



South East Clinical Senate

Kent, Surrey and Sussex

South East

Clinical
senate

**Review of the pre-consultation
business case for Cardiac
Services for East Sussex CCG**

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Foreword

The 12 regional clinical senates were established to provide strategic, independent, clinical advice to commissioners and health systems, to help them make the best decisions about health care for the populations they are responsible for. NHS England also strongly recommends a clinical senate review of major service change proposals before they go out to public consultation. In that light, the South East Clinical Senate (Kent, Surrey and Sussex) was asked by the East Sussex System to review the draft pre-consultation business case (PCBC) for the East Sussex Healthcare NHS Trust Acute Cardiology Services Transformation, and to provide recommendations.

A multi-disciplinary independent clinical review panel of health and care professionals with a wide range of expertise and experience, including specialist cardiology healthcare professionals, was brought together by the Clinical Senate to review the draft PCBC. Following this the Clinical Senate have produced a range of recommendations for how the PCBC could be improved and made more fit for purpose prior to public consultation.

We would like to thank the East Sussex team for taking time to present the proposals to the panel and field their questions. I would particularly also like to thank all the members of the clinical senate panel for giving of their own time to participate in this review.

Finally, a thank you to the support team of the clinical senate for coordinating the review and bringing the report together.



Paul Stevens,
South East Clinical Senate, Kent Surrey Sussex Chair

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1. Executive summary

Background

Cardiovascular Disease (CVD) has been highlighted in the NHS Long Term Plan as one of the 8 clinical priority areas and cardiac services was one of 14 areas identified for rapid establishment of networks to support emergency and urgent care during a pandemic surge as part of COVID-19 preparedness. The long-term vision for cardiac services in the South East region builds on the nationally identified optimum model of care for cardiac services, and on the national COVID-19 emergency preparedness networks. This vision aims to integrate cardiac care and embed collaborative cardiac systems of working, delivering on the ambitions of the NHS Long Term Plan. Currently, acute cardiology services are focused around hospitals rather than care pathways. Moving to a network model, shaped by local need rather than geography, is aimed at delivering more equitable, accessible high-quality care and improved outcomes.¹

The East Sussex population has an elderly, multiply co-morbid, demographic driving demand for cardiac services. The changing needs of the population, the changing nature of cardiology care and the associated challenges in providing cardiology services have made the redesign of cardiology a key priority for the East Sussex system. The proposed transformation includes faster access to an expert opinion at the “front door”, recovery of services impacted by COVID-19, and improved outcomes for patients (including reduced hospital length of stay and reduced waiting times).

The strong recommendations from East Sussex Healthcare Trusts (ESHT) Getting It Right First Time (GIRFT) cardiology review were to consolidate cardiac laboratory services and inpatient beds onto one site and ensure they provide clearly defined chest pain and electrophysiology patient pathways for the provision of timely best quality emergency treatment.² The East Sussex Case For Change outlined the key drivers behind the need for the current service to change, providing a basis for local patient and clinician engagement which highlighted 4 key themes in provision of cardiac services: the care provided; equality and diversity; access and transport; and the clinical services themselves.

East Sussex Healthcare Trust (ESHT) currently provides cardiac services across three main sites in East Sussex: Conquest Hospital in Hastings, Eastbourne District General Hospital (EDGH), and Bexhill Hospital. Specialist commissioned services include complex device therapy; cardiac electrophysiology and ablation; inherited cardiac conditions; and primary percutaneous coronary intervention (pPCI) for ST segment elevation myocardial infarction (STEMI). The current location of cardiology services is shown below.

¹ NHS Commissioning A05 Cardiac services. <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/a05/>

² Appendix 1 of the PCBC: ESHT Getting It Right First Time (GIRFT) cardiology review summary



Current service model

Outpatients and diagnostics will continue to be provided 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)	✗	✗	✗

Following pre-consultation engagement, 3 options development and appraisal workshops took place to identify and consider a longlist of possible options for the future provision of acute cardiology services. The options presented for consideration in the options development workshops included:

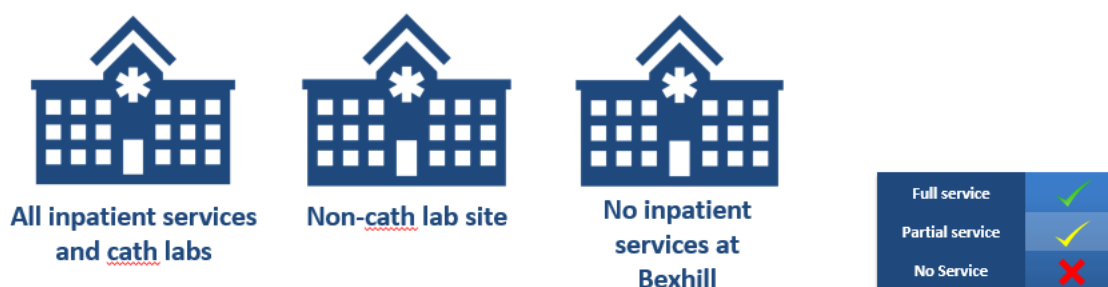
- Option 1: Retaining current services as they are
- Option 2: Retaining current services as they are while adding new assessment areas in emergency departments and ‘hot clinics’ at both acute hospital sites
- Option 3: Building up both acute hospitals, with the addition of assessment areas and ‘hot clinics’ (‘everything, everywhere’)
- 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 on one acute hospital site, with acute outpatients and diagnostic services at both acute sites.

These options were assessed against 5 appraisal criteria:

1. Quality and Safety
2. Clinical Sustainability
3. Access and Choice
4. Financial Sustainability
5. Deliverability

Leading to the short-listing of two options to be taken forward to formal consultation on the future of cardiology services in East Sussex detailed below:

- Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from EDGH, with acute outpatients and diagnostic services at both sites.
- Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from Conquest, with acute outpatients and diagnostic services at both 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.

In considering these options the NHS England South East Clinical Senate has been requested to undertake an independent clinical review of the proposals and the evidence presented; to evaluate the proposals alongside the case for change; to detail recommendations to support commissioners to finalise the pre-consultation business case (PCBC); and to 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 PCBC focussed on the following adult services: interventional cardiology pathways; inpatient pathways that require admission under a cardiac specialist; front-door pathways including A&E review; and cardiac specialist opinion. The PCBC detailed the range of other cardiology services in place locally but deemed these to be outside of scope. Those services included: diagnostic imaging, radiology, pathology, echocardiogram, outpatients, community services; and rehabilitation.

Summary of Feedback

This was a very well constructed PCBC with a detailed description of the national and local drivers for change together with a thorough overview of the population demography driving the demand for cardiology services. Despite the exigencies of the COVID-19 pandemic the PCBC sought to involve a range of stakeholders in pre-consultation engagement including local people, patients, clinicians and commissioners.

An extensive set of recommendations was produced, centred around the following themes:

Being very clear in the executive summary that no change is not an option. The PCBC details that the current service meets a number of existing standards and needs to be explicit from the outset about the reasons for co-location of interventional and inpatient cardiology onto one site. This has obvious benefits in terms of meeting and exceeding all the quality standards and for the workforce. The rationale is clearly stated in the GIRFT review as a necessity, this needs highlighting and emphasising at each opportunity in the document.

A critical success factor for the proposals for change is that populations served by the non-intervention site receive the same quality of care and access to that care as those served by the intervention site. There is an opportunity for that to be demonstrated using data from the period when the interventional service has been alternating between sites.

The PCBC describes the development of a front door cardiology service. The case would be very much strengthened and patient and public confidence improved by describing how the front door service will work and integrate with emergency care at the front door; detailing the anticipated improved outcomes with comparison with models described in the literature; and ensuring that the front door service on the non-intervention site is at least as comprehensive as that on the intervention site.

Workforce is a challenge which is driving change and the argument that a centre of excellence can recruit is quite clear. However, it is important that the whole system can recruit, and the workforce strategy needs to be clearer. This needs a clear description of innovative use of the skills in the multidisciplinary team and how the new clinical model will improve teaching, training, recruitment and retention.

There is an opportunity to link innovative use of information technology to lessons learned from COVID-19 and sustainability in healthcare.

A key requirement is that changes in services should demonstrate strong patient and public engagement and be consistent with current patient need and patient choice. This needs to be much more evident and robust in the PCBC.

Conclusion

There has been extensive and detailed work undertaken in constructing the draft PCBC, with evidence of initial clinical engagement and involvement. The clinical benefits of consolidating interventional cardiology and inpatient cardiology onto one site are clearly stated and can be evidenced. There is clear potential to create a single centre of excellence from an improved patient outcome perspective and a research and training perspective. The ambition to create a sustainable model for invasive cardiology that culminates in a better-quality service with better outcomes is well placed. However, the PCBC could be improved further by including a more detailed description of the impact of consolidating services on access and clinical outcomes for the whole population served and in particular how the population served by the non-interventional site will benefit. The risks involved with consolidating onto one site and the associated mitigations should be described and further consideration should be made as to how best to present the options for consultation. The Clinical Senate's understanding is that the proposals are also supported by the new South East cardiology network.

Clinical senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the material shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to ensure that the proposals going forwards are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for the population of East Sussex.

2. Review Methodology

The panel membership is listed in Appendix D. Great care was taken to ensure that all panel member's declarations of interest and confidentiality agreements were valid.

The initial documentation supplied for this review was the draft PCBC together with appendices describing: the ESHT Getting It Right First Time (GIRFT) cardiology review summary; the Cardiology extended Equality and Health Inequalities Impact Assessment (EHIA); the Public Engagement report; the Transforming Cardiology Services in East Sussex Options Appraisal Report; Cardiology Pathways Current vs. Proposed; the Quality Impact Assessment (QIA) for the Transformation of ESHT Cardiology Services; and the ESHT Transformation Travel Mini-project (see Appendix C). Documentation was provided to the clinical senate team on 9th July 2021, who then developed the key lines of enquiry (KLOE, see Appendix A).

The PCBC, impact assessments, additional resources and KLOEs were shared with the panel on 14th July 2021.

A half-day panel meeting was held on 28th July 2021. Members of the East Sussex Clinical Commissioning Group (CCG) and ESHT (see Appendix E) presented a summary of the proposed cardiology transformation and the proposed options and took detailed questions from the panel. The second half of the panel meeting was for the clinical senate panel alone to consider their response and recommendations. The full agenda for the panel is shown in Appendix D.

The notes from the meeting and comments made were synthesised into a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to the East Sussex CCG, ESHT and NHS England for consideration of matters of accuracy on 13th August 2021, and for review, comment then sign off by the clinical senate council.

3. General Recommendations

R1. The strategic context and national drivers for change are clearly articulated in the PCBC but the Senate would recommend being explicit that the national and regional transformation of cardiac services, together with GIRFT review recommendations make doing nothing an untenable option. The co-location recommendations from the GIRFT review and the rationale for a single site for interventional cardiac services and inpatient cardiology should be prominently highlighted in the executive summary.

R1.1 The PCBC clearly states that the current service meets (and in areas exceeds) cardiology standards and that the pilot of alternating intervention between sites was successful. Why this is not sustainable and how the changes both provide sustainability and improve on existing outcomes must be clearly highlighted in the executive summary.

R1.2 The NHS standard contract for primary percutaneous coronary intervention (pPCI) recommends the requirement for 2 or more catheter laboratories where pPCI is being undertaken with built in contingency for a patient to return to the catheter laboratory and/or for equipment failure.³ Highlighting the unsustainability of single laboratory sites together with the current inefficiencies of utilisation of the catheter laboratories would strengthen the case for co-location.

R1.3 Recommended numbers of interventional procedures for a single site in the NHS standard contracts for pPCI; electrophysiology and ablation services; and for implantable cardioverter defibrillator (ICD) and cardiac resynchronisation therapy (CRT) also render continuing with interventional procedures on 2 sites untenable. These standards and numbers should be highlighted in the context of ESHT's activity to strengthen the case for co-location on a single site.^{3,4,5}

³ 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>

⁴ 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>

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.pdf>

4. Population health/inequalities. Improved health outcomes and associated activity projections

R2. The health needs of the population and the demography driving the prevalence and incidence of cardiovascular disease have been clearly identified and described in the PCBC. There are pockets of high levels of deprivation and the population overall is older than the England average, varying from 20.3% over the age of 65 in Hastings to 32.1% in Rother. The Senate recommends that the narrative should consider the trade-offs between co-locating services on a single site and access to those services considering the demography and deprivation in the different population areas.⁶

R2.1 Pockets of deprivation are evident within both the Eastbourne and Hastings/Rother localities. The difficulties in differentiating between the two localities from a health needs perspective should be discussed, for example the population profile is generally younger in Hastings (specifically town centre) than those in Eastbourne.^{7,8} Either option under consideration may impact negatively on the most deprived wards. The narrative should consider whether there are material differences that would influence the option appraisal/consultation.

R2.2 The Senate recommends making clearer how the equity of access against each option will be addressed, specifically in the context of any cross-border flows. Reference should be made to work currently being undertaken that focuses on health inequalities and understanding whether there are specific issues of access for patients requiring interventional cardiology and cardiology inpatient care. The PCBC should reflect anything specific about these patients beyond the broader population access to services stating what mitigations are planned to address risks.

⁶ Chief Medical Officer's annual report 2021: health in coastal communities
<https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities>

⁷ East Sussex JSNA <http://www.eastsussexjsna.org.uk/> Hastings and Rother needs and assets profile note 2016

⁸ http://www.eastsussexjsna.org.uk/JsnaSiteAspx/media/jsna-media/documents/overviews/2016%20LNAP/CCG_H-R_2016.pdf

R3. The Senate recommends quantifying the impact of the proposals on patient experience. The PCBC states that 90% of patients will not be affected and that the majority of services will be provided out of both sites, but it may be helpful to model the activity (numbers). With only 10% of referrals requiring access to emergency procedures and the cardiology laboratories this does not help to clarify the rationale to determine the best single site provision.

R3.1 The PCBC describes how patients presenting as emergencies will receive much more rapid treatment but does not provide sufficient information with respect to the health outcome benefits of the changes proposed. For example, East Sussex has the highest prevalence of atrial fibrillation and randomised controlled trial data very clearly illustrates the future clinical benefits of early rhythm control including ablation therapy.^{9,10,11,12,13} The PCBC should illustrate and quantify the health gain, differentiating across the options presented.

R3.2 Additional analysis of the impact of the changes proposed on the current cross-border flows in terms of inequalities and access for patients would determine whether or not patients previously accessing cross-border services will be further disadvantaged by the options proposed. It was stated that there is no material impact across borders where activity may flow out, especially in the east of the county. It would be helpful to use case studies to illustrate the planned changes, the differences and the mitigations proposed to date.

⁹ Willems S, Meyer C, de Bono J, Brandes A, Eckardt L, Elvan A, van Gelder I, Goette A, Gulizia M, Haegeli L, et al. Cabins, castles, and constant hearts: rhythm control therapy in patients with atrial fibrillation. *Eur Heart J*. 2019;40:3793-3799c. DOI: [10.1093/eurheartj/ehz782](https://doi.org/10.1093/eurheartj/ehz782)

¹⁰ Rillig A, Makimoto H, Wegner J, Lin T, Heeger C, Lemes C, Fink T, Metzner A, Wissner E, Mathew S, et al. Six-Year Clinical Outcomes After Catheter Ablation of Atrial Fibrillation in Patients With Impaired Left Ventricular Function. *J Cardiovasc Electrophysiol*. 2015;26:1169-1179. <https://doi.org/10.1161/CIRCULATIONAHA.116.026054>

¹¹ Marrouche NF, Brachmann J, Andresen D, Siebels J, Boersma L, Jordaens L, Merkely B, Pokushalov E, Sanders P, Proff J, et al. Catheter Ablation for Atrial Fibrillation with Heart Failure. *N Engl J Med*. 2018;378:417-427. DOI: [10.1056/NEJMoa1707855](https://doi.org/10.1056/NEJMoa1707855)

¹² Kirchhof P, Camm AJ, Goette A, Brandes A, Eckardt L, Elvan A, Fetsch T, van Gelder IC, Haase D, Haegeli LM, et al. Early Rhythm-Control Therapy in Patients with Atrial Fibrillation. *N Engl J Med*. 2020;383:1305-1316. [Early Rhythm-Control Therapy in Patients with Atrial Fibrillation | NEJM](https://doi.org/10.1056/NEJMoa1911281)

¹³ Rillig A, Magnussen C, Ozga AK, Suling A, Brandes A, Breithardt G, Camm AJ, Crijns HJGM, Eckardt L, Elvan A, Goette A, Gulizia M, Haegeli L, Heidbuchel H, Kuck KH, Ng A, Szumowski L, van Gelder I, Wegscheider K, Kirchhof P. Early Rhythm Control Therapy in Patients with Atrial Fibrillation and Heart Failure. *Circulation*. 2021 Jul 30. doi: [10.1161/CIRCULATIONAHA.121.056323](https://doi.org/10.1161/CIRCULATIONAHA.121.056323). Epub ahead of print. PMID: 34328366. <https://doi.org/10.1161/CIRCULATIONAHA.121.056323>

4.1 Catchment areas and populations in relation to the presented options: Travel

R4. The PCBC very clearly articulates the potential impact on ambulance and patient transport services and describes the road and rail networks and public transport services, illustrated with several non-emergency transport scenarios. Further detail in relation to the management of patients requiring emergency transport would enhance the case in particular the mitigations to ensure that patients requiring intervention go straight to the intervention site and not to the non-intervention site.

R4.1 The Senate heard that the current model of percutaneous coronary intervention alternating between sites has significant implications for South East Coast Ambulance service operational delivery and engenders potential clinical risk in the long term and this should be reflected in the PCBC case for change narrative.

R4.2 The inter hospital transfer between the non-intervention and intervention site of both patients presenting at the front door as emergencies and existing inpatients would benefit from better description and an analysis of risk which includes mitigations for surges in activity would strengthen the case.

R4.3 The pathway for patients requiring transfer, whether as emergencies or routine, would benefit from clearer description. The hot clinics will not run 24/7 or at weekends and walk in patients will continue to present to the non-intervention centre. Inclusion of modelling around the numbers of emergency transfers from the non-intervention centre would provide greater clarity here.

R4.4 The PCBC should reflect the issues relating to non-emergency patient transport raised in feedback from the engagement work and describe the possible solutions alluded to during the panel meeting including hospital transport services and the voluntary sector. The arrangements for non-emergency transport out of hours should be included here.

R4.5 The PCBC suggests that further engagement work is being undertaken with a focus on travel and access and location, including areas of deprivation and elderly demographic in order to test whether there are any wider reasons to indicate a preferred site. This must be completed prior to formal public consultation.

5. Bed and activity modelling across the shortlisted options

R5. The PCBC currently reflects modelling of anticipated demand, specifically around an aging population, multiple co-morbidities and the influence of deprivation. The PCBC also describes various cardiovascular disease prevention initiatives but there is no link through to the expected reduction in demand from primary prevention and improved atrial fibrillation services. The Senate recommends that this is included within the narrative indicating potential impacts on demands and the risks and mitigations of associated assumptions.

R5.1 The demand projections should also articulate the impact of the service reconfiguration on neighbouring health systems and any differences inherent in the location of the intervention and non-intervention sites. The risks and any mitigation should be described.

R6. The assurance section of the PCBC clearly states that there will be no significant bed reduction through co-location of cardiology services onto one site and this should be made clearer in the narrative description within the PCBC. Table 22 on page 54 of the PCBC (estimated capital investment) could be misconstrued and we recommend including an additional figure detailing the proposed bed capacity similar to figure 8 on page 26 which details the current cardiology bed capacity.

R6.1 Improved efficiency and reduced lengths of stay are described within the PCBC, earlier and more effective treatment is also described. These should all translate to a reduction in bed requirements, although this may be a future benefit more clarity and additional capacity and activity modelling would strengthen the case. The descriptors used in the PCBC suggest a reduction in length of stay for heart failure from 8-9 days to 3 days and an up to 6 day reduction in length of stay for unstable chest pain.

6. Clinical Model

R7. The principles underlying the proposal within the PCBC represent an excellent strategically placed clinical proposal with a focus on ‘front of house cardiology provision through a streamlined model’, improving clinical performance and outcomes. The ESHT cardiology department has a history of the development of exemplary services over a number of decades and the new plans and proposals have great primacy. It may be helpful to again reference the rationale that sits behind the GIRFT recommendations in order to avoid any challenge as to why there is a need to change.

R7.1 There will be practical challenges to delivering the proposed model, specifically a realistic assessment of the intention to transfer patients from one site to another within a very short timeframe and the very real possibility that emergencies do not always occur in an orderly fashion and may swamp any proposed system. How has this been stress tested? The PCBC narrative needs to seek to reassure the reader and evidence that the proposed model is deliverable and sustainable, illustrating through modelling how the patient pathway will function when there is more than one patient at any time on the non-intervention site requiring transfer. The risks around patient flow and potential mitigations that ensure equal access to the same high-quality service need to be articulated.

R7.2 The PCBC narrative should provide reassurance and evidence that the non-intervention site will continue to provide services of equal standard and that patients entering an intervention pathway via that route will be in receipt of the same quality service. The pathway algorithm should illustrate the differential approach between sites demonstrating how there will be with no reduction in standards/performance indicators and that the same improved patient outcomes will be achieved. Risks and mitigation need to be articulated to provide greater confidence in the proposed model.

R7.3 It is important to understand how removing intervention from one site facilitates improved front door provision of cardiology on both emergency hospital sites? The PCBC narrative needs to clearly connect the proposals to co-locate onto a single site with improved front door provision at both sites. The Senate panel suggest that the current narrative is insufficiently clear.

R7.4 The description of the front door service in the PCBC suggests that there will be a lesser service on the non-intervention site, with the negative connotations that this engenders. The Senate recommends that if it is not yet possible to provide 24/7, 7/7 front door cardiology on both sites you might want to consider providing the full service on the non-intervention site, given that it is likely that there will always be a senior cardiology decision maker on the intervention site.

R7.5 During the panel meeting the Senate heard that the proposed front door cardiology service has been successfully piloted on one of the ESHT sites as a nurse led service. This demonstrates real improvement, putting patients on the right pathway as soon as they present to hospital. The Senate recommends that greater detail of this pilot should be included in the PCBC, describing how the response team operate and the roles, responsibilities and availability of its constituent members.

R7.6 As the East Sussex team will be aware a nurse led front door cardiology service has also been successfully piloted elsewhere too with impressive results reported in the literature.¹⁴ It would be helpful to include outcome data from the ESHT pilot to provide further assurance, particularly for the population served by the non-intervention site, and to draw parallels with outcome data in the literature.

R7.7 Provision of front door emergency cardiology risks de-skilling emergency care medical and nursing staff. The PCBC needs to clarify how the risks associated with de-skilling these staff will be mitigated.

R7.8 The Senate recommend including a narrative that acknowledges the disadvantages of co-location of services onto a single site and how these will be mitigated, being clear up front that not all issues and challenges facing the current service provision are easily solved by co-location on a single site.

R7.9 The Senate panel heard that provision of cardiology 'hot clinics' would obviate the need for hospital admission and provide rapid access to cardiology opinion, investigation and treatment for patients presenting acutely. This is an excellent initiative for moderate risk patients, but experience suggests that such initiatives quickly attract low risk patient referrals. The PCBC should articulate the criteria for access to these services and how the risk of them being overwhelmed will be mitigated.

R7.10 The PCBC needs to articulate what the response will be to common cardiological emergencies encountered in the inpatients in all the other specialties on the non-intervention site and how these emergencies will receive a standard of care that passes the 'friends and family test'.

R7.11 The Senate panel explored the impact of single site co-location of interventional services on key clinical adjacencies and recommended further detail within the narrative of the PCBC. In particular the impact on critical care beds and on interventional radiology, vascular surgery and stroke.

¹⁴ Kwok CS, Naneishvili T, Curry S, Aston C, Beeston M, Chell S, Cripps J, Gunter B, Jackson D, Thomas D, Jones A, Bethell H, Sandhu K, Morgan-Smith D, Beynon R. Description and development of a nurse-led cardiac assessment team. *Future Healthc J.* 2020 Feb;7(1):78-83. doi: 10.7861/fhj.2018-0078. PMID: 32104771; PMCID: PMC7032590. <https://doi.org/10.7861/fhj.2018-0078>

R7.12 Although non-interventional diagnostics have been deemed to be out of scope the Senate understood that provision of access to 7 day echocardiography services and radiological cardiac imaging (especially CT coronary angiography including functional flow reserve capability) on both acute sites are key to the success of the proposals and request further detail within the PCBC. The senate panel understood that ESHT have been at the forefront of cardiac CT imaging and this further detail (including cardiac magnetic resonance imaging) would particularly provide assurance to the population served by the non-interventional acute site. Additional demand should be built into the modelling.

7. Ambulance triage, transfer and capacity

R8. Timely interhospital transfer and direct transport of time sensitive cardiological emergencies to the interventional cardiology site are critical success factors for the proposals to transform cardiology services in the PCBC. Detail concerning how these will be achieved would strengthen the case.

R8.1 The NHS standard for primary percutaneous coronary intervention call to balloon time is less than 150 minutes³ and the PCBC details that this is currently met for out of hospital conveyances. That time constraint includes an assumed door to balloon time of 30-40 minutes for an expected patient,³ the travel time between the 2 ESHT acute sites is 35 minutes. The PCBC should describe how the inter hospital transfer of either a front door presentation or an inpatient requiring this treatment on the non-intervention site will meet the same standard of less than 150 minutes (given that to achieve this the initial response, inpatient assessment, referral to and acceptance by the interventional site, and arrangement for transfer would need to be accomplished at least within the remaining 75 minute timeframe).

R8.2 As per R7.1 the risks around patient flow and potential mitigation for when there is a requirement for more than 1 emergency inter-hospital transfer within a short timeframe need to be articulated.

R8.3 The Senate panel heard that the ambulance service routinely send ECGs through to the pPCI intervention site to facilitate direct transfer of patients requiring immediate intervention. It is recommended that the PCBC narrative also includes exploration of the feasibility of a similar approach to electrophysiology emergencies.

8. Workforce strategy and issues

R9. The PCBC highlights the potential benefits of co-location of interventional services on one site, including benefits to the front door service for the non-intervention site. The PCBC also highlights the difficulties in recruitment and retention and the shortages in specialist cardiology staff as drivers to develop a clinically sustainable workforce and suggests that ‘Creating a centre of excellence for cardiology would be more attractive for the recruitment of all staff, allow appropriate training and supervision to develop subspecialisation, and enable flexibility in cross-subject training for the multidisciplinary team’. The Senate panel recommends strengthening this section with more detail and evidence where available.

R9.1 The focus is predominantly on retention with insufficient detail of optimal workforce modelling aligned with the proposed clinical model. The Senate recommend detailing a strategy that looks at skill mix, training and development all the way through the pipeline for medical, nursing and allied health professionals (undergraduate and postgraduate). This should also demonstrate how East Sussex are working with educational providers.

R9.2 A description of the current skill mix and the current pressures across the workforce that articulates how the proposed changes will mitigate these issues should be included in the PCBC. The PCBC states that ‘For the ESHT clinicians present, this model of care would be optimal in helping overcome workforce challenges and meet national standards around procedure numbers’ but gives no detail to support this. For example, the NHS standard for ablation suggests that a training centre needs to perform at least 200 standard and 100 complex ablations per annum.⁴

R9.3 Similarly the workforce strategy would be enhanced through a clear statement of plans on how to future proof proposals. A description of how workforce will be retained when part of that workforce will be required to change site in the future would provide some reassurance. There should be a particular focus on staff either able to work in a different specialty, for example radiographers, and staff who might re-locate to a neighbouring Trust.

R9.4 The model suggests that there will be limited interaction with the two emergency departments if all cardiac cases are triaged by the cardiology response team. The narrative should include an assessment of any potential negative impact on emergency care medical and nurse training and planned mitigation.

R9.5 Additional clarity concerning electrophysiology staffing on the non-intervention site and how the clinical model retains attractiveness for those staff should be included in the narrative. Risks around attrition of electrophysiology staff particularly should be articulated with suggested mitigation.

R9.6 The Senate panel had concerns about the level of service being provided on the non-interventional site and recommend additional use of the patient scenarios within the PCBC to provide additional clarity and illustrate the 'pinch points' i.e. on a Friday evening or on a bank-holiday weekend.

R9.7 The narrative should reflect the role of Paramedics, for example diagnosis of STEMI. The panel questioned the potential to similarly train paramedics to diagnose and treat total heart block (see R8.3 above).

R9.8 The PCBC details engagement with clinicians and their support for the new model of care and the panel heard that the cardiologists had all agreed to the model of care. The PCBC should also detail what additional staff engagement has taken place with all members of the multidisciplinary team.

9. Level of patient, public and clinical engagement

R10. During the panel meeting the Senate heard that there had been an extensive engagement exercise with patients and public and with primary care and clinicians and an overview of the process is provided in the PCBC. We recommend that this could be significantly strengthened, albeit acknowledging the difficulties engendered by COVID-19 lockdown.

R10.1 The PCBC details that following pre-consultation engagement, three options development and appraisal workshops were independently chaired and facilitated by Opinion Research Services (ORS) to identify and consider a longlist of possible options for the future provision of acute cardiology services leading to a proposal to take forward the two preferred options for formal consultation. It would be helpful to include both the ORS credentials in the PCBC narrative and the graph detailing the patient and public engagement on page 6 of Appendix 3 (Public Engagement Report) to improve confidence in the process.

R10.2 The panel heard that ORS had collated the views of around 80 interviewees unable to attend workshop events due to COVID-19 and we recommend an accurate representation of those views in the PCBC narrative in order to convey the robustness of the approach. Broad public dissemination was also mentioned on questioning (newsletters, social media). Clarity and ensuring that the objectivity of the process is clearly described would strengthen confidence in patient and public involvement to date.

R10.3 The Senate panel were unclear how well the Black, Asian and Minority Ethnic (BAME) population were represented in the patient and public engagement. The PCBC clearly details both the vulnerability of this population to heart and circulatory disease and the association of the BAME population with increased deprivation. Their engagement and involvement are therefore paramount and a description of how the BAME population and the wider patient population were involved in co-design and development of the proposals would strengthen the PCBC.

R10.4 A critical success factor for the cardiac services transformation proposals will be the patient and public confidence that both the quality of service and access to the service are no different for the population served by the non-intervention site in comparison to that served by the intervention site. This will be key in future consultation and feedback from the pre-consultation engagement is included within the PCBC. However, the action being taken to mitigate the concerns heard and documented in the summary of the key points is very unclear and needs describing (currently merely saying that action plans are being developed).

R10.5 Better use of the excellent primary care support and engagement could be made within the narrative, highlighting the total end to end pathway focus. The narrative could also be strengthened particularly with reference to broadening the team engagement.

10. Digital

R11. There is acknowledgement in the PCBC that improvements to digital infrastructure can benefit and support patient pathways. The PCBC states that the focus is on improving digital interfaces, improving outpatient experiences, and harnessing digital technology to provide a more convenient service for patients. The case would benefit from more detail in the narrative and some illustrative examples.

R11.1 The PCBC would benefit from a description of how information is shared between primary and secondary care and in particular how clinicians managing emergency and urgent referrals can access data from the patient records.

R11.2 The Senate panel heard during the East Sussex presentation of initiatives around transfer of ECG data between the ambulance service and cardiology. More detail would provide assurances for patient and public engagement in the clinical model.

R11.3 There are opportunities here to include/reference any learning from use of virtual clinics, or other digital gains, for example the potential use of wearable technology and transmission of results using wireless applications. Such remote monitoring examples also link to sustainability in health care.

11. Sustainability

R12. The Senate recommend taking the opportunity to link new ways of working driven by COVID-19 to innovative use of technology and video communication to the net zero carbon initiative required in all new proposals for service change.¹⁵

R12.1 It is likely that the new front door cardiology service will result in fewer patient journeys and fewer inappropriate investigations requiring patients to travel. Similarly reduced hospital length of stay and avoidance of unnecessary admission also reduces patient and relative/carer journeys. All of these link through to sustainability and these opportunities should be captured in the PCBC. For example, a case study analysing the benefits of early mobilisation in a cardiac intensive care unit realised a reduction in hospital length of stay of 8 days per patient in 119 patients. This led to a significant financial saving but also the carbon footprint of the number of days saved was 48.5 tonnes CO₂e, equivalent to the annual carbon footprint of almost 5 UK citizens and 18 return flights London to Sydney.¹⁶

12. COVID-19

R13. The PCBC narrative highlights that as part of the emergency response to the COVID-19 pandemic ESHT had to alternate their interventional cardiology service between the 2 acute sites. This will have provided an opportunity to test single siting and some data relating to access and outcomes from this period would be helpful. What were the lessons learned from the pandemic including the learning from other specialities?

R13.1 The PCBC acknowledges that there has been an impact on activity from COVID-19, but it would be helpful to understand what that has been locally. There are examples in the literature providing some understanding of this and some additional narrative here would help.^{17,18,19}

¹⁵ Haleem A, Javaid M, Singh RP, Suman R. Applications of Artificial Intelligence (AI) for Cardiology during Covid-19 pandemic. Sustainable Operations and Computers 2 (2021) 71-78 DOI: [10.1016/j.susoc.2021.04.003](https://doi.org/10.1016/j.susoc.2021.04.003)

¹⁶ Case report: Pioneering Early Mobilisation in a Cardiac Intensive Care (CICU) unit: a Sustainable Healthcare Initiative. Available from <https://networks.sustainablehealthcare.org.uk/networks/physio-susnet/case-study-pioneering-early-mobilisation-cardiac-intensive-care-unit>

¹⁷ Hasan S, Rahman H, Patil A et al. Impact of COVID-19 on cardiology services in a district hospital and adapting to the new normal. Postgrad Med J May 2021 Vol 97 No 1147 [postgradmedj-2020-138228 1..2 \(bmj.com\)](https://doi.org/10.1093/postgrad/97.1147)

¹⁸ Fersia O, Bryant S, Nicholson R, et al. The impact of the COVID-19 pandemic on cardiology services. Open Heart 2020;7: e001359. doi:10.1136/openhrt-2020-001359 [The impact of the COVID-19 pandemic on cardiology services \(bmj.com\)](https://doi.org/10.1136/openhrt-2020-001359)

¹⁹ Mafham MM, Spata E, Goldacre R, Gair D, Curnow P, Bray M, Hollings S, Roebuck C, Gale CP, Mamas MA, Deanfield JE, de Belder MA, Luescher TF, Denwood T, Landray MJ, Emberson JR, Collins R, Morris EJA, Casadei B, Baigent C. COVID-19 pandemic and admission rates for and management of acute coronary syndromes in England. Lancet. 2020 Aug 8;396(10248):381-389. doi: 10.1016/S0140-6736(20)31356-8. Epub 2020 Jul 14. PMID: 32679111; PMCID: PMC7429983. [https://doi.org/10.1016/S0140-6736\(20\)31356-8](https://doi.org/10.1016/S0140-6736(20)31356-8)

R13.2 There are opportunities to include/reference any learning from the innovative use of technology or other digital gains.

R13.3 It would be helpful to understand what has been done differently with reference to the proposed clinical models and pathways and to understand what should now continue and what requires further adaptation to ensure sustainability.

13. The options appraisal process

R.14. It is not the role of clinical senate to make recommendations on option appraisal process issues. However, the current PCBC narrative focuses predominantly on the option to centralise interventional cardiology and cardiology inpatient care onto one site. Although the way in which the proposed options were arrived at is described the PCBC should clearly describe the process of discarding options 1-4. We recommend revising the narrative describing this and Table 11 on page 39 of the PCBC in order to assure both inclusivity and objectivity in the option appraisal and scoring process.

R14.1 In the engagement meetings described in the PCBC the issues raised around transport and access would be resolved by developing both sites and the PCBC therefore needs to be more explicit on why options 2 and 3 were eliminated. The trade-offs between option 5 and these other options in being made obvious would remove concerns from external parties about the other drivers.

Appendix A. Key Lines of Enquiry (KLOEs)

East Sussex: - Cardiology - Clinical Senate Review Proposed key lines of enquiry (KLOE) FINAL
A. General KLOEs
Has the Case for Change, and the health needs of the population been clearly identified? Do the proposals deliver improved and high-quality patient outcomes?
Are projections for changes in demand realistic? Taking account of: <ul style="list-style-type: none"> • Factors increasing demand (population ageing, population growth and increasing incidence of acute and chronic conditions) • Factors reducing demand (prevention, better long term care, demand management, more proactive primary/community based care).
Have clinical standards been identified and are they sufficiently comprehensive as the framework for delivering high quality care and added value. How will the new proposed model ensure that ESHT will consistently meet the range of performance indicators and national guidance (improved patient outcomes from the available resources)?
What is the potential impact on travel times (SECAMB (ambulance, patient transport, public transport for visitors)) and how have you mitigated any adverse impacts? What are the must do times and can you achieve them for all the population, >90% of the population, >80% of the population?
Is there a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce, training and education, and the opportunities provided by new roles and ways of working?
Are there benefits for education and training for doctors, cardiology specialist nurses, clinical scientists and technicians?
Co-dependencies of related clinical services: Has the impact on critical care, operating theatres, medical and surgical specialties and support services, especially diagnostics, therapies and radiology (demand for radiographers) been fully articulated?
How will the Eastbourne District General Hospital and the Conquest Hospital Hastings build on existing network services and deliver seamless clinical information sharing?
Are there any major inconsistencies in the proposed reconfiguration of services with the NHS Long Term Plan/GiRFT recommendations, 21/22 Planning Guidance.
What approaches have been taken to ensure that the future clinical model for cardiology takes full account of sustainable healthcare requirements for the future?
Has the relevant system learning from COVID-19 been taken into account as part of the plans?
Has the breadth and depth of clinical engagement been sufficient?
Has there been meaningful patient and public involvement in coming to the options being proposed. How has the involvement to date sought to be inclusive of seldom heard, minority and deprived population groups?

B. Cardiology Service specific KLOEs

Acute inpatient cardiology 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

General comments on the proposed patient pathway; is it clear and sound?

With an increasingly ageing population it can be expected that there will be an increase in heart failure and atrial fibrillation. How confident are you in your demand projections for urgent intervention for both PCI and electrophysiology (pacemakers, cardiac resynchronisation etc)?

How do you deliver those 24/7 front door rotas and deliver 24/7 catheter lab services for both PCI and electrophysiology?

Are the benefits and risks (including mitigation) of centralising the acute cardiology services on to one site clearly articulated and why will cardiac inpatient care be better in a single acute centre?

How will the co-location of the various key clinical support specialties and services support the proposed model?

Is there sufficient assurance that a model that provides non-invasive investigations and outpatients on both sites has the appropriate infrastructure and sufficient volumes of activity to be sustainable in the longer term?

Will the proposal to provide pPCI and PCI on a single site be sustainable in the longer term? How does the Trust plan to mitigate the risk of insufficient activity to provide operators with a minimum number of 75 procedures each year? What opportunities are there for further networking of services?

Will the proposal to provide CTO on a single site be sustainable in the longer term? How does the Trust plan to mitigate the risk of insufficient activity if volumes do not increase? What opportunities are there for further networking of services – provider collaboratives?

There is currently a CTCA service delivering around 600 scans at both sites. How will the new clinical model support the expansion of this activity to ensure NICE Guidance compliance and access to CT – FFR in the future? (and also less dependency on invasive coronary angiography)?

What clinical review mechanisms will be put in place to assess the development of CMR and cardiac CT within the Trust and as a consequence consider the long term future of the nuclear cardiology service with a view to potentially considering decommissioning cardiac work?

Does the current activity and capacity modelling demonstrate that planned bed capacity will be sufficient to ensure there is no delay in the patient pathway?

Is sufficient detail provided on the total beds required based on projected demand and demand management?

What impact may weekend working and out of hours arrangements have on the proposed pathway. What are the risks and how are they mitigated?

Have clinical standards been identified, and are they sufficiently comprehensive as the framework for delivering high quality care and added value (improved patient outcomes from the available resources)?

Is there a clear and deliverable workforce plan? (inclusive of all roles).

What model is proposed to provide continuous on call cover across both sites? Inevitably not every consultant will be able to contribute to emergency PCI and emergency cardiac electrophysiology intervention, describe how these different rotas will be filled?

Do the plans take suitable account of the benefits of centralising subspecialist work onto a single site? How is it proposed to improve MDT working? How has the Trust considered new ways of working to address this challenge and work towards a video based virtual MDT – to allow East Sussex patients to be discussed as part of a full MDT, ideally on a daily basis with other centres (Brighton)?
How confident are you that an inpatient requiring intervention on the non-catheter lab site will receive sufficiently timely intervention? What plans are in place to work collaboratively with associated disciplines (including imaging and IR, critical care)?
How does the Trust plan to provide 7 day echo cover at both sites?
Is there confidence that the SECamb triage and transfer pathways and capacity issues have been sufficiently addressed?
Are the interface and pathways between the acute hospital cardiology service and the community cardiac rehabilitation and heart failure services adequately described?
What approach and mitigation have you taken to any potential unintended consequences of centralising cardiology inpatient services onto a preferred single site e.g. introducing delayed discharge through loss of existing relationships with community care and community rehabilitation services.
What consideration has been given to coordination of care and support with primary care, specifically acknowledging the population demographic and the likely impact of multiple co morbidities.
How will the Trust ensure that the benefits of a current and well-developed GPSI led community cardiac service that significantly reduces unnecessary referrals are maximised within the new clinical model and patient pathways?
C. KLOEs relating to the shortlisted options - (Option 5a and 5b)
Option 5a: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from EDGH, with acute outpatients and diagnostic services at both sites.
Option 5b: Co-locating all catheterisation laboratories and specialist cardiology inpatient services from Conquest, with acute outpatients and diagnostic services at both sites.) for future cardiology services configuration.
Are there option-specific issues that need highlighting in relation to: <ul style="list-style-type: none"> • Impact on quality of care and clinical outcomes • Equitable access for the population. • Clinical co-dependencies between services • Impact on specific major inpatient clinical services. • Workforce implications • Capacity (Beds, theatres, critical care) • Patient flow?
Is the impact on neighbouring hospitals clearly described and quantified for the clinical model within either option presented, and are there any associated issues of concern that may be option specific that are not described in the PCBC?
Is the impact on surrounding acute trust's cardiology services clear? Have you considered whether poor access to each of the options will lead to flow of some patients to alternative providers? - What provision is in place for the development of a sustainable Regional model, with other units at Brighton and Ashford (WHH) Kent?

Appendix B. Glossary

A&E	Accident and Emergency
AF	Atrial Fibrillation
BX	Bexhill Hospital
CCG	Clinical Commissioning Group
CCU	Coronary Care Unit
CHD	Chronic Heart Disease
CMR	Cardiovascular Magnetic Resonance Imaging
CQ	Conquest Hospital
CQC	Care Quality Commission
CRT	Cardiac Resynchronisation Therapy
CT	Computed Tomography
CTCA	Computed Tomography Coronary Angiography
CT-FFR	Computed Tomography - Fractional Flow Reserve. (A means of calculating how much blood is flowing through the coronary arteries)
CTO	Chronic Total Occlusion
CVD	Cardiovascular disease
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
GIRFT	Getting It Right First Time
GP	General Practice and/or General Practitioner
HR	Hastings and Rother
ICD	Implantable Cardioverter Defibrillator
ICS	Integrated Care System
IP	Inpatients
JSNA	Joint Strategic Needs Assessment
LTP	Long-Term Plan
MDT	Multidisciplinary Team
MINAP	Myocardial Ischaemia National Audit Project
NHS	National Health Service
NHSE/I	NHS England and Improvement
NSTEACS	Non-ST Elevation Acute Coronary Syndrome
NSTEMI	Non-ST Segment Elevation Myocardial Infarction
NT-pro BNP	Blood test used to diagnose or rule out heart failure
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
PPCI	Primary Percutaneous Coronary Intervention
PPM	Permanent Pacemaker
PCN	Primary Care Network
PIFU	Patient Initiated Follow-Up
SECAmb	South East Coast Ambulance Service
STEMI	ST Elevation Myocardial Infarction

Appendix C. Documentation Provided by East Sussex Team

Document Number	Document Name
1	East Sussex Healthcare NHS Trust Acute Cardiology Services Transformation DRAFT Pre consultation Business Case V0.16.
2	Appendix 1 – Summary of ESHT Cardiology GIRFT Review and Visit, November 2019. (inclusive of visit notes).
3	Appendix 2 - Equality and Health Inequalities Impact Assessment (EHIA).
4	Appendix 3 – Transforming Cardiology Services in East Sussex Public Engagement Report.
5	Appendix 4 - Transforming Acute Cardiology Services in East Sussex Options Development and Appraisal - Report of Findings.
6	Appendix 5 – Cardiology Pathways V5 25/06/2021.
7	Appendix 6 - Comprehensive Quality Impact Assessment Tool
8	Appendix 7 – Travel Analysis
9	Appendix 8 – Draft Consultation Document

Appendix D. South East Clinical Senate (KSS)

Review Group membership, declarations of interest and agenda

1. South East Clinical Senate (KSS) Council Review Group Membership

Name	Roles
Paul Stevens	Kent Surrey and Sussex Clinical Senate Chair
Amanda Allen	Clinical Director of Therapies, Maidstone and Tunbridge Wells NHS Trust
Andrew Bishop	Chief medical officer and Consultant cardiologist, Hampshire Hospitals Foundation Trust
May Bullen	Patient and Public Partner
Stephen Bourne	Patient and Public Partner (Observer)
Priscilla Chandro	Patient and Public Partner
David Fluck	Medical Director, Ashford and St Peters Foundation NHS Trust
Peter Green	Kent and Medway ICS
Huw Griffiths	Senior Cardiologist, Portsmouth Hospitals University NHS Trust
Patricia Little	Arrhythmia Specialist Nurse, Ashford and St Peters Foundation NHS Trust
Fionna Moore	Medical Director, South East Coast Ambulance Service
Jonathan Richenberg	Consultant Radiologist, Sussex University Hospitals NHS Trust
James Rosengarten	Cardiology Lead, East Kent University Hospitals Foundation Trust
Mohit Sharma	Public Health England, South East Region
Sally Smith	Maidstone and Tunbridge Wells NHS Trust
Becki Turner	Physiology lead for Pacing, Cardiac Clinical Scientist, Hampshire Hospitals NHS Foundation Trust
Jane Barrett	Hampshire and Thames Valley Clinical Senate Chair
Helen Bell	Programme Manager, South East Clinical Senates'
Pat Hays	Assistant Director, Clinical Programme Delivery, Regional Medical Directorate, NHS England and Improvement – South East (Observer)
Ali Parsons	Senate Manager, South East Clinical Senates'

2. Declarations of Interest

Name	Personal pecuniary interest	Indirect pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Paul Stevens	None	None	None	None	None
Amanda Allen	None	None	None	None	None
Andrew Bishop	None	None	None	None	None
May Bullen	None	None	None	None	None
Stephen Bourne	None	None	None	None	None
Priscilla Chandro	None	None	None	None	None
David Fluck	None	<i>Private Consultant Cardiologist:</i> Nuffield Hospital, Woking. St Anthony's, Cheam. Runnymede Hospital, Chertsey. <i>Director:</i> Fluck & Griffiths LLP	None	None	None
Peter Green	None	None	None	None	None
Huw Griffiths	None	None	None	None	None
Patricia Little	None	None	None	None	None
Fionna Moore	None	None	None	None	None
Jonathan Richenberg	None	None	None	None	None
James Rosengarten	None	None	None	None	None
Mohit Sharma	None	None	None	None	None
Sally Smith	None	None	None	None	None
Becki Turner	None	None	None	None	None
Jane Barrett	None	None	None	None	None
Helen Bell	None	None	None	None	None
Pat Haye	None	None	None	None	None
Ali Parsons	None	None	None	None	None

3. Panel Day Agenda

**South East Clinical Senate Expert Review Panel - 28th July 2021:
Review of the proposals to re design cardiology services in East Sussex.**

*(Please note: Clinical Senate Panel **only** Pre meet 12.30-13.00pm)*

Via TEAMS link

[Click here to join the meeting](#)

Item	Time	Item	Lead
1.	12.15	Registration/Join TEAMS (<i>Clinical Senates panel only</i>)	
2.	12.30	South East Clinical Senate Expert Review Panel <i>only</i> pre-meet.	PS
	13.00	<i>Sussex Transformation Partnership team to join the meeting</i>	
3.	13.00	Welcome, Introduction, context and approach to the review.	PS
4.	13.05	Presentation from the Sussex Transformation team , summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, criteria used for options shortlisting and brief overview of options.	Sussex Team
5.	13.20	Discussion and Q&A between the clinical senate panel and the Sussex team, relating to the strategic approach and overarching themes and options overview KLOE (Q&A).	PS
6.	13.50	<p>Clinical Models and Pathways presentations and discussion:</p> <p>Clinical model presentation Review of the proposed clinical models and pathways:</p> <ol style="list-style-type: none"> 1. Acute inpatient cardiology 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. Inclusive of: <ul style="list-style-type: none"> • cardiac catheter laboratories • coronary care units (CCU) • cardiology inpatient ward beds • capacity to provide front end triage. 2. Outpatient cardiology services 3. Options presentation 	
7.	15.00	Discussion and Q&A between the clinical senate panel and the Sussex team, relating to Clinical Models, Pathways, Outpatients and options.	
8.	15.20	Sussex Team to leave the meeting - Comfort break	
9.	15.30	Panel Discussion: Key findings, evidence base and emerging themes for recommendations.	PS
10.	16.50	Summing up, next steps	PS
11.	17.00	Meeting close	

Appendix E. East Sussex Panel Membership

Name	Roles
Jessica Britton	Executive Managing Director, East Sussex CCG
Antonia Bennett	Patient and Public Involvement Lead, East Sussex CCG
Hazel Church	Heart Failure Specialist Nurse, East Sussex Healthcare NHS Trust
Mike Farrer	Strategy, Innovation & Planning Team, East Sussex Healthcare NHS Trust
Sharon Grain	Matron, East Sussex Healthcare NHS Trust
Claire Hall	Specialist Paramedic (Urgent and Emergency Care) South East Coast Ambulance Service NHS Foundation Trust
Lesley Houston	General Manager, Cardiovascular, East Sussex Healthcare NHS Trust
Suneeta Kochhar	GP Principal and Clinical Director, East Sussex CCG
Nik Patel	Cardiology Clinical Lead, East Sussex Healthcare NHS Trust
Victoria Spencer-Hughes	Consultant in Public Health, East Sussex
Harriet Vogt	Community Ambassador
Kevin Wilcox	Head of Planned Care and Cancer, East Sussex and Brighton and Hove CCGs