with an increasing level of ambition. It is dynamic work we are committed to as carbon dioxide assessments are undertaken across all services, as technology evolves, the regulatory environment changes, resources materialise and more data becomes available.

4. Local context – our response to the national drivers across Sussex and within East Sussex

4.1. Sussex Health and Care Partnership

The Sussex Health and Care Partnership brings together 13 organisations into what is known as an Integrated Care System (ICS). These organisations include the Local Authorities, NHS Clinical Commissioning Groups (e.g. East Sussex CCG) and NHS Trusts (e.g. East Sussex Healthcare Trust) with responsibility for health and care services across Sussex. From 1 April 2022, the Integrated Care System will be established as a statutory NHS body.

The Sussex Health and Care Partnership 'Strategy Delivery Plan' identified planned care services as one of the core priorities for all health systems across the Sussex Health and Care Partnership. The plan is the Sussex response to the NHS Long Term Plan and has a focus on the key priorities for reducing waiting times and digitally transforming outpatient care to improve access and increase patient choice.

These plans aspire to change the profile of our planned care activity in Sussex, , through our commitment to reduce face-to-face outpatient appointments and increase digital appointments, increase advice and guidance provision and encourage patients, through initiatives like patient initiated follow-up (PIFU), to increase the responsibility, ownership and decisions made around their own care. The Sussex Health and Care Partnership believes that digital tools and new technologies will allow local people to access and interact with their care in radically different ways[22].

[21] ESHT Building Better for our Future Programme, http://nww.esht.nhs.uk/building-for-our-future/
[22] Introduction | Community Eye Care Guidelines (scot.nhs.uk)

The NHS Long Term Plan includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years, up to 2024-25. The aim is to harness digital technology to provide a more convenient service for patients, whilst enabling services to make best use of their workforce and wider resources in a way that balances service provision with the expected growth in demand. It will also reduce travel time for staff and patients, improve patient experience and reduce the carbon footprint of the Sussex healthcare system. We will do this by increasing the use of digital tools to transform how outpatient services are offered and provide more options, better support, and properly joined-up care at the right time in the optimal care setting through a blend of face-to face and virtual outpatient appointments, as appropriate for the care required.

A Sussex Outpatient Transformation Board has been established to own the transformation work plans across the Integrated Care System, working with the three places (Brighton & Hove, East Sussex, and West Sussex) on local action plans to progress this programme. The board has defined the Integrated Care System vision as “having the right clinicians, the right place to treat the patient, and the right outcomes against which to measure treatment, where patients do not have to attend an outpatient appointment unless absolutely required to do so”.

In addition, from the 1 April 2022, the responsibility of primary care services, including optometry contracts, will be transferred from NHS England to the Integrated Care System. Therefore, there may be further opportunities that arise following this change.

4.2. East Sussex Healthcare Trust Ophthalmology Transformation Programme

In East Sussex Healthcare Trust, a clinically-led Ophthalmology Transformation Working Group (OTWG) was established in 2019 and the group identified the need to change clinical practice and the model of care to ensure that services deliver timely, high quality care in the right place that is sustainable over the long term. Development of the service will enable new guidelines to be met and the changing needs of the local population to be effectively served. The following principles were developed for the future strategy of acute ophthalmology:

To engage with key stakeholders to discuss the challenges that ophthalmology services in East Sussex faces, and work with them to jointly identify solutions that:

- Address the issues around demand and capacity
- Align to national and local recommendations, best practice and priorities
- Address the issue of longer term clinical, operational and financial sustainability of ophthalmology across East Sussex
- Have due regard to resourcing requirements so that we can make best use of our resources.

While the ophthalmology department at East Sussex Healthcare Trust has worked hard to increase its core capacity and improve their skill mix to meet increases in demand, there continues to be a number of challenges that need to be addressed for the East Sussex system to deliver a service that meets the needs of the patient population by;

- Providing a clinically excellent ophthalmology service
- Reducing avoidable sight loss and improving the eye health of our patient population
- Increasing our ability to look after a growing and ageing population
- Providing increased support and development for the ophthalmology workforce
- Developing services that are financially, clinically and environmentally sustainable.

4.3. Sussex Ophthalmology Transformation Programme

A Sussex-wide ophthalmology workstream is reviewing the whole ophthalmology pathway with a particular focus on integrating the work of community optometrists with that of hospital departments. This is a Sussex-wide piece of work based on national recommendations and best practice. The expectation is that, over the next one to two years, community optometrists, i.e. “high street opticians”, will become increasingly involved in delivering parts of the ophthalmology service that does not require attendance at a hospital, often as part of a shared care arrangement between the hospital and the specialist high street optometrist. The ophthalmology department at East Sussex Healthcare Trust is actively involved in this programme and the East Sussex Healthcare Trust transformation directly links into the Sussex programme, although is not dependent on it.

Of particular relevance to the East Sussex Healthcare Trust Ophthalmology Transformation is the potential for a ‘hub and spoke’ approach to diagnostic tests, in which community optician practices could undertake new and repeat investigations on behalf of a hospital diagnostic hub, sharing images for consultant review. Many ophthalmic pathways rely on patients regularly having specialised diagnostic tests, such as Optical Coherence Tomography and Visual Field Testing, as part of the ongoing management of their condition. As the number of optician practices with the capacity to undertake these tests has grown – along with the number of optometrists with advanced skills – there is greater scope than before to create integrated pathways that enable patients to be tested within the community in locations closer to home as part of their NHS pathway and for these tests to be reviewed by the hospital.

Central to the above is work that has already commenced to enhance digital communication between the hospital department and community optometrists. The hospital is currently in the process of upgrading the Medisoft digital ophthalmology records system to Medisite. This is a cloud-based system that enables real-time access to, and sharing of, patient records between clinicians regardless of where they are based. It includes a community portal to support shared care and information exchange between trust and community clinicians, enabling a level of collaboration that has not previously been achievable. Parallel to this development, the Sussex system is piloting, at East Sussex Healthcare Trust, a new Electronic Eyecare Referral System (EERS), that enables community practitioners to refer directly and electronically to the hospital, instead of using paper referrals and, vice versa, to have patients discharged back into their care following, for instance, cataract surgery. The intention is that Electronic Eyecare Referral System will dovetail with Medisite, to create an efficient, single electronic management system that forms the foundation of integrated acute-and-community eyecare pathways.

Similarly, the Sussex programme expects to introduce new or revised pathways for cataract and glaucoma in the course of 2021/22, which will also see more community optician practices delivering parts of these pathways, reducing the need for patients to always attend appointments at a hospital site. The national pathways that the Sussex-wide programme is informed by can be found in appendix 9.

However, the Sussex-wide transformation programme is outside the scope of the East Sussex Healthcare Trust transformation, therefore this pre-consultation business case is centred on the changes that East Sussex Healthcare Trust itself is able to make within the context of the Sussex programme.

In East Sussex, our focus on proactively managing population health, better anticipating care needs and integrated working across health and social care, will enable us to deliver the best possible outcomes for local people, and achieve the best use of collective public resources. There is a strong national and international evidence base that demonstrates the value of integrated working in improving patient experience and outcomes, as well as better value for money. Overall, redesigning our ophthalmology services within the context of the wider system will help to moderate need for hospital services, protecting them so they are available when they are most needed by our population in a more sustainable way.

4.4. South East Region Eye Care Improvement Programme Board

The South East Region Eye Care Improvement Programme aims to provide a strategic overview for the region and to ensure and support systems in developing their plans in line with the eye care planning guidance; to:

- Provide accountability, challenge and assurance of programme delivery across the South East England region and to report on progress nationally.
- Ensure coherence and a common sense of direction across the plans
- Facilitate and access areas of good practice and to avoid duplication of effort where appropriate
- Identify where further work, within or across plans might be needed to achieve the aims of the eye care programme.

The national eye care planning guidance aims to:

- Improve the equity of access within and between Integrated Care Systems and reduce the backlog of cases through the establishment of a Patient Tracking List (PTL) and setting up High Volume Low Complexity (HVLC) surgical pathways.
- Implement standardised integrated pathways across cataracts, urgent eye care, medical retina and glaucoma pathways.

- Risk stratification for new and follow up patients, failsafe processes and regular recording of delays to follow up patients to reduce harm.
- Embed digitally enabled system transformation.

The opportunities for the South East region are:

- High Volume Low Complexity pathways for cataract care, with pre and post op pathways provided in community.
- Development of virtual imaging provision.
- Theatres productivity / independent operational productivity review
- Procurement of electronic eye referral systems will enable pathway developments.
- Refined referral management supported by training and education offers.
- Co-produced workforce modelling pilot (with Integrated Care System and Health Education England (HEE))

4.5. Making the best use of our resources

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country. Within this, many people live their later years in ill-health, often with more than one long term condition, and this is driving increasing need and pressure on health and care services and resources across our health and care system, as is outlined in this Pre-Consultation Business Case in relation to ophthalmology services.

The opportunities for transforming ophthalmology services are expected to improve patient experience through quicker care, more targeted follow up care alongside improved use of our resources (including workforce, equipment and estates). However, these benefits are contingent on the consolidation of ophthalmology services.

4.6. Mental Health and its relationship with ophthalmology

Older people with sight loss are almost three times more likely to experience depression than people with good vision. Depression is a significant public health issue, with a prevalence of 10.5% in East Sussex[23]. Additionally, agoraphobia and social phobia are the most prevalent anxiety disorders in visually impaired older adults[24]. Reducing avoidable sight loss is therefore important for reducing depression and improving wellbeing, but there must also be a focus on ensuring blind and partially sighted people have access to emotional support and rehabilitation services from the point of diagnosis onwards.

An estimated 250,000 people in the UK have both dementia and sight loss[25]. This number is likely to increase as the population ages. People with dementia are more likely to experience visual misinterpretations and hallucinations. Sight loss exacerbates the symptoms of dementia, impairing orientation, cognition and communication. Sight loss decreases quality of life and

[23] http://www.eastsussexjsna.org.uk/JsnaSiteAspx/media/jsna-media/documents/nationalprofiles/profileassests/MH%20JSNA%20Profiles/EastSussex-MH-JSNA-Profile-2017.pdf
[24] Hilde et al. *Major Depressive and Anxiety Disorders in Visually Impaired Older Adults.* Investigative Ophthalmology & Visual Science. February 2015, Vol.56, p849-854.
[25] https://setrust.hscni.net/wp-content/uploads/2019/09/dementia-and-sight-loss-2_0.pdf

increases the care needs of this group. People with dementia may be less likely to access eye health care, both for routine sight tests and for evaluation of symptoms. They may be also less likely to be aware that they have problems with their sight. The Royal College of Ophthalmologists has published a quality standard for people with sight loss and dementia in ophthalmology departments.

Many of the challenges for patients with dementia also apply to care home residents. NHS domiciliary care is available for all care home residents, but this relies on care home managers recognising the need for regular sight tests in residents who may be unaware of, or unable to communicate, a problem with their vision.

Across Sussex, we have identified improving mental health as a key priority as well as mental health services as one of the core priorities for all health systems across the Integrated Care System, challenging systems and processes across physical, social and mental health settings to more effectively address the physical and mental health integration agenda. Whilst this is not within the scope of this pre-consultation business case, there is a significant work programme in place to support improved mental health and well-being as part of our Integrated Care System mental health collaborative and it is an important part of our wider work to support improved ophthalmic health, alongside our work on prevention and promoting good health.

5. Our local health needs

East Sussex has a varied and diverse population and is a county with contrasting characteristics across urban and rural communities, where 74% of the population live in urban areas, and a quarter live in more rural towns, villages or dispersed dwellings. As of 2019, the population size was approximately 560,000. The East Sussex population is predicted to increase by 64,000 people over the 15 year period 2019 to 2034 (11.6%)[26]. people over the 15 year period 2019 to 2034 (11.6%)[27]. Population growth over the period will mostly be among the over 65s as the population continues to age. The population is older than the England average, with the proportion of over 65 year olds varying by district and borough:

Table 1: Percentage of over 65s in East Sussex localities, 2019[28]

Locality	% of over 65s
Hastings	20.3%
Eastbourne	25.1%
Lewes	25.8%
Wealden	26.1%
Rother	32.1%

Figure 1: East Sussex age profile, 2019[29]

[26] East Sussex County Council, April 2021, *Demographic projections…in brief*
[27] East Sussex County Council, April 2021, *Demographic projections…in brief*
[28] East Sussex County Council Public Health, Percentage of over 65s in East Sussex
[29] East Sussex County Council Public Health, East Sussex age profile, 2019

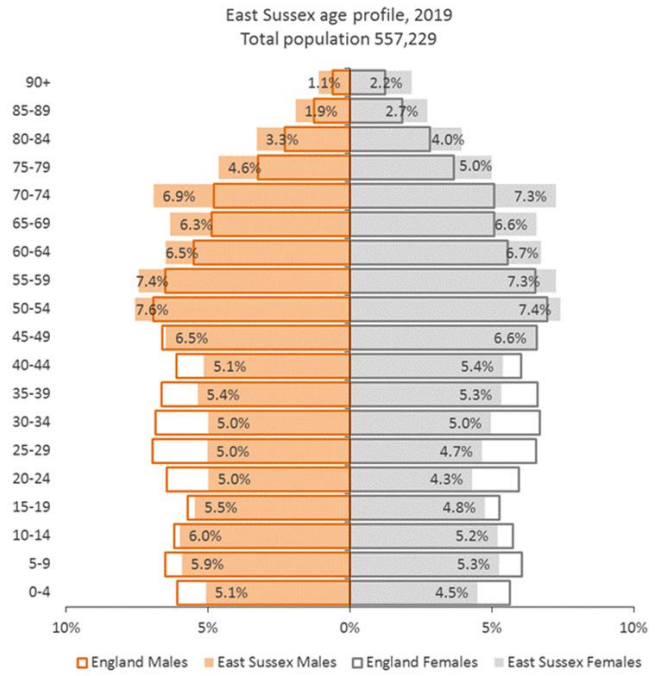


Figure 2: East Sussex Predicted Population Growth 2018 – 2030[30]

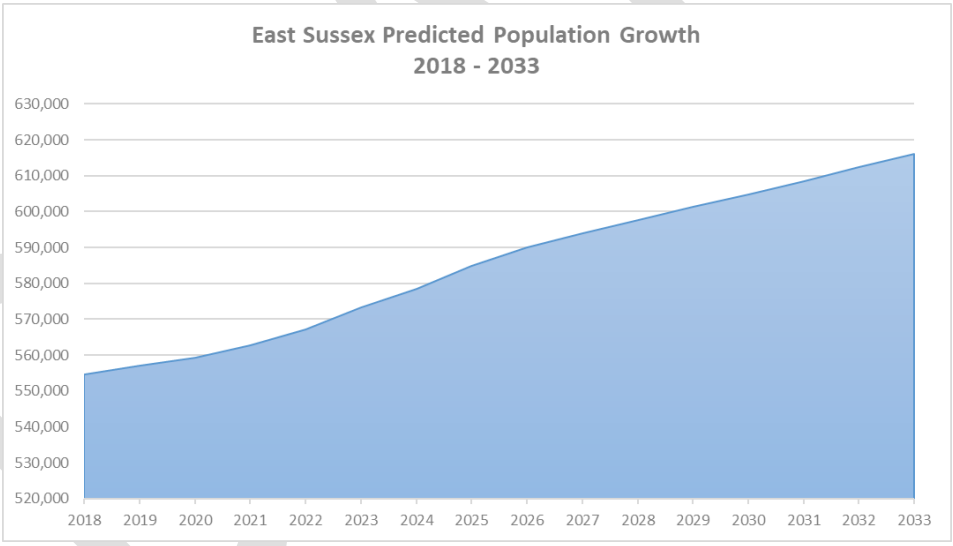
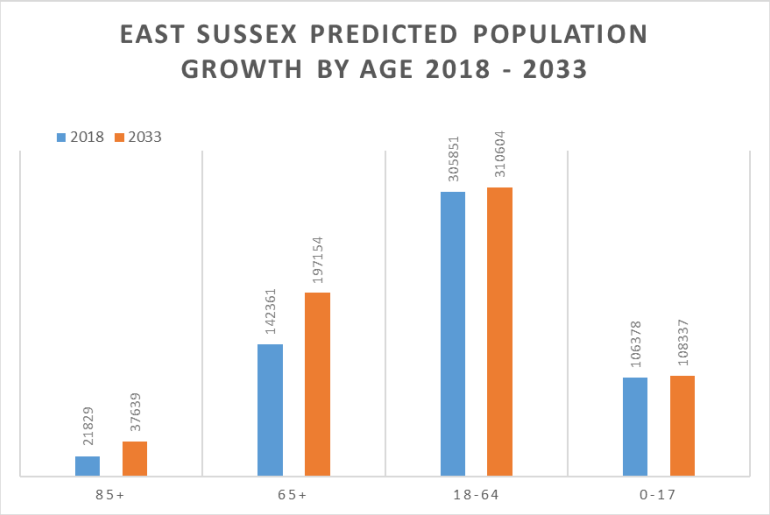


Figure 3: East Sussex Predicted Population Growth by Age[31]

[30] East Sussex County Council Public Health, East Sussex predicted population growth
[31] East Sussex County Council Public Health, East Sussex predicted population growth by age



The growth in the over 65 year old cohort is of particular significance because most ophthalmic conditions – cataract, glaucoma, age-related macular degeneration – occur in the older population, indicating that, over the next 15 years, need will grow disproportionately to general population expansion. Due to the age distribution in East Sussex, the county has a higher percentage of people living with sight loss than the national average.

The 2019 East Sussex Long Term Plan response identified that the East Sussex population has the following characteristics and health and care needs[32][33].

- The number of young people (aged 0-17) will increase by 3% in the next three years
- The proportion of people over 65 in East Sussex is already considerably higher than nationally at 26% in East Sussex compared to 18% in England. By 2023 this will have risen to 27% (19% in England)
- The proportion of those aged over 85 is already significantly higher in East Sussex than nationally and is expected to continue to rise sharply. It is this group that are the most likely to need our services (more detail can be found in our Equality and Health Inequalities Assessment in Appendix 1)

[32] Sussex Health and Care Partnership, 2019, *East Sussex Placed Based Response to the Long Term Plan (draft)*
[33] The information about East Sussex that has been used to understand our population health and care needs and the priorities for East Sussex can be found in the following documents:
East Sussex Joint Strategic Needs Assessment: http://www.eastsussexjsna.org.uk/
Director of Public Health Report 2018/19 "Picture of East Sussex":
http://www.eastsussexjsna.org.uk/publichealthreports
State of the County 2021, Focus on East Sussex':
https://www.eastsussex.gov.uk/yourcouncil/about/keydocuments/stateofthe-county/
Supporting People to Live Well in East Sussex', the market position statement for adult services and support (April 2019): https:// https://new.eastsussex.gov.uk/social-care/providers/funding/market
Sussex and East Surrey Sustainable Transformation Partnership Population Health Check:
https://www.seshealthandcare.org.uk/2019/02/population-health-check-published-across-the-stp/

- Health and its determinants are not distributed evenly across the county, with a strong link between poverty and poor outcomes; rurality can also impact access to services (more detail can be found in our Equality and Health Inequalities Assessment in Appendix 1)
- The number of children in need of help and protection is rising locally and nationally, linked to the increase in families experiencing financial difficulties
- There is a growth in the numbers of children with statements of Special Education Needs (SEND) or Education Health and Care Plans, some of whom will have complex medical and care needs
- Demand for health and social care is set to continue to increase, both as a result of the growth in the proportion of older people in the population and the complexity of their needs with increasing longevity, frailty and multi-morbidity; on average men spend the last 15.5 years of life in poorer health, while women spend 20.2 years in poorer health
- There is a clear gap in life expectancy between people who live in the most and least deprived areas of the county; this gap is 7 years for men and 4.3 years for women while ward level differences are even greater.

The tables and figures that follow provide further detail about the health needs of local people.

Table 2: Number of people in East Sussex living with a Limiting Long-Term Illness (LLTI), 2019[34]

	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
People with LLTI	107,145	20831	19,956	19054	21242	26,062
% of total population	20%	21%	22%	20%	23%	18%

[34] East Sussex County Council Public Health, Number of people living in East Sussex with a LLTI

Figure 4: Map of areas of people with Limiting Long-Term Illness in East Sussex CCG area[35]

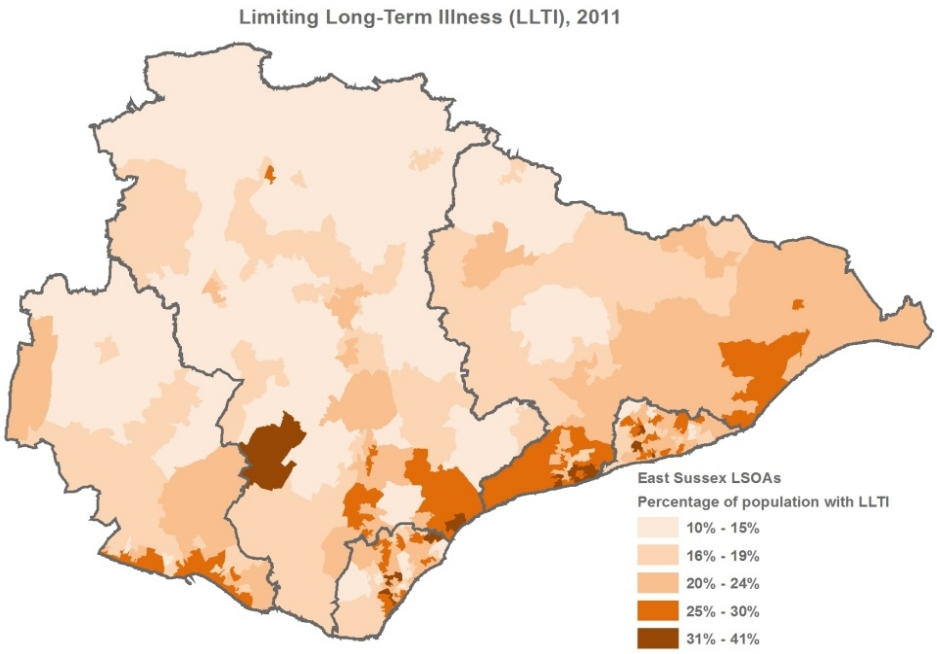
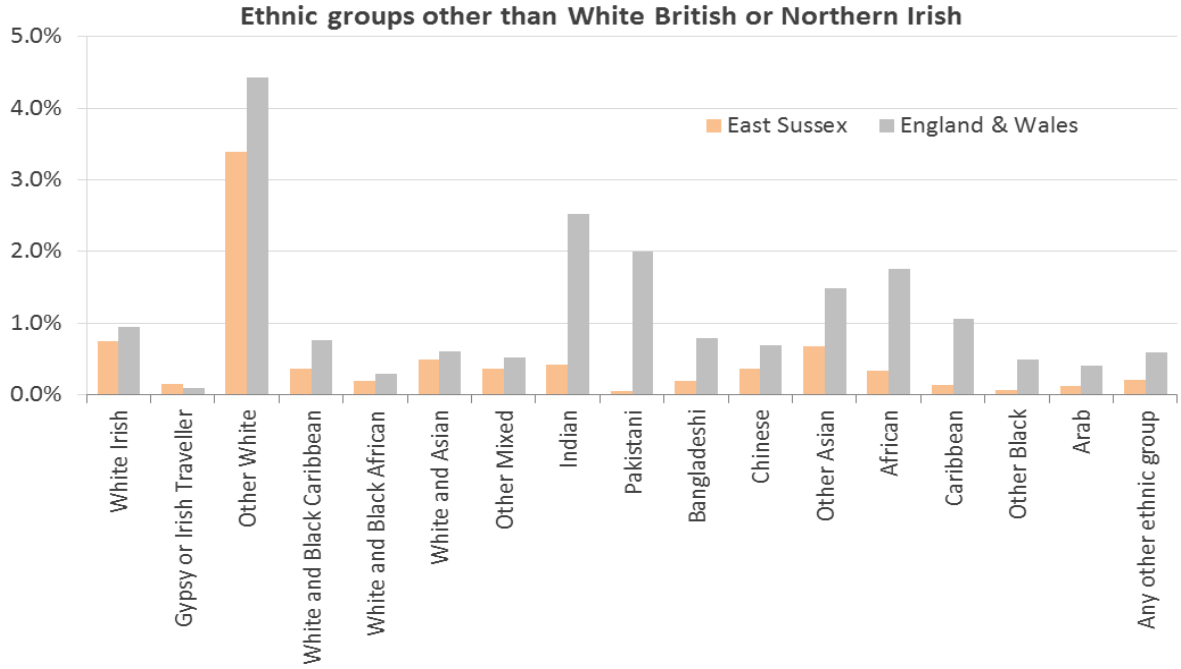


Figure 5: Race and ethnicity populations in East Sussex CCG area[36]

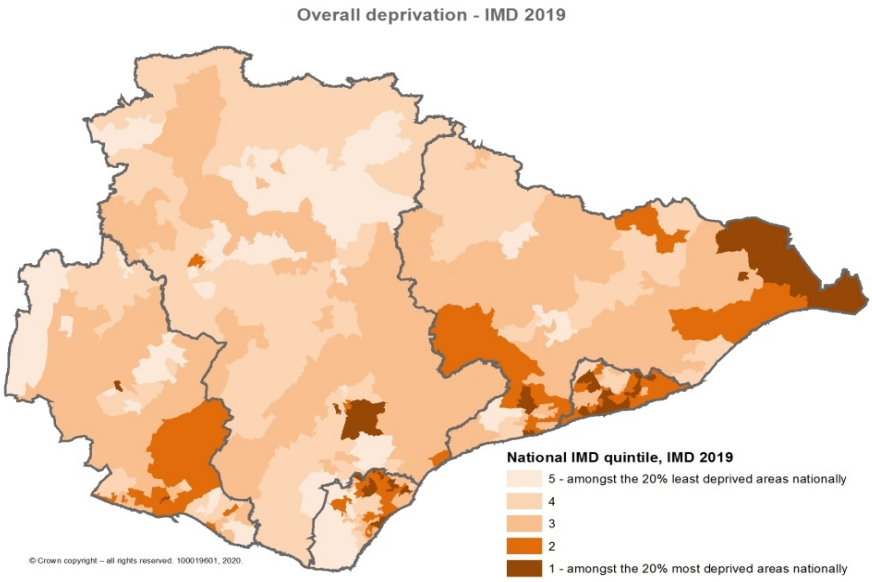


In the East Sussex CCG area, the most deprived wards are Eastbourne Central, Eastbourne

[35] East Sussex County Council Public Health, Map of areas of people living with a LLTI
[36] East Sussex County Council Public Health, Race and ethnicity population in East Sussex

North, Hailsham, Hastings and Rother East. Figure 6 shows the areas of deprivation in the East Sussex CCG areas.

Figure 6: Map of areas of deprivation in the East Sussex CCG area[37]



The deprivation is slightly lower overall in East Sussex than the England average, however this varies greatly between district and borough council area:

Table 3: Percentage of deprivation in East Sussex by district and borough council area[38]

Locality	% of deprivation
Lewes	4%
Wealden	9%
Rother	13%
Eastbourne	26%
Hastings	49%

The East Sussex Joint Strategic Needs Assessment (JSNA)[39] key lifestyle indicators for these deprived localities, compared to East Sussex, include:

- A low proportion of babies fully or partially breastfed at 6-8 weeks old;
- A high proportion of children with excess weight;
- Childhood immunisation rates below the 95% population target level;
- A significantly lower uptake of national cancer screening programmes;
- A higher rate of adults on drug treatment programmes;
- A higher rate of mortality from Chronic Obstructive Pulmonary Disease;

[37] East Sussex County Council Public Health, Map of areas of deprivation in East Sussex
[38] East Sussex County Council Public Health, Percentage of deprivation by district and borough in East Sussex
[39] http://www.eastsussexjsna.org.uk/

- A higher rate of premature mortality from circulatory diseases, cancer, liver disease and respiratory diseases;
- A higher prevalence of GP-reported smoking in 15yrs+;
- A higher prevalence of GP-reported depression;
- A higher prevalence of GP-reported hypertension, atrial fibrillation, Chronic Obstructive Pulmonary Disease, diabetes, chronic kidney disease and palliative care needs.

As part of our review we have considered local health needs with our partners including East Sussex County Council (ESCC) Public Health, NHS providers and the voluntary and community sector. People with these health needs have access a wide range of services available locally. Some of these services are summarised in Table 4 below. In addition, local people with the above life indicators are supported by GP practices across East Sussex.

We are confident that our system will continue to address the needs of local people and communities by providing integrated universal and targeted services to improve health outcomes and to further reduce health inequalities.

Table 4: Support for lifestyle indicators based on the Joint Strategic Needs Assessment[40]

Key lifestyle indicators for the most deprived East Sussex localities	Examples of existing local services	What are we doing to improve the lifestyle indicators?
Low proportion of babies fully or partially breastfed at 6-8 weeks	East Sussex Healthy Child Programme supports the best possible start in life for all babies and young children so that they develop well and are safe and healthy.	• Develop and sustain local Primary Care Network leadership to prevent ill-health and address equality and health inequalities • Enhance and integrate prevention services and take action on reducing health inequalities in partners' workforce plans. • Build on the strengths, skills, knowledge and networks that individuals, families and communities have to enable people to take more control of their health and wellbeing.
High proportion of children with excess weight	The East Sussex whole-system healthy weight plan aims to increase healthy weight through system-wide action on healthy eating and physical activity.	
Childhood immunisation rates are below the 95% population target level	East Sussex Healthy Child Programme supports the best possible start in life for all babies and young children so that they develop well and are safe and healthy.	
Uptake for national cancer screening programmes is significantly lower	GP Practices targeted and supported to engage with those patients who have not responded to national cancer screening programme invitations to encourage participation.	

[40] http://www.eastsussexjsna.org.uk/

High rate of adults on drug treatment programmes	Personal and community resilience programme supports prevention and early intervention. East Sussex drug and alcohol recovery service provides advice and support collaboratively with statutory and voluntary and community sector organisations.	• Collaboratively with our key partners continue to engage with targeted population groups and communities in order to understand how best to support them • East Sussex has comprehensive multi-agency strategies to tackle obesity (East Sussex Healthy Weight plan 2021-26) and reduce the harm caused by alcohol (East Sussex alcohol harm reduction strategy 2021-26)"
High rate of mortality from Chronic Obstructive Pulmonary Disease	Multi-disciplinary health and social care teams support people with long-term conditions to be diagnosed earlier and provided with more personalised care in the community or at home.	
High rate of premature mortality from circulatory diseases, cancer, liver disease and respiratory diseases	Multi-disciplinary health and social care teams support people with long-term conditions to be diagnosed earlier and provided with more personalised care in the community or at home.	
High prevalence of GP-reported smoking in 15yrs+	GP Practices targeted and supported to engage with those patients who are known smokers and encourage participation in smoking cessation programmes. One You East Sussex provides high-quality, evidence-based smoking cessation support. Patients are four times more likely to quit smoking for good with their support.	
High prevalence of GP-reported depression	Multi-agency partners provide accessible mental health advice and support services in a range of settings and communities. Services enable people to manage and maintain their mental health and wellbeing, so that they and their carers can manage their condition.	
High prevalence of GP-reported hypertension and diabetes	Multi-disciplinary health and social care teams support people with long-term conditions to be diagnosed earlier and provided with more personalised care in the community or at home.	

Having considered how the proposals within this Pre-Consultation Business Case impact on health inequalities and how we can take action to address them through this proposal, we will also continue to work with key partners and stakeholders (including primary, community and voluntary sectors, around access to prevention services that will further address health inequalities.

5.1. Health Inequalities

Reducing health inequalities and the gap in life expectancy in the county requires coordinated action with services that impact on the wider determinants of health, such as housing, employment and leisure, as well as targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes. Below is a summary of some of the health inequalities that have been identified during the course of this work programme (more information on the impacts this programme will have on the population can be found in Section 10):

- Race/ethnicity
  - Black African and Caribbean people are 4 – 8 times more at risk of developing glaucoma compared to white people[41]
  - South Asian people are 3 times more at risk of diabetic eye disease compared to white people (RNIB, 2016)
  - Age-related Macular Degeneration is a leading cause of sight loss in the UK, and is more prevalent in the white population (RNIB, 2016)
  - Evidence suggests that people from black and ethnic minority communities do not receive the same level of access to eye care services compared to most white people (RNIB, 2016)
  - Sussex Black, Asian and Minority Ethnic (BAME) Population Needs Review (2021) states that there is a strong association between socio-economic disadvantage and ethnicity. People from a minority ethnic community are more likely to experience multiple aspects of deprivation; including lower income, poorer housing, more likely to be a victim of crime, unemployment/low paid work.

- Sex
  - Women are at a higher risk of developing cataracts and primary angle closed glaucoma than men (NICE, 2020)
  - It is estimated that 60% of blindness worldwide is among women, underlining that gender equity in eye health has not yet been achieved (Inequality and Inequity in Eye Health, 2016)

- Age
  - Sight loss and ophthalmic conditions affect people of all ages, but as we get older we are increasingly likely to experience issues with our sight. Sight loss is more common in those aged 75 and over, with age-related macular degeneration, glaucoma and cataracts all being more common as people age (RNIB, 2016)
  - Primary open angle glaucoma affects 1% of the population aged over 40, 3% of the population aged over 60, and 8% of people over 80 (NICE, 2020)

[41] The State of the Nation: Eye Health 2016, RNIB, https://www.rnib.org.uk/sites/default/files/RNIB-State-of-the-Nation-2016-APDF%20format.PDF

  - It is estimated that 1-3% of the population in western countries suffer with an advanced stage of age-related macular degeneration. Therefore, it is estimated that approximately 16,500 people would have advanced age-related macular degeneration across East Sussex (NICE, 2020). Age-related macular degeneration mainly affects those 50 years or older (RNIB, 2009)
  - Most cataracts occur as a result of ageing and are most common in people aged over 60 years. It is estimated that 16% of people aged 65-69, 24% of people aged 70-74, 42% of people aged 75-79, 59% of people aged 80-84, and 71% of people 85 and over are visually impaired due to cataracts (NICE, 2020)
  - Amblyopia (or "lazy eye") is reduced vision in one eye caused by abnormal visual development early in life. It is the most common cause of vision problems in children, affecting 3.6% of children. We estimate that across East Sussex there are 500 children aged 4-5 referred into East Sussex Healthcare Trust per annum for suspected amblyopia
  - Evidence suggests that there are more than 25,000 blind and partially sighted children in the UK, and around 15,000 aged 17-25 (RNIB, 2016)
  - Children who are at higher risk of vision impairment are:
    - Very premature and very low birth weight babies and children; from the most economically deprived backgrounds
    - Children and young people from some South Asian ethnic groups
    - Children with learning difficulties

- Disability (including long-term conditions)
  - Approximately 20% of the total population have a long-term health problem or disability that limits day to day activities in East Sussex, which is higher than the national and regional average
  - 31.9% of women and 26.2% of men in East Sussex have two or more long-term conditions
  - In 2020, there were 65,510 people in East Sussex over the age of 65 with a long-term condition whose ability to carry out day-to-day tasks were limited/significantly limited
  - Adults with a learning disability are ten times more likely to have eye problems, but are less likely to receive timely and appropriate care than the rest of the population (Vision care requirements among intellectually disabled adults: a residence-based pilot study, 1996)
  - Children with a learning disability are 28 times more likely to have a serious sight problem (Vision care requirements among intellectually disabled adults: a residence-based pilot study, 1996)
  - There are circa 3,300 people in East Sussex on the GP Learning Disability register

There is variation in the uptake of health checks by local people and in the recognition, recording and management of risk behaviours and physiological markers by GP practices.

We have a duty to take action on health inequalities and we know this has been exacerbated during the Covid-19 pandemic. We are committed to addressing health inequalities and, as we develop proposals to redesign services we will continue to involve local people. There are opportunities to work across the system to improve disease recognition and recording and

ensure pathways to support behavioural change are robust and accessible to local people. We will continue to do this as part of a comprehensive approach to ophthalmic diseases in East Sussex and Sussex more widely.

6. Case for Change

This section of the Pre-Consultation Business Case describes the key strategic drivers that have led the development of these proposals to transform acute ophthalmology services. These drivers informed our discussions during pre-consultation and options development and appraisal.

6.1. Current clinical provision

The ophthalmology services at East Sussex Healthcare Trust are consultant-led and provide emergency and planned care across the three acute district general hospitals, Bexhill Hospital, Conquest Hospital in Hastings and Eastbourne District General Hospital in Eastbourne, with some service provision within the community.

Figure 7: East Sussex Healthcare Trust's current ophthalmology service provision for adults and children (paediatrics)

Service/treatments, e.g.:	Conquest	EDGH	Bexhill	Community
Outpatients	✓	✓	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓	✓	✓
Monitoring/review (in person*)	✓	✓	✓	✓
Diagnostic testing	✓	✓	✓	✓
Pre- / post-operative assessment	✓	✓	✓	✓
Day surgery	✓	✓	✓	✗
Inpatient surgery	✓	✓	✗	✗
Non-elective (emergency)	✓	✓	✗	✗

*Virtual clinics have been developed during the COVID-19 pandemic, and this shift to non face to face activity will continue to be developed where clinically appropriate

NB: Green tick = service is provided, Yellow tick = service is partially provided, Red cross = service not provided.

Note: this transformation programme focuses on the services provided by East Sussex Healthcare Trust only, therefore the primary/community services (that provide eye tests, healthchecks/management, pre and post operative cataract assessments and glaucoma measures) included above table is out of scope of this programme.

Ophthalmology services at East Sussex Healthcare NHS Trust are Consultant-led and provide services for children (paediatric) and adults across three hospital sites. Paediatric services are also provided from community sites across Hailsham, Crowborough and Seaford, and these will remain as this Pre-Consultation Business Case is focussed on the provision of services across East Sussex Healthcare NHS Trust's three main hospital sites, Eastbourne District General Hospital, Conquest and Bexhill. East Sussex Healthcare Trust provide specialist medical and surgical ophthalmology services for the population of East Sussex. Medical ophthalmology involves diagnosis and management of disorders affecting a patient's vision, while surgical ophthalmology involves a surgical procedure to correct or improve a patient's vision, for example; cataract surgery.

Paediatric provision is as follows:

- Eastbourne District General Hospital: 1 paediatric session per week
- Bexhill Hospital: 1 paediatric session per month

- Conquest Hospital: 1 paediatric session per week

As part of continual service improvement, East Sussex Healthcare Trust provide a Glaucoma Referral Refinement clinic. The purpose of these appointments is to determine a patient's risk of having glaucoma. From the referral coming in the patient is booked into the Glaucoma diagnostic hub where various diagnostic tests are undertaken, Optical Coherence Tomography scan of patient's optic nerves and macula, measure patients' vision (Visual Acuity check) and intraocular pressures and a visual field examination. The Glaucoma Specialist reviews all of the information and makes clinical decision about the patient's eyes and sets the next appointment. This means that patients receive a confirmed diagnosis more quickly and where appropriate patients are being discharged from the service sooner. Referral refinement process enables patients to be seen by the right person at the right time.

Eye care provision can be described across three main tiers in the UK and locally as outlined below:

Table 5: Ophthalmic Service Provision

Care Setting	Service Description	East Sussex Provision
Primary Eye Care Services	Services provided by community optometrists that are necessary prior to referral for specialist ophthalmic opinion for example: • Refraction (eye sight tests and prescription for spectacles or contact lenses) • Identification of possible eye disease requiring referral	Widely available from 'high street' opticians
Community Ophthalmology Services	Services provided by optometrists within optician practices, to manage eye conditions that are at low risk of deterioration who are either referred by primary care for assessment or discharged from secondary care for monitoring, thereby providing care closer to people's home.	Variable availability, some services only provided in particular locations, including; Minor Eye Condition Service (MECS), pre/post-operative cataract assessments, glaucoma repeat measures

Hospital Eye Services	Specialist ophthalmic services for diagnosis, intervention and management of acute and chronic eye conditions; and emergency and urgent eye care.	Available at Conquest and Eastbourne District General Hospital acute hospital sites; partially from Bexhill hospital; and limited availability at Independent Sector hospitals

Community Ophthalmology

Whilst there is a range of community services in East Sussex the majority of ophthalmology provision for local people is centred at East Sussex Healthcare Trust.

Historically the provision of ophthalmology services in the community has been constrained for a number of reasons;

- Limited capability of community optometrists to autonomously manage patients with acute eye conditions such as glaucoma and age-related macular degeneration (AMD)
- Shared care pathways are currently varied across different localities
- IT infrastructure is limited, which prevents optometrists communicating seamlessly with hospital eye departments and sharing patient records and imaging
- Availability to acute-level diagnostic equipment in the community, such as Optical Coherence Tomography (OCT), Humphreys Field Tests, Applanation Tomography, is variable.

A major national ophthalmology programme commenced in early 2021, aimed at increasing community capability to facilitate services that are integrated across the care pathway. Over the last one or two years many optician practices have invested in equipment and training such that it is now more common for patients to be offered, for instance, a self-funded Optical Coherence Tomography scan as part of their routine eye examination. Similarly, while the number remains relatively small, more optometrists have upskilled or are interested in providing additional services. This means that there is now a greater opportunity to develop integrated pathways between the community and secondary care, however the number of optometrists qualified to autonomously manage patients remains limited.

A major shift though has been the introduction of the Electronic Eyecare Referral System (EERS) by NHS England/Improvement in early 2021. This is an electronic platform that could potentially overcome the current communication barriers between community and acute providers and unlock the potential for an integrated eyecare service. Within Sussex, Electronic Eyecare Referral System will be piloted in East Sussex from late 2021 to early 2022, to ascertain its' potential for standardisation across Sussex.

On the back of Electronic Eyecare Referral System, the Integrated Care System Ophthalmology Programme is initially focussing on standardising certain pathways across Sussex with a view to, in the short term, trialling electronically-driven enhanced services for cataract and glaucoma in East Sussex. Of particular relevance to the East Sussex Healthcare Trust Ophthalmology Transformation is the potential for a 'hub and spoke' approach to diagnostics, in which community practices could undertake new and repeat investigations on behalf of an acute diagnostic hub, sharing images for consultant review.

Simultaneously, the programme is reviewing the Minor Eye Conditions Service (MECS) model which is currently being piloted in the Eastbourne and Hastings areas of East Sussex. This is an NHS-funded service provided by some opticians, that acts as a 'first contact practitioner' for patients with common, minor eye ailments that might otherwise be referred to the hospital or result in an unnecessary A&E attendance. If the review shows that this is an effective pathway for patients and the wider system, we will most likely seek to expand coverage to the rest of Sussex.

It is likely to take time to develop a mature integration of community and acute eyecare services and, over the period ahead, the Integrated Care System programme will also look at other pathways which might lend themselves to shared care, such as those for some retinal conditions and children's pathways.

Most local people in the western part of East Sussex receive their hospital eye service from the Sussex Eye Hospital in Brighton (part of University Hospitals Sussex East NHS Trust previously Brighton and Sussex University Hospitals NHS Trust) and those in the northern part are referred to the Maidstone Tunbridge Wells NHS Trust. The focus of this Pre-Consultation Business Case is on the paediatric and adult pathways relating to patients who use services at East Sussex Healthcare Trust and the surrounding areas.

Activity

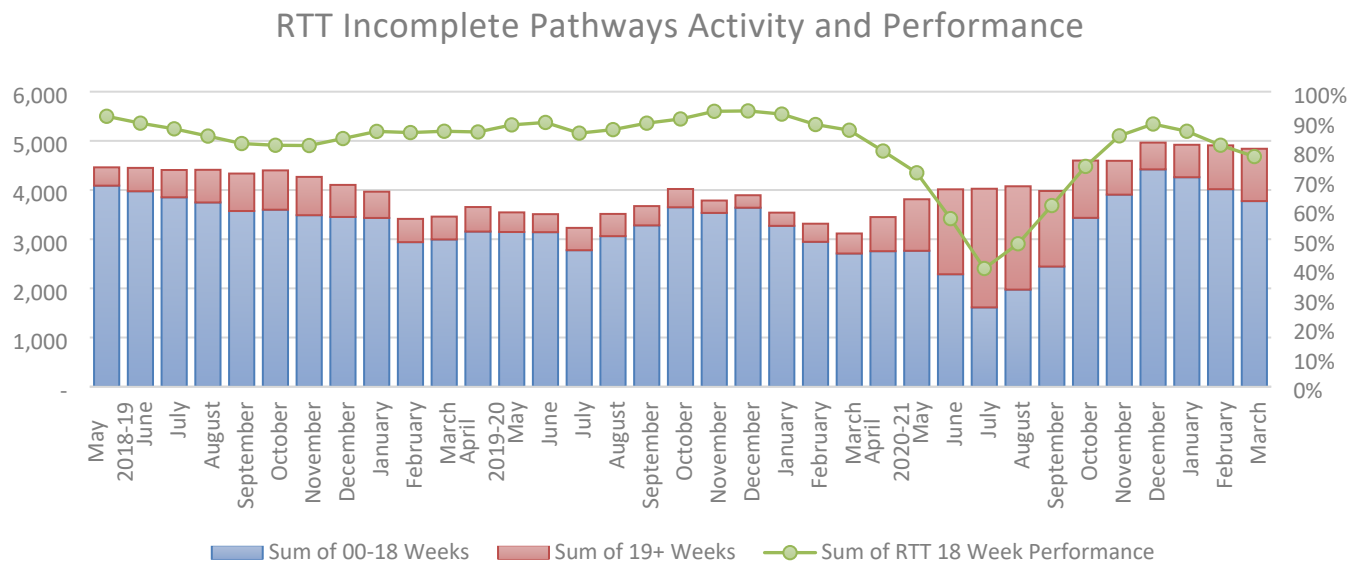
Details of ophthalmology activity is provided in the table below across the three years 2017/18, 2018/19, and 2019/20. For the purposes of this Pre-Consultation Business Case, our activity modelling is based on April to February 2019-20 (months 1-11), projected to full year effect because:

- The impact of the Covid-19 pandemic meant that activity was artificially low between March 2020 and April 2021 (month 12 2019-20 and months 1-12 2020-21).
- The reduced level of activity that the ophthalmology department at East Sussex Healthcare Trust was able to deliver in 2018-19 primarily due to workforce vacancies.

Table 6: Ophthalmology activity at East Sussex Healthcare Trust

	Non-Elective	Elective		Outpatients	
Activity		Inpatient	Day Case	New	Follow Up
2017/2018	39	43	4,846	16,086	70,494
2018/2019	30	27	4,512	16,088	68,536
2019/2020	33	45	4,949	17,972	64,963

Figure 8: East Sussex Healthcare Trust Ophthalmology 18 week Referral to Treatment standard



As outlined in Figure 8 above, the green line shows East Sussex Healthcare Trust's performance against the 18 week Referral to Treatment standard over the last few years, and it is clear that the Trust has performed well. In addition, there is a sharp decline in performance, due to the impact of Covid-19.

Historically, the time a patient has waited for a follow-up appointment has not been systematically recorded or monitored by the NHS. However, in recognition of the importance of timely follow-up treatment, in 2020 the NHS introduced a requirement for ophthalmology departments to record the ideal time at which a patient should attend for follow-up treatment and that 85% of patients should be seen within 25% of that timeframe i.e. if the typical follow-up should take place at 6 months, 85% of patients should be seen within a maximum of 32.5 weeks. East Sussex Healthcare Trust are not currently able to meet this standard and some patients have needed to wait longer for their follow-up appointment.

A Failsafe Officer has been in post for two years now at East Sussex Healthcare Trust. The proposed transformation would mean that more physical space is available for Ophthalmology and therefore capacity to undertake cataract surgery could be increased. These more streamlined services, coupled with better use of skill mix within the workforce, will enable a reduction in waiting times and in numbers of patients waiting (in terms of the backlog).

Patient experience

Friends and Family Testing

The Friends and Family Tests (FFT) is an anonymous way for patients to provide feedback on a service, and was created to help service providers and commissioners understand whether patients are happy with the service provided, and where improvements might be needed. The below table outlines the responses to the Friends and Family Tests in 2018/19 and 2019/20. The response for service users is largely positive, with the service showing improvement in the Friends and Family Tests responses in 2019/20.

Table 7: Friends and Family Testing

Friends and Family Test	2018/19			2019/20		
Recommendation Rate	No. Returned		% Positive of total	No. Returned		% Positive of total
	Positive	**Neutral or Negative**		**Positive**	**Neutral or Negative**	
Day Surgery Unit Bexhill - Ophthalmology	689	5	99.3%	881	14	98.4%
Jubilee Eye Suite - Eastbourne	1137	31	97.3%	1103	25	97.8%
Bexhill Eye Clinic – Orthoptist*	27	0	100.0 %	2	0	100.0%
Conquest Eye Clinic – Orthoptist*	16	0	100.0 %	36	1	97.3%
Eastbourne District General Hospital Eye Clinic - Orthoptist*	8	1	88.9%	14	0	100.0%
Diabetic Eye Screening	272	23	92.2%	889	29	96.8%

** An orthoptist is a type of outpatient appointment but there are other types outpatient appointments.*

** During the pandemic, the Friends and Family Tests was suspended, which means we have not been able to capture feedback from services users during 2020-21, however our engagement with local people that informs these proposals provide insight into local services during this time period.

Complaints and Patient Advice and Liaison Services (PALS)

East Sussex Healthcare Trust has robust processes for monitoring and responding to formal complaints and concerns raised through the Trust's Patient Advice and Liaison Service (PALS). The below table outlines the formal complaints and Patient Advice and Liaison Service concerns that East Sussex Healthcare Trust received for ophthalmology in 2018/19 and 2019/20. The majority of Patient Advice and Liaison Service concerns and formal complaints during this time were from patients who had experienced difficulty accessing the service in a timely manner.

Table 8: Complaints and Patient Advice and Liaison Services

	2018/19			2019/20		
	PALS Concerns	Formal Complaints	Total Appoint-ments.	PALS Concerns	Formal Complaints	Total Appoint-ments.
Bexhill	4	4	19,630	6	0	17,535
Conquest	50	10	24,402	15	1	26,545
Eastbourne District General Hospital	148	8	43,957	97	5	43,857
TOTAL	**202**	**22**	**87,989**	**118**	**6**	**87,937**

6.2. Current services (workforce, constraints and service patterns)

Workforce

Operationally providing comprehensive services across three sites is a significant workforce challenge, exacerbated by difficulties with recruitment and retention of the workforce. These challenges are detailed below:

- There is a national shortage of ophthalmologists but East Sussex Healthcare Trust is engaged in “training our own”, however the demand makes retention an issue.
- Consultants are required to supervise clinics that are not necessarily where they are based that day.
- There are difficulties with staff sometimes being required to run clinics at multiple sites.
- Creating a centre of excellence for ophthalmology would be more attractive for the recruitment of all staff and allow appropriate training and supervision.

Performance

Ophthalmology is the largest outpatient specialty nationally, and the largest at East Sussex Healthcare Trust with the service seeing 18,075 new outpatients and 65,511 follow-up appointments in 2019/20.

For elective/planned hospital attendances requiring specialist review, the national standard is that at least 92% of patients are seen and treated within 18 weeks of referral from primary care or community services. The performance data for East Sussex Healthcare Trust shows that the Trust’s 18 week Referral to Treatment pathway performance met the national standards prior to the Covid-19 pandemic.

Nationally mandated service changes to non-urgent services, in response to the pandemic, meant the service was not able to operate at their full capacity. This caused a sharp decline in performance against the national standard, and a sharp increase in patients waiting over 18 weeks for their treatment. This is now recovering.

Quality

In 2018, NHS England introduced a High Impact Intervention (HII)[42] for ophthalmology that focussed on failsafe prioritisation in ophthalmology services. Failsafe prioritisation has two distinct but interdependent elements which ensure that patients with chronic eye conditions receive follow-up review and/or treatment from the right person, in the right place, within their specified timeframe. These elements are:

- Prioritisation of patients with chronic eye conditions, based on their risk of significant avoidable harm (i.e. irreversible sight loss) from delay to treatment and their intended date for follow up.
- Implementation of 'closed loop' failsafe processes that complement existing ophthalmology pathways to identify any actual or possible delays to follow up and identify and complete any actions necessary to ensure a safe outcome for patients.

The high impact intervention describes the key enablers and the actions that trusts responsible for Hospital Eye Services, CCGs and Sussex Transformation Partnership/Integrated Care System leaders should take to minimise the risk of significant harm to those patients most at risk of sight loss due to chronic eye conditions. There were three actions each Hospital Eye Service needed to deliver:

- Action 1: Develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients
- Action 2: Undertake a clinical risk and prioritisation audit of existing ophthalmology patients
- Action 3: Undertake Eye Health Capacity reviews to understand local demand for eye services and to ensure that capacity matches demand with appropriate use of resources and risk stratification.

The clinical case for NHS England publishing a high impact intervention for ophthalmology was due to the growing demand on ophthalmology services and the clinical risk this poses. The high impact intervention is a support tool for systems to redesign ophthalmology services so that patients are seen in the right place first time, and that they're seen as quickly as possible in line with their constitutional rights.

The challenge surrounding timely follow-up at East Sussex Healthcare Trust presents a clinical risk, as delay leading to harm could affect patients requiring regular follow-up, with the risk that

[42] NHS England, 2018, *High Impact Intervention: Ophthalmology*

this could lead to damage to eyesight and possible irreversible sight loss. All patients with long waits for treatment are subject to clinical harm reviews to identify and prevent where possible harm occurring and to continually prioritise patients waiting for treatment.

6.3. The future of ophthalmology and associated support services

Demand

Over the next 20 years it has been forecast that all Hospital Eye Services will see sharp increases in demand for their adult ophthalmic services. The Royal College of Ophthalmologists report; *The Way Forward*[43] identifies options for meeting the increase in demand in high-volume areas of eye care:

- Cataracts: it is estimated that the demand for cataract services will rise by 25% over the next 10 years and by 50% over the next 20 years. This will require new approaches to referral, patient assessment, surgical flow and follow-up.
- Glaucoma: it is estimated that over the next 20 years, glaucoma cases are expected to rise by 44%. As technology improves more cases will be diagnosed, increasing the demand for services further. While there is hope that therapeutic delivery for glaucoma will shift from topical medications to surgically implantable long acting-medications, there will continue to be a critical need for an expansion in capacity for ongoing monitoring.
- Medical Retina: it is anticipated that the incidence of medical retina (macular degeneration, diabetic retinopathy) will increase by 20% over the next 10 years. Again, while treatments are being continually developed and improved, the cohort of patients is broadly cumulative, meaning more patients require long-lasting care each year.
- Emergency Care: the number of people seeking urgent and emergency care is increasing year on year. This is partly a natural consequence of population growth but also reflects changing behaviours around minor eye conditions.

As part of the NHS England's High Impact Intervention Scheme, in 2018-19, East Sussex Healthcare Trust and the former Eastbourne Hailsham and Seaford CCG and Hastings and Rother CCG undertook an Eye Health Capacity review to understand local need for eye services. The graphs below show demand from these areas and how it will impact on local people and services over the coming years:

[43] The Royal College of Ophthalmologists, 2016, *The Way Forward*

Figure 9: New Outpatient Referral Projection

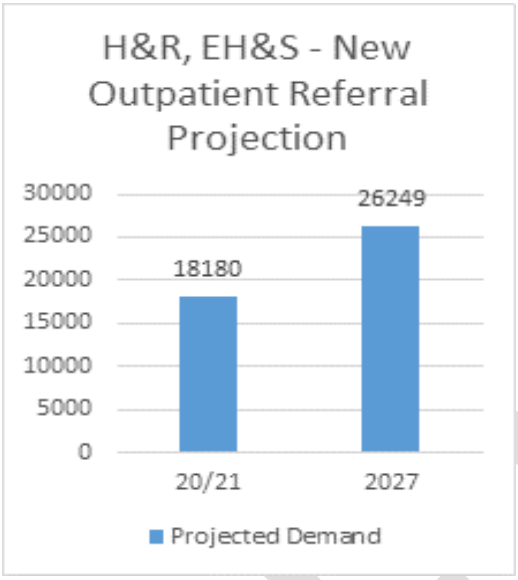


Figure 10: Follow-up Projection

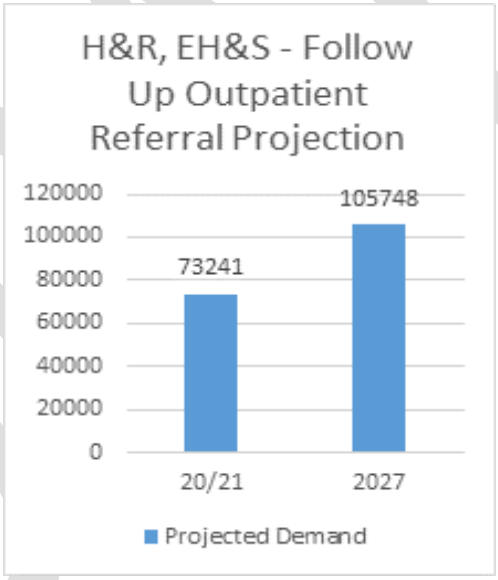


Figure 11: Day Case Projection

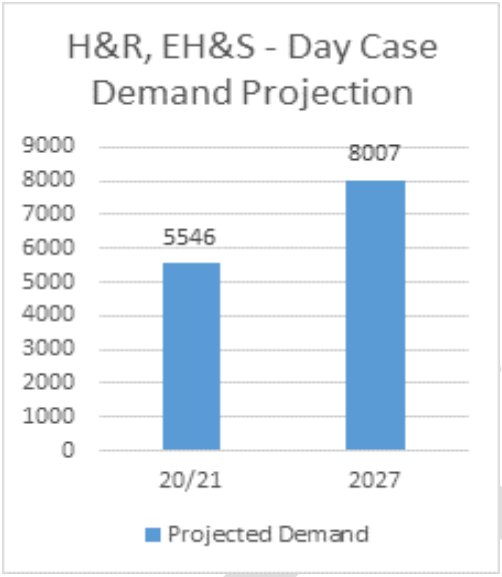
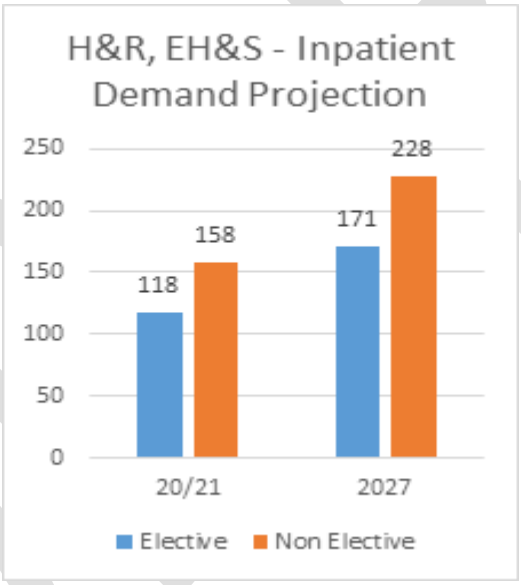


Figure 12: Inpatient Projection



Workforce

A national census carried out by the Royal College of Ophthalmologists in 2018 identifies gaps in recruitment for ophthalmologists and workforce planning, amid a predicted 40% increase in demand over the next 20 years[44]:

- Over the previous two-years, an extra 230 consultants and 204 Staff Associate Specialist (SAS) posts were required nationally
- 67% of hospital eye services were employing locum doctors to fill consultant posts, an increase of 56% since 2016
- 85% of services were undertaking waiting list initiatives to attempt to manage demand

[44] The Royal College of Ophthalmologists, 2018, *Workforce Census*

- Around 25% of the current workforce was nearing retirement

There has been no material change to those findings to date. Recruiting to vacant consultant posts has been a significant challenge for the East Sussex Healthcare Trust ophthalmology service in recent years; taking the Trust two and a half years to successfully recruit a glaucoma consultant. The difficulty in recruiting to posts is largely due to the national shortage in consultant ophthalmologists, which is made harder by applicants being drawn to vacancies within better-equipped and resourced London providers.

While the ophthalmology service has no medical vacancies for the first time in four and a half years, the service is still reliant on locum consultants for ad hoc clinics and weekend work to care for patients on the waiting list, which impacts on the resilience of the service and demonstrates a residual shortfall between capacity and demand.

Additionally, if staff were not required to work across three separate sites and were more consolidated, training opportunities such as the Ophthalmology Practitioner's Framework (OPF) would become viable to deliver, as the different skill mix of staff could be streamlined together to enable staff to engage in mutual training. This training in particular would enable optometrists to be able to undertake urgent care and laser clinics. Other opportunities would be created for other staff groups, including HCAs who would be able to help with injection clinics as well as there being more non-medical injectors trained up. New metrics could be created, including around Referral to Treatment standards and demonstrating a decrease in waiting times for patients to be seen and treated.

Developments in IT/Digital and future ophthalmology service provision
It is recognised that the NHS can significantly benefit from having the appropriate digital infrastructure in place to support patient pathways. In line with the ambitions of the Long Term Plan, we aim to harness digital technology to provide a more convenient service for patients, whilst enabling services to make best use of their workforce and wider resources in a way that balances service provision with the expected growth in need for local services.

While there is no universal definition of ‘digital technology’, it moves beyond an accepted perception of personal computers and databases to concepts such as machine learning underpinned by artificial intelligence to assist with identification task, mobile computing (which includes patient’s own access to technology and smartphones) as well as personal and wearable devices that are generally in direct contact with wearers for long durations and are capable of gathering large quantities of data on specific biometrics and behaviours. The possibility of the proliferation of remote monitoring technology creates opportunities for more sustainability in healthcare we can offer.

Our experience during Covid-19 demonstrated our ability as a system to adapt to different forms of service delivery and that we can continue to further develop them. The opportunity to deliver

services closer to people's homes in a way that is more convenient and makes better use of resources is a key driver for any service changes. We will continue to do this by increasing the use of digital tools to transform services by providing more options, better support, and joined-up care at the right time in the optimal care setting, offering a blend of face-to face and virtual outpatient appointments, as appropriate for the care required.

Like many other services, ophthalmology has recently begun moving towards virtual clinics for patients, with 11% of follow-ups being virtual at September 2020. However, across Sussex the IT/digital infrastructure across primary, community and secondary care requires further development to support greater numbers of patients accessing virtual clinics as appropriate. Developments in IT/digital infrastructure would enable greater availability of virtual clinics, more Advice and Guidance (A&G) from consultants to community optometrists and GPs supporting patients to receive their care from the most appropriate healthcare professional and improved systems to ensure patients are safe and receiving the care and treatment they require.

Maximising the use of digital technology presents opportunities that support service transformation:

- Transforming patient pathways – the ophthalmology service is highly dependent on diagnostic imaging for diagnosis and treatment decisions and the system-wide IT infrastructure (across primary, community and secondary care) would allow images to be taken, shared and interpreted in a way that supports patients to be cared for by a range of health professionals as appropriate to their needs.
- Patient care delivered in the most appropriate way: improved IT infrastructure supports provision of Advice and Guidance (A&G) and the opportunity for optometrists to refer directly to an ophthalmic consultant. This means that some patients could be most appropriate cared for in the community with hospital consultant providing advice to the community healthcare professionals instead of attending an outpatient appointment (where appropriate).
- Ensuring timely follow-up: whilst East Sussex Healthcare Trust have a bespoke ophthalmic Electronic Patient Record (EPR) system called Medisoft, this system is not currently fully integrated with other IT systems within the Trust; improved IT systems would support better patient follow-up care.
- Investment into the digital/IT platforms would enable improvements to ophthalmology patient pathways (including the supporting administrative processes), enabling the local system to transform ophthalmology services at the pace and scale indicated by national policy and best practice.

A lot of the above opportunities will, in turn, improve communication with patients and support Covid-19 recovery plans.

From July 2021 East Sussex CCG and East Sussex Healthcare Trust will be participating in a NHS England/Improvement-sponsored pilot of an Electronic Eyecare Referral System (EERS) that enables East Sussex Healthcare Trust and community optometrists to exchange clinical information and images. The aim of the pilot is to help address the issues outlined above and support the introduction of new, integrated pathways through which community optometrists can safely manage cases that do not need to be treated in a hospital, improve the quality of referral information, allowing quicker decision-making and reducing unnecessary hospital attendances. If the pilot proves successful it is likely that the system will be rolled out across the whole of Sussex and become a core part of ophthalmology services.

In addition, delivering a "Net Zero" NHS involves a multifaceted approach to decarbonising buildings, travel, and the products we rely on. By also reimagining aspects of how care is delivered to include providing greater access to telemedicine[45] and digitalisation[46], it could enable more patients to make virtual appointments that help reduce travel, reduce carbon, while ensuring a better continuity of care.

Estates and equipment

As part of the Trust's estates strategy, there is the opportunity to enhance the availability of services at our Bexhill site to make best use of our estate for the benefit of local people.

The diagnosis and monitoring of ophthalmic patients is highly dependent on equipment such as ophthalmic cameras, visual field machines and optical coherence tomography (OCT) scanners.

Much of the equipment currently used by the department is ageing and are not consistently operating reliably. This can impact on the department's capacity and often resulting in clinics being delayed and cancelled. This impedes the service's ability to work efficiently and effectively and increases the associated inconvenience for patients, prolonging waits for care. To ensure financial sustainability in the medium to long term, we need to re-think how and where ophthalmology services are delivered so that we make the best use of existing assets and capital investments.

6.4. Learning from our Covid-19 response

In response to Covid-19, East Sussex Healthcare Trust had to reconfigure their hospital services to ensure they operated in a safe manner and also increased the number of beds available for Covid-19 patients. With adult and paediatric ophthalmology services operating at a reduced level of capacity, the service was moved to operate solely from Bexhill during the first peak with particular focus on urgent services. This was also important from the perspective of infection prevention and control and services responded to the pandemic. With its staff together at one location it enabled the department to deliver whole-team training events for its staff and learn from different ways of arranging services that had not been previously explored.

[45] Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology.
[46] Digitalisation is the conversion of text, pictures, or sound into a digital form that can be processed by a computer.

The requirement of the service to respond to the needs of local people in a different way during the early stages of the Covid-19 response, coupled with the service being temporarily consolidated on one site, led to the service working in new ways including new diagnostic pathways and virtual clinics. Feedback from the service is that working in this way has been positive, improving the working relationships of the team through improved communication, and more supervision and support for junior staff.

The service has also been offering patient initiated follow-up as part of the medical retina pathway, over the last few months, with the aim to expand this to neuro-ophthalmology and oculoplastic pathways shortly. No evaluation has yet taken place, however the service is actively collecting data on this for future evaluation and analysis purposes.

Although clinical activities have increased over time and the challenge of working through the pandemic has remained, innovation has continued. For example, recently the optometrists designed and delivered new Urgent Care Clinics. The clinics are supervised by a consultant and are an example of a successful initiative that utilises the varied skill set of all the professionals in the team. It is anticipated that further and long-term consolidation will enable more opportunities for new initiatives that will improve quality of care and patient experience.

During the pandemic, the Friends and Family Test was suspended, which means we have not been able to capture feedback from services users on the changes that were made in response to the pandemic. To address this, East Sussex Healthcare Trust have conducted an analysis of Patient Advice and Liaison Service enquiries and complaints and this has shown that there was no increase in complaints nor any complaints specific to site provision at Bexhill. Anecdotal feedback from patients has been largely positive, including on the quality of care, efficiency of having appointments at the same time, and the ability to have their appointments at a site without Covid-19 inpatients. East Sussex Healthcare Trust are conducting further targeted engagement with those service users that would have been impacted by the consolidation of sites to Bexhill, and this is due to be completed in November 2021. Once the results of this engagement are available we will review them in relation to this transformation programme.

Orthoptist and paediatric services have gradually moved back to Conquest hospital since September 2020 and outpatient activity restarted at Eastbourne District General Hospital at the end of July 2020, although both services are running at lower capacity than previously due to Covid-19 restrictions and infection, prevention and control regulations; however currently other services are not able to repatriate as the space they previously occupied is still being used to manage the impact of Covid-19.

6.5. Current health outcomes

Ophthalmic disease prevalence in East Sussex adults

Age-related Macular Degeneration

Age-related macular degeneration (AMD) affects a small part of the retina at the back of the eye, called the macula. Age-related macular degeneration causes changes to the macula affecting central vision, the part used when looking straight at something, for example when undertaking ordinary daily activities such as cooking, driving, reading or watching television. Central vision can become distorted or blurry, and over time, the patient may lose some or all central vision. Age-related macular degeneration has a higher prevalence in western countries. It is estimated that 1-3% of the population in western countries suffer with an advanced stage of age-related macular degeneration. We estimate that across East Sussex, approximately 16,800 people are living with advanced age-related macular degeneration.

Cataracts

Cataracts are a common condition as people age. Over time the lens becomes cloudy, causing blurred, misty vision. Although rare in the UK, if left untreated cataracts can cause complete (but reversible) blindness. It is estimated that 16% of people 65-69 (5,850), 24% of people 70-74 (9,308), 42% of people 75-79 (10,728), 59% of people 80-84 (13,201), and 71% of people 85 and over (15,499) are visually impaired due to cataracts. We estimate that across East Sussex, approximately 54,586 people are visually impaired by cataracts.

Diabetic Retinopathy

Diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the blood vessels at the back of the eye (retina). It can cause irreversible blindness if left undiagnosed and untreated. It is estimated that across East Sussex, 12,239 people with type 1 diabetes are living with diabetic retinopathy, and 8,610 people are living with type 2 diabetes and diabetic retinopathy.

Glaucoma

Glaucoma is a common eye condition where the optic nerve, which connects the eye to the brain, becomes damaged. It's usually caused by fluid building up in the front part of the eye, which increases pressure inside the eye. Glaucoma can lead to loss of vision if it's not diagnosed and treated early. It can affect people of all ages, but is most common in adults in their 70s and 80s. Primary open angle glaucoma (the most common form of glaucoma) affects 1% of the population aged over 40 (1,486), 3% of the population aged over 60 (4,110), and 8% of people over 80 (3,319). It is thought that approximately 50% of people living in the UK with primary open angle glaucoma have not been diagnosed. We therefore estimate that across East Sussex, approximately 11% of the population has primary open angle glaucoma that has not been diagnosed.

Ophthalmic disease prevalence in East Sussex children and young people

Amblyopia

“Lazy eye” (amblyopia) is reduced vision in one eye caused by abnormal visual development early in life. The weaker — or lazy — eye often wanders inward or outward. Amblyopia generally develops from birth up to age 7 years. Amblyopia is the most common cause of vision problems in children, affecting 3.6% of children. We estimate that across East Sussex there are 500 children aged 4-5 years referred into East Sussex Healthcare Trust per annum for suspected amblyopia.

Sight Loss in East Sussex

Over two million people in the UK are living with sight loss, and of these, around 360,000 are blind or partially sighted. According to the Royal National Institute for Blind People, 1 in 5 people aged over 75, and half of people aged over 90, live with some degree of sight loss. Due to the age distribution in East Sussex, the county has a higher percentage of people living with sight loss than the national average. The following table shows the percentage of patients living with sight loss in East Sussex compared with both the South East and England.

	East Sussex	South East	England
2015	4.3%	3.3%	3.1%
2020	4.5%	3.5%	3.2%
2025	4.9%	3.8%	3.5%
2030	5.4%	4.2%	3.9%

This percentage is predicted to rise in line with population growth.

Table 9: Sight Loss in East Sussex

The Public Health England (PHE) Outcomes Framework for 2016-18 shows that East Sussex had a slightly higher rate of preventable sight loss due to age-related macular degeneration than the National benchmark figure. The framework also shows that East Sussex had a higher rate of preventable sight loss due to glaucoma than the National benchmark figure. There is a relationship between sight loss and a range of factors, in particular:

- Age, East Sussex has among the highest proportions of over 65 and 85 year olds nationally and this is projected to grow,
- Ophthalmic conditions (e.g. glaucoma, cataract, age-related macular degeneration) and related conditions (e.g. diabetes, dementia). These conditions also disproportionately impact some ethnic groups (notably Black African and Caribbean, South Asian and White).
- Deprivation and lifestyle factors. Deprivation varies significantly across East Sussex with the most significant deprivation in Hastings where admissions due to alcohol related conditions are also highest.

National research implies that take-up of routine sight tests is lower than would be expected. This is particularly prevalent in areas of social deprivation. Routine sight tests are often the point at which more sight conditions are potentially identified early. Late presentation can lead to later detection of preventable conditions and therefore increased risk of sight loss, due to the late intervention. Research by the Royal National Institute for Blind People suggests that 50% of blindness and serious sight loss could be prevented if detected and treated in time. In East Sussex our rates of preventable site loss from age-related macular degeneration, glaucoma and diabetic eye disease are similar to the England rates as outlined in Table 10 below.

Table 10: Rates of preventable sight loss from three nationally reported causes in East Sussex are statistically similar to those for England (2018/19)

Cause	Rate per 100,000 population	
	East Sussex	England
Age-related macular degeneration	117.3	109.5
Glaucoma	15.6	13.3
Diabetic eye disease	2.7	2.7

Additionally, smoking is a risk for sight loss:

- It increases the risk of sight threatening conditions, such as glaucoma, Wet Age-related Macular Degeneration (WAMD)
- Cigarette smoke contains toxic chemicals that can irritate and harm the eyes
- Smoking can make diabetes-related sight problems worse by damaging the blood vessels at the back of the eye (the retina)
- Smokers are around three times more likely to get age-related macular degeneration
- Smokers are 16 times more likely than non-smokers to develop sudden loss of vision by optic neuropathy, where the blood supply to the eye becomes blocked.

Table 11: Smoking prevalence in East Sussex population

	Smoking prevalence in adults
Eastbourne	16.7%
Hastings	16.5%
Lewes	10.1%
Rother	12.4%
Wealden	9.4%
England	13.9%

National Ophthalmology Database (NOD) Audit

The Royal College of Ophthalmologists (RCOphth) runs the National Ophthalmology Database (NOD) Audit which measures the outcomes of cataract surgery, specifically the two primary indicators of surgical quality, Posterior Capsular Rupture (PCR) and Visual Acuity (VA) loss. East Sussex Healthcare Trust participates in the NOD audit submitting data annually on behalf of its Conquest, Eastbourne District General Hospital and Bexhill hospital sites. The most recent published results follow:

Table 12: East Sussex Healthcare Trust Posterior Capsular Rupture and visual loss percentages for the 1 year period from 01 September 2018 to 31 August 2019

Organisation	Cataract operations	PCR percentage (risk adjusted)	Within expected limits?	Number of qualifying cataract operations performed	Visual loss percentage (risk adjusted)	Within expected limits?
East Sussex Healthcare Trust	**3,522**	**0.7%**	✓	**2,063***	**0.4%**	✓
National comparison	**-**	**1.1%**	**n/a**	**-**	**0.9%**	**n/a**

* *Centres or surgeons where less than 40% of operations have both a pre- and post-operative record of VA are not reported*

Across both quality measures of PCR and VA loss, all East Sussex Healthcare Trust sites (where enough data exists) are operating within expected limits as determined by the NOD (https://www.nodaudit.org.uk/public/trusts/east-sussex-healthcare-nhs-trust). As more NHS organisations, nationally and locally, participate in the audit it will create a future opportunity for system benchmarking.

7. Pre-consultation engagement – what matters to local patients, clinicians and key stakeholders

There are several phases of pre-consultation engagement, which aims to find out what local people, patients, clinicians and stakeholders think of the current service, to hear their ideas around transformation, what matters to them and to review ideas and proposals as they evolve. The key aim of our engagement process to date has been to ensure that a robust and transparent approach was established to enable stakeholders to inform and test approaches for this Pre-Consultation Business Case.

This approach ensured that a range of stakeholders were given the opportunity to be involved in the early engagement discussions. The approach also included opportunities for engagement targeted at those who have a particular stake in East Sussex Healthcare Trust ophthalmology services to help inform the Pre-Consultation Business Case: for example, patients attending ophthalmology outpatient appointments were offered the opportunity to take part in interviews in order to provide insight into the patient journey and experiences of accessing ophthalmology. 19 patients took up this opportunity.

We undertook public engagement which commenced on 4th January 2021 and lasted six weeks (concluding on 14th February 2021). During this time we engaged with local people and stakeholders to:

- communicate the need for transformation of acute ophthalmology services at East Sussex Healthcare Trust;

- understand their experiences of the ophthalmology services for children, young people and adults at Eastbourne District General Hospital, the Conquest Hospital in Hastings and Bexhill Hospital;
- gather their feedback and ideas about how the service could be provided in the future.

The insight gathered from this work was used to inform options development, appraisal and planning for any formal consultation.

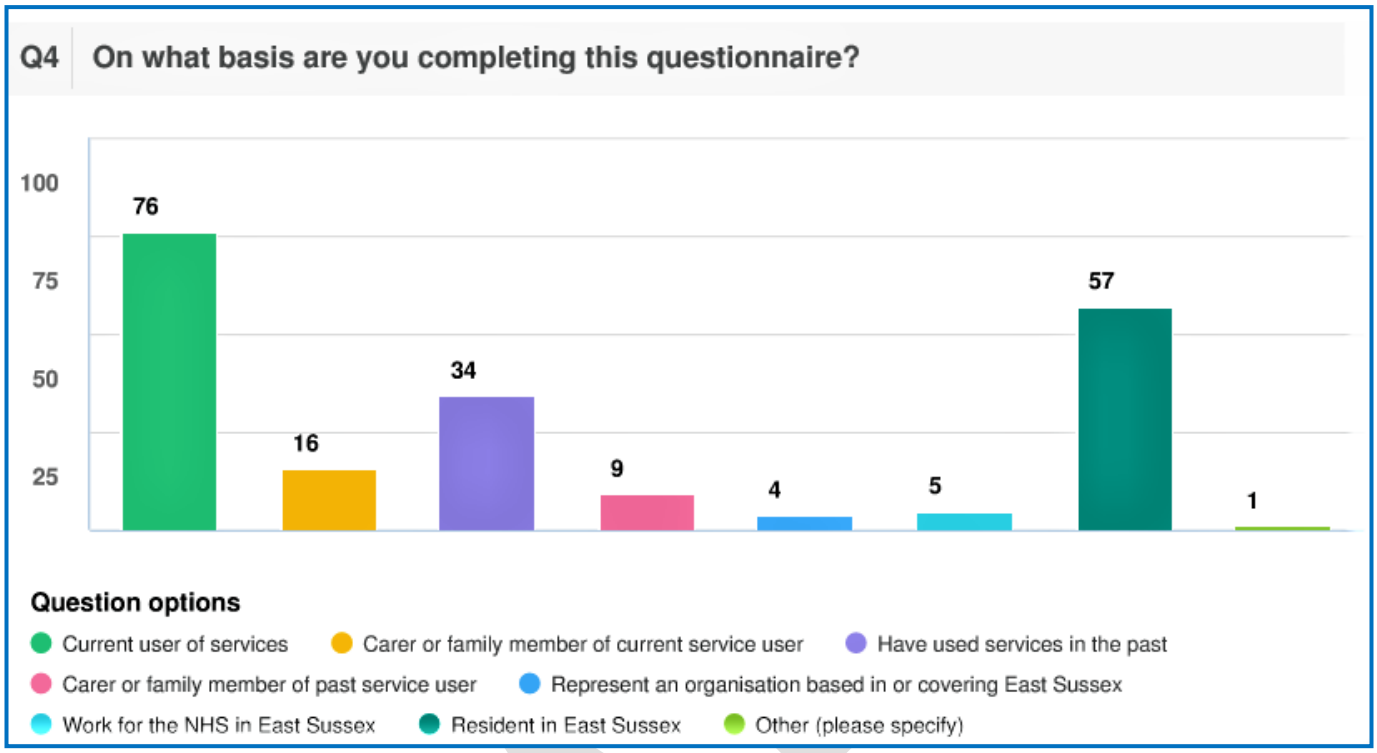
Throughout our pre-consultation engagement, we incorporated the findings from the Equality and Health Inequalities Impact Assessment – this is described in more detail in Section 10.2 and in Appendix 1.

A questionnaire to understand people's experiences of ophthalmology services was co-designed with partners and members of the public and published on the Sussex Health and Care Partnership's Engagement HQ (online engagement) platform. The survey was promoted through a multitude of pre-established distribution lists and newsletters.

It was also sent out widely to local voluntary, community and social enterprise sector organisations, including Healthwatch, with the request to support promotion. Paper copies of the survey were sent out to organisations including the Rough Sleepers Initiative (homeless and rough sleepers) and foodbanks (to reach those living in deprivation) as well as to individuals requesting copies. A freepost address for returning the questionnaires was included.

Posters were distributed to display in hospital waiting rooms to encourage people to complete the questionnaire or to get in touch to arrange a telephone interview. Social media coverage was used to promote the surveys, utilising the CCG pages and accounts and posting on local community Facebook pages. In all, 126 responses were received to the questionnaire, of which 19 were conducted as in-depth interviews.

Figure 13: Results of those who engaged in the questionnaire and why



NB: participants could choose more than one option

The Public Involvement team attended a range of virtual forums and groups to promote the programme and inform people of the ways to get involved.

To support accessibility, local linguists in East Sussex were asked to work with people for whom English was an additional language, to complete the questionnaires and the CCG received a total of eight completed questionnaires with a variety of languages represented.

Additionally, to ensure people with learning disabilities (LDs) could share their views, the team provided Easy Read versions of the consultation document summary and the questionnaire. This was shared with the LD partnership board and Autism Partnership board. There were several responses from people with LDs and some recommendations that have been taken forward with East Sussex Healthcare Trust in the short term. The team will also be focusing on people with LD as part of the consultation and will look to attend both boards, link in with local authority colleagues and work closely with carer organisations to ensure there is a representative response rate.

Following our poster promotion in hospital waiting rooms, we had hoped to receive more responses from patients outside of the 19 in-depth interviews arranged in collaboration with East Sussex Healthcare Trust. Therefore, as part of the formal consultation, and if Covid-19 restrictions are not in place, the team would spend at least 6 days sitting in the waiting rooms promoting the consultation and gathering feedback.

The team also arranged for British Sign Language copies of the summary and questionnaire to enable Deaf people to take part and received 5 responses, and about 8% of the respondents did have a hearing impairment.

To enable people who did not have access to technology and were from some of the most deprived areas of East Sussex, questionnaires (with a freepost return address) were sent out with food parcels from several foodbanks.

Older people are one of the patient cohorts most likely to be affected by any change of location and we did hear from this cohort – we attended East Sussex Seniors Association and 86 of 126 responses were from people aged 65 and over. For the formal consultation we will also focus efforts on parents with young children as we had a low response during the pre-consultation due to the national lockdown meaning limited access to schools and no access to toddler groups, children's clubs etc.

A full pre-consultation engagement report is provided in Appendix 2. The key themes which have emerged from the surveys, social media comments and discussions at stakeholder meetings and forums during the pre-consultation engagement are summarised in Table 13.

Table 13: Feedback from the pre-consultation engagement

Theme	Summary of key points	Action we are taking
Care provided	• Most people reported that the service was very good, staff were professional and they were treated with kindness • People reported problems with communication, being treated with a lack of respect or "talked down to"	• An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.
Equality and Diversity	• Problems with communication were reported for both adults and children with autism, for those with Learning Disabilities and for the d/Deaf • Disabled people and their carers told us about problems with access and arranging transport • LGBTQ+ people felt staff needed more training and awareness	• An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.
Access and transport	• Many people reported difficulties accessing and attending appointments, including problems with public transport, mobility issues, not having access to a car and struggling to afford public transport or taxis	• We have undertaken an initial and internal review of travel and access for patients across East Sussex. • There will be particular focus on this theme during any further engagement work and/or a part of any formal consultation. • An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.

Clinical services	• People reported problems with communications between High Street optometrists and secondary care • People using Patient Knows Best liked the system and felt it kept them informed • People told us about their anxiety when there is a lack of continuity of care and information about them isn't passed on • People worry about long waits for appointments, especially when they have a degenerative eye condition such as Wet Age-related Macular Degeneration	• The Public Involvement team attended meetings of the Local Optical Committee to promote communication with secondary care. • An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.
Community optometry	• Many optometrists told us that they felt more could be done in the community e.g. glaucoma referral refinement • Optometrists felt that communication with secondary care could be improved and more training offered	• The Integrated Care System Ophthalmology Transformation Programme is focussing on the end-to-end redesign of ophthalmology pathways across the Integrated Care System, such as pre and post-op cataract, glaucoma referral refinement, etc., and explicitly targeting the role of community practitioners in delivering parts of these pathways. • Engagement to date has led to greater collaboration and improved communication between community optometry and secondary care
Covid-19 Pandemic	• In addition to the above, people told us about their experiences of ophthalmology services during the pandemic. They told us that communications had deteriorated and appointments had been cancelled and not reinstated. However, people also praised staff and infection control processes.	• The Integrated Care System Ophthalmology Transformation Programme is part of a national programme aimed in part at recovering services from the impact of Covid-19. The programme is interlinked with a Getting It Right First Time initiative that seeks to maximise the capacity of acute services as well as engaging community support.

It should be noted that although most of the points raised during this engagement can be addressed by these proposals, there are some that can be addressed independently from this transformation programme. For example, the importance of support from primary care and community optometry services.

A summary of our engagement schedule is provided below.

Table 14: Engagement Schedule

Stage	Approach	Dates
1.	Pre-consultation engagement and communications	January-February 2021
2.	Options development and appraisal	March 2021
3.	Additional engagement following options development and appraisal has taken place	May 2021 – June 2021
4.	Clinical Senate (Section 11.2)	July 2021
5.	Formal consultation on proposal (planned subject to approval of the Pre-Consultation Business Case by the CCG)	December 2021 – March 2022

The pre-consultation engagement work undertaken by East Sussex CCG provided a strong foundation on which to build the formal programme of activities subsequently undertaken as part of the options development and appraisal processes (described in further detail in the next section). As well as providing valuable insights in its own right, which helped to inform options development, the pre-consultation activities also helped to identify and recruit patients and patient representatives to participate in this next stage.

8. Options Appraisal

Formal options development and appraisal activities are an important part of developing any final proposals for changes to the way that acute ophthalmology services might be delivered in the future. It is important to note though that the outcomes reported here are by no means the only basis on which change decisions might be taken. They are one element of a longer-term and ongoing dialogue in which stakeholders, including members of the public, have engaged with East Sussex CCG and East Sussex Healthcare Trust about the way that NHS services are delivered, and part of the evidence base which relevant bodies will need to consider when making decisions.

8.1. Overview of the Process

Between 9 March 2021 and 23 March 2021, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services researchers) took place to identify and consider a longlist of possible options for the future provision of acute ophthalmology services. Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.

Table 15: Summary of Options Development and Appraisal workshops

Workshop	Date/Time	Description
1	Tuesday 9 March 2021 13:00-17:00	'Listening and engagement'

		• Bridging from the pre-consultation engagement undertaken by East Sussex CCG into the formal options development and appraisal • Introducing the background and rationale to the transformation • Discussion around the clinical vision and priorities and patients' priorities for acute ophthalmology services • Initial discussions on how the need to address current and future challenges, meet national guidelines and standards, and to address clinical requirements and patients' needs, might require a balance or compromise to be found between different priorities Key outputs • Feedback from patients and patient representatives, community optometrists, primary care clinicians and other stakeholders to inform possible new models of care
2	Tuesday 16 March 2021 13:00-17:00	'Options development' • Drawing on key themes and suggestions identified from pre-consultation engagement, feedback from Workshop 1, and information and data provided by East Sussex CCG and East Sussex Healthcare Trust • Discussion about possible approaches to acute ophthalmology service provision, using suggestions from East Sussex NHS partners as a starting point with opportunity to explore additional ideas and approaches • Initial consideration of possible advantages and disadvantages, impacts and potential mitigations of each possible approach • Consideration of the implications of possible approaches in relation to the vision, priorities and challenges discussed in Workshop 1 • Brief introduction to the appraisal criteria to be used in Workshop 3 Key outputs • Feedback from patients and patient representatives, community optometrists, primary and secondary care clinicians and other stakeholders to generate a 'longlist' of possible approaches/options to be considered and appraised at Workshop 3
3	Tuesday 23 March 2021 13:00-17:00	'Options appraisal' • Summary of outputs from Workshops 1 and 2

		• Discussion and agreement on the five appraisal criteria against which the longlist of possible options would be tested • "Qualitative" discussion/appraisal of each longlisted option for future East Sussex Healthcare Trust acute ophthalmology service provision, and location options if acute services were to be delivered from a reduced number of sites • Anonymous ranking and scoring of each longlisted option and possible location(s) against the agreed appraisal criteria Key outputs • Feedback and data to inform shortlisting and recommendations of options for consultation

The pre-consultation engagement which ran from 4 January 2021 – 14 February 2021 (as described above), formed part of the preparation for these workshops. Additionally, participants were provided with information to enable informed discussion, including summaries of key contextual information (e.g. population health needs, clinical standards, activity demand and capacity, finances, estate footprint, workforce) and summaries of key programme documents (e.g. Equality and Health Inequality Assessment and Case for Change).

The workshop attendees were as follows:

Table 16: Stakeholders in attendance at Options Development and Appraisal workshops

Stakeholder type	Number	Description (roles/organisations represented)
Patient / representatives	5	East Sussex Association of Blind and Partially Sighted People East Sussex Seniors' Association East Sussex CCG Community Ambassador
Other NHS Staff	4	Local GP CCG GP Clinical Lead East Sussex Local Optical Committee
East Sussex Healthcare Trust clinicians	4	Acute ophthalmology clinical leads and East Sussex Healthcare Trust optometrists

Note: NHS managers attended to observe, present key information and respond to questions, but did not actively participate in the options appraisal scoring and ranking activities.

A mixed methodology was used to appraise the longlist of options, comprising:

- 'Qualitative' discussions which drew out the reasons for which different individuals and groups held certain views, and particularly to identify and elaborate on any key factors or concerns; and
- A two-part 'quantitative' exercise to generate ranks and scores for each option.

In both the qualitative and quantitative stages of the appraisal, the following five 'appraisal criteria' (which were discussed and agreed upon at workshops 2 and 3) were used:

1. Quality and Safety
2. Clinical Sustainability
3. Access and Choice
4. Financial Sustainability
5. Deliverability

The same methodologies were used to appraise different options for locations of acute ophthalmology services in East Sussex, in the event that any proposed options were to require that services currently delivered at three hospitals were to be reconfigured to be located at fewer sites.

At workshops 2 (options development) and 3 (options appraisal), the following various potential models of care were discussed:

- Option 1: Retain current services as they are at present: Everything provided everywhere. All "Core" services provided at all three sites

- Option 2: Two hospital sites. Consolidate services to two sites. All “core” services provided across two sites.
- Option 3: One hospital site. Consolidate services to one site. All “core” services provided from a single location
- Option 4: One hospital site with community clinics. Consolidate services to one site. All “core” services provided from one location. Expand outpatient based services to clinics at community hospitals
- Option 5: One hospital site with mobile clinics. Consolidate services to one site. All “core” services provided from one location. Expand outpatient based services to include mobile ‘roving’ clinics

Discussions were initially based on three suggested approaches, which included maintaining the status quo (Option 1) and two- and one-site models (Options 2 and 3). Participants were also invited to suggest alternative approaches for consideration, of which two were forthcoming (Options 4 and 5).

During workshop 3, participants were asked to rank and score each of the five possible options for a future model of care against the five “appraisal criteria”.

Following this, in order to better understand the relative differences between options, participants were also asked to score each of the five options against the five “appraisal criteria”. When interpreting the options appraisal scoring outcomes, unlike the ranking exercise, participants were able to give the same scores to several or even all options, if they chose to.

- The results showed that Options 2 (two hospital sites) and 3 (one hospital site) were ranked highest against all criteria – albeit variably by the different stakeholder groups. The scoring results were more mixed: overall, Option 3 was scored highest by East Sussex Healthcare Trust clinicians and other NHS staff, whereas patients and representatives variously scored Options 1, 2 and 4 highest against different criteria.
- Conversely, Options 1 (retain current services) and 5 (one hospital site and mobile clinics) tended to be ranked and scored lowest – although Option 3 was thought to be poorest for Access & Choice by other NHS staff and patients/representatives. This is reflected in the qualitative data inasmuch as:
    - There was general agreement that Option 1 is unfeasible due to: current and future capacity; staff recruitment and retention difficulties; challenges in providing senior supervision due to consultants being ‘spread too thinly’; insufficient physical space for clinics to meet growing need; and the need to ensure sustainable services;
    - While clinicians thought Option 3 would result in a timelier service and better outcomes for patients, and aid recruitment and retention through the centralisation of specialisms and specialists, patients referred to travel and access concerns

around travel time, distance and cost, and the ease of getting to appointments; and
    - Option 5, after being proposed in workshop 2, was not discussed in detail at workshop 3 as it was felt that the key points regarding local access had been covered in discussions on Options 3 and 4.
- It should be noted that although Option 4 (a single-site model with some community hospital-based clinics) rarely featured at the top of the ranking/scoring results, it was commonly in second place. This may reasonably be seen as a reflection of the prioritisation of local access to acute services by many patients, and the view that enhanced community-based provision could enable care closer to home, reduced travel and faster decision-making and mitigate concerns around travel and access, particularly in the event of a single-site model.

The results also showed that there was a clear preference across all stakeholder groups for a combination of Eastbourne District General Hospital and Bexhill under the two hospital sites model, whereas Bexhill and Conquest was the least favoured combination overall.

For the one site model of care, there was clear support for Bexhill among East Sussex Healthcare Trust clinicians, whereas the options was more divided between Bexhill and Eastbourne District General Hospital among patients/representatives and other NHS staff. Conquest was generally the least favoured option, as it was ranked poorly against all criteria by all stakeholder groups, although it should be noted that patients/representatives scored Eastbourne District General Hospital lowest against all criteria.

From the discussions at the workshops, the reasons for the low ranking of Conquest in both the two site and one site options were noted as:

- The current theatre capacity at Conquest is not adequate to accommodate the activity at Bexhill or Eastbourne (both of which have established and dedicated Ophthalmology Day Surgery Units).
- Theatre space at Conquest is primarily used for other more acute surgical interventions, with the clinical interdependencies required at an acute site. Conversely, the ophthalmology activity that is proposed to move does not have any acute clinical interdependencies.
- Adapting the Conquest site to accommodate the proposed changes in activity is likely to be prohibitively costly in terms of capital requirements.
- If capital requirements could be overcome, physical space limitations at Conquest means that it is difficult to expand and build the required infrastructure.
- The location of Conquest, being outside of the main centre of population for Hastings, does not provide a benefit to access and choice when compared with other sites.
- There is slightly poorer parking and access at Conquest, compared to other sites.

- The Conquest site, as an acute site, was more likely to have confirmed COVID positive inpatients. Conversely, Bexhill does not have inpatients as was thus considered a site that could be utilised for safe of provision of services during the pandemic, and therefore a better choice for the provision of outpatient and day case procedures.
    - N.B. It was noted that any complex surgery requiring General Anaesthetic would remain at Conquest hospital and is out of scope of the proposals.

There are clear advantages for increasing use of Bexhill rather than Conquest. The Bexhill Hospital site offers greater opportunities and flexibility in terms of how space can be used and how different parts of the service can be placed to enable the most seamless service provision. This will in turn provide a good patient experience and improved outcomes by enabling effective and timely flow across the care pathway, which particularly supports patients who use these services who are often older, partially sighted and experiencing a range of conditions. East Sussex Health NHS Trust's Estates team will continue to remain flexible in its approach to space utilisation, when and if future opportunities for using space differently at different locations become viable.

Overall, the outcomes of the options development and appraisal process suggest that Options 2 (two hospital sites), 3 (one hospital site) and 4 (a single-site model with some community hospital-based clinics) could reasonably be taken forward to formal public consultation.

In addition, Bexhill and Eastbourne District General Hospital appear to be the favoured locations for a two-site model, and opinion was divided between the same two hospitals when considering the best site for a single hospital. Conquest was not considered a viable option by the development group in either the one site or two site model, as outlined above, and therefore was not taken forward for shortlisting.

Each of the three options in the final shortlist are described in detail using comparative analysis, within Section 8.2 and 9 of this Pre-Consultation Business Case. Section 14 then specifies which are the preferred options and the rationale for that.

To further extend our engagement (designed in the context of the pandemic), we also commissioned Opinion Research Services to complete an additional piece of engagement following the options development and appraisal process. The aim of this was to present the options development and appraisal process followed, the outcomes those involved had come to, and to test these to inform our plans if/when moving forward to public consultation.

8.2. Short list of options

Throughout the design and consultation phases, we have continually tested our proposals and consultation approaches against the Equality and Health Inequalities Impact Assessment, updating where appropriate. Taking this into account, following completion of the workshops and report from Opinion Research Services researchers (Appendix 3), three options were short

listed to be recommended to be taken forward to formal consultation on the future of ophthalmology services in East Sussex:

- **Option 2: Ophthalmology services located at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.**
- **Option 3a: Ophthalmology services located at one hospital site, Bexhill Hospital, supported by one stop clinics and a diagnostic eye hub at Bexhill Hospital.**
- **Option 3b: Ophthalmology services located at one hospital site, Eastbourne District General Hospital, supported by one stop clinics and a diagnostic eye hub at Eastbourne District General Hospital**
- **Option 4: Ophthalmology services located at one hospital site, supported by one stop clinics and a diagnostic eye hub at the site, and community hospital clinics**

8.2.1. Option 2: Ophthalmology Services located at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital

Figure 14: Option 2 – Ophthalmology services located at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.

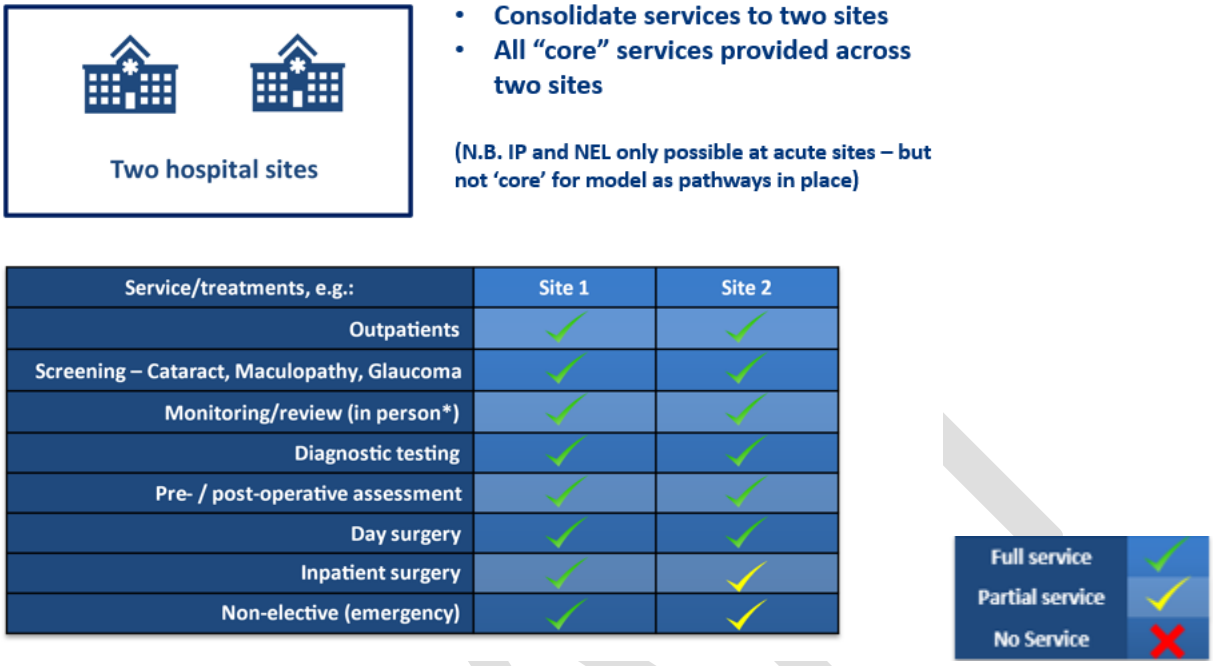
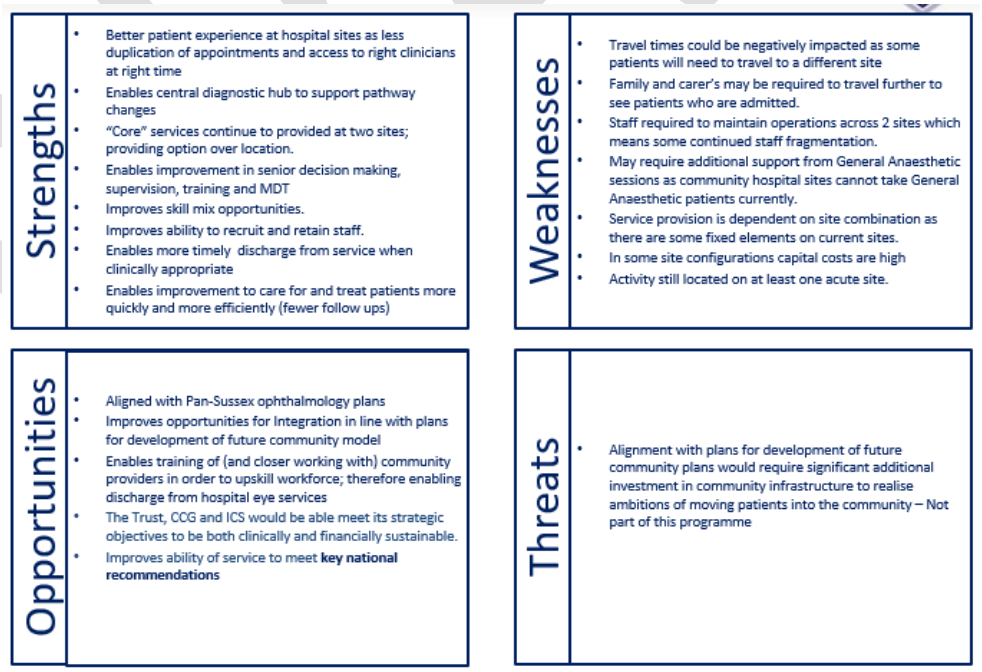


Figure 15: Analysis of Option 2



In the options appraisal workshop it was said that this option would:

- begin to address 'bottlenecks' and lengthy waiting times for patients
- represent a compromise situation
- but, it was questioned whether it would be able to cope with growing patient need

This option ranked the highest against Quality and Safety, Clinical Sustainability and Financial Sustainability among patients and patient representatives.

Option 2 was ranked highest against Access and Choice by all stakeholder groups, and Deliverability by patients, patient representatives and other NHS staff.

Under the 2 sites option, emergency care provision will remain unchanged at Conquest Hospital and Eastbourne District General Hospital. There is no significant activity at either site, so any risk to the patient remains negligible. In addition, patients who currently require an urgent review by an ophthalmologist at Conquest Hospital will not be disadvantaged by any aspect of this proposal if provision moves it will remain business as usual for these patients.

This option would also support the NHS' move towards "net zero" by 2050, as it will be reducing patient travel between hospitals for numerous appointments as they would have done previously, plus a potentially additional reduction in staff travel between sites.

8.2.2. Options 3a and 3b: Ophthalmology services located at one hospital site, supported by one stop clinics and a diagnostic eye hub (Bexhill or Eastbourne District General Hospital)

Figure 16: Option 3 – Ophthalmology services located at one hospital site, supported by one stop clinics and a diagnostic eye hub (Bexhill or Eastbourne District General Hospital)

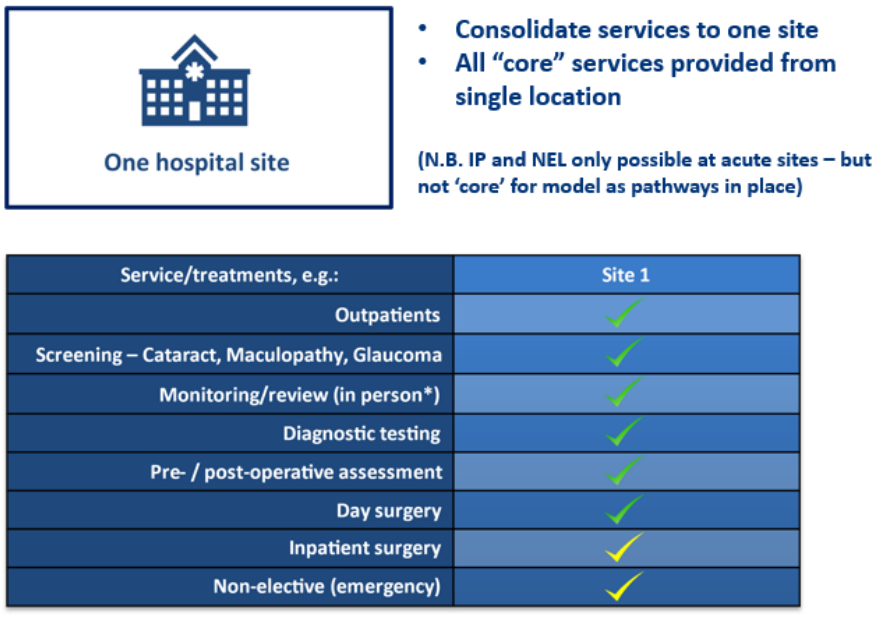
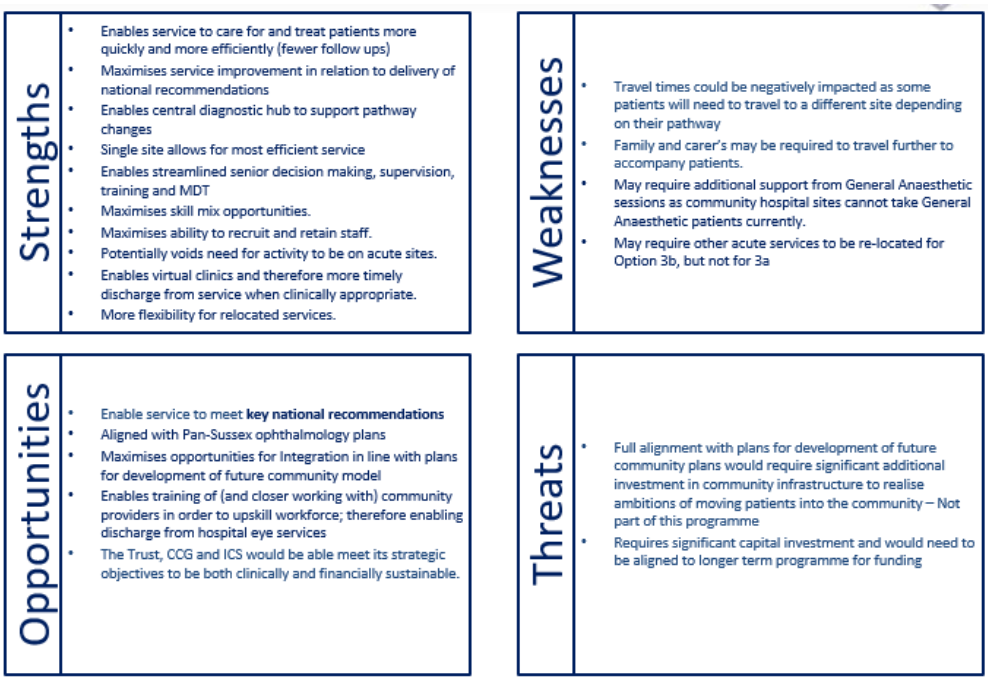


Figure 17: Analysis of Option 3



This option, to clinicians, represented an efficient use of our resources that would result in a timelier service and better outcomes for patients, and aid recruitment and retention through the centralisation of specialisms and specialists.

Patients, though, referred to travel and access including concerns around travel time, distance and cost, and the ease of getting to appointments. Indeed, there was recognition of patient access issues among clinicians also – as a need to futureproof services to account for future need increases.

This option ranked the highest against Quality and Safety, Clinical Sustainability and Financial Sustainability among East Sussex Healthcare Trust clinicians and other NHS staff, but only third highest amongst patients and patient representatives. It should be noted, however, that there was a wide-range of opinions among the latter group regarding this option.

This option would also support the NHS' move towards "net zero" by 2050, as it will be reducing patient travel between hospitals for numerous appointments as they would have done previously, plus a potentially additional reduction in staff travel between sites.

Option 3 was ranked lowest against Access and Choice by patients, patient representatives, and other NHS staff (which included community-based private optometrists).

A single site option was ranked highest by East Sussex Healthcare Trust clinicians against Deliverability. However, it was recognised that to fully realise the benefits of a single site model, it would require significant changes in the community infrastructure so that patients could access care without reliance on Hospital Eye Services. In the absence of the community model (which are part of the Sussex Transformation), the additional benefits above and beyond a two site model were felt to be marginal at this point in time.

There was general consensus that a single site option would be likely to have high capital costs and if this was to be taken forward, there would need to be a significant source of capital identified in order to make it affordable. The high capital requirement applied to whichever site was chosen, as all sites would need significant development and new build.

Due to these considerations, it was not anticipated that Option 3 would be taken forward as a proposed option.

8.2.3. Option 4: Ophthalmology services located at one hospital site, supported by one stop clinics and diagnostic eye hub at the site, and community hospital clinics

Figure 18: Option 4 – Ophthalmology services located at one hospital site, supported by one stop clinics and a diagnostic eye hub at the site, and community hospital clinics

- Consolidate services to one site
- All "core" services provided from one location
- Expand OP based services to clinics in the community

(N.B. IP and NEL only possible at acute sites – but not 'core' for model as pathways in place)

Service/treatments, e.g.:	Site 1	Community clinics
Outpatients	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓
Monitoring/review (in person*)	✓	✓
Diagnostic testing	✓	✓
Pre- / post-operative assessment	✓	✓
Day surgery	✓	✗
Inpatient surgery	✓	✗
Non-elective (emergency)	✓	✗

Full service	✓
Partial service	✓
No Service	✗

Figure 19: Analysis of Option 4

Strengths

- Enables service to care for and treat patients more quickly and more efficiently (fewer follow ups)
- Enables central diagnostic hub to support pathway changes
- Enables some improvement to senior decision making, supervision, training and MDT
- Potentially avoids need for activity to be on acute sites.
- Enables more timely discharge from service when clinically appropriate.
- More flexibility for relocated services.

Weaknesses

- Travel times could be negatively impacted as some patients will need to travel to a different site depending on their pathway
- Family and carer's may be required to travel further to accompany patients.
- May require additional support from General Anaesthetic sessions as community hospital sites cannot take General Anaesthetic patients currently.
- May require other acute services to be re-located, if core site is decided as being CQ or EDGH
- Does not maximise skill mix opportunities.
- Does not maximise ability to recruit and retain staff.
- Does not fully address staff capacity issues to tackle backlog of follow ups.
- Does not maximise opportunity for supervision and training.

Opportunities

- Aligned with Pan-Sussex ophthalmology plans
- Presents opportunities for Integration in line with plans for development of future community model
- Enables training of (and closer working with) community providers in order to upskill workforce; therefore enabling discharge from hospital eye services

Threats

- Does not make best use of our resources – especially in the short to medium term.
- Limited service improvement in relation to delivery of national recommendations
- Alignment with plans for development of future community plans would require significant additional investment in community infrastructure to realise ambitions of moving patients into the community – Not part of this programme
- Requires significant capital investment and would need to be aligned to longer term programme for funding

Overall, there was widespread support among workshop participants – and particularly the optometrists responding to the pre-engagement survey – for an alternative model of care that incorporates more community-based provision, particularly in terms of offering local care and going some way to addressing patients' travel and access concerns (and especially in the event of a single-site hospital model).

Discussions of Option 4 at the options development workshops included general consensus that although this model scored relatively highly, the provision of community hospital clinics was either:

- Not deliverable within the current East Sussex Healthcare Trust workforce due to the running of additional clinics at community hospitals fragmenting the workforce and therefore not addressing the key drivers to the case for change, and not enabling the most efficient use of resources.
- Or, if community hospital clinics were to be run by community staff, then the proposal lies outside of the scope of this transformation, but could be explored as part of the wider Sussex programme.

Due to these considerations, it was not anticipated that Option 4 would be taken forward as a proposed option.

8.2.4. General points to note across all three options

The number of patients requiring general anaesthetic work is in the very low numbers (0.01% of ophthalmology surgery is done under GA), but it should be noted that under all three of these options, Hastings patients requiring general anaesthetic work will continue to have the procedure completed at Conquest Hospital; as there are two afternoon sessions a month which would remain.

There is also the tangible opportunity to provide general anaesthetic surgery at Eastbourne and initial discussions have been held about the possibility of undertaking general anaesthetic work at Bexhill Hospital's Day Surgery Unit. Therefore, there should be no impact on the local population regarding this should there be any change in site.

It should also be noted that the number of patients presently requiring inpatient stays is very small, so as not to be of consequence to East Sussex Healthcare Trust service provision overall. Therefore, the service will continue to offer inpatient stay at Conquest Hospital, under all three of these options, should it be needed.

Under all three of these possible options, the paediatric pathway itself will remain unchanged, as will the locations of inpatient and theatre services for paediatric ophthalmology services. However, the location of where paediatric outpatients is delivered will change, in line with adult

outpatient services. The move of paediatric outpatients from Conquest means the team is able to work closer together with orthoptists, optometrists and consultants at the same site. There are no clinical adjacencies that require paediatric outpatient services to be co-located alongside paediatric services. (NB: child screening services is out of scope of this transformation programme and therefore these services are not impacted and will remain the same).

Also under all three of these options it is not expected for Emergency Ophthalmology activity to change. East Sussex Healthcare Trust do not provide an eye casualty at present, therefore patients with emergency eye conditions are seen and treated by A&E, and will continue to be able to present to Accident & Emergency at either Conquest or Eastbourne following the proposed change. This means patients in A&E will continue to be supported by an on call ophthalmologist, as per current service arrangements.

The diagnostic hub that is part of all of these options is a huge positive for the local eye health system and will be able support further integration between primary and secondary eye care services.

The one-stop clinics that are part of all these options lead to a reduction in unnecessary hospital visits, as a diagnosis is made and treatment commences within the same visit. These clinics will also make communication to patients easier and clearer. Often conditions are time limited so prompt treatment leads to better outcomes.

If patients have no active ocular pathology then they do not require being seen at the hospital eye service and can be discharged to local community providers. This enables patients with active problems to be linked with community providers for the condition. Discharging unnecessary follow-up appointments will be vital to help deal with capacity issues in the immediate future; this is part of the Royal College of Ophthalmologists way forward plan.

National and Sussex-wide ophthalmology transformation

As outlined in more detail within Sections 3 and 4, a major national ophthalmology programme commenced in early 2021, aimed at creating greater integration between community optometry and acute ophthalmology. The Sussex element of this national programme – the Integrated Care System Ophthalmology Transformation Programme – is underway and our expectation is that, over the next one to two years, community optometrists, i.e. ‘high street opticians’, will become increasingly involved in delivering parts of the ophthalmology service that does not require attendance at a hospital, often as part of a shared care arrangement between the hospital and the specialist high street optometrist.

However, the Sussex-wide transformation programme is outside the scope of the East Sussex Healthcare Trust transformation, therefore this pre-consultation business case is centred on the changes that East Sussex Healthcare Trust itself is able to make within the context of the Sussex programme.

Equality and Health Inequalities Assessment Workshops

Following our options development and appraisal workshops, the programme team held two workshops dedicated to the Equality and Health Inequalities Assessment. The focus of these workshops were:

- Lessons Learnt, following feedback from NHS England/Improvement Stage 1 Assurance and team learning from our Equality and Health Inequalities Assessment process for this programme
- A Look at Options Development through an Inequalities Lens, where our Equality and Health Inequalities Assessment was reviewed alongside our short listed options to ensure consideration was given to them from an equality and health inequalities perspective.

Proposed options to be taken forward

A single site option (3a and 3b) remains an aspiration, however, due to the points considered in the above section, this cannot be considered at this point in time due to the following reasons:

- Access and choice were a high priority for patients, as evidenced in the feedback from pre-engagement and from the options appraisal workshops.
    - Moving to a once site model without the complimentary community provision that is planned as part of the Sussex programme was felt to not adequately address the concerns raised around access and choice at this time.
- The additional benefits and efficiencies of moving to a one site model are only fully realised in conjunction with the wider Sussex programme. The additional benefits from a one site model for the East Sussex Healthcare Trust transformation alone are not in the order of magnitude required to justify pursuing consolidation to a single site at this time.
- Financial modelling was conducted for options 3a and 3b, both of which require substantial new build and estates development; capital requirements were therefore felt to be unaffordable at this point in time.

Therefore, following the options development and appraisal process, and in light of the above information, it was agreed by the East Sussex Cardiology and Ophthalmology Steering Board that Options 2 (Two sites; Eastbourne and Bexhill) be taken forward as the proposed option.

Summary of Recommended Option

The recommended option taken forward by this business case is:

Option 2 – Ophthalmology services located at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.

- This Ophthalmology programme seeks to consolidate activity from Conquest Hospital to Bexhill, **from three sites to two**
    - We currently provide services from three sites – Eastbourne, Conquest and Bexhill
    - There will be no change at the Eastbourne site.
    - We are proposing changes as to what moves from Conquest to Bexhill only.
    - Bexhill is 6.6 miles from Conquest Hospital
    - Both Conquest and Bexhill are outside of the Hastings main population centre.
- Activity being moved relates to outpatients and Day Surgery at the Conquest.

POD	Number of Conquest patients
Outpatient First Appt	7,113
Outpatient Follow Up	17,158
Day Case	111

    - Outpatient activity amounts to approximately 24,000 appointments per annum.
    - Day case activity is just over 100 patients per annum (approximately 2 sessions per month).
    - The activity above is pre-COVID.
- Emergency and General Anaesthetic surgical cases, (including cases which require overnight stay), will continue to be done at Conquest Hospital, there are no proposed changes to this work.
- The 2019/20 data shows that the split of Outpatients and Day Case surgery work is currently (pre-COVID):

Percentage Activity Split per Site by Point of Delivery (Current Pre-COVID)			
POD	Bexhill	Conquest	Eastbourne
Outpatient First Appt	5.3%	39.3%	55.4%
Outpatient Follow Up	25.4%	26.3%	48.3%
Day Case	46.2%	2.4%	51.4%

- The surgical day case activity can be accommodated within the Day Surgery Unit (DSU) at Bexhill, no additional estates work is required to enable this.
- There will be estates reconfiguration necessary to accommodate the outpatient clinics from Conquest, the costs of this are approx. £1.3m, which can be funded from internally generated capital / Integrated Care System allocation (see finance section).
- The changes will allow us to redesign pathways to increase quality of care and efficiency, (including High Volume Low Complexity work), provide one-stop clinics, and provide a consultant led (as opposed to delivered) model of working that efficiently utilise skill mix and training opportunities.

- This change also enables the wider Sussex Ophthalmology plan, which will be reliant on training and supervision from the East Sussex Healthcare Trust consultant body to upskill the community Optometry workforce.

9. Impact of the pre-consultation proposal

9.1. Overview of the impacts of the pre-consultation proposal on patients

As outlined in the section above, following the activity and financial modelling of Options 2, 3a and 3b, Option 2 (consolidate ophthalmology services to two sites) is recommended to be taken forward as the preferred option in this Pre-Consultation Business Case.

To increase our understanding of the impact of our pre-consultation proposal on patients, we looked at the evidence from the pre-consultation engagement and from analysis of activity data. This showed us that people who use our ophthalmology services share many common experiences.

To illustrate the impact of our proposal on patients, we used people's experiences to create a series of stories that show the experiences that people have at the moment and how these would be different. The stories show how, as a result of our proposal, people would be supported to access a more efficient and sustainable ophthalmology service than they do at the moment and would experience an improved outcome. In addition, it should be highlighted that the proposed changes will reduce waiting times and the number of appointments patients will be required to attend, thereby improving patient experience and quality of care on our population's health.

The patient stories in table 17 following this section illustrate these experiences.

Table 17: Patient stories

The Patient	The Pathway	What happens now?	How long does all this take?	What would happen to the patient in the future?	How long would all this take in the future?	What would be the benefits of the new pathway?
Patricia is 80 years old and lives in Eastbourne: she and her husband, Robert, moved to Eastbourne from the Midlands when they retired. Patricia is a widow – sadly, Robert died last year. Patricia has three grown-up children who live in the Midlands. **Recently, when watching TV, Patricia has noticed a funny, blurred black spot in the middle of her vision. She has also noticed that, when she looks at things like the shelves in her kitchen or her**	**Medical Retina Age-related Macular Degeneration (AMD)**	At the Eastbourne District General Hospital Patricia has some tests on her eyes, after which she goes home. The results of Patricia's tests are reviewed by a consultant ophthalmologist: the tests show that Patricia has Wet Age-related Macular Degeneration (Wet AMD). If the consultant decides it is necessary, Patricia will be referred urgently	If Patricia's eye problems are urgent, the time it takes from seeing her GP to beginning treatment is between five and eight weeks. If Patricia's eye problems are not urgent, the time it takes from seeing her GP to having treatment is usually up to 18 weeks but may be longer.	Patricia's GP would refer her to the ophthalmology department's **One Stop Clinic** at Bexhill Hospital. At the **One Stop Clinic** Patricia would be seen by specialist eye clinicians and she would have all the necessary tests on her eyes. The results of these tests would be looked at straight away by the clinicians and, if necessary, Patricia would begin treatment the same day.	The time it would take from Patricia being referred by her GP to having her first treatment would be a maximum of two weeks if her eye problems were urgent. If they were not urgent Patricia would be seen within 18 weeks.	Patricia would have fewer appointments: at the **One Stop Clinic** all her tests would be carried out and reviewed straight away by a specialist clinician. If necessary, Patricia would begin treatment straight away. If Patricia's eye problems were urgent, she would only have to wait two weeks for treatment to begin, rather than four to 18 weeks.

wardrobe, the edges, instead of being straight, look odd and wobbly. **Patricia contacts her GP about her eye problems. Her GP refers her to the ophthalmology (eye) outpatients department at Eastbourne District General Hospital.**		for treatment. The hospital's admin team will arrange an outpatient appointment for treatment for Patricia and they will write to her to tell her about this. At the outpatient appointment Patricia will see a specialist eye clinician and her treatment will begin. If Patricia's eye problems are not urgent, the consultant will write to her to tell her this. The hospital admin team will then arrange a routine appointment for Patricia at the outpatient department at the Eastbourne		If it wasn't necessary to treat Patricia's problems the same day, the hospital admin team would make an appointment for her to come back and would write to tell her this.		

		District General Hospital and they will write to her to tell her this. At the outpatient appointment Patricia will see the consultant and they will discuss her diagnosis.				
Marcus is 72 years old and lives in Hastings: he came to the UK from Jamaica as a young child in the 1950s and lived in London for many years before moving to Sussex. Marcus is married to Gloria and they have two grown-up children and five grandchildren, all of whom live in London. **Marcus has always been proud of his**	**Glaucoma**	At the hospital the referral is reviewed by a consultant ophthalmologist. The consultant decides that Marcus needs to come and have some tests. The hospital admin team makes an appointment for Marcus to have these tests at Bexhill Hospital and writes to Marcus to tell him. Marcus	The time it takes from Marcus seeing his optician to having treatment is up to 30 weeks.	Marcus's optometrist would refer Marcus to the new **Diagnostic Eye Hub** at Bexhill Hospital. At the Hub, Marcus would have all the tests he needed and the results of these tests would be reviewed by a specialist eye clinician within one week.	If Marcus's glaucoma was urgent, the time it would take from being referred by his optometrist to beginning treatment would be between 9 and 11 weeks. If Marcus's glaucoma was not urgent, the time it would take	Marcus would still be visiting Bexhill Hospital (he could also go to the Eastbourne District General Hospital if that was more convenient) for the same number of appointments but he would be seen and treated much more quickly – between 9 and 17 weeks

"20-20" vision and he doesn't think there is anything wrong with his eyes at the moment, particularly as Marcus has always looked after his eyes and visits his local optician in Hastings regularly for free checkups. **However, at a checkup the optometrist spots some symptoms they think might be signs of glaucoma, so they refer Marcus to the ophthalmology outpatients department at Bexhill Hospital.**		attends his appointment at Bexhill Hospital and has the tests. Marcus then goes home. The hospital admin team then arranges an outpatient appointment for Marcus to come back and discuss the results of his tests with a specialist eye clinician and they write to tell him this. Marcus attends his appointment at Bexhill Hospital. The specialist eye clinician tells Marcus that they have diagnosed glaucoma and they decide on the best		If the clinician diagnosed glaucoma they would then decide how urgently Marcus needed to be seen. The hospital admin team would arrange an outpatient appointment for Marcus at either Bexhill Hospital or the Eastbourne District General Hospital and they would write to Marcus to tell him. If urgent, the appointment would happen within 2 weeks, if non-urgent, the appointment would happen within 6-8 weeks. Marcus would attend his outpatient appointment at	from being referred by his optometrist to beginning treatment would be between 13 and 17 weeks.	rather than 30 weeks. For some of his appointments Marcus might not need to go to the hospital at all as these could be done virtually.

		treatment for him. The most common treatment for glaucoma is eye drops: in this case the clinician gives Marcus a prescription for these drops. Marcus then takes the prescription to his pharmacist and begins treatment. Once treatment has begun, Marcus's eyes are regularly reviewed by a specialist eye clinician at Bexhill Hospital.		either Bexhill Hospital or the Eastbourne District General Hospital where he would be seen by a specialist eye clinician who would decide on the right treatment for him. This treatment would begin straight away. Marcus's eyes would continue to be monitored by a consultant ophthalmologist, both at face-to-face appointments and virtual (online) appointments.		
Harriet is 68 years old and lives in Rye. She owns an antiques shop and is very involved in her community, where she is a	**Cataract**	At the Bexhill clinic Harriet is seen by a consultant ophthalmologist who confirms that she has cataracts	The time it takes from Harriet seeing her optometrist to having the cataracts	Harriet's optometrist would refer her to the ophthalmology department's **One Stop Clinic** at Bexhill Hospital.	The time it would take from being referred by the optometrist to having the	Harriet would have to make fewer journeys to Bexhill Hospital: she would make one visit to the

volunteer driver helping older people get out and about. Harriet lives on her own, with her beloved dog Arnie. Harriet is very independent and enjoys being busy and active, however, she is a bit overweight and was recently diagnosed with Type II Diabetes. **Harriet has noticed recently that, whilst out driving in the evening, the streetlights appear to have "haloes" around them and the headlights of oncoming cars seem more dazzling than usual. Harriet decides to get her eyes checked at her local opticians in Rye.**		and that she needs an operation to remove them. Harriet is referred for her operation by the consultant. The hospital admin team puts Harriet on the waiting list for an operation. Before having her operation, an appointment is arranged for Harriet by the hospital admin team so that she can be assessed to make sure she is well enough for surgery. The hospital admin team writes to Harriet to tell her about this. After this appointment, and as long as Harriet	removed is between 28 and 32 weeks.	At the clinic Harriet would be examined by a specialist eye clinician and a decision would be taken straight away about whether to operate or not. If it was decided to operate, Harriet would see a nurse straight away who would assess Harriet to see if she was well enough for surgery. If Harriet was well enough, she would be put on the waiting list for her operation straight away. Harriet's operation would be done at either	operation would be between 12 and 16 weeks.	**One Stop Clinic** for all her tests and these would be reviewed and a decision taken about whether to operate or not straight away. Harriet would be seen on the same day to be assessed for her operation. Harriet would have to wait 12 to 16 weeks, rather than 28 to 32 weeks for her operation.

Harriet is examined by an optometrist who decides that Harriet may have cataracts. The optometrist refers Harriet to the cataract clinic at Bexhill Hospital.		is well enough, the operation to remove Harriet's cataracts is carried out at Bexhill Hospital in the cataract clinic. After the operation the hospital writes to a specially trained optometrist in the community to arrange for them to see Harriet after her operation to check that all is well.		the Eastbourne District General Hospital or Bexhill Hospital. After her operation, the hospital admin team would arrange for Harriet to be seen by a specially trained optometrist in the community to check that all is well.		

* This is based on more detailed development of the patient pathways.

9.2. Overview of the impacts of the pre-consultation proposal on workforce

The proposed model of care will have an impact on how the ophthalmology workforce is able to deliver its services. Consolidating services onto either two sites or to a single site allows for the creation of flexible and resilient rotas, which in turn enable the ophthalmology workforce the opportunity to grow and train staff to perform roles that they would not be able to provide without the appropriate senior supervision and guidance, which are integral to realising the benefits inherent in the model.

Due to the national shortages of Medical Ophthalmologists, East Sussex Healthcare NHS Trust is training its orthoptists and optometrists to undertake sub-specialty clinics such as face-to-face and virtual glaucoma clinics, and training for orthoptists and nurses to undertake Diabetic Macular Oedema/Retinal Vein Occlusion injections; these free up doctors to undertake the more complex patients and face-to-face clinics. The service has increased its nurse led clinics to be able to carry out Fundus Fluorescein Angiography (FFA) Botox clinics. The department is looking to train more Advanced Health Practitioners under the Ophthalmology Practitioner Framework to increase the expertise and knowledge of the orthoptists and nurses to extend their roles further. This Framework is very new and having the multidisciplinary staff in one area together helps reinforce training and supervision, maintaining quality and retaining staff for the future. Non-consultant staff that join the department have the opportunity to have one theatre list with a consultant to help increase their clinical knowledge and increase staff retention.

The proposed clinical model of care will have a beneficial impact on workforce for the ophthalmology service, including:

- Adequate staffing to manage demand for services and future growth
- Increase in senior supervision; increasing the skills of its workforce and allowing for skill-mixing opportunities.
- High quality clinical training for junior doctors and other health professionals
- Developing non-consultant roles such as Highly Trained Optometrists, and Nurse Injectors.
- Increasing sub-speciality training, staff development, and career progression.
- Increasing recruitment and retention, and enabling succession planning, in all staff groups.

This proposal would bring further benefits including training for other staff groups to be able to undertake urgent care clinics and allowing time to be freed up for clinicians to be able to undertake more complex clinical work. This will create more capacity which could be immediately utilised, as presently the service is cancelling less complex clinics to deliver urgent care ones. Other opportunities would be created for different staff groups, including HCAs who would be able to help with injection clinics as well as there being more non-medical injectors

trained up. There will also be opportunities for optometrists and orthoptists to deliver additional clinics, e.g. glaucoma.[47]

At this early stage, full rota analysis has not been undertaken. Current state staffing was established for areas that will undergo change**,** broken down by staffing type.

At this point in time, the workforce model is based on realistic assumptions of the scale of opportunity to how different healthcare professionals can support patients (for example more patients cared for by appropriately trained staff, freeing up consultants and medical staff to upskill and train colleagues in the community, reduce the reliance on a consultant (and to some degree a medical) workforce, in favour shifting this activity to other, appropriately trained, health professionals).

From a wider perspective, the Sussex Integrated Care System Ophthalmology Programme is currently working with Health Education England (HEE) and NHS England with a view to undertake the award-winning CLEAR workforce programme in late 2021. The CLEAR programme empowers clinical staff to explore new models of care and ways of working that allows teams to maximise their capacity through understanding how pathways can be made most efficient. While this programme is likely to take place at Sussex system level, our intention would be to replicate and apply the learning to the East Sussex Healthcare Trust system, both in the acute department and within the community.

Eye Care Liaison Officers (ECLOs) are another effective way of supporting ophthalmology services. They are key in helping patients understand their diagnosis and providing them with emotional and practical support for their next steps, deal with any sight loss experienced and help patients maintain their independence. Additionally, ECLOs work closely with medical and nursing staff in the eye clinic, and the sensory team in social services. Most importantly, ECLOs have the time to dedicate to patients following consultation, so that they can discuss the impact the condition may have on their life. Our current ECLO service in East Sussex Healthcare Trust is via a Service Level Agreement with the Royal National Institute of Blind People who provide and manage our ECLO, who currently has to split their time between the various sites which means some patients will not benefit from the positive impact of having an ECLO available at their point of diagnosis. By reducing the sites the ophthalmology service runs on, the ECLO service at the point of diagnosis will be more accessible for patients because the ECLO will not be spread thinly across three sites. This enables East Sussex Healthcare Trust to achieve one of the recommendations from Getting It Right First Time.

The programme team will work with East Sussex Healthcare Trust and service colleagues to undertake a full workforce mapping exercise ahead of the Decision-making Business Case.

[47] The Royal College of Ophthalmologists, 2016, *The Ophthalmic Common Clinical Competency Framework (OCCCF)*

9.3. Activity and financial modelling

The purpose of the financial case is to set out the impact of the preferred way forward on the Trust's financial performance and position, and to show the impact of the key financial risks. This is important as it demonstrates whether the options being considered for consultation are financially sustainable.

Activity growth assumptions

Activity modelling has been conducted to inform financial modelling, with the growth rates below as being a realistic forecast of activity over the ten years.

Table 19: Admitted patients and outpatients - baseline growth rate per year over ten years

Baseline growth rate per year Years 1-10	Admitted patients	Out patients
Glaucoma	1.8%	1.8%
Age-related Macular Degeneration	2.4%	2.4%
Diabetic Macular Oedema & Retinal Vein Occlusion	1.7%	1.7%
Cataracts	1.8%	1.8%
Oculoplastics	1.8%	2.1%
Paediatrics	1.8%	2.1%
Neuro Ophthalmology	1.8%	2.1%
Urgent Care Clinic (Subsequent Procedure Required Non-A&E)*	1.8%	2.1%

*Please note: Urgent care clinics in Ophthalmology are Urgent Outpatient clinics, but are not part of the Emergency Department, and are not Non-Elective activity.

The above growth rates have been used to construct the baseline activity model as compared with the current service configuration (Do nothing).

Based on the growth assumptions outlined in the above, forecast activity is provided in table 19 compared with the current service model. This shows a reduction in outpatient activity of 1,044 clinic appointments against rising growth.

Table 20: Total activity by Point of Delivery by option, at year 10

	Do Nothing			Option 2		
Point of delivery	**Bexhill**	**Conquest**	**Eastbourne**	**Bexhill**	**Conquest**	**Eastbourne**
Emergency IP	0	20	20	0	20	20
Elective IP	0	1	13	0	0	0
Day Case	2629	127	3370	2755	0	3370
First OP Attendance	1791	2494	4277	4286	0	4277
Follow up OP Attendance	6411	8927	15307	14823	0	14793
Outpatient Procedure	13288	18502	31726	31790	0	31726
Sub Total	24120	30072	54714	53655	20	54187
Total	**108906**			**107862**		

Option 2 has slightly lower activity as a result of the reduced outpatient activity, relative to 'Do nothing'. As a result, Option 2 is modelled as showing East Sussex Healthcare NHS Trust having lower overall Ophthalmology income (as well as reduced costs – see financial case below) meaning a saving of income payments of approximately £200k per annum. Combined with lower operating costs, this translates to a whole system cost saving.

Scope

Ophthalmology services are currently run across three main sites: Bexhill, Conquest, and Eastbourne District General Hospital. This financial case financially appraises the proposed configuration option to consolidate to two sites, compared to a "Do Nothing" option:

1. **Do Nothing**: Ophthalmology services continue to be delivered across Bexhill, Conquest and Eastbourne, as they are now. Activity grows over time. Refurbishment and lifecycle works across the three sites will be required to deliver this.
2. **Option 2: Consolidate to two sites (Eastbourne & Bexhill)**: Ophthalmology services consolidate to Bexhill and Eastbourne District General Hospital in 2022-23. Activity grows over time, however, consolidation to two sites will bring improved operational efficiencies. In order for Bexhill to take on activity from Conquest, existing space, will be reconfigured and refurbished.

The following areas are out of scope of reconfiguration:

- Emergency Ophthalmology activity. The configuration for this activity is not expected to change, East Sussex Healthcare Trust do not provide an eye casualty at present. Patients with emergency eye conditions are seen and treated by A&E, and will continue to be able to present to Accident & Emergency at either Conquest or Eastbourne.

Financial Case - Summary of findings and next steps

Consolidation of ophthalmology services is expected to drive operational efficiencies through seven key levers:

1. An ability to use senior supervision of outpatient clinics more effectively, leading to better training, and in particular supporting better discharge decisions from outpatient services leading to an improved outpatient new-to-follow up ratio
2. An ability to use staff skill mix more efficiently in the consolidated options, leading to an ability to accommodate activity growth with less growth in medical staffing, and instead growth through hospital based optometrists, orthoptists and advanced nurse practitioners. This leads to pay cost savings between the consolidated options
3. An ability to optimise theatre list design and pre-operative assessments to enable a (very slight) increase in the average number of patients per theatre list in the consolidated options relative to doing nothing
4. An ability to avoid underutilised outpatient clinic lists in the consolidated options, thereby leading to a (very slight) increase in the average number of patients per outpatient clinic.

5. An ability to reduce the need for ad hoc and waiting list initiatives to keep up with underlying demand, relative to that used in 2019/20
6. Reduction in the need for temporary staff through a reduction in vacancies, due to an improved ability to use skill mix and due to more attractive service configuration/ building design for ophthalmology (this will lead to lower hourly costs where permanent staff are used in place of temporary staff)
7. An ability to reduce equipment inventory and associated maintenance costs through consolidation of services

It is expected that the service will be able to use these levers to reduce total expenditure (across operational expenditure and capital charges) compared to 'Do nothing' by 2031-32. This would result in a forecast surplus position for Option 2 that is £2,057k better than the 'Do nothing' option per annum by 2031-32 and total expenditure over the reference period that is £10.7m less.

The table below provides a summary of the financials over a 10 year period compared with the 'Do nothing' option:

Table 21: Cumulative income and expenditure compared with 'Do nothing' (£'000)

	1. Do minimum	2. Two sites
Income from Commissioners	165,220	164,614
Other Income	2,740	2,140
Total Income	**167,960**	**166,754**
Pay Costs	(88,138)	(81,273)
Non Pay (exc cost of capital)	(74,457)	(69,655)
Cost of Capital	(9,708)	(10,605)
Total Expenditure	**(172,304)**	**(161,533)**
Net	(4,344)	5,221
Efficiency savings (%)	-	6.4%

Table 22: Summary of surplus deficit for each Option per year (£'000)

£'000	19/20	20/21	21/22	22/23 Yr1	23/24 Yr2	24/25 Yr3	25/26 Yr4	26/27 Yr5	27/28 Yr6	28/29 Yr7	29/30 Yr8	30/31 Yr9	31/32 Yr10
Do Nothing	610	(366)	(353)	2,397	(391)	(447)	(510)	(583)	(664)	(756)	(859)	(1,029)	(1,209)
Option 2	610	611	609	2,337	(305)	(205)	(104)	11	127	246	367	256	137

Comparison

Based on the above summary of analysis, Option 2 (consolidate to two sites – Eastbourne District General Hospital and Bexhill) is the most favourable option. Option 2 generates a surplus from 26/27 through to 31/21 relative to significant ongoing net losses for 'do nothing'.

Capital investment

The capital investment required under each option is given below:

	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000	Total £'000
Option 1: Do nothing						
Buildings	-	-	-	-	-	-
Equipment	1,634	1,634	-	-	-	-
	1,634	**1,634**	**-**	**-**	**-**	**3,268**
Option 2: Two sites						
Buildings	1,292	-	-	-	-	1,292
Equipment	1,760	1,760	-	-	-	3,520
	3,052	**1,760**	**-**	**-**	**-**	**4,812**

The additional capital costs for Option 2 are therefore:

- **£1,292k** for buildings and refurbishments, including:
  - Reprovision of space for Physio and X-Ray at Bexhill
  - Refurbishment of existing Physio and X-Ray space at Bexhill to accommodate activity from Conquest
  - Estates works on Bexhill main building outpatients.
- **£252k** for equipment costs, including:
  - Additional / upgraded equipment required as part of the transformation.
  - Replacement of equipment that cannot contractually be moved to the Bexhill site (e.g. donations with contractual stipulations on site)

Funding

The levels of capital outlined in this case for the proposed option (Option 2) can be funded from either internally generated capital or the Integrated Care Systems' Capital allocation in agreement with system partners.

- The capital required for equipment (£3,520k) will be funded from East Sussex Healthcare Trust internally generated annual capital.
- The funding source for the estates work (£1,292k) is yet to be confirmed, but will either come from Integrated Care System capital allocation or East Sussex Healthcare Trust internally generated capital, both of which are considered sufficient to fund the relatively low level of addition capital required for this programme.

Sensitivities

To test the robustness of the conclusions we have modelled a number of sensitivities against the options:

- **Activity changes**: we have modelled activity growth at 1% higher/lower per annum for all options. Activity volumes are a key driver for any service and hard to accurately predict over a long time period. However, the options are not driven by certain activity thresholds as rate limiting factors with it anticipated that the impact will be similar across each options.
- **Efficiency**: one of the key benefits when considering the financial model is the ability to deliver additional efficiency under the proposed option. We have considered the impact if only half the efficiency modelled under the base case is delivered. No change to the Option 1.

A Note on Capital Sensitivities: The base case includes optimism bias of 30% in all capital expenditure delivery of significant construction projects always brings inherent risk. Capital expenditure in Option 1 and Option 2 (the proposed option) is predominately around refurbishment of existing estate to deal with backlog issues. The risk is considered much less compared with new build projects and therefore no sensitivity has been applied to Capex.

Table 18: Sensitivity analysis

	Base case	Activity Increase	Activity Decrease	Efficiency
	£'000	£'000	£'000	£'000
Option 1. Do nothing	(6,996)	(5,268)	(8,556)	(6,996)
Option 2. Two sites (EDGH & Bexhill)	7,072	7,695	6,491	3,091

The modelling shows that the proposed option is still favourable to the do nothing. Overall this provides further assurance around the conclusion to the financial case that it is reasonable that the proposed option is favourable.

Recommendation

Based on the above analysis, Option 2 is the most favourable from an overall modelling perspective. It is recommended that Option 2 (consolidate ophthalmology services to 2 sites, Eastbourne and Bexhill), is taken forward as the preferred option based on the outcome of the modelling exercise conducted. This option also offers greater access in the context of continued work on a strategic approach to expanding community and digital based improvements.

Therefore, the proposed option (Option 2) is the preferred option that this Pre-Consultation Business Case will take forward to consultation.

Figure 20: Option 2 – Ophthalmology services located at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.

- Consolidate services to two sites
- All "core" services provided across two sites

(N.B. IP and NEL only possible at acute sites – but not 'core' for model as pathways in place)

Service/treatments, e.g.:	Site 1	Site 2
Outpatients	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓
Monitoring/review (in person*)	✓	✓
Diagnostic testing	✓	✓
Pre- / post-operative assessment	✓	✓
Day surgery	✓	✓
Inpatient surgery	✓	✓
Non-elective (emergency)	✓	✓

Full service	✓
Partial service	✓
No Service	✗

9.4. Impact on neighbouring areas

ESCCG and East Sussex Healthcare Trust colleagues have liaised with a number neighbouring areas to ensure we are clear and transparent about our proposals and plans to date, and will continue to keep local areas informed of progress as we continue with this programme. The table below shows these Trusts, and details how much activity from East Sussex attends their ophthalmology services. At present, there are no plans to reconfigure ophthalmology services within these Trusts.

Table 25: Patient flows to local and neighbouring ophthalmology services (based on 2020-21 data)

Trust	Elective activity	Outpatient Follow Up	Outpatient New	Total
East Sussex Healthcare NHS Trust (ESHT)	2,537	39,859	12,723	**55,119**
Hampshire Hospitals NHS Foundation Trust	0	0	0	**0**
Maidstone and Tunbridge Wells NHS Trust (MTW)	92	2,285	543	**2,920**
Portsmouth Hospitals NHS Trust (PUH)	0	2	1	**3**
Queen Victoria Hospital (QVH)	391	5,367	515	**6,273**
Surrey and Sussex NHS Trust (SaSH)	71	174	79	**324**
University Hospital of Southampton NHS Foundation Trust (UHS)	0	2	1	**3**
University Hospitals of Sussex NHS Foundation Trust (East) (UHSx East) (previously Brighton and Sussex University Hospitals)	707	7,013	1,468	**9,188**
University Hospitals of Sussex NHS Foundations Trust (West) (UHSx West) (previously Western Sussex Hospitals)	1	24	12	**37**

Note: Elective activity includes inpatient and day case activity; diagnostics is not included in this data

9.5. Overview of the impacts

The consolidation of sites would enable clinics to be appropriately staffed as well as provide senior decision making and input when it is required, reducing waiting times for treatment and the amount of follow-ups; patients will see the right people, in the right place, at the right time. In addition, fewer sites makes more effective use of resources in terms of estates, equipment and associated maintenance.

Table 26: Summary of the impacts of the pre-consultation business case proposal

Impact of proposal	Would the impact of the proposal be better or worse than now?	Why is the impact better or worse?	Action required
Local health need	Better	The proposed options will make East Sussex Healthcare Trust's ophthalmology service more sustainable and better able to serve its current and future population. Additionally, the introduction of one stop clinics and a diagnostic hub will reduce waiting times, reduce the number of appointments required for patients and repeated tests. These are key quality improvement to the ophthalmology service.	In collaboration with our system partners, continue to lead and further develop integrated universal and targeted services to improve health outcomes.
Health inequalities	Better	As we develop proposals to redesign services we will involve local people, and focus on those who our Equality and Health Inequality Assessment has highlighted are at greater risk of ophthalmic diseases and in need of ophthalmology services at East Sussex Healthcare Trust, particularly as health inequalities have been exacerbated during the Covid-19 pandemic.	In collaboration with our system partners, continue to lead and further develop integrated universal and targeted services to reduce health inequalities.
Fewer transfers between services	Better	There will be fewer transfers between services for patients, as they receive an expert opinion and treatment earlier in the patient	Implementation of the proposal, including communications and engagement programme.

		pathway, as shown in Section 9.3	
Value for money	Better	The proposed options are better value for money in the longer term, as shown in Section 9.2, compared to retaining the current services.	Implementation of the proposal, including communications and engagement programme.
Possible confusion during initial stages of any change	Worse	If/when a change does take place, it is likely there will be an embedding period where local people, stakeholders and partners become aware of the change and get used to the change.	Further develop and implement a communications and engagement programme to ensure patients are supported to access the right services. Include a focus on groups identified in the Equality and Health Inequality Assessment and those experiencing deprivation and inequality.
Possible changes to travel and access arrangements for patients if locations change	A mixture of neutral, better and worse	Depending the outcome of this consultation, and any subsequent siting of ophthalmology services on two sites, some patients may have to travel to the same or a different site to where they have usually had to travel: • some patients may have to travel to the same site as they previously would have done • some patients may have to travel a bit further than they previously would have done • but others may be able to travel a shorter distance than they previously would have done. • whilst some patients may have to travel further they may have to make fewer journeys and stay in hospital for less time.	Further develop and implement a communications and engagement programme to ensure patients are supported to access the right services. Include a focus on groups identified in the Equality and Health Inequality Assessment and those experiencing deprivation and inequality. A specific element of the proposed formal consultation will focus on travel and access.

		However, it should be noted that Bexhill and Conquest hospitals are both outside of Hastings town centre.	

10.Impact Assessments

10.1. Quality Impact Assessment

A Quality Impact Assessment has been completed with the CCG's Quality Team (refer to Appendix 4 for the full version). The purpose of the Quality Impact Assessment is to assess the impact of the proposal on safety and the principal findings of the Quality Impact Assessment are:

- The transformation of ophthalmology services at East Sussex Healthcare Trust will have a positive impact on patient safety. Whilst East Sussex Healthcare Trust is currently providing a safe and effective ophthalmology service, the challenges in relation to changing patterns of service delivery, facilities, estates and recruitment in existence are not sustainable in the medium to long term. The current model is not sustainable in the medium to long term given the findings of the Royal College of Ophthalmologists (RCOphth) in 2019, which:
    - identified national gaps in recruitment for ophthalmologists and workforce planning;
    - predicated 40% increase in demand over the next 20 years;
    - noted that 67% of hospital eye services are locum doctors to fill consultant posts (an increase of 56% since 2016);
    - that 85% of services are undertaking waiting list initiatives to attempt to manage demand;
    - and that around 25% of the current workforce is nearing retirement.
- The transformation of ophthalmology services at East Sussex Healthcare Trust will have a positive impact on the effectiveness of the service. The proposed model of care is expected to improve the effectiveness of the service against the following drivers for change:
    - demand (as outlined previously) for ophthalmology services is likely to exceed the capacity of the service in its' current form. This may adversely impact on patient care, particularly around waiting times and follow up appointments. This would increase the risk of harm arising from delayed care.
    - challenges in maintaining the standards set by the 2019 NHS England High Impact Intervention for ophthalmology. The high impact intervention was designed to ensure that:
        - failsafe prioritisation systems were in place to reduce avoidable harm,
        - places the requirement on service providers to develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients, and undertake clinical risk and prioritisation audits of existing ophthalmology patients,

- and requires eye health capacity reviews to be implemented to understand local need for eye services and to ensure that capacity matches demand with appropriate use of resources and risk stratification.

- The transformation of ophthalmology services at East Sussex Healthcare Trust will have a positive impact on patient experience. The ophthalmology service has reported high levels of patient satisfaction from patients in relation to the Friends and Family Test (FFT) from April 2018 to March 2020 with returns averaging upwards of 96% and has reported a below average number of formal complaints April 2018 to March 2020.
- As a result of the impact of the Covid-19 pandemic the service was temporarily reconfigured to operate from a single site (Bexhill Community Hospital). Learning from this temporary reconfiguration includes for example, that the service has been able to improve clinical stratification, enabling patients to be seen more quickly by the most appropriate healthcare professional for their particular pathway and condition, by improving the availability of senior clinicians.
- Overall, the Quality Impact Assessment indicates that, for the shortlisted option, transformation would bring about quality improvement.

10.2. Equality and Health Inequalities Impact Assessment

An Equality and Health Inequalities Impact Assessment process has been followed throughout the project to date, updating the assessment as the project has progressed (refer to Appendix 1 for the full version).

The Equality and Health Inequality Assessment looks at the potential impacts of the proposal on different sections of the local population, including those classed as having protected characteristics as laid down in the Equality Act 2010:

Table 27: Summary of the Equality and Health Inequalities Impact Assessment

Protected Characteristic	Equality and Health Inequality Assessment	Proposed Action to mitigate any negative impacts against all protected characteristics	Proposed Action to mitigate any negative impacts against specific protected characteristics
Race/Ethnicity	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our ethnic communities. Look to action changes that would reduce health inequalities and ensure equity of access; for example the information available and how this is shared across our communities. Ensure links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement. Ensure that Friends, Families and Travellers receive information on all involvement activity. Attendance at Eastbourne Cultural Involvement Group to promote engagement opportunities. Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities.

			Promote interpreting services to local services and communities. Make communications about service changes available in community languages. Increase awareness for staff in local services about Black, Asian and Minority Ethnic needs through service contracts. East Sussex Healthcare Trust are currently working on a separate wider Trust piece of work to review data collection to ensure they are able to more accurately monitor data collections and identify any themes of inequality, e.g. patients' race/ethnicity, and address any identified challenges.
Sex	Neutral	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, model/interventions are developed that meet the needs of our communities, including taking account of the needs of women in respect of their being at greater risk of poor eye health and greater risk of developing blindness (based on national evidence). As part of the formal consultation process we will take measures to identify and engage with gender specific groups in East Sussex.
Gender reassignment	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regards to the issue of access

		our understanding of existing health inequalities within the service. Consider issues of intersectionality when planning engagement with local people including taking account of potential impact of intersectionality in developing options and future proposals for ophthalmology services.	and experience in our transgender community and that our transformation plans include trans awareness training for ophthalmology staff. For example, to be aware of and consider the right of privacy for people who are transgender, including, but not exhausted to, record sharing and information in line with the trusts policy and legal requirements of the gender reassignment act. As part of the formal consultation process we will take measures to identify and engage with trans groups in East Sussex, approach Hastings & Rother Rainbow Alliance Trans Support Group and Bourne Out via Facebook.
Age	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service. Consider issues of intersectionality when planning engagement with local people including taking account of potential impact of intersectionality in developing options and future proposals for ophthalmology services. The Equality and Health Inequality Assessment suggests that this particularly relates to this protected characteristic in relation to ophthalmology services.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regards to the issue of access and experience in our older community. As part of the formal consultation process we will take measures to identify organisations that support younger and middle aged people living with ophthalmic disease, approach East Sussex Senior Association, Age Concern, Royal National Institute of Blind People, East Sussex Association for the Blind, Macular Society, East Sussex County Council, Patient Participation Groups, Patient Carer Forums, and engage with the Public Health Vision Screening Service for Children and Age UK East Sussex.

			Publicity about the change in service to be targeted at younger people, young parents and older people through appropriate channels such as the Voluntary and Community Sector, local colleges and local parent groups. Target communications about service changes via channels to reach all age groups.
Religion and belief	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, model/interventions are developed that meet the needs of our communities, including giving due regards to the issue of access and experience of our patients of different religions and beliefs. As part of the formal consultation process we will ensure that we forge links with faith communities in East Sussex to engage in this project. We will review the Chapels, religious places and services within the Hospitals. Ensure links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement.
Disability (including long-term conditions)	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regards to the issue of access and experience of those patients living with a disability

			or long-term condition, including patients with vision or hearing loss, patients with physical and/or learning disabilities, mental health conditions or dementia may require longer appointments. As part of the formal consultation process we will explore opportunities with Voluntary and Community Sector organisations to see what networks or forums we can utilise to support engagement, approach Hastings Disability Forum, East Sussex Community Learning Disability Team and East Sussex Dementia Adviser Service. We will review the disabled and learning disabilities access and accessibility services within the Hospitals. Ensure materials can be made available in easy read and British Sign Language on request. As part of this project a further analysis of transport needs will be undertaken and measures agreed to mitigate adverse outcomes. There will be further engagement with patients and the public on the travel impact if a proposed option includes a change of site as part of the formal consultation process, with particular emphasis on the impact this will have on those who are visually impaired. East Sussex Healthcare Trust are developing a plan to deliver cultural and insight training on British Sign Language, Neuro diversity, hidden disabilities,

			including, but not exhausted to, mental health, British Sign Language, Neuro diversity challenges as well as adult and young carers. East Sussex Healthcare Trust are also developing plans to have dedicated champions in the team, for patients with hidden disabilities and Carers, and ensure they are available and visible to support patients and sign post where required.
Sexual Orientation	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regards to the issue of access and experience of our LGBTQ+ patients and that our transformation plans include awareness training for ophthalmology staff. As part of the formal consultation process we will take measures to identify any LGBTQ+ groups in East Sussex. East Sussex Healthcare Trust are currently working on a separate wider Trust piece of work to review data collection to ensure they are able to more accurately monitor data collections and identify any themes of inequality, e.g. patients' sexual orientation in line with NHS England's Sexual Orientation Monitoring Guidance, and address any identified challenges.
Pregnancy and maternity	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities,

		our understanding of existing health inequalities within the service. Consider issues of intersectionality when planning engagement with local people including taking account of the potential impact of intersectionality in developing options and future proposals for ophthalmology services. The Equality and Health Inequality Assessment suggests that this particularly relates to this protected characteristic in relation to ophthalmology services.	including giving due regard to the issue of access and experience of our pregnant people, those who are breastfeeding and those with young children. As part of the formal consultation process we will take measures to identify service users who fall into this category, encouraging them to undertake an in-depth interview, triangulate data on women at child bearing age with attendances at East Sussex Healthcare Trust to estimate the prevalence of women in the service that would/could be pregnant. Maternity departments are currently moving to a new model of care called “continuity of carer”, where pregnant people will have a single named midwife from their first appointment through to birth and post-partum discharge. The first tranche of pregnant people to benefit from this model are those who require additional care needs, such as young mums, those with pre-existing conditions or previous birth traumas. Therefore, any pregnant people with a pre-existing condition will be booked onto the continuity of care pathway with their own midwife with a greater level of expertise. Work with our East Sussex Maternity Voices Partnership to ensure that the voices of pregnant women are heard and consulted with.
Social deprivation	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve	Ensure that as part of the formal options development and consultation processes, model/interventions are developed that meet the needs of people that are

		our understanding of existing health inequalities within the service.	socially and economically deprived/disadvantaged, notably residents living in our most deprived areas where risk of sight loss is highest. As part of this project a further analysis of transport needs will be undertaken and measures agreed to mitigate adverse outcomes. There will be further engagement with patients and the public on the travel impact if a proposed option includes a change of site as part of the formal consultation process, with particular emphasis on the impact this will have on those who are visually impaired. As part of the formal consultation process we will approach foodbanks, Rother Voluntary Action, Hastings Voluntary Action, Voluntary Action in Eastbourne, Lewes and Wealden to support our engagement and target those living in areas of deprivation. There are organisations providing support for refugees and asylum seekers in East Sussex. Engagement with these agencies during consultation will take place to establish if the transformation to ophthalmology services will impact them. Obtain General Ophthalmic Service sight test data from NHS England to map attendances against areas of deprivation and triangulate the two to develop a comprehensive picture of attendances from deprived/disadvantaged backgrounds.

			A Sussex-wide ophthalmology group has been established that is focussing on the end-to-end redesign of ophthalmology pathways across the Integrated Care System. An action for this group is to take forward the promotion of eye health across Sussex with a focus on; modifiable risk factors and eye health, the importance of presenting early, and who is eligible for free sight tests. Working with Acute Trusts, the Local Optical Committee, Public Health, voluntary organisations, patient and patient representatives.
Other Disadvantaged Groups	Positive	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, model/interventions are developed that meet the needs of people that are socially and economically deprived/disadvantaged, notably residents living in our most deprived areas where risk of sight loss is highest. As part of this project a further analysis of transport needs will be undertaken and measures agreed to mitigate adverse outcomes. There will be further engagement with patients and the public on the travel impact if a proposed option includes a change of site as part of the formal consultation process, with particular emphasis on the impact this will have on those who are visually impaired. As part of the formal consultation process we will approach carers associations, care home groups and

			frameworks, work with homeless initiatives, Matthew 25, YMCA, and Armed forces community leads. A Sussex-wide ophthalmology group has been established that is focussing on the end-to-end redesign of ophthalmology pathways across the Integrated Care System. An action for this group is to take forward the promotion of eye health across Sussex with a focus on; modifiable risk factors and eye health, the importance of presenting early, and who is eligible for free sight tests. Working with Acute Trusts, the Local Optical Committee, Public Health, voluntary organisations, patient and patient representatives.
Transient population (e.g. visitors)	Unknown impact	To support the East Sussex system in co-developing potential options for ophthalmology services, we need to improve our understanding of existing health inequalities within the service. Consider issues of intersectionality when planning engagement with local people including taking account of potential impact of intersectionality in developing options and future proposals for ophthalmology services.	See above.

Our initial assessment of impact and risk in our Equality and Health Inequality Assessment has shown that the patients from ethnic communities, our population, women, patients with a learning disability or a long term condition (such as diabetes and dementia), residents in care homes and communities living in the most deprived areas are at the highest risk of widening health inequalities within ophthalmology services. However, this does not mean that there isn't a risk for other communities across our patient population.

The learning from Covid-19 that our Equality and Health Inequality Assessment has shown is that improvement to the transformation programme centres around communications. There is evidence that shows in areas of deprivation visits to primary and secondary care are left longer resulting in long term conditions or new conditions becoming worse for patients, which in turn can lead to longer stays in hospital and recovery times. During the pandemic this increased, some GP localities held phone check-in sessions with patients that live in areas of deprivation with long term conditions to see how they are and if they need any further support, this is now continuing. This is alongside Public Health who are working with patients on campaigns around improving prevention, diagnosis, supporting patients living well and/or dying well.

Our pre-consultation engagement helped us to refine the Equality and Health Inequality Assessment and define the work we will do to support patients in the future to access the right services for them. As part of our proposal we are continuing to develop a wide-ranging communications and engagement programme, which includes the principles of social marketing, to support our patient population to make the right choices for their healthcare.

During pre-consultation engagement there were some groups and/or their representatives with whom we did not connect and we will focus on these groups during consultation to ensure that their needs and those of their representatives are fully incorporated into our proposals. These are:

- deprived areas and those who may have additional health needs (including homelessness);
- the deaf community;
- Black, Asian and Minority Ethnic communities;
- Lesbian, Gay, Bisexual and Transgender communities;
- Refugees and asylum seekers.

Additionally, during pre-consultation engagement, participants were asked if there were any groups that engagement should focus on once the proposed shortlisted options have been developed and chosen. Responses included:

- The elderly
- Disabled
- Those without transport
- Opticians

- People in deprived communities
- People from different ethnicities, e.g. local Hungarian and Portuguese communities

10.2.1. Travel impact

During the pre-consultation period, local people have reflected a significant importance in the distance that patients might have to travel to receive services as a result of any reconfiguration. Therefore, we recognise the importance of ensuring that services reduce health inequalities and ensure reasonable access, and are therefore producing an action plan to address issues or concerns raised through engagement and consultation. This travel impact analysis seeks to outline the travel options available to local people who use the East Sussex Healthcare Trust ophthalmology services, as well as how the proposed changes may impact them. It should be noted that both Bexhill Hospital and the Conquest Hospital are located a few miles from Hastings town centre (approximately 6 and 3 miles respectively depending on routes taken).

The Eastbourne District General Hospital and Conquest Hospital are 19.3 miles apart with a road journey time of approximately 35 minutes (which can vary depending on traffic).

Bexhill Hospital is 14.2 miles away from the Eastbourne District General, with an approximate road journey time of 25 minutes and 6 miles away from Conquest Hospital with an approximate road journey time of 10 minutes.

Example road travel times from East Sussex areas if services are sited at either Conquest or Eastbourne District General:

Figure 21: East Sussex travel times to Bexhill Hospital

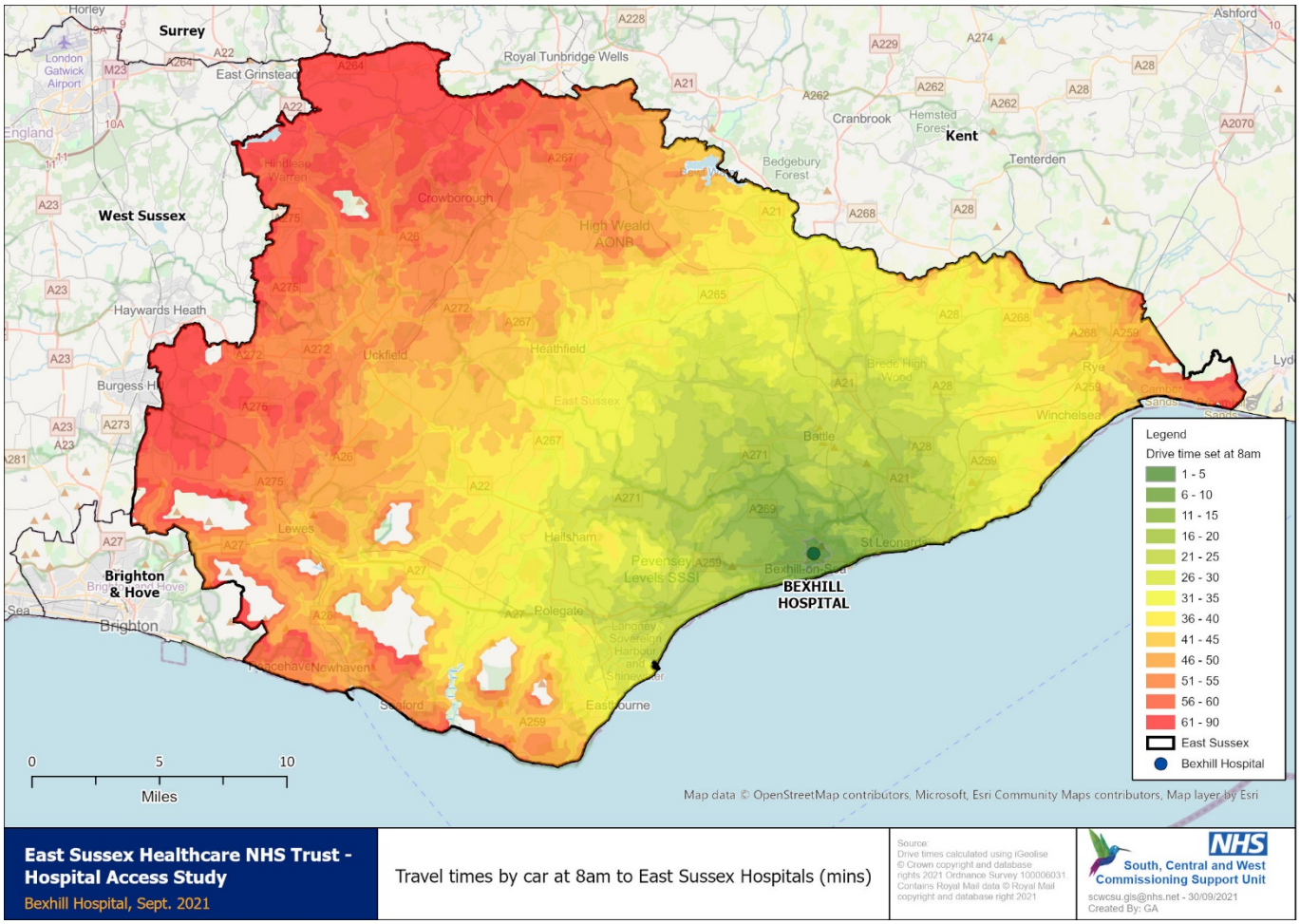


Figure 22: East Sussex travel times to Conquest Hospital

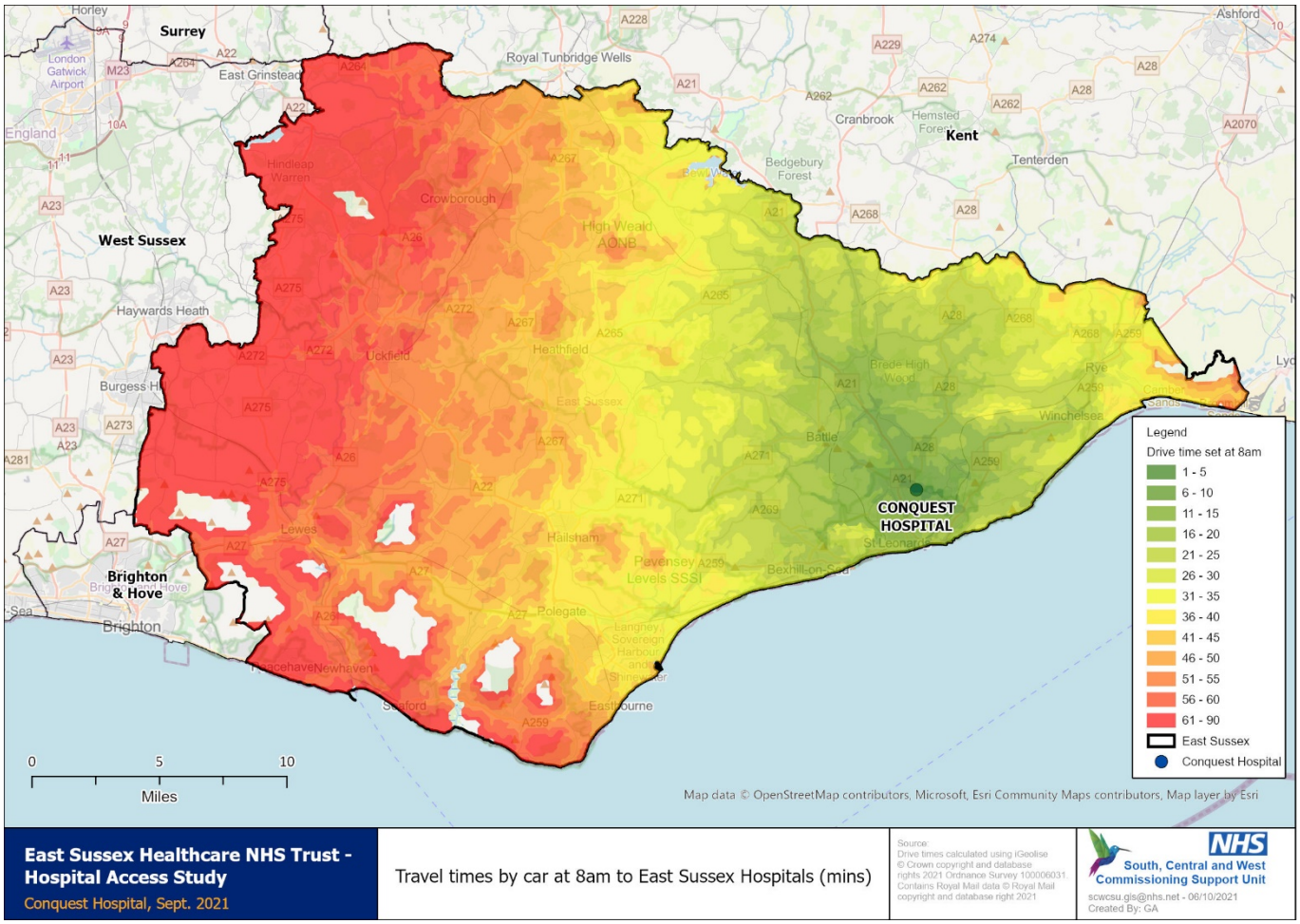
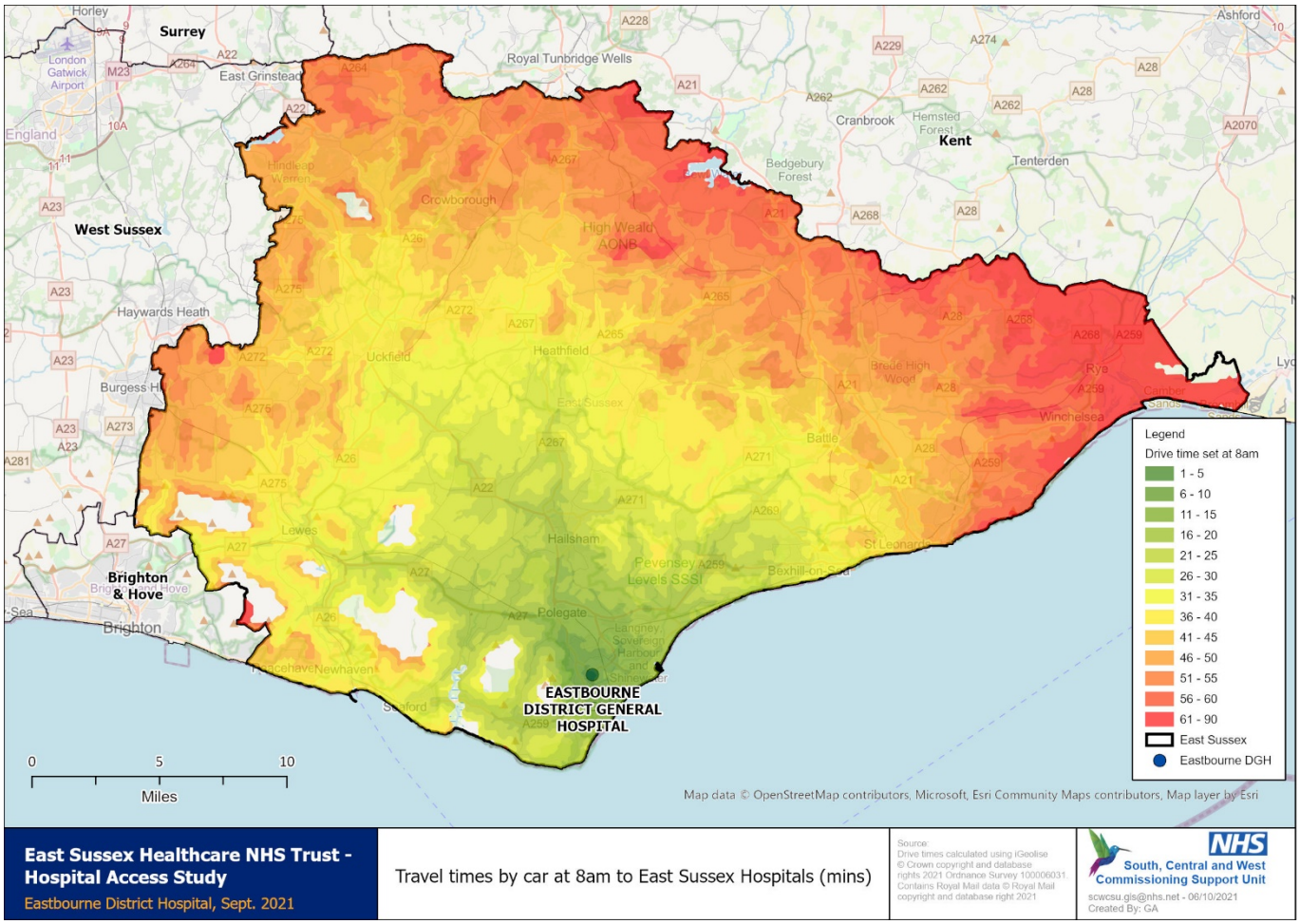


Figure 23: East Sussex travel times to Eastbourne District General Hospital



Public Transport

By bus:

Eastbourne District General Hospital is served by these bus routes: -

- From Eastbourne town centre/train station: Stagecoach services LOOP, 1A, 51, 54, 56, 98
- From Hastings and Bexhill, Stagecoach service 99 to Eastbourne town centre then the Stagecoach service 54a, 51 or LOOP to the District General Hospital.
- From the Polegate area Stagecoach services 51, 54, 56, 98

Conquest Hospital is served by the following bus routes:

- From the Bexhill area: Stagecoach services 99, 22A, 98 all travel to Hastings and St Leonards from Bexhill, but will need a change of bus to continue to Conquest Hospital.
- From Hastings and St Leonards: Stagecoach services 23A, 26 and 26A, 100, 359 directly or indirectly serve the Conquest Hospital. These services go via Hastings Town Centre and/or St Leonards.
- From the Rye area: Stagecoach services 100, 101, 313, 342 directly or indirectly serve the Conquest Hospital. All travel to Hastings, but may need a change of bus to continue to Conquest Hospital.

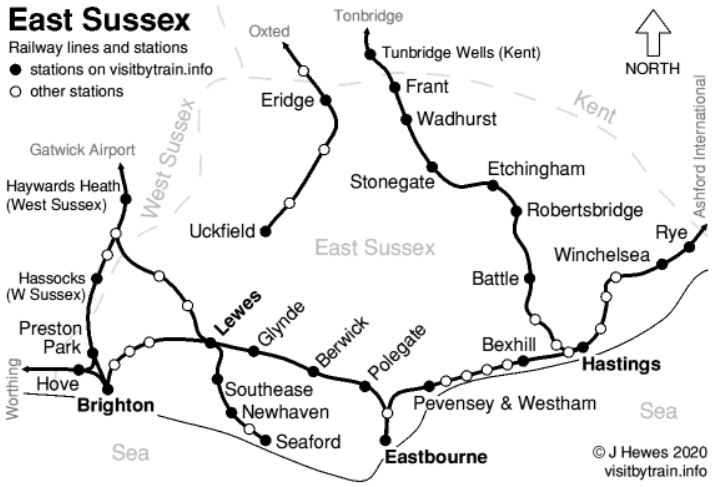
Bexhill Hospital is served by one direct route -

- Stagecoach route 12 which runs hourly from Bexhill town centre.
- Stagecoach bus route 98 from the Eastbourne direction and route 99 from the Hastings direction run every 20 minutes and go to Bexhill town centre then need to change for the route 12 bus.

More information around bus routes, visual aids and maps are available at https://new.eastsussex.gov.uk/roadsandtransport/public/buses/routes

By train:

Figure 24: Train routes in East Sussex



Eastbourne District General Hospital can be accessed by train to Eastbourne Station and then a bus or taxi to the Hospital.

Conquest Hospital can be accessed by train to Hastings Station and then a bus or taxi to the Hospital.

Bexhill Hospital can be accessed by train to Bexhill Station and then a bus or taxi to the Hospital.

Services to help with patient travel arrangements:
There are various community and voluntary services available in East Sussex which can be accessed via the council website - https://www.eastsussex.gov.uk/roadsandtransport/public/communitytransport/

Patients with health conditions that mean they are not able to travel by car or public transport can apply to the CCG's Non Emergency Patient Transport Service. Eligibility criteria do apply and this service is only for secondary care settings.
https://www.scas.nhs.uk/our-services/non-emergency-patient-transport-service/

Reclaiming NHS healthcare travel costs:
Patients with low income and those in receipt of certain state benefits are entitled to help with healthcare costs, including travel to hospital appointments. The claim form and eligibility criteria can be found at:
https://www.nhs.uk/nhsengland/healthcosts/documents/hc5(t).pdf
https://www.nhs.uk/NHSEngland/Healthcosts/Documents/2016/HC1-April-2016.pdf

The programme team plan to work and liaise with transport providers to ensure plans are aligned across services.

There will also be a focus around travel and access during further engagement and any potential consultation activities, as well as an independent review which is currently being completed ahead of public consultation to be able to feed outcomes into consultation plans and discussions.

10.3. Data Protection Impact Assessment

After consultation with the Sussex NHS Commissioners Information Governance team and Data Protection Officer the following has been concluded:

For Option 2: Ophthalmology services, including one stop clinics and diagnostic eye hub, located at two hospital sites , Eastbourne District General Hospital and Bexhill Hospital

- There would be no changes to what data was processed nor how it would be processed.
- No new or different organisations and/or providers would be involved in accessing and/or sharing patient information.
- No new data processing systems would be utilised.

No further Data Privacy Impact Assessment is, therefore, required.

11.Assurance

11.1. Reconfiguration: The Four Tests

In 2010, the Government introduced four conditions that must be met when considering major service changes. The tests require any NHS organisations considering a change of service to be able to demonstrate evidence of:

- strong public and patient engagement;
- consistency with the current and prospective need for patient choice;
- a clear, clinical evidence base;
- support for proposals from clinical commissioners.

A further test was introduced in 2017 that covers any proposals that significantly reduce hospital bed numbers. This test does not apply to this Pre-Consultation Business Case.

Table 28: NHS Four Tests

Strong public and patient engagement	• Pre-consultation engagement and communication programme took place from January to February 2021. • Stakeholder surveys to gain views on current ophthalmology services. These were made available online and through remote interviews. • Public engagement on the East Sussex Healthcare Trust ophthalmology services to understand what matters most to local people when using services – we have used the outcomes of this feedback to shape our proposals for ophthalmology services. • Regular communications with our stakeholder GPs via newsletters and locality meetings.

	• Participation by public and patient representatives (alongside key stakeholders including provider representative and clinicians) in the options appraisal process, including workshops where they could share their views and add to potential options to transform the delivery of ophthalmology services. This included development and appraisal of options, and is further described in Section 8.
Consistency with current and prospective need for patient choice	• Patients' right to choice of secondary care provider will remain protected. What may change is the location of services. • The proposed configuration of services means that patients will be seen in by the right professional, in the right place, at the right time. • The proposed configuration of services will also reduce the number of transfers between services.
Clear, clinical evidence base.	• The proposal is aligned to national best practice for ophthalmology[48] and also to the NHS England/Improvement-Integrated Care System Ophthalmology Transformation Programme. • The proposed transformation is based on national requirements and research studies, taking into account the role of East Sussex Healthcare Trust in wider Sussex ophthalmology provision. • As the Case for Change was developed, various possible solutions were tested with clinicians and service staff, including other medical and surgical specialties to ensure interdependencies were taken account of. • Common themes from the engagement to date were identified and used to formulate this proposal and the Case for Change. • The East Sussex Health Overview and Scrutiny Committee and NHS England South East Clinical Senate will be reviewing and providing assurance and advice on the appropriateness of the proposal. The outcomes of this review will be outlined in Section 11.2. • GP and East Sussex Healthcare Trust clinical leads have been involved in the options development and appraisal workshops that informed this proposal and are members of our Cardiology and Ophthalmology Transformation Steering Board. • GP members and the CCG Governing Body have been part of our engagement programme which has informed this proposal. • The proposals have been discussed at the Sussex Acute Collaborative Network (SACN).
Support for proposal from clinical commissioners	• There is a GP clinical lead as part of the team developing this proposal. • Clinical leads and Governing Bodies for East Sussex Healthcare Trust and ESxCCG have been part of the engagement programme that has informed this proposal. • We are regularly communicating with our member GPs via locality meetings to ensure full awareness of proposed transformation and enable any feedback to shape the proposal. • Regular updates have been provided to our Cardiology and Ophthalmology Transformation Steering Board for this particular project, along with updates to the East Sussex & Brighton and Hove Local Management Team and the Integrated Care System Planned Care Board.

[48] https://www.rcophth.ac.uk/standards-publications-research/clinical-guidelines/

- The proposal is aligned to the Integrated Care System Ophthalmology Transformation strategy.

11.2. NHS England/Improvement Stage 1 Assurance

Stage 1 Assurance is an opportunity for NHS England/Improvement and the Sussex Integrated Care System to provide support and guidance regarding the service reconfiguration process. It offers an additional level of assurance scrutiny to give confidence to patients, staff and the public that proposals are well thought through, have taken on board their views and will deliver real benefits.

The Stage 1 Assurance meeting for this programme took place on 29 January 2021 following which NHS England/Improvement gave approval that the programme should progress including a range of actions to further develop the Pre Consultation Business Case.

11.3. Clinical Senate review

We requested the NHS England South East Clinical Senate to undertake an independent clinical review of our proposal to transform East Sussex Healthcare Trust's ophthalmology services, and also for the pre-consultation proposal. We also asked the Clinical Senate to assess the evidence we have gathered and reviewed to develop this Pre-Consultation Business Case. More specifically, the Clinical Senate was asked to:

- evaluate the proposals alongside the Case for Change;
- provide a narrative that details any recommended mitigations that will support commissioners to finalise the Pre-Consultation Business Case;
- evaluate the proposals in terms of future services being accessible and continuing to meet the needs of the patient population to ensure any inequality issues would be suitably mitigated.

The Clinical Senate Panel reviewed the Pre-Consultation Business Case and met on 11 August 2021 to discuss the proposal with CCG, Trust and other stakeholder colleagues, in detail. The Clinical Senate made a number of recommendations which we have addressed and that have informed and strengthened this Pre-Consultation Business Case.

The Clinical Senate provides a helpful mechanism to test the clinical model with a clinical peer group; alongside reflections about our clinical model the clinical senate also provided a range of helpful reflections about our approach to options development and appraisal and about our process of engagement with stakeholders and local people.

Overall, the Clinical Senate report and findings provided a useful framework for the development of the Pre-Consultation Business Case and our future discussions and consultation with the stakeholders on the final pre-consultation proposal.

11.4. NHS England/Improvement Stage 2 Assurance

Stage 2 Assurance is an opportunity for NHS England/Improvement to ensure there is a strong case for change, local level of consensus, patient and public engagement, consistency with patient choice, clear clinical evidence base, finance best practice, and consideration for any

proposed bed closures. It also ensures a full range of options are being considered, and that potential risks are identified and mitigated.

The Stage 2 Assurance meeting for this programme took place on 14 October 2021, following which NHS England/Improvement at Stage 2 confirmed that all relevant aspects of the proposed transformation programme had been consider and approval was given to move to public consultation subject to approval by the CCG.

12.Proposed consultation process

In undertaking any further engagement and consultation, the CCG will continue to adopt a transparent, best practice approach based on several key principles. We will

- build on our wide range of previous engagement with local people and describe our journey, the purpose of our review and our intent to consult;
- incorporate the findings from our Equalities and Health Inequalities Impact Assessment, which have helped us identify the groups and communities we should target for our communications and engagement work;
- proactively engage with any other groups (in their own environments) not identified as a result of the Equality and Health Inequality Assessment;
- “strength-test” all aspects of our thinking, planning and approach;
- involve patients through a variety of activities, go out into local communities and attend pre-existing engagement opportunities, with a clear focus on involving the seldom-heard communities as described in the Equality and Health Inequality Assessment;
- acknowledge the importance our communities place on accessible ophthalmology service provision and clearly communicate our interest in all available feedback and insight to further inform our proposals;
- share information about the range of ophthalmology services that are available to local people;
- utilise our stakeholder mapping to ensure that we engage with all groups and partners with an interest in our plans including our partners in East Sussex County Council, local councillors and Members of Parliament;
- be clear about our strategic goals to deliver better and more integrated high quality care in the right place and at the right time for local people, whilst also being transparent about our financial challenge;
- be transparent about the benefits and risks of our approach and test our thinking on those.

We will continue to engage with key stakeholders to:

- review data, evidence and feedback from the pre-consultation engagement;
- share information about local patient demand analysis together;
- develop a shared understanding of the changing nature of ophthalmology care and the wider Sussex and national context.

12.1. Outline of the consultation process

- The consultation process will run for a period of 12 weeks (with an additional 10 working days to account for Christmas and New Year Bank Holidays) from December 2021 to March 2022.
- The responses to the consultation process will be independently analysed and a report will be published outlining how we have considered these in coming to our decision.
- The process will be promoted through social media and other established channels (including posters, adverts in local media, via newsletters to local stakeholder groups and existing forums).
- Leaflets/flyers will be provided (written in plain English and any other languages identified as a result of the Equality and Health Inequality Assessment and our engagement) promoting the consultation across the CCG's area.
- Any leaflets/flyers will be made available to GP practices and will also be prominently displayed at East Sussex Healthcare Trust.
- East Sussex Healthwatch will be engaged during the consultation process to provide support and further advice on the consultation process if required.
- We will work in partnership with the local voluntary and community sector to ensure that seldom-heard groups, particularly those identified as a result of the Equality and Health Inequality Assessment, are fully engaged with the consultation process.
- As part of any implementation plan for these proposals, the programme team will work with Trust and CCG colleagues to ensure a robust communications plan is developed to inform the public about any changes.

12.2. Process for decision-making following close of the consultation

Subject to scrutiny, review and approval of the Pre-Consultation Business Case by the CCG's Governing Body, we will formally consult with the public on these proposals and with a wider community and those who have a stake in East Sussex's ophthalmology services. We will also consult with the East Sussex Health Overview Scrutiny Committee and ensure we meet any requirements of this scrutiny process.

Following the close of the formal consultation, the CCG will establish a panel that will review all the available evidence and any new and relevant information received during the consultation period to inform a decision making business case to propose a final recommend proposal for approval.

13.Project management

13.1. Risk management arrangements

The project team working on the delivery of this Pre-Consultation Business Case are maintaining a risk register, which is included within the CCG's overall risk management and governance arrangements.

Any risks to the Pre-Consultation Business Case and this programme of work will be continually updated and refined as our proposed model is being refined and in response to feedback from stakeholders throughout the consultation period and as any other relevant information about the impacts of the final pre-consultation proposal becomes available.

13.2. Monitoring and evaluation of impacts of the pre-consultation proposal

Through targeted conversations with local people and activity and performance data, we will continually monitor and evaluate patient experience and the quality of the services that form part of our proposal. In addition, we will monitor that we are undertaking actions as indicated through our impact assessments.

The impact of the final proposal on other services will also be monitored and evaluated. The monitoring and evaluation plan will be produced as part of the Decision Making Business Case, once a final decision is chosen/recommended, including a review to evaluate success, impact and learning compared with the current service and the temporary service arrangements during the pandemic.

13.3. Next steps

The high-level project milestones for the proposal are:

Table 29: Current plan and Milestones for this proposal

Milestone	Date
Engagement with stakeholders, continuous evidence gathering	Ongoing
Draft Pre-Consultation Business Case, Equality and Health Inequalities Assessment and Quality Impact Assessment reviewed by the Joint Cardiology and Ophthalmology Steering Board	July/August 2021
Draft Pre-Consultation Business Case reviewed by Clinical Senate Panel	July/August 2021
Draft Pre-Consultation Business Case submitted to the CCG Local Management Team	September 2021
NHS England/Improvement Stage 2 Assurance Meeting	October 2021
Draft Pre-Consultation Business Case submitted to the CCG Quality Committee	October/November 2021
Final Pre-Consultation Business Case submitted to East Sussex Healthcare Trust Board	November 2021
Final Pre-Consultation Business Case submitted to the Sussex CCGs' Joint Committee	November 2021
East Sussex Health Overview and Scrutiny Committee Meeting to review the proposal	December 2021
Formal consultation on the final pre-consultation proposal (subject to approval by East Sussex Healthcare Trust Board/CCG Governing Body and review by East Sussex Health Overview and Scrutiny Committee)	December 2021 – March 2022

Following the end of the consultation period in March 2022, we will evaluate the outcomes of the consultation to ensure that relevant information gathered during this period informs our Decision Making Business Case. This Decision Making Business Case will be then considered in line with NHS Governance arrangements, following which we anticipate consideration by East Sussex Health Overview and Scrutiny Committee which is likely to be in June 2022.

14.Conclusions and Recommendations

This Pre-Consultation Business Case outlines the process by which we have reviewed the existing services that currently serve the needs of people who use East Sussex Healthcare Trust's ophthalmology services. It describes the national and local context within which we are commissioning services. We have asked local people and clinicians what is important to them about ophthalmology services, and this feedback has informed this Pre-Consultation Business Case.

The future East Sussex service will meet all relevant best practice guidelines for ophthalmology. Transformation presents an opportunity to improve the service so that in some cases some patients will experience a three to six week reduction in referral access time.

NHS England South East Clinical Senate has undertaken an independent clinical review of our proposals to transform East Sussex Healthcare Trust's ophthalmology services, and East Sussex Health Overview and Scrutiny Committee will review our proposals. We have used national research, our impact assessments (quality, equality and health inequalities, and data and privacy), and our pre-consultation engagement into who uses the ophthalmology services, how and why they use it.

The conclusion from this wide range of insight and evidence is that we pursue the following options to transform East Sussex Healthcare Trust ophthalmology services, by formally consulting patients and the public and produce a Decision Making Business Case to confirm the preferred approach:

- **Option 2: Ophthalmology services located at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.**

Our proposal takes account of a move towards a more efficient and sustainable acute ophthalmology service at East Sussex Healthcare Trust, by improving quality of care and patient experience through shorter waiting time, less travelling to appointments, and aimed at ensuring patients receive the right care in the right place and at the right time.

This proposal also supports financial sustainability of acute ophthalmology services by maximising the use of existing commissioned services. It also means increased and more flexible use of existing services, in addition to the effective use of workforce across existing services.

This recommendation has been made on the basis of ensuring future sustainability of ophthalmology services and improving outcomes and experience for local people.

If this Pre-Consultation Business Case proposal is supported by the CCG Governing Body, and the East Sussex Health Overview Scrutiny Committee consider that the proposal constitutes a substantial variation to services and should therefore be subject to public consultation, then this process will begin in December 2021.

It is anticipated that during this time there will be further opportunity to gather information, evidence and stakeholder feedback and explore learning from other areas who have

transformed their ophthalmology services already, that will enable the CCG Governing Body to make an informed decision on the proposal in the best interests of local people.

Ophthalmology Clinical Glossary

Term	Definition
Amblyopia	Amblyopia or “Lazy eye” is reduced vision in one eye caused by abnormal visual development early in life. The weaker — or lazy — eye often wanders inward or outward. Amblyopia generally develops from birth up to age 7 years.
Age-related Macular Degeneration (AMD)	Age-related macular degeneration affects a small part of the retina at the back of the eye, called the macula. Age-related macular degeneration causes changes to the macula affecting central vision, the part used when looking straight at something, for example when undertaking ordinary daily activities such as cooking, driving, reading or watching television. Central vision can become distorted or blurry.
Cataracts	Cataracts are a common condition as people age. Over time the lens becomes cloudy, causing blurred, misty vision.
Diabetic Macular Oedema (DMO)	The macula is part of the retina responsible for central vision. Diabetes can damage blood vessels in the macula which then leak, causing the surrounding retina to become swollen or ‘waterlogged’, this is known as oedema.
Diabetic Retinopathy (DR)	Diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the blood vessels at the back of the eye (retina). It can cause irreversible blindness if left undiagnosed and untreated.
Glaucoma	Glaucoma is a common eye condition where the optic nerve, which connects the eye to the brain, becomes damaged. It's usually caused by fluid failing to drain out of the front part of the eye, which increases pressure inside the eye. Glaucoma can lead to irreversible loss of vision if it's not diagnosed and treated early.
Neuro-ophthalmology	Neuro-ophthalmology is a subspecialty that merges the disciplines of ophthalmology (eyes) and neurology (nervous system), focusing on the complex interaction between the eyes, brain and nerves. Neuro-ophthalmologists carry out diagnosis and treatment of conditions affecting the nerve pathways that connect the eyes to the brain.

Medical retina	Medical retina is a term used to describe the assessment and treatment of medical conditions that affect the retina, such as age-related macular degeneration, retinal blood vessel disorders and diabetic retinopathy.
Oculoplastic	Oculoplastic surgery is surgery on the eye lid and facial plastic surgery; this includes removal of eyelid cancers, cysts and reconstruction, ptosis corrections (drooping eyelids) and blepharoplasty (eyelid reshaping).
Optical Coherence Tomography (OCT)	This is a non-invasive test that uses light and light waves to make a map of the retina at the back of the eye. This shows up any damaged areas.
Retinal Vein Occlusion (RVO)	Retinal vessel occlusion is a blockage in the blood vein at the back of the eye.
Wet age-related Macular Degeneration (WAMD)	Wet Age-related Macular Degeneration is a type of age-related macular degeneration. The condition develops when the cells of the macula stop working correctly and the body starts growing new blood vessels to fix the problem. These blood vessels grow in the wrong place and cause swelling and bleeding underneath the macula.

All descriptions have come from the Ophthalmology Pre-Consultation Business Case, NHS website or Royal National Institute of Blind People website.

Abbreviations Glossary

A&E	Accident and Emergency
A&G	Advice and Guidance
AMD	Age-related Macular Degeneration
BAME	Black, Asian and Minority Ethnic
BFF	Building for our Future
BSL	British Sign Language
BX	Bexhill Hospital
CCEHC	Clinical Council for Eye Health Commissioning
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQ	Conquest Hospital
CUES	Covid-19 Urgent Eyecare Service
DMBC	Decision Making Business Case
DMO	Diabetic Macular Oedema
DPIA	Data and Privacy Impact Assessment
DR	Diabetic Retinopathy
ECTP	Elective Care Transformation Programme
ECAD	Earliest Clinically Appropriate Date
EDGH	Eastbourne District General Hospital

EERS	Electronic Eyecare Referral System
EHIA	Equality and Health Inequalities Impact Assessment
EHS	Eastbourne, Hailsham and Seaford
EPR	Electronic Patient Record
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare NHS Trust
FFT	Friends and Family Test
GB	Governing Body
GIRFT	Getting It Right First Time
GOS	General Ophthalmic Service
GP	General Practice and/or General Practitioner
H&R	Hastings and Rother
HCP	Healthcare Professional
HCQ	Hydroxychloroquine
HEE	Health Education England
HES	Hospital Eye Services
HII	High Impact Intervention
HLOP	Healthy Living Optical Practice
HOSC	Health Overview Scrutiny Committee
HVA	Hastings Voluntary Action
HVLC	High Volume Low Complexity
HWLH	High Weald, Lewes and Havens
ICS	Integrated Care System
IP	Inpatients

ITU	Intensive Care Unit
JSNA	Joint Strategic Needs Assessment
LLTI	Limiting Long Term Illness
LOC	Local Optical Committee
LOCSU	Local Optical Committee Support Unit
LTP	Long-Term Plan
MDT	Multi-disciplinary
MECS	Minor Eye Conditions Service
MP	Member of Parliament
MVP	Maternity Voices Partnership
NEL	Non-elective
NHS	National Health Service
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
NPV	Net Present Value
OCT	Optical Coherence Tomography
OP	Outpatients
ORS	Opinion Research Services
OTWG	Ophthalmology Transformation Working Group
PALS	Patient Advice and Liaison Service
PCBC	Pre-consultation Business Case
PDC	Public Dividend Capital
PCN	Primary Care Network
PHE	Public Health England

PIFU	Patient Initiated Follow-Up
PIP	Personal Independence Payment
POD	Point of Delivery
PPG	Patient Participation Group
PTL	Patient Tracking List
QIA	Quality Impact Assessment
RCOphth	Royal College of Ophthalmologists
RNIB	Royal National Institute of Blind People
RTT	Referral to Treatment Time
RVA	Rother Voluntary Action
RVO	Retinal Vein Occlusion
SACN	Sussex Acute Collaborative Network
SAFE	Systems and Assurance Framework for Eye Health
SAS	Staff Associate Specialists
SCFT	Sussex Community NHS Foundation Trust
SEND	Special Educational Needs and Disabilities
SHCP	Sussex and Health Care Partnership
SMI	Serious Mental Illness
SOCI	Statement of Comprehensive Income
SPFT	Sussex Partnership NHS Foundation Trust
STP	Sustainability and Transformation Plan
VAT	Value Added Tax
VCS	Voluntary and community sector
VCSE	Voluntary, community and social enterprise

WAMD	Wet age-related Macular Degeneration
YMCA	Young Men's Christian Association
3VA	Voluntary Action in Eastbourne, Lewes and Wealden

EXTENDED

Equality and Health Inequalities Impact Assessment (EHIA)

An EHIA is a tool to explore the potential for a policy, strategy, service, project or procedure to have an impact on a particular group, groups or community. This includes the impact on one or more of these groups:

- Protected characteristic groups (as outlined in the Equality Act 2010)
- Disadvantaged or marginalised groups or communities
- Deprivation and socio-economic disadvantage within local communities
- Local health inequalities for groups and communities

Please complete this Equality and Health Inequalities Impact Assessment when the proposed change has a potential negative impact on staff, patients, public or local communities.

Please note:
To comply with our agreed Equality Policy and Procedure and meet our requirements under legislation, all new policies and new and proposed services or strategies must be impact assessed before being introduced. Within this document, you will need to provide evidence to demonstrate:

- Consideration of the impact of your initiative for each protected characteristic and other disadvantaged groups and communities
- Assessment of the impact you have identified and a clear action plan to mitigate the issues and concerns which arise from this.

For further support or advice please contact:

- **Jane Lodge – Associate Director of Public Involvement**
  jane.lodge1@nhs.net
- **Nicky Cambridge – Head of Equality, Diversity and Inclusion**
  nicky.cambridge@nhs.net

1. Introduction and overview

<table>
<tr><td>Title of EHIA</td><td colspan="6">Transforming East Sussex Ophthalmology Services</td><td colspan="3">ID No. #057</td></tr>
<tr><td>Team / Department</td><td colspan="3">Planned Care and Cancer</td><td colspan="2">Assessor Completing the EHIA</td><td colspan="3">Assistant Head of Planned Care/Senior Planned Care Manager/Planned Care Officer</td></tr>
<tr><td>Date EHIA Started</td><td colspan="3">6th November 2020</td><td colspan="2">Date EHIA Completed</td><td colspan="3"></td></tr>
<tr><td>What is the focus of this EHIA?</td><td>Workforce Policies</td><td>Organisational strategy</td><td>Clinical services</td><td>Clinical policies</td><td colspan="5">Other: Assessing the East Sussex ophthalmology case for change; information engagement and options development.</td></tr>
<tr><td>What is the status of this policy / function / practice or provision?</td><td>New

X</td><td>Revised</td><td>Monitoring</td><td>End</td><td>Who will be affected?</td><td>Staff

X</td><td>Carers

X</td><td>Patients / service users
X</td><td>Communities</td><td>Other</td></tr>
<tr><td>Brief description of the aims of the service, policy, strategy, function that this EHIA relates to.</td><td colspan="9">This EHIA is an initial assessment of the pre-consultation phase to transform ophthalmology services in East Sussex. It has been carried out to ensure that options for transformation are informed by population and public health data and the experience of local people, notably those with protected characteristics and other disadvantaged groups and communities, to ensure that any transformation plans promote equality and reduce inequalities.

The impact of proposed options will be assessed fully through the EHIA using feedback from this engagement and further work described in this document to inform the next phase.

Ophthalmology is a branch of medicine and surgery that provides diagnosis, treatment and prevention of conditions that affect the eye and visual system. Medical ophthalmology involves diagnosis and management of disorders affecting a person’s vision, while surgical ophthalmology involves a surgical procedure to correct or improve a person’s vision, for example, cataract surgery. While there are many clinical conditions that can affect the eye and its surrounding structure in people of all ages, many eye conditions are age-related, making eye health (ophthalmology) services more and more important as people get older. Whilst still considering clinical conditions for Children although cases are far lower.

East Sussex Healthcare NHS Trust (ESHT) are commissioned by East Sussex CCG to provide specialist medical and surgical ophthalmology services for the population of East Sussex (560,000 people). ESHT provide both adult and paediatric services across three hospital sites:</td></tr>
</table>

	• Eastbourne District General Hospital • Bexhill Hospital • Conquest Hospital (Hastings) ESHT also provide paediatric services at community sites across Hailsham, Crowborough and Seaford. This transformation project is focussed on the provision of services offered across their three hospital sites. This is very much an acute change regarding pathway reconfiguration, with shifts away from the traditional acute model to digital and community models, which will be reflected in the assessment. The national and local policy drivers are set out in the Case for Change for Transforming East Sussex Ophthalmology Services. In summary these are: • **Changing patterns of service delivery:** nationally policy makers are indicating that NHS services generally, and ophthalmology services specifically, are in need of redesign. • **Performance:** a reduction in performance against the targets for referral to treatment (RTT) waiting times and timely follow up. • **Quality:** a slightly higher rate of preventable sight loss in East Sussex due to AMD and glaucoma than the National benchmark figures • **Sustainability:** challenges recruiting to vacant consultant posts, ageing equipment and the national aim of making the NHS more environmentally sustainable and 'net zero' by 2050. • **IT/Digital:** maximising use of digital technology when appropriate to manage demand, transform patient pathways and ensure timely follow-up • **Demand:** projected sharp increases in demand • **Making the best use of resources:** moderating demand for hospital services, protecting them so they are available when they are most needed by our population in a more sustainable way. Health inequalities: taking action to reduce health inequalities. As part of a comprehensive approach to eye health, the system will work together to ensure local people have access to support that could help in making lifestyle changes that prevent illness and/or manage existing conditions effectively. As we improve services through the programme, we will consider potential impact on and opportunity to address health inequalities including pathway reconfiguration and what any changes will mean to our patients and local communities. The vision for the East Sussex Health and Care System is to provide high-quality eye care for patients, carers and families. This includes:

	• Providing a clinically excellent ophthalmology service • Reducing avoidable sight loss and improving the eye health of our patient population through ensuring equality of access and equitable provision • Increasing our ability to look after a growing and ageing population • Providing increased support and development for the ophthalmology workforce • Developing services that are financially, clinically and environmentally sustainable This EHIA has been written in the context of the case for change; recognising that it will need to be continually refreshed at each stage of the programme, informed by ongoing community engagement.

Outline the links to national and local policy and strategy.	• **The Royal College of Ophthalmologists (RCOphth)** published The Way Forward in 2016, a major analysis of the provision of ophthalmology services. The report details options to help meet demand for the current and future for each sub specialty within Ophthalmology, and the main four areas; Cataract, Glaucoma, Medical Retina (encompassing macular degeneration and diabetic eye disease) and emergency eye care. • **The Clinical Council for Eye Health Commissioning (CCEHC)** has been set up to bring together representatives from multiple professional bodies to provide collective input to policy-makers, commissioners and providers. An example is its Systems and Assurance Framework for Eye health (SAFE), which aims to help commissioners develop a more strategic and consistent approach to service planning. • **NHS England Elective Care Transformation Programme (ECTP)** ophthalmology was one of the first specialties to benefit from the scrutiny of the ECTP, an NHS England initiative which focuses on identifying opportunities to transform services at pace. In early 2019, the programme published an Ophthalmology handbook, drawing on best practice to provide practical guidance on changes to service delivery. The handbook and case studies look at streamlining investigations and diagnostics, utilising virtual clinics and diversifying the workforce to better manage rising demand. • **Get It Right First Time (GIRFT)** which is a national programme to improve the quality of care by addressing unwarranted variation in care. Ophthalmology is currently a key priority area. • **The NHS Long Term Plan** has a key focus on developing ICS, (Integrated Care Systems) between Primary, Community and Secondary services to join up the planning and delivery of services to improve population health. There are also key focuses on improving the digital interfaces between care settings, and a drive to move away from the traditional outpatient models of care. • **East Sussex Place-Based Response to the Long Term Plan** includes plans to deliver a comprehensive approach to prevention, universal personal care and reducing health inequalities that cuts across our key clinical priorities and care pathways from supporting healthy lifestyles and wellbeing, greater levels of self-management, shared decision-making, and personalised care and support planning, through to early intervention, proactive care and re-ablement.

What patient and public engagement has already taken place in relation to this proposal?

Pre Consultation Engagement - The pre-consultation period was for six weeks and ran from 4 January 2021 to 14 February 2021 and is informed by a range of previous engagement exercises including:

Shaping Health and Care events carried out as part of the East Sussex Better Together programme

Feedback received during the first two months of the Big Health and Care Conversation (July – Sept 2020)

Healthwatch in Sussex and Sussex NHS Commissioners Accessing health and care services – findings during the Coronavirus pandemic Research carried out in Brighton & Hove by the Trust for Developing Communities in July 2019

Friends and family testing data shows a slight reduction in satisfaction with the Day Surgery Unit in Bexhill and Conquest Eye Clinic and increased satisfaction with the Jubilee Eye Suite and Diabetic Eye Screening. Overall, satisfaction is high at 97.7% of the total returned.

FFT	**2018/19**			**2019/20**		
Recommendation Rate	No. Returned		% ↑ of total	No. Returned		% ↑ of total
	↑	↓/→		↑	↓/→	
Day Surgery Unit Bexhill - Ophthalmology	689	5	99.3%	881	14	98.4%
Jubilee Eye Suite - Eastbourne	1137	31	97.3%	1103	25	97.8%
Bexhill Eye Clinic - Orthoptist	27	0	100.0%	2	0	100.0%
Conquest Eye Clinic - Orthoptist	16	0	100.0%	36	1	97.3%
EDGH Eye Clinic - Orthoptist	8	1	88.9%	14	0	100.0%
Diabetic Eye Screening	272	23	92.2%	889	29	96.8%

FFT – Key	
Extremely Likely/Likely to recommend service to friends or family	↑

Neither Likely or Unlikely/Unlikely/Extremely Unlikely to recommend service to friends or family or No Answer	↓/→

The pre-consultation engagement period was designed to gather feedback and insight to inform development of options which will be consulted on fully. This engagement involved a combination of questionnaires and in-depth interviews. Full analysis of the engagement has been completed. The feedback and analysis from this engagement will help us better understand what matters to our patients, their experiencing of accessing services, and how these could improve. The outputs of this engagement will directly inform the options development process for ophthalmology services in East Sussex.

NHSE Stage 1 Assurance; In March the CCG and EHST met with NHSEI for Stage 1 Assurance. The feedback centered on the importance of in-depth Equality and Health Inequality Impact Assessment and ensuring the proposals were fully integrated into, and consistent with, the broader ICS service recovery and transformation plans.

Options Appraisal Workshops; In April/March we held three Options Appraisal workshops. These workshops were designed, developed and delivered in collaboration with the CCG by an external consultancy: Opinion Research Services (ORS), factoring in the themes and feedback from the pre-consultation engagement and the key areas identified within the EHIA's. The workshops had representation from a wide range of stakeholders; patient and public representatives, Public Health, Healthwatch, ESHT consultants, clinical leads, CCG clinical leads, Nurse specialists, GP's, community optometrists, SECAMB, as well as a wide range of attendees from CCG and ESHT departments (communications and engagement, HR, Quality, Finance, Business Intelligence, service management and commissioning).

ORS provided a comprehensive report on the workshops covering the qualitative feedback around external challenges, internal challenges, national drivers and opportunities for improvements. In both qualitative and quantitative stages of the appraisal, five appraisal criteria where discussed and agreed for the Ophthalmology workshops. These criteria are: Quality and Safety; Clinical sustainability; Access and Choice; Financial Sustainability; and Deliverability, however the early indications are as follows;

	Ophthalmology: The Options were: 1) Retain Current Services over all 3 sites 2) Two Hospital Sites 3) One Hospital Site 4) One Hospital Site and community Hospital clinics 5) One Hospital site and mobile clinics The outcomes of the options development and appraisal process reported here suggest that Options 2 (two hospital sites) could reasonably be taken forward to formal consultation on the future of ophthalmology services in East Sussex. Bexhill and EDGH appear to be the favoured locations for a two-site model, and opinion was divided between the same two hospitals when considering the best site for a single hospital. Proposals are informed by a range of further activities including, the outcome of EHIA workshops, additional engagement, further GP engagement, further travel and access analysis alongside the refreshed QIAs. **Equalities Health Impact Assessments (EHIA's);** EHIA workshops took place at the end of April/May and will be designed to support a lessons learnt session and a work shop to look at the Options Development through an inequalities lens as we develop our preferred options for likely consultation. Key themes from these workshops included further considerations in relation to the following: homelessness, veterans, refugees, asylum seekers, access for wheelchair users, substance misuse and hearing impairment alongside specific clinical areas related to ophthalmology. Further details can be found in sections 8 and 13. **Travel and Access**; We recognize the importance of ensuring that the services commissioned reduce health inequalities and ensure reasonable access so this paper concentrates on demonstrating the possible impact on patient travel times if East Sussex Healthcare Trust (ESHT) services were to be redesigned in line with the each of the options arising from the options appraisal workshops held in March. The paper provides an overview of locations and accessibility of ESHT hospital sites alongside the postcode data showing that patients admitted at each site were predominately from the local postcode area. The paper has also been aligned with every EHIA characteristic i.e. deprivation, alongside travel cost and timings for travel and ensured these are aligned to all x5 options for Ophthalmology. Steering Board have provided approval to add these findings into the PCBCs and the EHIA's, which is complete. Further analysis is required and we have started the process of procuring an external provider via an invitation to quote for a more in-depth review/analysis of travel and access looking at: ➢ Impacts on travel times by different modes for staff and patients and visitors ➢ Impacts on travel costs by different modes for staff and patients and visitors ➢ Impacts on travel costs by different modes of transport car/public transport specific to population segmentation (including areas Deprivation and age and the impacts)

	➢ Overall against site locations and the preferred high scoring options (Ophthalmology option number 3) ➢ To summarise the methodology and findings into a report. This analysis will ensure that the protected characteristics within the EHIA are considered within the preferred options to ensure we have an independent view. • **GP locality Forums** – Further engagement is being provided at the GP Locality Forums across East Sussex (Bexhill, Hastings, High Weald, Lewes Havens, Rural Rother, Eastbourne, Hailsham, and Seaford) during July and August. The programme's clinical lead, who is also a GP, has attended all of the Options Appraisal workshops, has presented at each GP Locality Forum. Feedback was, as follows; • Presentation at Clinical Director (of PCNs) level and at individual locality forums ensured wide GP representation. • The transformation work was positively received, some concern was expressed with regards to communication with the public regarding perception of access and actual access. • There was much interest in ophthalmology services such that senior opinions meant that hospital admissions were reduced and that communication to primary care would therefore be more timely. • Primary care colleagues expressed interest in harmonisation of Locally Commissioned Services for glaucoma as well as development of an intermediate ophthalmology service across the patch to support pathways from primary to secondary care. **Areas considered;** When developing our options and all of the above, transformation proposal and the Pre-Consultation Business Cases (PCBCs): • We have considered the outputs from engagement with local people and clinicians and used these to inform the PCBCs • We have developed the PCBCs with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties • We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment (QIA) and an Equality and Health Inequalities Impact Assessment (EHIA) to identify any potential negative impacts and identified appropriate mitigating actions • We will be taking into account the recommendations of the South East Clinical Senate and HOSC • We have assessed our proposal against the NHS Four Tests for service reconfigurations.[1] • We have developed our proposal and associated consultation plans in line with the Gunning Principles[2] to ensure that: ○ a decision will not be taken until after public consultation

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

	○ local people and stakeholders have information that enables them to engage in the consultation and inform our decision; ○ there is adequate time for people to participate in the consultation taking account of the Christmas holiday period. Consequently, we are planning to increase the consultation period from 12 weeks to 14 weeks; ○ we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

2. Update on previous EHIA (where one exists) and outcomes of previous actions or if this is new, then record N/A.

What actions did you plan last time? (List them from the previous EIA)	**How has this action progressed?**	**What <u>further</u> actions do you need to take?** (add these to the Action plan below)
N/A		

3. Health inequalities

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
Will this initiative help to reduce health inequalities for any specific groups and communities? ***e.g. access to services, improved health outcomes***			X	• The College of Optometrists reports that: "There are significant inequalities in the eye health of different UK populations, with people in deprived socio-economic groups and certain ethnic groups more likely to lose their sight and less likely to access services, even if they are readily available." The key messages from a 2016 RCO report on eye health and inequalities were: *Uncorrected refractive error (URE) can adversely affect quality of life, impair education and increase the risk of falling. *URE is more likely if you live in a deprived population but mapping realistic prevalence levels is problematic. *While there is a lack of evidence for an association between socio-economic status and patient access to eye services, qualitative studies suggest that public perceptions of optometry and optical services are a key factor. (https://www.college-optometrists.org/the-college/policy/see-the-gap-health-inequalities.html) While the transformation of acute ophthalmology services will not, of itself, address URE, since this is managed by primary care optometrists, URE can be an indicator of poor access to other eye care services. The ophthalmology service at ESHT only collects demographic data on age and sex. Due to having limited demographic data for other protected characteristics and disadvantaged groups and communities, further analysis is required particularly around smoking, obesity and alcohol our areas of deprivation. This is documented in the action plan below, to ensure that we have a comprehensive understanding of the impact of health inequalities within the ophthalmology service. While there are many eye conditions that affect the eye and its surrounding structure, it is estimated that glaucoma, medical retina and cataracts make up approximately 90% of the demand on the ophthalmology service at ESHT. For the purpose of understanding disease prevalence in this EHIA, we have focussed on the areas of highest prevalence:

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
				• Glaucoma • Medical retina (AMD and diabetic retinopathy) • Cataracts • Amblyopia (Children's) **Disease prevalence across East Sussex (NICE, 2020)** • AMD has a higher prevalence in western countries. It is estimated that 1-3% of the population in western countries suffer with an advanced stage of AMD. We estimate that across East Sussex, approximately 16,800 people would be living with advanced AMD. • Primary open angle glaucoma (the most common form of glaucoma) affects 1% of the population aged over 40 (1,486), 3% of the population aged over 60 (4,110), and 8% of people over 80 (3,319) • It is thought that approximately 50% of people living in the UK with primary open angle glaucoma have not been diagnosed. We therefore estimate in East Sussex the disease prevalence of people with primary open angle glaucoma without a diagnosis to be approx. 11%. • Cataracts are a common condition as people age. It is estimated that 16% of people 65-69 (5,850), 24% of people 70-74 (9,308), 42% of people 75-79 (10,728), 59% of people 80-84 (13,201), and 71% of people 85 and over (15,499) are visually impaired due to cataracts. We estimate the disease prevalence of people visually impaired by cataracts across East Sussex to be 54,586. • It is estimated that across East Sussex, 12,239 people with type 1 diabetes are living with diabetic retinopathy, and 8,610 people are living with type 2 diabetes and diabetic retinopathy. • Amblyopia is the most common cause of vision problems in children, affecting 3.6% of children. We estimate that across East Sussex there are 500 children aged 4-5years referred into ESHT per annum for suspected amblyopia. **Sight loss** It is estimated that 4.5% of the population in East Sussex are living with sight loss (25,200 people). This is set to rise of 5.9% in 2025 and 5.4% in 2030. East Sussex has higher levels of sight loss than the South East region and nationally.

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
				Health Outcomes Across East Sussex: The Public Health England (PHE) Outcomes Framework for 2016-18 shows that: East Sussex had a higher rate of preventable sight loss due to glaucoma and AMD than the national benchmark figure. There is a relationship between sight loss and a range of factors, in particular: • Age, East Sussex has among the highest proportions of over 65 and 85 year olds nationally and this is projected to grow, • Ophthalmic conditions (e.g. glaucoma, cataract, AMD) and related conditions (e.g. diabetes, dementia). These conditions also disproportionately impact some ethnic groups (notably Black African and Caribbean, South Asian and White). • Deprivation and lifestyle factors. Deprivation varies significantly across East Sussex with the most significant deprivation in Hastings where admissions due to alcohol related conditions are also highest. • Smoking. Smoking causes harm to the tissues of the eye. Research has confirmed the harmful effects of smoking on eyesight, particularly in the development of age-related macular degeneration (AMD) - one of the UK's leading causes of sight loss - and cataracts. https://www.rnib.org.uk/eye-health/looking-after-your-eyes/smoking-and-sight-loss As part of the pre-consultation engagement for the service re-design process, we have engaged with local communities, building on our health inequalities work across East Sussex and (in particular our Healthy Hastings and Rother Health Inequalities programme) to understand the experience of service users in East Sussex, and understand where health inequalities may exist. Any proposed options for the future of ophthalmology services in East Sussex will include targeted action to address any identified health inequalities. Any shortlisting or selecting of options will include information from this EHIA and the data underlying so that we are clear that our options will have a material impact upon our options for consultation and decision making process.

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
				Our initial assessment of impact and risk in this EHIA shows that older people, people from ethnic communities, people with learning disabilities, people living with a disability or long term condition, (such as diabetes and dementia) and those living in the most deprived areas are at the highest risk of health inequalities within existing ophthalmology services. We are always conscious that there will be risks that we may not be aware of and other communities that we may need to consider so we will continue to include information as it becomes available.

4. Impact assessment

Please consider each protected characteristic and consider whether the policy / function / practice or provision has the potential to impact on each protected characteristic group and / or community.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
Race/Ethnicity					When looking at the breakdown for ethnicity categories the data of greatest reliance is the 2011 census data. The census shows that East Sussex has the lowest Black Asian and Minority Ethnic (BAME) population in Sussex, depicting just over 4.3% of the East Sussex population are from BAME groups with a further 4.3% from other White non-British groups. **Ethnicity and disease prevalence** • Black African and Caribbean people are four to eight times more at risk of developing certain forms of glaucoma compared to white people (RNIB, 2016) • The risk of diabetic eye disease is around three times greater in South Asian people compared to white people (RNIB, 2016) • Black African and Caribbean people are also at a higher risk of diabetic eye disease (RNIB, 2016) • AMD is a leading cause of sight loss in the UK, and is more prevalent in the white population (RNIB, 2016) • Evidence suggests that people from these communities do not receive the same level of access to eye care services as most white people (RNIB, 2016) **Diabetes** • In the UK, the risk of developing type two diabetes has been shown to be 2-6 times higher in South Asian communities compared to the White British population (RNIB, 2017). This will increase the risk in South Asian communities of developing diabetic retinopathy. **Hypertension** • Patients with hypertension are at a greater risk of developing cataracts. Across East Sussex there are 92,800 people on the hypertension register, and an estimated 12,604 undiagnosed. Research by The British Heart	Research carried out in Brighton & Hove by the Trust for Developing Communities in July 2019 showed that the following issues around care were important to the BAME community: - Better and more appropriate information about the range of services available and their functions - Good dissemination of information, including through VCS organisations and existing community groups - More training for healthcare staff on BAME communities and their needs Engagement with BAME communities where English is a second language has indicated that cultural and language issues may prove barriers to accessing NHS care Where Gypsy and Traveller communities are not in	Given that ethnicity (particularly in relation to poorer communities) can increase the risk of poor eye health and evidence suggests that people from BAME communities do not receive the same level of access to eye care services, we will ensure that as part of the formal options development process, models/interventions are developed that consider these needs and this informs our proposals and any associated service changes (for example changes to eye care pathways). Areas of particular focus will include relationship between specific ethnicity (described in more detail to the left) and glaucoma, diabetic eye disease, AMD, hypertension, cataracts and higher risk of visual impairment in children and young people. Where possible, we will look to immediately action changes that would reduce health inequalities and

<table>
<tr><th></th><th>Positive</th><th>Neutral</th><th>Negative</th><th>No Impact</th><th>Data to support your assessment

This can be census data, research, complaints, surveys, reports etc.</th><th>Engagement / feedback information to support your assessment</th><th>Actions to take forward with a focus on</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Foundation https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity found that some ethnic groups are more vulnerable to heart and circulatory diseases, which are at greater risk of developing cataracts. It identified that ethnicity can increase the risk of developing heart and circulatory diseases and that for those people who are South Asian, African, or African Caribbean in the UK, the risk of developing some heart and circulatory diseases can be higher than white Europeans of developing some heart and circulatory diseases can be higher than white Europeans.

Ethnicity and deprivation
The Sussex BAME Population Needs Review (2021) states that there is a strong association between socio-economic disadvantage and ethnicity. This is a complex relationship. People from minority ethnic backgrounds are more likely to experience multiple aspects of deprivation, including having a low income, live in poorer housing, be victims of crime, experience unemployment or low paid work.

The below table outlines the percentage of the population by ethnic group as reported at the 2011 census. The table shows estimated population size by ethnic community based on the East Sussex Population of 560,000.

<table>
<tr><th>Ethnic Group</th><th>East Sussex</th><th>Pop size</th></tr>
<tr><td>All categories: Ethnic group</td><td>100.00%</td><td>560,000</td></tr>
<tr><td>White: English/Welsh/Scottish/Northern Irish/British</td><td>91.66%</td><td>513,296</td></tr>
<tr><td>White: Irish</td><td>0.75%</td><td>4,200</td></tr>
<tr><td>White: Gypsy or Irish Traveller</td><td>0.15%</td><td>840</td></tr>
<tr><td>White: Other White</td><td>3.39%</td><td>18,984</td></tr>
<tr><td>Mixed/multiple ethnic group: White and Black Caribbean</td><td>0.37%</td><td>2,070</td></tr>
<tr><td>Mixed/multiple ethnic group: White and Black African</td><td>0.19%</td><td>1,064</td></tr>
</table>
</td><td>settled accommodation, they report that the lack of a permanent address can impact on access to care, especially primary care (therefore may stop them presenting earlier with symptoms)

As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; ‘What is your ethnic group?’

Responses:

- White (113)
- Mixed or multiple ethnic groups (2)
- Asian or Asian British (3)
- Other ethnic group (2)
- Prefer not to say (4)
- Arab (1)
- Black, African, Caribbean, and Black British (1)

The ESHT website contains:</td><td>ensure equity of access; for example; the information available and how this is shared across our communities.
Any new services will be required to undertake equality monitoring of patients including children and young people and report regularly on actions to tackle any disparity. In addition, new services will work with general practice and community services to improve pathways.

We have undertaken a workshop to examine this data with our clinical and transformation teams to consider specific actions to address the inequality.

For formal consultation we will ensure:
• links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement.
• that Friends, Families and Travellers receive</td></tr>
</table>

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
						• Information on travelling by public transport to each site. • Instructions for travelling to each site by car including general parking information and blue badge holder parking. • A link to the local county council website that gives information on voluntary services that offer transport services. • A section on how to claim under the NHS Healthcare Travel Costs Scheme. • This is not advertised on the website as being available in alternative languages	information on all involvement activity. • Attendance at Eastbourne Cultural Involvement Group to promote engagement opportunities • Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities • Further information to come from BAME Disparity Programme Team. This section will be updated as work progresses • that ESHT website page on travel and access to sites is available in alternative languages and formats • Translate questionnaire into community languages as a standard approach

Mixed/multiple ethnic group: White and Asian	0.49%	2,744
Mixed/multiple ethnic group: Other Mixed	0.36%	2,016
Asian/Asian British: Indian	0.43%	2,408
Asian/Asian British: Pakistani	0.06%	336
Asian/Asian British: Bangladeshi	0.20%	1,120
Asian/Asian British: Chinese	0.37%	2,072
Asian/Asian British: Other Asian	0.68%	3,808
Black/African/Caribbean/Black British: African	0.34%	1,904
Black/African/Caribbean/Black British: Caribbean	0.15%	840
Black/African/Caribbean/Black British: Other Black	0.06%	336
Other ethnic group: Arab	0.12%	672
Other ethnic group: Any other ethnic group	0.21%	1,176

East Sussex has relatively low levels of ethnic diversity when considered against the national picture. The most recent census data records that just over 91% of the population are white compared with a national average of 85% white.

Children and young people from South Asian ethnic are at a higher risk of visual impairment (RNIB, 2016).

Travel – specific impact:
There is no data on ethnicity of patients attending ophthalmology appointments but the East Sussex in Figures for 2019 shows that Eastbourne, Hastings and St Leonards-on-Sea, which have high levels of deprivation, also have the highest proportion of BAME people and also people where English is an additional language. The postcodes that include the most deprived areas of East Sussex are: TN34 (the central Hastings and Ore wards) and TN37 (St Leonards wards) in HR and BN21 (Devonshire ward area) and BN22

<table>
<tr><th></th><th>Positive</th><th>Neutral</th><th>Negative</th><th>No Impact</th><th>Data to support your assessment

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<tr><td></td><td></td><td></td><td></td><td></td><td>(Hamden Park ward area).
TN34 (the central Hastings and Ore wards), 58.6% (2723) of patients from this postcode have previously attended their appointments at Conquest and 38.5% (1787) at Bexhill. Only 2.9% (133) were seen at EDGH.
TN37 (St Leonards wards) 61.6% (1686) of patients from this postcode have previously attended their appointments at Conquest and 33.5% (918) at Bexhill. Only 4.86% (133) were seen at EDGH
BN21 (Devonshire ward area) 97.6% (2142) of patients from this postcode have previously attended their appointments at EDGH and 2.3% (50) at Conquest. Only 0.2% (4) were seen at Bexhill.
BN22 (Hampden Park ward area) 99.4% (2263) of patients from this postcode have previously attended their appointments at EDGH and 0.5% (12) at Conquest. Only 0.09% (2) were seen at Bexhill.

The 2011 Census showed that a higher percentage of persons identifying as of Black African/Caribbean ethnicity did not have access to a household car or van – 29.7% compared with 19% of those of Asian ethnicity and 18.2% of those identifying as white British or other.

The table below shows that we have 3,555,463 people in the south east that own a car or a van.
<table>
<tr><td>date</td><td colspan="4">ONS Crown Copyright Reserved [from Nomis on 23 June 2021]</td></tr>
<tr><td>geography</td><td colspan="4">South East</td></tr>
<tr><td>measures</td><td colspan="4">value</td></tr>
<tr><td>Cars or Vans</td><td>All categories: Car or van availability</td><td>No cars or vans in household</td><td>1 car or van in household</td><td>2 or more cars or vans in household</td></tr>
<tr><td>Ethnic Group of HRP</td><td></td><td></td><td></td><td></td></tr>
<tr><td>All categories: Ethnic group of HRP</td><td>3,555,463</td><td>660,430</td><td>1,483,911</td><td>1,411,122</td></tr>
<tr><td>White: Total</td><td>3,317,589</td><td>605,337</td><td>1,379,729</td><td>1,332,523</td></tr>
</table>
</td><td></td><td>The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access;
• Future of the service and the collection of data on protected characteristics
* Address prevention issues in areas of deprivation.
* Further understanding of service use and patient experience
* Undertake Comms and Engagement work to support communities and cultures
* Work with the Community Optom Team & LCN
* Ensure patient feedback can be analysed by ethnicity and address any concerns identified
• Further work around the clinical view on treatment and ethnicity diverse workforce and what further work can be done to improve this.</td></tr>
</table>

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					<table><tr><td>White: English/Welsh/Scottish/Northern Irish/British</td><td>3,128,740</td><td>560,585</td><td>1,296,066</td><td>1,272,089</td></tr><tr><td>White: Irish</td><td>39,964</td><td>9,848</td><td>16,696</td><td>13,420</td></tr><tr><td>White: Other White</td><td>148,885</td><td>34,904</td><td>66,967</td><td>47,014</td></tr><tr><td>Mixed/multiple ethnic group</td><td>36,279</td><td>9,869</td><td>15,683</td><td>10,727</td></tr><tr><td>Asian/Asian British</td><td>132,857</td><td>25,269</td><td>58,184</td><td>49,404</td></tr></table> A 2015 report on public usage and awareness of opticians from the General Optical Council found that among the adults surveyed who were of BAME background: 69% last visited an optician two years ago or more recently, compared to 74% of white adults. In addition, BAME adults (39%) are much more likely than white adults (18%) to say that you should only go to the opticians if there is something wrong with your vision or eyes, rather than regularly. However, they are also more likely to associate opticians with detecting any eye health problems than white adults (21% of BAME adults report that their main association with opticians is detecting any eye health problems, compared to 16% of white adults).		
People who have English as a second language.					JSNA data indicates that in 2011, 96% of the East Sussex population had English as a first language, with 92% of those living in the Eastbourne area having English as a first language. ESHT do not routinely capture data on those using the ophthalmology department at ESHT who have English as a second language. Eastbourne, Hastings and St Leonards-on-Sea, which have high levels of deprivation, also have the highest proportion people for whom English is an additional language.	Engagement with BAME communities where English is a second language has indicated that cultural and language issues may be barriers to accessing NHS care Without adequate action such as interpreting and translation, services may not	Work with the ophthalmology service and interpretation and translation providers to further understand numbers and needs of people accessing the ophthalmology service where English is an additional language; and use this information to

<table>
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This can be census data, research, complaints, surveys, reports etc.</th><th>Engagement / feedback information to support your assessment</th><th>Actions to take forward with a focus on</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>In 2019/20 ESHT were required to supply an interpreter to assist 25 ophthalmology patients:-

<table><tr><th>Department</th><th>Interpreters (Total)</th></tr><tr><td>Ophthalmology Eastbourne</td><td>12</td></tr><tr><td>Ophthalmology Bexhill</td><td>7</td></tr><tr><td>Ophthalmology Conquest</td><td>6</td></tr><tr><td>Total</td><td>25</td></tr></table></td><td>adequately communicate, understand or deliver services to people with English as a second language.</td><td>inform the development of options and future proposals for the service including targeted work with relevant area/communities.

Where actions of communication are highlighted as an area of improvement required, we will take immediate action to address these issues and ensure equitable access for our patients.

We will ensure the development of new service models include strong infrastructure in relation to language access issues including translated materials about the services and patient interpreting services in the models.

For formal consultation we will:

• Work with organisations that provide translation services to better understand the need for translation support for patients accessing ophthalmology services in East</td></tr>
</table>

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
							Sussex • Offer telephone interpretation to support those who speak English as a second language and wish to engage • Translate materials into community languages as a standard approach • Work with ESHT to ensure that ESHT website page on travel and access to sites is available in alternative languages and formats The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Work with Primary Care, local support workers and interpreters to work closer with local communities around communication / engagement and prevention • Identify if the e translation service offered matches the need across East Sussex

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
Sex					East Sussex has c.560, 000 residents: • 288,042 female residents (51.5%) and; • 271,367 male residents (48.5%) (JSNA 2020 data). There is a strong correlation between age and disease prevalence for the most common ophthalmic conditions; AMD, glaucoma and cataracts. The below table breaks down the age demographic across East Sussex for people 60 and over. **Age Female Male** 60-64 18,994 17,125 65-69 19,192 17,374 70-74 20,046 18,378 75-79 13,738 11,786 80-84 11,021 8,637 85+ 13,980 7,849 **Total 96,971 81,149** We estimate that: • 2,910 women in East Sussex over 60 are living with advanced AMD • 2,434 men in East Sussex over 60 are living with advanced AMD • 2,160 women over 60 are living with primary open angle glaucoma • 1,940 men over 60 are living with primary open angle glaucoma • 2,000 women over 80 are living with primary open angle glaucoma • 1,319 men over 80 are living with primary open angle glaucoma **Ophthalmology attendances at ESHT 2019/20** **Age Female Male Unknown** 0-18 3,072 3,140 2 19-64 9,538 8,935 65-74 9,610 9,573 75+ 25,876 18,378 **This data reflects the service usage we would anticipate.** **Sex and disease prevalence (NICE, 2020)** • Women are at a higher risk of developing cataracts than men • Women are at a higher risk of developing primary angle closed	As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; *'What is your gender?'* Responses: - Men (45) - Women (79) - Other (1) - Prefer not to say (1)	Attendances for ESHT are higher for women than men, which we would expect to see given that they make up a higher proportion of the patient population. Women across East Sussex are at a greater risk of poor eye health than men. We will ensure that as part of the formal options development process, we take account of the needs of women in respect of their being at greater risk of poor eyesight and greater risk of blindness (based on national evidence), poor eye health in developing, models/interventions to ensure the right service reach for our population into the future. For formal consultation we will: • Take measures to identify and engage with gender specific groups in East Sussex, targeting women as appropriate as the data suggests.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					glaucoma than men It is estimated that 60% of blindness worldwide is among women, underlining that gender equity in eye health has not yet been achieved (Inequality and Inequity in Eye Health, 2016). A 2015 report on public usage and awareness of opticians from the General Optical Council showed that: • Men tend to be less aware than women of opticians' role in identifying eye health issues. • 7% of male patients say that one of the main reasons for their last visit to the optician was to detect any eye health problems, compared to 10% of female patients. • Men are less likely than women to say that they would go to the opticians first if they woke up tomorrow morning with an eye problem (16% compared to 21%). **Long term conditions** 31.9% of women in East Sussex have two or more long term conditions compared to 26.2% of men. **Carer responsibilities** A higher proportion of women claim carers allowance in East Sussex than men: • Women - 11.9% • Men – 4.9% Travel –specific impact: • Ophthalmology attendances recorded by ESHT in 2019/20 showed that slightly more females than males attended appointments but that the proportion significantly increased in the over 75 age group. • This indicates that any increase in journey times to hospital would impact the female population more than the male population. • DVLA figures for 2019 show that nationally - 89% of males and 81% of females aged 40-59 hold a driver's licence 90% of males and 79% of females 60-69 hold a driver's licence 81% of males and 55% of females aged 70+ hold a driver's licence. (https://www.gov.uk/government/collections/vehicles-statistics) • There is no evidence currently available that show implications for		

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					travel by public transport are different for any particular gender.		
Gender reassignment					There is no current census data on gender reassignment or data on Trans patients accessing ophthalmology services at ESHT. It is estimated that the Trans population based on the needs assessments as documented above is approx. 2% of the local population.	Whilst there is no direct data for Trans users of the ophthalmology service at ESHT, feedback from wider work such as the Trans Needs Assessment in Brighton and Hove (2015) and work carried out through the Brighton and Hove commissioned engagement project indicates: • Trans people may fear engaging with services, with concerns about being mis- gendered, about lack of understanding of gender reassignment and concerns about intimate care. • Trans people may have concerns about record keeping by health services and how this reflects their Trans status. Whilst the above does not relate directly to the ophthalmology service at ESHT, it is important to recognise this feedback relating to health services more widely and the perceptions this may create.	We will work with the ophthalmology service to better understand numbers of Trans people needing or using ophthalmology services. We will ensure that as part of the formal options development process we give due regards to the issues of access and experience in our Transgender community and that our transformation plans including Trans awareness training for ophthalmology staff. For formal consultation we will: • Take measures at the outset to identify any trans groups in East Sussex so we can involve them in the pre-consultation engagement and programme development and gain feedback • Approach Hastings & Rother Rainbow Alliance Trans Support Group to talk about

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
						As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; *'do you identify as the sex you were at birth?'* Responses: - Yes (119) - No (1) - Prefer not to say (4) We recognise that engagement from this community was low and this will be addressed in the full consultation process.	opportunities to get involved • Approach Bourne Out via Facebook and ask for support with promotion of the questionnaire • Contact The Clare Project and Switchboard in Brighton and Hove to see if they have reach in East Sussex to encourage participation The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; * Service to record data around the use of ophthalmology services by the transgender community * Service to review and consider further training and education around gender reassignment and LGBTQ+
Age					**Ophthalmology attendances at ESHT 2019/20** Age Female Male Unknown 0-18 3,072 3,140 2 19-64 9,538 8,935	Research by Age UK in Brighton and Hove (2018) indicated that older people wanted to see longer opening hours for health	Age is the primary risk factor for eye health. With the East Sussex population growing, notably among the 65 and overs, future models

<table>
<tr><th></th><th>Positive</th><th>Neutral</th><th>Negative</th><th>No Impact</th><th>Data to support your assessment

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<tr><td></td><td></td><td></td><td></td><td></td><td>65-74 9,610 9,573
75+ 25,876 18,378

East Sussex Age Profile:
• 0 -15 (17%)
• 16 – 64 (57%)
• 64+ (26%)

East Sussex has among the highest proportions of over 65-year olds and over 85-year olds in the country. 4.7% of the females in East Sussex are over 85 and 2.7% of the males (East Sussex JSNA).

Currently the over 65s represent over a quarter of the local population in East Sussex, with this projected to increase to almost one third by 2031.

All elderly age groups are expected to increase in size, with the number of very elderly people aged 85 and over expected to increase by 40%, from 22,000 in 2019 to 30,900 in 2029. (East Sussex in Figures, ESCC and Demographic Projects in Brief (April 2020).

Hastings & St Leonards, Havens and Lewes have the highest percentages of people aged under 20 and the lowest percentages of older people, whereas Bexhill (which is adjacent to Hastings & St Leonards) and Seaford have the lowest percentages of people aged under 20 and the highest percentages of older people

Due to the age distribution in East Sussex, the county has a higher percentage of people living with sight loss than the national average. The following table shows the percentage of people living with sight loss in East Sussex compared with both the South East and England. This percentage is predicted to rise in line with population growth.
Percentage people with sight loss
<table>
<tr><th>Year</th><th>East Sussex</th><th>South East</th><th>England</th></tr>
<tr><td>2015</td><td>4.3%</td><td>3.3%</td><td>3.1%</td></tr>
<tr><td>2020</td><td>4.5%</td><td>3.5%</td><td>3.2%</td></tr>
</table>
</td><td>services and more intelligent services – where repeat visits are flagged and the individual is redirected accordingly, or where there is better communication between primary and secondary care.

Older people also reported concerns about moving to “online” appointments and away from a face to face option.

The elderly population may also have co-morbidities that restrict their mobility, which may make accessing hospital appointments difficult. Future options will include accessibility considerations.

Sight plays a vital part of a child’s development of language, social and cognitive skills. Vision impairment in children creates unique challenges to learning and development, which can have a profound impact on their education and wellbeing. Children and their parents may need specialist support. Many children and young people have more than one sight condition and many have</td><td>of care need accommodate for this increase in demand to ensure the service can meet the needs of the population.

Older people are also more likely to have reduced mobility, so travel/ locations for service delivery will be considered.

As we develop our options and proposals for the future of ophthalmology services we will take into consideration the needs of our older population whose eye health deteriorates with age (a particular issue in East Sussex with its significant over 65 and 85 year olds) including any particular needs of care home residents and consideration of where people live in relation to where services are delivered.

In terms of pediatric ophthalmology services, as we develop the model, options and future proposals we will take into account the needs of children who are at higher</td></tr>
</table>

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					<table><tr><td>2025</td><td>4.9%</td><td>3.8%</td><td>3.5%</td></tr><tr><td>2030</td><td>5.4%</td><td>4.2%</td><td>3.9%</td></tr></table> **Black Asian and minority ethic (BAME)** Whilst the BAME population have greater prevalence and have a much younger age profile, with the 2011 Census showing that 26% were aged under 15 years, 68% aged 15-64 years, and 6% aged 65 years and over. This compares to 16% (under 15), 61% (15-64), and 23% (65 and over) for the White population. **Residents in care homes** Across East Sussex for people aged over 65 there are 503 people in care homes per 100,000 population. Applying this to the population of East Sussex, we estimate there to be 2,817 people in care homes aged over 65. (State of the County, Focus on East Sussex, 2020). People living in care homes will often need to supported to book and attend ophthalmology appointments by the care home staff. The NHSE Enhanced Health in Care Homes Framework ensures that care and support is coordinated and consistent, and that interventions are offered as early as possible to meet each individual's needs. It cites best practice in this area as – 'Care coordinators provide dedicated support to residents and their carers who are having multiple simultaneous interactions with different health, care, and voluntary sector services. **Hearing loss** In East Sussex, 120,000 people are reported to have hearing loss. 80% of people with moderate to severe hearing loss are over 65. **Carer responsibilities** The 2011 Census showed that in East Sussex, over 45% of carers were aged over 65. A pilot study carried out by Care for the Carers (East Sussex) between Dec 2020 – Mar 2021 concluded that; .."there are significant correlations between the local health inequalities identified by the Healthy Hastings & Rother	other special education needs (RNIB, 2016). As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; *'What was your age on your last birthday?'* Responses: - Under 25 (4) - 25 – 34 (1) - 35 – 44 (9) - 45 – 54 (5) - 55 – 64 (22) - 65 – 74 (47) - 75 – 84 (27) - 85+ (10) - Prefer not to say (2) There were a lower number of responses for people 55 and under. While attendance data shows older people are higher users of ophthalmology services, there is still a need to engage with younger and middle aged people within the population during the formal consultation to understand their experiences as they are still significant users of the service.	risk of visual impairment, in particular relationship with: • very premature and very low birth weight babies and children; from the most economically deprived backgrounds • children and young people from some South Asian ethnic groups • children with learning difficulties For formal consultation we will: • Work in collaboration with the local authority to ensure we reach care home residents and staff • Take measures at the outset to identify organisations that support younger and middle aged people living with ophthalmic disease • Attend East Sussex Senior Association to talk about ophthalmology service transformation and provide opportunities to feedback/ get involved

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					programme, and the impact of caring on health & wellbeing, in particular for hidden carers". **Deprivation** The Annual Report from Public Health in East Sussex showed that in 2015, 13% of people aged 65+ were living in poverty in East Sussex. **Mobility** In 2020 there were 37,200 people over 65 living with a long term illness whose ability to carry out day-to-day tasks was limited. There were 28,310 people whose ability to carry out day-to-day tasks was significantly limited (Picture East Sussex, 2019) **Age and disease prevalence** Sight loss and ophthalmic conditions affect people of all ages, but as we get older we are increasingly likely to experience issues with our sight. Sight loss is more common in those aged 75 and over, with AMD, glaucoma and cataracts all being more common as people age (RNIB, 2016) **Glaucoma** Primary open angle glaucoma (the most common form of glaucoma) affects 1% of the population aged over 40, 3% of the population aged over 60, and 8% of people over 80 (NICE, 2020) **Age Related Macular Degeneration** It is estimated that 1-3% of the population in western countries suffer with an advanced stage of AMD. This would estimate that across East Sussex, approximately 16,800 would have advanced AMD (NICE, 2020). The disease affects mainly those 50 years or older (RNIB, 2009) **Cataracts** A cataract may form in one or both eyes, at any age. Most cataracts occur as a result of ageing and are most common in people aged over 60 years. It is estimated that 16% of people 65-95, 24% of people 70-74, 42% of people 75-79, 59% of people 80-84, and 71% of people 85 and over are visually impaired due to cataracts (NICE, 2020). **<u>Population change 2020-2024:</u>**	Our YouGov poll included around 2,000 parents of children aged three to 16. We found that: Almost two thirds of parents said that their children had an eye test before the age of eight (62%). A similar proportion say that their children have had a test in the last two years (63%), however, 16% have never had a test. In the RNIB's 2016 report on the State of the Nations Eye Health highlighted that children from economically deprived backgrounds, children and young people from South Asian ethnic groups and children with learning difficulties are at a higher risk of visual impairment.	• Contact Age Concern to ask about attending some drop in sessions • Engage with RNIB, East Sussex Association for the Blind, Macular Society • Engage with the Public Health Vision Screening Service for Children • Attend PPG forums across East Sussex and offer drop in session if enough interest • Liaison with Age UK East Sussex • Approach the County Council to support us in engaging with Parent Carer forums The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; • Work closely with Public Health on prevention and promotion and local support groups i.e. Age Concern. Interdependencies around ethnicity and age need to be reviewed

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					It is important to note the likely increase and changing demographics with regard to numbers of people and older people living in East Sussex. Compared to 2020, by 2024 there will be: - 19,024 more people living in East Sussex (+3.4%) An increase of 2.2% (2,366 people) in the number of children and young people An increase of 1.4% (4,407 people) in the working age population 8.3% (12,252) more people aged 65 and over In East Sussex 4.3% of people will be aged 85+, a greater proportion than England, 2.7%. Ranked 2nd in England for the highest proportion of population 85+, (ONS estimate 2019) **Children and Young People** Amblyopia is the most common cause of vision problems in children, affecting 3.6% of children. We estimate that across East Sussex there are 500 children aged 4-5 referred into ESHT per annum for suspected amblyopia. RNIB estimates suggest that there are more than 25,000 blind and partially sighted children in the UK, and around 15,000 aged 17-25 (RNIB, 2016). Children at higher risk of vision impairment • very premature and very low birth weight babies and children; from the most economically deprived backgrounds • children and young people from some South Asian ethnic groups • children with learning difficulties A 2015 report on public usage and awareness of opticians from the General Optical Council showed that younger people are more likely to say that you should only visit the opticians if there is something wrong with your eyes (35% aged 18 - 20 compared to 13% aged 75+). In addition, they are more likely to say that they have never been to the opticians (18% aged 18-29 compared to 5% aged 75+). Travel – Specific Impact: DVLA figures for 2019 show that nationally 86% of 40 – 59-year-olds, 85% of 60 - 69-year-olds and 67% of those aged 70+ hold a driver's licence. (https://www.gov.uk/government/collections/vehicles-statistics)		

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					The 2011 census showed that in East Sussex 29.4% of lone parent households and 6.4% of other households with dependent children did not have access to a car. 36% of pensioner households did not have access to a car. (eastsussexinfigures.org.uk) The Seaford postcode area is BN25. ESHT patient data from 2017-2020 shows that the vast majority of patients from Seaford, 99.73% (4054), have previously attended their appointments at the Eastbourne District General Hospital. The Bexhill postcodes are is TN39 and TN40. ESHT patient data from 2017-202 shows that the majority of patients from these postcodes have previously attended their appointments at either Bexhill Hospital, 61.3% (5758), Conquest, 32.4% (3585) or EDGH, 6.5% (724). A 2015 ESHT survey of patient methods of travel to the main sites and usage of ESHT car parks showed that 75% of those surveyed had arrived by car (driver or passenger). Over 40% of those surveyed were in the over 65 age group.		
Religion and belief					There is no data on the religion or faith of those using the ophthalmology department at ESHT. According to the last census, 73.6% of the East Sussex population said they were Christian. The second highest figure was 1.6% who said they had no religion. Other religions, including Buddhist, Hindu, Muslim, Jewish and Sikhs ranged from 0.0 to 0.6% of the East Sussex population. The 2011 Census showed that the number of people in East Sussex that stated their religion was Christian fell from 74% in 2001 to 60% in 2011, while the number of people following 'other religion'(2%) and 'no religion' (30%) increased in East Sussex. Islam (0.8% of the population) is the most popular religion after Christianity, followed by Buddhism (0.4%) and Hinduism 0.3%) (www.eastsussex.gov.uk 2011 Census results) **Conquest Hospital** The Chaplaincy Office and the Chapel of the Holy Cross are on Level 2 near the main lift and stairs. There is a multi-faith prayer room adjacent to the Chapel. **EDGH**	As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; '*what is your religion or belief?'* Responses: - Christian (73) - Jewish (1) - Muslim (1) - Pagan (0) - Buddhist (0) - Agnostic (18) - Atheist (13) - Prefer not to say (21) - Other (8)	From this assessment we feel the risk of widening the health inequalities gap for people of different religions and ethnicities is low. We will however continue to engage with patients of different religions and beliefs as part of our work so considerations on faith inclusive and culturally competent services will be included in the options development and future service proposals. We will also ensure that as part of the formal options development process we give due regards to the issue of access and religion and belief to ensure that we do not unduly increase health inequalities.

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					The Chaplaincy Office and the Chapel of Christ the Healer is on Level 3 in the same corridor as the Michelham Unit and Critical Care. There is also a multi-faith prayer room. **Bexhill** Chaplains are in attendance on a regular basis through the week, visiting inpatients on the Irvine Unit wards. A meeting room can be arranged if needed. With respect to Ophthalmology, only outpatient and daycase activity is undertaken at Bexhill.		For formal consultation we will: • Ensure that we have forged links with faith communities in East Sussex to engage in this project. Invite Faith elders to engage, and offer translated versions of materials where required. The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; Service to analyse chapel usage at each site and how often a chaplain is being asked for • Review how this data can be recorded going forward.
Disability (and Long Term Conditions)					Approximately 20% of the total population have a long-term health problem or disability that limits day to day activities in East Sussex, which is higher than the national and regional average. In East Sussex, 43,632 people of working age (16-64) have a long-term health problem or disability. This group accounts for 8.2% of the county's population, rising to 11.6% in Hastings. (www.eastsussex.gov.uk 2011 Census results)	D/deaf people have said that they face significant barriers to accessing health care, through inequity of communication People with physical	As part of the options development and appraisal process, future models of care will need to take into account the needs of patients living with a disability or long term

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Long term conditions
31.9% of women in East Sussex have two or more long term conditions compared to 26.2% of men.

Mobility
In 2020 there were 37,200 people over 65 living with a long term illness who's ability to carry out day-to-day tasks was limited. There were 28,310 people whose ability to carry out day-to-day tasks was significantly limited (Picture East Sussex, 2019).

In June 2021, East Sussex County Council report Blue Badge holders in East Sussex as:

Eastbourne 4,155
Hastings 3,660
Lewes 4,658
Rother 4,870
Wealden 6,066

The 2011 Census showed that 13% of persons reporting a long term health problem or disability did not have access to a household car or van.
<table>
<tr><td></td><td colspan="4">ONS Crown Copyright Reserved
[from Nomis on 23 June 2021]</td></tr>
<tr><td>geography</td><td colspan="4">South East</td></tr>
<tr><td>measures</td><td colspan="4">value</td></tr>
<tr><td>Disability</td><td>All categories: Long-term health problem or disability</td><td>Day-to-day activities limited a lot</td><td>Day-to-day activities limited a little</td><td>Day-to-day activities not limited</td></tr>
<tr><td>Cars or Vans</td><td></td><td></td><td></td><td></td></tr>
<tr><td>All categories: Car or van availability</td><td>8,446,500</td><td>536,424</td><td>742,540</td><td>7,167,536</td></tr>
</table>
</td><td>
disabilities have told us that physical access to buildings is important, and that being able to travel to, and park at, care locations is important.

We know from people with learning disabilities that understanding of health conditions, of care, and of treatment can be affected through lack of accessible information, and/or explanation to carers. People with learning disabilities have also said that they struggle with making appointments by phone and accessing remote appointments, due to communication difficulties.

People with a disability or a long term health condition that affects their mobility may find travelling more of a challenge or require an escort for hospital appointments.

Patients that are less mobile and find it difficult to attend appointments delay visits until they experience symptoms (RNIB 'Eye Health and sight loss stats and facts' April 2018).
</td><td>
conditions. Future models need to consider the travel impact on patients, and also the requirements of patients that may have more complex needs and require reasonable adjustments, for example; patients with vision and hearing loss, patients with learning disabilities, mental health conditions and dementia may require longer appointments.

The relationship between eye health, Diabetes and poverty will be considered when carrying out any travel impact assessments once the options are developed and these will be utilised in decision making.

For formal consultation we will:Explore opportunities with CVS organisations such as Possibility People to see what forums and networks we can utilise to support engagement
Approach Hastings disability forum to ask for support
Arrange a drop in opportunity for d/Deaf members to come and talk about experiences

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	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
						People with dementia are more likely to experience visual misinterpretations and hallucinations. Sight loss exacerbates the symptoms of dementia, impairing orientation, cognition and communication. Sight loss decreases quality of life and increases the care needs of this group. People with dementia may be less likely to access eye health care, both for routine sight tests and for evaluation of symptoms. They may be also be less likely to be aware that they have problems with their sight. The Royal College of Psychiatrists estimates that 85% of older people with depression receive no help at all from the NHS (Age UK. Later Life in the United Kingdom, 2017). As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; *'Are your day-to-day activities limited because of a health problem or disability which has latest or is expected to last 12 months?'*	of ophthalmology services • Make the materials available in Easy Read and British Sign Language as a standard approach. • Approach the East Sussex Dementia Adviser Service to support the reach of our engagement • Approach the East Sussex Community Learning Disability Team for support • Take action to identify and engage with charities and organisations that support patients with diabetes • Take action to identify and engage with charities and organisations that support patients with their mental health • Take action to identify and engage with local mental health services As part of the project, an analysis of transport needs is being undertaken and measures will be agreed to mitigate any adverse outcomes. There will be

No cars or vans in household	1,099,671	189,253	174,902	735,516
1 car or van in household	3,086,959	230,108	326,240	2,530,611
2 or more cars or vans in household	4,259,870	117,063	241,398	3,901,409

Hearing loss
In East Sussex, 120,000 people are reported to have hearing loss. This is approximately 22% of the East Sussex population. 80% of people with moderate to severe hearing loss are over 65.

From this we can infer that:
- 3,600 people are living with hearing loss and advanced AMD
- 4,200 people living with hearing loss and primary open angle glaucoma

In 2019/20, ESHT supplied a British Sign Language interpreter for patients on 211 occasions. There is no data on how many of these patients were visiting the ophthalmology department.

Obesity
Is a major public health problem in England and globally. In adults overweight and obesity are associated with life limiting conditions such as type 2 diabetes, cardiovascular disease and some cancers. Childhood obesity is predictive of adult obesity, but also separately increases the risks of asthma, early onset type 2 and CVD risk factors.

Health Survey for England 2019 Overweight and obesity in adults and children NHS Digital
27% of men and 29% of women were obese. Around two thirds of adults were overweight or obese, this was more prevalent among men 68% than women 60%
Obesity increased with age from 13% of adults aged between 16 and 24, to 36% of those aged 65 to 74. It was lower among adults aged 75 and over 26%

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
					59% of men and 69% of women had a higher than desirable waist circumference. This proportion increased broadly in line with age from 29% of adults aged 16 to 24 to 83% of those aged 75 and over Inequalities were seen for both obesity and raised waist circumference. Adults living in the most deprived areas were the most like to be obese. This difference was particularly with women where 39% of women in the most deprived areas were obese, compared with 22% in the least deprived areas **Long term conditions** 31.9% of women in East Sussex have two or more long term conditions compared to 26.2% of men. **Diabetes** People with diabetes are at an increased risk of diabetic eye disease, as well as glaucoma and cataract RNIB 'Eye Health and sight loss stats and facts' April 2018). Within 20 years of being diagnosed, nearly all people with type 1 diabetes, and almost two thirds of people with type two diabetes will have developed some form of diabetic retinopathy (RNIB, 2016). 9% of the East Sussex patient population were estimated to have diabetes in 2016/17 (England also 9%). 57% of people with diabetes receiving all 8 care processes were estimated to have type 2 diabetes. (Report from the Director of Public Health in East Sussex, 2019). Given the increase in population size, we would estimate there to be 50,400 people living with diabetes in East Sussex. We estimated 28,700 would be living with type 2 diabetes. In 2014, the prevalence of diabetic retinopathy was 56.4% of people living with type 1 diabetes and 30% for people living with type 2 diabetes (RNIB, 2017). It is therefore estimated that across East Sussex, 12,239 people with type 1 diabetes living with diabetic retinopathy, and 8,610 people living with type 2 diabetes and diabetic retinopathy. Adults with diabetes are 2-5 times more likely than those without diabetes to develop cataract. Cataract also tends to develop at an earlier age in people	Responses: - Yes a lot (19) - Yes a little (38) - No (65) - Prefer not to say (2) Respondents were then asked; *'If yes, please state the types of impairments, tick all that apply'* Responses: - Physical impairment (36) - Long standing illness (20) - Mental health (5) - Sensory (10) - d/Deaf (5) - Autistic (1) - Learning disabilities/difficulties (2) - Prefer not to say (4) - Other (6) The 2019 Patient Led Assessment of the Care Environment (PLACE) rated ESHT sites' access for disabled patients as follows against a National Average score of 84 .25%: Bexhill: 71.90% Eastbourne: 81.64% Conquest 77.28%	engagement with patients and the public on the travel impact if an option includes a change of site part of the formal consultation process. The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; *To ensure new contracts collect data on protected characteristics * work with Primary Care more closely around patients with LTC's diabetes clinics, dementia yearly reviews, carers groups, Mental Health issues and local services *look at current training and education packages for Staff and how these could be improved by really understanding what our communities want and need from our services and the overall patient experience *Review the area of Wealden in terms of demographics as this is the highest area for blue badge holders and understand what services these patients access

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					with diabetes. In adults, diabetes nearly doubles the risk of glaucoma (RNIB,2016) **Dementia** Across East Sussex, 11,500 people aged 65 and over were living with dementia in 2020. This is expected to rise to 12,350 in 2024, and to 15,900 in 2030 (JSNA 2016) The 2019 report for the Director of Public Health in East Sussex showed that the prevalence of dementia is 0.3% higher in East Sussex (1.1%) compared to England (0.8%): • 1.3% EHS • 1.2% HR • 1.0% HWLH In 2012, the RNIB estimated that 1,230,000 people were living with dementia and sight loss across the UK (c.0.20%). Based on today's population size, we estimate there to be 1,120 people living with dementia and sight loss across East Sussex. This number is expected to grow as the population ages. **Mental Health** The incidence of sight loss increases as people age, and this can have a crucial effect on their overall mental health. Sight loss has a significant impact on confidence. People feel they lose their independence and become isolated (GM Journal, 2020) Older people with sight loss are almost three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007). Loss of vision can have grave consequences on people's quality of life, which can have a significant impact on their mental health. Loss of vision is often considered to be irreversible or progressive, meaning people can experience continuous mental distress due to anxiety and fear of isolation (EPMA Journal, 2018). The Sussex Health and Care Partnership Population Healthcheck (2019) shows common mental health prevalence across East Sussex (2014/15 data): • 12% in HWLH		* Link in with CCG Deaf engagement /BSL Service and Sign Live. * Building on general insight already gathered, engage with local d/Deaf people through local Deaf organisations to gather insight on barriers and possible solutions. Work with ESHT to provide BSL interpreting services to all patients by including a Video Relay Service (such as Signlive) linked to the department contact details which enables d/Deaf people to call ahead of their appointment to confirm any additional needs using a BSL interpreter and their mobile device" * Link in with Primary care on refining data for patients needing an BSL interpreter *Include provision for making longer appointments for patients that require reasonable adjustments to allow for interpreting time and appointments later in the day as some disabled people need more time to prepare and get to appointments.

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					• 12.4% in EHS • 13.8% HR From this we can infer that: • 2,016 people are living with a common mental health issue and advanced AMD • 2,353 are people are living with a common mental health condition and primary open angle glaucoma Serious mental health prevalence across East Sussex: • 0.8% HWLH • 1.1% EHS • 1.2% HR From this we can infer that: • 168 people are living with advanced AMD and a serious mental health issue • 196 people are living with primary open angle glaucoma and a serious mental health condition **Learning disabilities** There is no definitive record of the number of people with learning disabilities in the UK or East Sussex, there are currently 3,332 people on GP Learning Disability registers in East Sussex. Adults with learning disabilities are ten times more likely to have eye problems, but are less likely to receive timely and appropriate care than the rest of the population, while children with a learning disability are 28 times more likely to have a serious sight problem (Vision care requirements among intellectually disabled adults: a residence-based pilot study, 1996). **Hypertension** Patients with hypertension are at a greater risk of developing cataracts. Across East Sussex there is 92,800 on the hypertension register, and an estimated 12,604 undiagnosed. Research by The British Heart Foundation states that some ethnic groups are more vulnerable to heart and circulatory diseases. **Glaucoma** Primary open angle glaucoma (the most common form of glaucoma) affects		

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					1% of the population aged over 40 (1,486), 3% of the population aged over 60 (4,110), and 8% of people over 80 (3,319). It is thought that approximately 50% of people living in the UK with primary open angle glaucoma have not been diagnosed. We estimate that across East Sussex there are 8,915 are living with undiagnosed open angle glaucoma. We estimate the disease prevalence for open angle glaucoma across East Sussex to be 17,830. **Age Related Macular Degeneration** AMD has a higher prevalence in western countries. It is estimated that 1-3% of the population in western countries suffer with an advanced stage of AMD. We estimate that across East Sussex, approximately 16,800 people would be living with advanced AMD. **Sight loss** It is estimated that 4.5% of the population in East Sussex are living with sight loss (25,200 people). This is set to rise of 5.9% in 2025 and 5.4% in 2030. East Sussex has higher levels of sight loss than the South East region and nationally. **Travel – Specific impacts** Eastbourne Hospital has 46 designated blue badge parking spaces and Conquest has 60 spaces. Ophthalmic patients with conditions that affect their ability to travel by car or public transport can apply to the CCG's Non Emergency Patient Transport Service for assistance.		
Sexual orientation					There is no data on sexual orientation of those using the ophthalmology department at ESHT. Data on the UK's lesbian, gay and bisexual population is not currently collected during a census. It is being considered for inclusion from 2021. Estimates range between 5% and 7%, however there is a recognised reluctance to be open with policy makers and researchers, as individuals see few benefits and fear discrimination and harassment through doing this.	Research by Stonewall (2018) indicates: • Almost one in four LGBT people (23%) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. • One in five LGBT people aren't out to any	From this assessment we feel the risk of widening the health inequalities gap for our LQBQ communities is low. We will however continue to engage will patients from LQBQ communities in East Sussex as part of the formal consultation to better understand where health

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						healthcare professional about their sexual orientation when seeking general medical care. This number rises to 40% of bi men and 29% of bi women. • One in seven LGBT people (14%) have avoided treatment for fear of discrimination because they're LGBT. • One in eight LGBT people (13%) have experienced some form of unequal treatment from healthcare staff because they're LGBT. One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT. (Stonewall Report ' LGBT in Britain (2018) Whilst the above does not directly relate to the ophthalmology service at ESHT, it is important to recognise this feedback relating to health services more widely and the perceptions this may create.	inequalities may exist. We will also ensure that as part of the formal options development process we give due regards to the issue of access and experience and our LGBQ to ensure that we do not unduly increase health inequalities, for example; awareness training for staff. For formal consultation we will: • take measures at the outset to identify any LQBQ groups in East Sussex so we can involve them in the programme development and gain feedback • take measures to ensure any new services hold LGBTQ awareness materials The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; • further training and education is required across the service raising awareness and providing conscious consideration • Monitoring and data collection is needed •Equal

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							consideration of same sex partners in care services – care plans and advance care plans/ RESPECT forms
Marriage or civil partnership					There is no data on the marital status of those using the ophthalmology department at ESHT.		It is not considered pertinent to target engagement related to marital or civil partnership status
Pregnancy and maternity					There is no data on those using the ophthalmology department at ESHT relating to pregnancy and maternity. There are just under 5,000 births per year in East Sussex. Hastings has the highest overall birth rate as well as for women aged 15-19 years. Lewes and then Rother have the highest birth rates for women aged 35-44 years. (East Sussex Equality Profile 2020). **Pregnancy/ maternity and disease prevalence** Pregnant women with pre-existing diabetes are at an increased risk of progressing diabetic retinopathy. https://www.nice.org.uk/guidance/QS109/chapter/Quality-statement-4-Referral-for-retinal-assessment	As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; *'Are you currently pregnant?'* Responses: - No (95) - N/A (31) - Prefer not to say (0) - Yes (0)	Clarification is required as to the number of pregnant women accessing ophthalmology services at ESHT. We will continue to engage with relevant groups that support pregnant women as part of our formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development process we give due regards to pregnant women to ensure that we do not unduly increase health inequalities. For formal consultation we will: • Attend East Sussex Maternity Voices Partnership meeting • ESHT to identify any service users

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							who may fall into this category and encourage them to undertake an in-depth interview • Triangulate data on women at child bearing age with attendances at ESHT to estimate the prevalence of women within the service that would be pregnant. The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; *triangulate data on local birth rate (5,000 per year) with attendance to ESHT ophthalmology department as we need to review inequalities in areas of deprivation such as smoking, drinking, diabetes etc. * Look at prevalence of eye conditions and what issues this presents. Develop an action plan to address outcomes. *Liaise with local Maternity Team to ascertain if further information is available

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Other Disadvantaged or inclusion groups					**Carers** At the time of the 2011 Census there were: • over 59,400 people (11% of the total population), providing unpaid care in East Sussex • 33% of carers provide over 50 hours of informal care a week • Nearly 12% provided 100 hours or more • 45% of carers are aged over 65 The 2020 East Sussex Equality Profile reported there were 10,603 persons claiming carer's allowance in East Sussex. A higher proportion of women claim carers allowance in East Sussex than men: • Women - 11.9% • Men – 4.9% The East Sussex Care for the Carers Association have estimated there are about 68,229 unpaid carers in East Sussex. This calculation was done pre-Covid. It is believed that many carers do not identify themselves as such (for various reasons), and therefore it is believed this number would be greater, but it is not known to what extent. A pilot study carried out by Care for the Carers (East Sussex) between Dec 2020 – Mar 2021 concluded that; .."there are significant correlations between the local health inequalities identified by the Healthy Hastings & Rother programme, and the impact of caring on health & wellbeing, in particular for hidden carers". Care for the Carers' Intensive Support to Carers in Hastings project was a 4-month pilot project providing intensive support to carers in areas of known high health inequalities in the Hastings area, during December 2020-March 2021. It was commissioned by East Sussex County Council (ESCC) and NHS East Sussex Clinical Commissioning Group (CCG), through the Healthy Hastings and Rother Programme, and was a collaboration project with the Hastings and St Leonards Primary Care Network (PCN). 288 unique carers in the Hastings PCN area received 1:1 support during the pilot project period, representing an increase of 67 carers (30%) on the baseline data for the same period in the previous year, when 221 unique carers accessed Care for the Carers' support.	**Carers** The Carers Centre Hospital Report highlights the key areas for improvement as information and support for carers, discharge planning, medicine management and communication with GPs. Training for hospital staff on carers' issues would benefit both staff and carers. (Hospital Report- Carers Centre) The Rough Sleepers Initiative (RSI) was commissioned in East Sussex by the five district and borough councils and is funded by the Ministry of Housing Communities and Local Government (MHCLG). RSI is designed to improve rough sleepers' ability to gain access to services. As part of the pre-consultation engagement for ophthalmology redesign, respondents to the questionnaire were asked; *are you a carer? A carer provides unpaid support to family or friends who are ill,*	As part of the options development, appraisal and decision processes, we will need to ensure that models of care meet the needs of people from disadvantaged groups, notably residents in care homes, domiciliary care, and carers where access to services and support is a barrier. For formal engagement we will: • be engaging with carers throughout the project to seek their views, through one-to-one interviews, liaison with representative groups and questionnaires • link into the Care homes group for East Sussex but this link needs to be taken forward to ensure care planning and carers are supported • engage with homeless and rough sleepers through pre-existing relationships with supporting

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					All the participating surgeries strongly support the longer term continuation of the project as, even within the challenging context of the pandemic, they reported having seen the positive results it can bring for carers and the surgeries, including enabling them to meet the requirements of the CQC key lines of enquiry in relation to carers. It is positive that 12 months' continuation funding has been agreed to enable the project to continue to develop during 2021/22, building on the successes and learning from the pilot, and including the proposal to work with an additional two surgeries from October 2021. There is also significant potential to deliver the same project model in other areas of health inequality across the County, should further investment be available. The Red Cross offers a free Carer Crisis Service to support carers with their caring responsibilities. **Adults receiving long term support** Across East Sussex there were 9,533 adults receiving long term support as of 2020 (State of the County, Focus on East Sussex, 2020) **Residents in care homes** Across East Sussex for people aged over 65 there are 503 people in care homes per 100,000 population. Applying this to the population of East Sussex, we estimate there to be 2,817 people in care homes aged over 65. (State of the County, Focus on East Sussex, 2020). It is estimated that up to 50% of people living in care homes have some form of sight loss. This means of the 2,817 people aged over 65 residing in care homes, approximately 1,408 have some form of sight loss (RNIB, 2016). Many of the challenges for patients with dementia also apply to care home residents. NHS domiciliary eye care is available for all care home residents, but this relies on care home managers recognising the need for regular sight tests in residents who may be unaware of, or unable to communicate, a problem with their vision. **Homelessness and Rough Sleepers** Homeless populations have a higher prevalence of eye health issues than the general population, and there is a strong association between visual	*frail, disabled or have mental health or substance misuse problems.* Responses: - Yes (30) - No (92) - Prefer not to say (2) During Options Appraisal Workshops run by ORS in March 2021, it was noted that travel and access appear to be the primary issues for patients. It was said that transport is already an issue for patients living further from hospital sites. It was considered particularly essential that the travel and (physical and psychological) access needs of particular groups be borne in mind in service redesign. Participants explicitly mentioned: those living in rural and/or deprived areas; people with protected characteristics; the elderly and those with mobility issues; children and young people; those who rely on public transport; and rough sleepers.	organisations such as Rough Sleepers Initiative, Matthew25 and YMCA • work with the NHS Armed Forces Community lead to ensure we hear from this cohort • Ensure that the Red Cross ' Carer Crisis Service' and the Care for the Carers 'intensive support to carers in areas of known high health inequalities' schemes are included in consultation and are made known to local population. The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access; • Establish how many carers have registered with ESCC and local hospital sites – review the data and progress what could be done further to support carers

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					impairment and lower wellbeing as well as reduced earning potential. Health needs, such as dentistry and eye care, can often be neglected when someone doesn't have a permanent home. Many people without permanent residence have uncorrected refractive errors, many of whom need treatment or glasses. Blurry vision can be a huge barrier that makes searching for work and finding housing more difficult. Those in receipt of state benefits automatically receive free eye care but people who do not receive benefits may find access difficult. A principal barrier is that the lack of a fixed abode usually means that benefits and healthcare are not provided. They cannot access GOS if they are unable to provide an address, and to be referred to hospital services they would need to be referred by a GP or community optometrist. At the beginning of the pandemic, the number of verified rough sleepers remained low. Since lockdown measures have begun to be eased in July 2020, there has been an increase in the number of people rough sleeping. It is estimated that: • There are currently 33 people continuing to rough sleep across East Sussex. • There are also 141 former rough sleepers living in emergency accommodation in East Sussex. The emergency accommodation is provided by East Sussex County Council (ESCC). Covid-19 has led to an increase in households placed in emergency accommodation. At the end of September 2020, East Sussex had 550 households placed in emergency accommodation, of which 209 (38%) were from Eastbourne. Brighton & Hove City Council (BHCC) also placed at least 195 households in Eastbourne in Lewes. **Veterans and Armed Forces Communities** There is no data currently collected to help us to understand the impact on Veterans and Armed Forces Communities. We need to understand areas such as substance misuse, where English is a second language, carers, LGBTQ+, trans gender and religion and belief. Armed Forces Personnel – assessment has been done by the Armed Forces Network CCG Team.		• What can the service do and what additional provision can be put into place • As part of the consultation we will link into the Care homes group for East Sussex but this link needs to be taken forward to ensure care planning and carers are supported • Review the Stop Look Care booklet as this has recognised training that staff can access • Comms and engagement to undertake some work around care homes as they all now have NHS email accounts • To ensure new contracts holds data collection on all disadvantaged groups • Link in with the British Red Cross who are commissioned to deliver assist discharge, home from hospital and carer crisis service • Contact Care for the Carers to understand carers needs in relation to service developments in ophthalmology • Link in with Public Health whilst reviewing health checks and ascertain how many refugees, age, LTCs,

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					Refugees and Asylum Seekers There is no data currently collected to help us to understand the impact on refugees and asylum seekers. We need to understand areas such as age, gender, and substance misuse, where English is a second language, carers, LGBTQ+, trans gender and religion and belief.		gender, where they are living and what support is needed • Link in with Public Health as they are working closely with the Hastings settlement programme for Asylum seekers • Link in with Primary care on refining data for patients needing an BSL interpreter Any changes to the number/location of sites will be considered alongside possible measures to mitigate transport issues (e.g. non face to face or formulation of community provider service options) Homelessness: * Link in with the consultation the Homeless Association Link in with the Assistant Head of Health, Wellbeing and Partnerships in the CCG and the Rough Sleeping Initiative - County Coordinator * To ensure new contracts collect data on all disadvantaged groups
Deprivation and socio-					**Areas of Deprivation**	Informal feedback from people in areas of	As part of the options development and appraisal,

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economic disadvantage					Across East Sussex, there are some affluent areas and some of the most deprived areas in the country. The Indices of Deprivation 2019 show how deprived some local areas are, in comparison to other parts of England. They are calculated by combining data on employment, low incomes, education, health, crime, living environment, and barriers to housing and services. In East Sussex there are 329 Lower-layer Super Output Areas (LSOAs), of which 22 are in the most deprived 10% nationally, 16 of these are in Hastings, 4 Eastbourne, and 2 Rother. Hastings is ranked as the 13th most deprived local council area out of 317 areas in England. According to these figures, Hastings is the most deprived local council area in the South East of England by far. Looking at the other council areas in East Sussex, Eastbourne is ranked 106, Rother is 135, Lewes is 194, and Wealden is ranked 254 out of 317 local council areas in England The Annual Report from Public Health in East Sussex showed that in 2015, 13% of people aged 65+ were living in poverty in East Sussex. The prevalence of sight loss is associated with having a lower income. Children and older people living in poverty are less likely to go for sight tests despite being eligible for free NHS funded eye tests (RNIB, 2016) Those living in areas of deprivation may not be able to travel to access services due to cost, which may impact on early presentation of symptoms. In some areas of deprivation, literacy levels may be lower and awareness of signs and symptoms reduced. **Deprivation and disease prevalence** Higher rates of deprivation were found to be associated with a higher risk of severe diabetic retinopathy amongst patients with type 2 diabetes (RNIB, 2017). A 2015 report that focussed on addressing inequalities in eye health found that neighbourhood deprivation is associated with age-related eye disease in both men and women (Shickle et al 2015).	deprivation indicates that cost of travel may be a barrier to accessing services. Difficulty in getting to an optometrist and concerns about the cost of glasses can result in people not going for eye tests as often as they want, or delaying visits until they experience symptoms (RNIB, 2016). Some people are entitled to free NHS-funded eye tests. In England, Wales and Northern Ireland, this includes people on certain welfare benefits, people aged 60 or over, aged under 16, or under 19 and in full-time education (RNIB, 2016). The ESHT website contains: • Information on travelling by public transport to each site. • Instructions for travelling to each site by car including general parking information and blue badge holder parking. • A link to the local county council website that gives information on	we need to ensure that models of care meet the needs of people that are socially and economically deprived/disadvantaged, notably residents living in our most deprived areas where risk of sight loss is highest, including how services can improve accessibility and reach particularly amongst populations where utilisation of services is lower than would be expected. In addition, the following analysis will be taken account of as we develop options and proposals: • To better understand the ophthalmology attendances at ESHT from our most deprived areas, we will be mapping patient postcode against attendances at ESHT by Point of Delivery (PoD) to understand whether disease prevalence and deprivation correlates to the demand seen at ESHT.

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					Prevalence of sight loss is associated with having a lower income. Children and older people living in poverty are less likely to go for sight tests despite being eligible for free NHS-funded eye tests (RNIB, 2016). People from deprived communities tend to present later with more advanced ophthalmic conditions (RNIB, 2011). **Travel** – Specific Impact The postcodes that include the most deprived areas of East Sussex are: **TN34 (the central Hastings and Ore wards)**, 58.6% (2723) of patients from this postcode have previously attended their appointments at Conquest and 38.5% (1787) at Bexhill. Only 2.9% (133) were seen at EDGH. **N37 (St Leonards wards)** 61.6% (1686) of patients from this postcode have previously attended their appointments at Conquest and 33.5% (918) at Bexhill. Only 4.86% (133) were seen at EDGH. **TN31 (Rye wards 004E and 002E)** 90.7% (1372) of patients from this postcode have previously attended their appointments at Conquest and 8.9% (135) at EDGH. Only 0.3% (5) were seen at Bexhill. **TN39 (Sidley ward)** 56.07% (3607) of patients from this postcode have previously attended their appointments at Bexhill and 36.27% (2333) at Conquest. Only 7.66% (493) were seen at EDGH. **BN21 (Devonshire ward area)** 97.6% (2142) of patients from this postcode have previously attended their appointments at EDGH and 2.3% (50) at Conquest. Only 0.2% (4) were seen at Bexhill. **BN22 (Hampden Park ward area)** 99.4% (2263) of patients from this postcode have previously attended their appointments at EDGH and 0.5% (12) at Conquest. Only 0.09% (2) were seen at Bexhill. Cost of travel to a hospital may reasonably be expected to be more significant for those living in areas of deprivation.	voluntary services that offer transport services. • A section on how to claim under the NHS Healthcare Travel Costs Scheme.	• We will also Obtain GOS sight test data from NHSE to map attendances against areas of deprivation and triangulate the two to develop a comprehensive picture of attendances from deprived backgrounds. • A Sussex-wide ophthalmology group has been established that will be focussing on the end-to-end redesign of ophthalmology pathways across the ICS. An action for this group is to take forward the promotion of eye health across Sussex with a focus on; modifiable risk factors and eye health, the importance of presenting early, and who is eligible for free sight tests. Working with Acute Trusts, the LOC, Public Health and voluntary organisations.

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					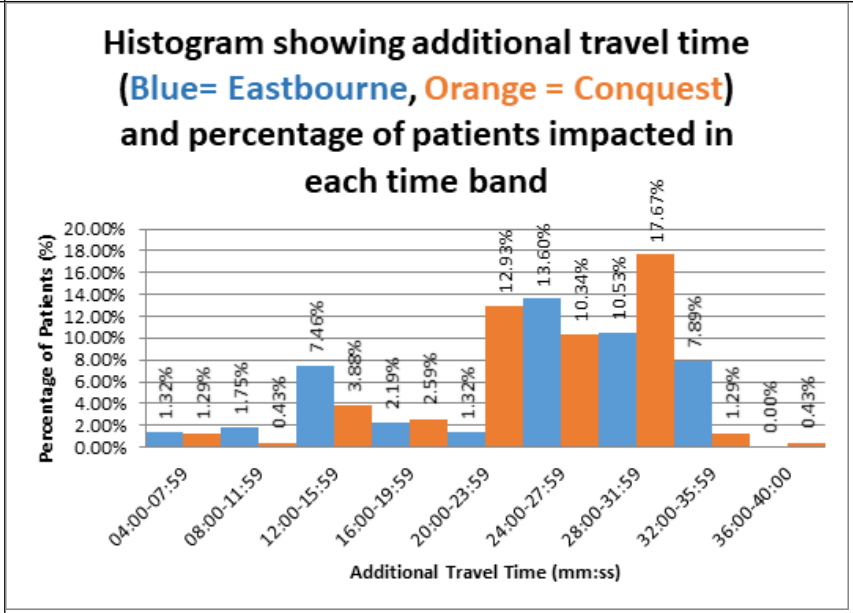 Obesity: 2019 Health survey for England data shows that 27% of men and 29% of women were obese. Around two thirds of adults were overweight or obese, this was more prevalent among men (68%) than women (60%). Adults living in the most deprived areas were the most likely to be obese. This difference was particularly pronounced for women, where 39% of women in the most deprived areas were obese, compared with 22% in the least deprived areas. Smoking: Smoking causes harm to the tissues of the eye. Research has confirmed the harmful effects of smoking on eyesight, particularly in the development of age-related macular degeneration (AMD) - one of the UK's leading causes of sight loss - and cataracts. Public Health data briefing over 80,000 adults in East Sussex who were current smokers with more males (20%) smoking than females (15%). The latest estimates (2012) suggest that the difference in the prevalence of smoking within the county ranges from around 10% of adults in Rother to around 28% in Hastings.		In formal consultation we will: • Utilise foodbanks to share paper copies of questionnaires with freepost address • Ask for support from RVA, HVA and 3VA to target those living in areas of deprivation. As part of the project, an analysis of transport needs is being undertaken and measures agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site as part of the formal consultation process. The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access ; * review what work is happening in primary and secondary care on prevention, what numbers go through primary and secondary care.

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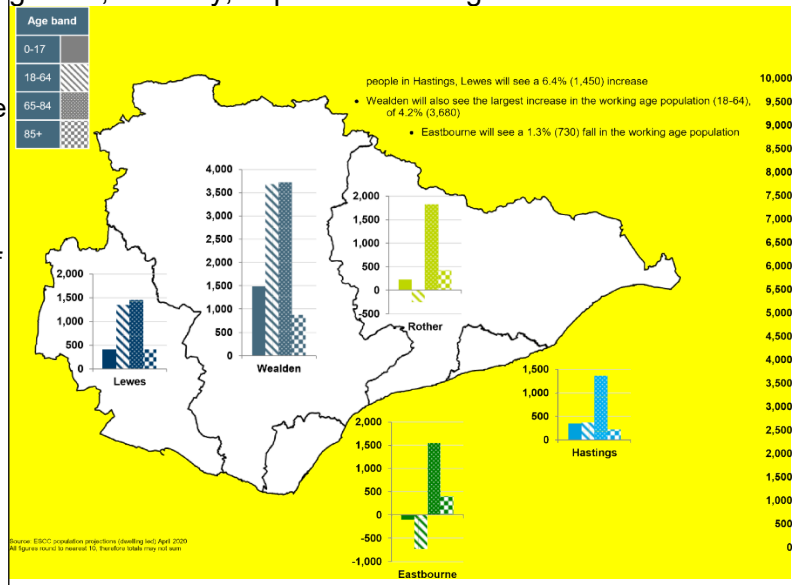
					UPDATE: Smoking Cessation Services are Commissioned by PH (LA) - As from 1 April 2021, General Practice will not provide “stop smoking” services; the service will be provided by One You East Sussex (OYES) and by some community pharmacies.		Areas to link in and keep in view are: NHS-funded Tobacco Dependence Treatment Services are due to commence for inpatients and high risk Mental Health outpatients. Being phased in from July 21 - full implementation by 2024. This is to be delivered in conjunction with Local Authority Stop Smoking Services. ESCC Public Health has been working with maternity to agree the best way to apply the model in East Sussex for pregnant smokers. However, ESHT are now at the early stage of reviewing the approach for inpatients. Funding is being made available to ICS’s across the country that will enable secondary care trusts to get their systems in place by 23/24. There is a relatively small amount this year (21/22) of just over 500k across Sussex but I understand this is likely to increase each year up to 23/24 (not confirmed). The expectation is that 70% of

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment	Actions to take forward with a focus on
							patients who smoke are identified and treated in 21/22 moving to 100% by 23/24.
Community Cohesion					Key indicators of community cohesion relate to how local people feel about their local area. It will therefore be used as a measure of how well different minority and majority communities develop and relate to each other. Communities may define themselves by neighbourhood, ethnicity or culture, age group, faith, sexual orientation, language, gender or other characteristics or interests. This will be reviewed at the time of full consultation.		It is not considered at this time that our pre engagement will have impact related to Community Cohesion. This will be reviewed at time of full consultation.

5. Cumulative Impact

What factors could increase the impact of this proposed change for some groups of people?	Which groups of people or communities are affected?	Are there any additional actions to include in this EIA?

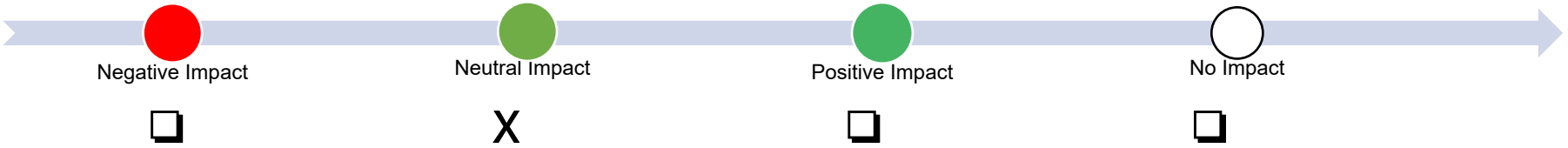
What factors could increase the impact of this proposed change for some groups of people?	Which groups of people or communities are affected?	Are there any additional actions to include in this EIA?
We will develop our understanding of these factors and their impact on our local people with protected characteristics as we gain insight from our engagement and develop our options for appraisal and associated proposals for transformation. Options Appraisal Workshops Options for Ophthalmology were: 1) Retain Current Services over all 3 sites 2) Preferred Option: Two Hospital Sites 3) Once Hospital Site 4) One Hospital Site and community Hospital clinics 5) One Hospital site and mobile clinics The outcomes of the options development and appraisal process reported here suggest that Options 2 (two hospital sites), 3 (one hospital site) and 4 (one hospital site with community clinics) could reasonably be taken forward to formal consultation on the future of ophthalmology services in East Sussex. Bexhill and EDGH appear to be the favoured locations for a two-site model, and opinion was divided between the same two hospitals when considering the best site for a single hospital. We have considered the 5 appraisal criteria around Quality and Safety / Clinical Sustainability / Access and Choice / Financial Sustainability / Deliverability. We also given conscious	Intersectionality issues: women, ethnicity and poverty & age as a pinch point . This data is taken from the EHIA/travel and access work/Public Health and ESHT. We will have an increase of 14.1% (870) more people aged 85+ in Wealden. Between 2015-2018 we have had 11,656 people aged 65+ move into East Sussex the largest flow of people arrived from Kent, Brighton, Croydon and Surrey. We need to ensure the new services is sustainable. Households subject to the benefit cap, housing benefit and universal credit by district show that as at February 2020 we have Eastbourne and Hastings showing the highest numbers. These are recorded in areas of deprivation as we have documented in East Sussex there are 329 LSOA's of which 22 are in the most deprived 10% nationally, 16 of these are in Hastings, 4 in Eastbourne and 2 in Rother. People that are more deprived may	Consider of the particular issues of inequality in relation to the intersection of gender, ethnicity, deprivation and age.  We are completing an internal piece of work around travel and access and this now needs to be worked on further with an external provider. It needs to focus on the patients, local communities, characteristics as well as sites..

What factors could increase the impact of this proposed change for some groups of people?	Which groups of people or communities are affected?	Are there any additional actions to include in this EIA?
consideration throughout the appraisal process the health inequalities and inequalities of people within East Sussex.	produce higher demand for County Councils and other public services. They are characterised by poorer health and disability, lower skills, educational disadvantage, higher crime and drug misuse *Department of works and pensions & eastsussexinfigures.org.uk. New facilities will improve access for physically disabled patients. When rated for disability access, the current site's 2019 PLACE rating is only 81.65% accessible when compared to the national average of 84.25%, and the even higher rating for comparative Mental Health Trusts at 93.32% accessible. *Public Health 2021	

6. Equalities or health inequalities data gaps

	YES	NO	DON'T KNOW	Provide evidence to support your assessment and include this as an Action below.
As a result of undertaking this EHIA, are there any gaps in equalities or health inequalities data or information?	x			• The only demographic data ESHT collect currently is for age and sex. However going forward the new contract will hold data collection on all disadvantaged groups, including all of the protected characteristics. • We need to better understand the issues and actions in relation to our Armed Forces community, people with substance misuse issues, people with English as their second language; pregnant women; carers, LGBQ people, Trans people and religion and belief groups. • We need to better understand travel and pathway flows into acute sites from areas of deprivation, particularly where we have higher levels of ethnic diversity. • Further research is required to identify disease prevalence data in East Sussex • In developing our future models we need to ensure that the services collect a wide range of monitoring data and provide regular reports analysing this that enable continual improvement.

7. Overall summary of impact. Please tick an overall equality impact grade for this initiative.



Please explain your decision:
This EHIA has been developed to support the scoping to pre-consultation engagement and transformation plans. The EHIA will be reviewed at each milestone of the programme to ensure the neutral impact is mitigated.
Please see below the summary of where we have got to and where we need to be to support equalities and health inequalities.

Where have we got to and where do we need to be:

- We have agreed cases for change
- Completed a public engagement process with over 190 interviews taking place
- Completed six Options Appraisal workshops x3 for Cardiology and x3 for Ophthalmology.

We had fantastic participation from ESHT consultants, clinical leads, CCG clinical leads, Nurse specialists, GP's, Optometrists out in the community, SECAM, comms and engagement, HR and workforce, Quality / Finance / Business intelligence from both CCG and ESHT, patients, patient representatives, Public Health, Health Watch, Lay Members and Managers and Commissioners from both CCG and ESHT.
A comprehensive report on the workshops covering external challenges, internal challenges, national drivers and opportunities for improvements has been developed by ORS with full review and feedback from all that attended the workshops.
Within the report from Opinion Research Services (ORS) the five appraisal criteria covered were quality and safety, clinical sustainability, access and choice, financial sustainability and deliverability the indications were:-
Cardiology: The outcomes of the options development and appraisal process reported here suggest that Option 5 (co-location of the cathererization labs and inpatients to one acute site) could reasonably be taken forward to formal public consultation on the future of cardiology services in East Sussex. Whether or not other options are also included in proposals depends, in large part, on whether the key areas in which they scored and ranked poorly are able to be addressed and or mitigated.

Ophthalmology: The outcomes of the options development and appraisal process reported here suggest that Options 2 (two hospital sites), 3 (one hospital site) could reasonably be taken forward to formal consultation on the future of ophthalmology services in East Sussex. Bexhill and EDGH appear to be the favoured locations for a two-site model, and opinion was divided between the same two hospitals when considering the best site for a single hospital.

We have gathered further evidence as part of the consideration in the decision making process around all the options. We have completed a wide range of activities:

- Options Modelling with the support of the CCG and ESHT Teams across Business Intelligence/Finance/HR and Workforce Considered, actioned and documented outcomes from the EHIA workshops
- Held read through's and walk through sessions with key stakeholders for both the Cardiology and Ophthalmology EHIA's and developed a Data Gap Analysis tool to support progress
- Reviewed and refreshed the EHIA's and QIA's to support the pre-consultation business cases and also in readiness for NHSE State 2 assurance in October

- Held read through's and walk through sessions with key stakeholders for both the Cardiology and Ophthalmology Pre-consultation business cases
- Held further patient engagement sessions via a set of interviews which were designed, developed and delivered by Opinion Research Services
- In attendance and presenting at all the GP Locality Forums across East Sussex
- We have internally developed a travel and access piece around an overview of locations and accessibility of ESHT hospital sites alongside postcode data showing that patients admitted at each site were predominately from the local postcode area.
- We have ensured this is aligned to the options and Steering Board have provided approval for this to be added to the Pre-consultation business cases and EHIA's. Further analysis is onging for a more in-depth independent review.
- South East Clinical Senate during July (as Cardiology and Ophthalmology have gone to separate panels). Attendance at Clinical Senate panel for Cardiology was the 28th July and Ophthalmology was the 11th August of which key stakeholders and business sponsors will provide a presentation and overview of the programme.
- LMT approval was granted 21st September 2021
- NHSE Stage 2 Assurance took place on 14th October 2021, and formal letter received on 8 November 2021

8. Summary of Actions

Record all your EHIA assessment potential concerns (impact) and actions below:

Please try and prioritise your actions	**Potential Impact**	**Actions to mitigate impact** These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	**Staff or Patient Engagement** Outline any proposed engagement to achieve these actions	**Lead Person**	**Deadline**
0 – appendix to support the actions	Positive	To support the East Sussex ophthalmology services we have summarised a Gap Analysis Document which focuses on all characteristics, what we know, where the gaps are, actions and mitigations with supporting tabs for site details, options, data etc.	 ESHT Transformation data	Assistant Head of Planned Care, Senior Planned Care Manager, Planned Care Officer	Ongoing throughout the lifetime of the EHIA
1 – Ethnicity and Race	Unknown	To support the East Sussex system in co-developing potential options for ophthalmology services, we need improve our understanding of existing health inequalities within the service. The following pieces of work will be addressed with the provider during and post mobilisation in order to	Ethnicity/ Race: Given that ethnicity can increase the risk of poor eye health, we will ensure that as part of the formal options development process, models/interventions are developed that meet the needs of our ethnic communities.	Public Health / CCG Project Team / ESHT	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		reduce health inequalities and ensure equity of access; • Future of the service and the collection of data on protected characteristics • Address prevention issues in areas of deprivation Further understanding of service use and patient experience • Undertake Comms and Engagement work to support communities and cultures • Work with the Community Optom Team & LCN • Ensure patient feedback can be analysed by ethnicity and address any concerns identified • Further work around the clinical view on treatment and ethnicity diverse workforce and what further work can be done to improve this.	Where possible, we will look to immediately action changes that would reduce health inequalities and ensure equity of access; for example; the information available and how this is shared across our communities. • ensure links have been made with local faith communities or cultural groups in order to • encourage involvement and gain feedback through all stages of patient and public involvement. • ensure that Friends, Families and Travellers receive information on all involvement activity. • Translate questionnaire into community languages as a standard approach • Attendance at Eastbourne Cultural Involvement Group to promote engagement opportunities • Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities • Further information to come from BAME Disparity Programme Team. This section will be updated as work progresses	Project Team	
2 – People who have English as a second language	Unknown	As above. We will ensure the development of new service models include strong infrastructure in relation to language barriers including translated materials about the services and patient interpreting services in the models.	People who have English as a second language: Clarification is required as to the number of people accessing the ophthalmology service where English is not their first	ESHT Project Team / CCG Project Team	In line with Project Timelines which are currently

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access; • Work with Primary Care, local support workers and interpreters to work closer with local communities around communication / engagement and prevention • Identify if the e translation service offered matches the need across East Sussex Whilst also: • Work with organisations that provide translation services to better understand the need for translation support for patients accessing ophthalmology services in East Sussex • Offer telephone interpretation to support those who speak English as a second language and wish to engage • Translate materials into community languages (on request) • Ensure information on travel to the ESHT sites and help with Health Travel costs is readily available in other languages and formats	language. • Translate questionnaire into community languages as a standard approach Where actions of communication are highlighted as an area of improvement required, we would want to take immediate action to address these issues and ensure equitable access for our patients. UPATE: The CCG PI team have taken forward any actions identified during pre-engagement that can be addressed prior to the transformation project outcome.		being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
3 - Sex	Unknown	We will work with the organisation to future action changes that would reduce health inequalities and ensure equity of access; • Further training and education is required across the service raising awareness and providing conscious consideration • Monitoring and data collection is needed • Equal consideration of same sex partners in care services – care plans and advance care plans/ RESPECT forms	Sex: Attendances for ESHT are higher for women than men, which we would expect to see given that they make up a higher proportion of the patient population. Women across East Sussex are at a greater risk of poor eye health than men. We will ensure that as part of the formal options development process, models/interventions are developed that meet the needs of our communities. It is estimated that 60% of blindness worldwide is among women, underlining that gender equity in eye health has not yet been achieved (Inequality and Inequity in Eye Health, 2016). We will ensure that as part of the formal options development process, we take account of the needs of women in respect of their being a greater risk of poor and greater risk of blindness (based on national evidence) eye health in developing, models/interventions to ensure the right service reach for our population into the future. For formal consultation we will: • Take measures to identify and engage with gender specific groups in East Sussex	ESHT Project Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
4 – Gender Reassignment	Unknown	As above. The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access; • Service to record data around the use of ophthalmology services by the transgender community • Service to review and consider further training and education around gender reassignment and LGBTQ+	Gender reassignment: Clarification is required as to the number of Trans patients residing in East Sussex. We will ensure that as part of the formal options development process we give due regards to the issues of access and experience in our Transgender community and that our transformation plans including Trans awareness training for ophthalmology staff. For formal consultation we will: • Take measures at the outset to identify any trans groups in East Sussex so we can involve them in the pre-consultation and programme development and gain feedback • Approach Hastings & Rother Rainbow Alliance Trans Support Group to talk about opportunities to get involved • Approach Bourne Out via Facebook and ask for support with promotion of the questionnaire • Contact The Clare Project and Switchboard in Brighton and Hove to see if they have reach in East Sussex to encourage participation	ESHT Project Team	In line with Project Timelines which are currently being reviewed.
5 - Age	Unknown	As above. The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access;	Age: Age is the primary risk factor for eye health. With the East Sussex population growing, notably among the 65 and overs, future models of care need accommodate	CCG Project Team / ESHT Project Team	In line with Project Timelines which are currently

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		• Work closer with Public Health on prevention and promotion and local support groups i.e. Age Concern Interdependencies around ethnicity and age need to be reviewed	for this increase in demand to ensure the service can meet the needs of the population. Older people are also more likely to have reduced mobility, so travel/ locations for service delivery will need to be considered. For formal consultation we will: • Take measures at the outset to identify organisations that support younger and middle aged people living with ophthalmic disease • Attend East Sussex Senior Association to talk about ophthalmology service transformation and provide opportunities to feedback/ get involved • Contact Age Concern to ask about attending some drop in sessions • Engage with RNIB, East Sussex Association for the Blind, Macular Society • Engage with the Public Health Vision Screening Service for Children • Attend PPG forums across East Sussex and offer drop in session if enough interest • Liaison with Age UK East Sussex • Approach the County Council to support us in engaging with Parent Carer forums		being reviewed.
6 – Religion and Belief	Unknown	As above. The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access;	Religion and belief: From this assessment we feel the risk of widening the health inequalities gap for people of different religions and ethnicities	CCG Engagement Team / CCG Project	In line with Project Timelines which are currently

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Service to analyse chapel usage at each site and how often a chaplain is being asked for • Review how this data can be recorded going forward	is low. We will however continue to engage with patients of different religions and beliefs as part of the formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to the issue of access and religion and belief to ensure that we do not unduly increase health inequalities. For formal consultation we will: • Ensure that we have forged links with faith communities in East Sussex to engage in this project. • Invite Faith elders to engage, and offer translated versions of materials where required.	Team / ESHT Project Team	being reviewed.
7 – Disability and long term conditions	Unknown	As above. The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access; • To ensure new contracts collect data on protected characteristics • work with Primary Care more closely around patients with LTC's diabetes clinics, dementia yearly reviews, carers groups, Mental Health issues and local services • look at current training and education packages for Staff and how these could be improved by really understanding what our communities want and need from our services and the overall patient experience	Disability: As part of the options development, appraisal and decision process, future models of care will need to take into account the needs of patients living with a disability or long term conditions. Future models need to consider the travel impact on patients, and also the requirements of patients that may have more complex needs and require reasonable adjustments, for example; patients with vision and hearing loss, patients with learning disabilities, mental health conditions and dementia may require longer appointments. For formal consultation we will:	CCG Engagement Team / CCG Project Team / ESHT Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Review the area of Wealden in terms of demographics as this is the highest area for blue badge holders and understand what services these patients access • Link in with CCG Deaf engagement /BSL Service and Sign Live	• Explore opportunities with CVS organisations such as Possibility People to see what forums and networks we can utilise to support engagement • Approach Hastings disability forum to ask for support • Arrange a drop in opportunity for d/Deaf members to come and talk about experiences of ophthalmology services • Make the materials available in Easy Read and British Sign Language as a standard approach. • Include provision for making longer appointments for patients that require reasonable adjustments to allow for interpreting time and appointments later in the day as some disabled people need more time to prepare and get to appointments. • Approach the East Sussex Dementia Adviser Service to support the reach of our engagement • Approach the East Sussex Community Learning Disability Team for support • Take action to identify and engage with charities and organisations that support patients with diabetes • Take action to identify and engage with charities and organisations that support patients with their mental health As part of the project, an analysis of transport needs is being undertaken and measures will be agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			the travel impact if an option includes a change of site as part of the formal consultation process.		
8 – Sexual Orientation	Unknown	As above. The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access; • further training and education is required across the service raising awareness and providing conscious consideration • Monitoring and data collection is needed Equal consideration of same sex partners in care services – care plans and advance care plans/ RESPECT forms	Sexual orientation: From this assessment we feel the risk of widening the health inequalities gap for our LQBQ communities is low. We will however continue to engage will patients from LQBQ communities in East Sussex as part of the formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to the issue of access and experience and our LGBQ to ensure that we do not unduly increase health inequalities, for example; awareness training for staff. For formal consultation we will: • take measures at the outset to identify any LQBQ groups in East Sussex so we can involve them in the programme development and gain feedback	CCG Engagement Team / CCG Project Team / ESHT Project Team	In line with Project Timelines which are currently being reviewed.
9 – Pregnancy and Maternity	Unknown	As above. The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities and ensure equity of access; • Whilst triangulate data on child bearing age (5,000 per year) with attendance to ESHT we need to review inequalities as such	Pregnancy and maternity: Clarification is required as to the number of pregnant women accessing ophthalmology services at ESHT. We will continue to engage with relevant groups that support pregnant women as	ESHT Project Team / CCG Engagement Team / CCG	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		areas of deprivation, smoking, drinking, diabetes etc. • Look at prevalence of eye conditions and what issues this presents. Develop an action plan to address outcomes. • Liaise with local Maternity Team to ascertain if further information is available	part of our formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development process we give due regards to pregnant women to ensure that we do not unduly increase For formal consultation we will: • Attend East Sussex Maternity Voices Partnership meeting • ESHT to identify any service users who may fall into this category and encourage them to undertake an in-depth interview • Triangulate data on women at child bearing age with attendances at ESHT to estimate the prevalence of women within the service that would be pregnant.	Project Team	
10 – Other disadvantaged groups	Unknown	The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Establish how many carers have registered with East Sussex County Council and local hospital sites – review the data and progress what could be done further to support carers • What can the service do and what additional provision can be put into place • As part of the consultation we will link into the Care homes group for East Sussex but this link needs to be taken forward to	Other disadvantaged or inclusion groups: As part of the options development, appraisal and decision processes, we will need to ensure that models of care meet the needs of people from disadvantaged groups, notably residents in care homes and the homeless, where access to services is a barrier. For formal engagement we will: • be engaging with carers throughout the project to seek their views, through one-to-one interviews,	ESHT Project Team / CCG Engagement Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		ensure care planning and carers are supported • Review the stop look care booklet as this has recognised training that Staff can access • Comms and engagement could do some work around care homes as they all now have NHS email accounts • To ensure the new contract holds data collection on all disadvantaged groups • Link in with the British Red Cross who are commissioned to deliver assist discharge, home from hospital and carer crisis service • Contact Care for the carers to understand carers needs in relation to service developments in ophthalmology • Link in with Public Health whilst reviewing health checks and ascertain how many refugees, age, LTCs, gender, where they are living and what support is needed • Link in with Public Health as they are working closely with the Hastings settlement programme for Asylum seekers • Link in with Primary care on refining data for patients needing an BSL interpreter • Link in with the consultation the homeless association • Link in with the CCG homeless commissioners • Link in with the Armed Forces Team CCG regarding care and outcomes • Work with PH Lead to ensure we hear from the Asylum Seeker group	liaison with representative groups and questionnaires • engage with homeless and rough sleepers through pre-existing relationships with supporting organisations such as Rough Sleepers Initiative, Matthew25 and YMCA • work with the NHS Armed Forces Community Service lead to ensure we hear from this cohort		
11 - Deprevation	Unknown	As above.	Deprivation and socio-economic disadvantage:	ESHT Project Team / CCG	In line with Project Timelines which are

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		The following pieces of work will be addressed with the provider during and post mobilisation in order to reduce health inequalities • Link in with Primary care on refining data for patients needing an BSL interpreter	As part of the options development, appraisal and decision processes, we need to ensure that models of care meet the needs of people that are socially and economically deprived/disadvantaged, notably residents living in our most deprived areas where risk of sight loss is highest, including how services can improve accessibility and reach particularly amongst populations where utilisation of services is lower than would be expected. To better understand the ophthalmology attendances at ESHT from our most deprived areas, we will be mapping patient postcode against attendances at ESHT by Point of Delivery (PoD) to understand whether disease prevalence and deprivation correlates to the demand seen at ESHT. We will also Obtain GOS sight test data from NHSE to map attendances against areas of deprivation and triangulate the two to develop a comprehensive picture of attendances from deprived backgrounds. A Sussex-wide ophthalmology group has been established that will be focussing on the end-to-end redesign of ophthalmology pathways across the ICS. An action for this group is to take forward the promotion of eye health across Sussex with a focus on; modifiable risk factors and eye health, the importance of presenting early, and who is eligible for free sight tests. Working with Acute Trusts, the LOC, Public Health and voluntary organisations.	Engagement Team / CCG Project Team	currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			In formal consultation we will: • Utilise foodbanks to share paper copies of questionnaires with freepost address • Ask for support from RVA, HVA and 3VA to target those living in areas of deprivation. As part of the project, an analysis of transport needs is being undertaken and measures will be agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site part of the formal consultation process.		
12 - Prevention	Multiple impact on some parts of the population that are affected across more than one protected characteristic/ health inequality indicator	As above	Consider issues of intersectionality when planning engagement with local people including taking account of potential impact of intersectionality in developing options and future proposals for ophthalmology services. The EHIA suggests that this particularly relates to women, ethnicity and poverty & age in relation to ophthalmology service development. We will ensure that any impact on travel time to hospital are considered in the options development and consultation process.	ESHT Project Team / CCG Engagement Team / CCG Project Team	
13 – Actions from EHIA Workshops	Positive	**Additional actions from the EHIA workshop – these are embedded back throughout this document** ESHT Transformation – EHIA Workshop – Look at the Options Development through an inequalities lens			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		<u>Homelessness</u> • Link in with the consultation the Homeless Association • Link in with East /B&H CCG homeless links (ARCH Care in Brighton) Rough Sleepers Initiative Coordinator confirmed: • Currently 35 people rough sleeping across E.Sussex • 186 placements across East Sussex – these are funded by the LAs not ESCC • We have not received an update from BHCC since 02/07/21. They've advised this is due to systems issues - BHCC total placements (229). Eastbourne – 112 / Lewes area – 117 = Numbers are believed to be higher. The following pieces of work will be addressed with the provider during and post mobilisation to reduce health inequalities and ensure equity of access • To ensure new contracts collect data on all disadvantaged groups <u>Care Homes and Domiciliary Care</u> • Link in with the British Red Cross who are commissioned to deliver Assisted Discharge, Home from Hospital and Carer Crisis Service. • Contact Care for the Carers to understand carers needs in relation to service developments in ophthalmology • To ensure any new contract collects data on carers <u>Veterans</u> • To ensure new contracts collect data on veterans			

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		• Link into the Armed Forces Team CCG - care and outcomes <u>Armed force community</u> • To ensure new contracts collect data on armed forces • Link into the Armed Forces Team CCG - care and outcomes <u>Refugees</u> • for formal engagement we will work with public health lead to ensure we hear from this cohort * Whilst working with PH review the health check records and ascertain how many refugees, what age, gender where they are living and what support is needed. <u>Asylum seekers</u> • for formal engagement we will work with public health lead to ensure we hear from this cohort • Whilst working with PH understand the settlement programme and ascertain how many asylum seekers are using the programme <u>Hearing impairment/deafness</u> • Work with ESHT on refining data on BSL interpreter. Work with Primary Care to ensure an excellent patient experience * Link in with Public Involvement team - Deaf engagement / BSL service / Sign live • Building on general insight already gathered, engage with local d/Deaf people through local Deaf organisations to gather insight on barriers and possible solutions. Work with ESHT to provide BSL interpreting services to all patients			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		by including a Video Relay Service (such as Signlive) linked to the department contact details which enables Deaf people to call ahead of their appointment to confirm any additional needs using a BSL interpreter and their mobile device" <u>Smoking</u> • review what work is happening in primary and secondary care on prevention, what numbers go through primary and secondary care Update: Smoking Cessation Services are Commissioned by PH (LA) - As from 1 April 2021, General Practice will not provide “stop smoking” services; the service will be provided by One You East Sussex (OYES) and by some community pharmacies. NHS-funded Tobacco Dependence Treatment Services are due to commence for inpatients and high risk Mental Health outpatients. Being phased in from July 21 - full implementation by 2024. This is to be delivered in conjunction with Local Authority Stop Smoking Services. ESCC Public Health has been working with maternity to agree the best way to apply the model in East Sussex for pregnant smokers. However, ESHT are now at the early stage of reviewing the approach for inpatients. Funding is being made available to ICS’s across the country that will enable secondary care trusts to get their systems in place by 23/24. There is a relatively small amount this year (21/22) of just over 500k across Sussex but I understand this is likely to increase each year up to 23/24 (not confirmed).			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		The expectation is that 70% of patients who smoke are identified and treated in 21/22 moving to 100% by 23/24. <u>Overweight/obesity</u> • Check if there is any relevant data for T3 and T4 services • Link with PH around diabetes services <u>Amblyopia (Children's)</u> • Check to see if children's waiting times are the same as adults Update: ESHT have confirmed that there is no different in wait times <u>Blindness/partial sighted</u> • Link in with CCG PI team • think creatively to link into these communities • Link with Head of Planned Care at CCG re the outpatient transformation programme <u>Population impacted</u> • Need to understand population growth and service gap via PH and Commissioning. This is to be taken forward by the CCG health inequalities team <u>Drug users/substance misuse</u> (excluding alcohol and smoking) • consider how to record ophthalmology patients with history of substance abuse • liaise with Public Health and the CCG MH - Substance Abuse commissioner <u>Wheelchair use/access</u> • To ensure new contracts collect data on wheelchair users & blue badge holders			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		<u>Alcohol</u> Work closely with Primary and secondary care to establish numbers, demographic other LTC's etc. • consider how to record ophthalmology patients with history of alcohol abuse • liaise with Public Health and the CCG MH -Substance Abuse commissioner			

EHIA written by:	Assistant Head of Planned Care Senior Planned Care Manager Planned Care Officer		Date:	05/02/2021 2/06/2021 2/07/2021 1/09/2021
EHIA reviewed by:	Head of Planned Care Head of Equality, Diversity and Inclusion Head of Public Involvement Assistant Head of Health, Wellbeing and Partnership Associate Director of Public Involvement Assistant Head of Planned Care Associate Director of Commissioning Interim Senior Equality Assessment Manager		Date: 04/10/2021	• 05/02/2021 – 10/03/2021 for NHSE Stage 1 Assurance • NHSE Stage 2 Assurance – 14/10/2021
EHIA authorised by: (manager)	Managing Director Associate Director of Commissioning		Date:	
EHIA approved:(governance)	YES	~~NO~~	Date: 21 September 2021	East Sussex and Brighton and Hove Local Management Team
Further comments			Date:	

EHIA published on the Sussex CCGs' website		Date	
Person to review EHIA post implementation		Date	

TRANSFORMING OPHTHALMOLOGY SERVICES IN EAST SUSSEX

PUBLIC ENGAGEMENT REPORT

Date:	8 APRIL 2021
Version:	2.2
Name of originator/ author:	Emma Baxter, Public Involvement Manager Antonia Bennett, Public Involvement Lead

Contents

1.0 Executive Summary

We are developing proposals for how acute ophthalmology services, provided by East Sussex Healthcare NHS Trust (ESHT), can best provide high quality treatment, care and support for local people and meet increasing local population need. Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England have duties to consult the public when a significant service change is likely to take place. This report provides insight from local people into the patient journey and experiences of accessing ophthalmology services gathered in January and February 2021, in order to inform service change and potential public consultation.

To reach the local population in East Sussex, the NHS East Sussex Clinical Commissioning Group (CCG) co-developed a questionnaire with partners and members of the public, which was promoted widely in paper copies and electronically. The CCG undertook interviews with current and former patients of the services and joined virtual local forums and groups to hear from people about their experiences.

The key themes from this engagement include:

- communication both before and during appointments;
- communication between health care settings;
- the need for faster diagnosis
- requirements for patients' additional needs to be met.

This insight has informed the development and appraisal of options for the future of ophthalmology services.

2.0 Background

The East Sussex Health and Social Care Plan sets out how partners will align local priorities with the Sussex Health and Care Partnership's "Vision 2025". This includes:

- a comprehensive approach to prevention;
- reducing health inequalities;
- supporting our workforce to develop and grow;
- developing a new model of care that will be sustainable for generations to come.

ESHT provides acute and community care in East Sussex, at Eastbourne District General Hospital (EDGH) and at the Conquest Hospital, Hastings, at two community hospitals in Bexhill and Rye, in community clinics across East Sussex and in people's own homes. Acute ophthalmology services for adults, children and young people in East Sussex are provided at EDGH, the Conquest Hospital and Bexhill Hospital.

The Sussex Health and Care Partnership's "Vision 2025" focuses on proactively managing population health, better anticipating care needs and integrated working across health and social care to enable the delivery of the best possible outcomes for local people. This, alongside advances in medicine and innovation/technology, will ensure the best use of collective public resources in East Sussex. Reviewing and redesigning ophthalmology services within this context will help ensure the right services are available in a way that is sustainable for the future and in response to the needs of the local population.

The vision for the future of ophthalmology services in Sussex is to provide a high-quality service for patients, carers and their families regardless of age, disability, gender or ethnicity. This includes:

- providing a clinically excellent ophthalmology service that prevents avoidable sight loss and improves the eye health of all patients;
- increasing the ability to look after a growing and ageing population;
- providing increased support and development for the ophthalmology workforce;
- developing a service that is clinically, environmentally and financially sustainable now and in the future.

3.0 Public Engagement

To consider how the service should be transformed the CCG undertook public engagement which commenced on 4th January 2021 and lasted six weeks (concluding on 14th February 2021). This engagement was informed by an Equality and Health Inequality Impact Assessment, which highlighted the need to reach particular groups and communities. During this time the CCG's Public Involvement team engaged with local people and stakeholders to:

- communicate about the need for transformation of acute ophthalmology services at ESHT;
- understand their experiences of the ophthalmology services for children and adults at EDGH, the Conquest Hospital in Hastings and Bexhill Hospital;

- gather their feedback and ideas about how the service could be provided in the future.

The insight gathered from this work will be used to inform options development, appraisal and planning for any formal consultation.

A questionnaire to understand people's experiences of ophthalmology services was co-designed with partners and members of the public and published on the Sussex Health and Care Partnership's Engagement HQ (online engagement) platform. The survey was promoted through a multitude of pre-established distribution lists and newsletters including:

- 3VA weekly bulletin (Eastbourne residents)
- HVA weekly bulletin (Hastings residents)
- East Sussex Local Voices (over 2000 recipients)
- East Sussex Health and Care Newsletter (over 4000 recipients throughout East Sussex)
- Over 60 churches in East Sussex and a mailing list of 800 stakeholders.

It was also sent out widely to local voluntary, community and social enterprise (VCSE) sector organisations, including Healthwatch, with the request to support promotion. Paper copies of the survey were sent out to organisations including the Rough Sleepers Initiative (homeless and rough sleepers) and foodbanks (to reach those living in deprivation) as well as to individuals requesting copies. A freepost address for returning the questionnaires was included.

Posters were distributed to display in hospital waiting rooms to encourage people to complete the questionnaire or to get in touch to arrange a telephone interview. Social media coverage was used to promote the surveys, utilising the CCG pages and accounts and posting on local community Facebook pages.

The Public Involvement team attended a range of virtual forums and groups to promote the programme and inform people of the ways to get involved including:

- Patient Participation Groups (PPGs) Steering Group and three local forums
- East Sussex Seniors Association (ESSA)
- Eastbourne Cultural Inclusion Group (ECIG)
- East Sussex Communications and Engagement Steering Group (CESG)

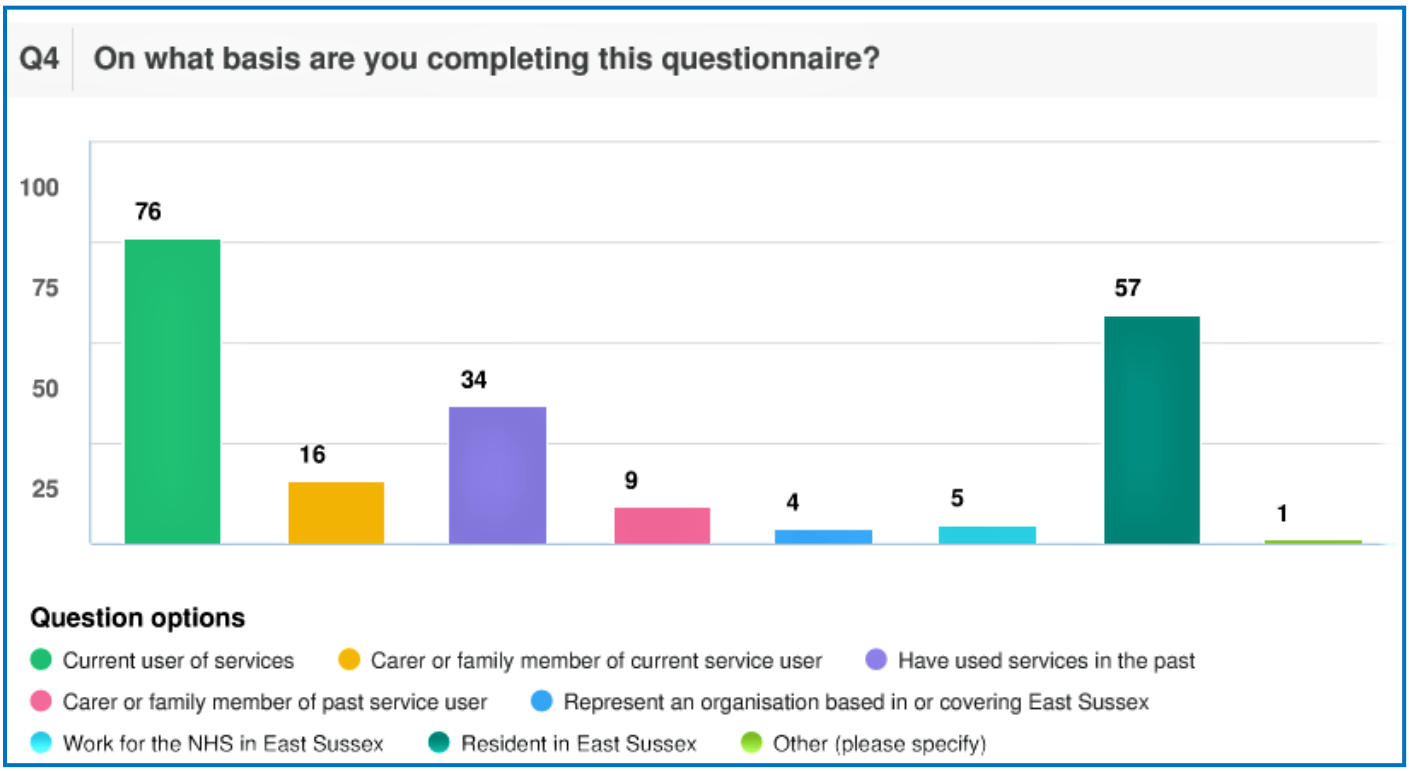
To support accessibility, local linguists in East Sussex were asked to work with people for whom English was an additional language to complete the questionnaires and the CCG received a total of eight completed questionnaires with a variety of languages represented including:

- Filipino
- Kurdish
- Portuguese
- Cantonese
- Mandarin
- British Sign Language

The survey was also produced in Easy Read and community languages were available on request.

The insight gathered will be fed into options development workshops where key stakeholders will be invited to come together to co-design feasible options. These will be followed by a further options appraisal workshop to inform a final set of proposals.

4.0 Results of public engagement

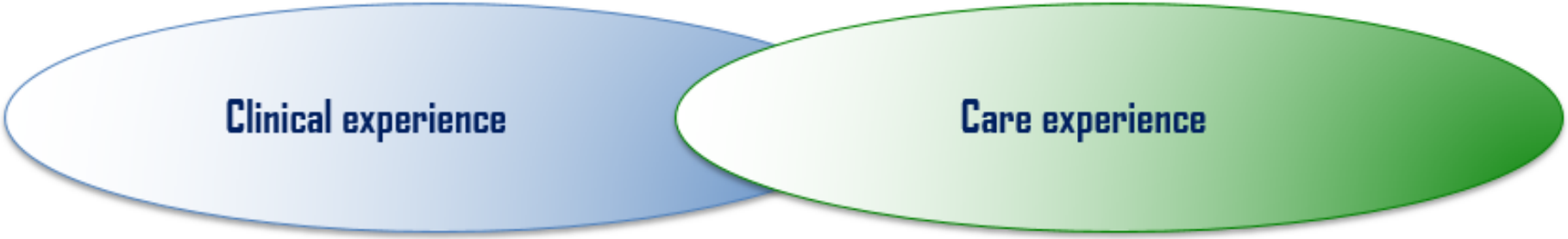


(Please note participants could choose more than one option)

In total there were 126 responses including 19 in-depth interviews.

The following pages illustrate some of the significant themes that emerged from the submissions: these have been split into care and clinical themes.

Ophthalmology Service Delivery: the Patient Perspective



Rapid diagnosis (reassurance)

Regular predictable appointments

Manageable access/travel

Joined-up communications: hospital-GP-patient

Personal relationship with consultant

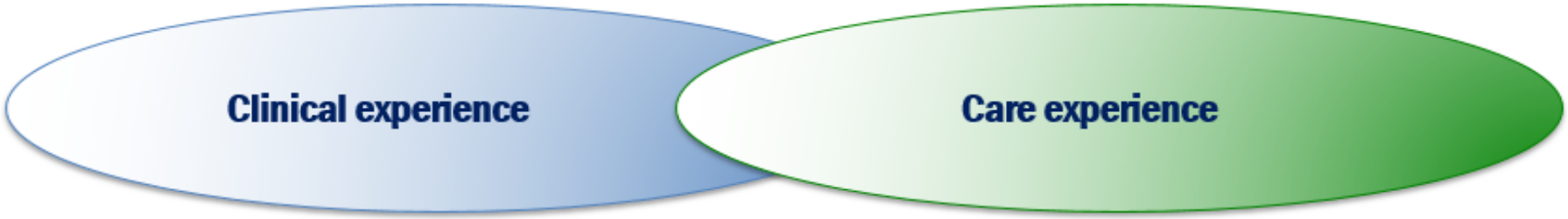
Time taken to listen, explain

Treated with care, respect and warmth

Individual adaptions

Ideal service delivery is accessible

Ophthalmology Service Delivery: the Patient Perspective
Majority : Very Positive



Rapid diagnosis (reassurance)
"Two appointments at Bexhill Hospital. I was seen straight away. Everyone was very kind and explained what they were going to do. I had my scan and then saw the consultant. All done very well and clearly explained"
"Macular service is great, email referral system with feedback on how patient is to be managed".

Regular predictable appointments
"After delays and appointments getting cancelled for 11 months I eventually got seen and treated within four weeks of the appointment".

Manageable access/travel
"Providing transport was most welcome so as not to impose long waits for friends or family" .

Personal relationship with consultant
"Both these operations went really well. I found Mr Hickman Casey approachable, easy to understand and I trusted him"
"Staff were very attentive, kind and professional. Mr Hickman-Casey and Mr Tham made sure we understood exactly the problem, the treatment and what to expect."

Time taken to listen, explain
"Helpful and caring services when accessed. Good explanation and care once in the system although have had to travel to DGH which isn't easy if you can't see !"

Treated with care, respect and warmth
"Whilst working under the most difficult circumstances, I have been treated with care and a high degree of professionalism".

Individual adaptions
"I walk with a stick and when I have to attend they always help me if I need to go to different places in the hospital. They help me sit down as I sometimes miss the chair."

Ophthalmology Service Delivery: the Patient Perspective
Significant Obstacles

Rapid diagnosis (reassurance)
"Getting help quickly […] has been difficult. A&E often don't have access to opthalmology. Once I was redirected from Hastings to Eastbourne then told the eye doctor had left".
"The consultant confirmed I had AMD but I couldn't have NHS treatment until it was more severe, I would have to go private".

Regular predictable appointments
"Generally good as a referring practitioner. Communication about follow-ups to patients seems poor and glaucoma patients have their appointments continually changed or delayed or missed altogether"

Manageable access/travel
"I live in Seaford and it takes an hour to get to Bexhill and transport can be difficult. I have back and heart problems and breathing difficulties so public transport is out of the question."

Joined up communications: clinician-GP-patient
"Sent by GP to A&E, found nothing so sent away. Not advised they were referring to ophthalmology until call received asking to attend next day".

Personal relationship with consultant
"Every appointment appears not to be related to previous ones. There is little or no continuity between appointments. Appointment letters are too vague as to what is going to happen and should be more specific as to what is scheduled."

Time taken to listen, explain
"The young specialist gave my partner too much information, quickly, which he could not grasp as he is partially deaf."
"There is no point of contact on arriving in the outpatient department, you are left to work it out for yourself that you are in the right place. And then just sit down and just WAIT and WAIT "

Individual adaptions
"The ophthalmology clinic at the Conquest was very small and difficult for wheelchair users but where it is now in Bexhill Hospital it is even worse".

Ideal service delivery is accessible

4.1 Care

Patient Experience

The majority of people reported that the service was very good and that staff were professional, kind and explained things clearly at each stage of the appointment. Several people praised Bexhill specifically. People who had had surgery told us what a difference this had made to their lives and that the surgeons were excellent.

When people gave negative feedback this was often to do with communication: people talked about being treated with a lack of respect or being “talked down to”. One person told us that all they wanted was to:

> “Be made to feel like I am a patient, rather than just another name on the day's workload.”

Staff are seen as expert and committed to providing the best care for people.

4.2 Equality and Diversity issues

Some adult autistic people reported being treated as if they were a child, not an adult. People with a Learning Disability said that they need disabled-friendly communication, perhaps with pictures of their clinicians so that they can become more familiar.

Access for disabled people is difficult: there is a lack of space at the Conquest and Bexhill for wheelchair users and some rooms are not accessible. Carers told us that arranging transport to clinics can be challenging, particularly if they are moved to a different hospital further away.

For people who are d/Deaf, respondents told us that communication can be more difficult as face masks make lip-reading impossible and some clinicians talk too quickly and also didn’t engage well with carers.

LGBTQ+ people felt that staff needed more training and awareness. They had experienced inappropriate and irrelevant questions from clinical staff.

Parents with young children find the long waits at the hospital challenging: although there is a designated area for children it is often already occupied by adults when the department is crowded. It is especially difficult for children with Learning Disabilities. Patients told us that the audiology service provides double slots and it was felt that this would be good for ophthalmology appointments.

"My daughter's autism makes her senses very keen and she is easily overwhelmed by noise, flickering lights and shouting. These can cause meltdown and exacerbate anxiety and depression. Being seen in the children's department was not helpful. She needed a quiet waiting area, a timely appointment and not to be sitting for nearly two hours in an area where children are. Medical staff need to be trained to understand how to communicate with patients who have conditions like this as individuals and not speak to them like children. They need to be asked open questions and given plenty of time to answer. They need to hear accessible language as well as be given easy read information. The Traffic Light Health Passport system in place previously was very good as it contained everything that clinicians needed to know about my daughter, but people don't seem to know what they are any more. Reasonable adjustments are no longer made."

Language barriers make things difficult for some people and they said the service providers needed to think more about this and about people of different ethnicities.

4.3 Access/transport issues

Many people told us about difficulties getting to appointments. They told us that public transport is limited and unreliable and, if you are elderly, with sight issues and potentially other mobility issues, it's not suitable. When you attend an appointment they usually put drops in your eyes which mean that you can't see well afterwards. Not everyone has family living locally nor has access to a car. For many people it would be a struggle to afford the cost of a taxi.

"The only drawback at the beginning of last year was that they cancelled my appointment And then re-booked it at Bexhill. This is difficult to get to, you have to book a taxi. There is a bus service but not before 9.30 a.m. and it's very unreliable and there's only one bus each hour. My husband could take me but other patients without means of transport would either spend a lot of money or they wouldn't be able to go."

Some people use hospital transport: they are expected to be ready to leave a long time (two hours) before their appointment which feels like too much and they often have a long wait before transport home.

Moving ophthalmology services to Bexhill as a result of the pandemic was stressful for many people and increased journey times. Other people found Bexhill easier to get to. Most people would like their appointments to take place as close to their home as possible.

"I often use Bexhill Hospital and I have to ask for a lift from a friend. I was upset that it would not be at the Conquest because it is much closer to where I live. The car park [at Bexhill] is not good and it is difficult to park. There are quite a few different waiting areas and my friend never knows where to pick me up from. Perhaps the letter could tell you waiting room A, B, C etc."

4.4 The impact of COVID-19

Some people reported that communication from the hospitals had deteriorated during the pandemic and that their appointments had been cancelled, with no indication of when they would be reinstated. Other people told us that they were very happy with communications.

Some people couldn't attend appointments during the pandemic because they were shielding. There was praise for staff where people did attend, with feedback about feeling safe and people told us that there were clear COVID-19 processes in place.

4.5 Clinical

Communications between different healthcare teams/professionals

People told us about problems of communication between the High Street optometrists and secondary care e.g. someone was referred by their optician but has since heard nothing. Other people told us that, when this communication works well, they feel very reassured.

There is sometimes a lack of continuity of care: people see different clinicians every time and feel that their information is not passed on, so tests end up being repeated and this causes anxiety for them. Their notes are often missing and time is wasted finding these.

Communications between healthcare professionals and people, especially of results

People using Patient Knows Best liked this system and felt that it kept them informed. Other people told us that information is sometimes not clear enough, leading to misunderstandings e.g.

one person told us that they thought the consultant had agreed they needed surgery and then changed their mind and they didn't understand why. Some people went to Bexhill for an appointment expecting to see a consultant and were then disappointed as they only had a scan, the appointment was very short and they felt it was a waste of time. Many people told us about long waits for appointments or appointments being cancelled and not knowing when they will next be seen, which is worrying if they have degenerative eye conditions.

Speed and ease of service delivery

The majority of people told us that the service is very good - "efficient and caring". People told us about mix-ups in outpatients e.g. one person arrived in advance for their appointment but the consultant missed them off the list so they had to wait until the end of the clinic to be seen. Another was re-directed from Hastings to Eastbourne but, when they got there, the consultant had left and they had to call to make another appointment.

One person told us of the difficulty in getting the right diagnosis: it took four years before the correct diagnosis - of a neurological condition - was made. Many people felt it was better to have all the different aspects of their treatment carried out in one visit e.g. eye tests, OCT (Optical Coherence Tomograph) scans, reviewing the results with the consultant and injections if required. When these are done on different days people feel more stressed and anxious and it increases any difficulties they have with transport.

Waiting times for appointments and follow-ups

People reported spending a lot of time sitting and waiting for appointments and that they always have to allow extra time to account for this. Appointments are often cancelled and communication about a new appointment is lacking. People told us how difficult it is when this happens and how anxious they become, not knowing when they will get another appointment. This particularly worries people who have conditions such as AMD (Age-related Macular Degeneration) which deteriorate.

> "Sometimes when I've been told I will get my next appointment in say three months it hasn't happened. I know times are very difficult at the moment, but my diabetic nurse had to remind the clinic I was due an appointment."

People told us how their eye conditions, or those of their loved ones, had deteriorated due to appointments being delayed and/or cancelled and what an enormous loss this was for them.

"The waiting time to meet the ophthalmologic consultant was too long, my husband [the patient] had to wait for seven months to meet them. My husband has a brain tumour which presses on the eye's nerves and caused damage to the right eye which lost 50% of its eyesight power. The eyesight power of the right eye became 50% and the left eye was 100%, but after that long waiting for the appointment the left eye has lost the eyesight completely which is a great loss."

4.6 Other themes

The lack of an ophthalmologist in A&E was mentioned several times.

"An ophthalmologist should either be on A&E or on registering with A&E patients should be sent directly to ophthalmology. Having come via A&E and waited almost four hours before they contact the eye doctor I was told it was too late to save my sight but had I been seen by a specialist there was every chance my sight could have been saved."

Several people told us about an issue with the treatment threshold for AMD. They reported being referred to the hospital by a High Street optometrist such as Specsavers. Having been reviewed by the consultant they were then told that the condition was not sufficiently severe to meet the NHS treatment threshold and that, if they wanted to be treated, they would need to pay for this privately at a cost of £400 per injection. Some people had taken up this option and had received treatment privately from the same consultant. Many people told us how worrying this was: they don't want to lose any more of their sight but not everyone can afford to pay for private treatment.

"There is a serious deficiency in the provision of care for some people with AMD in that the existing policy adopted in East Sussex does not allow for treatment where the affected eye is judged to be "too good to treat". This is a callous policy which condemns those who are not able to afford private treatment to eventual loss of vision which will severely affect their quality of life."

Of the optometrists who completed the survey, many felt that more could be done in the community e.g. glaucoma referral refinement, children's eye examinations after a borderline school screening, annual examinations for ocular hypertension and glaucoma. Some also told us

that the process for urgent referrals is difficult. They felt that there could be better communication and training for community optometry.

"Give optometrists more responsibility. Patients do not want to come to the hospital to sit for hours when they could be taken care of in practice, especially in triage cases. Pay us to carry out repeat tests like visual fields/intra-ocular pressure readings/anterior eye checks or dilations and that will help hospital eye service case loads and leave patients better taken care of."

4.7 Participant priorities

To encourage respondents to consider their priorities when it comes to healthcare and understand if people would be willing to travel further to receive care, a prioritisation question was asked where the participants had to rank each statement 1 to 6 with 1 being the most important and six being the least important. It is important to recognise that this question is useful but, given the relatively small number of respondents, the results should not be viewed as an overall reflection of people's priorities.

1. I need to consider how to get to my appointment i.e. is there a regular bus available, would I be able to cover the cost to get to the appointment.
2. I need to consider the time taken to travel to get to my appointment.
3. When I am at the hospital, I want appointments to run on time.
4. I would prefer my treatment to be done in a day so I do not have to travel to multiple appointments.
5. I would like to have the most up-to-date facilities and equipment available.
6. I don't want to have to wait too long to get an appointment.

4.8 Other groups the CCG should engage with during the public consultation

Participants we asked if there are any groups that engagement should focus on once the set of proposals have been developed. Responses included:

- The elderly
- Disabled
- Those without transport
- Opticians
- People in deprived communities
- People from different ethnicities e.g. local Hungarian and Portuguese communities

5.0 Conclusion

Public engagement reached a significant number of people, despite the limitations of lockdown during COVID-19, and the CCG heard from a wide variety of individuals, organisations and stakeholders.

The findings have been shared with ESHT and an action plan is being developed using some of the early findings to make small but effective changes to the way the current service is provided.

The outputs of the public engagement will inform and shape the options development and appraisal process, and will be used to shape any future business case and formal consultation, if required.

6.0 Appendix 1 - Equality data

There was a widespread response from across East Sussex with the highest number of responses coming from the Heathfield and Seaford areas. Not all respondents completed the equality data section of the questionnaire.

TN21	Heathfield area	16
BN25	Seaford area	10
BN27	Hailsham	9
BN22	Eastbourne	8
TN34	Hastings	8

7 responses from TN39

6 responses from TN19, T28, BN20, BN23

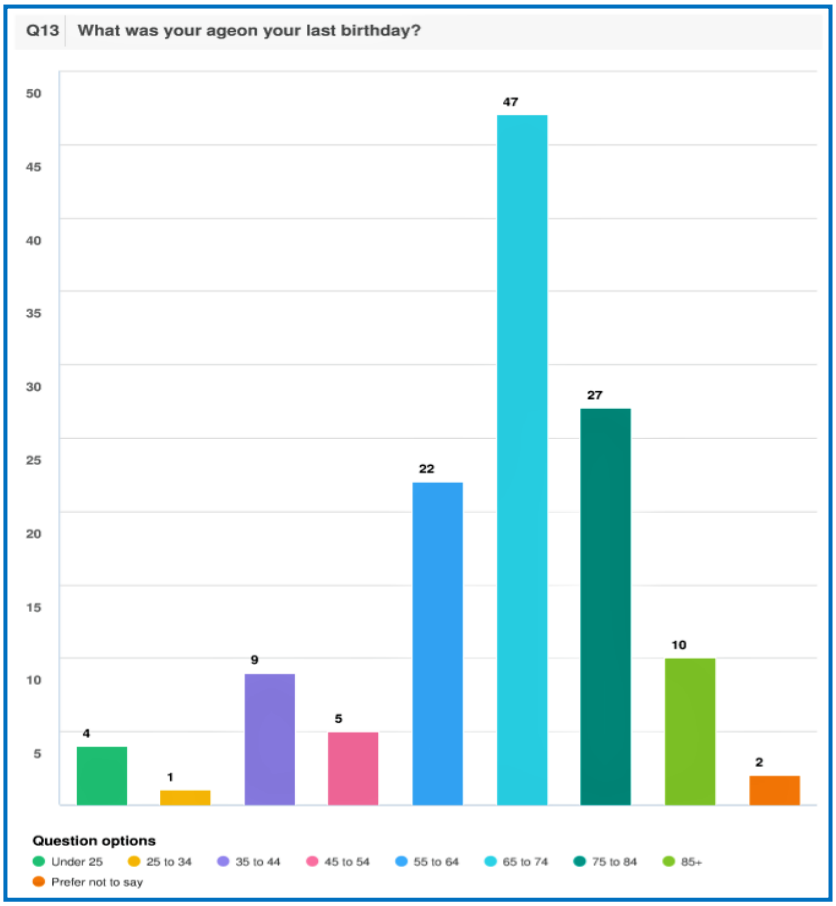
4 responses from BN21, TN6, TN35, TN40

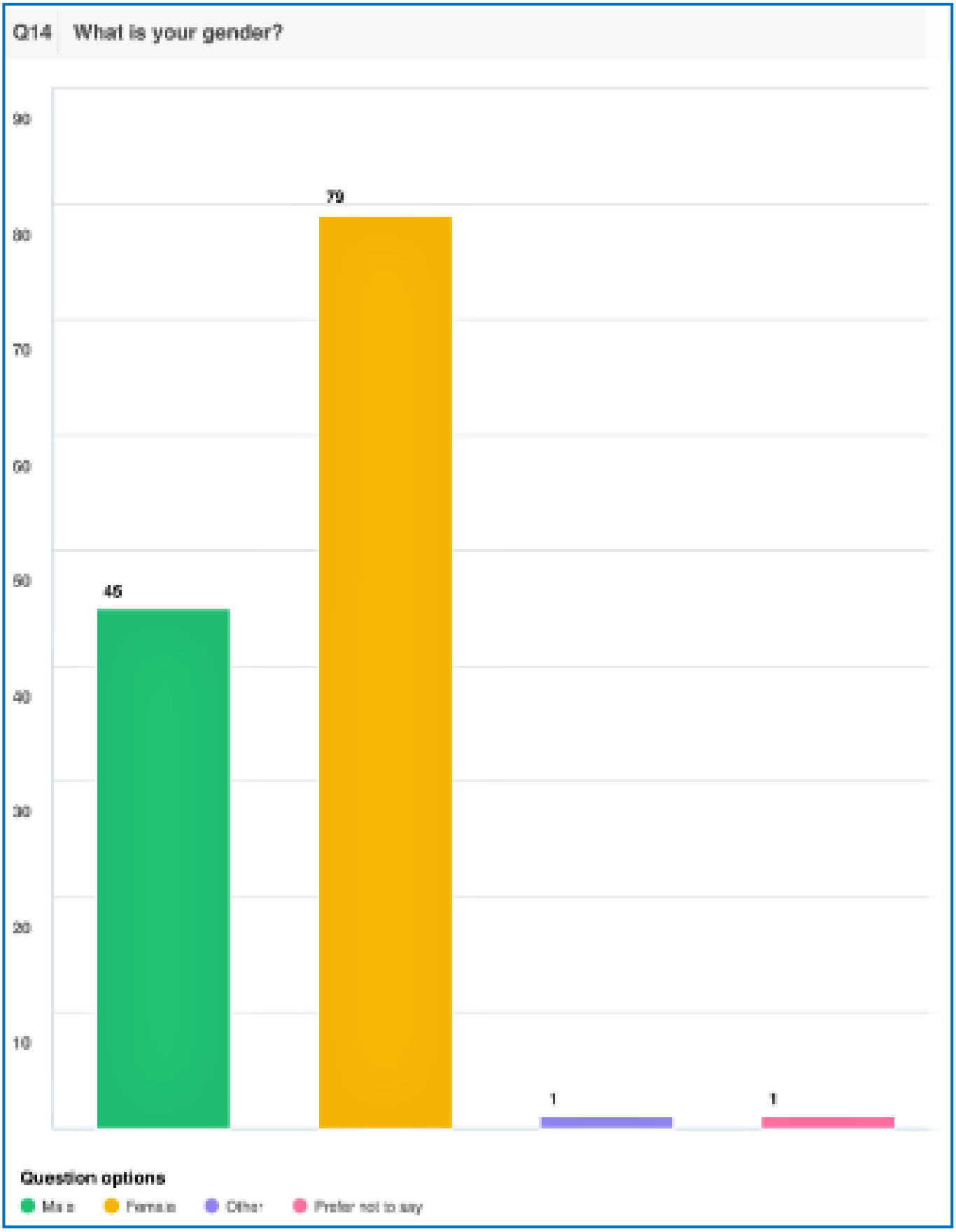
3 responses from BN10, TN33

2 responses from TN20, TN31, TN36, TN37, BN9, BN24, BN26

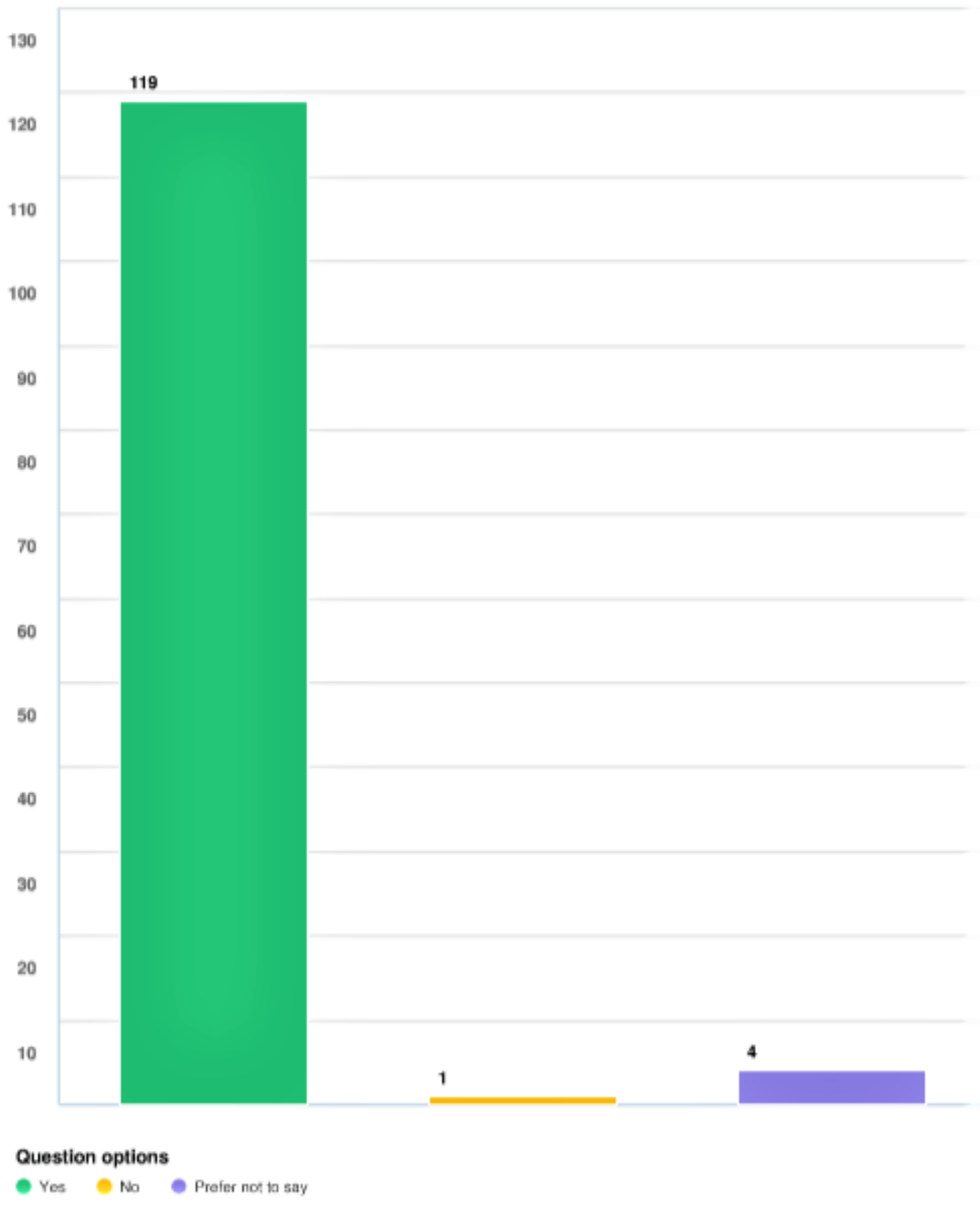
1 response from TN5, TN22

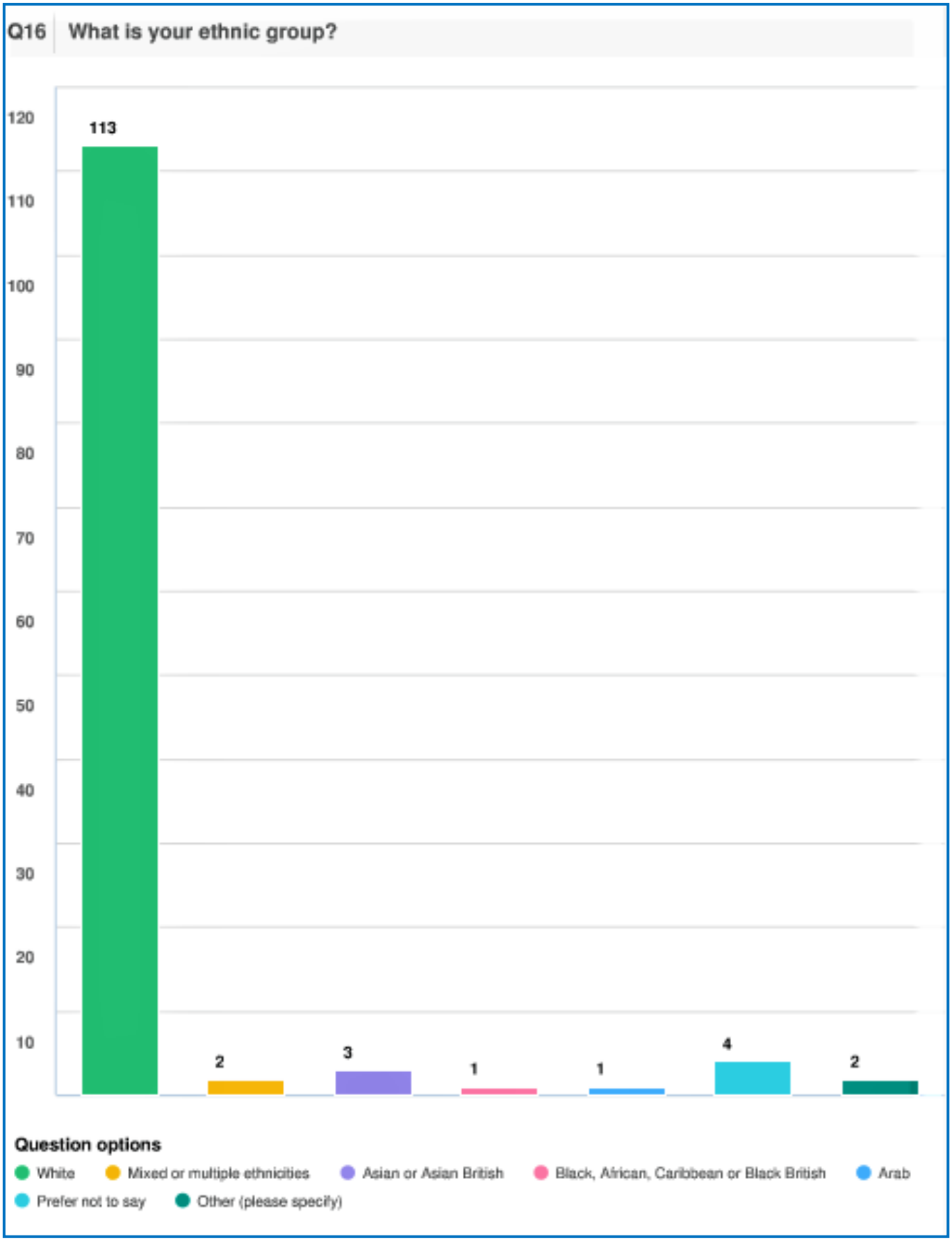
Five out of area responses were received, all from Brighton postcodes.

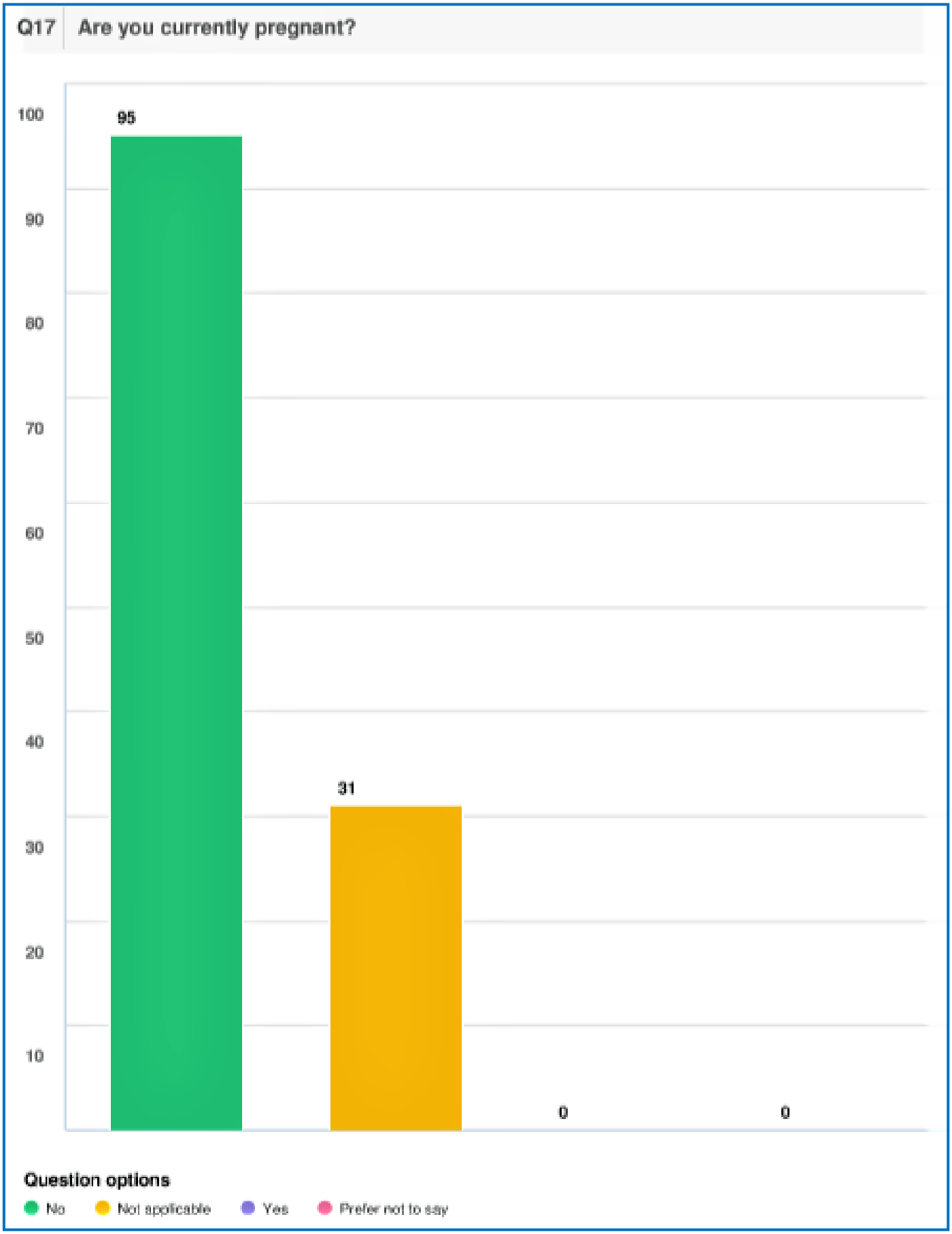



Q14 What is your gender?
90
80
70
60
50
40
30
20
10
45
79
1
1
Question options
Male
Female
Other
Prefer not to say

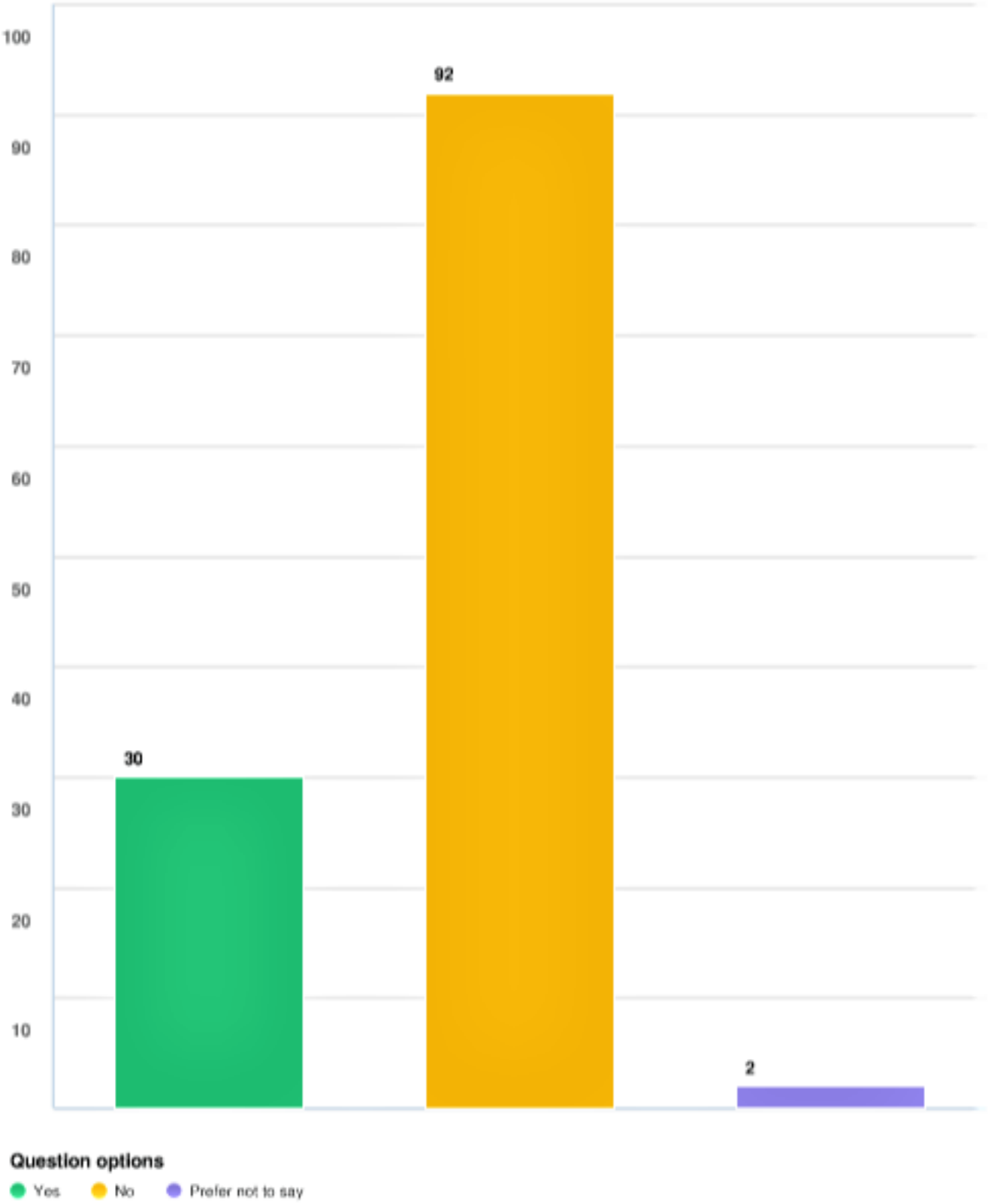
Q15 Do you identify as the sex you were assigned at birth? For people who are transgender, the sex they were assigned at birth is not the same as their own sense of gender.



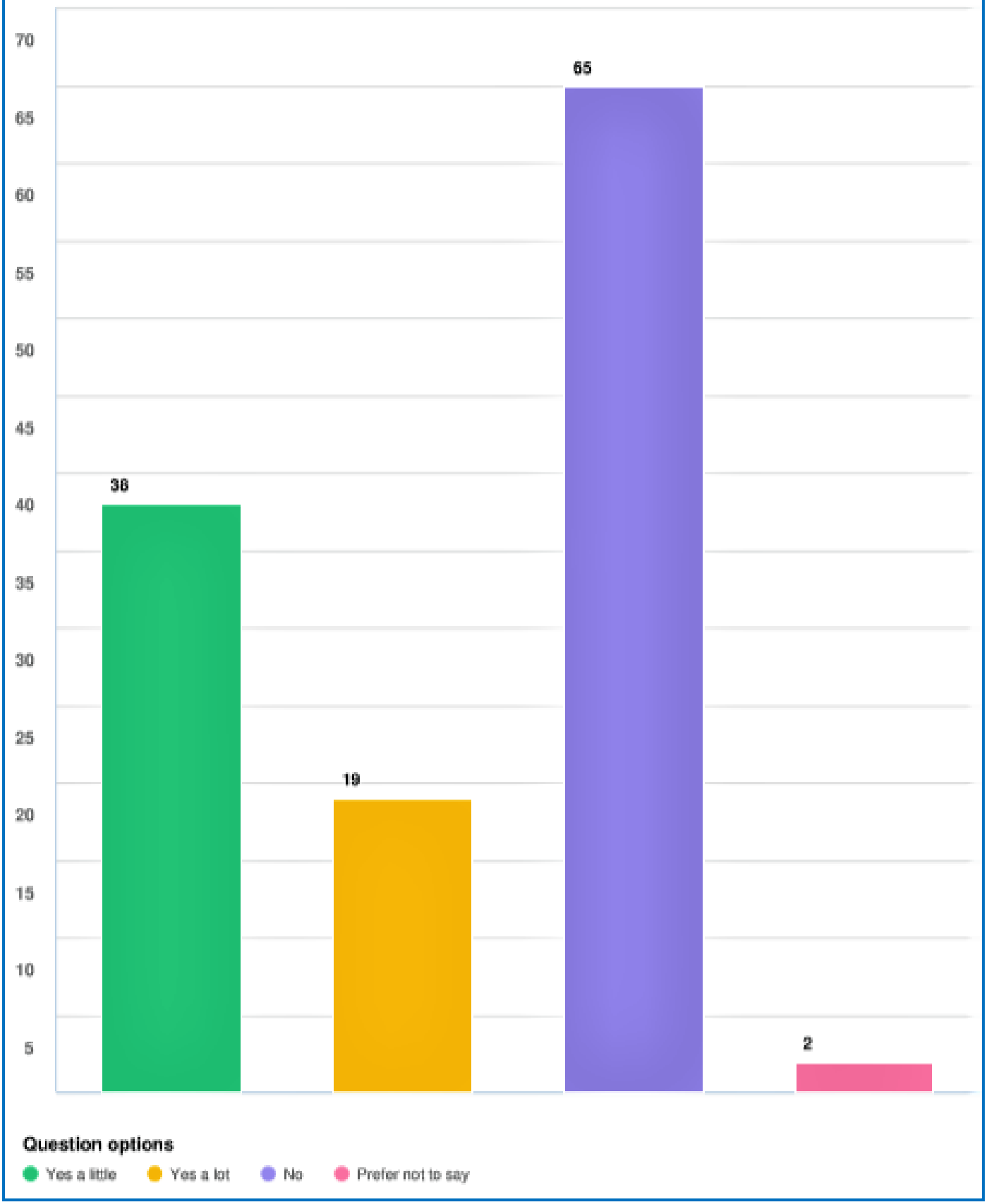

Q16 What is your ethnic group?
120
110
100
90
80
70
60
50
40
30
20
10
113
2
3
1
1
4
2
Question options
White
Mixed or multiple ethnicities
Asian or Asian British
Black, African, Caribbean or Black British
Arab
Prefer not to say
Other (please specify)

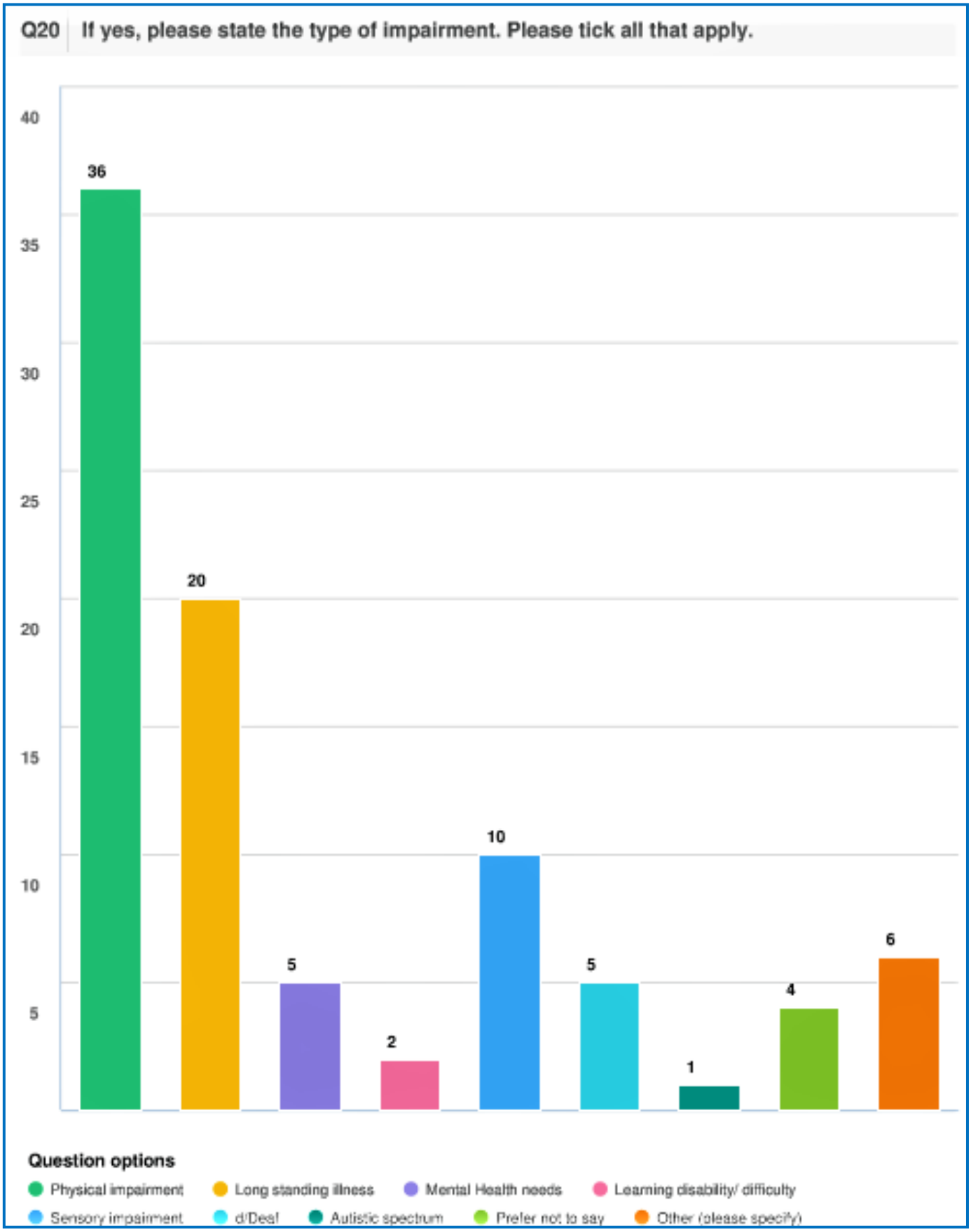

Q17
Are you currently pregnant?
100
90
80
70
60
50
40
30
20
10
95
31
0
0
Question options
No
Not applicable
Yes
Prefer not to say

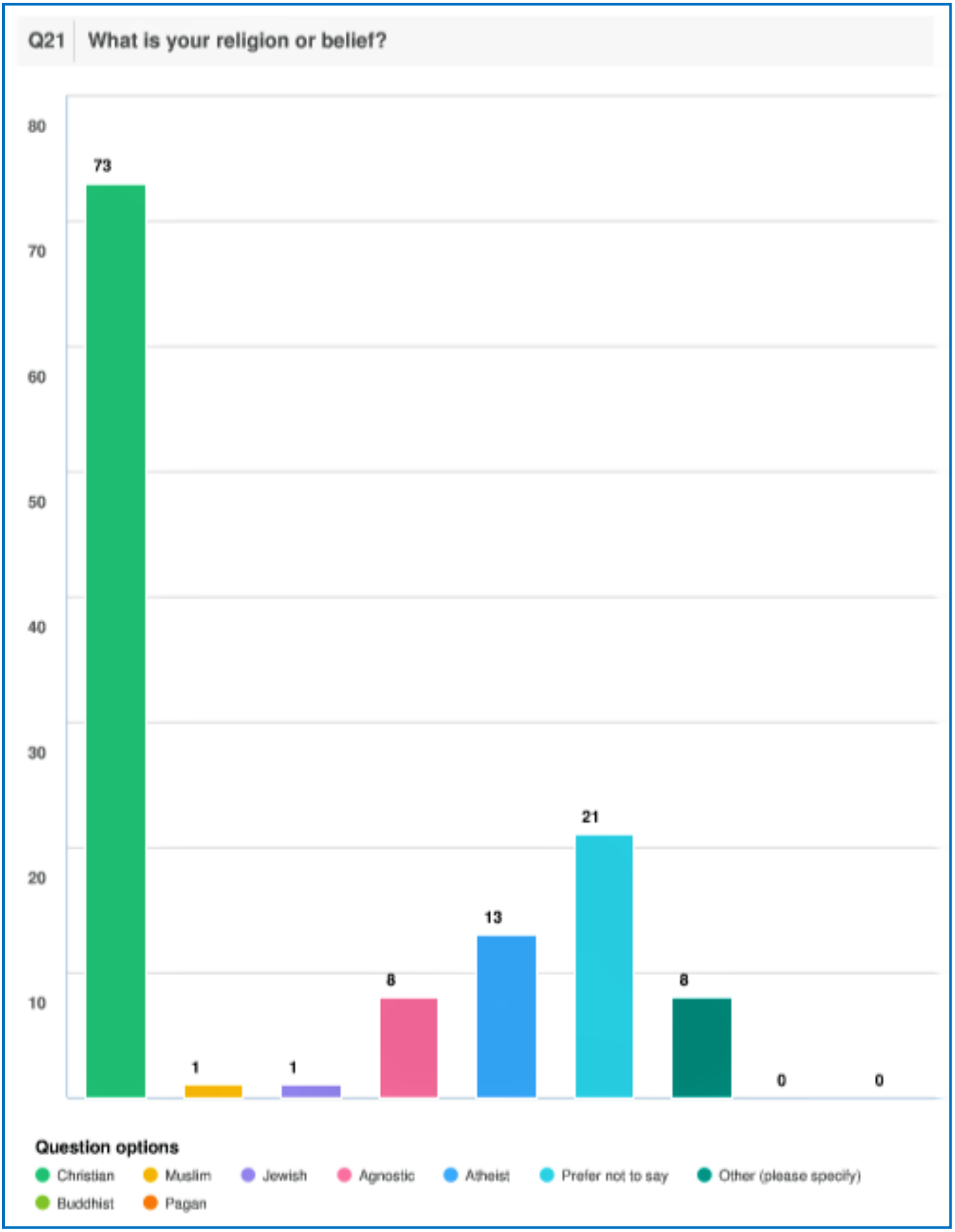
Q18 Are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.



Q19 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?




Q20
If yes, please state the type of impairment. Please tick all that apply.
40
35
30
25
20
15
10
5
36
20
5
2
10
5
1
4
6
Question options
Physical impairment
Long standing illness
Mental Health needs
Learning disability/ difficulty
Sensory impairment
d/Deaf
Autistic spectrum
Prefer not to say
Other (please specify)


Q21 What is your religion or belief?
80
70
60
50
40
30
20
10
73
1
1
8
13
21
8
0
0
Question options
Christian
Muslim
Jewish
Agnostic
Atheist
Prefer not to say
Other (please specify)
Buddhist
Pagan

Transforming Acute Ophthalmology Services in East Sussex

Options Development and Appraisal

Report of Findings

Opinion Research Services

The Strand | Swansea | SA1 1AF
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Sussex Clinical Commissioning Groups

Transforming Ophthalmology Services in East Sussex

Options Development and Appraisal

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Contents

1. Summary of key findings

Introduction and commission

1.1 The NHS East Sussex Clinical Commissioning Group (East Sussex CCG) and East Sussex Healthcare NHS Trust (ESHT) are working to improve ophthalmology services across East Sussex. Acute (hospital-based, consultant-led) ophthalmology services in East Sussex are delivered by ESHT at Eastbourne District General Hospital (EDGH), Conquest Hospital in Hastings (hereafter 'Conquest'), and Bexhill Hospital (Bexhill).

1.2 East Sussex CCG and ESHT believe that current acute ophthalmology service provision is no longer fit-for-purpose. While patient satisfaction with the current provision is high, the service in its present form is unlikely to be able to continue to meet current and future demand and it is therefore necessary to explore options for improvement.

1.3 As part of the Transforming Ophthalmology Services in East Sussex programme, East Sussex CCG and ESHT are undertaking extensive engagement with service users, their carers and families, clinicians, and other stakeholders. This was initially in the form of early involvement to inform the programme, followed by a more formal options development and appraisal process. It is these latter options development and appraisal activities which have provided the basis for this report.

1.4 In early 2021, East Sussex CCG appointed Opinion Research Services (ORS) (a spin-out company from Swansea University with a UK-wide reputation for social research and statutory consultations) to advise on and independently manage and report the programme reported here.

Options development and appraisal workshops

1.5 Between 9th March 2021 and 23rd March 2021, three options development and appraisal workshops (independently chaired and facilitated by ORS researchers) took place to identify and consider a longlist of possible options for the future provision of acute ophthalmology services in East Sussex. The workshop attendees were as follows:

Stakeholder type	Number	Description (roles/organisations represented)
Patients/ representatives	5	East Sussex Association of Blind and Partially Sighted People East Sussex Seniors' Association East Sussex CCG Community Ambassador
Other NHS staff	4	Local GP CCG GP Clinical Lead East Sussex Local Optical Committee
ESHT clinicians	4	Acute ophthalmology clinical leads and hospital optometrists

1.6 NHS managers attended to observe, to present key information to inform discussions, and to respond to questions but *did not* actively participate in the options development and appraisal scoring and ranking activities.

1.7 A mixed methodology was used to appraise the longlist of options, comprising:

- 'Qualitative' discussions which drew out the reasons for which different individuals and groups held certain views, and particularly to identify and elaborate on any key factors or concerns; and
- A two-part 'quantitative' exercise to generate ranks and scores for each option.

1.8 In both the qualitative and quantitative stages of the appraisal, five 'appraisal criteria' (which were discussed and agreed upon at workshops 2 and 3) were used. These criteria are: Quality and Safety; Clinical Sustainability; Access and Choice; Financial Sustainability; and Deliverability. The same methodologies were used to appraise different options for locations of acute ophthalmology services in East Sussex, in the event that any proposed options were to require that services currently delivered at three hospitals were to be reconfigured to be located at fewer sites.

Key findings and considerations

1.9 Formal options development and appraisal activities are an important element of the process for developing any final proposals for changes to the way that acute ophthalmology services might be delivered in future. The workshops should nonetheless be viewed as just one element of a longer-term and ongoing dialogue in which stakeholders, including members of the public, have engaged with East Sussex CCG and ESHT about the way that NHS services are delivered.

1.10 It is important to note, therefore, that the outcomes reported here are by no means the only basis on which the decisions might be taken about which options move forward to public consultation. Options appraisal is a useful tool to inform the shortlisting process, but it forms just one part of the evidence base which the relevant bodies will need to consider when making decisions.

Challenges, opportunities, clinical vision, and priorities

1.11 There was widespread recognition of ESHT's challenges, which were thought to mirror patients' experiences. There was particular recognition of the pressure on services, which manifests as long waiting times for appointments and delays once at clinics - sometimes of several hours.

1.12 There was also support for the clinical vision for ophthalmology and for ESHT's priorities and considerations, including that ESHT's acute ophthalmology services should be high quality, accessible, and delivered in a timely and equitable manner for all patients, serving the needs of the local population.

Patient concerns typically revolve around travel and access

1.13 Travel and access appear to be the primary issues for patients. It was said that transport is already an issue for patients living further from hospital sites - some of whom are unable able to drive at all - while for others the tests/treatment they receive mean they cannot drive home.

1.14 It was considered particularly essential that the travel and (physical and psychological) access needs of particular groups be borne in mind in service redesign. Participants explicitly mentioned: those living in rural and/or deprived areas; people with protected characteristics; the elderly and those with mobility issues; children and young people; those who rely on public transport; and rough sleepers.

1.15 Given the importance of these issues to patients, it was strongly suggested that any solutions and changes (and especially those that involve providing acute services across fewer sites) should include measures to address them.

An 'ideal' ophthalmology service and a future model of care

1.16 According to patients and their representatives, an 'ideal' ophthalmology service: is founded on good communication (between clinicians and patients, and between community/primary and secondary healthcare providers); is accessible and considers travel and transport needs; harnesses new digital opportunities that reduce the need for face-to-face care (and, by association, extensive travel for both patients and clinicians); is sustainable in the long-term; and considers equality and diversity impacts.

1.17 Although not within the remit of the acute service primarily being considered as part of this options development and appraisal process, participants were also keen to stress the importance of prevention and early intervention going forward, to both improve population health and reduce service demand.

1.18 Various potential models of care were discussed at workshops 2 (options development) and 3 (options appraisal). Discussions began on the basis of three possible approaches suggested by ESHT: maintaining the status quo, and two-site and one-site models. Participants were asked to suggest other approaches, and two variations on a one hospital site model were forthcoming (Models 4 and 5, discussed below).

Options appraisal findings

1.19 In a three-part process, participants in workshop 3 were asked to first 'qualitatively' appraise the possible options through facilitated group discussions, before independently and anonymously ranking and scoring each of the five possible options for a future model of care against the five agreed 'appraisal criteria' (Quality and Safety; Clinical Sustainability; Access and Choice; Financial Sustainability; and Deliverability).

1.20 In the ranking exercise, participants were asked to place the five options in order based on which they felt best met each criterion. Participants were then asked to score each of the five possible options separately against the five 'appraisal criteria'. Unlike in the ranking exercise, participants were able to give the same scores to several or even all options if they chose to, allowing them to indicate where they might view several of the options as quite evenly matched on one area, or where one possible approach was viewed significantly more positively or negatively than others.

1.21 It is important to view all aspects of the appraisal exercise as equally important, with the deliberative discussions - which themselves represent a continuation of earlier pre-consultation engagement - providing an equally important 'test' of the longlist of options as the quantitative ranking and scoring.

Models of care

1.22 The results show that potential Options 2 (two hospital sites) and 3 (one hospital site) were viewed most positively in relation to most appraisal criteria, albeit variably between stakeholder groups. In discussion, Option 2 was seen as being able to address 'bottlenecks' and long waiting times, and it was ranked highest by patients and representatives against all criteria, and by all stakeholder types against Access and Choice.

1.23 Questions were raised, however, about whether a two-site model of care would have the capacity to accommodate increased demand in the future, and ESHT clinicians, alongside other NHS staff and community optometrists, expressed the view in the qualitative discussions that a single hospital site for all acute ophthalmology services would represent the best use of resources, provide the best patient outcomes, and aid recruitment and retention of staff. ESHT clinicians ranked Option 3 highest against all appraisal criteria except Access and Choice, and other NHS staff ranked it highest against Quality and Safety, and Clinical and Financial Sustainability.

1.24 The scoring results were more mixed: overall, Option 3 was scored highest overall by both ESHT clinicians and other NHS staff (including community optometrists) against all criteria except Access and Choice (see below), whereas patients and representatives variously scored Options 1, 2 and 4 highest against different criteria, generally giving Option 3 the second highest mean scores except in regard to Access and Choice.

1.25 Option 4 (a single-site model with some community hospital-based clinics) was added to the long-list of possible options in response to extensive discussions around mitigating against increased travel times by delivering more ophthalmology services locally, including through community-based optometrists. Although it rarely featured at the top of the ranking/scoring results, it was commonly in second place. This may reasonably be seen as a reflection of the prioritisation of local access to acute services by many patients, and the view that enhanced community-based provision could enable care closer to home, faster decision-making and reduced travel and access impacts for patients, in the event of a single-site model.

1.26 In qualitative discussions and in the quantitative scoring and ranking exercises, Options 1 (retain current services) and 5 (one hospital site and mobile clinics) tended to fare poorly; one or other of these options were general ranked and scored lowest by the participant groups against all criteria (although Option 3 was ranked and scored lowest against Access and Choice by other NHS staff and patients/representatives.

- There was general agreement in discussions that Option 1 is unfeasible due to: current and future capacity; staff recruitment and retention difficulties; lack of senior supervision due to consultants being 'spread too thinly'; lack of physical space for clinics; and the need for sustainable services;
- While clinicians thought Option 3 would result in timelier access to services and better outcomes for patients, patients referred to travel and access concerns around travel time, distance and cost, and the ease of getting to appointments; and
- Option 5, after being proposed in workshop 2, was not discussed in detail at workshop 3 as it was felt that the key points regarding local access had been covered in discussions on Options 3 and 4.

Locations under a two-site model of care (Option 2)

1.27 There was a clear preference across all stakeholder groups for a combination of EDGH and Bexhill. Bexhill and Conquest was the least favoured combination overall.

Locations under a one-site model of care (Options 3-5)

1.28 There was clear support for Bexhill among ESHT clinicians, whereas opinion was more divided between Bexhill and EDGH among patients/representatives and other NHS staff. Conquest was generally least favoured, though it should be noted that patients/representatives scored EDGH lowest against all criteria.

Overall…

1.29 The outcomes of the options development and appraisal process reported here suggest that Options 2 (two hospital sites), 3 (one hospital site) and 4 (a single-site model with some community hospital-based clinics) could reasonably be taken forward to formal consultation on the future of ophthalmology services in East Sussex. Bexhill and EDGH appear to be the favoured locations for a two-site model, and opinion was divided between the same two hospitals when considering the best site for a single hospital. East Sussex CCG and ESHT will, though, need to take all other evidence into consideration - particularly with regard to feasibility - in its decision-making processes around which options might be taken forward to public consultation.

2. Pre-consultation overview

Background

2.1 The NHS East Sussex Clinical Commissioning Group (East Sussex CCG) and East Sussex Healthcare NHS Trust (ESHT) are working to improve ophthalmology services across East Sussex. Acute (hospital-based, consultant-led) ophthalmology services in East Sussex are delivered by ESHT at Eastbourne District General Hospital (EDGH), Conquest Hospital in Hastings (hereafter 'Conquest'), and Bexhill Hospital (Bexhill).

2.2 Although not the focus of the current programme to improve acute ophthalmology services in East Sussex, it should be noted that ESHT works already works closely with primary care and community-based optometric services delivered across East Sussex. Work to improve and increase the scope of primary and community-based care is ongoing and provides an important context to the process of developing and appraising options for future approaches to acute services.

2.3 Changes to acute ophthalmology services as a result of the current programme would certainly take into account and make best use of any future advancements and improvements in primary care and community-based services. It should be noted, however, that the options which are the subject of this report relate *only* to those services delivered by ESHT and neither rely upon nor are likely to be able to 'wait' for changes which may also take place in due course in primary and community-based care. Nonetheless, the possibility of future opportunities for collaboration was kept in mind in discussions.

2.4 East Sussex CCG and ESHT acknowledge the need to substantially change the way acute ophthalmology services are delivered in order to provide clinically excellent patient care that reduces avoidable sight loss and improves the eye health of all patients, which is also clinically, environmentally and financially sustainable. Several internal and external challenges and drivers for change, which must be addressed in any future service transformation, have been identified by East Sussex CCG and ESHT:

- **External challenges**, including increased demand for services from a growing, diverse and aging population which includes groups particularly impacted by health inequalities;
- **Internal challenges**, including those of recruiting and retaining adequate staff, ongoing difficulties in delivering the existing service model, and the need to make the most of new technologies and opportunities for improvements to diagnosis, treatment and ongoing care for all patients;
- **National drivers**, including changes to the way that acute ophthalmology services are being delivered nationally by the NHS, changes to standards and guidelines set out by NHS England and the Royal College of Ophthalmologists, and changes to 'performance indicators' and targets; and
- **Opportunities for improvement**, including updated IT and other digital solutions to enable multidisciplinary team working, and new service delivery models which make best use of all existing and new resources.

2.5 In light of these challenges and drivers, East Sussex CCG and ESHT believe that current acute ophthalmology service provision is no longer fit-for-purpose. While, as described in the following chapters, ***patient satisfaction*** with the current provision is high, the reality is that the service in its present form is unlikely to be able to continue to meet current and future demand and it is therefore necessary to explore options for improvements.

2.6 As part of the Transforming Ophthalmology Services in East Sussex programme, East Sussex CCG and ESHT are undertaking extensive engagement with service users, their carers and families, clinicians, and other stakeholders. This was initially in the form of early involvement to inform the programme, followed by a more formal options development and appraisal process. It is these latter options development and appraisal activities which have provided the basis for this report.

2.7 Finally, East Sussex CCG and ESHT have a duty to consider any potential impacts on, and opportunities to address, inequality and health inequalities in relation to possible changes to acute ophthalmology services. Relevant feedback and other evidence were considered in discussions at the workshops and in the appraisal scoring and ranking, and additional feedback in this area was encouraged.

The commission

2.8 In early 2021, East Sussex CCG appointed Opinion Research Services (ORS) (a spin-out company from Swansea University with a UK-wide reputation for social research and statutory consultations) to advise on and independently manage and report the options development and appraisal programme. The acute ophthalmology transformation options development and appraisal activities undertaken by ORS on behalf of East Sussex CCG and ESHT comprised a series of three workshops held over a three-week period in March 2021, as described below.

2.9 ORS would like to take this opportunity to express gratitude for the support from NHS colleagues and other community partners and stakeholder organisations to ensure the success of the workshops, as well as to all those individuals who contributed time and effort by taking part in the programme.

East Sussex CCG's pre-consultation activities with service users

2.10 Between 4th January 2021 to 14th February 2021, East Sussex CCG undertook a programme of pre-consultation engagement activities with local people and stakeholders to: communicate the need for transformation to acute ophthalmology services provided by ESHT; understand their experiences of current services; and gather feedback and ideas about how services might be delivered in the future.

2.11 There were two principal pre-consultation activities: the first was an online and paper questionnaire, promoted widely via existing engagement channels, bulletins and newsletters, via voluntary, community and social enterprise sector organisations (e.g., Healthwatch), posters, social media, and through East Sussex CCG staff members attending relevant forums and groups meetings. Specific work was undertaken by East Sussex CCG to reach out to those living in areas of deprivation and to the homeless and rough sleeper community. The second was a series of in-depth interviews with current and former patients.

2.12 The work undertaken by East Sussex CCG provided a strong foundation on which to build the formal programme of activities subsequently undertaken by ORS (see below). As well as providing valuable insights in its own right which helped to inform options development, the pre-consultation activities also helped to identify and recruit patients and patient representatives for the workshops (see below).

2.13 In all, 126 responses were received to the questionnaire, of which 19 were conducted as in-depth interviews with responses entered into the relevant open text response. These engagement activities are reported by East Sussex CCG (Appendix II), and elements of the feedback are covered in this report, where relevant, alongside the feedback received from patients and patients' representatives at the workshops.

Options development and appraisal workshops

2.14 Between 9th March 2021 and 23rd March 2021, three options development and appraisal workshops took place to identify and consider and longlist of possible options for future provision of acute ophthalmology services in East Sussex. The workshop attendees fell into four broad categories:

- Acute ophthalmology service users and patient representatives (hereafter 'patients and representatives' or 'patients' for brevity);
- Primary care clinicians and community optometrists ('other NHS staff');
- ESHT ophthalmology clinical leads and hospital optometrists ('ESHT clinicians');
- NHS East Sussex Commissioners and ESHT managers ('NHS managers').

2.15 It should be noted that NHS managers (including those responsible for acute services and planned care, quality and safety, business and finance, strategy and transformation, workforce planning, patient transport, and patient and public engagement) attended to observe, to present key information to inform discussions, and to respond to questions when required. They *did not* actively participate in the options development and appraisal scoring and ranking activities and are therefore excluded from Table 1 below.

2.16 Particular effort was made by East Sussex CCG to ensure that service users' views were appropriately represented at the workshops, building on the extensive promotion of the pre-consultation engagement in January-February 2021, which included approaching ophthalmology outpatients at East Sussex hospitals directly to invite them to take part in the various engagement activities. All interview participants were personally offered the opportunity to take part in additional activities, including the workshops reported here. To further encourage participation, patients attended the workshops had the option of claiming £25 for each meeting under East Sussex CCG's Reward and Recognition policy.

2.17 Additional measures were taken to increase the 'patient voice' at the workshops; several of the patient participants (as well as the community optometrists) were members of relevant organisations and were therefore able to represent the views of a wider group of stakeholders, as was the Sussex Health and Care Partnership Community Ambassador[1]. Finally, a member of East Sussex CCG's Engagement Team contributed to discussions by relaying feedback from pre-consultation engagement with patients.

2.18 The table below details the 'active' participants (i.e., those who took part in the options development and appraisal activities, rather than informing or observing them) across the three workshops.

Table 1: Workshop participants 'actively' involved in options development and appraisal activities

Stakeholder type	Number	Description (roles/organisations represented)
Patients and representatives	5	East Sussex Association of Blind and Partially Sighted People East Sussex Seniors' Association East Sussex CCG Community Ambassador
Other NHS staff	4	Local GP CCG GP Clinical Lead East Sussex Local Optical Committee
ESHT clinicians	4	Acute ophthalmology clinical leads and hospital optometrists

[1] Community ambassadors are volunteers recruited specifically to help the Sussex Health and Care Partnership, which includes East Sussex CCG, to understand the views of local people around key health and social issues. The role involves extensive first-hand engagement with members of the public, including users of specific NHS services, and providing a 'lay' perspective at a strategic level in Sussex-wide NHS programmes.

Workshops overview

2.19 The workshops (Table 2), while organised by East Sussex CCG, were independently chaired and facilitated by ORS researchers. ESHT and East Sussex CCG managers and senior clinicians presented relevant information to provide the context and background to the discussions. The workshops also benefitted from the input of a Public Health Consultant who provided data and explanation around the demographic profile of the population of East Sussex, highlighting groups that might be considered at higher risk of poor eye health, and the prevalence of any risk factors at play (e.g., co-morbidity; lifestyle).

Table 2: Acute ophthalmology services options development and appraisal workshops held in March 2021

Workshop	Date/time	Description
1	Tues 9th March 13:00 - 17:00	**'Listening and engagement'** • Bridging from the pre-consultation engagement undertaken by East Sussex CCG into the formal options appraisal • Introducing the background and rationale to the transformation • Discussion around the clinical vision and priorities *and* patients' priorities for acute ophthalmology services in East Sussex • Initial discussions on how the need to address current and future challenges, meet national guidelines and standards, and to address clinical requirements and patients' needs, might require a balance or compromise to be found between different priorities **Key outputs** • Feedback from patients and patient representatives, community optometrists and primary care clinicians to inform possible new models of care for East Sussex
2	Tues 16th March 13:00 - 17:00	**'Options development'** • Drawing on key themes and suggestions identified from pre-consultation engagement, feedback from Workshop 1, and information and data provided by East Sussex CCG and ESHT • Discussion about possible approaches to acute ophthalmology service provision, using suggestions from East Sussex NHS partners as a starting point before generating and considering additional ideas and possible approaches • Initial consideration of possible advantages and disadvantages, impacts and potential mitigations of each possible approach • Consideration of the implications of possible approaches in relation to the vision, priorities and challenges discussed in Workshop 1 • Brief introduction to the appraisal criteria to be used in Workshop 3 **Key outputs** • Feedback from patients and patient representatives, community optometrists and primary care clinicians to generate a 'longlist' of possible approaches/options to be considered and appraised at Workshop 3
3	Tues 23rd March 13:00 - 17:00	**'Options appraisal'** • Summary of outputs from Workshops 1 and 2 • Discussion and agreement on the five appraisal criteria against which the longlist of possible options would be tested • "Qualitative" discussion/appraisal of each longlisted option for future ESHT acute ophthalmology service provision, and location options if acute services were to be delivered from a reduced number of sites • Anonymous ranking and scoring of each longlisted option and possible location(s) against the agreed appraisal criteria **Key outputs** • Feedback and data to inform shortlisting of options for consultation

Options development and appraisal methodology

Purpose of options development and appraisal

2.20 Formal options development and appraisal activities are an important element of the process for developing any final proposals for changes to the way that acute ophthalmology services might be delivered in future. The workshops should nonetheless be viewed as just one element of a longer-term and ongoing dialogue in which stakeholders, including members of the public, have engaged with East Sussex CCG and ESHT about the way that NHS services are delivered.

2.21 It is important to note, therefore, that the outcomes reported here are by no means the only basis on which the decisions might be taken about which options move forward to public consultation. Options appraisal is a useful tool to inform the shortlisting process, but it forms just one part of the evidence base which the relevant bodies will need to consider when making decisions.

Appraisal criteria

2.22 When different types of stakeholder come together to discuss and score or rank options against appraisal criteria, there can be both similarities and significant differences in opinions between individual participants *and* between stakeholder groups. Where there is divergence in opinion, it often reflects the way that different stakeholder groups prioritise different elements of the services and their delivery. For this reason, a mixed methodology was used to appraise the longlist of options, comprising:

- 'Qualitative' discussions which drew out the reasons for which different individuals and groups held certain views, and particularly to identify and elaborate on any key factors or concerns; and
- A two-part 'quantitative' exercise to generate ranks and scores for each option.

2.23 In both the qualitative and quantitative stages of the appraisal, five 'appraisal criteria' (which were discussed and agreed upon at workshops 2 and 3) were used. These criteria are:

- **Quality and Safety**: quality of service, patient and staff safety and experience and delivery of good outcomes;
- **Clinical Sustainability**: how the service will be delivered now and in years to come, keeping in view the recruitment and retention of staff groups;
- **Access and Choice**: current and future needs, access to the right service at the right place at the right time, ensuring everyone has access to the service of their choice;
- **Financial Sustainability**: making the best use of resources now and in years to come and how efficient the service is able to be; and
- **Deliverability**: how the approach/approaches can be delivered in the short, medium and long term, keeping in view the model of care and the environmental footprint.

2.24 The same methodologies were used to appraise different options for locations of acute, hospital-based ophthalmology services in East Sussex, in the event that any proposed options were to require that services currently delivered at three hospitals were to be reconfigured to be located at fewer sites.

2.25 Each stage of the process above is covered in more detail in the Workshops Findings chapter. There follows below a brief explanation of the way in which the options appraisal outputs are presented.

Interpretation of the appraisal ranking and scoring data

2.26 In order to ensure that the views of any particular group or groups of participant stakeholders do not dominate the scoring and ranking outcomes from workshop 3, the results for each of the stakeholder groups (i.e., 'Patients', 'Other NHS staff' and 'ESHT clinicians') are presented separately. This approach also allows comparison and contrast between the views of the different groups.

2.27 The results for the options appraisal ranking and scoring exercises are presented in tables and graphical format. The bar charts and other graphics show mean scores and ranking for each stakeholder group, for each individual option against each individual appraisal criterion. For example, the mean score given by ESHT clinicians has been calculated as follows:

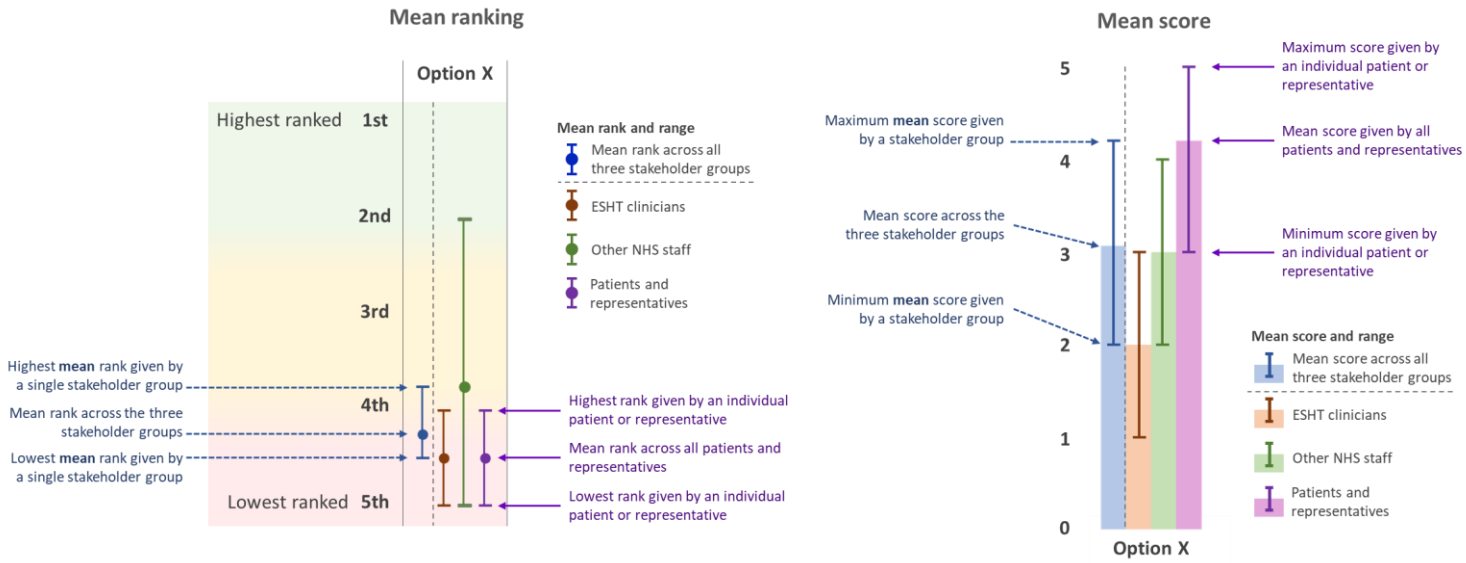
$$\frac{\text{Sum of scores given by all ESHT clinicians for Option 1 vs Deliverability}}{\text{Total number of ESHT clinicians}} = \text{Mean score by ESHT clinicians for Option 1 vs Deliverability}$$

2.28 To give an indication of the 'overall' view of all stakeholder types, the calculation below was used. It should be noted, however, that in the Workshops Findings chapter below, the commentary focuses on the scores given by *each stakeholder type*.

$$\frac{\text{Mean score given by ESHT clinicians + mean score given by 'other NHS staff' + mean score given by patients and representatives}}{3} = \text{Mean score across all three stakeholder groups}$$

2.29 To indicate the extent of the range of opinions within and between stakeholder groups, min-max lines have been included on charts (Figure 1). In each case, the shorter the lines, the smaller the range of scores and therefore the more closely aligned the views of individual participants and/or stakeholder types.

Figure 1: Example of charts showing mean rankings and scores for options against one of the appraisal criteria



2.30 The colours of the charts have been standardised so that results for each stakeholder type or group are presented consistently. Patients and representatives in **purple**, other NHS staff (including community optometrists) in **green** and ESHT clinicians in **orange**. The mean ranks and scores across the three stakeholder groups (the 'mean of means') is presented in **blue**.

Impacts of Covid-19 and mitigations

2.31 The ongoing coronavirus pandemic and subsequent lockdown and social distancing measures placed restrictions on the methods by which East Sussex CCG and ORS could engage with and involve stakeholders. Under normal circumstances, options development and appraisal workshops might be undertaken face-to-face. In the current programme, however, the workshops were held 'virtually' via the Microsoft Teams video-conferencing platform.

2.32 To allow for the possibility of technical issues related to the online format, clear joining instructions for each meeting were provided in advance, and telephone support by East Sussex CCG and ORS staff was available for those participants less familiar or confident with video conferencing software to help to ensure that those who wished to take part were able to do so.

2.33 The online workshop format worked well, and had the advantage that, without the need to travel to physical venues, a range of stakeholders were able to commit to attending all three workshops of 3-4 hours each, thus providing opportunity for detailed and robust debate, and good continuity for the discussions.

The report

2.34 This report, rather than separating out feedback from each individual workshop, presents a thematic account of the feedback received and data collected through all three of the virtual events held in March 2021 and, where appropriate, refers to the pre-consultation engagement activities undertaken by East Sussex CCG. It first covers the outcomes from the deliberative discussions, before presenting and discussing the data collected from the ranking and scoring activities.

2.35 Verbatim quotations are used, in indented italics, not because we agree or disagree with them - but for their vividness in capturing recurrent or contrasting points of view. ORS does not endorse any opinions and statements made by individual participants but seeks only to portray them accurately and clearly.

3. Workshops findings

Qualitative feedback

3.1 The first (listening and engagement) workshop began with a comprehensive overview of ESHT's external and internal challenges, the national drivers for change and opportunities for improving services, which are summarised in the diagram below. Participants were asked whether they recognised these and whether they were reflected in their experience of the ophthalmology service.

There was widespread recognition of ESHT's challenges

3.2 There was a definite sense that the challenges and opportunities identified by the Trust mirror many of those expressed by patients, with particular recognition of the pressure on services in relation to waiting times for appointments and delays once at clinics - sometimes of several hours. This mirrors the findings from East Sussex CCG's pre-engagement, whereby participants reported spending significant time both wating for and at appointments.

> *"What is really encouraging, from a patient perspective, is that the problems that those delivering services have identified is a mirror image of the problems that the patients are identifying, which isn't always the case. People are talking about, 'Helpful and caring service **when accessed**; good explanation **once in the system**, although you have to travel to the EDGH which isn't easy…' People are conscious of very long waiting times, appointments being cancelled, a sense of a lack of continuity … There is a very good opportunity that [restructuring] will address exactly those sorts of problems."*
>
> *"There is a tremendous pressure... As a patient you will often sit for a couple of hours before being called in for your appointment…"*

3.3 For the Trust clinicians present, the challenges outlined are key drivers for fundamental service change that must go beyond simply treating more patients in the community – although this is certainly an opportunity that must be grasped in conjunction with changes to acute care.

> *"Some patients are followed up and they don't need to be seen in the hospital so we could discharge some of these to take them out of system and back into the community … it does make a difference, but it is a very limited way of dealing with the problems we have"*
>
> *"The space, resources, staff etc. is limited by the sites we work on, and being split onto three sites means we are spread thinly…"*

There was support for the clinical vision for ophthalmology and for ESHT's priorities and considerations.

That ophthalmology service in East Sussex will deliver:

A clinically excellent service

Reduction of avoidable sight loss and improved eye health

Increased ability to care for growing and ageing population

Increased support and development for workforce

Financial, clinical and environmental sustainability

3.4 There was general agreement in the listening and engagement workshop that the clinical vision for ophthalmology as above is appropriate, but that (with respect to 'increased support and development for the workforce') delivering high-quality services in the community will be challenging and complex. This issue is discussed further later in this chapter.

> *"…we need to think about optometrists. It's providing secondary care with enough support in the community and that is key…"*

3.5 Moreover, ESHT's priorities and considerations (as below) were also supported, including that ESHT's acute ophthalmology services should be high quality, accessible, and delivered in a timely and equitable manner for all patients, thereby serving the needs of the whole of the local population.

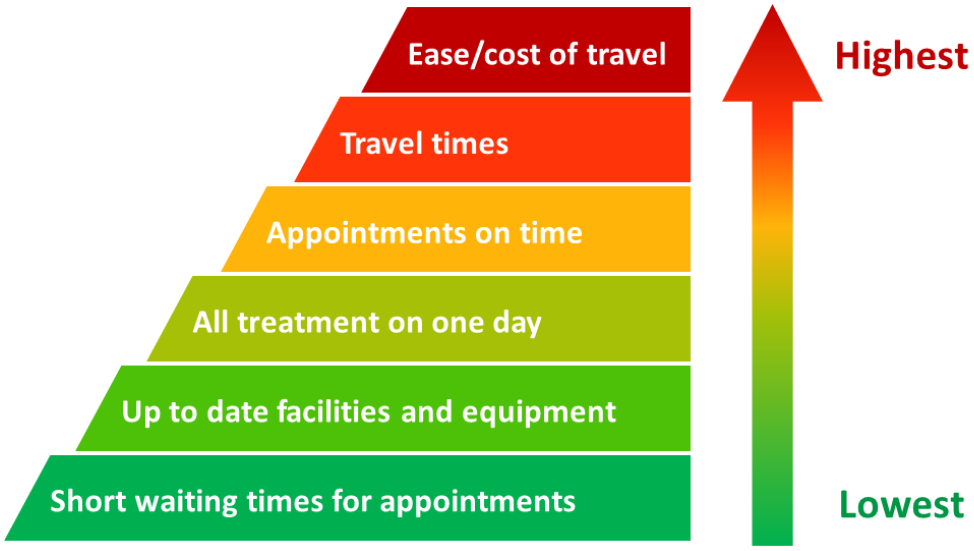
Quality:	Excellence; Safety; Timeliness; Equity; Equality
Clinical:	Best practice; Clinical outcomes; Staff support/development
Premises/Equipment:	Quality; Accessibility
Flexibility:	Responsiveness; Future-proofing
Staffing:	Expertise; Numbers; Recruitment; Retention
Value:	Viability; Sustainability; Value for money
Engagement:	Patient and public involvement; Co-development

3.6 It was, though, suggested that 'communication' should be added to 'engagement' to emphasise its importance.

> *"…one thing missing is communication, and this is on all sides…"*

Travel and access are the primary issues for patients

3.7 The pre-engagement undertaken by the East Sussex CCGs with 126 participants[2] across the county showed that when asked to rank six priorities around service provision, those relating to travel, transport and access (ease and cost of travel, travel times and timely appointments) were ranked highest[3].



3.8 Moreover, difficulties getting to and from appointments were described by pre-engagement participants, especially for those needing to rely on *"limited"* and *"unreliable"* public transport.

3.9 This was clearly reflected at all three workshops, where travel and access were of particular concern as both a driver and a priority for change. It was said that transport is already an issue for patients living further from hospital sites - some of whom are unable able to drive at all - while for others the tests/treatment they receive mean they cannot drive home.

> *"Travel is absolutely fundamental given sight problems"*

3.10 Furthermore, it was considered essential that the travel and (physical and psychological) access needs of particular groups be borne in mind in service redesign. Participants explicitly mentioned: those living in rural and/or deprived areas; people with protected characteristics; the elderly and those with mobility issues; children and young people; those who rely on public transport; and rough sleepers.

[2] Residents; patients; carers; family members; NHS staff; organisation representatives.

[3] Caution is required in the interpretation of these results as there were only six priorities to .choose from, the respondent group was a relatively small one, and it is impossible to tell the 'distance' between the ranked priorities (i.e. how important each was relative to the others).

"You have to think about the deprivation in the rural areas. And as people are getting older, losing their eyesight, they have to stop driving and they can't get to various sites for their appointments"

"As we heard about the areas of deprivation in Hastings, Eastbourne and more especially the rural areas of East Sussex, [travel] is very costly for people in these areas. With the ever-increasing age groups and people having to stop using their own transport, it makes it very awkward"

"Access for groups highlighted by the engagement work done so far e.g., those with disabilities, with learning disabilities, the LGBTQ community, the rough sleeper community"

"Equality and diversity issues i.e., adult autism individuals [are] not always treated how they would like, needing more user-friendly information. Access for disabled people making it difficult; also an issue for carers. LGBTQ community felt more training and awareness of their needs is needed. Parents of young children [saying] although there is an area for children it is sometimes taken up by adults waiting, which is particularly an issue for children with learning difficulties. Transport issues important for a lot of people, particularly elderly people"

"… communicating [change] will be important and looking at the problems people will have … If you change how people with mobility problems get to a service they regularly use for example, there is a fair bit of input needed into that. For example, people using public transport may need training and confidence building in getting somewhere new…"

3.11 This again echoes what East Sussex CCGs heard in the pre-engagement phase, particularly in relation to providing proper access to and communication with autistic patients and those with a learning disability.

3.12 Given the importance of these issues to patients, it was strongly suggested that any solutions and changes (and especially those that involve providing acute services across fewer sites) should include measures to address them – although it was recognised that these may not be in the gift of the Trust itself.

"Given that transport is a major issue for people with vision problems, for those who do have to travel is there a system for enabling people to go home? Is transport organised in some sort of system for patients?"

"If you are going to be delivering services from multiple sites in an area with poor public transport, you almost need [something like] an airport transportation service between terminals. It is a fundamental issue for people with sight issues"

"If models move to one or two sites we would have concerns about transport, especially for people living on the edge of the county. When looking at any model we need to look at how people access it…"

"The principle of doing more in the community and people being able to access services locally is excellent, the key to it will be enabling people to access the [acute] service when you make that change"

Travel and access issues are possibly amplified by clinical excellence

3.13 It should be noted that the ophthalmology patients involved in both the pre-engagement and the options development and appraisal workshops almost universally praised the clinical service they received as excellent. It was thus suggested that high satisfaction with quality of care *"brings other aspects further to the top",* as clinical excellence is 'taken for granted'.

> *"We don't have any evidence people are unhappy with the clinical care; they are unhappy about going to the eye clinics and being there for three or four hours because there are so many people there. When they get to the clinicians, they are happy ... Transport and access are key, because the general rule of thumb is that clinical care is excellent"*
>
> *"Last week … I phoned a few of my group's members and … they all said the service was excellent from beginning to end. The only problem was transport because sometimes they had to be at the hospital at 7am…"*
>
> *"The feedback we always have is that the clinical care people receive is second to none"*

3.14 Indeed, there was a definite sense that (in reference to the priority ranking exercise reported above) *"the order of priority … would be different for clinicians".*

An 'ideal' ophthalmology service has several facets

3.15 Although patients demonstrated a high level of trust in and satisfaction with the existing service, they did offer some further ideas as to what an 'ideal' ophthalmology service should look like in the listening and engagement workshop.

3.16 Patients agreed that good, respectful communication between themselves and healthcare staff is key to: 'reassure' them that they are still in the system (and the reasons for any delays); advise on the implications of any tests/treatment post-appointment; and ensure they are aware of the right community-based options. Moreover, communication between community/primary and secondary healthcare services was also considered essential.

> *"People want the communication. They want to have someone who talks to them and treats them with respect, intelligence so they feel cared for and respected"*
>
> *"Communications must mean joined-up communications all round between patients and clinicians"*

3.17 An ESHT clinician suggested that some of the remote communication measures implemented due to Covid-19 provide a possible way forward in improving and maintaining patient/clinician communication moving forward.

> *"In addition to triage exercise for our patients, we have introduced telephone review services. We have realised we can provide a positive process; instead of needing to see them for follow-up we have been able to speak to them over the phone. We intend to continue with this going forward"*

3.18 Other aspects of an 'ideal' ophthalmology service were that it: is accessible and considers travel/transport needs; harnesses new digital opportunities that reduce the need for face-to-face care (and, by association, reduce extensive travel for both patients and clinicians); is sustainable in the long-term; and considers equality and diversity impacts.

> *"Patients trust the service and expertise and care. They don't want to go over an obstacle course to get this service. So, it is finding this balance moving forward"*
>
> *"IT is going to have an impact. Is there anything on the horizon where an app could help opticians so people may need to travel less or at all?"*
>
> *"I think the staff in ophthalmology do a great job under difficult circumstances, but it does seem somehow we need to address the situation, so we don't have people shooting off all over the place. We need more of the IT there is, to explore new ways of utilising the team"*
>
> *"I'm concerned about the finance of the situation. Regarding the workforce are we saying the workforce is sufficient or insufficient? Do we require better equipment? Which all leads onto the situation of finance? If the finance isn't coming, we are spending many hours chatting about something that can't be done"*
>
> *"Those with cognitive issues/stroke/dementia; co-morbidities. Support to attend appointments and to make sure they aren't digitally excluded…"*

3.19 Finally, although not within the remit of the acute service primarily being considered as part of this engagement process, participants were keen to stress the importance of prevention end early intervention going forward to both improve population health and reduce service demand.

> *"Is there any way we can take a step back and look into prevention, so we didn't have to get to this"*
>
> *"At a population level, even if only 5% of cases are preventable, it makes a difference to the system. And collectively a number of behavioural changes can make a bigger difference"*
>
> *"Thinking about the 50% of impairment being preventable statistic - focusing on this group and picking them up before. We need to make sure pathways for children are right which should lead to cutting down number of people ending up with sight impairments"*
>
> *"Publicity in terms of telling patients to have a regular eye test would be helpful. Health visitors never tell new mums and dads to take children for an eye test before starting school[4] … There are many people who don't get eye tests – there is very little publicity"*

[4]Quote included verbatim; it should be noted, however, that East Sussex School Health Service offers vision screening to all Reception class school children to facilitate early identification of eye problems.

A future model of care - qualitative appraisal

3.20 Various potential models of care were discussed at workshops 2 (options development) and 3 (options appraisal). The qualitative views that emerged in discussion across both have been amalgamated in this section, which is followed by the results from workshop 3's options scoring exercise.

3.21 Discussions began on the basis of three possible approaches suggested by ESHT, which included maintaining the *status quo* (potential model 1) and two- and one-site models. Participants were also invited to suggest alternative approaches for consideration, of which two were forthcoming (possible models 4 and 5 below).

Potential model (option) 1: retain current services

- **Retain current service model**
- **Everything provided everywhere**
  - **All "Core" services provided at all three sites**

Service/treatments, e.g.:	Site 1	Site 2	Site 3
Outpatients	✓	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓	✓
Monitoring/review (in person*)	✓	✓	✓
Diagnostic testing	✓	✓	✓
Pre- / post-operative assessment	✓	✓	✓
Day surgery	✓	✓	✓
Inpatient surgery	✓	✓	✗
Non-elective (emergency)	✓	✓	✗

3.22 There was general agreement among patients/patient representatives and stakeholders that a 'do nothing' approach is unfeasible due to: current and future capacity; staff recruitment and retention difficulties; and the need to ensure sustainable services.

> *"I think staying still … is not an option because of supervision, senior opinion, staff recruitment and retention, and the ability to cross-cover etc."*
>
> *"…doing nothing can't be sustainable. The number of people needing outpatients is growing and will be unmanageable unless more units are built, which I can't see happening. Utilising community optometrists and hospitals is definitely the way forward"*
>
> *"From the patient perspective the current model is not sustainable. People are waiting months for appointments, there's no continuity. Demand is excessively burdensome and service deliverers can't do their jobs as well as they want…"*

"The clinical delivery when people get it is regarded as excellent. But if the clinicians are unable to deliver it because they can't hire and retain people or have the right equipment, then they have to be the priority…"

"Lack of clinical sustainability makes it impossible surely?"

3.23 When asked for their views in workshop 3, the ESHT clinicians present agreed – again citing:

- Recruitment and retention issues (and the need to offer attractive opportunities [including training and development] to current and potential staff).

"Recruitment and retention […] has been very difficult in more recent years … There is a national shortage of optometrists anyway and the south east has the least as there aren't any universities nearby that provide optometry degrees … and there's a big salary difference between working in a hospital and the community. So, for a long time we have been quite short staffed because of the issue of attracting optometrists to the area and retaining them. We need to make the department as forethinking as possible, and [make sure] that staff are well supported with consultant input and increased training and development…"

"Ophthalmology is a speciality where we do work hand-in-hand with other professionals and all of these clinicians help to deliver care to patients, not just medical staff. We are keen to continue to expand the service that other clinicians can deliver which gives patients more opportunities to access clinical care and gives those professionals the opportunities to upskill into other areas … We need the ability to offer more of these opportunities for staff which translates to members of staff wanting to work in hospital trusts. In order to do that we need the space and facilities to be able to accommodate those members of staff and provide training…"

- A lack of senior supervision due to consultants being 'spread too thinly' and having to travel between multiple sites – and physical space for clinics (an issue also raised during the pre-engagement).

"We have enough members of staff to deliver the service, but we have issues with consultant supervision when spread across multiple sites. In order for many clinics to run they need consultant supervision and if we are spread across three sites it is difficult for us to be present and spend the time required to supervise the clinics. We do have adequate workforce, what we lack is space for a) staff themselves to do clinics and see patients and b) to be able to utilise consultant staff most efficiently, so they don't have to travel around multiple different sites to provide supervision"

"The problem with trying to provide across three sites is that staff are spread so thinly, and the more senior staff have to be spread across the sites to make sure they are supervising more junior staff"

"It is less popular for staff to have to travel and swap sites at lunch time. We lose capacity, we lose the benefit of staff, it is an expensive option having to keep moving your workforce across three sites"

» The need for clinical sustainability.

> *"Another factor that has to be taken into account is that the demand for ophthalmology services has grown disproportionally because of the aging population, better treatments etc. That is going to continue. Even if we had the right number of consultants today, we won't in two- or three-years' time unless we do it differently. Ophthalmologists are like gold dust. Recruiting them is difficult for most trusts and we certainly feel that here in the south east"*

Potential model (option) 2: two hospital sites

- **Consolidate services to two sites**
- **All "core" services provided across two sites**

Service/treatments, e.g.:	Site 1	Site 2
Outpatients	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓
Monitoring/review (in person*)	✓	✓
Diagnostic testing	✓	✓
Pre- / post-operative assessment	✓	✓
Day surgery	✓	✓
Inpatient surgery	✓	✓
Non-elective (emergency)	✓	✓

3.24 In the options appraisal workshop, it was said that this option would:

» Begin to address 'bottlenecks' and lengthy waiting times for patients.

> *"The biggest bottleneck to all of the clinics is 1) the space where the patients can get processed through to the decision-maker and 2) the decision being made … We need to make sure the patient journey is as efficient as possible and not encumbered by this bottleneck" (Clinician)*
>
> *"Patients are concerned about waiting times, I imagine it is because you have a greater concentration of clinicians you will have faster throughput?"*

» Represent a compromise situation.

> *"If we go back a step, one thing coming out in previous weeks is ease of access for patients in terms of travel times. Having three sites is as ideal as you can get it, but it's not efficient. One site would make it really difficult; two sites seems a way in between so you get a bit of both. As a compromise that is acceptable, I guess"*

3.25 It was, though, questioned whether it would be able to cope with growing patient demand.

> *"Two sites could work but do they have capacity for expansion to accommodate the additional patients coming through?"*

Potential model (option) 3: one hospital site

- **Consolidate services to one site**
- **All "core" services provided from single location**

Service/treatments, e.g.:	Site 1
Outpatients	✓
Screening – Cataract, Maculopathy, Glaucoma	✓
Monitoring/review (in person*)	✓
Diagnostic testing	✓
Pre- / post-operative assessment	✓
Day surgery	✓
Inpatient surgery	✓
Non-elective (emergency)	✓

3.26 This option, to clinicians, represents an efficient use of scarce resources that would result in a timelier service and better outcomes for patients, and aid recruitment and retention through the centralisation of specialisms and specialists.

> *"One site would mean the most efficient use of our resources in terms of allocating staff to do clinics, theatres etc., the amount of kit we have and the ease of utilising staff around the Trust"*

"During the pandemic we have centralised our injection service and retinal service at Bexhill because we didn't have the facilities at Eastbourne … what we have found is that being single-sited has been a far more efficient use of resources. Patients are getting their appointments at much more timely intervals and are having better outcomes"

"Having a single site makes it more attractive when trying to recruit and retain staff because they are working among more specialists and specialities. It also helps with reputation when trying to attract staff from other parts of the country … some of the strongest ophthalmology and optometry departments are the teaching hospitals on single sites and they are usually the ones that are talked about as leading the way ... In terms of recruitment and retention having a single site would be more beneficial in attracting the best clinicians…"

3.27 Patients, though, again referred to travel and access concerns around travel time, distance and cost, and the ease of getting to appointments.

"After Covid, when we get back to patients having visitors it is going to mean a hell of a lot of cost for people just going down to one site"

"If you go down to a one site unit the biggest problem we have in East Sussex, is the transport infrastructure. It's very poor; the roads are very poor. Someone coming to, say, Eastbourne from Camber Sands; it will take a long time"

3.28 Indeed, there was recognition of patient access issues among clinicians also – as was a need to futureproof services to account for future demand increases.

"We are not tone deaf to access issues; we are aware this is a problem…"

"There is a trade-off, and we have to think about the availability of the service to the patients"

"From the patients' point of view they want as many sites as possible, but from the clinicians and certainly the consultant point of view they want less…"

"We have to be careful to futureproof it, so we have the base to expand going forward. Other trusts who are single-sited are looking to expand to other sites as they've outgrown their footprint"

Potential model (option) 4: one hospital site and community hospital clinics

- **Consolidate services to one site**
- **All "core" services provided from one location**
- **Expand outpatient-based services to clinics at community hospitals**

Service/treatments, e.g.:	Site 1	Community hospitals
Outpatients	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓
Monitoring/review (in person*)	✓	✓
Diagnostic testing	✓	✓
Pre- / post-operative assessment	✓	✓
Day surgery	✓	✗
Inpatient surgery	✓	✗
Non-elective (emergency)	✓	✗

3.29 Overall, there was widespread support among workshop participants - and indeed the optometrists responding to the pre-engagement survey - for an alternative model of care that incorporates more community-based provision, particularly in terms of offering local care and mitigating against patients' aforementioned travel and access concerns (and especially in the event of a single-site hospital model). Typical comments are below.

> *"I like the idea of the one hospital and then a combination of community hospitals, maybe with optometrists working there feeding into the main hospitals. Plus, the optometry practices of course. Everyone working alongside each other but feeding information into the main hospital hub"*
>
> *"If the service is restructured with a far greater community element then great and if this requires more concentration onto less sites then that's the cost of doing business if you like … excellent clinical delivery is what it has to be about. Yes, it has to be accessible, but the community dimension would change so much of that"*
>
> *"This is clearly a forerunner and is desirable in delivering care close to home. It supports recruitment and retention"*
>
> *"Model 4 … community hospitals supporting the one main hospital makes sense when the bulk is follow-up appointments"*
>
> *"The transport solution … lies mostly in restructuring the service to embrace more local delivery"*

"If the number of patients having to attend a hospital site were reduced due to increased community provision, travel solutions might be more achievable"

"If we did have one hospital it could work quite well if there was plenty of provision in the community because far less patients would have to attend the hospital"

"If we were to go to single site, we get issues of transport, travel ... The community service would buffer to an extent that to minimise travel. In terms of the post-cataract community service for example, it is excellent, and patients really like it"

"We are in a rural area so the geographic spread is quite wide but if we can move forward to the modernised centres, increase community provisions (for lower-risk patients), or we can make better use of IT facilities … and it is only patients at higher-risk that need more specialist appointments, maybe that is a price we have to pay. And … maybe we can't deliver it across three sites as we previously have done"

3.30 However, several participants sought clarification around exactly what enhanced community provision would involve; that is, would it be offered by NHS staff in local community hospitals and/or offered by 'high-street' optometrists.

"I am assuming community services could well be not just optometrists but smaller sites like community hospitals?"

"In terms of other options, I would need to know more about what is meant by community. Is it going to be mainly enhancing provision in optometry? In which case it's a question of, 'Is this realistic; will there be enough optometrists to do this?' Or, when you say doctors in the community is it that you could run a 'community clinic' from a site or sites? I'm unsure how or which professionals would be encompassed in this community role, and do we have the numbers to do this with demand increasing?"

3.31 While there was support for the latter, there were also some concerns, particularly in relation to the 'commercial' element of the service delivered by high-street providers and the different levels of expertise, and diagnoses/treatments, among community optometrists versus consultants.

"A patient may go to their GP with a problem with their eyes and then get referred to [a private optician or high street chain] which is commercialised … You go to them and they will often try and sell you something else, or create other services where they can recruit a form of finance…"

"I've been going to [a high street chain of opticians]. They diagnosed the cataracts in my right eye, but they never came up with glaucoma until I went to the clinic … Although the opticians are very good, I don't feel they are as good as the medics"

"I think that care closer to home is a good thing, but it is teamed with problems that you haven't got the right type of [clinicians] dealing with issues"

3.32 In the event that community provision is expanded in future (be it through community hospitals and/or commercial providers), other noted considerations were around:

- Capacity (some optometrists suggested that the capacity/appetite is there in the community whereas other stakeholders [a GP in particular] were less positive).

> *"There are over 50 optometry practices across East Sussex [and] some will have multiple consulting rooms. So, in terms of actual optometrists, a good couple of hundred. The capacity is there and the appetite to do this in the community is there and optometrists are keen to get involved"*
>
> *"I worry about capacity as it is a growing service. With ophthalmology, a large number of patients are not discharged and need ongoing care. We do have an MEC scheme for primary care patients to refer into directly, but we struggle to get a single referral accepted … because of lack of capacity. We keep being told there is enough capacity, but practically, on the ground, I don't feel we have enough provision"*

- The need for improved communication - and, crucially, IT provision - between community optometrists and acute hospitals (a point also raised during the pre-engagement).

> *"IT in the short term we need to fix … the communication link between the community optometrists and the hospitals needs to be better. It is the big challenge at the moment and if we can resolve that problem, it will fix a lot of problems"*
>
> *"It boils down to excellent IT links between community and the most senior opinion"*
>
> *"Without a robust IT infrastructure, this option can't work. If we can make it work you might be able to have clinicians being supervised remotely for instance, but we don't yet fully have this in place yet"*

- The need for equipment audits of community-based practices (encouragingly it was said that more specialist equipment is available now than pre-Covid).

> *"Having multiple sites, we will have to have multiple pieces of equipment. We need to discuss with optometrists what kit they have, what they can offer, what we can offer them…"*
>
> *"We need to ask our practices what equipment they actually have. More have special equipment now than they did a year ago"*
>
> *"Equipment is a big one. Optometrists are investing in equipment on a daily basis. The equipment is out there so why spend money again? Let's utilise what we've got"*
>
> *"… since Covid, more practices have invested in the type of equipment we would need so we're set up better"*
>
> *"In a lot of optometrist practises they have highly trained optical advisers. That is something in an optometrist practice that can cut down time. A lot of practices have all the right equipment at their fingertips to deliver this service…"*

» The need for a skills audit to determine what can be delivered in the community, coupled with long-term training plans to ensure the successful implementation of any changes.

> *"Looking at the model of one main hospital and multiple community hospitals, we need to look at what these will be. If it's community optometrists, it needs a lot of infrastructure change. It also requires a significant skills examination to determine what can be delivered in the community"*
>
> *"Do we have the people and skill mix to run this option?"*
>
> *"Training is a big thing; when these schemes are in place the opportunities for training will follow. We need to look forward; a five-to-ten-year plan and the training will come with that and the community will follow that"*
>
> *"Training and accrediting optometrists sounds a great idea but there will be a lead time before we're up and going. This needs to be factored in when thinking about a community model…"*

» Remuneration for optometrists, who would need to balance NHS provision and commercial interests.

> *"One thing is how we remunerate [the optometrists] … sometimes things haven't taken off as expected as they haven't been of financial benefit. But if we can make that work the workforce is there to do this"*
>
> *"The Vision is really good and on I'm on board, as are many optometrists. The problems we have had is getting enough optometry practices training up optometrists and making appointments available for these other services. Creating a situation where you have enough practices covering the area has been a problem for us. Optometrists are [part of NHS services] but they can only be run by having a private side too as they are in commercial shops; we have to pay our bills. Appointments are very precious […] and when setting up shared services there has been resistance [from opticians] to set up appointments that might be used for commercial practice. It is getting a balance and making it viable for these optometrists to hold these appointments"*

» Lead-in times in the context of needing to make urgent changes to acute services.

> *"My main concern is viability and the lead in time required for it. Even though I like this idea it is difficult to vote for it because of the lead in time…"*

3.33 ESHT clinicians also recognised these challenges but were of the view that with the right training and technology in place, community-based care can work successfully alongside acute care.

> *"…we need to make sure the optometrists are trained and skilled to provide this care. We do have this is Sussex; a lot of patients are being asked to see optometrists … and the majority of patients manage without any technical input. We have to keep working on this to improve it over time"*
>
> *"The community optometry services are always going to be an integral part of how care will be delivered. However, we have to assess what the IT infrastructure will be to support that and what skills the optometrists in the community can offer. I am confident that ultimately they will be a significant section going forward"*
>
> *"If we can make it less onerous for patients to travel to multiple sites that would help … the problem we have had is that consultants are unable to supervise all of the activity going on across the sites and make decisions [but] community optometrists wouldn't be out on their own; technology will make it easier to have a two-way conversation"*

3.34 Moreover, there was a sense among the primary-care clinicians and community optometrists present that the increased community-based delivery of services is already seeing positive outcomes via the Minor Eye Conditions Service (MECS) scheme.

> *"The MECS scheme has been very well received. A number of practices have joined up to it … the uptake has been very well received by patients and the hospital. It would be nice to see this developed…"*
>
> *"Overall, the MECS scheme has been highly successful. High satisfaction … there has been a lot more interaction between community and practice. Experience and training will improve things, and this is the way things are going to be [going] forward"*

3.35 Given the significant change this possible model of care represents, there was a strong sense that if it were to be introduced, East Sussex CCGs and ESHT would need to properly and carefully communicate its strengths and benefits – not least the prospect for care closer to home (which most respondents to East Sussex CCG's pre-engagement activity said they wanted), reduced travel and faster decision-making.

> *"We look after a lot of people who live very complex lives and change can be difficult, so moving out to community models we need to be sure the communication is good, so people understand where they're going. The idea of doing things in the community is a great idea in bringing things closer to people's homes … but those communications must be good"*
>
> *"I'm wondering the extent to which patients recognise community optometry as working hand-in-hand with hospital services … the link needs reinforcing publicly doesn't it?"*
>
> *"To what extent, in the deprived communities, do people know and believe that their local optician (as they see them) is a specialist service?"*
>
> *"It's highlighting the advantages of a new system … emphasising that there are a number of positives which will result in less travel and time for outpatients"*

"From a clinical perspective you need to have the most senior clinicians giving their opinion on what to do next. If the decision-maker is the most senior possible, it minimises and mitigates travel as patients will only have to come back once rather than three times for example. It's about working more efficiently. And if we're going down the community route and having appropriate cases dealt with by optometrists, while those not in their remit are seen in in secondary care, this will improve capacity"

3.36 Indeed, it was generally agreed that public awareness and acceptance will be the key to future success if this model of care is introduced.

"How do we get the message out? … There needs to be communication going out nationally and locally, and the question is how this information goes out to make awareness better that optometrists are the first point of contact"

"There's patient credibility and awareness. Communication is so important, so it will really have to be joined-up"

Potential model (option) 5: one hospital site and mobile clinics

- **Consolidate services to one site**
- **All "core" services provided from one location**
- **Expand OP based services to include mobile 'roving' clinics**

Service/treatments, e.g.:	Site 1	Mobile clinics
Outpatients	✓	✓
Screening – Cataract, Maculopathy, Glaucoma	✓	✓
Monitoring/review (in person*)	✓	✓
Diagnostic testing	✓	✓
Pre- / post-operative assessment	✓	✓
Day surgery	✓	✗
Inpatient surgery	✓	✗
Non-elective (emergency)	✓	✗

3.37 This option was suggested by patients at the options development workshop as a means of mitigating against some patients' travel and access difficulties.

"If you look at the one centre idea, it has some merit in that you can have all the specialists and equipment in one place, but people do have difficulty in travel and so it does give an indication that we need two or three hospitals involved … The other side of the equation is … the expansion into the community … would help people by being closer to home, maybe with clinicians having roving clinics?"

"With the glaucoma side of things, it could work very well if various things that are quite time-consuming are done in the community in one setting, but with an ophthalmology overview. So, a remote clinic"

"We have a couple of areas we could look into further. One is additional community expansion, perhaps with roving clinics etc. And the other is to push everything into one centre where all the specialists across the field are gathered together, plus the latest up-to-date equipment they need to move forward…"

3.38 However, no further comments were made at the options appraisal stage (workshop 3).

A staged approach?

3.39 There was some discussion in workshop 3 about the feasibility of a 'phased' or 'staged' approach to any changes – particular whether it would be possible to initially implement proposed model 2 (two hospital sites) with a view to ultimately proceeding to proposed model 4 (one hospital site with community hospital clinics) once community provisions and travel and transport mitigations are fully in place.

"From a clinical excellence point of view one site would be ideal. But the whole thing is predicated on what can be managed in the community versus hospital and how quickly the situation can be evolved. Maybe it's something that's going to happen more gradually than just a jump to one site … maybe it's two to start with and you take it from there"

"I can see it's quite attractive to have one main hospital and lots of community clinics, but I appreciate there will be a long lead in time to get it up and running. Would you go to two sites while the one site model is being developed?"

"It seems clear that we are looking at an evolutionary process. There is a very urgent short-term need to concentrate activity and make the whole thing more efficient, but then there may be a vision seven, eight years down the line when you see a much more evolved community model that supports a one site hospital model"

"At the moment the service is excellent, but we have to sort out the transport. When that is sorted out then we can move on to the next stage of trying to find the best sites"

3.40 Indeed, an ESHT clinician suggested that this may indeed be the case, and that any move to a two-site model may well not be a permanent one.

"The one hospital option became a possibility when the government decided to offer … money for the building of new hospitals. It wasn't within our reach before. If we did go down that route, we are talking six to eight years before the building is up and running and, in the meantime, we have a service that needs a radical restructuring to deliver a good service and meeting standards. The two-site change may or may not be a permanent thing" (clinician)

3.41 However, there was also recognition that this approach may not be possible in light of clinical sustainability and that urgent and possibly significant changes will likely be needed to secondary care quickly, followed by the refinement of the community model and accessibility improvements.

"Thinking about how time-critical it is that we make a decision as to whether we have one site, two sites, three sites … the biggest driver is the clinical need, taking away transport and access. If it is time-critical we need to make changes to help secondary care as we don't want the whole service to collapse, then the refinement of the model can come later. We've already identified issues around sustainability, developing community services etc. and all of that may take time…"

A future model of care - appraisal ranking and scoring

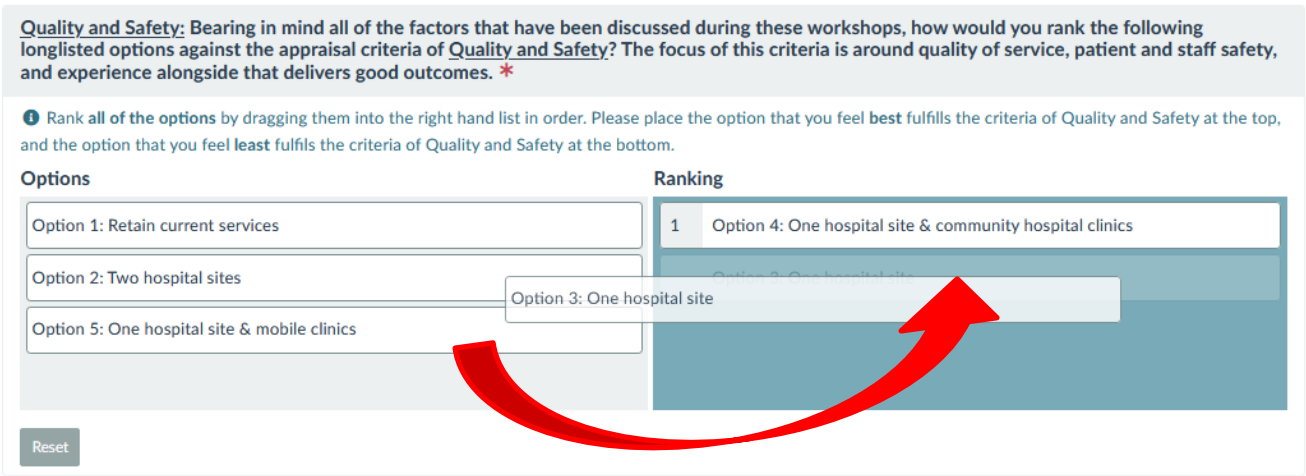
Model of care options ranked against appraisal criteria

3.42 In workshop 3, participants were asked to rank each of the five possible options for a future model of care against the following five 'appraisal criteria' (which were agreed at workshop 2).

- **Quality and Safety**: quality of service, patient and staff safety and experience and delivery of good outcomes;
- **Clinical Sustainability**: how the service will be delivered now and in years to come, keeping in view the recruitment and retention of staff groups;
- **Access and Choice**: current and future needs, access to the right service at the right place at the right time, ensuring everyone has access to the service of their choice;
- **Financial Sustainability**: making the best use of resources now and in years to come and how efficient the service is able to be; and
- **Deliverability**: how the approach/approaches can be delivered in the short, medium and long term, keeping in view the model of care and the environmental footprint.

3.43 This activity was undertaken by participants either during, or shortly after, workshops using a short online questionnaire (designed and hosted by ORS) as in Figure 2 below. Participation was limited to individuals who had taken part in Workshop 3 in order to ensure that everyone had heard the same information before undertaking the exercise.

Figure 2: Example of appraisal criteria ranking question as completed by workshop 3 participants



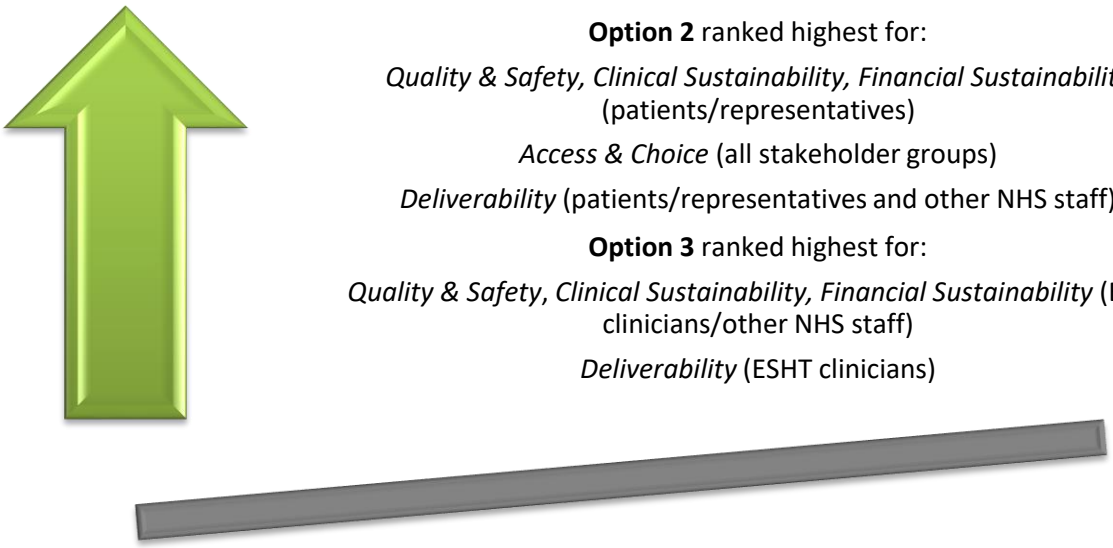
3.44 The results from the ranking exercise are summarised in the infographic below (Figure 3), followed by a more detailed breakdown of the results which are presented in graphical and tabular formats. As described in Chapter 2 above, the results are presented using the average (mean) ranks given by each stakeholder group.

3.45 Five patients and patient representatives took part in the ranking exercise, but one individual only chose one possible option (Option 4 - One hospital site with community hospital clinics) in each case rather than ranking all five options. As it is not possible to know what impact their ranking of other options might have had across all of the mean scores, they are not included in charts and tables but are reported in the accompanying text.

Summary of options ranking

3.46 The results show that Options 2 (two hospital sites) and 3 (one hospital site) were ranked highest against all criteria – albeit variably by the different stakeholder groups. Conversely, Options 1 (retain current services) and 5 (one hospital site and mobile clinics) tended to be ranked lowest – although Option 3 was thought to be poorest for Access & Choice by other NHS staff and patients/representatives.

Figure 3: Summary outcomes of ranking exercise for options for future acute ophthalmology service provision



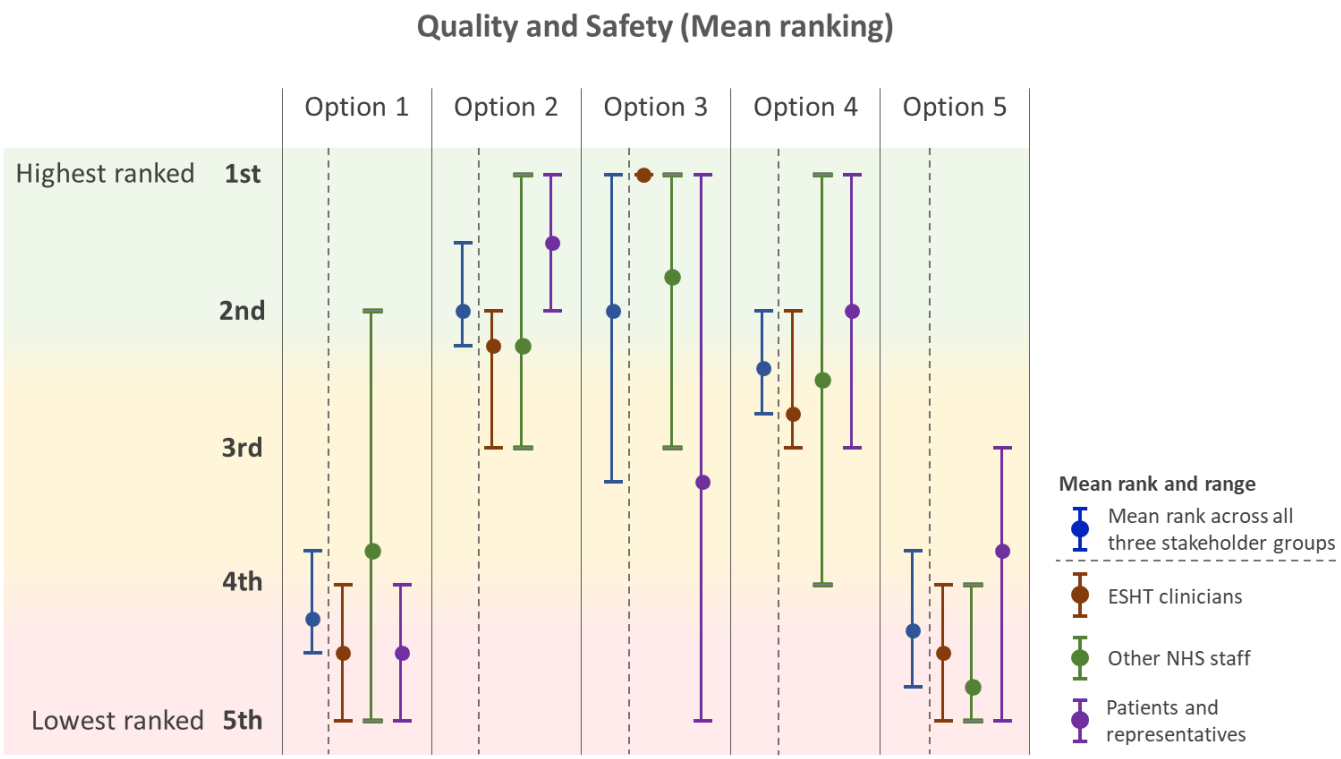
Quality and Safety rankings

3.47 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Quality and Safety*. As noted above, one individual only chose one possible option (Option 4 - One hospital site with community hospital clinics) rather than ranking all five options.

Table 3 - Mean rankings of each longlisted option against *Quality and Safety*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	QUALITY AND SAFETY - MEAN RANKINGS				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (12)	*4.3*	*2.0*	*2.0*	*2.4*	*4.3*
ESHT clinicians (4)	4.5	2.3	1.0	2.8	4.5
Other NHS staff and community optometrists (4)	3.8	2.3	1.8	2.5	4.8
Patients and representatives (4)	4.5	1.5	3.3	2.0	3.8

Figure 4: Mean rankings of each longlisted option against *Quality and Safety*



3.48 A single-site model of care (Option 3) ranked highest against Quality and Safety among ESHT clinicians and other NHS staff, but only third highest among patients and patient representatives who preferred a two-site model overall (Option 2). It should be noticed, however, that there was a wide-range of opinions among the latter group regarding Option 3, and a single-site model with some community hospital-based clinics (Option 4) was ranked second highest overall by patients and representatives. This may reasonably be seen as a reflection of the prioritisation of local access to acute services by many patients, and the view that enhanced community-based provision (which in discussions in workshops 1 and 2 included lengthy consideration of the role that community optometrists might play in supporting acute ophthalmology services in the future).

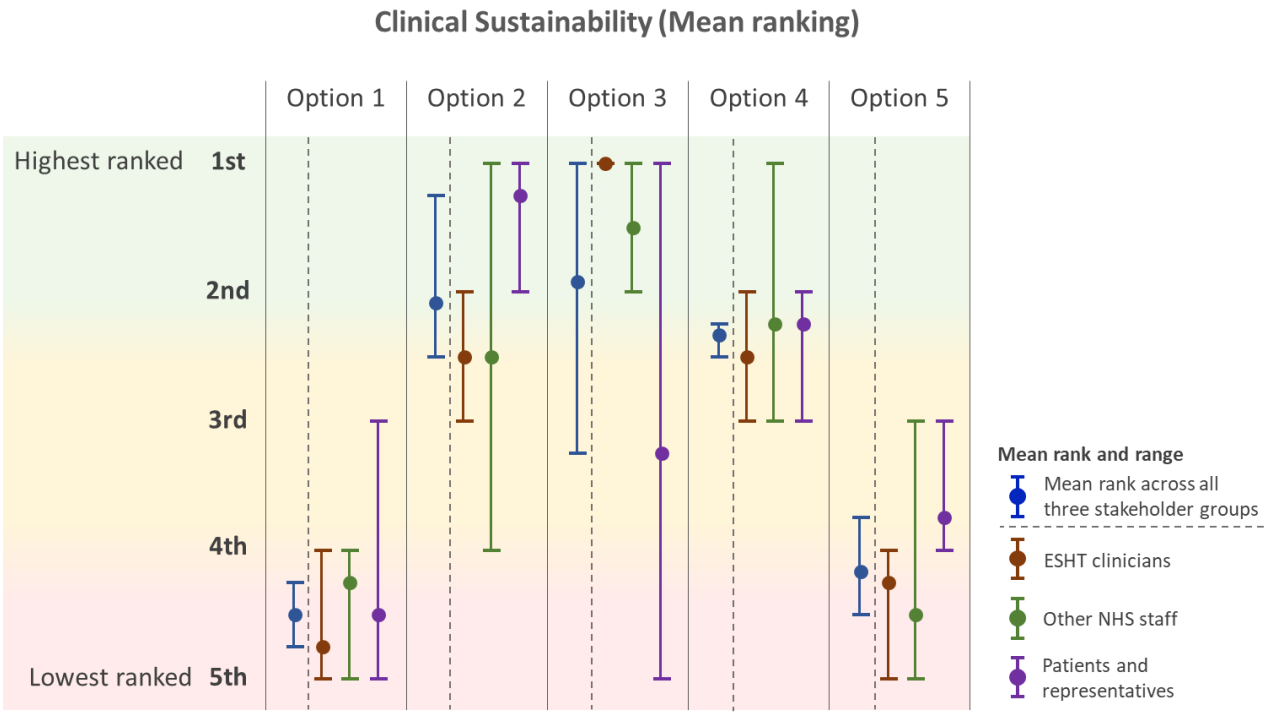
Clinical Sustainability rankings

3.49 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Clinical Sustainability*. As noted above, one individual only chose Option 4, rather than ranking all five options and this result is not included in the table and charts below.

Table 4 - Mean rankings of each longlisted option against *Clinical Sustainability*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	CLINICAL SUSTAINABILITY - MEAN RANKINGS				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (12)	*4.5*	*2.1*	*1.9*	*2.3*	*4.2*
ESHT clinicians (4)	4.8	2.5	1.0	2.5	4.3
Other NHS staff and community optometrists (4)	4.3	2.5	1.5	2.3	4.5
Patients and representatives (4)	4.5	1.3	3.3	2.3	3.8

Figure 5: Mean rankings of each longlisted option against *Clinical Sustainability*



3.50 As with Quality and Safety, a single-site model of care (Option 3) ranked highest against Clinical Sustainability among ESHT clinicians and other NHS staff, but only third highest among patients and patient representative who again preferred a two-site model overall (Option 2). Again, as was the case with Quality and Safety, there was a wide-range of opinions among patients and patient representatives regarding Option 3, and they again ranked a single-site model with some community hospital-based clinics (Option 4) second highest.

3.51 As was the case with Quality and Safety, Option 1 (retaining the current service model) and Option 5 (a single hospital with mobile clinics) were given low mean rankings by all stakeholder types.

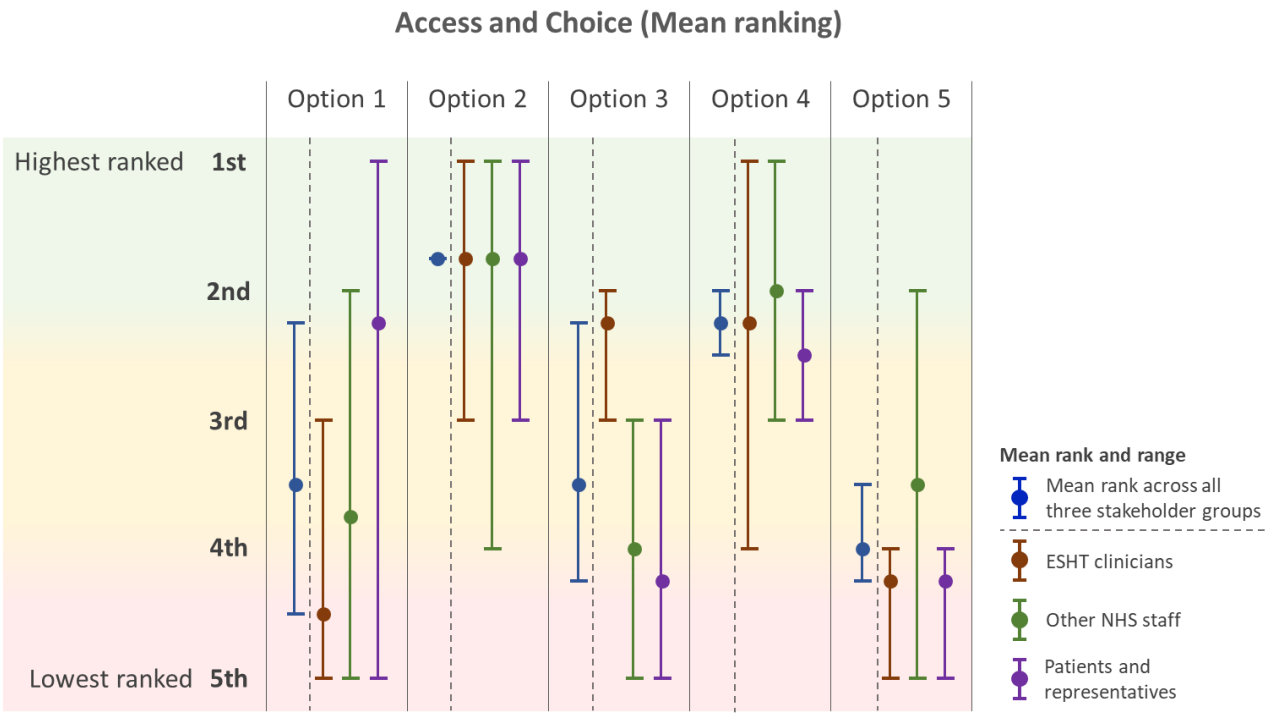
Access and Choice rankings

3.52 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Access and Choice*. As noted above, one individual only chose Option 4 (One hospital site with community hospital clinics) rather than ranking all five options and this result is not included in the table and charts below.

Table 5 - Mean rankings of each longlisted option against *Access and Choice*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	ACCESS AND CHOICE - MEAN RANKINGS				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (12)	*3.5*	*1.8*	*3.5*	*2.3*	*4.0*
ESHT clinicians (4)	4.5	1.8	2.3	2.3	4.3
Other NHS staff and community optometrists (4)	3.8	1.8	4.0	2.0	3.5
Patients and representatives (4)	2.3	1.8	4.3	2.5	4.3

Figure 6: Mean rankings of each longlisted option against *Access and Choice*



3.53 Against the criterion of Access and Choice, Option 2 was ranked highest by all stakeholder types. Option 3 was ranked lowest against Access and Choice by both patients and patient representative, and other NHS staff (which included community-based private optometrists). A model of care which combined a single hospital-site with some clinics at community hospitals (Option 4) was ranked second highest among ESHT clinicians and other NHS staff, whereas patients and representatives gave the current model of care (Option 1) the second highest mean ranking, albeit with a very wide range of scores between different individuals within that group.

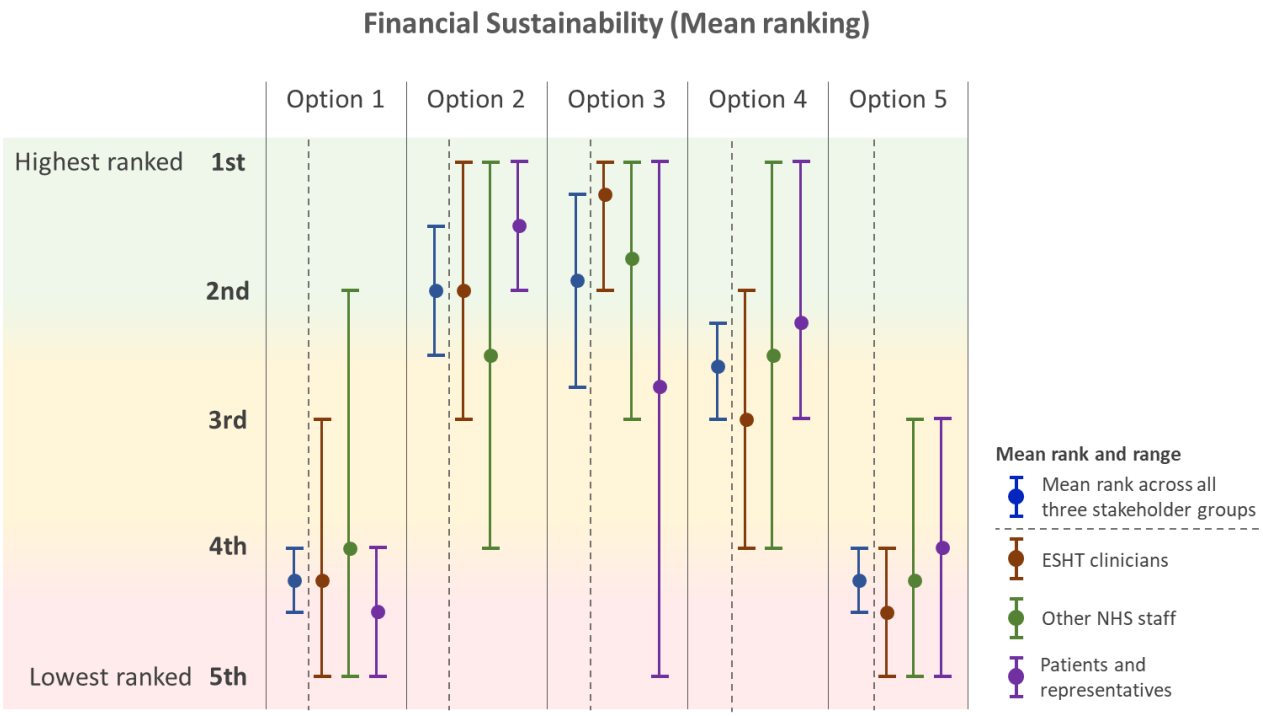
Financial Sustainability rankings

3.54 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Financial Sustainability*. It should again be noted that one individual chose only Option 4 (one hospital site with community hospital clinics) rather than ranking all five options and this result is not included in the table and charts below.

Table 6 - Mean rankings of each longlisted option against *Financial Sustainability*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	FINANCIAL SUSTAINABILITY - MEAN RANKINGS				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (12)	*4.3*	*2.0*	*1.9*	*2.6*	*4.3*
ESHT clinicians (4)	4.3	2.0	1.3	3.0	4.5
Other NHS staff and community optometrists (4)	4.0	2.5	1.8	2.5	4.3
Patients and representatives (4)	4.5	1.5	2.8	2.3	4.0

Figure 7: Mean rankings of each longlisted option against *Financial Sustainability*



3.55 Option 3 - a single hospital-site model of care - ranked highest against Financial Sustainability among ESHT clinicians and other NHS staff, but only third highest among patients and patient representatives who again ranked a two-site model highest overall (Option 2). It should be noticed, however, that there was again a wide-range of opinions among the latter group regarding Option 3, and a single-site model with some community hospital-based clinics (Option 4) was ranked second highest overall by patients and representatives. Options 1 and 5 were given poor rankings in terms of Financial Sustainability by all stakeholder types.

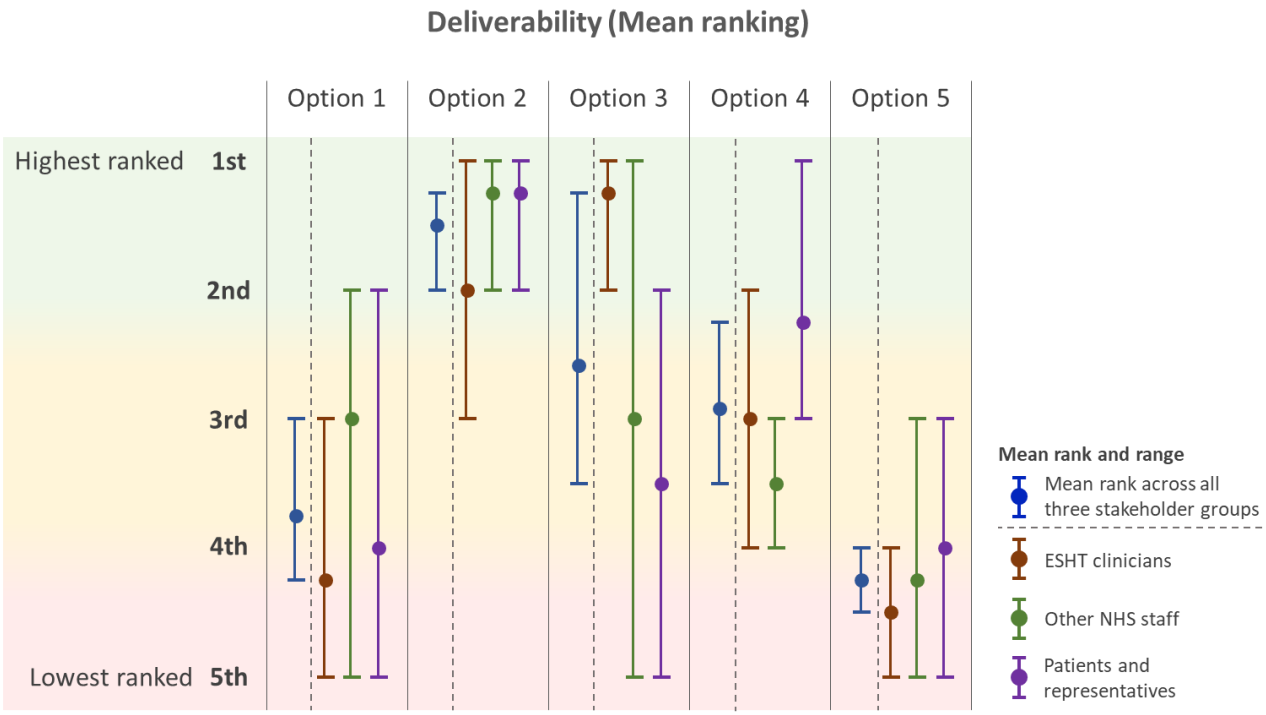
Deliverability rankings

3.56 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Deliverability*. It should again be noted that one individual only chose Option 4 rather than ranking all five options and this result is not included in the table and charts below.

Table 7 - Mean rankings of each longlisted option against *Deliverability*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	DELIVERABILITY - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Two hospital sites	**Option 3** One hospital site	**Option 4** One hospital site + community clinics	**Option 5** One hospital site + mobile clinics
All stakeholder groups (12)	*3.8*	*1.5*	*2.6*	*2.9*	*4.3*
ESHT clinicians (4)	4.3	2.0	1.3	3.0	4.5
Other NHS staff and community optometrists (4)	3.0	1.3	3.0	3.5	4.3
Patients and representatives (4)	4.0	1.3	3.5	2.3	4.0

Figure 8: Mean rankings of each longlisted option against *Deliverability*



3.57 A model of care in which acute ophthalmology services in East Sussex would be delivered from two hospital sites (Option 2) was ranked highest for Deliverability by patients and patient representatives and 'Other NHS staff' (comprising primary care clinicians and community optometrists). By contrast, ESHT clinicians ranked Option 2 second highest after the single-site model (Option 3).

3.58 Option 5 was ranked lowest by all stakeholder types (jointly with Option 1 in the case of patients and representatives. There was, considerable variability in opinions on Option 3 among other NHS staff and patients and representatives; as previously, the latter group ranked a single-site model with community hospital-based clinics (Option 4) higher than Option 3 and in second place overall.

Model of care options scored against appraisal criteria

3.59 In order to better understand the relative differences between the options, participants were also asked to score each of the five possible options for a future model of care against the five 'appraisal criteria' as in Figure 9 below. When interpreting the options appraisal scoring outcomes, unlike in the ranking exercise, participants were able to give the same scores to several or even all options, if they chose to.

Figure 9: Example of appraisal criteria scoring exercise as completed by workshop 3 participants

Section 5: Options appraisal scoring exercise - Models of Care

Option 1: Retaining current services - Bearing in mind all of the factors that have been discussed during these workshops, how well do you feel that Option 1 fulfils each of the appraisal criteria below? *

Select one response for each of the appraisal criteria below.

	1 - It fulfils this criteria very poorly	2 - Quite poorly	3 - Neither poorly nor well	4 - Quite well	5 - It fulfils this criteria very well	
Quality and Safety	◉	○	○	○	○	×
Clinical Sustainability	○	○	◉	○	○	×
Access and Choice	○	◉	○	○	○	×
Financial Sustainability	○	○	○	◉	○	×
Deliverability	○	○	○	○	◉	×

3.60 The scoring results were more mixed than those for the rankings: overall, Option 3 was scored highest by ESHT clinicians and other NHS staff, whereas patients and representatives variously scored Options 1, 2 and 4 highest against different criteria. Again, Options 1 and 5 scored lowest overall, but Option 3 was thought to be poorest for Access & Choice by other NHS staff and patients/representatives.

Figure 10: Summary outcomes of scoring exercise for options for future acute ophthalmology service provision

Option 1 scored highest for *Quality & Safety* and *Access & Choice* by patients/representatives (jointly with **Option 2** for Quality & Safety)

Option 2 scored highest for *Quality & Safety* (jointly with **Option 1**), *Clinical Sustainability* and *Deliverability* (jointly with **Option 4**) by patients/representatives

Option 3 scored highest for *all criteria except Access & Choice* by ESHT clinicians and other NHS staff (the latter scored **Option 2** joint highest for *Financial Sustainability*)

Option 4 scored highest for *Access & Choice* by ESHT clinicians and other NHS staff - and for *Financial Sustainability* and *Deliverability* (jointly with **Option 2**) by patients/representatives

Option 1 scored lowest for *all criteria* by ESHT clinicians – and *all except Access & Choice* by other NHS staff (who also ranked **Option 5** joint lowest for *Financial Sustainability*)

Option 3 scored lowest for *Access & Choice* by other NHS staff and patients/ representatives

Option 5 scored lowest for *all criteria except Access & Choice* by patients/ representatives

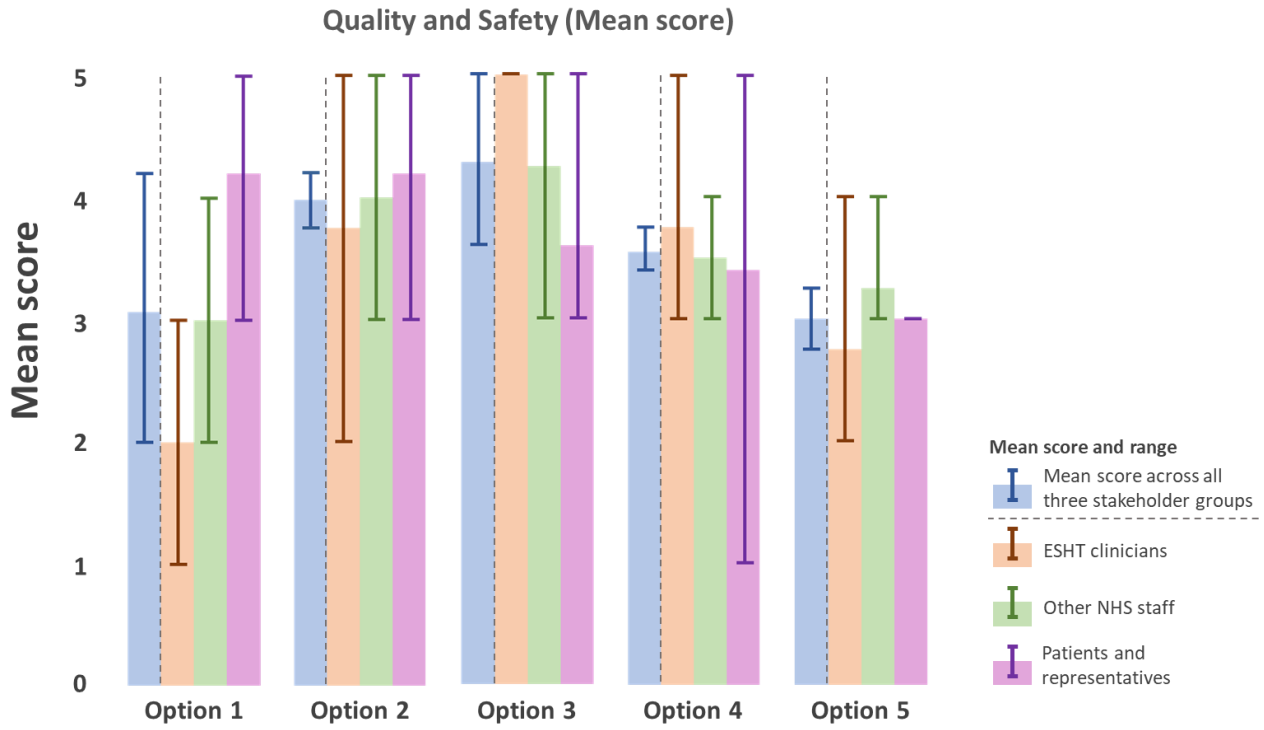
Quality and Safety scoring

3.61 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Quality and Safety*.

Table 8 - Mean scores for each longlisted option against *Quality and Safety*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	QUALITY AND SAFETY - MEAN RANKINGS				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (13)	*3.1*	*4.0*	*4.3*	*3.6*	*3.0*
ESHT clinicians (4)	2.0	3.8	5.0	3.8	2.8
Other NHS staff and community optometrists (4)	3.0	4.0	4.3	3.5	3.3
Patients and representatives (5)	4.2	4.2	3.6	3.4	3.0

Figure 11: Mean scores for each longlisted option against *Quality and Safety*



3.62 As in the ranking exercises, a single-site model of care (Option 3) scored highest against Quality and Safety among ESHT clinicians and other NHS staff, whereas patients and patient representatives scored a two-site model (Option 2) and the retention of currently services (Option 1) highest, with Option 3 scoring second highest.

3.63 In contrast to the views of patients and representatives on Option 1, ESHT clinicians and other NHS staff (the latter groups also including community optometrists) scored the retention of the current acute ophthalmology service model lowest of the five options in terms of Quality and Safety. Overall, patients and patients' representatives scored Option 5 lowest.

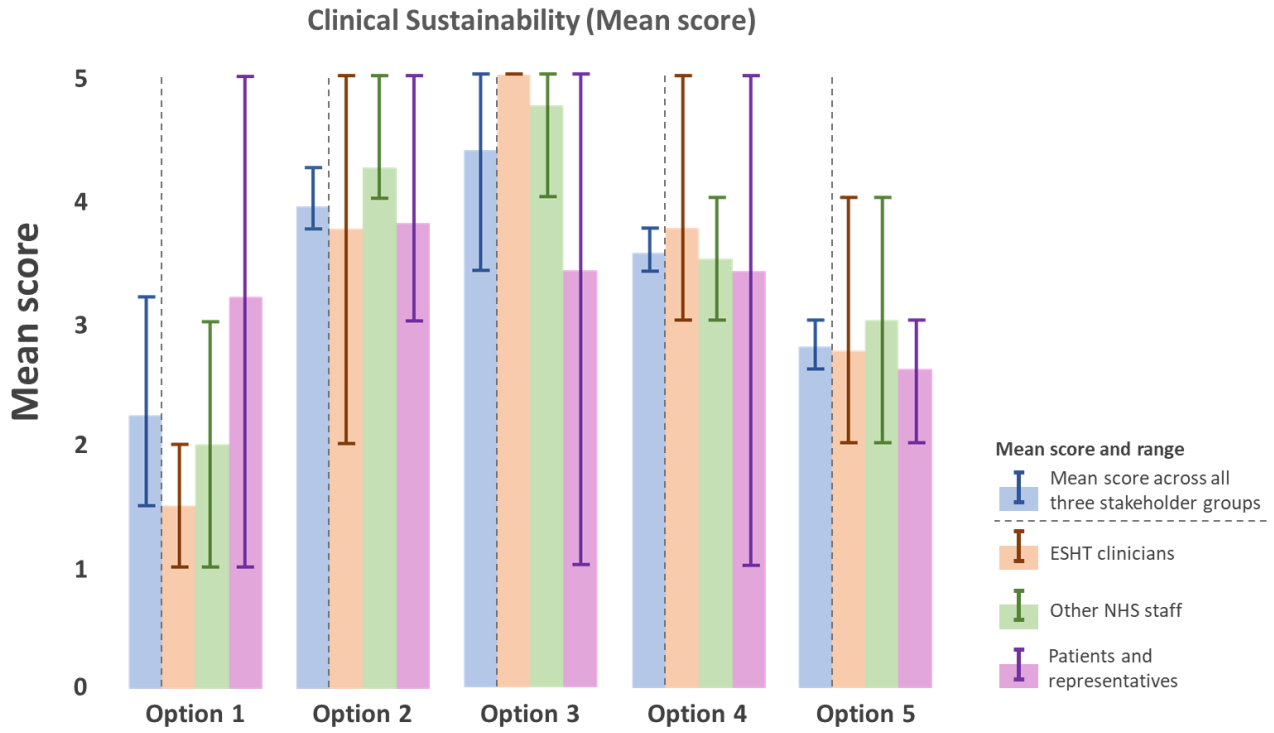
Clinical Sustainability rankings

3.64 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Clinical Sustainability*.

Table 9 - Mean scores for each longlisted option against *Clinical Sustainability*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	CLINICAL SUSTAINABILITY - MEAN SCORES				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (13)	*2.2*	*3.9*	*4.4*	*3.6*	*2.8*
ESHT clinicians (4)	1.5	3.8	5.0	3.8	2.8
Other NHS staff and community optometrists (4)	2.0	4.3	4.8	3.5	3.0
Patients and representatives (5)	3.2	3.8	3.4	3.4	2.6

Figure 12: Mean scores for each longlisted option against *Clinical Sustainability*



3.65 Scoring of the five longlisted options against Clinical Sustainability yielded similar results as for Quality and Safety, with ESHT clinicians scoring Option 3 highest and Option 2 second highest (jointly with Option 4 in the case of ESHT clinicians). Among patients and representatives, Option 2 (with acute services delivered at two hospital sites) scored highest overall, with Options 3 and 4 being scored joint second highest.

3.66 Option 1 received the lowest scores overall from ESHT clinicians and other NHS staff, while Option 5 scored lowest with patients and representatives.

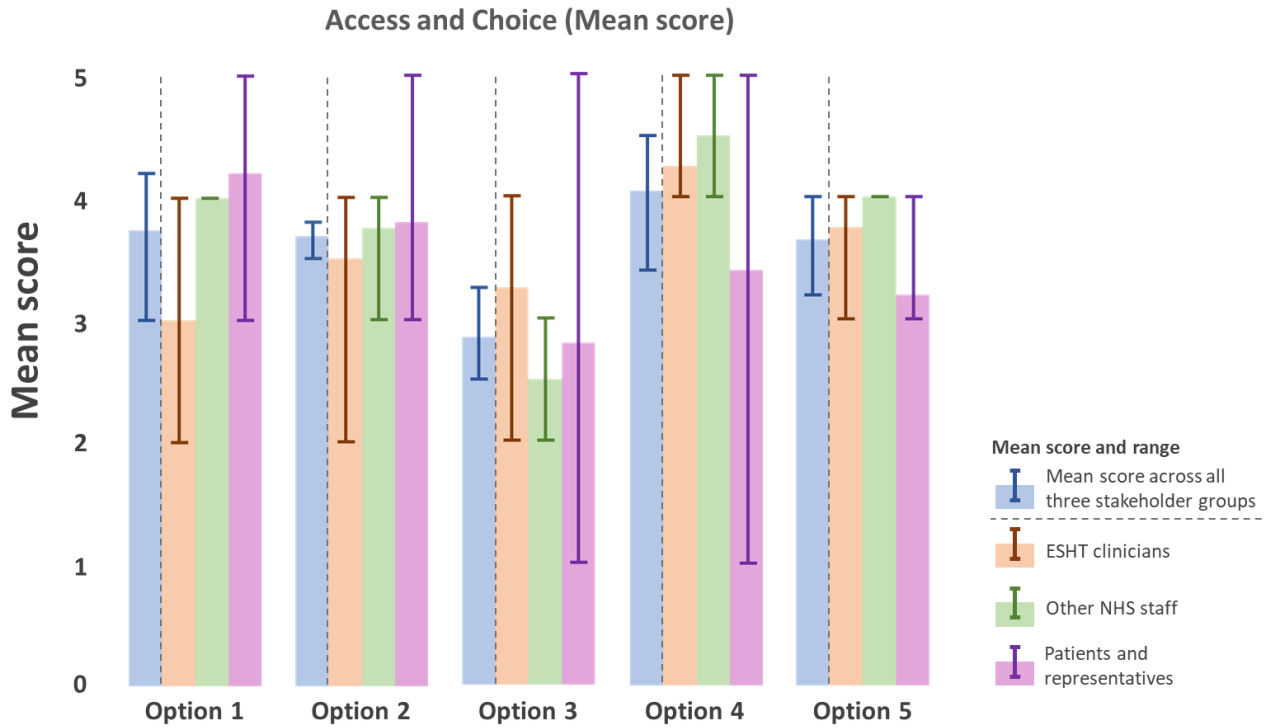
Access and Choice scoring

3.67 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Access and Choice*.

Table 10 - Mean scores for each longlisted option against *Access and Choice*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	ACCESS AND CHOICE - MEAN SCORES				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (13)	*3.7*	*3.7*	*2.9*	*4.1*	*3.7*
ESHT clinicians (4)	3.0	3.5	3.3	4.3	3.8
Other NHS staff and community optometrists (4)	4.0	3.8	2.5	4.5	4.0
Patients and representatives (5)	4.2	3.8	2.8	3.4	3.2

Figure 13: Mean scores for each longlisted option against *Access and Choice*



3.68 In contrast to the ranking exercise for Access and Choice, in which Option 2 was ranked highest by all stakeholder types, views were split among different stakeholder types when scoring each option individually. Option 1 received the lowest mean score from ESHT clinicians while other NHS staff and patients and their representatives scored Option 3 lowest.

3.69 The highest scoring option in regard to Access and Choice was Option 4 among ESHT clinicians, and other NHS staff and community optometrists. Patients and patients' representatives scored Option 1 highest overall against this criterion.

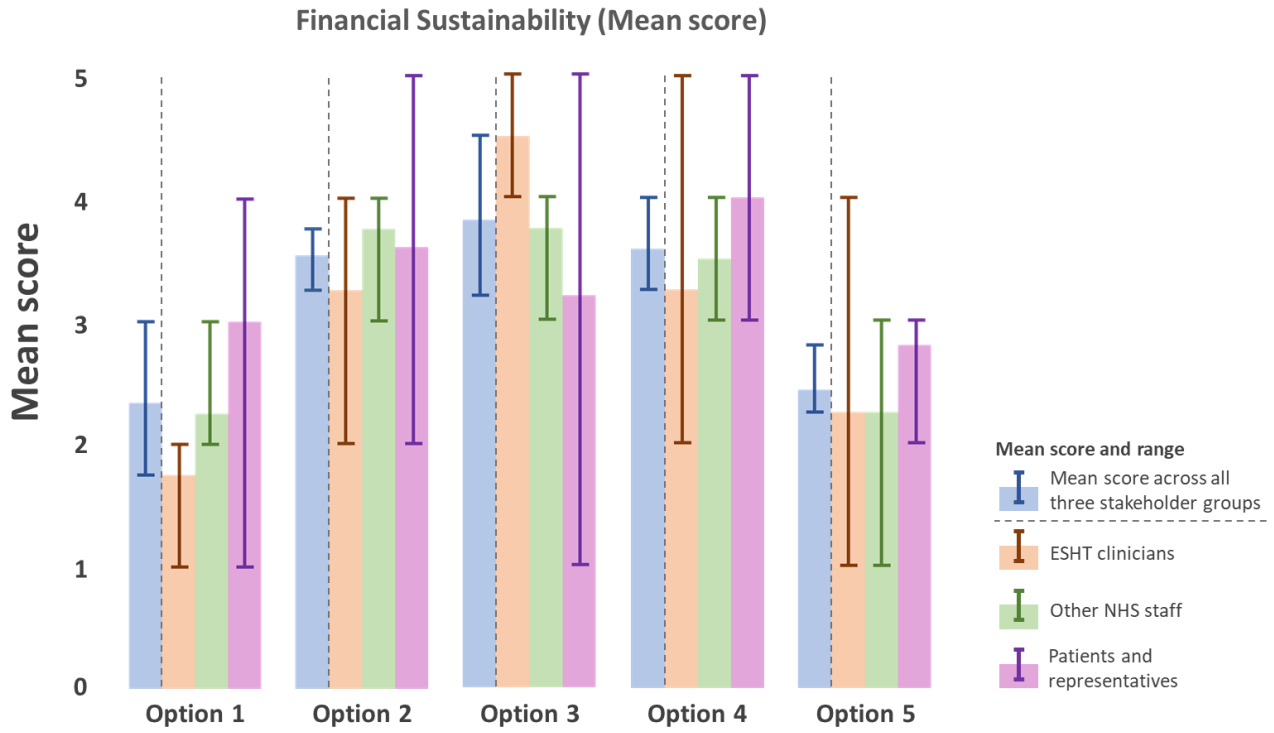
Financial Sustainability scoring

3.70 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Financial Sustainability*.

Table 11 Mean scores for each longlisted option against *Financial Sustainability*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	FINANCIAL SUSTAINABILITY - MEAN SCORES				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (13)	*2.3*	*3.5*	*3.8*	*3.6*	*2.4*
ESHT clinicians (4)	1.8	3.3	4.5	3.3	2.3
Other NHS staff and community optometrists (4)	2.3	3.8	3.8	3.5	2.3
Patients and representatives (5)	3.0	3.6	3.2	4.0	2.8

Figure 14: Mean scores for each longlisted option against *Financial Sustainability*



3.71 As with the ranking exercise against the Financial Sustainability , Option 3 received the highest mean score against Financial Sustainability from ESHT clinicians and joint highest (alongside Option 2) from other NHS staff and community optometrists. Patients and patient representatives scored Option 4 highest, followed by Option 2.

3.72 As was the case in many of the criteria, Options 1 and 5 again scored least well - the former with ESHT clinicians and the latter with the other stakeholder types.

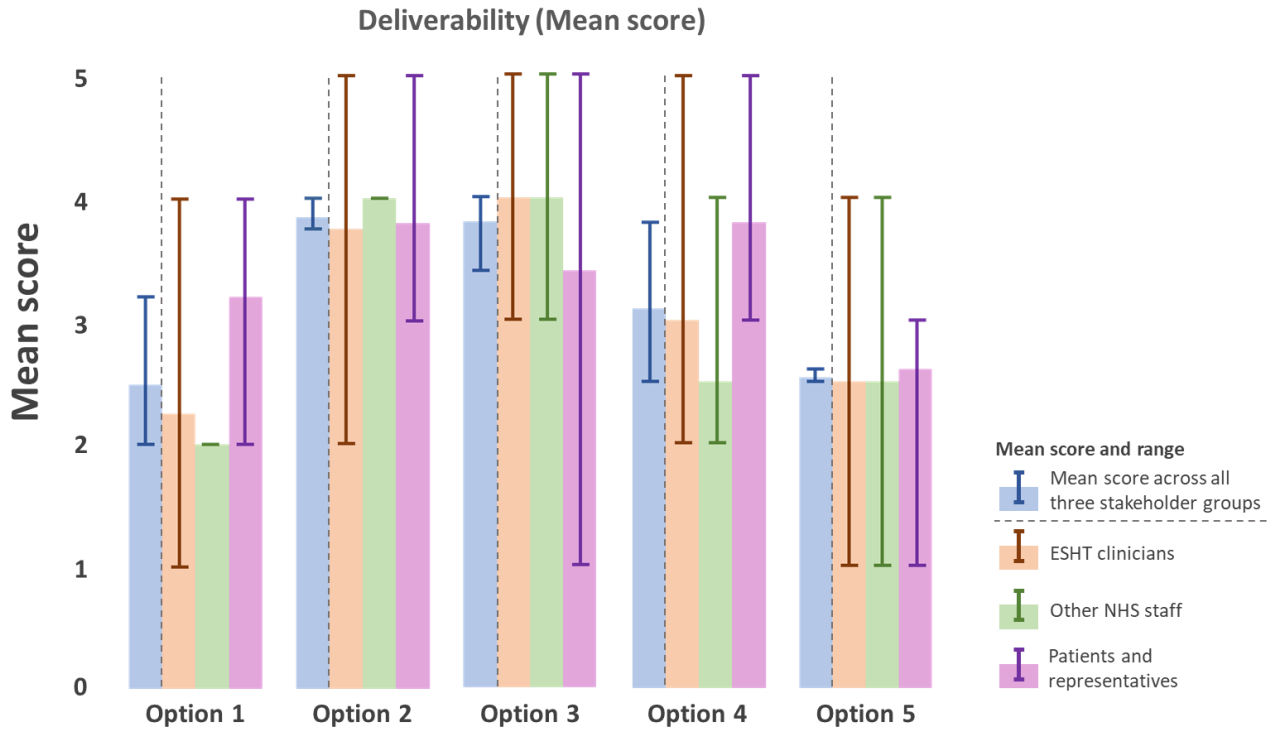
Deliverability scoring

3.73 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Deliverability*.

Table 12: Mean scores for each longlisted option against *Deliverability*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	DELIVERABILITY - MEAN SCORES				
	Option 1 Retain current services	Option 2 Two hospital sites	Option 3 One hospital site	Option 4 One hospital site + community clinics	Option 5 One hospital site + mobile clinics
All stakeholder groups (13)	*2.5*	*3.9*	*3.8*	*3.1*	*2.5*
ESHT clinicians (4)	2.3	3.8	4.0	3.0	2.5
Other NHS staff and community optometrists (4)	2.0	4.0	4.0	2.5	2.5
Patients and representatives (5)	3.2	3.8	3.4	3.8	2.6

Figure 15: Mean scores for each longlisted option against *Deliverability*



3.74 Against the final appraisal criteria of Deliverability, all three of Options 2, 3 and 4 were given the highest mean scores by at least one group of stakeholders; ESHT clinicians scored Option 3 highest overall, while other NHS staff and community optometrists scored both Options 2 and 3 highest. Patients and representatives gave the same mean score for Deliverability to Options 2 and 4, again favouring either a two-site model of care, or one in which ophthalmology services were delivered from a single acute hospital, with clinics held at community hospitals or clinics.

Options Appraisal: Locations under a two-site model of care (Option 2)

3.75 After ranking and scoring the five possible models of care, participants undertook the same exercises around possible hospital locations for acute ophthalmology services, if a two-site model (Option 2) were introduced.

3.76 Overall, the ranking and scoring exercises indicated a clear preference across all stakeholder groups for EDGH and Bexhill. This result echoed the qualitative feedback, which highlighted this combination's: flexibility and ease of implementation; better (although not perfect) access; and that it can serve both 'sides' of county.

> *"Eastbourne and Bexhill have greatest flexibility. With regard to parking Bexhill does not have much parking although parking on streets is free. At Conquest, patient parking is almost impossible. Parking is not great on any sites, but it is something we need to consider"*
>
> *"There are things we can do quickly … particularly at Bexhill. We can transform our services quite rapidly if we get the go ahead …. It will revolutionise some of the services we are running to make them much more efficient …"*
>
> *"We are fortunate to have day case units at Bexhill and Eastbourne … so Eastbourne and Bexhill would be the preferred models. We can also increase outpatients at Bexhill"*
>
> *"The advantage of Bexhill is that you can drop a patient at the door, and they can come in directly, and it's difficult to do that at the other acute sites"*
>
> *"Eastbourne on one site and Bexhill on the other site means both sides of the community are served"*

3.77 There were, though, some concerns around 'moving services west' and how that might lead to some patients in easternmost parts of East Sussex using services in other areas, as well as parking provision at Bexhill.

> *"The suggestion of two hospital sites being Bexhill and EDGH, it is moving the hospitals to the west, those in the east will go to other hospitals … like Ashford and Pembury"*
>
> *"The Bexhill site … is very awkward for access and parking especially for disabled patients like myself … the lack of on-site parking causes problems … having to cross the main road from Bexhill Old Town to the A271 and beyond to the A22"*
>
> *"This is something that both the facilities manager and the League of Friends are looking into; various schemes to support transport are being looked at"*

3.78 Bexhill and Conquest (Option 2b) was the least favoured and lowest ranked option across all stakeholder groups against all criteria, and lowest scored.

Two-site hospital location options ranked and scored against appraisal criteria

3.79 The results from the ranking and scoring exercises are summarised in the infographics below (Figure 16 and Figure 17), followed by a more detailed breakdown of the results which in tabular formats. As described in Chapter 2 above, the results are presented using the average (mean) ranks given by each stakeholder group.

3.80 As with the previous ranking exercise, one individual only chose one locations option (EDGH & Conquest) in each case rather than ranking all three locations options. As it is not possible to know what impact their ranking of other options might have had across all of the mean scores, they are not included in ranking table.

Figure 16: Summary of outcomes from appraisal ranking of two-site model hospital locations

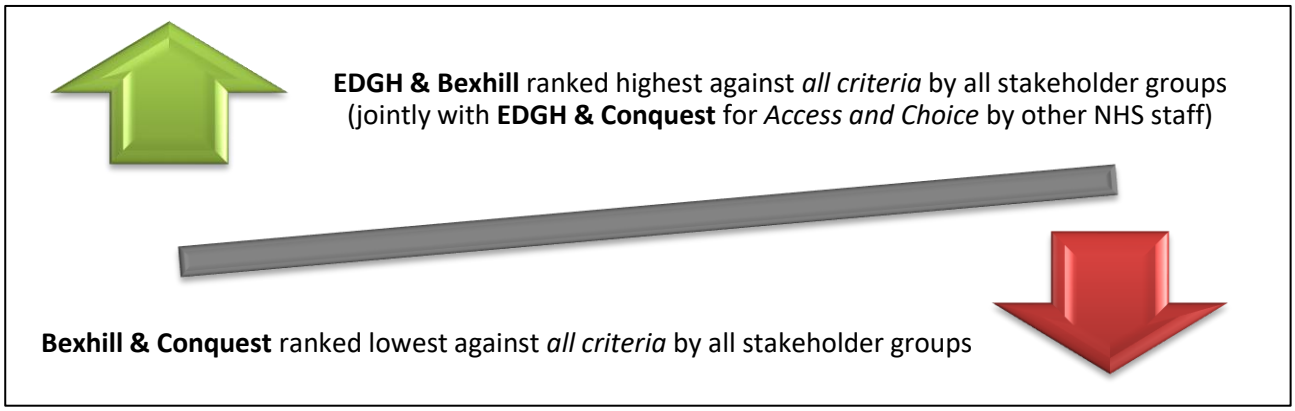


Table 13: Mean rankings against the appraisal criteria for each option for hospital locations in two-site model. The highest ranked options against each criterion are highlighted in green, and the lowest ranked options in red (Base numbers in brackets)

Criteria	Stakeholder type	EDGH and Conquest	Bexhill and Conquest	EDGH and Bexhill
Quality and Safety	*All stakeholder groups (12)*	*2.0*	*2.8*	*1.2*
	ESHT clinicians (4)	2.3	2.8	1.0
	Other NHS staff and community optometrists (4)	2.0	2.8	1.3
	Patients and representatives (4)	1.8	3.0	1.3
Clinical Sustainability	*All stakeholder groups (12)*	*2.1*	*2.8*	*1.2*
	ESHT clinicians (4)	2.3	2.8	1.0
	Other NHS staff and community optometrists (4)	2.3	2.5	1.3
	Patients and representatives (4)	1.8	3.0	1.3
Access and Choice	*All stakeholder groups (12)*	*1.8*	*2.9*	*1.3*
	ESHT clinicians (4)	2.0	2.8	1.3
	Other NHS staff and community optometrists (4)	1.5	3.0	1.5
	Patients and representatives (4)	1.8	3.0	1.3
Financial Sustainability	*All stakeholder groups (12)*	*2.0*	*2.8*	*1.2*
	ESHT clinicians (4)	2.3	2.8	1.0
	Other NHS staff and community optometrists (4)	2.0	2.8	1.3
	Patients and representatives (4)	1.8	3.0	1.3
Deliverability	*All stakeholder groups (12)*	*2.0*	*2.8*	*1.2*
	ESHT clinicians (4)	2.3	2.8	1.0
	Other NHS staff and community optometrists (4)	2.0	2.8	1.3
	Patients and representatives (4)	1.8	3.0	1.3

Figure 17: Summary of outcomes from appraisal scoring of two-site model hospital locations

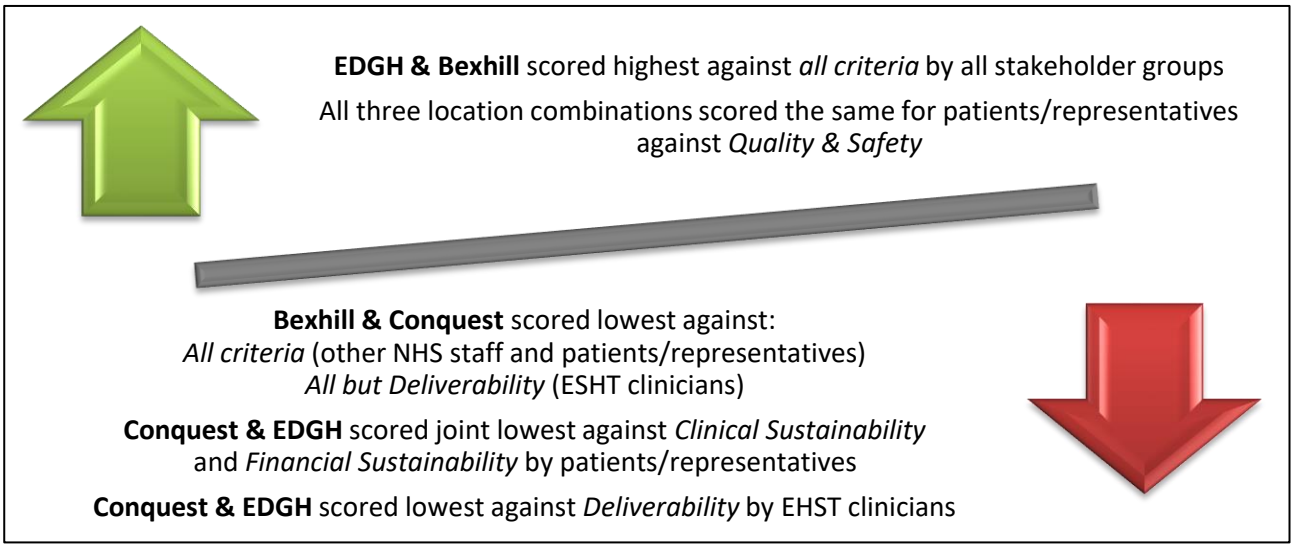


Table 14: Mean scores against the appraisal criteria for each option for hospital locations in two-site model. The highest scored options against each criterion are highlighted in green, and the lowest scored options in red (Base numbers in brackets)

Criteria	Stakeholder type	EDGH and Conquest	Bexhill and Conquest	EDGH and Bexhill
Quality and Safety	*All stakeholder groups (12)*	*3.1*	*2.9*	*4.0*
	ESHT clinicians (4)	2.5	2.3	4.3
	Other NHS staff and community optometrists (4)	3.5	3.0	4.3
	Patients and representatives (4)	3.4	3.4	3.4
Clinical Sustainability	*All stakeholder groups (12)*	*3.1*	*2.7*	*3.9*
	ESHT clinicians (4)	2.3	2.0	4.0
	Other NHS staff and community optometrists (4)	3.5	2.8	4.0
	Patients and representatives (4)	3.4	3.4	3.8
Access and Choice	*All stakeholder groups (12)*	*3.2*	*2.3*	*3.9*
	ESHT clinicians (4)	3.0	1.5	4.0
	Other NHS staff and community optometrists (4)	3.5	2.5	3.8
	Patients and representatives (4)	3.2	3.0	3.8
Financial Sustainability	*All stakeholder groups (12)*	*3.0*	*2.7*	*3.9*
	ESHT clinicians (4)	2.5	2.3	4.0
	Other NHS staff and community optometrists (4)	3.3	2.5	3.8
	Patients and representatives (4)	3.2	3.2	3.8
Deliverability	*All stakeholder groups (12)*	*2.8*	*2.7*	*4.0*
	ESHT clinicians (4)	1.8	2.0	4.3
	Other NHS staff and community optometrists (4)	3.3	2.8	4.0
	Patients and representatives (4)	3.4	3.2	3.6

Options Appraisal: Locations under a one-site model of care (Options 3-5)

3.81 Finally, participants were asked to use the same ranking and scoring exercises in relation to hospital locations for acute ophthalmology services, if a model with one acute hospital site (Options 3-5) were to be introduced. As with the previous ranking exercises, one individual chose only one location option (Bexhill) in each case rather than ranking all three and their results are therefore not included in ranking table.

3.82 The ranking and scoring exercises demonstrated clear support for Bexhill among ESHT clinicians, whereas opinion was more divided between Bexhill and EDGH for patients/representatives and other NHS staff. Conquest was ranked poorest against all criteria across the three stakeholder types, though in the scoring exercise EDGH was scored lowest for all criteria by patients/representatives (jointly with Conquest for Deliverability) and for Access & Choice by ESHT clinicians.

One-site hospital location options ranked and scored against appraisal criteria

Figure 18: Summary of outcomes from appraisal ranking of one-site model hospital locations

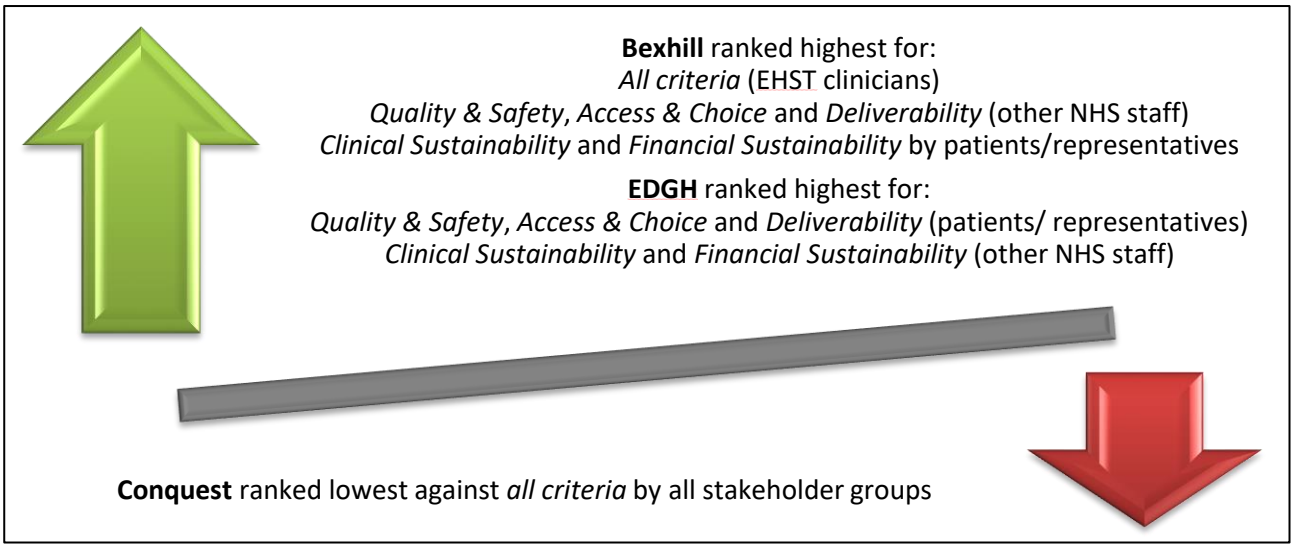


Figure 19: Summary of outcomes from appraisal scoring of one-site model hospital locations

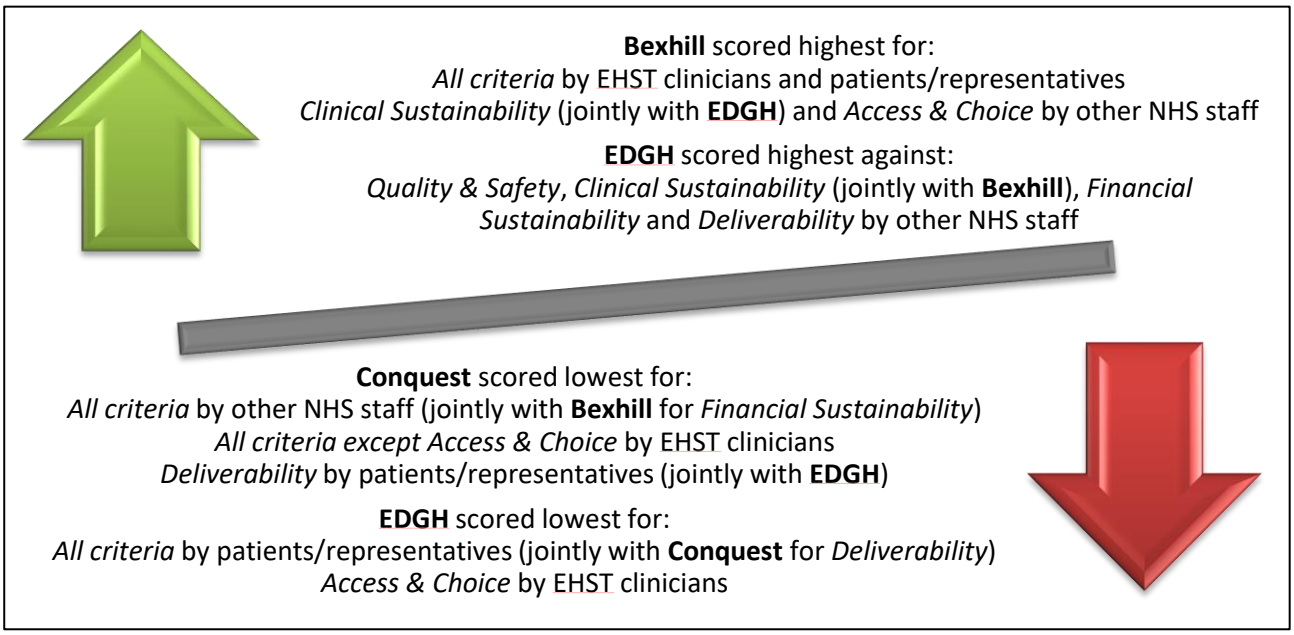


Table 15: Mean rankings against the appraisal criteria for each option for hospital locations in two-site model. The highest ranked options against each criterion are highlighted in green, and the lowest ranked options in red (Base numbers in brackets)

Criteria	Stakeholder type	EDGH	Conquest	Bexhill
Quality and Safety	*All stakeholder groups (12)*	*1.7*	*2.9*	*1.4*
	ESHT clinicians (4)	2.0	3.0	1.0
	Other NHS staff and community optometrists (4)	1.5	3.0	1.5
	Patients and representatives (4)	1.5	2.8	1.8
Clinical Sustainability	*All stakeholder groups (12)*	*1.8*	*2.8*	*1.4*
	ESHT clinicians (4)	2.0	3.0	1.0
	Other NHS staff and community optometrists (4)	1.5	2.8	1.8
	Patients and representatives (4)	1.8	2.8	1.5
Access and Choice	*All stakeholder groups (12)*	*1.8*	*2.9*	*1.3*
	ESHT clinicians (4)	2.0	3.0	1.0
	Other NHS staff and community optometrists (4)	1.8	3.0	1.3
	Patients and representatives (4)	1.5	2.8	1.8
Financial Sustainability	*All stakeholder groups (12)*	*1.8*	*2.8*	*1.4*
	ESHT clinicians (4)	2.0	3.0	1.0
	Other NHS staff and community optometrists (4)	1.5	2.8	1.8
	Patients and representatives (4)	1.8	2.8	1.5
Deliverability	All stakeholder groups (12)	1.8	2.8	1.4
	ESHT clinicians (4)	2.0	3.0	1.0
	Other NHS staff and community optometrists (4)	1.8	2.8	1.5
	Patients and representatives (4)	1.5	2.8	1.8

Table 16: Mean scores against the appraisal criteria for each option for hospital locations in a one-site model. The highest scored options against each criterion are highlighted in green, and the lowest scored options in red (Base numbers in brackets)

Criteria	Stakeholder type	EDGH	Conquest	Bexhill
Quality and Safety	*All stakeholder groups (13)*	*3.4*	*2.7*	*4.0*
	ESHT clinicians (4)	3.5	2.3	5.0
	Other NHS staff and community optometrists (4)	4.3	3.3	4.0
	Patients and representatives (5)	2.4	2.6	3.0
Clinical Sustainability	*All stakeholder groups (13)*	*3.5*	*2.9*	*4.1*
	ESHT clinicians (4)	3.8	3.0	5.0
	Other NHS staff and community optometrists (4)	4.0	3.0	4.0
	Patients and representatives (5)	2.6	2.8	3.2
Access and Choice	*All stakeholder groups (13)*	*2.1*	*2.2*	*3.0*
	ESHT clinicians (4)	2.0	2.3	4.0
	Other NHS staff and community optometrists (4)	2.3	2.0	2.5
	Patients and representatives (5)	2.0	2.4	2.6
Financial Sustainability	*All stakeholder groups (13)*	*3.2*	*2.9*	*3.6*
	ESHT clinicians (4)	3.8	3.0	4.8
	Other NHS staff and community optometrists (4)	3.5	3.0	3.0
	Patients and representatives (5)	2.4	2.6	3.0
Deliverability	*All stakeholder groups (13)*	*3.1*	*2.6*	*3.8*
	ESHT clinicians (4)	3.3	2.0	5.0
	Other NHS staff and community optometrists (4)	3.8	3.3	3.5
	Patients and representatives (5)	2.4	2.4	3.0

Appendix I - Table of figures

Appendix II - East Sussex CCG pre-consultation engagement report

Between 4th January 2021 to 14th February 2021, East Sussex CCG undertook a programme of pre-consultation engagement activities with local people and stakeholders to: communicate the need for transformation to ophthalmology services provided by ESHT; understand their experiences of current services; and gather feedback and ideas about how services might be delivered in the future. The report of the findings from this early engagement, prepared by the Patient Engagement and Involvement team, can be found below.

TRANSFORMING OPHTHALMOLOGY SERVICES IN EAST SUSSEX

PUBLIC ENGAGEMENT REPORT

Date:	8 APRIL 2021
Version:	2.2
Name of originator/ author:	Emma Baxter, Public Involvement Manager Antonia Bennett, Public and Patient Involvement Lead

Contents

1.0 Executive Summary

We are developing proposals for how acute ophthalmology services, provided by East Sussex Healthcare NHS Trust (ESHT), can best provide high quality treatment, care and support for local people and meet increasing local population need. Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England have duties to consult the public when a significant service change is likely to take place. This report provides insight from local people into the patient journey and experiences of accessing ophthalmology services gathered in January and February 2021, in order to inform service change and potential public consultation.

To reach the local population in East Sussex, the NHS East Sussex Clinical Commissioning Group (CCG) co-developed a questionnaire with partners and members of the public, which was promoted widely in paper copies and electronically. The CCG undertook interviews with current and former patients of the services and joined virtual local forums and groups to hear from people about their experiences.

The key themes from this engagement include:

- communication both before and during appointments;
- communication between health care settings;
- the need for faster diagnosis
- requirements for patients' additional needs to be met.

This insight has informed the development and appraisal of options for the future of ophthalmology services.

2.0 Background

The East Sussex Health and Social Care Plan sets out how partners will align local priorities with the Sussex Health and Care Partnership's "Vision 2025". This includes:

- a comprehensive approach to prevention;
- reducing health inequalities;
- supporting our workforce to develop and grow;
- developing a new model of care that will be sustainable for generations to come.

ESHT provides acute and community care in East Sussex, at Eastbourne District General Hospital (EDGH) and at the Conquest Hospital, Hastings, at two community hospitals in Bexhill and Rye, in community clinics across East Sussex and in people's own homes. Acute ophthalmology services for adults, children and young people in East Sussex are provided at EDGH, the Conquest Hospital and Bexhill Hospital.

The Sussex Health and Care Partnership's "Vision 2025" focuses on proactively managing population health, better anticipating care needs and integrated working across health and social care to enable the delivery of the best possible outcomes for local people. This, alongside advances in medicine and innovation/technology, will ensure the best use of collective public resources in East Sussex. Reviewing and redesigning ophthalmology services within this context will help ensure the right services are available in a way that is sustainable for the future and in response to the needs of the local population.

The vision for the future of ophthalmology services in Sussex is to provide a high-quality service for patients, carers and their families regardless of age, disability, gender or ethnicity. This includes:

- providing a clinically excellent ophthalmology service that prevents avoidable sight loss and improves the eye health of all patients;
- increasing the ability to look after a growing and ageing population;
- providing increased support and development for the ophthalmology workforce;
- developing a service that is clinically, environmentally and financially sustainable now and in the future.

3.0 Public Engagement

To consider how the service should be transformed the CCG undertook public engagement which commenced on 4th January 2021 and lasted six weeks (concluding on 14th February 2021). This engagement was informed by an Equality and Health Inequality Impact Assessment, which highlighted the need to reach particular groups and communities. During this time the CCG's Public Involvement team engaged with local people and stakeholders to:

- communicate about the need for transformation of acute ophthalmology services at ESHT;
- understand their experiences of the ophthalmology services for children and adults at EDGH, the Conquest Hospital in Hastings and Bexhill Hospital;
- gather their feedback and ideas about how the service could be provided in the future.

The insight gathered from this work will be used to inform options development, appraisal and planning for any formal consultation.

A questionnaire to understand people's experiences of ophthalmology services was co-designed with partners and members of the public and published on the Sussex Health and Care Partnership's Engagement HQ (online engagement) platform. The survey was promoted through a multitude of pre-established distribution lists and newsletters including:

- 3VA weekly bulletin (Eastbourne residents)
- HVA weekly bulletin (Hastings residents)
- East Sussex Local Voices (over 2000 recipients)
- East Sussex Health and Care Newsletter (over 4000 recipients throughout East Sussex)
- Over 60 churches in East Sussex and a mailing list of 800 stakeholders.

It was also sent out widely to local voluntary, community and social enterprise (VCSE) sector organisations, including Healthwatch, with the request to support promotion. Paper copies of the survey were sent out to organisations including the Rough Sleepers Initiative (homeless and rough sleepers) and foodbanks (to reach those living in deprivation) as well as to individuals requesting copies. A freepost address for returning the questionnaires was included.

Posters were distributed to display in hospital waiting rooms to encourage people to complete the questionnaire or to get in touch to arrange a telephone interview. Social media coverage was used to promote the surveys, utilising the CCG pages and accounts and posting on local community Facebook pages.

The Public Involvement team attended a range of virtual forums and groups to promote the programme and inform people of the ways to get involved including:

- Patient Participation Groups (PPGs) Steering Group and three local forums
- East Sussex Seniors Association (ESSA)
- Eastbourne Cultural Inclusion Group (ECIG)
- East Sussex Communications and Engagement Steering Group (CESG)

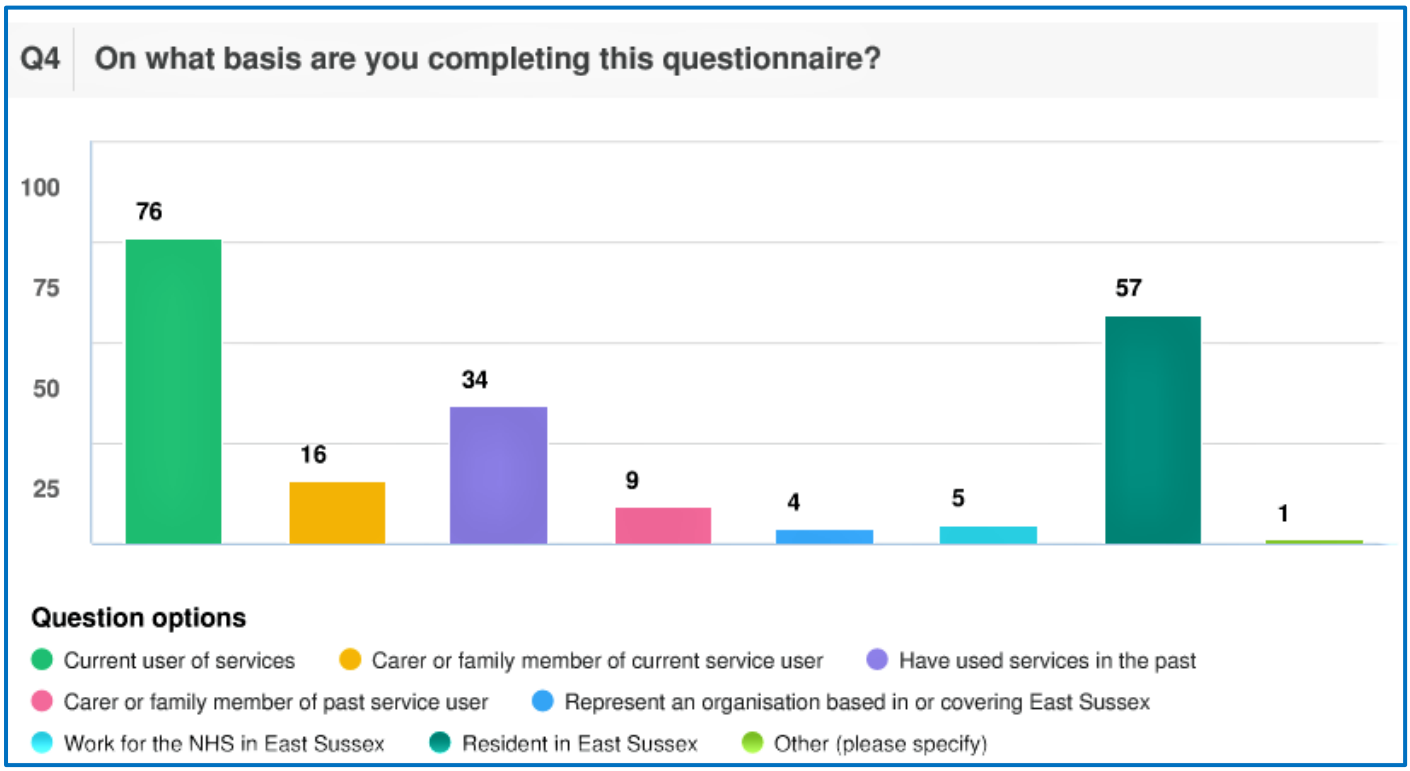
To support accessibility, local linguists in East Sussex were asked to work with people for whom English was an additional language to complete the questionnaires and the CCG received a total of eight completed questionnaires with a variety of languages represented including:

- Filipino
- Kurdish
- Portuguese
- Cantonese
- Mandarin
- British Sign Language

The survey was also produced in Easy Read and community languages were available on request.

The insight gathered will be fed into options development workshops where key stakeholders will be invited to come together to co-design feasible options. These will be followed by a further options appraisal workshop to inform a final set of proposals.

4.0 Results of public engagement

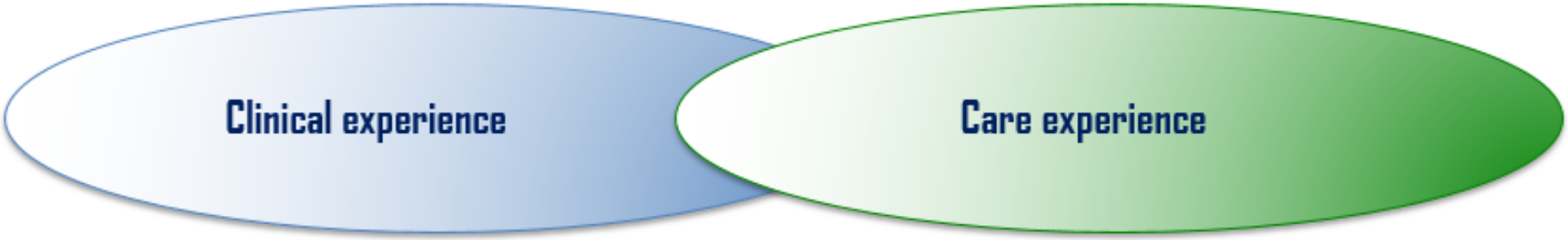


(Please note participants could choose more than one option)

In total there were 126 responses including 19 in-depth interviews.

The following pages illustrate some of the significant themes that emerged from the submissions: these have been split into care and clinical themes.

Ophthalmology Service Delivery: the Patient Perspective



Rapid diagnosis (reassurance)

Regular predictable appointments

Manageable access/travel

Joined-up communications: hospital-GP-patient

Personal relationship with consultant

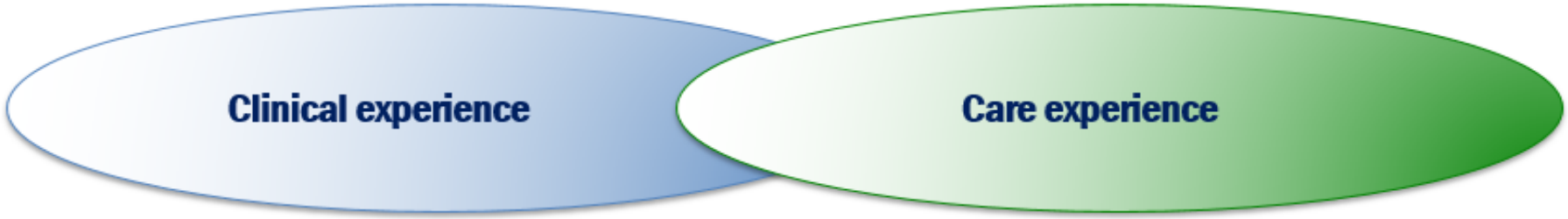
Time taken to listen, explain

Treated with care, respect and warmth

Individual adaptions

Ideal service delivery is accessible

Ophthalmology Service Delivery: the Patient Perspective
Majority : Very Positive



Rapid diagnosis (reassurance)
"Two appointments at Bexhill Hospital. I was seen straight away. Everyone was very kind and explained what they were going to do. I had my scan and then saw the consultant. All done very well and clearly explained"
"Macular service is great, email referral system with feedback on how patient is to be managed".

Regular predictable appointments
"After delays and appointments getting cancelled for 11 months I eventually got seen and treated within four weeks of the appointment".

Manageable access/travel
"Providing transport was most welcome so as not to impose long waits for friends or family" .

Personal relationship with consultant
"Both these operations went really well. I found Mr Hickman Casey approachable, easy to understand and I trusted him"
"Staff were very attentive, kind and professional. Mr Hickman-Casey and Mr Tham made sure we understood exactly the problem, the treatment and what to expect."

Time taken to listen, explain
"Helpful and caring services when accessed. Good explanation and care once in the system although have had to travel to DGH which isn't easy if you can't see !"

Treated with care, respect and warmth
"Whilst working under the most difficult circumstances, I have been treated with care and a high degree of professionalism".

Individual adaptions
"I walk with a stick and when I have to attend they always help me if I need to go to different places in the hospital. They help me sit down as I sometimes miss the chair."

Ophthalmology Service Delivery: the Patient Perspective
Significant Obstacles

Rapid diagnosis (reassurance)
"Getting help quickly […] has been difficult. A&E often don't have access to opthalmology. Once I was redirected from Hastings to Eastbourne then told the eye doctor had left".
"The consultant confirmed I had AMD but I couldn't have NHS treatment until it was more severe, I would have to go private".

Regular predictable appointments
"Generally good as a referring practitioner. Communication about follow-ups to patients seems poor and glaucoma patients have their appointments continually changed or delayed or missed altogether"

Manageable access/travel
"I live in Seaford and it takes an hour to get to Bexhill and transport can be difficult. I have back and heart problems and breathing difficulties so public transport is out of the question."

Joined up communications: clinician-GP-patient
"Sent by GP to A&E, found nothing so sent away. Not advised they were referring to ophthalmology until call received asking to attend next day".

Personal relationship with consultant
"Every appointment appears not to be related to previous ones. There is little or no continuity between appointments. Appointment letters are too vague as to what is going to happen and should be more specific as to what is scheduled."

Time taken to listen, explain
"The young specialist gave my partner too much information, quickly, which he could not grasp as he is partially deaf."
"There is no point of contact on arriving in the outpatient department, you are left to work it out for yourself that you are in the right place. And then just sit down and just WAIT and WAIT "

Individual adaptions
"The ophthalmology clinic at the Conquest was very small and difficult for wheelchair users but where it is now in Bexhill Hospital it is even worse".

Ideal service delivery is accessible

4.1 Care

Patient Experience

The majority of people reported that the service was very good and that staff were professional, kind and explained things clearly at each stage of the appointment. Several people praised Bexhill specifically. People who had had surgery told us what a difference this had made to their lives and that the surgeons were excellent.

When people gave negative feedback this was often to do with communication: people talked about being treated with a lack of respect or being "talked down to". One person told us that all they wanted was to:

> "Be made to feel like I am a patient, rather than just another name on the day's workload."

Staff are seen as expert and committed to providing the best care for people.

4.2 Equality and Diversity issues

Some adult autistic people reported being treated as if they were a child, not an adult. People with a Learning Disability said that they need disabled-friendly communication, perhaps with pictures of their clinicians so that they can become more familiar.

Access for disabled people is difficult: there is a lack of space at the Conquest and Bexhill for wheelchair users and some rooms are not accessible. Carers told us that arranging transport to clinics can be challenging, particularly if they are moved to a different hospital further away.

For people who are d/Deaf, respondents told us that communication can be more difficult as face masks make lip-reading impossible and some clinicians talk too quickly and also didn't engage well with carers.

LGBTQ+ people felt that staff needed more training and awareness. They had experienced inappropriate and irrelevant questions from clinical staff.

Parents with young children find the long waits at the hospital challenging: although there is a designated area for children it is often already occupied by adults when the department is crowded. It is especially difficult for children with Learning Disabilities. Patients told us that the audiology service provides double slots and it was felt that this would be good for ophthalmology appointments.

"My daughter's autism makes her senses very keen and she is easily overwhelmed by noise, flickering lights and shouting. These can cause meltdown and exacerbate anxiety and depression. Being seen in the children's department was not helpful. She needed a quiet waiting area, a timely appointment and not to be sitting for nearly two hours in an area where children are. Medical staff need to be trained to understand how to communicate with patients who have conditions like this as individuals and not speak to them like children. They need to be asked open questions and given plenty of time to answer. They need to hear accessible language as well as be given easy read information. The Traffic Light Health Passport system in place previously was very good as it contained everything that clinicians needed to know about my daughter, but people don't seem to know what they are any more. Reasonable adjustments are no longer made."

Language barriers make things difficult for some people and they said the service providers needed to think more about this and about people of different ethnicities.

4.3 Access/transport issues

Many people told us about difficulties getting to appointments. They told us that public transport is limited and unreliable and, if you are elderly, with sight issues and potentially other mobility issues, it's not suitable. When you attend an appointment they usually put drops in your eyes which mean that you can't see well afterwards. Not everyone has family living locally nor has access to a car. For many people it would be a struggle to afford the cost of a taxi.

"The only drawback at the beginning of last year was that they cancelled my appointment and then re-booked it at Bexhill. This is difficult to get to, you have to book a taxi. There is a bus service but not before 9.30 a.m. and it's very unreliable and there's only one bus each hour. My husband could take me but other patients without means of transport would either spend a lot of money or they wouldn't be able to go."

Some people use hospital transport: they are expected to be ready to leave a long time (two hours) before their appointment which feels like too much and they often have a long wait before transport home.

Moving ophthalmology services to Bexhill as a result of the pandemic was stressful for many people and increased journey times. Other people found Bexhill easier to get to. Most people would like their appointments to take place as close to their home as possible.

"I often use Bexhill Hospital and I have to ask for a lift from a friend. I was upset that it would not be at the Conquest because it is much closer to where I live. The car park [at Bexhill] is not good and it is difficult to park. There are quite a few different waiting areas and my friend never knows where to pick me up from. Perhaps the letter could tell you waiting room A, B, C etc."

4.4 The impact of COVID-19

Some people reported that communication from the hospitals had deteriorated during the pandemic and that their appointments had been cancelled, with no indication of when they would be reinstated. Other people told us that they were very happy with communications.

Some people couldn't attend appointments during the pandemic because they were shielding. There was praise for staff where people did attend, with feedback about feeling safe and people told us that there were clear COVID-19 processes in place.

4.5 Clinical

Communications between different healthcare teams/professionals

People told us about problems of communication between the High Street optometrists and secondary care e.g. someone was referred by their optician but has since heard nothing. Other people told us that, when this communication works well, they feel very reassured.

There is sometimes a lack of continuity of care: people see different clinicians every time and feel that their information is not passed on, so tests end up being repeated and this causes anxiety for them. Their notes are often missing and time is wasted finding these.

Communications between healthcare professionals and people, especially of results

People using Patient Knows Best liked this system and felt that it kept them informed. Other people told us that information is sometimes not clear enough, leading to misunderstandings e.g.

one person told us that they thought the consultant had agreed they needed surgery and then changed their mind and they didn't understand why. Some people went to Bexhill for an appointment expecting to see a consultant and were then disappointed as they only had a scan, the appointment was very short and they felt it was a waste of time. Many people told us about long waits for appointments or appointments being cancelled and not knowing when they will next be seen, which is worrying if they have degenerative eye conditions.

Speed and ease of service delivery

The majority of people told us that the service is very good - "efficient and caring". People told us about mix-ups in outpatients e.g. one person arrived in advance for their appointment but the consultant missed them off the list so they had to wait until the end of the clinic to be seen. Another was re-directed from Hastings to Eastbourne but, when they got there, the consultant had left and they had to call to make another appointment.

One person told us of the difficulty in getting the right diagnosis: it took four years before the correct diagnosis - of a neurological condition - was made. Many people felt it was better to have all the different aspects of their treatment carried out in one visit e.g. eye tests, OCT (Optical Coherence Tomograph) scans, reviewing the results with the consultant and injections if required. When these are done on different days people feel more stressed and anxious and it increases any difficulties they have with transport.

Waiting times for appointments and follow-ups

People reported spending a lot of time sitting and waiting for appointments and that they always have to allow extra time to account for this. Appointments are often cancelled and communication about a new appointment is lacking. People told us how difficult it is when this happens and how anxious they become, not knowing when they will get another appointment. This particularly worries people who have conditions such as AMD (Age-related Macular Degeneration) which deteriorate.

> "Sometimes when I've been told I will get my next appointment in say three months it hasn't happened. I know times are very difficult at the moment, but my diabetic nurse had to remind the clinic I was due an appointment."

People told us how their eye conditions, or those of their loved ones, had deteriorated due to appointments being delayed and/or cancelled and what an enormous loss this was for them.

"The waiting time to meet the ophthalmologic consultant was too long, my husband [the patient] had to wait for seven months to meet them. My husband has a brain tumour which presses on the eye's nerves and caused damage to the right eye which lost 50% of its eyesight power. The eyesight power of the right eye became 50% and the left eye was 100%, but after that long waiting for the appointment the left eye has lost the eyesight completely which is a great loss."

4.6 Other themes

The lack of an ophthalmologist in A&E was mentioned several times.

"An ophthalmologist should either be on A&E or on registering with A&E patients should be sent directly to ophthalmology. Having come via A&E and waited almost four hours before they contact the eye doctor I was told it was too late to save my sight but had I been seen by a specialist there was every chance my sight could have been saved."

Several people told us about an issue with the treatment threshold for AMD. They reported being referred to the hospital by a High Street optometrist such as Specsavers. Having been reviewed by the consultant they were then told that the condition was not sufficiently severe to meet the NHS treatment threshold and that, if they wanted to be treated, they would need to pay for this privately at a cost of £400 per injection. Some people had taken up this option and had received treatment privately from the same consultant. Many people told us how worrying this was: they don't want to lose any more of their sight but not everyone can afford to pay for private treatment.

"There is a serious deficiency in the provision of care for some people with AMD in that the existing policy adopted in East Sussex does not allow for treatment where the affected eye is judged to be "too good to treat". This is a callous policy which condemns those who are not able to afford private treatment to eventual loss of vision which will severely affect their quality of life."

Of the optometrists who completed the survey, many felt that more could be done in the community e.g. glaucoma referral refinement, children's eye examinations after a borderline school screening, annual examinations for ocular hypertension and glaucoma. Some also told us that the

process for urgent referrals is difficult. They felt that there could be better communication and training for community optometry.

"Give optometrists more responsibility. Patients do not want to come to the hospital to sit for hours when they could be taken care of in practice, especially in triage cases. Pay us to carry out repeat tests like visual fields/intra-ocular pressure readings/anterior eye checks or dilations and that will help hospital eye service case loads and leave patients better taken care of."

4.7 Participant priorities

To encourage respondents to consider their priorities when it comes to healthcare and understand if people would be willing to travel further to receive care, a prioritisation question was asked where the participants had to rank each statement 1 to 6 with 1 being the most important and six being the least important. It is important to recognise that this question is useful but, given the relatively small number of respondents, the results should not be viewed as an overall reflection of people's priorities.

1. I need to consider how to get to my appointment i.e. is there a regular bus available, would I be able to cover the cost to get to the appointment.
2. I need to consider the time taken to travel to get to my appointment.
3. When I am at the hospital, I want appointments to run on time.
4. I would prefer my treatment to be done in a day so I do not have to travel to multiple appointments.
5. I would like to have the most up-to-date facilities and equipment available.
6. I don't want to have to wait too long to get an appointment.

4.8 Other groups the CCG should engage with during the public consultation

Participants we asked if there are any groups that engagement should focus on once the set of proposals have been developed. Responses included:

- The elderly
- Disabled
- Those without transport
- Opticians
- People in deprived communities
- People from different ethnicities e.g. local Hungarian and Portuguese communities

5.0 Conclusion

Public engagement reached a significant number of people, despite the limitations of lockdown during COVID-19, and the CCG heard from a wide variety of individuals, organisations and stakeholders.

The findings have been shared with ESHT and an action plan is being developed using some of the early findings to make small but effective changes to the way the current service is provided.

The outputs of the public engagement will inform and shape the options development and appraisal process, and will be used to shape any future business case and formal consultation, if required.

6.0 Appendix 1 - Equality data

There was a widespread response from across East Sussex with the highest number of responses coming from the Heathfield and Seaford areas. Not all respondents completed the equality data section of the questionnaire.

TN21	Heathfield area	16
BN25	Seaford area	10
BN27	Hailsham	9
BN22	Eastbourne	8
TN34	Hastings	8

7 responses from TN39

6 responses from TN19, T28, BN20, BN23

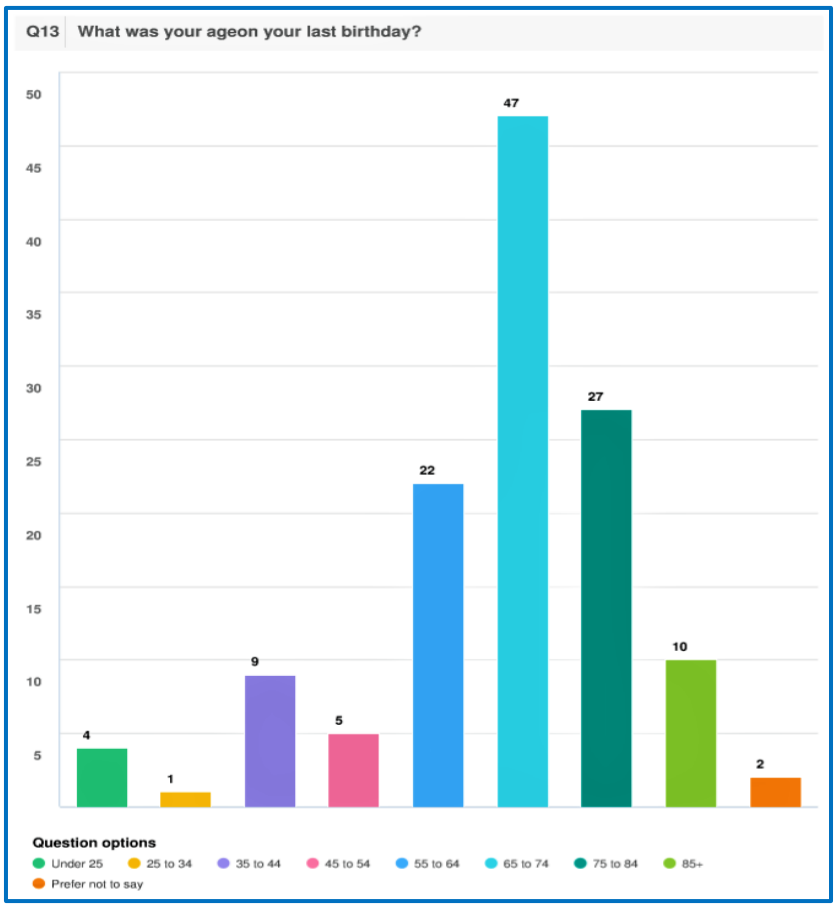
4 responses from BN21, TN6, TN35, TN40

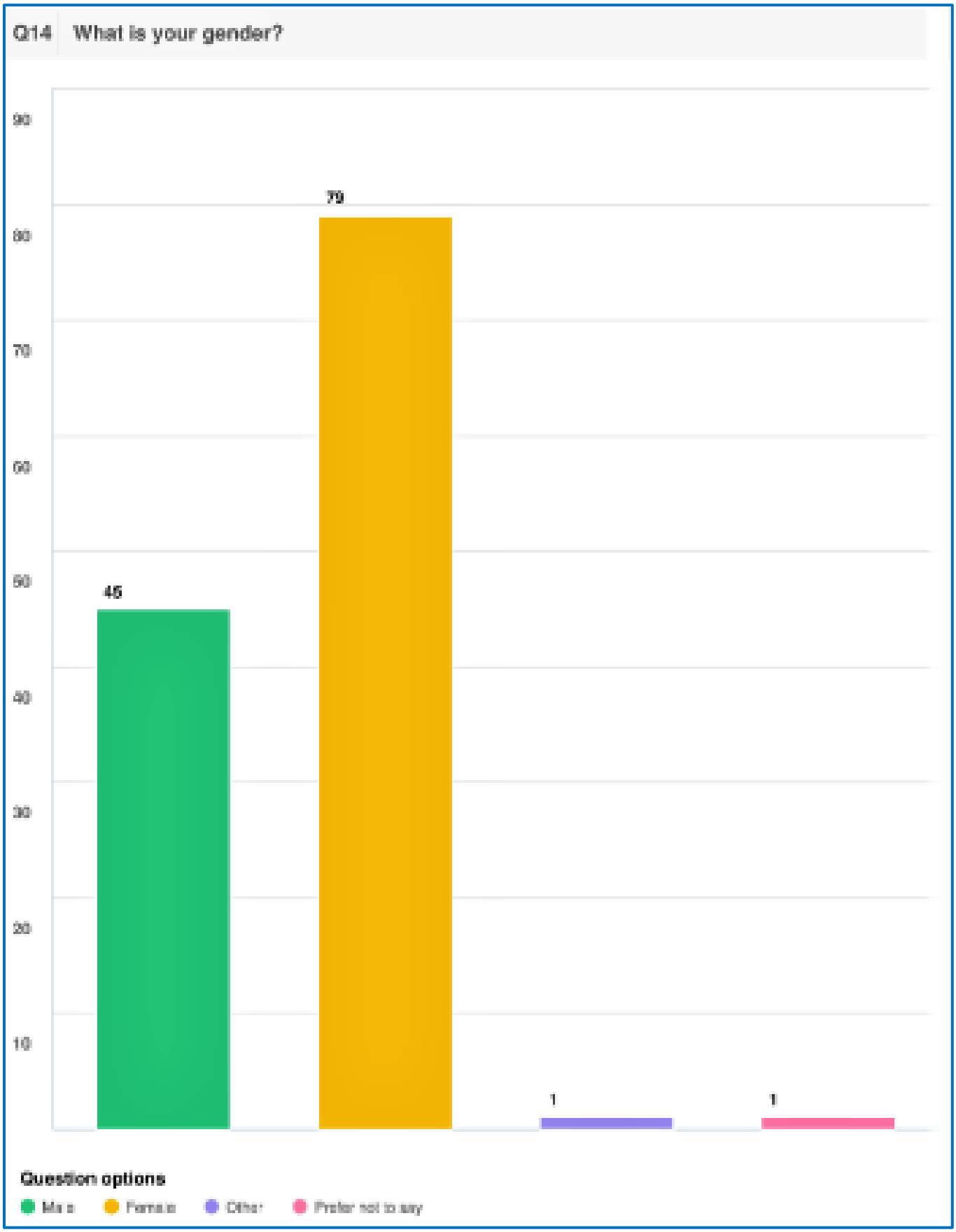
3 responses from BN10, TN33

2 responses from TN20, TN31, TN36, TN37, BN9, BN24, BN26

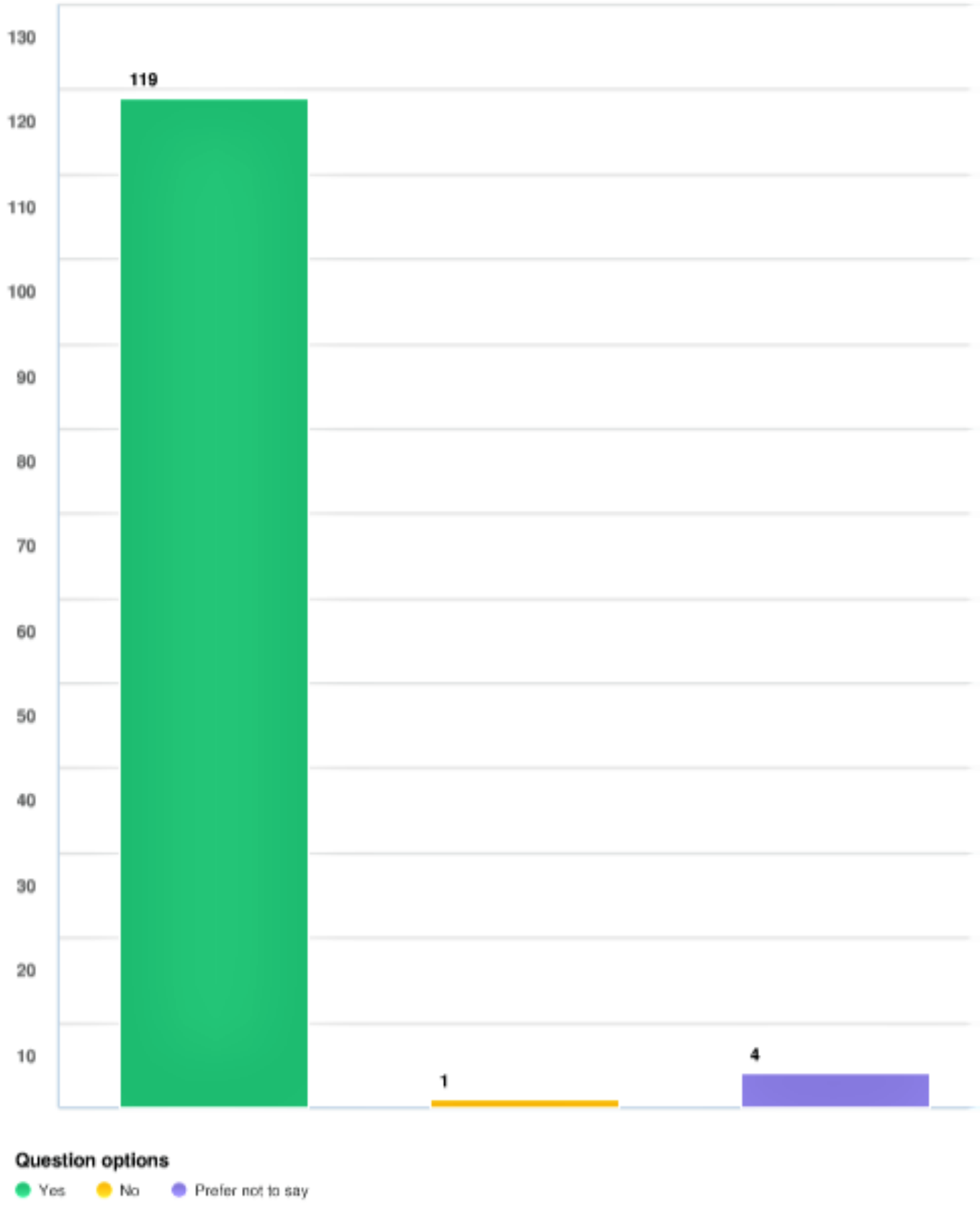
1 response from TN5, TN22

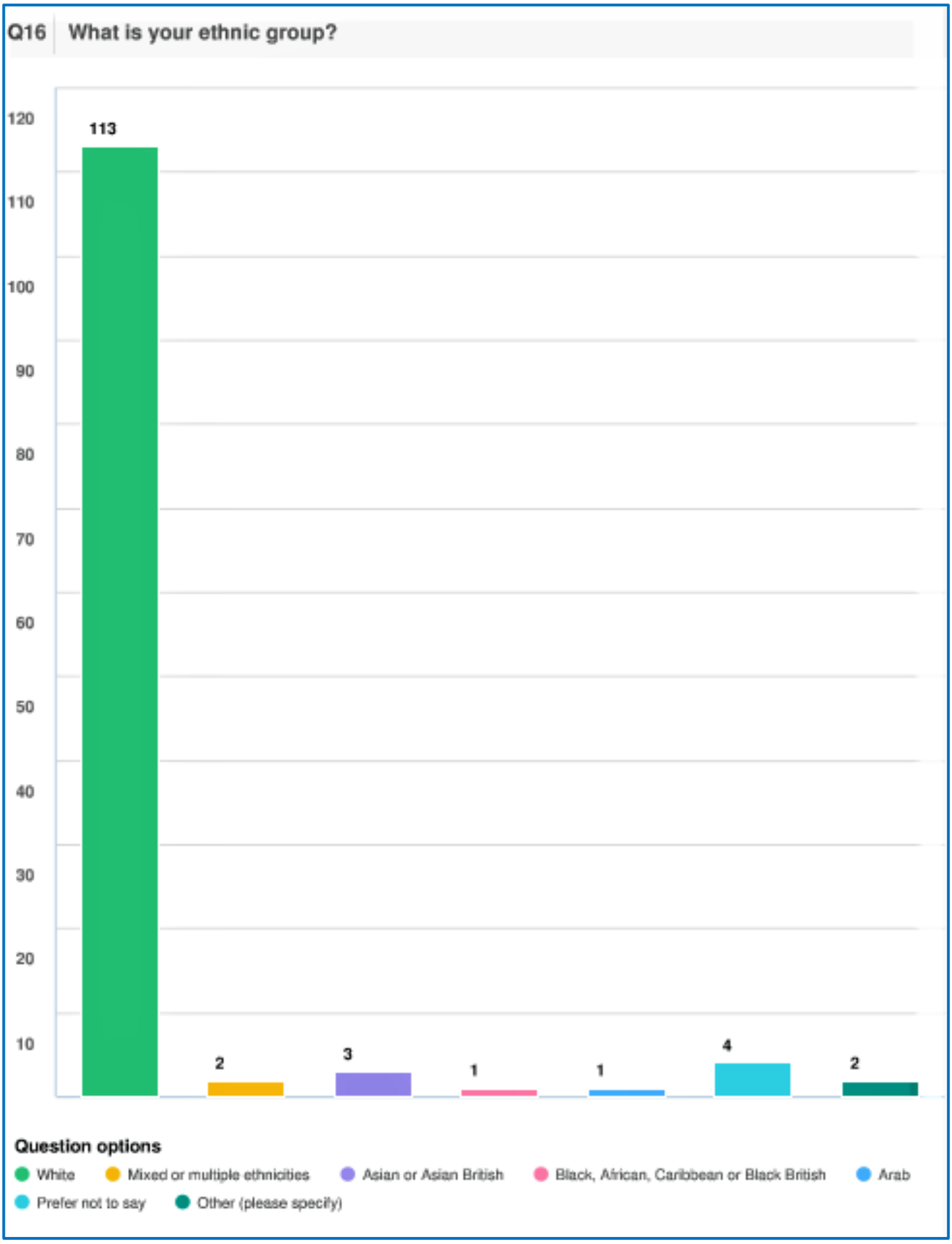
Five out of area responses were received, all from Brighton postcodes.

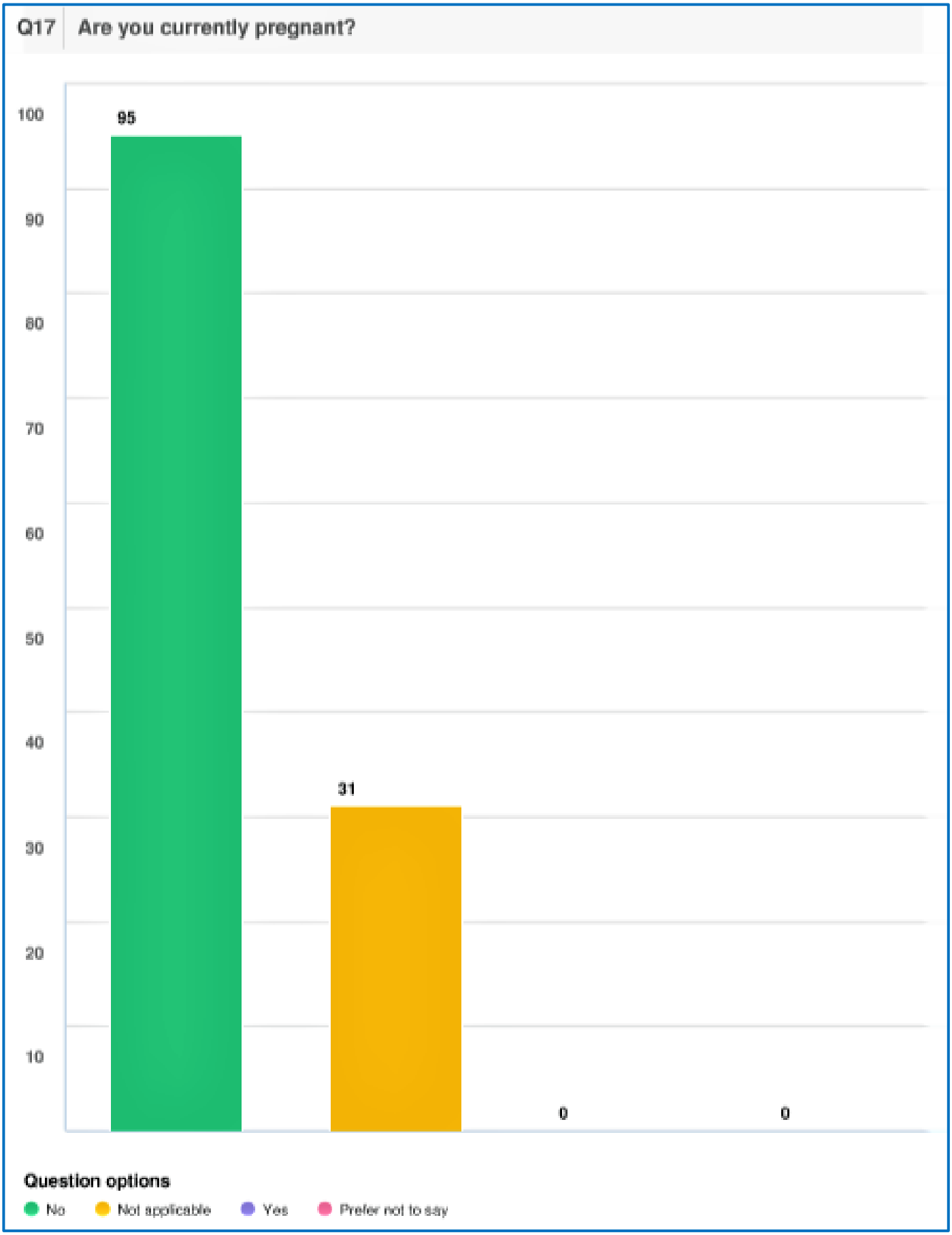



Q14 What is your gender?
90
80
70
60
50
40
30
20
10
79
45
1
1
Question options
Male
Female
Other
Prefer not to say

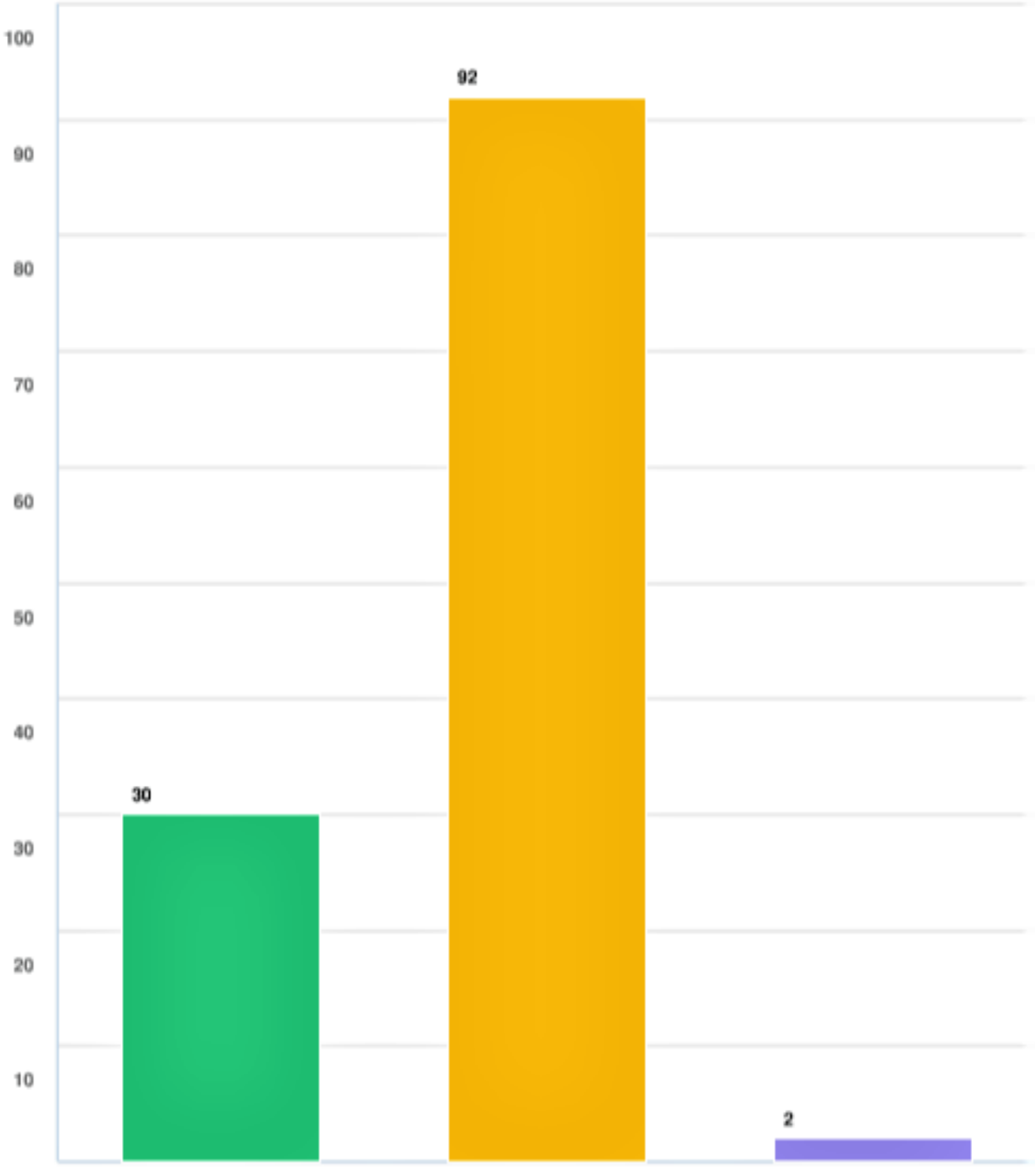
Q15 Do you identify as the sex you were assigned at birth? For people who are transgender, the sex they were assigned at birth is not the same as their own sense of gender.

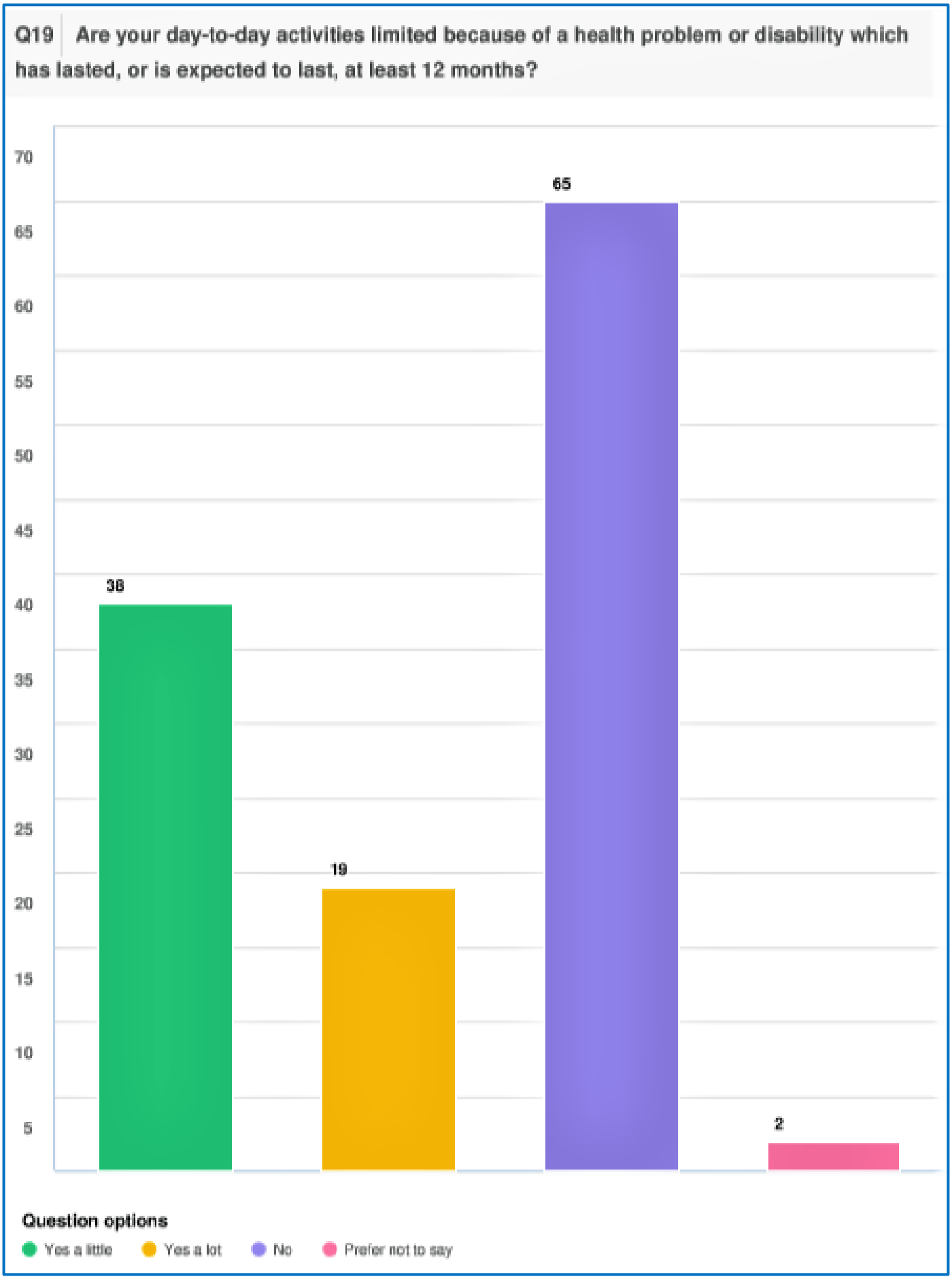


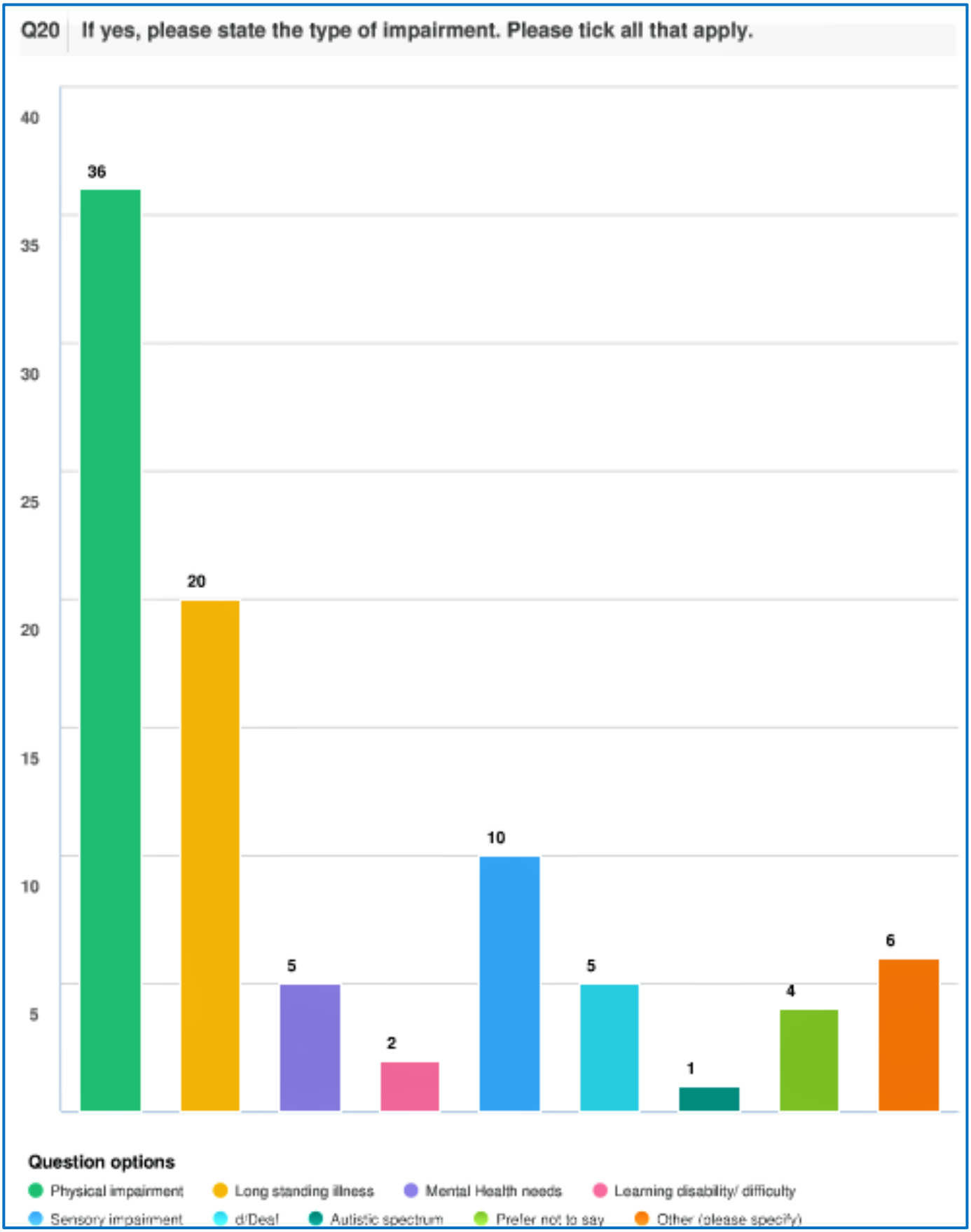

Q16 What is your ethnic group?
120
110
100
90
80
70
60
50
40
30
20
10
113
2
3
1
1
4
2
Question options
White
Mixed or multiple ethnicities
Asian or Asian British
Black, African, Caribbean or Black British
Arab
Prefer not to say
Other (please specify)

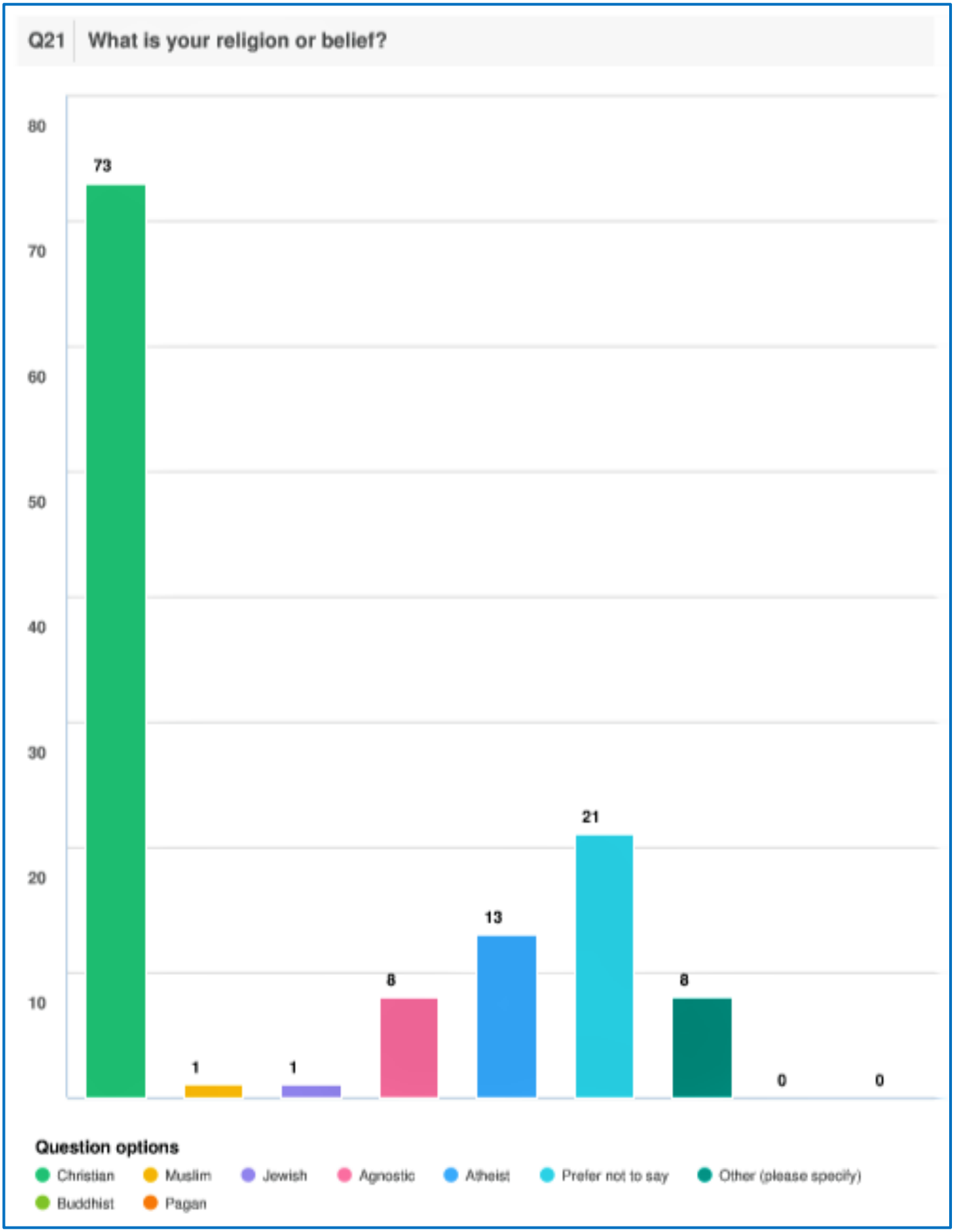

Q17
Are you currently pregnant?
100
90
80
70
60
50
40
30
20
10
95
31
0
0
Question options
No
Not applicable
Yes
Prefer not to say

Q18 Are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.




Q19 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?
70
65
60
55
50
45
40
35
30
25
20
15
10
5
38
19
65
2
Question options
Yes a little
Yes a lot
No
Prefer not to say


Q20 If yes, please state the type of impairment. Please tick all that apply.
40
35
30
25
20
15
10
5
36
20
5
2
10
5
1
4
6
Question options
Physical impairment
Long standing illness
Mental Health needs
Learning disability/ difficulty
Sensory impairment
d/Deaf
Autistic spectrum
Prefer not to say
Other (please specify)


Q21 What is your religion or belief?
80
70
60
50
40
30
20
10
73
1
1
8
13
21
8
0
0
Question options
Christian
Muslim
Jewish
Agnostic
Atheist
Prefer not to say
Other (please specify)
Buddhist
Pagan

Transforming Ophthalmology Services Consultation
Draft Delivery Plan December 2021 – March 2022

Introduction

This plan describes how we will communicate and engage with the public and our stakeholders during the formal consultation process regarding the proposals to transform ophthalmology (eye) services at East Sussex Hospital Trust (ESHT) which is due to take place between Monday 6th December 2021 and Monday 14th March 2022. The plan has been informed by our pre-consultation engagement work, by the options development and appraisal process and by the Equalities and Health Inequalities Impact Assessment (EHIA).

The plan does not include any communications and engagement that may be required with staff.

Background and context

The CCG is developing proposals for how hospital-based ophthalmology services can best provide high quality treatment, care and support for local people and meet increasing local population need. Acute ophthalmology services for adults in East Sussex are provided by ESHT at Eastbourne District General Hospital, the Conquest Hospital in Hastings and Bexhill Hospital.

Ophthalmology is a branch of medicine and surgery that provides diagnosis, treatment and prevention of conditions that affect the eye and visual system. Medical ophthalmology involves diagnosis and management of disorders affecting a person's vision, while surgical ophthalmology involves a surgical procedure to correct or improve a person's vision, for example, cataract surgery. The ways in which ophthalmology specialists work have changed over time, as have the technologies and treatments they use for ophthalmology conditions. For example, it is now possible to provide more services virtually through teleconsultations. While there have been positive advancements, the demand on the service is increasing year-on-year, and this is set to rise further because Sussex has a growing and ageing population.

The CCG's vision for the future is to provide:

- a clinically excellent ophthalmology service;
- a service that reduces avoidable sight loss and improves the eye health of all our patients;
- the ability to look after a growing and ageing population;
- a service that provides increased support and development for the ophthalmology workforce;
- a service that is clinically, environmentally and financially sustainable now and in the future.

Pre-consultation Engagement

To consider how ophthalmology services could be transformed, the Public Involvement (PI) team undertook pre-consultation engagement which commenced on 4 January 2021 and lasted six weeks (concluding on 14 February 2021).

To reach the local population in East Sussex the PI team co-developed questionnaires with partners and members of the public and these were promoted widely in paper copies and electronically. The team undertook interviews with current and former patients of the service and joined virtual local forums and groups to hear from people about their experiences. The insight gained from this engagement then informed the development and appraisal of options for the future of the service.

Options Development and Appraisal

The CCG commissioned the independent organisation Opinion Research Services (ORS) to lead the options development and appraisal process. Patients, representatives from relevant VCS organisations and Community Ambassadors were invited to attend: five representatives attended for ophthalmology. PI team members and ophthalmologists from ESHT attended to observe, present key information and respond to questions, but did not actively participate in the options appraisal scoring and ranking activities.

Three options development and appraisal workshops (independently chaired and facilitated by ORS researchers) took place in March 2021 to identify and consider a longlist of possible options for the future provision of acute ophthalmology services. Participants were provided with information to enable informed discussion, including summaries of key contextual information (e.g. population health needs, clinical standards, activity demand and capacity, finances, estate footprint, workforce) and summaries of key programme documents (e.g. Equality and Health Inequalities Impact Assessment and Case for Change).

Various potential models of care were developed and discussed at the workshops and participants then ranked and scored the options against the agreed criteria, as a result of which three options were shortlisted for ophthalmology:

1. Ophthalmology services located at two hospital sites, Eastbourne District General Hospital (EDGH) and Bexhill Hospital, supported by one stop clinics at both and a diagnostic eye hub at Bexhill
2. Ophthalmology services located at one hospital site, Bexhill Hospital, supported by one stop clinics and a diagnostic eye hub at Bexhill
3. Ophthalmology services located at one hospital site, Eastbourne District General Hospital, supported by one stop clinics and a diagnostic eye hub at EDGH

These options were then reviewed by ESHT and the CCG and it was decided to proceed to full consultation on Option 1.

Participants at the workshops raised a series of concerns which the PI team will ensure form a focus of the full public consultation currently scheduled to take place in early 2022. These concerns were:

- travel and access: time, distance and cost;
- the ability to cope with increased patient demand;
- concerns about moves to digital appointments.

Clinical Senate Recommendations

In August 2021 the CCG submitted the Pre-Consultation Business Case to the Southeast Clinical Senate for review. The Clinical Senate made the following recommendation regarding Patient and Public Engagement:

> In the pre-engagement work do the patient and user views and opinions include those who would normally be seldom heard including those with hearing difficulties, learning disabilities, those who either have no access to or choose not to use IT and those with poor health seeking behaviours? Have you reached those users of the service who will be most affected by the service changes?

In response this Delivery Plan ensures that there is a focus on the groups mentioned in this recommendation.

Equality and Health Inequalities Impact Assessment (EHIA)

The CCG has reviewed the EHIA. This document made a series of recommendations that are given below: responses to each of these recommendations have been included in the Delivery Plan.

Protected characteristic	Engagement activity
Race	• Ensure links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement. • Ensure that Friends, Families and Travellers receive information on all involvement activity. • Attendance at Eastbourne Cultural Involvement Group to promote engagement opportunities

	• Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities
People who have English as a second language	• Offer telephone interpretation to support those who speak English as a second language and wish to engage • Translate materials into community languages (on request)
Gender reassignment	• Approach Hastings and Rother Rainbow Alliance Trans Support Group to talk about opportunities to get involved • Approach Bourne Out via Facebook and ask for support with promotion of the questionnaire
Age	• Work in collaboration with local authority partners to ensure we reach care home residents and staff • Attend East Sussex Senior Association to talk about ophthalmology service transformation and provide opportunities to feedback/ get involved • Attend Age Concern drop in sessions • Engage with RNIB, East Sussex Association for the Blind, Macular Society • Engage with the Public Health Vision Screening Service for Children • Attend PPG forums across East Sussex and offer drop in session if enough interest • Liaise with Age UK East Sussex • Engage with Parent Carer forums
Religion and Belief	• Ensure that faith communities in East Sussex are engaged in this project. • Invite faith elders to engage, and offer translated versions of materials where required.
Disability	• Explore opportunities with CVS organisations such as Possibility People to see what forums and networks we can utilise to support engagement • Approach Hastings disability forum to ask for support • Arrange a drop in opportunity for d/Deaf members to come and talk about experiences of ophthalmology services • Make the materials available in Easy Read and British Sign Language on request. • Approach the East Sussex Dementia Adviser Service to support the reach of our engagement • Approach the East Sussex Community Learning Disability Team for support • Take action to identify and engage with charities and organisations that support patients with diabetes • Take action to identify and engage with charities and organisations that support patients with their mental health

	• Take action to identify and engage with local mental health services • Take action to identify and engage with charities and organisations that support patients with cardiovascular disease
Pregnancy and Maternity	• Attend East Sussex Maternity Voices Partnership meeting •
Other disadvantaged or inclusion groups	• Engage with carers throughout the project to seek their views, through one-to-one interviews, liaison with representative groups and questionnaires • Engage with homeless and rough sleepers through pre-existing relationships with supporting organisations such as Rough Sleepers Initiative, Matthew25 and YMCA • Work with the NHS Armed Forces Community lead to ensure we hear from this cohort • Ensure that the Red Cross ' Carer Crisis Service' and the Care for the Carers 'intensive support to carers in areas of known high health inequalities' schemes are included in consultation and are made known to local population
Deprivation and socio-economic disadvantage	• Utilise foodbanks to share paper copies of questionnaires with freepost address • Ask for support from RVA, HVA and 3VA to target those living in areas of deprivation.

*This list is not exhaustive but provides examples of the activities planned to reach marginalised groups

Governance

The Ophthalmology Communications and Public Involvement Task and Finish Group will be overseen by the Joint Cardiology and Ophthalmology Steering Group which reports to LMT. An assurance oversight group with membership from Healthwatch, Local Authority and a Community Ambassador will be established to ensure the process is robust and there are no avoidable gaps in engagement.

Key principles

In undertaking communications and engagement around our formal consultation we will adopt a transparent, best practice approach based on a number of key principles:

- Building on our wide range of previous engagement with local people and describing our journey, the purpose of our review and our intent to consult.
- 'Strength-testing' all aspects of our thinking, planning and approach.

- Acknowledging the importance our communities place on local services and our interest in all available feedback and insight to further inform our options.
- Incorporating the findings from our Equalities/Health Inequalities Impact Assessment (EHIA) to help us identify the groups and communities we should target for our communications and engagement work.
- Utilising our stakeholder mapping to ensure that we engage with all groups and partners with an interest in our plans including local councillors and MPs.
- Approaching our conversations with transparency in relation to our financial challenge and our need to balance the sustainability of local services whilst offering high quality care, at the right time and place for local people.
- Being transparent about the benefits and risks of our approach and testing our thinking on those.

Supporting information/materials

EngagementHQ

EngagementHQ is an interactive platform that enables people to give their views and feedback on programmes and public consultations. For this public consultation a project page will be created which holds all important documents, promotes all engagement opportunities and encourages the public to share their views through the use of the official survey, quick polls, sharing stories, a live Q and A section and an ideas area.

The CCG's public website will be updated with the correct documents and promotes the new webpage.

Item	Location/format	Details	Responsible
Consultation document	Available in print and on CCG website and EngagementHQ website	Information on the consultation, including all relevant documentation, to be widely shared by email and be made available to download online. There will also be an option for people to call or email to request a hard copy of the consultation	Communications lead

		document and other relevant documents.	
Easy Read Consultation document	Available in print and on CCG website and EngagementHQ website		Involvement Lead
Overseas language translated consultation summary	Top five languages translated	Will be translated further as required	Involvement Lead
Survey	Link on CCG website and EngagementHQ website; paper copies provided at engagement events and on request		Involvement Lead
BSL survey	BSL translated survey on CCG website and EngagementHQ website		Involvement Lead
Easy Read survey	Easy Read survey on CCG website and EngagementHQ website		Involvement Lead
EHIA	On CCG website and EngagementHQ website		Involvement Lead
PCBC	On CCG website and EngagementHQ website		Project team
Frequently Asked Questions	On CCG website and EngagementHQ website	To be updated during consultation	Comms lead/project lead/involvement lead
Posters	A4 poster, display in local hospitals, high street opticians, GP practices, libraries, cafes, etc.	"Have your say" generic message	Communications lead
Leaflets	A5 leaflet, available at local hospitals, high street opticians and GP practices, in any other languages identified as a result of the EHIA and our engagement. Also to be sent out with food parcels from foodbanks.	To include dates and details of key engagement opportunities	Communications Lead/Involvement Lead
Social media/online assets	Imagery and suggested copy for social media posts and use on websites, online newsletters, etc.	To be shared with all relevant partners and stakeholders	Communications Lead

Draft consultation activity plan for the period January – April 2022

Note: some activity subject to change and confirmation of dates

Communications	
Date	**Activity**
October – December 2021	**Planning** Key documents to be revisited including: Pre-consultation Business Case EHIA - reviewed to include any learning from COVID-19 and from the initial stages of the consultation (prior to the pause) Engagement plan – updated engagement delivery plan recognising updated EHIA Consultation document updated, approved and printed Frequently Asked Questions - updated Posters, flyers and leaflets updated, website approved and printed Press release for launch of consultation drafted and approved Stakeholder update for launch of consultation drafted and approved, along with plan to cascade information
Pre consultation launch 16.11.21 onwards	Phone calls to identified stakeholders Stakeholder briefing to be issued on day of Joint Committee MP briefing Reactive media statement in place
06.12.21 onwards	**Implementation** • Consultation document and associated supporting documents published on East Sussex CCG website with link to complete consultation questions on independent organisation webpage • Leaflets to be distributed via food banks, Community and Voluntary Sector (CVS) organisations and digitally via newsletters • Launch press release issued (including press release in British Sign Language) and added to CCG/ESHT websites • Tailored emails to: ➢ Key stakeholders (based on stakeholder mapping)

	➢ East Sussex Patient Participation Group members ➢ East Sussex GP practices ➢ Healthwatch East Sussex • Social media posts • Inclusion in GP bulletin • Article in East Sussex Health and Social Care News • Articles in local newsletters - ongoing • Content sharing by key partners (e.g. ESHT, ESCC, Healthwatch, voluntary and community sector etc.) on social media, public websites, intranets, newsletters, etc.)
Between December 2021 and March 2022	• Press releases issued to remind people of options to take part before end date • Social media posts continue until end of the consultation • Articles in GP bulletin • Articles in East Sussex Health and Social Care News • Articles in local newsletters - ongoing • Content sharing by key partners (e.g. ESHT, ESCC, Healthwatch, voluntary and community sector etc.) on social media, public websites, intranets, newsletters, etc. • Tailored emails to: ➢ Key stakeholders ➢ East Sussex PPG members and GP practices
14.03.22	• Press release announcing end of consultation and next steps • Social media posts announcing end of consultation and next steps • Article in GP Bulletin announcing end of consultation and next steps • Article in East Sussex Health and Social Care News announcing end of consultation and next steps • Articles in local newsletters announcing end of consultation and next steps • Tailored emails to key stakeholders announcing end of consultation and next steps
Post Consultation and final report	• Tailored emails to: ➢ Key stakeholders ➢ Ophthalmology public distribution list ➢ East Sussex PPG members and GP practices ➢ CVS organisations who supported the public consultation • Article on East Sussex CCG website

	• Press release which includes highlights from consultation feedback report and a link to the full report • Provide update and copies of the final report at all forums and groups that took part in the consultation

Engagement Activities - 06.12.21- 14.03.21		
Membership and provider engagement		
Date	**Activity**	**Lead**
Fortnightly	Attendance at East Sussex Communications and Engagement Steering Group: distribution of materials including questionnaires, posters, etc.	Public Involvement team
January 2022	Dedicated webinar for Eastbourne Hailsham and Seaford, Hastings and Rother, High Weald and Lewes and Havens locality members	Clinical leads
Patient and public involvement		
Ongoing throughout consultation	Provide information on consultation to Sussex Health and Care Partnership, District, Borough and Parish Councils, community and voluntary sector organisations and relevant services and neighbouring CCGs and Acute Trust: include material for distribution, questionnaires, web links etc. and offer attendance if requested: HVA, RVA, 3VA, Healthwatch, Southdown, Fulfilling Lives, East Sussex County Council Young People's Services, YMCA, Red Cross, Citizens' Advice Bureau, East Sussex Chambers of Commerce, Eastbourne and Hampden Park Libraries, Beacon Shopping Centre, Maternity Voices, Action in Rural Sussex, Deaf Cultural Outreach Group (DeafCOG), Diabetes UK (local groups), St John's Ambulance, Sussex Community Development Association, Sussex U3A groups, Armed Forces Network, Age Concern, Age UK, Amaze SENDIASS East Sussex, Churches Together Sussex, Friends, Families and Travellers, Rough Sleepers' Initiative, Mathew 25, Salvation Army, Homeless and Rough Sleepers' Service, East Sussex food banks, Leagues of Friends, Save the DGH, Friends of the Conquest Hospital, Save the NHS, Rainbow Alliance, Bourne Out, Public Health Vision Screening Service for Children, Possability People, MIND East Sussex, Grace Eyre, Amaze, HEART Hastings.	Communications and Public Involvement team
06.12.21 onwards	Attendance at meetings:	Public Involvement team

	East Sussex Association of Blind and Partially Sighted Eastbourne Blind Society Hastings and Rother Voluntary Association for the Blind East Sussex Disability Association Care for the Carers – East Sussex Autism Partnership Board LD Partnership Board Hastings HEART East Sussex County Federation of WIs Fellowship of St Nicholas Hub on Rye Hill Community Centre Oasis Community Projects (Ore Valley) Rotherfield St Martin (community hub) Pelham Community Hub (Bexhill) Shinewater North Langney Neighbourhood Partnership (Eastbourne) Blue Van Veterans East Sussex Seniors' Association Dementia Alliances: Eastbourne, Hastings and St Leonard's, Bexhill, Wealden, Havens Deaf Cultural Outreach Group (DeafCOG) Eastbourne Cultural Involvement Group Black Butterfly (ethnically diverse communities, asylum seekers, refugees) Seaview Centre St Leonards Hastings and Rother Interfaith Forum (tbc) Eastbourne Faith Forum (tbc) Hastings Older People's Ethnic Group HOPE-G Hastings Age-friendly Community Coffee Mornings Hellingly Over-60s Coffee Mornings Parent Carer Forums (via ESCC) LGBTQ – contacts being investigated	
06.12.21 onwards	Individual interviews with service users and carers	Public Involvement team
January 2022	Stakeholder workshop(s) e.g. Local Optical Committee, Patient Transport Services, Healthwatch	Public Involvement team

06.12.21	Local Voices Network – invitations to participate in events, links to questionnaires, regular updates on consultation progress	Public Involvement team
	East Sussex Local Strategic Partnership Boards – information prior to and during consultation, updates re: consultation, offer to attend	Public Involvement team
30th November 4th December 7th December 21st December 18th January	High Weald PPG forum Eastbourne Hailsham and Seaford PPG forum Hastings and Rother PPG forum Lewes and Havens PPG forum East Sussex PPG Steering Group	Public Involvement team
06.12.21	GP practices sent information on consultation including material for distribution, questionnaires, information for electronic screens, posters	Communications team
06.12.21 onwards	Telephone interviews offered to members of the public using dedicated telephone number, with Signlive assigned and interpretation available	Public Involvement team
January / February 2022	Public meetings: focus on communities identified by EHIA/Clinical Senate recommendations: Hastings/St Leonards: Hollington Four Towers - Rural Rother: Hub on Rye Hill Community Centre - High Weald: Uckfield Civic Centre: one virtual event	Chief Executive ESHT/CCG and clinicians
06.12.21 onwards	Public events – e.g. Eastbourne Open Air Market, Rye Market, Hastings Priory Meadow, Hollington Tesco, Beacon Shopping Centre Eastbourne, Hailsham shopping centre, Crowborough Farmers Market, Seaford Library, Newhaven Country Market, Lewes Farmers' Market, Newhaven and Peacehaven Community Supermarkets	Public Involvement team/other CCG teams/Healthwatch volunteers

This is a live document and dates and opportunities will continue to be added to during the consultation period.

Report to	Joint Sussex Committee
CCGs applicable to	East Sussex CCG
Meeting date	17 November 2021
Report title	East Sussex Healthcare NHS Trust: transformation of Ophthalmology Services
Report from	Jessica Britton, Executive Managing Director, East Sussex CCG
Clinical leads	Dr Rachel Cottam, GP Clinical Lead, ophthalmology
Report author	Victoria Hill, Senior Planned Care Manager
Item number	

Recommendation/action required:

The members of the Joint Sussex Committee are asked to:

- **review and consider** the Pre-Consultation Business Case for the Transformation of Ophthalmology Services delivered by East Sussex Healthcare NHS Trust
- **approve** the proposals in principle, subject to the outcome of the East Sussex Healthcare NHS Trust Board meeting on 30 November 2021, and **delegate** authority for final decision-making on this business case to the Chair of the Joint Committee.
- **endorse** the recommendation that these should be subject to formal public consultation
- **agree** that the decision of the CCG should be submitted to the East Sussex Health Overview and Scrutiny Committee, on 2 December 2021, to consider if they would like the CCG to formally consult with them on the proposals.

Executive summary

The purpose of this Pre-Consultation Business Case is to describe the wide engagement to date in communicating the drivers for change, reviewing all possible options to transform ophthalmology services provided by East Sussex Healthcare NHS Trust to deliver the best possible care for local people. The Pre-Consultation Business Case includes the available information and evidence that has supported the development of models of care, analysis of possible options to deliver these models of care, and it proposes preferred viable options to transform ophthalmology services.

These Pre-Consultation Business Case recommends to the Joint Sussex Committee one option to take forward to public consultation, and, if approved by the Joint Sussex Committee, to submit to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this constitutes substantial variation to services and that they would like the CCG to consult with them on this.

The Process of Assurance

When developing our options, our final draft proposals, and this Pre-consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[1]
- We have developed our proposal and associated consultation plans in line with the Gunning Principles[2] to ensure that:
    - a decision will not be taken until after public consultation
    - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
    - there is adequate time for people to participate in the consultation
    - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.

Programme Governance

We have established an East Sussex Cardiology and Ophthalmology Steering Board including membership from key partners and patient representatives to provide clear oversight and governance. This reports to the East Sussex, Brighton and Hove Local Management Team and the Executive Management Team as appropriate, with regular updates provided as part of the Chief Executive Officer and Executive Managing Director reports to the Joint Sussex Committee.

Independent Assurance

Options Development and Appraisal Workshops

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

In March and April 2021, we held three Options Appraisal workshops. These workshops were designed, developed and delivered in collaboration with the CCG by an external independent consultancy, Opinion Research Services (ORS), factoring in the themes and feedback from the pre-consultation engagement and the key areas identified within the EHIAs. These workshops comprised a good range of stakeholders including patients.

ORS provided a comprehensive report on the outcomes of the workshops, including the most appropriate options to take forward for consideration and a qualitative and quantitative analysis of the feedback. Five appraisal criteria were discussed and agreed for both Cardiology and Ophthalmology workshops (Quality and Safety; Clinical sustainability; Access and Choice; Financial Sustainability; and Deliverability). This informed the final proposal and the PCBC.

Our approach to equalities and health inequalities

The Equality and Health Inequalities Assessment (EHIA) has been iterated throughout the programme and was further informed by a health inequalities workshop to review the shortlisted options through an inequalities lens, following the options appraisal. This supported the development of the preferred options for likely public consultation. Key actions have included:

- ensuring that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regard to the issue of access and experience of patients with protected characteristics or other disadvantaged communities:
- ensuring links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement.
- attendance at multiple engagement opportunities to ensure we reach wide-ranging cohorts of the East Sussex population, e.g. Eastbourne Cultural Involvement Group, Hastings and Rother Rainbow Alliance Trans Support Group, Age UK East Sussex, East Sussex Senior Association, PPGs, Public Health, Patient Carer Forums, to promote engagement opportunities.
- target communications about service changes via channels to reach various patient groups.
- ESHT are currently working on a separate wider Trust piece of work to review data collection to ensure they are able to more accurately monitor data collection and identify any themes of inequality and address any identified challenges
- a further analysis of transport needs has been undertaken and this will inform the consultation and development of final Decision Making Business Case
- linking into Sussex wide work targeted on reducing health inequalities for ophthalmic diseases, notably in relation to social deprivation.
- further training and education is required across the services, raising awareness and providing conscious consideration to those with protected characteristics

These EHIAs are live documents and are being re-iterated throughout each phase of the programme.

Clinical Senate

We requested the NHS England South East Clinical Senate to undertake an independent clinical review of our proposal. We also asked the Clinical Senate to assess the evidence we have gathered and reviewed to develop this Pre-Consultation Business Case. More specifically, the Clinical Senate was asked to:

- evaluate the proposals alongside the Case for Change;
- provide a narrative that details any recommended mitigations that will support commissioners to finalise the Pre-Consultation Business Case;
- evaluate the proposals in terms of future services being accessible and continuing to meet the needs of the patient population to ensure any inequality issues would be suitably mitigated.

The Clinical Senate Panel reviewed the Pre-Consultation Business Case and met to discuss the proposals with the CCG, Trust and other stakeholder colleagues, in detail. The Clinical Senate made a number of recommendations which we have addressed and that have informed and strengthened this Pre-Consultation Business Case.

The Clinical Senate provides a helpful mechanism to test the clinical model with a clinical peer group; alongside reflections about our clinical model the clinical senate also provided a range of helpful reflections about our approach to options development and appraisal and about our process of engagement with stakeholders and local people.

Overall, the Clinical Senate report and findings provided a useful framework for the development of the Pre-Consultation Business Case and our future discussions and consultation with the stakeholders on the final pre-consultation proposal.

NHS England/Improvement Stage 1&2 Assurance

The stage 1 assurance meeting was held in January 2021. The feedback centered on the importance of further in-depth Equality and Health Inequality Impact Assessment and ensuring the proposals were fully integrated into, and consistent with, the broader Integrated Care System service recovery and transformation plans. The programme was approved to proceed further and agreed actions completed.

The stage 2 assurance meeting was held on 14 October 2021. The review considered the key tests for service reconfiguration and the proposals has now been approved to move forward to public consultation.

Proposed consultation approach

In undertaking any further engagement and consultation, the CCG will continue to adopt a transparent, best practice approach based on several key principles. We will

- build on our wide range of previous engagement with local people and describe our journey, the purpose of our review and our intent to consult;
- incorporate the findings from our Equalities and Health Inequalities Impact Assessment, which have helped us identify the groups and communities we should target for our communications and engagement work;

- proactively engage with any other groups (in their own environments) not identified as a result of the Equality and Health Inequality Assessment;
- "strength-test" all aspects of our thinking, planning and approach;
- involve patients through a variety of activities, go out into local communities and attend pre-existing engagement opportunities, with a clear focus on involving the seldom-heard communities as described in the Equality and Health Inequality Assessments;
- acknowledge the importance our communities place on accessible service provision and clearly communicate our interest in all available feedback and insight to further inform our proposals;
- share information about the range of services that are available to local people;
- utilise our stakeholder mapping to ensure that we engage with all groups and partners with an interest in our plans including our partners in East Sussex County Council, local councillors and Members of Parliament;
- be clear about our strategic goals to deliver better and more integrated high quality care in the right place and at the right time for local people, whilst also being transparent about our financial challenge;
- be transparent about the benefits and risks of our approach and test our thinking on those.

We have developed a Consultation Delivery Plan that brings together our planned communications and engagement activity during this period including:

- The consultation process will run for a period of 12 weeks (with an additional 10 working days to account for Christmas and New Year Bank Holidays) from December 2021 to March 2022.
- The responses to the consultation process will be independently analysed and a report will be published outlining how we have considered these in coming to our decision.
- The process will be promoted through social media and other established channels (including posters, adverts in local media, via newsletters to local stakeholder groups and existing forums).
- Leaflets/flyers will be provided (written in plain English and any other languages identified as a result of the Equality and Health Inequality Assessment and our engagement) promoting the consultation across the CCG's area.
- Any leaflets/flyers will be made available to GP practices and will also be prominently displayed at East Sussex Healthcare Trust.
- East Sussex Healthwatch will be engaged during the consultation process to provide support and further advice on the consultation process if required.
- We will work in partnership with the local voluntary and community sector to ensure that seldom-heard groups, particularly those identified as a result of the Equality and Health Inequality Assessment, are fully engaged with the consultation process.

Conclusion

The Pre-Consultation Business Case reflects a robust process of service redesign for this area of focus, demonstrating how the proposal will improve the quality and sustainability of services for our local population. The proposal will now be subject to a full public consultation.

Previously considered by [governance/ engagement pathway to date]		
Org./Group/ Name	**Date**	**Outcome**
East Sussex, Brighton and Hove LMT	8 December 2020	Case for change endorsed
Executive Management Team	21 December 2020	Case for change approved
East Sussex Governing Body	10 February 2021	Brief update on early engagement work on ophthalmology to understand people's experiences and inform next steps
East Sussex, Brighton and Hove LMT	4 May 2021	Progress update and approval to proceed
East Sussex Governing Body	7 April 2021	Update on engagement and workshops to develop options
East Sussex, Brighton and Hove LMT	20 July 2021	Progress update and approval to proceed
East Sussex, Brighton and Hove LMT	21 September 2021	Approval of draft EHIA, QIA, and PCBC in readiness for stage 2 assurance
Executive Management Team	25 October 2021	EMT noted the significant progress made and agreed the proposal and that the PCBC should be submitted to the CCGs' Joint Committee for approval to commence public consultation, and that the decision should be submitted to the East Sussex Health Overview and Scrutiny Committee.
Joint Quality Committee	9 November 2021	The committee noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The committee reviewed the summary PCBC, together with the EHIA and QIA and endorsed the case for consideration by the Joint Sussex Committee.

What happens next?

Following approval by Joint Sussex Committee, these will be submitted to the East Sussex HOSC and subject to formal public consultation.

Key Milestones	Detail	End
Pre Consultation Engagement	Questionnaires and interviews, resulting in report	14 Feb 2021
NHSE Stage 1 Assurance	Case for change, developing options, EHIA shared with NHSE/I and feedback received	27 Feb 2021
Options Appraisal Process	2 x 3 Options Appraisal workshops to produce recommendations for shortlist	19 April 2021
EHIA Workshops	Learning from NHSE Stage 1 Assurance Preparation for NHSE Stage 2 Assurance	Mid May 2021
NHSE Stage 2 Assurance	Full draft PCBC and feedback received	14 October 2021
Pre-Consultation Business Case	Clinical Senate Panel East Sussex, Brighton and Hove LMT Executive Management Team (paper and PCBC executive summary) CCG Joint Quality Committee (PCBC executive summary, Equality and Health Inequality Impact Assessment and Quality Impact Assessment) CCG approval to proceed, via Joint Sussex Committee delegated authority ESHT Trust Board East Sussex HOSC	Jul-Aug 2021 21 Sept 2021 25 Oct 2021 9 Nov 2021 17 Nov 2021 30 Nov 2021 2 Dec 2021
Formal Public Consultation	Planned for December 2021 – March 2022 (extended past 12 weeks to allow for Christmas break)	

Following the end of the consultation period in March 2022, we will evaluate the outcomes of the consultation to ensure that relevant information gathered during this period informs our Decision-Making Business Case. This will be then considered in line with NHS governance arrangements, following which we anticipate consideration by East Sussex Health Overview and Scrutiny Committee which is likely to be summer 2022.

Implications	
Corporate goals this relates to	• Improved population health outcomes and patient experience • Improved quality of services, access and operational performance

	• Improved financial performance • Delivering system reform • Local priority objectives
Financial	There would be a positive financial impact on the Trust of implementing the changes outlined, this is as a result of implementing best practice and benefiting from resulting economies of scale. **Ophthalmology** **Revenue** The case shows that under co-location there will be net efficiency savings (takes into account the cost of capital) of c6% which will also eradicate the service deficit within the Trust. **Capital** The total capital required capital for both schemes is between £8.1m and £10.3m. For Cardiology the capital costs of the laboratories will be met by the Trust through internally generated capital, with the £6.8m cost of an additional ward being considered a priority against the system wide capital allocation. For Ophthalmology the building costs will be met by the Trust the equipment costs of £1.3m being considered a priority against the system wide capital allocation.
Risk, legal and other compliance	East Sussex CCG has a legal requirement under the NHS Act 2006 to ensure patients and the public are involved in service changes. If it is agreed that a consultation is required, the following Gunning Principles will need to be followed: • That consultation must be at a time when proposals are still at a formative stage; • That the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response; • That adequate time is given for consideration and response; and • That the product of consultation is conscientiously taken into account when finalising the decision. This underpins the engagement and the proposed consultation process. The PCBC demonstrates compliance with CCG statutory duties.
Quality and safety	The aim of transforming these services is to deliver significant clinical improvements that will improve quality, outcomes and safety for patients. The Quality Impact Assessment (QIA) was completed in relation to the current service and in conjunction with the quality team. This QIA is a live document and is re-iterated throughout each phase of the programme and shown to have positive impacts.

Equality, diversity and health inequalities	CCGs have a duty to reduce inequalities between patients in respect to outcomes and access and this transformation will embed health inequality considerations into the redesign process. A Screening Equality and Health Inequality Assessment (EHIA) was initially developed for ophthalmology, followed by a full EHIA taking account of feedback from ICS colleagues and NHSE/I. This EHIA is a live document and is re-iterated throughout each phase of the programme. Action from this is underway, is reflected in the model of care and options for consultation and has informed the consultation communications and engagement delivery plan.
Patient and public engagement	Following historical informal engagement, full pre-consultation engagement has taken place to understand what is important to local people. The information gathered during this engagement process has informed our model of care and options appraisal process. The transformation programme will be further informed by local people through a likely formal consultation process should the proposed changes be considered significant variation in service.
Health and wellbeing	The transformation of services in East Sussex is expected to improve access to care and health outcomes for our patient population, supporting the health and wellbeing agenda.

List of appendices

- Executive Summary Ophthalmology Pre-Consultation Business Case

Note, the full Pre-Consultation Business Case, including the following appendices for the case, will be available on the CCG website.

  - *Appendix 1: Ophthalmology Equality and Health Inequalities Assessment*
  - *Appendix 2: Ophthalmology Pre-consultation Engagement Report*
  - *Appendix 3: Ophthalmology Options Development and Appraisal Report*
  - *Appendix 4: Quality Impact Assessment*
  - *Appendix 5: Consultation Delivery Plan*

East Sussex Healthcare Trust

Cardiology transformation: executive summary pre-consultation business case

Joint Sussex Committee

Date:	November
Version:	1
Name of originator/ author:	CCG Programme Team

Contents

Executive Summary

1.0 Purpose

The purpose of this Pre-Consultation Business Case (PCBC) is to describe the wide engagement to date in communicating the drivers for change, reviewing all possible options to transform cardiology services provided by East Sussex Healthcare NHS Trust to deliver the best possible care for local people. The Pre-Consultation Business Case includes the available information and evidence that has supported the development of a model of care, an analysis of possible options to deliver this model of care, and it proposes preferred viable options to transform acute cardiology services, including inpatients and interventional services.

This Pre-Consultation Business Case recommends to the East Sussex CCG (via Joint Sussex Committee delegated authority) two options to take forward to public consultation and, if approved by the CCG, to submit to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this constitutes substantial variation to services and that they would like the CCG to consult with them on this.

The full pre-consultation business case and associated document including the Equality and Health Inequality Impact Assessment, Quality Impact Assessment, the pre-consultation engagement report and options development and appraisal reports will all be available and published on the CCG websites.

2.0 Context

In 2019, the NHS Long Term Plan was published outlining the ambition that the NHS will increasingly be: more joined-up and coordinated in its care; more proactive in the services it provides; and more differentiated in its support offer to individuals, with the aim being that population health would be improved through coordinated service planning and delivery[1].

In alignment with the Sussex Health and Care Partnership (SHCP), the East Sussex system - East Sussex Clinical Commissioning Group (CCG), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership Foundation NHS Trust (SPFT) developed its East Sussex Health and Care Plan in 2019. This built on improvements over recent years including:

- A comprehensive and co-ordinated range of preventative services
- Ongoing development of community health and social care services
- Strong whole system performance
- Integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system wide basis for the benefit of our population.

3.0 Our population

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. Within this, many people live their later years in ill-health, often with more than one long term condition. This means that increasing numbers of people are needing to use local health and care services that are not always designed to support

[1] NHS Long Term Plan, 2019

the growing numbers of local people needing their support. The NHS Long Term Plan outlines that heart and circulatory disease, also known as cardiovascular disease, causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. With elderly patients and those who live in areas of deprivation tending to have higher prevalence of cardiovascular disease, the system needs to reflect on how best to meet the changing needs of the local population, and to rethink how we deliver an equitable service that can ensure the best health outcomes for our population, and can adapt to the challenges of the future, and represents good value.

The recognition of the changing needs of the population, the changing nature of cardiology care and the associated challenges in providing cardiology services has made the redesign of cardiology a key priority for East Sussex system. Our overall objectives are to:

- improve health, experience and quality of care
- improve the overall sustainability of health and social care services.

Delivering financial sustainability will also contribute to delivering these broader objectives.

4.0 Case for Change

We have reviewed the strategic drivers for change, the existing cardiology services and the availability of other relevant existing and new services. This led us to the following conclusions:

- Subspecialisation – cardiology has become increasingly complex and specialised and the current configuration of services limits our effectiveness by spreading our sub-specialist workforce across multiple sites and reducing opportunities for effective multidisciplinary team working.
- Workforce – operationally providing complete and comprehensive services that directly mirror each other on both sites is a significant workforce challenge, exacerbated by subspecialisation, and further complicated by difficulties with recruitment and retention of the workforce.
- The national Getting It Right First Time (GIRFT)[2] programme reviewed the cardiology service in November 2019. It was recommended that:
    - All inpatient cardiology activity consolidated onto a single site. Non-invasive investigations and outpatients should be provided on both sites subject to appropriate infrastructure and sufficient volumes of activity.
    - Percutaneous Coronary Intervention (PCI) activity at Eastbourne District General Hospital falls short of meeting British Cardiovascular Intervention Society (BCIS) criteria for minimum institutional volumes, and individual numbers of procedures for some operators on both sites are below the minimum of 75 cases per year. Coupled with a low volume alternating Primary Percutaneous Coronary Intervention (PPCI) service at both sites, this arrangement is not sustainable in the longer term and the Trust should aim to consolidate all Percutaneous Coronary Intervention activity on a single site. The number of operators should be reviewed to ensure that all are performing at least 75 procedures per year.
    - Volumes of Chronic Total Occlusion (CTO) are low across the Trust and should be consolidated on one site. The Trust should review the long-term sustainability of the service if volumes do not increase.

[2] The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

    - The volume of complex devices at the Conquest site is well below the British Heart Rhythm Society (BHRS) recommended minimum activity levels and device implants should be consolidated on one site. This will also allow for more effective management of device related emergencies.
    - The Trust should aim to provide 7-day echo cover at both sites.
- Quality: performance indicators and national guidance. There are a range of performance indicators and national guidance for cardiology care, that East Sussex Healthcare Trust is not currently able to consistently meet all of these due to the service's current configurations.
- Nationally, what does the future of cardiology services look like?
    - medical advancements in research and technology are reshaping the way in which we will deliver cardiology care in the future. Increasing subspecialisation, means that cardiologists now specialise in one or two types of treatment, rather than offering the full range, along with the development of new technologies, diagnostics and treatment options. These modernising changes reduce risk, pain and infection, and allow patients to recover more quickly, which means that many planned procedures are now done safely as day-cases, without having to stay overnight in hospital.
    - Evidence, from other areas of the country where a "front door" cardiac assessment model has been implemented, has shown that early cardiac specialist involvement in a patient's care can lead to early and effective patient management, timely patient care and avoids admission to hospital, 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 as they present due to a quick and efficient service providing the care they need. This thereby makes the best use of the workforce and bed availability.
- Net Zero NHS: the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
- IT / Digital: it has been recognised that improvements to the digital infrastructure can benefit and support patient pathways.
- Estates and equipment: the engineering infrastructure is no longer fit for purpose, some of the catheterisation labs are due for replacement and are not operating reliably.
- Making best use of our resources: we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.

As a result, this Pre-Consultation Business Case proposes changes to a limited range of acute cardiology services provided by East Sussex Healthcare NHS Trust.

5.0 How we developed our proposal

Following analysis of the current service provision and the emerging future needs of local people, we developed a Case for Change that outlined the key drivers behind the need for the current service to change. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about cardiology services. This engagement has indicated several key themes:

- Care provided
- Equality and diversity
- Access and transport
- Clinical services.

Alongside finding out what is important to local people and clinicians, we have reviewed local health needs in East Sussex. This tells us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We have taken account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in this Pre-Consultation Business Case (more detail on this can be found in Appendix 1 - Equality and Health Inequalities Assessment).

Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services[3]) took place, during March 2021, to identify and consider a longlist of possible options for the future provision of acute cardiology services, to appraise these options and make recommendations for preferred viable options.

Following this, and as part of our in-depth comparative analyses for this Pre-Consultation Business Case, we have also reviewed quality indicators, travel analysis, the impact this transformation could have on other services (within Sussex and outside of Sussex), the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.

6.0 The process of assurance

When developing our options, our final draft proposals, and this Pre-Consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequality Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[4]
- We have developed our proposal and associated consultation plans in line with the Gunning Principles[5] to ensure that:
    - a decision will not be taken until after public consultation
    - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
    - there is adequate time for people to participate in the consultation
    - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

[3] Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.

[4] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[5] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.

7.0 Our proposal

We are proposing to locate the most specialist cardiac services, needed by a small number of patients, at one of our two acute hospitals and form 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 of our acute hospital sites.

These specialist cardiac services include surgical procedures or investigations that might require an overnight or longer stay in hospital. The introduction of this front door model and hot clinics will ensure 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. These are key quality improvements to the cardiology service.

We are not proposing to change the vast majority of our services, so there will still be cardiology care for anyone who needs it. To make sure that the majority of patients receive good quality care close to home, outpatients, non-invasive diagnostics, cardiac monitored beds, cardiac rehabilitation and heart failure services will stay at both hospitals or in the community. For the many patients who are referred to a consultant by their GP (for non-urgent cases) they will continue to be seen in outpatient clinics, which will still be provided at both hospitals and some clinics in the community.

To help develop this Pre-Consultation Business Case we have engaged with local people and stakeholders. Our next step is to seek further feedback through a formal and public consultation process with local people and with the East Sussex Health Overview Scrutiny Committee (HOSC). We will gather this feedback and comments and consider and respond to these before we make the final decision on the future of East Sussex Healthcare NHS Trust's acute cardiology services.

If this Pre-Consultation Business Case proposal is approved by the CCG, and East Sussex Health Overview Scrutiny Committee consider that the proposal constitutes a substantial variation to services and should therefore be subject to consultation, then this process will begin in December 2021.

Through our engagement and options process we developed 5 options. The conclusion from engagement and the options appraisal is a proposal to take forward two options for formal consultation with patients, the public and local stakeholders:

- **Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites.**
- **Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites.

The proposed transformation, with the front door model, will make key quality improvements to the service, such as:

- change the general medical model to ensure faster access to an expert opinion at the "front door" which will improve care, recovery of services impacted by Covid-19, East Sussex Health Trust's performance and outcomes for our patients; reducing the waiting time for patients, and the amount of time patients have to stay in hospital.
- allow for the creation of flexible and resilient rotas, which in turn enables the workforce to provide front-end assessments (clinical assessments at the "front-end" of the patient pathway, when they arrive in A&E), through the introduction of a new cardiac response team and establishment of hot clinics, all of which are integral to realising the benefits inherent in the proposed model.
- enable East Sussex Healthcare NHS Trust to more sustainably achieve service standards and ensure that local people now and into the future have access to the best possible care we can offer.

Evidence, from other areas of the country where a "front door" cardiac assessment model has been implemented, has shown that early cardiac specialist involvement in a patient's care can lead to early and effective patient management, timely patient care and avoids admission to hospital, 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 as they present due to a quick and efficient service providing the care they need; enabling the best use of our staff and services.

These options will have positive impacts for our patients, as well as workforce, and will improve our ability to meet service standards and patient outcomes in the long term, through a more efficient service and one that is more sustainable for the future.

We recognise that both of these options will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the consultation process to understand the implications of our proposals. All new information and evidence gathered as part of a consultation will inform a decision on the model of delivery and the site of delivery for the specialist aspect of the service.

Once a decision is reached, during any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to communicate any changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

8.0 Recommendation

It is recommended that the East Sussex CCG (via Joint Sussex Committee delegated authority):

- **review and consider the Pre-Consultation Business Case for the Transformation of Acute Cardiology Services delivered by East Sussex Healthcare NHS Trust**
- **approve the proposals and endorse the recommendation that these should be subject to formal public consultation**

- **agree that the decision of the CCG should be submitted to the East Sussex Health Overview Scrutiny Committee to consider if they would like the CCG to formally consult with them on the proposals**

East Sussex Healthcare NHS Trust Transformation of Acute Cardiology Services

Summary Report for: East Sussex Health Oversight Scrutiny Committee

Date:	December
Version:	1
Name of originator/ author:	CCG Programme Team

Contents

1.0 Background

Improving cardiology health outcomes is a key priority area for the Sussex Health and Care Partnership (SHCP).

On 4th March 2021, East Sussex Clinical Commissioning Group (ESCCG) and East Sussex Healthcare NHS Trust (ESHT) presented early draft proposals for a change in the way that acute cardiology services are provided in East Sussex to the Heath Overview and Scrutiny Committee. At that meeting East Sussex HOSC confirmed that any proposals that include a relocation of current acute cardiology services will likely constitute a substantial variation in services and will require a formal consultation.

A pre-consultation business case has now been prepared that builds on the early draft proposals and this has been supported by NHS England and NHS Improvement as part of an assurance process.

At its meeting on Tuesday 30 November 2021, members of the East Sussex Healthcare NHS Trust Board are invited to review and consider the pre-consultation business case (PCBC) for the re-configuration of acute cardiology services, endorse the proposals and agree that the CCG commences a consultation process with the East Sussex Health Overview and Scrutiny Committee (HOSC), and agree that the proposal should be subject to formal public consultation. It has also been considered and approved, in principle pending approval from ESHT, by the CCGs' Joint Sussex Committee at its meeting on Wednesday 17 November 2021.

The full pre-consultation business case and associated documents, including the Equality and Health Inequality Impact Assessment, Quality Impact Assessment, the pre-consultation engagement report and options development and appraisal reports, will all be available and published on the CCG website. The PCBC Executive Summary is provided as Annex 1 to this report together with our plans for consultation which are set out in Annex 2.

2.0 The Proposal

Our proposal is to co-locate the most specialist cardiac services, needed by a small number of patients, at one of our two acute hospitals and form 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 of our acute hospital sites.

These specialist cardiac services include surgical procedures or investigations that might require an overnight or longer stay in hospital. The introduction of this front door model and hot clinics will ensure 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. These are key quality improvements to the cardiology service.

The services could be co-located to:

- Eastbourne District General Hospital, King's Drive, Eastbourne. Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites.

- This would mean the activity provided at the Conquest site would be moved to Eastbourne. This equates to:

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%

NB: this data is based on 2018/19 data.

- As part of the proposed model, it will be possible to convert a proportion of day cases to an outpatient procedure, which means patients would be able to access their care at either site. This would reduce the day case numbers needing to move by approximately 25%.
- Eastbourne is 19.3 miles from Conquest.
- Outpatients and diagnostics will continue to be delivered from both sites.

The services could be co-located to:

- Conquest Hospital, The Ridge, Hastings, Saint Leonard's-on-sea. Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites.
- This would mean all catheter labs and specialist cardiology inpatient services currently run from Eastbourne would be moved to Conquest.
- The activity provided at the Eastbourne site would be moved to Conquest. This equates to:

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%

NB: this data is based on 2018/19 data.

  - As part of the proposed model, it will be possible to convert a proportion of day cases to an outpatient procedure, which means patients would be able to access their care at either site. This would reduce the day case numbers needing to move by approximately 25%.
  - Conquest is 19.3 miles from Eastbourne.
  - Outpatients and diagnostics will continue to be delivered from both sites.

We are not proposing to change the vast majority of our services, so there would still be cardiology care for anyone who needs it locally. To make sure that the majority of patients receive good quality care close to home, outpatients, non-invasive diagnostics, cardiac

monitored beds, cardiac rehabilitation and heart failure services would stay at both hospitals or in the community. For the many patients who are referred to a consultant by their GP (for non-urgent cases) they would continue to be seen in outpatient clinics, which will still be provided at both hospitals and some clinics in the community.

Maidstone and Tunbridge Wells NHS Trust
Maidstone and Tunbridge Wells NHS Trust is also currently undertaking an in-depth engagement process around a similar transformation for their cardiology services. The potential options for their proposals are as follows, and have been included in our PCBC for transparency:

- Option 1: Do nothing. Leave services as they are
- Option 2: Consolidate specialist inpatient and cardiac catheter lab services at Maidstone Hospital by reconfiguring existing space
- Option 3: Consolidate specialist inpatient and cardiac catheter lab services at Tunbridge Wells Hospital by reconfiguring existing space
- Option 4: Consolidate specialist inpatient and cardiac catheter lab services at Maidstone Hospital by building a new space and reconfiguring existing space

NB: The proposed changes will not affect the outpatient services MTW provide, which will stay the same.

East Sussex CCG and ESHT continue to engage with MTW and Kent CCG colleagues to ensure that, whilst a relatively small number of East Sussex residents would be impacted by MTW proposals, the impact on our local people is fully understood.

3.0 How we developed the Proposal

We have worked with patients, their families and carers, wider public and stakeholders, alongside our clinical teams and local GPs throughout the development of this programme, specifically engaging in how we have:

- set out the case for change for the reconfiguration and consolidation of the current acute cardiology services delivered at the East Sussex Healthcare NHS Trust (ESHT) in the context of a wider programme of transformation and improvement
- described the agreed clinical model for acute cardiology services in the context of the Trust's wider service provision and wider national and local drivers
- worked with stakeholders to inform, develop and evaluate viable options for the redesign of acute cardiology services in East Sussex.

All information gathered in the pre-consultation phase has shaped the development and selection of the shortlisted options and feedback has provided a rich source of information which has been used to further shape and refresh the Pre-Consultation Business Case (PCBC), Equality and Health Inequality Impact Assessment (EHIA), and Quality Impact Assessment (QIA).

This PCBC describes our case for change, needs assessment, engagement process, development of options, and sets out the scope of the shortlisted options for reconfiguration and modernisation and the associated costs, risks and benefits.

4.0 The process of assurance

When developing our options, our final draft proposals, and this Pre-Consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequality Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[1]
- We have developed our proposal and associated consultation plans in line with the Gunning Principles[2] to ensure that:
    - a decision will not be taken until after public consultation
    - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
    - there is adequate time for people to participate in the consultation
    - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.
- We have engaged extensively with NHS England and Improvement (NHSE/I) and completed a rigorous NHSE assurance process in relation to the proposal and our consultation and engagement plans.

A Quality Impact Assessment (QIA) has been completed and scored highly in terms of a positive impact on safety, experience and effectiveness. The QIA will continue to be developed as the proposals progress to ensure that quality and safety considerations are built into the outcome.

The Programme has also completed an Equalities and Health Inequalities Impact Assessment (EHIA). The EHIA concludes that the proposed changes will have a positive impact on service users with protected characteristics. The EHIA also indicated that through the design and location, there may be an opportunity to reduce health inequalities through these proposals. The EHIA is a live document and will continue to be developed with the proposals.

5.0 Conclusion

This proposal represents an opportunity to significantly improve acute cardiology services in East Sussex. The CCG and ESHT welcome the opportunity for wider engagement through public consultation and look forward to engagement with and feedback from the HOSC.

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[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

East Sussex Healthcare NHS Trust Acute Cardiology Services Transformation

Pre-Consultation Business Case

2 November 2021

Table of Contents

1. Executive Summary

The purpose of this Pre-Consultation Business Case (PCBC) is to describe the wide engagement to date in communicating the drivers for change, reviewing all possible options to transform cardiology services provided by East Sussex Healthcare NHS Trust to deliver the best possible care for local people. The Pre-Consultation Business Case includes the available information and evidence that has supported the development of a model of care, an analysis of possible options to deliver this model of care, and it proposes preferred viable options to transform acute cardiology services, including inpatients and interventional services.

This Pre-Consultation Business Case recommends to the East Sussex Governing Body two options to take forward to public consultation and, if approved by the Governing Body, to submit to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this constitutes substantial variation to services and that they would like the CCG to consult with them on this.

Context

In 2019, the NHS Long Term Plan was published outlining the ambition that the NHS will increasingly be: more joined-up and coordinated in its care; more proactive in the services it provides; and more differentiated in its support offer to individuals, with the aim being that population health would be improved through coordinated service planning and delivery[1].

In alignment with the Sussex Health and Care Partnership (SHCP), the East Sussex system - East Sussex Clinical Commissioning Group (CCG), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership Foundation NHS Trust (SPFT) developed its East Sussex Health and Care Plan in 2019. This built on improvements over recent years including:

- A comprehensive and co-ordinated range of preventative services
- Ongoing development of community health and social care services
- Strong whole system performance
- Integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)
- Developing our approach to understanding and using our collective resources on a system wide basis for the benefit of our population.

Our population

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. Within this, many people live their later years in ill-health, often with more than one long term condition. This means that increasing numbers of people are needing to use local health and care services that are not always designed to support the growing numbers of local people needing their support. The NHS Long Term Plan outlines that heart and circulatory disease, also known as cardiovascular disease, causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. With elderly patients and those who live in areas of deprivation tending to have higher

[1] NHS Long Term Plan, 2019

prevalence of cardiovascular disease, the system needs to reflect on how best to meet the changing needs of the local population, and to rethink how we deliver an equitable service that can ensure the best health outcomes for our population, and can adapt to the challenges of the future, and represents good value.

The recognition of the changing needs of the population, the changing nature of cardiology care and the associated challenges in providing cardiology services has made the redesign of cardiology a key priority for East Sussex system. Our overall objectives are to:

- improve health, experience and quality of care
- improve the overall sustainability of health and social care services.

Delivering financial sustainability will also contribute to delivering these broader objectives.

Case for Change

We have reviewed the strategic drivers for change, the existing cardiology services and the availability of other relevant existing and new services. This led us to the following conclusions:

- Subspecialisation – cardiology has become increasingly complex and specialised and the current configuration of services limits our effectiveness by spreading our sub-specialist workforce across multiple sites, and reducing opportunities for effective multidisciplinary team working.
- Workforce – operationally providing complete and comprehensive services that directly mirror each other on both sites is a significant workforce challenge, exacerbated by subspecialisation, and further complicated by difficulties with recruitment and retention of the workforce.
- The national Getting It Right First Time (GIRFT)[2] programme reviewed the cardiology service in November 2019. It was recommended that:
    - All inpatient cardiology activity consolidated onto a single site. Non-invasive investigations and outpatients should be provided on both sites subject to appropriate infrastructure and sufficient volumes of activity.
    - Percutaneous Coronary Intervention (PCI) activity at Eastbourne District General Hospital falls short of meeting British Cardiovascular Intervention Society (BCIS) criteria for minimum institutional volumes, and individual numbers of procedures for some operators on both sites are below the minimum of 75 cases per year. Coupled with a low volume alternating Primary Percutaneous Coronary Intervention (PPCI) service at both sites, this arrangement is not sustainable in the longer term and the Trust should aim to consolidate all Percutaneous Coronary Intervention activity on a single site. The number of operators should be reviewed to ensure that all are performing at least 75 procedures per year.
    - Volumes of Chronic Total Occlusion (CTO) are low across the Trust and should be consolidated on one site. The Trust should review the long term sustainability of the service if volumes do not increase.

[2] The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

  - The volume of complex devices at the Conquest site is well below the British Heart Rhythm Society (BHRS) recommended minimum activity levels and device implants should be consolidated on one site. This will also allow for more effective management of device related emergencies.
  - The Trust should aim to provide 7 day echo cover at both sites.
- Quality: performance indicators and national guidance. There are a range of performance indicators and national guidance for cardiology care, that East Sussex Healthcare Trust is not currently able to consistently meet all of these due to the service's current configurations.
- Nationally, what does the future of cardiology services look like?
  - medical advancements in research and technology are reshaping the way in which we will deliver cardiology care in the future. Increasing subspecialisation, means that cardiologists now specialise in one or two types of treatment, rather than offering the full range, along with the development of new technologies, diagnostics and treatment options. These modernising changes reduce risk, pain and infection, and allow patients to recover more quickly; which means that many planned procedures are now done safely as day-cases, without having to stay overnight in hospital.
  - Evidence, from other areas of the country where a "front door" cardiac assessment model has been implemented, has shown that early cardiac specialist involvement in a patient's care can lead to early and effective patient management, timely patient care and avoids admission to hospital, 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 as they present due to a quick and efficient service providing the care they need. This thereby makes the best use of the workforce and bed availability.
- Net Zero NHS: the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
- IT / Digital: it has been recognised that improvements to the digital infrastructure can benefit and support patient pathways.
- Estates and equipment: the engineering infrastructure is no longer fit for purpose, some of the catheterisation labs are due for replacement and are not operating reliably.
- Making best use of our resources: we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.

As a result this Pre-Consultation Business Case proposes changes to a limited range of acute cardiology services provided by East Sussex Healthcare NHS Trust.

How we developed our proposal

Following analysis of the current service provision and the emerging future needs of local people, we developed a Case For Change that outlined the key drivers behind the need for the current service to change. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about cardiology services. This engagement has indicated several key themes:

- Care provided
- Equality and diversity
- Access and transport
- Clinical services.

Alongside finding out what is important to local people and clinicians, we have reviewed local health needs in East Sussex. This tells us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We have taken account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in this Pre-Consultation Business Case (more detail on this can be found in Appendix 1 - Equality and Health Inequalities Assessment).

Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services[3] took place, during March 2021, to identify and consider a longlist of possible options for the future provision of acute cardiology services, to appraise these options and make recommendations for preferred viable options.

Following this, and as part of our in-depth comparative analyses for this Pre-Consultation Business Case, we have also reviewed quality indicators, travel analysis, the impact this transformation could have on other services (within Sussex and outside of Sussex), the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.

The process of assurance

When developing our options, our final draft proposals, and this Pre-Consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequality Impact Assessment to identify any potential negative impacts, and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[4]

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- We have developed our proposal and associated consultation plans in line with the Gunning Principles[5] to ensure that:
  - a decision will not be taken until after public consultation
  - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
  - there is adequate time for people to participate in the consultation
  - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.

Our proposal

We are proposing to locate the most specialist cardiac services, needed by a small number of patients, at one of our two acute hospitals and form 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 of our acute hospital sites.

These specialist cardiac services include surgical procedures or investigations that might require an overnight or longer stay in hospital. The introduction of this front door model and hot clinics will ensure 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. These are key quality improvements to the cardiology service.

We are not proposing to change the vast majority of our services, so there will still be cardiology care for anyone who needs it. To make sure that the majority of patients receive good quality care close to home, outpatients, non-invasive diagnostics, cardiac monitored beds, cardiac rehabilitation and heart failure services will stay at both hospitals or in the community. For the many patients who are referred to a consultant by their GP (for non-urgent cases) they will continue to be seen in outpatient clinics, which will still be provided at both hospitals and some clinics in the community.

To help develop this Pre-Consultation Business Case we have engaged with local people and stakeholders. Our next step is to seek further feedback through a formal and public consultation process with local people and with the East Sussex Health Overview Scrutiny Committee (HOSC). We will gather this feedback and comments and consider and respond to these before we make the final decision on the future of East Sussex Healthcare NHS Trust's acute cardiology services.

If this Pre-Consultation Business Case proposal is approved by the CCG Governing Body, and East Sussex Health Overview Scrutiny Committee consider that the proposal constitutes a substantial variation to services and should therefore be subject to consultation, then this process will begin in December 2021.

[5] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

Through our engagement and options process we developed 5 options. The conclusion from engagement and the options appraisal is a proposal to take forward two options for formal consultation with patients, the public and local stakeholders:

- **Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites.**
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The proposed transformation, with the front door model, will make key quality improvements to the service, such as:

- change the general medical model to ensure faster access to an expert opinion at the "front door" which will improve care, recovery of services impacted by Covid-19, East Sussex Health Trust's performance and outcomes for our patients; reducing the waiting time for patients, and the amount of time patients have to stay in hospital.
- allow for the creation of flexible and resilient rotas, which in turn enables the workforce to provide front-end assessments (clinical assessments at the "front-end" of the patients pathway, when they arrive in A&E), through the introduction of a new cardiac response team and establishment of hot clinics, all of which are integral to realising the benefits inherent in the proposed model.
- enable East Sussex Healthcare NHS Trust to more sustainably achieve service standards and ensure that local people now and into the future have access to the best possible care we can offer.

Evidence, from other areas of the country where a "front door" cardiac assessment model has been implemented, has shown that early cardiac specialist involvement in a patient's care can lead to early and effective patient management, timely patient care and avoids admission to hospital, 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 as they present due to a quick and efficient service providing the care they need; enabling the best use of our staff and services.

These options will have positive impacts for our patients, as well as workforce, and will improve our ability to meet service standards and patient outcomes in the long term, through a more efficient service and one that is more sustainable for the future.

We recognise that both of these options will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders

throughout the consultation process to understand the implications of our proposals. All new information and evidence gathered as part of a consultation will inform a decision on the model of delivery and the site of delivery for the specialist aspect of the service.

Once a decision is reached, during any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to communicate any changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

Recommendation

It is recommended that the East Sussex CCG Governing Body:

- **review and consider the Pre-Consultation Business Case for the Transformation of Acute Cardiology Services delivered by East Sussex Healthcare NHS Trust**
- **approve the proposals and endorse the recommendation that these should be subject to formal public consultation**
- **agree that the decision of the Governing Body should be submitted to the East Sussex Health Overview Scrutiny Committee to consider if they would like the CCG to formally consult with them on the proposals**

2. Introduction

2.1. Background to this proposal

With advances in medicine and treatment, changing health and care needs, and new developments influencing wider society, we have to continually move forward so that we have a health and care system that is fit for the future. In East Sussex, the NHS and county council have been working closely together over recent years, alongside wider partners, to improve population health and wellbeing and reduce health inequalities, to deliver the right services, in the right places at the right time.

Thanks to this work we are seeing more treatment, care and support being delivered where people want it – in their own homes or locally in their community. This shift in the way we provide health and care means that many people are avoiding hospital altogether. And when they do need planned or urgent hospital care they are able to see clinicians and receive treatment more quickly and spend fewer unnecessary days in hospital with better support when they go home.

We work together in the context of the wider Sussex Health and Care Partnership bringing together the health and care organisations across the Sussex Integrated Care System who serve over 1.7 million people at a cost of £4 billion per year. The Sussex Health and Care Partnership has agreed its vision for 2025. A vision where people live for longer in good health. A vision where the gap in healthy life expectancy between people living in the most and least disadvantaged communities will be reduced. A vision where people's experiences of using services will be better and where staff feel supported and work in a way that makes the most of their dedication, skills and professionalism. A vision where the cost of health and care will be affordable and sustainable in the long term.

In 2019, the NHS Long Term Plan was published outlining the ambition that the NHS will increasingly be: more joined-up and coordinated in its care; more proactive in the services it provides; and more differentiated in its support offer to individuals, with the aim being that population health would be improved through coordinated service planning and delivery[6].

In alignment with the Sussex Health and Care Partnership, the East Sussex system - East Sussex Clinical Commissioning Group (CCG), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership Foundation NHS Trust (SPFT) developed its East Sussex Health and Care Plan in 2019. This built on improvements over recent years including:

- A comprehensive and co-ordinated range of preventative services
- Ongoing development of community health and social care services
- Strong whole system performance
- Integrated Outcomes Framework to better enable us to measure whether our work as a system (activity) was having the desired results (outcomes)

[6] NHS Long Term Plan, 2019

- Developing our approach to understanding and using our collective resources on a system wide basis for the benefit of our population.

Our East Sussex Health and Care Plan (2019) outlined plans for the next three to five years focusing on the transformation priorities we need to deliver jointly as a health and social care system to meet the future health and care needs of our population; priorities for programmes of change covering prevention, community, urgent care, planned care and mental health and our plans to work with Primary Care Networks, the voluntary and community sector and others to support delivery of a "new service model for the 21st century"[7] grounded in the needs of our local population. The plan also describes the local implications for workforce planning, IT, digital and estates. We have refreshed our local plan for 2020/21 to ensure we continue this work, whilst recovering access to services that have been impacted by the Covid-19 pandemic. This ensure a focus on:

- Population health management using public health principles
- Health inequalities
- Transformation of clinical pathways and health and social care service models
- Primary care
- Priorities for social care and housing, and other services related to delivering outcomes for our community
- Operational issues and pressures

East Sussex CCG is responsible for commissioning healthcare services for our patient population, with the majority of acute and community services being commissioned from East Sussex Healthcare NHS Trust. The Trust is one of the largest organisations in East Sussex, employing over 7,000 staff and providing acute hospital and community health services. East Sussex Healthcare Trust provides services across three main sites in East Sussex; Conquest Hospital in Hastings, Eastbourne District General Hospital, and Bexhill Hospital, and there are also some satellite sites across East Sussex. In early 2020, East Sussex Healthcare Trust received an overall Care Quality Commission rating of Good, with Eastbourne District General Hospital and Bexhill Hospital rated as Good, and Conquest Hospital rated as Outstanding. Most people in the north and west of East Sussex receive community services from Sussex Community NHS Foundation Trust, and their acute services from University Hospitals Sussex East (in Brighton and Haywards Heath, previously Brighton and Sussex University Hospitals NHS Trust), Maidstone and Tunbridge Wells NHS Trust (predominantly from their Pembury site) or East Sussex Healthcare NHS Trust (from Eastbourne District General Hospital).

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country, and this is expected to grow further. Within this, many people live their later years in ill-health, often with more than one long term condition, leading to an increasing need and

[7] NHS Long Term Plan Implementation Framework(July 2019) a copy can be found here

pressure on health and care services and resources. This increase in need is being felt within the system across Sussex and locally. Our Long Term Plan outlines that heart and circulatory disease, also known as cardiovascular disease, causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. With elderly patients and those who live in areas of deprivation tending to have higher prevalence of cardiovascular disease and the modernisation of approaches to care and technology developments, we need to reflect on how best to meet the changing needs of the local population, to rethink how we deliver an equitable service that ensures the best health outcomes for our population, can adapt to the challenges of the future, and represents good value.

Cardiology is a branch of medicine that deals with diseases and abnormalities of the heart. While there are many clinical conditions that can affect the heart in people of all ages, many heart conditions are age-related, making heart health (cardiology) services increasingly important as people get older.

In recent years, there have been medical advancements in research and technology which are reshaping the way in which we will deliver cardiology care in the future. Increasing subspecialisation, whereby cardiologists now specialise in one or two types of treatment, rather than offering the full range, along with the development of new technologies, diagnostics and treatment options mean that many of the treatment options that are now routinely offered did not exist when the configuration of our services were originally designed. These modernising changes reduce risk, pain and infection, and allow patients to recover more quickly; which means that many planned procedures are now done safely as day-cases, without having to stay overnight in hospital. This modernisation of care, coupled with the projected population demographics, means we need to change the configuration of our services to best meet the needs of our population today and in the future.

Following the impact of Covid-19 on the provision of services since March 2020, East Sussex Healthcare NHS Trust is working to restore current service provision.

The recognition of the changing needs of the population, the changing nature of cardiology care and the associated challenges in providing cardiology services has made the redesign of cardiology a key priority for East Sussex system. Our overall objectives are to improve health, experience and quality of care and improve the overall sustainability of health and social care services. Delivering financial sustainability will contribute to delivering these broader objectives.

This Pre-Consultation Business Case outlines the current cardiology services; the key drivers for change that indicate a redesign is required; pre-consultation engagement that has taken place; along with proposed options to deliver cardiology services in the future. It also outlines the processes that will be followed to agree a preferred option for delivery.

2.2. Our engagement

The CCG is committed to involving local people in all stages of our work, including the development of our proposals for how acute cardiology services can best provide high quality

treatment, care and support for local people and meet increasing local population need. We have worked to gather insight from local people about the patient journey and experiences of accessing cardiology services in order to inform these proposals and potential public consultation. To enable wider public/stakeholder feedback, our plans and supporting information have also been publicised via social media, the Sussex Health and Care Partnership website, and our Engagement HQ platform. We have also ensured Healthwatch has been fully involved in the work so far and have included patients, patient champions, and Healthwatch as part of our options appraisal process.

GP engagement has been sought through attendance at all GP locality forums across East Sussex, providing presentations about the cardiology transformation programme work to date with opportunities for questioning and clarification at the time of presentation and post-presentation. Presentation to Primary Care Network Clinical Directors and individual locality forums ensured wide GP representation that has informed this work.

This work was positively received, including feedback with regards to the importance of communication with the public about the proposals and what they might mean in terms of how services would be accessed.

There was much interest in "front-end" cardiology services such that senior clinical opinion and decision-making meant that the most appropriate care plan for patients could be made in a more timely way, meaning avoidance of unnecessary hospital admissions and more timely communication to primary care. "Hot clinics[8]" for cardiology were welcomed in addition to current Advice and Guidance pathways available to primary care.

Primary care colleagues expressed interest in harmonisation of the Locally Commissioned Service for cardiovascular disease, as well as development of intermediate cardiology services to support pathways from primary to secondary care. Whilst outside the scope of this Pre-Consultation Business Case, as these developments progress their relationship with acute cardiology services will be considered.

Additionally, the Trust has undertaken internal engagement to ensure clinicians delivering interdependent services (such as, acute medicine, emergency department, intensive therapy unit (ITU)) have had an opportunity to review the proposals to consider how any proposed changes may impact across interdependent services. Following this engagement, interdependent services have confirmed that they are supportive of this programme.

2.3. Key duties for consideration

It is important that, as we develop proposals for change, we ensure this takes account of the needs of local people in relation to protected characteristics and health inequalities, in a way that responds to the diverse needs of the population. In relation to this there are key duties that the CCG must have due regard to as outlined below.

[8] A hot clinic is a consultant-led clinic which provides rapid access to assessment for adults with either acute or sub-acute symptoms.

In line with the Health and Social Care Act 2012, the CCG is mindful that it must have due regard to:

- reducing inequalities between patients with respect to their ability to access health services;
- reducing inequalities between patients with respect to outcomes achieved for them by the provision of health services.

As such, consideration has been given to a wide range of information about the CCG's population including issues such as deprivation, ability to access services, demographic trends and patterns of service use. This evidence has informed the development of our proposals to ensure that local people continue to have access to high quality, safe and sustainable services to meet their needs.

These duties have been considered as part of our process in developing this proposal, supporting clinical and financial sustainability across our local system and supporting the delivery of a wide range of services within our local community.

In addition, in order to fulfil our public sector equality duty under Section 149 of the Equality Act 2010, the CCG has undertaken an Equality and Health Inequalities Impact Assessment. This is to ensure that the impact of our proposals is understood and that there is no adverse impact on any particular group of individuals (of protected characteristics and groups who may be most impacted by health inequalities) and to identify actions to mitigate any identified impact where necessary. This is described in more detail in Section 10.2.

3. Strategic context – national drivers for change

Nationally, policy makers are clear that NHS services need to continue to transform to support best outcomes for people and address improved population health and well-being. This section outlines standards and quality of services we want to ensure we deliver for cardiology and the ways in which cardiology service delivery is changing.

3.1. NHS Long Term Plan

In January 2019, the NHS published its Long Term Plan. This sets out the need to modernise current service provision across all care types, including elective care services.

The NHS Long Term Plan also has a key focus on developing Integrated Care Systems, between Primary, Community and Secondary services, as well as local authorities, to join up the planning and delivery of services to improve population health by:

- Being more proactive, joined up, coordinated and differentiated in the services we provide and how we offer support to patients
- Use technology to enable us to redesign clinical pathways and support health and care staff to deliver joined up services
- Improve the role of prevention and reduce health inequalities
- Tackle workforce shortages and support staff

There are also key focuses on improving the digital interfaces between care settings, and a drive to move away from the traditional outpatient models of care.

The plan outlines that heart and circulatory disease, also known as cardiovascular disease, causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years.

3.2. Getting It Right First Time (GIRFT)

Getting It Right First Time is a national NHS England/Improvement programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data driven evidence base to support change. The programme draws on national and international best practice. The Getting It Right First Time programme across East Sussex Healthcare NHS Trust is in progress, and the Trust medical director leads this. A Getting It Right First Time review of cardiology was undertaken in November 2019, and the recommendations are summarised below. Implementation of the transformation proposals in this Pre-Consultation Business Case would enable the Trust to achieve these and associated recommendations:

- All inpatient cardiology activity consolidated onto a single site. Non-invasive investigations and outpatients should be provided on both sites subject to appropriate infrastructure and sufficient volumes of activity.
- Percutaneous Coronary Intervention (PCI) activity at Eastbourne District General Hospital falls short of meeting British Cardiovascular Intervention Society (BCIS) criteria for minimum institutional volumes, and individual numbers of procedures for some operators on both sites are below the minimum of 75 cases per year. Coupled with a low volume alternating Primary Percutaneous Coronary Intervention (PPCI) service at both sites, this arrangement is not sustainable in the longer term and the Trust should aim to consolidate all Percutaneous Coronary Intervention activity on a single site. The number of operators should be reviewed to ensure that all are performing at least 75 procedures per year.
- Volumes of Chronic Total Occlusion (CTO) are low across the Trust and should be consolidated on one site. The Trust should review the long term sustainability of the service if volumes do not increase.
- The volume of complex devices at the Conquest site is well below the British Heart Rhythm Society (BHRS) recommended minimum activity levels and device implants should be consolidated on one site. This will also allow for more effective management of device related emergencies.
- There is continuous 24/7 consultant cardiology cover at Eastbourne District General Hospital but not at Conquest when it is not on call for Primary Percutaneous Coronary Intervention. The Trust should aim to provide continuous on call cover across both sites. The consultant of the week should be free of other commitments.
- The Trust should aim to provide 7 day echo cover at both sites.

3.3. NHS England Elective Care High Impact Interventions (Cardiology)

The NHS England Elective Care Transformation Programme identifies good practice, evidence-based practice and collates it into simple specifications and advice for systems to implement, e.g. a High Impact Intervention (HII). A HII helps systems identify issues that impact various elements of a specialty; e.g. consultant to consultant referrals; supporting patients to be treated closer to home, within the community where possible; supporting GPs to manage their patient's treatment; reducing the number of referrals in the system; making more effective use of resources and managing demand.

Opportunities in cardiology from this HII programme include:

- prevention and earlier detection of risk factors
- improving assessment and referral processes
- removing unwarranted variation
- addressing capacity requirements in secondary care
- improving processes in outpatient clinics
- supporting patients to share decisions about their care with clinicians to better manage their condition
- by supporting patients with co-morbidities, aid patient understanding of their condition and improve their quality of life.

3.4. Net Zero NHS

With the NHS being responsible for 6.3% of England's total carbon emissions, and 5% of its total air pollution, there is increasing pressure for health services to be delivered in ways that are environmentally sustainable. This has led to an NHS plan outlining how the NHS will tackle what has been described as a climate healthcare emergency, with the aim of making the NHS 'net zero' by 2050[9].

Committing to reaching net zero by 2050 means significantly reducing our carbon emissions within the UK through looking at pharmaceuticals, estates, procedures and travel. The NHS Long Term Plan is clear on its goals to reduce the burden of unnecessary travel within the NHS, encouraging service delivery to happen virtually where appropriate, and locally where patient attendance is required. With 17% of the NHS' carbon emissions being attributed to patient and public travel, it is evident that there is great scope for improvement.

With the UK as a whole committed to reducing greenhouse gas emissions by 34% in 2020 and 80% by 2050, sustainable changes in service models are required to reduce healthcare related carbon emissions in line with wider national targets. As a result, we need to pay due attention to the carbon impact of service redesign and new models of care at a local level, focussing on projects that will improve efficiency from a carbon and cost perspective, while maintaining and improving the quality of care received by patients.

[9] NHS England, 2020, *Delivering a 'Net Zero' National Health Service*

Although some improvement can be made by increasing efficiency at the operational level (for example, through use of energy-efficient technologies) this alone is unlikely to be sufficient. The scale of the challenge suggests a fundamental transformation in service models will be needed, so the transformation of this service presents an opportunity to work towards the Net Zero NHS goal. Potential areas of consideration for carbon reduction during transformation include the number of sites services are offered from, the locations of those sites in relation to the population they serve and redefining criteria for face-to-face and virtual appointments, especially where the overall quantity and mileage of journeys can be reduced and optimised, including in relation to the workforce. It is likely that transformed service models would adopt environmental sustainability as a core value, akin to equity or accessibility, with meaningful mechanisms to monitor and hold the system to account for its environmental performance. These proposals offer improvements through the likely need for fewer appointments across the clinical pathways described and therefore a reduced need for repeated appointments and related travel.

East Sussex Healthcare Trust's Building for our Future (BFF) programme[10] will transform the environment in which we provide care for patients in East Sussex. This transformation programme is not directly dependent on BFF but will be aligned to it to ensure that changes made inform, and are informed by, the wider BFF plans. Together these programmes will be a complete redesign of our ageing hospitals, taking advantage of new technologies and improvements in healthcare to ensure that we can meet the future needs of our population. The estates implementation of any transformation in the service will be delivered in harmony with East Sussex Healthcare Trust's BFF programme.

Our approach to achieving net zero emissions will be iterative and adaptive and aims to continuously improve with an increasing level of ambition. It is dynamic work we are committed to as carbon dioxide assessments are undertaken across all services, as technology evolves, the regulatory environment changes, resources materialise and more data becomes available.

4. Local context – our response to the national drivers across Sussex and within East Sussex

4.1. Sussex Health and Care Partnership

The Sussex Health and Care Partnership brings together 13 organisations into what is known as an Integrated Care System (ICS). These organisations include the Local Authorities, NHS Clinical Commissioning Groups (e.g. East Sussex CCG) and NHS Trusts (e.g. East Sussex Healthcare Trust) that cover Sussex. From 1 April 2022, the Integrated Care System will be established as a statutory NHS body.

[10] ESHT Building Better for our Future Programme, http://nww.esht.nhs.uk/building-for-our-future/

Our Sussex Health and Care Partnership 'Strategy Delivery Plan' identified planned care services as one of the core priorities for all health systems across the system. This plan is the Sussex response to the NHS Long Term Plan and has a focus on the key priorities for reducing waiting times and digitally transforming outpatient care to improve access and increase patient choice.

These plans aspire to change the profile of our planned care activity in Sussex, through our commitment to reduce face-to-face outpatient appointments and increase digital appointments, increase advice and guidance provision and encourage patients, through initiatives like patient initiated follow-up (PIFU), to increase the responsibility, ownership and decisions made around their own care. The Sussex Health and Care Partnership believes that digital tools and new technologies will allow local people to access and interact with their care in radically different ways.

The NHS Long Term Plan includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years, up to 2024-25. The aim is to harness digital technology to provide a more convenient service for patients, whilst enabling services to make best use of their workforce and wider resources in a way that balances service provision with the expected growth in demand. It will also reduce travel time for staff and patients, improve patient experience and reduce the carbon footprint of the Sussex healthcare system. We will do this by increasing the use of digital tools to transform how outpatient services are offered and provide more options, better support, and properly joined-up care at the right time in the optimal care setting through a blend of face-to face and virtual outpatient appointments, as appropriate for the care required.

Within Sussex, we have defined our vision for this work as "having the right clinicians, the right place to treat the patient, and the right outcomes against which to measure treatment, where patients do not have to attend an outpatient appointment unless absolutely required to do so".

In East Sussex Healthcare Trust, a clinically led cardiology transformation working group was established in January 2018 and the group identified the need to change clinical practice and the model of care to ensure that services deliver timely, high quality care in the right place that is sustainable over the long term. Development of the service will enable new guidelines to be met and the changing needs of the local population to be effectively served. The following principles were developed for the future strategy of acute cardiology:

1. There will be evidence-based cardiac care for the local people.
2. The aim will be to have care as close to home for patients without compromising clinical outcomes.
3. Any future model of care must deliver NHS Constitutional Standards.
4. The need to develop a clinically sustainable workforce.
5. The service must deliver the care within the context of other relevant system services that is financially sustainable.

4.2. Sussex ICS Cardiology Programme

A Sussex-wide cardiology workstream is reviewing the whole of cardiology with a particular focus on the development of cardiac networks to take forward improvements in patient care, both in terms of enhancing collaboration and aiding service restoration and recovery following the Covid-19 pandemic, and to drive the service transformation required as part of the NHS Long-Term Plan. The priorities of the cardiac networks reflect the 2021-22 NHS planning guidance. This is a Sussex-wide piece of work based on national recommendations and best practice and interlinked with a Getting It Right First Time initiative that seeks to maximise the capacity of acute services as well as engaging community support, e.g. cardiovascular disease prevention and detecting risk factors earlier, improving Atrial Fibrillation (AF) and Heart Failure (HF) services. The cardiology department at East Sussex Healthcare Trust is actively involved in this programme and the East Sussex Healthcare Trust transformation directly links into the Sussex programme.

In East Sussex, our focus on proactively managing population health, better anticipating care needs and integrated working across health and social care, will enable us to deliver the best possible outcomes for local people, and achieve the best use of collective public resources. There is a strong national and international evidence base that demonstrates the value of integrated working in improving patient experience and outcomes, as well as better value for money. Overall, redesigning our cardiology services within the context of the wider system will help to moderate need for hospital services, protecting them so they are available when they are most needed by our population in a more sustainable way.

4.3. Making best use of our resources

East Sussex has amongst the highest numbers of over 65-year olds and over 85-year olds in the country. Within this, many people live their later years in ill-health, often with more than one long term condition, and this is driving increasing demand and pressure on health and care services and resources across our health and care system, as is outlined here in relation to cardiology services.

The opportunities for transforming cardiology services are expected to improve patient experience through quicker care, avoidable admissions and decreased length of stay for people in hospital enabled by earlier senior input; alongside improved use of our resources (including workforce, equipment and estates). However, these benefits are contingent on the ability for the service to provide specialist cardiac opinion at the front door[11]. The front door service cannot be provided under the current model of care as staff are spread out across sites. This means there is less availability of staff to provide a front door model, less availability of senior clinicians to support decision making, and less opportunity for Multi-disciplinary team working.

[11] A front door service is when a clinical assessment takes place at the “front-end” of the patients pathway, e.g. when they arrive in A&E

4.4. Mental Health and its relationship with cardiology

Significant health inequalities have been found for people living with severe mental illness (SMI). Life expectancy is 15-20 years lower than the general population. People with severe mental illness, including schizophrenia, bipolar disorder and major depressive disorders have an increased risk of developing coronary heart disease, a 53% higher risk of having cardiovascular disease and 85% higher risk of death from cardiovascular disease. 16% of the population of East Sussex have a common mental health disorder (2017) and 12.6% have depression (2017-18). This is slightly above the English average.

The prevalence of depression is significantly higher in patients with coronary heart disease, compared with the general population. More than one fifth of all patients with coronary heart disease have depression and up to one third report elevated depressive symptoms. In observational studies, both clinically diagnosed depressions and elevated depressive symptoms predict increased risk of cardiac recurrence and earlier mortality (Nicholson, Kuper, and Hemingwat, 2006).

Therefore, addressing mental health disorders early by providing access to appropriate services and support to increase healthy behaviours (e.g. increased physical activity, improved diet quality, reduced smoking) can reduce someone's risk of experiencing a heart disease event.

People who experience a sudden cardiac event, followed by intrusive treatment such as coronary surgery, can sometimes develop post-traumatic stress disorder (PTSD).

Across Sussex, we have identified improving mental health as a key priority as well as mental health services as one of the core priorities for all health systems across the Integrated Care System, challenging systems and processes across physical, social and mental health settings to more effectively address the physical and mental health integration agenda. Whilst this is not within the scope of this Pre-Consultation Business Case, there is a significant work programme in place to support improved mental health and well-being as part of our Integrated Care System mental health collaborative and it is an important part of our wider work to support improved cardiac health, alongside our work on prevention and promoting good health.

5. Our local health needs

East Sussex has a varied and diverse population and is a county with contrasting characteristics across urban and rural communities, where 74% of the population live in urban areas, and a quarter live in more rural towns, villages or dispersed dwellings. As of 2019, the population size was approximately 560,000. The East Sussex population is predicted to increase by 64,000 people over the 15 year period 2019 to 2034 (11.6%)[12]. Population growth over the period will mostly be among the over 65s as the population continues to age. The population is older than the England average, with the proportion of over 65 year olds varying by district and borough:

Table 1: Percentage of over 65s in East Sussex localities, 2019[13]

[12] East Sussex County Council, April 2021, *Demographic projections…in brief*
[13] East Sussex County Council Public Health, Percentage of over 65s in East Sussex

Locality	% of over 65s
Hastings	20.3%
Eastbourne	25.1%
Lewes	25.8%
Wealden	26.1%
Rother	32.1%

Figure 1: East Sussex age profile, 2019[14]

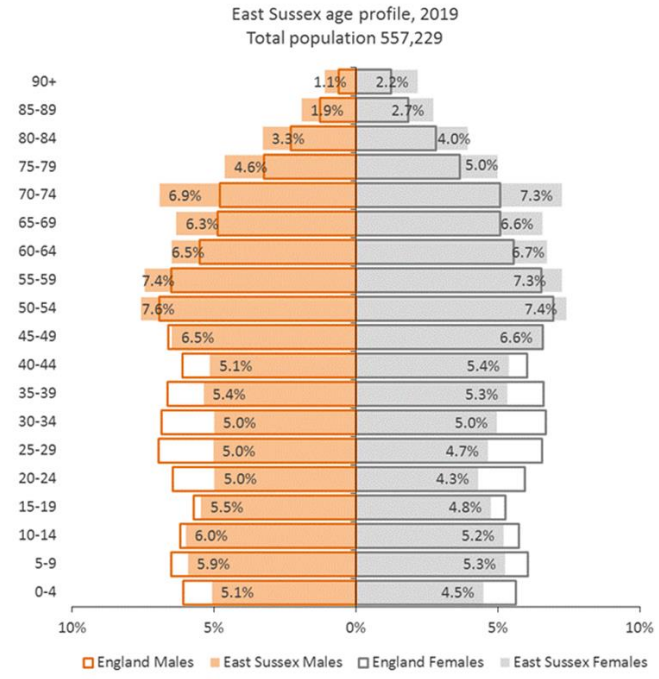


Figure 2: East Sussex Predicted Population Growth 2018 – 2030[15]

[14] East Sussex County Council Public Health, East Sussex age profile, 2019
[15] East Sussex County Council Public Health, East Sussex predicted population growth

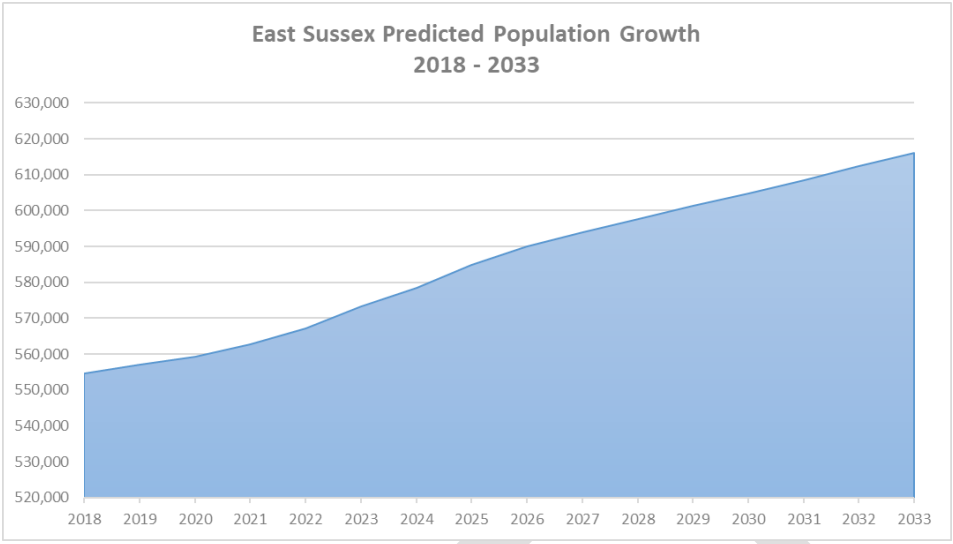
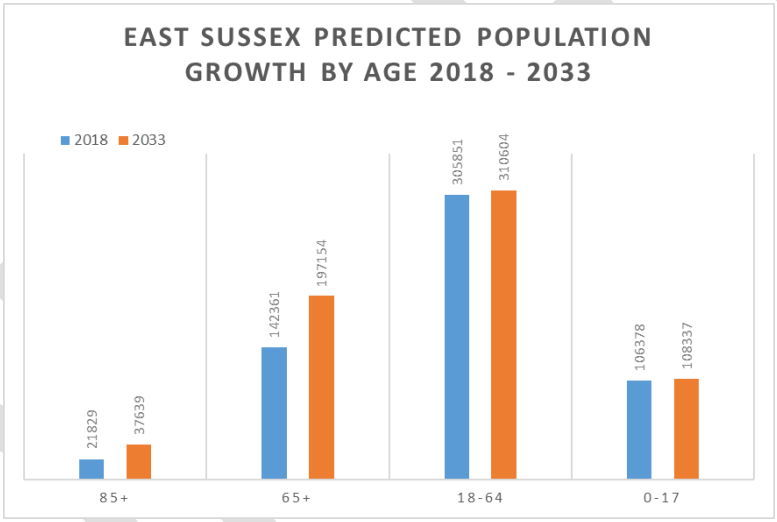


Figure 3: East Sussex Predicted Population Growth by Age[16]



The growth in the over 65 year old cohort is of particular significance because many cardiovascular conditions occur in older people, indicating that, over the next 15 years, demand will grow disproportionately to general population expansion.

The 2019 East Sussex Long Term Plan response identified that the East Sussex population has the following characteristics and health and care needs[17][18].

[16] East Sussex County Council Public Health, East Sussex predicted population growth by age
[17] Sussex Health and Care Partnership, 2019, *East Sussex Placed Based Response to the Long Term Plan (draft)*
[18] The information about East Sussex that has been used to understand our population health and care needs and the priorities for East Sussex can be found in the following documents:
East Sussex Joint Strategic Needs Assessment: http://www.eastsussexjsna.org.uk/
Director of Public Health Report 2018/19 "Picture of East Sussex":
http://www.eastsussexjsna.org.uk/publichealthreports

- The number of young people (aged 0-17) will increase by 3% in the next three years
- The proportion of people over 65 in East Sussex is considerably higher than nationally at 26% in East Sussex compared to 18% in England. By 2023 this will have risen to 27% (19% in England)
- The proportion of those aged over 85 is already significantly higher in East Sussex than nationally and is expected to continue to rise sharply. It is this group that are the most likely to need our services (more detail can be found in our Equality and Health Inequalities Assessment in Appendix 1)
- Health and its determinants are not distributed evenly across the county, with a strong link between poverty and poor outcomes; rurality can also impact access to services (more detail can be found in our Equality and Health Inequalities Assessment in Appendix 1)
- The number of children in need of help and protection is rising locally and nationally, linked to the increase in families experiencing financial difficulties
- Demand for health and social care is set to continue to increase, both as a result of the growth in the proportion of older people in the population and the complexity of their needs with increasing longevity, frailty and multi-morbidity; on average men spend the last 15.5 years of life in poorer health, while women spend 20.2 years in poorer health
- There is a clear gap in life expectancy between people who live in the most and least deprived areas of the county; this gap is 7 years for men and 4.3 years for women while ward level differences are even greater.

The tables and figures that follow provide further detail about the health needs of local people.

Table 2: Number of people in East Sussex living with a Limiting Long-Term Illness (LLTI), 2019[19]

	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
People with LLTI	107,145	20831	19,956	19054	21242	26,062
% of total population	20%	21%	22%	20%	23%	18%

Figure 4: Map of areas of people with Limiting Long-Term Illness in East Sussex CCG area

State of the County 2021, Focus on East Sussex':
https://www.eastsussex.gov.uk/yourcouncil/about/keydocuments/stateofthe-county/
Supporting People to Live Well in East Sussex', the market position statement for adult services and support (April 2019): https:// https://new.eastsussex.gov.uk/social-care/providers/funding/market
Sussex and East Surrey Sustainable Transformation Partnership Population Health Check:
https://www.seshealthandcare.org.uk/2019/02/population-health-check-published-across-the-stp/
[19] East Sussex County Council Public Health, Number of people living in East Sussex with a LLTI

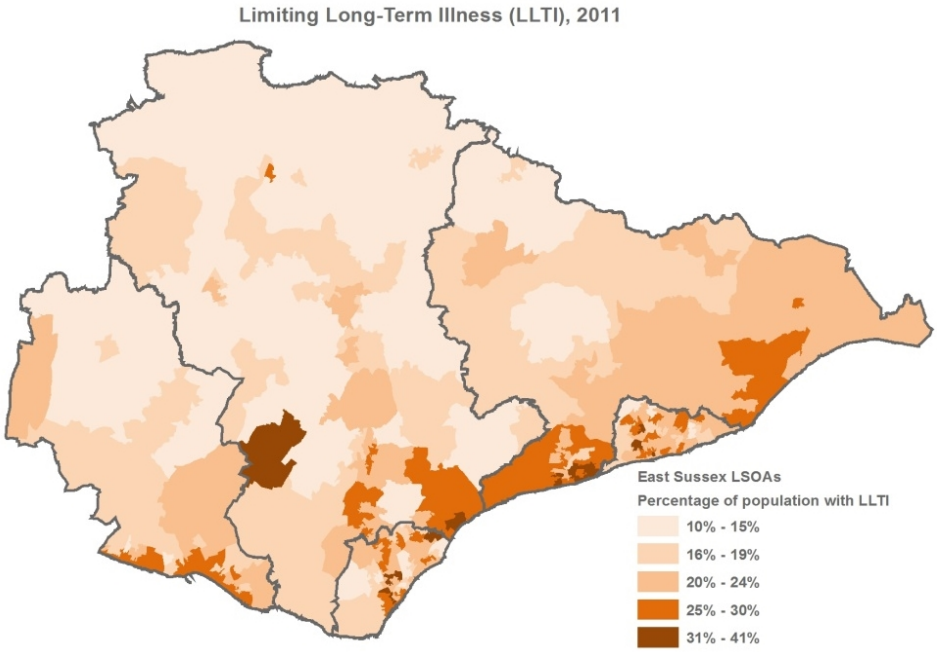
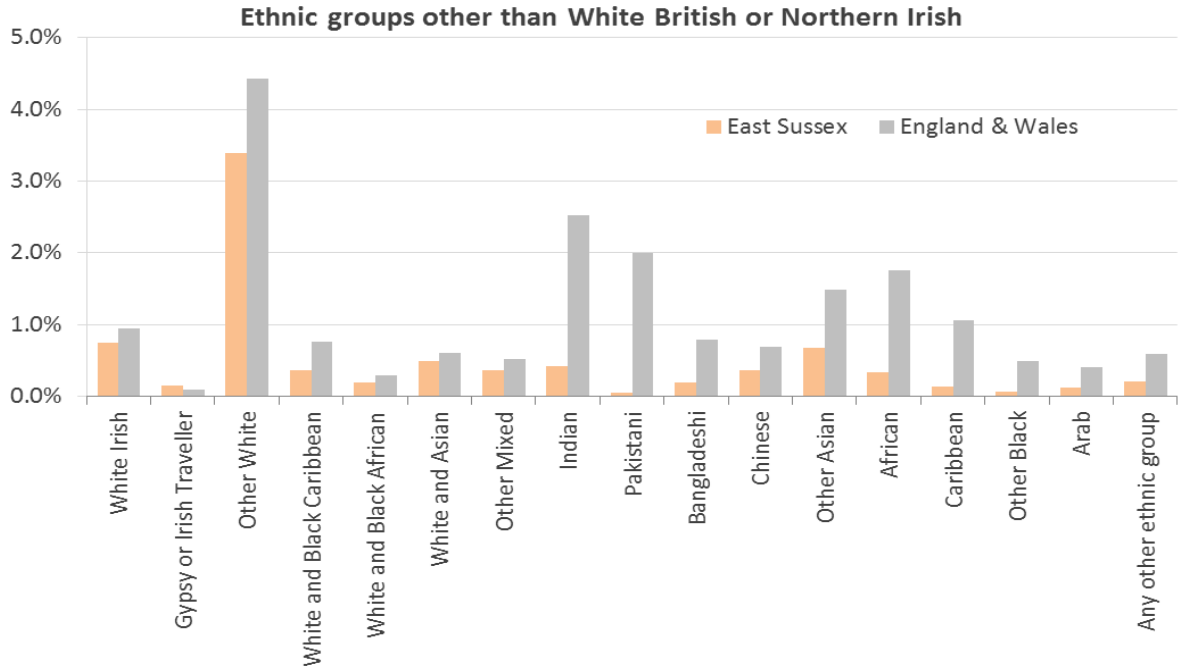
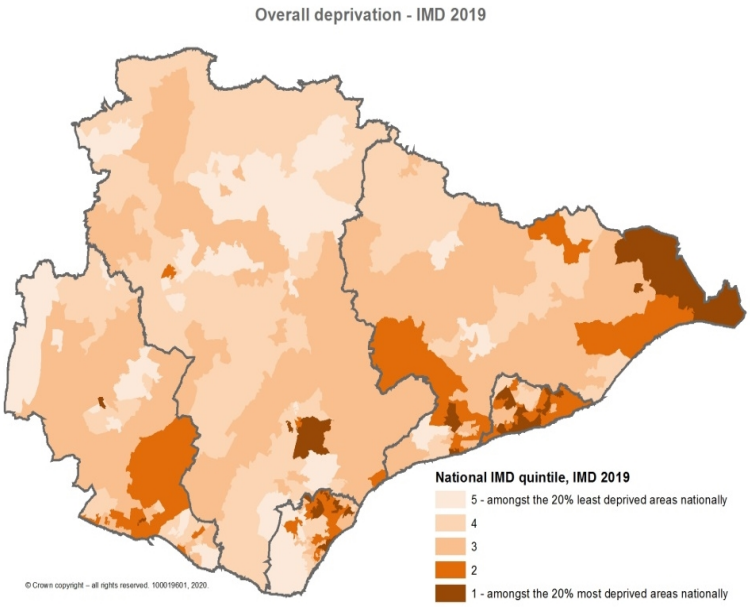


Figure 5: Race and ethnicity populations in East Sussex CCG area



In the East Sussex CCG area, the most deprived wards are Eastbourne Central, Eastbourne North, Hailsham, Hastings and Rother East. Figure 6 shows the areas of deprivation in the East Sussex CCG areas.

Figure 6: Map of areas of deprivation in the East Sussex CCG area



The deprivation is slightly lower overall in East Sussex than the England average, however this varies greatly between district and borough council area:

Table 3: Percentage of deprivation in East Sussex by district and borough council area

District/Borough Council area	% of deprivation
Lewes	4%
Wealden	9%
Rother	13%
Eastbourne	26%
Hastings	49%

The East Sussex Joint Strategic Needs Assessment (JSNA)[20] key lifestyle indicators for these deprived localities, compared to East Sussex, include:

- A low proportion of babies fully or partially breastfed at 6-8 weeks old;
- A high proportion of children with excess weight;
- Childhood immunisation rates below the 95% population target level;
- A significantly lower uptake of national cancer screening programmes;
- A higher rate of adults on drug treatment programmes;
- A higher rate of mortality from COPD;
- A higher rate of premature mortality from circulatory diseases, cancer, liver disease and respiratory diseases;
- A higher prevalence of GP-reported smoking in 15yrs+;
- A higher prevalence of GP-reported depression;

[20] http://www.eastsussexjsna.org.uk/

- A higher prevalence of GP-reported hypertension, atrial fibrillation, COPD, diabetes, chronic kidney disease and palliative care needs.

As part of our review we have considered local health needs with our partners including East Sussex County Council (ESCC) Public Health, NHS providers and the voluntary and community sector. People with these health needs have access to a wide range of services available locally. Some of these services are summarised in Table 4 below. In addition, local people with the above life indicators are supported by GP practices across East Sussex.

We are confident that our system will continue to address the needs of local people and communities by providing integrated universal and targeted services to improve health outcomes and to further reduce health inequalities.

Table 4: Support for lifestyle indicators based on the Joint Strategic Needs Assessment

Key lifestyle indicators for the most deprived East Sussex localities	Examples of existing local services	What are we doing to improve the lifestyle indicators?
Low proportion of babies fully or partially breastfed at 6-8 weeks	East Sussex Healthy Child Programme supports the best possible start in life for all babies and young children so that they develop well and are safe and healthy.	• Develop and sustain local Primary Care Network leadership to prevent ill-health and address equality and health inequalities • Enhance and integrate prevention services and take action on reducing health inequalities in partners' workforce plans. • Build on the strengths, skills, knowledge and networks that individuals, families and communities have to enable people to take more control of their health and wellbeing. • Collaboratively with our key partners continue to engage with targeted population groups and communities in order to
High proportion of children with excess weight	The East Sussex whole-system healthy weight plan aims to increase healthy weight through system-wide action on healthy eating and physical activity.	
Childhood immunisation rates are below the 95% population target level	East Sussex Healthy Child Programme supports the best possible start in life for all babies and young children so that they develop well and are safe and healthy.	
Uptake for national cancer screening programmes is significantly lower	GP Practices targeted and supported to engage with those patients who have not responded to national cancer screening programme invitations to encourage participation.	
High rate of adults on drug treatment programmes	Personal and community resilience programme supports prevention and early intervention. East Sussex drug and alcohol recovery service provides advice and support collaboratively with	

	statutory and voluntary and community sector organisations.	understand how best to support them. • East Sussex has comprehensive multi-agency strategies to tackle obesity (East Sussex Healthy Weight plan 2021-26) and reduce the harm caused by alcohol (East Sussex alcohol harm reduction strategy 2021-26)"
High rate of mortality from COPD	Multi-disciplinary health and social care teams support people with long-term conditions to be diagnosed earlier and provided with more personalised care in the community or at home.	
High rate of premature mortality from circulatory diseases, cancer, liver disease and respiratory diseases	Multi-disciplinary health and social care teams support people with long-term conditions to be diagnosed earlier and provided with more personalised care in the community or at home.	
High prevalence of GP-reported smoking in 15yrs+	GP Practices targeted and supported to engage with those patients who are known smokers and encourage participation in smoking cessation programmes. One You East Sussex provides high-quality, evidence-based smoking cessation support. Patients are four times more likely to quit smoking for good with their support.	
High prevalence of GP-reported depression	Multi-agency partners provide accessible mental health advice and support services in a range of settings and communities. Services enable people to manage and maintain their mental health and wellbeing, so that they and their carers can manage their condition.	
High prevalence of GP-reported hypertension, atrial fibrillation, COPD, diabetes, chronic kidney disease and palliative care needs	Multi-disciplinary health and social care teams support people with long-term conditions to be diagnosed earlier and provided with more personalised care in the community or at home.	

Having considered how the proposals within this Pre-Consultation Business Case impact on health inequalities and how we can take action to address them through this proposal, we will also continue to work with key partners and stakeholders (including primary, community and voluntary sector), around access to prevention services that will further address health inequalities.

5.1. Health Inequalities

Reducing health inequalities and the gap in life expectancy in the county requires coordinated action with services that impact on the wider determinants of health, such as housing, employment and leisure, as well as targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes. Below is a summary of some of the health inequalities that have been identified during the course of this work programme (more information on the impacts this programme will have on the population can be found in Section 9):

- Race/ethnicity
  - Research by The British Heart Foundation states that some ethnic groups are more vulnerable to heart and circulatory diseases, e.g. if you are South Asian, African or African Caribbean in the UK your risk of developing some heart and circulatory conditions can be higher than White people
  - Sussex Black, Asian and Minority Ethnic (BAME) Population Needs Review (2021) states that there is a strong association between socio-economic disadvantage and ethnicity. People from a minority ethnic community are more likely to experience multiple aspects of deprivation; including lower income, poorer housing, more likely to be a victim of crime, and experience unemployment/low paid work.

- Sex
  - In East Sussex, between 2016 and 2018, heart disease was the leading cause of death in men and the third leading cause of death in women
  - 13.6% of males and 8.3% of females die from ischemic heart disease (Public Health England, 2017)
  - High alcohol consumption is linked to a number of poor health outcomes, including cardiovascular disease. High alcohol intake can lead to high blood pressure, heart failure and stroke. In East Sussex, 1 in 10 women and 1 in 3 men drink at high risk (2016)

- Age
  - Cardiovascular disease is most common in people over 50 years, and risk of developing it increases as you get older (www.nhs.uk)
  - Ageing causes changes to the heart and blood vessels that may increase a person's risk of developing cardiovascular disease (National Institute on Ageing)
  - Across the South East, East Sussex has one of the highest rates for cardiovascular mortalities for people ages over 65 per 100,000 patient population (1,106.2) (Public Health Outcomes Framework)

- Disability (including long-term conditions)
  - Approximately 20% of the total population have a long-term health problem or disability that limits day to day activities in East Sussex, which is higher than the national and South East average
  - 31.9% of women and 26.2% of men in East Sussex have two or more long-term conditions

- In 2020, there were 65,510 people in East Sussex over the age of 65 with a long-term condition whose ability to carry out day-to-day tasks were limited/significantly limited
- Risk factors for cardiovascular disease are common in people with learning disabilities
- Cardiovascular disease is associated with some genetic causes of learning disabilities, e.g. almost half of all people with Down's Syndrome are affected by congenital heart defects (Public Health England, 2017)
- Additionally, behaviour related risk factors for cardiovascular disease identified for the general population are common in people with learning disabilities. People with learning disabilities may have poor diets, high rates of obesity, high levels of sedentary behaviour, and be less active
- There are circa 3,300 people in East Sussex on the GP Learning Disability register[21]
- People with diabetes are more at risk of heart disease (Diabetes UK, 2020), it is estimated that 42,628 patients in East Sussex are living with cardiovascular disease and diabetes
- Research shows that certain heart disease risk factors, such as high blood pressure and smoking, are associated with an increased risk for dementia (National Institute for Health, 2017)

There is variation in the uptake of health checks by local people and in the recognition, recording and management of risk behaviours and physiological markers by GP practices. For example, information about the recording and management of hypertension varies within Sussex.[22]

We have a duty to take action on health inequalities and we know this has been exacerbated during the Covid-19 pandemic. We are committed to addressing health inequalities and, as we develop proposals to redesign services we will continue to involve local people. There are opportunities to work across the system to improve disease recognition and recording and ensure pathways to support behavioural change are robust and accessible to local people. We will continue to do this as part of a comprehensive approach to cardiovascular disease in East Sussex and Sussex more widely.

6. Case for Change

This section of the Pre-Consultation Business Case describes the key strategic drivers that have led the development of these proposals to transform acute cardiology services. These drivers informed our discussions during pre-consultation and options development and appraisal.

6.1. Current clinical provision

The cardiology services at East Sussex Healthcare Trust are consultant-led and provide emergency and planned care across the two acute district general hospitals, Conquest Hospital

[21] East Sussex Learning Disability Register, 2020. ESCC Adults Social Care Learning Disabilities Team
[22] https://fingertips.phe.org.uk/documents/NCVIN_Hypertension_Prevalence_and_Management_Oct20.xlsx

in Hastings and Eastbourne District General Hospital, with some service provision within the community.

Figure 7: East Sussex Healthcare Trust's current cardiology service provision

Current service model

	Site 1	Site 2	BX
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients	✓	✓	✗
Interventional Procedures (In Hours)	✓	✓	✗
Interventional Procedures (Out of Hours)	✓	✓	✗
Cardiology Assessment in A&E	✗	✗	✗
A&E Follow-Up Clinics (Hot clinics)	✗	✗	✗

NB: Green tick = service is provided, Yellow tick = service is partially provided, Red cross = service not provided.

Figure 8: East Sussex Healthcare Trust's current cardiology service capacity

	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	×

The ESHT cardiology department:

- is consultant-led
- provides emergency and planned care across 2 Hospitals: Conquest Hospital and EDGH, with some service provision within the community
- supports acute admissions from emergency departments and acute assessment areas
- accepts patients for admission on a referral basis from these areas when immediate intervention is not required

Table 5: East Sussex Healthcare Trust's current cardiology services

	Service Description	East Sussex Provision
Community Cardiology Services	• Cardiac rehabilitation and heart failure services provided in community	• Community cardiology
ESHT Hospital Services	Range of services at ESHT cardiology department. • Dedicated inpatient wards • Coronary care units (CCU) • 3 catheter laboratories across 2 sites • Cardiac pacemaker and diagnostic imaging services • Outpatient cardiology clinics (at Conquest, Eastbourne District General (EDGH) Hospitals and at Bexhill and Uckfield Community Hospitals) • On-call 24/7 primary percutaneous coronary intervention (PPCI) service for patients suffering acute heart attack • Electrophysiology (EP) services	• Acute hospitals • Admission directly to cardiology wards/ catheter laboratories for urgent cases • Majority of outpatient cardiology clinics at Conquest and EDGH hospitals and there is one clinic a week at Bexhill and Uckfield Community Hospitals • Emergency PPCI service across 2 sites in working hours • On-call out of hours PPCI service on alternate sites weekly (1 week at Conquest and following week at EDGH) - always a consultant on call for emergency PPCI procedures • Comprehensive Electrophysiology (EP) services (not routinely offered elsewhere) • Recent review recognised ESHT at forefront of District General Hospital (DGH) for Cardiology, specifically regarding development of EP services

The East Sussex Healthcare Trust's cardiology department encompasses a range of services; Primary Percutaneous Coronary Intervention (PPCI), Electrophysiology (EP), Inpatient Care, Coronary Care Unit (CCU), cardiac catheter laboratories, cardiac pacemaker and diagnostic imaging services, cardiac rehabilitation and heart failure services in the community and outpatient cardiology clinics. Further detail about these services is provided below:

- On call 24/7 primary percutaneous coronary intervention (PPCI) service is provided for patients suffering with acute heart attack
- The Primary Percutaneous Coronary Intervention service provides emergency treatment to patients who need immediate life-saving intervention
- The Primary Percutaneous Coronary Intervention service is currently provided at both sites during core hours of operation, and is provided on a single site out of hours, and at weekends
- The site at which Primary Percutaneous Coronary Intervention is provided out of hours and at weekends alternates between Eastbourne District General and Conquest hospitals
- The service provides and elective Percutaneous Coronary Intervention service for patient who require Percutaneous Coronary Intervention, but not as an emergency.
- Three cardiac catheter laboratories across the two sites (one at Conquest and 2 at Eastbourne District General Hospital), which provide the Primary Percutaneous Coronary Intervention and Percutaneous Coronary Intervention services. These are minimally

invasive interventional cardiology treatments for patients who are suffering from acute myocardial infarction or angina caused by narrowing of the arteries. Single laboratory sites along with the existing inefficiencies of utilisation of the catheter laboratories is unsustainable.[23]

- Angiography is also performed in cardiac catheter labs and is a diagnostic procedure which measures the extent of narrowing of the arteries and helps to inform patient treatment plans. Angiography can now also be performed non-invasively via a CT scanner (CTCA – Computed Tomography Cardiac Angiography) which a developing technology.
- Electrophysiology (EP) services (currently provided only at Eastbourne District General Hospital), which deals with diagnosis and treatment of problems related to the electrical conduction systems of the heart. The Electrophysiology labs contain equipment used to; monitor the electrical impulses throughout the heart to help electrophysiologists see where an irregular heart rhythm may be originating; deliver ablation; device insertion/implantation, e.g. pacemaker or implantable cardioverter defibrillator.
- There are dedicated cardiology inpatient wards, which provide a specialist inpatient environment for those who require admission under the cardiology department for diagnosis and treatment but whose needs can be met on an acute hospital ward without requiring higher level input that would normally be given by a coronary care unit; and coronary care units (CCU), a hospital ward that specialises in the care of higher acuity cardiology patients (e.g. with heart attacks, unstable angina, cardiac dysrhythmia and various other cardiac conditions) that require continuous monitoring and treatment, or a level of care that cannot be provided in a normal ward environment.
- Cardiac pacemaker and diagnostic imaging services, e.g. angiography, cardiac MRI, echocardiograms, x-rays, ultrasounds (ECGs).
- Cardiac rehabilitation and heart failure services are provided in the community.
- Outpatient cardiology clinics at Conquest and Eastbourne hospitals and Bexhill and Uckfield Community Hospitals.

The cardiology service in East Sussex Healthcare Trust utilises a range of estates across their sites and equipment. This Pre-Consultation Business Case focuses on the following adult services: interventional cardiology pathways; in patient pathways that require admission under a cardiac specialist; front-door pathways including A&E review; and cardiac specialist opinion.

There are a range of other cardiology services in place locally such as, diagnostic imaging, radiology, pathology, echocardiogram, out patients, community services, and rehabilitation. Whilst these proposals should be seen in the context of these services, they are outside of the scope of this Pre-Consultation Business Case, and therefore no proposals to change these services are included here.

Current general medical model

East Sussex Healthcare Trust currently have a medical model for patients who present to A&E with cardiology related problems. This means that unless a patient needs to go to the catheter

[23] NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: PRIMARY PERCUTANEOUS CORONARY INTERVENTION (PPCI) (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-prim-percutaneous.pdf

lab immediately (for Primary Percutaneous Coronary Intervention, as described above), patients are first seen in A&E by the emergency teams, and acute medical teams. If the patient needs to come in to hospital, the patient is admitted under the care of the acute medical doctors.

Cardiology opinion can be requested, and cardiologists attend ward rounds in order to provide specialist opinion for patients, however, patients remain under acute medicine unless there is a need to refer them directly to a cardiologist.

We believe that faster access to an expert opinion at the front door would improve care, recovery, and outcomes for our patients; reducing the amount of time patients have to wait for their appointment or procedure and stay in hospital.

Subspecialisation and the workforce

Cardiology nationally has become increasingly complex and specialised. This increase in complexity, coupled with technological advances in the field, has led to increasing sub-specialisation of the workforce; whereby cardiologists now specialise in one or two types of treatment, rather than offering the full range. Therefore, 'generic' skills and abilities are becoming less common.

The current service model was designed at a time when sub-specialisation was not so advanced; cardiologists could perform multiple types of procedures to the standards of the day – East Sussex Healthcare Trust's cardiology services have used this model since 2002 (just under 20 years). Sub-specialisation has led to improved outcomes as cardiologists specialise in specific treatments, and we naturally want to keep developing skills and services to ensure that we can provide good quality treatment and care for patients now and into the future.

However, this increased trend toward sub-specialisation presents challenges. Our current configuration of services limits our effectiveness by spreading our sub-specialists across multiple sites, and reducing opportunities for effective multidisciplinary team working; making it difficult for different experts to collaborate in the treatment of one patient.

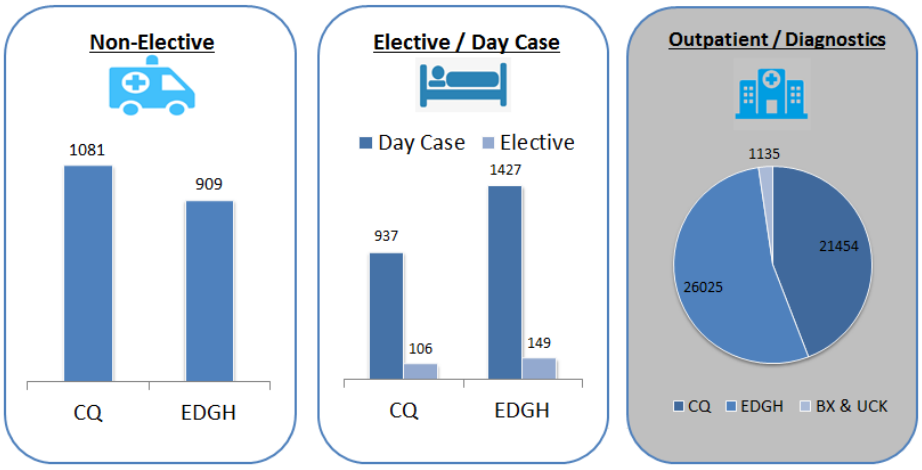
Activity

Overall cardiology activity for 2018/19[24] is given in Figure 9 below.

Figure 9: Cardiology Activity for East Sussex Healthcare Trust, 2018-19

[24] 2018/19 data has been used as the baseline for activity and finance because;

- The final quarter of 2019/20 was disrupted by the Covid-19 response.
- The full year of 2020/21 was disrupted by the Covid-19 response.
- This activity can be triangulated with audited NICOR activity data.
- This activity was impacted less by workforce and downtime issues compared with the 2019/20 data, which would not provide a representative baseline.
- For the purposes of appraising the future impact of the three options above, this period is the most appropriate.



It should be noted that Kent and Medway Integrated Care System is in the process of a similar transformation programme for cardiology services, however the Maidstone and Tunbridge Wells NHS Trust (MTW) service does not include Primary Percutaneous Coronary Intervention. We will ensure these plans are taken into account with regard to any potential affect they will have on the East Sussex population (during 2020/21 there were 2,599 East Sussex patient cardiology activity episodes at MTW) and these proposals. The outcome of the engagement about the future of cardiology services provided by MTW, further detailed independent travel analysis and further feedback from local people will inform our final business case.

Patient experience

Friends and Family Testing

The Friends and Family Tests (FFT) is an anonymous way for patients to provide feedback on a service, and was created to help service providers and commissioners understand whether patients are happy with the service provided, and where improvements might be needed. The below table outlines the responses to FFT in 2018/19 and 2019/20. The response for service users is largely positive, with the service showing improvement in FFT responses in 2019/20. During the pandemic, the FFT was suspended, which means we have not been able to capture feedback from services users during 2020-21.

Table 6: Friends and Family Testing

FFT	2018/19			2019/20		
Recommendation Rate	No. Returned		% Positive of total	No. Returned		% Positive of total
	Positive	Neutral or Negative		Positive	Neutral or Negative	
Cardiac Rehab - Conquest	74	1	98.7%	148	1	99.3%
Cardio Cath Lab - Conquest	638	2	99.7%	501	3	99.4%
James Ward - Conquest	823	14	98.3%	904	14	98.5%
Berwick Ward – Eastbourne	318	16	95.2%	313	17	94.8%
Cardiac Diagnostics - Eatbourne	6	1	85.7%	8	0	100.0%
Cardiac Rehab Eastbourne	651	3	99.5%	191	3	98.5%
Cardio Cath Lab - Eastbourne	245	2	99.2%	496	2	99.6%
Coronary Care Unit - Eastbourne	74	1	98.7%	509	3	99.4%

Complaints

East Sussex Healthcare Trust has robust processes for investigating and responding to formal complaints. The below table outlines the formal complaints that the Trust received for cardiology in 2018/19 and 2019/20. The key themes of these related to patient issues with standard of care, and more specifically patients' confidence in the delivery of their care; lack of holistic approach; and lack of diagnosis. The current service delivery model limits the number of patients who can benefit from early senior decision making, multi-disciplinary working and shared decision making and access to faster diagnostics. It is the aim of this programme to be able to provide an improved model which will address the root causes of these issues.

Table 7: Complaints across Cardiology

	2018/19	2019/20
TOTAL	**15**	**20**

6.2. Current services (workforce, constraints and service patterns)

Workforce

Operationally providing comprehensive services that directly mirror each other on both sites is a significant workforce challenge, exacerbated by subspecialisation, and further complicated by difficulties with recruitment and retention of the workforce. These challenges are detailed below:

- Cardiologists are becoming increasingly specialised and covering all disciplines of cardiology across two sites is becoming unsustainable.
- 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 one remaining vacancy.
- There is a challenge covering the interventional cardiology rotas.
- There is a national shortage of physiologists but East Sussex Healthcare Trust is engaged in "training our own", however the demand makes retention an issue. The physiologists are encouraged to work cross site and the departments are promoting this work pattern. Both lead physiologists on each site have cross site responsibilities.
- There are challenges with recruitment of trained cardiac nurses.
- There are challenges with cardiac radiographers covering both acute sites.
- There are difficulties with staffing 2 coronary care units (CCU) and wards with the appropriately skilled staff.
- 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.

Quality: performance indicators and national guidance

There are a range of performance indicators and national guidance for cardiology care. Key areas are summarised below alongside the East Sussex Healthcare Trust position on each area.

Table 8: East Sussex Healthcare Trust position against national guidance and performance indicators

Performance indicator/national guidance	East Sussex Healthcare Trust position
There is national evidence that heart failure care has better outcomes with cardiac specialist input. Patients with heart failure should have an echocardiogram undertaken within 24 hours; this care is associated with a best practice tariff.	The recent Getting It Right First Time review recommended that the Trust should aim to provide 7 day echo cover at both sites in order to support this best practice; this is difficult to provide within the current workforce and the way that the service is currently configured.
Guidelines on Non-ST elevation myocardial infarction (NSTEMI, a type of	East Sussex Healthcare Trust meets and exceeds this standard; however, future

heart attack but less typically damaging to your heart) / acute coronary syndrome or non-ST segment elevation acute coronary syndrome (NSTEACS, a type of heart attack but either short-lived or only affects a small territory of the heart) require access to the Catheter Lab within 72 hours.	guidelines will require 24 hours to intervention. The future guidelines will be a challenge to meet under the current service configuration.
The Myocardial Ischaemia National Audit Project (MINAP) reports on the quality of Primary Percutaneous Coronary Intervention and ST elevation myocardial infarction, a heart attack (STEMI) care.	East Sussex Healthcare Trust meets all national Myocardial Ischaemia National Audit Project standards, including guidelines which dictate 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. These standards are achieved both in hours, and out of hours, when the catheter labs operate at one site only.
Primary Percutaneous Coronary Intervention centres 24/7 should ideally have a minimum of two adjacent cardiac catheterisation laboratories (British Cardiovascular Intervention Society clinical guideline[25] / NHS Standard Contract for Cardiology: Primary Percutaneous Coronary Intervention[26]).	The cardiology department has two labs at Eastbourne, but only one dedicated lab at Conquest. This is supplemented with access to the interventional radiology suite at Conquest to support quality and safety. This is not a sustainable position due to radiology workforce constraints which is reflected nationally. East Sussex Healthcare Trust is engaged in recruitment/training of workforce as mitigation.
Cardiologists are recommended to undertake a minimum number of procedures in their area per year.	Due to the current configuration of services, East Sussex Healthcare Trust are not able to provide all of our consultants with the opportunity to undertake the recommended number of specialist procedures.
Similarly, catheter labs on individual hospital sites are also required to complete 400 Percutaneous Coronary Intervention procedures per year as a minimum (British Cardiovascular Intervention Society clinical guideline /	Each of our hospital sites on their own are unable to meet these requirements due to both the changing profile of demand resulting from the changing patterns of service delivery, as well as the staffing challenges.

[25] British Cardiovascular Intervention Society https://www.bcis.org.uk
[26] NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: PRIMARY PERCUTANEOUS CORONARY INTERVENTION (PPCI) (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-prim-percutaneous.pdf

NHS Standard Contract for Primary Percutaneous Coronary Intervention).	
For Electrophysiology (EP) and ablation, the Guidance from Heart Rhythm UK (HRUK) states these need to be co-located with catheter lab services. Additionally, centres should complete a minimum of 200 Electrophysiology cases per annum. (British Heart Rhythm Society Standards for Electrophysiology and Ablation[27] / NHS Standard Contract for Electrophysiology & Ablation[28]).	East Sussex Healthcare Trust is keen to continue to develop its Electrophysiology service, which is currently provided at Eastbourne District General Hospital, and guidance on co-location will be considered as part of these service reconfiguration proposals. East Sussex Healthcare Trust delivers minimum numbers of Electrophysiology procedures currently, provided at Eastbourne District General Hospital.
Device Guidelines from Heart Rhythm UK suggest that for Cardiac Resynchronisation Therapy (CRT) and Implantable Cardiac Defibrillators (ICD), there should be an aspiration to provide a 24 hour service, in order to deal with patients admitted with multiple shock delivery or other device related issues. Additionally, centres should complete a minimum of 60 Cardiac Resynchronisation Therapy (CRT)/Implantable Cardiac Defibrillators (ICD) cases per annum. (NHS Standard Contract for Cardiac Resynchronisation Therapy and Implantable Cardiac Defibrillators[29]).	Delivering on these aspirations would be challenging under the current service configuration. Consolidation of activity would be required to meet this number as a single centre. East Sussex Healthcare Trust delivers minimum numbers of Cardiac Resynchronisation Therapy (CRT) and Implantable Cardiac Defibrillators (ICD) procedures currently, but this is split across the two acute sites.

The recommended numbers of interventional procedures for a single site in the NHS standard contracts for Primary Percutaneous Coronary Intervention; Electrophysiology and ablation

[27] British Heart Rhythm Standards https://www.bhrs/standards/
[28] NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: ELECTROPHYSIOLOGY AND ABLATION SERVICES (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-electrophysiology.pdf
[29] 5 NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD) AND CARDIAC RESYNCHRONISATION THERAPY (CRT) (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-implant-cardi-defib.

services; Implantable Cardioverter Defibrillator (ICD) and cardiac resynchronisation therapy (CRT) also render continuing with interventional procedures on two sites untenable.[30][31][32]

A recent report from the National Institute for Cardiovascular Outcomes Research (NICOR), has highlighted that East Sussex Healthcare Trust performs variably against the national standard of 75% of people arriving at hospital receiving Primary Percutaneous Coronary Intervention (PPCI) treatment within one hour (this is often referred to as door to balloon time), The Trust believes that by consolidating catheter laboratories, it will be able to improve the care pathways and the door to balloon times. This will mean that the national target of 75% will be achievable, and access to catheter laboratories will improve. This is due to the increased capacity available on the interventional site and improved staff resources that will enable quicker access to services for patients along the pathway.

Estates and Equipment

Some of the cardiac catheterisation laboratories at East Sussex Healthcare Trust are due for replacement and are not consistently operating reliably. In addition, the engineering infrastructure is no longer fit for purpose. It is therefore makes sense to consider the design of our cardiology service alongside considerations to bring the associated equipment and estates up to date.

6.3. The future of cardiology and associated support services

There are a range of national developments in relation to how cardiology services are delivered that can inform how we support local people who need these services, including:

- **Front-End Cardiac Assessment –** Evidence, from other areas of the country where a "front door" cardiac assessment model has been implemented, has shown that early cardiac specialist involvement in a patient's care can lead to early and effective patient management, timely patient care and avoids admission to hospital, 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 as they present due to a quick and efficient service providing the care they need. This thereby makes the best use of the workforce and bed availability.
- **Growth in the use of Cardiac CT versus historical use of Interventional Angiography –** there has been a pattern identified which shows a reduction in interventional cardiac angiography, this is due to an increase in CT coronary angiography, which can check for narrowing or blocked arteries non-invasively, and doesn't require any recovery time. This will have an impact on how services are used

[30] NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: PRIMARY PERCUTANEOUS CORONARY INTERVENTION (PPCI) (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-prim-percutaneous.pdf
[31] NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: ELECTROPHYSIOLOGY AND ABLATION SERVICES (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-electrophysiology.pdf
[32] NHS England 2013/14 NHS STANDARD CONTRACT FOR CARDIOLOGY: IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD) AND CARDIAC RESYNCHRONISATION THERAPY (CRT) (ADULT) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-implant-cardi-defib.pdf

with fewer having to go to the catheter lab in future in order to determine a treatment plan.

- **Heart Failure/Atrial Fibrillation (AF)** – with an increasingly ageing population it can be expected that there will be an increase in heart failure and Atrial Fibrillation. "Front-end" intervention may improve the care of syncope (fainting) and help identify if there is a cardiac cause which requires treatment. In an ageing population this can have further benefits for the quality of life of patients. Better risk stratification of syncope, with a team focussed approach with elderly care and neurology, can improve care for patients on the most appropriate pathway, and reduce the ongoing risk of falls, fractures and other injuries.
- **Developments in IT/Digital and future cardiology service provision**
  It is recognised that the NHS can significantly benefit from having the appropriate digital infrastructure in place to support patient pathways. In line with the ambitions of the Long Term Plan, we aim to harness digital technology to provide a more convenient service for patients, whilst enabling services to make best use of their workforce and wider resources in a way that balances service provision with the expected growth in need for local services.

  While there is no universal definition of 'digital technology', it moves beyond an accepted perception of personal computers and databases to concepts such as machine learning underpinned by artificial intelligence to assist with identification task, mobile computing (which includes patient's own access to technology and smartphones) as well as personal and wearable devices that are generally in direct contact with wearers for long durations and are capable of gathering large quantities of data on specific biometrics and behaviours. The possibility of the proliferation of remote monitoring technology creates opportunities for more sustainability in healthcare we can offer.

  Our experience during Covid-19 demonstrated our ability as a system to adapt to different forms of service delivery and that we can continue to further develop them. The opportunity to deliver services closer to people's homes in a way that is more convenient and makes better use of resources is a key driver for any service changes. We will continue to do this by increasing the use of digital tools to transform services by providing more options, better support, and joined-up care at the right time in the optimal care setting, offering a blend of face-to face and virtual outpatient appointments, as appropriate for the care required. For example, the coronary care unit uses a system which enables ambulance crews to send information about patients requiring a Primary Percutaneous Coronary Intervention while travelling to hospital[33]. East Sussex Healthcare Trust is developing its new Digital Strategy due in 2022, which will be informed by learning from Covid-19.

[33] This is possible for EP, however this is not contingent on the proposed transformation in this Pre-Consultation Business Case, but can be progressed outside of proposals and explored with the planned pre-alert system for stroke and cardiology.

Delivering a "Net Zero" NHS involves a multifaceted approach to decarbonising buildings, travel, and the products we rely on. By also reimagining aspects of how care is delivered to include providing greater access to telemedicine[34] and digitalisation[35], it could enable more patients to make virtual appointments that help reduce travel, reduce carbon, while ensuring a better continuity of care.

Which patients will our proposals affect?

91.5% of the service will remain the same. There is no change to outpatient or diagnostic services, and outpatient procedures will continue to be offered at both sites.

Table 9: Number of patients at each point of delivery who will be unaffected by this proposal, compared to those who will be

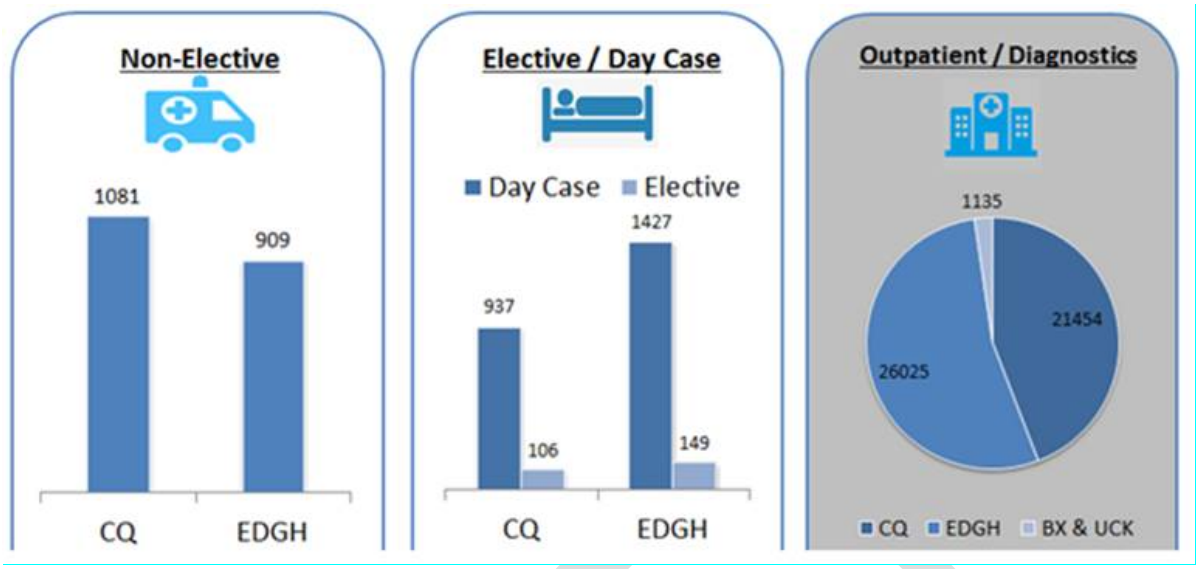
Point of Delivery	Number of Patients	Percentage
Outpatients	29567	54.5
Outpatient Procedures	11057	20.4
Outpatient Diagnostics	8992	16.6
Emergency / Unplanned Inpatients	1990	3.7
Planned Day Case Procedures	2364	4.4
Planned Inpatient Procedures	255	0.5
Grand Total	54225	

- The services in green would be unaffected by the new model.
- This means that 91.5% of the service is unaffected by the proposed model.
- Approx. 50% of the remaining patients, which would equal approximately 3.5% of patients (1,904 patients), would potentially change the site at which care is given - although for emergencies this already happens out of hours.
- The proposed changes would affect less than 2% of patients who access the service for emergency treatment, and just over 2% for elective (however some services are on a single site already - Electrophysiology /ADCHD)

The figure below shows how many potential patients are affected, per site, broken down by non-elective (emergency / unplanned), and elective or day case (planned) activity. Outpatients and diagnostics are show greyed out, as this activity is not impacted by the changes.

Figure 10: Number of patients, per site and by point of delivery, who will potentially be affected by this proposal

[34] Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology.
[35] Digitalisation is the conversion of text, pictures, or sound into a digital form that can be processed by a computer.



Suspected Myocardial Infarction / South East Coast Ambulance Service Conveyances
Some South East Coast Ambulance Service Conveyances will require a longer journey from that in the current model due to permanently offering the service from a single site. However, currently we only operate a Primary Percutaneous Coronary Intervention from one site out of hours, which alternates weekly.

The current model of alternating single site Primary Percutaneous Coronary Intervention provision out of hours means that we know that we can safely provide timely care from either site, and meet all national safety and access targets.

South East Coast Ambulance Service have expressed their support for permanent consolidation to one site, as this avoids the potential risk of conveyance to the non- Primary Percutaneous Coronary Intervention site in an alternating model.

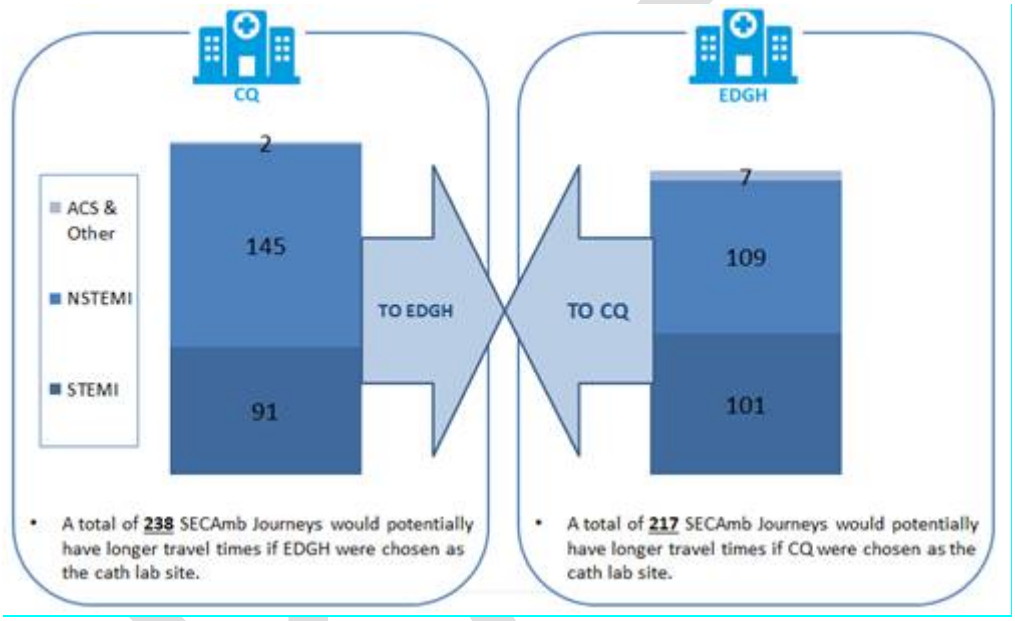
Consolidating Percutaneous Coronary Intervention provision has been further tested during the Covid pandemic. East Sussex Healthcare Trust had to single site the Percutaneous Coronary Intervention service due to operational pressure, availability of workforce, and to expand critical care capacity. This has provided a proof of concept for consolidation, especially in relation to patient safety, national call to balloon and door to balloon times, and workforce resilience. During the pandemic there were a number of scenarios as follows:

1. Management of ST elevation myocardial infarction & out of hours Cardiac Arrest through one site
2. Management of Non-ST elevation myocardial infarction & Arrhythmia patients through one site
3. Elective procedural work through one site
4. Management of cardiac patients presenting to both non-interventional and interventional sites.
5. Enhanced front door model on one of the sites with improvements in patient pathways.
6. Workforce deployment for on-call rota through one site

These elements illustrated the benefits previously outlined and tested the transfer models for patients and for South East Coast Ambulance Service.

The figure below shows the annual number of patients that would potentially require longer conveyance times for different types of heart attack; illustrating per site how many cases would require transfer to the interventional site, depending on the site chosen.

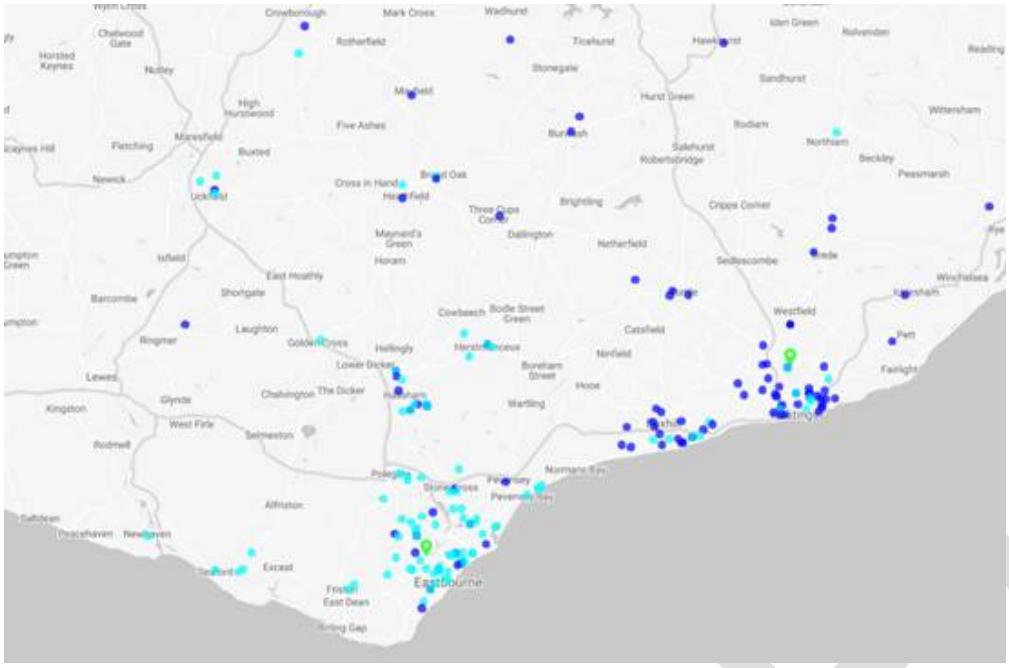
Figure 11: Number of patients, per annum, who may potentially require a longer conveyance time



The potential number of ambulance conveyances that will be impacted equates to between four-five per week.

The below map shows the annual distribution of patients across the county who were admitted for heart attack treatment as part of the above pathway.

Figure 12: Annual distribution of patients admitted for heart attack treatment in East Sussex



Key
The green icons show the locations of the two acute sites.
The light blue icons indicate a patient postcode with an admission to Eastbourne District General Hospital
The dark blue icons indicate a patient postcode with an admission to Conquest.

The map illustrates that the majority of conveyances are centred around urban areas, with minimal number at the fringe:

- There would be a low number of diverts required to Brighton if the service was provided at Conquest, postcode analysis on the data above shows that approximately 6 cases would require divert, per year, to Brighton for suspected myocardial from the Seaford area.
- There would be a low number of diverts required to Ashford if the service was provided at Eastbourne District General Hospital, postcode analysis on the data above shows that approximately 6 cases would require divert, per year, to Ashford for suspected myocardial infarction from the Rye area.

Consultation with South East Coast Ambulance Service has suggested that approximately 20-24 total diverts per year may be required across all conditions, including suspected myocardial infarction.

Both acute providers have confirmed that the diverts would not cause an operational or clinical problem, and would be subsumed within their normal activity.

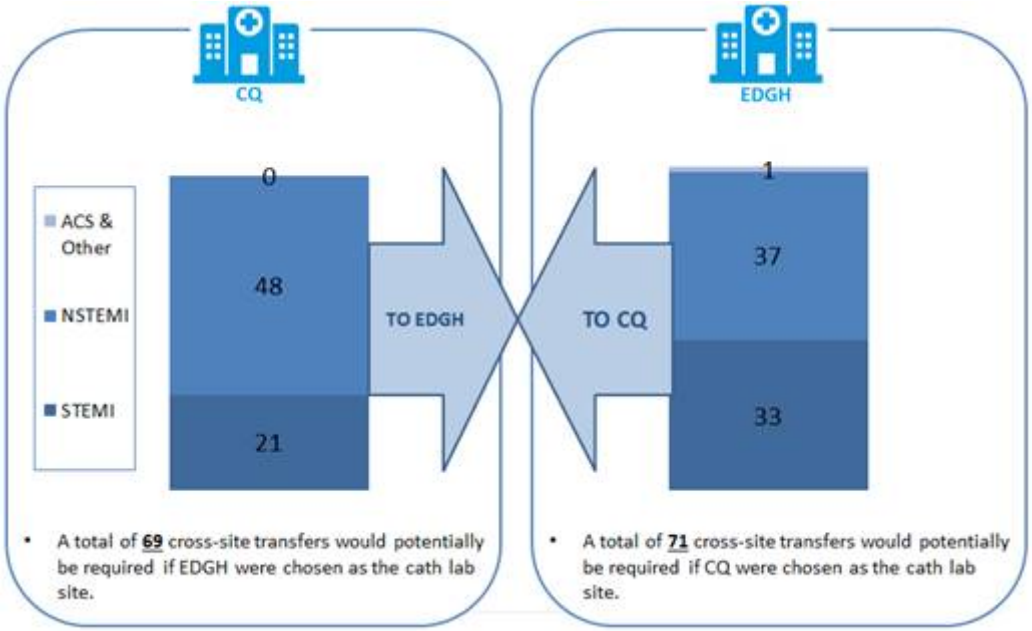
Both providers routinely accept diverts currently from fringe areas out of hours when East Sussex Healthcare Trust operates from a single site.

Inpatient Cardiac Events
Some patients suffer an acute coronary event whilst an inpatient at East Sussex Healthcare Trust, and would need to be transferred to the interventional site for immediate treatment.

- For this cohort of patients, immediate ambulance transfer, or a ‘critical care’ transfer (accompanied by an anaesthetist), would be provided to ensure care is provided in

transit, and timely access to intervention would be provided in line with national guidelines (call to balloon time).
- The pathway employed would be the same as our current out of hours pathway, and so it is well tested and we know it is safe – conforming to all access guidelines.

Figure 13: Number of transfers for inpatient heart attacks



The potential number of transfers for inpatient heart attacks equates to between 1-2 per week.

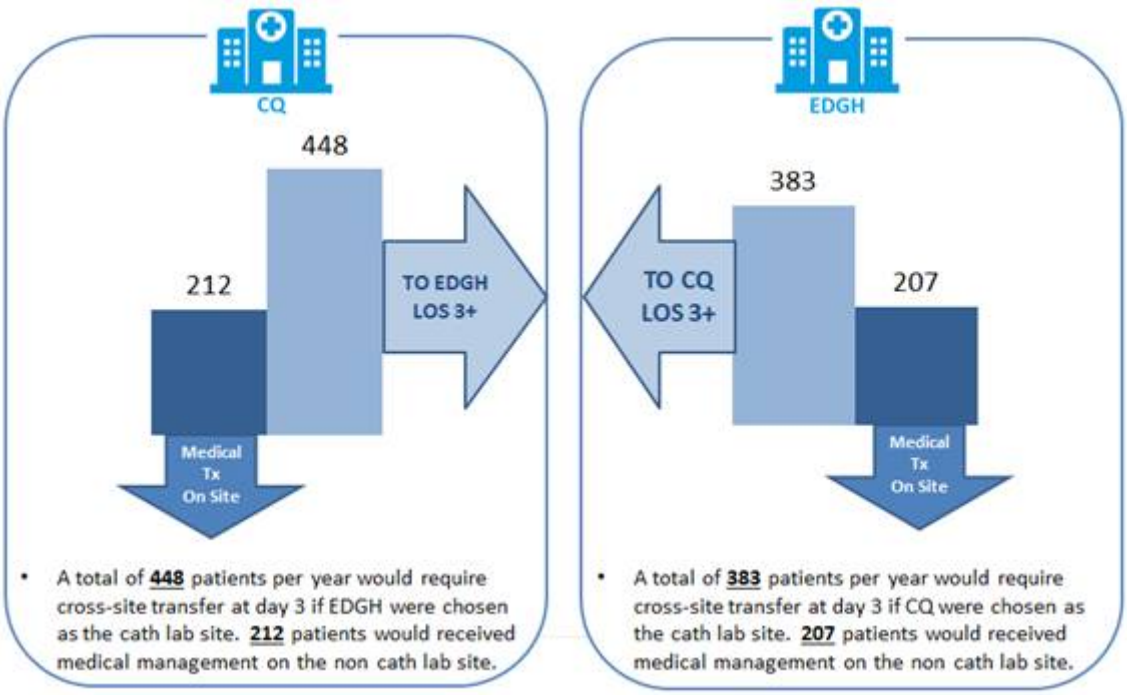
Unplanned (Non-Elective) Admissions
There will be a cohort of patients who require non-elective admission, but would not require immediate intervention, or transfer to a cardiology specialist ward.

- For patients who arrive unplanned (via A&E), but who do not require intervention, there will be access to cardiac monitored beds, support of an ITU if required, and cardiology ward rounds (as per the current model).
- Additionally, there will be access to front-end cardiac opinion in hours (additional to the current model), which will help improve treatment decisions from the point of admission for all patients, across both sites – this is an increase in the service provision offered under the current model.
- Patients who stay on the non-interventional site would continue to be managed on medical wards on the non-interventional site, under joint care with Cardiology (as per the current model).

There will be a cohort of patients who require non-elective admission, but would not require immediate intervention, but do require specialist input and transfer to a cardiology ward.

- Patients who require more specialist care under the cardiac team, hospital transfer will be arranged, and the patient will be admitted to the cardiology ward on the interventional site.

Figure 14: Number of patients potentially requiring transfer to the cardiology inpatient ward

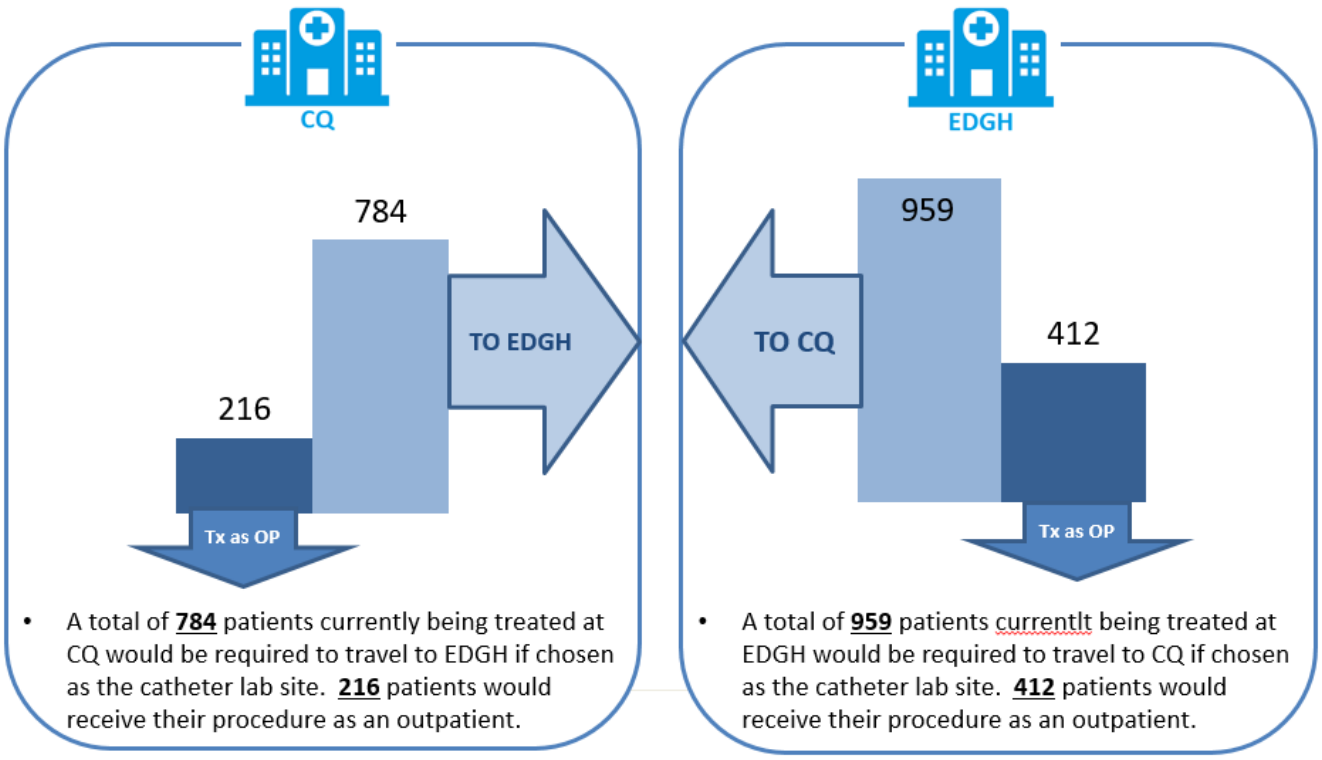


The potential number of patients requiring transfer to the cardiology inpatient ward equate to between 7-9 per week.

Planned Elective / Day Case
Planned (elective and day case) patients, who do not require transfer to hospital via PTS or South East Coast Ambulance Service, make up approximately 4.9% of activity in Cardiology

- As part of the transformation, some procedures currently conducted as elective or day case procedures can be conducted as outpatient procedures, and therefore will not need to travel to the interventional site.
- For the remaining activity, a journey to the interventional site would be required.

Figure 25: Number of patients who will be required to travel further to the interventional site



The total number of patients who will be required to travel further to the interventional site in order to access elective care would equate to between 15-18 per week. Further information regarding the impact to patient journeys can be found in section 10.2.1.

It should be noted that East Sussex Healthcare Trust does currently meet the NHS standard for Primary Percutaneous Coronary Intervention call to balloon time of less than 150 minutes as part of the current out of hour's service and is normal practice. All transfers conform to British Cardiovascular Intervention Society standards and are included in regular national audit datasets.

Mitigation during times of increased activity
It is acknowledged that at times there will be increases in activity that go above the normal expectations. However, these periods of surge are encountered routinely during current out of hours operation when Primary Percutaneous Coronary Intervention is only offered on a single site.

Currently, South East Coast Ambulance Service convey patients to across site as required, designated as "escalations of care". There are robust protocols in place for managing these transfers safely, as we all clear actions as part of a "full capacity protocol" within the hospital.

On occasions of surge, and when limited transfers are possible, patients will triaged according to clinical need – however, those requiring immediate intervention are always transferred by the Ambulance service as escalations of care. The current model uses this same triage process, which works well, and this process will continue following any transformation.

Cross site transfer scenarios have been tested with surgery and stroke across both sites and is shown to work well and not impact outcomes.

In addition to surges of emergency patients, there are some low risk patients who may require transfer. These patients (designated treat and transfer) are transferred using SCAS service (Non-emergency hospital transfer provider), as they do not need a cardiac monitor. This also applies to heart failure patients, who can be transferred at low risk. This follows current protocols already in place.

Non-emergency patient transfers do not occur out of hours, as there is not clinical requirement to do so. Patients can access cardiac monitored beds at the site that is not offering Primary Percutaneous Coronary Intervention, and if treatment is needed, can be transferred in hours the following day.

Hospital Transport
East Sussex Healthcare Trust will ensure there is a robust SLA to cover inter-hospital transfer requirements as set out above. The Trust are considering commissioning separately a dedicated transport service to enable transfers across site which will meet the needs of not only this transformation programme, but also other services currently provided from only one site (e.g. surgery, stroke and maternity services).

6.4. Learning from our Covid-19 response

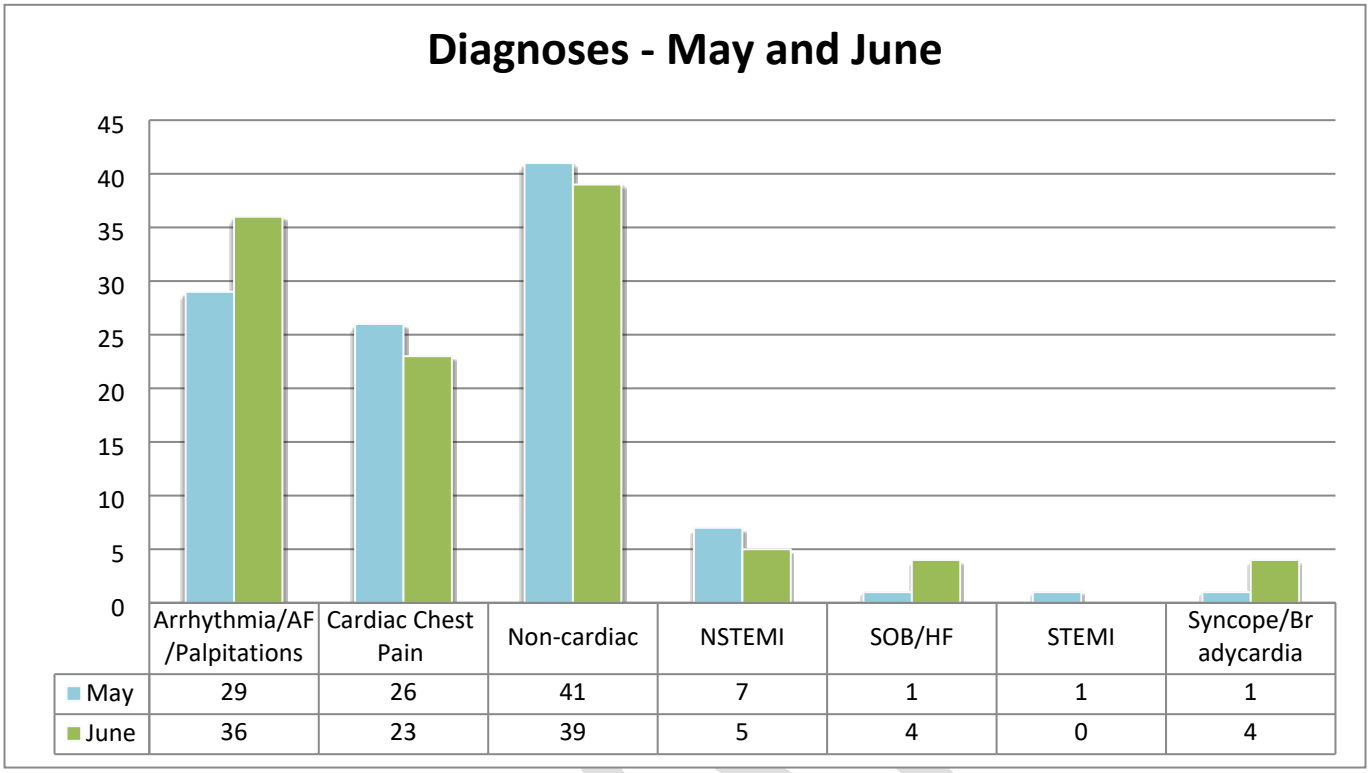
The evolution of the Covid-19 pandemic required East Sussex Healthcare Trust to take steps to increase its critical care capacity during the summer months of 2020. As part of this, cardiology facilities at the Conquest Hospital were identified as required to support the response to the pandemic; meaning that the Conquest Cardiac Catheter Labs were unable to be used for cardiology procedures. The interventional service therefore had to be temporarily consolidated to Eastbourne District General Hospital.

As part of the temporary change to services due to the Covid-19 pandemic, cardiology were also able to test out a front-end model of care in the Emergency Department; where senior clinicians were able to provide assessment and opinion to patients presenting to A&E. This enabled the service to provide more timely access to expert opinion, appropriate diagnostics, and treatment; in many cases reducing the need for admission whilst also improving the quality of care received. From this perspective of cardiology service provision, the change in provision of interventional services demonstrated the associated benefits of a front-end model.

6.4.1. Outcomes from the introduction of a front-end model of care as part of Covid-19 service changes (May and June 2020)

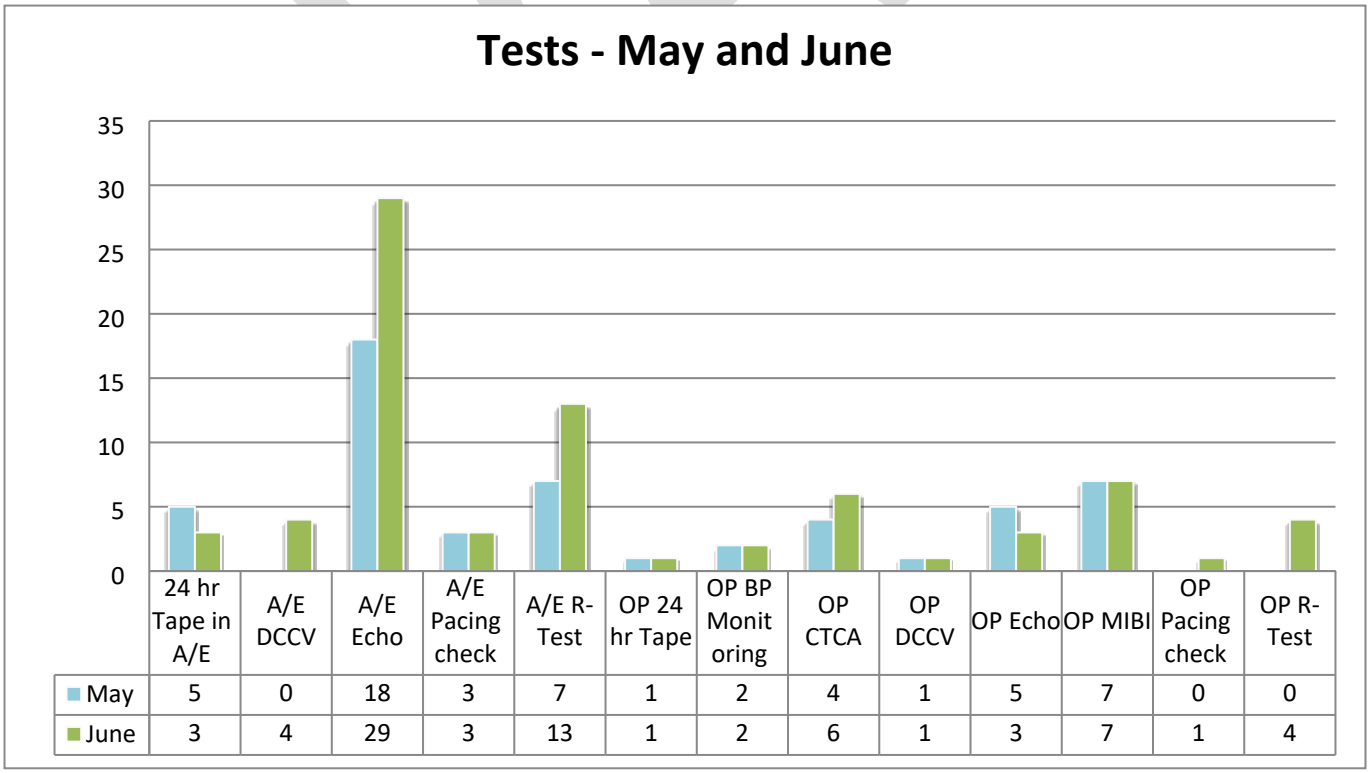
The Cardiac Response Team provides the front-end model of care, assessing patients in A&E. The figure below shows the number of tests and diagnoses made by the Cardiac Response Team in May and June 2020, during the Covid pandemic.

Figure 15: Diagnoses during May and June 2020



	Arrhythmia/AF /Palpitations	Cardiac Chest Pain	Non-cardiac	NSTEMI	SOB/HF	STEMI	Syncope/Bradycardia
May	29	26	41	7	1	1	1
June	36	23	39	5	4	0	4

Figure 16: Diagnostic tests completed during May and June 2020



	24 hr Tape in A/E	A/E DCCV	A/E Echo	A/E Pacing check	A/E R-Test	OP 24 hr Tape	OP BP Monitoring	OP CTCA	OP DCCV	OP Echo	OP MIBI	OP Pacing check	OP R-Test
May	5	0	18	3	7	1	2	4	1	5	7	0	0
June	3	4	29	3	13	1	2	6	1	3	7	1	4

All the investigations performed or organised by the Cardiac Response Team would historically not have happened under the current medical model. Patients would have either been admitted for further investigations, or, if admission was not required, the patient would have been discharged from ED with the discharge letter asking GP to refer in to Cardiology for these tests in an outpatient setting. The data also highlights the large number of non-cardiac chest pain patients who would have been referred into the Rapid Access Chest Pain Clinic unnecessarily.

This demonstrates the effectiveness of the Cardiac Response Team at the front door in streamlining patients for diagnostic tests and onto an appropriate pathway.

There will be a further opportunity to evaluate the front door model towards the end of 2021, during the replacement of a cardiac catheter lab. A series of KPIs and metrics are currently being developed in order to be able to better evaluate the Cardiac Response Team Front Door model.

6.4.2. Outcomes from the introduction of hot-clinics as part of Covid-19 service changes

The challenge of Covid-19 to the cardiology service led to the temporary situation where usual aspects of the clinical service were reduced. Therefore, as part of the Covid-19 response, East Sussex Healthcare Trust started to provide a skeleton form of the hot clinic model, in line with the front-end model of care. A hot clinic is a consultant-led clinic which provides rapid access to assessment for adults with either acute or sub-acute symptoms. This rapid access to an assessment then leads to faster diagnosis for patients and reduced waiting times, which are key quality improvements to the service.

This led to a unique circumstance to release capacity, the service used this opportunity to introduce ad hoc hot clinics during Covid-19. This continued until the service started to recover from the immediate disruption of Covid-19, therefore the hot clinics were not formally established. Permanent hot clinics are included as part of our proposals in this Pre-Consultation Business Case.

As a result of this trial period, it was found that there was a potential risk of booking hot clinic slots for low risk patients (who generally do not need a follow up in a hot clinic) and therefore limiting capacity for those moderate risk patients it was designed for in order to avoid admission.

To ensure that hot clinic slots are most effectively used, we developed an early referral from incorporating the following criteria:

- Presenting signs, symptoms and duration
- Presence of Chest Pain / Shortness of Breath / Palpitations
- Previous Cardiac History/Risk
- Relevant Previous Medical History
- Relevant Observations (Blood Pressure / Heart Rhythm / Rhythm)

- Outcome of any Investigations (Bloods / ECG / Chest X-ray)
- Current Medications
- Reason / Indication for Hot Clinic

6.5. Current health outcomes

Cardiovascular disease prevalence in East Sussex

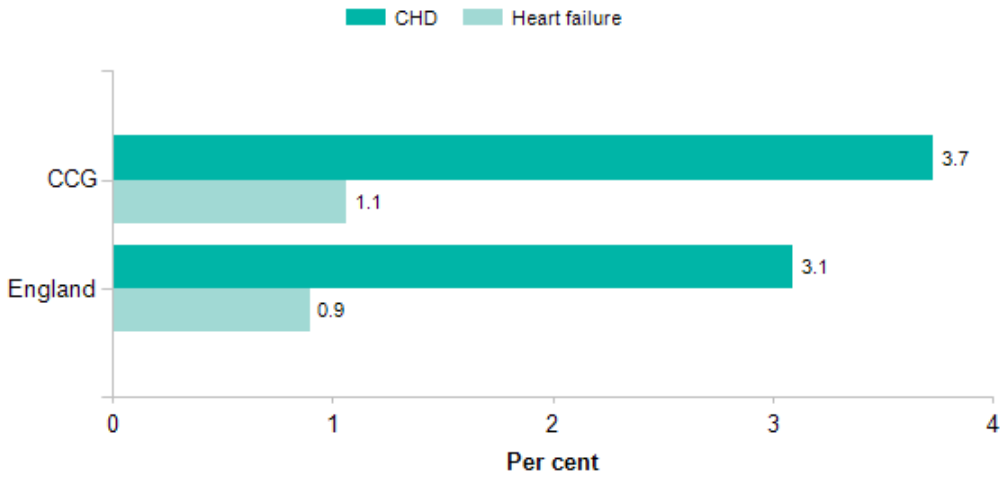
Cardiovascular disease affects millions of people in the UK and is one of the biggest causes of early death and disability, plus the leading cause of premature mortality.

East Sussex has a significantly higher prevalence of circulatory diseases compared to average across England. GP practices with a high proportion of elderly patients and GP practices in deprived areas will tend to have a higher prevalence of disease (and generally a higher prevalence of undiagnosed disease). In East Sussex, for the years 2014 – 2016, heart disease was the leading cause of death in males and the second leading cause of death in females[36]. Across East Sussex, there are approximately:

- 20,300 people with a diagnosis of coronary heart disease, a prevalence of almost 4%;
- 5,500 on the heart failure register;
- 16,300 on the atrial fibrillation register, and;
- 92,800 on the hypertension registers.

The diagrams below show how East Sussex's prevalence for these conditions compares to the England average:

Figure 17: Coronary heart disease and heart failure prevalence, 2019-20 (per cent) East Sussex CCG compared with England Source: Quality Outcome Framework



[36] East Sussex Public Health Intelligence (2018). Picture East Sussex, Annual report of the Director of Public Health 2018/19

In East Sussex, 3.7% of the population has a diagnosis of chronic heart disease, as compared with 3.1% nationally. Whilst 1.1% of East Sussex's population has a diagnosis of heart failure, as compared with 0.9% nationally.

Figure 18: Stroke and Atrial Fibrillation prevalence, 2019-20 (per cent) East Sussex CCG compared with England

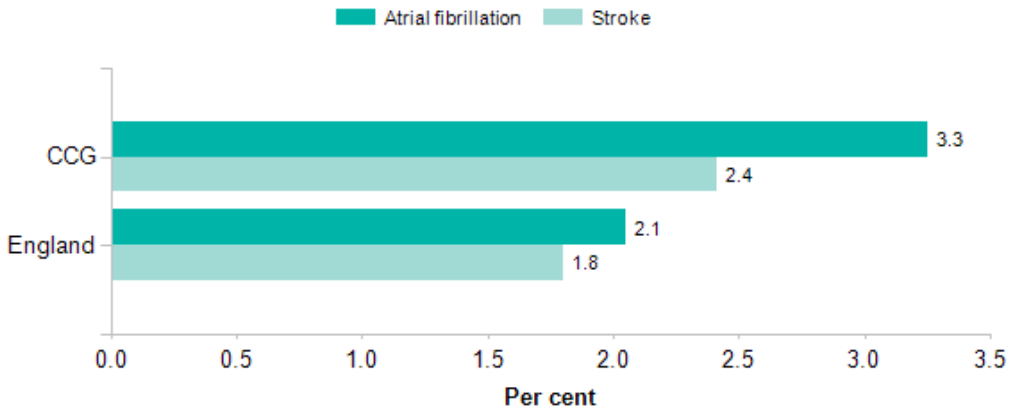
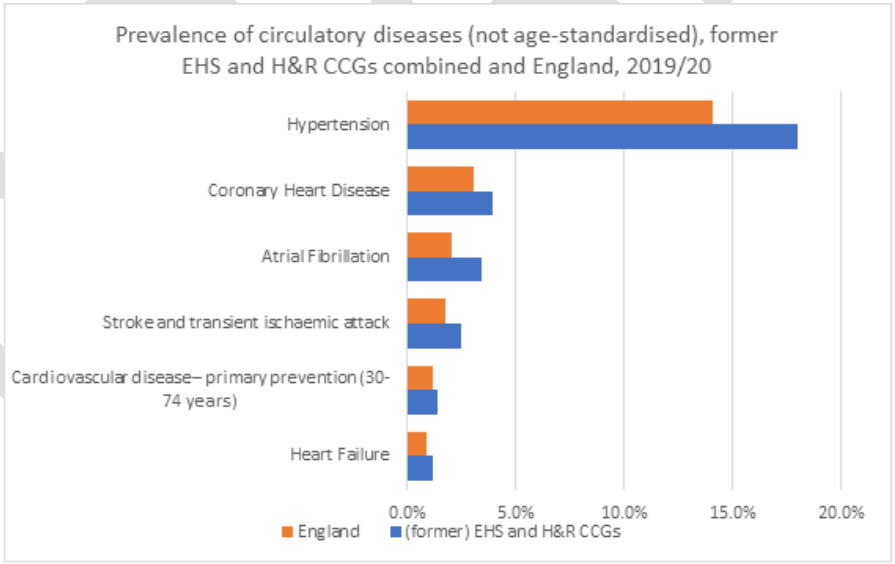


Figure 19: Prevalence of circulatory diseases locally compared with England



Cardiovascular disease is one of the conditions that has been most strongly associated with health inequalities, with people in England's most deprived areas being almost four times more likely to die prematurely of cardiovascular disease than those in the least deprived areas (Public Health England, 2019). It also shows a strong age dependence, predominantly affecting people older than 50 years. Risk factors for cardiovascular disease include non-modifiable factors such

as age, sex, family history of cardiovascular disease, ethnic background and modifiable risk factors such as smoking, raised blood pressure and cholesterol.

Table 10: Our population – Coronary Heart Disease risk factors

	Smoking prevalence - adults	% of adults overweight or obese	% of physically active adults	% of adults meeting 5 fruit or veg per day	Admission episodes for alcohol specific conditions (persons) 2019-20
Eastbourne	16.7	65.8	69.2	62.9	609
Hastings	16.5	61.1	65.9	56.0	845
Lewes	10.1	59.2	69.6	62.4	421
Rother	12.4	63.4	65.1	59.6	396
Wealden	9.4	62.5	68.4	58.5	399
England	13.9	62.3	67.2	54.6	644

As Table 10 shows, the localities in East Sussex greatly vary above and below the England levels in relation to modifiable risk factors for coronary heart disease.

There are a number of varying primary and community services available across Sussex to support patients in preventing cardiovascular disease and in detecting risk factors earlier. It should be noted that the expected reduction in demand from primary prevention and improved primary/community Atrial Fibrillation services forms part of the Sussex ICS Cardiology Programme; and our work in East Sussex complements this wider approach.

7. Pre-consultation engagement – what matters to local patients, clinicians and key stakeholders

There are several phases of pre-consultation engagement, which aim to find out what local people, patients, clinicians and stakeholders think of the current service, to hear their ideas around transformation, what matters to them and to review ideas and proposals as they evolve. The key aim of our engagement process to date has been to ensure that a robust and transparent approach was established to enable stakeholders to inform and test approaches for this Pre-Consultation Business Case.

This approach ensured that a range of stakeholders were given the opportunity to be involved in the early engagement discussions. The approach also included opportunities for engagement targeted at those who have a particular stake in East Sussex Healthcare Trust cardiology services to help inform the Pre-Consultation Business Case: for example, patients attending cardiology outpatient appointments were offered the opportunity to take part in interviews in order to provide insight into the patient journey and experiences of accessing cardiology. 20 patients took up this opportunity.

Engaging with local people in a flexible way in light of the limitations of the pandemic, we undertook public engagement which commenced on 4th January 2021 and lasted six weeks

(concluding on 14th February 2021). During this time we engaged with local people and stakeholders to:

- communicate the need for transformation of acute cardiology services at East Sussex Healthcare Trust;
- understand their experiences of the cardiology services for adults at Eastbourne District General Hospital, the Conquest Hospital in Hastings and Bexhill Hospital;
- gather their feedback and ideas about how the service could be provided in the future.

The insight gathered from this work was used to inform options development, appraisal and planning for any formal consultation.

Throughout our pre-consultation engagement, we incorporated the findings from the Equalities and Health Inequalities Impact Assessment – this is described in more detail in Section 10.2 and in Appendix 1.

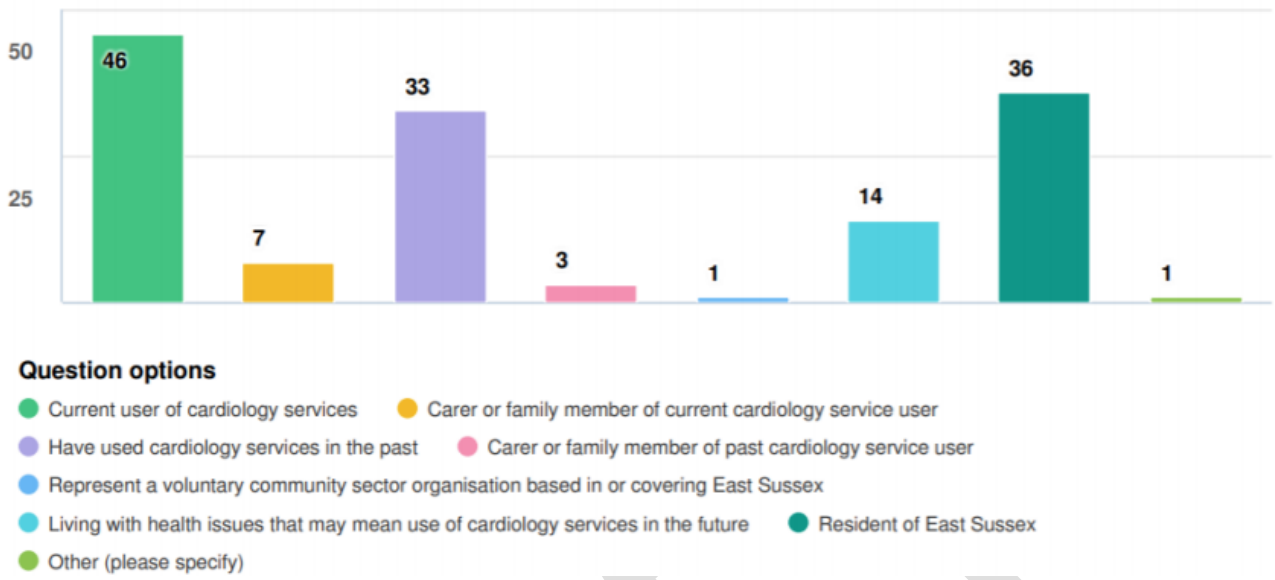
There were two principal pre-consultation activities: the first was an online and paper questionnaire to understand people's experiences of cardiology services was co-designed with partners and members of the public and published on the Sussex Health and Care Partnership's Engagement HQ (online engagement) platform. The survey was promoted through a multitude of pre-established distribution lists and newsletters.

It was also sent out widely to local voluntary, community and social enterprise sector organisations, including Healthwatch, with the request to support promotion. Paper copies of the survey were sent out to organisations including the Rough Sleepers Initiative (homeless and rough sleepers) and foodbanks (to reach those living in deprivation) as well as to individuals requesting copies. A freepost address for returning the questionnaires was included.

Posters were distributed to display in hospital waiting rooms to encourage people to complete the questionnaire or to get in touch to arrange a telephone interview. Social media coverage was used to promote the surveys, utilising the CCG pages and accounts and posting on local community Facebook pages.

The second activity was a series of in-depth interviews with current and former patients. In all, 82 responses were received to the questionnaire, of which 20 were conducted as in-depth interviews and 10% were received from ethnically diverse communities (with potentially a further five who did not complete the "about you" question), which is in line with the diversity of the local population.

Figure 20: Those who engaged in the questionnaire and why



NB: participants could choose more than one option

The Public Involvement team attended a range of virtual forums and groups to promote the programme and inform people of the ways to get involved.

To support accessibility, local linguists in East Sussex were asked to work with people, for whom English was an additional language, to complete the questionnaires and the CCG received a total of eight completed questionnaires with a variety of languages represented. Additionally the team attended Eastbourne Cultural Inclusion Group and shared the opportunity with over 20 people from ethnically diverse backgrounds. They then shared the information with their networks to encourage take up.

We recognise some communities are particularly at greater risk of Cardiovascular Disease, as stated in the Equality and Health Inequality Impact Assessment, and in a formal public consultation there will continue to be a strong focus on reaching these communities. To be successful the team will be holding an informal workshop with local ethnically diverse Voluntary and Community Sector organisations, community ambassadors and partners to discuss lessons learned from the pre engagement and another public consultation and to consider how best to engage. The outputs will be fed into the engagement delivery plan.

A full pre-consultation engagement report is provided in Appendix 2. The key themes which have emerged from the surveys, social media comments and discussions at stakeholder meetings and forums during the pre-consultation engagement are summarised in Table 11.

Table 11: Feedback from the pre-consultation engagement

Theme	Summary of key points	Action we are taking
Care provided	• Most people told us that the service was very good, especially for	• An action plan is being prepared by East Sussex Healthcare Trust

	emergency care. When care was good, patients felt reassured and respected. • When people reported negative experiences, they described feeling scared, stressed, emotional and, sometimes, that their life was "on the line". • People told us they were anxious about delays in testing and receiving results.	and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.
Equality and Diversity	• People told us about communications barriers for those with protected characteristics and the need for longer appointments for these cohorts. • Transgender patients reported poor treatment and a lack of knowledge and understanding from clinicians. • Issues of accessibility for patients with disabilities were raised.	• An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.
Access and transport	• People told us that they were concerned that, if the service were available at fewer sites, this would affect access. • People reported problems with public transport, particularly at the Conquest Hospital. • People were worried about access for the elderly, the disabled and those living in rural villages where public transport is limited.	• We have undertaken an initial and internal review of travel and access for patients across East Sussex. • There will be particular focus on this theme during any further engagement work and/or a part of any formal consultation. • An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.
Clinical services	• People reported problems with communication between different healthcare teams and professionals, leading to delays in treatment and repetition of tests. • People also told us about problems communicating with patients: some people felt ignored or undermined. • People felt that time was a crucial element of the service, especially regarding ambulance times.	• An action plan is being prepared by East Sussex Healthcare Trust and East Sussex CCG's Public Involvement, Equality and Diversity teams to address these issues.

	• People told us that delays to procedures left them feeling very anxious, especially when the communication was poor.	
Covid-19 Pandemic	• In addition to the above, people told us about their experiences of cardiology services during the pandemic. Some people told us that the move to video and telephone appointments had worked well for them, whilst others felt that they didn't receive the same level of detail as they would have done from a face-to-face appointment. However, people also praised staff and infection control processes.	• The Integrated Care System Cardiology Programme is part of a national programme aimed in part at restoring and recovering services from the impact of Covid-19, as well as implementing the priorities included in the 2021/22 planning guidance. The programme is interlinked with a Getting It Right First Time initiative that seeks to maximise the capacity of acute services as well as engaging community support.

People also told us about the importance of prevention and monitoring of medication.

It should be noted that although most of the points raised during this engagement can be addressed by these proposals, there are some that can addressed independently from this transformation programme. For example, the importance of prevention and monitoring of medication, will require support from primary care and community services around access to prevention services and liaising around medications suitable for their patients.

Table 12: Engagement Schedule

Stage	Approach	Dates
1.	Pre-consultation engagement and communications	January-February 2021
2.	Options development and appraisal	March 2021
3.	Additional engagement following options development and appraisal has taken place	May 2021 – June 2021
4.	Clinical Senate (Section 11.1)	July 2021
5.	Formal consultation on proposal (planned subject to approval of the Pre-Consultation Business Case by the CCG)	December 2021 – March 2022

The pre-consultation engagement work undertaken by East Sussex CCG provided a strong foundation on which to build the formal programme of activities subsequently undertaken as part of the options development and appraisal processes (described in further detail in the next section). As well as providing valuable insights in its own right, which helped to inform options development, the pre-consultation activities also helped to identify and recruit patients and patient representatives to participate in this next stage.

8. Options Appraisal

Formal options development and appraisal activities are an important part of developing any final proposals for changes to the way that acute cardiology services might be delivered in the future. It is important to note though that the outcomes reported here are by no means the only basis on which change decisions might be taken. They are one element of a longer-term and ongoing dialogue in which stakeholders, including members of the public, have engaged with East Sussex CCG and East Sussex Healthcare Trust about the way that NHS services are delivered, and part of the evidence base which relevant bodies will need to consider when making decisions.

8.1. Overview of the Process

Between 8 March 2021 and 22 March 2021, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services researchers) took place to identify and consider a longlist of possible options for the future provision of acute cardiology services. Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.

Table 13: Summary of Options Development and Appraisal workshops

Workshop	Date/Time	Description
1	Monday 8 March 2021 13:00-17:00	'Listening and engagement' • Bridging from the pre-consultation engagement undertaken by East Sussex CCG into the formal options development and appraisal • Introducing the background and rationale to the transformation • Discussion around the clinical vision and priorities and patients' priorities for acute cardiology services • Initial discussions on how the need to address current and future challenges, meet national guidelines and standards, and to address clinical requirements and patients' needs, might require a balance or compromise to be found between different priorities Key outputs • Feedback from patients and patient representatives, primary care clinicians and other stakeholders to inform possible new models of care
2	Monday 15 March 2021 13:00-17:00	'Options development'

		• Drawing on key themes and suggestions identified from pre-consultation engagement, feedback from Workshop 1, and information and data provided by East Sussex CCG and East Sussex Healthcare Trust • Discussion about possible approaches to acute cardiology service provision, using suggestions from East Sussex NHS partners as a starting point with opportunity to explore additional ideas and approaches • Initial consideration of possible advantages and disadvantages, impacts and potential mitigations of each possible approach • Consideration of the implications of possible approaches in relation to the vision, priorities and challenges discussed in Workshop 1 • Brief introduction to the appraisal criteria to be used in Workshop 3 Key outputs • Feedback from patients and patient representatives, primary and secondary care clinicians and other stakeholders to generate a 'longlist' of possible approaches/options to be considered and appraised at Workshop 3
3	Monday 22 March 2021 13:00-17:00	'Options appraisal' • Summary of outputs from Workshops 1 and 2 • Discussion and agreement on the five appraisal criteria against which the longlist of possible options would be tested • "Qualitative" discussion/appraisal of each longlisted option for future East Sussex Healthcare Trust acute cardiology service provision • Anonymous ranking and scoring of each longlisted option against the agreed appraisal criteria Key outputs • Feedback and data to inform shortlisting and recommendations of options for consultation

The pre-consultation engagement which ran from 4 January 2021 – 14 February 2021 (as described above), formed part of the preparation for these workshops. Additionally, participants were provided with information to enable informed discussion, including summaries of key contextual information (e.g. population health needs, clinical standards, activity demand and

capacity, finances, estate footprint, workforce) and summaries of key programme documents (e.g. Equality and Health Inequality Impact Assessment and Case for Change).

The workshop attendees were as follows:

Table 14: Stakeholders in attendance at Options Development and Appraisal workshops

Stakeholder type	Number	Description (roles/organisations represented)
Patients / representatives	3	Service users East Sussex CCG Community Ambassador
Other NHS Staff	3	Local GP South East Coast Ambulance Service (SECAmb) representative
East Sussex Healthcare Trust clinicians	5	Acute Cardiology Clinical Leads and Clinicians

Note: NHS managers attended to observe, present key information and respond to questions, but did not actively participate in the options appraisal scoring and ranking activities.

A mixed methodology was used to appraise the longlist of options, comprising:

- 'Qualitative' discussions which drew out the reasons for which different individuals and groups held certain views, and particularly to identify and elaborate on any key factors or concerns; and
- A two-part 'quantitative' exercise to generate ranks and scores for each option.

In both the qualitative and quantitative stages of the appraisal, the following five 'appraisal criteria' (which were discussed and agreed upon at workshops 2 and 3) were used:

1. Quality and Safety
2. Clinical Sustainability
3. Access and Choice
4. Financial Sustainability
5. Deliverability

It is the view of East Sussex Healthcare Trust that possible options which might involve different services being provided from either of the acute hospital sites (Eastbourne District General Hospital and Conquest) could be configured either way round. Furthermore, the likelihood is that, if such options were to be shortlisted for public consultation, both possible site configurations would be included for consideration and feedback. For this reason, participants at Workshop 3 were not asked to rank or score locations, but to focus on models of care.

At workshops 2 (options development) and 3 (options appraisal), the following various potential models of care were discussed. Three of these would see current services at both acute sites retained or expanded:

- Option 1: Retaining current services as they are
- Option 2: Retaining current services as they are while adding new assessment areas in emergency departments and 'hot clinics' at both acute hospital sites. A "hot clinic" provides patients with rapid access to a cardiology assessment.
- Option 3: Building up both acute hospitals, with the addition of assessment areas and 'hot clinics' ('everything, everywhere')

The remaining options would involve a different suite of acute cardiology services being delivered at each of the acute hospital sites, although with the addition of cardiology assessment areas and 'hot clinics' at both acute hospitals under both options:

- Option 4: Separating services so that Percutaneous Coronary Interventions (PCI) are delivered at one acute hospital site, while elective Electrophysiology (EP), Permanent Pacemaker (PPM) and Devices services are delivered on the other acute site
- Option 5: Co-locating all catheterisation laboratories and specialist cardiology inpatient services one acute hospital site, 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 our acute hospital sites.

Discussions were based on these five possible approaches. Participants in the workshops were also invited to suggest other approaches for consideration and appraisal, but the consensus was that the five options above were appropriate therefore no further options were added.

During workshop 3, participants were asked to rank and score each of the five possible options for a future model of care against the five "appraisal criteria".

Following this, in order to better understand the relative differences between the options, participants were also asked to score each of the five possible options against the five "appraisal criteria". When interpreting the options appraisal scoring outcomes, unlike the ranking exercise, participants were able to give the same scores to several or even all options, if they chose to.

In discussion, the proposed addition of assessment areas in Emergency Departments and 'hot clinics' at both acute hospitals in Options 2, 3, 4 and 5 was welcomed as providing consistency and timely access to specialist care. Patients, it was felt, would find the addition of these

services reassuring, while local GPs and their patients would benefit from faster access to specialist clinical expertise when needed.

The results showed that models of care in which all current acute cardiology services were either retained or built up at both acute hospitals (Options 1, 2 and 3) tended to be appraised poorly overall. While seen as desirable in 'an ideal world', these options were not viewed during discussions as clinically or financially sustainable, and therefore also viewed as undeliverable. This view was also evident in the results of the quantitative appraisal activities, in which Options 1, 2 and 3 were scored and ranked lower than other options against three of the appraisal criteria: Clinical Sustainability, Financial Sustainability and Deliverability. Against Access and Choice, however, Option 3 (building up cardiology services at both acute sites) was scored and ranked highest of the five possible options by two groups ('patients and patient representatives' and 'other NHS staff').

Separation of Percutaneous Coronary Intervention elective and non-elective services to one acute hospital site, and Electrophysiology, Permanent Pacemaker and Devices to the other (Option 4) scored and ranked poorly against Access and Choice in comparison to other options, although somewhat better with the patient and patients' representative group. Against the other criteria it was generally scored and ranked similarly or slightly higher than Options 1, 2 and 3, but often with differences in opinion between the three stakeholder groups.

Co-location of all catheterisation laboratories and specialist cardiology inpatient care onto one or other acute hospital site (Option 5) was viewed positively by all stakeholder types, and it was ranked and scored highest by all stakeholder groups (East Sussex Healthcare Trust clinicians, other NHS staff, patients and patient representatives) in terms of Quality and Safety, Clinical Sustainability, Financial Sustainability and Deliverability. East Sussex Healthcare Trust clinicians also ranked Option 5 highest against Access and Choice, and all three groups of stakeholders gave Option 5 the second highest mean scores against the same criteria.

Overall, the outcomes of the options development and appraisal process suggest that Option 5 could reasonably be taken forward to formal public consultation, as options 1-3 were rated poorly by the appraising stakeholders (particularly around financial and clinical sustainability) and as Option 4 ranked poorly around access and choice. The full report detailing the discussions and process followed during the options development and appraisal can be found in Appendix 3.

Additionally, it was considered that Option 4 would likely require increased cross-site transfers, which could in turn place increased pressure on South East Coast Ambulance Service, as the provider of this service, and therefore be unsustainable in the longer term.

Each of the two options in the final shortlist are described in detail using comparative analysis, within Section 8.2 and 9 of this Pre-Consultation Business Case. Section 14 then specifies which are the preferred options and the rationale for that.

To further extend our engagement (designed in the context of the pandemic), we also commissioned Opinion Research Services to complete an additional piece of engagement following the options development and appraisal process. The aim of this was to present the options development and appraisal process followed, the outcomes those involved had come to, and to test these to inform our plans if/when moving forward to public consultation. More information around this can be found in Appendix 4.

8.2. Short list of options

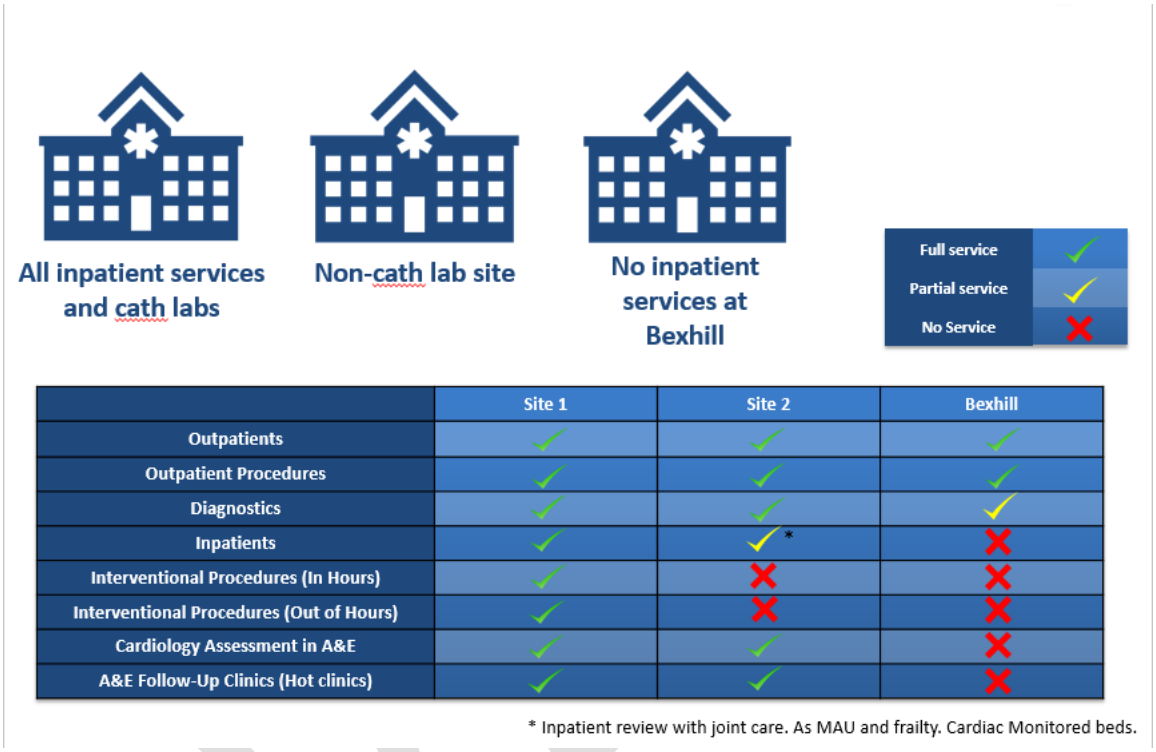
Throughout the design and consultation phases, we have continually tested our proposals and consultation approaches against the Equality and Health Inequalities Impact Assessment, updating where appropriate. Taking this into account, following completion of the workshops, and report from Opinion Research Services researchers (Appendix 3), two options were short listed to be recommended to be taken forward to formal consultation on the future of cardiology services in East Sussex:

- **Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from Eastbourne District General Hospital, with acute outpatients and diagnostic services at both acute 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 from 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 our acute hospital sites.**

A full range of inpatient services will remain available on the site that doesn't have specialist cardiology inpatient services, and will include access to cardiac monitoring equipment. These patients will remain under the care of the acute physicians, jointly managed with input and review from the cardiology team (as happens currently under the medical model). If specialist cardiology care is required, patients will be transferred to the site with cardiology inpatient beds as clinically required. In addition, this programme does not directly affect diagnostics (that will remain on both sites), but it will enable East Sussex Healthcare Trust's separate improvement plan around this. The separate improvement plan will model future diagnostic need.

- **Figure 21: Option 5 – Co-locating all catheterisation laboratories and specialist cardiology inpatient services one acute hospital site, 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 our acute hospital sites.



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

* Inpatient review with joint care. As MAU and frailty. Cardiac Monitored beds.

Note: services at Bexhill Hospital remain unchanged

Option 5 has been analysed across its strengths, weaknesses, opportunities and threats followed by development of plans that would address the weaknesses alongside a description of the mitigating factors that are inherent within this option.

Figure 22: Analysis of Option 5

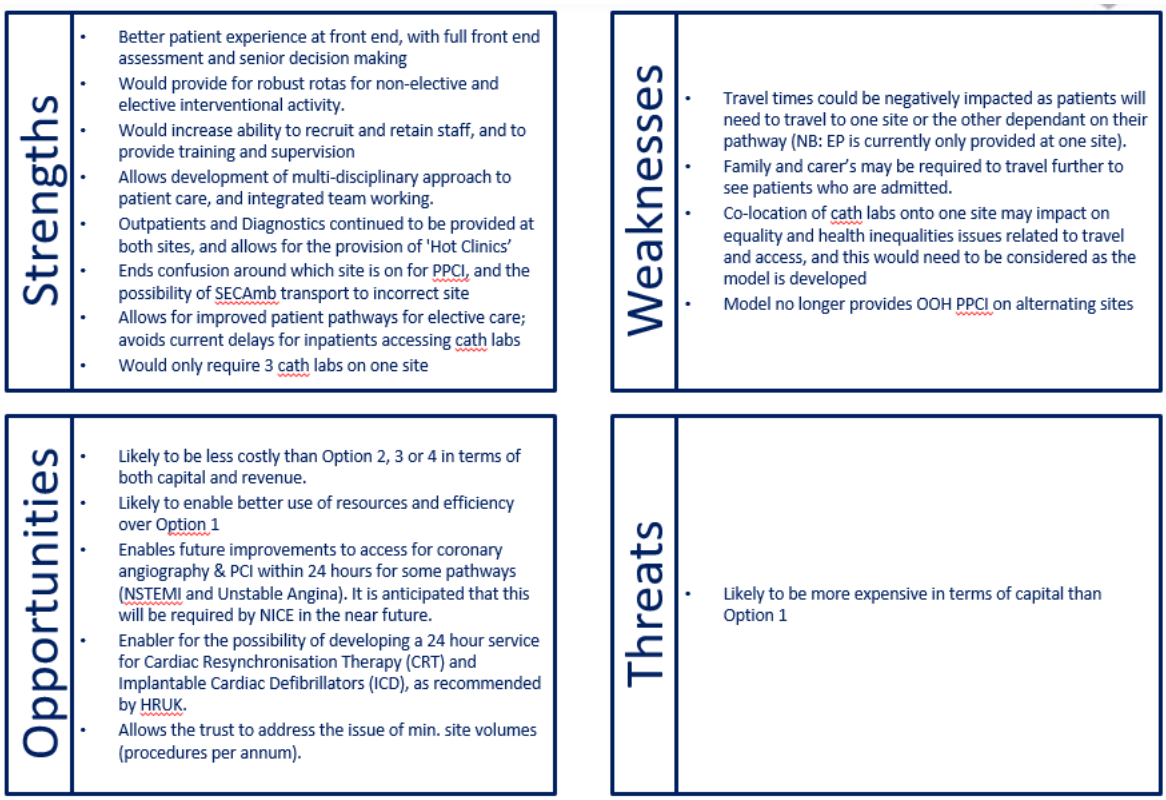


Table 15: Plans to address the weaknesses of Option 5 and mitigating factors inherent in the option.

Weakness	Mitigation
Travel times could be negatively impacted as patients will need to travel to one site or another dependent on their pathway	• Engagement with South East Coast Ambulance Service to co-design and appropriately resource conveyances for emergency patients. • Explore commissioning of dedicated hospital transport service for cross site transfer • Use of triage and escalation system, which is already currently in place out of hours, to deal with surge across all hours of the service. • The introduction of a front-end Cardiac Response Team service and hot clinics would mean a reduced number of admissions and readmissions, reducing number of times required to travel • Provision of day cases as outpatient procedures where possible, which can be provided cross site.
Family and carers may be required to travel further for patients who are admitted.	• The introduction of a front-end Cardiac Response Team service and hot clinics would mean a reduced number of admissions and

	readmissions, reducing number of times required to travel, and therefore reducing travel for relatives / carers • The increased availability of more senior clinical staff would mean more streamlined decision-making and therefore reduces length of stay, and minimising journeys for relatives / carers. • Strong feedback from public engagement sessions that quality of care and expertise for cardiology admissions was more important than time to travel.
Co-location of catheter labs onto one site may impact on equality and health inequalities issues related to travel and access.	• Proposed model provides improved service at both sites. • 91.5% of cardiology service will be available at both sites, including outpatients and diagnostics, helping to ensure health inequalities in access to services do not increase. • In most cases the same improved secondary pathways will be available at both sites (some instances require transfer). • Ensure local community voluntary and social enterprise organisations and support services are aware of the changes and can signpost to appropriate support. • Facilitate access to community transport and other transport options available through the voluntary and community sector. • Explore the commissioning of dedicated hospital transport service for cross site transfer.
Model no longer provides out of hours Primary Percutaneous Coronary Intervetion on alternating sites	• Consolidation onto one site improves access and quality of care through robust rotas and increased subspecialisation • Patients accessing Primary Percutaneous Coronary Intervention are not disadvantaged as all national guidelines are met and exceeded in single site model. • Avoids confusion for South East Coast Ambulance Service conveyancing, obviates risk of conveyance to wrong site. • Inpatients for Percutaneous Coronary Intervention will benefit from faster access, as the model will mean a quicker decision is made and there will be shorter waiting times, as outlined throughout this Pre-Consultation Business Case

	• Both sites will benefit from increased cardiology service through provision of new front door model

For the East Sussex Healthcare Trust clinicians present, this model of care would be optimal in helping overcome workforce challenges, and meet national standards around procedure numbers. Clinicians also believed that this option would contribute to reducing health inequalities and improving access inasmuch as the patients who require it would receive specialist healthcare much faster than they do currently – even in the event that they have to travel further for it.

There was also strong support for the co-location of catheterisation laboratory services among patients, representatives and other NHS staff. This option, they felt, would aid recruitment and retention through the co-location of specialities and specialists in a centralised facility, enable senior-decision making at the earliest possible stage, and generally improve service provision and patient outcomes. South East Coast Ambulance Service representatives were also of the view that co-location would ensure the service is able to 'get it right first time'.

There were, though, concerns around travel and access (as there were during the CCG's pre-consultation engagement), particularly for those living on the periphery of the county. Indeed, participants anticipated that if a co-location model is proposed, the public and patients will be particularly interested by the issue of travel time/distance in an emergency. Although, Option 5 is the current arrangement for how the existing services run during out of hours, and at weekends; and it is important to note that all quality and safety measures (such as call to balloon time for Primary Percutaneous Coronary Intervention) are met and exceeded when the service operates in either site out of hours.

In light of this, the clinical strengths and benefits of this option (including the prospect of cardiac specialists at the front door (i.e. A&E), faster senior clinical input and simply being in the right place at the right time) will need to be seen in the context of the impact on travel and access. For example, digital and community-based alternatives to face-to-face hospital care are a key factor in how local people access services and the travel that will be required to do so, as well as supporting our recovery from the pandemic.

It should be noted, though, that responses to the CCG's pre-engagement were mixed around moving to video and telephone appointments due to Covid-19: some participants found the remote communication convenient, whereas others complained that their appointments felt rushed and did not offer as much detail as they may have received during a face-to-face appointment. This will need to be borne in mind if the use of these alternatives is to continue in future.

It should also be noted this option will affect only the small proportion of patients requiring very specialist care whilst the proposed changes will benefit the far more widely used elective cardiology service; and cardiology services will still be delivered across two sites.

This option would also support the NHS' move towards "net zero" by 2050, as it will be reducing patient travel to and from hospital for numerous appointments as they would have done previously, plus a potentially additional reduction in staff travel between sites.

Finally, clinicians highlighted that this proposed model of care has already been operating during the Covid-19 pandemic (with the catheter labs co-located at Eastbourne District General Hospital) and that national targets have been met. In addition, this proposal will enable East Sussex Healthcare Trust to achieve the Getting It Right First Time recommendations made in the cardiology department's 2019 review, e.g. all inpatient cardiology, Percutaneous Coronary Intervention, chronic total occlusion, and complex device/implants activity should be consolidated on one site.

Therefore, in light of the above information Option 5a and Option 5b are being proposed in this Pre-Consultation Business Case to be taken forward for formal and public consultation. It is recognised that no option is perfect and there will always be some disadvantages, however it is viewed that the positives of these options outweigh the negatives.

Equality and Health Inequalities Assessment Workshops

Following our options development and appraisal workshops, the programme team held two workshops dedicated to the Equality and Health Inequalities Assessment. The focus of these workshops were:

- Lessons Learnt, following feedback from NHS England/Improvement Stage 1 Assurance and team learning from our Equality and Health Inequalities Assessment process for this programme
- A Look at Options Development through an Inequalities Lens, where our Equality and Health Inequalities Assessment was reviewed alongside our short listed options to ensure consideration was given to them from an equality and health inequalities perspective.

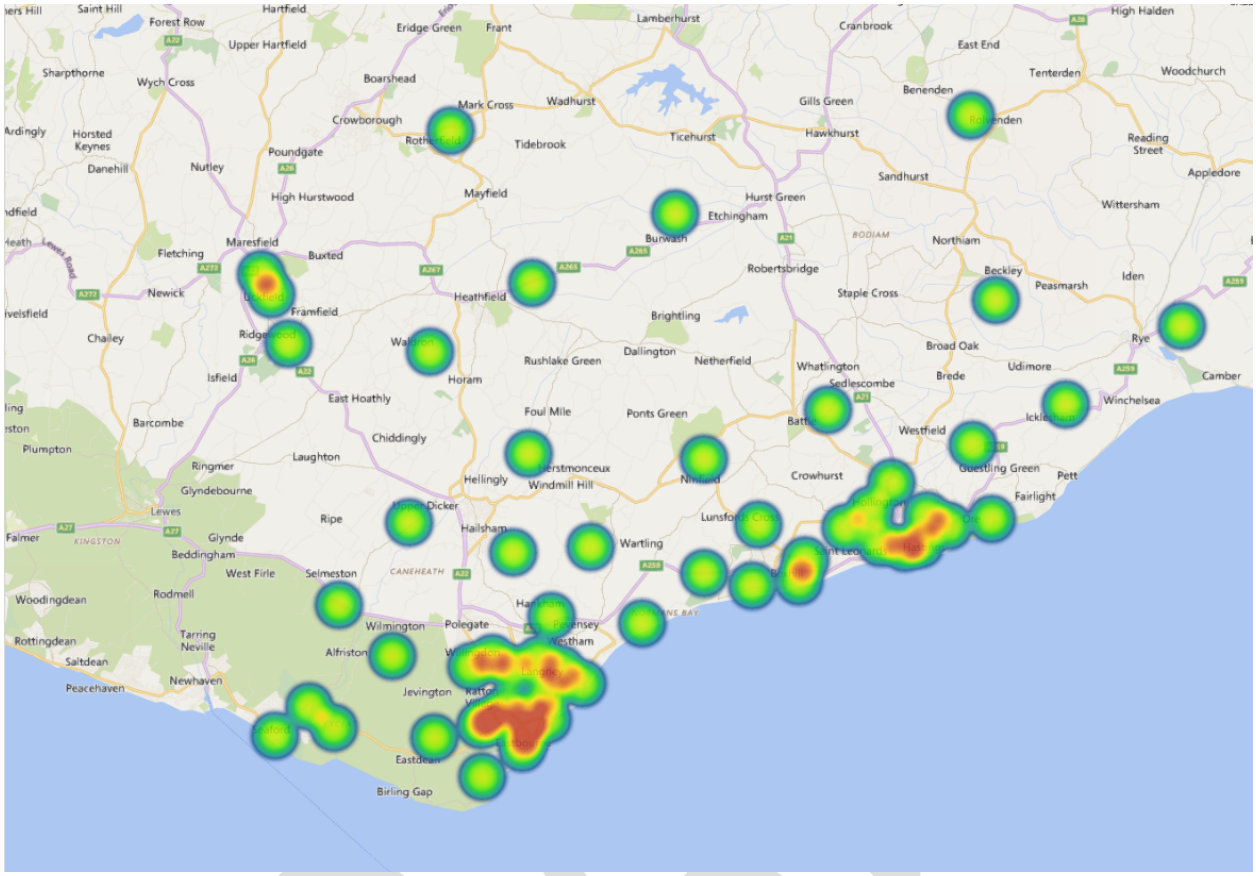
8.3. Why we have not indicated a preference for site (at this stage)

The shortlist of options above has not at this stage identified a preferred site option for the specialist aspect of the service (i.e. either Conquest Hospital, or Eastbourne District General Hospital). This is because both options are viable and deliverable.

During the development of the options, numerous factors have been considered with regard to site. However, at this stage there is no clear definitive reason to choose one particular site over another for clinical reasons. This is because:

- The proposed model of care has been demonstrated to work out of hours and at weekends at both sites, with benefits to clinical care being illustrated during periods of operating at a single site during the Covid pandemic.
- All national standards continue to be met and exceeded when the catheter labs are only in operation on one site (out of hours and weekends), regardless of the site of operation.
- There are no clinical interdependencies with other services unique to either site that would be required for cardiology to provide its interventional services.
- Analysis of South East Coast Ambulance Service conveyance data shows that the impact on ambulance journeys is equal, regardless of which site is chosen:
    - Using South East Coast Ambulance Service conveyance data for Cardiac Arrests between 01 May 2017 and 01 May 2018 (the latest data available on which statistical modelling has been conducted), there is no significant difference in the mean conveyance time between the two proposed options.
    - Refreshed statistical modelling is not felt to be required, as consultation with South East Coast Ambulance Service has confirmed that the expected distribution of calls for Cardiac Arrest, does not significantly change in the time frames elapsed, since the original modelling was conducted.
    - The distribution of Cardiac Arrest conveyances contained in the data analysed is illustrated on the heatmap below:

Figure 23: Cardiac Arrest Conveyances Heat Map, 2017-18



- From a specialist commissioning perspective, the services provided under contract with NHS England/Improvement are already single sited to Eastbourne District General Hospital, and could equally be provided at Conquest. These services are given below:

Table 16: Specialist Cardiac services provided under a specialised commissioning contract with NHS England/Improvement

Service Specification Code	Service Specification Name
A09/S/a	Cardiology: Implantable Cardioverter Defibrillator (ICD) and Cardiac Resynchronisation Therapy (CRT) (Adult)
A09/S/b	Cardiology Electrophysiology and Ablation Services (Adult)

- Early analysis of data collected and feedback obtained during the development of the Equality and Health Inequality Impact Assessment has shown that the east (Hastings area) of the county has a higher proportion of social and economic deprivation than the centre (Eastbourne area). Conversely, the centre of the county has a higher proportion of elderly population than the east. Prevalence of cardiovascular disease is positively

correlated with increases in both deprivation and age, and therefore from a demographic perspective there is no clear factors supporting preference of site.

- It must be noted that although both age and deprivation are associated with higher levels of cardiovascular disease, patients will be able to continue to access a full range of primary, diagnostic and secondary outpatient services at either site.
- The model only impacts on those patients requiring elective inpatient operations, or emergency care which can be delivered safely for all demographic groups from either site.

As is currently the case for the out of hours service, there is some risk that patients will either self-present, develop a ST elevation myocardial infarction en route to a non- Primary Percutaneous Coronary Intervention centre or have borderline symptoms which did not 'trigger' a journey to the Primary Percutaneous Coronary Intervention centre. A recent audit of these cases within South East Coast Ambulance Service found that approximately one patient a month fell into this category. These patients may be conveyed to a hospital which does not have Primary Percutaneous Coronary Intervention capability. In these cases the patient is transferred to the nearest Primary Percutaneous Coronary Intervention capable centre as a category 2 transfer (mean 18 minutes, 90th centile 40 minutes). In addition, recent communications within South East Coast Ambulance Service have encouraged staff to transmit borderline ECGs to Primary Percutaneous Coronary Intervention centres, and this proposal would include actions to embed this process within South East Coast Ambulance Service.

East Sussex Healthcare Trust and the CCG are undertaking further engagement work, and particular focus will be on travel and access and location, including areas of deprivation and our demographic in order to support wider discussion as part of formal public consultation.

Our current analysis indicates that neither site option would impact our out of county pathways. However, Maidstone and Tunbridge Wells NHS Trust (MTW) is currently reviewing the configuration of their acute cardiology services too, therefore East Sussex CCG and East Sussex Healthcare Trust colleagues will continue to work with MTW and Kent and Medway CCG colleagues to understand the impact for local people of any proposals to change site of provision at MTW alongside our proposals.

8.4. Appraisal on preferred site

This Pre-Consultation Business Case outlines our intention to consult on the proposed model, alongside proposed sites, and we will assess and recommend a decision based on feedback from the consultation, additional evidence and analysis, progress of engagement and proposals about MTW services and criteria for decision making, This decision will take place once the consultation has closed to ensure all feedback is incorporated into the process.

This information will be used to assess each of the options against weighted criteria that take into account our Equality and Health Inequality Impact Assessment. The criteria will take account of:

- Population demographics
- Health need
- Health Inequalities
- Travel times
- Accessibility of services
- Conveyances and inter-hospital transfers
- Differences of infrastructure on each site
- Patients/public and cardiology service staff views
- Activity by point of delivery and site, including number of patients impacted
- Implementation/operational considerations
- Finances
- Best use of resources

It is recognised that there will be differential impacts, benefits and risks associated with each site option.

A stakeholder group will support this process. The group will apply agreed weightings to the proposed objective criteria measures and we will publish details of these. These criteria have been informed by the pre-consultation engagement, options development and appraisal processes, our Equality and Health Inequality Impact Assessment financial and activity modelling, and the analyses required for this pre-consultation business case.

The outcomes of the appraisal will inform the decision of a preferred site.

Following consultation closure, a final location impact analysis will be built into the work of the programme's understanding of the impact and incorporates other relevant information gathered during consultation.

9. Impact of the pre-consultation proposal

9.1. Overview of the impacts of the pre-consultation proposal on patients

To increase our understanding of the impact of our pre-consultation proposal on patients, we looked at the evidence from the pre-consultation engagement and from analysis of activity data. This showed us that people who use our cardiology services share many common experiences.

To illustrate the impact of our proposal on patients, we used people's experiences to create a series of stories that show the experiences that people have at the moment and how these

would be different. The stories show how, as a result of our proposal, people would be supported to access a more efficient and sustainable acute cardiology service than they do at the moment and would experience an improved outcome.

The stories on the next page illustrate these experiences.

Table 17: Patient stories

The Patient	The Pathway	What happens now?	How long does all this take?	What would happen to the patient in the future?	How long would all this take in the future?	What would be the benefits of the new pathway?
Alistair is 73 years old and lives in Bexhill with his wife, Jill. **Alistair is working in his garden one afternoon when he faints. This has never happened before – his wife is very worried and dials 999.**	**High Risk Syncope**	The ambulance arrives and the paramedics decide to take Alistair to A&E at the Conquest Hospital, Hastings. At the hospital the A&E doctors decide that Alistair should be admitted. Alistair stays in hospital for two days while the doctors carry out tests. Nothing abnormal is found and Alistair is then sent home. Alistair goes to see his GP who refers him for a cardiology	The length of time it takes from Alistair fainting to having his procedure is between 20 and 28 weeks.	The ambulance would arrive and the paramedics would take Alistair to A&E at the Conquest Hospital. On arrival Alistair would be seen and assessed by the new specialist **Cardiac Response Team**. This team would arrange for him to have the small procedure to implant the device that monitors his heart and this would happen on the same day. Alistair would then be sent home and his care would then	Alistair would be sent home the same day.	Alistair would be seen by the new specialist **Cardiac Response Team** straight away and all the tests he needs would be done that day. This means Alistair wouldn't have to go home, make an appointment with cardiology and then come back again. Alistair's heart problem would be dealt within one day rather than in 20-28 weeks.

		outpatient appointment and arranges for him to have special tests for his heart. At this appointment, the consultant cardiologist decides that Alistair needs to come back to the hospital for a small procedure to implant a special device that will monitor Alistair's heart. He won't need to stay overnight.		be managed by his GP.		
Lucy is 78 years old and lives with her husband John in St Leonards. **Lucy is often short of breath these days and feels very tired a lot of the time. Lucy gets up one morning feeling**	**Heart palpitations - Atrial Fibrillation**	On arrival at A&E Lucy is seen by an A&E doctor who decides to admit her to hospital. Lucy is in hospital for one to two days while tests are carried out and she is then sent home. The hospital then asks Lucy's	The length of time it takes from Lucy arriving at A&E to having her treatment is between 24 and 28 weeks.	On arrival at A&E Lucy would be seen by the new specialist **Cardiac Response Team**. The team would arrange for Lucy to have an echocardiogram (a special scan which looks at the heart	Lucy would either be sent home the same day, having completed her treatment or she would return within four weeks to complete her treatment and then be discharged.	Lucy would be seen by the new specialist **Cardiac Response Team** straight away and the tests she needs would be done that day. This means that Lucy wouldn't have to keep

even more breathless than usual and, whilst making tea, feels her heart racing. Lucy's husband is worried and they decide to get the bus to A&E at the Conquest Hospital.		GP to refer her to cardiology for an outpatient appointment. While Lucy is waiting for her appointment, more cardiology tests are done. Lucy then goes for her appointment where the cardiologist explains that the tests show that Lucy has Atrial Fibrillation – a problem causing the heart to beat irregularly – and she needs treatment that will resolve this problem. Lucy has further tests and then returns to the hospital to have her treatment. Lucy is then discharged.		and nearby blood vessels) straight away. Depending on the results, Lucy would either be treated or discharged the same day, or she would be prescribed a specialist medicine and then asked to return within four weeks for further treatment if needed. Lucy would then be discharged.		coming to the hospital for treatment and face the effort and cost of public transport. It would also be easier for Lucy's husband who wouldn't have to worry about getting to the hospital for visits. Lucy's heart problem would be dealt within either one day or within four weeks, rather than in 24 to 28 weeks.

David is 58 years old and lives in Eastbourne with his husband Michael. **David and Michael enjoy cycling on Eastbourne seafront but David has noticed recently that he's getting out of breath during these rides, feels very tired and can't cycle as far.** **After a bike ride one day David feels very unwell and so decides to go to A&E at the District General Hospital in Eastbourne.**	**Shortness of breath – heart failure**	When David arrives at the District General Hospital the A&E doctors decide to admit him to hospital. While David is in hospital, tests are carried out. Depending on the results of those tests, one of two things may happen: 1. David is sent home after two or three days and the hospital makes him an appointment to come back and see a cardiologist. David and the cardiologist work together to agree a plan	The length of time it takes from David arriving at A&E to having his treatment and being discharged is from eight to twelve weeks for (1) and eight to nine days for (2).	On arrival at A&E David would be seen and assessed by the new specialist **Cardiac Response Team**. They would arrange for David to have an echocardiogram straight away. Depending on the results of this scan, one of two things would happen: 1. David would be admitted to hospital for treatment. 2. David would be sent home the same day. The hospital would make an appointment for David at a specialist cardiac clinic that would	1. David would have tests and treatment might be started. He would then be discharged from hospital a couple of days later. 2. David would be sent home the same day. His appointment with the specialist cardiac clinic would happen within two days.	David would be seen by the new specialist **Cardiac Response Team** straight away and would only be admitted if really necessary. In that case David's treatment would happen quickly and he would be discharged within a couple of days. If David didn't need to be admitted, the hospital would make his appointment with the specialist cardiac clinic, which means he wouldn't have to go and see his GP.

		to manage his heart condition. David will also be seen by a Heart Failure Specialist Nurse and a Heart Failure Consultant and he will be supported to manage his heart condition at home by the Community Heart Failure team. David is also helped by his GP. 2. David stays in hospital a little longer – eight or nine days – during which time more tests are carried out and treatment is started for his		plan David's ongoing treatment for his heart problem.		David's heart problem would be dealt with in a few days and his ongoing care planned quickly and easily.

		heart problems. David is then sent home and his heart condition is managed by his GP and the Community Heart Failure team.				
James is 55 years old and lives in Rye. **James has noticed recently that, whenever he climbs the stairs or the hill in town he gets an ache or a feeling of discomfort in his chest, neck and jaw. If he sits down for a few minutes the chest pain goes away but he's getting worried.**	**Stable chest pain – angina**	When James arrives at the hospital he is seen by an A&E doctor who decides to admit him. James is in hospital for two days, during which time he has tests. James is then sent home. The hospital then asks James' GP to refer him to cardiology for an outpatient appointment.	The length of time it takes from James arriving at A&E to having his treatment and being discharged is from 24 to 28 weeks.	On arrival at A&E James would be seen by the new specialist **Cardiac Response Team**. They would arrange for James to have an echocardiogram straight away. Depending on the results of this scan, the team would do one of two things: 1. If possible, they would treat James' condition with medicine	1. James would be sent home the same day, having completed his treatment. 2. James would be sent home the same day and the further tests would be completed within two to four weeks. If further treatment were required, this would take place two to	1. James would be seen by the new specialist **Cardiac Response Team** straight away and the tests he needs would be done that day. This means that James wouldn't have to keep coming to the hospital for treatment. 2. James' heart problem would

One weekend James is visiting friends locally and the feeling of discomfort in his chest starts again. His friends are worried and take James to A&E at the Conquest Hospital.		While James is waiting for his appointment, more tests are done. James goes for his cardiology appointment where the cardiologist decides whether treatment is needed or not. If no treatment is needed, James contacts his GP who helps him manage his condition. If James does need treatment, the cardiologist arranges for this to take place. Once he's been treated, James comes back for a further appointment with his cardiologist after which he is discharged and his GP helps him		and send him home the same day. If the medicine worked, James' GP would help him manage his condition. 2. If James' condition can't be treated with medicine the same day, he would be sent home and the hospital would make an appointment for James to come back for further tests and, if necessary, a procedure which wouldn't need an overnight stay. After this James' GP would help him manage his condition.	six weeks after the tests.	be dealt with within four to six weeks, rather than 24 to 28 weeks and he wouldn't have to come back to the hospital as many times.

		manage his condition.				
Roy is 60 years old and lives in Hailsham with his two grown-up children. **For several months now, Roy has been getting regular bouts of chest pain and breathlessness. He often feels sick as well. Whenever he feels unwell, Roy sits down for a bit but it doesn't seem to make much difference and sometimes the discomfort lasts several hours.** **One evening Roy is getting a lot of chest pain: his children are worried and**	**Unstable chest pain – angina**	When Roy arrives, the A&E doctors decide to admit Roy to hospital. While Roy is in hospital various tests are carried out, which take around two to four days. The doctors then decide that Roy needs a procedure. Once Roy has had the procedure, he is sent home. He comes back to the hospital for another appointment after the procedure and then his care is managed by his GP.	The total time that Roy has to spend in hospital is up to eight days.	On arrival at A&E Roy would immediately be assessed by a new specialist **Cardiac Response Team**. If they decided that Roy needed a procedure, they would admit him to hospital straight away and his procedure would be done within one to two days. Roy would then be sent home. He would return to the hospital for an appointment after the procedure and his care would then be managed by his GP.	Roy would be seen, assessed, have his procedure and be sent home within a maximum of two days.	Roy would be seen by the new specialist **Cardiac Response team** who would make a quick and accurate diagnosis. Roy would be treated within one to two days and then be able to go home. He would only need to return to the hospital one more time for his follow-up appointment.

decide to take him to A&E at the District General Hospital in Eastbourne.						
Jack is 50 years old and lives in Hastings, with his wife Stella and his children. **Jack is a bit overweight, enjoys a pint at the pub and doesn't take much exercise. For the last few days Jack has been feeling ill, with pain in his chest that he thinks might be indigestion. He has also felt breathless and a bit sick.** **One afternoon the pain starts to spread from his chest into his arm**	**Primary Percutaneous Coronary Intervention – heart attack**	The ambulance arrives and the paramedics think Jack is having a heart attack. They call ahead to the hospital so that the doctors can get ready to help Jack as soon as he arrives. The paramedics then take Jack to the Conquest at Hastings. At the hospital the doctors take Jack to a special room called a Catheter Laboratory (or "Catheter Lab") where they carry out a procedure called a Primary Percutaneous	The total time it takes from Jack arriving at the hospital to being discharged is around three days.	The ambulance would arrive and the paramedics would call ahead so that the doctors could prepare to help Jack. The paramedics would take Jack to hospital. If the Catheter Labs were at the Conquest, then Jack's journey time would be the same. If the Catheter Labs were at Eastbourne District General Hospital, then Jack would have a slightly longer journey. At the hospital the doctors would take	The total time it would take from Jack arriving at the hospital to being discharged would be around three days.	**The team of doctors and nurses who carry out Primary Percutaneous Coronary Interventions is a specialist team.** Being able to work together on one site all the time, rather than having to work across two sites with the same number of people, enables the team to work better and more efficiently. It brings all the experts together in one place. Therefore, better care is provided

and neck: Stella is frightened and dials 999.		Coronary Intervention (Primary Percutaneous Coronary Intervention, also sometimes called an angioplasty) which is a procedure to unblock a coronary artery. After the procedure Jack stays in hospital for around three days and is then sent home and his heart condition is managed by his GP and, if necessary, a consultant cardiologist.		Jack to a Catheter Lab where they would carry out a Primary Percutaneous Coronary Intervention. After the procedure Jack would stay in hospital for around three days and would then be sent home and his heart condition would be managed by his GP and, if necessary, a consultant cardiologist.		to the patients as there is better access to the workforce's expertise.

* This is based on more detailed development of the patient pathways
** Hot clinics are not part of the pathways that would require transfer, there are bookable follow ups that the cardiac response team can use when there is no requirement for admission, but patients need to have a follow up.

9.2. Overview of the impacts of the pre-consultation proposal on workforce

The proposed model of care will have an impact on how the cardiology workforce delivers its services. Consolidating interventional services onto a single site allows for the creation of flexible and resilient rotas, which in turn enable the cardiology workforce to provide a front-end assessment model, form a cardiac response team, and establish hot clinics, all of which are integral to realising the benefits inherent in the model.

1.1.1.1

The proposed clinical model of care will have a beneficial impact on workforce for the cardiology service, including:

- Adequate staffing to manage demand for services (in and out of hours)
- Stable on-call rotas
- Front door assessment presence and hot clinic provision
- Front-end cardiology assessment model, reducing reliance on other specialties
- Increased ability to recruit and retain all staff groups
- Ability to develop staff and provide career progression
- Sub-specialisation and defined career pathways
- High quality clinical training for junior doctors and other health professionals

The analysis of the impact of the proposal on the workforce is based on the activity and capacity modelling developed as part of this Pre-Consultation Business Case. The levels of activity and capacity take into account projected changes such as activity growth, admission avoidance opportunities, increases in utilisation rate for Catheter labs and coronary care unit, rota efficiencies, and skill mixing.

The proposal would allow for the formation of the Cardiac Response Team providing the front door model, which is not currently provided within existing services. The Cardiac Response Team will be comprised of:

- A consultant
- A registrar
- A cardiac physiologist
- A cardiac trained nurse

This team will provide all front-end care, including cardiac triage, assessment, diagnostics (including radiology and pathology), prescribing, treatment and onward referral, if required. The change from the current model is that they would do all this on the patient's arrival to A&E, rather than later in the patient's pathway as is the process at present.

The provision of a front-end service will also support training of A&E clinicians, particularly by providing education sessions, involving simulation and virtual digital work. This will ensure that there is no risk of de-skilling other front-end staff.

Clinical Co-Dependencies

The chart below gives the clinical co-dependencies of the cardiology services provided at East Sussex Healthcare Trust.

Figure 24: Dependencies of acute services on other clinical specialties and functions: services that should be based on the same site

Dependencies of acute services on other clinical specialties and functions: services that should be based on the same site

	COLUMN TITLES: Clinical specialties and functions supporting the 11 major acute services in the rows																																																		
ROW TITLES: The 11 major acute services whose dependencies on the specialties and functions in the columns is being described.	A&E /Emergency Medicine	Acute and General Medicine	Elderly Medicine	Respiratory Medicine (including bronchoscopy)	Medical Gastroenterology	Urgent GI Endoscopy (upper & lower)	Diabetes and Endocrinology	Rheumatology	Ophthalmology	Dermatology	Gynaecology	General Surgery (upper GI and lower GI)	Trauma	Orthopaedics	Urology	ENT	Maxillo-facial Surgery	Hub Vascular Surgery	Spoke Vascular Surgery	Neurosurgery	Plastic Surgery	Burns	Critical Care (adult)	Critical Care (paediatric)	General Anaesthetics	Acute Cardiology	Thoracic Surgery	Cardiac Surgery	Hyper-acute Stroke Unit	Acute Stroke Unit	Nephrology (not including dialysis)	Inpatient Dialysis	Acute Oncology	Palliative Care	Neurology	Acute Paediatrics (non-specialised paediatrics and paediatric surgery)	Neonatology	X-ray and Diagnostic Ultrasound	CT Scan	MRI Scan	Cardiac MRI	Nuclear Medicine	Interventional Radiology (including neuro-IR)	Clinical Microbiology/ Infection Service	Laboratory microbiology	Urgent Diagnostic Haematology and Biochemistry	Acute Inpatient Rehabilitation	Occupational Therapy	Physiotherapy	Speech and Language	Dietetics	Acute Mental Health Services
Cardiology: Non-interventional																							■		■	■												■	■							■						
Cardiology: Interventional - primary PCI for STEMI																							■		■	■												■	■							■						
Cardiology: Interventional - PCI (non-STEMI) and devices																							■		■	■												■	■							■						

The purple boxes show where there is an interdependency that should be based on the same site as Cardiology.

All interdependent specialities are provided at both sites, and therefore there is no impact on consolidation on other services, or on the effectiveness of running a cardiology service.

Critical care requirements have been modelled as part of the activity modelling, and would require an additional 0.5 beds (per annum) on either site. Discussions with critical care have confirmed that this capacity is available on both sites, and is not a limiting factor to transformation.

Recruitment and Retention

Other national models where cardiology services are able to provide minimum numbers of procedures to support training and subspecialisation have shown that this increases attractiveness of the service to potential candidates.

The workforce currently do a mix of cases which doesn't allow minimum volumes for specialisation to be undertaken. A consolidated service would allow for efficient rota design to allow clinicians to complete the minimum volumes required for sub-specialisation.

If a service is able to provide training and career progression (which is currently limited by operator volumes and availability of senior staff to train / supervise), then this increases the likelihood of both recruiting and retaining staff.

Similarly, this applies to other staff groups such as physiologists, cardiac radiographers, and cardiac nurses. Training and career progression are important aspects of career satisfaction, and the absence of these is often cited at exit interviews as a factor in a decision to leave. By addressing these issues, we are confident that East Sussex Healthcare Trust can reproduce the benefits seen elsewhere in increasing recruitment and retention.

To improve and overcome recruitment and retention challenges East Sussex Healthcare Trust has taken a multi-faceted approach including:

- A review of recruitment advertising to increase attractiveness and ensure advertising uses targeted journals in addition to NHS Jobs
- Securing organisational support for incentives to join the Trust
- Putting in place cover for roles from agency / bank staff whilst substantive recruitment is underway
- Scoping and developing alternative roles, such as Physician Associate, Advanced Care Practitioners and Consultant Pharmacist
- Collaborative working with Kent, Surrey and Sussex Health Education England, and the Sussex Integrated Care System to advertise vacancies
- Collaborative working with tertiary centres to incentivise recruitment
- Internal recruitment from student cohort

East Sussex Healthcare 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.

Table 18: Aims of East Sussex Healthcare Trust's Cardiology Workforce Strategy

	Cardiology Workforce Strategy
1	Increase opportunity for sub-specialisation to attract and train medical workforce
2	Succession planning to include appropriate subspecialty education and career progression for junior and middle grades
3	Recruitment / training and expansion of role for Cardiac Physiologists
4	Upskill / train Clinical Nurse Specialist (CNS) role to create additional Consultant capacity
5	Develop role for Cardiology Consultant Pharmacist
6	Physiologist role to be expanded to support Radiology requirements
7	AHP role to be expanded to support Catheter Laboratory utilisation and Primary Percutaneous Coronary Intervention rota
8	Training and progression for Front-End Cardiac Nurse
9	Training and progression for Arrhythmia Nurse
10	Explore nurse prescriber role to support front-end and ward review
11	Look at opportunities for extending role of Cardiac Physiologists, e.g. stress echos etc.
12	Extended roles and nurse run clinics for Heart Failure (HF), chest pain and arrhythmia, and to carry out cardioversion.

The aims listed in the table above will be further enabled by the transformation proposals in this Pre-Consultation Business Case.

9.3. Activity and financial modelling

The purpose of the financial case is to set out the impact of the preferred way forward on the Trust's financial performance and position, and to show the impact of the key financial risks. This is important as it demonstrates whether the options being considered for consultation are financially sustainable.

Activity modelling has been conducted to inform the financial modelling, with the growth rates below agreed between East Sussex Healthcare Trust and CCG colleagues as being a realistic forecast of activity over the ten year period of the project.

Table 19: Baseline growth rates by Point of Delivery (POD)

POD	Rate
Non-elective (NEL)	3.0%
Elective Inpatients (EL)	0.3%
DayCase (DC)	0.3%

Only Points of Delivery (PODs) that are impacted by the proposed model have been included in the analysis, and all others (e.g. Outpatients) have been excluded as they are out of scope of this transformation.

The above growth rates have been used to construct the baseline activity model given below

Table 20: Activity model forecast to year 10 if current services are retained

POD	Baseline (18/19)	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	TOTAL
NEL	1,965	2,024	2,212	2,278	2,346	2,417	2,489	2,564	2,641	2,720	2,802	2,886	**27,378**
EL	295	296	298	299	299	300	301	302	302	303	304	305	**3,309**
DC	2,448	2,454	2,473	2,479	2,485	2,491	2,497	2,504	2,510	2,516	2,522	2,529	**27,460**
Sub-Total	**4,708**	**4,774**	**4,982**	**5,055**	**5,131**	**5,208**	**5,288**	**5,369**	**5,453**	**5,539**	**5,628**	**5,719**	**58,147**
OP	53904.0	54038.8	54445.1	54581.2	54717.6	54854.4	54991.6	55129.0	55266.9	55405.0	55543.5	55682.4	**604,655**
Total	**58,612**	**58,813**	**59,427**	**59,637**	**59,848**	**60,062**	**60,279**	**60,498**	**60,720**	**60,944**	**61,172**	**61,402**	**662,802**

Table 19: Activity model forecast to year 10 for Options 5a and 5b

POD	Baseline (18/19)	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	TOTAL
NEL	1778	1832	1989	2044	2101	2159	2220	2281	2345	2410	2478	2,547	**24,405**
EL	177	177	178	179	179	179	179	180	180	180	180	181	**1,972**
DC	2025	2030	2040	2043	2046	2049	2053	2056	2059	2062	2066	2,069	**22,573**
Sub-Total	**3981**	**4039**	**4207**	**4266**	**4326**	**4388**	**4451**	**4517**	**4584**	**4653**	**4724**	**4,796**	**48,950**
OP	54444.8	54580.9	54991.2	55128.7	55266.5	55404.7	55543.2	55682.1	55821.3	55960.8	56100.7	56241.0	**610,721**
Total	**58,425**	**58,620**	**59,198**	**59,394**	**59,592**	**59,793**	**59,995**	**60,199**	**60,405**	**60,614**	**60,824**	**61,037**	**659,671**

Outpatient activity for Scenario 5a and 5b, above, includes a shift of activity from elective and day case where these can be conducted as outpatient procedures under the new model. Other than this shift of patients, which can be seen at either site, the remainder outpatient activity is not impacted by the proposed model.

Scope

Cardiology services are currently run across two sites: Conquest and Eastbourne District General Hospital. This Finance Case financially appraises three configuration options:

- **Do nothing option:** Services continue to be delivered across both sites. Activity, and the associated space and workforce required grow over time.
- **Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from Eastbourne District General Hospital, with acute outpatients and diagnostic services at both acute sites; alongside establishment of Cardiac Response Team in A&E and hot clinics providing rapid assessment at**

both acute hospital sites. Coronary care unit and inpatient cardiology beds and catheter labs consolidated at the Eastbourne site. Activity will grow over time, however the consolidation of services will mean improved occupancy and utilisation of beds and catheter labs, and a corresponding improvement in workforce productivity.

- **Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites.** Coronary care unit and inpatient cardiology beds and catheter labs consolidated at the Conquest site. Activity will grow over time, however the consolidation of services will mean improved occupancy and utilisation of beds and catheter labs, and a corresponding improvement in workforce productivity.

The following areas are out of scope of this financial analysis, as they are not materially financially impacted by the proposed model:

- Outpatients (OP) and cardiology inpatients (IP) with a length of stay below two days and no catheter intervention are out of scope of these changes and will continue at the existing sites these take place.
- Diagnostic and outpatient activity, and the space and workforce required to deliver these services have not been included in this analysis.

The Trust has projected the income and expenditure position for options 1, 5a and 5b. See Table 18 for further details on the assumptions underpinning these analyses.

Table 21: Assumptions underpinning the financial analysis of options

Scenario	Do nothing option	Option 5a Eastbourne	Option 5b Conquest
Capital requirement	£4.4m once upfront	£11.2m once upfront	£13.7m once upfront
Income	Rises in line with activity growth, tariff uplift and tariff inflation	Rises in line with activity growth, tariff uplift, tariff inflation and new clinical model	As in Option 5b
Expenditure	Pay costs grow in line with activity growth, scaling factors, efficiency and inflation Non-pay costs grow in line with inflation, activity growth, efficiency and scaling factors	Pay costs grow in line with workforce modelling, activity growth, scaling factors, efficiency and inflation Non-pay costs grow in line with inflation, activity growth, efficiency and scaling factors	As in Option 5b

1.1.1.2

For modelling purposes, it is assumed that all capital expenditure occurs in 2022-23 (Year 1) and the new model of care is in place from 2022-23 (Year 1). The capital investment has been modelled to allow for a FYE for 2023-24. However, this may be subject to change in line with the capital investment plan, any external bids for capital funding, and the phasing and completion of implementation works required.

Table 22: Differential forecast year 10 surplus/deficit

Heading (£000s)	Do Nothing	Option 5a Eastbourne	Option 5b Conquest
Surplus/(deficit) position (Year 10)	(126)	1,806	1,517

Option 5a is the most favourable option financially by year ten, with a net financial surplus of £1,806k, compared to £1,517k in Option 5b, and -£723k in a "do nothing" scenario. This is driven by:

- Lower capital investment than 5a, due to less new infrastructure required.
- Productive improvements reducing payroll costs compared to a "do nothing" scenario, driven by higher utilisation of catheter labs and inpatient ward beds. A key driver of this is the reduction in locum workforce required.

Payroll cost analysis

At this early stage, full rota analysis has not been undertaken. Current state staffing was established for areas that will undergo change**,** broken down by doctors, nursing, and non-medical. (Physiologists are not expected to be impacted by a change in FTE, and therefore have not been included in the financial analysis.)

For each group and each area, the following factors have been applied:

- Activity growth
- Wage inflation
- Scaling factors
- Increased utilisation / occupancy of catheter labs and ward beds under a consolidated clinical model, and corresponding workforce impact. It is assumed that savings reduce locum staffing first (average annual cost of £233,352). Reductions in nursing locum staff have been based on average nursing working time equivalent (WTE) salary.
- Additional team requirements (e.g. Hot clinics, assessment areas) within a new model of care.
- Growth, inflation and scaling are aligned with those applied earlier.

Projected staff costs in the do nothing option

Table 23: Projected workforce requirements over time for a 'do nothing scenario'

WTE	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Doctors	13.6	14.1	14.8	15.5	16.3	17.1	17.9	18.9	19.8	20.9	21.9
Nursing	147	154.9	163.2	191.5	202	213.1	224.8	237.2	250.3	264.2	278.9
Non-clinical	10.1	10.2	10.7	11.3	11.9	12.5	13.2	14	14.7	15.6	16.4
Total pay expenditure £k	**7,314**	**7,886**	**8,541**	**10,063**	**10,828**	**11,654**	**12,546**	**13,508**	**14,546**	**15,666**	**16,876**

Table 24: Summary table of productivity savings between do nothing option and options 5a and 5b

	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Medical WTE saving	-	-	-	3.2	3.4	3.5	3.7	3.8	4.0	4.2	4.4
Pay saving £k	-	-	-	305	318	332	347	362	378	395	413
Nursing WTE saving	-	-	-	32.7	34.3	36.0	37.7	39.6	41.6	43.7	45.9
Pay saving £k	-	-	-	1,253	1,314	1,379	1,447	1,519	1,595	1,675	1,759
Non-clinical WTE saving	-	-	-	2.1	2.2	2.3	2.5	2.6	2.7	2.8	3.0
Pay saving £k	-	-	-	84	88	93	97	102	107	113	118
Total saving £k	-	-	-	**1,642**	**1,721**	**1,803**	**1,891**	**1,983**	**2,080**	**2,182**	**2,291**

The deficit shown for the service in the baseline period (2019/20) is already included in the Trust's overall financial position and plan, it is therefore assumed that this level of deficit will be managed within the overall financial envelope of the Trust.

Capital investment

Estimated capital investment required is shown in Table 22 below.

Table 1 Estimated capital investment

Heading (£000s)	Do Nothing	Option 5a Eastbourne	Option 5b Conquest
New catheter lab including estate[37]	1 x 1,367	1 x 1,367	2 x 1,367

[37] Catheter lab numbers:

- The new replacement lab going into Conquest is starting now.
  - Conquest has only 1 lab.
- Eastbourne District General Hospital has 2 labs, 1 of which will be refurbished once the Conquest lab replacement is complete.
- When/if transformation is undertaken and a site is chosen, the service needs 3 labs on one site.
  - The modelling calls for 2.5 labs but naturally one can't have half a lab in a meaningful sense.
- If Conquest is chosen, 2 more labs will be need to be built.
- If Eastbourne District General Hospital is chosen, 1 more lab will need to be built.
- All the new labs are moveable (including the recent one at Conquest.)

Replaced catheter lab (new catheter lab excluding estate)	2 x 1,016	1 x 1,016	1 x 1,016
Additional bed space (Coronary Care Unit / Recovery / Ward Beds)	0	(37 beds) 6,243	(37 beds) 6,794
Sub total (including VAT)	3,399	8,626	10,544
Optimism bias	30%	30%	30%
Total	**4,419**	**11,214**	**13,707**

The investment figure quoted for addition bed space above differs per site due to the different capacity that is required to be built in addition to current (c.f. Figure 8 on current capacity). The consolidation will not reduce the overall number of Cardiology beds.

The new bed requirements modelled also take into account growth anticipated over the next ten years, and while efficiency reductions are modelled, any possible reduction in beds is offset by growth.

Furthermore, a decision has been made to increase the bed base to ensure that the unit can accommodate the need over the next ten years.

The following table shows the capacity that will be required compared with current at year ten.

Table 26: Bed capacity

Beds required	Current Capacity (cross site)	Do Nothing (Year 10)	Option 5a Eastbourne (Year 10)	Option 5b Conquest (Year 10)
Coronary Care Unit beds required	17	30	22	22
Inpatient beds required	30	54	37	37
Total	**47**	**84**	**59**	**59**

The do nothing option shows bed requirements at ten years with no improvements in efficiency, based on the baseline activity model and agreed growth rates.

Options 5a and 5b have the same bed requirements, and take into account growth, as well as efficiencies relating to admission avoidance, improved length of stay, and improved occupancy under the new model.

Reconfiguration would be aligned with the BFF programme to identify whether the ward space costs can be reduced, but it is not dependent on this programme.

The ability to implement these options will depend on access to capital as set out in the financial modelling which at this point is uncertain. The Trust and Integrated Care System are given an annual capital allocation by NHS England/Improvement and therefore spend is not entirely in

control of the Trust or Integrated Care System. Insofar as possible, the Integrated Care System commits to prioritising the funding of this scheme.

Funding

Capital has been modelled such that all funding takes place in year 1. However, this is dependent on the capital investment plan, and the phasing and completion of works required. In reality, it is likely to be a phased plan with investment over years 1 and 2.

Currently there is approximately £3,200k earmarked in the Trust's funding plan for years 1 and 2 of the project.

Table 27: Planned funding and the estimated funding gaps

Heading (£000s)	Do Nothing	Option 5a Eastbourne	Option 5b Conquest
Total funding required	4,419	11,214	13,707
Year one funding	3,200	3,200	3,200
Year two funding	1,219	3,200	3,200
Funding total	4,419	6,400	6,400
Funding gap	**0**	**4,814**	**7,307**

The funding gap identified would need to be met by the wider capital allocation made to the Sussex Health and Care Partnership Integrated Care System for which there is provisional support.

Finance Case Summary

Option 5a – intervention only at Eastbourne is the most favourable by year 10, with a surplus of £1,806k compared to a surplus of £1,517k in Option 5b, and a deficit of £126k in a "do nothing" scenario.

9.4. Impact on neighbouring areas

East Sussex CCG and East Sussex Healthcare NHS Trust colleagues have liaised with a number of neighbouring areas to ensure we are clear and transparent about our proposals and plans to date, and understand the impacts of any proposals from other areas on local people. We will keep local areas informed of progress as we continue with this programme. The table below shows these Trusts, and details how much activity from East Sussex attends their cardiology services. There are only plans to reconfigure cardiology services, specifically inpatient and cardiac catheter lab services, at Maidstone and Tunbridge Wells NHS Trust (MTW). There is no plan to change the outpatient and outpatient diagnostic services at MTW.

There are no current plans to change cardiology services at any other neighbouring providers.

Maidstone and Tunbridge Wells NHS Trust have recently begun a 12 week engagement[1] process to understand what patients, the public, staff and stakeholders think of their proposed options:

- Option 1: Do nothing. Leave services as they are
- Option 2: Consolidate specialist inpatient and cardiac catheter lab services at Maidstone Hospital by reconfiguring existing space
- Option 3: Consolidate specialist inpatient and cardiac catheter lab services at Tunbridge Wells Hospital by reconfiguring existing space
- Option 4: Consolidate specialist inpatient and cardiac catheter lab services at Maidstone Hospital by building a new space and reconfiguring existing space

Maidstone and Tunbridge Wells NHS Trust's current preferred option, following a scored evaluation, is Option 2. However, the Trust remains open-minded while the current engagement process takes place, to ensure the views from patients, the public, staff and stakeholders can be taken into account, and a final decision will be made early in 2022 following completion of the engagement activity in January. More information around Maidstone and Tunbridge Wells NHS Trust's cardiology transformation and the engagement process can be found at: MTW Cardiology Engagement

Table 28: Patient flows to local and neighbouring cardiology services (based on 2020-21 data)

Trust	Non-elective activity	Elective activity	Outpatient Follow Up	Outpatient New	Total

[1] https://www.mtw.nhs.uk/cardiology-engagement/?referrer=http%3A%2F%2Fwww.mtw.nhs.uk%2F%3Fs%3Dcardiology&from=search

East Sussex Healthcare NHS Trust (ESHT)	1,354	1,585	25,466	5,220	**33,617**
Hampshire Hospitals NHS Foundation Trust	0	0	1	1	**2**
Kent and Medway NHS and Social Care Partnership Trust	0	0	1	1	**2**
Maidstone and Tunbridge Wells NHS Trust (MTW)	57	117	1,412	546	**2,133**
Portsmouth Hospitals NHS Trust (PUH)	0	0	0	0	**0**
Queen Victoria Hospital (QVH)	0	0	101	35	**136**
Surrey and Sussex NHS Trust (SaSH)	6	5	44	51	**106**
University Hospital of Southampton NHS Foundation Trust (UHS)	1	0	5	6	**12**
University Hospitals of Sussex NHS Foundation Trust (East) (UHSx East) (previously Brighton and Sussex University Hospitals)	380	581	3,938	1,779	**6,685**
University Hospitals of Sussex NHS Foundations Trust (West) (UHSx West) (previously Western Sussex Hospitals)	0	4	7	7	**18**

Note: Elective activity includes inpatient and day case activity; diagnostics is not included in this data

9.5. Overview of the impacts

Table 29: Summary of the impacts of the pre-consultation business case proposal

Impact of proposal	Would the impact of the proposal be better or worse than now?	Why is the impact better or worse?	Action required
Local health need	Better	The proposed options will make East Sussex Healthcare Trust's cardiology service more sustainable and better able to serve its current and future population.	In collaboration with our system partners, continue to lead and further develop integrated universal and targeted services to improve health outcomes.

		Additionally, the introduction of a front door model and hot clinics will reduce waiting times, reduce the number of appointments required for patients, and ensure faster diagnosis. These are key quality improvement to the cardiology service.	
Health inequalities	Better	As we develop proposals to redesign services we will involve local people, and focus on those who our Equality and Health Inequality Impact Assessment has highlighted are at greater risk of cardiovascular disease and in need of cardiology services at East Sussex Healthcare Trust, particularly as health inequalities have been exacerbated during the Covid-19 pandemic.	In collaboration with our system partners, continue to lead and further develop integrated universal and targeted services to reduce health inequalities.
Fewer transfers between services	Better	There will be fewer transfers between services for patients, as they receive an expert opinion earlier in the patient pathway, as shown in Section 4.3	Implementation of the proposal, including communications and engagement programme.
Value for money	Better	The proposed options are better value for money in the longer term, as shown in Section 4.2, compared to retaining the current services.	Implementation of the proposal, including communications and engagement programme.
Possible confusion during initial stages of any change	Worse	If/when a change does take place, it is likely there will be an embedding period where local people, stakeholders and	Further develop and implement a communications and engagement programme to ensure patients are supported to access the right services. Include a focus on groups identified in the Equality and Health

		partners become aware of the change and get used to the change.	Inequality Impact Assessment and those experiencing deprivation and inequality.
Possible changes to travel and access arrangements for patients if locations change	Better for some, worse for others	Depending the outcome of this consultation, and any subsequent siting of specialist cardiac services on one site, some patients may have to travel to a different site to where they have usually had to travel: • some patients may have to travel a bit further than they previously would have done • but others may be able to travel a shorter distance than they previously would have done. • whilst some patients may have to travel further they may have to make fewer journeys and stay in hospital for less time.	Further develop and implement a communications and engagement programme to ensure patients are supported to access the right services. Include a focus on groups identified in the Equality and Health Inequality Impact Assessment and those experiencing deprivation and inequality. A specific element of the proposed formal consultation will focus on travel and access.

1.2

The proposed model will lead to:

1. Specialist decision making at the front door from the cardiac response team.
2. Faster access to required diagnostics, and early formation of a treatment plan or access to treatment.

The current model may not allow for cardiology input until an outpatient referral is made, and early senior decision making is widely acknowledged to produce better experience and outcomes for patients.

For example, East Sussex has one of the highest prevalence of atrial fibrillation. East Sussex has a cardio version service and PVI (Pulmonary Vein Isolation) service and Electrophysiology Ablation service. Randomised controlled trials have illustrated clinical benefits and better outcomes as a result of early rhythm control, including ablation therapy. The proposed pathways support this earlier access to treatment in this, and in other clinical pathways (through the introduction of the front-end Cardiac Response Team service.

Improved catheter lab efficiency as a result of consolidation would also increase procedure numbers, in line with national guidance, increasing expertise and subspecialisation, which is acknowledged to improve patient outcomes. Anticoagulation rates in primary care are good and the models of care would not impact on this service.

Across the board, the proposed pathways will reduce will reduce the time that patients are waiting for treatment, which directly addresses one of the aims of the NHS Long Term Plan.

10. Impact Assessments

10.1. Quality Impact Assessment

A Quality Impact Assessment has been completed with the CCG's Quality Team (refer to Appendix 5 for the full version). The purpose of the Quality Impact Assessment is to assess the impact of the proposal on safety and the principal findings of the Quality Impact Assessment are:

- The transformation of cardiology services at East Sussex Healthcare Trust will have a positive impact on patient safety. Whilst East Sussex Healthcare Trust is currently providing a safe and effective cardiology service the challenges in relation to changing patterns of service delivery, facilities, estates and recruitment in existence are not sustainable in the medium to long term. The proposed model of care is expected to deliver improvements in quality and safety.
- The transformation of cardiology services at East Sussex Healthcare Trust will have a positive impact on the effectiveness of the service. The proposed model of care is expected to improve the effectiveness of the service against the following drivers for change:
    - Primary Percutaneous Coronary Intervention centres working 24/7 should ideally have a minimum of two adjacent cardiac catheterisation laboratories, however East Sussex Healthcare Trust Cardiac catheter laboratories utilisation is less than 60% on both sites falling from 80% due to workforce pressures, catheter lab breakdowns and a changing need profile.
    - Cardiologists are required to undertake a minimum number of procedures in their area per year, however due to the current configuration of services, East Sussex Healthcare Trust cannot provide all their consultants with the opportunity to undertake the required number of special procedures.
    - Catheter labs, on individual hospital sites, are required to complete a minimum number of procedures per year, however each of East Sussex Healthcare Trust's hospital sites on their own are unable to meet these requirements due to both the changing profile of need, as well as the staffing challenges.
    - Device Guidelines from Heart Rhythm UK suggest that for Cardiac Resynchronisation Therapy (CRT) and Implantable Cardiac Defibrillators (ICD), there should be an aspiration to provide a 24 hour service to deal with patients admitted with multiple shock delivery or other device related issues. Currently East Sussex Healthcare Trust are unable to deliver this service.

- While current services are effective in the short term, changes are required to ensure continued effectiveness in meeting rising need, national guidelines and recommendations and being financially sustainable, resulting in a medium and longer term risk to effectiveness service provision.

- The transformation of cardiology services at East Sussex Healthcare Trust will have a positive impact on patient experience. At present, there is patient choice in attending cardiology services across both sites, however with some of the cardiology catheter labs not currently fully functioning, and the recovery bay beds issue (mentioned above), this has the adverse effect on patient experience due to increased risk of delays due to reduced capacity. These delays are addressed as part of the proposed model of care.
- Overall, the Quality Impact Assessment indicates that, for each of the shortlisted options, transformation would bring about quality improvement.

10.2. Equality and Health Inequalities Impact Assessment

An Equality and Health Inequalities Impact Assessment process has been followed throughout the project to date, updating the assessment as the project has progressed (refer to Appendix 1 for the full version).

The Equality and Health Inequality Impact Assessment looks at the potential impacts of the proposal on different sections of the local population, including those classed as having protected characteristics as laid down in the Equality Act 2010:

Table 30: Summary of the Equality and Health Inequalities Impact Assessment

Protected Characteristic	Equality and Health Inequality Impact Assessment	Proposed Action to mitigate any negative impacts against all protected characteristics	Proposed Action to mitigate any negative impacts against specific protected characteristics
Race/Ethnicity	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our ethnic communities. Look to action changes that would reduce health inequalities and ensure equity of access; for example the information available and how this is shared across our communities. Ensure links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement. Ensure that Friends, Families and Travellers receive information on all involvement activity. Attendance at Eastbourne Cultural Involvement Group to promote engagement opportunities.

			Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities. Promote interpreting services to local services and communities. Make communications about service changes available in community languages. Increase awareness for staff in local services about Black, Asian and Minority Ethnic needs through service contracts. East Sussex Healthcare Trust are currently working on a separate wider Trust piece of work to review data collection to ensure they are able to more accurately monitor data collections and identify any themes of inequality, e.g. patients' race/ethnicity, and address any identified challenges.
Sex	Neutral	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including taking account of the needs of men in respect of their being at greater risk of cardiovascular disease and that cardiovascular disease is a leading cause of death for both men and women.

			As part of the formal consultation process we will take measures to identify and engage with gender specific groups in East Sussex.
Gender reassignment	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service. Consider issues of intersectionality when planning engagement with local people including taking account of the potential impact of intersectionality in developing options and future proposals for cardiology services.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regards to the issue of access and experience in our transgender community and that our transformation plans include trans awareness training for cardiology staff. For example, to be aware of and consider the right of privacy for people who are transgender, including, but not exhausted to, record sharing and information in line with the trusts policy and legal requirements of the gender reassignment act. As part of the formal consultation process we will take measures to identify and engage with transgender and non-binary groups in East Sussex, approach Hastings and Rother Rainbow Alliance Trans Support Group and Bourne Out via Facebook.
Age	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due

		Consider issues of intersectionality when planning engagement with local people including taking account of the potential impact of intersectionality in developing options and future proposals for cardiology services. The Equality and Health Inequality Impact Assessment suggests that this particularly relates to this protected characteristic in relation to cardiology services.	regards to the issue of access and experience of various age groups across our community. As part of the formal consultation process we will take measures to identify organisations that support younger and middle aged people living with cardiovascular disease, approach East Sussex Senior Association, Age Concern, Patient Participation Groups, Patient Carer Forums, and engage with the Public Health and Age UK East Sussex. Publicity about the change in service to be targeted at younger people, young parents and older people through appropriate channels such as the Voluntary and Community Sector, young people's forums, local colleges and local parent groups. Target communications about service changes via channels to reach all age groups.
Religion and belief	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions, are developed that meet the needs of our communities, including giving due regards to the issue of access and experience of our patients of different religions and beliefs.

			As part of the formal consultation process we will ensure that we forge links with faith communities in East Sussex to engage in this project. We will review the Chapels, religious places and services within the Hospitals. Ensure links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement.
Disability (including long-term conditions)	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions, are developed that meet the needs of our communities, including giving due regards to the issue of access and experience of those patients living with a disability or long-term condition, including patients with vision or hearing loss, patients with physical and/or learning disabilities, mental health conditions or dementia may require longer appointments. As part of the formal consultation process we will explore opportunities with Voluntary and Community Sector organisations to see what networks or forums we can utilise to support engagement, approach Hastings Disability Forum, East Sussex Community Learning Disability Team and East Sussex Dementia Adviser Service.

			We will review the disabled and learning disabilities access and accessibility services within the Hospitals. Ensure materials can be made available in easy read and British Sign Language on request. As part of this project a further analysis of transport needs will be undertaken and measures agreed to mitigate adverse outcomes. There will be further engagement with patients and the public on the travel impact if a proposed option includes a change of site as part of the formal consultation process. East Sussex Healthcare Trust are developing a plan to deliver cultural and insight training on BSL, Neuro diversity, hidden disabilities, including, but not exhausted to, mental health, BSL, Neuro diversity challenges as well as adult and young carers. East Sussex Healthcare Trust are also developing plans to have dedicated champions in the team, for patients with hidden disabilities and Carers, and ensure they available and visible to support patients and sign post where required.

Sexual Orientation	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions, are developed that meet the needs of our communities, including giving due regards to the issue of access and experience of our LGBTQ+ patients and that our transformation plans include awareness training for cardiology staff. As part of the formal consultation process we will take measures to identify any LGBTQ+ groups in East Sussex. East Sussex Healthcare Trust are currently working on a separate wider Trust piece of work to review data collection to ensure they are able to more accurately monitor data collections and identify any themes of inequality, e.g. patients' sexual orientation in line with NHS England's Sexual Orientation Monitoring Guidance, and address any identified challenges.
Pregnancy and maternity	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service. Consider issues of intersectionality when planning engagement with local people including taking account of the potential impact	Ensure that as part of the formal options development and consultation processes, models/interventions, are developed that meet the needs of our communities, including giving due regard to the issue of access and experience of our pregnant people, those who are breastfeeding and those with young children.

		of intersectionality in developing options and future proposals for cardiology services. The Equality and Health Inequality Impact Assessment suggests that this particularly relates to this protected characteristic in relation to cardiology services.	As part of the formal consultation process we will take measures to identify service users who fall into this category, encouraging them to undertake an in-depth interview, triangulate data on women at child bearing age with attendances at East Sussex Healthcare Trust to estimate the prevalence of women in the service that would/could be pregnant. The first tranche of pregnant people to benefit from this model are those who require additional care needs, such as young mums, those with pre-existing conditions or previous birth traumas. Therefore any pregnant people with a pre-existing conditions such as a cardiac condition, will be booked onto the continuity of care pathway with their own midwife with a greater level of expertise. Maternity departments are currently moving to a new model of care called “continuity of carer”, where pregnant people will have a single named midwife from their first appointment through to birth and post-partum discharge. Work with our East Sussex MVP to ensure that the voices of pregnant women are heard and consulted with.
Social deprivation	Positive	To support the East Sussex system in co-developing potential options for cardiology	Ensure that as part of the formal options development and consultation processes, models/interventions, are developed that meet the

		services, we need to improve our understanding of existing health inequalities within the service.	needs of people that are socially and economically deprived/disadvantaged, notably residents living in our most deprived areas, as social deprivation is a significant driver for cardiovascular disease. As part of this project a further analysis of transport needs will be undertaken and measures agreed to mitigate adverse outcomes. There will be further engagement with patients and the public on the travel impact if a proposed option includes a change of site as part of the formal consultation process. As part of the formal consultation process we will approach foodbanks, Rother Voluntary Action, Hastings Voluntary Action, Voluntary Action in Eastbourne, Lewes and Wealden to support our engagement and target those living in areas of deprivation. There are organisations providing support for refugees and asylum seekers in East Sussex. Engagement with these agencies during consultation will take place to establish if the transformation to cardiology services will impact them. This programme will be linking in to wider work happening across the Sussex Integrated Care

			System that is targeted on reducing health inequalities for cardiovascular disease, notably social deprivation.
Other Disadvantaged Groups	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	Ensure that as part of the formal options development and consultation processes, models/interventions, are developed that meet the needs of people that are socially and economically deprived/disadvantaged, notably residents living in care homes, residents that are carers, adults receiving long term support, homelessness, rough sleepers, veterans and armed forces, refugees and asylum seekers as social deprivation is a significant driver for cardiovascular disease. As part of this project a further analysis of transport needs will be undertaken and measures agreed to mitigate adverse outcomes. There will be further engagement with patients and the public on the travel impact if a proposed option includes a change of site as part of the formal consultation process. As part of the formal consultation process we will approach carers associations, care home groups and frameworks, work with homeless initiatives, Matthew 25, YMCA, and Armed forces community leads.

			This programme will be linking in to wider work happening across the Sussex Integrated Care System that is targeted on reducing health inequalities for cardiovascular disease, notably social deprivation.
Transient population (e.g. visitors)	Unknown impact	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service.	See above.

Our initial assessment of impact and risk in our Equality and Health Inequality Impact Assessment has shown that the patients from ethnic communities, our older population, men, patients with a disability or long term condition, residents in care homes and communities living in the most deprived areas are at the highest risk of widening health inequalities within cardiology services. However, this does not mean that there isn't a risk for other communities across our patient population.

Our pre-consultation engagement helped us to refine the Equality and Health Inequality Impact Assessment and define the work we will do to support patients in the future to access the right services for them. As part of our proposal we are continuing to develop a wide-ranging communications and engagement programme, which includes the principles of social marketing, to support our patient population to make the right choices for their healthcare.

During pre-consultation engagement there were some groups and/or their representatives with whom we did not connect and we will focus on these groups during consultation to ensure that their needs and those of their representatives are fully incorporated into our proposals. These are:

- deprived areas and those who may have additional health needs (including homelessness);
- the deaf community;
- Black, Asian and Minority Ethnic communities;
- Lesbian, Gay, Bisexual and Transgender communities;
- Refugees and asylum seekers.

Additionally, during pre-consultation engagement, participants were asked if there were any groups that engagement should focus on once the proposed shortlisted options have been developed and chosen. Responses included:

- The elderly
- Trans people
- Carers
- Disabled people
- Those with learning disabilities
- Homeless and rough sleepers
- Those without transport
- Staff at the ambulance trust (South East Coast Ambulance Service)

10.2.1. Travel impact

During the pre-consultation period, local people have reflected a significant importance in the distance that patients might have to travel to receive services as a result of any reconfiguration. Therefore, we recognise the importance of ensuring that services reduce health inequalities and ensure reasonable access. This travel impact analysis seeks to outline the travel options available to local people who use the East Sussex Healthcare Trust cardiology services, as well as how the proposed changes may impact them.

The Eastbourne District General Hospital and Conquest Hospital are 19.3 miles apart with a road journey time of approximately 35 minutes (which can vary depending on traffic).

Bexhill Hospital is 14.2 miles away from the Eastbourne District General, with an approximate road journey time of 25 minutes and 6 miles away from Conquest Hospital with an approximate road journey time of 10 minutes.

Example road travel times from East Sussex areas if services are sited at either Conquest or Eastbourne District General:

Figure 25: East Sussex travel times to Bexhill Hospital

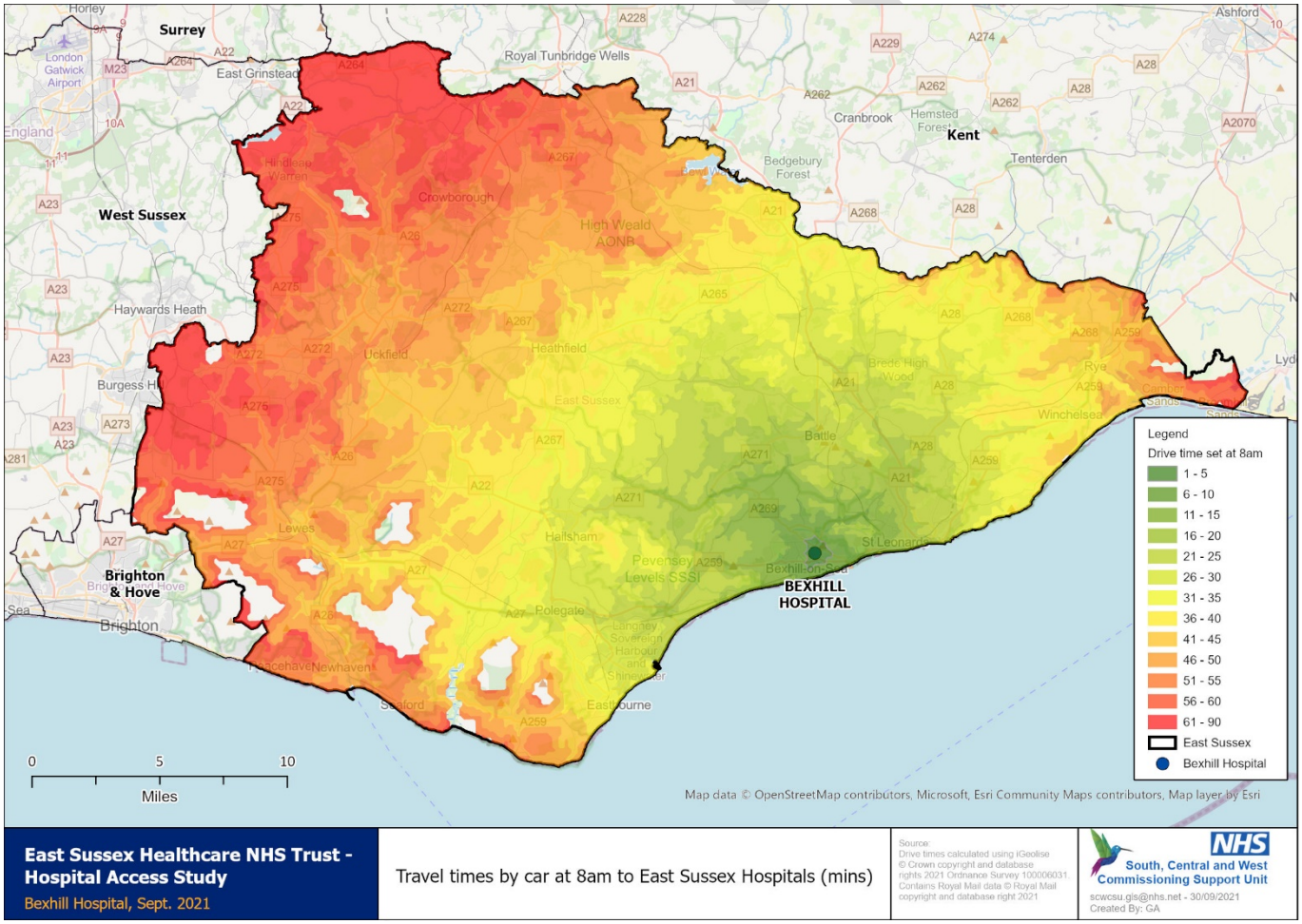


Figure 26: East Sussex travel times to Conquest Hospital

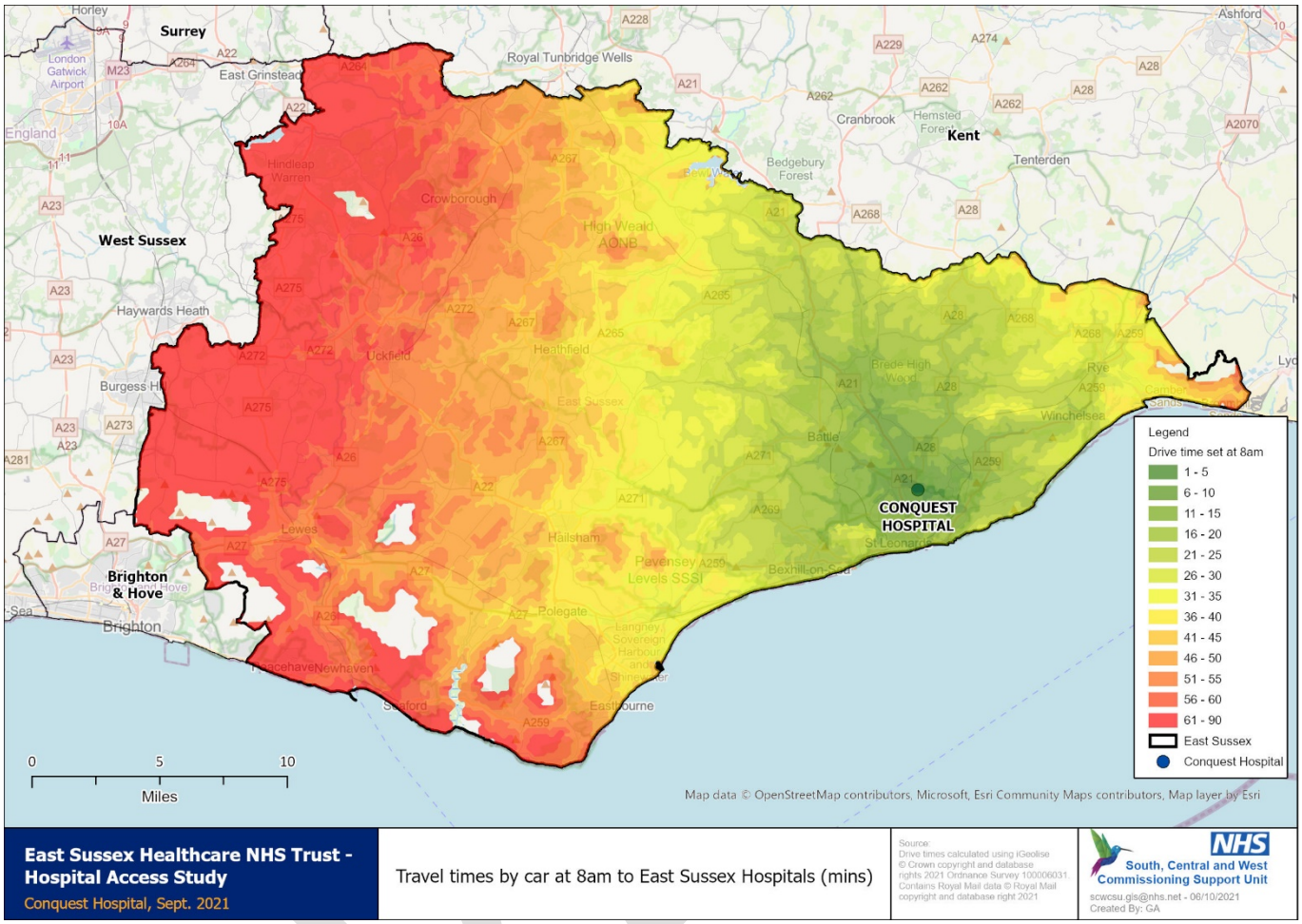
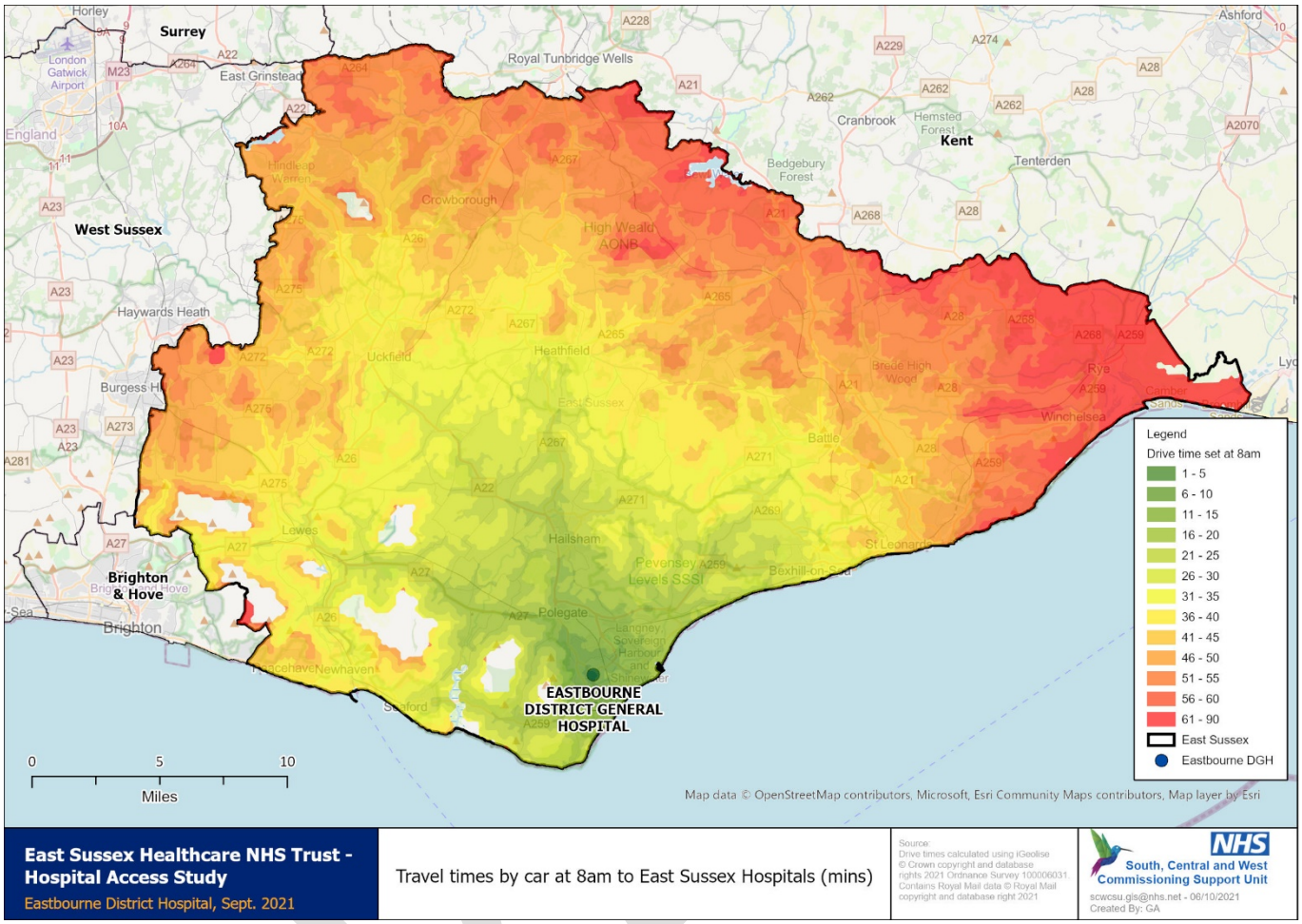


Figure 27: East Sussex travel times to Eastbourne District General Hospital



Public Transport

By bus:

Eastbourne District General Hospital is served by these bus routes: -

- From Eastbourne town centre/train station: Stagecoach services LOOP, 1A, 51, 54, 56, 98
- From Hastings and Bexhill, Stagecoach service 99 to Eastbourne town centre then the Stagecoach service 54a, 51 or LOOP to the District General Hospital.
- From the Polegate area Stagecoach services 51, 54, 56, 98

Conquest Hospital is served by the following bus routes:

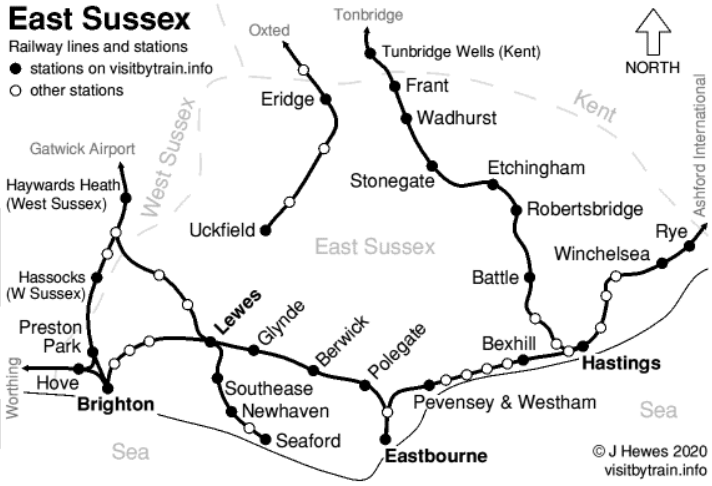
- From the Bexhill area: Stagecoach services 99, 22A, 98 all travel to Hastings and St Leonards from Bexhill, but will need a change of bus to continue to Conquest Hospital.
- From Hastings and St Leonards: Stagecoach services 23A, 26 and 26A, 100, 359 directly or indirectly serve the Conquest Hospital. These services go via Hastings Town Centre and/or St Leonards.
- From the Rye area: Stagecoach services 100, 101, 313, 342 directly or indirectly serve the Conquest Hospital. All travel to Hastings, but may need a change of bus to continue to Conquest Hospital.

Bexhill Hospital is served by only one direct route -

- Stagecoach route 12 which runs hourly from Bexhill town centre.
- Stagecoach route 98 from the Eastbourne direction and route 99 from the Hastings direction go to Bexhill town centre then change for the route 12 bus.

By train:

Figure 28: Train routes in East Sussex



Eastbourne District General Hospital can be accessed by train to Eastbourne Station and then a bus or taxi to the Hospital.

Conquest Hospital can be accessed by train to Hastings Station and then a bus or taxi to the Hospital.

Bexhill Hospital can be accessed by train to Bexhill Station and then a bus or taxi to the Hospital.

Services to help with patient travel arrangements:
There are various community and voluntary services available in East Sussex which can be accessed via the council website -
https://www.eastsussex.gov.uk/roadsandtransport/public/communitytransport/

Patients with health conditions that mean they are not able to travel by car or public transport can apply to the CCG's Non-Emergency Patient Transport Service. Eligibility criteria do apply and this service is only for secondary care settings.
https://www.scas.nhs.uk/our-services/non-emergency-patient-transport-service/

Reclaiming NHS healthcare travel costs:
Patients with low income and those in receipt of certain state benefits are entitled to help with healthcare costs, including travel to hospital appointments. The claim form and eligibility criteria can be found at:
https://www.nhs.uk/nhsengland/healthcosts/documents/hc5(t).pdf
https://www.nhs.uk/NHSEngland/Healthcosts/Documents/2016/HC1-April-2016.pdf

There will also be a focus around travel and access during further engagement and any potential consultation activities, as well as an independent review which is currently being completed ahead of public consultation to be able to feed outcomes into consultation plans and discussions.

10.3. Data Protection Impact Assessment

After consultation with the Sussex NHS Commissioners Information Governance team and Data Protection Officer the following has been concluded:

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

- There would be no changes to what data was processed nor how it would be processed.
- No new or different organisations and/or providers would be involved in accessing and/or sharing patient information.
- No new data processing systems would be utilised.

No further DPIA is, therefore, required.

For Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from 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 our acute hospital sites:

- There would be no changes to what data was processed nor how it would be processed.
- No new or different organisations and/or providers would be involved in accessing and/or sharing patient information.
- No new data processing systems would be utilised.

No further DPIA is, therefore, required.

11. Assurance

11.1 Reconfiguration: The Four Tests

In 2010, the Government introduced four conditions that must be met when considering major service changes. The tests require any NHS organisations considering a change of service to be able to demonstrate evidence of:

- strong public and patient engagement;
- consistency with the current and prospective need for patient choice;
- a clear, clinical evidence base;
- support for proposals from clinical commissioners.

A further test was introduced in 2017 that covers any proposals that significantly reduce hospital bed numbers. This test does not apply to this Pre-Consultation Business Case.

Table 31: NHS Four Tests

Strong public and patient engagement	• Pre-consultation engagement and communication programme took place from January to February 2021. • Stakeholder surveys to gain views on current cardiology services. These were made available online and through remote interviews. • Public engagement on the East Sussex Healthcare Trust cardiology services to understand what matters most to local people when using

	services – we have used the outcomes of this feedback to shape our proposals for cardiology services. • Regular communications with our stakeholder GPs via newsletters and locality meetings. • Participation by public and patient representatives (alongside key stakeholders including provider representatives and clinicians) in the options appraisal process, including workshops where they could share their views and add to potential options to transform the delivery of cardiology services. This included development and appraisal of options, and is further described in Section 8.1.
Consistency with current and prospective need for patient choice	• Patients' right to choice of secondary care provider will remain protected. What may change is the location of services. • The proposed configuration of services means that patients will be seen in by the right professional, in the right place, at the right time. • The proposed configuration of services will also reduce the number of transfers between services.
Clear, clinical evidence base	• The proposal is aligned to national best practice for cardiology and also to the NHS England/Imrovement-Integrated Care System Cardiology programme. • The proposed transformation is based on national requirements and research studies, taking into account the role of East Sussex Healthcare Trust in wider Sussex cardiology provision. • As the Case For Change was developed, various possible solutions were tested with clinicians and service staff, including other medical and surgical specialties to ensure interdependencies were taken account of. • Common themes from the engagement to date were identified and used to formulate this proposal and the case for change. • The East Sussex Health Overview and Scrutiny Committee (HOSC) and NHS England South East Clinical Senate will be reviewing and providing assurance and advice on the appropriateness of the proposal. The outcomes of this review are outlined in Section 11.1. • GP and East Sussex Healthcare Trust clinical leads have been involved in the options development and appraisal workshops that informed this proposal and are members of our Cardiology and Ophthalmology Transformation Steering Board. • GP members and the CCG Governing Body have been part of our engagement programme which has informed this proposal. • The proposals have been discussed at the Sussex Acute Collaborative Network (SACN).
Support for proposal from clinical commissioners	• There is a GP clinical lead as part of the team developing this proposal. • We are regularly communicating with our member GPs via locality meetings to ensure full awareness of the proposed transformation and enable any feedback to shape the proposal. • Regular updates have been provided to our Cardiology and Ophthalmology Transformation Steering Board for this particular project, along with updates to the East Sussex and Brighton and Hove CCG Local Management Team, and the Integrated Care System Planned Care Board. • The proposal is aligned to the Integrated Care System cardiology strategy.

11.2 NHS England/Improvement Stage 1 Assurance

Stage 1 Assurance is an opportunity for NHS England/Improvement and the Sussex Integrated Care System to provide support and guidance regarding the service reconfiguration process. It

offers an additional level of assurance scrutiny to give confidence to patients, staff and the public that proposals are well thought through, have taken on board their views and will deliver real benefits.

The Stage 1 Assurance meeting for this programme took place on 29 January 2021 following which NHS England/Improvement gave approval that the programme should progress including a range of actions to further develop the Pre Consultation Business Case.

11.3 Clinical Senate review

We requested the NHS England South East Clinical Senate to undertake an independent clinical review of our proposal to transform East Sussex Healthcare Trust's cardiology services, and also for the pre-consultation proposal. We also asked the Clinical Senate to assess the evidence we have gathered and reviewed to develop this Pre-Consultation Business Case. More specifically, the Clinical Senate was asked to:

- evaluate the proposals alongside the case for change;
- provide a narrative that details any recommended mitigations that will support commissioners to finalise the Pre-Consultation Business Case;
- evaluate the proposals in terms of future services being accessible and continuing to meet the needs of the patient population to ensure any inequality issues would be suitably mitigated.

The Clinical Senate Panel reviewed the Pre-Consultation Business Case and met on 28 July 2021 to discuss the proposal with CCG, Trust and other stakeholder colleagues, in detail. The Clinical Senate made a number of recommendations which we have addressed and that have informed and strengthened this Pre-Consultation Business Case.

The Clinical Senate provides a helpful mechanism to test the clinical model with a clinical peer group; alongside reflections about our clinical model the clinical senate also provided a range of helpful reflections about our approach to options development and appraisal and about our process of engagement with stakeholders and local people.

Overall, the Clinical Senate report and findings provided a useful framework for the development of the Pre-Consultation Business Case and our future discussions and consultation with the stakeholders on the final pre-consultation proposal.

11.4 NHS England/Improvement Stage 2 Assurance

Stage 2 Assurance is an opportunity for NHS England/Improvement to ensure there is a strong case for change, local level of consensus, patient and public engagement, consistency with patient choice, clear clinical evidence base, finance best practice, and consideration for any proposed bed closures. It also ensures a full range of options are being considered, and that potential risks are identified and mitigated.

The Stage 2 Assurance meeting for this programme took place on 14 October 2021, following which NHS England/Improvement at Stage 2 confirmed that all relevant aspects of the proposed transformation programme had been consider and approval was given to move to public consultation subject to approval by the CCG.

12. Proposed consultation process

In undertaking any further engagement and consultation, the CCG will continue to adopt a transparent, best practice approach based on several key principles. We will:

- build on our wide range of previous engagement with local people and describe our journey, the purpose of our review and our intent to consult;
- incorporate the findings from our Equality and Health Inequalities Impact Assessment, which have helped us identify the groups and communities we should target for our communications and engagement work;
- proactively engage in their own environments with any other groups not identified as a result of the Equality and Health Inequality Impact Assessment;
- "strength-test" all aspects of our thinking, planning and approach;
- involve patients through a variety of activities, go out into local communities and attend pre-existing engagement opportunities, with a clear focus on involving the seldom-heard communities as described in the Equality and Health Inequality Impact Assessment;
- acknowledge the importance our communities place on accessible cardiology service provision and clearly communicate our interest in all available feedback and insight to further inform our proposals;
- share information about the range of cardiology services that are available to local people;
- utilise our stakeholder mapping to ensure that we engage with all groups and partners with an interest in our plans including our partners in East Sussex County Council, local councillors and Members of Parliament;
- be clear about our strategic goals to deliver better and more integrated high quality care in the right place and at the tight time for local people, whilst also being transparent about our financial challenge;
- be transparent about the benefits and risks of our approach and test our thinking on those.

We will continue to engage with key stakeholders to:

- review data, evidence and feedback from the pre-consultation engagement;
- share information about local patient need analysis together;
- develop a shared understanding of the changing nature of cardiology care and the wider Sussex and national context.

12.1. Outline of the consultation process

- The consultation process will run for a period of 12 weeks (with an additional 10 working days to account for the Christmas and New Year Bank Holidays) from December 2021 to March 2022.
- The responses to the consultation process will be independently analysed and a report will be published outlining how we have considered these in coming to our decision.
- The process will be promoted through social media and other established channels (including posters, adverts in local media, via newsletters to local stakeholder groups and existing forums).
- Leaflets/flyers will be provided (written in plain English and any other languages identified as a result of the Equality and Health Inequality Impact Assessment and our engagement) promoting the consultation across the CCG's area.
- Any leaflets/flyers will be made available to GP practices and will also be prominently displayed at East Sussex Healthcare Trust.
- East Sussex Healthwatch will be engaged during the consultation process to provide support and further advice on the consultation process if required.

- We will work in partnership with the local voluntary and community sector to ensure that seldom-heard groups, particularly those identified as a result of the Equality and Health Inequality Impact Assessment, are fully engaged with the consultation process.

12.2. Process for decision-making following close of the consultation

Subject to scrutiny, review and approval of the Pre-Consultation Business Case by the CCG's Governing Body, we will formally consult with the public on these proposals and with a wider community and those who have a stake in East Sussex's cardiology services. We will also consult with Health Oversight Scrutiny Committee and ensure we meet any requirements of this scrutiny process.

Following the close of the formal consultation, the CCG will establish a panel that will review all the available evidence and any new and relevant information received during the consultation period to inform a decision making business case to propose a final recommend proposal for approval.

13. Project management

13.1. Risk management arrangements

The project team working on the delivery of this Pre-Consultation Business Case are maintaining a risk register, which is included within the CCG's overall risk management and governance arrangements.

Any risks to the Pre-Consultation Business Case and this programme of work will be continually updated and refined as our proposed model is being refined and in response to feedback from stakeholders throughout the consultation period and as any other relevant information about the impacts of the final pre-consultation proposal becomes available.

13.2. Monitoring and evaluation of impacts of the pre-consultation proposal

Through targeted conversations with local people and activity and performance data, we will continually monitor and evaluate patient experience and the quality of the services that form part of this proposal. In addition, we will monitor that we are undertaking actions as indicated through our impact assessments.

The impact of the final proposal on other services will also be monitored and evaluated. The monitoring and evaluation plan will produced as part of the Decision Making Business Case, once a final decision is chosen/recommended.

13.3. Next steps

The high-level project milestones for the proposal are:

Table 32: Current plan and Milestones for this proposal

Milestone	Date
Engagement with stakeholders, continuous evidence gathering	Ongoing
Draft Pre-Consultation Business Case, Equality and Health Inequalities Assessment and Quality Impact Assessment reviewed by the Joint Cardiology and Ophthalmology Steering Board	July/August 2021
Draft Pre-Consultation Business Case reviewed by Clinical Senate Panel	July/August 2021

Draft Pre-Consultation Business Case submitted to the CCG Local Management Team	September 2021
NHS England and Improvement Stage 2 Assurance Meeting	October 2021
Draft Pre-Consultation Business Case submitted to the CCG Quality Committee	October/November 2021
Final Pre-Consultation Business Case submitted to East Sussex Healthcare Trust Board	November 2021
Final Pre-Consultation Business Case submitted to the Sussex CCGs' Joint Committee	November 2021
East Sussex Health Overview and Scrutiny Committee (HOSC) Meeting to review the proposal	December 2021
Formal consultation on the final pre-consultation proposal (subject to approval by East Sussex Healthcare Trust Board/CCG Governing Body and review by East Sussex Health Overview and Scrutiny Committee)	December 2021 – March 2022

Following the end of the consultation period in March 2022, we will evaluate the outcomes of the consultation to ensure that relevant information gathered during this period informs our Decision Making Business Case. This Decision Making Business Case will be then considered in line with NHS Governance arrangements, following which we anticipate consideration by East Sussex Health Overview and Scrutiny Committee which is likely to be in June 2022.

14. Conclusions and Recommendations

This Pre-Consultation Business Case outlines the process by which we have reviewed the existing services that currently serve the needs of people who use East Sussex Healthcare Trust's cardiology services. It describes the national and local context within which we are commissioning services. We have asked local people and clinicians what is important to them about cardiology services, and this feedback has informed this Pre-Consultation Business Case.

NHS England South East Clinical Senate are undertaking an independent clinical review of our proposals to transform East Sussex Healthcare Trust's cardiology services, and East Sussex Health Overview and Scrutiny Committee will review our proposals. We have used national research, our impact assessments (quality, equality and health inequalities, and data and privacy), and our pre-consultation engagement into who uses the cardiology services, how and why they use it.

The conclusion from this wide range of insight and evidence is that we pursue the following options to transform East Sussex Healthcare Trust cardiology services, by formally consulting patients and the public and produce a Decision Making Business Case to confirm the preferred approach:

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

Our proposal takes account of a move towards a more efficient and sustainable acute cardiology service at East Sussex Healthcare Trust, aimed at ensuring patients receive the right care in the right place and at the right time.

This proposal also supports financial sustainability of acute cardiology services by maximising the use of existing commissioned services. It also means increased and more flexible use of existing services, in addition to the effective use of workforce across existing services.

This recommendation has been made on the basis of ensuring future sustainability of cardiology services and improving outcomes and experience for local people.

If this Pre-Consultation Business Case proposal is supported by the CCG Governing Body, and Health Oversight Scrutiny Committee consider that the proposal constitutes a substantial variation to services and should therefore be subject to public consultation, then this process will begin in December 2021.

It is anticipated that during this time there will be further opportunity to gather information, evidence and stakeholder feedback that will enable the CCG Governing Body to make an informed decision on the proposal in the best interests of local people.

Cardiology Clinical Glossary

Term	Definition
Acute coronary syndrome (ACS)	The term 'acute coronary syndrome' (ACS) encompasses a range of conditions that are due to a sudden reduction in blood flow to the heart. This is usually caused by a blood clot that forms on a patch of atheroma within a coronary artery. There are three main types of ACS: • Unstable angina • Non-ST-segment-elevation myocardial infarction (NSTEMI); also known as Non-ST-segment-elevation acute coronary syndrome (NSTEACS) • ST-segment-elevation myocardial infarction (STEMI)
Angina	A type of chest pain or discomfort caused by reduced blood flow to the heart muscle.
Atrial fibrillation (AF)	A common abnormal heart rhythm that causes an irregular and often abnormally fast heart rate.
Cardiac arrest	A sudden loss of blood flow resulting from the failure of the heart to pump blood around the body. Someone suffering from a cardiac arrest will lose consciousness and stop breathing. Without immediate treatment the person will die.
Cardiac catheter laboratory / cath lab	A room with special X-ray imaging equipment where tests and procedures to diagnose and treat heart problems (including angiograms, angioplasty, ablation and pacemaker implants) are carried out.
Cardiac magnetic resonance imaging (MRI)	A cardiac MRI scan is a detailed scan of the heart and major blood vessels using a technology called magnetic resonance imaging. Unlike X-rays and CT scans it does not involve radiation.
Cardiac resynchronisation therapy (CRT)	CRT is a special sort of pacemaker treatment used in some patients with heart failure to help improve the pumping function of the heart, and thereby improve heart failure symptoms. It usually entails inserting three pacing leads: one to the right atrium, one to the right ventricle and one to the side of the left ventricle, connected to a battery implanted under the skin. It can be used in combination with an Implantable Cardiac Defibrillator (CRT-D) or as a pacemaker alone (CRT-P).

Cardiomyopathy	A general term for diseases of the heart muscle, where the walls of the heart have become stretched, thickened or stiff; this affects the heart's ability to pump blood around the body.
Cardiovascular disease	The general term for conditions affecting the heart or blood vessels. It is usually associated with a build-up of fatty deposits inside the arteries (atherosclerosis) and an increased risk of blood clots. It can also be associated with damage to arteries in organs such as the brain, heart kidneys and eyes.
Catheter ablation	A procedure that aims to correct certain types of abnormal heart rhythms by blocking electrical pathways in the heart. It uses either heat or freezing on the area of the heart that is causing the abnormal rhythm; this creates scar tissue which breaks abnormal circuits in the heart and destroys areas of the heart muscle which are triggering abnormal rhythms.
Chronic total occlusion (CTO)	The term used to describe the situation in which one of the coronary arteries has been completely blocked (occluded) for three months or longer.
Coronary angiography / angiogram	A procedure that uses X-ray imaging to see the blood vessels of the heart (coronary arteries). The images produced during angiography are called angiograms.
Coronary Care Unit (CCU)	A hospital ward that specialises in the care of higher acuity cardiology patients that require continuous monitoring and treatment, or a level of care that cannot be provided in a normal ward environment.
Coronary heart disease	Also known as ischaemic heart disease (IHD) or coronary artery disease (CAD), this term describes the condition in which the coronary arteries become narrowed or blocked by a build-up of fatty material within their walls.
CT coronary angiography (CTCA)	A sophisticated type of X-ray scan which uses computed tomography (CT) angiography to assess the heart and coronary arteries in order to diagnose coronary artery disease.
Echocardiogram	Also known as an 'echo', this is a scan which uses high frequency sound waves to take pictures of the heart and surrounding blood vessels to assess for any abnormalities of heart structure or function, including analysing how blood flows through them and assessing the heart valves and pumping chambers of the heart.
Electrocardiogram (ECG)	A simple test that can be used to check the heart rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by the heart each time it beats. These signals are recorded by a machine and can be displayed on a screen or printed out on paper.
Electrophysiology (EP) study	A test used to assess the heart's electrical system and to diagnose abnormal heart rhythms. The test is performed by

	inserting catheters and then wire electrodes, which measure electrical activity, through blood vessels that enter the heart. It is used to diagnose and (in combination with catheter ablation) treat a wide variety of abnormal heart rhythms. It is carried out in a catheter laboratory.
Hypertension	The medical term for high blood pressure.
Implantable cardiac defibrillator (ICD)	An ICD is a device similar to a pacemaker which can treat dangerous abnormal heart rhythms. It continuously monitors the heartbeat and delivers electrical pulses or shocks, when needed, to restore normal heart rhythm.
Interventional Procedure	An interventional procedure is defined as any procedures used for diagnoses or treatment that involves incision; puncture; entry into a body cavity; or the use of ionising, electromagnetic or acoustic energy. Cardiac interventional procedures include coronary angiography and/or Percutaneous Coronary Intervention, pacemaker implantation, and catheter ablation.
Myocardial infarction (MI)	The medical term for a heart attack. A heart attack happens when the blood supply to the heart is suddenly blocked, usually by a blood clot.
Non-invasive investigation	A test or procedure that does not involve tools that break the skin or physically enter the body. Examples include ECG, echocardiography, X-rays, and CT or MRI scans.
Non-ST-segment elevation myocardial infarction (NSTEMI)	A type of heart attack and part of the ACS spectrum (see above). Usually caused by a partial or near-complete occlusion of a coronary artery resulting in reduced blood flow to the heart muscle, leading to muscle damage that can be detected using ECG and blood tests.
Percutaneous coronary intervention (PCI)	Also known as angioplasty or coronary angioplasty, this is a procedure used to widen blocked or narrowed coronary arteries of the heart. The term “angioplasty” means using a balloon to stretch open a narrow or blocked artery. Most modern angioplasty procedures also involve inserting a short wire-mesh tube, called a stent, into the artery during the procedure. The stent is left in place permanently to allow blood to flow more freely. The combination of coronary angioplasty with stenting is usually referred to as percutaneous coronary intervention (PCI).
Permanent Pacemaker (PPM)	A Permanent Pacemaker is a small electrical device that is implanted in the chest or abdomen, and used to treat abnormal heart rhythms that can cause the heart to beat to slowly or miss beats. Some pacemakers can also help the chambers of the heart beat in sync. The pacemaker system comprises a battery and pulse generator connected to one or two (or occasionally three) electrical leads.

Primary percutaneous coronary intervention (PPCI)	Also known as primary angioplasty, this is the urgent use of Percutaneous Coronary Intervention in patients presenting with particular types of heart attack (ST elevation myocardial infarction). Patients are taken directly to the catheter laboratory to undergo treatment to reopen the blocked coronary artery causing the heart attack; this may include angioplasty, stent implantation and other measures.
ST-segment elevation myocardial infarction (STEMI)	The most serious type of heart attack, which occurs when a coronary artery becomes completed blocked by a blood clot, causing damage to the heart muscle supplied by that artery. It is part of the spectrum of acute coronary syndromes (see ACS above). ST elevation myocardial infarction may be treated with Primary Percutaneous Coronary Intervention (see above).

All descriptions are based on definitions from the Cardiology Pre-Consultation Business Case, NHS, National Institute for Health and Care Excellence (NICE) and/or British Heart Foundation websites.

Abbreviations Glossary

A&E	Accident and Emergency
AF	Atrial Fibrillation
BCIS	British Cardiovascular Intervention Society
BHRS	British Heart Rhythm Society
BX	Bexhill Hospital
CCG	Clinical Commissioning Group
CCU	Coronary Care Unit
CHD	Coronary heart disease
CNP	Cardiac Nurse Practitioner
CQ	Conquest Hospital
CQC	Care Quality Commission
CRT	Cardiac Resynchronisation Therapy
CSU	Commissioning Support Unit
CT	Computed Tomography
CTO	Chronic Total Occlusion
CVD	Cardiovascular disease
DGH	District General Hospital
DMBC	Decision Making Business Case
EP	Electrophysiology
ESCC	East Sussex County Council
EHIA	Equality and Health Inequalities Impact Assessment

EHS	Eastbourne, Hailsham and Seaford
EDGH	Eastbourne District General Hospital
ESHT	East Sussex Healthcare NHS Trust
FYE	Fiscal Year End
GIRFT	Getting It Right First Time
GP	General Practice and/or General Practitioner
HR	Hastings and Rother
HIP2	Hospital Improvement Programme – Tranche 2
HOSC	Health Overview Scrutiny Committee
HR	Human Resources
HRUK	Heart Rhythm UK
HVA	Hastings Voluntary Action
HWLH	High Weald, Lewes and Havens
ICD	Implantable Cardioverter Defibrillator
ICS	Integrated Care System
IP	Inpatients
JSNA	Joint Strategic Needs Assessment
LTP	Long-Term Plan
MINAP	Myocardial Ischaemia National Audit Project
MP	Member of Parliament
NHS	National Health Service
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
NICOR	National Institute of Cardiovascular Outcomes Research
NPV	Net Present Value
NSTEACS	Non-ST Elevation Acute Coronary Syndrome

NSTEMI	Non-ST Segment Elevation Myocardial Infarction
OOH	Out of hours (i.e. after 6.30pm on a weekday and all day on Saturday and Sunday)
OP	Outpatients
ORS	Opinion Research Services
PCBC	Pre-consultation Business Case
PCI	Percutaneous Coronary Intervention
PDC	Public Dividend Capital
PPCI	Primary Percutaneous Coronary Intervention
PPM	Permanent Pacemaker
PCN	Primary Care Network
PIFU	Patient Initiated Follow-Up
PIP	Personal Independence Payment
POD	Point of Delivery
PPG	Patient Participation Group
QIA	Quality Impact Assessment
QOF	Quality Outcomes Framework
RVA	Rother Voluntary Action
SCFT	Sussex Community NHS Foundation Trust
SCW CSU	South, Central and West CSU
SECAmb	South East Coast Ambulance Service
SHCP	Sussex and Health Care Partnership
SMI	Serious Mental Illness
SOB	Shortness of Breath
SOCI	Statement of Comprehensive Income
SPFT	Sussex Partnership NHS Foundation Trust
STEMI	ST Elevation Myocardial Infarction

UCK	Uckfield Hospital
VAT	Value Added Tax
VCS	Voluntary and community sector
VCSE	Voluntary, community and social enterprise
WAU	Weighted Activity Unit
WTE	Working Time Equivalent
YMCA	Young Men's Christian Association
3VA	Voluntary Action in Eastbourne, Lewes and Wealden

EXTENDED

Equality and Health Inequalities Impact Assessment (EHIA)

An EHIA is a tool to explore the potential for a policy, strategy, service, project or procedure to have an impact on a particular group, groups or community. This includes the impact on one or more of these groups:

- Protected characteristic groups (as outlined in the Equality Act 2010)
- Disadvantaged or marginalised groups or communities
- Deprivation and socio-economic disadvantage within local communities
- Local health inequalities for groups and communities

Please complete this Equality and Health Inequalities Impact Assessment when the proposed change has a potential negative impact on staff, patients, public or local communities.

Please note:
To comply with our agreed Equality Policy and Procedure and meet our requirements under legislation, all new policies and new and proposed services or strategies must be impact assessed before being introduced. Within this document, you will need to provide evidence to demonstrate:

- Consideration of the impact of your initiative for each protected characteristic and other disadvantaged groups and communities
- Assessment of the impact you have identified and a clear action plan to mitigate the issues and concerns which arise from this.

For further support or advice please contact:

- **Jane Lodge – Head of Engagement**
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- **Nicky Cambridge – Stakeholder Engagement Lead**
  nicky.cambridge@nhs.net

1. Introduction and overview

Title of EHIA	East Sussex Healthcare Trust – Acute Cardiology Service Transformation							**ID No.** #056		
Team / Department	Planned Care – East Sussex				**Assessor Completing the EHIA**			Assistant Head of Planned Care/Senior Planned Care Manager/Planned Care Officer		
Date EHIA Started	15 October 2020				**Date EHIA Completed**					
What is the focus of this EHIA?	Workforce Policies	Organisational strategy	Clinical services X	Clinical policies	Other: Please state					
What is the status of this policy / function / practice or provision?	New X	Revised	Monitoring	End	**Who will be affected?**	Staff X	Carers X	Patients / service users X	Communities	Other
Brief description of the aims of the service, policy, strategy, function that this EHIA relates to.	This EHIA is an initial assessment of the pre-consultation phase to transform cardiology services in East Sussex. It has been carried out to ensure that options for transformation are informed by the experience of local people, notably those with protected characteristics and other disadvantaged groups and communities, to ensure that any transformation plans promote equality and reduce inequalities. The impact of proposed options will be assessed fully through a new EHIA using this feedback in the next phase of the work. Cardiology services are consultant-led and provide emergency and planned care across the two acute district general hospitals, Conquest Hospital in Hastings and Eastbourne District General Hospital (EDGH) in Eastbourne, with some service provision within the community. The ESHT cardiology department encompasses a range of services as follows: • dedicated inpatient wards, coronary care units (CCU) • three cardiac catheter laboratories across the two sites. • cardiac pacemaker and diagnostic imaging services. • cardiac rehabilitation and heart failure services are provided in the community. • outpatient cardiology clinics at Conquest and Eastbourne hospitals and Bexhill and Uckfield Community Hospitals.									

	• on call 24/7 primary percutaneous coronary intervention (PPCI) service is provided for patients suffering with acute heart attack. • Electrophysiology (EP) services The national and local policy drivers are set out in the Case for Change for Transforming Acute Cardiology Services at East Sussex Healthcare NHS Trust. In summary these are: • **Changing patterns of service delivery:** nationally policy makers are indicating that NHS services generally are in need of redesign. • **The current medical model:** patients who present to A&E with cardiology related problems are admitted under the care of the acute medical doctors. • **Subspecialisation:** cardiology nationally has become increasingly complex and specialised and cardiologists now specialise in one or two types of treatment however the current service model was designed at a time when sub-specialisation was not so advanced and cardiologists could perform multiple types of procedures to the standards of the day. • **Workforce:** operationally providing complete and comprehensive services that directly mirror each other on both sites is a significant workforce challenge, exacerbated by subspecialisation, and further complicated by difficulties with recruitment and retention of the workforce. • **Quality:** there are challenges meeting the national performance indicators and guidance, • **Nationally**: re-thinking what the future of cardiology services looks like, to ensure we reduce inequalities and improve health outcomes. • **Net Zero NHS:** the national aim of making the NHS more environmentally sustainable and 'net zero' by 2050. • **IT/Digital:** maximising use of digital technology when appropriate to manage demand, transform patient pathways and ensure timely follow-up. • **Estates and equipment:** some of the cardiac catheterisation laboratories are due for replacement and are not operating reliably. In addition, the engineering infrastructure is no longer fit for purpose. • **Making best use of resources:** moderating demand for hospital services, protecting them so they are available when they are most needed by our population in a more sustainable way. Working with primary care and other partners - early identification and modification of risk factors high blood pressure, cholesterol and fasting plasma glucose are amongst the top 10 risk factors for years of life lost in England. Treatment of these risk factors and atrial fibrillation reduces the risk of cardiovascular events. Late diagnosis of these high risk conditions and under treatment are common.

	• **Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society:** taking action to reduce health inequalities. CVD is a key health inequality, accounting for 30.4% (men) and 33.7% (women) of the life expectancy gap between most and least deprived quintiles in East Sussex (2015-17 – PHE segment tool). The vision for the East Sussex Health and Care System is to provide high-quality cardiology services for patients, carers and families that tackle these inequalities. This includes: • A centre of clinical excellence and quality • Innovation in delivery of cardiology services • An improved service • Clinical and financial sustainability This EHIA has been written in the context of East Sussex Acute Cardiology Case for Change, Pre-consultation engagement, Options Appraisal workshops, EHIA workshops, Pre-consultation business case and Quality Impact assessment. It is recognised that this document will need to be continually refreshed at each stage of the programme to include additional insight and data as it becomes available and we will continue to address data gaps to inform the programme and improve our understanding of health inequalities in East Sussex
Outline the links to national and local policy and strategy.	**<u>Context</u>** • **NHS Long Term Plan** – has a key focus on developing ICS, (Integrated Care Systems) between Primary, Community and Secondary services to join up the planning and delivery of services to improve population health. There are also key focuses on improving the digital interfaces between care settings, and a drive to move away from the traditional outpatient models of care. The plan outlines that heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years. • **NHS Rightcare** – a programme committed to reducing unwarranted variation, improve people's health outcomes, reduce inequalities in access experience. "All systems will work with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20. They will also be expected to address variation and improve care in at least one additional pathway outside of the national priority initiatives."

	Smoking Cessation - Public Health will maximise the opportunities that patient contact and hospital admissions bring to help people to improve their health. Ref Public Health National Strategy We will fund new evidence-based NHS prevention programmes that focus on reducing smoking, obesity and alcohol intake. Our new services will help more people to stop smoking, maintain a healthy weight and make sure their alcohol intake is within a healthy limit. ***What we will do*** • Make sure that everyone who has to stay overnight in hospital is given the chance and provided with help to stop smoking • Make sure that every pregnant woman is offered help to stop smoking • Help people using outpatient services for conditions that are made worse by smoking (for example cancer) to quit smoking • **Getting It Right First Time (GIRFT) –** National programme to improve the quality of care by addressing unwarranted variation in care. • **NHS England Elective Care High Impact Interventions (Cardiology)** – challenges and opportunities in cardiology from this programme include: prevention and earlier detection of risk factors, improving assessment and referral processes – removing unwarranted variation, addressing lack of capacity in secondary care and improving processes in outpatient clinics, supporting patients to share decisions and better manage their condition, to aid understanding, prevent future harm and improve quality of life, supporting patients with co-morbidities. **Model Hospital** – supports trusts to identify and tackle unwarranted variation. • **East Sussex Place-Based Response to the Long Term Plan** includes plans to deliver a comprehensive approach to prevention, universal personal care and reducing health inequalities that cuts across our key clinical priorities and care pathways from supporting healthy lifestyles and wellbeing, greater levels of self-management, shared decision-making, and personalised care and support planning, through to early intervention, proactive care and re-ablement.

What patient and public engagement has already taken place in relation to this proposal?	**Pre Consultation Engagement** - As part of this programme a six-week period of pre-consultation engagement took place from 04/01/2021 to 14/02/2021. This engagement was informed by a range of previous engagement exercises including: • Shaping Health and Care events carried out as part of the East Sussex Better Together programme • Feedback received during the first two months of the Big Health and Care Conversation (July – Sept 2020) • Healthwatch in Sussex and Sussex NHS Commissioners Accessing health and care services – findings during the Coronavirus pandemic • Research carried out in Brighton & Hove by the Trust for Developing Communities in July 2019 The pre-consultation engagement period was designed to gather feedback and insight to inform development of options which will be consulted on fully. This engagement involved a combination of questionnaires and 40 in-depth interviews. Fully analysis of the engagement is underway. The feedback and analysis from this engagement will help us better understand what matters to our patients, their experiencing of accessing services, and how these could improve. The outputs of this engagement will support the options development process for cardiology services in East Sussex. **NHSE Stage 1 Assurance**; In March the CCG and EHST met with NHSEI for Stage 1 Assurance. The feedback centered on the importance of in-depth Equality and Health Inequality Impact Assessment and ensuring the proposals were fully integrated into, and consistent with, the broader ICS service recovery and transformation plans. **Options Appraisal Workshops;** In April/March we held three Options Appraisal workshops. These workshops were designed, developed and delivered in collaboration with the CCG by an external consultancy: Opinion Research Services (ORS), factoring in the themes and feedback from the pre-consultation engagement and the key areas identified within the EHIA's. The workshops had representation from a wide range of stakeholders; patient and public representatives, Public Health, Healthwatch, ESHT consultants, clinical leads, CCG clinical leads, Nurse specialists, GP's, community optometrists, SECAMB, as well as a wide range of attendees from CCG and ESHT departments (communications and engagement, HR, Quality, Finance, Business Intelligence, service management and commissioning).

	ORS provided a comprehensive report on the workshops covering the qualitative feedback around external challenges, internal challenges, national drivers and opportunities for improvements. In both qualitative and quantitative stages of the appraisal, five appraisal criteria where discussed and agreed for the Cardiology workshops. These criteria are: Quality and Safety; Clinical sustainability; Access and Choice; Financial Sustainability; and Deliverability, however the early indications are as follows; Cardiology: The Options were: 1) Retain Current Services over 2 sites 2) Retain Current Services with assessment area at both front ends 3) Build up both acute sites 4) PCI (plumbing) on one acute site and EP (electrics) on the other acute site 5) Co-location of catheterization labs and inpatients to one acute site. The outcomes of the options development and appraisal process reported here suggest that Option 5 could reasonably be taken forward to formal public consultation on the future of cardiology services in East Sussex. Proposals are informed by a range of further activities including, the outcome of EHIA workshops, additional engagement, further GP engagement, further travel and access analysis alongside the refreshed QIAs. **Equalities Health Impact Assessments (EHIA's);** EHIA workshops took place at the end of April/May and will be designed to support a lessons learnt session and a workshop to look at the Options Development through an inequalities lens as we develop our preferred options for likely consultation. Key themes from these workshops included further considerations in relation to the following: homelessness, veterans, refugees, asylum seekers, access for wheelchair users, substance misuse and hearing impairment alongside specific clinical areas related to cardiology. Further details can be found in sections 8 and 13. **Travel and Access**; We recognize the importance of ensuring that the services commissioned reduce health inequalities and ensure reasonable access so this paper concentrates on demonstrating the possible impact on patient travel times if East Sussex Healthcare Trust (ESHT) services were to be redesigned in line with the each of the options arising from the options appraisal workshops held in March. The paper provides an overview of locations and accessibility of ESHT hospital sites alongside the postcode data showing that patients admitted at each site were predominately from the local postcode area. The paper has also been aligned with every EHIA characteristic i.e. deprivation, alongside travel cost and timings for travel and ensured these are aligned to all x5

	options for Cardiology. Steering Board have provided approval to add these findings into the PCBCs and the EHIA's, which is complete. Further analysis is required and we have started the process of procuring an external provider via an invitation to quote for a more in-depth review/analysis of travel and access looking at: ➢ Impacts on travel times by different modes for staff and patients and visitors ➢ Impacts on travel costs by different modes for staff and patients and visitors ➢ Impacts on travel costs by different modes of transport car/public transport specific to population segmentation (including areas Deprivation and age and the impacts) ➢ Overall against site locations and the preferred high scoring options (Cardiology option number 5) ➢ To summarise the methodology and findings into a Cardiology report. This analysis will ensure that the protected characteristics within the EHIA are considered within the preferred options to ensure we have an independent view. **Additional Engagement**; Due to lower numbers than expected of patients and patient representatives at our Options Appraisal workshops for Cardiology, we have taken Consultation Institute advice and organized a number of additional interviews. These interviews took place in July 2021 with the focus around the options and the preferred options for Cardiology. These interviews are recorded and documented whilst also being put back into the PCBC's/EHIA's and the consultation document. **GP locality Forums** – Further engagement has been provided at the GP Locality Forums across East Sussex (Bexhill, Hastings, High Weald, Lewes Havens, Rural Rother, Eastbourne, Hailsham, and Seaford) during July and August. The clinical lead for the programme, who is also a GP, attended all of the forums and provided the following feedback: • Presentation at Clinical Director (of PCNs) and individual locality forums ensured wide GP representation.

	• The transformation work was positively received, some concern was expressed with regards to communication with the public regarding perception of access and actual access.
	• There was much interest in 'front end' cardiology services such that senior opinions meant that hospital admissions were reduced and that communication to primary care would therefore be more timely. 'Hot clinics' for cardiology were welcomed as an adjunct to current Advice and Guidance pathways available to primary care.
	• Primary care colleagues expressed interest in harmonisation of Locally Commissioned Services for cardiovascular disease as well as development of an intermediate cardiology service across the patch to support pathways from primary to secondary care.
	
	Areas considered; When developing our options and all of the above, transformation proposal and the Pre-Consultation Business Cases (PCBCs):
	• We have considered the outputs from engagement with local people and clinicians and used these to inform the PCBCs
	• We have developed the PCBCs with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties
	• We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment (QIA) and an Equality and Health Inequalities Impact Assessment (EHIA) to identify any potential negative impacts and identified appropriate mitigating actions
	• We will be taking into account the recommendations of the South East Clinical Senate and HOSC
	• We have assessed our proposal against the NHS Four Tests for service reconfigurations.[1]
	• We have developed our proposal and associated consultation plans in line with the Gunning Principles[2] to ensure that:
	  ○ a decision will not be taken until after public consultation
	  ○ local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
	  ○ there is adequate time for people to participate in the consultation taking account of the Christmas holiday period. Consequently, we are planning to increase the consultation period from 12 weeks to 14 weeks;
	  ○ we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

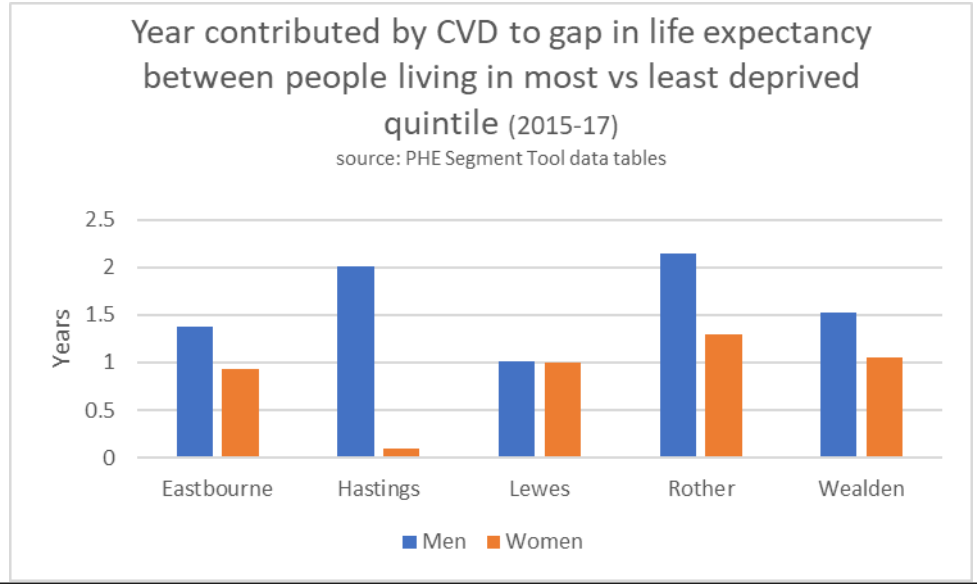
2. Update on previous EHIA (where one exists) and outcomes of previous actions or if this is new, then record N/A

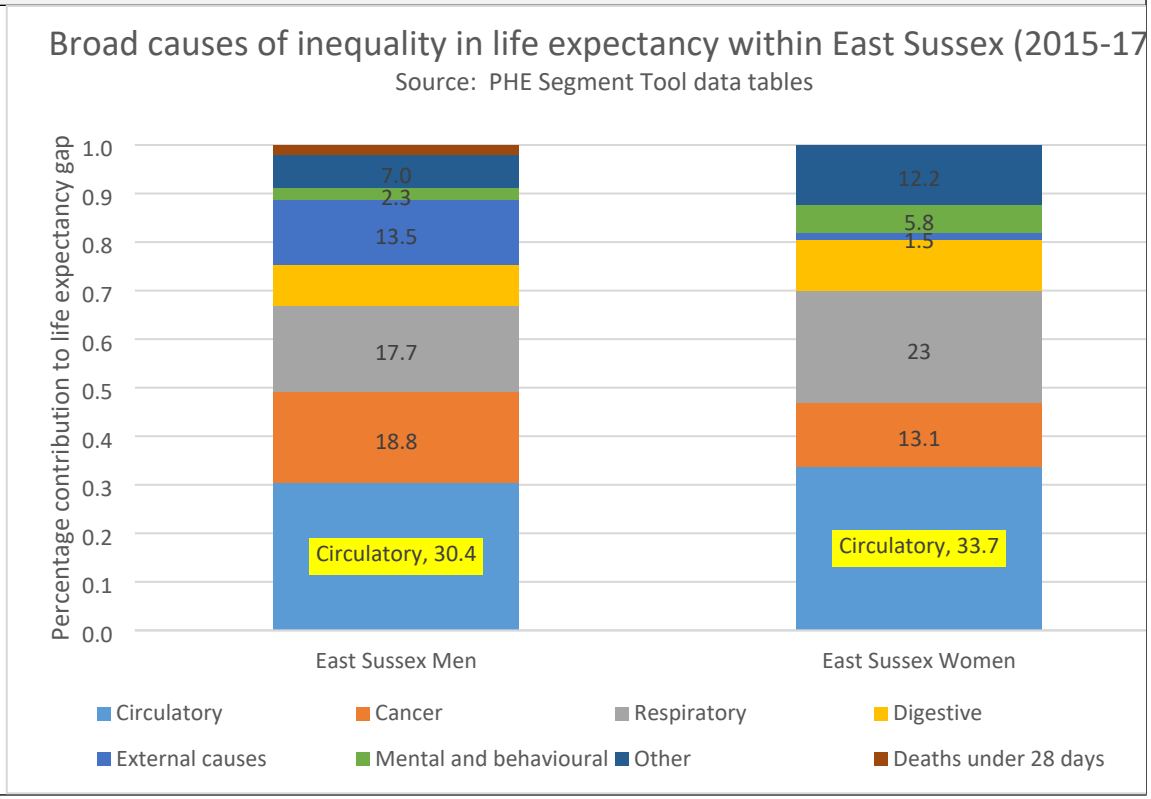
What actions did you plan last time? (List them from the previous EIA)	**How has this action progressed?**	**What <u>further</u> actions do you need to take?** (add these to the Action plan below)
N/A		

3. Health inequalities

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
Will this initiative help to reduce health inequalities for any specific groups and communities? ***e.g. access to services, improved health outcomes***			X	"Cardiovascular disease (CVD) remains the leading cause of premature mortality in England, and the rate of improvement seen in recent years has slowed. It is also one of the conditions most strongly associated with health inequalities, with people living in England's most deprived areas being almost four times more likely to die prematurely of CVD than those in the least deprived area." (Public Health England 2019) CVD premature mortality is the biggest driver in health inequalities between most and least deprived groups in East Sussex. By improving early identification and management of risk factors in the most deprived communities, and by putting measures in place within cardiology services to review proportions of patients from deprived areas, and increase access where necessary, we aim to reduce health inequalities. Although this is outside the scope of this transformation programme, this will be addressed as part of our wider Sussex-wide cardiology programme. We know that smoking is a leading risk factor for CVD, and that smoking rates are higher in more deprived areas. By ensuring that cardiology services routinely encourage /refer all patients to smoking cessation services, we will help to target the inequalities gap. We will undertake the same action in relation to exercise, weight management and behaviour change. Again, although this is outside the scope of this transformation programme, this will be addressed as part of our wider Sussex-wide cardiology programme. CVD is higher in people who are Black, Asian and Minority Ethnic (BAME) and therefore ensuring services are accessible and appropriate will also reduce health inequalities for these patient groups The East Sussex CCGs combined have a significantly higher prevalence of circulatory diseases compared to average across England regions, with the driving factor being an older population than the England average. Across East Sussex there are approximately: • 20,300 people have a diagnosis of coronary heart disease, a prevalence of almost 4%; • 5,500 on the heart failure register; • 16,300 on the atrial fibrillation register, and;

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
				• 92,800 on the hypertension register. (NB: QOF data is not age-adjusted, hence why East Sussex has a higher prevalence than England, as East Sussex's population is older). We estimate there to be an undiagnosed rate of 16% of atrial fibrillation and 13% for hypertension, i.e. a further proportion of the population with these conditions: • Atrial fibrillation: 2,608 (16%) • Hypertension: 12,604 (13%) Including those we have identified as being undiagnosed, we estimate there to be 149,572 people across East Sussex living with a circulatory disease of coronary heart disease, heart failure, atrial fibrillation and hypertension. That is approximately 27% of the adult population. We recognise that patients could have one or more circulatory conditions. The risk of developing CVD increases with age and predominantly affects people older than 50 years. Risk factors for CVD include non-modifiable factors such as age, sex, family history of CVD, ethnic background and modifiable risk factors such as smoking, raised blood pressure and cholesterol. CVD is strongly associated with low income and social deprivation (NICE, 2014). The existing cardiology service provided by East Sussex Healthcare Trust only collects demographic data on age and sex. Due to having limited demographic data for other protected characteristics and disadvantaged groups and communities', further work is required to ensure that we have a comprehensive understanding of health inequalities, and whether certain population groups are not able to access the cardiology service or experiencing different health outcomes. This EHIA supports our action on this. As part of the pre-consultation engagement for the service re-design process, we have engaged with local communities, building on our health inequalities work across East Sussex with the Health Inequalities Board and in particular our Healthy Hastings and Rother Health Inequalities programme to understand the experience of service users in East Sussex, and how, why and where health inequalities are created and exist.

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
				We will ensure that any proposed options for the future of cardiology services in East Sussex will take targeted action to address any identified inequalities. Any shortlisting or selecting of options will include information from this EHIA and the data underlying so that we are clear that our options will have a material impact upon our options for consultation and decision making process. Our initial assessment of impact and risk for CVD in this EHIA shows that the people from ethnic communities, our older population, men, patients with a disability or long-term condition, residents in care homes and communities living in the most deprived areas are at higher risk of developing CVD. Cardiology services are accessible via GP referral or A&E attendance, which are as accessible to people from these groups as to people not from these groups. Therefore, we are engaging and working with hard-to-reach groups i.e. care home networks to ensure the population is aware of the services available to them and signs of when they should use them. This does not mean that there is not a risk for other communities across our patient population and this EHIA considers all groups. 

	YES	NO	DON'T KNOW	Provide evidence to support your assessment
				

4. Impact assessment

Please consider each protected characteristic and consider whether the policy / function / practice or provision has the potential to impact on each protected characteristic group and / or community.

	Positive	Neutral	Negative	No Impact	**Data to support your assessment** This can be census data, research, complaints, surveys, reports etc.	**Engagement / feedback information to support your assessment** This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	**Actions:** • advance equality of opportunity, • eliminate discrimination • foster good relations
Race/Ethnicity					When looking at the breakdown for ethnicity categories the reliable available data is the 2011 census data. The census shows that East Sussex has the lowest BAME population in Sussex. Just over 4.3% of the East Sussex population are from BAME groups with a further 4.3% from other White non-British groups. Whilst the BAME population are likely to have a higher prevalence of heart disease compared to their white peers, and have a much younger age profile, with the 2011 Census showing that 26% were aged under 15 years, 68% aged 15-64 years, and 6% aged 65 years and over. This compares to 16% (under 15), 61% (15-64), and 23% (65 and over) for the White population. **Race and disease prevalence** There are certain disease groups where data indicates that the prevalence is higher or the risk of developing cardiovascular disease is greater in the BAME population (Sussex BAME Population Needs Review, 2021). Research by The British Heart Foundation https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity found that some ethnic groups are more vulnerable to heart and circulatory diseases. It identified that ethnicity can increase the risk of developing heart and circulatory diseases and that for those people who are South Asian, African, or African Caribbean in the UK, the risk of developing some heart and circulatory diseases can be higher than white Europeans. **Ethnicity, deprivation and disease prevalence**	As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; *'What is your ethnic group?'* Responses: - White (75) - Mixed or multiple ethnic groups (1) - Asian or Asian British (4) - Other ethnic group (1) - Prefer not to say (1) There were not responses from Black, African and Caribbean, Black British or Arab ethnic groups. Research carried out in Brighton & Hove on race and ethnicity by the Trust	Given that ethnicity can increase the risk of CVD, we will ensure that as part of the formal options development process, models/interventions are developed that meet the needs of our ethnically diverse communities. Where possible, we will look to immediately action changes that would reduce health inequalities and ensure equity of access by: a) Improving the information available and how this is shared

	Positive	Neutral	Negative	No Impact	**Data to support your assessment** This can be census data, research, complaints, surveys, reports etc.	**Engagement / feedback information to support your assessment** This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	**Actions:** • advance equality of opportunity, • eliminate discrimination • foster good relations
					The Sussex BAME Population Needs Review (2021) states that there is a strong association between socio-economic disadvantage and ethnicity. This is a complex relationship. People from minority ethnic backgrounds are more likely to experience *multiple* aspects of deprivation, including having a low income, live in poorer housing, be victims of crime, experience unemployment or low paid work. The below table outlines the percentage of the population by ethnic group as reported at the 2011 census. The table shows estimated population size by ethnic community based on the East Sussex Population of 560,000.	for Developing Communities in July 2019 showed that the following issues around care were important to the BAME community: • Better and more appropriate information about the range of services available and their functions • Good dissemination of information, including through VCS organisations and existing community groups • More training for healthcare staff on BAME communities and their needs The Sussex Black, Asian and Minority Ethnic (BAME) Population Needs Review (2020) examined current health,	across our communities b) Review our pathways in terms of how these are shared across our communities c) Establish the opportunities of working with the CVD Prevention Programme d) Review areas of deprivation with the focus on prevention programmes of activity e) Link Consultants up with GPs from areas of highest need to focus more on

Ethnic Group	East Sussex	Pop size
All categories: Ethnic group	100.00%	560,000
White: English/Welsh/Scottish/Northern Irish/British	91.66%	513,296
White: Irish	0.75%	4,200
White: Gypsy or Irish Traveller	0.15%	840
White: Other White	3.39%	18,984
Mixed/multiple ethnic group: White and Black Caribbean	0.37%	2,070
Mixed/multiple ethnic group: White and Black African	0.19%	1,064
Mixed/multiple ethnic group: White and Asian	0.49%	2,744
Mixed/multiple ethnic group: Other Mixed	0.36%	2,016
Asian/Asian British: Indian	0.43%	2,408

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
						care and wellbeing needs of the BAME population across Sussex; to understand the geographical and social impact and wider determinants of BAME health and its intersectionality with race, age, gender, with discrimination and disadvantage. Some of the challenges in producing this report were time and capacity during the current health and care challenges of a pandemic but more so the lack of routine and timely ethnicity data at local level. The main findings identified from the review were:	prevention and shared learning pathways and redesign f) Gathering the clinical view about treatments and ethnicity Communications and Engagement work to support communities and cultures For formal consultation we will ensure: • links have been made with local faith communities or cultural groups in order to encourage involvement and gain

Asian/Asian British: Pakistani	0.06%	336
Asian/Asian British: Bangladeshi	0.20%	1,120
Asian/Asian British: Chinese	0.37%	2,072
Asian/Asian British: Other Asian	0.68%	3,808
Black/African/Caribbean/Black British: African	0.34%	1,904
Black/African/Caribbean/Black British: Caribbean	0.15%	840
Black/African/Caribbean/Black British: Other Black	0.06%	336
Other ethnic group: Arab	0.12%	672
Other ethnic group: Any other ethnic group	0.21%	1,176

A 2015 Public Health study focussing on diseases in different ethnic groups found that:

- In all minority ethnic groups there was a general age-related increase in the prevalence of CVD
- In most CVD cases (excluding diabetes) Chinese men and women had lower rates than the general population.
- In most CVD areas, South Asian groups showed higher rates, with Pakistani and Bangladeshi groups higher than Indian groups
- South Asian men are 50% more likely to have coronary heart disease than men in the general population. Bangladeshis have the highest rates (followed by Pakistanis, then Indians and other South Asians).
- Black Caribbean men had lower prevalence of angina and heart attack than the general population.
- When all of these were taken into account simultaneously, it was found that the differences in prevalence between each minority ethnic group and the general

<table>
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This could be focus groups, face-to-face meetings, surveys, speak out events, etc.</td><td>Actions:
• advance equality of opportunity,
• eliminate discrimination
• foster good relations</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>population were not statistically significant. However, BAME populations the same age as white populations have higher rates of CVD, as BAME populations have shorter life expectancies than white populations. Therefore, white populations risk of CVD increases as they get older. Overall, there are no differences in proportions.
- Hypertension is more frequently encountered in ethnic minorities but differences do not reach statistical significance.

The table below shows that we have 3,555,463 people in the south east that own a car or a van.
<table>
<tr><td>date</td><td colspan="4">ONS Crown Copyright Reserved [from Nomis on 23 June 2021]</td></tr>
<tr><td>geography</td><td colspan="4">South East</td></tr>
<tr><td>measures</td><td colspan="4">value</td></tr>
<tr><td>Cars or Vans</td><td>All categories: Car or van availability</td><td>No cars or vans in household</td><td>1 car or van in household</td><td>2 or more cars or vans in household</td></tr>
<tr><td>Ethnic Group of HRP</td><td></td><td></td><td></td><td></td></tr>
</table></td><td>• There is inadequate ethnicity recording at local and service level across most health and care services which impeded a more comprehensive review. Therefore, some of the data was estimated or modelled from survey samples, such as the resident population data, lifestyle data and disease prevalence data.
• There are many areas where inequalities for BAME</td><td>feedback through all stages of patient and public involvement.
• that Friends, Families and Travellers receive information on all involvement activity.
• Translate questionnaire into community languages as a standard approach
• Attendance at Eastbourne Cultural Involvement Group to promote</td></tr>
</table>

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
						communities were significant around access to health and care interventions both preventative and for disease management • People living in very deprived geographical areas across Sussex especially where this intersects with high BAME communities face significantly more disadvantages that result in poor health and life outcomes. • Inconsistent access to linguistic/ translating	engagement opportunities • Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities • Further information to come from BAME Disparity Programme Team. This section will be updated as work progresses The following pieces of work will be addressed with the provider during and

All categories: Ethnic group of HRP	3,555,463	660,430	1,483,911	1,411,122
White: Total	3,317,589	605,337	1,379,729	1,332,523
White: English/Welsh/Scottish/Northern Irish/British	3,128,740	560,585	1,296,066	1,272,089
White: Irish	39,964	9,848	16,696	13,420
White: Other White	148,885	34,904	66,967	47,014
Mixed/multiple ethnic group	36,279	9,869	15,683	10,727
Asian/Asian British	132,857	25,269	58,184	49,404

Travel
There is no data on ethnicity of patients attending cardiology appointments but the Sussex BAME Population Needs Review (2021) states that there is a strong association between socio-economic disadvantage and ethnicity. Due to wider socio-economic inequalities, BAME people will face greater barriers to travel and are less likely to own cars, and therefore may find it harder to attend cardiology services.

JSNA data indicates that in 2011, 96% of the East Sussex population had English as a first language, with 92% of those living in the Eastbourne area having English as a first language.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					Eastbourne, Hastings and St Leonards-on-Sea, which have high levels of deprivation, also have the highest proportion of BAME people and also people where English is an additional language. The postcodes that include the most deprived areas of East Sussex are TN34 (the central Hastings and Ore wards) and TN37 (St Leonards wards) in HR and BN21 (Devonshire ward area) and BN22 (Hamden Park ward area). TN34 (the central Hastings and Ore wards), In 2019/20, 79.8% (403) of patients from this postcode were treated at Conquest Hospital. TN37 (St Leonards wards) In 2019/20, 80.2% (259) of patients from this postcode were treated at Conquest Hospital. BN21 (Devonshire ward area) In 2019/20, 98.3% (353) of patients from this postcode were treated at Eastbourne District General Hospital. BN22 (Hampden Park ward area) In 2019/20, 97.4% (337) of patients from this postcode were treated at Eastbourne District General Hospital.	• services across Primary, Community and Acute services • Lack of consistent and culturally aware messaging and service delivery at Place and system Where Gypsy and Traveller communities are not in settled accommodation, they report that the lack of a permanent address can impact on access to care, especially primary care (therefore may stop them presenting earlier with symptoms). Cardiovascular disease has a significant consequence for BAME individuals, their families and health care organisations as it is	post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Further work around the clinical view on treatment and ethnicity diverse workforce and what further work can be done to improve this. • Link in with other initiatives around CVD prevention programme, AF shared awareness • Future of the service and the collection

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
						predicted that cardiovascular disease will become the dominant cause of death and disability over the next decade. The average age of a UK heart failure patient is 75, this drops to 69 for people from Black and minority ethnic backgrounds. The average is in the low 60s for some cohorts, including the most socioeconomically deprived. The ESHT website contains: • Information on travelling by public transport to each site. Instructions for travelling to each site by car including general	of data on protected characteristics • Future of the service and recording if English is a first or second language • Future of the service - awareness of care plans and advanced care plans • Further understanding of service use and patient experience • Ensure patient feedback can be analysed by ethnicity and

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<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>parking information and blue badge holder parking.
• A link to the local county council website that gives information on voluntary services that offer transport services.
A section on how to claim under the NHS Healthcare Travel Costs Scheme.</td><td>address any concerns identified
• Address prevention in areas of deprivation
• Work with the Community Transformation team</td></tr>
<tr><td>People who have English as a second language</td><td></td><td></td><td></td><td></td><td>There is limited data available, due to low numbers via interpretation or translation services on those using the cardiology department at ESHT who have English as a second language or do not speak English fluently.

This data was taken over 2019/2020:-
<table><tr><th>Department</th><th>Interpreters (Total)</th><th>Interpreters</th><th>Interpreters (Face to Face)</th></tr><tr><td>Cardiology EDGH</td><td>20</td><td>10</td><td>10</td></tr></table></td><td>Engagement with BAME communities where English is a second language has indicated that cultural and language issues may prove barriers to accessing NHS care</td><td>Clarification is required as to the number of people accessing the cardiology service, as well as primary care, where English is not their first language.

Where actions of communication are</td></tr>
</table>

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					Cardiology CQ: 14 / 5 / 9 JSNA data indicates that in 2011, 96% of the East Sussex population had English as a first language, with 92% of those living in the Eastbourne area having English as a first language. Eastbourne, Hastings and St Leonards-on-Sea, which have high levels of deprivation, also have the highest proportion of people where English is an additional language.		highlighted as an area of improvement required, we will take immediate action to address these issues and ensure equitable access for our patients by removing barriers to accessing NHS care. For formal consultation we will: • Work with organisations that provide translation services to better understand the need for translation support for patients accessing cardiology services in East Sussex

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							• Offer telephone interpretation to support those who speak English as a second language and wish to engage • Translate materials into community languages as a standard approach The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access;

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							• Work with Primary Care, local support workers and interpreters to work closer with local communities around communication / engagement and prevention • Identify if the e translation service offered matches the need across East Sussex
Sex					East Sussex has c.560, 000 residents: • 288,042 female residents (51.5%) and; • 271,367 male residents (48.5%) (JSNA 2020 data).	As part of the pre-consultation engagement for cardiology redesign, respondents to the	Given that men are at an increased risk of CVD, and that CVD is a leading

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					4.7% of the females in East Sussex are over 85 and 2.7% of the males are over 85 (East Sussex JSNA). Globally more people die annually from CVDs than from any other cause. Heart disease is the one of England's leading causes of death, with 13.6% of males and 8.3% of females dying from ischemic heart disease. (Public Health England, 2017) **Cardiology attendances at ESHT 2019/20:** Age Female Male 0-18 118 127 19-64 5,971 7,171 65-74 4,416 6,648 75+ 9,075 11,070 Total 19,580 25,016 We can see that attendances at ESHT were higher for men than women across all age groups. **Long term conditions** 31.9% of women in East Sussex have two or more long term conditions compared to 26.2% of men. **Carer responsibilities** A higher proportion of women claim carers allowance in East Sussex than men: • Women - 11.9% • Men – 4.9% **Sex and disease prevalence** Heart disease was the leading cause of death in men and the third leading cause of death in women, in East Sussex for the years 2016 – 2018.	questionnaire were asked; *'What is your gender?'* Responses: - Men (46) - Women (34) - Prefer not to say (1)	cause of death for both men and women, we will ensure that as part of the formal options development process, models/interventions are developed that meet the needs of our communities. For formal consultation we will: • Take measures to identify and engage with gender specific groups in East Sussex • Review recommendations & design, provide that to Public Health on physical

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					Alcohol Consumption High alcohol consumption is linked to a number of poor health outcomes, including cardiovascular disease. High alcohol intake can lead to high blood pressure, heart failure and stroke. In East Sussex 1 in 10 women and 1 in 3 men drink at high risk (Public Health 2016). Travel DVLA figures for 2019 show that nationally - 89% of males and 81% of females aged 40-59 hold a driver's licence. 90% of males and 79% of females 60 - 69 hold a driver's licence. 81% of males and 55% of females aged 70+ hold a driver's licence. (https://www.gov.uk/government/collections/vehicles-statistics) A review of attendances at ESHT (inpatient and outpatient) showed that a slightly higher proportion of patients were male across all age groups (25016:19580). This indicates that any increase in journey times to hospitals in the area would impact the male population more however there is no evidence that travel implications are different for any specific gender.		activity programmes around early intervention and prevention
Gender reassignment					The 2011 census did not capture data for the number of Trans people residing in East Sussex.	The Trans Needs Assessment in Brighton and Hove (2015) and	While clarification is required as to the number of Trans

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					Gender reassignment and disease prevalence A study in the USA found that transgender women who received oestrogen had a higher risk of blood clots and strokes compared with men and women who aren't transgender. Their risk for blood clots and strokes increased over time. https://www.pcori.org/research-results/2013/examining-health-outcomes-people-who-are-transgender	work carried out through the and the insight gathered by Trans engagement partners indicates: • Trans people may fear engaging with services, with concerns about being mis gendered, about lack of understanding of gender reassignment and concerns about intimate care. • Trans people may have concerns about record keeping by health services and the way in which gender markers are recorded.	patients residing in East Sussex and using Cardiology services, we estimate the risk of widening the health inequalities gap for transgender patients is low. We will however continue to engage Trans communities as part of the formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to the needs of Trans patients to ensure that we do not unduly increase health inequalities; for example, with regard

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
						One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT. (Stonewall Report ' LGBT in Britain (2018) Whilst the above does not relate directly to the Cardiology service at ESHT, it is important to recognise this feedback relating to health services more widely and the perceptions this may create. As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; *'do you identify as the sex you were at birth?'* Responses: - Yes (78) - No (2)	to record keeping and training for staff. For formal consultation we will: • take measures at the outset to identify any Trans groups in East Sussex so we can involve them in the programme development and gain feedback • Approach Hastings & Rother Rainbow Alliance Trans Support Group and ask to establish focus groups

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
						- Prefer not to say (1) We recognise therefore that engagement from this community was low and this will be addressed in the full consultation process.	• Approach Bourne Out via Facebook and ask for support with engagement • Contact The Clare Project and Switchboard in Brighton and Hove to see if they have reach in East Sussex to encourage participation The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							• Service to record data around the use of cardiology services by the transgender community • Service to review and consider further training and education around gender reassignment as we know transgender women have high risk of blood clots and strokes compared to men and women who were

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							assigned male at birth

	Positive	Neutral	Negative	No Impact	**Data to support your assessment** This can be census data, research, complaints, surveys, reports etc.	**Engagement / feedback information to support your assessment** This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	**Actions:** • advance equality of opportunity, • eliminate discrimination • foster good relations
Age					**Cardiology attendances at ESHT 2019/20:** Age Female Male 0-18 118 127 19-64 5,971 7,171 65-74 4,416 6,648 75+ 9,075 11,070 **East Sussex Age Profile:** • 0 - 15 (17%) • 16 - 64 (57%) • 65+ (26%) East Sussex has among the highest proportions of over 65-year olds and over 85-year olds in the country - 4.7% of the females in East Sussex are over 85 and 2.7% of the males (East Sussex JSNA). Currently the over 65s represent over a quarter of the local population in East Sussex, with this projected to increase to almost one third by 2031. All elderly age groups are expected to increase in size, with the number of very elderly people aged 85 and over expected to increase by 40%, from 22,000 in 2019 to 30,900 in 2029. (East Sussex in Figures, ESCC and Demographic Projects in Brief (April 2020). Hastings & St Leonards, Havens and Lewes have the highest percentages of people aged under 20 and the lowest percentages of older people, whereas Bexhill (which is adjacent to Hastings & St Leonards) and Seaford have the lowest percentages of people aged under 20 and the highest percentages of older people.	Research by Age UK in Brighton and Hove (2020) indicated that older people wanted to see longer opening hours for health services and more intelligent services e.g. where repeat visits are flagged and the individual is redirected accordingly, or better communication between primary and secondary care. Older people also reported concerns about perceived moving to “online” appointments and away from a face-to-face option. As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; *‘What was your age on your last birthday?’*	Given that the risk of CVD increases with age, we will ensure that as part of the formal options development, appraisal and decision process, models/interventions are developed that meet the needs of our communities who are older. For formal consultation we will: • Take measures at the outset to identify organisations that support younger people living with cardiovascular disease

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					The BAME population has a much younger age profile with the 2011 Census showing that 26% were aged under 15 years, 68% aged 15-64 years, and 6% aged 65 years and over. This compares to 16% (under 15), 61% (15-64), and 23% (65 and over) for the White population.	Responses: - 35 – 44 (3) - 45 – 54 (9) - 55 – 64 (20) - 65 – 74 (27) - 75 – 84 (16) - 85+ (7)	

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					Residents in care homes Across East Sussex for people aged over 65 there are 503 people in care homes per 100,000 population. Applying this to the population of East Sussex, we estimate there to be 2,817 people in care homes aged over 65. (State of the County, Focus on East Sussex, 2020). **Hearing loss** In East Sussex, 120,000 people are reported to have hearing loss with 80% of people with moderate to severe hearing loss aged over 65. We estimate there to be 33,000 people in East Sussex that have hearing loss and CVD, we will ensure that our new services include options for reasonable adjustment including BSL for those patients that require it. **Mobility** In 2020 there were 37,200 people over 65 living with a long-term illness whose ability to carry out day-to-day tasks was limited. There were 28,310 people whose ability to carry out day-to-day tasks was significantly limited (Picture East Sussex, 2019). **Age and disease prevalence** Cardiovascular disease is most common in people over 50 and risk of developing it increases as you get older (www.nhs.uk). Adults age 65 and older are more likely than younger people to suffer from cardiovascular disease. Aging can cause changes in the heart and blood vessels that may increase a person's risk of developing cardiovascular disease (National Institute on Ageing) Across the South East, East Sussex has one of the highest rates for cardiovascular mortalities for people ages over 65 per 100,000 patient population (1,106.2) (Public Health Outcomes Framework)	There were no responses from people under 34 so this will be a target group for our formal consultation process. What were the key insights from the pre-consultation engagement with regard to different age groups. The ESHT website contains: • Information on travelling by public transport to each site. Instructions for travelling to each site by car including general parking information and blue badge holder parking. • A link to the local county council website that gives	• Attend East Sussex Senior Association to talk about acute cardiology service transformation and provide opportunities to feedback/ get involved • Contact Age Concern to ask about attending some drop in sessions • Attend PPG forums across East Sussex and offer drop in sessions • Liaison and engagement with Age UK East Sussex

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					<u>Population change 2020-2024:</u> It is important to note the likely increase and changing demographics with regard to numbers of people and older people living in East Sussex. Compared to 2020, by 2024 there will be: - 19,024 more people living in East Sussex (+3.4%) An increase of 2.2% (2,366 people) in the number of children and young people An increase of 1.4% (4,407 people) in the working age population 8.3% (12,252) more people aged 65 and over In East Sussex 4.3% of people will be aged 85+, a greater proportion than England, 2.7%. Currently ranked 2nd in England for the highest proportion of population 85+, (ONS estimate 2019) **Travel:** DVLA figures for 2019 show that nationally 86% of 40-59 year olds, 85% of 60 - 69 year olds and 67% of those aged 70+ hold a driver's licence.(https://www.gov.uk/government/collections/vehicles-statistics) 36% of pensioner households did not have access to a car (eastsussexinfigures.org.uk) This indicates that an increase in journey times to hospitals in the area could impact the older population in Bexhill and Seaford and the under 20s population in Hastings and St Leonards disproportionately (although it is noted that there are very low numbers of under 20 year olds accessing cardiology services)	information on voluntary services that offer transport services. • A section on how to claim under the NHS Healthcare Travel Costs Scheme. • The website would need to be reviewed and updated.	• Review recommendations & design in next iteration of EHIA using this feedback The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • ESHT work closer with Public Health on prevention and promotion and local support groups i.e.

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							Age Concern Interdependencies around ethnicity and age need to be reviewed

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Religion and belief					Religion and spirituality can impact decisions regarding diet, medicines based on animal products, modesty, and the preferred gender of their health providers. Some religions have strict prayer times that may interfere with medical treatment (see reference in comments). When looking at the breakdown of religion and belief the data of greatest reliance is the 2011 census data. - 73.6% said they were Christian - 1.6% said they had no religion - Other religions, including Buddhist, Hindu, Muslim, Jewish and Sikhs ranged from 0.0 to 0.6% of the East Sussex population. The census showed that the number of people in East Sussex that stated their religion was Christian fell from 74% in 2001 down to 60% in 2011, while the number of people following 'other religion'(2%) and 'no religion' (30%) increased in East Sussex. Islam (0.8% of the population) is the most popular religion after Christianity, followed by Buddhism (0.4%) and Hinduism 0.3%) Limited data on religion/belief and CVD. There is no data available that links religion and belief to cardiovascular disease. **Conquest Hospital** The Chaplaincy Office and the Chapel of the Holy Cross are on Level 2 near the main lift and stairs. There is a multi-faith prayer room adjacent to the Chapel. **EDGH** The Chaplaincy Office and the Chapel of Christ the Healer is on Level 3 in the same corridor as the Michelham Unit and Critical Care. There is also a multi-faith prayer room. **Bexhill**	As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; '*what is your religion or belief?'* Responses: - Christian (45) - Buddhist (1) - Agnostic (10) - Atheist (8) - Prefer not to say (9) - Other (7) There were no responses for Muslim, Jewish or Pagan.	From this assessment we feel the risk of widening the health inequalities gap for people of different religions and ethnicities is low. We will however continue to engage will patients of different religions and beliefs as part of the formal consultation to better understand where services might need to adapt to be appropriate for those whose religious views may influence e.g. gender of health provider, health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to

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					Chaplains are in attendance on a regular basis through the week visiting patients on the Wards. A meeting room can be arranged if needed. There is a very small chapel behind the building which is not really used.		the issue of access and religion and belief to ensure that we do not unduly increase health inequalities. For formal consultation we will: • Ensure that we have forged links with faith communities in East Sussex to engage in this project. • Invite Faith elders to complete the survey, and offer translated versions if required The following pieces of work will be addressed with the

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Service to analyse chapel usage at each site and how often a chaplin is being asked for • Review how this data can be recorded going forward
Disability (Including Long Term Conditions)					The East Sussex CCGs, combined, have a significantly higher prevalence of circulatory diseases, compared to average across England regions. This is due to the older age profile of East Sussex compared to England, and this data is not age-adjusted. Across East Sussex there are approximately: • 20,300 people have a diagnosis of coronary heart disease, a prevalence of almost 4%; • 5,500 on the heart failure register;	**d/Deaf** Research by SignHealth found that D/deaf people have said that they face significant barriers to accessing health care, through inequity of	Research shows that people living with long term conditions such as diabetes and dementia are at an increased risk of CVD, especially

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					• 16,300 on the atrial fibrillation register, and; • 92,800 on the hypertension register. Approximately 20% of the total population have a long-term health problem or disability that limits day to day activities in East Sussex, which is higher than the national and regional average. In East Sussex, 43,632 people of working age (16-64) have a long-term health problem or disability. This group accounts for 8.2% of the county's population, rising to 11.6% in Hastings. (2011 Census results) We estimate that approximately 30,000 patients in East Sussex are living with a long term health problem or disability and CVD. **Atrial Fibrillation** 2016 QOF data shows that across East Sussex there were 200 undiagnosed cases of AF: • 700 undiagnosed cased of AF in EHS • 950 undiagnosed cases of AF in HR, and; • 950 undiagnosed cases of AF in HWLH. The above figures demonstrated that across East Sussex, approximately 16% of AF cases are undiagnosed. There are Locally Commissioned Services (LCS) in place with general practices in ESH/HR areas — these focus on maximising the number of patients being treated for AF and other conditions via anti-coagulation treatment and then monitoring their therapy. The number of patients with AF are in the table below, taken from latest QOF data. NHS EAST SUSSEX CCG 18220 NHS WEST SUSSEX CCG 24561 NHS BRIGHTON AND HOVE CCG 4972 NHS SUSSEX 47753 *Provided by CCG Community Commissioners as at 26th July 2021	communication - Some deaf BSL users have restricted literacy in English. They also may not understand written English. This is due to leaving school with a reading age of 10 years old. (Deaf Toolkit – DeafCOG) • 8 in 10 deaf people want to communicate using BSL but only 3 in 10 are given the chance • Often deaf people are forced to communicate in ways that cause misunderstandings, confusions, missed diagnosis and poor treatment • Only 3% of deaf people want to communicate with their doctor by lip	where they are from socio-economically deprived backgrounds and/or ethnic communities. Supporting any reasonable adjustments or different packages of care and support. We also need to give due consideration to patients with both common and serious mental health issues given the prevalence and correlation with CVD across East Sussex. While further work is required to fully ascertain the size of the population that could be impacted by a service redesign, we will ensure we develop models/interventions

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					Hypertension: There is a gap to detection ambition of 20,390 people in East Sussex in order to meet NICE guideline of 80% of expected number of people with hypertension diagnosed by 2029. 2019/20 QOF data on Hypertension prevalence taken from PH fingertips site - Against a national rate of 14.1: • EHS - 17.7 • H&R -18.1 • HWLH - 15.5 **Heart Failure** UPDATE: 2019/20 QOF data on Heart Failure QOF **CCG name (practice parent)** / **Number of practices** / **List size** / **Register** / **Prevalence (%)** / **Number of practices** / **List size** / **Register** / **Prevalence (%)** / **(percentage point)** NHS East Sussex: 62 / 558,775 / 6,153 / 1.10 / 62 / 560,333 / 5,974 / 1.07 / -0.04 Provided by CCG Directorate Commissioning as at 2th July 2021 **Mobility** In 2020 there were 37,200 people over 65 living with a long-term illness who's ability to carry out day-to-day tasks way limited. There were 28,310 people whose ability to carry out day-to-day tasks was significantly limited (Picture East Sussex, 2019)	reading but 40% are forced to • Missed diagnosis and poor treatment is costing the NHS £30 million a year **Physical Disabilities:** Common feedback includes (GiG out of Hospital Support, 2020): • the importance of having continuity, "seeing the same person over several years has allowed him to really get to know me and therefore he can individualise the treatment plan to suit my needs" • importance of signposting to follow up organisations	are developed that meet the needs of our communities. Where able to do so, we will look to immediately action changes that will reduce health inequalities and ensure equity of access. For formal consultation we will: • Explore opportunities with VCS organisations such as Possibility People to see what forums and networks we can utilise to support engagement • Approach Hastings disability forum

<table>
<tr><td></td><td>Positive</td><td>Neutral</td><td>Negative</td><td>No Impact</td><td>Data to support your assessment

This can be census data, research, complaints, surveys, reports etc.</td><td>Engagement / feedback information to support your assessment

This could be focus groups, face-to-face meetings, surveys, speak out events, etc.</td><td>Actions:
• advance equality of opportunity,
• eliminate discrimination
• foster good relations</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Data from the National Audit of Cardiac Rehabilitation in 2019 shows that for patients attending cardiac rehab (CR) at ESHT shows that:
- 11% of patients attending Conquest reported having chronic back pain
- 4% of patients attending Eastbourne reported having chronic back pain
- 3% of patients attending Conquest reported having osteoporosis
- 1% of patients attending Eastbourne reported having osteoporosis
- 46 of patients attending Conquest reported having angina
- 17% of patients attending Eastbourne reported having angina
- 18 of patients attending Conquest reported having arthritis
- 13% of patients attending Eastbourne reported having arthritis
- 14% of patients attending Conquest reported having cancer
- 9% of patients attending Eastbourne reported having cancer
- 30% of patients attending Conquest reported having an ‘other’ co-morbidity or complaint
- 62% of patients attending Eastbourne reported having an ‘other’ co-morbidity or complaint

Current Blue Badge Holders:
• Eastbourne 4155
• Hastings 3660
• Lewes 4658
• Rother 4870
• Wealden 6066

As you can see from the table below we have 8,446,500 people in the South East that drive a van or car with a long-term health problem or disability:-
<table><tr><td></td><td>ONS Crown Copyright Reserved
[from Nomis on 23 June 2021]</td></tr><tr><td>geography</td><td>South East</td></tr></table></td><td>and groups that can support the patient post discharge “information pro-actively offered online and in the community on leaflets and posters rather than having to be actively sought”
• Lack of awareness in staff of impact of impairment

Engagement by the Fed Centre for Independent Living in 2016 found that:
• the appointment letter doesn’t mention any reasonable adjustments or a working contact number
• travelling to and parking at</td><td>to ask for support
• Arrange a drop in opportunity for d/Deaf members to come and talk about experiences of cardiology services
• Make the materials available in Easy Read and British Sign Language as a standard approach.
• Approach the East Sussex Dementia Adviser Service to support the reach of our engagement
• Review the Dementia Strategy 2020-2023 for West Sussex, approach West</td></tr>
</table>

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					measures value **Disability** / All categories: Long-term health problem or disability / Day-to-day activities limited a lot / Day-to-day activities limited a little / Day-to-day activities not limited **Cars or Vans** All categories: Car or van availability: 8,446,500 / 536,424 / 742,540 / 7,167,536 No cars or vans in household: 1,099,671 / 189,253 / 174,902 / 735,516 1 car or van in household: 3,086,959 / 230,108 / 326,240 / 2,530,611 2 or more cars or vans in household: 4,259,870 / 117,063 / 241,398 / 3,901,409 **Hearing loss** In East Sussex, 120,000 people are reported to have hearing loss with 80% of people with moderate to severe hearing loss aged over 65. We estimate there to be 33,000 people in East Sussex that have hearing loss and CVD, we will ensure that our new services include options for reasonable adjustment including BSL for those patients that require it.	hospitals can be challenging even with blue badges • some struggled to access / enter / navigate buildings as they can't see well, so a decent map would be very useful • lower desks for wheelchair users aren't staffed, or are used for storage for donation boxes • patients felt as though they were being rushed through their appointment, and too much jargon being used which made it difficult to understand what was going on **Learning Difficulties** Research by SpeakOut on accessible information	Sussex County Council Commissioner for support • Approach the East Sussex Community Learning Disability Team for support • Take action to identify and engage with charities and organisations that support patients with diabetes • Take action to identify and engage with charities and organisations that support patients with their mental health As part of the project, an analysis of

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					Blindness / Partial sighted We have no data currently being recorded. **Wheelchair Use/access** We have no date currently being recorded. **Learning disabilities** Risk factors for CVD are common in people with learning disabilities. CVDs are associated with some genetic causes of learning disabilities. For example, almost half of all people with Down syndrome are affected by congenital heart defects (Public Health England, 2017). Behaviour related risk factors for CVD identified for the general population are common in people with learning disabilities. People with learning disabilities may have poor diets, high rates of obesity, high levels of sedentary behaviour, and be less active. Whilst people with learning disabilities known to specialist services may be less likely to smoke and drink alcohol than the general population, rates are higher amongst those with mild learning disabilities. **Obesity** Obesity is a major public health problem in England and globally. In adults overweight and obesity are associated with life limiting conditions such as type 2 diabetes, cardiovascular disease and some cancers. Childhood obesity is predictive of adult obesity, but also separately increases the risks of asthma, early onset type 2 and CVD risk factors. **Health Survey for England 2019 Overweight and obesity in adults and children NHS Digital** 27% of men and 29% of women were obese. Around two thirds of adults were overweight or obese, this was more prevalent among men 68% than women 60% Obesity increased with age from 13% of adults aged between 16 and 24, to 36% of those aged 65 to 74. It was lower among adults aged 75 and over 26%	standards (2018) found that most people they spoke to were not receiving information in a way they can understand without support. This was the same for people living independently as it was for those living in supported accommodation. As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; *'Are your day-to-day activities limited because of a health problem or disability which has latest or is expected to last 12 months?'* Responses: - Yes a lot (17) - Yes a little (30) - No (31)	transport needs is being undertaken and measures will be agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site part of the formal consultation process. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; *To ensure new contracts collect data on protected characteristics * work with Primary Care more closely

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					59% of men and 69% of women had a higher than desirable waist circumference. This proportion increased broadly in line with age from 29% of adults aged 16 to 24 to 83% of those aged 75 and over Inequalities were seen for both obesity and raised waist circumference. Adults living in the most deprived areas were the most like to be obese. This difference was particularly with women where 39% of women in the most deprived areas were obese, compared with 22% in the least deprived areas **Long term conditions** 31.9% of women in East Sussex have two or more long term conditions compared to 26.2% of men. **Diabetes** People with diabetes are more at risk of heart disease (Diabetes UK, 2020). • In 2016-17 the estimated prevalence of diabetes in East Sussex residents was 9%, which is in line with the national figure. Whilst recorded prevalence of diabetes in East Sussex residents was 6% (lower than the national figure of 7%). (NB: diabetes register only includes patients aged 17 and over) • In East Sussex, 57% of people with Type 2 diabetes are receiving all 8 care processes against 48% in England. (Report from the Director of Public Health in East Sussex, 2019). Given the increase in population size, we would estimate there to be an increase in the number of people living with diabetes in East Sussex. Data from the National Audit of Cardiac Rehabilitation in 2019 shows that for patients attending cardiac rehab (CR) at ESHT: - 28% of patients attending CR at Conquest reported having a diagnosis of diabetes	- Prefer not to say (1) Respondents were then asked; *'If yes, please state the types of impairments, tick all that apply'* Responses: - Physical impairment (30) - Long standing illness (21) - Mental health (4) - Sensory (7) - d/Deaf (3) - Autistic (2) - Prefer not to say (1) - Not applicable (6) - Other (11) - Learning disabilities/difficulties (0) The 2019 Patient Led Assessment of the Care Environment (PLACE) rated ESHT sites' access for disabled patients as	around patients with LTC's diabetes clinics, dementia yearly reviews, carers groups, Mental Health issues and local services *look at current training and education packages for Staff and how these could be improved by really understanding what our communities want and need from our services and the overall patient experience *Review the area of Wealden in terms of demographics as this is the highest area for blue badge holders and understand what services these patients access

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					- 29% of patients attending Eastbourne Hospital reported having a diagnosis of diabetes From this, we can estimate that 28.5% of patients living with CVD also have diabetes. This would mean that approximately 40,000 patients in East Sussex are living with CVD and diabetes. Deprivation is a well-recognised indicator of poor health outcomes. National data suggests that diabetes is more common in people living in more socially deprived areas. Diabetes is 2.5 times more likely at any age for those from the most deprived areas and the most deprived are twice more likely to develop complications from diabetes than those in the least deprived. Evidence suggests a significantly higher prevalence of diabetes in people with learning disabilities than in the general population, which is a risk factor for CVD. (Public Health England, 2017) **Dementia** Across East Sussex, 11,500 people aged 65 and over were living with dementia in 2020. This is expected to rise to 12,350 in 2024. Research shows that certain heart disease risk factors, such as high blood pressure and smoking, are associated with an increased risk for dementia (National Institute of Health, 2017). **Mental Health** People are more at risk of developing heart and circulatory conditions where they have a mental health condition (The British Heart Foundation, 2020).	follows against a National Average score of 84.25%: Bexhill: 71.90% Eastbourne: 81.64% Conquest 77.28%	* Work with ESHT on refining data on BSL interpreters * Work with Primary Care to ensure an excellent patient experience * Link in with the Public Involvement team re: Deaf engagement / BSL service / Sign live * Building on general insight already gathered, engage with local d/Deaf people through local Deaf organisations to gather insight on barriers and possible solutions. Work with ESHT to provide BSL interpreting services to all patients by including a Video Relay Service (such as Signlive) linked to the department contact details which enables d/Deaf

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					It is estimated that across East Sussex, the population of common mental health problems (anxiety and depression) for people aged 18 and over was 48,848 in 2019. (The Market Position Statement for Adult Services and Support, 2019). The Sussex Health and Care Partnership Population Healthcheck (2019) shows common mental health prevalence across East Sussex (2014/15 data): • 12% in HWLH • 12.4% in EHS • 13.8% HR From this we can infer that there are approximately 19,400 patients with CVD and common mental health issues such as anxiety and depression. This is supported by data from the National Audit of Cardiac Rehabilitation in 2019 shows that for patients attending cardiac rehab (CR) at ESHT: - 7% attending CR at Conquest Hospital reported having anxiety - 7% attending Eastbourne Hospital for CR reported anxiety. - 12% of patients attending CR at Conquest reported having depression - 8% of patients attending Eastbourne for CR reported having depression. Serious mental health prevalence across East Sussex: • 0.8% HWLH • 1.1% EHS • 1.2% HR From this we can infer that there are approximately 4,600 patients with CVD and serious mental health issues in East Sussex.		people to call ahead of their appointment to confirm any additional needs using a BSL interpreter and their mobile device" *Include provision for making longer appointments for patients that require reasonable adjustments to allow for interpreting time and appointments later in the day as some disabled people need more time to prepare and get to appointments.

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					Research shows that there are significant health inequalities for people living with a severe mental health issue (SMI) and CVD. People with SMI are at a 53% higher risk of having CVD and 83% higher risk from dying of CVD. The Five Year Forward View for Mental Health Taskforce Report (2016) highlights that people with severe and prolonged mental illness are at risk of dying on average 15-20 years earlier than other people. Two thirds of these deaths are from avoidable physical illness such as CVD, e.g. heart disease, stroke. Those cardiology patients who also have other long-term conditions that reduce mobility may be more impacted by increased travel distance due to changes to hospital sites.		
Sexual orientation					Data on sexual orientation is not collected by ESHT. Data on the UK's lesbian, gay and bisexual population is not currently collected during a census. It is being considered for inclusion from 2021. Estimates range between 5% and 7%, however there is a recognised reluctance to be open with policy makers and researchers, as individuals see few benefits and fear discrimination and harassment through doing this.	Research by Stonewall (2018) indicates: • Almost one in four LGBT people (23%) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. • One in five LGBT people aren't out to any healthcare professional about their sexual orientation when	From this assessment we feel the risk of widening the health inequalities gap for our LQBTQ communities is low. We will however continue to engage with patients from LQBTQ communities in East Sussex as part of the formal consultation to better understand where health inequalities may exist. We will also ensure

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						seeking general medical care. This number rises to 40% of bi men and 29% of bi women. • One in seven LGBT people (14%) have avoided treatment for fear of discrimination because they're LGBT. • One in eight LGBT people (13%) have experienced some form of unequal treatment from healthcare staff because they're LGBT. One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination	that as part of the formal options development, appraisal and decision process we give due regards to the issue of access and our LGBTQ to ensure that we do not unduly increase health inequalities. For formal consultation we will: • take measures at the outset to identify any LQBTQ groups in East Sussex so we can involve them in the programme development and gain feedback • take measures to ensure any

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						because they're LGBT.(Stonewall Report ' LGBT in Britain (2018) Whilst the above does not relate directly to the Cardiology service at ESHT, it is important to recognise this feedback relating to health services more widely and the perceptions this may create.	new services hold LGBTQ awareness materials The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • further training and education is required across the service raising awareness and providing conscious consideratio n

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							• Monitoring and data collection is needed Equal consideration of same sex partners in care services – care plans and advance care plans/ RESPECT forms
Marriage or civil partnership					Data on marriage or civil partnership is not collected by ESHT. Access to cardiology services is not dependent on marital status. Married men live longer than single men, and single women live longer than married women. So potentially single men and married women are more likely to have CVD. People who live on their own may find rehab and attending appointments more difficult.		It is not considered pertinent to target engagement related to marital or civil partnership status.
Pregnancy and maternity					There are just under 5,000 births per year in East Sussex. Hastings has the highest overall birth rate as well as for women aged 15-19 years. Lewes and then Rother have the highest birth rates for women aged 35-44 years. (East Sussex Equality Profile 2020) **Pregnancy and disease prevalence**	No local engagement has been undertaken with pregnant women about the associated risks of heart problems when pregnant so any findings will be shared with	While clarification is required as to the number of pregnant women accessing cardiology services at ESHT, we feel the risk of widening the

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					Some women develop heart problems for the first time in pregnancy. The main risk for women with CHD is a heart attack during pregnancy (www.nhs.uk/conditions)	Maternity Voices Partnership, commissioners and ESHT. As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; *'Are you currently pregnant?'* Responses: - No (59) - N/A (24) - Prefer not to say (1) - Yes (0)	health inequalities gap for pregnant women is low. We will however continue to engage with relevant groups that support pregnant women as part of our formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development process we give due regards to pregnant women to ensure that we do not unduly increase health inequalities. For formal consultation we will: • Attend East Sussex Maternity Voices

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							Partnership meeting • ESHT to identify any service users who may fall into this category and encourage them to undertake an in-depth interview • Follow up with BSUH Maternity Clinic to co-design engagement opportunities • Triangulate data on child bearing age with attendances at ESHT to estimate the prevalence of women within the

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							service that would be pregnant. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; *Triangulate data on local birth rate (5,000 per year) with attendance to ESHT we need to review inequalities as such areas of deprivation, smoking, drinking, diabetes etc. *Liaise with local Maternity Team to ascertain if further information is available
Other Disadvanta					**Carers**	**Carers**	Given the number of care home residents

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ged or inclusion groups					Caring responsibilities may make it harder for people to attend appointments. If flexible appointment times for cardiology services are not available, then carers may be disadvantaged compared to other groups who are able to take time to attend set appointment times. Carers may be at greater risk of being rejected from services for multiple DNA. At the time of the 2011 Census there were: • over 59,400 people (11% of the total population), providing unpaid care in East Sussex • 33% of carers provide over 50 hours of informal care a week • Nearly 12% provided 100 hours or more • 45% of carers are aged over 65 The 2020 East Sussex Equality Profile reported there were 10,603 persons claiming carer's allowance in East Sussex. There is a higher proportion of women claiming carers allowance in East Sussex than men: • Women - 11.9% • Men – 4.9% The East Sussex Care for the Carers Association have estimated there are about 68,229 unpaid carers in East Sussex. This calculation was done pre-Covid. It is believed that many carers do not identify themselves as such (for various reasons), and therefore it is believed this number would be greater, but it is not known to what extent. People with caring responsibilities may be more affected by longer journey times impacting on their responsibilities. There is a Health Appointments Respite Grant in place, allocated by Care for the Carers: Grants for carers | Care for the Carers (cftc.org.uk). Care for the Carers' Intensive Support to Carers in Hastings project was a 4-month pilot project providing intensive support to carers in areas of known high health inequalities in	The Carers Centre Hospital Report highlights the key areas for improvement as information and support for carers, discharge planning, medicine management and communication with GPs. Training for hospital staff on carers' issues would benefit both staff and carers. (Hospital Report- Carers Centre) As part of the pre-consultation engagement for cardiology redesign, respondents to the questionnaire were asked; *are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.*	estimated to have CVD in East Sussex, we will ensure that as part of the options development, appraisal and decision process, models/initiatives are developed that meet the needs of this community. While clarification is required as to the number of carers at risk of CVD, we feel there is a risk here given the age profile and high percentage of carers across East Sussex. For formal engagement we will: • be engaging will carers throughout the project to seek their views,

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					the Hastings area, during December 2020-March 2021. It was commissioned by East Sussex County Council (ESCC) and NHS East Sussex Clinical Commissioning Group (CCG), through the Healthy Hastings and Rother Programme, and was a collaboration project with the Hastings and St Leonards Primary Care Network (PCN). 288 unique carers in the Hastings PCN area received 1:1 support during the pilot project period, representing an increase of 67 carers (30%) on the baseline data for the same period in the previous year, when 221 unique carers accessed Care for the Carers' support. All the participating surgeries strongly support the longer term continuation of the project as, even within the challenging context of the pandemic, they reported having seen the positive results it can bring for carers and the surgeries, including enabling them to meet the requirements of the CQC key lines of enquiry in relation to carers. It is positive that 12 months' continuation funding has been agreed to enable the project to continue to develop during 2021/22, building on the successes and learning from the pilot, and including the proposal to work with an additional two surgeries from October 2021. There is also significant potential to deliver the same project model in other areas of health inequality across the County, should further investment be available. **Adults receiving long term support** Across East Sussex there were 9,533 adults receiving long term support as of 2020 (State of the County, Focus on East Sussex, 2020) **Residents in care homes** Across East Sussex for people aged over 65 there are 503 people in care homes per 100,000 population. Applying this to the population of East Sussex, we estimate there to be 2,817 people in care homes aged over 65. (State of the County, Focus on East Sussex, 2020). Assuming a 27% prevalence rate, we estimate there to be 760 people over 65 residing in care homes across East Sussex. **Homelessness and Rough Sleepers** The Rough Sleepers Initiative (RSI) was commissioned in East Sussex by the five district and	Responses: - Yes (8) - No (68) - Prefer not to say (1)	through one-to-one interviews, liaison with representative groups and questionnaires • Ensure link with Carers Association and the Care Home Group in east Sussex around the advanced health and care homes framework • engage with homeless and rough sleepers through pre-existing relationships with supporting organisation

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					borough councils and is funded by the Ministry of Housing Communities and Local Government (MHCLG). RSI is designed to improve rough sleepers' ability to gain access to services. At the beginning of pandemic, the number of verified rough sleepers remained low. Since lockdown measures have begun to be eased in July 2020, there has been an increase in the number of people rough sleeping. It is estimated that: • There are currently 33 people continuing to rough sleep across East Sussex. • There are also 141 former rough sleepers living in emergency accommodation in East Sussex. The emergency accommodation is provided by East Sussex County Council (ESCC). • A report dated 16/8/21 from the Rough Sleeping Initiative County Coordinator at Eastbourne, Lewes, Hastings, Rother & Wealden Councils stated that currently 35 people were rough sleeping across East Sussex • 186 former rough sleepers were in emergency placements across East Sussex Covid-19 has led to an increase in households placed in emergency accommodation. At the end of September 2020, East Sussex had 550 households placed in emergency accommodation, of which 209 (38%) were from Eastbourne. Brighton & Hove City Council (BHCC) also placed at least 195 households in Eastbourne in Lewes. **Veterans and Armed Forces Communities** There is no data currently collected we need to understand the impact on Veterans and Armed Forces Communities. We need to understand areas such as substance misuse, where English is a second language, carers, LGBTQ+, trans gender and religion and belief. **Refugees and Asylum Seekers** There is no data currently collected we need to understand the impact on refugees and asylum seekers. We need to understand areas such as age, gender, and substance misuse, where English is a second language, carers, LGBTQ+, trans gender and religion and belief.		s such as Rough Sleepers Initiative, Matthew25 and YMCA • Link in with CCG's Assistant Head of Health, Wellbeing and Partnerships and Rough Sleeping Initiative - County Coordinator • ensuring all services have/hold LGBTQ aware materials • work with the NHS Armed Forces Community lead to

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							ensure we hear from this cohort As part of the project, an analysis of transport needs is being undertaken and measures agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site part of the formal consultation process. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access;

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							• Establish how many carers have registered with ESCC and local hospital sites – review the data and progress what could be done further to support carers • What can the service do and what additional provision can be put into place • As part of the consultation we will link into the Care homes group for East Sussex but

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							this link needs to be taken forward to ensure care planning and carers are supported • Review the stop look care booklet as this has recognised training that Staff can access • Comms and engagement could do some work around care homes as they all now have NHS email accounts • To ensure the new contract holds data

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							collection on all disadvantaged groups • Link in with the British Red Cross who are commissioned to deliver assist discharge, home from hospital and carer crisis service • Contact Care for the Carers to understand carers needs in relation to service developments in cardiology • Link in with Public Health whilst reviewing

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							health checks and ascertain how many refugees, age, LTCs, gender, where they are living and what support is needed • Link in with Public Health as they are working closely with the Hastings settlement programme for Asylum seekers • Link into the Armed Forces Team regarding care and outcomes

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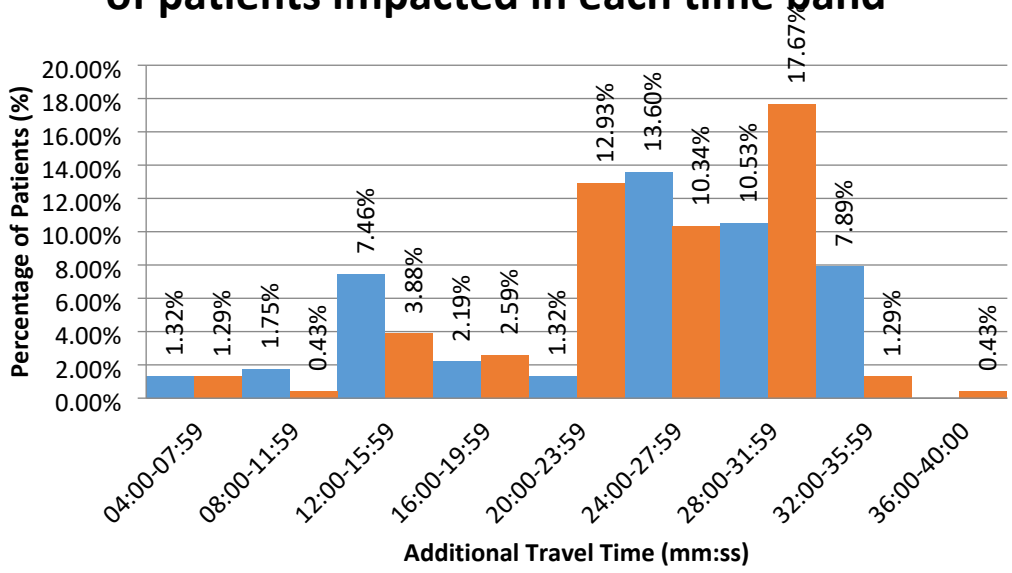
Deprivation and socio-economic disadvantage					**Areas of Deprivation** Across East Sussex, there are some affluent areas and some of the most deprived areas in the country. The Indices of Deprivation 2019 show how deprived some local areas are, in comparison to other parts of England. They are calculated by combining data on employment, low incomes, education, health, crime, living environment, and barriers to housing and services. In East Sussex there are 329 Lower-layer Super Output Areas (LSOAs), of which 22 are in the most deprived 10% nationally, 16 of these are in Hastings, 4 Eastbourne, and 2 Rother. Hastings is ranked as the 13th most deprived local council area out of 317 areas in England. According to these figures, Hastings is the most deprived local council area in the South East of England by far. Looking at the other council areas in East Sussex, Eastbourne is ranked 106, Rother is 135, Lewes is 194, and Wealden is ranked 254 out of 317 local council areas in England The Annual Report from Public Health in East Sussex showed that in 2015, 13% of people aged 65+ were living in poverty in East Sussex. **Deprivation and disease prevalence** Those in the most deprived 10% of the population are twice as likely to die as a result of CVD than those in the least deprived areas (NHS England, QOF prevalence highlights that the highest prevalence of heart disease in East Sussex is in Hastings. However, it should be noted that there also a higher number of care homes in this area which may skew this. In the NHS digital report 'Health Survey for England – Cardiovascular Disease 2017', cardiovascular disease was more prevalent in lower income households. 22% of adults aged	For many living in areas of deprivation it will not be practical to travel any great distance to access services due to cost, which may impact on early presentation of symptoms (Foodbank advocate- Eastbourne- The Future of Eastbourne Station Health Centre Consultation Final Report 2020) Those living in areas of deprivation may not be able to travel to access services due to cost, which may impact on early presentation of symptoms. In some areas of deprivation, literacy levels may be lower and awareness of signs and symptoms reduced. Disadvantaged communities may not immediately access	Given that social deprivation is a significant driver for CVD, we will ensure that as part of the formal options development, appraisal and decision process, models/interventions are developed that meet the needs of our communities noticeably in Hastings, as well as areas of Eastbourne. To better understand the cardiology attendances at ESHT from our most deprived areas, we will be mapping patient postcode against attendances at ESHT by Point of Delivery (PoD) to understand whether disease prevalence and deprivation

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					35 and over in the lowest income quintile and 16% in the highest income quintile reported any cardiovascular disease. Those in the most deprived areas are 30% more likely to have high blood pressure, which is the biggest single risk factor for a heart attack or stroke (Public Health, 2019). **Travel** The postcodes that include the most deprived areas of East Sussex are: TN34 (the central Hastings and Ore wards), In 2019/20, 79.8% (403) of patients from this postcode were treated at Conquest Hospital. TN37 (St Leonards wards) In 2019/20, 80.2% (259) of patients from this postcode were treated at Conquest Hospital. TN31 (Rye wards 004E and 002E) In 2019/20, 69.3% (138) of patients from this postcode were treated at Conquest Hospital. TN39 (Sidley ward) In 2019/20, 66.8% (338) of patients from this postcode were treated at Conquest Hospital.BN21 (Devonshire ward area) In 2019/20, 98.3% (353) of patients from this postcode were treated at Eastbourne District General Hospital BN22 (Hampden Park ward area) In 2019/20, 97.4% (337) of patients from this postcode were treated at Eastbourne District General Hospital. Cost of travel to a hospital could be more significant for those living in area of deprivation. The Histogram below shows travel times Cardiac arrest to Eastbourne and Conquest Hospitals:	services when health issues are apparent. In East Sussex, more BAME communities reside in Hastings, Rother, Bexhill and St Leonards Hill areas and face many socio-economical disadvantages. Hastings is significantly worse than England average across a range of indicators around the wider determinants of health including deprivation and child poverty, GCSE attainment, pupil absence, long term unemployment, hospital admissions and fuel poverty. There is a strong association between socio-economic disadvantage and ethnicity. This is a complex relationship.	correlates to the demand seen at ESHT. The programme will be linking in to the wider work happening across Sussex that is targeted on reducing health inequalities for CVD, notably social deprivation. For formal consultation will: • Utilise foodbanks to share paper copies of questionnaire with freepost address • Ask for support from RVA, HVA and 3VA to target those living in areas of deprivation.

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
					Histogram showing additional travel time (Blue= Eastbourne, Orange = Conquest) and percentage of patients impacted in each time band  	People from minority ethnic backgrounds are more likely to experience *multiple* aspects of deprivation, including having a low income, live in poorer housing, be victims of crime, experience unemployment or low paid work. The ESHT website contains information on: • Travelling by public transport to each site. Instructions for travelling to each site by car including general parking information and blue badge holder parking. • A link to the local county council website that gives information on voluntary services	As part of the project, an analysis of transport needs is being undertaken and measures agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site as part of the formal consultation process. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; *Review and work with Primary and

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
						• that offer transport services. • A section on how to claim under the NHS Healthcare Travel Costs Scheme.	Secondary care on prevention around smoking, heart failure, hypertension UPDATE: As from 1 April 2021, General Practice will not provide “stop smoking” services; the service will be provided by One You East Sussex (OYES) and by some community pharmacies. NHS-funded Tobacco Dependence Treatment Services are due to commence for inpatients and high risk Mental Health outpatients. Being phased in from July 21 - full implementation by 2024. This is to be delivered in conjunction with

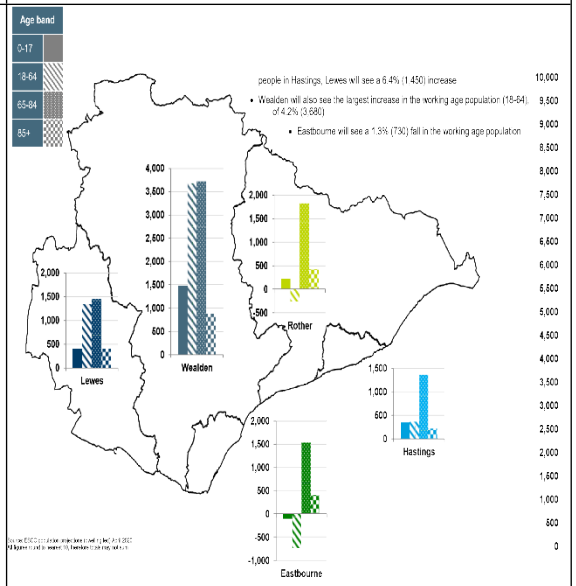
	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							Local Authority Stop Smoking Services. ESCC Public Health has been working with maternity to agree the best way to apply the model in East Sussex for pregnant smokers. However, ESHT are now at the early stage of reviewing the approach for inpatients. Funding is being made available to ICS's across the country that will enable secondary care trusts to get their systems in place by 23/24. There is a relatively small amount this year (21/22) of just over 500k across Sussex but I understand this is likely to increase each year up to

	Positive	Neutral	Negative	No Impact	Data to support your assessment This can be census data, research, complaints, surveys, reports etc.	Engagement / feedback information to support your assessment This could be focus groups, face-to-face meetings, surveys, speak out events, etc.	Actions: • advance equality of opportunity, • eliminate discrimination • foster good relations
							23/24 (not confirmed). The expectation is that 70% of patients who smoke are identified and treated in 21/22 moving to 100% by 23/24.
Community Cohesion					Key indicators of community cohesion relate to how local people feel about their local area. It will therefore be used as a measure of how well different minority and majority communities develop and relate to each other. Communities may define themselves by neighbourhood, ethnicity or culture, age group, faith, sexual orientation, language, gender or other characteristics or interests. This will be reviewed at the time of full consultation.		It is not considered at this time that our pre-engagement will have impact related to Community Cohesion. This will be reviewed at time of full consultation.

5. Cumulative Impact

<table>
<tr><th>What factors could increase the impact of this proposed change for some groups of people?</th><th>Which groups of people or communities are affected?</th><th>Are there any additional actions to include in this EIA?</th></tr>
<tr>
<td>We will develop our understanding of these factors and their impact on our local people with protected characteristics from the insight of our engagement and developed options for appraisal and associated proposals for transformation.

Options Appraisal Workshops Options for Cardiology:
1) Retain current service
2) Same both sites with assessment area at both front ends
3) Build up both sites
4) Two sites one with PCI non-elective and elective and the other electrophysiology, perm pacemakers and devices elective
5) Preferred Option: Co-location of catheterization labs and inpatients to one acute site – outpatients diagnostics will continue on both sites (Eastbourne and Conquest)

We have considered the 5 appraisal criteria around Quality and Safety / Clinical Sustainability / Access and Choice / Financial Sustainability / Deliverability. We have also given conscious consideration throughout the appraisal process to the health inequalities and inequalities of people within East Sussex.</td>
<td>The preferred option: Co-location of catheterization labs and inpatients to one acute site – outpatients diagnostics will continue on both sites (Eastbourne and Conquest)
<table>
<tr><th>Site</th><th>Summarised Data to support</th></tr>
<tr><td>EDGH
Large car park
Wheelchair access
Toilets – multiple
Chapel
Large waiting areas
Good Access
Sustainable going forward</td><td>% older population higher in Eastbourne
% deprivation slightly lower
Over 42,000 households
14% of community are smokers
66% of community are Overweight or Obese
23% of community Hypertension cases
Treated 98% (over 12 months) patients from deprived areas (BN21 & 22)
Highest levels of BAME communities
12,621 Carers in the community</td></tr>
<tr><td>Conquest
Large car park very expensive
Wheelchair access
Chapel
Small waiting areas
Average Access
Sustainable going forward</td><td>% older population slightly lower in Hastings
% deprivation slightly higher
37,000 households
17% of community are smokers
61% of community are Obese
13% of community Hypertension cases
Treated 80% (over 12 months) patients from deprived areas (TN34 & 37)
Highest levels of BAME communities
10,291 Carers in the community</td></tr>
</table>
This data is taken from the EHIA/travel and access work/Public Health and ESHT.</td>
<td> 

We have completed an internal piece of work around travel and access and this is now being worked on further with an external provider. It needs to focus on the patients, local communities, characteristics and the two hospitals The Eastbourne District General Hospital in Eastbourne and The Conquest in Hastings, as to the preferred site before we go out to Consultation in December 2021.</td>
</tr>
</table>

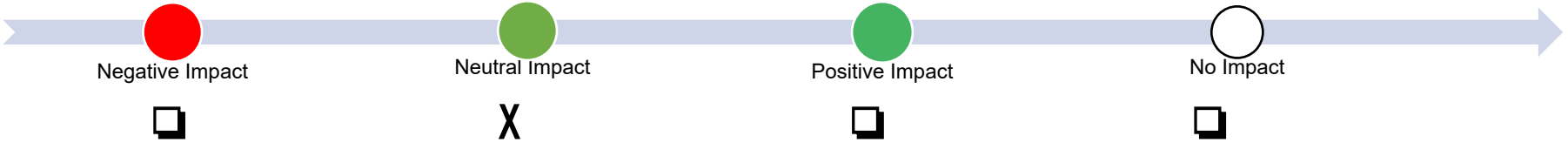
What factors could increase the impact of this proposed change for some groups of people?	Which groups of people or communities are affected?	Are there any additional actions to include in this EIA?
	We will have an increase of 14.1% (870) more people aged 85+ in Wealden. Between 2015-2018 we have had 11,656 people aged 65+ move into East Sussex the largest flow of people arrived from Kent, Brighton, Croydon and Surrey. We need to ensure the new services is sustainable. Households subject to the benefit cap, housing benefit and universal credit by district show that as of February 2020 Eastbourne and Hastings are showing the highest numbers. These are recorded in areas of deprivation as we have documented in East Sussex there are 329 LSOA's of which 22 are in the most deprived 10% nationally, 16 of these are in Hastings, 4 in Eastbourne and 2 in Rother. People that are more deprived may produce higher demand for County Councils and other public services. They are characterised by poorer health and disability, lower skills, educational disadvantage, higher crime and drug misuse *Department of works and pensions & eastsussexinfigures.org.uk. New facilities will improve access for physically disabled patients. When rated for disability access, the current site's 2019 PLACE rating is only 81.65% accessible when compared to the national average of 84.25%, and the even higher rating for comparative Mental Health Trusts at 93.32% accessible. *Public Health 2021	

6. Equalities or health inequalities data gaps

	YES	NO	DON'T KNOW	Provide evidence to support your assessment and include this as an Action below.
As a result of undertaking this EHIA, are there any gaps in equalities or health inequalities data or information?	X			• The demographic data ESHT collect currently is for age and sex, however going forward the new contract will hold data collection on all disadvantaged groups, including all the protected characteristics

	YES	NO	DON'T KNOW	Provide evidence to support your assessment and include this as an Action below.
				• We need to better understand the impact on the Armed Forces, substance misuse, where English is their second language, pregnant women carers, LGBQG, Trans and religion and belief. • We need to better understand travel flows into acute preferred site from areas of deprivation.

7. Overall summary of impact. Please tick an overall equality impact grade for this initiative.



Please explain your decision:
This EHIA has been developed to support the scoping to pre-consultation engagement and transformation plans. The EHIA will be reviewed at each milestone of the programme to ensure the neutral impact is mitigated.

Please see below the summary of where we have got to and where we need to be to support equalities and health inequalities.

Where have got to and where to we need to be:

- We have agreed cases for change
- Completed a public engagement process with over 190 interviews taking place
- Completed six Options Appraisal workshops x3 for Cardiology and x3 for Ophthalmology.

We had fantastic participation from ESHT consultants, clinical leads, CCG clinical leads, Nurse specialists, GP's, SECAmb, comms and engagement, HR and workforce, Quality / Finance / Business intelligence from both CCG and ESHT, patients, patient representatives, Public Health, Health Watch, Lay Members and Managers and Commissioners from both CCG and ESHT.
A comprehensive report on the workshops covering external challenges, internal challenges, national drivers and opportunities for improvements has been developed by ORS with full review and feedback from all that attended the workshops.
Within the report from Opinion Research Services (ORS) the five appraisal criteria covered were quality and safety, clinical sustainability, access and choice, financial sustainability and deliverability the indications were:-

Cardiology: The outcomes of the options development and appraisal process reported here suggest that Option 5 (co-location of the cathererization labs and inpatients to one acute site) could reasonably be taken forward to formal public consultation on the future of cardiology services in East Sussex. Whether or not other options are also included in proposals depends, in large part, on whether the key areas in which they scored and ranked poorly are able to be addressed and or mitigated.

Ophthalmology: The outcomes of the options development and appraisal process reported here suggest that Options 2 (two hospital sites), 3 (one hospital site) could reasonably be taken forward to formal consultation on the future of ophthalmology services in East Sussex. Bexhill and EDGH appear to be the favoured locations for a two-site model, and opinion was divided between the same two hospitals when considering the best site for a single hospital.

We have gathered further evidence as part of the consideration in the decision making process around all the options. We have completed a wide range of activities:

- Options Modelling with the support of the CCG and ESHT Teams across Business Intelligence/Finance/HR and Workforce Considered, actioned and documented outcomes from the EHIA workshops
- Held read through's and walk through sessions with key stakeholders for the Cardiology EHIA and developed a Data Gap Analysis tool to support progress
- Reviewed and refreshed the EHIA's and QIA's to support the pre-consultation business cases and also in readiness for NHSE State 2 assurance in October
- Held read through's and walk through sessions with key stakeholders for the Cardiology Pre-consultation business cases
- Held further patient engagement sessions via a set of interviews which were designed, developed and delivered by Option Research Services
- In attendance and presenting at all the GP Locality Forums across East Sussex
- We have internally developed a travel and access piece around an overview of locations and accessibility of ESHT hospital sites alongside postcode data showing that patients admitted at each site were predominately from the local postcode area.
- We have ensured this is aligned to the options and Steering Board have provided approval for this to be added to the Pre-consultation business cases and EHIA's. Further analysis is ongoing for a more in-depth independent review.
- South East Clinical Senate during July (as Cardiology and Ophthalmology have gone to separate panels). Attendance at Clinical Senate panel for Cardiology was the 28th July and Ophthalmology was the 11th August of which key stakeholders and business sponsors will provide a presentation and overview of the programme.
- LMT approval was granted on 21st September 2021
- NHSE Stage 2 Assurance took place on 14th October 2021, and formal letter received on 8 November 2021

8. Summary of Actions

Record all your EHIA assessment potential concerns (impact) and actions below:

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
0 – appendix to support the actions	Positive	To support the East Sussex cardiology services we have summarised a Gap Analysis Document which focuses on all characteristics, what we know, where the gaps are, actions and mitigations with supporting tabs for site details, options, data etc.	 ESHT Transformation data	Assistant Head of Planned Care/Senior Planned Care Manager/Planned Care Officer	Ongoing throughout the lifetime of the EHIA
1 – Race Ethnicity	Positive	To support the East Sussex system in co-developing potential options for cardiology services, we need to improve our understanding of existing health inequalities within the service, i.e. whether people with protected characteristics or people from socio-economically deprived backgrounds are underrepresented in services.. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Further work around the clinical view on treatment and ethnicity diverse workforce and what further work can be done to improve this • Link in with other initiatives around CVD prevention programme, AF shared awareness • Future of the service and the collection of data on protected characteristics • Future of the service recording if English is a first or second language	**Race/ethnicity:** Given that ethnicity can increase the risk of CVD, we will ensure that as part of the formal options development, appraisal and decision process, models/interventions are developed that meet the needs of our ethnic communities.	Public Health / CCG Project Team / ESHT Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Future of the service awareness of care plans and advanced care plans • Further understanding of service use and patient experience • Ensure patient feedback can be analysed by ethnicity and address any concerns identified • Address prevention in areas of deprivation • Work with the Community Transformation team	Where possible, we will look to immediately action changes that would reduce health inequalities and improve disease recognition in our BAME communities and ensure equity of access; for example; the information available and how this is shared across our communities. For formal consultation we will ensure: • Ensure links have been made with local faith communities or		

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			cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement. • Ensure that Friends, Families and Travellers receive information on all involvement activity. • Translate questionnaire into community languages		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			as a standard approach • Attendance at Eastbourne Cultural Involvement Group to promote engagement opportunities • Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse		

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			communities • Further information to come from BAME Disparity Programme Team. This section will be updated as work progresses.		
2 – People who have English as a second language	Positive	As above. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Work with Primary Care, local support workers and interpreters to work closer with local communities around communication / engagement and prevention • Identify if the translation service offered matches the need across East Sussex	**People who have English as a second language:** While clarification is required as to the number of people accessing the cardiology service where English is not their	ESHT Project Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			first language, we feel the risk to widen the gap in health inequalities is low. Where actions of communication are highlighted as an area of improvement required, we would want to take immediate action to address these issues and ensure equitable access for our patients. For formal consultation we will: • Work with organisations that provide translation services to better		

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			understand the need for translation support for patients accessing cardiology services in East Sussex • Offer telephone interpretation to support those who speak English as a second language and wish to engage • Translate materials into community languages as a standard		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			approach		
3 - Sex	Neutral	As above. We will work with the organisation to future action changes that would reduce health inequalities and ensure equity of access; • Further training and education is required across the service raising awareness and providing conscious consideration • Monitoring and data collection is needed • Equal consideration of same sex partners in care services – care plans and advance care plans/ RESPECT forms	**Sex:** Given that men are at an increased risk of CVD, and that CVD is a leading cause of death for both men and women, we will ensure that as part of the formal options development, appraisal and decision process, models/interventions are developed that meet the needs of our communities. For formal consultation we will: • Take measures to identify and	ESHT Project Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			• engage with gender specific groups in East Sussex • Take measures to ensure all current and new services hold LGBTQ+ awareness materials		
4 – Gender Reassignment	Positive	As above. The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Service to record data around the transgender community • Service to review and consider further training and education around gender reassignment as we know transgender women have high risk of blood clots and strokes compared to men and women who were assigned male at birth	**Gender reassignment:** While clarification is required as to the number of Trans patients residing in East Sussex, we feel the risk of widening the health inequalities gap for	ESHT Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			transgender patients is low. We will however continue to engage Trans communities as part of the formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to the issue of or Trans patients to ensure that we do not unduly increase health inequalities. For formal consultation we will: • take measures		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			at the outset to identify any Trans groups in East Sussex so we can involve them in the programme development and gain feedback • Approach Hastings & Rother Rainbow Alliance Trans Support Group and ask with support with engagement		

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			• Approach Bourne Out via Facebook and ask for support with engagement • Contact The Clare Project and Switchboard in Brighton and Hove to see if they have reach in East Sussex to encourage participation • Contact Public Health and ask for support		

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			with prevention, early intervention programmes and the prime ministers challenge: Preventing well, living well, diagnosing well, supporting well and dying well.		
5 - Age	Positive	As above The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access: • Work closer with Public Health on prevention and promotion and local support groups i.e. Age Concern Interdependencies around ethnicity and age need to be reviewed. Although this is outside the scope of this transformation programme, this will be addressed as part of our wider Sussex-wide cardiology programme.	**Age:** Given that the risk of CVD increases with age, and in East Sussex we have a growing and ageing population, we will ensure that as part of the formal	CCG Project Team / ESHT Project Team	In line with Project Timelines which are currently being reviewed.

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			options development, appraisal and decision process, models/interventions are developed that meet the needs of our communities and the demands and ageing population will bring. For formal consultation we will: • Take measures at the outset to identify organisations that support younger people living with cardiovasc		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			ular disease • Attend East Sussex Senior Association to talk about acute cardiology service transformation and provide opportunities to feedback/ get involved • Contact Age Concern to ask about attending some drop in sessions • Attend PPG		

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			forums across East Sussex and offer drop-in sessions • Liaison with Age UK East Sussex • Review recommendations and design in next iteration of EHIA using this feedback.		
6 - Religion and Belief	Positive	As above The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Service to analyse chapel usage at each site and how often a chaplain is being asked for • Review how this data can be recorded going forward	**Religion and belief:** From this assessment we feel the risk of widening the health inequalities gap for people of	CCG Engagement Team / CCG Project Team / ESHT Project Team	In line with Project Timelines which are currently being

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			different religions and ethnicities is low. We will however continue to engage will patients of different religions and beliefs as part of the formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to the issue of access and religion and belief to ensure that we do not unduly increase health inequalities. For formal		reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			consultation we will: • Ensure that we have forged links with faith communities in East Sussex to engage in this project • Invite Faith elders to complete the survey, and offer translated versions if required.		
7 – Disability and long term conditions	Positive	As above The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access • To ensure new contracts collect data on protected characteristics work with Primary Care more closely around patients with LTC's	**Disability and long-term conditions:** Research shows that people living with long term conditions such as	CCG Engagement Team / CCG Project Team / ESHT	In line with Project Timelines which are currentl

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		diabetes clinics, dementia yearly reviews, carers groups, Mental Health issues and local services • look at current training and education packages for Staff and how these could be improved by really understanding what our communities want and need from our services and the overall patient experience • Review the area of Wealden in terms of demographics as this is the highest area for blue badge holders and understand what services these patients access • Link in with CCG Deaf engagement /BSL Service and Sign Live • Building on general insight already gathered, engage with local d/Deaf people through local Deaf organisations to gather insight on barriers and possible solutions. Work with ESHT to provide BSL interpreting services to all patients by including a Video Relay Service (such as Signlive) linked to the department contact details which enables d/Deaf people to call ahead of their appointment to confirm any additional needs using a BSL interpreter and their mobile device	diabetes and dementia are at an increased risk of CVD, especially where they are from socio-economically deprived backgrounds and/or ethnic communities. We also need to give due consideration to patients with both common and serious mental health issues given the prevalence and correlation with CVD across East Sussex. While further work is required to fully ascertain the size of the population that could be impacted by a	Project Team	y being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			service redesign, we will ensure we develop models/interventions are developed that meet the needs of our communities. Where able to do so, we will look to immediately action changes that will reduce health inequalities and ensure equity of access. For formal consultation we will: • Explore opportunities with VCS organisations such as Possibility People to see what forums		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			and networks we can utilise to support engagement • Approach Hastings disability forum to ask for support particularly around proactive support • Arrange a drop in opportunity for d/Deaf members to come and talk about experiences of cardiology services and what does good look like • Make the materials available in Easy Read and British		

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			Sign Language as a standard approach. • Include provision for making longer appointments for patients that require reasonable adjustments to allow for interpreting time and appointments later in the day as some disabled people need more time to prepare and get to appointments. • Approach the East Sussex Dementia Adviser Service to support the		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			reach of our engagement • Approach the East Sussex Community Learning Disability Team for support • Take action to identify and engage with charities and organisations that support patients with diabetes • Take action to identify and engage with charities and organisations that support patients with their mental health to ensure the needs of the people are met with i.e.		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			longer appointment times, specialist support at appointments. As part of the project, an analysis of transport needs is being undertaken and measures agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site part of the formal consultation process.		
8 – Sexual Orientation	Positive	As above	**Sexual orientation:** From this	CCG Engagement Team / CCG	In line with Project Timelin

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • further training and education is required across the service raising awareness and providing conscious consideration • Monitoring and data collection is needed • Equal consideration of same sex partners in care services – care plans and advance care plans/ RESPECT forms	assessment we feel the risk of widening the health inequalities gap for our LQBTQ communities is low. We will however continue to engage with patients from LQBTQ communities in East Sussex as part of the formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and decision process we give due regards to the issue of access	Project Team / ESHT Project Team	es which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			and our LGBTQ to ensure that we do not unduly increase health inequalities. For formal consultation we will: • take measures at the outset to identify any LQBTQ groups in East Sussex so we can involve them in the programme development and gain feedback		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			• Take measures to ensure all current and new services hold LGBTQ+ awareness materials		
9 – Pregnancy and Maternity	Positive	As above The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Triangulate data on local birth rate (5,000 per year) with attendance to ESHT we need to review inequalities as such areas of deprivation, smoking, drinking, diabetes etc. • Liaise with local Maternity Team to ascertain if further information is available	**Pregnancy and Maternity:** While clarification is required as to the number of pregnant women accessing cardiology services at ESHT, we feel the risk of widening the health inequalities gap for pregnant women is low. We will however continue to engage with relevant groups that support pregnant	ESHT Project Team / CCG Engagement Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			women as part of our formal consultation to better understand where health inequalities may exist. We will also ensure that as part of the formal options development, appraisal and deicion process we give due regards to pregnant women to ensure that we do not unduly increase health inequalities. For formal consultation we will: • Attend East Sussex Maternity Voices		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			Partnership meeting • ESHT to identify any service users who may fall into this category and encourage them to undertake an in-depth interview • Follow up with UHSx Maternity Clinic to co-design engagement opportunities • Triangulate data on child bearing		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			age with attendances at ESHT to estimate the prevalence of women within the service that would be pregnant.		
10 – Other disadvantaged groups	Positive	As above The following pieces of work will be addressed with the provider during and post mobilisation to action changes that would reduce health inequalities and ensure equity of access; • Establish how many carers have registered with East Sussex County Council and local hospital sites – review the data and progress what could be done further to support carers • What can the service do and what additional provision can be put into place • As part of the consultation we will link into the Care homes group for East Sussex but this link needs to be taken forward to ensure care planning and carers are supported • Review the stop look care booklet as this has recognised training that Staff can access	Given the number of care home residents estimated to have CVD in East Sussex, we will ensure that as part of options development, appraisal and decision process, models/initiatives are developed that meet the needs of this community.	ESHT Project Team / CCG Engagement Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Comms and engagement could do some work around care homes as they all now have NHS email accounts • To ensure the new contract holds data collection on all disadvantaged groups • Link in with the British Red Cross who are commissioned to deliver assist discharge, home from hospital and carer crisis service • Contact Care for the carers to understand carers needs in relation to service developments in cardiology • Link in with Public Health whilst reviewing health checks and ascertain how many refugees, age, LTCs, gender, where they are living and what support is needed • Link in with Public Health as they are working closely with the Hastings settlement programme for Asylum seekers • Link in with Primary care on refining data for patients needing an BSL interpreter • Link in with the consultation the homeless association • Link in with the CCG homeless commissioners • Link in with the Armed Forces Team regarding care and outcomes • Work with PH Lead to ensure we hear from the Asylum Seeker group	While clarification is required as to the number carers at risk of CVD, we feel there is a risk here given the age profile and high percentage of carers across East Sussex. For formal engagement we will: • be engaging with carers throughout the project to seek their views, through one-to-one interviews, liaison with representative groups and		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			questionnaires • Ensure link with Carers Association and the Care Home Group in east Sussex around the advanced health and care homes framework • engage with homeless and rough sleepers through pre-existing relationships with supporting organisatio		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			ns such as Rough Sleepers Initiative, Matthew25 and YMCA • ensuring all services have/hold LGBTQ aware materials • work with the NHS Armed Forces Community lead to ensure we hear from this cohort As part of the project, an analysis of transport needs is being undertaken and measures agreed to mitigate		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site part of the formal consultation process.		
11 – Deprivation	Positive	As above	**Deprivation:** Given that social deprivation is a significant driver for CVD, we will ensure that as part of the formal options development, appraisal and decision process, models/interventions are developed that meet the needs of our communities noticeably in Hastings, as well	ESHT Project Team / CCG Engagement Team / CCG Project Team	In line with Project Timelines which are currently being reviewed.

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			as areas of Eastbourne. To better understand the cardiology attendances at ESHT from our most deprived areas, we will be mapping patient postcode against attendances at ESHT by Point of Delivery (PoD) to understand whether disease prevalence and deprivation correlates to the demand seen at ESHT. The programme will be linking in to the wider work happening across Sussex that is targeted on reducing health		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			inequalities for CVD, notably social deprivation. For formal consultation will: • Utilise foodbanks to share paper copies of questionnaire with freepost address • Ask for support from RVA, HVA and 3VA to target those living in areas of deprivation. • To better understand the cardiology attendances at ESHT from our most deprived areas, we will be mapping patient postcode		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			against attendances at ESHT by Point of Delivery (PoD) to understand whether disease prevalence and deprivation correlates to the demand seen at ESHT As part of the project, an analysis of transport needs is being undertaken and measures agreed to mitigate any adverse outcomes. There will be engagement with patients and the public on the travel impact if an option includes a change of site part of the		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			formal consultation process.		
12 - Prevention	Positive	As Above	**Prevention:** The Global Burden of Disease Study shows us that the leading causes of premature mortality include diet, tobacco (approx. 18% prevalence rate – whilst whole of the UK is at 17.2%), and obesity, raised blood pressure (approx. 78% prevalence rate – whilst whole of UK is 79.1%), physical inactivity and raised cholesterol. The radical upgrade in prevention needs population-level approaches. But it also needs	Public Health / ESHT Project Team / CCG Engagement Team / CCG Project Team	

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			interventions in primary care for individuals with behavioural and clinical risk factors. This will be part of the Project and considered in all pre-consolation activity. For formal consultation will: • Work with social prescribing and wellbeing hubs offer models for supporting behaviour change while reducing burden on general practice.		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			• Review with Primary Care the NHS Health Check, as this a systematic approach to identifying local people at high risk of CVD & stroke, offering behaviour change support and early detection of the high risk but often undiagnosed conditions such as		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			hypertension, atrial fibrillation, chronic kidney disease (CKD), diabetes and pre-diabetes • Promotion of tools and techniques alongside the patient safety audit tool – working with practices and local authorities to maximise update and clinical follow up		

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
			• Increase support for patient education and shared management		
13 – Actions from EHIA Workshops	Positive	**Additional actions from the EHIA workshop – these are embedded back throughout this document** ESHT Transformation – EHIA Workshop – Look at the Options Development through an inequalities lens <u>Homelessness</u> For formal engagement we will: • Link in with the consultation the Homeless Association • Link in with East/B&H Rough Sleeping Initiative - County Coordinator Additional actions to consider during and post mobilisation: • To ensure new contracts collect data on all disadvantaged groups <u>Veterans</u> For formal engagement we will: • by engaging will ensure Veterans are heard throughout the project to seek their views, through one-to-one interviews, liaison with representative groups and questionnaires Additional actions to consider during and post mobilisation: • How do we record to capture this data in the future			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Link into the Armed Forces Team regarding care and outcomes <u>Armed force community</u> For formal engagement we will: • work with the NHS Armed Forces Community lead to ensure we hear from this cohort Additional actions to consider during and post mobilisation: • How do we record to capture this data in the future? • Link into the Armed Forces Team regarding care and outcomes <u>Refugees</u> For formal engagement we will: • Work with public health lead to ensure we hear from this cohort Additional actions to consider during and post mobilisation: • Whilst working with PH review the health check records and ascertain how many refugees, what age, gender where they are living and what support is needed <u>Asylum seekers</u> For formal engagement we will • Work with public health lead to ensure we hear from this cohort. Additional actions to consider during and post mobilisation:			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Whilst working with PH understand the settlement programme and ascertain how many asylum seekers are using the programme <u>Hearing impairments/deafness</u> Additional actions to consider during and post mobilisation: • Work with ESHT on refining data on BSL interpreters • Work with Primary Care to ensure an excellent patient experience • Link in with Public Involvement team - Deaf engagement / BSL service / Sign live - Building on general insight already gathered, engage with local d/Deaf people through local Deaf organisations to gather insight on barriers and possible solutions. Work with ESHT to provide BSL interpreting services to all patients by including a Video Relay Service (such as Signlive) linked to the department contact details which enables d/Deaf people to call ahead of their appointment to confirm any additional needs using a BSL interpreter and their mobile device <u>Atrial fibrillation</u> Additional actions to consider: • link in with the Community/Long-term conditions team, regarding AF service in general practice. UPDATE: There are LCSs in place with general practices in ESH/HR areas — these focus on maximising the number of patients with AF and other conditions on anti-coag treatment and then monitoring their therapy The number of patients with AF are in the table below, taken from latest QOF data. NHS EAST SUSSEX CCG 18220 NHS WEST SUSSEX CCG 24561 NHS BRIGHTON AND HOVE CCG 4972			

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		NHS SUSSEX 47753 <u>Hypertension</u> Additional actions to consider: • Link in with ICS Cardiology Programme for additional information. A gap to detection ambition of 20, 390 people in East Sussex in order to meet NICE guideline of '80% of expected number of people with hypertension diagnosed by 2029 2019/20 QOF data on Hypertension prevalence taken from PH fingertips site - Against a national rate of 14.1 EHS - 17.7 H&R -18.1 HWLH - 15.5 <u>Smoking</u> Additional actions to consider: • review what work is happening in primary and secondary care on prevention, what numbers go through primary and secondary care. As from 1 April 2021, General Practice will not provide “stop smoking” services; the service will be provided by One You East Sussex (OYES) and by some community pharmacies. NHS-funded Tobacco Dependence Treatment Services are due to commence for inpatients and high risk Mental Health outpatients. Being phased in from July 21 - full implementation by 2024. This is to be delivered in conjunction with Local Authority Stop Smoking Services. ESCC Public Health has been working with maternity to agree the best way to apply the model in East Sussex for pregnant smokers. However, ESHT are now at the early stage of reviewing the approach for inpatients.			

<table>
<tr><th>Please try and prioritise your actions</th><th>Potential Impact</th><th>Actions to mitigate impact

These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.</th><th>Staff or Patient Engagement

Outline any proposed engagement to achieve these actions</th><th>Lead Person</th><th>Deadline</th></tr>
<tr><td></td><td></td><td>Funding is being made available to ICS’s across the country that will enable secondary care trusts to get their systems in place by 23/24. There is a relatively small amount this year (21/22) of just over 500k across Sussex but I understand this is likely to increase each year up to 23/24 (not confirmed). The expectation is that 70% of patients who smoke are identified and treated in 21/22 moving to 100% by 23/24.

<u>Heart failure</u>
Additional actions to consider:
review the data and link against map - distance to hospital
Link in with the Community/Long-term conditions team around Heart Failure
UPDATE:<table><tr><th>CCG name (practice parent)</th><th>Number of practices</th><th>List size</th><th>Register</th><th>Prevalence (%)</th><th>Number of practices</th><th>List size</th><th>Register</th><th>Prevalence (%)</th><th>(percentage point)</th></tr><tr><td>NHS East Sussex</td><td>62</td><td>558,775</td><td>6,153</td><td>1.10</td><td>62</td><td>560,333</td><td>5,974</td><td>1.07</td><td>-0.04</td></tr></table>
<u>Physical activity</u>
Additional actions to consider:</td><td></td><td></td><td></td></tr>
</table>

Please try and prioritise your actions	Potential Impact	Actions to mitigate impact These actions could prevent, reduce or control the negative impact on specific groups or the wider initiative.	Staff or Patient Engagement Outline any proposed engagement to achieve these actions	Lead Person	Deadline
		• Link in with PH to gain more information. This work will take place during and post mobilisation and will be addressed by Public Health <u>Overweight/obesity</u> Additional actions to consider: • Link in with PH to gain more information. This work will take place during and post mobilisation and will be addressed by Public Health <u>Blind/partially sighted</u> Additional actions to consider: during and post mobilisation • Link in with the Public Involvement Team • think creatively on how to link into these communities <u>Population impacted</u> Additional actions to consider: • Need to understand population growth and service gap via PH and Commissioning. This work will take place during and post mobilisation and will be addressed by PI team, however, the disease prevalence and areas of deprivation needs to be looked at further by health inequalities team in line with Place Based Plans. <u>Drug users / substance abuse (excl alcohol and smoking)</u> Additional actions to consider • *Link in the public health - this work will be addressed by Public Health during and post mobilisation <u>Wheelchair user/access</u> Additional actions to consider during and post mobilisation:			

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		• To ensure new contracts collect data on wheelchair users & blue badge holders			

EHIA written by:	Assistant Head of Planned Care Senior Planned Care Manager Planned Care Officer	Date:	4/2/2021 2/6/2021 2/7/2021 1/9/2021
EHIA reviewed by:	Head of Planned Care Head of Equality, Diversity and Inclusion Head of Public Involvement Assistant Head of Health, Wellbeing and Partnership Associate Director of Public Involvement Assistant Head of Planned Care Director of System Performance and Improvement Interim Senior Equality Assessment Manager	04/10/2021	• 05/02/2021 – 15/02/2021 for NHSE Stage 1 Assurance • NHSE Stage 2 Assurance – 14/10/2021
EHIA authorised by: (manager)	Managing Director Associate Director of Commissioning	Date:	

EHIA approved:(governance)	YES	~~NO~~	Date: 21 September 2021	East Sussex and Brighton and Hove Local Management Team
Further comments			Date:	
EHIA published on the SES website			Date	
Person to review EHIA post implementation			Date	

TRANSFORMING CARDIOLOGY SERVICES IN EAST SUSSEX

PUBLIC ENGAGEMENT REPORT

Date:	8 APRIL 2021
Version:	2.2
Name of originator/ author:	Emma Baxter, Public Involvement Manager Antonia Bennett, Public Involvement Lead

Contents

1.0 Executive Summary

We are developing proposals for how hospital based cardiology services, provided by East Sussex Healthcare NHS Trust (ESHT), can best provide high quality treatment, care and support for local people and meet increasing local population need. Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England have duties to consult the public when a significant service change is likely to take place. This report provides insight from local people into the patient journey and experiences of accessing cardiology services gathered in January and February 2021, in order to inform service change and potential public consultation.

To reach the local population in East Sussex, the Clinical Commissioning Group (CCG) co-developed a questionnaire with partners and members of the public, which was promoted widely in paper copies and electronically. The CCG undertook interviews with current and former patients of the services and joined virtual local forums and groups to hear from people about their experiences.

The key themes from this engagement include:

- communication both before and during appointments;
- communication between health care settings;
- the need for faster diagnosis;
- requirements for patients' additional needs to be met.

The results of this engagement have informed the development and appraisal of options for the future of cardiology services. This insight has informed the development and appraisal of options for the future of cardiology services.

2.0 Background

The East Sussex Health and Social Care Plan sets out how partners will align local priorities with the Sussex Health and Care Partnership's "Vision 2025". This includes:

- a comprehensive approach to prevention;
- reducing health inequalities;
- supporting our workforce to develop and grow;
- developing a new model of care that will be sustainable for generations to come.

ESHT provides acute and community care in East Sussex, at Eastbourne District General Hospital (EDGH) and at the Conquest Hospital, Hastings, at two community hospitals in Bexhill and Rye, in community clinics across East Sussex and in people's own homes. Acute cardiology services for adults in East Sussex are provided at EDGH, the Conquest Hospital and Bexhill Hospital.

The Sussex Health and Care Partnership's "Vision 2025" focuses on proactively managing population health, better anticipating care needs and integrated working across health and social care to enable the delivery of the best possible outcomes for local people. This, alongside advances in medicine and innovation/technology, will ensure the best use of collective public resources in East Sussex. Reviewing and redesigning cardiology services within this context will help ensure the right services are available in a way that is sustainable for the future and in response to the needs of the local population.

The vision for the future of cardiology is to provide a high-quality service for patients, carers and their families regardless of age, disability, gender or ethnicity. This includes:

- providing a clinically excellent cardiology service;
- increasing the ability to look after a growing and ageing population;
- developing and encouraging innovation in the delivery of cardiology services;
- providing increased support and development for the cardiology workforce.
- developing a service that is clinically, financially and environmentally sustainable;

3.0 Public Engagement

To consider how acute cardiology services should be transformed East Sussex CCG undertook public engagement which commenced on 4th January 2021 and lasted six weeks (concluding on 14th February 2021). This engagement was informed by an Equality and Health Inequality Impact Assessment which highlighted the need to reach particular groups and communities. During this time the CCG's Public Involvement team engaged with local people and stakeholders to:

- communicate the need for the transformation of acute cardiology services at ESHT;
- understand their experiences of the acute cardiology services at EDGH and the Conquest Hospital;
- gather feedback and ideas about how the service could be provided in the future.

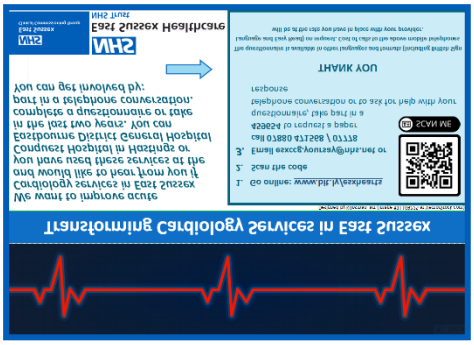
The insight gathered from this work will be used to inform options development, appraisal and planning for any formal consultation.

A questionnaire to understand people's experiences of acute cardiology services was co-designed with partners and members of the public and published on the Sussex Health and Care Partnership Engagement HQ platform. The survey was promoted through a multitude of pre-established distribution lists and newsletters including:

- 3VA weekly bulletin (Eastbourne residents)
- HVA weekly bulletin (Hastings residents)
- East Sussex Local Voices (over 2000 recipients)
- East Sussex Health and Care Newsletter (over 4000 recipients throughout East Sussex)
- Over 60 churches in East Sussex and a mailing list of 800 stakeholders.

It was also sent out widely to local voluntary, community and social enterprise (VCSE) sector organisations, including Healthwatch, with the request to support promotion. Paper copies of the survey were sent out to organisations including the Rough Sleepers Initiative (homeless and rough sleepers) and foodbanks (to reach those living in deprivation) as well as to individuals requesting copies. A freepost address for returning the questionnaires was included.

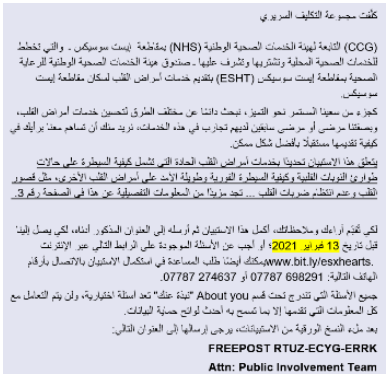
Posters were distributed to display in hospital waiting rooms to encourage people to complete the questionnaire or to get in touch to arrange a telephone interview. Social media coverage was used to promote the surveys, utilising the CCG pages and accounts and posting on local community Facebook pages.



The Public Involvement team attended a range of virtual forums and groups to promote the programme and inform people of the ways to get involved including:

- Patient Participation Groups (PPGs) Steering Group and three local forums;
- East Sussex Seniors Association (ESSA);
- Eastbourne Cultural Inclusion Group (ECIG);
- East Sussex Communications and Engagement Steering Group (CESG).

To ensure accessibility, local linguists in East Sussex were asked to support people for whom English was an additional language to complete the questionnaires and a total of eight completed questionnaires were received with a variety of languages represented including:



كلفت مجموعة التكليف المريزي

(CCG) التابعة لهيئة الخدمات الصحية الوطنية (NHS) بمقاطعة ايست سوسيكس - والتي تخطط للخدمات الصحية المحلية وتشتريها وتشرف عليها - صندوق هيئة الخدمات الصحية الوطنية للرعاية الصحية بمقاطعة ايست سوسيكس (ESHT) بتقديم خدمات أمراض القلب لسكان مقاطعة ايست سوسيكس.

كجزء من سعينا المستمر نحو التميز ، نبحث دائمًا عن مختلف الطرق لتحسين خدمات أمراض القلب، وبصفتنا مرضى أو مرضى سابقين لديهم تجارب في هذه الخدمات، نريد منك أن تساهم معنا برأيك في كيفية تقديمها مستقبلاً بأفضل شكل ممكن.

يتطلع هذا الاستبيان لتحديثا بخدمات أمراض القلب الحادة التي تشمل كيفية السيطرة على حالات طوارئ النوبات القلبية وكيفية السيطرة الفورية وطويلة الأمد على أمراض القلب الأخرى، مثل قصور القلب وعدم انتظام ضربات القلب ... تجد مزيدًا من المعلومات التفصيلية عن هذا في الصفحة رقم 3.

لكي تقدم آراءك وملاحظاتك، أكمل هذا الاستبيان ثم أرسله إلى العنوان المذكور أدناه، لكي يصل إلينا قبل تاريخ 13 فبراير 2021 أو أجب عن الأسئلة الموجودة على الرابط التالي عبر الإنترنت www.bit.ly/esxhearts. يمكنك أيضا طلب المساعدة في استكمال الاستبيان بالاتصال بأرقام الهاتف التالية: 07788 698291 أو 07787 274637.

جميع الأسئلة التي تندرج تحت قسم About you "لنبذة عنك" تعد أسئلة اختيارية، ولن يتم التعامل مع كل المعلومات التي تقدمها إلا بما تسمح به أحدث لوائح حماية البيانات.

بعد ملء النسخ الورقية من الاستبيانات، يرجى إرسالها إلى العنوان التالي:

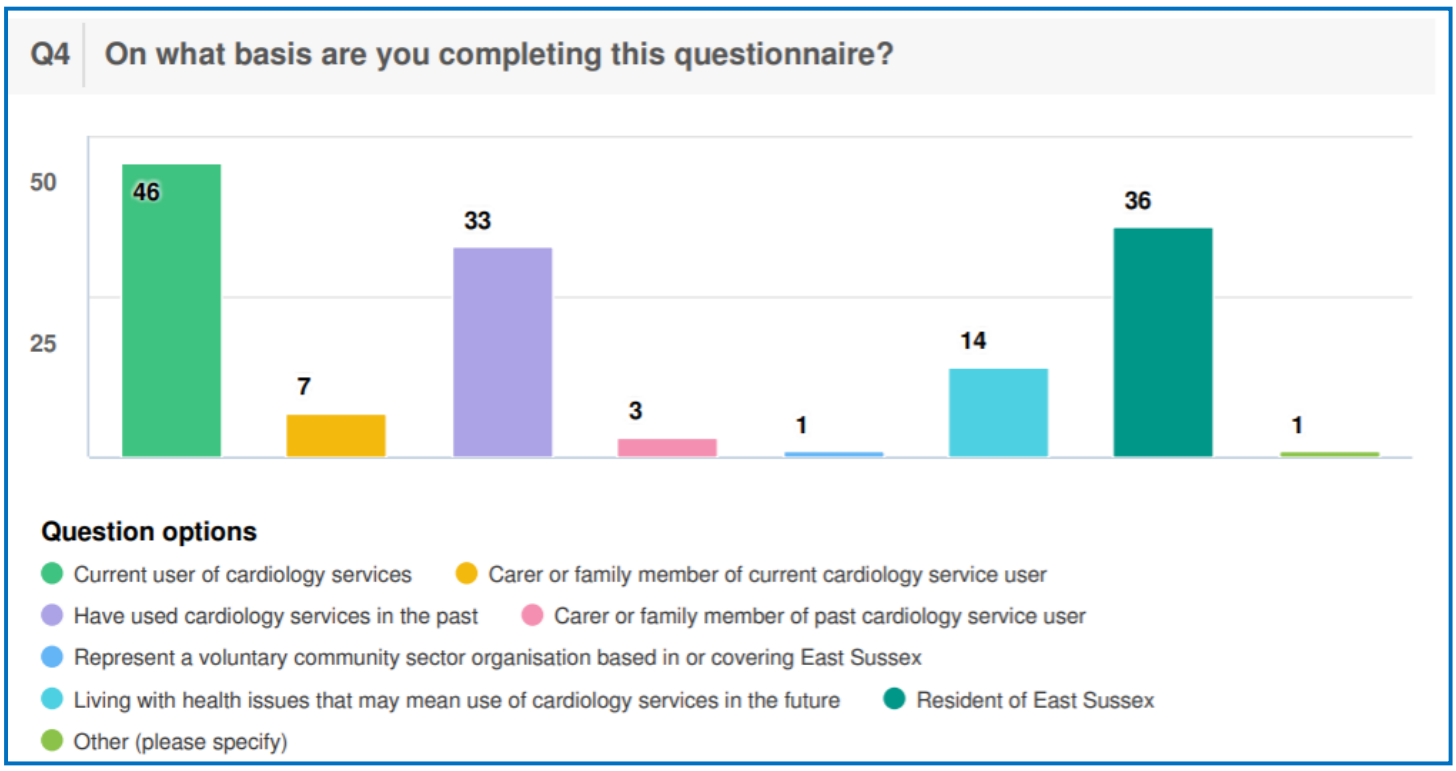
FREEPOST RTUZ-ECYG-ERRK
Attn: Public Involvement Team

- Kurdish
- Urdu
- Portuguese
- Cantonese
- Mandarin
- Polish
- British Sign Language

The survey was also produced in Easy Read and Arabic with further translations available on request.

The insight gathered will be fed into options development workshops where key stakeholders will be invited to come together to co-design feasible options. These will be followed by a further options appraisal workshop to inform a final set of proposals.

4.0 Results of engagement

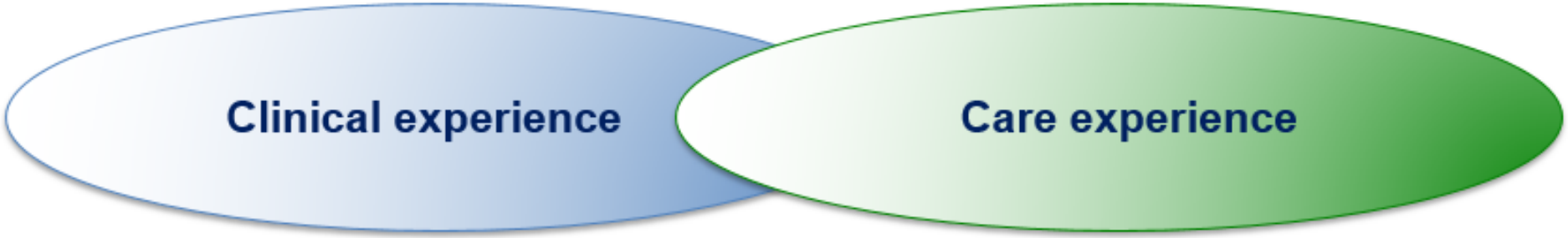


(Please note participants could choose more than one option)

In total there were 82 responses including 20 in-depth interviews.

The following pages illustrate some of the significant themes that emerged from the submissions: these have been split into care and clinical themes.

Cardiology Service Delivery: the Patient Perspective



Rapid ambulance/paramedic response

Rapid diagnosis and life-saving treatment

No long delays for treatment with a life-threatening condition - test results

Check-ups on time (COVID-19 reasoning)

Clarity from the clinical team: mixed messages = uncertainty

Joined-up communications: hospital-GP-patient

Personal relationship with the consultant

Time taken to listen, explain

Treated with care, respect and warmth

Individual adaptions

Ideal service delivery is 'clockwork'

Cardiology Service Delivery: the Patient Perspective

Majority Very Positive

Rapid ambulance/paramedic response
"Ambulance took me from Conquest to EDGH for angiogram and angioplasty, done in 20 minutes"

Rapid diagnosis and life-saving treatment
"Had treatment within the hour. Prevented damage to heart. Cannot fault process. Cardiac ward great".

Check-ups on time (Covid excuse)
"Get back to the tests so you can still have confidence in your safety and fears of another relapse".

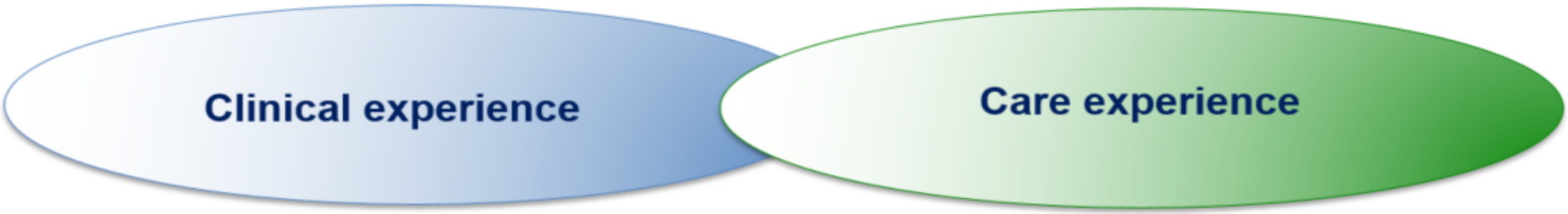
Personal relationship with the consultant
"I felt very reassured after both tests that I wasn't ill. Prof Patel explained that very clearly to me. A first class service".

Time taken to listen, explain
"Follow-up appointment explained in detail and plain speak diagnosis, prognosis and interventions available"

Treated with care, respect and warmth
"I have nothing but praise for the team. I was terrified but people talked to me all the time. One nurse told me not to worry – in two hours I'd be sorted out. She kept coming back to check on me". "Staff were caring and understanding and went out of their way to allay fears"

Ideal service delivery is 'clockwork'
"Admitted A&E with MI, CCU within six hours, diagnosed within eight hours. Correct treatment given, discharged within 24 hours with follow-up appointment'

Cardiology Service Delivery: the Patient Perspective
Minority Negative



Rapid ambulance/paramedic response
"The ambulance got lost. Cardiac staff were deployed 10 minutes into the call. What was the point?"

No long delays for treatment with life-threatening condition, test results
"Service when accessed was very good, lengthy wait for appointments when classed as at risk of a heart attack was not"

Clarity from clinical team:
mixed messages = uncertainty
"Mixed messages between consultants re: medication leading to uncertainty and anxiety"

Joined-up communications: hospital-GP-patient
""I didn't realise I'd be under general anaesthetic until I woke from the procedure. Sent home without any info or letter. Specialist did write to my GP but no-one got back to me and the letter was filed"

Check-ups on time (Covid)
"How can you possibly know if my heart is functioning as it should over the phone – it's ridiculous?"

Treated with care, respect and warmth
"Heartbeat was 28 bpm and shaking – asked if I 'take it up the nose' (cocaine)".

Individual adaptions
"Consultant judgmental, lacked understanding of my sporting lifestyle. Care targeted towards elderly".

"Complete ignorance by one doctor of the impact of hormones on my artery condition – he seemed to be very uninterested, bordering on dismissive".

4.1 Care

Patient experience

Feedback about cardiology services was overwhelmingly positive, especially with regard to emergency care. The majority of participants felt reassured, respected and the service is considered to be excellent and professional.

Where there were negative experiences of cardiology services there was a clear sense of the participant feeling scared, stressed, emotional and anxious with some people feeling their life was on the line:

"Having a heart issue is frightening. More support would be helpful"

People were also anxious about delays in testing and getting test results as these are perceived as critical to their health and wellbeing.

4.2 Equality and Diversity issues

People with learning disabilities, those who are d/Deaf and those who speak English as an additional first language said that they were not given the opportunity in advance to request additional support. This led to anxiety about the appointment and/or procedure. Language barriers and lack of interpretation support left people feeling confused, "unheard" and unsure of next steps and treatment. Longer appointments with additional support should be offered to these cohorts of people.

It was noted that once the staff knew one of the participants was autistic, they were quick to put measures in place including dimming lights and informing the consultants.

A transgender person reported that they were treated poorly due to:

"A complete lack of knowledge by one doctor about the impact of hormones on my artery 'condition' … he seemed to be very dismissive and uninterested bordering on 'it's your fault for taking them'".

Other accessibility concerns included spaces being cramped for wheelchair users, with the Cath Lab mentioned in particular and vision impaired participants receiving communications in font size 11 whereas size 20 in a plain font such as Arial would be more appropriate.

4.3 Access/transport issues

Some participants picked up on the possible option to single site elements of the service and had concerns that if the service were available at fewer sites it would affect access. Examples were given such as the distance between Seaford and Eastbourne/Hastings, and between Bexhill and Eastbourne. The Conquest Hospital in Hastings was mentioned as having poor provision of public transport. One participant felt strongly that single siting the service in Hastings could lead to destabilisation:

"If you single site any of the service in Hastings, people in Seaford and surrounding areas would be closer to Brighton and will go there. This would mean losing out financially as the money follows the patient and potentially could destabilise the service if not enough activity was at Hastings leading to cardiologists not fulfilling their expected annual number of procedures and leaving to go to an area where living costs are cheaper and they can reach their annual procedures to avoid retraining."

There were general travel and access concerns for:

- the elderly
- those with a physical disability
- those living in rural villages where public transport is minimal

However a few participants said they would be prepared to travel for emergency care and interventions if it meant they would be receiving expert care:

"I would like as much routine care as possible locally with a minimum of travelling. I would prefer emergency interventions to be carried out on a single site to concentrate expertise and opportunities for training. I would not mind travelling further for this."

"The centralisation of services - to enable better training of staff and justify better equipment and facilities"

4.4 The impact of COVID-19

Feedback about moving to video and telephone appointments due to COVID-19 was mixed, with some participants finding it convenient and others feeling the appointment was rushed and didn't provide the same level of detail that they may have received from a face-to-face appointment. There was a positive response from a participant with autism who found telephone and video appointments far more relaxing as there were no concerns about additional needs and they could have the appointment from the comfort of their home.

There was mixed feedback about attending appointments and undergoing procedures; there was praise for the team with people feeling safe and clear COVID-19 processes in place but a common theme was patients and carers not being asked to wear to a mask or social distance.

The lack of access to rehabilitation on site was accepted by participants and there was recognition that remote rehabilitation was successful but didn't meet the emotional needs of the person. Participants felt that meeting other people in similar situations would have provided some emotional support.

4.5 Clinical

Communications between different healthcare teams/professionals

Lack of communication between consultants, wards, the emergency department and GP practices was a strong theme. Healthcare services not having access to the same patient information and delays in GPs receiving information led to a delay in treatment. Test results not being shared with another local trust led to a repetition of tests. There were examples of people taking in copies of test results to GP/ follow up appointments as there was a lack of trust that the information would reach their GP. A suggestion of digitalising patient notes and medical files with all NHS health care settings having access was made, which would lessen and mitigate treatment errors and be easier to administer.

Communications between healthcare professionals and patients, especially of results

Communication between the cardiology team and the patient both before and during appointments was often cited as an issue. Lack of communication leads to anxiety.

"The key issue is the lack of information which increases worry, don't assume patients know things. There were no enquiries before discharge about what support I had at home and what situation I was going back to. I was pretty shaky and I was worried.

I don't have any support at home…"

The need for a working telephone number or email address for patients to be able to contact the service ahead of attending with any questions or additional needs was highlighted.

During consultations some people felt that they were ignored, undermined or that the clinician was dismissive. There were reports of people receiving mixed messages from different consultants and being anxious about which advice to follow.

Lack of post procedure communication led to several people feeling unsure of next steps, how long they should be on certain medication and whether delays to follow-up reviews due to COVID-19 would impact on their health.

Speed and ease of service delivery

There was one difficult experience shared of an ambulance being sourced from out of area due to no available local ambulances, getting lost and the 55 year old person dying before they could be treated.

Another participant was very clear in their view that any single siting will be putting lives at risk:

"The golden hour is paramount and travelling across the county does no-one any good - how many lives have been lost not just in travel but arriving too late for the team to do anything. You cannot put a price on people's lives and there needs to be a service on both sites that has the same structure in both teams."

Waiting times for appointments and follow-ups

Participants often mentioned longer than expected waiting times for tests and follow-up appointments; whilst there was an understanding that this was probably due to COVID-19, the lack of communication left some resorting to going private for tests and treatment. One person who chose to go private saw the same consultant privately as they would have seen as an NHS patient.

For the minority there were notable delays to acute procedures including heart bypass and urgent ablations leaving those participants feeling very anxious.

One participant has been waiting for a cardioversion that was supposed to take place four to six weeks after a stent was put in. The stent was put in during June 2020 and the patient has still not received a date for the cardioversion. Another patient had two postponements of a pacemaker check.

4.6 Other themes

Particularly when answering the question about the service vision and priorities, several participants highlighted the need for prevention to be high on the agenda:

"I agree with the objectives mentioned above, but have always thought that preventative measures are as important as post treatment once illness is diagnosed"

"Think about the long term effects of COVID-19; increasingly obese population, lack of exercise for many. Children are losing out on exercise. The impact will be seen in 10-20 years' time."

Monitoring of medication was also mentioned. One participant was concerned that they were put on a drug in 2019 that should only be used for a year but they have not yet been offered a follow-up appointment.

4.7 Participant priorities

To encourage participants to consider their priorities when it comes to healthcare and to understand if people would be willing to travel further to receive care, a prioritisation question was asked where the participants had to rank each statement from 1 to 6, with 1 being the most important and 6 being the least important. It is important to recognise that this question is useful but, given the relatively small number of respondents, the results should not be viewed as an overall reflection of peoples' priorities:

1. I want to see highly trained specialist cardiology specialist doctors and nurses.
2. I don't want to have to wait too long to get an appointment.
3. I would like to be treated in a setting where there are cutting edge facilities and equipment.
4. When I am at the hospital, I want appointments to run on time.
5. I need to consider the time taken to travel to get to my appointment.
6. I need to consider how to get to my appointment i.e. is there a regular bus available, would I be able to cover the cost to get to the appointment.

4.8 Other groups the CCG should engage with during any public consultation

We asked participants if there were any groups that we should focus on once we have a set of proposals. Responses included:

- The elderly
- Trans people
- Carers
- Disabled
- Those with learning disabilities
- Homeless and rough sleepers
- Those without transport
- Staff at the ambulance trust (SECAmb)

5.0 Conclusion

Public engagement successfully reached a significant number of people, despite the limitations of lockdown during COVID-19, and the CCG heard from a wide variety of individuals, organisations and stakeholders.

The findings have been shared with ESHT and an action plan is being developed using some of the early findings to make small but effective changes to the way the service is provided.

The outputs of the public engagement will inform and shape the options development and appraisal process and will used to shape any business case and formal consultation, if required.

6.0 Appendix 1 - Equality data

There was a widespread response from across East Sussex with the highest responses coming from Eastbourne and Hastings. Not all respondents completed the equality data section of the questionnaire.

BN22	Eastbourne	7
TN34	Hastings	7
TN35	Rural Rother	5
TN39	Bexhill	5

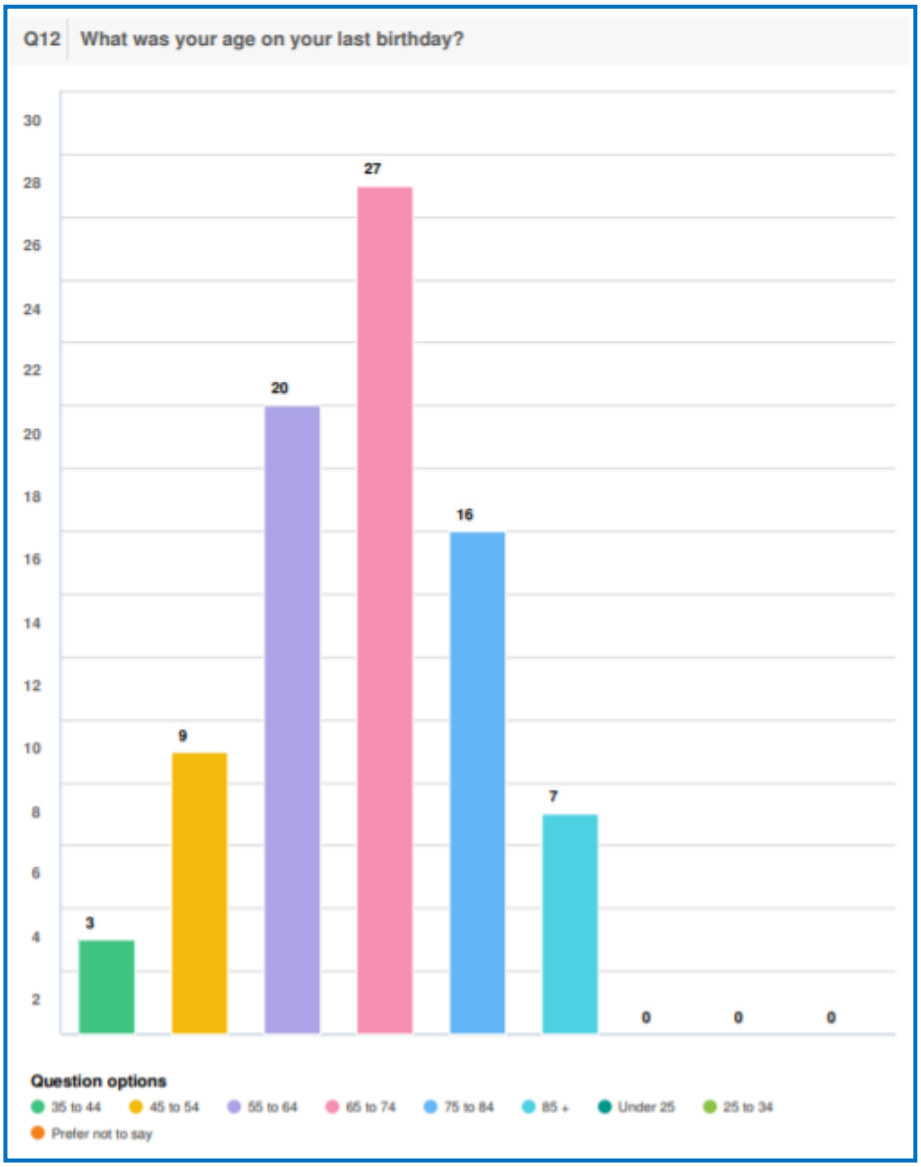
4 responses from BN20, BN21, BN23, BN25, TN31, TN33, TN38

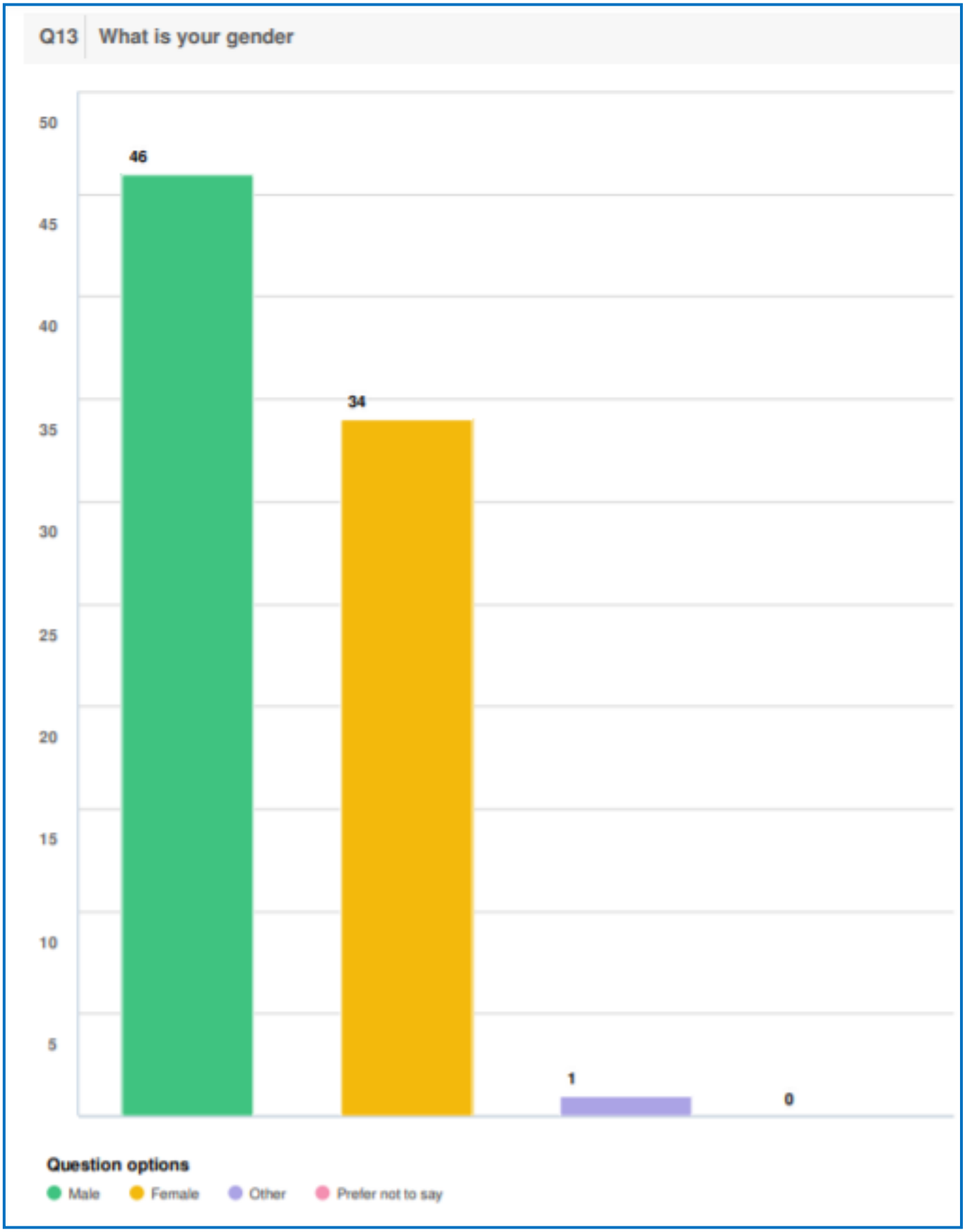
3 responses from BN7, BN27, TN19, TN40

2 responses from BN10, BN24, TN22

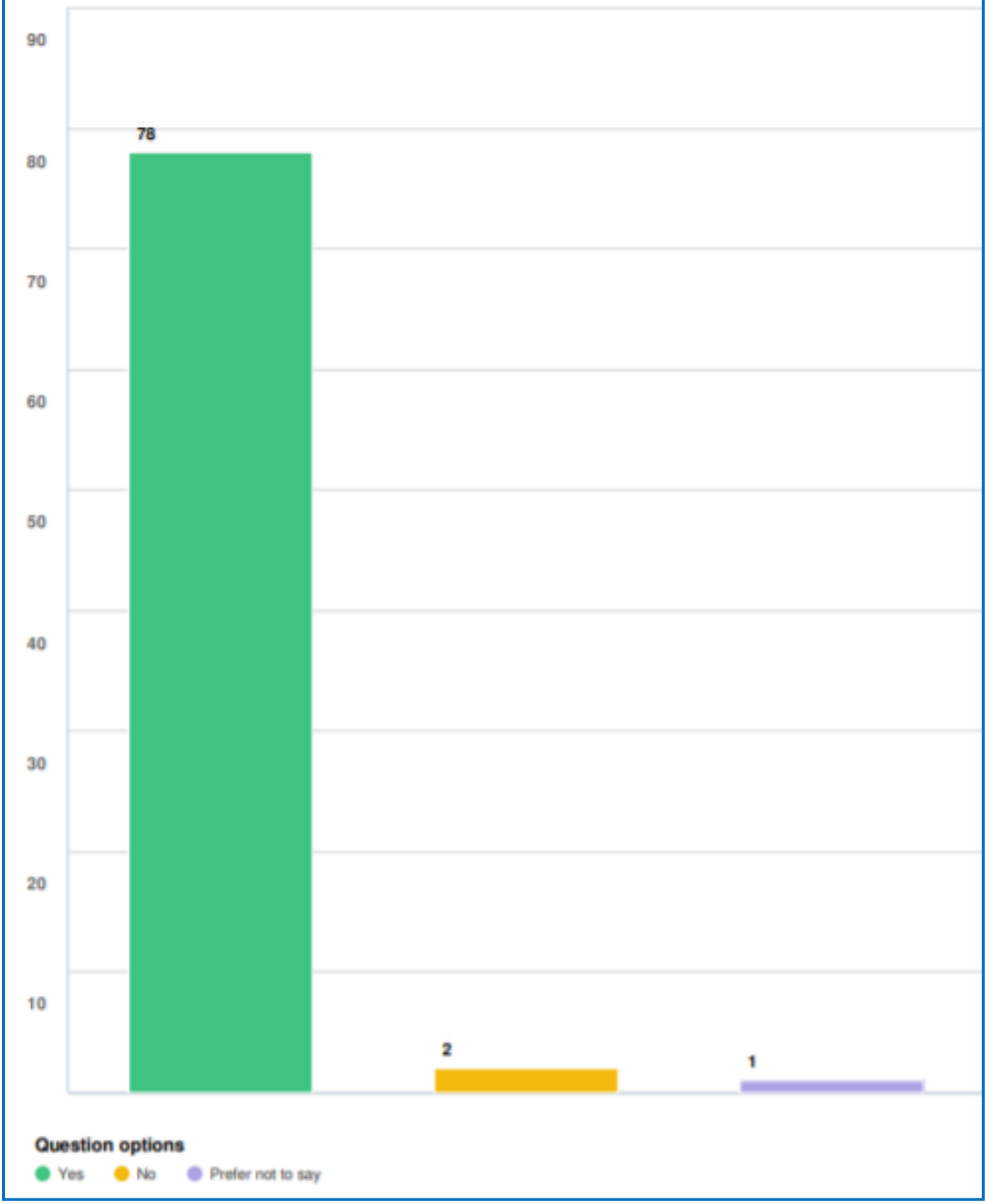
1 response from BN26, TN6, TN18, TN21, TN36, TN37

One out of area response was received from Brighton and Hove (BN2)

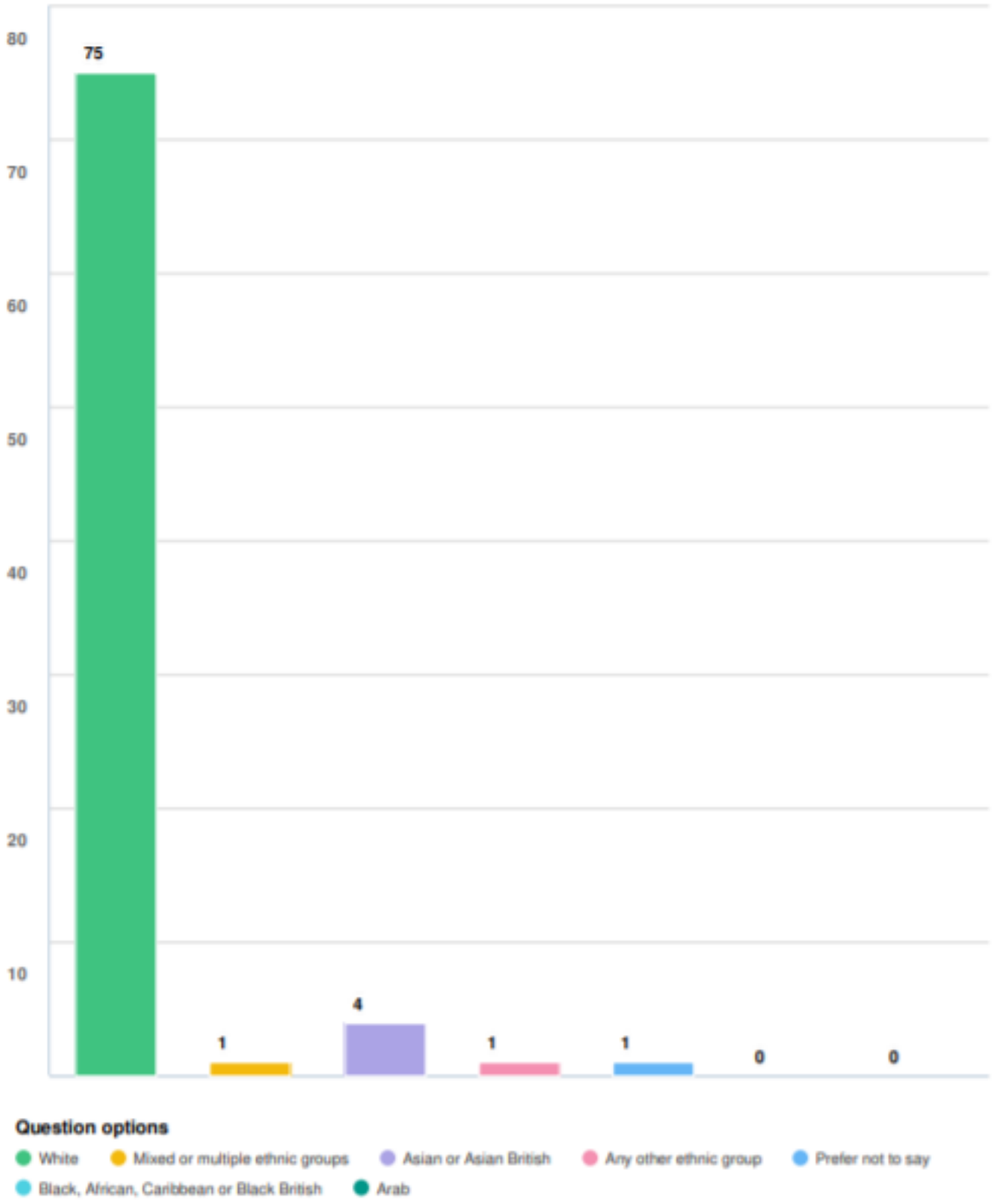


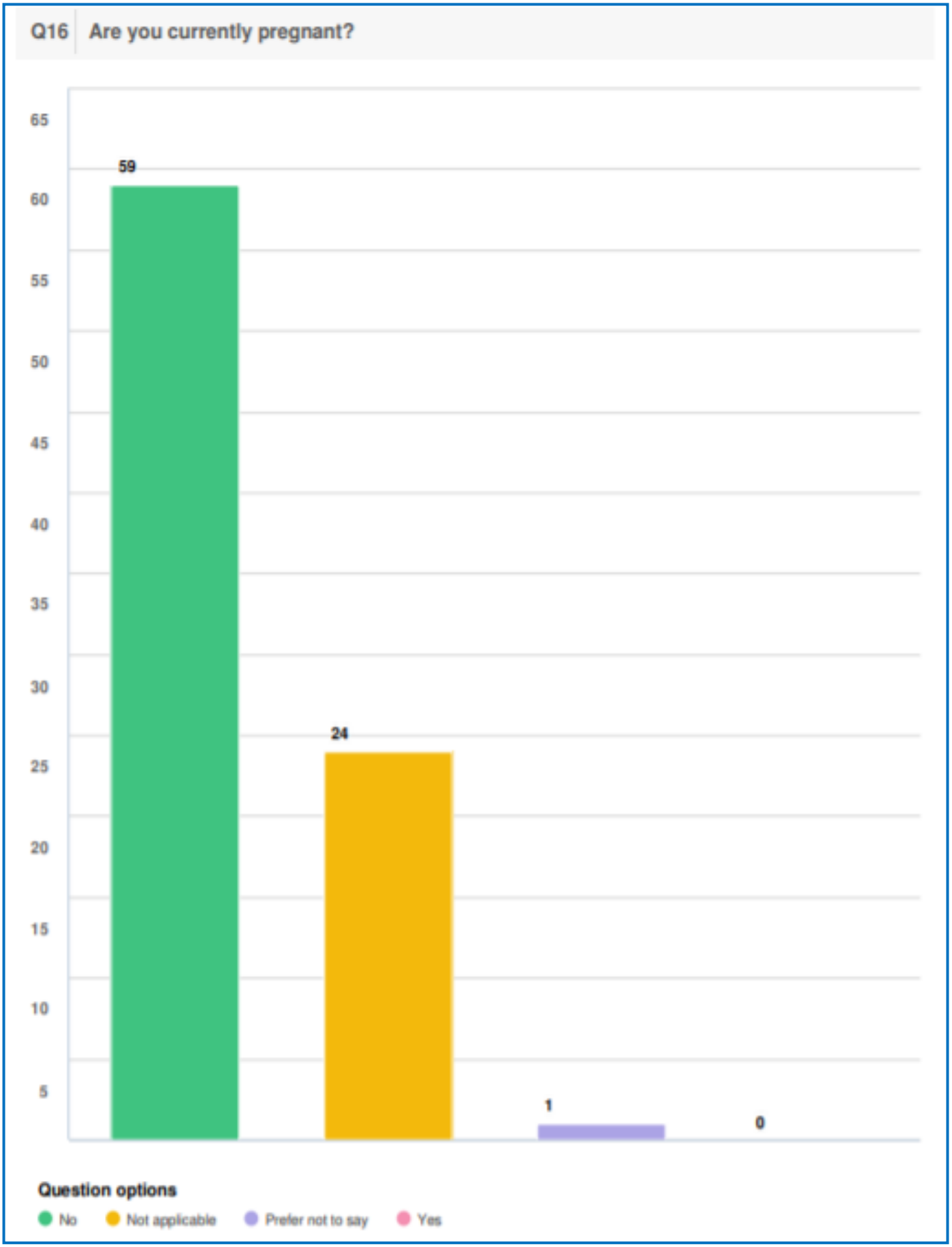

Q13 What is your gender
50
45
40
35
30
25
20
15
10
5
46
34
1
0
Question options
Male
Female
Other
Prefer not to say

Q14 Do you identify as the sex you were assigned at birth? For people who are transgender, the sex they were assigned at birth is not the same as their own sense of gender.

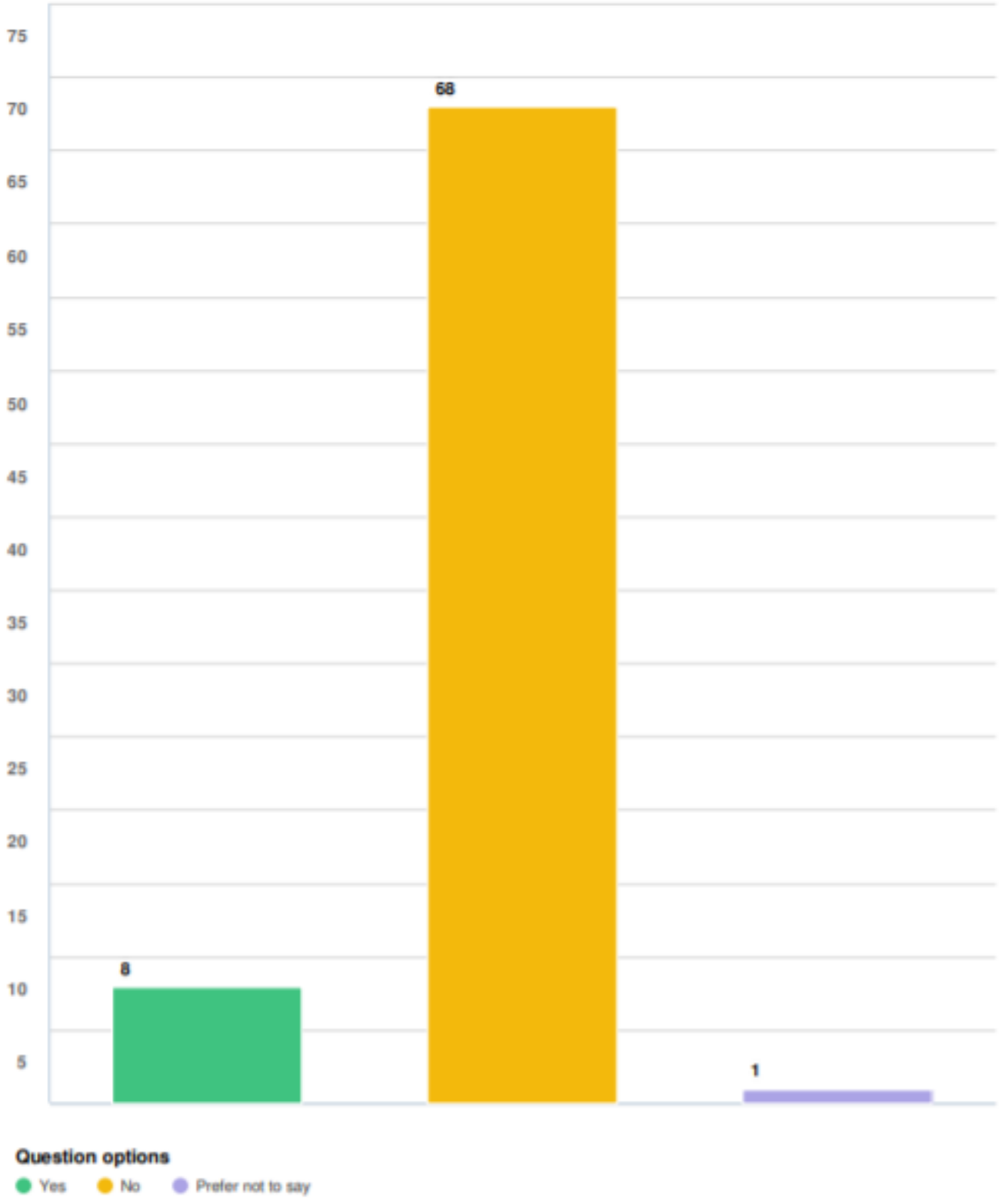


Q15 What is your ethnic group?

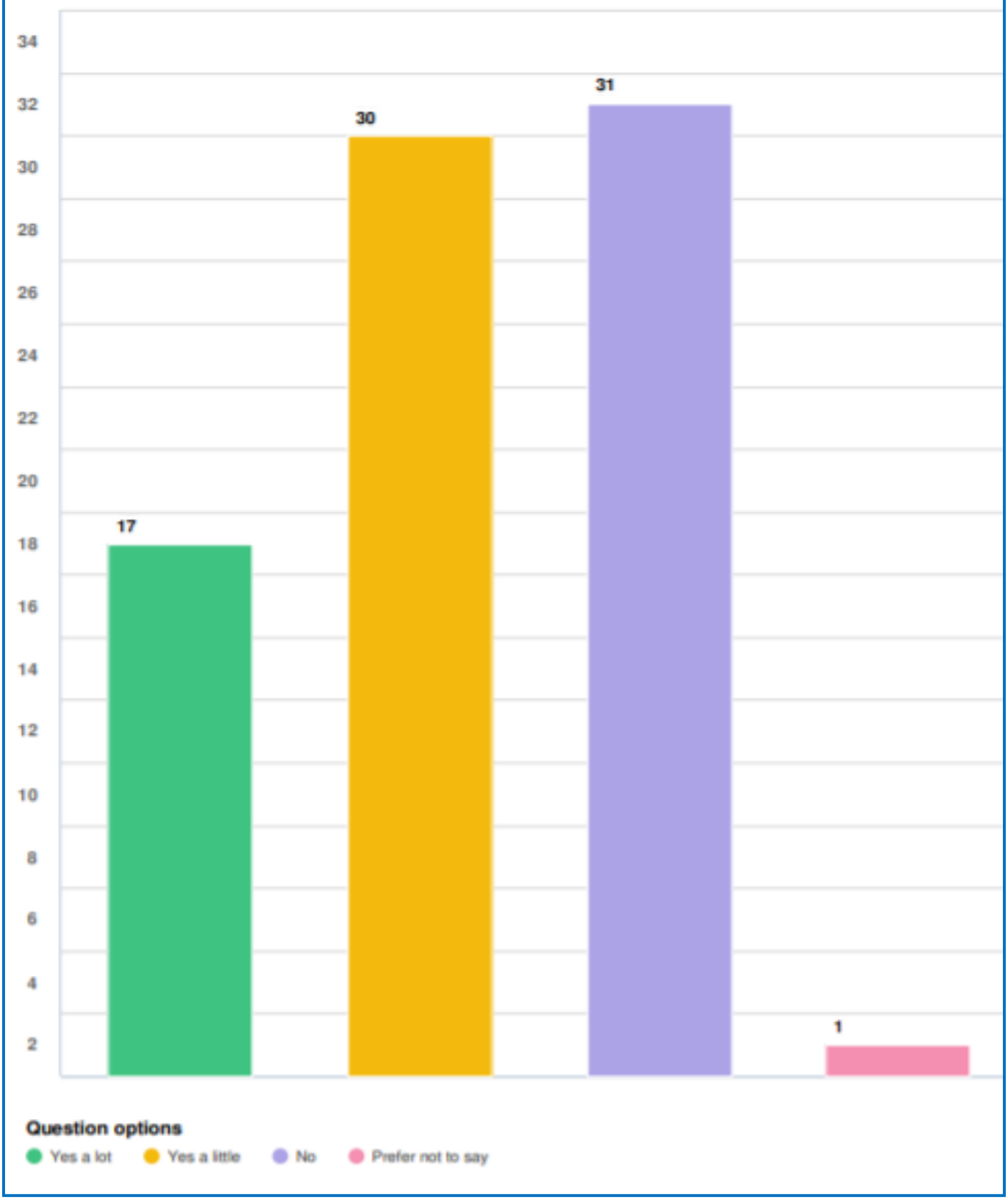



Q16 Are you currently pregnant?
65
60
55
50
45
40
35
30
25
20
15
10
5
59
24
1
0
Question options
No
Not applicable
Prefer not to say
Yes

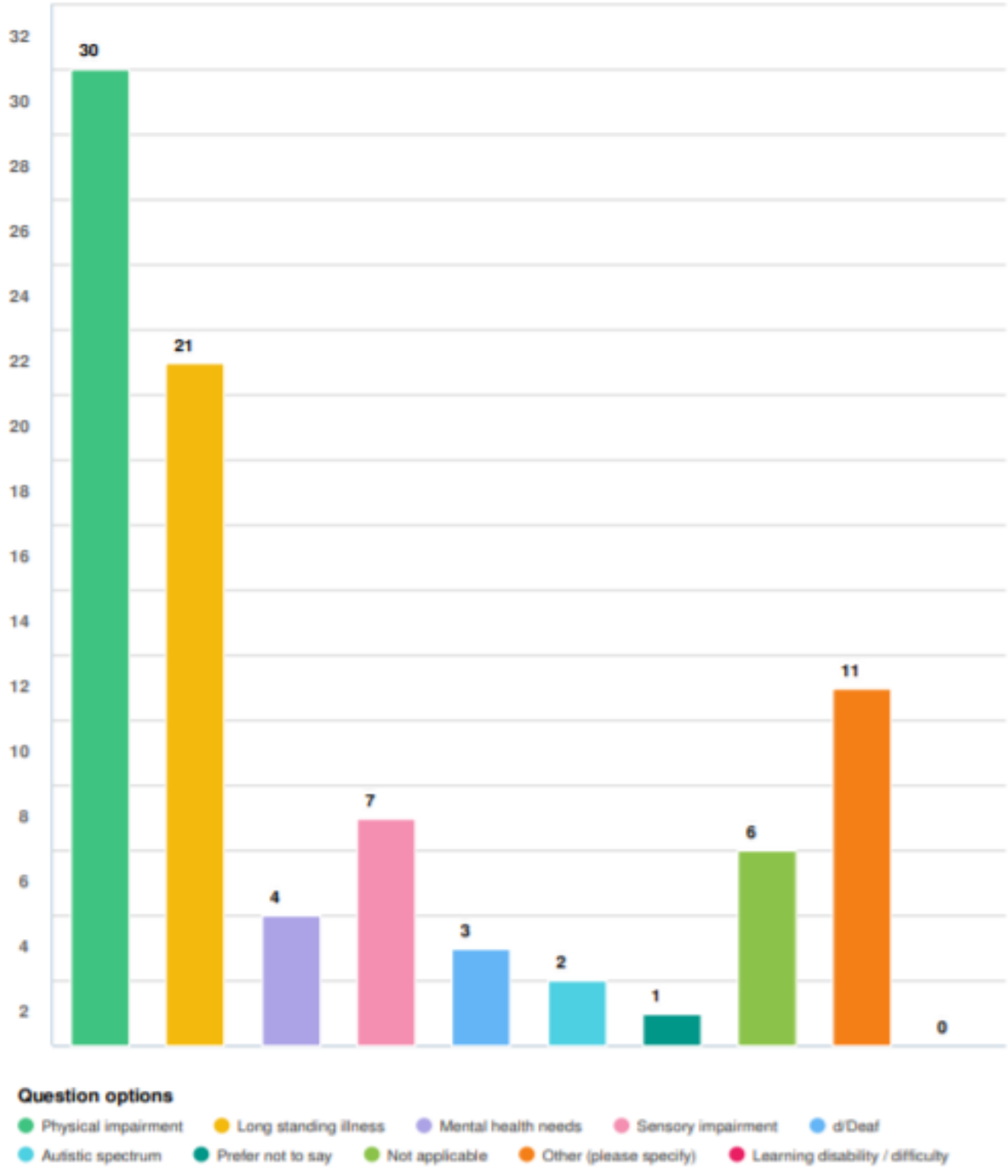
Q17 Are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.

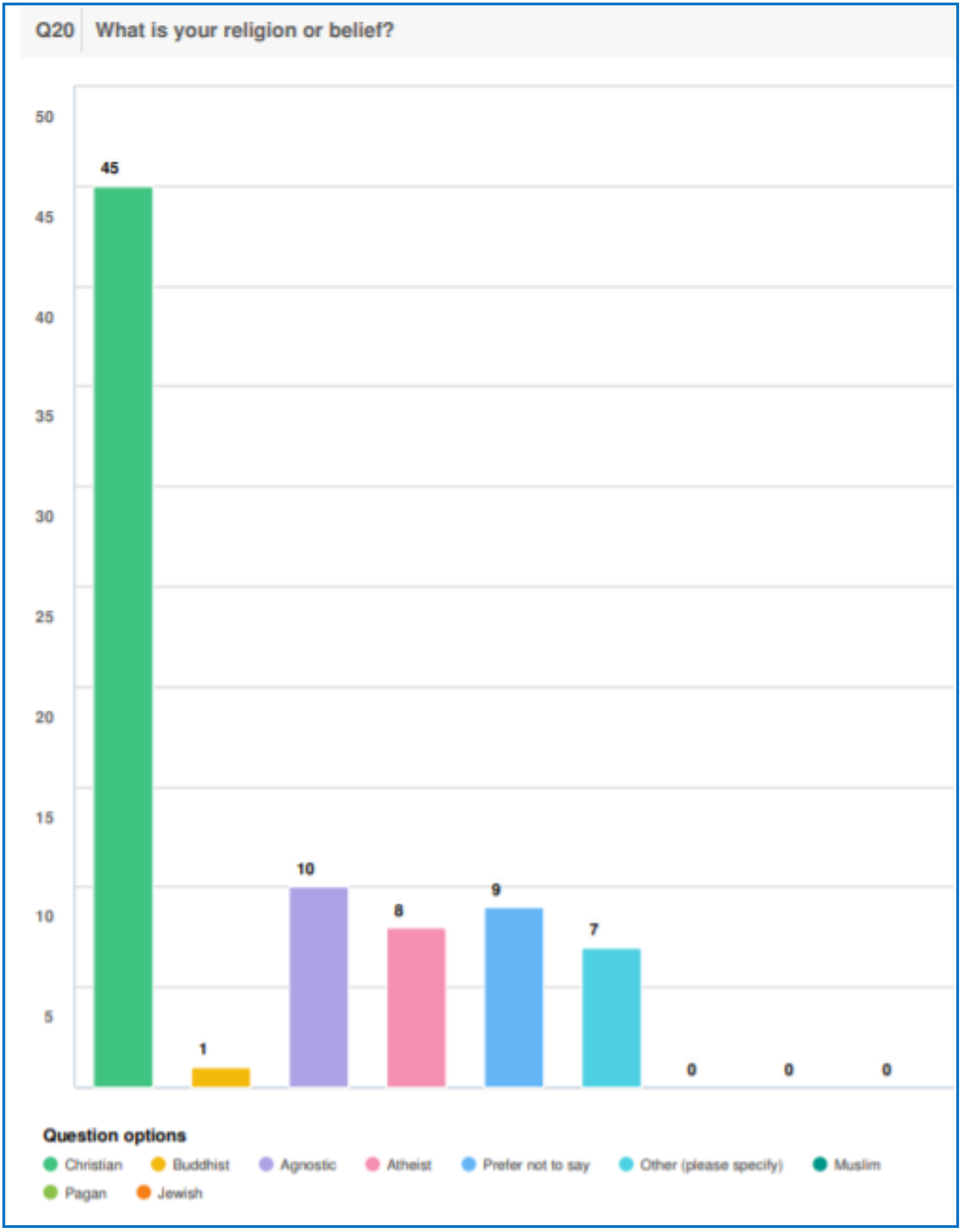


Q18 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?



Q19 If yes, please state the type of impairment. Please tick all that apply.




Q20 What is your religion or belief?
50
45
40
35
30
25
20
15
10
5
45
1
10
8
9
7
0
0
0
Question options
Christian
Buddhist
Agnostic
Atheist
Prefer not to say
Other (please specify)
Muslim
Pagan
Jewish

Transforming Acute Cardiology Services in East Sussex

Options Development and Appraisal

Report of Findings

Opinion Research Services

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Sussex Clinical Commissioning Groups

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Contents

1. Summary of key findings

Introduction and commission

1.1 The NHS East Sussex Clinical Commissioning Group (East Sussex CCG) and East Sussex Healthcare NHS Trust (ESHT) are working to improve cardiology services across East Sussex. Acute cardiology services in East Sussex are delivered by ESHT at Eastbourne District General Hospital (EDGH) and Conquest Hospital in Hastings (hereafter 'Conquest').

1.2 East Sussex CCG and ESHT believe that current acute cardiology service provision is no longer fit-for-purpose, and that the service in its present form is unable to continue to meet current and future demand and it is therefore necessary to explore options for improvements.

1.3 As part of the Transforming Acute Cardiology Services in East Sussex programme, East Sussex CCG and ESHT are undertaking extensive engagement with service users, their carers and families, clinicians, and other stakeholders. This was initially in the form of early involvement to inform the programme, followed by a more formal options development and appraisal process. It is these latter options development and appraisal activities which have provided the basis for this report.

1.4 In early 2021, East Sussex CCG appointed Opinion Research Services (ORS) (a spin-out company from Swansea University with a UK-wide reputation for social research and statutory consultations) to advise on and independently manage and report the programme reported here.

Options development and appraisal workshops

1.5 Between 8th March 2021 and 22nd March 2021, three options development and appraisal workshops took place to identify and consider a longlist of possible options for future provision of acute cardiology services in East Sussex. The workshop attendees who actively took part in the options development and, in particular, the options appraisal scoring and ranking, were as follows:

Stakeholder type	Number	Description (roles/organisations represented)
Patients and representatives	3	Service users East Sussex CCG Community Ambassador
Other NHS staff	3	Local GP South East Coast Ambulance service (SECamb) representative
ESHT clinicians	5	Acute cardiology clinical leads and clinicians/nurses

1.6 NHS managers attended to observe, to present information for discussion, and to respond to questions, but *did not* actively participate in the options development and appraisal scoring and ranking activities.

1.7 A mixed methodology was used to appraise the longlist of options, comprising:

- 'Qualitative' discussions which drew out the reasons for which different individuals and groups held certain views, and particularly to identify and elaborate on any key factors or concerns; and
- A two-part 'quantitative' exercise to generate ranks and scores for each option.

1.8 In both the qualitative and quantitative stages of the appraisal, five 'appraisal criteria' (which were discussed and agreed upon at workshops 2 and 3) were used. These criteria are: Quality and Safety; Clinical Sustainability; Access and Choice; Financial Sustainability; and Deliverability.

1.9 It is the view of ESHT that possible options which might involve different services being delivered at either of the acute hospital sites in East Sussex (EDGH and Conquest) could be configured either way round. Furthermore, the likelihood is that, if such options were to be shortlisted for public consultation, both possible site configurations would be included for consideration and feedback. For this reason, participants at Workshop 3 were not asked to rank or score locations, but to focus on models of care.

Key findings and considerations

1.10 Formal options development and appraisal activities are an important element of the process by which any final proposals for changes to the way that acute cardiology services are delivered in future. The workshops, and the outcomes reported here, should nonetheless be viewed as just one element of a longer-term and ongoing process by which stakeholders, including members of the public, have engaged in a dialogue with East Sussex CCG and ESHT about the way NHS services are delivered, and will be delivered in the future.

1.11 It is important to note, therefore, that the outcomes reported here are by no means the only basis on which might be taken about which options move forward to public consultation. Options appraisal is a useful tool to inform the shortlisting process, but it forms just one part of the evidence base which the relevant bodies will need to consider when making decisions.

Challenges, opportunities, clinical vision, and priorities

1.12 There was widespread recognition of the need for change, and all of the challenges and drivers identified by East Sussex CCG and ESHT as requiring changes to acute cardiology services in East Sussex were recognised by workshop participants.

1.13 Recruitment and retention of staff in particular was highlighted by participants as a cause for concern, as was the importance of meeting national standards to drive service improvements.

1.14 The clinical vision for acute cardiology services in East Sussex was viewed as appropriate by all stakeholders involved in the workshops, as were the priorities identified by ESHT in regard to the way that the services should be delivered. There was also agreement with ESHT's considerations for the future, including that acute cardiology services should be high quality, accessible, and delivered in a timely and equitable manner for all patients, serving the needs of the local population.

Quality of care is most important to cardiology patients

1.15 Pre-consultation engagement feedback received from service users in response to activities undertaken by East Sussex CCG in early 2021 highlighted the importance of specialist care, 'cutting-edge' facilities and short waiting times for appointments.

1.16 This outcome was further supported by feedback from the workshops, and patients and representatives, as well as other stakeholders, frequently ranked and scored options which would best meet national standards and guidelines for quality-of-care highest - even where those options might mean an increase to journey distances and durations for some patients.

An ideal acute cardiology service

1.17 In addition to high-quality clinical care, patients and patient representatives identified several key elements which might characterise an 'ideal' cardiology service. These included multi-disciplinary team working and strong, 'joined-up' communication between patients and carers and NHS staff, and between secondary and primary/community cardiology care services.

1.18 Accessibility of services, including in terms of travel and transport, was also raised in discussions - particularly for services users who might not have access to private transport or who live in rural locations.

1.19 Emergency admissions by ambulance, while recognised as high-profile and potentially emotive, were also viewed as requiring clarity and consistency around which specific hospital patients should be taken to, rather than necessarily relying on the shortest possible journey time to ensure good clinical outcomes.

1.20 The need for mindfulness and consideration of equality and diversity needs in options development and appraisal, and any potential impacts of changes to acute cardiology services related to the needs of particularly protected characteristics groups, around health inequalities and deprivation, was highlighted.

A future model of care

1.21 Various potential models of care were discussed and appraised at workshops 2 (options development) and 3 (options appraisal). Discussions were based on five possible approaches suggested by ESHT. Three of these would see current services at both acute sites retained or expanded:

- **Option 1**: Retaining current services as they are;
- **Option 2:** Retaining current services while adding new assessment areas in emergency departments and 'hot clinics' at both acute hospital sites; and
- **Option 3**: Building up both acute hospitals, with the addition of assessment areas and 'hot clinics' ('everything, everywhere').

1.22 The remaining options would involve a different suite of acute cardiology services being delivered at each of the acute hospital sites, although *with the addition of cardiology assessment areas and 'hot clinics' at both acute hospitals under both options*:

- **Option 4**: Separating services so that Percutaneous Coronary Interventions (PCI) are delivered at one acute hospital site, while elective Electrophysiology (EP), Permanent Pacemaker (PPM) and Devices services are delivered on the other acute site; and
- **Option 5**: Co-locating all catheterisation laboratories and inpatient services on one acute hospital site, with outpatient and diagnostic services at both acute sites.

1.23 Participants in the workshops were also invited to suggest other approaches for consideration and appraisal, but the consensus was that the five options above were appropriate and none were added.

Options appraisal findings

1.24 In a three-part process, participants in workshop 3 were asked to first 'qualitatively' appraise the possible options through facilitated group discussions, before independently and anonymously ranking and scoring each of the five possible options for a future model of care against the five agreed 'appraisal criteria' (Quality and Safety; Clinical Sustainability; Access and Choice; Financial Sustainability; and Deliverability).

1.25 In the ranking exercise, participants were asked to place the five options in order based on which they felt best met each criterion. Participants were then asked to score each of the five possible options separately against the five 'appraisal criteria'. Unlike in the ranking exercise, participants were able to give the same scores to several or even all options if they chose to, allowing them to indicate where they might view several of the options as quite evenly matched on one area, or where one possible approach was viewed significantly more positively or negatively than others.

1.26 It is important to view all aspects of the appraisal exercise as equally important, with the deliberative discussions - which themselves represent a continuation of earlier pre-consultation engagement - providing an equally important 'test' of the longlist of options as the quantitative ranking and scoring.

1.27 The proposed addition of assessment areas in Emergency Departments and 'hot clinics' at both acute hospitals in Options 2, 3, 4 and 5 was welcomed in the discussions as providing consistency and timely access to specialist care. Patients, it was felt, would find the addition of these services reassuring, while local GPs and their patients would benefit from faster access to specialist clinical expertise when needed.

1.28 In qualitative discussions, possible models of care in which all current acute cardiology services were either retained or built up at both acute hospitals (Options 1, 2 and 3) tended to be appraised poorly overall. While seen as desirable in 'an ideal world', these options were not viewed during discussions as clinically or financially sustainable, and therefore as undeliverable. This view was also evident in the other appraisal activities, in which Options 1, 2 and 3 were scored and ranked lower than other options against three of the appraisal criteria: Clinical Sustainability, Financial Sustainability and Deliverability. Against Access and Choice, however, Option 3 (building up services at both acute sites) was scored and ranked highest by two groups ('patients and patient representatives' and 'other NHS staff').

1.29 Separation of PCI elective and non-elective services to one acute hospital site, and EP, PPM and Devices to the other (Option 4) scored and ranked poorly against Access and Choice in comparison to other options, although somewhat better with the patient and patients' representative group. Against the other criteria it was generally scored and ranked similarly or slightly higher than Options 1, 2 and 3, but often with differences in opinion between the three stakeholder groups. In the qualitative appraisal, concerns were raised about the possibility of confusion and poor communication, and the potential need for transfers between sites and the resulting pressure on ambulance services

1.30 Co-location of all catheterisation laboratories and inpatient care onto one or other acute hospital site (Option 5) was viewed positively by all stakeholder types in the facilitated discussions, particularly in regard to meeting national guidelines and standards, and for recruiting and retaining staff. It was ranked and scored highest by all stakeholder groups (ESHT clinicians, other NHS staff, and patients and patient's representatives) in terms of Quality and Safety, Clinical Sustainability, Financial Sustainability and Deliverability. ESHT clinicians also ranked Option 5 highest against Access and Choice, and all three groups of stakeholders gave Option 5 the second highest mean scores against the same criteria.

Overall…

1.31 The outcomes of the options development and appraisal process reported here suggest that Option 5 could reasonably be taken forward to formal public consultation on the future of cardiology services in East Sussex. Whether or not other options are also included in proposals depends, in large part, on whether the key areas in which they scored and ranked poorly are able to be addressed and or mitigated. East Sussex CCG and ESHT will, however, need to take all other evidence into consideration in its decision-making processes around which options might be taken forward to public consultation.

2. Pre-consultation overview

Background

2.1 The NHS East Sussex Clinical Commissioning Group (East Sussex CCG) and East Sussex Healthcare NHS Trust (ESHT) are working to improve cardiology services across East Sussex. Acute cardiology services in East Sussex are delivered by ESHT at Eastbourne District General Hospital (EDGH) and Conquest Hospital in Hastings (hereafter 'Conquest').

2.2 Under the current acute cardiology service, there is a full range of outpatient and diagnostic services, inpatient beds, and catherisation labs for interventional procedures at both acute hospital sites. Outpatient and some diagnostic services are also provided at Bexhill Hospital, and it should be noted that these services at Bexhill would continue under all of the potential approaches considered in this report.

2.3 East Sussex CCG and ESHT acknowledge the need to substantially change the way acute cardiology services are delivered in order to provide clinically excellent, innovative, evidence-based patient care, which is also clinically, environmentally and financially sustainable. Several internal and external challenges and drivers for change, which must be addressed in any future service transformation, have been identified by East Sussex CCG and ESHT. These can be summarised as:

- **External challenges**, including increased demand for services from a growing, diverse and aging population which includes groups particularly impacted by health inequalities;
- **Internal challenges**, including those of recruiting and retaining adequate staff, ongoing difficulties in delivering the existing service model, and the need to ensure that ESHT estates and equipment are appropriate and available for the diagnosis, treatment and ongoing care for all patients;
- **National drivers**, including changes to the way that acute cardiology services are being delivered nationally by the NHS, changes to standards and guidelines, and to 'performance indicators' and targets, as set out by NHS England; and
- **Opportunities for improvement**, including increased sub-specialisation within cardiology clinical teams, updated IT and other digital solutions to enable multidisciplinary team working, and new service delivery models which make best use of all existing and new resources.

2.4 In light of these challenges and drivers, East Sussex CCG and ESHT believe that current acute cardiology service provision is no longer fit-for-purpose, and that the service in its present form is unable to continue to meet current and future demand and it is therefore necessary to explore options for improvements.

2.5 As part of the Transforming Acute Cardiology Services in East Sussex programme, East Sussex CCG and ESHT are undertaking extensive engagement with service users, their carers and families, clinicians, and other stakeholders. This was initially in the form of early involvement to inform the programme, followed by a more formal options development and appraisal process. It is these latter options development and appraisal activities which have provided the basis for this report.

2.6 Finally, East Sussex CCG and ESHT have a duty to consider any potential impacts on, and opportunities to address, inequality and health inequalities in relation to possible changes to acute cardiology services. Relevant feedback and other evidence were considered in discussions at the workshops and in the appraisal scoring and ranking, and additional feedback in this area was encouraged.

The commission

2.7 In early 2021, East Sussex CCG appointed Opinion Research Services (ORS) (a spin-out company from Swansea University with a UK-wide reputation for social research and statutory consultations) to advise on and independently manage and report the options development and appraisal programme.

2.8 The acute cardiology services transformation options development and appraisal activities undertaken by ORS on behalf of East Sussex CCG and ESHT comprised three workshops held over a three-week period in March 2021, as described below.

2.9 ORS would like to take this opportunity to express gratitude for the support from NHS colleagues and other community partners and stakeholder organisations to ensure the success of the workshops, as well as to all those individuals who contributed time and effort by taking part in the programme.

East Sussex CCG's pre-consultation activities with services users

2.10 Between 4th January 2021 to 14th February 2021, East Sussex CCG undertook a programme of pre-consultation engagement activities with local people and stakeholders to: communicate the need for transformation to acute cardiology services provided by ESHT; understand their experiences of current services; and gather feedback and ideas about how services might be delivered in the future.

2.11 There were two principal pre-consultation activities: the first was an online and paper questionnaire, promoted widely via existing engagement channels, bulletins and newsletters, via voluntary, community and social enterprise sector organisations (e.g., Healthwatch), posters, social media, and through East Sussex CCG staff members attending relevant forums and groups meetings. Specific work was undertaken by East Sussex CCG to reach out to those living in areas of deprivation and to the homeless and rough sleeper community. The second was a series of in-depth interviews with current and former patients.

2.12 The work undertaken by East Sussex CCG provided a strong foundation on which to build the formal programme of activities subsequently undertaken by ORS (see below). As well as providing valuable insights in its own right which helped to inform options development, the pre-consultation activities also helped to identify and recruit patients and patient representatives for the workshops (see below).

2.13 In all, 82 responses were received to the questionnaire, of which 20 were conducted as in-depth interviews with the responses being entered into the relevant open text response. These engagement activities are reported separately by East Sussex CCG (Appendix II), and some relevant elements of the feedback are covered in this report alongside feedback from patients and patients' representatives at the workshops.

Options development and appraisal workshops

2.14 Between 8th March 2021 and 22nd March 2021, three options development and appraisal workshops took place to identify and consider a longlist of possible options for future provision of acute cardiology services in East Sussex. The workshop attendees fell into four broad categories:

- Acute cardiology patient and patient representatives;
- Primary care clinicians and other NHS staff, including ambulance service staff ('other NHS staff');
- ESHT cardiology clinical leads and other acute clinical staff ('ESHT clinicians'); and
- NHS East Sussex Commissioners and ESHT managers ('NHS managers').

2.15 It should be noted that NHS managers (including those responsible for acute services and planned care, quality and safety, business and finance, strategy and transformation, workforce planning, patient transport, and patient and public engagement) attended to observe, to present key information to inform discussions, and to respond to questions when required. They *did not* actively participate in the options development and appraisal scoring and ranking activities and are therefore excluded from Table 1 below.

2.16 Particular effort was made by East Sussex CCG to ensure that service users' views were appropriately represented at the workshops, building on the extensive promotion of the pre-consultation engagement in January-February 2021, which included approaching cardiology outpatients at East Sussex hospitals directly to invite them to take part in the various engagement activities. All interview participants were personally offered the opportunity to take part in additional activities, including the workshops reported here. To further encourage participation, patients attended the workshops had the option of claiming £25 for each meeting under East Sussex CCG's Reward and Recognition policy.

2.17 Additional measures were taken to increase the 'patient voice' at the workshops; a Sussex Health and Care Partnership Community Ambassador[1] taking part in both discussion and the appraisal activities, and a member of East Sussex CCG's Engagement Team contributing to discussions by relaying feedback from pre-consultation engagement with patients.

2.18 The table below details the 'active' participants (i.e., those who took part in the options development and appraisal activities, rather than informing or observing them) across the three workshops.

Table 1: Workshop participants 'actively' involved in options development and appraisal activities

Stakeholder type	Number	Description (roles/organisations represented)
Patients and representatives	3	Service users East Sussex CCG Community Ambassador
Other NHS staff	3	Local GP South East Coast Ambulance service (SECamb) representative
ESHT clinicians	5	Acute cardiology clinical leads and clinicians/nurses

Workshops overview

2.19 The workshops (Table 2), while organised by East Sussex CCG, were independently chaired and facilitated by ORS researchers. ESHT and East Sussex CCG managers and senior clinicians presented relevant information to provide the context and background to the discussions.

2.20 The workshops also benefitted from the input of a Public Health Consultant who provided data and explanation around the demographic profile of the population of East Sussex, highlighting groups that might be consider at higher risk of cardiological health problems, and the prevalence of any risk factors at play (e.g., co-morbidity; lifestyle).

[1] Community ambassadors are volunteers recruited specifically to help the Sussex Health and Care Partnership, which includes East Sussex CCG, to understand the views of local people around key health and social issues. The role involves extensive first-hand engagement with members of the public, including users of specific NHS services, and providing a 'lay' perspective at a strategic level in Sussex-wide NHS programmes.

Table 2: Acute cardiology services options development and appraisal workshops held in March 2021

Workshop	Date/time	Description
1	Mon 8th March 13:00 - 17:00	**'Listening and engagement'** • Bridging from the pre-consultation engagement undertaken by East Sussex CCG into the formal options appraisal • Introducing the background and rationale to the transformation • Discussion around the clinical vision and priorities *and* patients' priorities for acute cardiology services in East Sussex • Initial discussions on how the need to address current and future challenges, meet national guidelines and standards, and to address clinical requirements and patients' needs, might require a balance or compromise to be found between different priorities **Key outputs** • Feedback from patients and patient representatives, primary care clinicians and other stakeholders to inform possible new models of care
2	Mon 15th March 13:00 - 17:00	**'Options development'** • Drawing on key themes and suggestions identified from pre-consultation engagement, feedback from Workshop 1, and information and data provided by East Sussex CCG and ESHT • Discussion about possible approaches to acute cardiology service provision, using suggestions from East Sussex NHS partners as a starting point with opportunity to explore additional ideas and approaches • Initial consideration of possible advantages and disadvantages, impacts and potential mitigations of each possible approach • Consideration of the implications of possible approaches in relation to the vision, priorities and challenges discussed in Workshop 1 • Brief introduction to the appraisal criteria to be used in Workshop 3 **Key outputs** • Feedback from patients and patient representatives, primary care clinicians and other stakeholders to generate a 'longlist' of possible approaches/options to be considered and appraised at Workshop 3
3	Mon 22nd March 13:00 - 17:00	**'Options appraisal'** • Summary of outputs from Workshops 1 and 2 • Discussion and agreement on the five appraisal criteria against which the longlist of possible options would be tested • "Qualitative" discussion/appraisal of each longlisted option for future ESHT acute cardiology service provision • Anonymous ranking and scoring of each longlisted option against the agreed appraisal criteria **Key outputs** • Feedback and data to inform shortlisting of options for consultation

Location options for acute cardiology services

2.21 It is the view of ESHT that possible options which might involve different services being delivered at either of the acute hospital sites in East Sussex (EDGH and Conquest) could be configured either way round. Furthermore, the likelihood is that, if such options were to be shortlisted for public consultation, both possible site configurations would be included for consideration and feedback. For this reason, participants at Workshop 3 were not asked to rank or score locations, but to focus on models of care.

2.22 It should also be noted that stakeholders were informed that outpatient care and some diagnostic services to continue to be delivered at Bexhill Hospital for the foreseeable future, under all possible options.

Options development and appraisal methodology

Purpose of options development and appraisal

2.23 Formal options development and appraisal activities are an important element of the process for developing any final proposals for changes to the way that acute cardiology services might be delivered in future. The workshops should nonetheless be viewed as just one element of a longer-term and ongoing dialogue in which stakeholders, including members of the public, have engaged with East Sussex CCG and ESHT about the way that NHS services are delivered.

2.24 It is important to note, therefore, that the outcomes reported here are by no means the only basis on which decisions might be taken about which options move forward to public consultation. Options appraisal is a useful tool to inform the shortlisting process, but it forms just one part of the evidence base which the relevant bodies will need to consider when making decisions.

Appraisal criteria

2.25 When different types of stakeholder come together to discuss and score or rank options against appraisal criteria, there can be both similarities and significant differences in opinions between individual participants *and* between stakeholder groups. Where there is divergence in opinion, it often reflects the way that different stakeholder groups prioritise different elements of the services and their delivery. For this reason, a mixed methodology was used to appraise the longlist of options, comprising:

- **'Qualitative' discussions** which drew out the reasons for which different individuals and groups held certain views, and particularly to identify and elaborate on any key factors or concerns; and
- A two-part 'quantitative' exercise to generate **rankings and scores** for each option.

2.26 In both the qualitative and quantitative stages of the appraisal, five 'appraisal criteria' (which were discussed and agreed upon at workshops 2 and 3) were used. These criteria are:

- **Quality and Safety**: quality of service, patient and staff safety and experience and delivery of good outcomes;
- **Clinical Sustainability**: how the service will be delivered now and in years to come, keeping in view the recruitment and retention of staff groups;
- **Access and Choice**: current and future needs, access to the right service at the right place at the right time, ensuring everyone has access to the service of their choice;
- **Financial Sustainability**: making the best use of resources now and in years to come and how efficient the service is able to be; and
- **Deliverability**: how the approach/approaches can be delivered in the short, medium and long term, keeping in view the model of care and the environmental footprint.

2.27 Each stage of the process above is covered in more detail in the Workshop Findings chapter. There follows below a brief explanation of the way in which the options appraisal outputs are presented.

Interpretation of the appraisal ranking and scoring data

2.28 In order to ensure that the views of any particular group or groups of participant stakeholders do not dominate the scoring and ranking outcomes from workshop 3, the results for each of the stakeholder groups (i.e., 'Patients', 'Other NHS staff' and 'ESHT clinicians') are presented separately). This approach also allows comparison and contrast between the views of the different groups.

2.29 The results for the opens appraisal ranking and scoring exercises are presented in tables and graphical format. The bar charts and other graphics show mean scores and ranking for each stakeholder groups, for each individual option against each individual appraisal criterion. For example, the mean score given by ESHT clinicians has been calculated as follows:

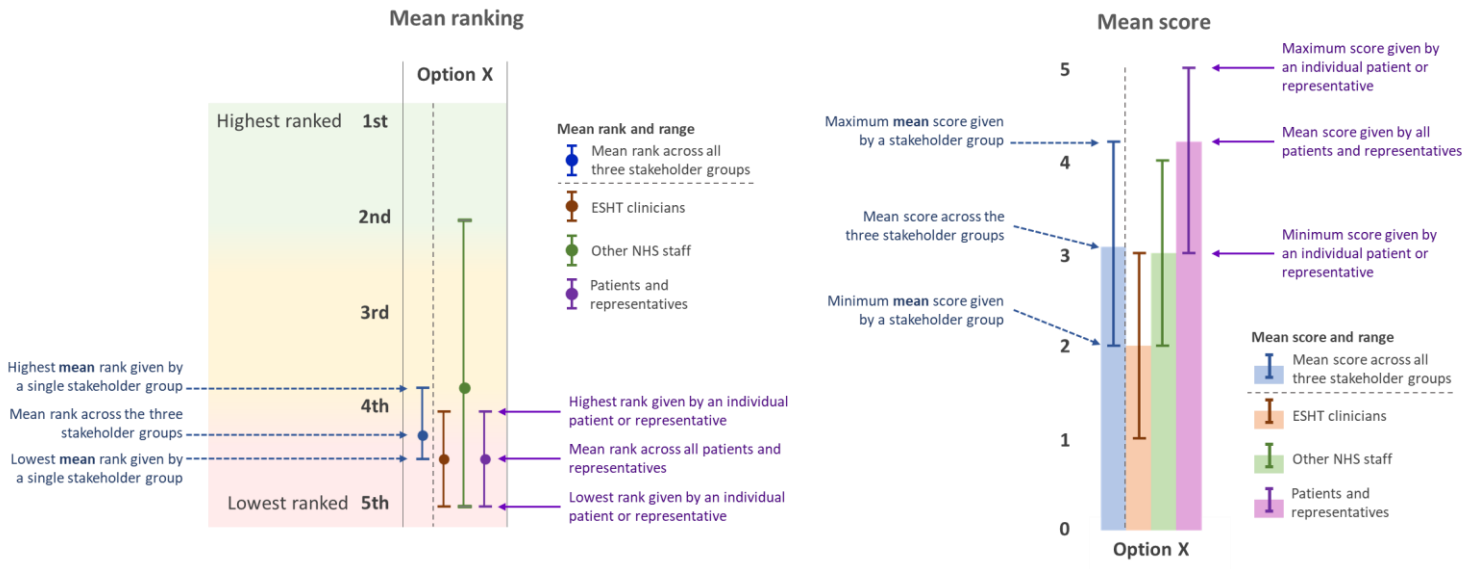
$$\frac{\text{Sum of scores given by all ESHT clinicians for Option 1 vs Deliverability}}{\text{Total number of ESHT clinicians}} = \text{Mean score by ESHT clinicians for Option 1 vs Deliverability}$$

2.31 To give an indication of the 'overall' view of all stakeholder types, and the calculation below was used. It should be noted, however, that in the Workshop Findings chapter below, the commentary focuses on the scores given by *each stakeholder type*.

$$\frac{\text{Mean score given by ESHT clinicians + mean score given by 'other NHS staff' + mean score given by patients and representatives}}{3} = \text{Mean score across all three stakeholder groups}$$

2.32 To indicate the extent of the range of opinions within and between stakeholder groups, min-max lines have been included on charts (Figure 1). In each case, the shorter the lines, the smaller the range of scores and therefore the more closely aligned the views of individual participants and/or stakeholder types.

Figure 1: Example of charts showing mean rankings and scores for options against one of the appraisal criteria



2.33 The colours of the charts have been standardised so that results for each stakeholder type or group are presented consistently. Patients and representatives in **purple**, other NHS staff in **green** and ESHT

clinicians in **orange**. The mean ranks and scores across the three stakeholder groups (the 'mean of means') is presented in **blue**.

Impacts of Covid-19 and mitigations

2.34 The ongoing coronavirus pandemic and subsequent lockdown and social distancing measures placed restrictions on the methods by which East Sussex CCG and ORS could engage with and involve stakeholders. Under normal circumstances, options development and appraisal workshops might be undertaken face-to-face. In the current programme, however, the workshops were held 'virtually' via the Microsoft Teams video-conferencing platform.

2.35 To allow for the possibility of technical issues related to the online format, clear joining instructions for each meeting were provided in advance, and telephone support by East Sussex CCG and ORS staff was available for those participants less familiar or confident with video conferencing software to help to ensure that those who wished to take part were able to do so.

2.36 The online workshop format worked well, and had the advantage that, without the need for travel to and from physical venues, a range of busy patient, community and clinical stakeholders were able to commit to attending all three workshops of 3-4 hours each, thus providing opportunity for detail and robust debate, and good continuity for the discussions.

The report

2.37 This report, rather than separating out feedback from each individual workshop, presents a thematic account of the feedback received and data collected through all three of the virtual events held in March 2021 and, where appropriate, refers to the pre-consultation engagement activities undertaken by East Sussex CCG. It first covers the outcomes from the deliberative discussions, before presenting and discussing the data collected from the ranking and scoring activities.

2.38 Verbatim quotations are used, in indented italics, not because we agree or disagree with them - but for their vividness in capturing recurrent or contrasting points of view. ORS does not endorse any opinions and statements made by individual participants but seeks only to portray them accurately and clearly.

3. Workshops findings

Qualitative feedback

3.1 The first (listening and engagement) workshop began with a comprehensive overview of ESHT's external and internal challenges, the national drivers for change and opportunities for improving services, which are summarised in the diagram below. Participants were asked whether they recognised these and whether they were reflected in their experience of the cardiology service.

There was broad recognition of the challenges and need for change

3.2 There was clear recognition of all ESHT's challenges, and particularly those around recruitment and retention, which apparently manifest to cardiac patients as *"frightening"* delays.

> *"Obviously there is a fundamental staffing problem that patients perceive as frightening delays. When it comes to cardiac there is inevitably a huge apprehension that you feel like your life's at risk of being snuffed out"*
>
> *"[Patients] get very frightened around the length of wait for appointments and that's an aspect that should be built into the case around why change is needed"*

3.3 One patient suggested that, in their experience of working to overcome such difficulties elsewhere, co-production between clinicians, patients and carers has been effective in developing solutions.

> *"Staffing recruitment and retention is really big problem. And when I've been involved in this sort of thing elsewhere it can be helpful to use the model of co-production. It can be helpful to have patients' and carers' input to try and help tackle the issues. This is something I can highly recommend in cardiology"*

3.4 An ESHT clinician also drew attention to the importance of national standards in driving service quality and improving patient experiences.

> *"My focus is drawn to the national standard. When you talk about quality of service, it's these that drive that forward … National guidance and standards are things that we have to deliver and with that comes a higher quality and in some regards the patient experience…"*

There was support for the clinical vision for acute cardiology and for ESHT's priorities and considerations

That cardiology service in East Sussex will deliver:
Clinical excellence and quality
Innovation in delivery of cardiology services
An improved service
Clinical and financial sustainability

3.5 There was general agreement in the listening and engagement workshop that the clinical vision for acute cardiology as above is appropriate, but that more consideration may be required 'around the edges' – especially with respect to communication between clinicians and patients in both acute and primary/community care, and support for patients as they leave the acute service.

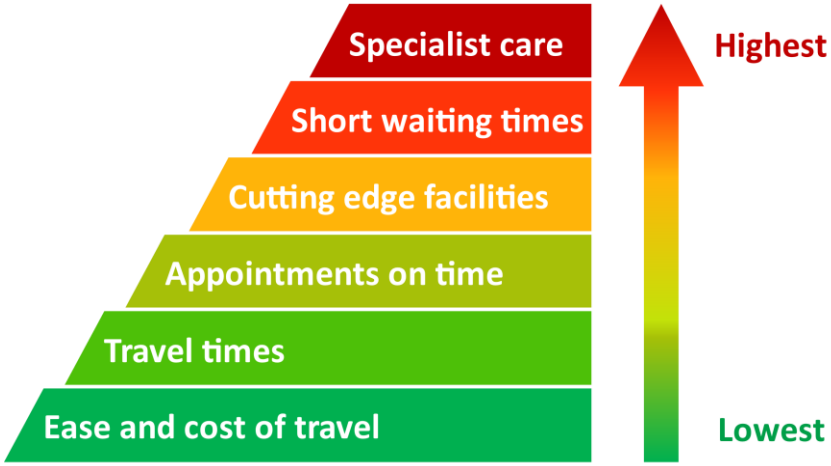
> *"I don't think there is anything essential around the core vision for an acute cardiology service missing but it's the stuff around the edges like communication with community care, primary care etc. And the importance of supporting people who have used cardiology as they transition back out to care in the community"*

3.6 ESHT's priorities and considerations (as below) were also supported, including that ESHT's acute cardiology services should be high quality, accessible, and delivered in a timely and equitable manner for all patients, serving the needs of the local population.

Quality:	Excellence; Safety; Timeliness; Equity; Equality
Clinical:	Best practice; Clinical outcomes; Staff support/development
Premises/Equipment:	Quality; Accessibility
Flexibility:	Responsiveness; Future-proofing
Staffing:	Expertise; Numbers; Recruitment; Retention
Value:	Viability; Sustainability; Value for money
Engagement:	Patient and public involvement; Co-development

Quality of care is most important to cardiology patients

3.7 The pre-engagement undertaken by the East Sussex CCGs with 82 residents/patients/carers and family members across the county showed that when asked to rank six priorities around service provision, those relating to specialist care provision, short waiting times and cutting-edge facilities were ranked highest[2].



3.8 This was endorsed at the listening and engagement workshop, where it was said that:

> *"It's about getting to the right people at the right time and getting the right clinical treatment at the right time. That does capture that"*

An 'ideal' cardiology service has several facets

3.9 When asked, patients and their representatives suggested several aspects of an 'ideal' cardiology service in the listening and engagement workshop.

3.10 Patients at these workshops and those responding to East Sussex CCGs' pre-engagement exercise agreed that good, joined-up communication between themselves and healthcare staff is key – and that any such communication and information must be easy to understand and accessible to those who currently 'slip through the net' (co-production activity was again suggested in this area). Patients who cannot communicate as effectively with their clinicians, those who are digitally excluded, and the elderly were mentioned in this context.

> *"Ensuring communications are easy read and can be understood. Checking patients' understanding; asking, 'Do you know what I have said to you?' Because they might be like, 'Yeah, yeah, yeah' but not understanding a word you're saying and too afraid to challenge you. Making sure communications are clear and easy to understand … that's a co-production piece of work"*

[2] Caution is required in the interpretation of these results as there were only six priorities to choose from, the respondent group was a relatively small one, and it is impossible to tell the 'distance' between the ranked priorities (i.e., how important each was relative to the others).

"… Some elderly and less information confident have concerns … those from deprived circumstances don't always have access to mobiles etc. [and] most digitally excluded people are likely to be at higher risk of poor outcomes. So, you need other options for those people"

The majority of patients are happy but some fall through the net … the ones who aren't so confident … aren't online, who perhaps don't have such a good relationship with their GPs …"

3.11 Moreover, communication between community/primary and secondary healthcare services was also considered essential by workshop and pre-engagement participants in offering the seamless service patients desire, particularly with respect to the reasons for and possible implications of diagnostic and treatment delays. This was thought to be especially important for cardiac patients, who often feel that they are in life-threatening situations and are reassured by regular communication from their healthcare providers.

"The … thing which is important in any service industry is joined up-communications. You get people saying, 'My GP didn't know this, my specialist said x …'"

"… What patients feel is that they are in a life-threatening situation when they have cardiac problems and what they are looking for is something that feels like it's running like clockwork … joined-up communications between Specialists, GPs and patients"

"Even when people are having a pacemaker checked, if those things aren't done on time … cardiology really is a service where any kind of pauses and gaps worry people. If you are having to delay something, then let them know and reassure them…"

"I recently had cardiac problem and I'm now down to have an ablation. But I don't know when and that is quite stressful … It would be reassuring and comforting if when you leave the inpatient department you are told, 'You'll hear within six weeks' or whenever … some timeframe in there. And if that's going to be missed that the patient is kept informed about what's going on"

3.12 Indeed, this was something that also came through strongly in East Sussex CCGs' pre-engagement work, with participants stating that they felt anxious, sometimes even that their life was on the line, in the event of delays and a lack of communication. On the other hand, those who reported positive communications spoke of how their clinicians had taken the time to build a relationship with them, listen to their concerns and explain their situation carefully. Again, the word 'clockwork' was used by those who reported good experiences of the cardiology service in East Sussex.

3.13 One participant offered a specific example of what they considered to be poor communication between a fellow patient and their clinicians, which had led to unnecessary anxiety for the former.

"Who is responsible for the ongoing care of a patient with a complex heart problem? … My friend has been under the care of a [private] hospital but is no longer able to access private care. The GP decided she should be known to cardiology in Eastbourne, so she was referred to the local hospital. She saw a consultant and he then sent her back into the care of the GP. She feels very scared about that … with her problems she felt she wanted someone from the hospital as a point of contact. The question is who leads on these things, is it the GP or the cardiology department?"

3.14 The clinicians present explained that GP care was appropriate in this particular case, while acknowledging that better communication would have helped alleviate unnecessary worry.

> *"It is clear there is no clinical need to follow up in this instance, but articulating this is the key bit"*
>
> *"I wonder if this was not communicated to your friend and that is where the issue lay? If the explanation had been given, perhaps they wouldn't have been worried"*
>
> *"This reinforces some of things we've heard … about communication. There are so many pathways, all of which are clinically valid, but it's how that's communicated to the patient. There is a big bit of learning around how this is done"*

3.15 Communication at- and post-discharge was frequently raised as a seemingly problematic issue (both at these workshops and during East Sussex CCGs' pre-engagement work). Patients and their representatives commented that it is difficult for many people to absorb and understand what they are being told in the often-stressful discharge situation.

> *"Some patients are very confident, cluey, knowledgeable etc. … they can speak very well with their consultants etc. But others fall through the net when it comes to communications at discharge, and I don't think there is an absolutely standard way of issuing all the various communications at discharge…"*
>
> *"I have nothing but praise for the way the staff went out of their way to make sure I was looked after on the ward. It happens when leaving after that. It is surprising that as a patient you get told something by a consultant and a nurse and it goes out of your head once you're out of the high-stress situation and this does concern me"*
>
> *"It's all about communication. I have been … a patient in a number of different hospitals. Recently when I had to visit inpatient in Eastbourne, one thing that really impressed me was the human attention people gave patients. It has changed a lot which is great. But when people get discharged …They don't always remember what's going on and sometimes they are overwhelmed"*

3.16 This can then be exacerbated, in some cases, by a lack of GP follow-up – leaving patients (especially those without a specialist nurse contact) anxious as they await further communication.

> *"The two facets … first, what you get told by the hospital department on discharge. But they also write to GPs and there is a problem with GPs who don't contact patients, who can be left for weeks and weeks without hearing … about something they've been scared about. They just need to be able to speak to someone"*
>
> *"Th[is] has identified a gap for the general cardiology patients who don't have specialist nurse follow-up"*

3.17 Ultimately, it was said that:

> *"You're much better at communications than you used to be, but there's a long way to go yet"*

3.18 Being mindful of equality and diversity impacts was thought to be another essential component of an 'ideal' service. Proactive offers of reasonable adjustments were strongly urged, as was a system whereby healthcare providers are aware of patients' communication needs in advance of appointments (particularly important for those with autism and/or learning disabilities).

> *"It's important to think about reasonable adjustments … They are by law obliged to offer those, but they are not offered proactively. So, if you get a letter for a hospital appointment but it doesn't say, 'If you need any help with anything, communication or mobility, ring this number and we'll sort it out for you'. What that means for me is that I get really upset about it beforehand. When you get there, they're absolutely lovely and accommodating and will do anything for you, but to take that worry away beforehand, that would be really nice, especially when you talk about cardiology and stress not being a very good combination. It's just a little thing of being able to communicate clearly and proactively reaching out"*
>
> *"People with learning disabilities … would very much like the hospital to already be informed about individual adaptions that are needed so again. Sensory issues for autistic people for example. So again, it's about streamlining communications within individual care"*
>
> *"Is there a system to flag considerations for individuals – autistic, sensory sensitivity etc. Is there a facility for doing this? How much of this type of information is already known to the patient's GP? Often it is the GP who will have that level of knowledge, making sure that level of granular detail is being passed on"*

3.19 More widely, the need to consider access not only in a physical sense but also in a psychological and environmental one for people with neurodevelopmental conditions was stressed. An 'ideal' service would thus be one that is designed to accommodate the needs of those with autism for example.

> *"When you say access, I am reading it as just physical access [but] here is more than one definition of the word access and this should be considered and clarified … There are neurodevelopmental conditions like autism where accessibility is partly about physical accessibility but also about the design of a place in terms of lighting, seating arrangements, appointments at specific times etc."*
>
> *"Access is important in terms of the physical and psychological, but it should also be in terms of environmental considerations"*

3.20 Moreover, being mindful of deprivation was said to be especially important in relation to cardiology given the greater prevalence of cardiovascular disease within deprived communities – as well as typically later presentation, reduced take-up of prevention and early intervention activity and residents' difficulties travelling further to access services.

> *"The prevalence of cardiovascular issues in more deprived communities and the implications of this in terms of people's ability to travel. We need to hold this in our minds"*

> *"We have to bear in mind where our greatest areas of deprivation are as this is where the highest levels of prevalence will sit. This is where you will have more people with cardiovascular problems, who are more likely to present later and be brought in as emergency patients. They are also least likely to take on board screening and lifestyle advice … these are the people we need to reach to make a population health difference to cardiovascular disease in this part of the world … If we are successful in those communities, we should be successful everywhere else…"*

3.21 Other aspects of an 'ideal' cardiology service were that it: offers a multi-disciplinary 'team around the patient' approach; and is accessible in considering travel and transport needs, especially for visitors.

> *"What are your plans for further developing MDTs? I'm thinking about the difficulty of having input from different specialism into one patient. I've done some work looking at ICU and that's where it's really important to have that multi-disciplinary team in place, around one table, for the patient to provide the best possible outcome. How do we develop this further?"*
>
> *"Travel is going to be very important. It's very important for the psychological wellbeing of patients who are recovering from operations and are frightened to have the people who love them around. Under normal circumstances that is part of their recovery. Don't underestimate the therapy of families!"*

3.22 With regard to the latter point, imaginative travel and transport solutions were thought to be needed – such as shuttle buses and 'outside the box' approaches to getting patients home.

> *"What you keep imagining is some sort of wonderful shuttle bus, which is probably not financially viable, but it would be great to know that, say, twice an hour there's a bus that'll take you to the Conquest or wherever it is"*
>
> *"Recently I had major surgery at Guy's Hospital, and I had a taxi home from there to Eastbourne. That happened on two occasions which rather threw me because here … I was talking to a patient to his 80s who had come into the DGH with a suspected coronary and he was going to get the bus home … He needed a lift home but was too proud to ask. I don't know if we have the budget to extend the getting home service to needy people"*

3.23 Finally, although not within the remit of the acute service primarily being considered as part of this engagement process, participants were keen to stress the importance of prevention activity and equity of access to primary and community care to improve population health and reduce acute service demand (an issue also raised by participants in East Sussex CCGs' pre-engagement work). It was, though, acknowledged that this is likely to be a long-term aspiration.

> *"The big one that is fantastically important is prevention. When you look at the stats for alcohol and smoking, that's a huge subject. And it's not simple things; it's quality of life, health inequalities. Prevention is something crucial"*

"Agree with comments about importance of prevention. But also aware that there is cohort of population who already have cardiac needs (whether recognised or not), and will need cardiology services in the short/medium-term. Long-term aspiration for population health is to hugely reduce disease through reduction of risk factors, but sadly, it's not going to be putting cardiology out of business (yet)"

"In an emergency situation I want clinical equality for patients everywhere … But the vast majority of patients are managed electively or semi-electively, and to address that sort of inequality is where you make more progress with population health. So, it's about providing equity of access, especially at primary and community level, if we want to improve the health of East Sussex … access for those patients who might be put off by having to travel somewhere"

A future model of care - qualitative appraisal

3.24 Various potential models of care were discussed at workshops 2 (options development) and 3 (options appraisal). The qualitative views that emerged in discussion across both have been amalgamated in this section, which is followed by the results from workshop 3's options scoring exercise.

3.25 Note that *all options* include outpatients and some diagnostic services at Bexhill Hospital as at present.

Potential models (Options) 1, 2 and 3

OPTION 1 - Retain current services

Retain current service model

Outpatients and diagnostics continue across both acute sites

	Site 1	Site 2	BX
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients	✓	✓	✗
Interventional Procedures (In Hours)	✓	✓	✗
Interventional Procedures (Out of Hours)	✓	✓	✗
Cardiology Assessment in A&E	✗	✗	✗
A&E Follow-Up Clinics (Hot clinics)	✗	✗	✗

OPTION 2 - Same both sites with assessment area at both front ends

Retain current service model…
… plus assessment areas in A&E
… plus Hot Clinics at acute sites

Outpatients and diagnostics continue across both acute sites

	Site 1	Site 2	BX
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients	✓	✓	✗
Interventional Procedures (In Hours)	✓	✓	✗
Interventional Procedures (Out of Hours)	✓	✓	✗
Cardiology Assessment in A&E	✓	✓	✗
A&E Follow-Up Clinics (Hot clinics)	✓	✓	✗

OPTION 3 - Build up both acute sites

Retain current service model…
…plus assessment areas in A&E
…plus Hot Clinics at both sites
…plus both acute sites providing PPCI cover out-of-hours

Outpatients and diagnostics continue across both acute sites

	Site 1	Site 2	BX
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients	✓	✓	✗
Interventional Procedures (In Hours)	✓	✓	✗
Interventional Procedures (Out of Hours)	✓	✓	✗
Cardiology Assessment in A&E	✓	✓	✗
A&E Follow-Up Clinics (Hot clinics)	✓	✓	✗

3.26 There was general agreement among patients/patient representatives and stakeholders that none of these approaches are feasible except *"in an ideal world"* as they are clinically and financial unsustainable, and generally undeliverable.

> *"Looking at the five options from a logical perspective, the first three need to be disregarded straight away because you don't have the staff, you are unlikely to recruit the staff and they won't meet national guidelines … options four and five seem more solution-focused"*
>
> *"The bottom line seems to be that this option is just not clinically sustainable … It's financially unsustainable too"* (Option 1)
>
> *"Not deliverable"* (Option 2)
>
> *"Option 3 … is that a realistic possibility or can we dismiss it as there's not enough money around?"* (Option 3)

3.27 The ESHT clinicians present agreed, citing unaffordability, unsustainability and the inability to meet national standards (particularly in terms of procedure numbers per site and per individual clinician).

> *"There is a deteriorating picture in terms of the cost and it's important to consider sustainability. It is currently running at a £4million cost deficit … we need to consider affordability"*
>
> *"With progress in medical science and the availability of different highly specialised procedures, physicians develop very specific skillsets. To maintain a high level of expertise there are minimum requirements we have to fulfil to be able to provide those … The way things are at the moment with services scattered across two sites … the density of individuals on both sites is such that we are struggling to maintain services at the required level, especially with the growth of patient numbers and having to deliver a 24/7 service. Also, when we are being appraised on being able to deliver the number of required procedures per interventional site, we are not fulfilling those numbers either"*
>
> *"Seems attractive to all. But … the workforce makes this unlikely to deliver with the financial challenges. It would be expensive"* (Option 3)

3.28 More specifically, ambulance service representatives said that the current (pre-Covid-19) model of out-of-hours interventional procedures alternating between sites weekly has caused some confusion and risk as patients have occasionally being taken to the wrong location.

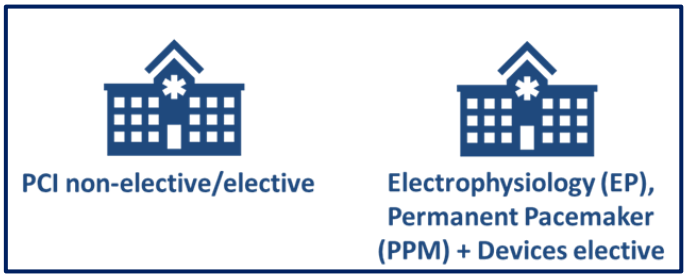
> *"As long as you have got alternating sites out-of-hours, that leaves room for confusion and taking patients to the wrong site and that has happened several times. Once every six months we would take the patient to the wrong site … inevitably this will happen, and the patient is put at risk"*
>
> *"What happens now in the alternating scenario … SECAmb will take patients to the correct site as they know which site is on this week, but inevitably mistakes might happen"*

3.29 It should, though, be noted that the 'Hot Clinics' proposed in Options 2 and 3 (and also in Options 4 and 5 below) were supported in offering patients fast and smooth access to care.

"The hot clinics will allow GPs to have access to faster opinion, which makes the process smoother…"

"Hot clinics seem to be an interesting intermediary bridging service which could be reassuring to patients. They seem to be able to do a lot of diagnostic work … it sounds like a brilliant solution for patients' need for 'clockworkness' and communication"

Potential model (Option) 4: PCI on one acute site and EP on the other acute site



'Plumbing' (PCI non-elective/ elective) on one acute site

'Electrics' (EP, PPM & Devices) elective on other acute site

Outpatients and diagnostics continue across both acute sites

	Site 1	Site 2	BX
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients	✓	✓	✗
Interventional Procedures (In Hours)	✓	✓	✗
Interventional Procedures (Out of Hours)	✓	✗	✗
Cardiology Assessment in A&E	✓	✓	✗
A&E Follow-Up Clinics (Hot clinics)	✓	✓	✗

3.30 Patients/representatives viewed this model of care as potentially confusing, with the prospect of disjointed communication and people 'slipping through the net'.

"From a patient perspective … it feels to me this could be a recipe for muddle and confusion. Patients have been talking about joined-up communications, and I just sense an opportunity for things to slip through the net without there being terrific advantages"

3.31 The ESHT clinicians present felt that this model would help address some but not all of the Trust's challenges, especially those around staffing and adherence to national guidelines.

"Option 4 gives a resolution to some of the problems. It's a better way to adhere to national guidelines and it does provide the expertise in a more focused way. There are downsides … some of our staffing issues cannot be resolved. It might be easier to manage in terms of the consultant workforce where more sub-specialties can be condensed on one site … but we still don't have futureproofing of staffing in other clinical areas including radiography, physiologists, larger numbers of nursing staff needed to maintain departments on two separate sites…"

> *"The guidance [is] that we have to have angiographic facilities and opportunities for PCI in the catheter labs … and we wouldn't be able to offer that wholly. You would need an interventionist on stand-by to help you out. It is a scrappy way of dealing with it"*

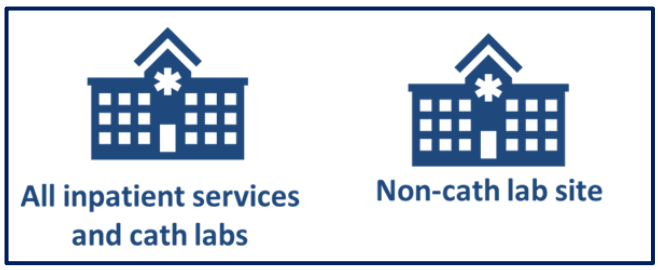
3.32 Furthermore, ambulance service representatives were concerned that a split-site model such as this would necessitate more cross-site transfers and place SECAmb under unsustainable pressure – and strongly urged that this be taken into consideration when making decisions about future service models.

> *"Inter-facility transfers account for about 2% of SECAmb's overall activity [and] if you have a model which is doing two different things on two different sites and needs regular inter-facility transfers … it is going to put more pressure on ambulances which may not be sustainable going forward…"*
>
> *"Can I make a plea that any option that involves transferring patients between two sites … needs to be futureproofed in terms of the ambulance service and ensures we can sustain emergency transfers between sites in a sustainable manner"*
>
> *"From the ambulance service perspective, if you split services over two sites you will inevitably have to transfer some patients from one site to another. It is a plea to include this into your thinking. We already do a lot of intra-hospital transfers between the two sites and this inevitably adds delays and costs into the system. Often (especially over winter) we do not meet our Category 2 response times which means those patients are going to be delayed and commissioning is going to have to include any additional conveyances. This should be kept in mind when looking at these options"*

3.33 Indeed, this worry was echoed by an ESHT clinician, who stated that:

> *"Patients often need invasive angiography and electrophysiology/pacing procedures during the same admission, so potential for multiple cross-site transfers!"* (ESHT clinician)

Potential model (Option) 5: co-location of catheterisation labs & inpatients to one acute site



PCI non-elective + elective on one acute site
Electrophysiology (EP), Permanent Pacemakers (PPM), and Devices on the same acute site as PCI
Outpatients, diagnostics continue across both acute sites

	Site 1	Site 2	BX
Outpatients	✓	✓	✓
Outpatient Procedures	✓	✓	✓
Diagnostics	✓	✓	✓
Inpatients	✓	✓	✗
Interventional Procedures (In Hours)	✓	✗	✗
Interventional Procedures (Out of Hours)	✓	✗	✗
Cardiology Assessment in A&E	✓	✓	✗
A&E Follow-Up Clinics (Hot clinics)	✓	✓	✗

3.34 For the ESHT clinicians present, this model of care would be optimal in helping the Trust overcome its workforce challenges, and would meet national standards around procedure numbers.

> *"Strength is in numbers, and by having a unified unit where we can combine our forces it is a more effective way for us to work. And maintaining the [procedure] numbers allocated to each individual is crucial for us to sustain our survival"*
>
> *"It's about volume of procedure as sites delivering the work and as an operator performing the work. It is clear we are struggling to meet those volumes in the current model. The future model needs to be robust and future-proof in getting the numbers we need to perform the complex cardiac procedures"*

3.35 Clinicians also argued that this option would actually reduce health inequalities and improve access inasmuch as the patients who require it would receive specialist healthcare much faster than they do currently – even in the event that they have to travel further for it.

> *"… with this model, it improves access to healthcare and would make health inequalities less. We are providing the care faster, improving quality of care through more expertise and as an inpatient you are getting faster care within 24 hours. There are two sides to health inequalities, the travel element has to be balanced against prompter, high quality care"*

3.36 There was also strong support for the co-location of catheterisation laboratory services among patients, representatives and other NHS staff. This option, they felt, would aid recruitment and retention through the co-location of specialities and specialists in a centralised facility, enable senior-decision making at the earliest possible stage, and generally improve service provision and patient outcomes.

"On the single site you have to have the best possible service. If you don't offer clinicians enough work and enough interesting work, they won't come here - and if you don't have the right people you don't have the best service. I understand the issues around time but equally if you don't have the people you can't deliver the service"

"If you know which place you're going to work at, rather than it changing the whole time, and thinking about different specialisations, it makes more sense to me to have one site …"

"It's better from a clinical point of view that the services that need to be co-located are next to each other or are in the same place … the catheter lab and the EP suite"

"There is a clear case for why we need a single site; you want the most senior person delivering the advice and care"

"You are going to a site where there is lot of senior support … There is a lot to be said for more senior decisions being made in a supportive way so that the right thing does happen the first time round"

3.37 SECAmb representatives were also of the view that co-location would ensure the service is able to 'get it right first time'.

"I think PCI on one site is a strength … as this is unplanned and an emergency and you want to get it right first time…"

"From an ambulance service perspective, the less chance for confusion the better…"

3.38 There were, though, concerns around travel and access (as there were during East Sussex CCGs' pre-engagement), particularly for those living on the periphery of the county.

"If you have a single site it's going to make it more difficult, especially in a county like East Sussex, for some people to get there…"

"I do believe the travel issues around one site would worry someone who lives near the coast. A lot of people, including myself, live in more rural areas and we always have to travel for anything"

3.39 Indeed, participants anticipated that if a co-location model is proposed, the public and patients will be most 'excited' by the issue of travel time/distance in an emergency.

"The public will worry about the one patient travelling far in emergency"

"… On an individual basis I'd be concerned that there will be a patient in Rye that needs to get to Eastbourne; could there be someone in Seaford that needs to get to Hastings? … I am thinking about where it is time critical and where we need quick intervention"

"The big thing with co-location on a single site is that it is emotive, as if someone needs the services we're talking about, it will be happening in an emergency situation. And this is where people get a bit more 'excited' about it because you're talking about time could be heart muscle for example. Single siting is fine for elective or semi-elective procedures etc. but when we're talking about acute intervention then travel time … may be critical to get into the lab"

"I understand that those needing the specialist emergency intervention is the minority, but thinking about how patients feel emotionally, that's what they think is the main thing"

"From a public perspective they will focus on these emergency examples although the data shows it is small minority. For an individual patient, the implications for them is all they and their relatives are going to care about…"

3.40 In light of this it was said that East Sussex CCGs and ESHT will need to properly and carefully communicate its clinical strengths and benefits to mitigate against travel and access concerns – not least the prospect for cardiac specialists 'at the front door' (i.e., in A&E), faster senior clinical input and simply being in the 'right place at the right time'.

"I completely understand the arguments for a single site; it makes complete sense. But you always have to bear in mind that patients are going to be concerned about time and distance. So, you have to be clear in your mitigation that there will be cardiac specialists at the front door wherever you go. There needs to be clear communication of a strategy of how cardiology is going to be delivered in this area and why you're not going to be left ten minutes short"

"… it's frightening for someone who is living beyond Eastbourne and has to get to, say, Conquest when the roads aren't good etc. You can kind of get round that if you have the massively important mitigation of acute cardio at the front door because that's what people are frightened of; that the ambulance is going to be late, that they're not going to get the specialist care they need"

"Public engagement with all the facts and clinical advantages of each option is vital, especially the advantages of specialism even with longer journeys"

"The key to this is good PR work in explaining that where patients end up is where's best for them and that should be the main concern … There is a reluctance to go to travel … but if you can sell it on the clinical advantages side, that is a strong point"

"Talking to patients' relatives, they want their loved ones to get to the right place to get the right treatment, even if that presents some difficulty and inconvenience for them in visiting"

3.41 Moreover, informing people about available transport and access solutions (including digital and community-based alternatives to face-to-face hospital care) will, it was said, be crucial in obtaining public support and overcoming travel concerns.

"What we do have in a lot of rural GP surgeries is a voluntary service where people who can't travel on public transport get taken to hospital and various appointments. It's important to remember this service is there and free and should remove quite a big barrier"

"In a previous workshop there was a comment about a free travel and transportation service. Of course, this all needs to be primarily presented as what it is, a much better service for patients, but there should also be communication about the transport available for relatives to go and see them"

"During the Covid pandemic due to reduced access for visiting, virtual visiting has been used via iPads on the wards for patients to contact their relatives"

"What we have learnt is a lot of our work is going to fall into the digital sphere and that the physical need for patients to travel to hospital to get an opinion will reduce … The way we work is going to change, meaning many patients will get faster decisions and more contact without the need to travel … This is all coupled with the community service, so in Rye Hospital there is an opportunity to have local outpatient services, there are community cardiology specialist on the Hastings patch and community cardiology projects. There are opportunities we already have to bring things closer to patients"

3.42 It should be noted, though, that responses to East Sussex CCGs' pre-engagement were mixed around moving to video and telephone appointments due to COVID-19: some participants found the remote communication convenient, whereas others complained that their appointments felt rushed and did not offer as much detail as they may have received during a face-to-face appointment. This will need to be borne in mind if the use of these alternatives is to continue in future.

3.43 Other suggestions around information provision were around the need to: ensure people are aware that this option will affect only the small proportion of patients requiring very specialist care; emphasise the benefits of proposed changes to the far more widely used elective cardiology service; and to stress that the cardiology service will still be delivered across two sites.

"Hopefully most people won't need to have multiple acute interventions so it's about understanding the proportion of time people need to be in the really specialist bit and the amount of time they need a good general cardiology service as they're recuperating. I think it would help people to understand the impacts more"

"A lot of cardiology activity is elective or semi-elective. So, it's more about chronic disease management or planning inserting pacemakers etc. But because cardiology is so emotive it is much more often associated with emergencies. But that is a small proportion of people"

"It's important that we get across that this is about redesigning a whole service and making it better so that wherever patients go there will be specialist cardiologists, hot clinics … and that it's only the small number of interventions that'll be at the one site if it's the way it pans out"

"There has been a strong focus on non-elective … but that is just one part of a much bigger service … there is a danger of focusing so much on that, and forgetting about the much higher number of elective or semi-elective patients"

"We have to talk about it as a whole service. Emotionally, people will focus on the emergency situation…"

"It's emphasising that we are not losing cardiology from one site to the other, just proposing changes to how interventional procedures are run"

3.44 Finally, clinicians highlighted that this proposed model of care has already been operating during the Covid-19 pandemic (with the catheter labs co-located at EDGH) and that national targets have been met. This information, it was said, should be widely communicated to alleviate any concerns the public and patients may have if the option is taken forward to formal consultation.

> *"We have a kind of 'proof of concept' for this model, in that a similar system was utilised during the first wave of the Covid pandemic (co-location of catheter labs to the EDGH site on this occasion), and seemed to work effectively"*
>
> *"It is worth emphasising in communications that you have already tried and tested this system of single siting and are meeting national targets. A lot of this will be overshadowed by, 'I may need emergency care and I'm going to have to travel much further for it' so in terms of that clinical equity it's about pointing out that the person in Rye isn't getting rough deal because those targets are being met"*
>
> *"We need to re-emphasise that people are travelling out-of-hours to the opposite sites in 'normal' times and that during Covid they've travelled to one site. For the last six months to a year, we've had a trial run of one of these proposals, knowing that it works well"*

3.45 Ultimately it was said that:

> *"Communication is going to be the key to this. Whatever comes out needs to be communicated in a way the public understand and in a way they can access it to understand it"*

A future model of care - appraisal ranking and scoring

3.46 In workshop 3, participants were asked to rank and score each of the five possible options for a future model of care against the following five 'appraisal criteria' (which were discussed and agreed at workshops 2 and 3).

- **Quality and Safety**: quality of service, patient and staff safety and experience and delivery of good outcomes;
- **Clinical Sustainability**: how the service will be delivered now and in years to come, keeping in view the recruitment and retention of staff groups;
- **Access and Choice**: current and future needs, access to the right service at the right place at the right time, ensuring everyone has access to the service of their choice;
- **Financial Sustainability**: making the best use of resources now and in years to come and how efficient the service is able to be; and
- **Deliverability**: how the approach/approaches can be delivered in the short, medium and long term, keeping in view the model of care and the environmental footprint.

Location options for acute cardiology services

3.47 It is the view of ESHT that possible options which might involve different services being delivered at either of the acute hospital sites in East Sussex (EDGH and Conquest) could be configured either way round. For example, Option 4 could see:

- All PCI elective and non-elective services delivered at EDGH, and Electrophysiology (EP), Permanent Pacemakers (PPM), and Devices at Conquest Hospital; **or**
- The same option could see PCI services delivered at Conquest and EP, PPM and Devices services delivered at EDGH.

3.48 Furthermore, the likelihood is that, if either Option 4 or Option 5 were to be shortlisted and taken forward to public consultation, both possible site configurations would also be included for consideration and feedback. For this reason, participants at Workshop 3 were not asked to rank or score possible options for locations, but rather to focus on the models of care.

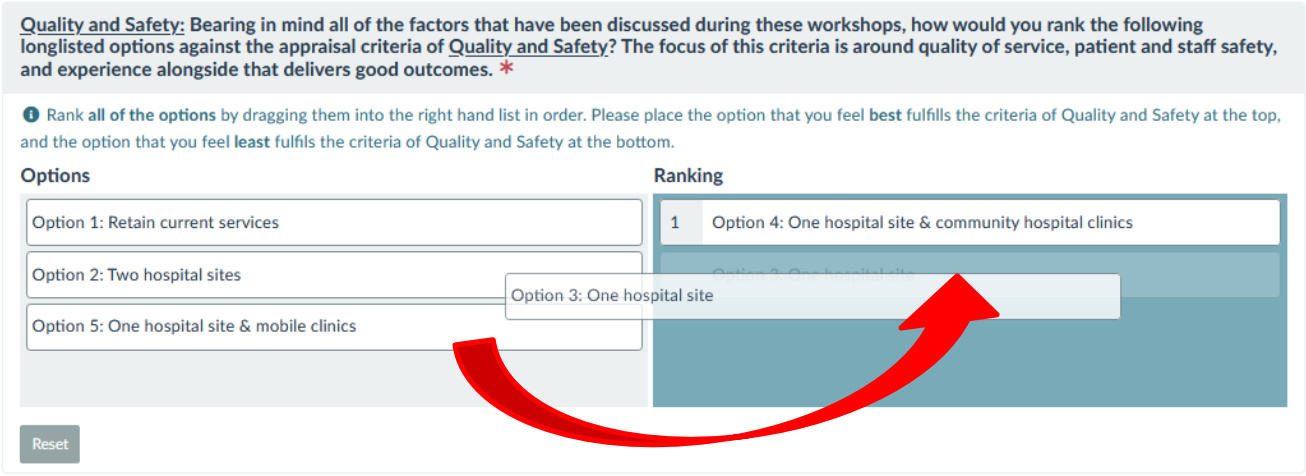
Acute cardiology services at Bexhill

3.49 As was the case when discussing possible options for acute cardiology service provision in East Sussex, participants were reminded that under all of the longlisted models, outpatient care and some diagnostic services would continue to be delivered at Bexhill Hospital.

Model of care options ranked against appraisal criteria

3.50 This activity was undertaken by participants either during, or shortly after, workshops using a short online questionnaire (designed and hosted by ORS) as in Figure 2 below. Participation was limited to individuals who had taken part in Workshop 3 in order to ensure that everyone had heard the same information before undertaking the exercise.

Figure 2: Example of appraisal criteria ranking question as completed by workshop 3 participants

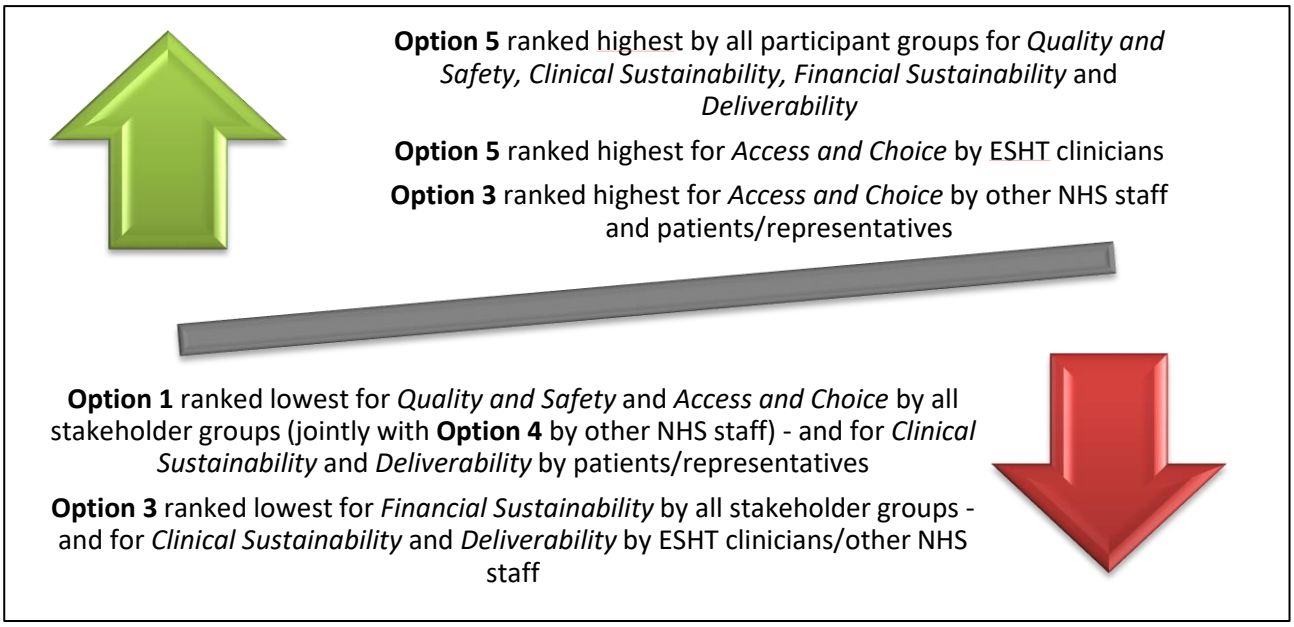


3.51 The results from the ranking exercise are summarised in the infographic below (Figure 3), followed by a more detailed breakdown of the results which are presented in graphical and tabular formats. As described in Chapter 2 above, the results are presented using the average (mean) ranks given by each stakeholder group.

Summary of options ranking

3.52 The results show that Option 5 (co-location of catheterisation labs and inpatients to one acute site) was ranked highest against most criteria by all stakeholder groups – although Option 3 (build up both sites) was preferred in relation to Access & Choice by other NHS staff and patients/representatives. Conversely, Options 1 (retain current services) and 3 (build up both sites) tended to be ranked lowest across most criteria.

Figure 3: Summary outcomes of ranking exercise for options for future acute cardiology service provision



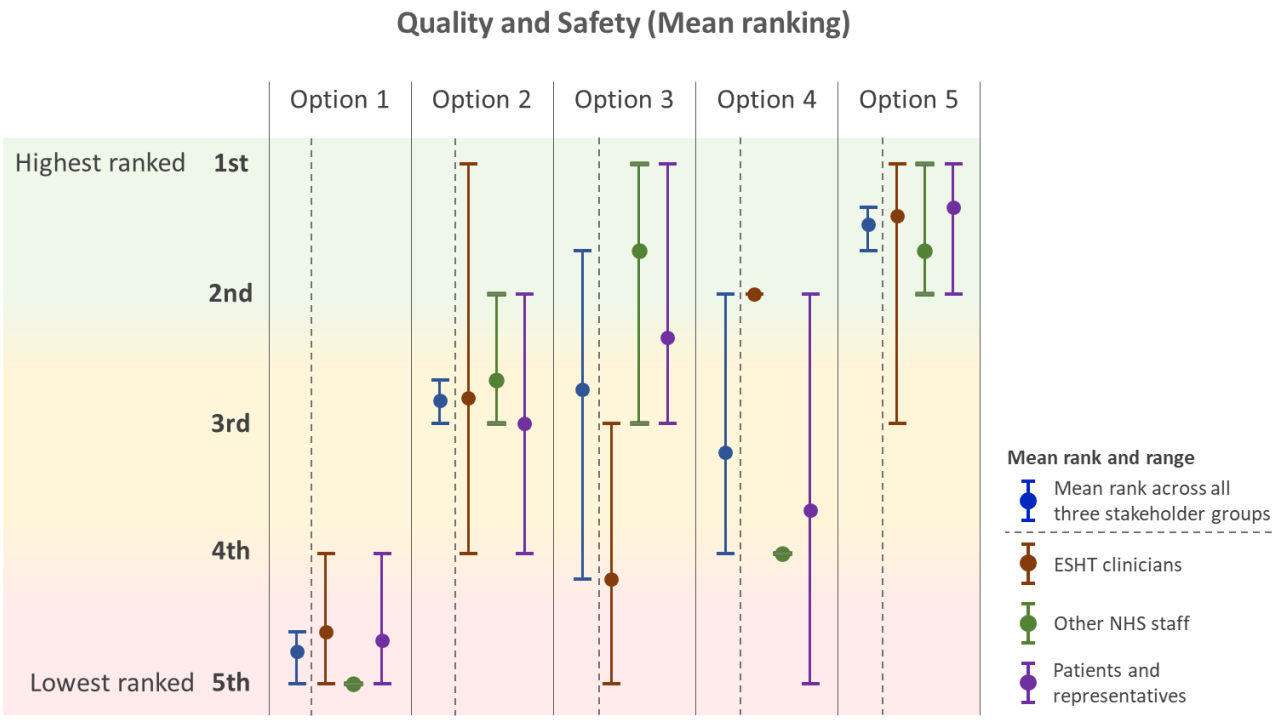
Quality and Safety rankings

3.53 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Quality and Safety*.

Table 3 - Mean rankings of each longlisted option against *Quality and Safety*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	QUALITY AND SAFETY - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*4.8*	*2.8*	*2.7*	*3.2*	*1.5*
ESHT clinicians (5)	4.6	2.8	4.2	2.0	1.4
Other NHS staff (3)	5.0	2.7	1.7	4.0	1.7
Patients and representatives (3)	4.7	3.0	2.3	3.7	1.3

Figure 4: Mean rankings of each longlisted option against *Quality and Safety*



3.54 A model of care which would see catheterisation labs and inpatient care co-located on a single acute hospital site (Option 5) ranked highest against Quality and Safety among all stakeholder groups, albeit jointly with Option 3 (building up both acute sites) among the other NHS staff. The current model of care (Option 1) was ranked lowest by all stakeholder types, with no individuals ranking it higher than 4th place, confirming the feedback received in discussions that the current model is not fit-for-purpose.

3.55 Views on Options 2, 3 and 4 were more variable, with ESHT clinicians ranking Option 4 (PCI non-elective and elective on one acute site, EP, PPM & Devices elective on the other acute site) second highest. Other NHS

staff ranked Option 3 joint highest, with patients and patient representative placing it in second place overall, while ESHT clinicians ranked the same option in 4th place.

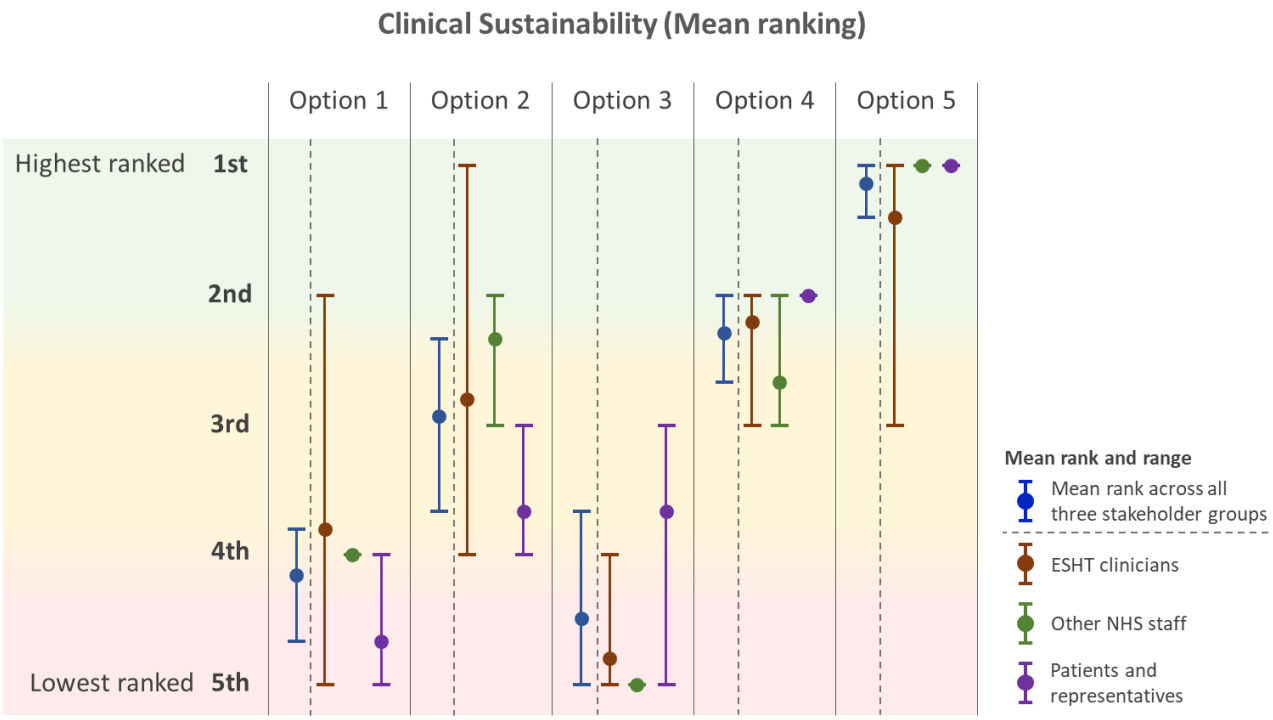
Clinical Sustainability rankings

3.56 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Clinical Sustainability*.

Table 4 - Mean rankings of each longlisted option against *Clinical Sustainability*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	CLINICAL SUSTAINABILITY - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*4.2*	*2.9*	*4.5*	*2.3*	*1.1*
ESHT clinicians (5)	3.8	2.8	4.8	2.2	1.4
Other NHS staff (3)	4.0	2.3	5.0	2.7	1.0
Patients and representatives (3)	4.7	3.7	3.7	2.0	1.0

Figure 5: Mean rankings of each longlisted option against *Clinical Sustainability*



3.57 As with Quality and Safety, Option 5 ranked highest for Clinical Sustainability among all stakeholder types. Option 4 ranked second highest among ESHT clinicians and patients and representatives, whereas other NHS staff ranked Option 2 in second place (retaining current services with new 'Hot' Clinics at both acute hospitals, and assessment areas in both A&E departments). Other NHS staff ranked Option 4 in close third place.

3.58 ESHT clinicians and other NHS staff ranked Option 3 in last place overall, while patients placed it in joint third place alongside Option 2. This is in contrast to the rankings for Quality and Safety, in which other NHS staff and patients and representatives placed Option 3 in joint first and second place respectively. This is perhaps an indication that, as in the discussion, a full cardiology service at both acute sites was viewed as desirable in principle, but there was also recognition that such a model would be challenging to deliver in the long term.

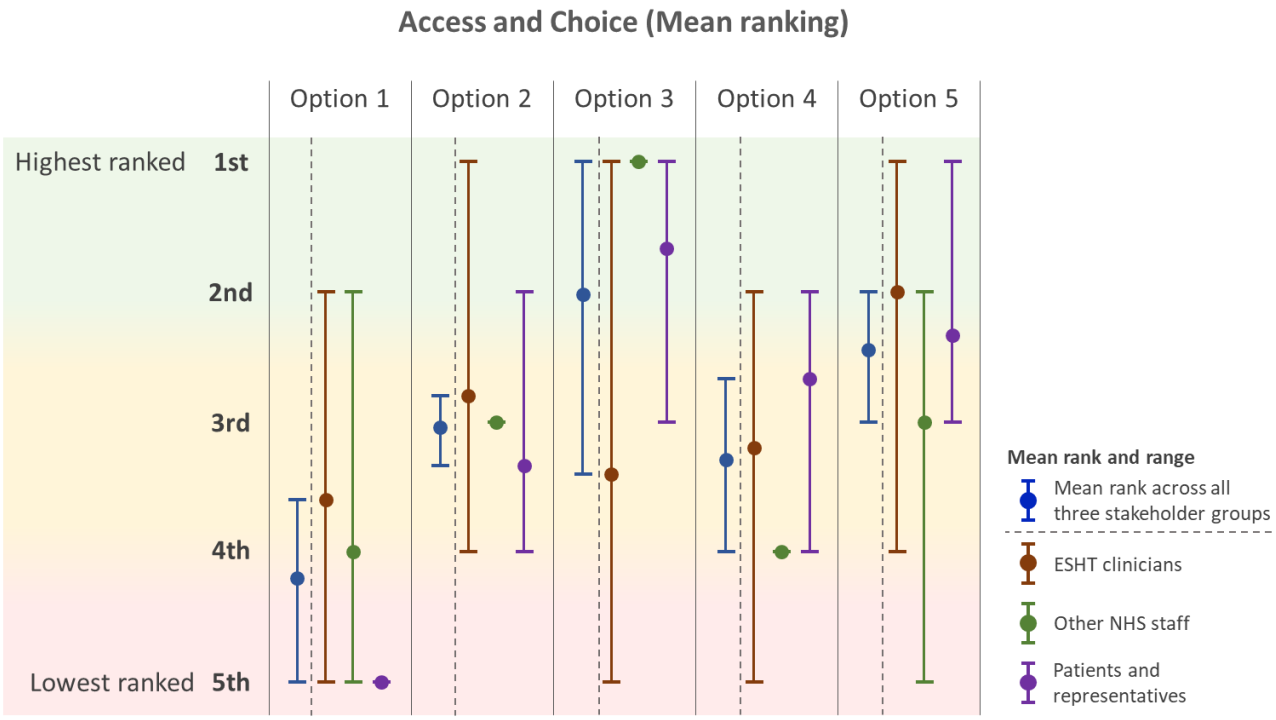
Access and Choice rankings

3.59 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Access and Choice*.

Table 5 - Mean rankings of each longlisted option against *Access and Choice*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	ACCESS AND CHOICE - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*4.2*	*3.0*	*2.0*	*3.3*	*2.4*
ESHT clinicians (5)	3.6	2.8	3.4	3.2	2.0
Other NHS staff (3)	4.0	3.0	1.0	4.0	3.0
Patients and representatives (3)	5.0	3.3	1.7	2.7	2.3

Figure 6: Mean rankings of each longlisted option against *Access and Choice*



3.60 Against Access and Choice, there was more variation between and within each of the groups of stakeholder participants. ESHT clinicians again ranked Option 5 highest overall, with Option 2 second highest. By contrast, other NHS staff, and patients and patient representatives, gave Option 3 the highest mean ranking; other

NHS staff gave the second highest mean ranking jointly to Options 2 and 5, while patients and representatives gave the second highest meant ranking to Option 5.

3.61 As previously, retaining current services (Option 1) was ranked lowest by all stakeholder types, jointly with Option 4 in the case of other NHS staff.

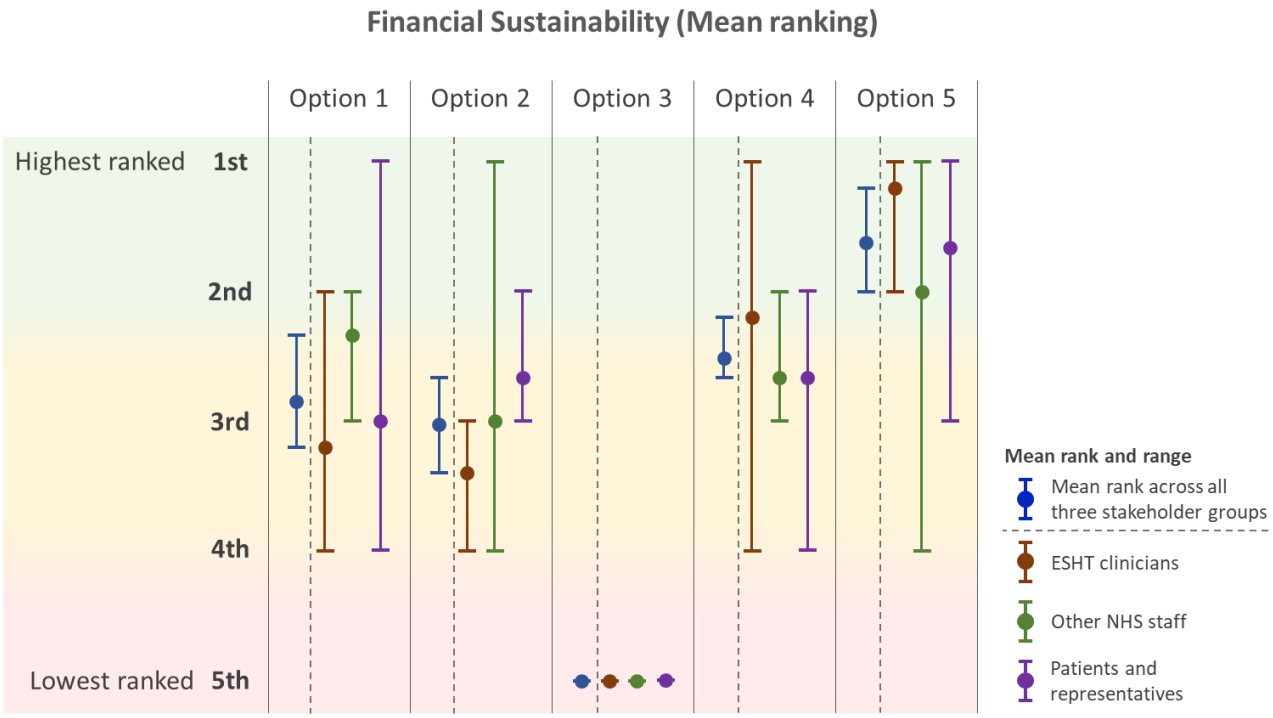
Financial Sustainability rankings

3.62 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Financial Sustainability*.

Table 6 - Mean rankings of each longlisted option against *Financial Sustainability*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	FINANCIAL SUSTAINABILITY - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*2.8*	*3.0*	*5.0*	*2.5*	*1.6*
ESHT clinicians (5)	3.2	3.4	5.0	2.2	1.2
Other NHS staff (3)	2.3	3.0	5.0	2.7	2.0
Patients and representatives (3)	3.0	2.7	5.0	2.7	1.7

Figure 7: Mean rankings of each longlisted option against *Financial Sustainability*



3.63 With regard to Financial Sustainability, all stakeholder groups ranked Option 5 - co-locating all catheterisation labs and inpatient care at one acute hospital site, with outpatient and diagnostic services at both acute sites

- highest overall. ESHT clinicians, and patients and patient representatives, ranked Option 4 second overall, whereas other NHS staff ranked Option 1 slightly higher than Option 4 overall.

3.64 Option 3, which perhaps understandably was ranked highly by many participants in relation to Access and Choice, was unanimously ranked in fifth place for Financial Sustainability by all participants. This is a strong indication, as corroborated by the discussions across all three workshops, that having all acute cardiology services available at both EDGH and Conquest was desirable in principle (particularly in terms of local access), this option was not viewed as financially viable.

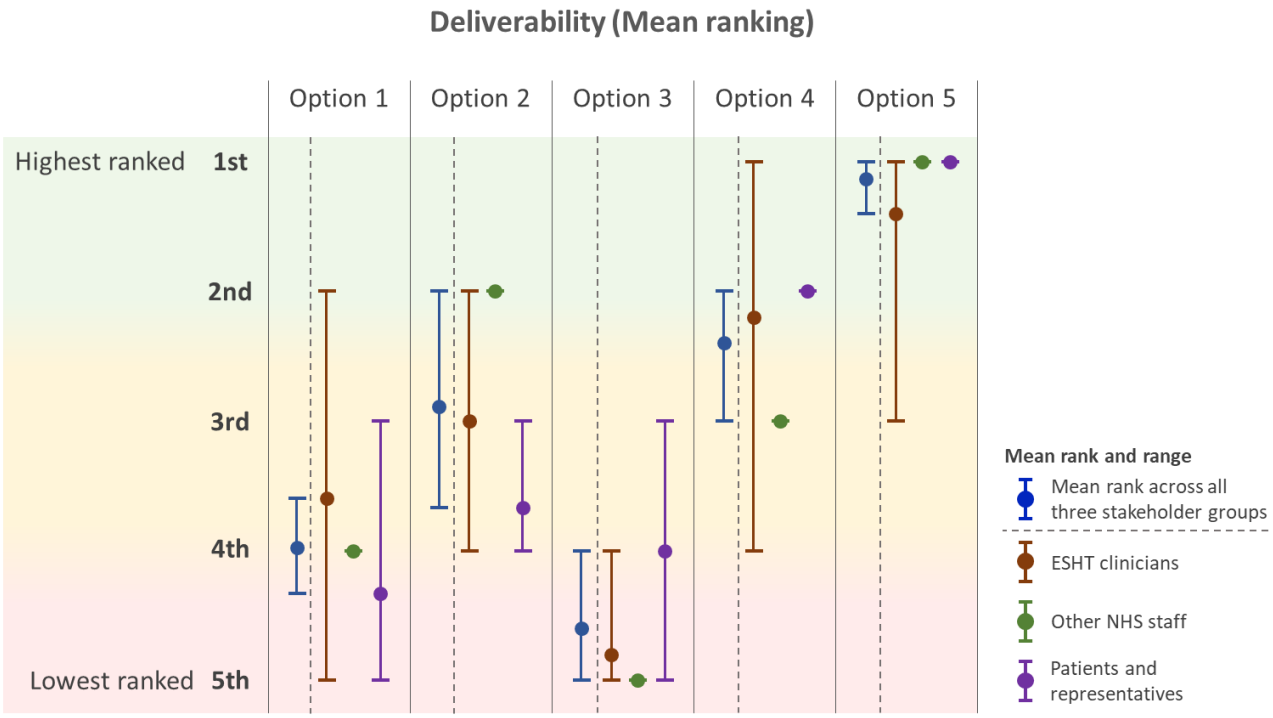
Deliverability rankings

3.65 The table and figure below show the mean rankings given to each of the longlisted options against the criterion of *Deliverability*.

Table 7 - Mean rankings of each longlisted option against *Deliverability*. The highest ranked options are highlighted in green, and the lowest ranked options in red (Base numbers of individuals in brackets)

	DELIVERABILITY - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*4.0*	*2.9*	*4.6*	*2.4*	*1.1*
ESHT clinicians (5)	3.6	3.0	4.8	2.2	1.4
Other NHS staff (3)	4.0	2.0	5.0	3.0	1.0
Patients and representatives (3)	4.3	3.7	4.0	2.0	1.0

Figure 8: Mean rankings of each longlisted option against *Deliverability*



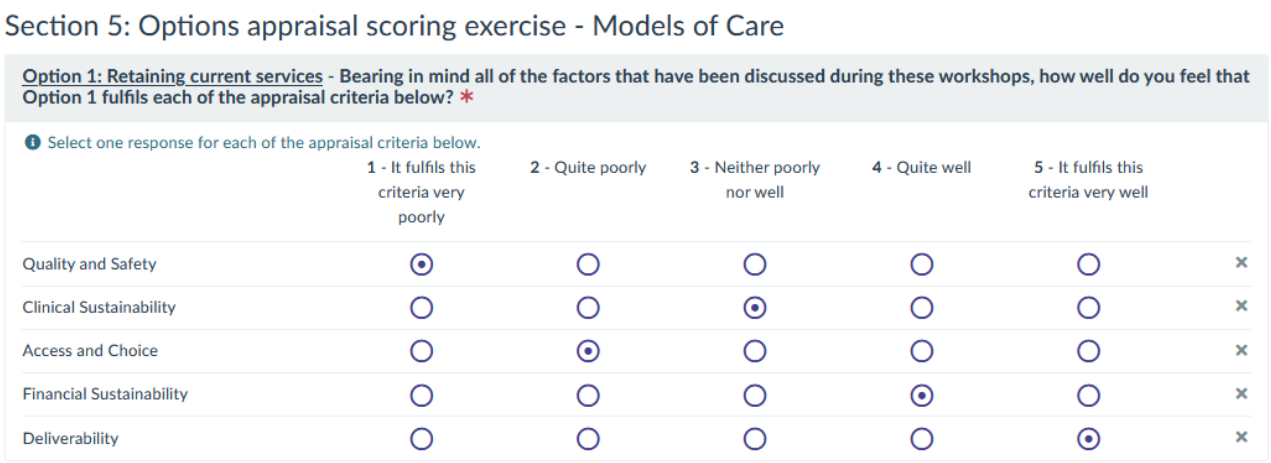
3.66 Similarly to the mean rankings for Quality and Safety, and Financial *and* Clinical Sustainability, Option 5 was ranked highest overall for Deliverability by all stakeholder groups. Option 4 was ranked second highest by patients and representatives, and ESHT clinicians, while Option 2 ranked second overall with other NHS staff.

3.67 Again, as seen with the mean ranking for Financial *and* Clinical Sustainability, Option 3 was ranked lowest overall by ESHT clinicians and other NHS staff (second lowest by patients and representatives) with Option 1 also ranking poorly in terms of Deliverability with all stakeholder types, and lowest by patients and patient representatives.

Model of care options scored against appraisal criteria

3.68 In order to better understand the relative differences between the options, participants were also asked to score each of the five possible options for a future model of care against the five 'appraisal criteria' as in Figure 9 below. When interpreting the options appraisal scoring outcomes, unlike in the ranking exercise, participants were able to give the same scores to several or all options, if they chose to.

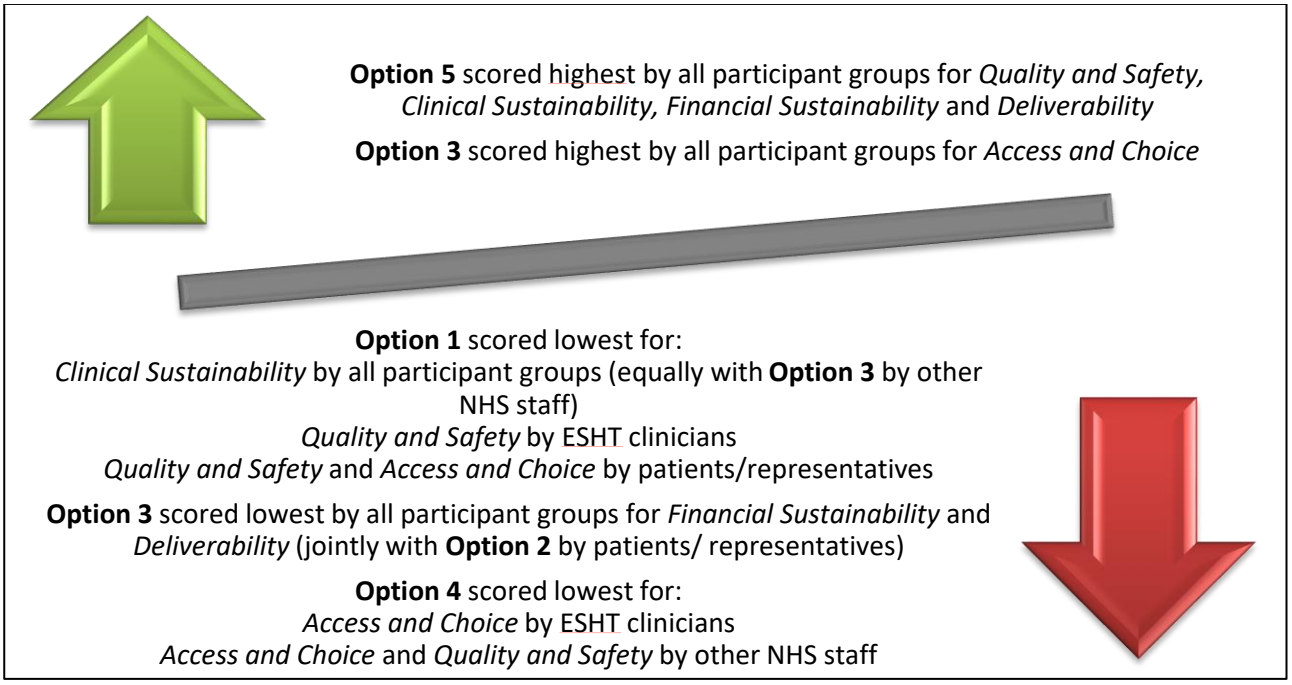
Figure 9: Example of appraisal criteria scoring exercise as completed by workshop 3 participants



Summary of options ranking

3.69 Option 5 (co-location of catheterisation labs & inpatients to one acute site) again scored highest against most criteria – while Option 3 (build up both sites) was considered better in terms of Access & Choice by all stakeholder groups. Options 1 (retain current services) and 3 (build up both sites) scored lowest overall, although Option 4 (PCI on one acute site and EP on the other acute site) was considered worse for Access and Choice by ESHT clinicians and for both Access & Choice and Quality & Safety by other NHS staff.

Figure 10: Summary outcomes of scoring exercise for options for future acute cardiology service provision



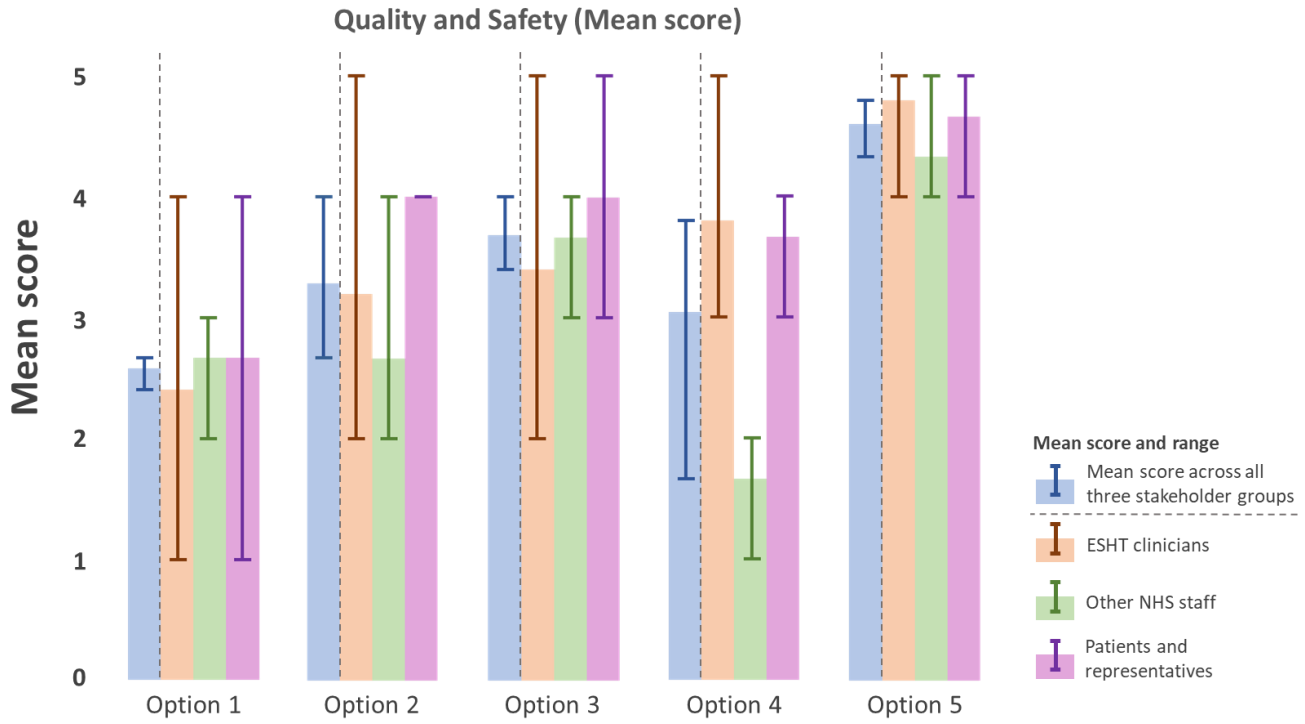
Quality and Safety scoring

3.70 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Quality and Safety*.

Table 8 - Mean scores for each longlisted option against *Quality and Safety*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	QUALITY AND SAFETY - MEAN RANKINGS				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*2.6*	*3.3*	*3.7*	*3.0*	*4.6*
ESHT clinicians (5)	2.4	3.2	3.4	3.8	4.8
Other NHS staff (3)	2.7	2.7	3.7	1.7	4.3
Patients and representatives (3)	2.7	4.0	4.0	3.7	4.7

Figure 11: Mean scores for each longlisted option against *Quality and Safety*



3.71 As in the ranking exercises, a model of care in which all catheterisation labs and inpatient acute cardiology services would be delivered from one hospital site, with outpatient and diagnostic services at both acute sites (Option 5) was view positively and given the highest mean score against Quality and Safety by all stakeholder groups.

3.72 The mean scores for the other possible options were more mixed, with patients and patients' representatives given joint second highest scores to Options 2 and 3, other NHS staff giving the same to Option 3, and ESHT clinicians scoring Option 4 second highest. Option 1 was scored lowest by ESHT clinicians, and patient and representatives; other NHS staff scored Option 4 lowest overall.

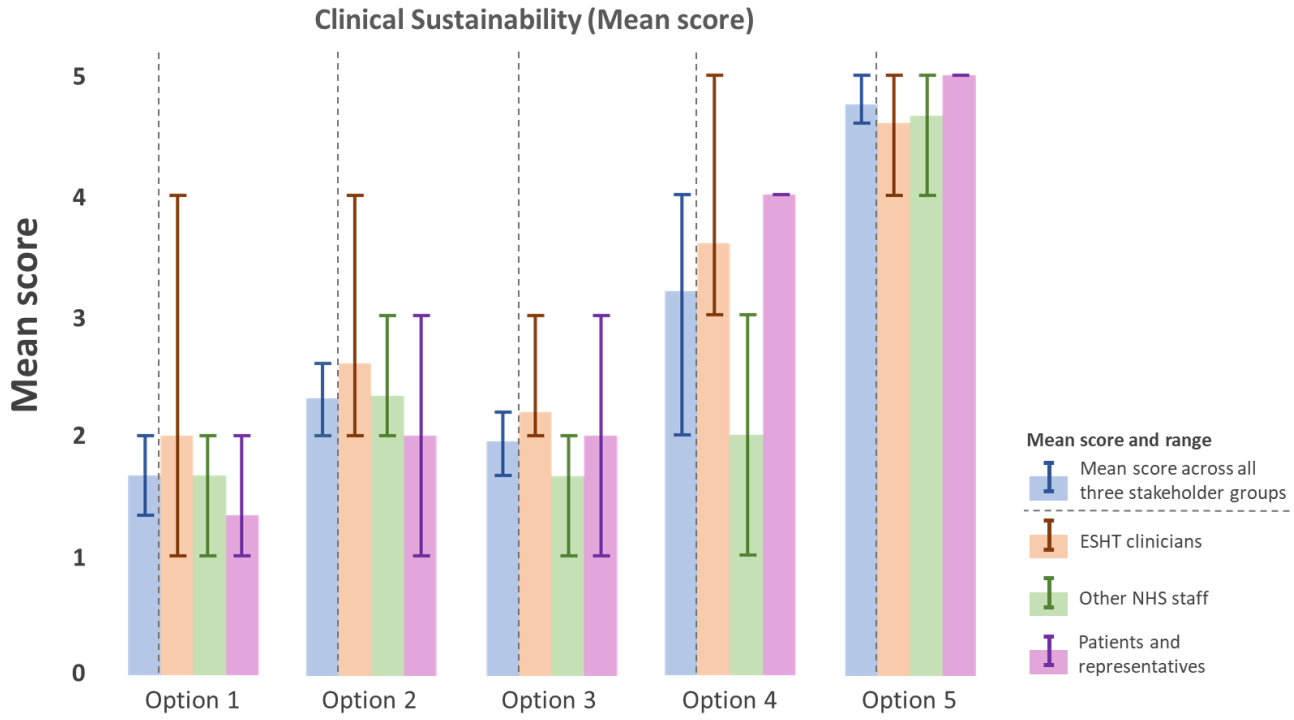
Clinical Sustainability rankings

3.73 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Clinical Sustainability*.

Table 9 - Mean scores for each longlisted option against *Clinical Sustainability*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	CLINICAL SUSTAINABILITY - MEAN SCORES				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*1.7*	*2.3*	*2.0*	*3.2*	*4.8*
ESHT clinicians (5)	2.0	2.6	2.2	3.6	4.6
Other NHS staff (3)	1.7	2.3	1.7	2.0	4.7
Patients and representatives (3)	1.3	2.0	2.0	4.0	5.0

Figure 12: Mean scores for each longlisted option against *Clinical Sustainability*



3.74 Option 5 was scored highest overall for Clinical Sustainability by all stakeholder groups, with patients and representatives, and ESHT clinicians, giving the second highest mean scores to Option 4.

3.75 Other NHS staff scored all four of the other options considerably lower than Option 5 against this criterion, and all stakeholder types gave the lowest scores overall to Option 1 (jointly with Option 3 in the case of other NHS staff). While caution should be used when interpreting the outcomes of scoring exercises, these results are corroborated by the outcomes of group discussions which focused on the need for adequate staffing and resourcing to make options viable, with concerns expressed about the current service model (Option 1 and the variant Option 2, which adds assessment and 'Hot' clinics are both acute sites), as well as about Option 3 which would require significantly more staff to be clinically sustainable.

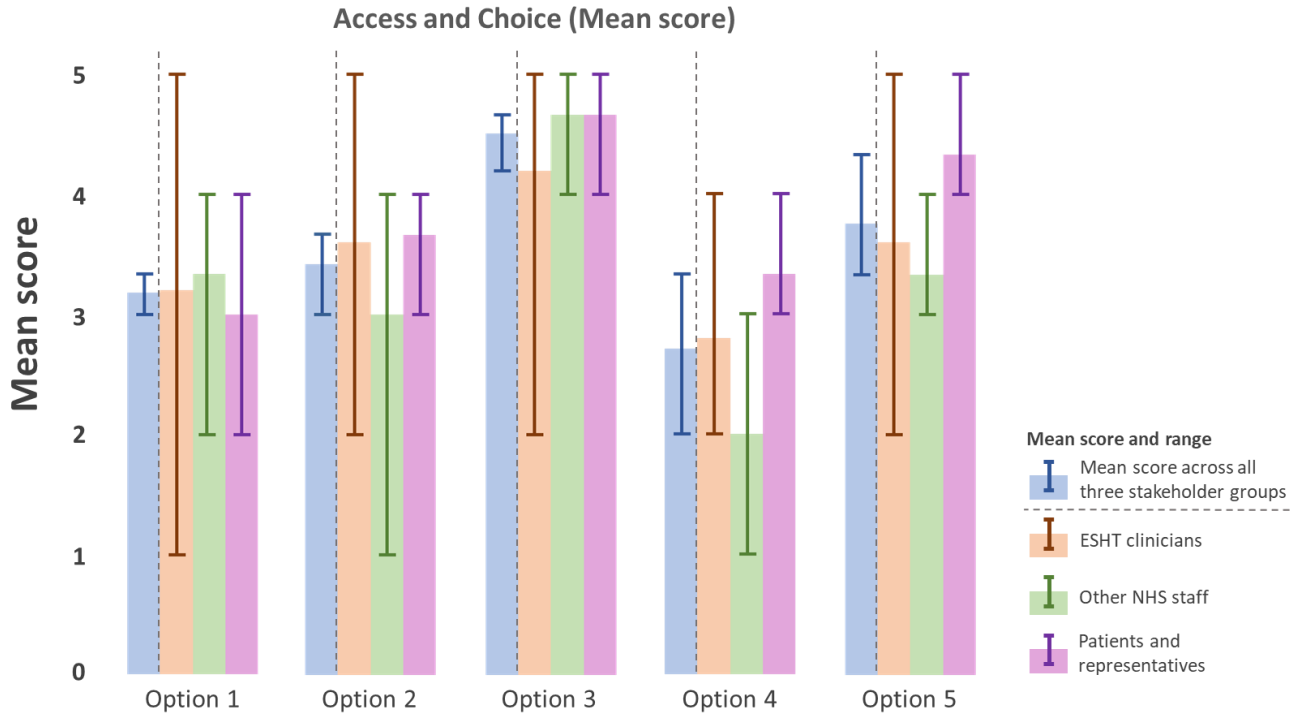
Access and Choice scoring

3.76 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Access and Choice*.

Table 10 - Mean scores for each longlisted option against *Access and Choice*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	ACCESS AND CHOICE - MEAN SCORES				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*3.2*	*3.4*	*4.5*	*2.7*	*3.8*
ESHT clinicians (5)	3.2	3.6	4.2	2.8	3.6
Other NHS staff (3)	3.3	3.0	4.7	2.0	3.3
Patients and representatives (3)	3.0	3.7	4.7	3.3	4.3

Figure 13: Mean scores for each longlisted option against *Access and Choice*



3.77 All stakeholder groups scored Option 3 (building up acute cardiology services at both sites) most highly for Access and Choice, with Option 5 scoring second highest (jointly with Option 1 for other NHS staff).

3.78 Option 4, which would see non-elective and elective PCI on one acute hospital site, and EP, PPM and Devices on the other acute site, received the lowest men scores from ESHT clinicians and other NHS staff. Patients and their representatives who participated in the scoring exercise scored Option 1 lowest overall in relation to Access and Choice.

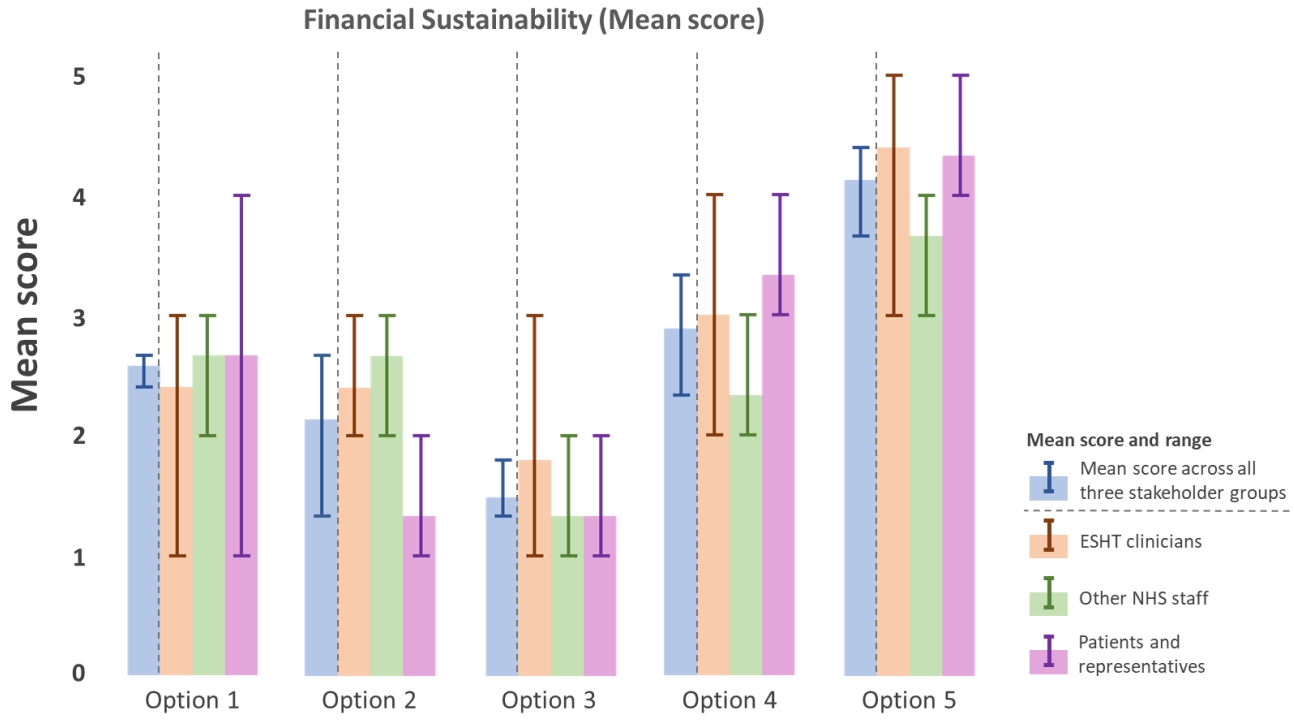
Financial Sustainability scoring

3.79 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Financial Sustainability*.

Table 11 Mean scores for each longlisted option against *Financial Sustainability*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	FINANCIAL SUSTAINABILITY - MEAN SCORES				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*2.6*	*2.1*	*1.5*	*2.9*	*4.1*
ESHT clinicians (5)	2.4	2.4	1.8	3.0	4.4
Other NHS staff (3)	2.7	2.7	1.3	2.3	3.7
Patients and representatives (3)	2.7	1.3	1.3	3.3	4.3

Figure 14: Mean scores for each longlisted option against *Financial Sustainability*



3.80 As was the case in the Financial Sustainability options ranking exercise, all stakeholder types gave the highest mean scores to Option 1. The second highest scoring option among ESHT clinicians and patients (and their representatives) was Option 4, while other NHS staff scored Options 1 and 2 marginally higher.

3.81 Option 3, which was both ranked and scored highly by many participants in relation to Access and Choice, was scored lowest overall for Financial Sustainability by all participants (jointly with Option 2 by patients and patients' representatives). This indicates again that this option was not viewed as financially viable in by participants, in addition to doubts about its Deliverability (see below) and Clinical Sustainability.

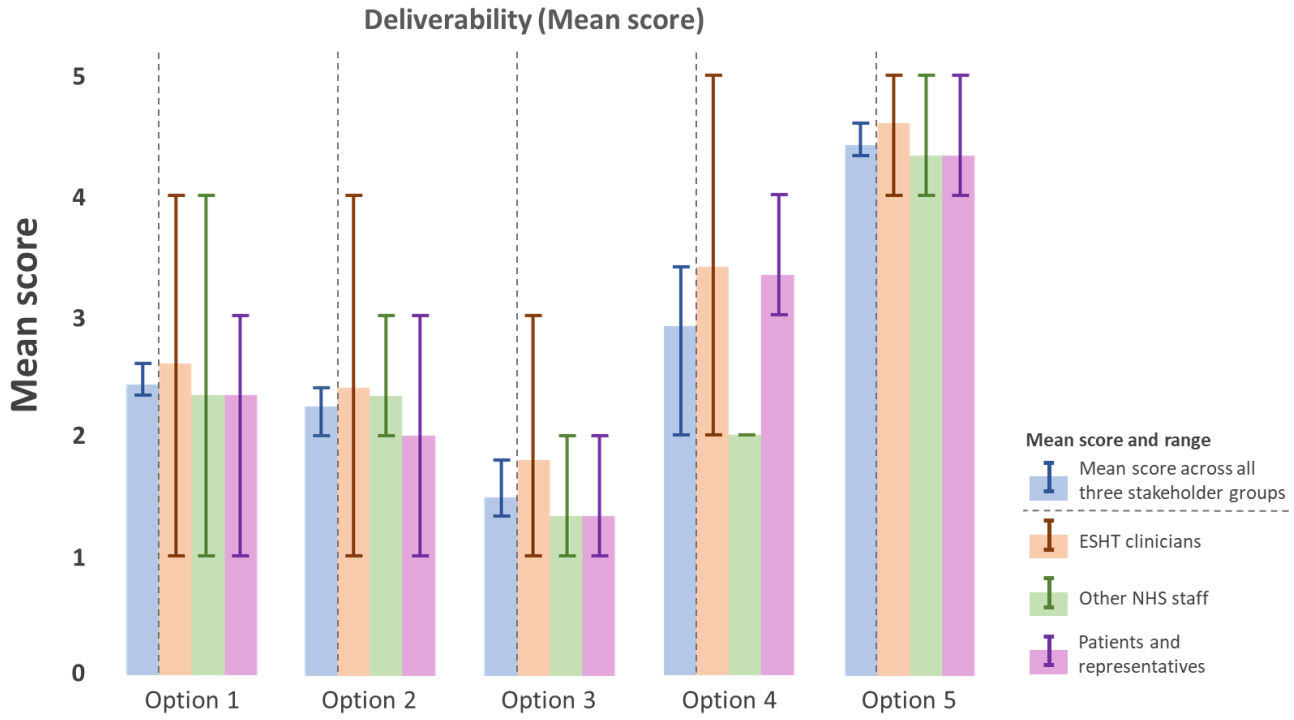
Deliverability scoring

3.82 The table and figure below show the mean scores given to each of the longlisted options against the criterion of *Deliverability*.

Table 12: Mean scores for each longlisted option against *Deliverability*. The highest scored options are highlighted in green, and the lowest scored options in red (Base numbers of individuals in brackets)

	DELIVERABILITY - MEAN SCORES				
	Option 1 Retain current services	**Option 2** Assessment at front ends	**Option 3** Build up both sites	**Option 4** PCI on one site EP on the other	**Option 5** Catheter labs/inpatients on one site
All stakeholder groups (11)	*2.4*	*2.2*	*1.5*	*2.9*	*4.4*
ESHT clinicians (5)	2.6	2.4	1.8	3.4	4.6
Other NHS staff (3)	2.3	2.3	1.3	2.0	4.3
Patients and representatives (3)	2.3	2.0	1.3	3.3	4.3

Figure 15: Mean scores for each longlisted option against *Deliverability*



3.83 Against the final appraisal criteria of Deliverability, Options 5 was given the highest mean scores by all groups of stakeholders. Again, as was the case for Financial Sustainability and Clinical Sustainability, ESHT clinicians, and patients and patients' representatives gave Option 4 the second highest scores overall; other NHS staff scored both Options 1 and 2 second highest, albeit by a small margin and with a range of scores by individuals.

3.84 Option 3 was scored lowest by all stakeholder groups, a reflection of previously mentioned concerns about the feasibility of delivering all acute cardiology services, as well as introducing assessment areas and two emergency departments and 'Hot' clinics, at both acute hospital sites in East Sussex.

Appendix I - Table of figures

Appendix II - East Sussex CCG pre-consultation engagement report

Between 4th January 2021 to 14th February 2021, East Sussex CCG undertook a programme of pre-consultation engagement activities with local people and stakeholders to: communicate the need for transformation to acute cardiology services provided by ESHT; understand their experiences of current services; and gather feedback and ideas about how services might be delivered in the future. The report of the findings from this early engagement, prepared by the Patient Engagement and Involvement team, can be found below.

TRANSFORMING CARDIOLOGY SERVICES IN EAST SUSSEX

PUBLIC ENGAGEMENT REPORT

Date:	8 APRIL 2021
Version:	2.2
Name of originator/ author:	Emma Baxter, Public Involvement Manager Antonia Bennett, Patient and Public Involvement Lead

Contents

1.0 Executive Summary

We are developing proposals for how hospital based cardiology services, provided by East Sussex Healthcare NHS Trust (ESHT), can best provide high quality treatment, care and support for local people and meet increasing local population need. Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England have duties to consult the public when a significant service change is likely to take place. This report provides insight from local people into the patient journey and experiences of accessing cardiology services gathered in January and February 2021, in order to inform service change and potential public consultation.

To reach the local population in East Sussex, the Clinical Commissioning Group (CCG) co-developed a questionnaire with partners and members of the public, which was promoted widely in paper copies and electronically. The CCG undertook interviews with current and former patients of the services and joined virtual local forums and groups to hear from people about their experiences.

The key themes from this engagement include:

- communication both before and during appointments;
- communication between health care settings;
- the need for faster diagnosis;
- requirements for patients' additional needs to be met.

The results of this engagement have informed the development and appraisal of options for the future of cardiology services. This insight has informed the development and appraisal of options for the future of cardiology services.

2.0 Background

The East Sussex Health and Social Care Plan sets out how partners will align local priorities with the Sussex Health and Care Partnership's "Vision 2025". This includes:

- a comprehensive approach to prevention;
- reducing health inequalities;
- supporting our workforce to develop and grow;
- developing a new model of care that will be sustainable for generations to come.

ESHT provides acute and community care in East Sussex, at Eastbourne District General Hospital (EDGH) and at the Conquest Hospital, Hastings, at two community hospitals in Bexhill and Rye, in community clinics across East Sussex and in people's own homes. Acute cardiology services for adults in East Sussex are provided at EDGH, the Conquest Hospital and Bexhill Hospital.

The Sussex Health and Care Partnership's "Vision 2025" focuses on proactively managing population health, better anticipating care needs and integrated working across health and social care to enable the delivery of the best possible outcomes for local people. This, alongside advances in medicine and innovation/technology, will ensure the best use of collective public resources in East Sussex. Reviewing and redesigning cardiology services within this context will help ensure the right services are available in a way that is sustainable for the future and in response to the needs of the local population.

The vision for the future of cardiology is to provide a high-quality service for patients, carers and their families regardless of age, disability, gender or ethnicity. This includes:

- providing a clinically excellent cardiology service;
- increasing the ability to look after a growing and ageing population;
- developing and encouraging innovation in the delivery of cardiology services;
- providing increased support and development for the cardiology workforce.
- developing a service that is clinically, financially and environmentally sustainable;

3.0 Public Engagement

To consider how acute cardiology services should be transformed East Sussex CCG undertook public engagement which commenced on 4th January 2021 and lasted six weeks (concluding on 14th February 2021). This engagement was informed by an Equality and Health Inequality Impact Assessment which highlighted the need to reach particular groups and communities. During this time the CCG's Public Involvement team engaged with local people and stakeholders to:

- communicate the need for the transformation of acute cardiology services at ESHT;
- understand their experiences of the acute cardiology services at EDGH and the Conquest Hospital;
- gather feedback and ideas about how the service could be provided in the future.

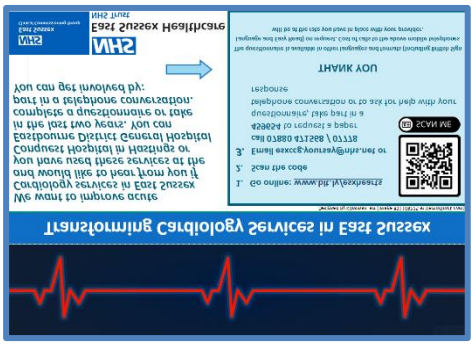
The insight gathered from this work will be used to inform options development, appraisal and planning for any formal consultation.

A questionnaire to understand people's experiences of acute cardiology services was co-designed with partners and members of the public and published on the Sussex Health and Care Partnership Engagement HQ platform. The survey was promoted through a multitude of pre-established distribution lists and newsletters including:

- 3VA weekly bulletin (Eastbourne residents)
- HVA weekly bulletin (Hastings residents)
- East Sussex Local Voices (over 2000 recipients)
- East Sussex Health and Care Newsletter (over 4000 recipients throughout East Sussex)
- Over 60 churches in East Sussex and a mailing list of 800 stakeholders.

It was also sent out widely to local voluntary, community and social enterprise (VCSE) sector organisations, including Healthwatch, with the request to support promotion. Paper copies of the survey were sent out to organisations including the Rough Sleepers Initiative (homeless and rough sleepers) and foodbanks (to reach those living in deprivation) as well as to individuals requesting copies. A freepost address for returning the questionnaires was included.

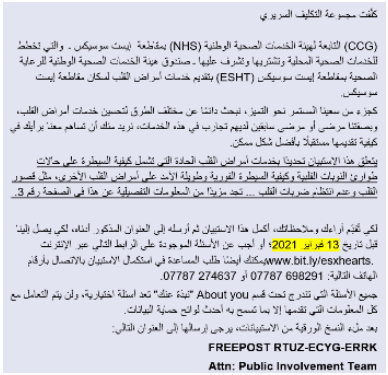
Posters were distributed to display in hospital waiting rooms to encourage people to complete the questionnaire or to get in touch to arrange a telephone interview. Social media coverage was used to promote the surveys, utilising the CCG pages and accounts and posting on local community Facebook pages.



The Public Involvement team attended a range of virtual forums and groups to promote the programme and inform people of the ways to get involved including:

- Patient Participation Groups (PPGs) Steering Group and three local forums;
- East Sussex Seniors Association (ESSA);
- Eastbourne Cultural Inclusion Group (ECIG);
- East Sussex Communications and Engagement Steering Group (CESG).

To ensure accessibility, local linguists in East Sussex were asked to support people for whom English was an additional language to complete the questionnaires and a total of eight completed questionnaires were received with a variety of languages represented including:



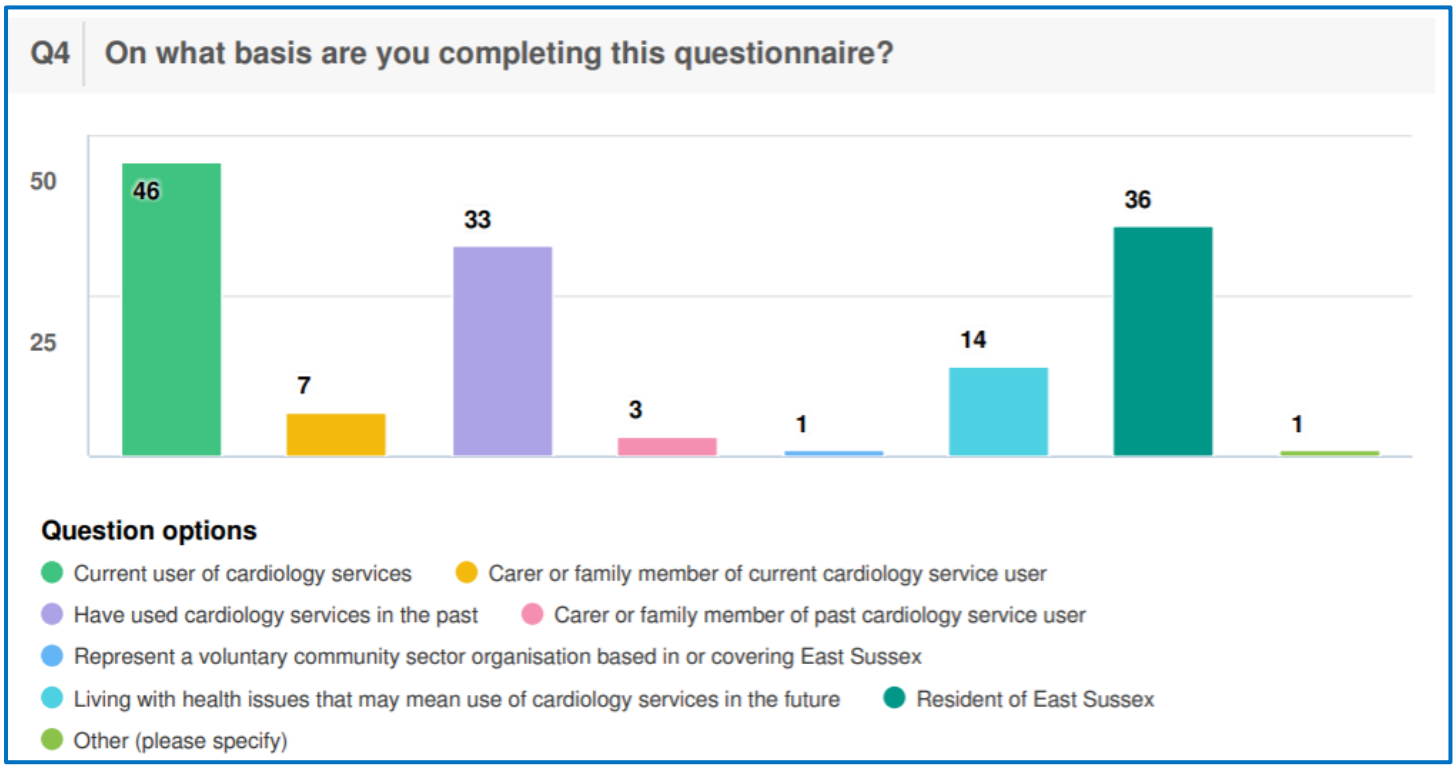
كلفت مجموعة التكليف المحلي
(CCG) التابعة لهيئة الخدمات الصحية الوطنية (NHS) بمقاطعة ايست سوسيكس - والتي تخطط للخدمات الصحية المحلية وتشتريها وتشرف عليها - صندوق هيئة الخدمات الصحية الوطنية للرعاية الصحية بمقاطعة ايست سوسيكس (ESHT) بتقديم خدمات أمراض القلب لسكان مقاطعة ايست سوسيكس.
كجزء من سعينا المستمر نحو التميز، نبحث دائما عن مختلف الطرق لتحسين خدمات أمراض القلب، وبصفتنا مرضى أو مرضى سابقين لديهم تجارب في هذه الخدمات، نريد منك أن تساهم معنا برأيك في كيفية تقديمها مستقبلاً بأفضل شكل ممكن.
يتعلق هذا الاستبيان تحديدا بخدمات أمراض القلب الحادة التي تشمل كيفية السيطرة على حالات طوارئ النوبات القلبية وكيفية السيطرة الفورية وطويلة الأمد على أمراض القلب الأخرى، مثل قصور القلب وعدم انتظام ضربات القلب ... تجد مزيدا من المعلومات التفصيلية عن هذا في الصفحة رقم 3.
لكي تُقيم آراءك وملاحظاتك، أكمل هذا الاستبيان ثم أرسله إلى العنوان المذكور أدناه، لكي يصل إلينا قبل تاريخ 13 فبراير 2021، أو أجب عن الأسئلة الموجودة على الرابط التالي عبر الإنترنت www.bit.ly/esxhearts. يمكنك أيضا طلب المساعدة في استكمال الاستبيان بالاتصال بأرقام الهاتف التالية: 07787 698291 أو 07787 274637.
جميع الأسئلة التي تتدرج تحت قسم "About you" "نبذة عنك" تعد أسئلة اختيارية، ولن يتم التعامل مع كل المعلومات التي تقدمها إلا بما تسمح به أحدث لوائح حماية البيانات.
بعد ملء النسخ الورقية من الاستبيانات، يرجى إرسالها إلى العنوان التالي:
FREEPOST RTUZ-ECYG-ERRK
Attn: Public Involvement Team

- Kurdish
- Urdu
- Portuguese
- Cantonese
- Mandarin
- Polish
- British Sign Language

The survey was also produced in Easy Read and Arabic with further translations available on request.

The insight gathered will be fed into options development workshops where key stakeholders will be invited to come together to co-design feasible options. These will be followed by a further options appraisal workshop to inform a final set of proposals.

4.0 Results of engagement

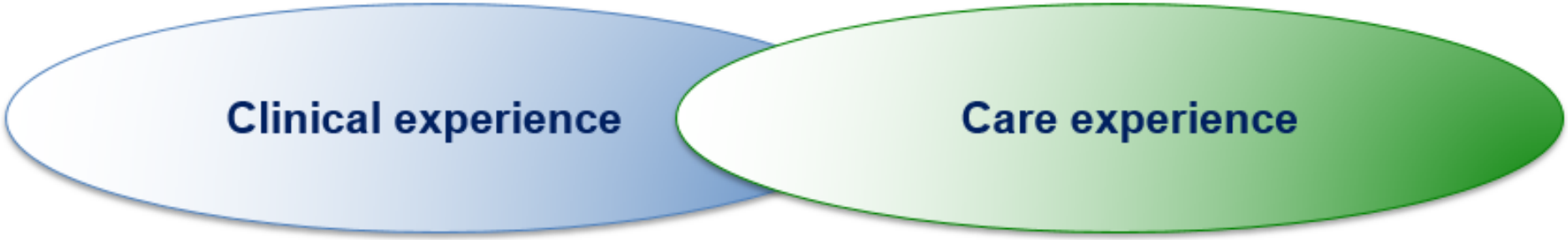


(Please note participants could choose more than one option)

In total there were 82 responses including 20 in-depth interviews.

The following pages illustrate some of the significant themes that emerged from the submissions: these have been split into care and clinical themes.

Cardiology Service Delivery: the Patient Perspective



Rapid ambulance/paramedic response

Rapid diagnosis and life-saving treatment

No long delays for treatment with a life-threatening condition - test results

Check-ups on time (COVID-19 reasoning)

Clarity from the clinical team: mixed messages = uncertainty

Joined-up communications: hospital-GP-patient

Personal relationship with the consultant

Time taken to listen, explain

Treated with care, respect and warmth

Individual adaptions

Ideal service delivery is 'clockwork'

Cardiology Service Delivery: the Patient Perspective
Majority Very Positive

Rapid ambulance/paramedic response
"Ambulance took me from Conquest to EDGH for angiogram and angioplasty, done in 20 minutes"

Rapid diagnosis and life-saving treatment
"Had treatment within the hour. Prevented damage to heart. Cannot fault process. Cardiac ward great".

Check-ups on time (Covid excuse)
"Get back to the tests so you can still have confidence in your safety and fears of another relapse".

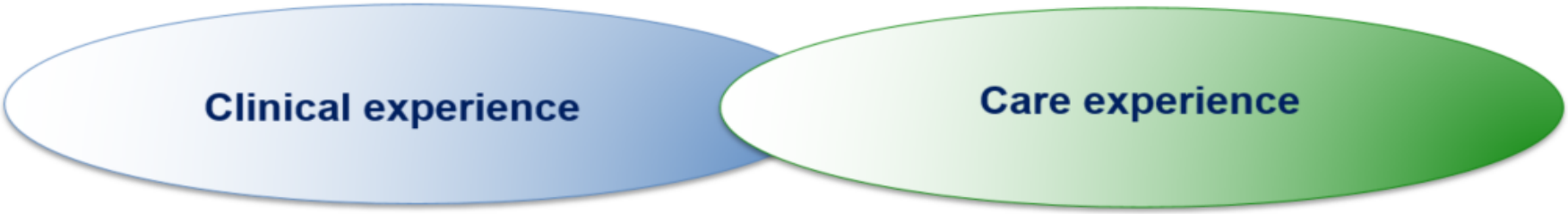
Personal relationship with the consultant
"I felt very reassured after both tests that I wasn't ill. Prof Patel explained that very clearly to me. A first class service".

Time taken to listen, explain
"Follow-up appointment explained in detail and plain speak diagnosis, prognosis and interventions available"

Treated with care, respect and warmth
"I have nothing but praise for the team. I was terrified but people talked to me all the time. One nurse told me not to worry – in two hours I'd be sorted out. She kept coming back to check on me". "Staff were caring and understanding and went out of their way to allay fears"

Ideal service delivery is 'clockwork'
"Admitted A&E with MI, CCU within six hours, diagnosed within eight hours. Correct treatment given, discharged within 24 hours with follow-up appointment'

Cardiology Service Delivery: the Patient Perspective
Minority Negative



Rapid ambulance/paramedic response
"The ambulance got lost. Cardiac staff were deployed 10 minutes into the call. What was the point?"

No long delays for treatment with life-threatening condition, test results
"Service when accessed was very good, lengthy wait for appointments when classed as at risk of a heart attack was not"

Clarity from clinical team:
mixed messages = uncertainty
"Mixed messages between consultants re: medication leading to uncertainty and anxiety"

Joined-up communications: hospital-GP-patient
""I didn't realise I'd be under general anaesthetic until I woke from the procedure. Sent home without any info or letter. Specialist did write to my GP but no-one got back to me and the letter was filed"

Check-ups on time (Covid)
"How can you possibly know if my heart is functioning as it should over the phone – it's ridiculous?"

Treated with care, respect and warmth
"Heartbeat was 28 bpm and shaking – asked if I 'take it up the nose' (cocaine)".

Individual adaptions
"Consultant judgmental, lacked understanding of my sporting lifestyle. Care targeted towards elderly".

"Complete ignorance by one doctor of the impact of hormones on my artery condition – he seemed to be very uninterested, bordering on dismissive".

4.1 Care

Patient experience

Feedback about cardiology services was overwhelmingly positive, especially with regard to emergency care. The majority of participants felt reassured, respected and the service is considered to be excellent and professional.

Where there were negative experiences of cardiology services there was a clear sense of the participant feeling scared, stressed, emotional and anxious with some people feeling their life was on the line:

"Having a heart issue is frightening. More support would be helpful"

People were also anxious about delays in testing and getting test results as these are perceived as critical to their health and wellbeing.

4.2 Equality and Diversity issues

People with learning disabilities, those who are d/Deaf and those who speak English as an additional first language said that they were not given the opportunity in advance to request additional support. This led to anxiety about the appointment and/or procedure. Language barriers and lack of interpretation support left people feeling confused, "unheard" and unsure of next steps and treatment. Longer appointments with additional support should be offered to these cohorts of people.

It was noted that once the staff knew one of the participants was autistic, they were quick to put measures in place including dimming lights and informing the consultants.

A transgender person reported that they were treated poorly due to:

"A complete lack of knowledge by one doctor about the impact of hormones on my artery 'condition' … he seemed to be very dismissive and uninterested bordering on 'it's your fault for taking them'".

Other accessibility concerns included spaces being cramped for wheelchair users, with the Catheter Lab mentioned in particular and vision impaired participants receiving communications in font size 11 whereas size 20 in a plain font such as Arial would be more appropriate.

4.3 Access/transport issues

Some participants picked up on the possible option to single site elements of the service and had concerns that if the service were available at fewer sites it would affect access. Examples were given such as the distance between Seaford and Eastbourne/Hastings, and between Bexhill and Eastbourne. The Conquest Hospital in Hastings was mentioned as having poor provision of public transport. One participant felt strongly that single siting the service in Hastings could lead to destabilisation:

"If you single site any of the service in Hastings, people in Seaford and surrounding areas would be closer to Brighton and will go there. This would mean losing out financially as the money follows the patient and potentially could destabilise the service if not enough activity was at Hastings leading to cardiologists not fulfilling their expected annual number of procedures and leaving to go to an area where living costs are cheaper and they can reach their annual procedures to avoid retraining."

There were general travel and access concerns for:

- the elderly
- those with a physical disability
- those living in rural villages where public transport is minimal

However, a few participants said they would be prepared to travel for emergency care and interventions if it meant they would be receiving expert care:

"I would like as much routine care as possible locally with a minimum of travelling. I would prefer emergency interventions to be carried out on a single site to concentrate expertise and opportunities for training. I would not mind travelling further for this."

"The centralisation of services - to enable better training of staff and justify better equipment and facilities"

4.4 The impact of COVID-19

Feedback about moving to video and telephone appointments due to COVID-19 was mixed, with some participants finding it convenient and others feeling the appointment was rushed and didn't provide the same level of detail that they may have received from a face-to-face appointment. There was a positive response from a participant with autism who found telephone and video appointments far more relaxing as there were no concerns about additional needs and they could have the appointment from the comfort of their home.

There was mixed feedback about attending appointments and undergoing procedures; there was praise for the team with people feeling safe and clear COVID-19 processes in place but a common theme was patients and carers not being asked to wear to a mask or social distance.

The lack of access to rehabilitation on site was accepted by participants and there was recognition that remote rehabilitation was successful but didn't meet the emotional needs of the person. Participants felt that meeting other people in similar situations would have provided some emotional support.

4.5 Clinical

Communications between different healthcare teams/professionals

Lack of communication between consultants, wards, the emergency department and GP practices was a strong theme. Healthcare services not having access to the same patient information and delays in GPs receiving information led to a delay in treatment. Test results not being shared with another local trust led to a repetition of tests. There were examples of people taking in copies of test results to GP/ follow up appointments as there was a lack of trust that the information would reach their GP. A suggestion of digitalising patient notes and medical files with all NHS health care settings having access was made, which would lessen and mitigate treatment errors and be easier to administer.

Communications between healthcare professionals and patients, especially of results

Communication between the cardiology team and the patient both before and during appointments was often cited as an issue. Lack of communication leads to anxiety.

"The key issue is the lack of information which increases worry, don't assume patients know things. There were no enquiries before discharge about what support I had at home and what situation I was going back to. I was pretty shaky and I was worried.

I don't have any support at home…"

The need for a working telephone number or email address for patients to be able to contact the service ahead of attending with any questions or additional needs was highlighted.

During consultations some people felt that they were ignored, undermined or that the clinician was dismissive. There were reports of people receiving mixed messages from different consultants and being anxious about which advice to follow.

Lack of post procedure communication led to several people feeling unsure of next steps, how long they should be on certain medication and whether delays to follow-up reviews due to COVID-19 would impact on their health.

Speed and ease of service delivery

There was one difficult experience shared of an ambulance being sourced from out of area due to no available local ambulances, getting lost and the 55 year old person dying before they could be treated.

Another participant was very clear in their view that any single siting will be putting lives at risk:

"The golden hour is paramount and travelling across the county does no-one any good - how many lives have been lost not just in travel but arriving too late for the team to do anything. You cannot put a price on people's lives and there needs to be a service on both sites that has the same structure in both teams."

Waiting times for appointments **and** follow-ups

Participants often mentioned longer than expected waiting times for tests and follow-up appointments; whilst there was an understanding that this was probably due to COVID-19, the lack of communication left some resorting to going private for tests and treatment. One person who chose to go private saw the same consultant privately as they would have seen as an NHS patient.

For the minority there were notable delays to acute procedures including heart bypass and urgent ablations leaving those participants feeling very anxious.

One participant has been waiting for a cardioversion that was supposed to take place four to six weeks after a stent was put in. The stent was put in during June 2020 and the patient has still not received a date for the cardioversion. Another patient had two postponements of a pacemaker check.

4.6 Other themes

Particularly when answering the question about the service vision and priorities, several participants highlighted the need for prevention to be high on the agenda:

"I agree with the objectives mentioned above, but have always thought that preventative measures are as important as post treatment once illness is diagnosed"

"Think about the long term effects of COVID-19; increasingly obese population, lack of exercise for many. Children are losing out on exercise. The impact will be seen in 10-20 years' time."

Monitoring of medication was also mentioned. One participant was concerned that they were put on a drug in 2019 that should only be used for a year but they have not yet been offered a follow-up appointment.

4.7 Participant priorities

To encourage participants to consider their priorities when it comes to healthcare and to understand if people would be willing to travel further to receive care, a prioritisation question was asked where the participants had to rank each statement from 1 to 6, with 1 being the most important and 6 being the least important. It is important to recognise that this question is useful but, given the relatively small number of respondents, the results should not be viewed as an overall reflection of peoples' priorities:

1. I want to see highly trained specialist cardiology specialist doctors and nurses.
2. I don't want to have to wait too long to get an appointment.
3. I would like to be treated in a setting where there are cutting edge facilities and equipment.
4. When I am at the hospital, I want appointments to run on time.
5. I need to consider the time taken to travel to get to my appointment.
6. I need to consider how to get to my appointment i.e. is there a regular bus available, would I be able to cover the cost to get to the appointment.

4.8 Other groups the CCG should engage with during any public consultation

We asked participants if there were any groups that we should focus on once we have a set of proposals. Responses included:

- The elderly
- Trans people
- Carers
- Disabled
- Those with learning disabilities
- Homeless and rough sleepers
- Those without transport
- Staff at the ambulance trust (SECAmb)

5.0 Conclusion

Public engagement successfully reached a significant number of people, despite the limitations of lockdown during COVID-19, and the CCG heard from a wide variety of individuals, organisations and stakeholders.

The findings have been shared with ESHT and an action plan is being developed using some of the early findings to make small but effective changes to the way the service is provided.

The outputs of the public engagement will inform and shape the options development and appraisal process and will used to shape any business case and formal consultation, if required.

6.0 Appendix 1 - Equality data

There was a widespread response from across East Sussex with the highest responses coming from Eastbourne and Hastings. Not all respondents completed the equality data section of the questionnaire.

BN22	Eastbourne	7
TN34	Hastings	7
TN35	Rural Rother	5
TN39	Bexhill	5

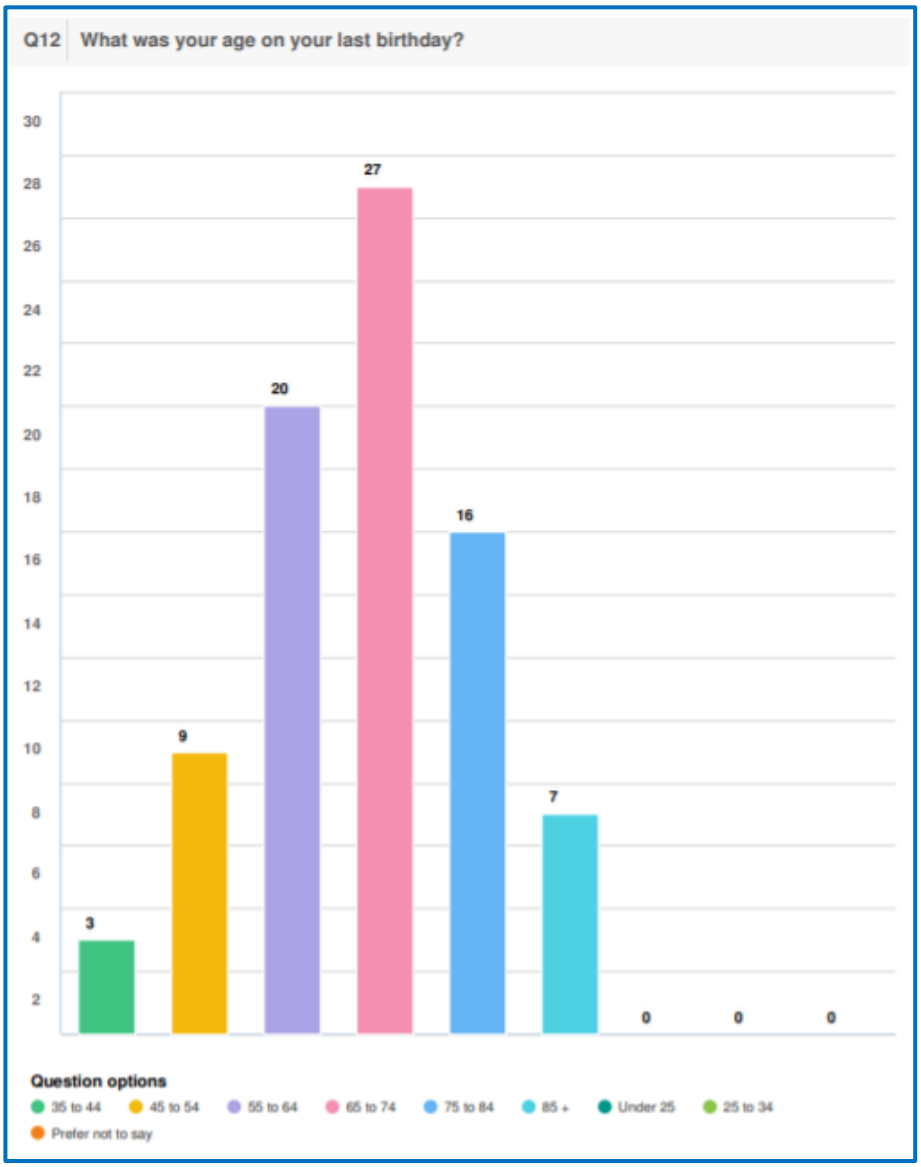
4 responses from BN20, BN21, BN23, BN25, TN31, TN33, TN38

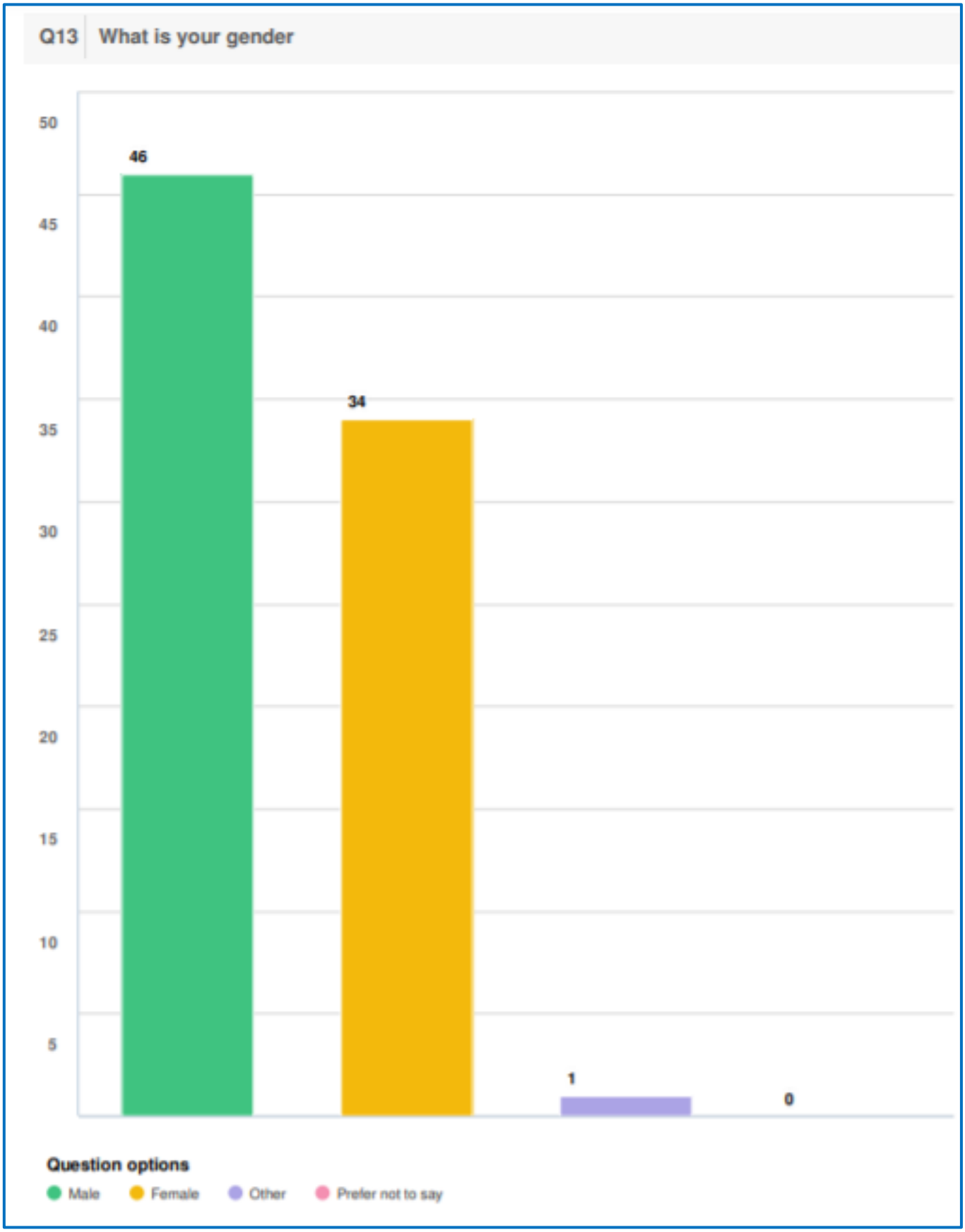
3 responses from BN7, BN27, TN19, TN40

2 responses from BN10, BN24, TN22

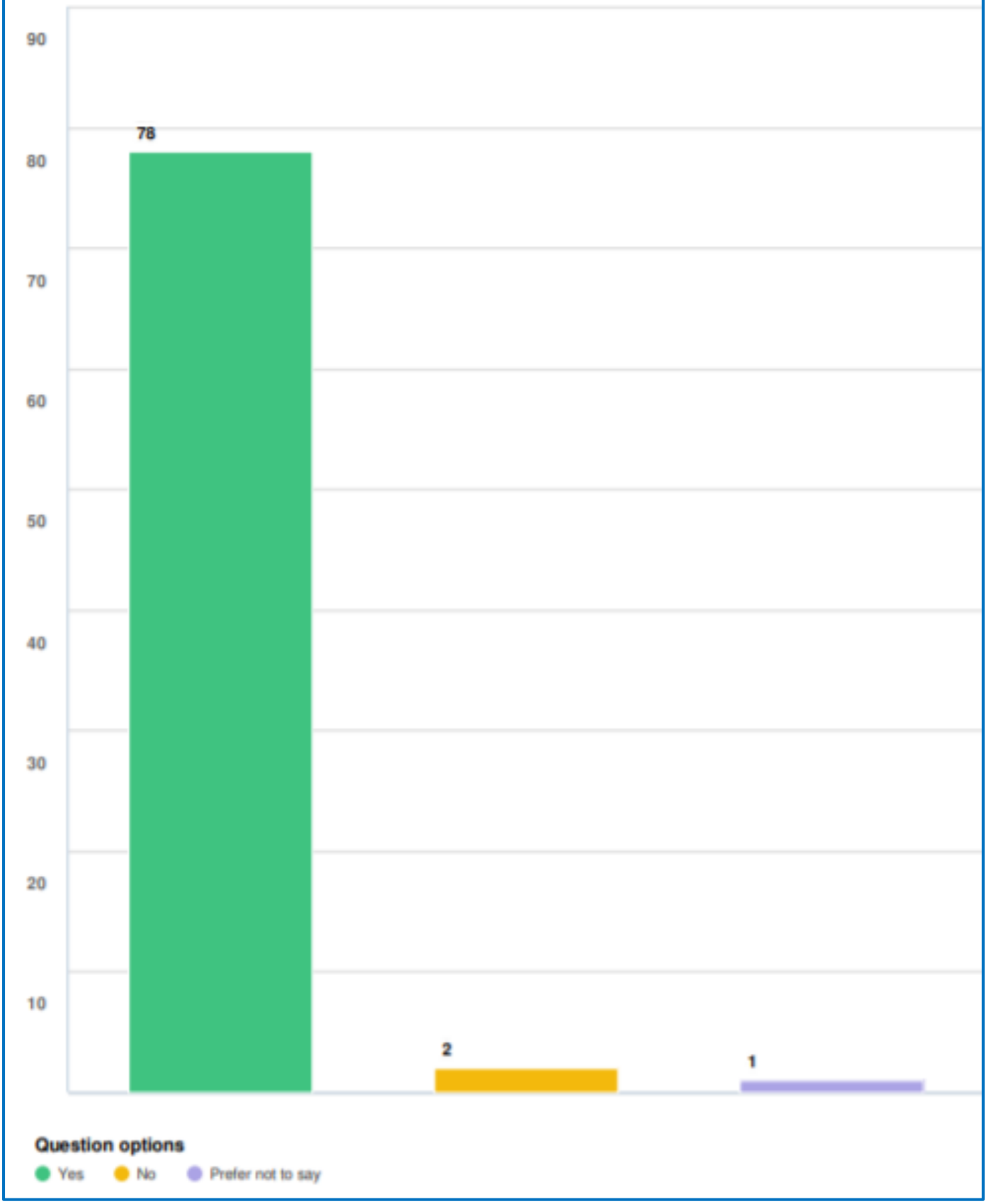
1 response from BN26, TN6, TN18, TN21, TN36, TN37

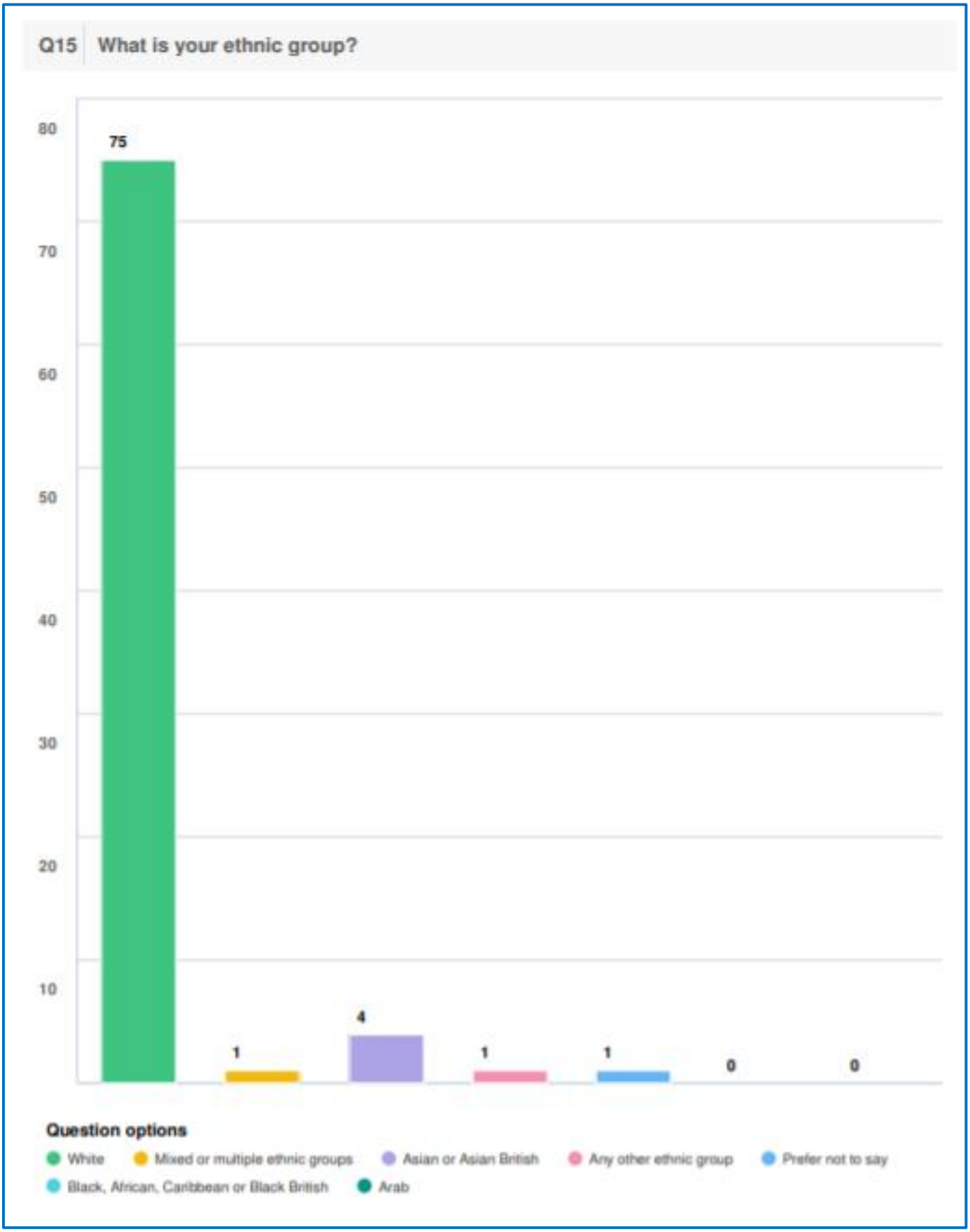
One out of area response was received from Brighton and Hove (BN2)

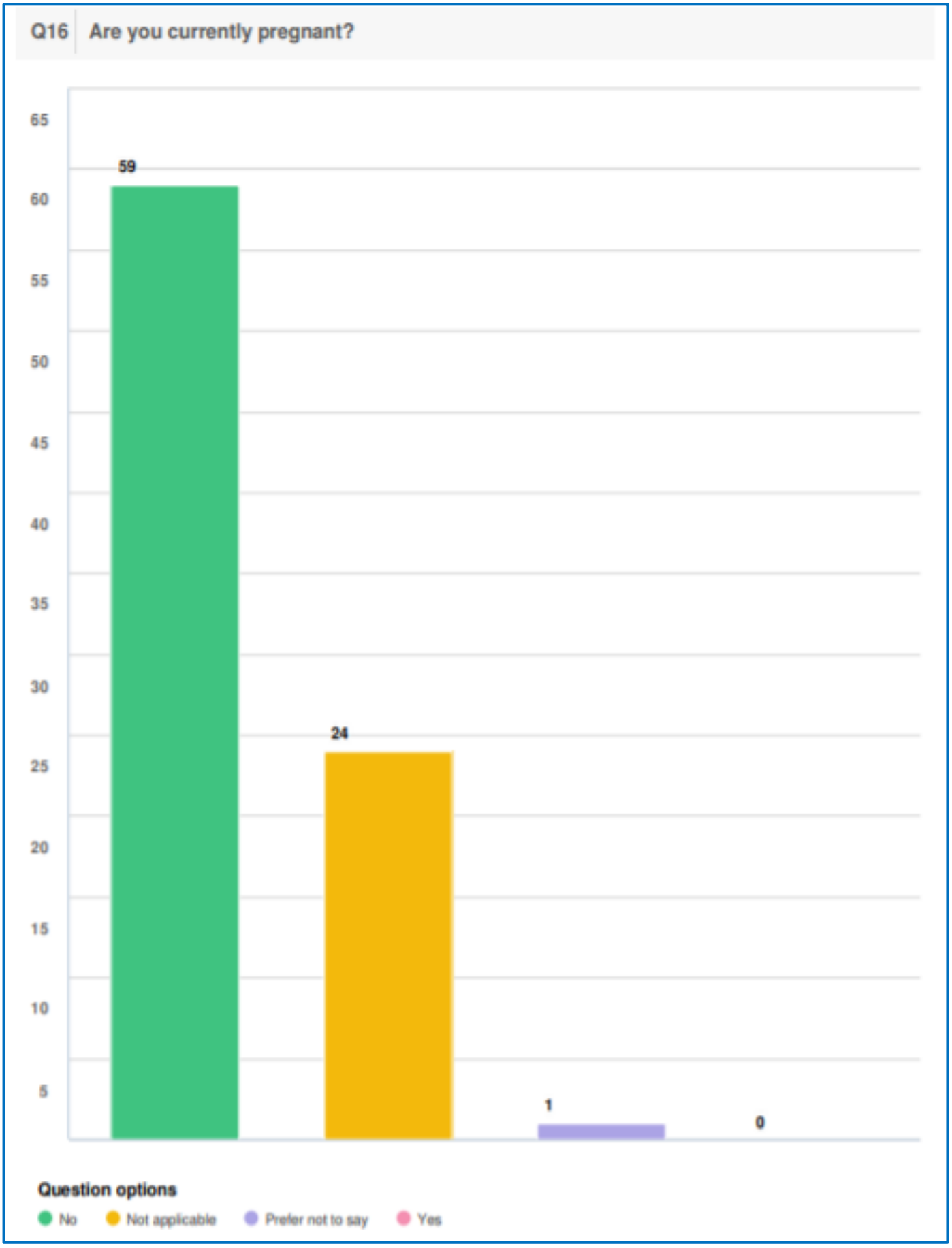



Q13 What is your gender
50
45
40
35
30
25
20
15
10
5
46
34
1
0
Question options
Male
Female
Other
Prefer not to say

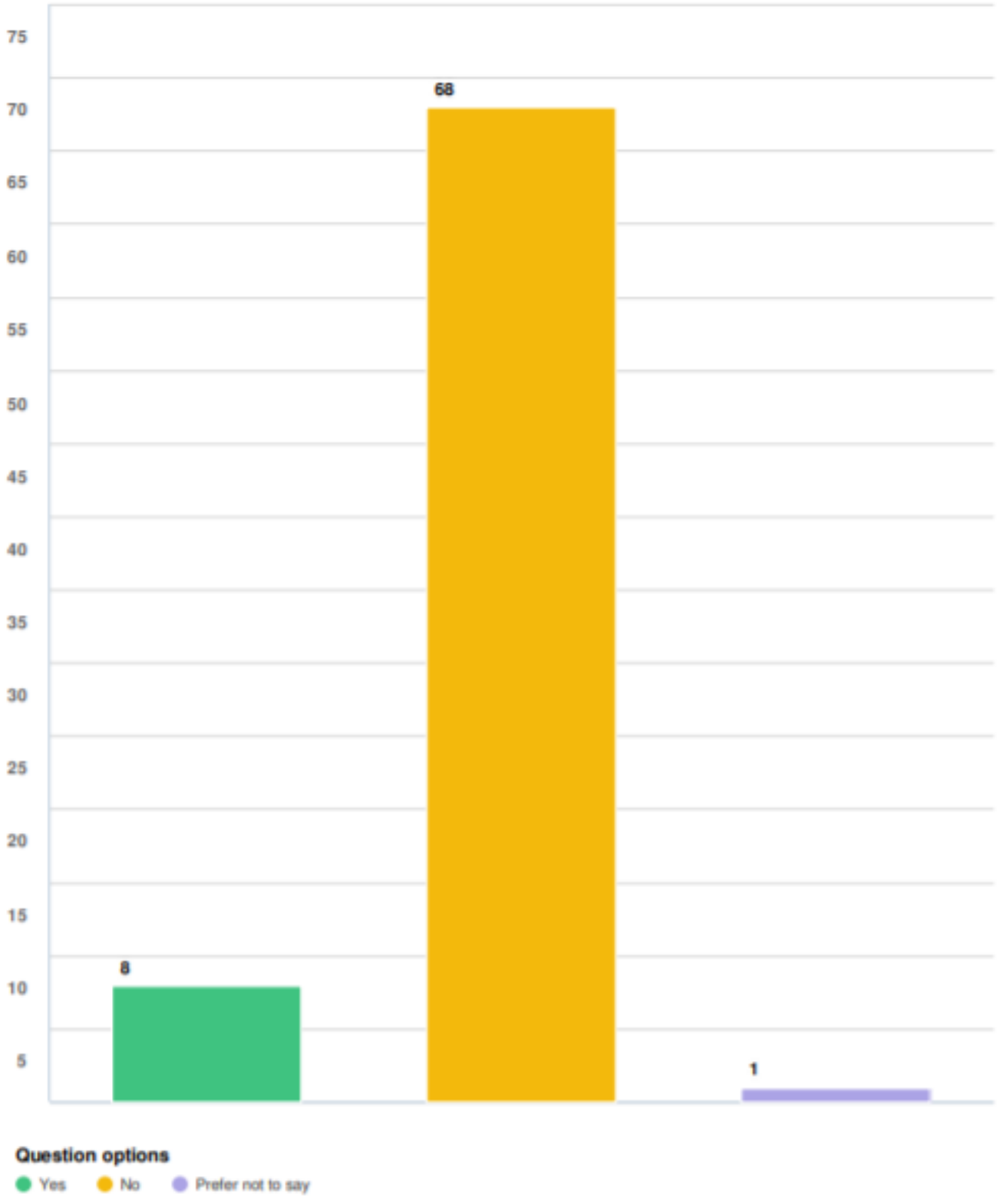
Q14 Do you identify as the sex you were assigned at birth? For people who are transgender, the sex they were assigned at birth is not the same as their own sense of gender.



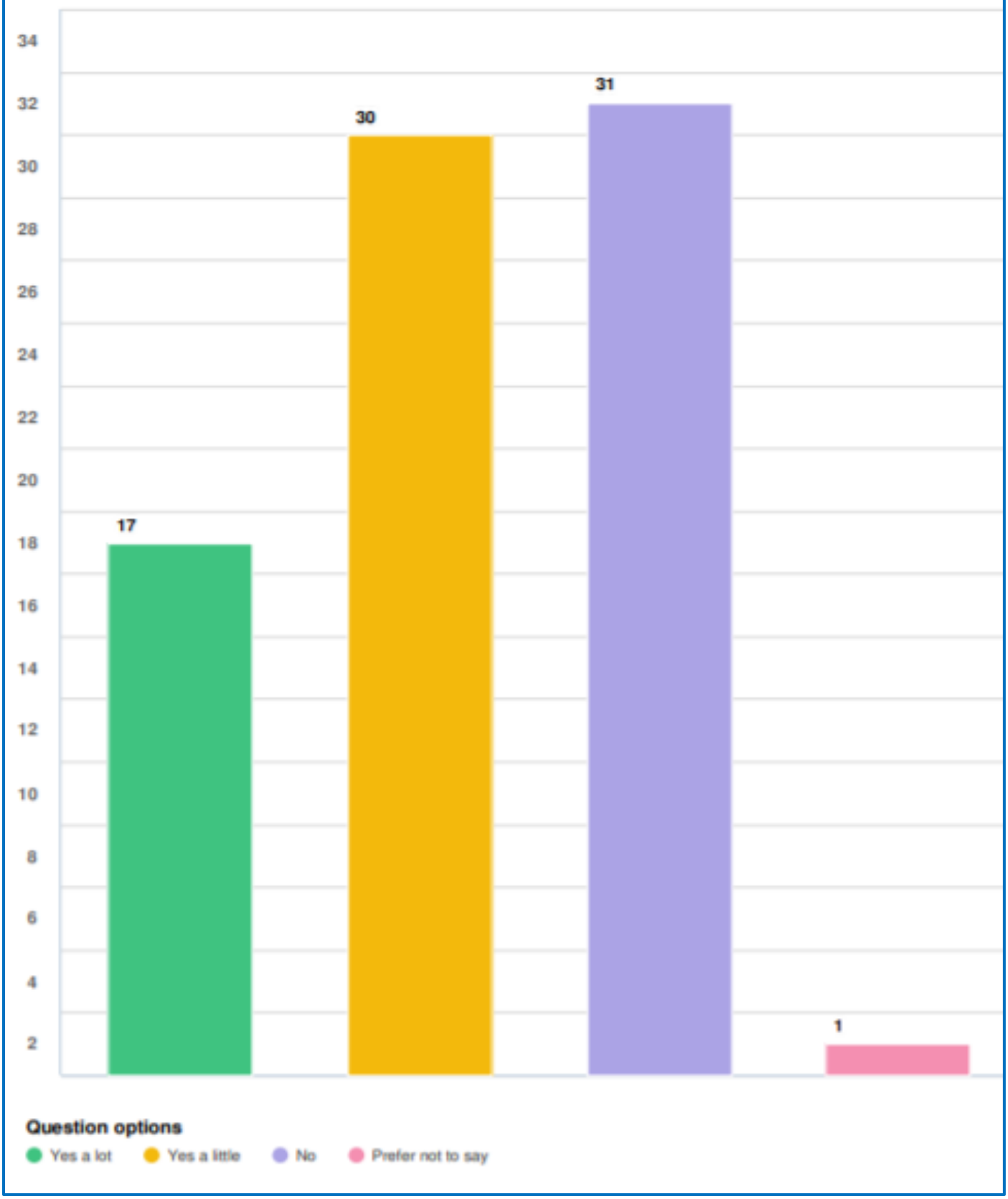

Q15 What is your ethnic group?
80
70
60
50
40
30
20
10
75
1
4
1
1
0
0
Question options
White
Mixed or multiple ethnic groups
Asian or Asian British
Any other ethnic group
Prefer not to say
Black, African, Caribbean or Black British
Arab

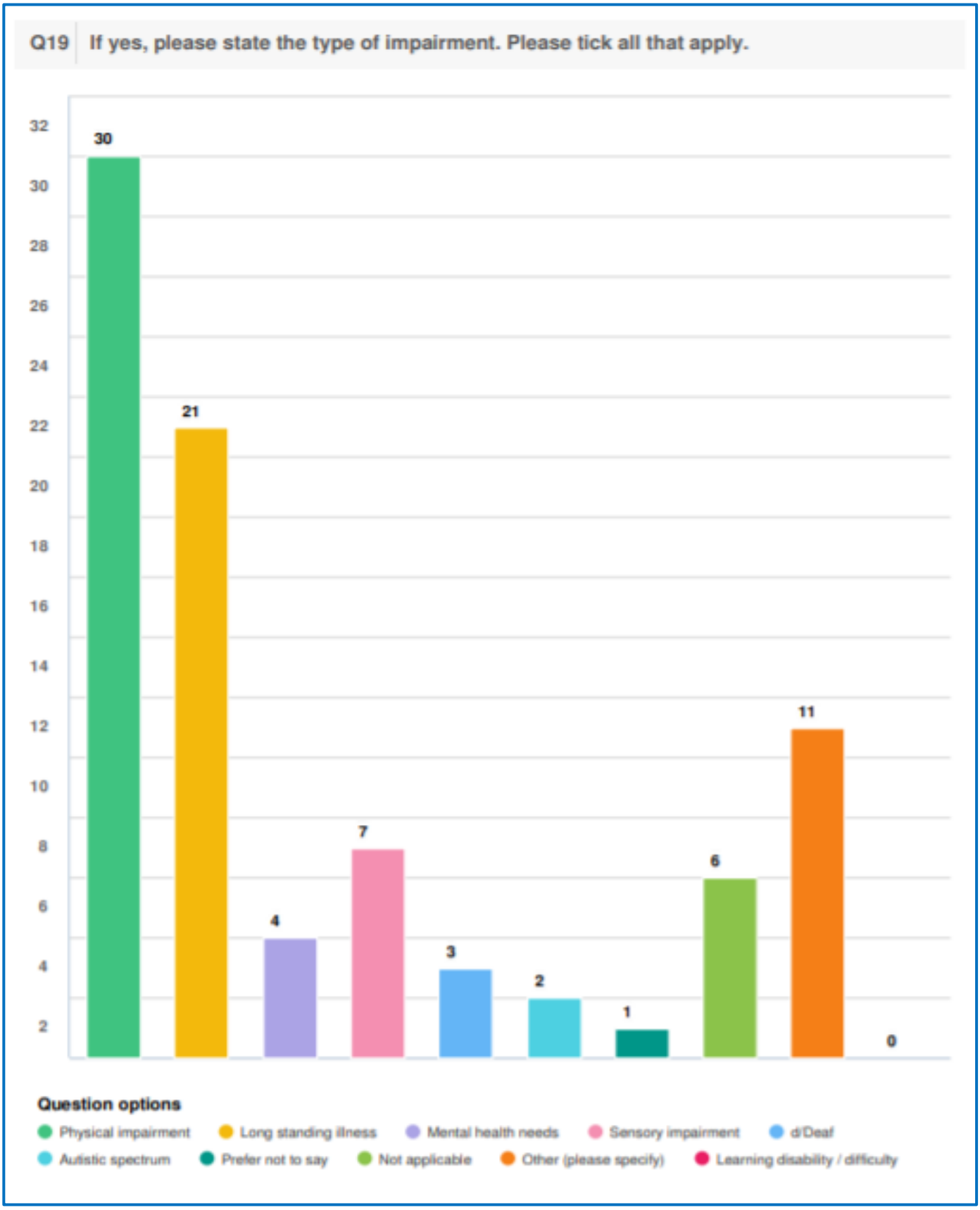

Q16 Are you currently pregnant?
65
60
55
50
45
40
35
30
25
20
15
10
5
59
24
1
0
Question options
No
Not applicable
Prefer not to say
Yes

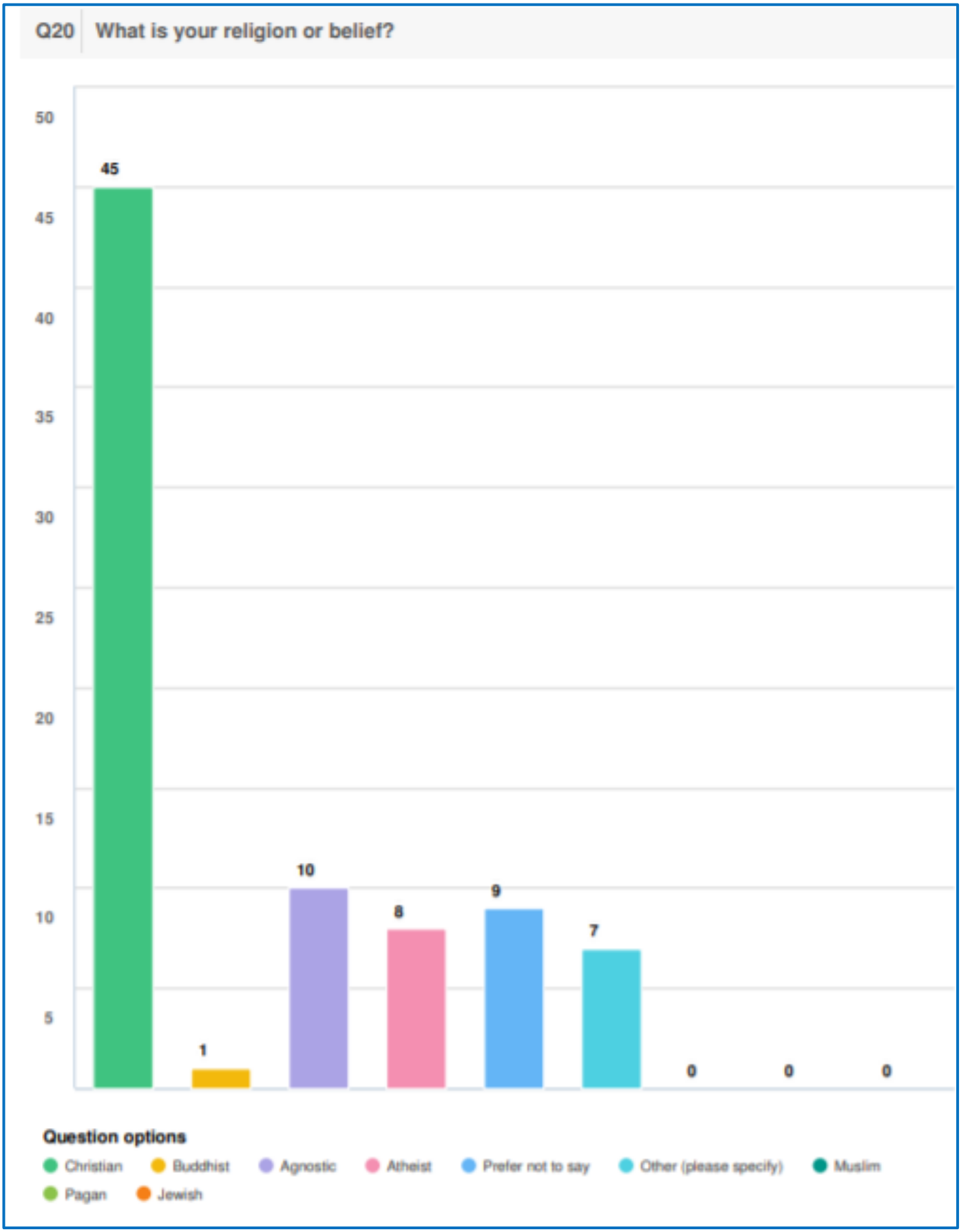
Q17 Are you a carer? A carer provides unpaid support to family or friends who are ill, frail, disabled or have mental health or substance misuse problems.



Q18 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?




Q19 If yes, please state the type of impairment. Please tick all that apply.
32
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
30
21
4
7
3
2
1
6
11
0
Question options
Physical impairment
Long standing illness
Mental health needs
Sensory impairment
d/Deaf
Autistic spectrum
Prefer not to say
Not applicable
Other (please specify)
Learning disability / difficulty


Q20 What is your religion or belief?
50
45
40
35
30
25
20
15
10
5
45
1
10
8
9
7
0
0
0
Question options
Christian
Buddhist
Agnostic
Atheist
Prefer not to say
Other (please specify)
Muslim
Pagan
Jewish

Transforming Acute Cardiology Services in East Sussex

Options Development and Appraisal

Addendum - July 2021

Opinion Research Services

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Addendum - Summary of additional ORS pre-consultation engagement

Following options development and appraisal in March 2021, ORS conducted three short interviews with cardiology service users around the way that future public consultation might be planned: who ought to be engaged with; possible activities and channels for feedback; and whether there are any groups of people who might need additional support or encouragement to take part. Interviewees also suggested key concerns which might arise during consultation. Finally, there were some broader comments around cardiology services in East Sussex. ORS does not endorse the views reported below, but rather seeks to report them fully and accurately for due consideration by decision makers as they plan for consultation in the future.

Summary of key themes from interviews

Preparing for future engagement and consultation

- Medical professionals across all sites must be engaged with, as well as a broad selection of patients who have experienced different levels of service. The wider public should also be included as long as it is not simply 'paying lip service' without follow-up action.
- One interviewee felt that, while it was 'nice to be asked' for their views, gratitude for the NHS is important as is a wide perspective. They would be happy as long as hospital staff are consulted to ensure the service works for them.
- It was suggested that assessments should be carried out to map which ailments are prevalent in different areas to ensure that services meet needs in those places.
- Interviewees identified several possible barriers to engagement which they felt ought to be taken into consideration when planning future consultation on proposals; in particular, it was suggested that a lack of digital skills or a perception that engagement channels and processes for giving feedback might be onerous could put people off taking part.
- Advertising in general media outlets would not necessarily be effective, as people may miss them, although it was also felt that older people tend to engage with print media and local news channels. One interviewee wondered if churches could be contacted to see if their members would take part.

Suggestions for possible engagement activities

- One participant commented that people with heart conditions could feel anxious about face-to-face events due to COVID-19. Virtual Zoom events were seen as practical and inclusive for people who are digitally literate, as was social media. It was also suggested that for people who work, physical events could be an inconvenience and virtual events might fit better with other commitments.
- Ongoing discussion forums would be valued to promote an 'open and honest' conversation with decision makers. This was viewed as preferrable to attending a single event and then not knowing how their views are used until final decisions are made. Furthermore, personal communication makes participants feel valued and that their contributions are important.

Encouraging and supporting engagement

- It was recommended that additional support be available to those who may need to take part in any future engagement or consultation. For example, it was suggested that volunteers could be found to assist older people, those with disabilities that might make it more difficult to take part, and those less comfortable with digital technology.
- It was felt that activities to which people can be personally invited could work well. One interviewee felt that women in their own ethnic community might be reticent to engage in public discussion and should therefore be helped and encouraged to take part by other means. Accessibility is key and the option to submit feedback by post as well as online was seen as important.

Concerns which may arise in future engagement and consultation once proposals are finalised

- If there are proposals for services to be co-located on one site, people are likely to be concerned that, in an emergency or time-critical situation, increased travel time and distance could pose a risk. This may be of particularly concern for those at increased risk of a heart attack, as well as for carers or family members of - for example - older patients.
- In terms of possible sites for any co-located services, it was felt that there might be acceptance that Conquest Hospital is more central for the county overall, although the older population in Eastbourne and people with mobility issues may be adversely affected if they have to travel further.
- Travel times and costs, transport, and parking would very likely be concerns, as could a lack of space for growth at hospital sites. Reassurance would be needed - particularly around possible improvements to infrastructure to facilitate travel to more distant hospitals.
- However, there may also be an understanding of the potential benefits of proposals, both financially and for providing the best quality of care, provided that members of the public do not simply feel that they are taking part in a cost-cutting exercise.
- There may also be recognition of the benefits of creating a 'centre of excellence' on a single site to ensure proper resourcing, staff development and retention - consultees may feel that the benefits outweigh concerns about travel and transport.
- Clinical staff might be seen as the most important consideration in terms of the location of services, as they need to be able to provide the best care possible however that may work in the future. There may be concerns around long commutes to work if their specialty is moved to a different location, as well challenges if staff need to transfer across sites due to emergencies.

Other comments on cardiology services in East Sussex

- Acute cardiology services are seen as good, but current after-care was felt to be not as effective as expected. More formal follow-up would be appreciated; one person suggested that online nurse consultations would work well. Another said that their pre-op care had been poor and that their situation had worsened significantly as a result.
- Patients would welcome some self-help groups for cardiology patients to improve the 'proactive' element of care and raise awareness of cardiology issues and signs of a problem. The education element is an important factor to improve the prevention of serious disease.

Transforming Cardiology Services Consultation
Draft Delivery Plan December 2021- March 2022

Introduction

This plan describes how we will communicate and engage with the public and our stakeholders during the formal consultation process regarding the proposals for the transformation of Cardiology Services at East Sussex Hospital Trust (ESHT) which is due to take place between Monday 6th December 2021 and Monday 14th March 2022. The plan has been informed by our pre-consultation engagement work, by the Options Development and Appraisal process and by the Equalities and Health Inequalities Impact Assessment.

The plan does not include any communications and engagement that may be required with staff.

Background and context

The CCG is developing proposals for how hospital-based cardiology services can best provide high quality treatment, care and support for local people and meet increasing local population need. Cardiology services for adults in East Sussex are provided by ESHT at Eastbourne District General Hospital and the Conquest Hospital in Hastings.

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, many heart conditions are age-related, making heart health (cardiology) services more and more important as people get older. Cardiology is also constantly evolving with new developments in disease prevention, diagnostics and therapeutics.

The CCG's vision for the future is to provide a high-quality cardiology service for patients, carers and their families regardless of age, disability, gender or ethnicity. This includes:

- providing clinically excellent specialised cardiology services;
- developing and encouraging innovation in the delivery of cardiology services;
- developing services that are clinically, financially and environmentally sustainable;
- increasing the ability to look after a growing and ageing population;
- providing increased support and development for the cardiology workforce.

Pre-consultation Engagement

To consider how cardiology services could be transformed, the Public Involvement (PI) team undertook pre-consultation engagement which commenced on 4 January 2021 and lasted six weeks (concluding on 14 February 2021).

To reach the local population in East Sussex the PI team co-developed questionnaires with partners and members of the public and these were promoted widely in paper copies and electronically. The team undertook interviews with current and former patients of the service and joined virtual local forums and groups to hear from people about their experiences. The insight gained from this engagement then informed the development and appraisal of options for the future of the service.

Options Development and Appraisal

The CCG commissioned the independent organisation Opinion Research Services (ORS) to lead the options development and appraisal process. Patients, representatives from relevant VCS organisations and Community Ambassadors attended. PI team members and cardiology specialists from ESHT attended to observe, present key information and respond to questions, but did not actively participate in the options appraisal scoring and ranking activities.

Three options development and appraisal workshops (independently chaired and facilitated by ORS researchers) took place in March 2021 to identify and consider a longlist of possible options for the future provision of cardiology services. Participants were provided with information to enable informed discussion, including summaries of key contextual information (e.g. population health needs, clinical standards, activity demand and capacity, finances, estate footprint, workforce) and summaries of key programme documents (e.g. Equality and Health Inequality Impact Assessment and Case for Change).

Various potential models of care were developed and discussed at the workshops and participants then ranked and scored the options against the agreed criteria, as a result of which five options were shortlisted for cardiology:

1. Option 1: keeping current services as they are;
2. Option 2: keeping current services as they are while adding new assessment areas in emergency departments and ‘hot clinics’ at both acute hospital sites;
3. Option 3: building up both acute hospitals, with the addition of assessment areas and ‘hot clinics’ (‘everything, everywhere’);
4. Option 4: separating services so that Percutaneous Coronary Interventions (PCI) are delivered at one acute hospital site, while elective Electrophysiology (EP), Permanent Pacemaker (PPM) and Devices services are delivered on the other acute site, with the addition of a cardiology assessment areas and ‘hot clinics’ at both acute sites;

5. Option 5: co-locating all catheterisation laboratories and inpatient services on one acute hospital site, with acute outpatients and diagnostic services at both acute sites, with the addition of cardiology assessment areas and 'hot clinics' at both acute sites.

Discussions were based on these five possible approaches. Participants in the workshops were also invited to suggest other approaches for consideration and appraisal, but the consensus was that the five options above were appropriate therefore no further options were added.

These options were then reviewed by ESHT and the CCG and it was decided to proceed to full consultation on Option 5.

Participants at the workshops raised a series of concerns which the PI team will ensure form a focus of the full public consultation currently scheduled to take place in early 2022. These concerns were:

- travel and access: time, distance and cost;
- the ability to cope with increased patient demand;
- concerns about moves to digital appointments.

Clinical Senate Recommendations

In August 2021 the CCG submitted the Pre-Consultation Business Case to the Southeast Clinical Senate for review. The Clinical Senate made the following recommendations regarding Patient and Public Engagement:

Black, Asian and Minority Ethnic (BAME) populations are vulnerable to heart and circulatory disease and are more likely to be associated with increased deprivation. Their engagement and involvement are therefore paramount.

In response, this Delivery Plan ensures that there is a focus on these groups.

Equality and Health Inequalities Impact Assessment (EHIA)

The CCG has reviewed the EHIA. This document made a series of recommendations and responses to each of these recommendations have been included in the Delivery Plan.

Protected characteristic	Engagement activity

Race	• Links with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement. • Friends, Families and Travellers will receive information on all involvement activity. • Questionnaires will be translated into community languages (on request) • Attend Eastbourne Cultural Involvement Group to promote engagement opportunities • Request support from Diversity Resource International to promote engagement opportunities with local ethnically diverse communities, including refugees and asylum seekers
People who have English as a second language	• Work with organisations that provide translation services to better understand the need for translation support for patients accessing cardiology services in East Sussex • Offer telephone interpretation to support those who speak English as a second language and wish to engage • Translate materials into community languages (on request)
Gender reassignment	• Approach Hastings and Rother Rainbow Alliance Trans Support Group and ask to establish focus groups • Approach Bourne Out via Facebook and ask for support with engagement • Contact The Clare Project and Switchboard in Brighton and Hove to see if they have reach in East Sussex to encourage participation
Age	• Take measures at the outset to identify organisations that support younger people living with cardiovascular disease • Attend East Sussex Senior Association to talk about acute cardiology service transformation and provide opportunities to feedback/ get involved • Contact Age Concern to ask about attending some drop in sessions • Attend PPG forums across East Sussex and offer drop in sessions • Liaison and engagement with Age UK East Sussex
Religion and Belief	• Ensure that we have forged links with faith communities in East Sussex to engage in this project. • Invite faith elders to complete the survey, and offer translated versions if required
Disability	• Explore opportunities with CVS organisations such as Possibility People to see what forums and networks we can utilise to support engagement • Approach Hastings disability forum to ask for support • Arrange a drop in opportunity for d/Deaf members to come and talk about experiences of cardiology services • Make the materials available in Easy Read and British Sign Language on request. • Approach the East Sussex Dementia Adviser Service to support the reach of our engagement • Approach the East Sussex Community Learning Disability Team for support

	• Take action to identify and engage with charities and organisations that support patients with diabetes • Take action to identify and engage with charities and organisations that support patients with their mental health
Sexual Orientation	• Take action to identify and engage with LGBTQ groups in East Sussex
Pregnancy and Maternity	• Attend East Sussex Maternity Voices Partnership meeting
Other disadvantaged or inclusion groups	• Engaging with carers through one-to-one interviews, liaison with representative groups and questionnaires • Engage with homeless and rough sleepers through pre-existing relationships with supporting organisations such as Rough Sleepers Initiative, Matthew25 and YMCA • Liaise with the NHS Armed Forces Network and relevant organisations e.g. Blue Van Veterans, to ensure this cohort is heard from •
Deprivation and socio-economic disadvantage	• Utilise foodbanks to share paper copies of questionnaires with freepost address • Ask for support from RVA, HVA and 3VA and other relevant organisations to target those living in areas of deprivation.

*This list is not exhaustive but provides examples of the activities planned to reach marginalised groups

Governance

The Cardiology Communications and Public Involvement Task and Finish Group will be overseen by the Joint Cardiology and Ophthalmology Steering Group which reports to LMT. An assurance oversight group with membership from Healthwatch, Local Authority and a Community Ambassador will be established to ensure the process is robust and there are no avoidable gaps in engagement.

Key principles

In undertaking communications and engagement around our formal consultation we will adopt a transparent, best practice approach based on a number of key principles:

- Building on our wide range of previous engagement with local people and describing our journey, the purpose of our review and our intent to consult.
- 'Strength-testing' all aspects of our thinking, planning and approach.
- Acknowledging the importance our communities place on local services and our interest in all available feedback and insight to further inform our options.

- Incorporating the findings from our Equalities/Health Inequalities Impact Assessment (EHIA) to help us identify the groups and communities we should target for our communications and engagement work.
- Utilising our stakeholder mapping to ensure that we engage with all groups and partners with an interest in our plans including local councillors and MPs.
- Approaching our conversations with transparency in relation to our financial challenge and our need to balance the sustainability of local services whilst offering high quality care, at the right time and place for local people.
- Being transparent about the benefits and risks of our approach and testing our thinking on those.

Supporting information/materials

EngagementHQ

EngagementHQ is an interactive platform that enables people to give their views and feedback on programmes and public consultations. For this public consultation a project page will be created which holds all important documents, promotes all engagement opportunities and encourages the public to share their views through the use of the official survey, quick polls, sharing stories, a live Q and A section and an ideas area.

The CCG's public website will also be updated with the correct documents and promotes the new webpage.

Item	Location/format	Details	Responsible
Consultation document	Available in print and on CCG website and EngagementHQ website	Information on the consultation, including all relevant documentation, to be widely shared by email	Communications lead
Easy Read Consultation document	Available in print and on CCG website and EngagementHQ website		Involvement Lead
Overseas language translated consultation summary	Top five languages translated	Will be translated further as required	Involvement Lead
Survey	Link on CCG website and EngagementHQ website; paper copies provided at engagement events and on request		Involvement Lead

BSL survey	BSL translated survey on CCG website and EngagementHQ website		Involvement Lead
Easy Read survey	Easy Read survey on CCG website and EngagementHQ website		Involvement Lead
EHIA	On CCG website and EngagementHQ website		Involvement Lead
PCBC	On CCG website and EngagementHQ website		Project team
Frequently Asked Questions	On CCG website and EngagementHQ website	To be updated during consultation	Comms lead/project lead
Posters	A4 poster, display in local hospitals, high street opticians, GP practices	"Have your say" generic message	Communications lead
Leaflets	A5 leaflet, available at local hospitals and GP practices, in any other languages identified as a result of the EHIA and our engagement. Also to be sent out with food parcels from foodbanks.	To include dates and details of key engagement opportunities	Involvement Lead

Draft consultation activity plan for the period 6th December 2021 – 14th March 2022

Note: some activity subject to change and confirmation of dates

Communications	
Date	**Activity**
October – November 2021	**Planning** Key documents to be revisited including: Pre-consultation Business Case EHIA - reviewed to include any learning from Covid-19 and from the initial stages of the consultation (prior to the pause) Engagement plan – updated engagement delivery plan recognising updated EHIA Consultation document updated, approved and printed Frequently Asked Questions - updated Posters, flyers and leaflets updated, website approved and printed

	Press release drafted and approved
Pre consultation launch : 16.11.21 onwards	Phone calls to identified stakeholders Stakeholder briefing to be issued on day of Joint Committee MP briefing Reactive media statement in place
6th December onwards	**Implementation** • Consultation document and associated supporting documents published on East Sussex CCG website with link to complete consultation questions on independent organisation webpage • Leaflets to be distributed via food banks, Community and Voluntary Sector (CVS) organisations and digitally via newsletters • Press release issued (including press release in British Sign Language) • Tailored emails to: ➢ Key stakeholders (based on stakeholder mapping) ➢ Eastbourne Patient Participation Group members ➢ Eastbourne, Hailsham and Seaford GP practices ➢ Healthwatch East Sussex • Social media posts • Inclusion in GP bulletin • Article in East Sussex Health and Social Care News • Articles in local newsletters - ongoing • Content sharing by key partners (e.g. ESHT, ESCC, Healthwatch, voluntary and community sector etc.) on social media, public websites, intranets, newsletters, etc.
6th December-14th March	• Social media posts continue until end of the consultation • Reminder in GP bulletin • Article in East Sussex Health and Social Care News • Articles in local newsletters - ongoing • Content sharing by key partners (e.g. ESHT, ESCC, Healthwatch, voluntary and community sector etc.) on social media, public websites, intranets, newsletters, etc. • Tailored emails to: ➢ Key stakeholders ➢ Eastbourne PPG members and GP practices

Post Consultation and final report	• Tailored emails to: ➢ Key stakeholders ➢ ESHC public distribution list ➢ Eastbourne PPG members and GP practices ➢ CVS organisations who supported the public consultation • Article on East Sussex CCG website • Press release which includes highlights from consultation feedback report and a link to the full report • Provide update and copies of the final report at all forums and groups that took part in the consultation

Engagement Activities 06.12.21- 14.03.21		
Membership and provider engagement		
Date	**Activity**	**Lead**
Fortnightly	Attendance at East Sussex Communications and Engagement Steering Group: distribution of materials including questionnaires, posters, etc.	Public Involvement Team
January 2022	Dedicated webinar for Eastbourne Hailsham and Seaford, Hastings and Rother, High Weald and Lewes and Havens locality members	Clinical leads
Patient and public involvement		
Ongoing throughout consultation	Provide information on consultation to Sussex Health and Care Partnership, District, Borough and Parish Councils, community and voluntary sector organisations and relevant services and neighbouring CCGs and Acute Trust (particularly Maidstone and Tunbridge Wells NHS Trust): include material for distribution, questionnaires, web links etc. and offer attendance if requested: HVA, RVA, 3VA, Southdown, Fulfilling Lives, East Sussex County Council Young People's Services, YMCA, Red Cross, Citizens' Advice Bureau, East Sussex Chambers of Commerce, Eastbourne and Hampden Park Libraries, Beacon Shopping Centre, Maternity Voices, Action	Communications and Public Involvement team

	in Rural Sussex, Deaf Cultural Outreach Group (DeafCOG), Diabetes UK (local groups), St John's Ambulance, Sussex Community Development Association, Sussex U3A groups, Armed Forces Network, Age Concern, Age UK, Amaze SENDIASS East Sussex, Churches Together Sussex, Friends, Families and Travellers, Rough Sleepers' Initiative, Mathew 25, Salvation Army, Homeless and Rough Sleepers' Service, East Sussex food banks, Leagues of Friends, Save the DGH, Save the NHS, Friends of the Conquest Hospital, Rainbow Alliance, Bourne Out, Possability People, MIND East Sussex, Grace Eyre, Amaze, HEART Hastings	
06.12.21 onwards	Attendance at meetings: British Heart Foundation Sussex Heart Charity East Sussex Disability Association Care for the Carers – East Sussex Autism Partnership Board LD Partnership Board East Sussex County Federation of WIs Fellowship of St Nicholas Hub on Rye Hill Community Centre Oasis Community Projects (Ore Valley) Rotherfield St Martin (community hub) Pelham Community Hub (Bexhill) Shinewater North Langney Neighbourhood Partnership (Eastbourne) Blue Van Veterans East Sussex Seniors' Association Dementia Alliances: Eastbourne, Hastings and St Leonard's, Bexhill, Wealden, Havens Deaf Cultural Outreach Group (DeafCOG) Eastbourne Cultural Involvement Group Seaview Centre St Leonards Hastings and Rother Interfaith Forum (tbc) Eastbourne Faith Forum (tbc) Hastings Older People's Ethnic Group HOPE-G Hastings Age-friendly Community Coffee Mornings Hellingly over-60s Coffee Mornings	Public Involvement team

	Parent Carer Forums (via ESCC) Black Butterfly (ethnically diverse communities, asylum seekers, refugees) LGBTQ – contacts being investigated	
06.12.21 onwards	Individual interviews with service users and carers	Public Involvement team
January 2022	Stakeholder workshops e.g. Patient Transport Services, Healthwatch, Community Cardiology Services	Public Involvement team
06.12.21	Local Voices Network – invitations to participate in events, links to questionnaires, regular updates on consultation progress	Public Involvement team
TBC	East Sussex Local Strategic Partnership Boards – information prior to and during consultation, updates re: consultation, offer to attend	Public Involvement team
30th November 4th December 7th December 21st December 18th January	High Weald PPG forum Eastbourne Hailsham and Seaford PPG forum Hastings and Rother PPG forum Lewes and Havens PPG forum East Sussex PPG Steering Group	Public Involvement team
06.12.21	GP practices sent information on consultation including material for distribution, questionnaires, information for electronic screens, posters	Communications team
06.12.21 onwards	Telephone interviews offered to members of the public using dedicated telephone number, with Signlive assigned and interpretation available	Public Involvement team
January / February 2022	Public meetings: focus on communities identified by EHIA/Clinical Senate recommendations: focus on communities identified by EHIA/Clinical Senate recommendations: Hastings/St Leonards: Hollington Four Towers - Eastbourne: Langney Community Centre - Rural Rother: Hub on Rye Hill Community Centre - High Weald: Uckfield Civic Centre	Chief Executive ESHT/CCG and clinicians
06.12.21 onwards	Public events e.g. Eastbourne Open Air Market, Rye Market, Hastings Priory Meadow, Hollington Tesco, Beacon Shopping Centre Eastbourne, Hailsham shopping centre,	Public Involvement team

	Crowborough Farmers Market, Seaford Library, Newhaven Country Market, Lewes Farmers' Market.	

This is a live document and will continue to be added to during the consultation period.

Report to	Joint Sussex Committee
CCGs applicable to	East Sussex CCG
Meeting date	17 November 2021
Report title	East Sussex Healthcare NHS Trust: transformation of Cardiology Services
Report from	Jessica Britton, Executive Managing Director, East Sussex CCG
Clinical leads	Dr Suneeta Kochhar, GP Clinical Lead, cardiology
Report author	Victoria Hill, Senior Planned Care Manager
Item number	

Recommendation/action required:

The members of the Joint Sussex Committee are asked to:

- **review and consider** the Pre-Consultation Business Case for the Transformation of Acute Cardiology Services delivered by East Sussex Healthcare NHS Trust (ESHT)
- **approve** the proposals in principle, subject to the outcome of the East Sussex Healthcare NHS Trust Board meeting on 30 November 2021, and **delegate** authority for final decision-making on this business case to the Chair of the Joint Committee.
- **endorse** the recommendation that these should be subject to formal public consultation
- **agree** that the decision of the CCG should be submitted to the East Sussex Health Overview and Scrutiny Committee, on 2 December 2021, to consider if they would like the CCG to formally consult with them on the proposals.

Executive summary

The purpose of this Pre-Consultation Business Case is to describe the wide engagement to date in communicating the drivers for change, reviewing all possible options to transform acute cardiology services provided by East Sussex Healthcare NHS Trust to deliver the best possible care for local people. The Pre-Consultation Business Case includes the available information and evidence that has supported the development of models of care, analysis of possible options to deliver these models of care, and it proposes preferred viable options to transform acute cardiology services.

These Pre-Consultation Business Case recommends to the Joint Sussex Committee two options to take forward to public consultation, and, if approved by the Joint Sussex Committee, to submit to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this constitutes substantial variation to services and that they would like the CCG to consult with them on this.

The Process of Assurance

When developing our options, our final draft proposals, and this Pre-consultation Business Case:

- We have considered the outputs from engagement with local people and clinicians and used these to inform the Pre-Consultation Business Case.
- We have developed the Pre-Consultation Business Case with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We have assessed the impacts of our proposal by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We have taken into account the recommendations of the South East Clinical Senate.
- We have been informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We have assessed our proposal against the NHS Four Tests for service reconfigurations.[1]
- We have developed our proposal and associated consultation plans in line with the Gunning Principles[2] to ensure that:
    - a decision will not be taken until after public consultation
    - local people and stakeholders have information that enables them to engage in the consultation and inform our decision;
    - there is adequate time for people to participate in the consultation
    - we will demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
- We have considered opinions and insight from a number service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.

Programme Governance

We have established an East Sussex Cardiology and Ophthalmology Steering Board including membership from key partners and patient representatives to provide clear oversight and governance. This reports to the East Sussex, Brighton and Hove Local Management Team and the Executive Management Team as appropriate, with regular updates provided as part of the Chief Executive Officer and Executive Managing Director reports to the Joint Sussex Committee.

Independent Assurance

Options Development and Appraisal Workshops

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

In March and April 2021, we held three Options Appraisal workshops. These workshops were designed, developed and delivered in collaboration with the CCG by an external independent consultancy, Opinion Research Services (ORS), factoring in the themes and feedback from the pre-consultation engagement and the key areas identified within the EHIA. These workshops comprised a good range of stakeholders including patients.

ORS provided a comprehensive report on the outcomes of the workshops, including the most appropriate options to take forward for consideration and a qualitative and quantitative analysis of the feedback. Five appraisal criteria were discussed and agreed for both Cardiology and Ophthalmology workshops (Quality and Safety; Clinical sustainability; Access and Choice; Financial Sustainability; and Deliverability). This informed the final proposals and the PCBC.

Our approach to equalities and health inequalities

The Equality and Health Inequalities Assessment (EHIA) has been iterated throughout the programme and were further informed by a health inequalities workshop to review the shortlisted options through an inequalities lens, following the options appraisal. This supported the development of the preferred options for likely public consultation. Key actions have included:

- ensuring that as part of the formal options development and consultation processes, models/interventions are developed that meet the needs of our communities, including giving due regard to the issue of access and experience of patients with protected characteristics or other disadvantaged communities:
- ensuring links have been made with local faith communities or cultural groups in order to encourage involvement and gain feedback through all stages of patient and public involvement.
- attendance at multiple engagement opportunities to ensure we reach wide-ranging cohorts of the East Sussex population, e.g. Eastbourne Cultural Involvement Group, Hastings and Rother Rainbow Alliance Trans Support Group, Age UK East Sussex, East Sussex Senior Association, PPGs, Public Health, Patient Carer Forums, to promote engagement opportunities.
- target communications about service changes via channels to reach various patient groups.
- ESHT are currently working on a separate wider Trust piece of work to review data collection to ensure they are able to more accurately monitor data collection and identify any themes of inequality and address any identified challenges
- a further analysis of transport needs has been undertaken and this will inform the consultation and development of final Decision Making Business Case
- linking into Sussex wide work targeted on reducing health inequalities for cardiovascular disease, notably in relation to social deprivation.
- further training and education is required across the services, raising awareness and providing conscious consideration to those with protected characteristics

These EHIA is a live document and is being re-iterated throughout each phase of the programme.

Clinical Senate

We requested the NHS England South East Clinical Senate to undertake an independent clinical review of our proposals. We also asked the Clinical Senate to assess the evidence we have gathered and reviewed to develop this Pre-Consultation Business Case. More specifically, the Clinical Senate was asked to:

- evaluate the proposals alongside the Case for Change;
- provide a narrative that details any recommended mitigations that will support commissioners to finalise the Pre-Consultation Business Case;
- evaluate the proposals in terms of future services being accessible and continuing to meet the needs of the patient population to ensure any inequality issues would be suitably mitigated.

The Clinical Senate Panel reviewed the Pre-Consultation Business Case and met to discuss the proposals with the CCG, Trust and other stakeholder colleagues, in detail. The Clinical Senate made a number of recommendations which we have addressed and that have informed and strengthened this Pre-Consultation Business Case.

The Clinical Senate provides a helpful mechanism to test the clinical model with a clinical peer group; alongside reflections about our clinical model the clinical senate also provided a range of helpful reflections about our approach to options development and appraisal and about our process of engagement with stakeholders and local people.

Overall, the Clinical Senate report and findings provided a useful framework for the development of the Pre-Consultation Business Case and our future discussions and consultation with the stakeholders on the final pre-consultation proposal.

NHS England/Improvement Stage 1&2 Assurance

The stage 1 assurance meeting was held in January 2021. The feedback centered on the importance of further in-depth Equality and Health Inequality Impact Assessment and ensuring the proposals were fully integrated into, and consistent with, the broader Integrated Care System service recovery and transformation plans. The programme was approved to proceed further and agreed actions completed.

The stage 2 assurance meeting was held on 14 October 2021. The review considered the key tests for service reconfiguration and the proposals have now been approved to move forward to public consultation.

Proposed consultation approach

In undertaking any further engagement and consultation, the CCG will continue to adopt a transparent, best practice approach based on several key principles. We will

- build on our wide range of previous engagement with local people and describe our journey, the purpose of our review and our intent to consult;
- incorporate the findings from our Equalities and Health Inequalities Impact Assessment, which have helped us identify the groups and communities we should target for our communications and engagement work;

- proactively engage with any other groups (in their own environments) not identified as a result of the Equality and Health Inequality Assessment;
- "strength-test" all aspects of our thinking, planning and approach;
- involve patients through a variety of activities, go out into local communities and attend pre-existing engagement opportunities, with a clear focus on involving the seldom-heard communities as described in the Equality and Health Inequality Assessment;
- acknowledge the importance our communities place on accessible service provision and clearly communicate our interest in all available feedback and insight to further inform our proposals;
- share information about the range of services that are available to local people;
- utilise our stakeholder mapping to ensure that we engage with all groups and partners with an interest in our plans including our partners in East Sussex County Council, local councillors and Members of Parliament;
- be clear about our strategic goals to deliver better and more integrated high quality care in the right place and at the right time for local people, whilst also being transparent about our financial challenge;
- be transparent about the benefits and risks of our approach and test our thinking on those.

We have developed a Consultation Delivery Plan that brings together our planned communications and engagement activity during this period including:

- The consultation process will run for a period of 12 weeks (with an additional 10 working days to account for Christmas and New Year Bank Holidays) from December 2021 to March 2022.
- The responses to the consultation process will be independently analysed and a report will be published outlining how we have considered these in coming to our decision.
- The process will be promoted through social media and other established channels (including posters, adverts in local media, via newsletters to local stakeholder groups and existing forums).
- Leaflets/flyers will be provided (written in plain English and any other languages identified as a result of the Equality and Health Inequality Assessments and our engagement) promoting the consultation across the CCG's area.
- Any leaflets/flyers will be made available to GP practices and will also be prominently displayed at East Sussex Healthcare Trust.
- East Sussex Healthwatch will be engaged during the consultation process to provide support and further advice on the consultation process if required.
- We will work in partnership with the local voluntary and community sector to ensure that seldom-heard groups, particularly those identified as a result of the Equality and Health Inequality Assessment, are fully engaged with the consultation process.

Conclusion

The Pre-Consultation Business Case reflects a robust process of service redesign for this area of focus, demonstrating how the proposals will improve the quality and sustainability of services for our local population. The proposals will now be subject to a full public consultation.

Previously considered by [governance/ engagement pathway to date]		
Org./Group/ Name	**Date**	**Outcome**
East Sussex, Brighton and Hove LMT	8 December 2020	Case for change endorsed
Executive Management Team	21 December 2020	Case for change approved
East Sussex Governing Body	10 February 2021	Brief update on early engagement work on cardiology to understand people's experiences and inform next steps
East Sussex, Brighton and Hove LMT	4 May 2021	Progress update and approval to proceed
East Sussex Governing Body	7 April 2021	Update on engagement and workshops to develop options
East Sussex, Brighton and Hove LMT	20 July 2021	Progress update and approval to proceed
East Sussex, Brighton and Hove LMT	21 September 2021	Approval of draft EHIA, QIA, and PCBC in readiness for stage 2 assurance
Executive Management Team	25 October 2021	EMT noted the significant progress made and agreed the proposals and that the PCBC should be submitted to the CCGs' Joint Committee for approval to commence public consultation, and that the decision should be submitted to the East Sussex Health Overview and Scrutiny Committee.
Joint Quality Committee	9 November 2021	The committee noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The committee reviewed the summary PCBC, together with the EHIA and QIA and endorsed the case for consideration by the Joint Sussex Committee.

What happens next?

Following approval by Joint Sussex Committee, these will be submitted to the East Sussex HOSC and subject to formal public consultation.

Key Milestones	Detail	End
Pre Consultation Engagement	Questionnaires and interviews, resulting in report	14 Feb 2021
NHSE Stage 1 Assurance	Case for change, developing options, EHIAs shared with NHSE/I and feedback received	27 Feb 2021
Options Appraisal Process	2 x 3 Options Appraisal workshops to produce recommendations for shortlist	19 April 2021
EHIA Workshops	Learning from NHSE Stage 1 Assurance Preparation for NHSE Stage 2 Assurance	Mid May 2021
NHSE Stage 2 Assurance	Full draft PCBCs and feedback received	14 October 2021
Pre-Consultation Business Case	Clinical Senate Panels East Sussex, Brighton and Hove LMT Executive Management Team (paper and PCBC executive summaries) CCG Joint Quality Committee (PCBC executive summaries, Equality and Health Inequality Impact Assessments and Quality Impact Assessments) CCG approval to proceed, via Joint Sussex Committee delegated authority ESHT Trust Board East Sussex HOSC	Jul-Aug 2021 21 Sept 2021 25 Oct 2021 9 Nov 2021 17 Nov 2021 30 Nov 2021 2 Dec 2021
Formal Public Consultation	Planned for December 2021 – March 2022 (extended past 12 weeks to allow for Christmas break)	

Following the end of the consultation period in March 2022, we will evaluate the outcomes of the consultation to ensure that relevant information gathered during this period informs our Decision Making Business Case. This Decision Making Business Case will be then considered in line with NHS governance arrangements, following which we anticipate consideration by East Sussex Health Overview and Scrutiny Committee which is likely to be summer 2022.

Implications	
Corporate goals this relates to	• Improved population health outcomes and patient experience

	• Improved quality of services, access and operational performance • Improved financial performance • Delivering system reform • Local priority objectives
Financial	There would be a positive financial impact on the Trust of implementing the changes outlined, this is as a result of implementing best practice and benefiting from resulting economies of scale. **Cardiology** **Revenue** The case shows that under co-location there will be net efficiency savings (takes into account the cost of capital) of 12% these will begin to be realised in year 3.
Risk, legal and other compliance	East Sussex CCG has a legal requirement under the NHS Act 2006 to ensure patients and the public are involved in service changes. If it is agreed that a consultation is required, the following Gunning Principles will need to be followed: • That consultation must be at a time when proposals are still at a formative stage; • That the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response; • That adequate time is given for consideration and response; and • That the product of consultation is conscientiously taken into account when finalising the decision. This underpins the engagement and the proposed consultation process. The PCBC demonstrates compliance with CCG statutory duties.
Quality and safety	The aim of transforming these services is to deliver significant clinical improvements that will improve quality, outcomes and safety for patients. The Quality Impact Assessment (QIAs) was completed in relation to the current service and in conjunction with the quality team. This QIA is a live document and is re-iterated throughout each phase of the programme and shown to have positive impacts.
Equality, diversity and health inequalities	CCGs have a duty to reduce inequalities between patients in respect to outcomes and access and this transformation will embed health inequality considerations into the redesign process. A Screening Equality and Health Inequality Assessment (EHIA) was initially developed for cardiology, followed by a full EHIA taking account of feedback from ICS colleagues and NHSE/I. This EHIA is a live document and is re-iterated throughout each phase of the programme. Action from this is underway, is reflected in the model of care and options for consultation and has informed the consultation communications and engagement delivery plan.

Patient and public engagement	Following historical informal engagement, full pre-consultation engagement has taken place to understand what is important to local people. The information gathered during this engagement process has informed our model of care and options appraisal process. The transformation programme will be further informed by local people through a likely formal consultation process should the proposed changes be considered significant variation in service.
Health and wellbeing	The transformation of services in East Sussex is expected to improve access to care and health outcomes for our patient population, supporting the health and wellbeing agenda.

List of appendices

- Executive Summary Cardiology Pre-Consultation Business Case

Note, the full Pre-Consultation Business Case, including the following appendices for the case, will be available on the CCG website.

  - *Appendix 1: Cardiology Equality and Health Inequalities Assessment*
  - *Appendix 2: Cardiology Pre-Consultation Engagement Report*
  - *Appendix 3: Cardiology Options Development and Appraisal Report*
  - *Appendix 4: Cardiology Options Development and Appraisal Report Addendum*
  - *Appendix 5: Quality Impact Assessment*
  - *Appendix 6: Consultation Delivery Plan*

East Sussex Healthcare Trust WORKFORCE DISABILITY EQUALITY STANDARD REPORT 2021

If you would like this report in a different format contact esht.workforceinclusion@nhs.net

Contents

1. INTRODUCTION

The Workforce Disability Equality Standard (WDES) is a set of ten specific, evidence based measures (metrics) that enables NHS organisations to compare the experiences of disabled and non-disabled staff. This information is used to develop an action plan, and enable East Sussex NHS Healthcare Trust (ESHT) to demonstrate progress against the indicators of disability equality. The rationale for the WDES is founded upon the wider context of Disabled people and their experiences in employment and work.

The WDES was commissioned by the Equality and Diversity Council (EDC) and developed through a pilot and extensive engagement with Trusts and key stakeholders. It is mandated through the NHS Standard Contract and was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.

East Sussex Healthcare NHS Trust welcomed the standard which has provided the opportunity to review disability workforce data enabling us to identify areas of practices where disability equality is lagging and develop action plans to advance disability equality.

The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES aims to highlight data that will drive forward year on year improvements in reducing barriers that impact most on the career and workplace experiences of Disabled staff or with long-term health conditions. With robust data reported yearly ESHT use the annual report to drive forward changes in attitudes, and confidence to improve employment and career opportunities that lead to long-lasting change for Disabled people employed or seeking employment opportunities at ESHT.

The metrics are used as a tool to help identify and close gaps between disabled and non-disabled staff within the organisation. The report is used to support us in improving recruitment practices and the experience of disabled staff across the organisation.

The WDES is being used along with the Equality Delivery System (EDS2), to assist the Trust in ensuring our workforce can be confident that the we are giving due regard to using the indicators (below) contained in the WDES to help ensure inequalities are identified and addressed.

The regulators, the Care Quality Commission (CQC) and NHS England & Improvement (NHSEi) monitor the WDES and EDS2 along with other equality reports to help assess whether East Sussex Healthcare NHS Trust is inclusive and well-led.

To demonstrate our commitment to advancing equality of opportunity as an equal opportunities employer, we use the outcomes of the ten metrics to improve representation and disability equality for staff. This supports us in becoming an

inclusive organisation whilst fulfilling its legal duties to comply with the Public Sector Equality Duty.

1.2 Data Collection and Monitoring

Electronic Staff Records (ESR) is the system used to hold employee information. As of 31st March 2021, we employed 7,255 members of staff of which 306 (3.96%) staff members were recorded as having a disability. Metrics 3 – 9 is drawn from the National NHS Staff Survey 2020 results. The results showed in some responses around 700 respondents reported having a physical or mental health condition, disability or illness that had or, they expected to last for 12 months or more.

The 2020 Census is still the most up to date information available to identify disability in the local areas. 'East Sussex in Figures' provides actual figures of the total local populations in 2021, along with 'projections' of the number of people living with a disability from 2019 – 2034. It is estimated that around 96,995 people with a disability live in East Sussex in 2020.

When referring to Disability in this report this also refers to those that have a long-term health condition as defined by the Equality Act 2010.

2.0 WDES METRICS

2.1 INDICATOR 1: Percentage of staff by disability status in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members)

Definitions

Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes

Table 1 Non-clinical staff

Percentage of non-clinical staff within cluster as of 31 March 2021			
Cluster 1	Disabled	Non-disabled	Unknown/not declared
1: AfC Band 1, 2, 3 and 4	5%	65. %	30%
2: AfC Band 5, 6 and 7	6%	71%	23%
3: AfC Band 8a and 8b	6%	61%	33%
4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	4%	51%	45%
Total Non-clinical	**5 %**	**66%**	**29%**

Percentage of non-clinical staff within cluster as of 31 March 2021			
Cluster 1	Disabled	Non-disabled	Unknown/not declared
Total in workforce clinical and non - clinical	**4%**	**68%**	**28%**

Table 2 Clinical staff

Percentage of clinical staff within cluster as of 31 March 2021			
Cluster 2	Disabled	Non-disabled	Unknown/not declared
1: AfC Band 1, 2, 3 and 4	3%	72%	25%
2: AfC Band 5, 6 and 7	4%	68%	28%
3: AfC Band 8a and 8b	4%	67%	29%
4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	0%	64%	36.%
Total Clinical	**3.7%**	**69.1%**	**27.2%**
Total in workforce	**4%**	**68%**	**28%**

Table 3 Medical and Dental staff

Percentage of Medical Staff as of 31 March 2021			
Cluster 3	Disabled	Non-disabled	Unknown/not declared
Consultant	1.1%	54.95%	43.96%
Non-Consultants Career Grade	2.86%	59.05%	38.10%
Trainee Grades	2.85%	89.49%	7.96%
Total by medical workforce	**2.02%**	**71.24%**	**26.73%**
Total in workforce	**4%**	**68%**	**28%**

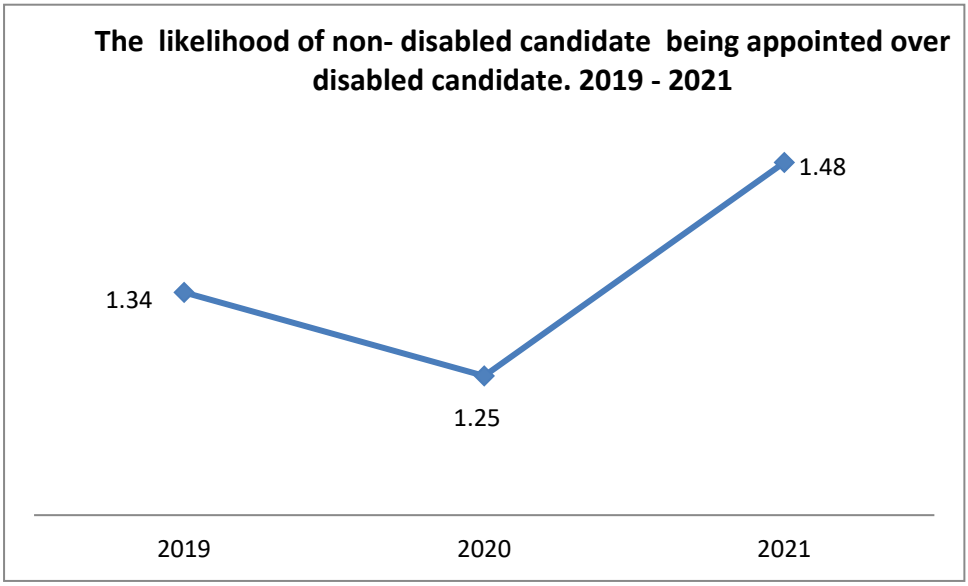
2.2 INDICATOR 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

Definitions

- This refers to all advertised for both internal and external posts from 1 April 2020 – 31 March 2021.

Calculation Formula

	Non-disabled	Disabled	Unknown
No. Shortlisted Applicants	16,754	1,093	252
Appointed from Shortlisting	11	250	77
Relative likelihood appointment from shortlisting	0.1	0.1	0.31



- A figure below 1:00 indicates that a non-disabled candidate is more likely than disabled candidate to be appointed from shortlisting.
- During 1 April 2020 – 31 March 2021, a non-disabled candidate being appointed over a disabled candidate is 1.48 times less likely.
- Since the 2020 return, successful outcomes for disabled candidates have decreased by 0.23 times.

2.3 INDICATOR 3: Relative likelihood of non-disabled staff, compared to disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

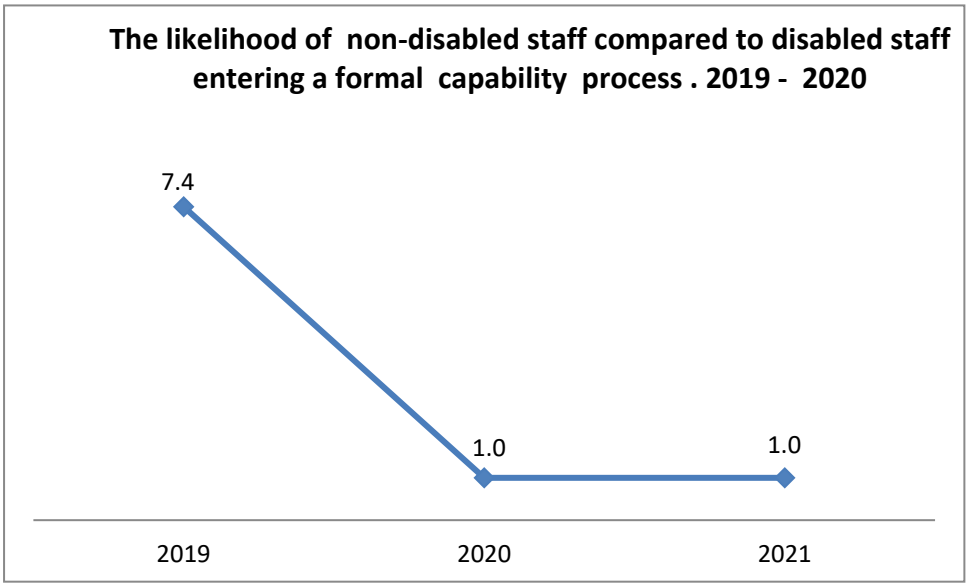
Definitions

- This metric was mandated in 2020.
- This metric is based on data from a two-year rolling average of the current year and the previous year.

- This metric looks at capability on the grounds of performance, rather than ill health.

Calculation Formula

	Non-Disabled	Disabled	Unknown
Number of staff entering a formal capability process	17.5	1	9
Likelihood of staff entering a formal capability process	0.0	0.0	0.0



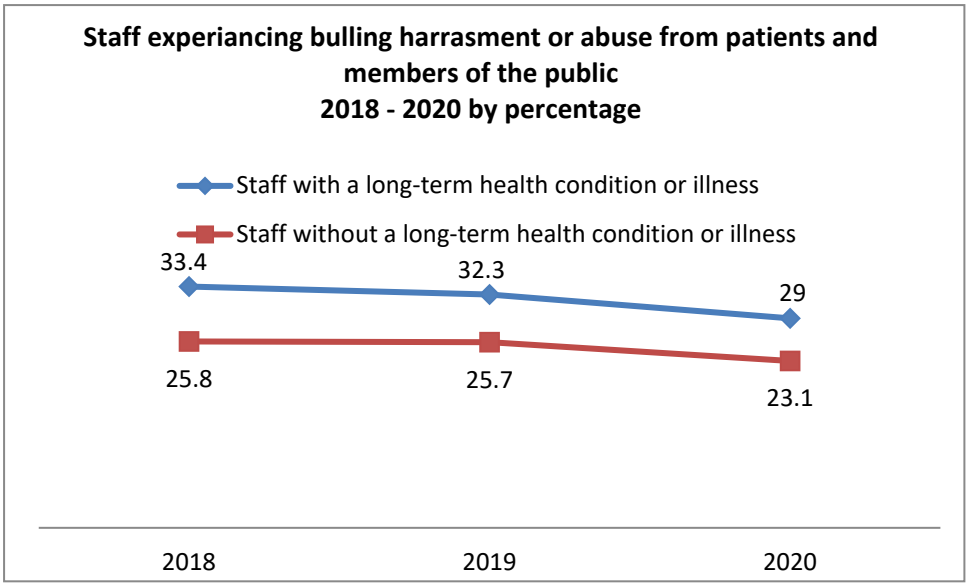
- A figure above 1:00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.
- The data shows us that over a 4 year period there is no bias in the formal capability process towards disabled staff entering a formal capability process.

For each of the following metrics 4- 9, data is drawn from the staff survey results. Data compares the experiences of our disabled staff and non-disabled staff. The WDES breakdowns are based on the responses to q26a. “Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more”? In 2020 the question text was shortened and the word ‘disabilities’ was removed and replaced with long-term health condition LTC) or illness, but the question and WDES results still remain historically comparable.

NB: Historically there are more staff that declare a disability completing the staff survey than declare their disability status on ESR at the Trust.

2.4.1 Indicators 4 (a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

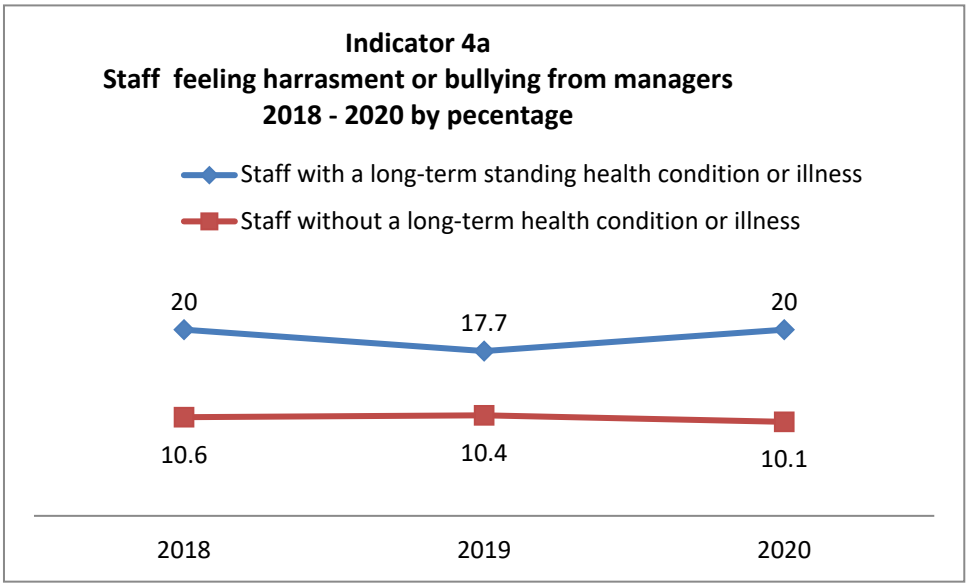
i. Patients/Service users, their relatives or other members of the public



2020 Summary

- The national average for staff with a long –term health condition or illness is 30.9%
- All staff have seen a downward trend since 2018 from staff experiencing bullying harassment and abuse from patients and members of the public.
- Staff members with a long-term health condition or illness are disproportionately affected than those whom do not.
- 29% represents a head count of 717 staff compared to 315 that declared a long term heath condition or illness on ESR.

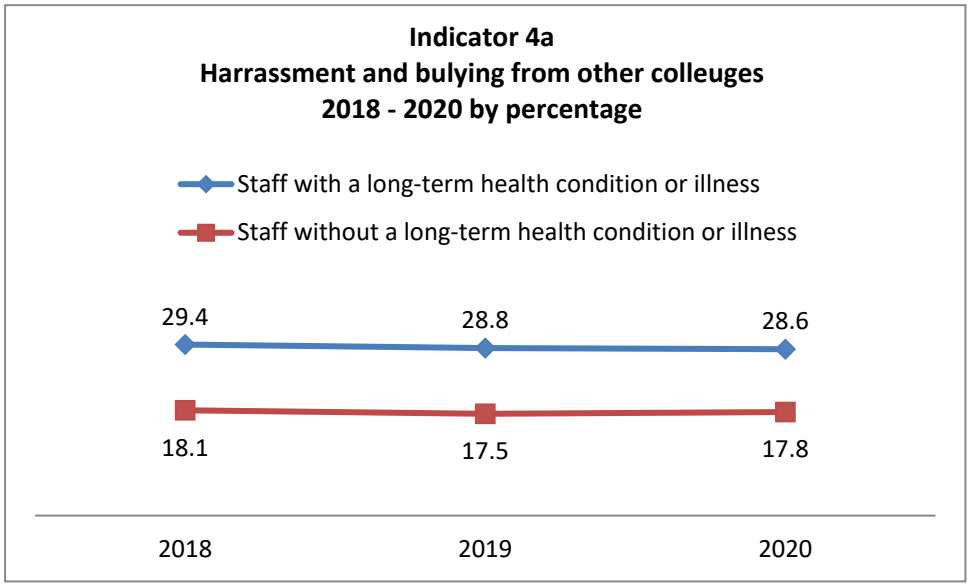
ii. **Managers**



2020 Summary

- The national average in 2020 for staff with a long –term health condition or illness is 19.3%.
- 709 staff with a long –term health condition or illness responded as having experienced bullying and harassment from their managers.
- 2.911 staff without a long-long term health condition or illness responded as having experienced harassment and bullying from a manager.

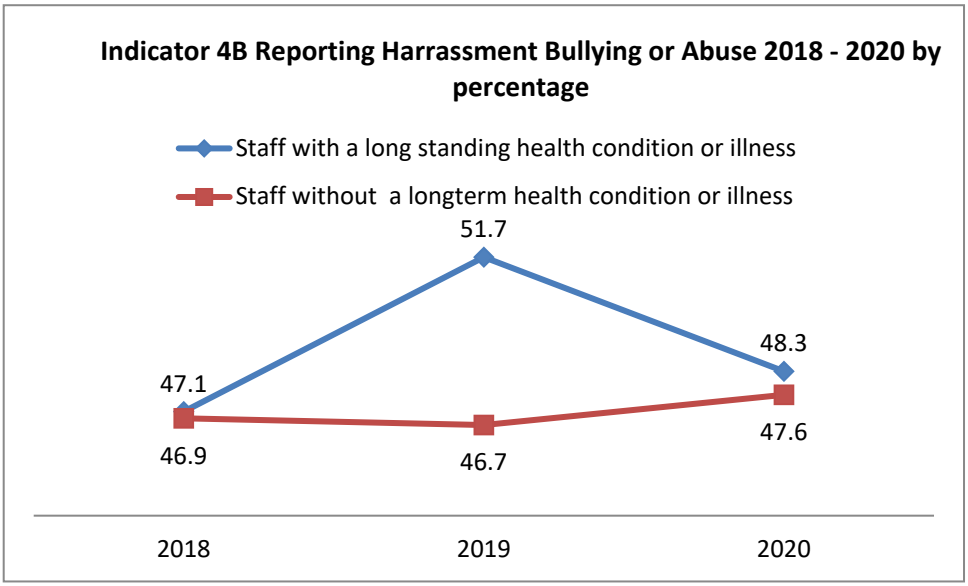
iii. Other colleagues



2020 Summary

- The national benchmark for staff with a long –term health condition or illness is 26.9%
- 28.% represents a headcount of 700 staff with a long –term health condition or illness that responded as having experienced harassment and bullying from another colleague
- 2,887 (17.8%) staff without a long-tern health condition or illness responded that they experienced harassment and bullying from another colleague

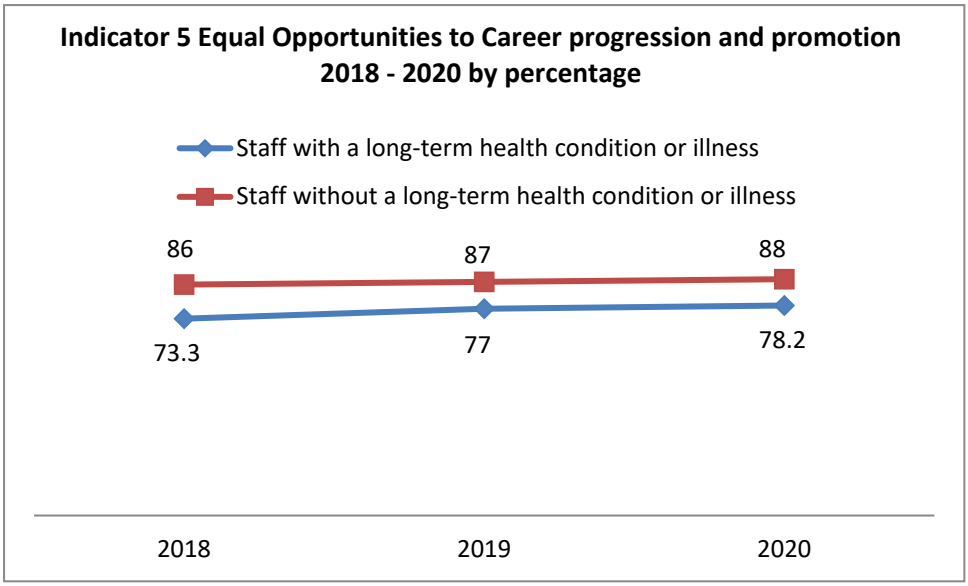
2.4.2 Indicator 4(b): Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



2020 Summary

- The national average for staff with a long-term health condition at work, say that they or a colleague reported harassment or bullying is 47%.
- 48.3 % represents a headcount of 331 for staff with a long-term health
- 47.6% represents a head count of 964 without a long term health condition or illness.
- The data shows us that there is a decline in reporting harassment and bullying for staff with a long –term health condition or illness and has increased for staff without.

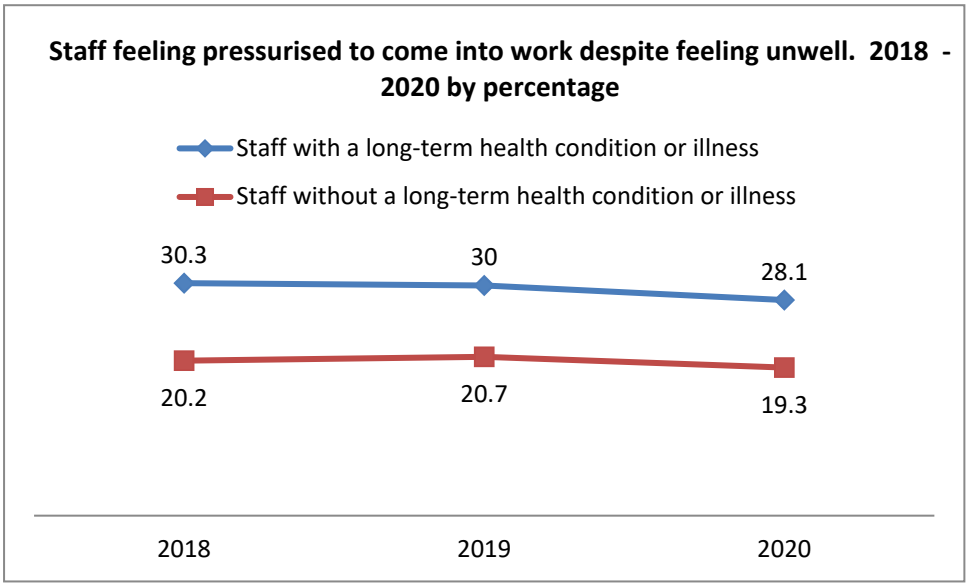
2.5 Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.



2020 Summary

- The national average for staff with a long –term health condition or illness is feeling that the trust acts fairly with progression is 79.6%
- 78.2 % represents a headcount of 459 staff with a long –term health condition or illness
- 88% represents a headcount of 2,001 staff without a long –term health condition or illness
- The data suggests that there has seen an increase for both staff groups since 2018 feeling that the trust acts fairly with progression.

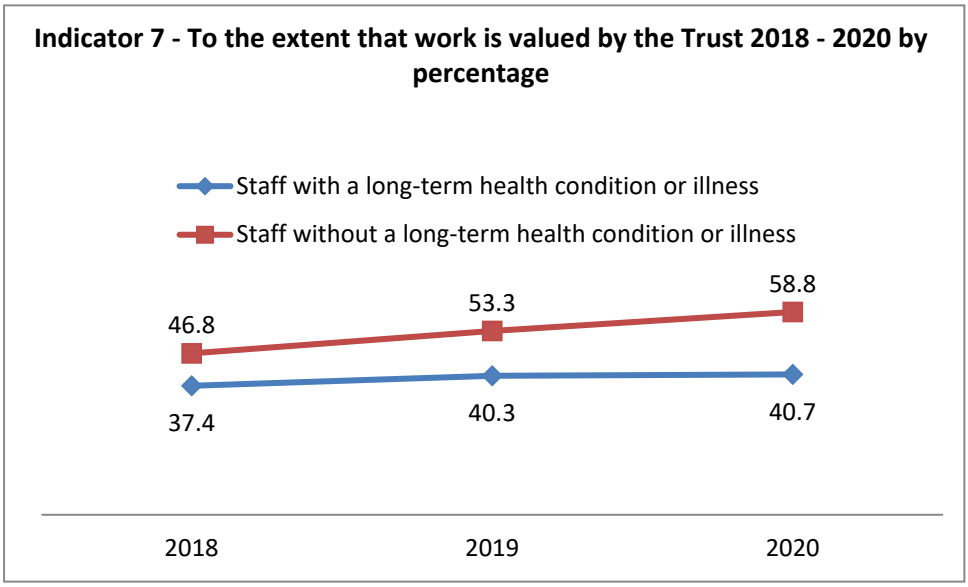
2.6 Indicator 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



2020 Summary

- The national benchmark for staff with a long –term health condition or illness feeling pressure to come into work feeling unwell is 33%
- 28% represents a headcount of 445 staff with a long –term health condition or illness feeling pressured to come into work feeling unwell
- 19.3 represents a headcount of 1,176 staff without a long –term health condition or illness feeling pressured to come into work feeling unwell
- For both staff groups there has seen a positive decline since 2018 of feeling pressured into coming into work feeling unwell.

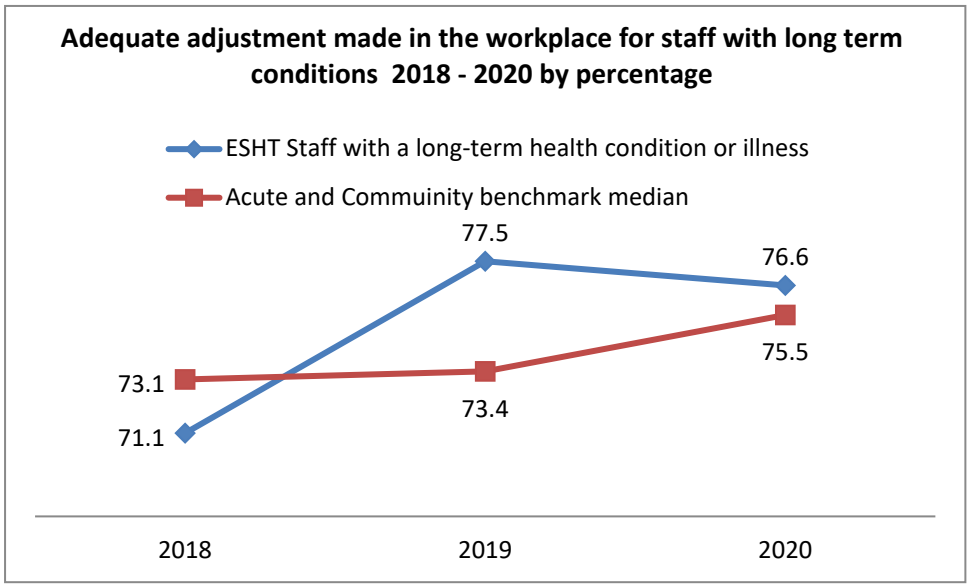
2.7 Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.



2020 Summary

- The national average for staff with a long –term health condition or illness feeling that the trust values their work is 37.4%
- 40.7% represents a headcount of 718 staff with a long –term health condition or illness feeling valued in the workplace
- 58.8% represents a headcount of 2,931 staff without a long –term health condition or illness feeling valued in the work place
- The data indicates that staff without a long-term health condition or illness feel more valued for the work that they do compared to staff with long-term conditions or illness.

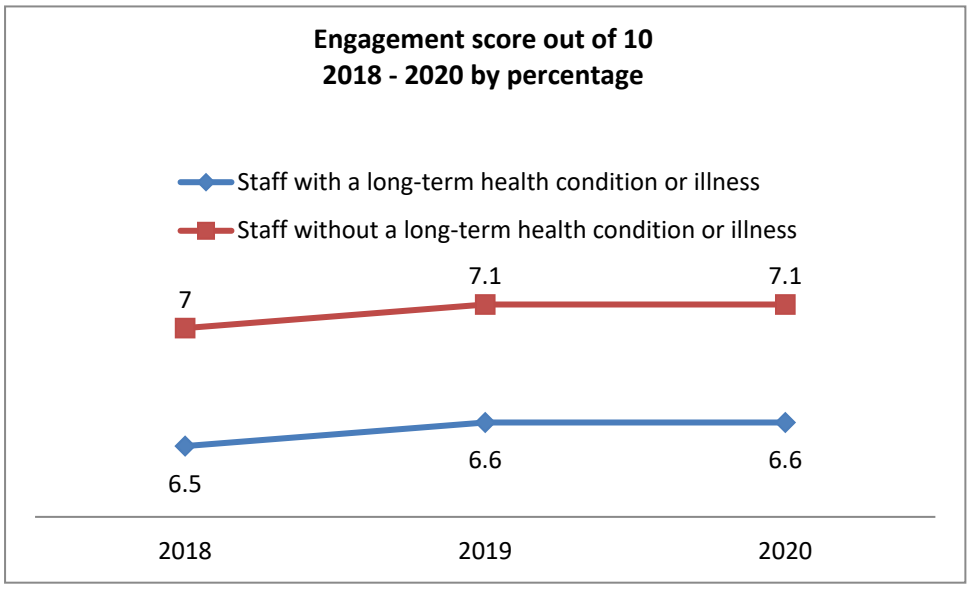
2.8 Indicator 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. This metric only includes the response of Disabled staff.



2020 Summary

- During 2020, ESHT was above (76.6%) the benchmark median for Acute and Community Trusts (75.5%) for making adequate adjustments in the workplace.
- 76.6% represents a headcount of 432 staff that responded to adequate adjustments made in the workplace.

2.9 Indicator 9a: The staff engagement score for Disabled staff, compared to non-disabled staff.



2020 Summary

- The national average engagement score for staff with a long-term health condition or illness is 6.7%
- 6.6% represents a headcount of 720 staff with a long-term health condition or illness
- 7.1% represents a headcount of 2,950 staff without a long-term health condition or illness
- Across a two year period(2019 – 2020), staff with and without a long-term health condition or illness, engagement scores have remained the same

2.9.1 Indicator 9b: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)
Yes

We have a newly established independently run '(Dis)Ability staff network' that meets bi-monthly and has an elected chair along with an Executive Board sponsor that supports the staff networks objectives

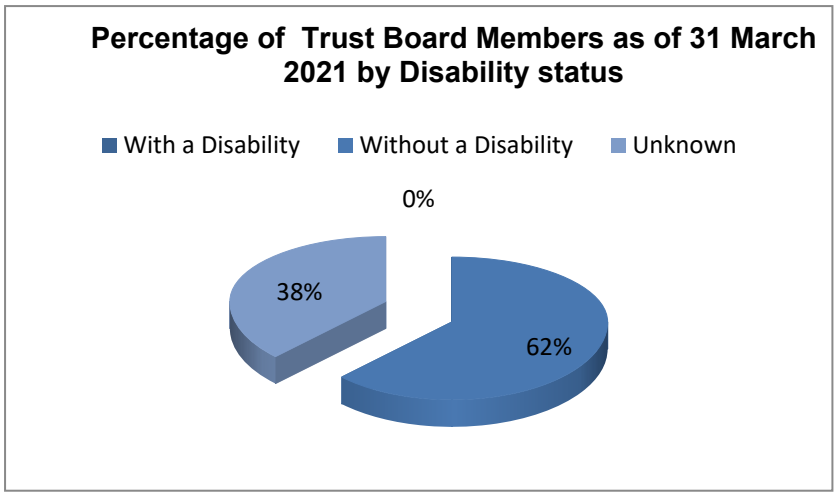
Members of the network are invited and included in our WDES Task and Finish group that meet monthly to ensure actions are driven into tangible outcomes. Our network chair is also a member of the Workforce Equality Group that feeds into the People and Organisation Development committee.

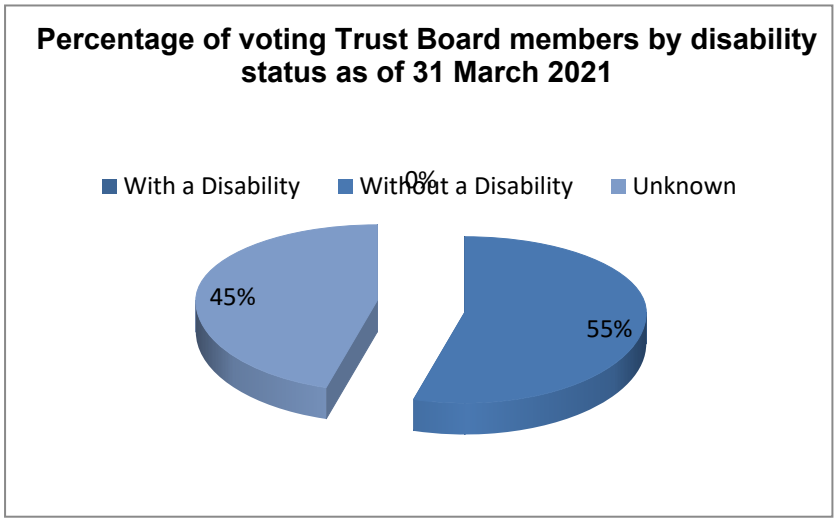
To ensure that the voices of disabled staff is amplified across the trust, the Trust Board sponsor, Chief Executive Officer and Chief Peoples Officer meet with the (Dis)Ability staff network chair on a regular basis. This gives our (Dis)Ability staff network chair direct contact to Trust Board members so that they are informed around the working experience and progress of staff that have a disability or long-term health condition.

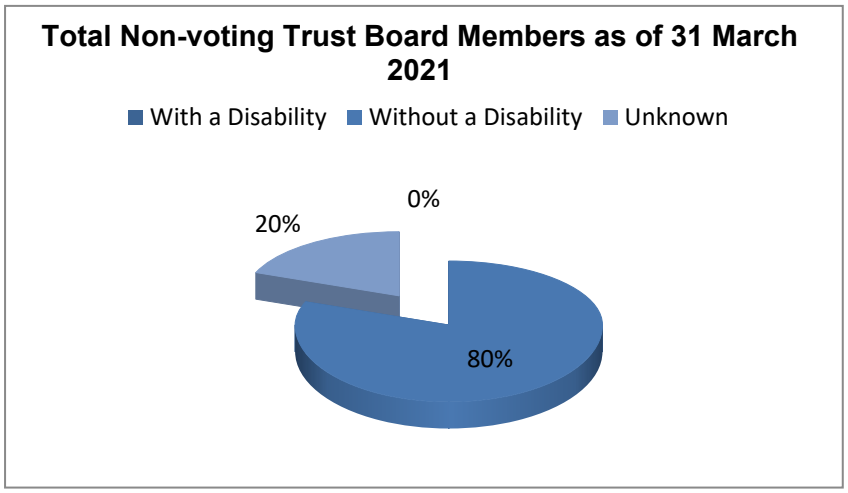
2.10 Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

• By voting membership of the Board

• By Executive membership of the Board







2021 Summary

- The data captured on ESR shows that there are no Trust Board members that have declared a disability as 31 March 2021.

3.0 Summary of Activities 20211/22

3.1 Health & Wellbeing

The COVID-19 pandemic has brought to light the need to support staff that were shielding due to a long-term health condition or illness that have nationally been placed in the ‘At Risk’ category in the workplace.

The Trust has responded by ensuring that staff in the ‘At Risk’ category and shielding has been given the opportunity to have robust Risk Assessments undertaken and the support from our Occupation Health (OH) department and Health and Wellbeing Team. ESHT has ensured that Reasonable Adjustments are in place and where possible equipment has been delivered to places of residence so that staff can work or be re-deployed into safer work environments.

The Trust is also providing a positive experience to staff currently shielding due to COVID-19 by undertaking risk assessments prior to their return to work and implementing appropriate support measures where necessary to ensure they feel sufficiently safe to return to the workplace.

Our Health & Wellbeing Team has a dedicated team that offer support to managers and staff these include:

- Mental Health First Aiders
- Visits to wards and departments
- Bespoke wellbeing support for individuals and teams.

Looking after our staff with a long-term health condition or illness remains a key priority for 2021/22

3.2 (Dis)Ability Staff Network

In December 2020, the (Dis)Ability Staff Network was established with an elected Chair and Trust Board sponsor. This group is in the early stages of development but is a priority objective.

Quarterly meetings have taken place with guest speakers in attendance. This has included Health and Wellbeing training and information about Trauma Risk Management (TRIM) Practitioners.

To positively promote disabilities at ESHT, staff network members have been story tellers in a Schwartz Round entitled ‘Living with a Disability throughout COVID’.

Our highlights: Disability History Month was celebrated with the guest speaker Miles Hilton Barber the blind adventurer. Following this NHS Employers equality lead, Paul Deemer gave a presentation on the WDES metrics.

3.3 Organisation Development (OD)

To support our (Dis)Ability staff network our OD team have provided sessions towards its development and growth of membership. A session has been offered to the chair for their own leadership development and another session on facilitation to amplify the voices of network members. A further session will take place around 'navigating around the political environment'.

3.4 (Dis)Ability and Health Passport, Reasonable Adjustments and Access to Work

The (Dis)Ability and Health passport and supporting documents (Reasonable Adjustments and Access to Work) have been co-produced in our WDES Task and Finish Group. Guidance and flow charts have been produced to, support staff and managers in making the process less onerous.

Our next steps include a Communication plan to promote its use and training for managers on how to use the passport.

We envisage that the success of the implementation of the passport may encourage more staff to declare their disability or health condition on ESR.

4.0 Conclusion

This is the third year that the Workforce Disability Equality Standard has operated which now gives us the opportunity to make a comparison to the previous years. This report includes a number of such comparisons which indicate that we made some progress in identifying the experience staff with disabilities.

One main influencing factor this year has been the effect of the Covid19 pandemic. Many of our staff who have disabilities have been shielding, are self-isolating or are working remotely. Efforts have been directed to ensure that these members of staff were fully supported by the trust where possible and included in meetings using MS Teams and other technology applications.

It became apparent that disabled staff had a number of concerns and questions around the Covid-19 vaccine. Our Chief Peoples Officer and Chief Pharmacist responded by holding confidential virtual events with the (Dis)Ability staff network in December 2020. The purpose of the meetings was so that staff could ask any questions around the vaccination in confidential, safe space, listen to concerns and act upon them.

The majority of workforce across all clusters in both our clinical and non-clinical workforces is either non-disabled or not-disclosed and therefore we should focus on the encouragement of greater self-disclosure.

There are several suggestions that may contribute to the data gap. This includes, staff developing long-term health conditions or illnesses after commencing employment and have not informed Human Resources (HR). We also recognise that

some people may choose to keep their status private but will disclose this on an anonymised survey. Others may feel that they will be unfairly disadvantaged by disclosing their disability and choose to keep it private. Some further reasons may include:

- Staff/Applicant does not feel employer needs to know (personal preference)
- Staff/Applicant does not want employer to know (personal preference)
- Staff/Applicant does not feel able to tell employer (perceived prejudice or stigma)
- Staff/Applicant is not aware of any reason to inform HR (lack of awareness)
- Staff/Applicant may feel disclosure may alter people's perception of them (perceived assumptions)
- Staff/Applicant does not recognise their condition as a disability (lack of awareness or personal preference).

This list is not exhaustive and further exploration is needed to understand and begin closing the data gap; this will be considered in the 2021 action plan.

There has been deterioration in likelihood of non-disabled being appointed from shortlisting compared to disabled staff during 1 April 2020 – 31 March 2021. Our end-to-end review of the recruitment process will better understand the barriers for disabled candidates and help us to make any improvements.

With employee relation cases, it is pleasing to note; for two year running there is no overrepresentation between staff that has a long-term health condition or illness with those that does not with formal capability cases.

The robust and fair management of all disciplinary cases is a focus for the Operational HR team who are committed to ensuring that continuous improvements continue to address the experience for all staff involved in a capability or disciplinary matter and avoiding formal processes wherever possible

Positively, the staff survey saw a reduction in the percentage of disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties and feeling that the trust acts fairly with progression. This year's results also indicate that we are above the national average for making adequate adjustments in the work place. The results also indicate a reduction in disabled staff experiencing harassment, bullying or abuse from patients and members of the public and colleagues; however percentages remained higher than for non-disabled staff.

An area of focus will be the increase of disabled staff feeling bullied and harassed by managers, and a reduction (negative) in the percentage of disabled staff compared to non-disabled staff reporting incidents relating to harassment and bullying. Through our Violence and Aggression group sub-group the trust will review ways of encouraging staff to speak up and report incidents of harassment and abuse.

Finally the Trust Board have 38% of its members that have not disclosed their disability status. Members should be encouraged to declare their disability status during 2021/22 to 100%.

5.0 Our top priorities for 2021/22

- To increase the disability declaration rates on ESR for staff as defined in the Equality Act 2010.
- Bullying and harassment and reporting incidents
- Increasing the membership of the (Dis)Ability Staff Network .
- Explore an asset register of equipment for Reasonable Adjustments.

For a copy of our action plan please contact esht.workforceinclusion@nhs.net

Guardian of Safe Working Hours – Report

Purpose

- The purpose of this report is to provide an update to the Trust Board by the Guardians of Safe Working Hours, on compliance of juniors working hours with their work schedule. This Report reflects our findings from the last 12 months for the junior doctor workforce.

Background

- The 2016 Junior Doctors Contract came into effect on 3rd August 2016. Implementation guidance was published by NHS Employers Total number of trainees across site that are on the 2016 contact and can Exception Report is 244.

Exception Reporting

- Trainees can Exception Report for a breach of working hours or for educational reasons. Training and information on Exception Reporting have been provided to trainees at Induction and they are offered the opportunity during the year to contact or meet and discuss areas of concern with Medical Staffing, the GoSWH and the DME.

- The remit of this report is to focus on Exception Reporting associated with safe working hours although there is some mention of educational related Exception Reports which are reviewed by the DME.

- **Eastbourne H@N surgical rota**
  There have been significant exception reports from the Urology department due to rota gaps and Consultants not following the acting down policy at times to support juniors. A new H@N surgical rota has been designed to accommodate those gaps. The Guardians will observe improvements in the conditions of junior's hours in the next few weeks.

Exception Reporting Education

- There were 20 education exception reports submitted for the period August 2020 – July 2021 compared to 19 for the period August 2019 – July 2020.

MONTHLY ANALYSIS OF EXCEPTION REPORTING - AUGUST 2020 TO JULY 2021

Month	Total Number of Posts (DiT)	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month 01.08.20 - 31.07.21	Previous Year 01.08.19 - 31.07.20	No of ER's processed previous year 01.08.19 - 31.07.20	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of ER
Aug-20	244	7	34	Aug-19	34	30.00	**825.29**	0.50	**22.36**	30.50	847.65
Sep-20	244	11	40	Sep-19	40	15.50	**458.38**	3.00	**127.23**	18.50	585.61
Oct-20	244	4	57	Oct-19	57	32.25	**927.65**	0.00	**0.00**	32.25	927.65
Nov-20	244	4	8	Nov-19	20	7.00	**228.48**	0.00	**0.00**	7.00	228.48
Dec-20	244	6	11	Dec-19	20	9.75	**318.24**	0.00	**0.00**	9.75	318.24
Jan-21	244	5	10	Jan-20	19	14.50	**442.98**	0.00	**0.00**	14.50	442.98
Feb-21	244	3	7	Feb-20	15	11.00	**288.45**	0.00	**0.00**	11.00	288.45
Mar-21	241	5	5	Mar-20	8	7.75	**221.48**	0.00	**0.00**	7.75	221.48
Apr-21	244	5	7	Apr-20	2	8.75	**260.08**	1.00	**44.72**	9.75	304.80
May-21	244	6	13	May-20	4	16.00	**507.09**	0.00	**0.00**	16.00	507.09
Jun-21	244	5	9	Jun-20	4	10.50	**316.29**	1.50	**67.08**	0.00	383.37
Jul-21	244	6	7	Jul-20	13	7.50	**180.61**	1.50	**54.11**	0.00	234.72
										Total	**5290.52**

MONTHLY ANALYSIS OF EXCEPTION EPORTING
Last quarter of the year (May- July)

Month	Total Number of Posts (DiT)	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees		Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay		Total Hours Paid Overall	Overall Cost of ER
May-20	244	2	4	7.00	**166.81**		0.00	**0.00**		7.00	166.81
Jun-20	244	4	4	18.75	**680.46**		0.00	**0.00**		18.75	680.46
Jul-20	244	9	13	14.25	**389.91**		3.00	**134.16**		17.25	524.07
											1371.34
May-21	244	6	13	16.00	**507.09**		0.00	**0.00**		16.00	507.09
Jun-21	244	5	9	10.50	**316.29**		1.50	**67.08**		0.00	383.37
Jul-21	244	6	7	7.50	**180.61**		1.50	**54.11**		0.00	234.72
											1125.18

Working pattern reviews

1. Rota gaps remain an ongoing issue across the Trust due to unfilled posts. Any gaps in Foundation are recruited to and may take up to 10 weeks for postholder to start mainly from abroad and sponsored by the Trust. Higher trainees had an 18% vacancy October 2020 which are harder to fill with senior doctors. LTFT trainees are part time whilst other gaps are due to maternity leave, long term sickness and some trainees exempted by Occupational Health due to a health condition, unable to work long days, weekends or night shifts. These gaps are difficult to plan for and the LTFT trainees in most cases are of 4 month duration. To backfill for short periods is difficult to recruit to the remaining 30-40% of the LTFT gap. The number of LTFT trainees averaged over the year at 31 with 8 on maternity leave.

2. **Conquest Paediatrics**
   Some departments faced recurring understaffing and looked at different options of staff competency mix. Following consultations with Medical Staffing, trainees and the GoSWH planned a change of rota from 1:16 to 1:12 pattern to start with the new intake of August 2021. This was possible with increased requirement to the PANP (paediatric advanced nurse practitioners) and the creation of a tier 2 on call rota together with the tier 1, 12 staff rota. The preparation for the new rota took place between April and July 2021.

3. **Conquest AE**
   August 2021 the department planned to increase from 1:15 to 1:18 aligning to Eastbourne's work pattern. This was achieved by 1 GP post in Trauma being decommissioned to Conquest and recruitment of two further Locally Employed Doctors (LEDs).

4. **CQ Anaesthetics**
   Following Covid circa April 2021, the decision was made to continue the CT1s working night shifts which they had not done before and this pattern was introduced August 2021.

5. Prior to this there was a Covid period January 2021 whereby a number of work patterns were adjusted for patient safety care:

General Surgery 1:6	18 January 2021 for 8 weeks
Obs&Gynae 1:6	4 January for 6 weeks
Paediatrics 1:8	4 January for 6 weeks
2 General Medicine 1:18	18 January for 6 weeks

   All DiTs were changed over on ESR to reflect the higher pay value and returned back to current patterns.

Guardian Fines

Period	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Period	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of Guardian Fines
07.12.16 - 30.04.17	76	379	254.25	**7369.78**	1	**43.46**	255.25	**7413.24**
01.05.17 - 31.07.17	28	153	279.55	**8089.73**	0	**0.00**	279.55	**8089.73**
01.08.17 - 31.10.17	50	241	74.15	**2372.69**	2	**78.86**	76.15	**2451.55**
01.11.17 - 05.12.17	20	50	1.00	**27.69**	0	**0.00**	1.00	**27.69**
06.12.17 - 31.03.18	26	83	0.00	**0.00**	2.3	**65.86**	2.30	**151.48**
01.04.18 - 31.07.18	17	105	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.08.18 - 30.11.18	24	82	12.00	**338.88**	0	**0.00**	12.00	**338.88**
01.12.18 - 31.03.19	22	57	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.19 - 31.07.19	16	45	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.08.19 - 30.11.19	30	157	0.00	**0.00**	2.25	**88.80**	2.25	**88.80**
01.12.19 - 31.03.20	18	65	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.20 - 04.08.20	13	22	15.50	**585.74**	0	**0.00**	15.50	**585.74**
05.08.20 - 01.12.20	17	62	0.00	**0.00**	0	**0.00**	0.00	**0.00**
02.12.20 - 31.03.21	12	33	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.21 - 31.07.21	13	34	0.00	**0.00**	0	**0.00**	0.00	**0.00**
				18784.51		276.98	TOTAL	**19147.11**

Guardian Fines total remining after subtraction of sum of fine application by DiT conclusion/summary £12,861.09

Fatigue and Facilities Charter

We are pleased to report great inroads have been made in the year improving the Working Lives of Junior Doctors. The completion of the upgrade to Eastbourne Mess 'Bob Webster Room' with expenditure in the region of £27,567. We were also able to support two wards at Eastbourne where rest rooms are shared with Junior Doctors with the purchase of furniture and kitchen utility items. Two wards at Conquest were also upgraded with reclining chairs, lockers, soft furnishings and the Doctors Mess was fully decorated and refurnished by August 2020 with an approximate spend of £15,000

The provision of hot food tender advanced with the new Hotel Facilities Manager inviting DiTs for a food tasting session for the vending machine upgrade and Contract.

The Guardians received a request on improved security in the Trust car parks particularly for lone shift workers at night. The request was for security to escort doctors who make a request to the car park at night as both car parks are accredited under the Association of Chief Police Officers as being safe having CCTV surveillance, vegetation, lighting and patrolling, security didn't think it was necessary nor had the capacity. The guardian team made a request to ensure that lighting in particular was up to standard during the dark winter months. Women's security is a current topical national discussed issue. It is important to acknowledge that the trust car parks are accessible to the public. It is essential that all Trust staff feel safe walking to and from their cars particularly in remote areas or parking and after dark.

Rooms are still reserved for doctors 'too tired to drive home' with CQ having 6 rooms and EB 10. Enquiry received for soundproofing, Facilities confirmed there were no plans for this as it is major capital funding and reported back to DiTs but CQ were having major upgrade work to all bathrooms and kitchens. A review of blackout blinds was being undertaken.

Good news on IMT at Eastbourne and 9 new posts were allocated for this training which introduces a 2nd tier of Registrar in the night rota which now has 2 Registrars, 2 Core Trainees and 1 Foundation Doctor. This will be a huge relief to the H@N doctors in medicine with this extra resource which Professor Patel has secured. This provides further safe levels of staff at night.

Conclusion/Summary

1. The outgoing academic year has been an exceptional year for 244 DiT employed by ESHT. They contributed an essential part to the safe care of patients during a challenging year. In addition to the professional challenges faced by all staff, many trainees were redeployed last winter. They rose to the challenge with professionalism and significant flexibility. This was in spite of their worries about their training, attaining competencies in their planned placements, passing exams and sign off for their next stage of training.

   Relatively few DiTs exception report and continues to be a challenge and the last JDF there was no attendance on behalf of the trainees. The Guardians will continue to improve the safety concerns, breaks facilities and work with the trainees to uphold the progress we have made to date.

   The guardian team acknowledge and commend the Trust for the great programme and resources of wellbeing for all staff including trainees put in place. Commend the Trust integrated Education Department for the employment of the pastoral fellows working tirelessly to support DiT.

   The guardian team acknowledge and commend the majority of the clinical supervisors who have acted on ERs in timely manner in spite of exceptional work challenges, the Department educational lead and clinical leads who have listened and acted on trainees concerns about rota design or gaps.

2. The guardian team seek reassurance from the board regarding the points raised in section 3.

3. Rota gaps and filling those gaps remains an ongoing change. Different departments have their own administrative and procedures for addressing rota gaps and short term vacancies. The guardian team have recommended a timely communication between departments of this information prior to periods of change over. Good practice to be shared and acknowledged and a shared accountability and systems to address areas that are struggling to maintain safe staffing levels and rota management.

East Sussex Healthcare
NHS Trust

Annual Safeguarding Report

2020 – 2021

Message from the Chief Nurse and Executive for Lead for Safeguarding Adults & Children Vikki Carruth

As Executive Lead for Safeguarding Children and Adults, it is my responsibility to ensure that East Sussex Healthcare NHS Trust (ESHT) meets the statutory requirements required and this is assured with updates via this report to the board. This work includes ensuring robust governance in recruitment, up to date policies, local and Sussex wide procedures, up to date learning & development and multiagency working including representation on both local safeguarding boards. The Chief Nurse also works closely with the Chief Operating Officer and others to ensure systems and processes are in place to safeguard patients presenting with mental ill-health who also need ESHT services.

This last year the Safeguarding Team have worked hard to ensure that despite the impact of the Covid 19 pandemic, staff have continued to have the appropriate access to safeguarding support and advice, this has however had to be much more of a virtual offer within the last year. There has been continued focus to ensure that Safeguarding Policies, Procedures and practices in place remain up to date, are reviewed regularly and are fit for purpose. All policies and procedures are accessible to staff via the Safeguarding Children and Safeguarding Adults pages on the trust intranet and advice and support is provided by our Safeguarding team.

Before the Covid19 Pandemic hit in the spring of 2020, Domestic Violence and Abuse had already seen an increase from the year before and sadly as anticipated the nationwide lockdowns led to a further increase. The same is sadly true for children and child neglect. The Chief Nurse with others led on the reintroduction of the role of the Health Independent Domestic Violence and Abuse Advisor role (HIDVA) and this was reintroduced to the trust in October 2020 with the contract now secure for the next five years. The post holder has worked with individual cases and supported the team in forward the programme of domestic abuse training.

The Covid 19 pandemic has sadly seen an increase in complex cases of child abuse and neglect and as a result an increase in the numbers of children referred to the East Sussex Safeguarding Children Partnership case review panel for consideration as to whether thresholds were met for a Child Practice review. Throughout the year the principal impact has been that of young people experiencing mental health crisis, which meant that young people requiring mental health support are often receiving care in acute in-patient beds. This is now a regional and national issue with a recent reduction locally in specialist residential provision further compounding the problem.

A key focus for this year has been the continued roll-out of the *Think Family* training agenda which recognises that Safeguarding is everybody's business. All registered staff are now signposted to access this training programme with compliance regularly reviewed at the Trust Safeguarding Strategic Committee and via divisional IPRMs using the training database. The Trust has a training strategy in place for the delivery of safeguarding training, including Mental Capacity Assessments and caring for those patients who may lack capacity who are in need of care and treatment.

The Trust is involved in both local Safeguarding Partnerships (the ESSCP for children and young people and the SAB for adults) and is committed to interagency working and positively supports opportunities to work with other agencies. A particular focus of work this year has been to review the DoLs process in readiness for forthcoming changes planned for 2022 with the implementation of the Liberty Protection Safeguards.

I would like to thank our former Head of Safeguarding for her many years of dedication, expertise and support, the new HoS and wider safeguarding teams for their commitment during a very difficult year, all other ESHT staff for their continued support with this complex agenda and also thank our system and multiagency partners for their collaborative and collegiate approach.

1.0 Introduction

The 2020/2021 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of the safeguarding work undertaken during the year, the work planned to further improve safeguarding practice in 2020/2021 and assurance regarding the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2018)
- The Children's Act (2004) - ESHT must be able to demonstrate that it safeguards children who access our care under section 11 of the act
- Safeguarding Vulnerable Adults in line with the Care Act (2014)
- Department of Health Care & Support Statutory Guidance under the Care Act (2014)
- The Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards amendment (2007)
- The Modern Slavery Act (2015)
- Safeguarding Children & Young People: Roles & Competences for Health Care Staff (2019)
- Safeguarding Adults: Roles & Competences for Health Care Staff (2018) and
- The Female Genital Mutilation Act (2003)
- Promoting the Health and well-being of Looked After Children (2015)

2.0 Safeguarding Governance

2.1 ESHT Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the "Safeguarding Vulnerable People in the NHS Accountability Framework" (2015). ESHT must demonstrate that it is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and commissioners that these arrangements are working. These arrangements include;

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults, as appropriate.
- A suite of policies including Safeguarding & Safeguarding Supervision
- Effective safeguarding training for all staff commensurate with their role and in accordance with;
    - Safeguarding Children and Young People: roles and competences for healthcare staff. Royal College of Paediatrics and Child Health (2019)
    - Looked After Children: Knowledge, skills and competences of healthcare staff. Royal College of Paediatrics and Child Health (2016)
    - Safeguarding Adults: Roles and Competences for Health Care Staff (2018)

- Effective safeguarding supervision arrangements for staff working with children/families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies

- Named Safeguarding Professionals covering specific specialist areas: Head of Safeguarding/Mental Capacity Act assessment Lead/Mental Health Lead posts.
- A statutory role in managing safeguarding allegations against staff, alongside Adult Social Care & HR colleagues.
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure any poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance, including MCA (2005) and the Children's Act (2004).

The Intercollegiate Document (2019) requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Chief Nurse is the Executive Lead and has responsibility for ensuring effective trust wide safeguarding governance, available advice and expertise, and robust arrangements and reporting are in place. The Chief Nurse supports the Head of Safeguarding and the Safeguarding team, and co-ordinates with the Divisional Assistant Directors of Nursing who are responsible for ensuring robust safeguarding arrangements and practice in each of their clinical areas. The Chief Nurse also ensures there is support and development for the Safeguarding team to ensure that knowledge and practice is current with suitable supervision of cases.

The trust governance and reporting arrangements are based on legislative changes and statutory requirements. Safeguarding Leads are required to provide support, advice, scrutiny and assurance. ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles and responsibilities. During 2020/2021;

- Safeguarding governance structures have been revised to improve operational understanding of safeguarding responsibilities.
- The Safeguarding Children Policy and associated training was updated in 2019/2020 to reflect current safeguarding issues, including Domestic Violence, PREVENT (radicalisation), Child Sexual Exploitation (CSE), County Lines, Cuckooing, Modern Slavery and Human Trafficking. This continues to be reviewed in line with national guidance.
- A flowchart has been updated within the Policy for Allegations of Abuse against- (by) Staff, it provides a framework (relevant to both adult and child safeguarding) to support Trust professionals when dealing with such allegations.
- Compliance with all safeguarding policies being in date was maintained at 100% throughout 2020/2021.
- The Domestic Abuse Bill passed through parliament in 2021 the Think Family training has delivered by the ESHT Safeguarding Team and the Domestic Abuse reflects the new legislation.
- LAC Policy was reviewed and updated

2.2 System Safeguarding and Covid 19

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate and support the wider system safeguarding practice and statutory partners including the Local Authority and the Police. The Chief Nurse is a member of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and

members of the team fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership with others. This ensures active learning from safeguarding reviews; partner agency reports, national safeguarding challenges and local issues, driving improvements in practice.

The pandemic had an impact on both the governance structure of the ESHT Safeguarding team and the broader context of Safeguarding.

- There were staffing challenges within the Safeguarding team with long term absence and vacancies within the Named Nurse cohort of staff. This was identified as a risk within the organisation and the Named Nurse Safeguarding Children acted up to the role of Head of Safeguarding between September 2020 and June 2021, prior to substantive recruitment into the post.
- The Safeguarding team are involved in Sussex wide work developing integrated health and social care for the residents of East Sussex. The team provides safeguarding advice and expertise to a range of colleagues and Safeguarding Board members however this had to move to a virtual offer during the Pandemic.
- The Safeguarding team continued to develop and implement the *Think Family* Safeguarding training, which has been facilitated as a virtual webinar since March 2020. This is regularly reviewed and refreshed to reflect feedback from delegates and include emerging research.
- During the periods of lock-down and high clinical demand across the Divisions, the usual practice of monthly Safeguarding Operational and Strategic meetings was suspended. Within these time-frames the Acting Head of Safeguarding provided monthly safeguarding summaries to the Chief Nurse.
- Divisional safeguarding reporting, via a standardised reporting tool, has improved visibility of safeguarding practice in clinical areas and highlighted challenges and good practice. This tool has been revised in 2021 to allow all Divisions to have oversight of Safeguarding trends and themes, ensuring that *'Safeguarding is everybody's responsibility'*. These reports are a standing item at every Strategic Children and Adults Safeguarding Group meeting.
- The Acting Head of Safeguarding also participated in Divisional governance meetings ensuring that Safeguarding was a standing agenda item and increasing Divisional ownership and engagement.
- During the Pandemic the Acting Head of Safeguarding and Named Paediatric Doctors participated in weekly Sussex wide Safeguarding forum's, led by the CCG and also in monthly national forums. These meetings have continued quarterly, with the focus altering to the sharing of Safeguarding expertise.
- Due to the impact of the Covid 19 pandemic, Staff now access the national e-learning Prevent and Wrap training packages. This further provides a robust method of capturing the compliance data.

2.3 Care Quality Commission (CQC) Inspection

The CQC inspection of the Trust in 2019/2020 found outstanding practice in relation to Safeguarding. There was specific mention of the changes to safeguarding practices following concerns raised, (Child T Serious Case Review). An example given was that clinical staff informed the inspectors that the trust had begun to run the level 3 "Think Family" safeguarding study day.

Topics covered included dealing with difficult family dynamics, female genital mutilation, forms of abuse including sexual abuse and the impact of parental mental health conditions.
Work on the Think Family agenda has continued to be progressed, attracting interest from other trusts.

2.4 Joint Targeted Area Assessment (JTAI)

The JTAI inspection occurred in February 2020, the purpose of which was for inspectors from Ofsted, CQC, HMICFRS and HMI Probation to undertake a deep dive into the provision of services with regards to children's and young people's mental health.

The JTAI report highlighted that there is an effective Safeguarding Children Partnership and Health and Wellbeing Board with an embedded culture of collaborative learning and development across the partnership in East Sussex.

Some of the key strengths points relevant to ESHT were:

- Assessments of children's needs are of consistently good quality demonstrating in-depth understanding of emotional well-being and mental health needs.
- Good information-sharing between partners ensuring that other professionals understand what the child has experienced, and how their responses are affected by their mental ill health.
- ESHT practitioners are well supported through robust supervision processes and their organisations' safeguarding specialists.
- ESHT has good coverage of safeguarding training at all levels, including for staff that are providing direct support to children.
- The safeguarding team in ESHT has good oversight of children who attend the emergency department due to mental ill health. Young people deemed at high risk are reviewed at weekly meetings and this ensures that appropriate follow-up has taken place and information is shared with universal health services and primary care.
- Improved frontline practice and training regarding working with older children with both long-term health conditions and mental ill health following the Child T SCR.

A robust system wide action plan has been progressed, supported by the Chief Nurse and many other ESHT colleagues.

The key areas of focus within the action plan relevant to ESHT were:

Acknowledgment from the JTAI that the current arrangements for assessing the mental health of children and young people who present at hospital emergency departments in crisis are insufficient due to limited capacity of the mental health liaison provided by CAMHS. The report highlighted that some children wait too long to be seen by specialist mental health practitioners and some are admitted to hospital unnecessarily.

- Sussex Partnership has now invested in an Accident and Emergency Liaison team who offer a broader range of CAMHS cover, including some out of hours provision. The CAMHS team, also participate in the weekly Safeguarding Children's Risk meeting.
- Underdeveloped communication and information sharing discharge letter from ED to GP following ED attendance potentially giving an inaccurate picture of children's needs or risks.
- The format for documentation within the emergency departments has changed following the launch of Nerve Centre. Within this new process it is mandatory for staff to identify whether there is a safeguarding issue.
- Further work and training is therefore planned with the Emergency departments to consider the assessment of risk.
- Emergency department staff undertook an audit of the use of the Mental Health triage tool the results of which were disseminated within the departments.

The JTAI identified that the child's voice is not consistently captured in the records, which means that practitioners cannot be assured of a holistic assessment of need, including consideration of the impact on a child, or their lived experience, when a parent or carer attends the emergency department.

- Senior clinicians led on an audit to understand whether children were spoken to within the department, the audit upheld the finding of the JTAI and learning has been disseminated within the organisation both on a departmental basis and as a discussion within the *Think Family* Training.

Communication between the Health Visiting Service and GP's was also considered within the JTAI;

- Pathways are in place for Health Visiting to notify General Practices when vulnerabilities have indicated a change in service provision, however staffing challenges within the service may have an impact. Health Visitor vacancies are on the trust risk register.

3.0 Key Achievements in Safeguarding 2020 - 2021 by various colleagues and teams

- The Safeguarding Team have continued to support all the Divisions with Safeguarding issues throughout the Pandemic even in surges.
- Safeguarding holistic *'Think Family'* training was relaunched as virtual webinar offer, to ensure that mandatory level 3 safeguarding continued throughout the pandemic. There has been continued interest shown in this presentation by other health trusts within the country, one of whom contacted the ESHT Safeguarding team following a recommendation by the CQC.
- The Named Doctors have facilitated a programme of peer training with Paediatric colleagues.
- The Safeguarding team and Named Doctors have embedded Royal College guidance regarding the management of perplexing cases with a bi-monthly forum to discuss complex cases with the relevant key staff.
- The team have worked with Occupational Health to develop pathways to support staff that are experiencing Domestic Abuse which increased during the pandemic and various lockdowns with some very significant cases.

- A Domestic Abuse rapid assessment tool has been developed to support staff to discuss domestic abuse, this has been uploaded to Nerve Centre for use within the Emergency departments and also has been adopted by Occupational Health,
- The Safeguarding Transition Specialist Nurse is now working with children from the age of 13 to 25 to ensure that work undertaken is both preventative and proactive; the practitioner moreover dovetail's with the broader trust transition team to ensure a cohesive service.
- The Safeguarding Transition Specialist has implemented the Healthy Teen Minds *'We can talk'* project which is designed to support staff in their conversations with young people.
- The team continue to develop and refine safeguarding governance systems and processes ensuring increased collaborative working with clinical and operational teams.
- Multi-disciplinary work has been undertaken with the CCG, Sussex Partnership, East Sussex Children's Social Care to consider how information can be shared with school when a child accesses health care as a result of an overdose.
- The team have worked to raise the profile of Deprivation of Liberty Safeguards as a precursor to the forthcoming changes to Liberty Protection Safeguards. Both the Head of Safeguarding and the Named Nurse for Adults are part of a Sussex wide LPS steering group.
- Supported the implementation of the mandatory Female Genital Mutilation Information System (FGM-IS) in maternity.
- Maternity Safeguarding Midwives continue to raise the profile of domestic abuse. They work closely with maternity staff supporting strategies to enable them to discuss the issue of domestic abuse with all pregnant women during their antenatal and postnatal care.
- The team worked closely with the Women's and Children's Division and Urgent Care to address concerns regarding the experiences of patients with Mental ill-health, specifically through audit, including a review of the risks on the Trust Risk Register and development of a more robust process of monitoring the patients that are referred to Child and Adolescent Mental Health and Children's Social Care database (GDPR compliant).
- The team have continued to provide a Safeguarding Supervision offer throughout 2020/2021, in Adult and Child Specialist areas, specifically the teams which have managed self-neglect and complex caseloads, the mode of delivery however altered to a virtual offer and has been well received.
- Contribution to ESSCP Quality Assurance Subgroup in monitoring and evaluating the effectiveness of the work carried out by board partners by contributing to 2 multiagency audits (injuries to infants and young children and domestic abuse)
- ESHT have contributed to the ESSCP Learning and Development sub group to consider the multi-agency training programmes going forward that are in line with current themes.
- ESHT safeguarding have worked alongside the Women's' and Children's division and the Emergency Departments to complete and take forward action from the Joint Targeted Area Inspection.
- Whole team meetings have occurred monthly to share best practice and learning in both adult and child cases.
- The weekly child risk meeting is multidisciplinary with representation included from Children's social care practitioners, CAMHS and the under 19 Substance misuse service
- The maternity safeguarding team has begun to provide targeted training/updates regarding domestic abuse, trafficking, forced marriage and modern slavery to the maternity day unit and early pregnancy clinic.

- The National Maternity Safeguarding Network together with The Centre for Child and Family Justice Research at Lancaster University are currently undertaking a piece of work exploring women (and families) who have their babies removed at birth due to care proceedings. Part of this work is exploring the trauma by an informed approach of gifting the women and their baby, a box filled with small keepsakes and memories. The ESHT maternity safeguarding team is working closely with this national group and this idea was implemented at ESHT in 2019.
- Since the introduction of Baby Boxes at ESHT, maternity safeguarding has provided approximately 40 boxes. The team are now offering both parents a Baby Box rather than one for each couple.
- Safeguarding supervision is offered to all midwives and maternity support workers annually and to the community maternity team quarterly. Safeguarding supervision will develop over the next fiscal year to include quarterly supervision to specialist midwives and the maternity day assessment unit.

Throughout 2020/2021 ESHT has supported changes in practice as a result of learning from Safeguarding Case Reviews (SCR's) including;

- Working alongside the CCG to develop pathways for the sharing of Safeguarding referrals with health partners such as GP's
- Working alongside STAR and clinical staff to develop pathways for vulnerable people using substances and alcohol (Adult C and a Domestic Homicide Review).
- Safeguarding learning will inform the work underway regarding discharge planning (Adult C - Safeguarding Adult Review)
- In three Domestic Homicide Reviews in 2020-2021 a lack of routine inquiry was a theme; a rapid assessment tool has been developed to support staff to enquire about Domestic Abuse.
- A Serious Case Review (Child T) highlighted risks associated with vulnerable children who transition from child to adult health and social care services. An innovative multiagency project is now being piloted where high risk complex safeguarding cases with long term medical needs are now jointly supervised by both ESHT and the Local Area Safeguarding team.
- Maternity services are improving practice in relation to the return of mother and baby hand held notes postnatally.

3.1 Maternity Safeguarding

- The maternity safeguarding team is currently composed of the named midwife for safeguarding, deputy named midwife for safeguarding and a maternity safeguarding administrator. Each of these positions are full-time reflecting the acknowledgement of the critical role of safeguarding within maternity by the senior team

- Maternity will be launching phase one of Badgernet July 2021. Badgernet allows healthcare professionals to record notes on maternity patients in real-time, whether they are in the hospital, the community or at home. Maternity service users can use a PC, tablet or smartphone to read their own medical notes, look at healthcare leaflets recommended by their midwife and self-refer to maternity services. Maternity have struggled with obtaining

the return of 100% of all hand-held maternity notes in the past. Badgernet will solve this problem as all information is stored digitally.

4.0 National Context

4.1 Covid and Safeguarding

In June 2020 the NSPCC produced a report that summarised the impact of the Pandemic and lock-down with regards to Safeguarding Children. The report suggested that the conditions created by COVID-19 increased the probability that both stressors and vulnerability will increase, at a time when the protective services have been weakened, and families have reduced social support and connections to rely on: Isolated and struggling: social isolation and the risk of child maltreatment, in lockdown and beyond (nspcc.org.uk)

The reports cited three main areas of risk

- Increase in stressors to parents and care givers.
- Increase in children's and young people's vulnerabilities
- Reduction in normal protective services

The NSPCC report was written after the primary lockdown and the risks identified have been mirrored in local data with increases in referrals by ESHT Safeguarding to the case reviews panels of serious cases.
The Social Care Institute for Excellence (SCIE) recognises similar patterns for vulnerable adults but with the addition of the risk of exploitation and Domestic Abuse increasing as a result of social isolation.
Furthermore, for both young people and adults, difficulties with mental ill health and drug and alcohol dependencies due to both isolation and a state of heightened anxiety have been cited and are also a theme reflected in local data.

4.2 Child Safeguarding Arrangements

Following the publication of *the Woods report* and *Working Together* in 2018 the Safeguarding Children's Board roles and functions were reviewed and have been revised to accommodate National guidance in respect of Serious Case Review (SCRs) and Child Death Overview Panels (CDOPs). The LSCB is now referred to as the East Sussex Safeguarding Children Partnership Board (ESSCP). The ESSCP board combines three key agencies, Local Authorities, Health and Police and retained the existing local pathways and ways of working.

The management of Serious Case Reviews has altered, firstly the process is now referred to as a Child Practice Review (CPR) and there is now a national independent body which oversees a new learning framework for inquiries into child deaths (CDOP) to which local boards are now accountable where children have experienced serious harm. The national panel published its annual report in 2020, within which it recorded the national notifications as 482 serious incidents, relating to 514 Children, 35% children under 1 and 30% 15-17 year olds. Further key points cited that Neglect featured in 35% of all incidents with Domestic abuse a background factor in 40% of

incidents and Parental mental ill health featured in 146 incidents, 78% relating to mothers. In 16% of incidents the child had also experienced mental ill health.

East Sussex has now managed several Serious Case reviews within the new frameworks which highlight the importance of rapid response and transparency in publicising how an area has learned from an incident and what has changed in local practice. Also key is advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.

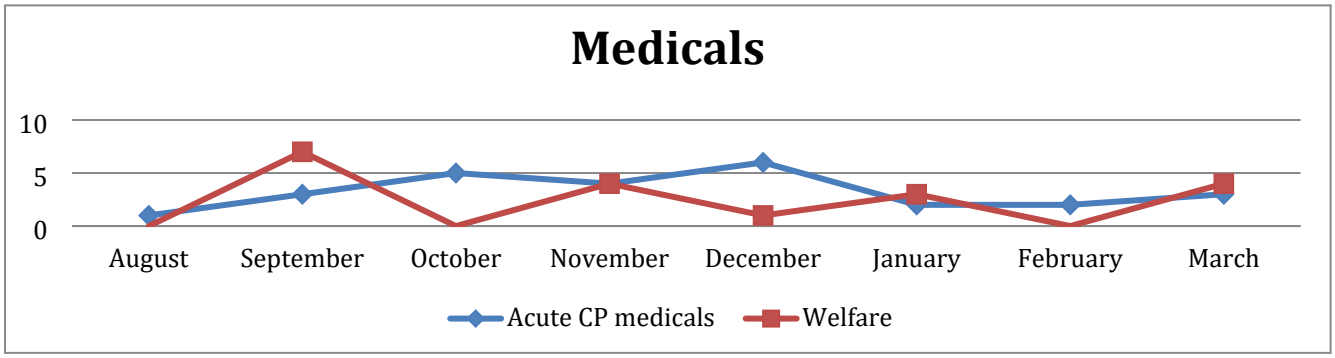
4.3 Named Doctors for Safeguarding Children

There are three named Doctors, two acute based and one community, all three work closely with the Head of Safeguarding and the Specialists Nurses for safeguarding Children. The three Named Doctors provide clinical advice guidance and support. Their work within the last year has included;

- Provision of direct access for social workers to Named Doctors for advice and review of clinical images during Covid lockdowns in order to assess risk to a child and avoid any unnecessary visits of the child and CSC staff to the hospitals.
- Participation in national network of named professionals to share best practice
- Introduction of consultant peer review of safeguarding cases, provision of safeguarding induction to paediatric and ED physicians, development of regular paediatric and ED safeguarding teaching programme (the last two are a work in progress)
- Regular meetings with CSC locality managers to improve inter-agency communication and working
- Support of colleagues at strategy meetings and case conferences, and in provision of written safeguarding medical reports.

Within a child protection investigation, Paediatricians may be asked to conduct an urgent child protection medical or welfare medical. In the last year the process for medicals has been more clearly defined and data is now collated as to how many medicals occur during a monthly period. Welfare medicals were adversely impacted due to the Pandemic as it was necessary to repurpose their clinic spaces .

During Covid, Social workers consulted with paediatricians as to whether a medical was proportionate to limit the risk of infection.



4.4 Learning Disabilities Safeguarding

The Trust has a Lead Nurse for Learning Disabilities, supporting and facilitating equality, access and treatment for children and adults with learning disabilities who access ESHT services, ensuring compliance with the Mental Capacity Act (2005) and the Equalities Act (2010) through training and advice/support.

The work of the network of LD champions across all sites was suspended due to the Pandemic. Going forward the LD Specialist Nurses aim to work alongside Equality and Diversity leads to develop links with Hidden Disability Sunflower Champions to promote and support best practice. The Lead Nurse for LD represents the Trust in the wider system and is a member of the Strategic Group.
ESHT fully participates in the LEDER programme, which ensures that all deaths of people with learning disabilities aged 4 years and over, are subject to external review following the nationally mandated processes. These reviews ensure all appropriate health and care records from all providers involved with the person are reviewed to identify learning.

The Chief Nurse and Acting Head of Safeguarding have highlighted to the CCG that there is a need for an increase in the Learning Disability resource within the organisation. Developing the service is key to fulfil the Learning Disability Standards and providing equity across the organisation to meet the needs of the patient population. Further work continues such as the flagging on information systems when a patient has a diagnosed LD. By flagging patients staff will be better able to anticipate and meet patients' needs and enhance the quality of the care people with LD receive.

4.5 Policing and Crime Act, 2017

The introduction of the Policing and Crime Act in December 2017;

- removed the use of police cells as places of safety for under 18 year olds
- restricted the use of police cells as places of safety for adults being held under the Mental Health Act (2007)
- reduced the length of time someone can be held from 72 hours to 24 hours under Section 135/6 powers

During 2020/2021, attendances at the Emergency Departments continued to increase including patients with mental ill-health as well as acute clinical care needs As a result, the Head of Safeguarding is working with colleagues in closely monitoring the numbers of patients subject to sections and any incidents that occur.

Senior Trust staff and the safeguarding team continue to collaborate with the key stakeholders across the system to ensure processes and procedures are aligned to implement the revised legislation locally. ESHT have seen, alongside other healthcare providers, an increase in mental health related presentations to both emergency departments. On occasions there are no physical health needs with often challenging and at times violent behaviour. This picture is being reflected nationally and local partnership work continues to ensure patients are assessed and treated in the most appropriate place but challenges remain.

4.6 The impact of County Lines

During 2020/2021, the virtual *Think Family* Safeguarding Training and Supervision has continued to include County Lines which is the term used to describe the distribution of drugs from major cities into counties. ESHT continues to support Emergency Department staff, Police and other agencies to identify children at risk of being drawn into serious crime including drug dealing with pressure to carry weapons. Unfortunately Children in Care have been overly represented in the overall amount of County Lines related cases presenting to our ED department bought in by Police.

The Specialist Safeguarding Nurse for Transition participates in the Multi-Agency Child Exploitation meetings, held monthly to discuss young people under the age of 18 at high risk of exploitation. Those young people discussed within the meeting are identified as at risk on the trust e-searcher system.

4.7 Modern Slavery/Human Trafficking

East Sussex LSCB, including its partner members, has pledged to reduce the risk of children being sexually exploited, trafficked or going missing from/in East Sussex. Section 54(1) of the Modern Slavery Act (2015) places a legal requirement on ESHT to prepare staff to identify patients at risk of modern slavery and being trafficked. Whilst it is not a mandated requirement yet to provide information centrally, ESHT continues to identify suspected cases which have been reported to the police. Both the Named Nurse for Adults and Head of Safeguarding are listed within the *'Stop the Traffic'*, single point of contact directory for Modern Slavery.
Members of the Safeguarding team participate in a monthly meeting chaired by Discovery that reviews local 'hot-spots' and Multi-agency actions to safeguard victims. Both the Head of Safeguarding and Named Nurse for Adults are listed within a local directory as points of contact**.**

4.8 Multi – Agency Female Genital Mutilation (FGM) Guidance

ESHT has effective arrangements in place to meet the requirements set out in the Home Office guidance for FGM. The FGM Lead is responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support to ensure staff can identify females at risk, detect FGM and report it effectively. Information about FGM is included in Think Family training.

Between April 1st 2020 and 31st March 2021, there were 12 cases of FGM reported by ESHT with data entered onto the NHS Digital National FGM Enhanced Dataset. All information was reported by maternity colleagues.

NHS Digital collects data on FGM on behalf of the Department of Health (DH) from acute trusts, mental health trusts and GP practices.

The data collected is used for the following:

- to improve how the NHS supports females who have had or who are at risk of FGM
- to plan the local NHS services needed now and in the future
- to help other organisations to develop plans to stop FGM happening in local communities

The FGM information sharing platform, known as FGM-IS, is a national IT system linked to the NHS spine that supports the early intervention and ongoing safeguarding of females, under the age of 18, who have a family history of Female Genital Mutilation (FGM). ESHT has implemented the system which is led by the Named and Deputy Named Midwife for Safeguarding.

4.9 The Care Act (2014) - Making Safeguarding Personal

It had been agreed that to enable ESHT to deliver MSP focused safeguarding practice, a framework of reflection and revised training alongside learning from complaints, safeguarding enquiries and case reviews was required. The Care Act (2014) defined safeguarding adults as 'protecting an adult's right to live in safety, free from abuse and neglect'. Making Safeguarding Personal (MSP) defines an approach to safeguarding which focuses on outcomes rather than process. It aims to answer, in partnership with the adult at risk / their advocate, three questions;

- What difference would they want or desire?
- How will you work with someone to enable that to happen?
- How will you know a difference has been made?

Historically Safeguarding Supervision had been the forum within which the ethos of Making Safeguarding personnel had been discussed, however during the period March 2020 to March 2021, the Pandemic affected the programme of Supervision facilitated within the organisation. As a result the *Think Family* training offer, which incorporates all staff at band 5 and above has been the main method by which the Safeguarding team have continued to deliver the MSP message to staff.

4.10 PREVENT

The Head of Safeguarding is the Trust lead for the PREVENT programme, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act, 2015.

Locally, the Trust is active on the PREVENT Board and submits numbers of PREVENT (Channel) referrals from health quarterly to the CCG and NHSE.

During the Pandemic, PREVENT training moved to an e-learning format, however compliance has fallen. This is in part due to the impact of the pandemic but predominately as the training requisite has altered from a standalone to a 3 yearly requirement. This has been raised as a risk within the organisation.

- Staff accessing the Think Family training are sign-posted to complete their PREVENT training
- PREVENT training is now being included within the mandatory training matrix

4.11 Domestic Abuse and Multiagency Risk Assessment Conference (MARAC)

MARAC is a multiagency forum managing high risk cases of domestic abuse, stalking and honour based violence. Chaired by *Swift*, they bring together statutory and voluntary partner organisations

to share information and work collaboratively to safeguard the person at risk by developing a coordinated plan of protection. ESHT are members of both MARACs in East Sussex, where specialist nurses and midwives represent the Trust.

Due to the volume of cases locally, the MARAC services piloted 'MARAC Hubs' to triage the cases and ensure robust safety plans are in place, however this forum did not initially include health, a decision challenged by the Head of Safeguarding and subsequently reversed. The full MARAC meetings do not proceed when safety plans are evidenced through the hubs. The Safeguarding team continue to provide health research to the new forum and the Specialist Health Visitors for Duty and Assessment participate in the now virtual meetings.

In early 2021, in response to one of the JTAI actions, members of the Safeguarding team undertook an audit of the health research submitted to the conference. The key findings of which were as follows;

- The results demonstrated that within 85% cases reviewed, there were health personnel participating in the MARAC forum, thus able to provide interpretation of any health issues.
- In 85% of the cases considered, health research was submitted pertaining to the adult victim.
- In 67% of the cases reviewed, health information was submitted in respect of pre-school children within the household.
- In 79% of cases health research was submitted in respect of acute hospital interventions for children within the household.
- In 79% of cases the health documentation did not identify sufficient detailed information to highlight Domestic Abuse as a causal or secondary risk. This was further reflected in analysis of patients' perception of identified priorities for their own safety.

As a result of this Multi-Agency engagement, confirmed cases of domestic abuse are flagged on patient administration systems. Furthermore, at the request of the Chief Nurse, meetings were convened and to strengthen arrangements, the "Care Grow Live" organisation and Sussex CCG agreed to resume the funding for the Health Independent Domestic Violence Advisor (HIDVA); the post focuses on supporting staff to identify domestic abuse through the process of referral, once made. The Health Independent Domestic Violence Advocate (HIDVA) Practitioner started work with the trust in October 2020 (ESHT hosts the post) and in addition to supporting staff to manage cases of abuse, the practitioner also works directly with victims and is developing the Domestic Abuse training offer within the organisation.

5.0 Local Case Reviews and referrals

A Domestic Homicide Review, Child Practice Review or Serious Adult Review is undertaken when it is identified that there is learning, following a referral to the Safeguarding Board regarding the management of a patient. This is a multi-agency undertaking with ESHT alongside other partner agencies undertaking report writing, identifying lessons to be learnt, recommendations and attendance at a learning event. The external reviewer then writes a report which is published once it has agency sign off.

5.1 Children's Activity

In 2020-2021, ESHT Safeguarding submitted 7 cases to the East Sussex Safeguarding Children Partnership Board case review panel; all the cases were subject to a rapid review as per the national guidance. Of these, 3 cases occurred at the start of Covid pandemic and involved young babies with multiple fractures; these were reviewed together within a thematic learning framework. Two of the cases are in progress as child practice reviews and a further case has been commissioned to launch in Autumn 2021.

One of the child cases for 2018/19 is yet to be published, due to the delays in criminal proceedings as a result of Covid; however the action plan was shared within the Safeguarding Strategic Committee for the Chief Nurse to have assurance.

One case (Child W) has been published within this year and learning and action plans have been shared within the organisation.

Themes from the Case Reviews will inform practice and the Head of Safeguarding will provide briefings for staff involved.

5.2 Safeguarding Adult Referrals

The Safeguarding Adults Board published Serious Adult Review Adult C in December 2020, learning and action plans have been shared within the organisation.

A Safeguarding Adults Review (SAR) referral was made by maternity safeguarding this year, this case is to be considered within the umbrella of a thematic review, alongside three other cases in which some common themes have been noted.

The thematic review will consider areas of multi-agency learning to be taken forward in relation to how well services identify and respond to a history of trauma in addition to how well agencies are able to work together to address domestic abuse for women with multiple complex needs. It has been identified that the cases also draw on the learning from the Adult C SAR published by the Safeguarding Adult Board last December and another thematic review that is currently being undertaken in Brighton and Hove.

Information gathering occurred this year on a further two cases, to support the Safeguarding Adult Board case review group to assess whether the threshold for a serious adult review is met. As a result two further serious adult reviews are to be commissioned in 2021/2022

5.3 Domestic Homicide reviews.

In the period 2020-2021, 5 Domestic Homicide reviews have been commissioned and the Head of Safeguarding has been a panel member for all the cases, A further 4 cases have been submitted to the Home Office; none of the cases are as yet published.

One of the cases has themes of substance misuse and homelessness, which are mirrored in the Serious Adult Review Adult C case. The Safeguarding team are part of the trust wide work regarding discharges within which the interface with the homeless population is being considered. Furthermore collaborative work is underway with "STAR' the local provider of substance and alcohol misuse services.

A further theme common to all the cases is that of a lack of routine enquiry about Domestic Abuse within acute settings. Some work has been taken forward this within the organisation to develop both understanding and pathways for victims of Domestic abuse.

- All trained staff now access the *Think Family* safeguarding training within which there is a large section on Domestic abuse.
- A rapid access tool has been developed to support discussions about Domestic Abuse; this is now uploaded to Nerve Centre.
- The trust now hosts the post of Health Independent Domestic Violence Advocate (HIDVA), supporting staff and victims.

Additional work continues to be progressed to incorporate Domestic Abuse as part of any initial assessment.

6.0 Deprivation of Liberty (DoLs)

As an organisation East Sussex Healthcare applies the Deprivation of Liberty Safeguards to those patients that are deemed to lack mental capacity and whom in order to ensure their care are effectively deprived of their liberty to treat them, in their best interests. It is not the same as being sectioned under the Mental Health Act.

The Deprivation of Liberty Safeguards were an amendment to the Mental Capacity Act 2005 and within which the procedure as prescribed in law, cites when it is necessary to deprive a person of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

This legislation was further developed following a supreme court judgement in 2014, referred to as Cheshire West directive, which made reference to the 'acid test' to see whether a person is being deprived of their liberty, and which consisted of two questions:

- Is the person subject to continuous supervision and control? *and*

- Is the person free to leave? – with the focus, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want/try to leave.

The government planned changes to DoLs have to date been delayed by the Covid pandemic, however it is anticipated that Liberty Protection Safeguards (LPS) are to be launched In April 2022, replacing the DoLs system.
There are key changes within this new format which will have an impact on ESHT.

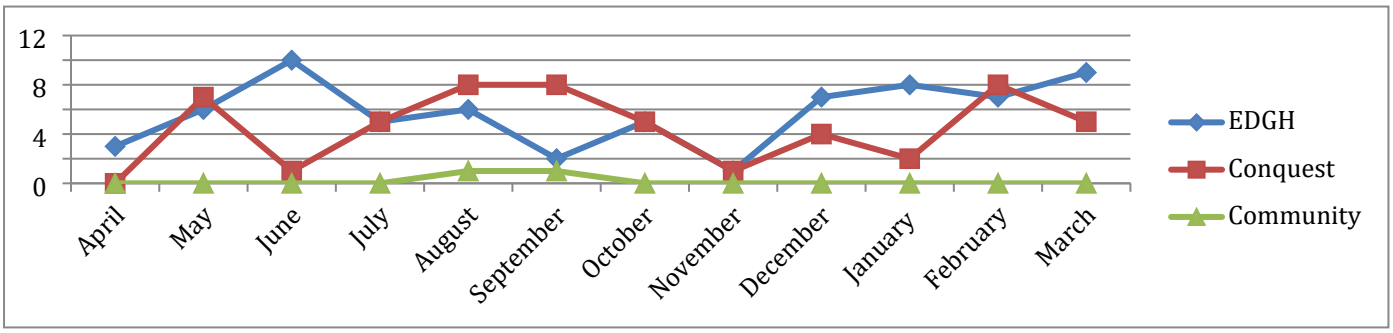
- LPS can be applied to a person aged 16 and above
- If the LPS is applied for within an NHS setting, the 'hospital manager' and the trust, become the responsible body
- An LPS can move with the person to differing settings i.e. between a care home and hospital
- An LPS can be applied to a patient's home environment.

In preparation for these forthcoming changes the safeguarding team have been reviewing the current DoLs process.

- A DoLs/ LPS page has been established on the intranet to provide information for staff.
- Head of Safeguarding and Named Nurse for Adults participate in a Sussex LPS steering group and information disseminated via the Professional Advisory group within the trust.
- The Head of Safeguarding has attended Matrons and Divisional meetings to discuss the forthcoming changes.

In readiness the team have reviewed the current DoLs process, benchmarking against the Cheshire West directive, this work is already increasing the number of DoLs applications and this is likely to increase more in the next few months.

During the Covid pandemic the numbers of DoLs submitted were variable across the sites.



7. 0 Safeguarding Work Plans

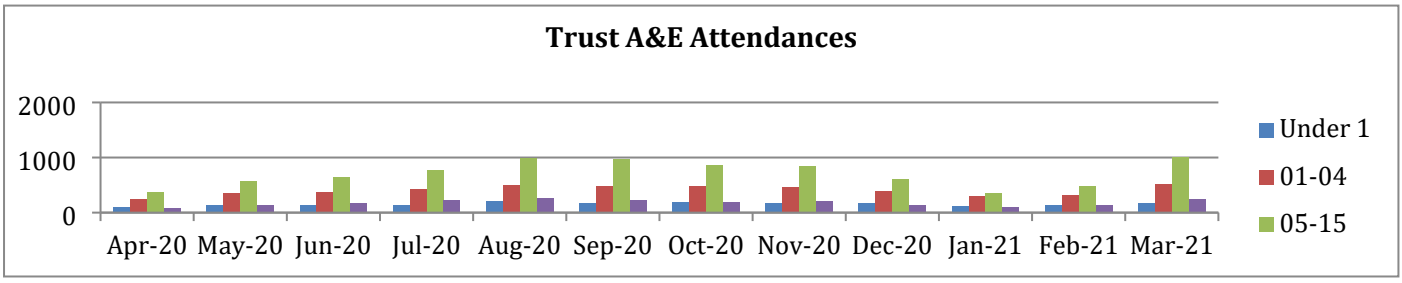
The work plans for all aspects of safeguarding and learning disabilities and the processes for reviewing and reporting progress, risks and compliance were revised as part of an overall review of safeguarding governance. During the period 2020/2021, the monthly Safeguarding Work Plan meetings, which ensure that there is a responsive forward strategy work to be undertaken by the team addressing both local and national Safeguarding agenda's, was suspended. The work plan was disseminated between staff virtually for comment and to continue to accurately capture the

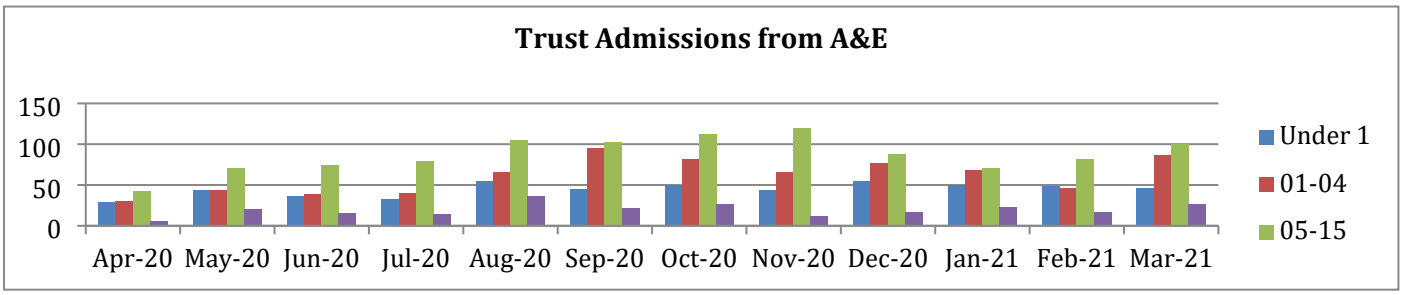
learning, mitigations, planned developments and improvements. The Safeguarding Children and Adults Strategic Group continues to monitor progress, compliance and risk through the Head of Safeguarding Report and the Divisional Safeguarding Reports received at each meeting.

8.0 Safeguarding Activity

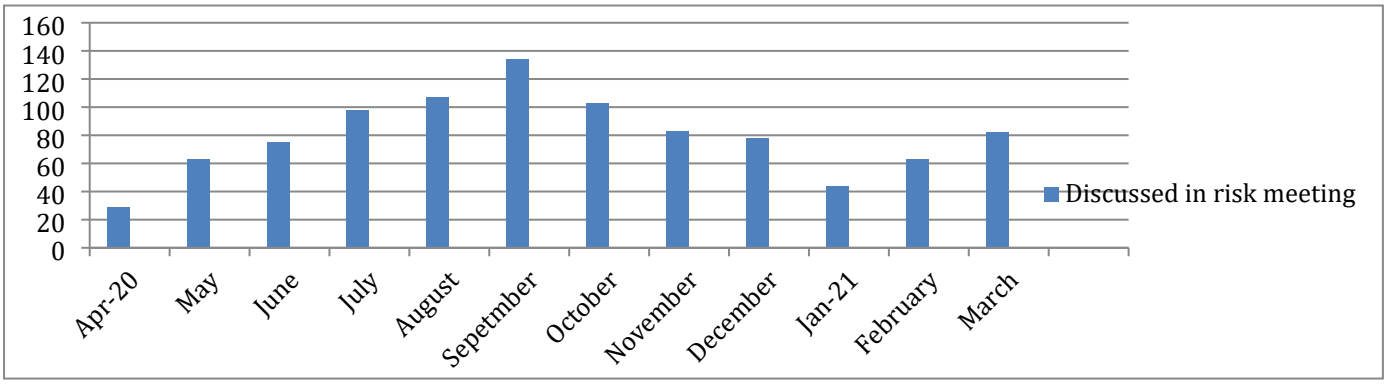
8.1 Safeguarding Children's referrals

During 2020/2021 over 17,000 children presented to both Emergency Departments, Over 2,546 required admission for different health issues, these figures are demonstrably lower than the previous years, which may be as a result of the pandemic and lockdowns.

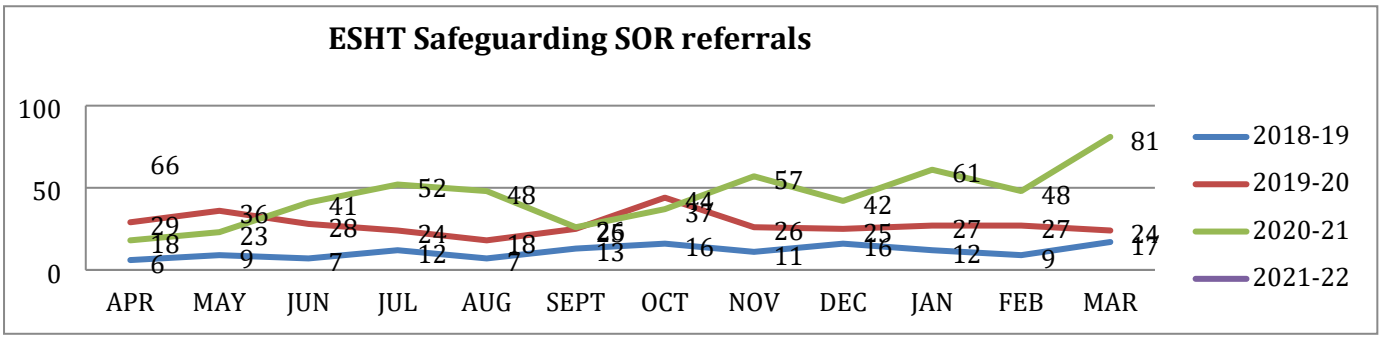


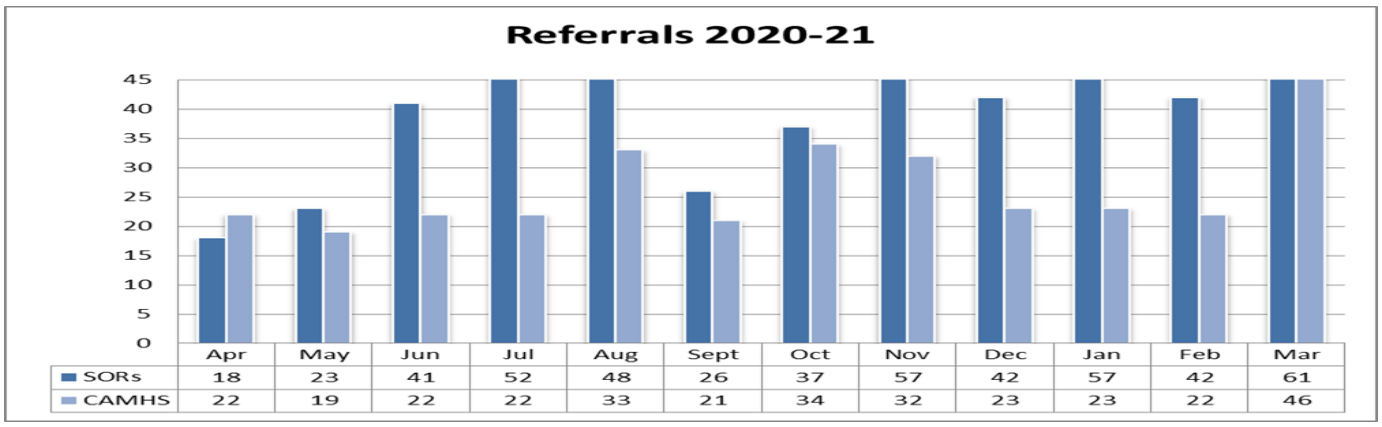


99% of all children's attendances were checked on CP-IS at first point of contact and 100% of these were checked on Liquid Logic by the safeguarding team. 962 of the overall ED attendances were risk assessed and discussed at the weekly ESHT Safeguarding Clinical Risk Meeting as they raised safeguarding concerns or were known to be vulnerable i.e. suffering from Social and Mental Health related issues.



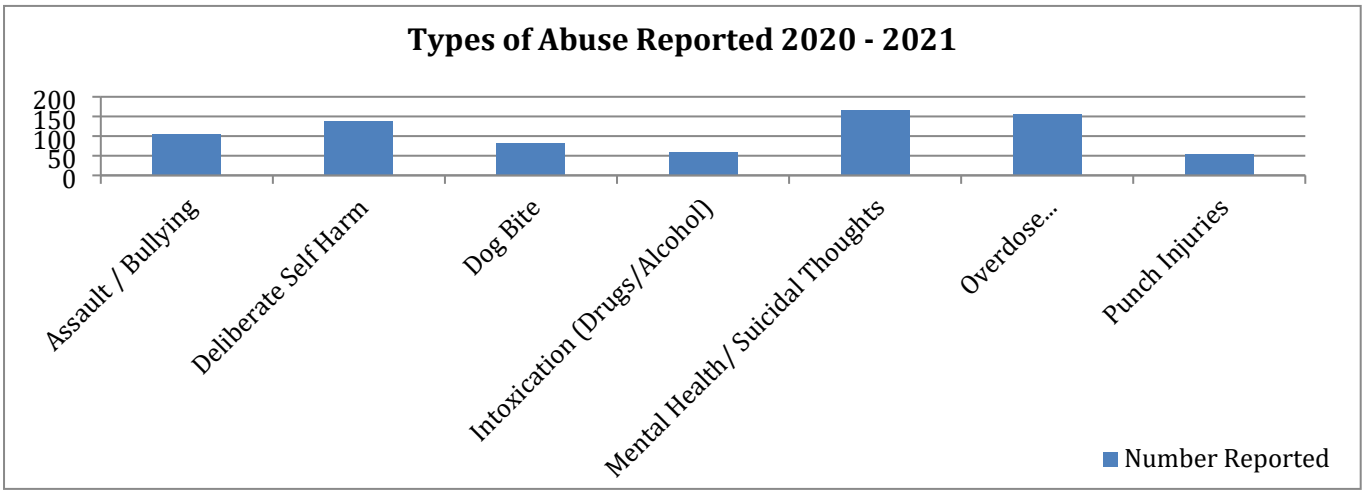
This figure is again lower than preceding years but alongside this was demonstrated a significantly higher increase in Statements of Referrals (SOR) to Children's Social Care.





	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
SORs	18	23	41	52	48	26	37	57	42	57	42	61
CAMHS	22	19	22	22	33	21	34	32	23	23	22	46

The predominant theme in Safeguarding Children has been that of mental health issues, demonstrated through presentations following overdose and various forms of self-harm and eating disorders in addition to an increase in referrals to CAMHS.

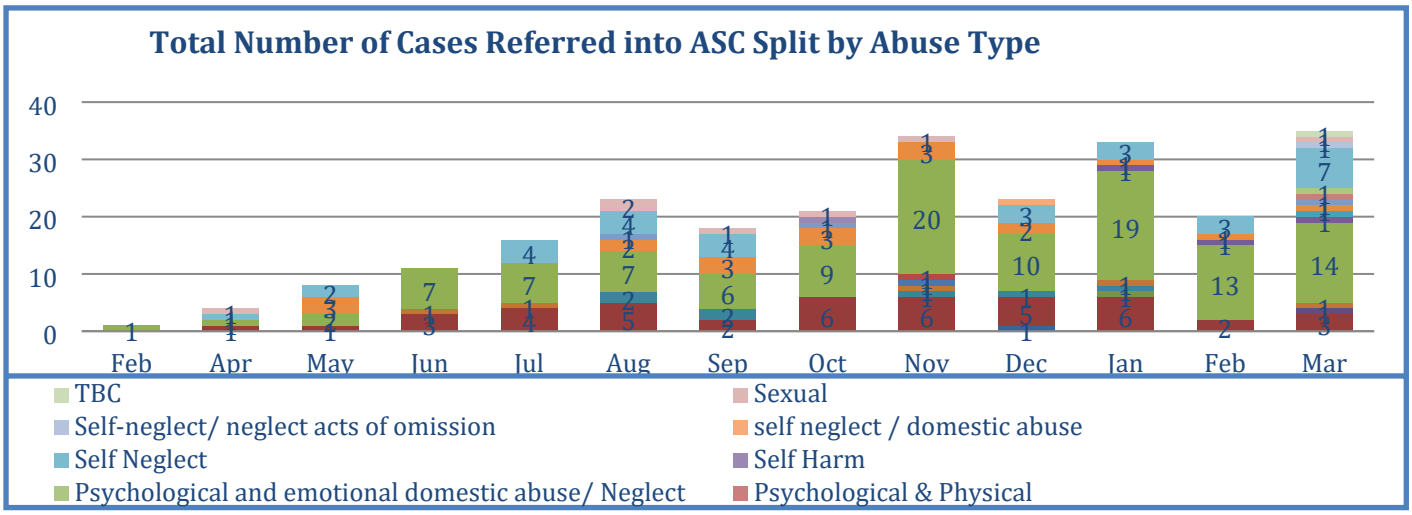


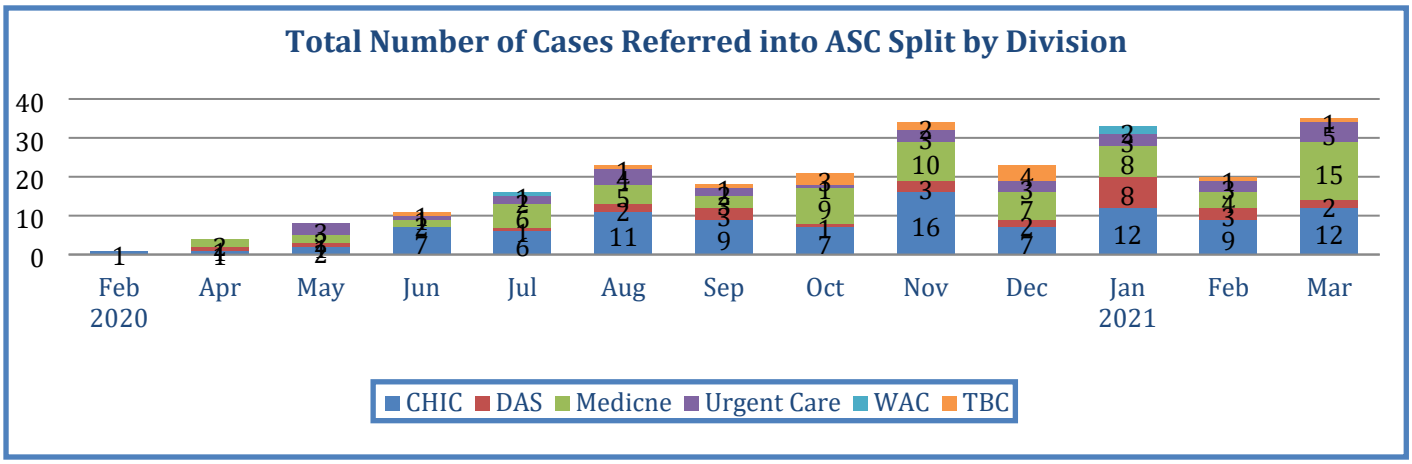
This trend has been further replicated with adolescents presenting with complex mental health needs requiring admission to the Paediatric ward. A further complication has been the lack of available Specialist Paediatric in-patient beds to transfer patients to with a result that some admissions have been for a sustained period whilst professionals sought therapeutic accommodation. This difficulty is reflected in neighbouring trusts, with a predominant theme of eating disorders.

- The Chief Nurse s raised this issue at senior county and regional forums
- The Head of Safeguarding is part of a Sussex Wide forum on “stranded” children

8.2 Safeguarding Adult Referrals

During 2020/2021, ESHT raised or were involved in 230 safeguarding enquiries, this is an increase on the previous year. This covers both acute and community services. Neglect, self-neglect and domestic abuse are identified as themes raised as safeguarding enquiries. Safeguarding supervision for some clinical teams was paused during the acute phases of the pandemic and has been offered virtually via Microsoft teams for those staff enabled to access, such as Dietetics and Sexual Health. The Safeguarding team are in the process of reinstating supervision and have made connections with both the community and acute settings. This has enabled teams to access team support whilst managing complex safeguarding cases and has also enabled the *Think Family* approach to be embedded further. The *Think Family* level 3 safeguarding training identifies current safeguarding themes and trends both locally and nationally and has been positively received and well evaluated.





8.4 Safeguarding Training

ESHT Safeguarding launched a new model of training in 2020, combining both adults and children's level 3 into a holistic *Think Family* offer.

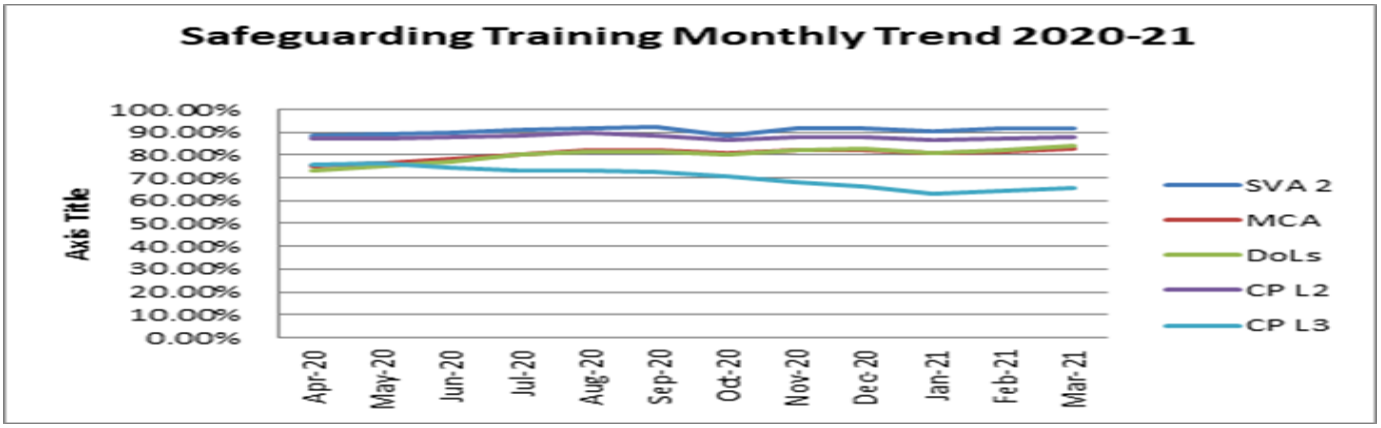
Furthermore, to provide consistency across the organisation and avoid fragmentation, all registered staff Band 5 and above have been migrated across to undertake *Think Family*. This provides assurance in line with the Intercollegiate frameworks (2019) that all trained staff have

accessed the required competency. Some of this cohort however, previously may have accessed level 2 training for either strand, whilst the migration of staff continues within the next year this will show as a compliance fall, further impacted by the pandemic.

The *Think Family* project was piloted prior to the Pandemic and launched in February 2020 as a whole day of face to face training. In March 2021 this converted to three separate 1.5 hour webinars. Due to Divisional requirements the version 3 offer is that of an assessed e-learning module followed by a 3 hour webinar. Each of the training sessions is facilitated by two members of staff from the Safeguarding team. There is a fall in compliance for level 3, this is in part due to the impact of the pandemic and staff access to the webinar but also as a result of now migrating all registered staff Band 5 and above over onto the *Think Family* programme.

The *Think Family* project has received interest from other trust and the Head of Safeguarding has met with staff from both Rotherham and Surrey to present the approach.

Training compliance



9.0 The Mental Health Act – ESHT Duties

There continues to be a service level agreement (SLA) with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements and ensure patients admitted to inpatient beds have their rights protected and their mental health care needs are met by a Responsible mental health clinician. The Head of Safeguarding attends regular 135/136 meetings, escalating risk when necessary to the Chief Nurse. The team has strived to improve safeguarding governance in monitoring ESHT compliance and works collaboratively with SPFT teams to address any areas of non-compliance. This work has included the following:

- The site team have all been trained to undertake the duties of the receiving officer and maintain detained patients' rights
- Section 135/136 training for ED staff continues to be delivered
- Revision of the Policy for the Mental Health Act to support staff
- Audit arrangements to be agreed with SPFT to begin to measure compliance more systematically

10.0 Looked After Children (LAC)

The demand for interventions associated with LAC activity has continued throughout 2020-21 despite the Covid pandemic and the whole team have been creative and worked innovatively to both maintain and improve service contacts, quality and performance.
A greater number of children (32) entered care than left care in 20-21. Aside from the Covid pandemic and lockdowns, Initial Health assessments (IHA) 20 day performance (from entering care) has been impacted by delayed administration from children's services, but with some improvement during the period that verbal consent had been accepted. The 16 day KPI performance was found to be affected by some internal administration processes. Now refined, there is evidence of improvement and the team also work to counteract external delays whenever there is the opportunity.
Adoption activity has not increased significantly but has been unpredictable and with tight notification timescales. The challenge of managing the health records of adopted children within the current legislation is being worked on across the organisation.
Medical staffing has been challenged with unfilled vacancies and there was a nurse vacancy for 4 months, but workload has been somewhat supported by exemplary staff attendance and commitment throughout the year. The nurse team has undergone a re structure with a positive effect on team dynamics and effectiveness.

Review Heath Assessment (RHA) performance continues to be impacted predominantly by late requests from children's services, although fewer are being rejected due to incomplete or incorrect documentation. Requests by Other Local Authorities (OLA) for RHA and the associated caseload work for these complex cases has been significant. A standardised 'Leaving Care Health Summary' and guiding principles document has been agreed for uniformity across the Integrated Care System (ICS). Collecting child and carer feedback continues to be a challenge that we aim to address over the coming months.

There is ongoing work to refine the performance data pulled directly from Systmone and progress on the IHA activity data is more advanced than the RHA data.
Covid and the associated lockdowns have had a significant impact on LAC workload and practices with clinical staff almost exclusively working from home for all of 20-21. The ceasing of face to face (f2f) contacts for the whole RHA and the move to virtual consultations with the carer that are followed up by a time limited f2f with the child/ young person is a less time efficient model. It also had the risk that the Looked After Child may not been seen in their home environment.
The nursing team RAG rated the vulnerability of children on their caseloads at the request of the CCG for up to date assessment of individual caseloads in the early part of 2020. During the second wave of COVID admissions to hospital, the Named Nurse was re-deployed for 11 weeks. The team have worked to support staff wellbeing, maintain team communication flow and looked to protect staff children and carers by identifying Covid safe venues for f2f contacts with access to appropriate PPE. Some Unaccompanied Asylum Seeking Children (UASC) have been seen in a sexual health clinic that has proved to be a suitable environment.

Training, supervision and QA of RHA was reduced for a period of time with mitigations put in place to ensure quality and safety was not compromised. Both have resumed and continue to be offered with the Trust agreeing that all ESHT staff should access level 1, 2 or 3 training as mandatory. The

nursing team now have access to the expertise of a clinical psychologist and speech and language therapist via the community paediatrics team to discuss cases.

Lansdowne secure children's home expanded its bed capacity from7 beds to 12 beds. NHS England looked for contract bids for a prime provider. Sussex Partnership Foundation Trust have been awarded the contract and therefore East Sussex Health Care NHS Trust will cease to provide the physical health nurse offer and administration to the home from 1st July 2021.
The teams have worked with the Local Authority to agree a process for booking of interpreters, and have established formal information sharing agreements with School Nursing and Continuing Health Care teams to aid the sharing of information between practitioners who are working with the same child.

Closer links have been established with the Looked After Children team, Child and Adolescent Mental Health Service (LACCAMHS) and a conversation is being had with the Local Authority about the administration of Strengths and Difficulties Questionnaires (SDQ)

10.1 LAC profile

	Year	Children who started to be looked after	Children who ceased to be looked after	Total number of looked after children
East Sussex	2017	198	185	555
	2018	203	162	602
	2019	192	192	600
	2020	193	203	590
	2021 (data unverified)	206	174	612

10.2 Initial Health Assessments (IHA)

Initial Health assessments-The IHA performance target within the Service Level Agreement is set at 85% completed in timescale

IHA	Distributed 20 days from entering care	Distributed 16 days from complete paperwork (referral) received
Q1	61%	79%
Q2	52%	76%
Q3	45%	88%
Q4	59%	78%
Year-end total	**52%**	**78%**

10.4 Review Health Assessments

ESCC and ESHT data numbers for RHA's due have consistently matched throughout Q3 and Q4 indicating that the databases have aligned which is positive. ESHT and ESCC administrators and management have worked on building closer working relationships with an ambition to continue to work jointly to tighten up on processes and practice that impact on those that are overdue.
The RHA performance target within the Service Level Agreement is 85% completed by due date

	Under 5 yrs	5-18 yrs	0-18 yrs combined
Q1	61.5%	49%	51%
Q2	84%	80%	81%
Q3	54.5%	69%	65.5%
Q4	57.5%	73.5%	69.5%
Annual total 0-18 yrs			**67%**

Over the 12 months the frequency of RHA requests that are rejected by the nurse team has reduced. A data cleansing exercise is underway to ensure that ESCC and ESHT have the same LAC children and RHA dues dates on their systems

Leaving Care Health Summaries
'Health Care Summary' document has been agreed for use across the ICS and work is ongoing to agree guiding principles for managing Leaving Care Health summaries.

Quarter	Number eligible/due	Number and percentage of completed health summary on personal record as child turns 18 years	
Q1	**Total - 14**	**9 / 64%**	4 started= 3 incomplete and 1 YP not yet discharged. 1 consent not given by YP
Q2	**Total - 6**	**5 / 83%**	1 started but not distributed
Q3	**Total - 17**	**15 / 88%**	1 started incomplete. 1 has National Autistic Society Health Passport/Summary.
Q4	**Total - 21**	**20 / 95%**	1 consent not given by YP

It has been agreed locally with the Named Dr that for young people who enter care aged 17yrs plus the Dr will include additional information on health promotion in the IHA to enable the IHA report to double up as the Leaving Care Health Summary. The team will need to consider how they are going to capture this activity for reporting purposes.

10.6 Quality Assurance by Audit of Health Assessments 'Quality and Dip samples'

Named Nurse undertakes dip sampling throughout the year of East Sussex RHAs and Other Local Authority (OLAs) RHAs undertaken by the ESHT LAC nurse team. This is usually on a quarterly basis

Q1 Throughout the dip sample there was evidence that consent had been sought where age appropriate, albeit verbal. There was evidence that information had been gathered to inform the assessment from a variety of professionals. Of note School health rarely had any information to contribute to the assessments. There was evidence that health events had been recorded since the last review, although not always evidence of a discussion during the RHA. There was good evidence throughout all RHA's reviewed that the physical, developmental and emotional/ behavioural health of the LAC had been considered and discussed at the RHA. There was evidence that dental health and vision was raised and discussed in all RHA, though not all LAC had dentist or up to date vision assessment. However, there was evidence that the LAC nurse had emphasized the importance of these two screenings to the foster carer(s) in addition to offering local dentists contact details.

Throughout there was evidence of health professional involvement where relevant. Immunisation status was always referenced and evidence from the LAC nurse of the importance of up to date immunisations. There was evidence that 'keeping safe' discussions had taken place predominantly with the 10-18 yr. olds and available community services for specific issues, e.g. SAS nurse. Where appropriate there is evidence of healthy relationship discussions. There was evidence that alcohol and/or substances have been discussed within the RHA, where applicable. Throughout the review the RHA's were personalised and the voice of the child was clear, evident and apparent. Some health care plans had general actions as opposed to SMART actions with some general deadlines, e.g. "ongoing" and some health care plans did not always have the priority concern as the first recommendation

For **Quarter 2** dip sampling of the RHAs carried out by the Named Nurse over 95% of RHA were carried out either as Phone consultations or Attend Anywhere video consultations. 2 RHAs were carried out as face to face, after discussion and agreement with Named Nurse. Dip samples found as above and in addition there was evidence that 30% of SDQ requests were not returned by the carer. Some had the SDQ request resent. Some still did not get returned. The LAC nurse specialist always noted this in the health care plan as an action for the Social worker to follow up

Q3 and 4 No dip sampling undertaken due to Named Nurse redeployment

10.7 Supervision and Training

Supervision

Medical- all doctors undertaking LAC assessments have the opportunity for monthly supervision this is usually group supervision but is occasionally 1 to 1 if felt to be more appropriate.

Named and designated doctors have additional meetings with opportunity for supervision (these are also monthly), there is informal supervision on an ad hoc basis between these also.

Training

In order to effectively promote the health and well-being of Looked After Children, all staff working in healthcare settings must have the knowledge and skills to carry out their roles, as set out in the Looked After Children; Knowledge, skills and competencies of healthcare staff, intercollegiate Framework (RCPCH, RCN, 2020).

ESHT ensures that the staff within the organisation are trained commensurate to their roles, and identified through regular performance appraisal. Level 2 and 3 LAC training is now mandatory for

all relevant staff, agreed at Trust Education Steering Group 07.12.2020. Level 3 training is now delivered via MS teams, as a webinar monthly by the LAC nurse specialist. It is anticipated that it will take until 2023 for the Trust to gain full compliance with the Level 3 training of the relevant staff groups.

Level 2 training will be delivered as an online e-learning platform. The Named Nurse is currently reviewing external e-learning packages to adapt to become relevant and appropriate for ESHT staff. The Named Nurse is in consultation with the Trust Induction and Compliance Facilitator to adapt the external e-learning for staff requiring Level 2 training. A L1 leaflet has been distributed to all Trust staff via the weekly communications bulletin in October 2020.

The Named Nurse for LAC has led the *Think Family* training for the Trust during 2020/21 due to a period of extended vacancies and long term sickness in the safeguarding team and was redeployed for 11 weeks to the women's and Children's division during COVID 19 . The Named Nurse LAC will co facilitate LAC L3 training alongside the Specialist nurses as required in 2021/22
All of the LAC nursing team staff have maintained a high level of compliance with their mandatory training. Annual appraisals are all in date and it has been agreed that LAC competencies will be reviewed as part of the appraisal process. Stay interviews have been introduced and are being completed with nursing staff.

10.8 LAC policy update

The LAC Policy has been revised this year to reflect the expectation with Leaving Care summaries and is current.

11.0 Conclusion

The last year has been very challenging for the safeguarding team with an increase in serious cases against the backdrop of the pandemic and significant absence and changes in the team. Throughout this, the team have remained passionate and professional continuing to support and advise all clinical areas in addition to driving forward the *Think Family* agenda.

The Q&SC and the board are asked to note the contents of this report and to continue to offer their support for what is an increasingly complex and challenging agenda.

Vikki Carruth, Chief Nurse
Gail Gowland, Head of Safeguarding

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Looked After Children Knowledge, Skill and Competences of Healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

Isolated and struggling Social isolation and the risk of child maltreatment, in lockdown and beyond Eleni Romanou and Emma Belton NSPCC Evidence team June 2020

Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH Guidance (2021)

APPENDIX 1 SAFEGUARDING WORKPLAN 2020/2021

Action Number	Source	Requirement	Action	Executive Lead	Responsible Person	Progress
1	Children Act 1989 and 2004 and the Care Act 2014	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care act 2014	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities training compliance all staff all settings Documentation of MCA processes in records	Chief Nurse	Head of Safeguarding	
2	ESSCP Current Child Practice Reviews (CPR)	To undertake the ESSCP Child Practice review	To undertake any action as required by the ESSCP in relation to commissioned child practice reviews	Chief Nurse	Named Nurse for children	
3	SAB SAAR	To undertake the SAB Safeguarding Adult Case reviews	Complete all actions to implement recommendations following publication	Chief Nurse	Named Nurse for Adults	
4	SAB DHR	To undertake the Domestic Homicide Reviews	Complete all actions to implement recommendations following publication	Chief Nurse	Named Nurse for Adults	
5	NHSE / NHS	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any noncompliance's with LD standards to achieve ESHT compliance	Chief Nurse	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legislation	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any noncompliance	Chief Nurse	Assistant Directors of Nursing April 2020	
7	CQC / Safeguarding Legislation	To ensure there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any non-compliances	Chief Nurse	Assistant Directors of Nursing April 2020	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	Chief Nurse	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	Chief Nurse	Deputy Director of Nursing	
10	PREVENT Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT awareness and WRAP and that the quarterly PREVENT return is submitted for ESHT	Chief Nurse	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM return is submitted for ESHT	Chief Nurse	Named Midwife	

East Sussex Healthcare NHS Trust

Annual Complaints and Patient Advice and Liaison Service (PALS) Report 2020-2021

Executive Sponsor:	Vikki Carruth, Chief Nurse and Director of Infection and Prevention Control
Report Author:	Amy Pain, Patient Experience Lead & Darren Langridge-Kemp, Complaints, PALS and Patient Experience Manager
Date:	November 2021

About the Trust

We are proud to provide 'Outstanding' care and to be a great place to work

At East Sussex Healthcare NHS Trust (ESHT) we provide safe, compassionate and high quality hospital and community care to the half a million people living in East Sussex and those who visit our local area.

We are one of the largest organisations in East Sussex with an annual income of £534 million and we are the only integrated provider of acute and community care in Sussex. Our extensive health services are provided by over 7,000 dedicated members of staff working from two acute hospitals in Hastings and Eastbourne, three community hospitals in Bexhill, Rye and Uckfield, over 100 community sites across East Sussex, and in people's own homes.

In 2020 the Care Quality Commission (CQC) rated us as 'Good' overall and 'Outstanding' for being Caring and Effective. The Conquest Hospital in Hastings and our Community Services were rated 'Outstanding' and Eastbourne DGH was rated 'Good'

Our two acute hospitals have Emergency Departments and provide 24 hour a day care, offering a comprehensive range of surgical, medical, outpatient and maternity services, supported by a full range of diagnostic and therapy services. Our centre for urology and stroke services is at Eastbourne DGH, while our centre for trauma services and obstetrics is at Conquest, Hastings.

During 2020/21, we saw a reduction in inpatient spells as a result of the pandemic to 89,000 from 112,000 the previous year. We also saw 116,000 attendances at our Emergency Departments and there were over 330,000 outpatient attendances.

At Bexhill Hospital we offer a range of outpatients, day surgery, rehabilitation and intermediate care services. At Rye, Winchelsea and District Memorial Hospital we offer outpatients, rehabilitation and intermediate services. At Uckfield Hospital we provide day surgery and outpatient care. We also provide rehabilitation services jointly with East Sussex County Council Adult Social Care.

In the community, we deliver services that focus on people with long term conditions living well outside hospital, through our Integrated Locality Teams working with district and Community Nursing teams. Community members of staff also provide care to patients in their homes and from a number of clinics, health centres and GP surgeries

1.0 Introduction

The Trust considers complaints to be an important source of patient feedback, providing opportunities for services to reflect on and improve the care and treatment provided to our local population. All complaints received are investigated in accordance with the Trust's "Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model)", which itself is underpinned by the principles of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the NHS Constitution.

The Trust makes every effort to resolve complaints locally as far as it is possible to through comprehensive investigations, high quality responses and, where appropriate (particularly in light of COVID-19), Local Resolution Meetings (LRM's). The Trust also promotes and appropriately signposts complainants to local advocacy services to ensure they can access and/or seek independent support with their complaint; our local advocacy service is provided by an organisation called The Advocacy People (TAP).

This report meets the reporting requirements detailed in regulation 18 of the Local Authority Social Services and NHS Complaints Regulations (2009) and will specify:

- The number of complaints received
- The number of complaints received by division
- Primary and secondary complaint subjects
- The number of complaints by speciality
- The number of complaints by location
- Closed complaints (response rates)
- The number of complaints which were upheld
- Learning from complaints
- Post complaint survey
- The number of complaints referred to the Health Service Ombudsman (PHSO)
- PALS activity
- Compliments

1.1 Headlines

- All data provided has been extracted from Datix, the risk management database the Trust uses for recording complaints and contacts with PALS.

- The Trust received **365** new complaints across all services in 2020/21; this compares with 583 in 2019/20 and 558 in 2018/19.

- The Trust acknowledged **100%** of new complaints within three working days.

- There were **32** complaints reopened in 2020/21; reduction on 2019/20 (complaints= 58) and 2018/19 (complaints=83).

- The Trust's compliance with published complaint response timescales fluctuated during 2020/21; the average overall compliance rate for 2020/21 was **34%**. This was with the backdrop of the Covid 19 pandemic with a hugely significant second wave over winter.

- There were **64** overdue complaints at the end of 2020/21; the most overdue complaint was 77 working days.

- PALS contact rate only dropped by **9%** compared to 2019/20 (2020/21 contacts=6123 and 2019/20 contacts=6737) despite closing to face-to-face (walk in) contacts as part of COVID infection management measures.

- The Trust received **11** enquiries and 7 case outcomes from the Parliamentary and Health Service Ombudsman (PHSO) in 2020/21.

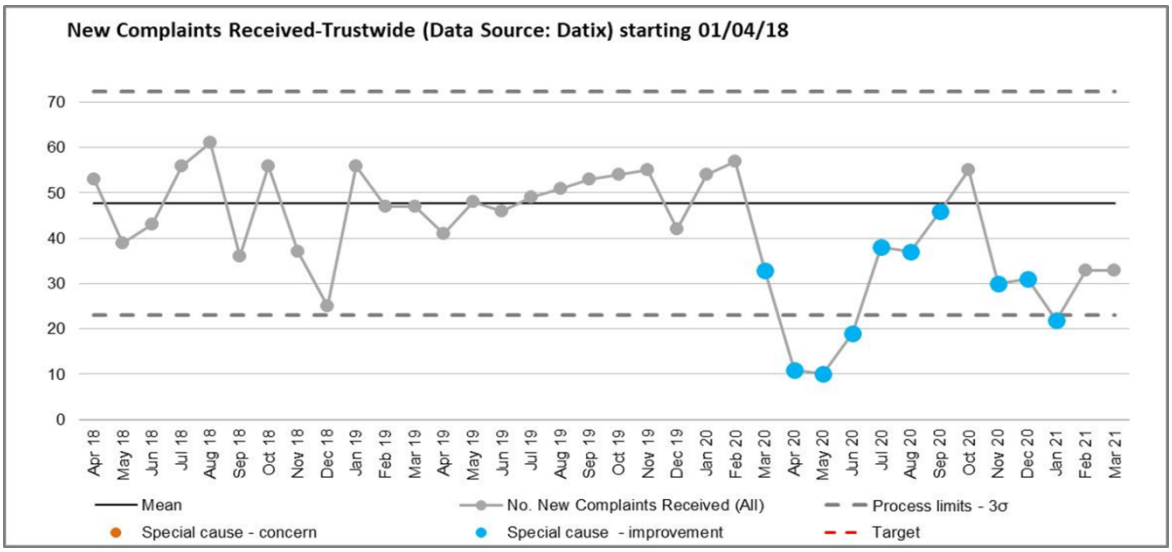
- The Trust received 10,910 compliments.

2.0 Complaints received in 2020/21

The Trust received 365 new complaints across all services in 2020/21;

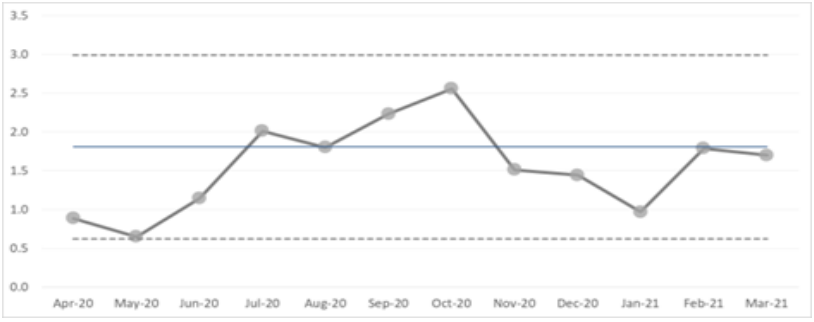
Year	Number of complaints recieved
2018/19	558
2019/20	583
2020/21	365

The following chart represents new complaints received by month between 1 April 18 and 31 March 2021.



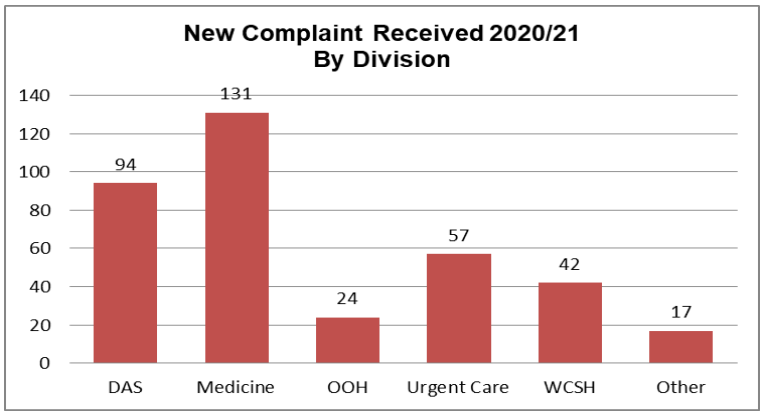
There was a reduction in complaints received for the first quarter of 2020/21 due to the COVID-19 pandemic and the national pause placed on complaint handling by NHS England. During this time, complainants were given the option of having their concerns handled by PALS for local resolution, or having their complaint logged and held until the national pause would be lifted on 1 July 2020. The complaint recieved rate climbed once the national pause was lifted, and subsequent fluctuations are likely to represent various stages of national COVID-19 management.

In terms of the complaints rate per 1,000 bed days (for all inpatient and day case complaints), the average rate for 2020/21 was 1.56. The following chart represents the complaints rate by month for the period 1 April 2020 to 31 March 2021:



2.1 Complaints by Division

The graph below shows the complaints received by Division during 2020/21(this is usually the clinical division most closely linked to the events that are the source of the complaint, or where the most serious matters have arisen if several clinical divisions are involved);

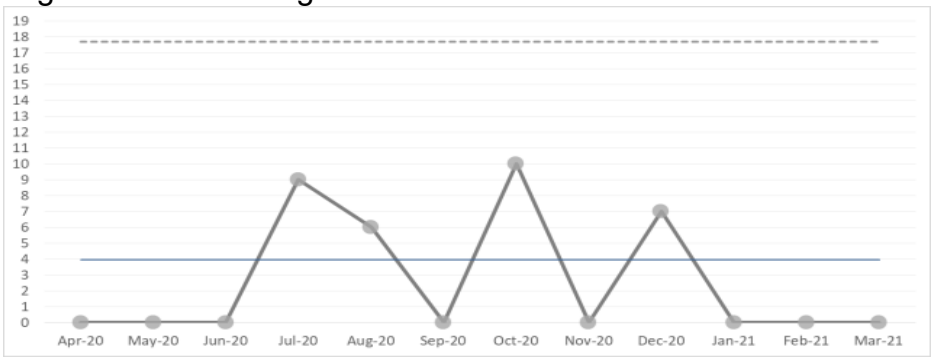


**Other denotes Corporate services/teams, including Estates and Facilities*

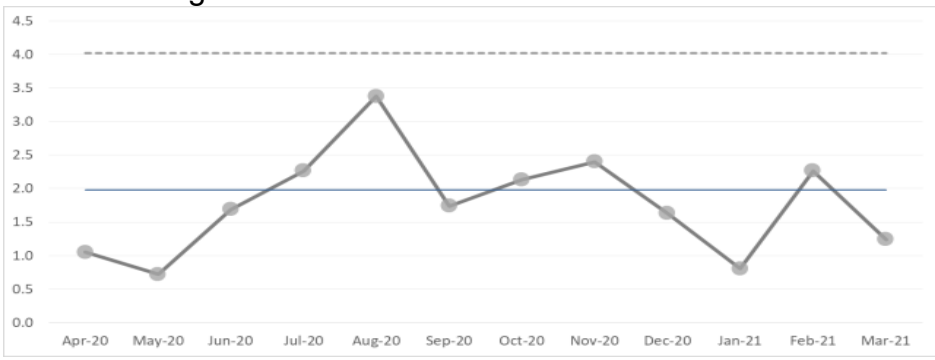
Medicine received the highest number of new complaints in 2020/21, and accounted for 36% (131) of all new complaints received. This is likely to represent increased inpatient activity related to COVID-19 and concerns such as staffing levels, families trying to contact wards, COVID-19 testing, and visiting restrictions. In addition, at various points a number of services were temporarily paused, with significant redeployment of staff to frontline services, especially over winter during Wave 2.

The table on the following page (page 6) represents complaints per 1000 bed days by division:

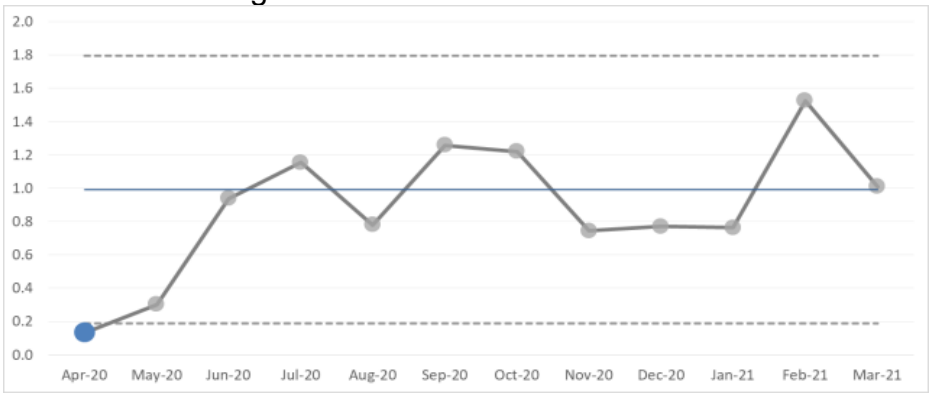
Urgent Care – Average 2.67



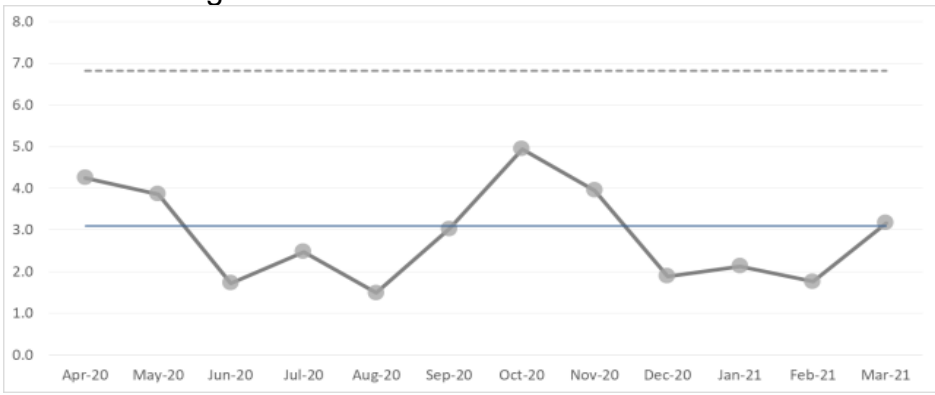
DAS – Average 1.78



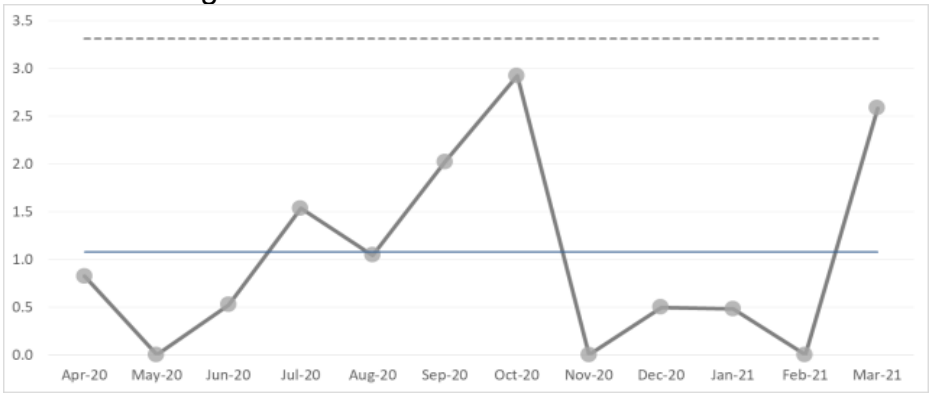
Medicine – Average 0.88



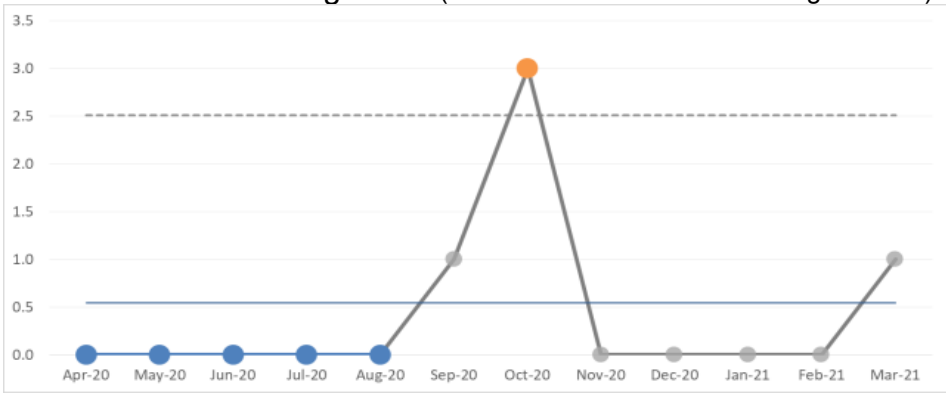
W&C – Average 2.89



CHIC – Average 1.04

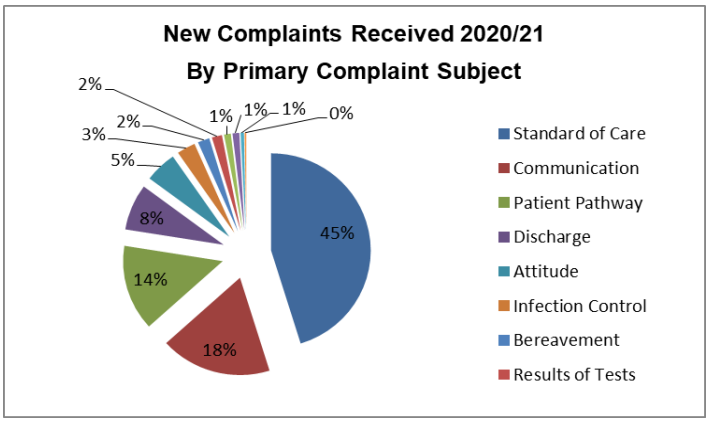


Core Services – Average 0.42 (Division was established in August 2021)



2.2 Primary and Secondary Complaint Subjects

As part of the assessment and triage process, new complaints are assigned a primary complaint subject to facilitate identification and analysis of themes and trends. The chart below shows new complaints received by primary subject codes:



The top primary complaint subject in 2020/21 was "Standard of Care" (number =165), which was also the top complaint primary subject in 2018/19 (number =226) and 20219/20 (number =238).

Whilst the number of new complaints assigned to "Standard of Care" subject reflects the overall reduction in new complaints received in 2020/21, it actually increased its share of all new complaints received from 41% in 2019/20 to 45% in 2020/21.

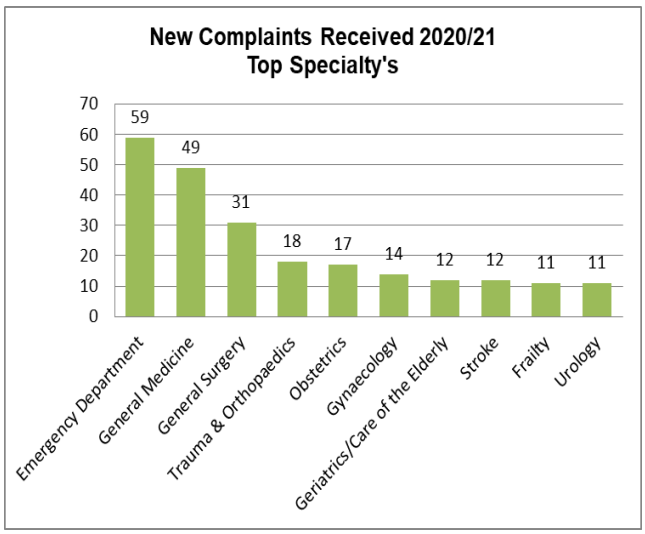
"Communication" accounted for 66 new complaints and "Patient Pathway" accounted for 52. In total, the top three primary complaint subjects accounted for 77% of all new complaints.

The table below shows some of the top sub-subjects raised under the top 3 primary complaints subjects:

Standard of Care (number =165)	**Communication** (number =66)	**Patient Pathway** (number =52)
1. Lack of confidence in delivery of care	1.Lack of communication/ information	1. Delays in access to service/ treatment (OPD)
2. Missed diagnosis	2. Confidentiality issues	2. Delays in access to service/ treatment (inpatient)
3. Overall care provided	3. Verbal information to relatives (including conflicting information provided) 3.Written information to patients (including discharge letters)	3. Lack of follow up/ monitoring

2.3 Complaints by Specialty

As part of the assessment and triage process, new complaints are assigned to the specialty to which the complaint relates. The following tables set out the top complaint specialties:



The Emergency Department was the top complaint specialty for 2020/21, a position it held in 2018/19 and 2019/20. Despite the reduction in the number of all new complaints received in 2020/21, it has maintained a similar proportion of all new complaints as in previous years (2018/19=15%, 2019/20=17%, 2020/21=16%).

General Medicine saw its share of all new complaints rise to 13% in 2020/21 (2019/20=4%) whilst the specialities below maintained a similar proportion of all new complaints as in the two previous years;

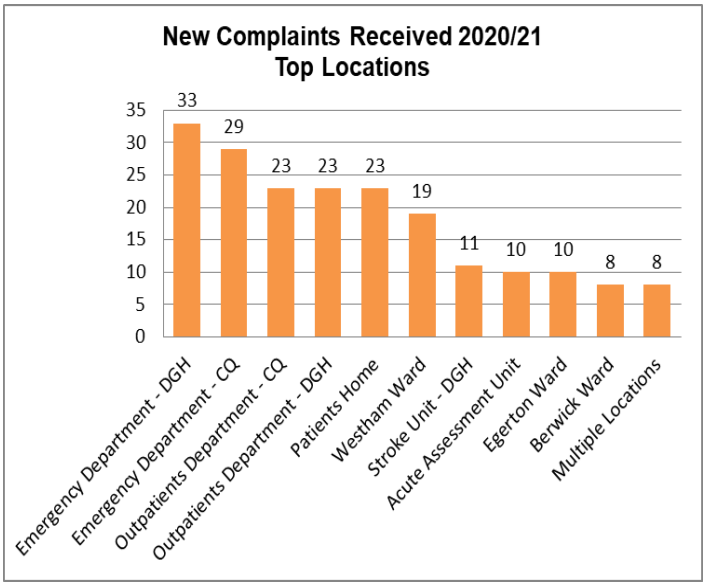
- General Surgery; and
- Trauma and Orthopaedics.

This may be due to the impact of Covid 19.

Obstetrics saw a small rise on previous years (2018/19=3%, 2019/20=3%, 2020/21=5%).

2.3 Complaints by Location

As part of the assessment and triage process, new complaints are assigned to the location to which the complaint relates. The following tables set out the top complaint locations:



The reduction in Outpatient Department activity at Conquest (CQ) and Eastbourne (EDGH) resulted in a drop in complaints about this area compared to 2019/20 (2019/20=28%, 2020/21=12%). It should be noted that the Outpatient areas accommodate numerous specialities so really act as a "host" for other specialities. The Emergency Departments, continued to operate normally, with huge surges at times, and therefore continued to receive complaints based on activity, making it a top location and speciality for complaints. The new Core Services Division has drilled down so there is an oversight regarding complaints and the specialities they relate to.

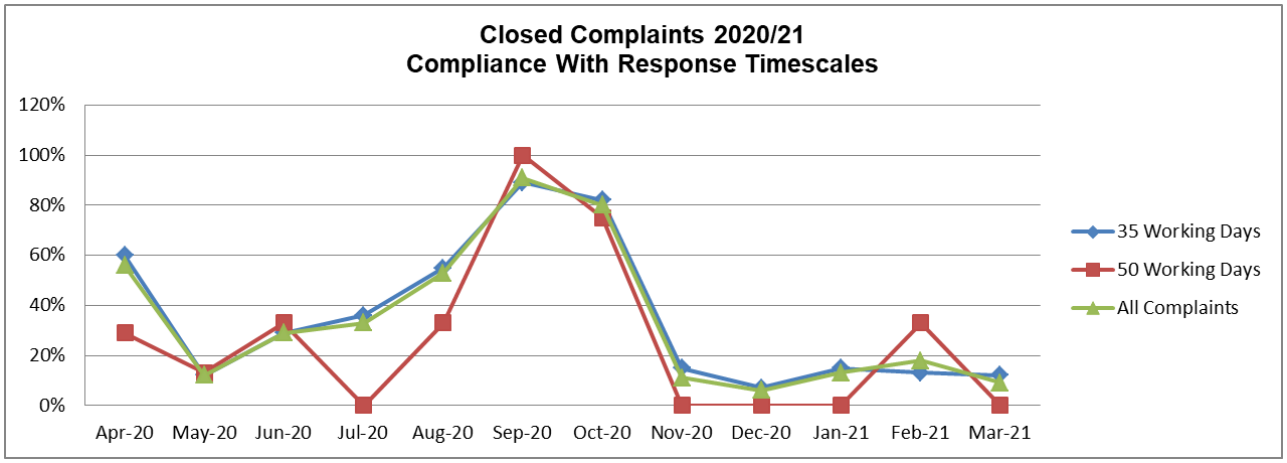
Whilst the Emergency Departments were the top complaint location in 2020/21, their share of all new complaints were on a par with previous years (2018/19=15%, 2019/20=16%, 2020/21=17%), as was the case with Patients Home as a location despite the increase in virtual appointments (2018/19=7%, 2019/20=5%, 2020/21=6%).

The other notable addition in top complaint locations for 2020/21 was Westham Ward, which incurred a much larger number of complaints than is usual most likely due to its significant role in COVID-19. A deeper dive into this location is being undertaken to better understand the trends and themes.

2.4 Closed Complaints, Response Rates and Outcomes

In 2020/21, the Trust closed a total of 364 complaints. This was an anticipated reduction on 2019/20 (complaints=620) given the correlating reduction in the number of new complaints received. The two pauses on complaint handling, resulted in a loss of six months complaint handling time and the Complaints Team, like many others, were redeployed to support front line care.

As a result of the aforementioned factors, coupled with a significant reduction in overall capacity to investigate and respond to complaints. Compliance with the Trust's published timescales for responding to complaints (35 working days for non-complex cases and 50 working days for complex cases) was significantly lower, particularly during the latter half of 2020/21 with a huge impact from wave 2 over winter (November 2020- March 2021).The chart below shows the closed complaints response rates (against 35 and 50 working days):



Despite COVID-19 it should be noted that the Trust's response rates to complaints were still significantly in time, when compared to the response metric of six months as set out in The Local Authority Social Services and National Health Service Complaints (England)

Regulations 2009. It should be noted that the 35 and 50 working day target is an internal ambition.

Regulation 17, Section (b), of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, states that the Trust is required to record an outcome for each complaint. ESHT treats all complaints as upheld and takes the opportunity to provide an apology to the complainants, for their experience of care and as a learning opportunity. The following table sets out complaints closed (both new complaints received and reopened complaints) by outcome in terms of numerical and percentage values:

Complaints closed- outcomes	No.	%
Investigated- apologies provided and actions/ learning required	107	29%
Investigated- apologies provided but no actions/ learning required	197	54%
Investigated- no actions/ learning required	57	16%
No investigation required	3	1%

2.5 Learning from Complaints

As part of complaint handling, the Trust is committed to the implementation of learning arising from complaint investigations to prevent, as far as it is possible, any recurrence of the source of complaints being raised. Divisions remain committed to learning from complaints, however progress has been slower than expected, understandably this is largely attributed to the impact of COVID-19 in and the huge pressures, many of which are still ongoing.

Alongside patients raising concerns about their discharge from hospital, we also received feedback from external stakeholders highlighting some of our processes regarding discharge and transfer of care which required improvements. The Deputy Director of Nursing has established a Multidisciplinary Discharge Improvement Group working group, and work streams have been identified to address the areas of concerns including; communication (systems and processes),discharge medication, discharge concerns (feedback received) and education and training.

2.6 Reopened Complaints

Whilst the Trust endeavours to resolve all complaints as far as it is possible to upon first received, there are occasions when complainants are not happy with the response they have been provided with or the response generates queries and questions that need clarification or further investigation. In some cases, the Trust can offer to reinvestigate the original complaint and go back to staff with the queries and questions raised, whilst in other cases a Local Resolution Meeting (LRM) might be helpful in achieving a satisfactory outcome when it is safe and appropriate given COVID-19. When there is further work on a complaint, the original complaint record is reopened as this generates a new set of investigation targets and deadlines for completion of a further response, and can be tracked as part of regular complaint reporting (this is local guidance as a way of tracking and monitoring progress of the complaint response).

The rate of reopened complaints has steadily decreased since 2016/17 and in 2020/21, dropped to 32 which represent 8.8% all of complaints closed.

Complaint Reopen Rate	2017/18	2018/2019	2019/20	2020/21
No. Complaints closed	612	599	605	364
No. Complaints reopened	92	80	58	32
% Complaints closed then reopened	15%	13.4%	9.6%	8.8%

This is a positive sign in terms of the quality of investigation and responses.

This may be the result of several factors including:

- Continued executive focus and support;
- Improved standards of complaint triage to better identify the issues that need investigating and responding to; and
- improved quality of complaint investigations, and further work undertaken to ensure complaint issues are fully answered as well as making sure that any new issues arising from investigations are also answered in full.

2.7 Post-Complaint Survey

It had been the Trust's intention to work with Healthwatch East Sussex in 2020/21 to develop a new post-complaint survey; COVID-19 prevented this work from progressing. In lieu of this, the Trust has developed its own post-complaint survey which will be rolled out during Quarter 4 2021/22, alongside a survey of staff to gather feedback on their experience of being involved in the complaint handling process.

2.8 Parliamentary and Health Service Ombudsman (PHSO) cases

If a complainant is unhappy with the Trust's response(s) to their complaint and all local avenues of resolution have been exhausted, they have the right to take their complaint to the PHSO. The PHSO are an independent body who make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations. The Trust complies with all requests for information made by the PHSO, and appropriately acts upon decisions and direction given in each case.

In 2020/21, the Trust received 18 contacts from the PHSO;

- 11 contacts were formal enquiries about cases the PHSO were considering for investigation.
- 7 case outcomes (it should be noted that some of the outcomes related to cases opened by the PHSO in previous years). In terms of the 7 case outcomes, the PHSO decided not to investigate 2 cases they had considered, 2 cases were investigated but referred back to the Trust for further resolution, 1 case was investigated but not upheld in favour of the complainant and 2 cases investigated were fully upheld in favour of the complainant.

The following provides a summary of the two cases fully upheld in the favour of the complainant, together with details of the PHSO's direction for resolution.

1. The complaint related to a delay in the patient receiving rehabilitation in community, this was likely to have impacted adversely on the patient's rehabilitation goal. The Local Government Office recommended that within four weeks both Adult Social Care and the Trust jointly apologise for the impact the failing had and pay £500.00 each in recognition of the adverse impact this had on the patient's wellbeing. They

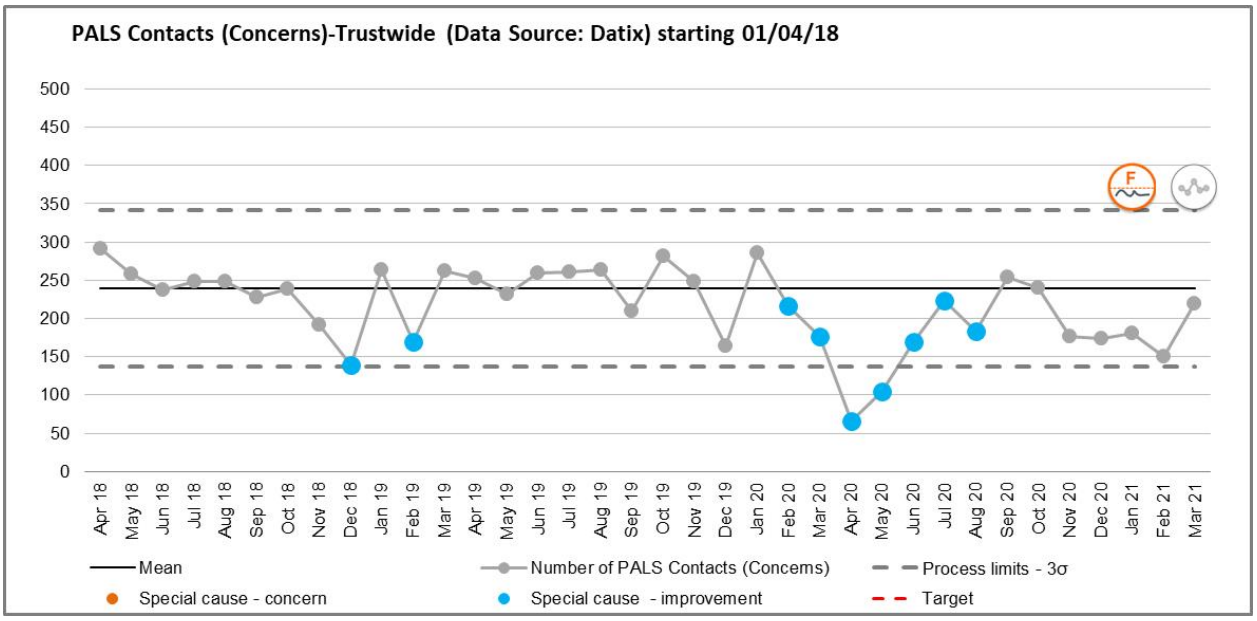
also recommended that the Trust remind Physiotherapists of the importance of good record keeping and ensure that there is a written procedure in place to show when and how a referral should be reprioritised.

2. The PHSO found evidence that the Trust did not follow its policy when arranging patient's discharge. This meant the patient did not receive an assessment for funding and became liable for the costs of the care. In view of this, the PHSO recommended the Trust pay the outstanding bill for the patient's care and apologise to the family and explain how the Trust will prevent this from happening again.

3.0 Patient Advice and Liaison Service (PALS)

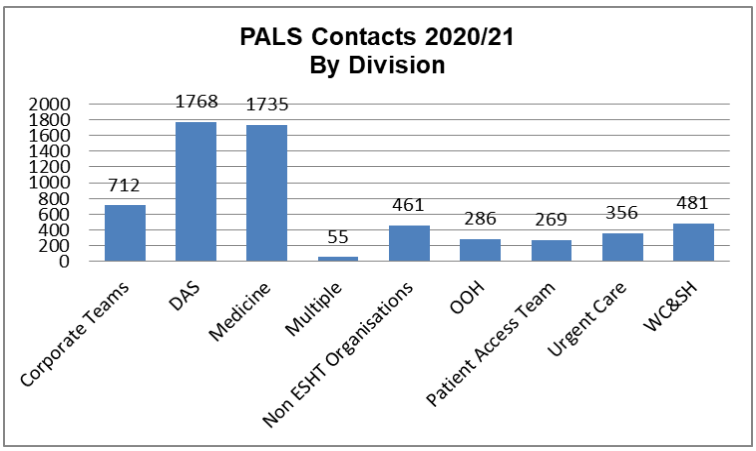
PALS provide a vital role for the Trust by helping patients, their relatives and members of the public with assistance, advice and information they require, or any concerns or issues they have that can be handled and resolved quickly and locally without the need for a formal complaint. The PALS offices at both acute hospital sites have operated fully throughout COVID-19, but contacts have been limited to telephone and email only.

In 2020/21, PALS recorded 6,123 contacts. Despite being closed to face-to-face contacts, this represents a reduction of just 9% on contact rates compared to 2019/20 (contacts=6,737). The following chart represents the PALS contacts by month for the period 1 April 2020 to 31 March 2021.The chart below shows PALS contacts by month 1 April 2018 and 31 March 2021:



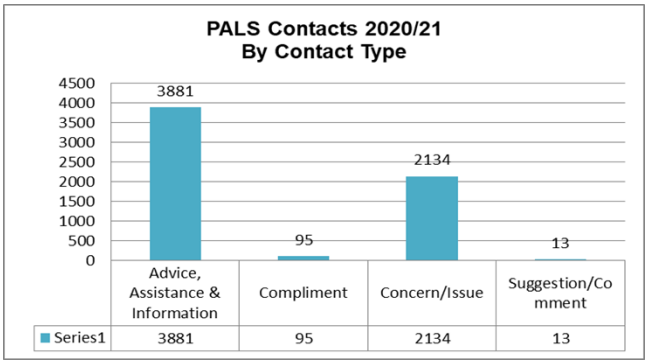
As with formal complaints, PALS experienced an initial decrease in contact rates in the wake of the first national lockdown and incurred the traditional seasonal dip in contacts in August. Otherwise, PALS maintained relatively consistent contact rates that were marked by increasing levels of distress due to necessary visiting restrictions and difficulties getting through to wards to find out how loved ones were.

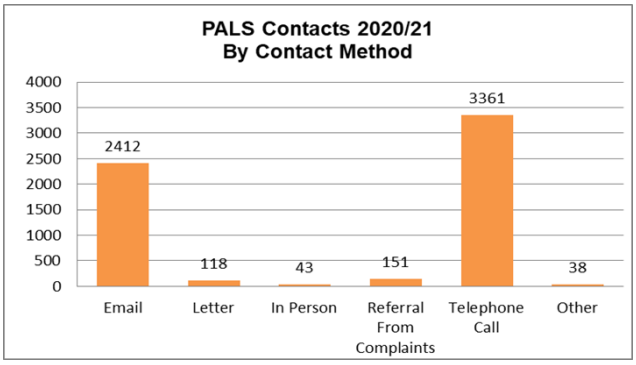
As with new complaints, PALS contacts are also assigned to a clinical division. Any contacts about non-clinical matters, such as car parking or toilet facilities, are assigned to the appropriate non-clinical division. In terms of distribution of PALS contacts, the following chart represents assignment to each division:



In 2020/21, DAS received the highest number and proportion of PALS contacts (contacts=1,768/ 29%). The proportion of PALS contacts for Medicine increased to 28% in 2020/21 (2019/20=24%) but conversely, those for Corporate Teams dropped by 9% to reflect the reduced activity in the Outpatient Departments (particularly where issues with appointments are traditionally an area of high contact rates).

In terms of the type and method of contact with PALS, the tables below set out data for 2020/21.





Given Covid-19, it is understandable that the proportion of PALS contacts coded in 2020/21 as providing "Advice, Assistance and Information" increased by 7% (2019/20=56%, 2020/21=63%), whilst those coded as raising a "Concern/Issue" fell by the same figure (2019/20=42%, 2020/21=35%).

PALS contacts by telephone rose by 9% (2019/20=46%, 2020/21=55%), and contacts by email rose by 15% (2019/20=24%, 2020/21=39%). Not surprisingly, face-to-face contacts fell by 24% to reflect the closure of PALS to those who would usually walk in and speak to staff in person.

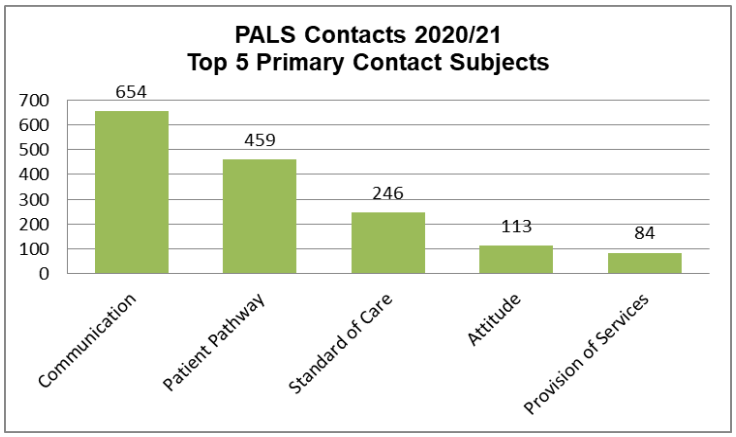
In terms of contacts coded as providing “Advice, Assistance and Information”, the largest proportion related to DAS (1,091). 926 contacts related to Medicine, whilst 476 contacts related to Corporate Teams; 229 of these 476 contacts were coded to Corporate Affairs, and are likely to relate to enquiries or requests for access to medical records.

Medicine received the highest number of contacts coded as raising a “Concern/Issue” (785); the top 3 specialities were General Medicine, Cardiology and Gastroenterology.

DAS was the second highest (658) and WCSH third (201).

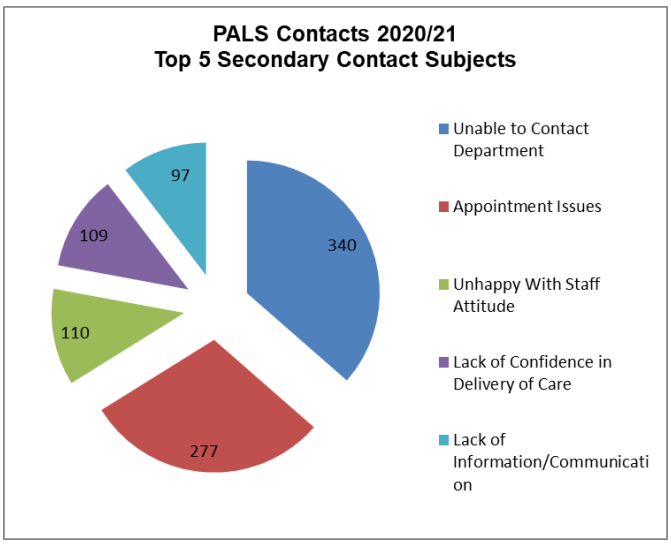
The Outpatient Department at EDGH was the top location and “Appointment Issues” was the top primary contact subject for all three of these divisional contacts. The top 3 specialities which these “Appointment Issues” relate to are Ear, Nose and Throat, Neurology and Ophthalmology.

All contacts coded to “Concern/Issue” are assigned a primary contact subject and since 2016/17, the top five primary contact subjects have been the same with only minor changes in ranking. The following chart sets out the top five primary contact subjects for 2020/21.



“Communication” has been the top primary contact subject every year since 2016/17. Medicine accounted for 261 (40%) of these contacts, DAS 166 (25%) and Corporate 80 (12%). 78 of the contacts for Corporate relate to concerns getting through to Switchboard. For “Patient Pathway”, DAS accounted for 216 (47%) contacts whilst Medicine accounted for 106 (43%) of contacts coded to “Standard of Care” (DAS contacts=52, Urgent Care contacts=51).

All PALS contacts are assigned a primary contact subject and a secondary contact subject wherever possible; this brings an additional layer of information to the data. The following chart shows the top five secondary contact subjects across all divisions and all secondary contact subjects:

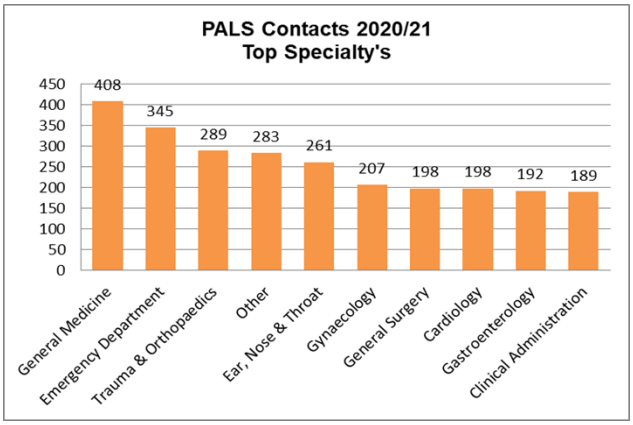


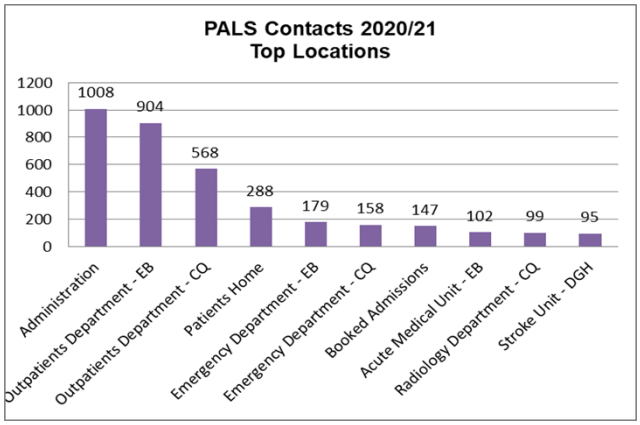
"Unable to Contact Department" has been the top secondary contact subject for three consecutive years, and it had been anticipated that the Trust's new telephony system would address this. However, the restriction on visiting during COVID increased telephone traffic, and resulted in subsequent contact with PALS to express concerns and distress at trying to get through to wards.

Despite the reduction in outpatient activity, "Appointment Issues" remains the second highest secondary contact subject for the third successive year. Of these 277 contacts, 175 relate to the Outpatient Department at EDGH which also accounted for 15 of the contacts coded to "Unhappy with Staff Attitude" (the Emergency Unit's combined accounted for a further 19 contacts about staff attitude; CQ contacts=12, EDGH contacts=7).

The Outpatient Department (contacts=27) and the Emergency Unit (contacts=20) both at EDGH were the top locations for concerns coded to "Lack of confidence in delivery of care" and the Outpatient Department at EDGH also accounted for the highest number of contacts (contacts=28/29%) that were coded to the secondary contact subject of "Lack of Information/Communication".

Given the role of PALS and the number of acute and community settings the Trust operates from, it is understandable that contacts with PALS can be attributed to a large number of different specialties, and in excess of 200 different locations. The charts below set out the top specialties and the top locations for PALS contacts for 2020/21.

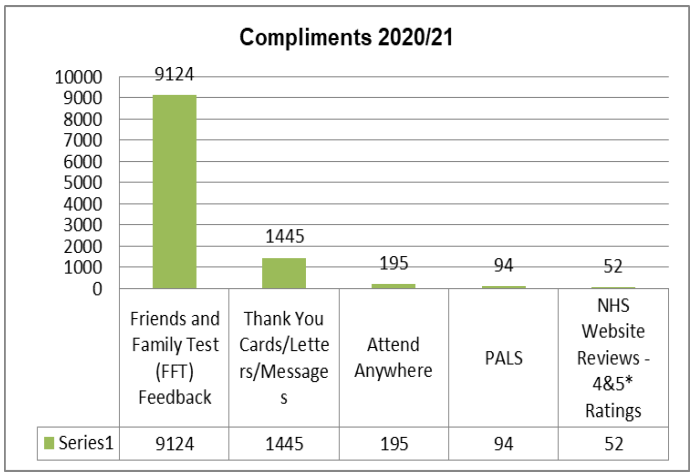




4.0 Compliments

It is important to recognise that a large volume of care and treatment takes place without issue, and the Trust receives many compliments and plaudits from patients.

In order to reflect on all types of feedback the Trust received from patients and their relatives in 2020/21, the following table sets out the number and type of compliments received.



In spite of COVID and a nine month pause placed on FFT, the Trust still accumulated almost 11,000 plaudits. This included compliments received through the Attend Anywhere system used for video appointments from October 2020.

The table below shows the Friends and Family Test (FFT) overall satisfaction score, in all but one area the Trust recommendation score has improved:

Survey	2019/20	2020/21
Inpatient	97.7%	99.4% ↑
A&E	93.7%	96.2% ↑
Maternity	97%	100% ↑
Community	98.2%	97.6% ↓
Outpatients	97.7%	97.4% ↔

Given virtual appointments and initiatives such as the Patient Initiated Follow Up are becoming part of business as usual going forward, the Trust will be moving to a digital approach for collecting feedback, particularly FFT, in the future.

The fact that patients and/or relatives have taken the time to contact the Trust with complimentary feedback and comment is hugely appreciated by staff.

5.0 Positive developments which have occurred in 2020/21 within the complaints handling process:

- Digitalised complaint records;
- Timely and helpful reports on the status and progress of complaints;
- Detailed weekly updates to named Executive;
- Maintained a high and quality standard of complaint responses;

- Changes to the complaint signing process to make it more efficient;
- Continually sought to improve the complaint handling process, and gained feedback from staff on how to further improve this; and
- Maintained a fully operational PALS provision.

6.0 Summary of actions to be taken in 2021/22 that have been identified this year and plan to be implemented during 2021/22 to improve complaint handling:

- Review and approve Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model);
- Complete the move to DatixWeb from Datix RichClient (upgrading our current reporting system);
- Review training provided to staff in relation to complaint handling (explore online training available);
- Survey staff about how they experience the complaint handling process;
- Reinstate post complaint survey; and
- Complete the self-assessment against the new NHS Complaints Standards Framework in preparation for the launch in March 2022.

7.0 Summary

2020/21 has been an exceptionally challenging year for the Trust, but also for the NHS as a whole. The effects of COVID-19 have been felt in every corner of the Trust, our teams have handled a high volume of incredibly challenging, complex and distressing concerns and complaints, sometimes exacerbated by the feelings, emotions and worries of patients, their relatives and by the general public. Both our clinical services and our corporate teams have had to work flexibly during this time.

Whilst the Trust has managed to respond to complaints and PALS contacts, it has incurred delays in our complaint responses resulting in a caseload of overdue complaints which is being proactively managed.

The Trust still has further work to do to ensure that we truly are listening and acting on feedback. The Trust will continue to focus on further improving the complaint handling process and implementing new initiatives, to ensure we are proactively listening and acting on feedback provided in a timely and high quality manner.

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EXECUTIVE SUMMARY

1 "The Nursing workforce is the most important factor in the provision of safe, effective high quality compassionate care in a timely, cost-effective and sustainable manner. Nursing staff work alongside a team of health and social care professionals to ensure the safety and highest level of care for those we care for. However, it is nurses who understand the complexity of nursing care provision and the nursing workload. It is registered nurses and nursing support workers who provide nursing care. Therefore it must be nurses who set the standard for nurse staffing and be assured that the nursing workforce is safe for the acuity and dependency of those they care for".

Rachel Hollis FRCN, Chair of RCN Professional Nursing Committee.
Royal College of Nursing – Nursing Workforce Standards July 2021[1].

Standard 1 of the 14 included, states that "Executive Nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision".

In addition, section 2 of the Developing Workforce Safeguards (DWS) recommendations state that;

Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes.

1.1 This report highlights the recommendations from the Assistant Directors of Nursing (ADNs) and Chief Nurse on the clinical and professional nursing requirements for 2021/2022. Nursing in this context is defined as all Registered Nurses (RN), Health Care Assistants (HCA) and Registered Nursing Associates (RNA). In scope were all inpatient wards where patients may stay overnight (excluding Maternity) and includes the 2 community hospital sites Bexhill Irvine Unit and the Rye Memorial Care Centre. Maternity is covered separately and the Allied Healthcare Professionals (AHP) review is underway and is being led by the Assistant Director of AHPs.

1.2 As part of the triangulation using nationally recognised methods and tools including the Shelford Nursing Care Tool (SNCT), a 4 week data collection was undertaken in September 2020 and the results were then collated by the Information Management team, analysed by the Divisional Assistant Directors of Nursing, Corporate Assistant Director of Nursing, and the Heads of Nursing incorporating clinical and professional judgement. The data was then scrutinised by the Chief Nurse. Occupancy and dependency/acuity were distorted due to Covid and the (ongoing) IPC

[1] RCN Workforce Standards | Publications | Royal College of Nursing

requirements and this was taken into account when reviewing the information in the round. Actual occupancy data was also used alongside the Shelford tool with the application of Professional Judgement.

1.3 A case for investment was then written and was due to be presented at the Business Planning Group on the 16th December 2020 but due to the COVID 2nd wave this meeting was cancelled and the process has been significantly delayed due to that and subsequent challenges.

1.4 Since last year, there has been considerable change following the 2nd wave of COVID-19 and the subsequent national finance controls imposed on the Trust. In addition, the bed base and service configuration has changed to support the recovery of unplanned activity. There is now a new Division called Core Services and community beds have increased their bed stock to accommodate the Non-Weight Bearing patient pathway.

1.5 There have been several movements in the budgeted nursing establishment between 2020/21 and 2021/22 (section 3.6) due to the impact of central planning changes as a result of the COVID-19 pandemic some of which is apparent in Appendix B where the ask was to reinstate budgets that were reduced/removed.

1.6 In August 2019 the NER suggested an increase of 30 FTE which was approved. Therefore the agreed funded FTE for those wards in August 2019 was 1,337 FTE with a plan to recruit from January 2020 and will be the baseline for this NER comparison against the recommended FTE (fig1). The number below from Finance colleagues is slightly lower than that at 1,326.8 FTE. This is being proposed as the baseline and not last year as it is felt that last year is not comparable given the impact of the pandemic on services and that this may be anomalous in terms of staffing and requirements.

Fig 1

Division	Beds	Dec 2019 agreed FTE (rostered)	NER Recommended (2020/2021)	Change in FTE	Est. Funding Impact
		FTE	FTE	FTE	£'000
Medicine	465	781.3	820.3	+39.0	1,370
DAS	213	418.5	478.3	+59.8	2,100
WCSH	30	56.2	72.4	+16.2	568
CHIC	243	70.8	86.1	+15.3	537
Total	**951**	**1,326.8**	**1,457.1**	**+130.3**	**4,575**

Data supplied by Finance @ ESHT

2. Introduction

2.1 The NHS People Plan (We are the NHS: People Plan for 2020/2021 – action for us all 2020) sets out NHS England's vision for people who work for the NHS to enable them to deliver the NHS Long Term Plan[2] (NHSE 2019). It recognises that the most urgent challenge is the current shortage of Nurses, Midwives and Allied Health Professionals, who are critical to safe and compassionate patient care. Support and retention of our existing Nurses, significantly increasing the number of newly qualified Nurses joining the NHS, welcoming Nurses from abroad and ensuring that we value those we already have are pivotal to successful delivery of services. In addition it is vital that we encourage the development of new roles such as Registered Nursing Associates. *Developing Workforce Safeguards* [3] (NHSI 2018) mandates that NHS Provider organisations must:

- Include an assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available)
- Be reported to the Trust Board by ward or service area twice a year, in accordance with NQB guidance[4] (NQB 2016) and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
- Ensure that there is no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.

2.2 NHSE/I will base this assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.

3. Contextual Background

3.1 The current situation that the Trust and the country find itself in is unprecedented. Whilst there is a real opportunity and appetite to recruit and re-train a population who might never have considered a career in healthcare before the pandemic, it has also created a nursing workforce who are exhausted, physically, emotionally and mentally and who may leave the profession as a result.

3.2 The financial impact of COVID-19 has also been unprecedented. Managing tight financial controls at a time of the highest and often unpredictable demand has been challenging. The rebasing of the nursing budget to usage in months 8-10 of 2019 meant reduced vacancies in a time of increased demand and potential supply. This demand was and still is to manage the

[2] Long Term Plan NHSE 2019
[3] Developing Workforce Safeguards NHSI 2018
[4] National Quality Board Report 2016

backlog of elective patient assessments and treatments, manage increased seasonal pressures with substantive staff spread thinly to staff escalation areas, manage new referrals into secondary care, manage more patients with mental health issues into gateway areas and manage patients diagnosed with COVID-19 with challenging infection control requirements.

3.3 Staff require more frequent breaks due to the wearing of Personal Protective Equipment (PPE) to reduce the incidence of urinary tract infections, dehydration, headaches and Post Traumatic Stress. These breaks are essential. In addition, NHS providers including ESHT were asked to lead on the mass vaccination programme for both ESHT staff and local Health and Care staff which was the biggest in the history of the NHS. These tight financial controls have continued into 2021/2022.

3.4 Whilst it is recognised that there was specific funding available to manage the COVID-19 requirements this report excludes that and the staffing of escalation areas. It focusses on the essential requirements in order to staff and safely care for patients in the funded bed stock. It is also recognised that the NHS will be looking to recoup some of the COVID-19 expenditure and that some compromises may need to be made. This should not be at the expense of equipping wards with safe nursing establishments that will enable Nurses to care for patients and themselves. The fact that escalation areas are excluded from this nursing establishment review makes it even more important that core areas are funded and staffed correctly as these temporary areas are frequently supported by substantive wards/departments with regular challenges in backfill.

3.5 The very significant impact of wave 2 on workforce (on ward nursing in particular) and the subsequent impact on quality was apparent and supports the discussion about the importance of minimum safe staffing, ratios and the skill mix of registered and unregistered staff.

3.6 Previous Years NER Comparison and Explanation of COVID-19 Impact based on papers and minutes from F&IC.

Fig 2

NER date	Approval date (F&I Committee)	Total Recommended FTE	Recommended Increase in FTE on wards	Subsequent Investment FTE/£
2017/18	Agreed funded FTE is 1,322	-	-	-
2017/2018	NER 18th March 2018 (Deferred)	1,427.63 (includes Winter and enhanced observations of 71.42 FTE)	+ 33.9	Deferred following Divisional appeals and also to allow for significant bed remodelling
2017/2018	NER 26th September 2018 (Approved)	1,306.50	+ 33.9	Reduction of £3.3 million from the nursing budget due to significant planned bed remodelling (reduction

				of 130 FTE) however this did not happen as planned with wards reopening.
2018/2019	NER 1st August 2019 (Approved)	1,340.6	+ 34.10	Healthroster templates updated from January 2020.
2019/2020	Global pandemic of COVID-19	-	-	Review postponed until data SNCT collection starts in Sept 2020. Completed and submitted to Finance in Dec 2020 but second wave hit and process delayed.
2020/2021	New national COVID-19 finance regime	-	-	The Holding budget from **Month 1 to 4 2020/21** was based on budgets set by FTE without agency costs. The **revised budget from Month 6 to 12 2020/21** was based on actual Month 8 to 10 of 2019/20 spend including agency costs, (not based on FTE). **From April 2020**, budgets were based on M7-10 of 2019 usage, resulting in high cost pressures mainly from Gastro and Respiratory due to high vacancy and the need to increase diagnostic activity. The over spend was not down to cost pressures in the in-patient areas.
2020/2021	NER March 2021 delayed to Oct 2021	1,457.08	+130 (compared to Finance baseline of Dec 2019 of 1,326 FTE)	H1 budgets (first six months) were set

4. Aim of the Chief Nurse's Nursing Establishment Review

4.1 To ensure that there is a safe level and appropriate skill mix of nursing staff to deliver a safe, high quality, effective and efficient service that protects the well-being of both staff and patients. The aim of the review is not to make a decision on what the Divisional budget will be, but to make recommendations of what is required in relation to patient acuity, current staffing levels, and clinical professional judgement from experienced senior clinical staff using nationally recommended tools and guidance.

4.2 The organisation's objectives are in the process of being developed for 2021/2022 and will be dependent on activity relating to, and recovery from, COVID-19. Without the appropriate workforce it will not be possible to achieve all performance indicators, quality metrics and the desired patient and staff experience outcomes across the Trust.

Divisional workforce plans include new roles such as Advanced Clinical Practitioners and so were not included in the scope of this review; in scope were, therefore, the essential requirements for a nursing workforce to deliver the essential care for in-patients which includes the care of patients who require enhanced intervention ("specials").

4.3 There are interdependencies with the national agenda such as the 17% rise in applicants for nurse training (a great opportunity), with Health Education England (HEE) aiming to increase over 50,000 undergraduate places by 2024[5]. There is also a drive to ethically recruit International Nurses and following a successful bid by ESHT for £143K to expand the programme, it is essential that there are enough vacancies for these recruits to fill.

5. Scope and Assumptions

5.1 The Nursing Establishment Review related to core nursing services in in-patient wards/areas (acute, community and paediatrics). For the purposes of the review 'Nursing' is defined as Registered Nurses (bands 5, 6 and 7), Healthcare Assistants (bands 2 and 3) and Registered Nursing Associates and Associate Practitioners (bands 4).

5.2 Out of scope and not included are:

- Allied Healthcare Professionals as a separate review is being undertaken and will report in due course.
- Both Emergency Departments and Cardiology as described previously - both need refreshed business cases.
- Community nursing which has recently had a revision to the community contract.

[5] HEE launches business plan for 2021/22 | Health Education England

- The nursing requirement to care for patients in additional escalation beds such as Polegate, Glynde, Cookson Attenborough, Benson, Litlington, Devonshire and Hailsham Level 1 and C bay. It should be noted that these areas rely heavily on the redeployment of substantive staff from other wards, who then rely on backfill with temp staff and the impact is considerable as shown in fill rates.
- The nursing levels required for caring for patients with COVID-19 infection (the impact of infection, prevention and control measures and the wearing of significant personal protective equipment).
- Enhanced observations/interventions (1:1 "specials"). To reduce ad hoc usage of large amounts of temp staff, previous reviews have recommended increases to include this in the core establishment but will not entirely eliminate the occasional/rare need for additional resource to support this cohort of high risk patients in all cases e.g. patients (adults and children) with mental health crisis or those who lack capacity or are violent/aggressive.
- The development of new roles to support medical gaps (Advanced Nurse Clinical Practitioners).
- The trainee posts for Registered Nursing Associates (RNA). Training for this role is funded by the apprenticeship levy, however, on-costs and backfill are not.
- Nursing outside of the ward areas; theatres, outpatients, diagnostics, Clinical Nurse Specialists, developments highlighted in the Divisional workforce plans that are required for service transformation.
- Very senior nurse leadership roles (above band 8).

6. Constraints

6.1 Establishments have been calculated by finance colleagues using 21%, not 22% uplift/headroom as recommended nationally by the Shelford Group in the Safer Nursing Care Tool (2020)[6] and by the Royal College of Nursing (RCN) Workforce Standards (July 2021). Depending on planned (annual leave and study) and unplanned absences (sickness, parenting leave etc) on a ward this may or may not be enough.

6.2 The complexity that COVID-19 and COVID-19 escalation requirements have added into separating out the core establishment required and how temporary workforce need is defined.

6.3 Centralised financial instructions and a delayed financial year and budget setting due to COVID-19.

6.4 In order to retain staff, the health and well-being of nurses (and of course all staff) working on the front line during the pandemic must be a priority. Ruth May, Chief Nursing Officer (CNO) for

[6] Safer Nursing Care Tool

England has implemented the role of Professional Nurse Advocate to ensure that restorative supervision and pastoral support is given[7]. This initiative cannot be achieved with an uplift of only 21% for ward establishments. It should also be noted that many non-ward nursing establishments have no uplift.

7. Interdependencies and the Case for Change

7.1 Increasing Non-Patient Facing Activity

Nursing is about more than direct/hands on care for patients.
Ward nurses complete an array of documentation for discharge and to support flow, monthly quality audits, audit every death that occurs, often have to duplicate documentary tasks as ESHT moves from paper to electronic documentation, risk assess for multiple clinical risks (nutrition, pressure areas, falls, moving and handling etc.), co-ordinate flow with ever increasing complex case management, attend multiple ward and board rounds, assess staffing levels and the acuity and dependency of patients three times a day, co-ordinate the discharge process, liaise with agencies families & support services, escort and transfer patients to and from various departments and any off site appointments, administer
medications and ensure optimisation and attend meetings relating to the safe and effective delivery of care to patients to name the most common activities.

7.2 More senior nurses also support staff well-being and performance including appraisals, risk assessments (individual and team), safeguarding and clinical incident investigations and RCAs, complaints responses, Employee Relations issues/investigations, team meetings and regular clinical supervision. The following data shows that an increasing amount of time is required to support patient flow and other tasks with a considerable increase since Winter. (Fig 3 below *Source ESHT SafeCare*).

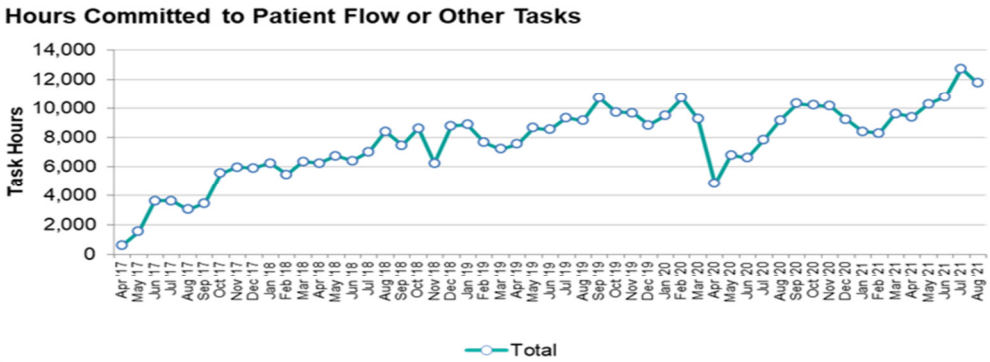


Fig 3

7.3 In addition, another fundamental and mandated role for a Registered Nurse is to mentor, coach, train and assess students, new to qualification and new to role (e.g. Advanced Clinical Practitioners and new to Trust - including International Nurses), to achieve the competencies

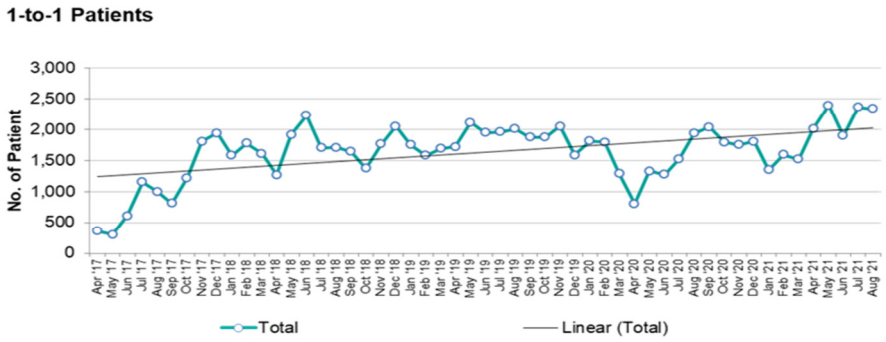
[7] NHS England » Professional Nurse Advocate

required to undertake the safe and effective delivery of care to patients[8] (NMC 2018). In addition, Registered Nurses are required to revalidate every 3 years to ensure that they have completed the necessary continuing professional education and have worked a minimum number of hours before they can re-register[9] (NMC 2019). Compliance is therefore heavily dependent on the right core nursing establishment with the correct uplift (minimum 22%) as recommended nationally in the Safer Nursing Care Tool by the Shelford Group (2020) and essential if ESHT is to retain a skilled, resilient and engaged nursing workforce.

7.4 Requirements for Patients who Need Enhanced Observations / 1 to 1 Interventions ('Specialling')

The data shows that whilst the majority of areas have fewer high risk patients requiring enhanced observation, in recent months areas such as Berwick, Newington, Pevensey, Wellington and Westham all report an increase. The graph below therefore shows an upward trend in 1:1 demand (Fig 4. *Source ESHT SafeCare)* which correlates with the increasing dependency as shown by the Shelford data shown in 8.4 later.

Fig 4



8. Benchmarking

8.1 Cares Hours per Patient Day (CHPPD) and Fill Rates

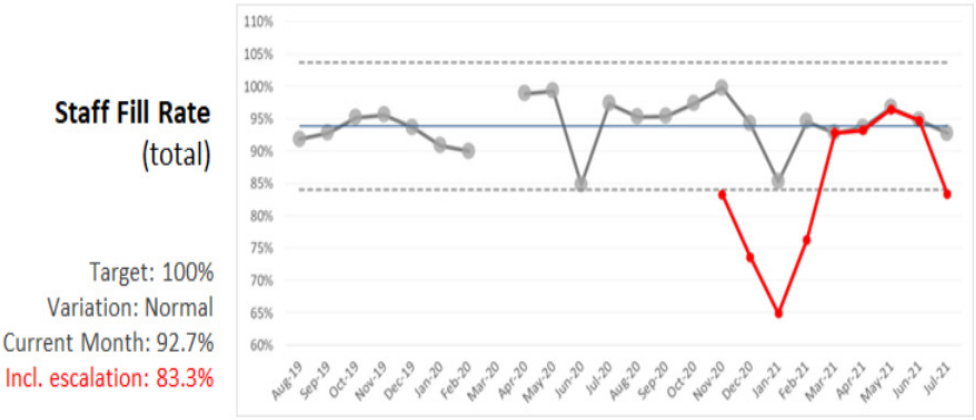
Compared to recommended peers in the Model Health System (formerly Model Hospital)[10] ESHT has an apparently high level of CHPPD. It is worth noting however that the way in which provider Trusts report this data nationally may not be standardised and recommended peers are not necessarily comparable to ESHT. The guidance stipulates that budgeted nursing hours should be reported as the planned baseline (so not including additional escalation capacity) by which fill rates are calculated. This is, therefore, how ESHT report with a review of neighbours and peers underway to compare submission processes. It is also important to understand that within the trust overall average (8.7 in August 2021) there is a range of values with data showing some wards above 10 and some less than 7 with the split of RN and HCA varying also. The same is true for fill rates which also vary by ward with the overall average not always showing certain

[8] The Nursing and Midwifery Code of Conduct
[9] Revalidation - The Nursing and Midwifery Council (nmc.org.uk)
[10] NHS England » The Model Health System

"hotspots". This will be monitored and reported going forward as part of the Safe Staffing report to the PS&QG and to the Q&SC and POD.

8.2 When escalation areas are open, which is relatively common place now in most trusts, for safety reasons substantive staff cover those areas and lead the shift to ensure areas are not solely staffed by a temporary workforce some of whom will not know the trust or not have worked at ESHT before. The guidance recommends organisational policy and practice include assessment of CHPPD, both on an operational basis (daily review and mitigation of planned versus actual) and retrospectively to inform bi-annual ward-level establishment setting, overseen at divisional and trust level. This data has therefore helped to inform the professional judgement review to formulate the recommendations (Fig 5). The red line indicates the fill rate when escalation areas have been open. The impact of wave 2 is stark as the nursing workforce was rapidly depleted. The impact on quality was sadly unavoidable with the highest rate of falls the trust has ever seen amongst other impacts. If the additional wards had not been included fill rates would have appeared considerably higher than was actually the case especially in wave 2.

Fig 5



8.3 **Changing Levels of Acuity and Dependency**

The data below *(source ESHT SafeCare)* is specifically focussed on Medicine ward based nursing only, due to the high proportion of ward based nursing in this division. The Safer Nursing Care Tool (SNCT) https://shelfordgroup.org/safer-nursing-care-tool/ measures acuity by levels and has been used by all wards daily for many years; All patients are scored with 0 requiring the least care, 1a being acutely ill/unstable, 1b being more dependent and 2 and above needing most care. NHS England and NHS Improvement supported the development of the suite of safer staffing tools which are now used widely across NHS organisations in England, private health providers and overseas healthcare organisations. The table below demonstrates how the acuity/dependency has changed since 2017, why the requirement has changed and therefore another rationale for why nursing establishments need to change to match the level of care required (Fig 6).

8.4 The volume of patients has fluctuated since COVID-19 and the footprint of wards has changed with COVID-19 making staffing less efficient due to essential Infection Prevention and Control requirements, a good example being the need for multiple Critical Care areas, separation of elective care and similar separation in the EDs and elsewhere where Aerosol Generating Procedures (AGPs) are undertaken as these present the highest risk. Alongside that, the data below shows that the trust is seeing proportionately more patients being recorded with acuity/dependency levels of 1b and above. The patient volumes have recently returned to pre-COVID-19 levels, however comparing the number of patients at lower acuity levels (Level 0 & 1a) to previous years, a shift to increasingly higher dependency is apparent with these kind of patients typically requiring more help (and often the help of 2 staff) and some being confused and requiring enhanced observation ("specialling").

Fig 6

Month	% patients at 1a or 0	% of patients at Level 1b or above
Aug '17	42.8%	57.2%
Aug '18	36.5%	63.5%
Aug '19	29.2%	70.8%
Aug '20	22.1%	77.9%
Aug '21	18.1%	81.9%

8.5 Even with funding allocated in the budget, additional shifts may still be created to request temporary workforce in the case of short notice absence. Historically this has often been coded as 1:1 "special" when it has been to cover a substantive absence (albeit a special may also be required so a ward may be even shorter) and work is ongoing with the Lead Safecare Nurse to ensure accurate coding of reasons for requests.

8.6 **System Comparators (RN to Patient Ratios)**

Royal College of Nursing (RCN) guidance recommends a RN should not have more than 8 patients *during the day* (with the nurse in charge of the ward not included) with a wealth of evidence to suggest increases can lead to higher mortality, poorer patient/staff experience, poorer quality of care and less efficient care delivery. "Guidance on Safe Nurse Staffing levels in the UK" RCN 2010. The table below compares the recommended nursing establishment review for 2020 with some peer wards at University Hospitals Sussex NHS Foundation Trust (Sept 2020) which demonstrates that there is a higher patient to RN ratio at ESHT (Fig 7). Currently on ESHT wards, if the band 7 Matron is not on duty the nurse in charge is also frequently one of those 4 RNs on duty so this affects that ratio further as does supporting the additional escalation areas, with wards often actually running on three RNs for 28 patients so a ratio of more than 9 pts per RN as currently the case in August/Sept data for some wards including Frailty. For more data on ratios please see Appendix C.

Fig 7

	ESHT	UHSFT (West)
Typical Frailty Ward	1RN:7.25	1RN:6.75
Typical Medical Ward	1RN:7	1RN:5.4
Typical Surgical Ward	1RN:7	1RN:6.75
Typical Trauma and Orthopaedic Ward	1RN:7	1RN:5.4
Typical Elective Surgical Ward and Day Unit	1RN:7	1RN:5.25

8.7 It is not possible to directly compare UHSFT (East) as they have a very different estates profile. They often run at 1RN:4 as they have smaller units where it is not safe to leave 1 RN working alone. An imminent system staffing peer review is underway with the Sussex CNOs.

9. Methodology

9.1 The Safer Nursing Care Data Collection Tool has been added to the ward tablet devices so that staff can easily input the data. The data was collected at or around 15.00 each day (excluding weekends) and measured the staffing levels on duty and the acuity of each patient using the Safer Nursing Care Tool – Decision Matrix (Appendix A). This was a 4 week data collection which commenced on 7th September 2020 and concluded on Friday 2nd October 2020.

9.2 The data was collected each day by the Information Management Team in the form of a spreadsheet which was sent to the Assistant Director of Nursing (ADN) Corporate at the end of the data collection. The Information Management and Clinical Effectiveness Team sent a daily reminder email to those who hadn't submitted on a daily basis.

9.3 The Corporate ADN (workforce) then collated the information and results of the survey (to include clinical professional judgement calculations) into Full Time Equivalents (FTE) to ensure an equitable comparison.

9.4 Clinical Professional judgement/challenge meetings were then held with each Divisional ADN to discuss the findings, considerations of service development and need, quality metrics and outcomes and performance indicators with a robust conclusion of what was required, to ensure the safe and effective delivery of care.

9.5 These recommendations were then presented to the Chief Nurse for final scrutiny, review & discussion. The Corporate ADN (workforce) then compiled a business case which was submitted and due for presentation to the Business Planning Group but the meeting was cancelled due to the 2nd wave of COVID-19.

10. Outcome and Analysis of the Review

10.1 This latest Nursing establishment review (NER), recommends that the FTE required to deliver safe and effective care for ward establishments is 1,457.08 FTE as described in the paper and shown in Fig 1 in the Divisional Summary table. Three options are provided with a suggested option given the circumstances in 2020 and the effect of Covid.

10.2 Given the complexity and scale for Urgent Care and Cardiology Services, updated business cases are urgently required so details are not included in this review as out of scope.

10.3 There is a necessity to focus on education and training if we are to retain staff and ensure well-being. The need to focus on new roles now and in the future when planning the workforce is key.

10.4 The outcome of the review in FTE can be found at Divisional and ward level (Appendix B). It is important to note that since the review, ward names and functions have changed in some cases, in order to accommodate COVID/IPC requirements and the recovery phase and it is likely that going forward considerable flexibility will be needed to accommodate new cases of patients with COVID-19.

11. Areas out of Scope

11.1 Maternity

ESHT maternity services currently have safe and appropriate establishment and funding to provide safe care in transformed services. However, it is recognised that an increase in establishment will be required to safely implement whole service Continuity of Carer[11]. The expectation of staff to work in a very different way and work in areas of the service they have not worked in for significant lengths of time, or in some cases ever, pose significant challenge and some risk. These issues are being worked through with ICS leads and concerns are being escalated to the national team. ESHT have been extremely successful in the recruitment and retention of midwifery staff and continue to see high levels of applications to advertisements. This is mainly due to an excellent preceptorship programme which supports newly qualified midwives and new midwives to the Trust.

11.1.1 ESHT Maternity has also once again commissioned a BirthRate+ establishment review to be undertaken in August (recommended 3 yearly, last completed in 2018). This assessment will review the acuity of service users and calculate the staffing establishment to provide safe care.

[11] implementing-better-births.pdf (england.nhs.uk)

This will include current service configuration and projected requirements for whole service Continuity of Carer, the expected implementation for this is by March 2023.

11.2 Emergency and Urgent Care

A business case was previously presented by the directorate in 2019. This needs to be updated and refreshed in line with planned increases in activity and changes/increases in cubicle spaces as well as new (Oct 2020) standards for staffing. Specific standards have never previously been established for EDs and in the collective interests of patient safety and quality of care, the Royal College of Nursing (RCN) Emergency Care Association (ECA) and the Royal College of Emergency Medicine (RCEM) have collaborated to define, for the first time, the nursing standard for Type 1 EDs (RCEM/RCN 2020)[12].

The standard recommends that the patient to RN ratio is 1:3 in the main department and 1:2 RN's for each patient in resus. Neither department currently achieve these standards and the business case needs updating for further urgent discussion as the current establishment also doesn't include the requirements for the additional capacity of 10 'majors' cubicles (some for *"Fit to Sit")* and 2 more in refurbished paediatric area as part of the *Building For our Future* (BFF) programme.

11.3 Medicine

Areas to highlight out of scope of the review are:

11.3.1 ***Pevensey Ward***

Pevensey Ward has seen an increase in acuity (evidence source: ESHT SafeCare). An increase from 1 HCA LD & LN to 2 HCA LD & LN is recommended.

11.3.2 ***Discharge Lounge***

The service is funded to deliver a 5 day a week service. This has been increased to a 7 day service to support patient flow and discharges as a cost pressure. Additional shifts are currently created and filled by Temporary Workforce Services whilst a business case is in development. It has been identified the increased establishment required will be: 1 RN and 2 HCAs each long day and closed at night. Discharge Lounge at EDGH closed and open as an escalation area at present.

11.3.3 ***Cardiology***

A business case has been written to support developments that have occurred in cardiology but have not been funded. If funding is agreed it will ensure compliance with national guidance[13], consistency across 24 hours, and enable advanced clinical practice developments.

[12] Workforce - Medical and Practitioner Workforce Guidance (rcem.ac.uk)
[13] afpp-chart-4.pdf

11.4 **Diagnostics, Anaesthetics and Surgery (DAS)**

The wards are safely staffed within DAS following H1 budget setting. The focus going forward is to concentrate on the increased surgical and diagnostic demands post COVID for the following areas:

- Endoscopy
- Theatres
- Critical Care

There are significant vacancies in these areas which is a national challenge. Staff require specialist skills and there are challenges covering with temporary workforce making it difficult to meet all the demands expected to support recovery. DAS are keen to look at band 4 development to support workforce demands.

11.5 **Community Health and Integrated Care (CHIC - formerly OOH)**

In consultation with Commissioners, a rebasing exercise was undertaken in 2019. This resulted in a paper submitted to the Contract Monitoring Board, and eventually additional investment into community services to meet the “as was" demand at that time. The investment did not include an allowance for any predicted future increased demand. CHIC has seen an approximate increase in referrals of 200%, which is reported via the monthly
Community Performance report using System One data. This demand has significantly outstripped capacity with a significant impact due to COVID-19.

11.5.1 The increased demand, particularly from urgent referrals and deferred activity, is defined by the Kings Fund as a proxy indicator of quality in Community Nursing[14]. There is also evidence of increased acuity and complexity of caseloads, and the unknown impact of Post COVID-19 syndrome/Long COVID on Community Nursing.

11.5.2 It is proposed therefore, to undertake an annual Community Nursing Establishment Review to define and agree the Nursing establishment, and to review this every 6-12 months as per *Developing Workforce Safeguards* recommendations. ESHT are working with the national team to develop a specific tool for community nursing.

11.5.3 ESHT have a separately commissioned contract for patients on the Non Weight Bearing (NWB) pathway. Previously this was sub-contracted to a company called HC1 for the past three years, but this arrangement ended on 16th May 2021, bringing the beds "in house" to the former escalation beds in Bexhill Irvine Unit (BIU) and Rye Hospital. Therefore the former escalation beds are now substantive beds, with substantive staffing, funded via the NWB contract income. The AHP staff for NWB patients are ESHT staff, and work in BIU and Rye Hospital.

[14] Community services | The King's Fund (kingsfund.org.uk)

11.6 **Outpatients**

ESHT outpatient departments have not been in scope for the review but as part of the new Core Services Division they will be included in future nursing establishment reviews.

11.7 **Women and Children**

In addition to the establishment reviews undertaken on the gynaecological and paediatric in-patient areas, it has been necessary to urgently employ a Practice Educator to educate paediatric nurses to safely and effectively use new equipment in anticipation of the paediatric surge in respiratory illness this Autumn/Winter as a result of COVID-19 and Respiratory Syncytial Virus (RSV) . Resource will also be required to deliver the RSV immunisation programme in the community setting.

11.7.1 Paediatric Community Nursing teams have also developed their own methodology in the absence of a national paediatric Safer Nursing Care Tool to measure patient acuity and staffing numbers in the community setting. It is hoped that ESHT can contribute to this work at a national level as adult community nursing is currently doing.

12. Education and Training

12.1 During a recent engagement exercise as part of International Nurses Day 2021 on the 12th May 2021, *retention* and *education* were the 2 main priorities that were deemed to be the most important to the staff when asked, for the next 5 years. A review of the appropriate uplift to support development is going to be required in the coming years as a focus on competency in the form of credentials is developed[15].

12.2 The NHS People Plan[16] highlights the importance of new ways of working if the trust is to meet the health and social care needs of the population. Education for new roles such as Advanced Clinical Practitioners and Registered Nursing Associates (RNA) has already been commissioned in small numbers within ESHT but if we are to ensure that we have the right

[15] HEE Credentials
[16] We Are the NHS People Plan - action for us all (2020)

staff with the right capabilities and skills then there needs to be a consideration of employing these roles at scale and with pace.

12.3 The pathway for nursing starts with the Healthcare Assistant, moving onto the Registered Nursing Associate and then to the Registered Nurse. We therefore have to have vacancies to recruit into and salary backfill for training and education to support the apprenticeship levies and HEE commissions.

12.4 Up to 2024, there will be an expansion of nursing students placements[17] newly qualified RNAs and RNs, and increased numbers of International Nurse recruits. There is therefore a need to consider how this large cohort of staff will be supported whilst continuing to deliver effective and safe patient care. In order to retain experienced nurses who may be thinking of leaving the profession, an investment in Practice Educator or Clinical Facilitator/Mentor roles will support the retention of all nursing staff, and likely other staff groups. These roles are out of scope of this review.

13. Risks

13.1 There is a risk that substantive staff may be challenged by the increased number of supernumerary staff, student placements, newly-qualified and international nurse recruits with the demand for support increasing.

13.2 If safe staffing levels are not maintained then quality will likely be adversely affected as was sadly demonstrated during wave 2 of the pandemic. Staff retention will also be affected if there is not an adequate provision for restorative and clinical supervision, continuing professional development and time to provide safe and compassionate care for patients.

14. Next Steps

14.1 The Chief Nurse's Corporate Nursing Team are already preparing for the next annual review for 2021/2022. In addition the Chief Nurse has asked for a system peer review of nurse staffing which will commence shortly. The next NER will incorporate this and will begin in late Autumn 2021. Together with the Divisional ADNs, Finance colleagues, the Information Management Team, and the Head of Workforce Planning, Information & Resourcing a process is being formulated that recommends the following:

- Data collection is overseen by the Corporate Nursing Team
- Data is collated by Information Management and the Corporate Nursing Team

[17] Nursing HEE 50k Expansion Programme

- The Clinical/Professional Judgement Challenge Reviews by the Chief Nurse are co-ordinated by the Corporate Nursing Team
- The NER will incorporate the system peer review/benchmarking data.
- Any case for investment is written by the speciality (or Division) and will therefore include all nursing staff requirements (including those out of scope of the NER process) and must be part of business planning
- The Exec, F&I report and the Trust Board report will be authored by the Corporate Nursing Team with sign off by the Chief Nurse

14.2 The Corporate Nursing Team will research and develop Safer Staffing processes collaboratively with the Divisions for those areas out of scope and without national guidance and tools.

14.3 The Trust Board will be informed of the outcome of this current Nursing Establishment Review at the public meeting in Dec 2021, once it has been through the appropriate governance processes/Committees.

15. Recommendations

15.1 That the Finance and Investment Committee acknowledge the contents of this report and that the proposed option (option 3) is agreed going forward with approval for investment of £503k against historical baseline.

Option 1 – do nothing. Not recommended as some key areas (elective) will not be able to safely continue and also will not manage required activity.

Option 2 – fund all as per NER. Not proposed at the moment as 2020 may be anomalous given the impact of Covid19 on services and staffing and the next NER is imminent. If the subsequent NER (which will include system benchmarking) demonstrates the same challenges and staffing requirements then a decision will need to be made regarding investment.

Option 3 – fund some areas whilst awaiting the next review and system peer review. This was going to include Critical Care and Elective areas given the impact of Covid19 and need to maintain safety/activity whilst managing the essential IPC requirements. A last minute development/challenge means that the planned increase in Critical Care beds and staffing will now not go ahead over the winter. On that basis, the suggestion is to increase staffing on Cookson Attenborough Elective as described in Appendix B at a cost of £503k. The next NER is about to start as scheduled and will involve system peer review and bench marking. The results of this and any recommendations will be presented to the F&IC for action and the Trust Board and will be part of business planning and budget setting.

15.2 That consideration is given to centrally investing in the Registered Nursing Associate role.

15.3 That there is a formal review of the Matron role in terms of working patterns and an agreed amount of supervisory time for the role and that resource is considered to support safe discharge and effective flow.

15.4 That workforce planning includes the Practice Educator/Clinical Facilitator role to support staff which will improve retention.

15.5 That the revised proposed process as above for the Nursing Establishment Review is agreed.

15.6 That a trust wide People review is considered, to be fully compliant with *Developing Workforce Safeguards*, and support efficiency, whilst streamlining services for patients.

16. Conclusion

16.1 The value of the NHS and Nursing as a profession has been brought into sharp focus as a result of the pandemic. In order to maintain safety high quality care for patients and well-being for staff it is a vital that we have the right people, with the right skills, in the right place supported by quality metrics that demonstrate safe, effective and efficient care.

This report is commended to the Executive Team, the Finance and Investment Committee and the Trust Board for their consideration and approval.

Vikki Carruth, Chief Nurse and DIPC
Oct 2021