HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 12 DECEMBER 2024

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -

East Sussex County Council Members
Councillors Sam Adeniji, Abul Azad, Colin Belsey (Chair), Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson (Vice Chair) and Alan Shuttleworth

District and Borough Council Members
Councillor Dr Kathy Ballard, Eastbourne Borough Council
Councillor Mike Turner, Hastings Borough Council
Councillor Christine Brett, Lewes District Council
Councillor Terry Byrne, Rother District Council
Councillor Graham Shaw, Wealden District Council

Voluntary Sector Representatives
Jennifer Twist, VCSE Alliance
Vacancy, VSCE Alliance

AGENDA

1. **Minutes of the meeting held on 3 October 2024** *(Pages 5 - 16)*

2. **Apologies for absence**

3. **Disclosures of interests**

   Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4. **Urgent items**

   Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5. **NHS Sussex Winter Plan 2024/25** *(Pages 17 - 94)*

6. **Changes to Paediatric Service Model at Eastbourne District General Hospital (EDGH) - Update report** *(Pages 95 - 124)*

7. **Ambulance Handovers at the Royal Sussex County Hospital (RSCH) - Update report** *(Pages 125 - 138)*

8. **Proposed changes to Colorectal Cancer Surgery Pathway at University Hospitals Sussex (UHSx) NHS Trust** *(Pages 139 - 154)*

9. **HOSC future work programme** *(Pages 155 - 160)*

10. **Any other items previously notified under agenda item 4**

PHILIP BAKER
Deputy Chief Executive
County Hall, St Anne's Crescent
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4 December 2024

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Next HOSC meeting: 10am, Thursday, 6 March 2025, County Hall, Lewes

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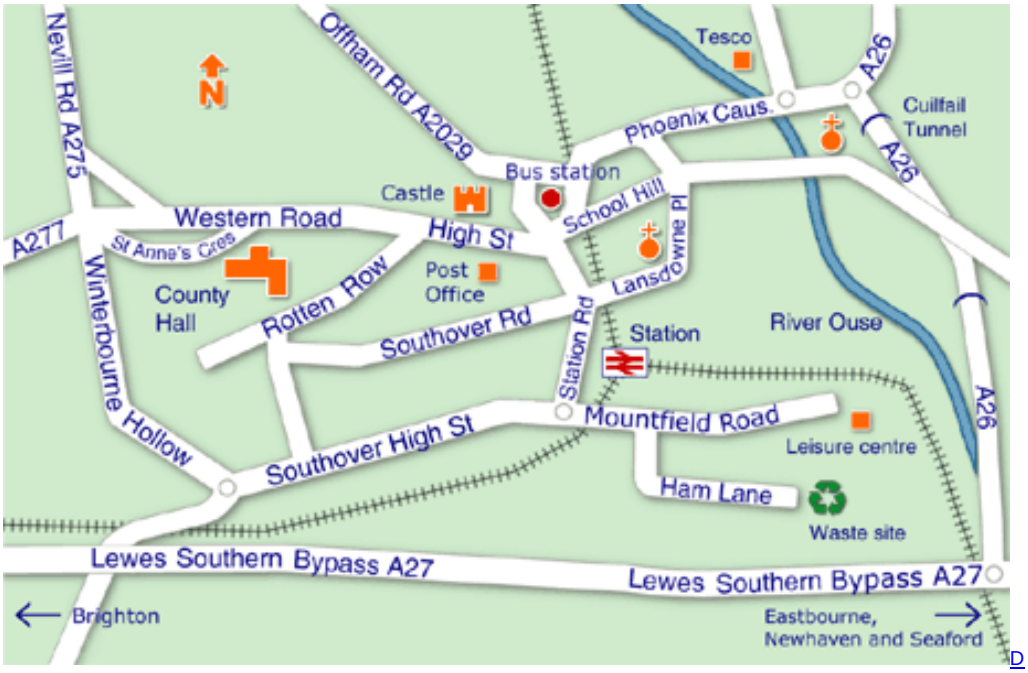

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 3 October 2024

PRESENT:

Councillors Colin Belsey (Chair), Councillors Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson and Alan Shuttleworth (all East Sussex County Council);
Councillor Dr Kathy Ballard (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Christine Brett (Lewes District Council) and
Councillor Graham Shaw (Wealden District Council)

WITNESSES:

NHS Sussex

Charlotte Keeble – Director of Primary, Community and Urgent Care Commissioning

Ashley Scarff – Director of Joint Commissioning and ICT Development (East Sussex)

Garry Money – Director of Primary Care Commissioning and Transformation

Carole Carthern – Head of Primary Care East Sussex

Kate Symons – Deputy Director of Primary Care

East Sussex Local Dental Committee

Nish Suchak

Margaret Case

East Sussex Healthcare NHS Trust

Richard Milner – Chief of Staff

David Garrett – Divisional Director for Core Services

LEAD OFFICER:

Martin Jenks and Patrick Major

10. MINUTES OF THE MEETING HELD ON 30 JULY 2024

10.1 The Committee noted that it was awaiting various pieces of information and updates from NHS Sussex under 6.6, 6.8, 6.11, 6.17, and 6.25 of the minutes of the previous meeting.

10.2 The minutes of the meeting held on 30 July 2024 were agreed as a correct record.

11. APOLOGIES FOR ABSENCE

11.1 Apologies for absence were received from Councillor Abul Azad, Councillor Terry Byrne, and Jennifer Twist.

12. DISCLOSURES OF INTERESTS

12.1 There were no disclosures of interest.

13. URGENT ITEMS

13.1 There were no urgent items.

14. ACCESS TO NHS DENTISTRY SERVICES

14.1 The Committee considered a report from NHS Sussex providing a progress update on work underway to enhance routine and urgent dental care access for people across the county.

14.2 The Chair requested that future reports from all NHS organisations should reference data that covered East Sussex only and avoid Sussex-wide data wherever possible.

14.3 The Committee commented that the current levels of provision were unacceptably low and asked how NHS Sussex were working to increase the number of units of dental activity (UDA) across the county.

14.4 Charlotte Keeble, NHS Sussex Director of Primary, Community and Urgent Care Commissioning outlined that nationally the Government had committed to review the NHS dental contract and address known challenges with it which currently presented issues for dental professionals. Locally, there were challenges attracting new NHS dentists to the area, and NHS Sussex was undertaking targeted action to address this. This included uplifting the minimum UDA rate and engaging with local dental providers to encourage them to overdeliver on their NHS contracts, which they were able to do by up to 10%. Providers had also been encouraged to take on temporary UDA, as sometimes they did not want to take these on permanently. An urgent dental care ‘test and learn’ pilot approach, which combined UDA and sessional payments, encouraging providers to take on more complex patients, had proven popular and been extended for the rest of the year. Given there had been five dental contract hand backs in East Sussex, there were plans to hold a market engagement event in Lewes in November to both procure new contracts and understand what would encourage greater take up from providers.

14.5 Nish Suchak, General Dental Practitioner and Chair of the East Sussex Local Dental Committee outlined that the current national contract meant that where practices failed to deliver their number of UDA in a year, they were required to make these up the following year, and the contract was not fit for purpose. There was insufficient funding for the system to meet the level of need and the national contract did not provide sufficient funding to support dentistry practices' costs, including staff.

14.6 Cllr Turner suggested that dentists should be required to accept new patients onto their books even if they were full, just as GPs were required to do. Nish Suchak commented that dentists were unable to take on more patients because the funding they received from the NHS was ringfenced and cannot afford to do any more NHS work.

14.7 The Committee commented that some people struggled to pay for certain treatments and asked how these people could be better supported.

14.8 Charlotte Keeble commented that NHS Sussex supported there being reforms made to the national contract. The feedback from dental professionals had identified three key drivers causing contract hand backs, which were the low UDA rate, the NHS dental contract and workforce recruitment and retention. NHS Sussex had tried to address these challenges where it was able to, but there were structural issues with the national contract, and there was no dental training school in the entire South East which meant trainees were not being attracted to the region or county.

14.9 Nish Suchak commented that patient charges for NHS dental work went up every April, and working in an area of high deprivation he noted that many patients asked for the minimum level of treatment to avoid higher costs. There was high level of tooth decay within children and prevention work in schools would be important in addressing this.

14.10 The Committee asked how NHS Sussex collaborated with ESCC to deliver a preventative approach to dental health in schools.

14.11 Charlotte Keeble explained that the NHS Sussex Dental Plan had been developed in partnership, including with Public Health teams in ESCC. There had also been discrete pieces of work, including working with ESCC to review the Looked After Children pathway, given the specific complexities related to their dental health. The new Government had committed in its manifesto to a toothbrushing campaign for 3-5 year olds, and public health consultants would be working on that campaign. Prevention was also embedded into the urgent dental care pilot, which was ringfenced for children, young people and clinically vulnerable people who had difficulties accessing dental services and needed longer appointments.

14.12 The Committee asked what the time delay until the workforce benefits were realised from the work with the NHSE Workforce Dental Deanery.

14.13 Charlotte Keeble explained that she had recently met with the Dental Deanery and Chichester College to explore the viability of a proposal for a dental school with the Deanery, as well as to test out the costs of such a development. A fully costed business case would need to be developed and discussions on this were ongoing. Nish Suchak added that it took five years to train a dentist followed by an additional year, which meant it took six years for newly qualified dentists to come onstream.

14.14 The Committee asked whether there were plans to increase the number of 'golden hellos'.

14.15 Charlote Keeble explained that there was a national allocation to each region for golden hello posts. Twenty eight were allocated to the South East and NHS Sussex took eleven, three of which were allocated to East Sussex. As this was centrally administered there was nothing NHS Sussex could do to increase the number of golden hello posts in East Sussex. Dental providers also needed to be willing to take on the golden hello posts, which required support and training and there were three providers in East Sussex which came forward to accept. Nish Suchak, added that the golden hellos required practitioners to stay for a minimum of three years, and if they did not stay for that length of time the money would be clawed back from practices, which many were not willing to risk.

14.16 The Committee asked when the issues in East Sussex would be in less of a crisis situation.

14.17 Charlotte Keeble explained that performance in East Sussex had been improving due to the programmes and interventions outlined in the report. A lot of progress was still required but it would never be the case that 100% of activity for dental contracts was delivered, and this had been the case prior to the pandemic. Despite work done locally, changes made at a national level were required for there to be the level of improvement that people were hoping for.

14.18 The Committee noted that there was a gap in appointment availability and the needs of patients and how this was managed.

14.19 Charlotte Keeble explained that NHS Sussex monitored all activity it commissioned, so every practice was being monitored to ensure they delivered the expected amount of activity, and the dental contract allowed for reviews to take place to address underperformance. If a dental provider chose not to deliver its NHS activity there was very little that commissioners could do in-year to address this, beyond working with the provider to develop an action plan for it to deliver its expected activity. Commissioners had very few contractual sanctions to enforce delivery of activity, particularly in the early part of the year. NHS Sussex also monitored availability of appointments, and where these did not change then NHS Sussex would make direct contact to confirm when providers would next be making new appointments available.

14.20 The Committee asked whether a national requirement for newly qualified dentists to be required to do a minimum amount of NHS work before they could go into private practice would be helpful.

14.21 Charlotte Keeble responded that she would be very supportive of such a change, and that any way to recruit and retain more dentists locally was vital for implementing the workforce plan.

14.22 The Committee asked for clarification at Figure 1 of the report to whether the numbers shown were only providers that delivered NHS contracts, as there were currently no NHS providers accepting patients in Seaford.

14.23 Charlotte Keeble explained that the map on Figure 1 showed all NHS service contracts. There were five NHS dental contracts in Seaford, but this did not mean there were five separate providers. Some providers held more than one NHS dental contract for different services. NHS Sussex was widely advertising its market engagement event in November where it hoped to attract new providers to the area, recognising that there were some gaps in provision across the county.

14.24 The Committee asked what the proportion of NHS to private activity was for the average dental provider.

14.25 Charlotte Keeble said that this was not data that NHS Sussex had available and would only been known by individual providers themselves. There was no national data on this, but most providers delivering NHS activity would deliver a level of private activity as well.

14.26 The Committee asked how NHS Sussex ensure there was sufficient provision in more deprived areas of the county.

14.27 Charlotte Keeble explained that comparative data was considered as part of the allocation of dental provision across the county, including indices of deprivation. The number of currently commissioned UDA were RAG rated against the number that would be expected to meet the level of need in an area based on indices of deprivation to assess whether this was higher or lower than required. Commissioning on this basis then meant that activity could be targeted at the areas with the most need, such as the commissioning of temporary activity or overactivity on dental contracts in areas where there had been dental contract hand backs. Charlotte agreed to share the commissioning methodology with the Committee.

14.28 The Committee asked whether it was possible to pay dentists to overperform and deliver more NHS activity.

14.29 Charlotte Keeble explained that NHS Sussex commissioned for its allocated dental budget in a year. Where providers underperformed on their commissioned activity, funding was then clawed back and used to pay for overperformance on contracts by other providers. The way NHS Sussex commissioned its services were within the confines of the national contract which the new Government had committed to reform. Margaret Case explained that the funding allocated is based on the amount of work that was actually delivered, which meant if patients did not attend then dentists would not be paid for it. The UK did not train enough dentists to meet the level of demand which meant the country was reliant on dentists coming from abroad, which was a protracted process for those arriving. Often these dentists found working within the NHS system difficult and would more likely than not go private.

14.30 The Committee asked whether it was possible to require dentists arriving from abroad to work for the NHS for a longer period of time.

14.31 Margaret Case explained that she was a clinical dental advisor for the South East and worked to onboard foreign dentists into the area. Foreign dentists mostly funded their own training, including the required conversion courses to work in the UK, and they also faced long delays to entering the system and found working with the NHS difficult to navigate. These things created barriers for foreign dentists staying in the NHS for an extended period of time. Paying some of their costs upfront and treating them as salaried workers might help but that would require national change.

14.32 The Committee RESOLVED to:

1) Note the report and recognise greater levels of funding were required from national government to improve NHS dental services in East Sussex;

2) Receive a further report in March 2025.

15. ACCESS TO GENERAL PRACTICE IN EAST SUSSEX

15.1 The Committee considered a report on primary care services and access to General Practice across the county, following on from a report on Primary Care Networks (PCN) the Committee had considered in September 2023. The report covered a number of areas that the Committee had previously asked about when it had considered earlier reports.

15.2 The Committee asked what the average wait time was for patients to have a GP appointment.

15.3 Garry Money, Director of Primary Care Commissioning and Transformation, noted that at 5.3 in the paper there were average figures for waiting times. The NHS only monitored the number of appointments booked on the same day and the number of appointments given within two weeks. Currently just under 80% of patients in East Sussex who tried to book a GP appointment got one within 2 weeks, which was a couple of percentage points below the England average. Some GP practices' ways of working skewed these figures slightly, such as by booking recurring appointments for long term conditions in advance, which gave the impression that a patient was waiting much longer than the 2-week target. NHS Sussex was working to address issues of variation between individual practices, to identify where GPs had issues that they needed support to reduce waiting times.

15.4 The Committee noted that workforce absences in East Sussex due to mental health problems was double the national average and asked how access to the Emotional Wellbeing Service would be improved.

15.5 Garry Money explained that NHS Sussex was working closely with Sussex Partnership Foundation Trust (SPFT) and with High Weald and Seaford PCNs to provide the Emotional Wellbeing Support Service in all PCNs in the county. This included exploring how to fund it and simplify employment arrangements. Garry agreed to provide the Committee with an update on the service in these two PCNs, as well as data on current performance, activity and impact of the service broken down by other areas.

15.6 The Committee noted that in some cases GP appointments available to book online were much further in the future than those available to book on the phone, and asked if this was a common issue.

15.7 Garry Money accepted that there was variation between practices in this issue, and that often appointments offered online were with a nurse rather than GP. Different practices varied in how they used online consultation systems, sometimes turning them off in the morning once capacity had been reached. There were other known communication issues and NHS Sussex was working to reduce the level of variation between practices. There was a programme of unwarranted variation quality improvements that it would be possible to provide an update on the next time the issue was discussed by the Committee.

15.8 The Committee commented that patients had a right to choose when being referred to secondary care by GPs and asked how the NHS ensured this right was being upheld.

15.9 Garry Money commented that GPs worked according to clinical pathways, and that when they referred patients to specific specialist services, patients should be offered the right to choose which hospital they were referred to. Some services were intermediary, sitting between GP practices and hospitals, such as musculoskeletal, and were a triaging service. If intermediary services then offered a referral to secondary care, then they should also offer the patient choice about where they were referred to. He added monitoring of GPs offering patient choice was done by sample as there was no data monitoring of it. GPs had systems for

comparing waiting times for services at different hospitals and this should be part of the conversation with the patient. Richard Milner, ESHT Chief of Staff, commented that ESHT was not forcing patients to particular services, but agreed to discuss the issue with colleagues outside of the meeting.

15.10 Some members of the Committee commented that they did not believe patient choice was being routinely offered in GP consultations. Garry Money noted the Committee's concerns and agreed to follow up with any specific examples that members had outside of the meeting.

15.11 The Committee welcomed that Richmond Road car park in Seaford was being considered for estates developments, and asked what assessments were being undertaken and for a timeline update.

15.12 Garry Money explained that Value for Money assessments would be required as part of any development, and the NHS worked with local authorities on these assessments. He agreed to provide more detail on this specific development ahead of the next scheduled update.

15.13 The Committee commented that one GP (SDHC) operated across many PCN geographies asked why this practice was not able to provide the Emotional Wellbeing Service in all the PCNs it was part of.

15.14 Garry Money agreed to provide more information about the Emotional Wellbeing Service outside of the meeting. The first priority was provide an equivalent service as soon as possible in Seaford and High Weald that was available in the rest of the county. There were many more locations than the 50 GP practices listed, as some were collaborations of individual surgeries under a single provider. Where a provider was across many geographies then it would be providing in the PCN areas where the Emotional Wellbeing Service was currently in place.

15.15 The Committee asked what cloud-based telephony was.

15.16 Garry Money explained that cloud-based telephony was a means by which telephone calls could be securely answered without staff being present in a building. This reflected the pandemic where not all staff worked permanently in one place and meant that a GP could take a telephone consultation in a secure location that was not a surgery, increasing the number of phone lines available.

15.17 The Committee asked how it was possible to mitigate digital exclusion through training if people did not have digital devices.

15.18 Garry Money noted that digital inclusion included several different elements, so the report only covered a high-level update on some of the work involved in it. There was a general trend to have more of a 'digital front door' in general practice, so it would be more important to understand whether all patients trying to access healthcare were able to. He agreed to provide a more detailed update in a future report, as the ICB was doing a lot of work in the area of digital exclusion.

15.19 The Committee asked how many extended hours appointments were taken up at each individual practice.

15.20 Garry Money noted that for the whole of East Sussex 606 hours of enhanced access was provided per week, but did not have the did not attend (DNA) figure for the enhanced access sites. He agreed to explore whether that data was available and provide it to the

Committee if possible, as well as a breakdown of the number of enhanced hours appointments available at each practice.

15.21 The Committee noted a recent news piece where a patient had died due to symptoms being missed despite having repeatedly being seen a physician associate, and asked whether physician associates had sufficient training.

15.22 Garry Money commented that he was not aware of the level of training required or what the clinical governance around the physician associate role were specifically, but was aware of the national news. NHS Sussex was positive about the role of physician associates and other ARRS roles and agreed to provide further detail on training outside of the meeting.

15.23 The Committee asked for further detail on the distribution of specific roles between PCNs under the Additional Roles Reimbursement Scheme (ARRS), and how PCNs were able to access funding for those roles.

15.24 Garry Money explained that all the ARRS roles were available to PCNs to choose from. Every PCN had a notional allocation of the national funding it would receive for the recruitment of ARRS roles, and there was then a bidding process to receive the funding. The role of NHS Sussex was to maximise the number of roles employed in the area based on its notional allocation, which it had to draw down from to receive. It engaged PCNs throughout the year to encourage and support the uptake of ARRS roles. Garry agreed to provide a breakdown of which PCNs recruited to which roles.

15.25 The Committee noted that some GP practices no longer offered online appointments which they did during the pandemic, and asked which surgeries offered online appointments currently, and whether NHS Sussex could encourage an increase in the number offering it.

15.26 Gary Money explained that GPs were contractually required to offer a live online consultation tool, and NHS Sussex followed up with surgeries where there were reports that this was not available. However, the GP contract did not specify at what hours these tools needed to be available, and there was a potential safety issue associated with online tools where the level of need being presented was not able to actively be met. NHS Sussex was actively exploring how to improve access to online consultation and reduce the level of variation seen across the county

15.27 The Committee asked where Pharmacy First services were available.

15.28 Gary Money explained that there was a paper on Pharmacy First going to a future meeting of the Integrated Care Board, and agreed to come back on the detail of which pharmacies were offering Pharmacy First services. There were seven specific pathways that allowed patients to avoid having to go through general practice for certain common issues. Where it was in place it was working well and NHS Sussex was supporting pharmacies with it, as well as communicating to GPs how it operated.

15.29 The Committee commented that the availability of COVID-19 vaccinations in Eastbourne had been limited when people were trying to book online and asked how this was being addressed.

15.30 Gary Money confirmed there were vaccination sites available in Eastbourne and agreed to quickly investigate this issue.

15.31 The Committed commented that there were often delays in GPs signing off repeat prescriptions sent by pharmacies, which presented issues for patients and prevented pharmacies from offering the service.

15.32 Garry Money commented that a focus of the development of Integrated Community Teams was to improve join up between GPs and pharmacies. Pharmacists were not contracted to provide a repeat prescription ordering service, but it was a very valuable one for patients. NHS Sussex was able to facilitate discussions between GPs and pharmacies to improve working relationships and address this issue. There was communication activity on Pharmacy First and more targeted work to explain to the public what the offer was would be explored ahead of winter.

15.33 The Committee commented that there was not a GP surgery in Baird ward in Hastings despite previous site allocations, and asked for an update.

15.34 Gary Money agreed to provide an update outside of the meeting.

15.35 The Committee RESOLVED to:

1) Note the report; and

2) schedule an update report on primary care for its meeting in June 2025.

16. NHS MISSED APPOINTMENTS

16.1 The Committee considered a report from NHS Sussex on work being undertaken to minimise missed appointments in secondary care (hospitals) across East Sussex. An update on missed appointments in primary care was included in the report on agenda item 6, Access to General Practice in East Sussex.

16.2 The Committee raised a concern that often people would call East Sussex Healthcare NHS Trust (ESHT) and their calls would not be answered, which was a barrier for some people cancelling appointments they could not attend.

16.3 David Garrett, ESHT Divisional Director for Core Services accepted that at certain times of day it was difficult to get through on the phone lines. He added that very few members of the booking team worked remotely, with call handlers based at both Eastbourne and Conquest hospitals. Teams had information on how many people were waiting and how long they had been waiting for, so it was possible to get more staff to answer phones as required. There were periods of high traffic and ESHT was considering implementing a semi-automated switchboard for the booking team which would allow people to cancel appointments without needing to have someone answer the phone.

16.4 The Committee commented that sometimes patients were unable to attend appointments as hospital transport required advanced booking which could not always be arranged in time.

16.5 Ashley Scarff, NHS Sussex Director of Joint Commissioning and ICT Development (East Sussex) commented that communication between patient transport and hospital trusts should be improved to avoid missed appointments. If there were issues with providing patient transport for a patient to get to their appointment, then a link back to the hospital or service should be

made so that the appointment can be rearranged for a time when the patient would be able to attend.

16.6 Cllr Turner commented that if a patient missed an appointment because of a lack of available transport, then there was a risk they could go to the back of a waiting list through no fault of their own.

16.7 The Committee asked what the cost to the NHS was of missed appointments.

16.8 David Garrett explained that it was difficult to quantify the cost of missed appointments, as all clinics were booked based on a model of likely attendance to that particular clinic. This meant that if everyone booked in attended their appointment, then the clinic would likely overrun. Where clinics regularly underran then the model would be reviewed, and additional appointment slots would be added. Did not attends (DNAs) added some unpredictability to the running of a clinic that meant while every effort was made to try and adjust for them, it could only be determined on the day whether a clinic would over or under subscribed. Ashley Scarff added that the key cost would be the opportunity cost of having staff present at a clinic without anyone to attend to.

16.9 The Committee asked whether patients were able to request specific times for appointments to avoid having to pay for peak travel fares.

16.10 David Garrett explained that there would have to be a dialogue with patients to understand their travel needs, and they should be given two reasonable time offers for an appointment. Patients had to inform whoever was booking appointments of times at which they could not attend, and there was a function on the patients' notes system where important patient information could be logged that would support discussions with patients on these issues.

16.11 The Committee asked what was meant by stricter policies in reference to repeat non-attendees of appointments.

16.12 David Garrett responded that ESHT had a Patient Access Policy which stated that if a patient did not attend an appointment twice then consideration would be given to discharging them back to their GP, subject to the advice of clinicians. There were a very small number of difficult to engage patients where a disproportionate amount of time was spent trying to contact and arrange suitable appointments, and so a process was required for dealing with patients that did not respond to any communication.

16.13 The Committee asked for more information on how short notice appointments were taken up.

16.14 David Garrett explained that short notice appointments lists had been introduced across a number of specialities to avoid clinical time not being utilised. Staff in the booking team had short notice lists of patients by speciality which allowed them to fill appointment slots that became available with less than 24 hours notice. Appointments that became available with more than 24 hours would be filled according to clinical need as usual.

16.15 The Committee asked if there was a link between DNAs and the number of times appointments were rearranged.

16.16 David Garrett commented that there can be a correlation between a DNA and a patient having their appointment rearranged. ESHT tried to set clinics six weeks ahead of time in order to give patients 4-6 weeks' notice of their appointments. The exception to this was for urgent

suspected cancer patients who were given appointments within seven days, which meant that it was not uncommon for patients to agree to an appointment without realising that they cannot actually attend and then have to have their appointment rearranged. ESHT was aware that sending patients different appointment letters could be confusing and tried to avoid it where possible.

16.17 The Committee commented that some communications to patients on long waiting lists suggested that they should consider being seen privately.

16.18 David Garrett explained the appointment validation process, whereby patients on long waiting lists were contacted to confirm whether they still needed an appointment. ESHT had found that a significant proportion (around 10-15%) of patients would respond that they no longer needed the appointment. The wording of communication may ask whether the patient has had their issue resolved privately, which was helpful information for understanding why a patient no longer needed their appointment. However, communications from the hospital should not be suggesting people be seen privately and if there were examples of that taking place David agreed to investigate.

16.19 The Committee RESOLVED to note the report.

17. HOSC FUTURE WORK PROGRAMME

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

17.2 The Committee discussed the development of Integrated Community Teams (ICTs) and asked whether this was something it should receive a report on. Ashley Scarff commented that there was a standing item on the development of ICTs at the Health and Wellbeing Board and agreed to suggest an appropriate time in the future that HOSC may wish to discuss this topic.

17.3 The Committee RESOLVED to amend its work programme in line with paragraphs 14.32 and 15.35.

18. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

18.1 None.

The meeting ended at 12.27 pm.

Councillor Colin Belsey

Chair

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**12 December 2024**
By:	**Deputy Chief Executive**
Title:	**NHS Sussex Winter Plan 2024/25**
Purpose:	**To provide an overview of the NHS Sussex Winter Plan 2024/25.**

RECOMMENDATIONS

The Committee is recommended to consider and comment on the report.

1. Background

1.1. Winter planning is an annual national requirement of the NHS to ensure that the local health and social care system has sufficient plans in place to effectively manage the capacity and demand pressures anticipated during the Winter period. The Sussex System Winter Plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. The Plan period runs this year from November 2024 to March 2025 and was approved by the NHS Sussex Integrated Care Board on 27th November 2024.

1.2. Winter Plans are developed with input from partners across the system including local authorities, providers, commissioners and the voluntary sector. Underpinning the overarching Sussex system winter plan, each provider Trust has developed their own winter plans and have contributed to the system wide demand and capacity modelling.

1.3. This report highlights the Sussex wide and East Sussex specific elements of the plan. It should be noted that the system has continued to see increased demand across primary, secondary, community and mental health services. Over the winter months this can become increasingly challenging as there are seasonally driven increases in illness such as acute respiratory illness, flu, Covid-19, and norovirus, together with the impact of cold weather and the ongoing impact from the cost-of-living pressures which constrains the ability of the most vulnerable in our population to keep themselves well.

2. Supporting information

2.1. The key focus of the NHS Sussex plan is action to support people to stay well and to maintain patient safety and experience. There is a focus on five key areas as part of this:

- Prevention and case finding to support people to stay well and to target additional support to our most vulnerable populations to prevent hospital admission where possible.
- Same day urgent care to help maximise access to urgent help for local people, reducing the need for people to attend Emergency Departments.
- Improvements in discharge to support patient flow to help people to get home from hospital in a timely way and to ensure good access to inpatient beds when people need them.
- Sound operational management to ensure we have robust mechanisms in place with clear coordination across the system and rapid routes for escalation where required.
- Oversight, governance and escalation to ensure we have the right oversight in place.

2.2. A summary of the NHS Sussex Winter Plan 2024/25 is attached as **Appendix 1**, which highlights the Sussex-wide and East Sussex specific approaches and aims to provide information to HOSC that the health and social care needs of the local population will be met over the winter period.

2.3. The full Winter Plan as approved by the ICB is attached as **Appendix 2** for information. This includes summaries of provider trust winter plans in the final pages.

3. Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider and comment on the NHS Sussex Winter Plan.

PHILIP BAKER
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East Sussex County Council Health Overview and Scrutiny Committee (HOSC)

Sussex System Winter Plan 2024/25
November 2024

1. Introduction

1.1 This report provides a summary of the approach to the Sussex System Winter Plan that spans the period from November 2024 to March 2025. The report highlights the Sussex wide and East Sussex specific approaches and aims to provide information to the East Sussex County Council HOSC that the health and social care needs of the local population will be met over the winter period. The final Winter Plan was considered and agreed by the NHS Sussex Integrated Care Board on 27 November 2024.

1.2 The Sussex System Winter Plan is a whole system health and social care plan, recognising the interdependencies of the system to meet the needs of the local population. It is an annual national planning requirement and provides assurance that the system and partners have the necessary measures in place to deliver health and care for the local population.

1.3 We know there has been continued increased demand across primary, secondary, community and mental health services. Over the winter months this can become increasingly challenging as there are seasonally driven increases in illness such as acute respiratory illness, flu, Covid, and norovirus, together with the impact of cold weather and the ongoing impact from the cost-of-living crisis which constrains the ability of the most vulnerable in our population to keep themselves well.

1.4 The key focus of the plan is action to support people to stay well and to maintain patient safety and experience. We will focus on five key areas as part of this:

1. Prevention and case finding to support people to stay well and to target additional support to our most vulnerable populations to prevent hospital admission where possible
2. Same day urgent care to help maximise access to urgent help for local people, reducing the need for people to attend Emergency Departments
3. Improvements in discharge to support patient flow to help people to get home from hospital in a timely way and to ensure good access to inpatient beds when people need them

4. Sound operational management to ensure we have robust mechanisms in place with clear coordination across the system and rapid routes for escalation where required
5. Oversight, governance and escalation to ensure we have the right oversight in place.

1.5 Our plans are underpinned by a series of principles designed to ensure that a focus on quality and safety in maintained. These are:

- Maintaining the quality and safety of services is the primary objective of all system partners
- System partners will work together to ensure timely access to services for the entire population, supported by a clinical risk-based focus at times of surge in demand
- We will prioritise the most vulnerable and at risk
- System resources will be targeted in the areas where we will get greatest impact or in the areas of greatest need
- We will protect the wellbeing of our workforce
- System partners will work together to balance clinical risk
- Our clinical leaders will be at the heart of decision making throughout the winter period.

2. Sussex system approach to developing our Winter Plan

2.1 The Sussex system approach to developing our Winter Plan was driven by two key influences.

National requirements

2.2 Every year NHS England issue guidance to local systems setting out key priorities. This includes a planning and financial framework and focuses on:

- Providing safe care over winter, including a focus on access to urgent and emergency care with the further development of same day emergency care; the development of access hubs, and the further development of virtual wards.
- Supporting people to stay well, including the national flu immunisation programme; the COVID-19 autumn/winter vaccination programme for eligible groups; and the Respiratory Syncytial Virus (RSV) Vaccine
- Maintaining patient safety and experience.

2.3 In addition to this, NHS England has indicated specific requirements for all trusts and provider organisations. These relate to:

- reviewing general and acute core and escalation bed capacity plans
- reviewing and testing full capacity plans.

- ensuring the fundamental standards of care are in place in all settings at all times:
- ensuring appropriate senior clinical decision-makers are able to make decisions in live time to manage flow.
- ensuring plans are in place to maximise patient flow throughout the hospital, 7 days per week.

Sussex requirements

2.4 In addition to the national requirements, the Sussex system considers what specific priorities or areas of focus are required to best meet the needs of the local population, based on locally observed demand and capacity, and the governance arrangements required to ensure all parts of the system work together to best mitigate the risks for the entire population.

2.5 We bring together actions and intelligence at neighbourhood, place and system level, and prioritise the areas of focus so we can respond effectively together. We also undertake a learning exercise after winter every year to ensure that the system follows a cycle of continuous improvement. We therefore build on learning from previous years to improve our framework for system oversight with a focus on the key actions all system partners are taking to deliver continued access to safe services.

2.6 Together with our key priority areas of focus, we have the following four areas of work that underpin these:

- Demand and Capacity modelling
- Principles designed to ensure that we maintain a focus on quality and safety
- Clinical risk monitoring and escalation processes
- Clinical Leadership.

3. Key Areas of Focus

Prevention and Case finding

3.1 The key aim is to support our population to stay well and ensure we have proactive care in place for those most at risk.

3.2 Our vaccination programme is central to this in protecting the Sussex population and we are working with partners to optimise the take up of this within eligible populations.

3.3 For the Covid vaccination we are working with across Sussex with network of providers which include 24 local Primary Care Networks (PCN), 107 Community Pharmacies and 3 General Practice Federations to develop and deliver our programme. In Sussex there are 609,706 people eligible for the Covid Booster as of 11th November 2024, 291,285 doses have been administered[1]. In East Sussex 209,830 people are eligible for a Covid Booster, as of 11th November 2024, 93,154 doses have been administered.

3.4 As with previous campaigns we will be working alongside our local public health colleagues, engagement teams and local providers to deliver our targeted access and inequalities programme.

3.5 Flu Vaccination: Sussex has a total eligible cohort of 1,009,239 people. Between 1 September 2024 and 11 November 2024, 470,125 vaccinations have been administered. In East Sussex there are 335,636 eligible people and as of 11th November 2024, 96,195 vaccines have been administered. Flu vaccinations are delivered across a range of providers organisations and settings, including general practice.

3.6 Respiratory Syncytial Virus (RSV) Vaccinations: In August it was announced that the NHS would be rolling out a new vaccination for RSV for all adults turning 75 after 1st September 2024, women who are 28 weeks pregnant or more, and a catch-up programme for adults between 75-79 years. Sussex has a total eligible population of 75-79 years old of 93,612 and in East Sussex the eligible population is 34,812. To date, 28.9% of older adults (27,073) have been vaccinated in Sussex, including 9,127 in East Sussex. Communication promotions are underway, with news stories being shared, films with clinicians, targeted social media and work through community and voluntary groups to share the message.

3.7 ***Case finding*** is the Sussex system proactive approach to identifying those patients most at risk of needing non-elective care or urgent and emergency care over the winter months. We want to better support these people and will focus on:

- Identifying at risk individuals and ensuring a proactive care approach is taken to minimise the risk of a deterioration in their health
- Optimising VCSE support, and reprofiling existing resource to focus on at risk patients
- Ensuring that there are clear alternatives to acute admission and should their health deteriorate.

[1] The Federated Data Platform does not yet show uptake for the full eligible population for AW24 and therefore the data provided will be subject to change.

- Ensuring that we have a clear 7-day support offer for care home in order to reduce the risk of admission for vulnerable residents.

3.8 This is supported by General Practice who are best placed to identify those in most need who can be supported by a multi-disciplinary teams' approach linked to wider voluntary and community sector support offers.

3.9 In East Sussex there are services designed to support this proactive approach including the colocation and joint triage of ASC and Community nurses in Eastbourne, supporting long-term frequent attenders in Hastings, improved Multidisciplinary Teams (MDT) working in Lewes, a hydration project in Rother and clinics in community settings in Wealden.

Same Day Urgent Care

3.10 The approach to improving same day urgent care for the winter period focuses on four key areas to: improving access to same day non-urgent care services; improve flow in the Emergency Departments; improve access to community physical and mental health services; and ensure people are supported by our services out of hospital where possible and appropriate.

3.11 To respond to this we are focusing on:

- Optimising our existing services such as Urgent Treatment Centres to make sure people are seen in a timely way that responds to need
- Increasing capacity in the system by increasing how we use virtual wards to support people and increasing the use of pharmacy services
- Navigating people to the right service and implementing our unscheduled care hubs which will support the utilisation of alternatives to hospital and reduce conveyances to hospital by the ambulance service.

Improving discharge from hospital

3.12 Our aim is to reduce the number of patients in acute, community and mental health beds who are ready to be discharged home or to their onward setting of care. This improves patient outcomes and experience as well as supporting system flow. We have a system wide discharge improvement programme to focus on rapidly reducing the numbers of people waiting for discharge and freeing up bed capacity to support patient flow over the winter months.

3.13 The four workstreams that will support this are:

- Implementation of the SAFER patient flow bundle
- Support to patients to stay active whilst in hospital to minimise any deterioration in their health and well-being
- Optimisation of the Transfer of Care Hubs which are multi-disciplinary hubs focused on getting the right support in place to enable timely discharge
- Development of a needs-based demand and capacity model to help us get the right type of support in place to respond to people's needs.

3.14 In East Sussex, specific work includes the implementation of a control centre to support management of the sites based on live data, and increasing staffing to enable expansion of Respiratory Virtual Wards to a capacity of 66 beds by March 2025. In addition, Home First (Minerva) and therapy resources will be increased to support discharge and patient flow.

4. Workforce and Wellbeing

4.1 As in previous years, maintaining the capacity and resilience of our workforce will be key to the delivery of safe and high-quality services and is an important part of our plan.

4.2 A range of targeted action is in place to help us: manage our temporary workforce; improve our staff wellbeing; increase uptake of vaccinations amongst staff; manage our staff absences; maximise opportunities to share staff; work with our voluntary and community sector; and minimise the risk of the cost of living on staff. This will be regularly monitored throughout the period.

5. Clinical Leadership

5.1 We will ensure effective clinical leadership throughout winter, and we will focus on key metrics that help us understand how the system is performing and any action we may need to take to continue to ensure safe and effective access to care.

6. Public Communication

6.1 A coordinated system wide communications and engagement plan has been developed with system partners to ensure clear communications are in place to support operational delivery over the winter period. This includes global approaches

to key messages for the public, partners, and staff, as well as targeted and focused approaches based on data and insight.

6.2 The plan will bring together activity over the Winter period, covering Flu and Covid-19 vaccinations, preventative advice and support to key audience groups such as respiratory advice for children and young people and urgent and emergency care pathway information.

6.3 Our communications plans will focus on addressing health inequalities, and insight will shape communications activity and ensure that work considers the whole population.

7. Sound Operational Management and Governance and Oversight

7.1 Our objective is to ensure that the Sussex system has robust operational management in place with clear coordination across the system and rapid routes for escalation where required.

7.2 The following systems and processes are in place to support this objective:

System Co-ordination Centre (SCC)
a dedicated operational team who provides support interventions across the ICS on key systemic issues that influence patient flow.
Winter Standard Operating Model
seven days a week capability to monitor and respond to operational pressures in the system.
ICB Rapid improvement approach
a multi-disciplinary team that can respond in an agile way to emerging pressures.
Protect the delivery of elective care, cancer and diagnostic services
system capacity will be prioritised for the effective operational management of elective care throughout winter.

7.3 We have clear governance for overseeing delivery of the winter plan, with clear routes to escalation where needed. This includes clear roles and responsibilities; clear reporting; implementation of national escalation frameworks; and clear underpinning policies in place.

8. Individual organisational plans

8.1 Underpinning the overarching Sussex system winter plan, each of our provider Trusts have developed their own winter plans and have contributed to the system wide demand and capacity modelling.

8.2 These ensure a specific focus on ensuring the right capacity is in place, the right processes are in place to support timey care and good patient flow, the use of all extra capacity and schemes in place are maximised and robust infection prevention and control measures are maintained.

8.3 Local authorities play a role in many of the initiatives that are developed to support winter and as in previous years, our approach to planning has been in collaboration across all organisations Sussex wide, and with a focus on each place, including East Sussex. In addition to work focusing directly on supporting the plan, work is underway to consider any further action that could be taken to support people living in or at risk of deprivation.

9. Conclusion

9.1 The approach to the Winter Plan will enable us to focus on the action we need to take to maximise support for people this winter focusing on particular initiatives that will help keep people well; avoid unnecessary hospital admission; and ensure access to safe services for local people. The plan was approved by the NHS Sussex Integrated Care Board on 27 November 2024 and will be closely monitored over the winter as part of a whole system approach.

Sussex Health&Care

Sussex Winter Plan

November 2024 - March 2025

Improving Lives Together

Winter plan 24/25 - Overview

As set out in NHSE's letter of 16 September, demand is running above expected levels as we approach winter and operational performance is challenged in a range of areas. Consequently, the key focusses for this winter need to be on supporting people to stay well and maintaining patient safety and experience.

In order to achieve this we have developed a Winter plan focussed around 5 key pillars:

Prevention and case finding

Same day urgent care

Improvements in discharge to support patient flow

Sound operational management

Oversight, governance and escalation

Winter plan 24/25 - Overview

This pack sets out at a high level, the key elements which underpin each of these 5 areas. The approach to Winter 24/25 in Sussex builds on learning from previous years and intends to ensure a robust framework for system oversight with a focus on the key actions all system partners are taking to deliver continued access to safe services.

Clinical leadership and a focus on maintaining quality and safety is at the heart of this plan, along with a focus on protecting the most vulnerable in our communities and ensuring we maintain access to urgent care. The plans aim to build on and strengthen existing programmes of work, and wherever possible to link into the longer term aims of our agreed system strategy.

Principles and risk measures

Underpinning the plan are a series of principles designed to ensure that we maintain a focus on quality and safety over the period.

- **Maintaining the quality and safety of services is the primary objective of all system partners**
- **System partners will work together to ensure timely access to services for the entire population, supported by a clinical risk-based focus at times of surge in demand**
- **We will prioritise the most vulnerable and at risk**
- **System resources will be targeted in the areas where we will get greatest impact or in the areas of greatest need**
- **We will protect the wellbeing of our workforce**
- **System partners will work together to balance clinical risk**
- **Our clinical leaders will be at the heart of decision making throughout the winter period.**

To support decision making over the winter period we will focus on a small number of measures which will act as a proxy for clinical risk as follows:

- **% of patients waiting over 12 hrs from arrival in an emergency department**
- **Number of patients being cared for in a corridor**
- **Category 1 and 2 response times**
- **Number of mental health patients waiting for admission into an inpatient bed**
- **Number of patients classified as NCTR**

These are supported by a wider winter dashboard with a concise range of operational and performance measures to enable clear clinically-led decision making in support of our patient population.

The challenge for this winter

- Modelling undertaken by the NHS Sussex BI team indicates that based on current bed occupancy and a series of demand assumptions (demand uplift for respiratory and non-respiratory conditions, predicted impact of COVID, Flu and RSV etc), a reasonable worst case scenario results in a predicted **starting gap of 164 beds** in the Sussex System in the first week of January 2025 (winter peak). A key aim of the winter plan is to mitigate this bed gap and ensure that there is sufficient capacity available throughout the winter to support flow and the safe delivery of services. The following sections of the plan, focussed around the 5 pillars, set out the pan system actions being taken to help mitigate this bed gap and support the effective use of resources to meet demand.

- The actions described in this plan are supplemented by the actions being taken by individual providers. A high level overview of the organisation level plans for each of our Providers is set out in the appendix. The System BI team have quantified the impact of the actions articulated both within this system-wide plan and the provider plans in order to provide assurance over our collective ability to close the bed gap. Actions quantified to date have reduced the gap to **6**. However, the impact of risk stratification and proactive care, as set out under Pillar 1 of this plan has not yet been quantified. Once patient cohorts have been identified further work will be undertaken and this is expected to bridge the remaining gap.

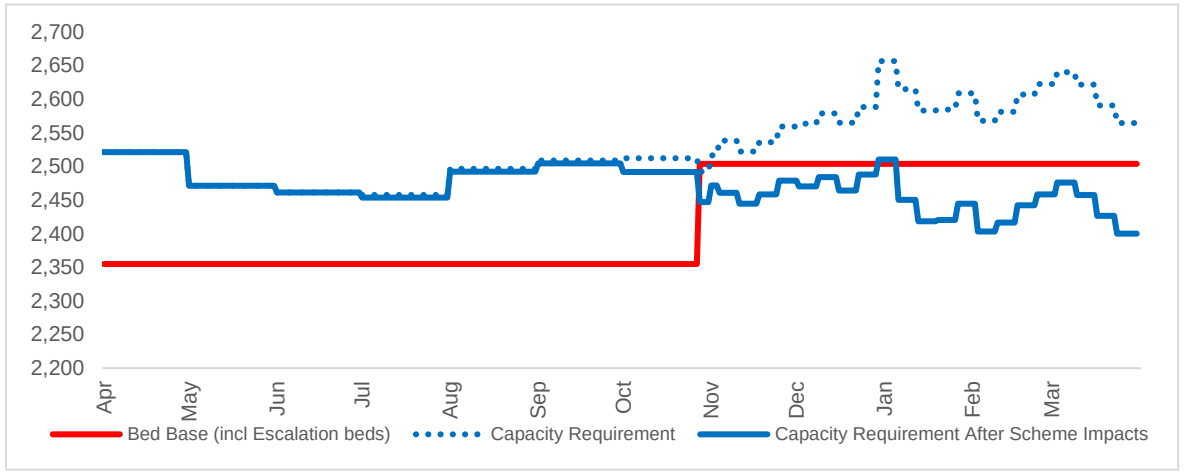
	Sussex
	w/c 06 Jan
Bed Base (starting position)	**2,504**
Starting Capacity Requirement	**2,657**
Starting Gap to Capacity Requirement	**164**
(a) Discharge Plan	**-120**
Amended Gap	**45**
(b) UEC and Frailty Demand Reduction Plans	**-28**
Amended Gap	**17**
(c) Local Place based plans	**-11**
Amended Gap	**6**
(d) Planned Care Stoppages	**0**
Amended Gap	**6**

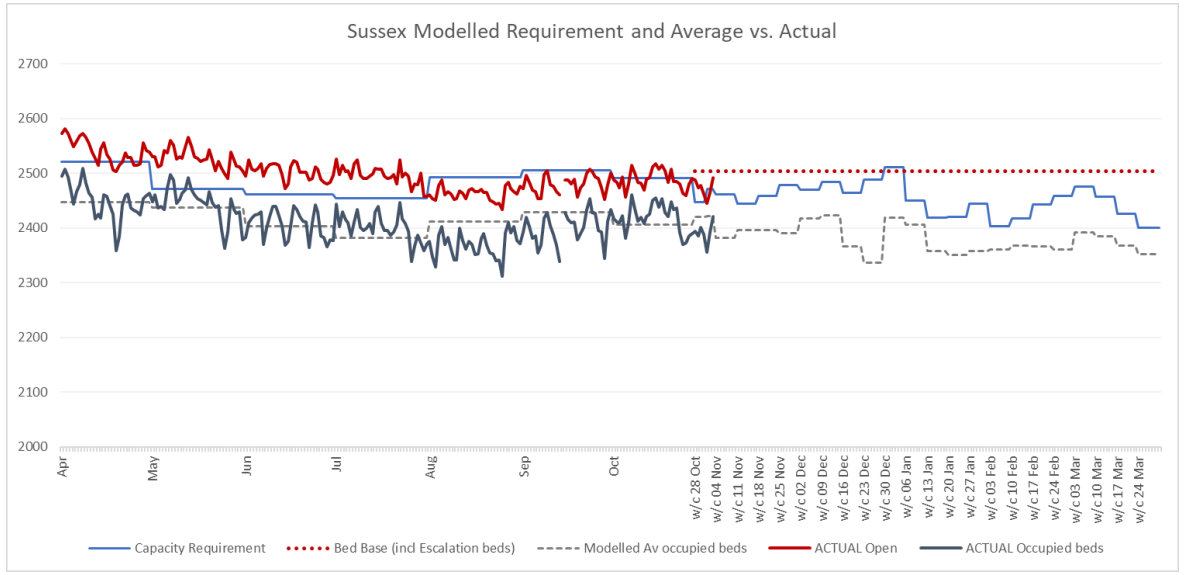
The challenge for this winter

- Acute Bed Pressure is projected to rise from November to a peak in the first week of January and then again in mid march
- These times are expected to remain pressure points in the system and present a greater risk of quality issues
- However with mitigations applied and escalation capacity open there should be sufficient capacity to support the 95th centile of demand

- With mitigations applied the model projects an average Acute bed occupancy of 94%

- As of 5th November, the actual beds occupied is matching close the modelled average





Bridging the Gap

The below schemes have been quantified in terms of the expected impact on performance over the winter period:

- Following the SAFER bundle
- Supporting patients to stay active whilst in hospital
- Dementia pathway/ Development of a defined protocol for early escalation of complex patients
- UEC Navigation Hubs
- Virtual Wards Capacity and Utilisation Increase
- UCR Activity increase
- Additional BCF schemes West
- Additional BCF schemes East
- Additional BCF schemes Brighton
- Provider internal schemes

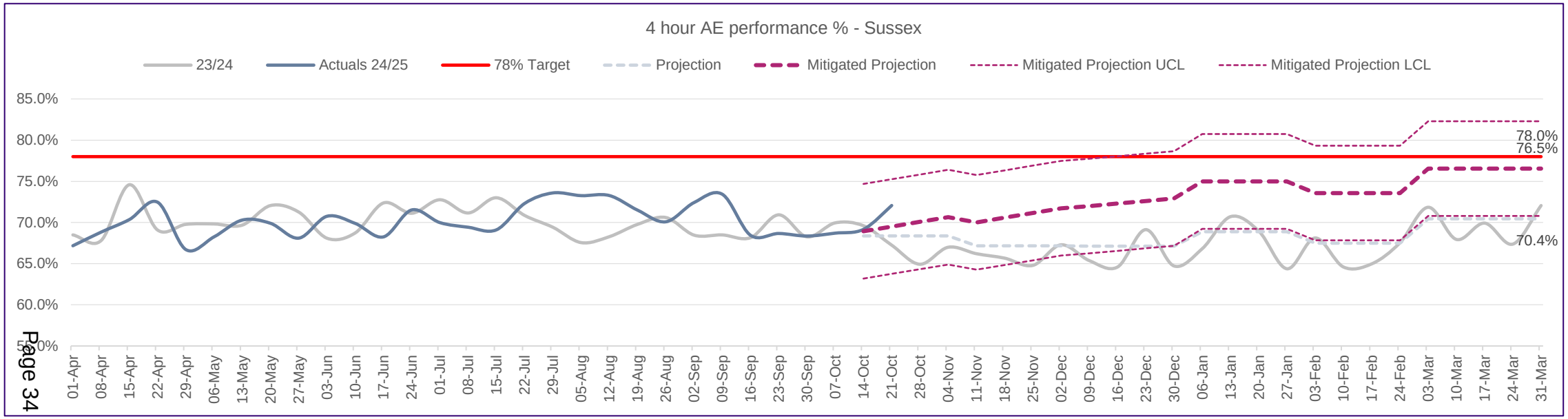
Measure	Projection Mar-25	Target	Gap
A&E 4-hour	76.50%	78.00%	1.5 p.p
12 Hours in dept.	2.20%	0	-2.2 p.p
Average LoS	8.7	8.3	0.4
NCTR	780	726	54

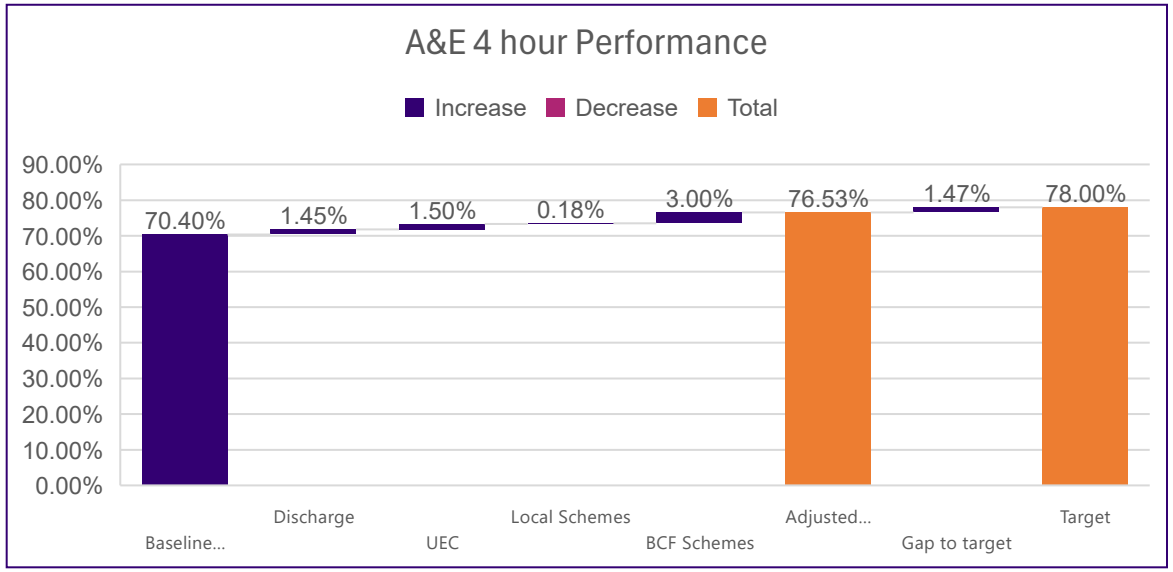
The modelled impact has been applied to the baseline trajectories for the following metrics:

- A&E 4 hour performance
- 12 hour in department
- Average Length of Stay
- No criteria to reside

A small gap remains for each of the metrics – see table to the right. However, the impact of risk stratification and proactive care, as set out under Pillar 1 of this plan has not yet been quantified. Once patient cohorts have been identified further work will be undertaken to understand the extent to which this programme of work will bridge the remaining gap. The following slides set out in more detail the revised trajectories for each measure.

Bridging the Gap – A&E 4 Hour





Projection Mar-25	76.5%
Target	78.0%
Gap	1.5%

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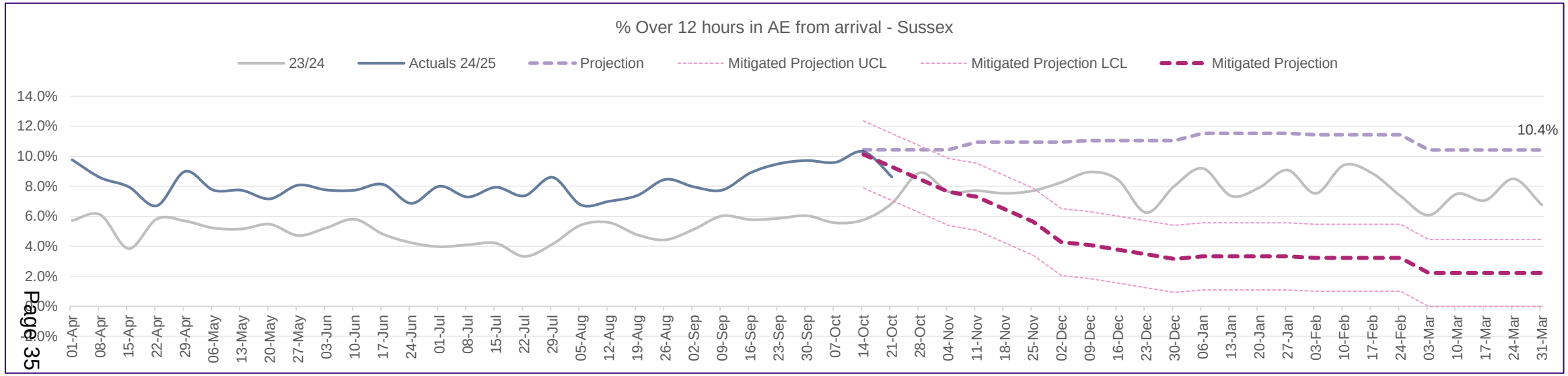
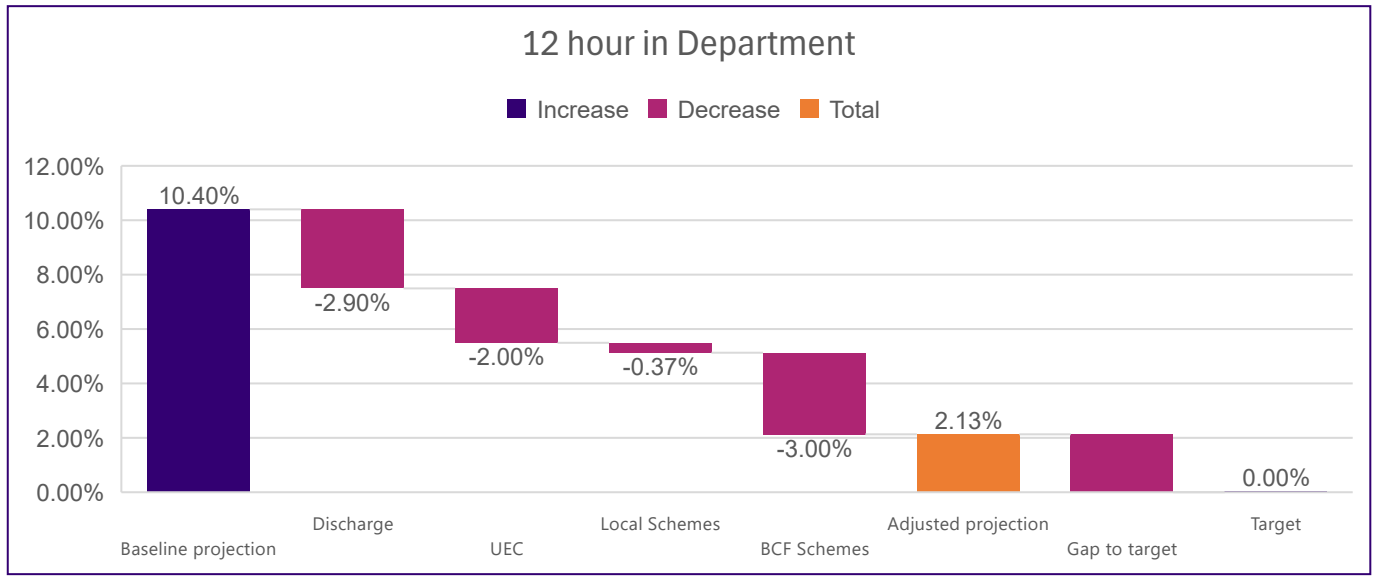
Bridging the Gap – 12 Hour in department

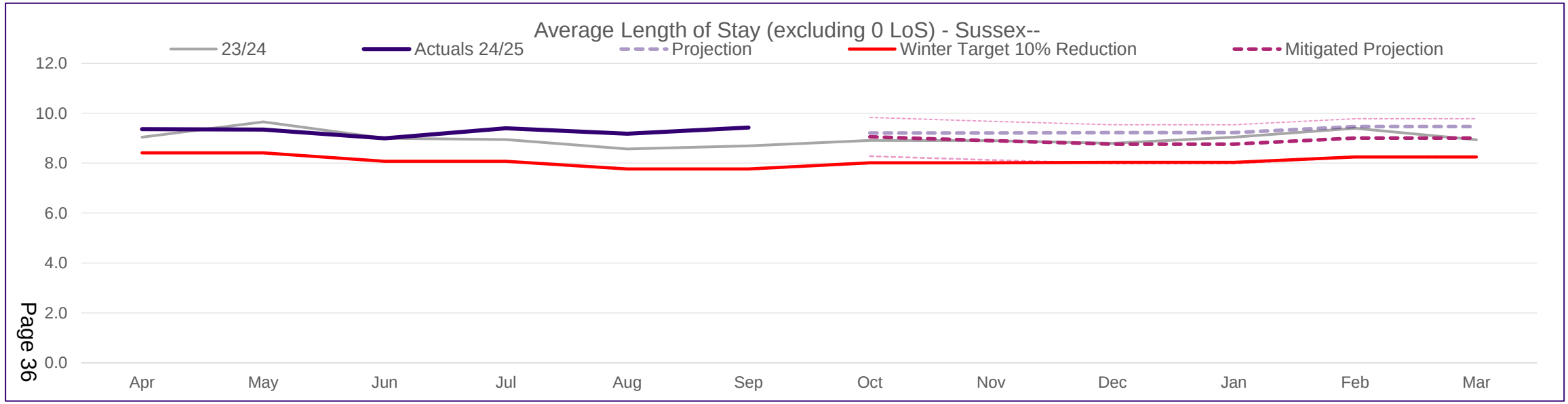


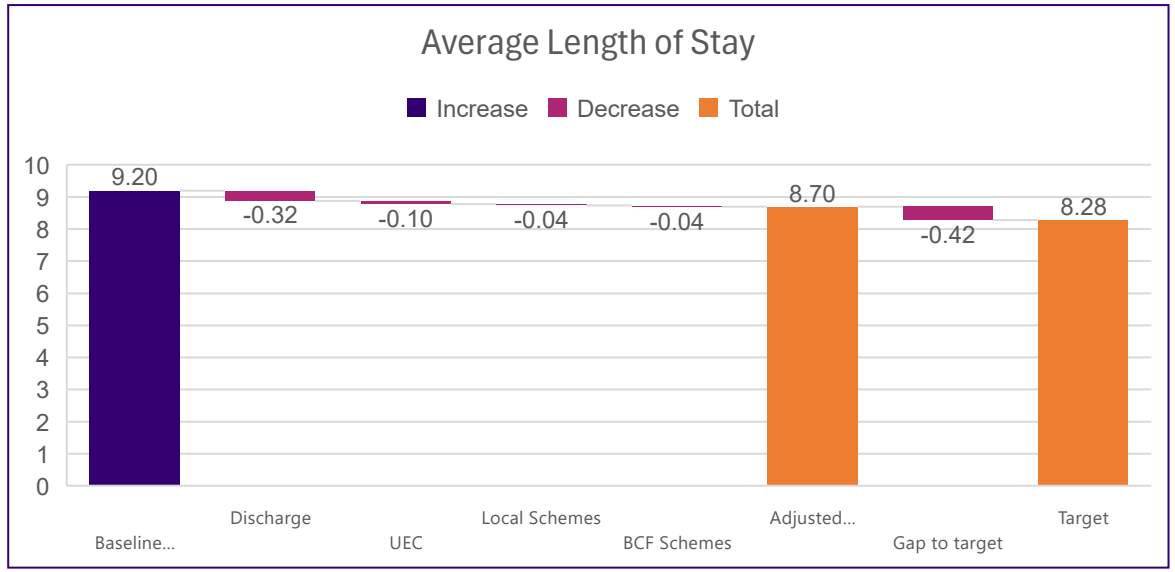


Projection Mar-25	2.2%
Target	0
Gap	-2.2%

Improving Lives Together

Bridging the Gap – Average LOS





Mar-24	9.2
Projection Mar-25	8.7
Target	8.3
Gap	0.4

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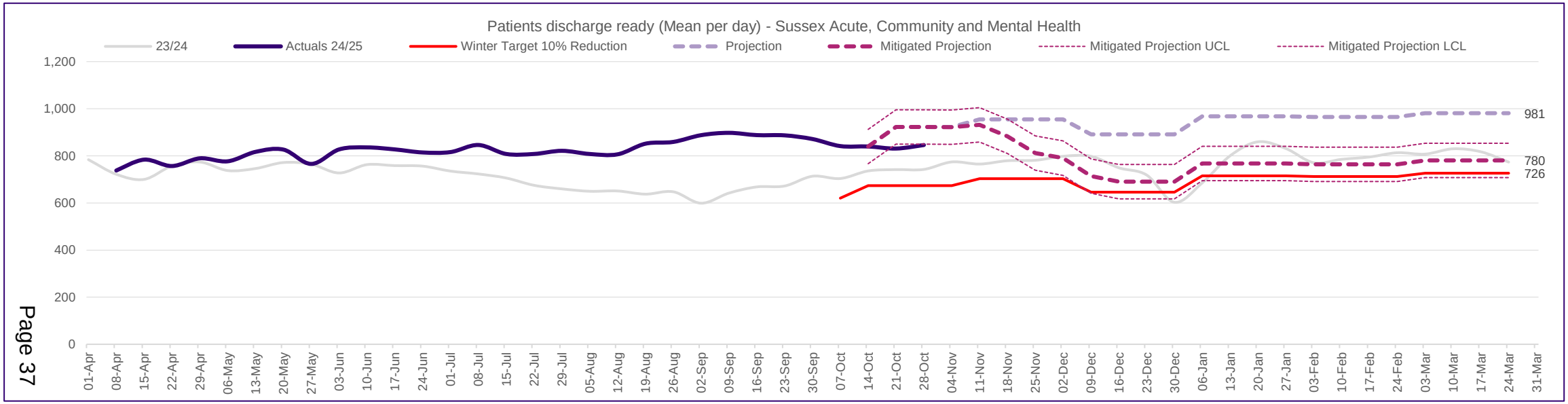
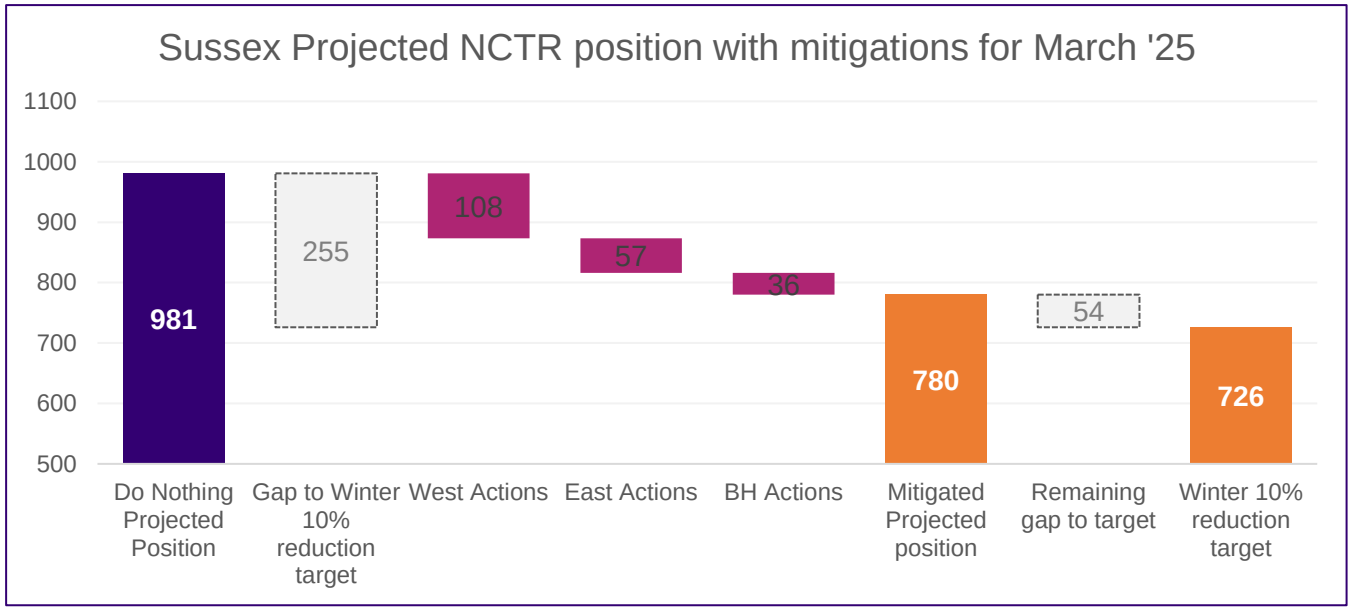
Bridging the Gap – NCTR





Projection Mar-25	780
Target	726
Gap	54

Improving Lives Together

Workforce and Wellbeing

In addition to ensuring bed capacity challenges are mitigated, maintaining the capacity and resilience of our workforce will be key to the delivery of safe and high-quality services over the course of winter.

All providers are taking action to address these key aims.

Our aims:

1. Manage our temporary workforce
2. Improve our staff wellbeing
3. Increase uptake of vaccinations amongst staff
4. Manage our staff absences
5. Maximise opportunities to share staff
6. Work with VCSE to support workforce gap

The achievement of these aims is supported by the delivery of detailed plans (which can be provided on request) which will be overseen by the pan system Chief People Officer Group

Pillar 1 Prevention and Case Finding

Prevention and Case Finding

Objective – support our population to stay well and ensure we have proactive care in place for those most at risk

- Vaccination programme (Flu, COVID, RSV)
- Case finding
- ICT proactive care approach
- Place level plans
- Comms and engagement

Vaccination

Vaccination Programme

Vaccination is a key element of protecting our population. Maximising uptake of COVID, Flu and RSV vaccinations is a priority for our system

COVID vaccination

On 15th August the Joint Committee of Vaccinations and Immunisations (JCVI) advised that the groups to be offered a COVID-19 vaccine in autumn/winter 2024/25 are:

- **residents in care homes for older adults**
- **all adults aged 65 years and over**
- **persons aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the UK Health Security Agency (UKHSA) Green Book on immunisation against infectious disease.**

Across Sussex we are working with a network of Providers, which include 24 local Primary Care Networks (PCN), 107 Community Pharmacies and 3 General Practice Federations to develop and deliver our Covid-19 vaccination programme to all those eligible for a vaccine. As with previous campaigns we will be working alongside our local public health colleagues, engagement teams and local providers to deliver our targeted access and inequalities programme.

Vaccination Programme

COVID vaccination

There are 721,483 people eligible for an AW24 Covid-19 vaccination This includes 504 eligible care homes, with 15,880 eligible residents.

The AW24 Covid-19 delivery model addresses Sussex's population and geographical diversity which includes facilitating access in areas of deprivation and low uptake, rural population needs and addressing health inequalities across each place. Preparation for AW24 has been supported by four 'inter-seasonal' communication and engagement Access and Inequalities projects – two in West Sussex, one in East Sussex and one in Brighton & Hove running until the end of September

Using available Access and Inequalities funding, vaccination access will be supplemented by additional mobile vaccination units, temporary sites and localised community outreach, and targeted communications and engagement. As with previous campaigns we are working alongside our local public health colleagues, engagement teams and local providers to deliver our targeted access and inequalities programme. We also ensure that we work with our providers, NHS England, and local partners to monitor data and address any trends in lower uptake – targeting outreach activities where this is identified

Weekly webinars lead by the Sussex ICB Vaccinations Team take place to share key messages with our Primary Care Provider colleagues, this includes uptake rates and areas of focus.

Communications and engagement is underway, in line with the national campaign, to promote key messages and encouragement to increase uptake. The activity is taking two core approaches – overarching Sussex promotion and hyper local targeted communications to reach specific communities geographically and demographically.

Since the start of the programme on 3rd October there have been 274,901 vaccinations given. As part of the winter plan we are aiming to achieve 58% coverage of the eligible population.

Vaccination Programme

Flu vaccination

As with previous programmes, Flu vaccinations are delivered across a range of provider organisations and settings including general practice, community pharmacy, community provider organisations and local hospital trusts. All GP practices in Sussex are signed up to offer flu vaccinations in Sussex.

Sussex has a total eligible cohort of 1,009,368 people. Between 1 September 2024 and 13 November 2024, 455,246 vaccinations have been administered. This data has been taken from the Federated Data Platform

The Sussex vaccination team links closely with the Regional NHS E Screening and Immunisation Team to monitor performance and address any specific areas of focus to ensure vaccination plans are targeted to enhance uptake.

Sussex Community NHS Foundation Trust (SCFT) is commissioned by NHSE to provide the schools vaccination programme. In preparation of the start of term, a programme of visits was coordinated with schools from reception to year 11, so that these could be mobilised from the start of the new school year.

Communications and engagement is underway in line with COVID-19 vaccination promotion, working closely with local authorities and wider system partners.

As part of the winter plan we are aiming to achieve the national ambition which is to improve on our uptake from 2023/24 by 5% across all eligible cohorts.

Vaccination Programme

RSV vaccination

On 22 August it was announced that from the beginning of September the NHS would be rolling out a new vaccination for Respiratory Syncytial Virus (RSV). From 1 September, all adults turning 75 were invited to get their vaccination from their GP Practice and will remain eligible until the day before their 80th birthday. A one off catch up campaign also launched on 1st September for those already aged 75-79 years old with the aim of vaccinating at the earliest opportunity but completing the majority by 31 August 2025.

Women who are 28 weeks pregnant or more are also eligible for a vaccination.

Sussex has a total eligible older adult population (75-79) of 93,579. Since the start of the programme on 1 September we have vaccinated 23,388 (30%) of our population for the older adult element of the programme. Significant work is underway to increase this uptake to include:

- Clear messages disseminated to a wide audience through the GP Webinar which outlined the RSV programme approach and need to vaccinate eligible cohorts before Winter
    - Targeted engagement with practices that have been identified as having delivered 0-20 vaccinations (as agreed with NHSE regional team)
- Further target to those practices with a lower uptake rate than the regional average of 24% to address any issues or concerns and discuss ways in which to increase uptake
- Gaining wider insight in terms of barriers to RSV roll out through our networks including practice managers and clinical leads
- Daily data review to continue to monitor and enhance performance with all 156 practices.

Communication promotion is underway, with news stories being shared, films with clinicians, targeted social media promotion, and work through community and voluntary groups to amplify and further share messages. Hyper local social media and community promotion is being developed in line with the latest uptake data.

Since the start of the programme on RSV there have been 28,388 vaccinations given to older adults and 1809 given to pregnant women. As part of the winter plan we are aiming to achieve as great an uptake as possible. There are currently no nationally set uptake targets.

Case finding and proactive care

Case finding

Case finding is our approach to identifying those patients most at risk of needing non-elective care or urgent and emergency care over the winter months and ensuring that we are taking a proactive approach to their care. This will require join up between primary care, community service providers and the VCSE and has the potential to fast track the development of ICT's through a focus on some of the most vulnerable in our population

The approach we will be taking this winter includes focusing on 4 key areas:

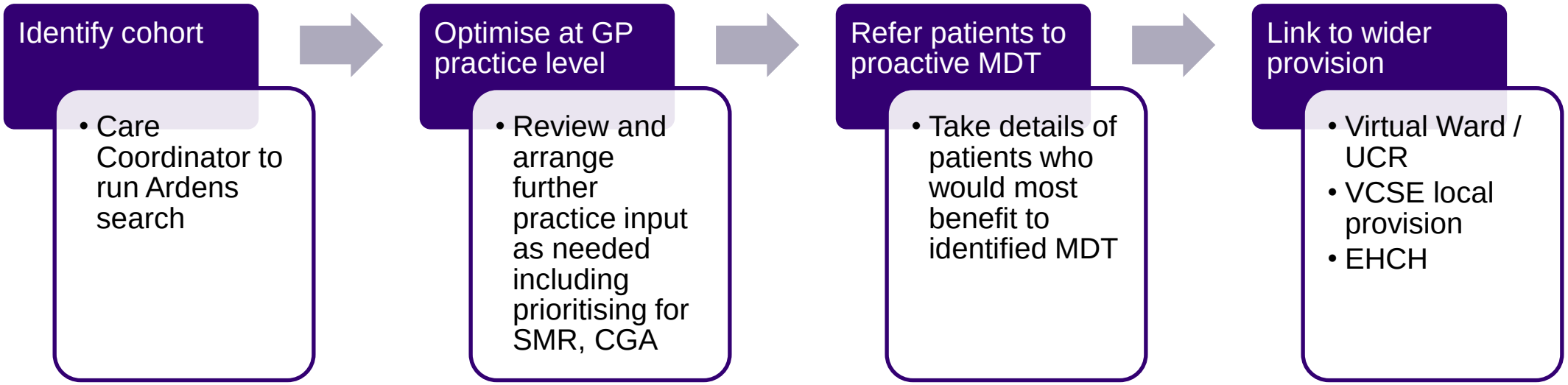
- Identifying at risk individuals at practice level, prioritising for optimisation and working with proactive teams to ensure the right support is in place to avoid admission
- Optimising Voluntary and Community Sector support, reprofiling existing resource to focus on at risk patients
- Ensuring that there are clear alternatives to acute admission should their health deteriorate.
- Ensuring that we have a clear 7 day support offer for care homes in order to reduce the risk of admission for vulnerable residents.

General Practice will identify patients most at risk of unscheduled admission patients through a standardised search tool :

- Patient lists will be provided compiled to the named Practice lead
- GPs will review patient list and optimise patients care by taking action which could involve:
    - Identifying patients who require a co-ordinated MDT proactive approach for patients requiring additional health and care.
    - Optimising medications (including up to date rescue packs for respiratory patients)
    - Optimise and expand community support offer, including through Community Prescribers and the VCSE (for example increasing referrals to British Red Cross and expansion and scale of mobility volunteer role)

Proposed approach

A standardised approach that is tailored to local assets



Monitoring of numbers identified, actions taken and outcomes to show impact

ICT proactive care approach

Alongside a pan system case finding approach, this winter we will also use the 13 areas as an organising unit to prepare for offering proactive care for people with highest needs, by working differently using currently commissioned services this winter. This will be led through our primary and community provider collaboratives in partnership with relevant system partners.

Examples of the Tests of Change agreed to date include:

- **Brighton and Hove West** – Multi-Disciplinary Team frail elderly pilot
- **Brighton and Hove East and Central** – Development of an East Health Hub
- **Eastbourne** – Colocation and joint triage of ASC and Community nurses
- **Hastings** – Support to long term frequent attenders
- **Lewes** – Improved MDT working to better support those most at risk
- **Rother** – Hydration project to reduce the risk of a deterioration in the Health of the most vulnerable
- **Wealden** – Clinics in community settings, bringing care closer to those most at risk
- **Horsham** – Identifying those at risk to better align proactive care (linking fallers with Low income family tracker)
- **Crawley** – Development of proactive care services
- **Worthing** –Development of Proactive care services
- **Adur** – Increased support for care homes

Place level plans

Place level plans

Alongside the work in our ICT's significant work is underway at place level to ensure that services are in place to support the most vulnerable this winter. Partners in Brighton and Hove, East Sussex and West Sussex are putting in place a range of interventions locally focussed in the following areas:

- Developing user friendly directories of local services
- Supporting the most at risk, building on the approach to supporting shielding cohorts developed during the pandemic, including home 'safe and well'' visits and the use of home visiting paramedics offering proactive care
- Developing severe weather plans to support the homeless, alongside schemes such as fuel poverty coordinators in West Sussex
- Support for Carers, in particular in relation to end of life care
- Sussex wide support for those with multiple compound needs.

Communications and Engagement

Communications and engagement approach

Supporting people to stay well

It is recognised that clear communications and engagement can have a positive impact on prevention and how people access help and care over the winter period. A coordinated communication approach has been developed across the system focused on two key areas:

Helping you this winter – a focus to share assurance that plans, services and systems are in place and how partners are working together to ensure that patients get the care they need over the winter period.

Help us help you – promotion of key information, advice and public health messaging:

Help us help you stay well this winter

- **Help Us Help You: Make the Right Choice** – including signposting to local services, encourage positive use of appropriate services, heavy promotion of Pharmacy First, promote services for children and young people with respiratory conditions, repeat prescriptions, and mental health advice and support.
- **Help Us Help You: Stay Warm and Well** – including information to look after yourself and others to stay well over winter, including information provided by local authorities focused on heating and community support.
- **Help Us Help You: Stay protected** – a focus on vaccination to encourage uptake for Covid, Flu and RSV. This covers the public and staff.

Communications and engagement approach

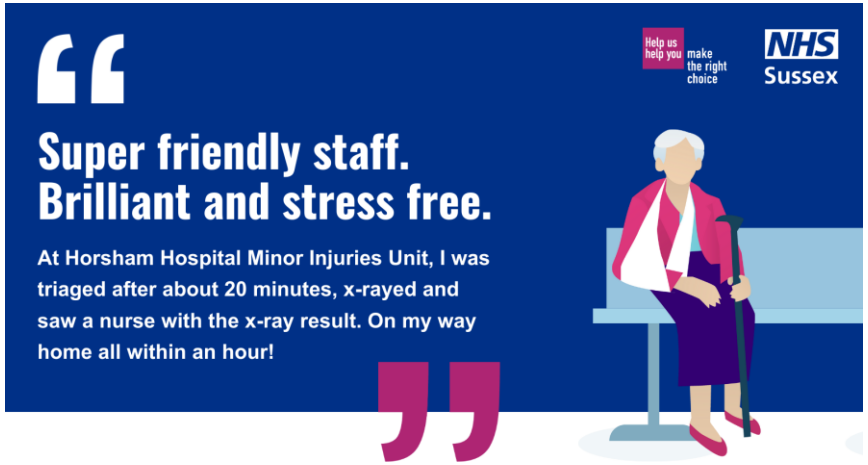
Supporting people to stay well

System coordination

- This approach will be overseen by the Sussex System Communications Leaders' Group and coordinated through the Sussex Communications Cell.
- It also links and aligns with the regional NHS England communication team and partner systems the Regional Communications Strategic Delivery and Planning Group. This includes assurance of the communication approach at system level.
- It will also ensure it is flexible and adapts to specific pressures that may be seen during the winter period, with close links with the NHS Sussex System Co-ordination Centre.

Catch coughs and sneezes and wash hands regularly to stop the spread of winter viruses.

Help us help you stay well this winter



Improving Lives Together

Pillar 2
Same day urgent care

Same Day Urgent Care

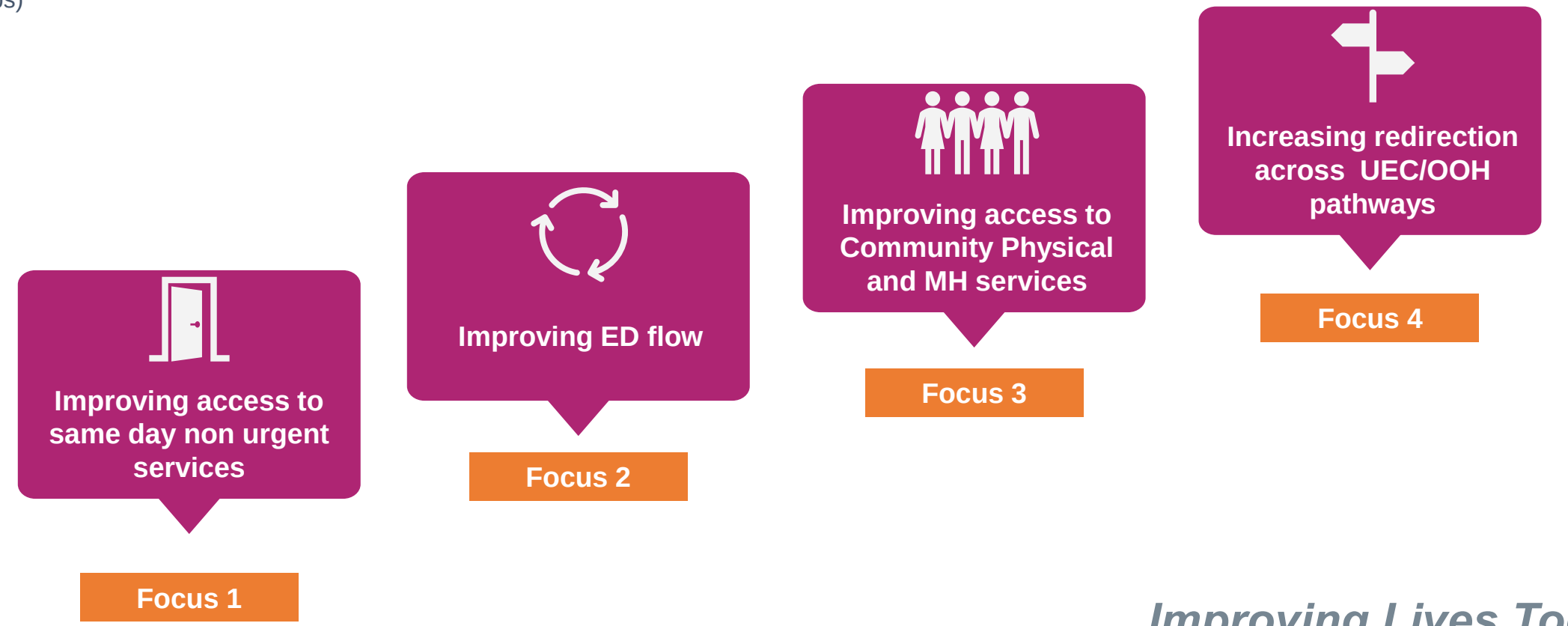
Objective: Ensure patients receive rapid access to the service which best meets their needs

- Improving access to same day non urgent services
- Improving Emergency Department flow
- Improving access to community physical and mental health services
- Improving redirection to ensure patients are seen by the most appropriate service for their needs.

Same Day Urgent Care

The approach to improving same day urgent care for Winter 24/25 focuses on 4 key areas as set out below.

These were identified as key areas of constraint through detailed analytical work undertaken in July. The following slides set out the key programmes of work being mobilised with system partners in each area and what we are aiming to achieve by when. Work is underway to quantify the expected impact of each of these interventions. Actions focus in 3 areas (1) optimising existing services (UTCs, SDEC etc), (2) increasing capacity in the system (for example virtual wards, pharmacy first), (3) redirecting patients into the right service to relieve pressure on Emergency Departments (unscheduled care hubs)



Improving Lives Together

Improving access to same day non urgent services

Our aims

1. Implement a quality improvement programme to address unwarranted variation in General Practice
2. Maximise Pharmacy First capacity and embed as a simple pathway option for patients and referrers
3. Support patients to access the right service for their needs through improved utilisation of 111, increasing clear alternatives to Emergency Departments

Our aims in detail:

Aim	October 2024	March 2025	March 2026
Implement a quality improvement programme to address unwarranted variation in General Practice	• Develop a quality improvement dashboard based on PCN footprints to bring together measures to inform PCNs and practices on their performance. • Metrics to be confirmed through the establishment of a clinically led Task and Finish Group. • Design Quality Improvement programme with Practices and PCNs, including data packs, Quality Improvement support and protected time for teams.	• Assess metrics to identify priority areas for further improvement. • Evaluation of Phase one of the quality improvement programme and finalise outcome report.	Evaluate programme to inform forward plan.
Maximise Pharmacy First capacity and embed as a simple pathway option for patients and referrers	• National roll out of digital enablers allowing community pharmacy to access GP records and transmit Pharmacy First consultation directly into the GP record (awaiting NHSE confirmation). • Evaluate effectiveness of UHSx pharmacy first standard operating process (in development) and share learning across Sussex. • Development of performance dashboard to drive insight. • Identify ten practice outliers as part of a phase 1 quality improvement plan and deploy PCN Community Pharmacy leads to support increased referrals from General Practice.	• Achieve 9,280 referrals per month. • Implement a communications plan to increase population understanding of the service. • Implement monitoring and evaluation to include cost, activity, capacity, sustainability, behavioural change.	Evaluate as part of pathway and iterate plans to optimise usage.
Support patients to access the right service for their needs through improved utilisation of 111, increasing clear alternatives to Emergency Departments.	• Review the DOS to test alignment to available capacity • Review capacity constraints which result in capacity not being available for redirection (time and frequency of services going red). • Promote 111 further to increase utilisation both telephone and online resource.	• Assess the benefits of a mobile application designed to assist patients seeking urgent minor care by providing real-time waiting time information and routing guidance.	Evaluate impact of actions and reassess DOS alignment.

Improving Emergency department flow

Our aims

1. Implement consistent model of GP led front door at Emergency Departments (through true Urgent Treatment Centre front door)
2. Optimise Urgent Treatment Centre services
3. Standardise Same Day Emergency Care services and acute assessment services, in line with best practice.
4. Improve in hospital management of frailty

Aim	October 2024	March 2025	March 2026
Implement consistent model of GP led front door at ED's (through true UTC front door), standalone UTCs and MIUs, aligned to wider primary care capacity and Integrated Care Teams	• Ensure GP streaming in place with GPs with an understanding of the local area supported by administrative and management links to practices in the area. • First sites to include St. Richards, Princess Royal, and Eastbourne District General Hospitals, working with commissioned services.	• Link to wider primary care capacity including surge, enable cross directional booking and use of risk stratification. information for pilot practices	Roll out of cross directional booking, link to wider ICT provision including Virtual Ward Potential procurement of overall model.
Optimise UTC services	• Analyse activity date to determine optimum operating hours. • Strengthen current Sussex UTC/Front door Emergency Department models to ensure they are truly GP led and that collocated UTCs are acting as the front door to Emergency Departments. • Develop options for standard models of UTC based on national standards.	• Conduct evaluations and optimise processes based on initial implementation results. • Standardise the UTC model and ensure ability to flex UTC resources to meet surge demands.	Achieve consistent, efficient UTC service delivery across Sussex, with sufficient capacity to meet demand and deliver 4 hour performance in line with the constitutional standard across all co-located and non-co-located UTCs.
Standardise SDEC services and acute assessment services, in line with best practice.	• Strengthen and optimise current SDEC and acute assessment units and associated pathways across providers. • Ringfence SDEC and assessment units for their intended purpose and patient cohort, ensuring areas are designed and designated to meet need.	• Benchmark services against best practice guidance and address gaps and/or sub-optimal pathways. • Maximise direct access opportunities to further reduce the volume of patients passing through Emergency Departments.	Evaluate to ensure full adherence to standardised protocols, with ongoing performance monitoring and continuous improvement initiatives.
Improve in hospital management of frailty	• Optimise current acute frailty services and ensure each provider has a clear approach to managing frailty, with rapid assessment and clear pathways both to avoid admission and to proactively support patients with frailty should an inpatient stay be necessary.	• Address gaps in current in hospital frailty service provision to align with national best practice.	Develop a seamless interface between in hospital and out of hospital frailty services, with outreach from secondary care frailty specialists providing advice and guidance, and early intervention in order to reduce the number of avoidable admissions

Improving access to community physical and mental health services

Our aims

1. Increase capacity of Virtual Wards to 250 and attain a balance of admission avoidance and discharge support
2. Optimise the Urgent Community Response
3. Improve management of frailty in the community
4. Improve the urgent care pathway for mental health

Aim	October 2024	March 2025	March 2026
Increase capacity of Virtual Wards to 250 and attain a balance of admission avoidance and discharge support	• Trial step up of patients with long term conditions with a view to admission avoidance. • Integrate the model with the Urgent care Co-ordination hubs. • Model opportunity for patients with long term conditions based on national and regional evidence. • 239 beds in place.	• Evaluate the model and the clinical and financial cost benefits. • Evaluate use of the new remote monitoring system against capability and connectivity across the clinical pathway with primary care to enable wider admission avoidance 'step up' opportunities.	Build on capabilities for wider admission avoidance pathways and capacity including remote monitoring and co-ordination of interventions to support Care Home residents.
	• Data analysis of GP practices with highest admission rates to Emergency Departments for patients with Long Term Conditions	• Test clinical pathway with GP practices with highest opportunity to support admission avoidance of cases with long term condition via Virtual Wards.	Evaluate programme to iterate improvement plan.
	• Develop clinical Pathway for palliative care for Virtual Wards	• Evaluate clinical and financial cost benefits of delivering a palliative end of life care Virtual Ward • Align evaluation with plans for PEoLC care co-ordination functions to optimise remote monitoring	Evaluate programme to iterate improvement plan
Optimise the Urgent Community Response	• Increase the volume of Cat 3 and Cat 4 activity pulled from the SECAMB stack.	• Establish an integrated urgent care pathway between the ambulance, community and acute providers to enable a flexible and seamless approach to inpatient, virtual ward and urgent community response services.	Integrate pathway into the ICT footprints to maximise localised responsive support.
Improve management of frailty in the community	• Baseline current out of hospital frailty services and optimise current services ahead of the winter, ensuring strong links with primary care and secondary care services	• Address gaps in current in out of hospital frailty service provision in order to align with national best practice	Develop a seamless interface between in hospital and out of hospital frailty services, with outreach from secondary care frailty specialists providing advice and guidance, and early intervention in order to reduce the number of avoidable admissions.
Improve the urgent care MH pathway mental health	• Utilise the MenSat tool to identify any gaps in commissioned out of hospital services and agree priorities for development • Review the in-hospital pathway and agree clinically led optimum approach.	• Design and implement alternative to the current observation unit at the Brighton site.	Evaluate impact of the wider urgent and emergency care programme for mental health and the benefits of the specific actions in this plan to inform further improvements.

Increasing redirection across Urgent and Emergency Care and out of hospital pathways.

Our aims

1. Support utilisation of alternatives to hospital and reduce conveyances to hospital by 15% each year by developing and embedding Integrated Care Co-ordination hubs across Sussex, aligned to core urgent and emergency care model

2. Identify gaps in service provision to support full alternatives to Emergency Departments

Aim	October 2024	March 2025	March 2026
Support utilisation of alternatives to hospital and reduce conveyances to hospital by 15% each year by developing and embedding Integrated Care Co-ordination hubs across Sussex, aligned to core urgent and emergency care model	• Implement two integrated care coordination hubs, with a single point of access, one within the ESHT footprint and one within the UHSX footprint to test proof of concept.	• Evaluate to ensure a focus on paramedic access to clinical advice to support alternative pathways to Emergency Departments and test reduction in conveyance. • Implement a third hub in the West (SASH). • Test concept of incorporating SPOA into Care Co-ordination hubs to deliver a true single point of access for health and care advice for clinicians and care homes across the system.	Model fully integrated into wider model including clear pathways enabling access to whole pathway including general practice, same day urgent care, 111 and, with ambulance crews being supported to embed 'call before convey'. Evaluate effectiveness to determine whether there is benefit in further expansions of hubs.
Identify gaps in service provision to support full alternatives to Emergency Departments	• Joint analysis of the current conveyance data with SECAMB to understand where there may be service gaps.	• Realign existing resource where opportunities exist to address gaps in current provision, with a focus on matching capacity to demand.	Look to align alternatives to Emergency Department with a consistent model of out of hospital care as part of the South East regional ambulance programme.

Pillar 3 Improvements in discharge to support patient flow

Improvements in discharge to support patient flow

Objective – reduce the number of patients who reside in acute, community and mental health beds in order to improve patient experience, outcomes and system flow

Improvement to discharge

Across Sussex we continue to see a high number of patients remaining in inpatient beds despite being defined as either Not Meeting Criteria To Reside (NCTR) or are Clinically Ready for Discharge (CRFD). As at 23 September we had 884 people residing in beds across the system who had no clinical need to do so.

There are a range of reasons for why discharge is delayed for these patients including waiting for NHS community care, waiting for social care, waiting for residential care, waiting for non-clinical processes to be completed etc

Recognising that having this number of patients delayed in inpatient beds is an unacceptable position, head of winter, a system-wide reset of our approach to improving discharge has been undertaken. The ICB CEO stepping in as SRO to ensure it receives the necessary focus. The programme is now focussed on 4 key workstreams (set out on the following slide) with the aim of driving a rapid reduction and freeing up bed capacity to support patient flow over the winter months. Fortnightly meetings are taking place between the ICB CEO and Local Authority CEOs to drive this forward, recognising the critical importance of improvement in order to support a safe winter. Additionally £4.4m of discharge funding has been released to increase capacity over winter.

The Mental Health discharge workstream is receiving support from IMPOWER to develop agreed improvement trajectories for each of our local authority areas which will support a reduction in patients who remain in an inpatient setting but are classed as clinically ready for discharge over Winter. In addition,NHS Sussex is working with Sussex Partnership NHS Foundation Trust on the development of a business case to increase utilisation of independent sector bed capacity in Sussex over the Winter period in order to improve flow on the urgent care pathway and reduce long waits for patients in Emergency Departments.

Immediate improvement priorities

4 key discharge workstreams for winter

Implement the SAFER patient flow bundle

Improving discharge processes and experience for patients in all acute settings in Sussex to ensure timely discharge, reduced delays, reduce length of stay and maximise opportunities to take a home first approach

Support patients to stay active whilst in hospital

Optimising mobilisation and independence for patients in all acute settings in Sussex through consistent and equitable access to therapy services, reducing the need for care post discharge.

Optimise the Transfer of Care Hub (TOCHs)

Optimising the hubs to promote and support safe and timely discharges from hospital for people on pathway 1-3, reducing discharge delays

Develop a needs-based demand and capacity model

Understanding how our workforce, care support and bedded rehabilitation capacity can be reprofiled to better meet the needs of our population facilitating faster discharge and a reduction in delays.

Improvement Priority 1: Implement the SAFER patient flow bundle

Aim	Improvement Actions	Impact
Improve discharge processes and experience for patients in all acute settings in Sussex to ensure timely discharge, reduced delays and maximised home first approach.	- The ICB is engaging with acute partners to review and understand the opportunities for full implementation of the SAFER bundle. This work will be integrated with wider reviews and support led by ECIST and regional nursing teams to maximise impact and opportunities for improvement against best practice. - Trusts have developed actions plans for implementation at each site and implementation will commence by 1st November with a review on impact and improvement in early December. Additionally: - Agreement on consistent discharge pathways across all three places with thresholds and standards, reducing unwarranted variation.	• Onward demand is managed by ensuring mobilisation as early as possible. • Reduced length of stay • Improved patient safety • Reduced harm for patients waiting up to 12 hours in Emergency Departments

Improvement Priority 2: Support patients to stay active whilst in hospital

Aim	Improvement Actions	Impact
Reduce avoidable patient harm and deconditioning through developing an empowering and recovery ethos and culture, promoting activities of daily living and physical activity.	- Drive an enabling and empowering culture across all settings (acute, community and mental health) to encourage patients to remain active - Explore various tools and methodologies and then work with clinical leaders to embed within all setting - Develop a change in approach that supports mobilisation, reablement and recovery for all patients during an inpatient stay and development of a business case for increasing therapy. - Clarify the role and impact of therapists and therapy leadership within intermediate care and acute settings	• Adherence to best practice discharge processes leading to reductions in pre discharge length of stay and improved patient outcomes • Reduced deconditioning for all patient groups • Improved culture of home first and the negative impacts and potential harm of unnecessary inpatient stays

Improvement Priorities 3: Optimise the Transfer of Care Hub (TOCHs)

Aim	Improvement Actions	Impact
To develop the capacity and capability of the TOCHs in Sussex to streamline and coordinate safe and efficient transfer of patients from hospital to appropriate settings. - **To promote the Homefirst culture across system partners** - **To maximise the opportunity for patients to return home efficiently**	- Review of all 3 TOCH against national best practice and action plan to ensure full functionality is achieved via the use of maturity matrix. - Confirm TOCH Specification for all TOCHs - Robust action plans developed to build TOCH functionality. Actions plans to be fully implemented by April 2025. Specifically, actions plan will include: - Improved data quality and clear escalation and joint decision-making routes established by end of September. - Improve the TOCH IT and development of the TOCH dashboard to enable - Develop existing Long length of stay weekly reviews to support all partners until TOCH is at full functionality via system, in progress.	• Reduce length of stay in acute setting • Reduction in NCTR rates • Closer to the optimum model and thresholds pathways 0-3 and agreed discharge standards in the Sussex Optimal Discharge model • Timely escalation of issues or challenges in relation to discharge • Clarity and understanding of complex patient discharge pathways and escalation routes • Improved coordination and pace of decision making resulting in reduced delays • Improved expectations from patients and carers around hospital stays and care options • Fully functioning TOCHS that are able to manage and coordinate discharge placing people appropriately • Wider impact on hospital flow and efficiency and Emergency Departments

Workstream 4: Develop a needs-based demand and capacity model

Aim	Improvement Actions	Impact
To ensure that Sussex system capacity is aligned to evidenced need, resources are maximised and there is 'One version of the truth'.	- Developed a scheme of work that all system leaders agree that pulls together existing data and develop consistent management information that can demonstrate the key indicators on discharge to all partners, aligned to revised governance, creating 'a single version of the truth' - Identify and develop patient outcome and experience information - Provide population management information to enable longer term capacity planning including intermediate care, reablement and acute settings to facilitate timely discharge. - Implement the workforce modelling tool recommendations from the Rehab and Reablement Programme to ensure the Sussex Intermediate Care workforce is aligned to the needs of the population; specifically picking up on the identified shortfall in capacity for Pathway 1 and over performance in some parts of Sussex in pathway 3. This will involve developing a business case and projections to financially sustain significant shifts in investment across care settings. - Ensure Discharge funding is aligned to evidenced based need (both short term and long term) - Review the existing short term interventions to increase capacity on pathway 1 for impact against emerging demand and capacity models - Review and align BCF and Discharge funds to ensure maximised resources and impact on winter - Develop consistent and standard NCTR recording processes	- Partners will be able to understand the delay and pressure areas quickly and develop robust action plans and responses - Partners have a shared understanding of the challenges and strengths within the system to support discharge - Decisions are made from an informed position; balancing activity information and patient outcomes. - Ability to develop a trajectory to sustainably reduce the use of beds. - Ensure that the BCF monies are allocated to support the development of best practice and a sustainable system

Pillar 4
Sound operational management

Sound operational management

Objective – ensure that we have robust operational management in place with clear coordination across the system and rapid routes for escalation where required.

Monitoring and Escalation Routes

System Co-ordination Centre (SCC)

The SCC provides a central coordination service to providers of care across the ICB footprint, supporting maintenance of access to services and delivery of safe care.

As part of its role, the SCC is responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies. The OPEL Framework contains specified and incremental core actions for the SCC at each stage of OPEL.

The SCC uses available information and intelligence to assess and validate local planning for operational pressures and events and supports proactive co-ordination of a system response if required.

The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow. Where an individual provider is facing pressures which threaten the safe delivery of services, which it is unable to mitigate through its own internal actions, the SCC will coordinate actions across the wider system, and potentially beyond the system footprint to help disperse pressures and return the system to a state of balance.

The SCC also links into the NHS England South East regional coordination centre ensuring that the system is able to rapidly respond to national and regional asks or escalations over the winter period, and escalate requirements for support if required.

SCC Winter Standard Operating Function

The SCC Winter Operating Function will run from 1st November 2024 to 31st March 2025. This will operate in link with the national SCC specification and will:

- Provide 7 days a week capability to provide situational awareness and respond to pressures.
- Provide a mechanism for leading the system through winter and monitor progress against delivery of winter priorities / workstreams
- Convene risk-focused meetings with system partners in response to rising pressures and work together to agree how these can be mitigated
- Ensure consistent application of the Operational Pressures Escalation Levels (OPEL) framework.
- Ensure senior clinical leadership is available to support risk mitigation across the system
- Link with neighbouring systems and the South East region where necessary to deliver an effective response to winter pressures.
- Act as the single point of contact (SPOC) with NHSE South East region for cascades of information both into and out of the system.

MDT Rapid Improvement Team (M-RIT) operating model

The SCC will report daily into an ICB Chief Officer meeting, attended, amongst others, by the CMO and CNO. Where there are persistent rising pressures which existing plans are providing insufficient mitigation to, an MDT Rapid improvement team will be convened at the Chief Officer's request. The purpose of the MDT is to consider the issues and using the breadth of their expertise, develop solutions. Each Chief Officer team has a nominated participant for the rapid improvement team. This team will:

Respond in an agile way to emerging pressures

Be led by senior clinical and operations leaders who have experience in responding to escalations

Use data and intelligence to understand the root cause of issues and draw on relevant expertise from across the ICB and the Sussex system

Mobilise further resources where necessary to develop a rapid improvement approach to addressing issues

Protecting the delivery of Planned Care

A key part of delivering sound operational management over the winter period is ensuring that the system maintains delivery of its planned care recovery plans, ensuring patients who required planned procedures, cancer care or access to planned diagnostics can continue to do so

Key areas of focus to maintain delivery of planned care over the winter period will be:

- Ring-fencing of elective beds, with any use of those beds for non-elective purposes requiring executive approval.
- Delivery of the agreed H2 elective, cancer and diagnostic recovery plans.
- Prioritisation of system capacity, including independent sector capacity, for long waiting patients via the Elective Coordination Centre (ECC) with weekly oversight via the System Capacity Group.
- Securing additional insourcing activity for challenged specialties
- Maximise usage of Community Diagnostic Centres (CDCs) and implementation of direct access and new pathways
- Ensuring capacity operates at optimum levels through delivery of key productivity metrics including theatre utilisation, day case rates and LOS.
- Mobilisation of tier 1 funded capacity to support cancer improvements at UHSx
- Consideration of movement of increased levels of inpatient activity to cold sites during peak winter months in order to protect delivery and free up inpatient beds on hot sites.

Pillar 5 Governance, Oversight and Escalation

Improving Lives Together

Governance, Oversight and Escalation

Objective – ensure that we have robust approach to overseeing delivery of the winter plan, with clear routes for escalation where issues are encountered

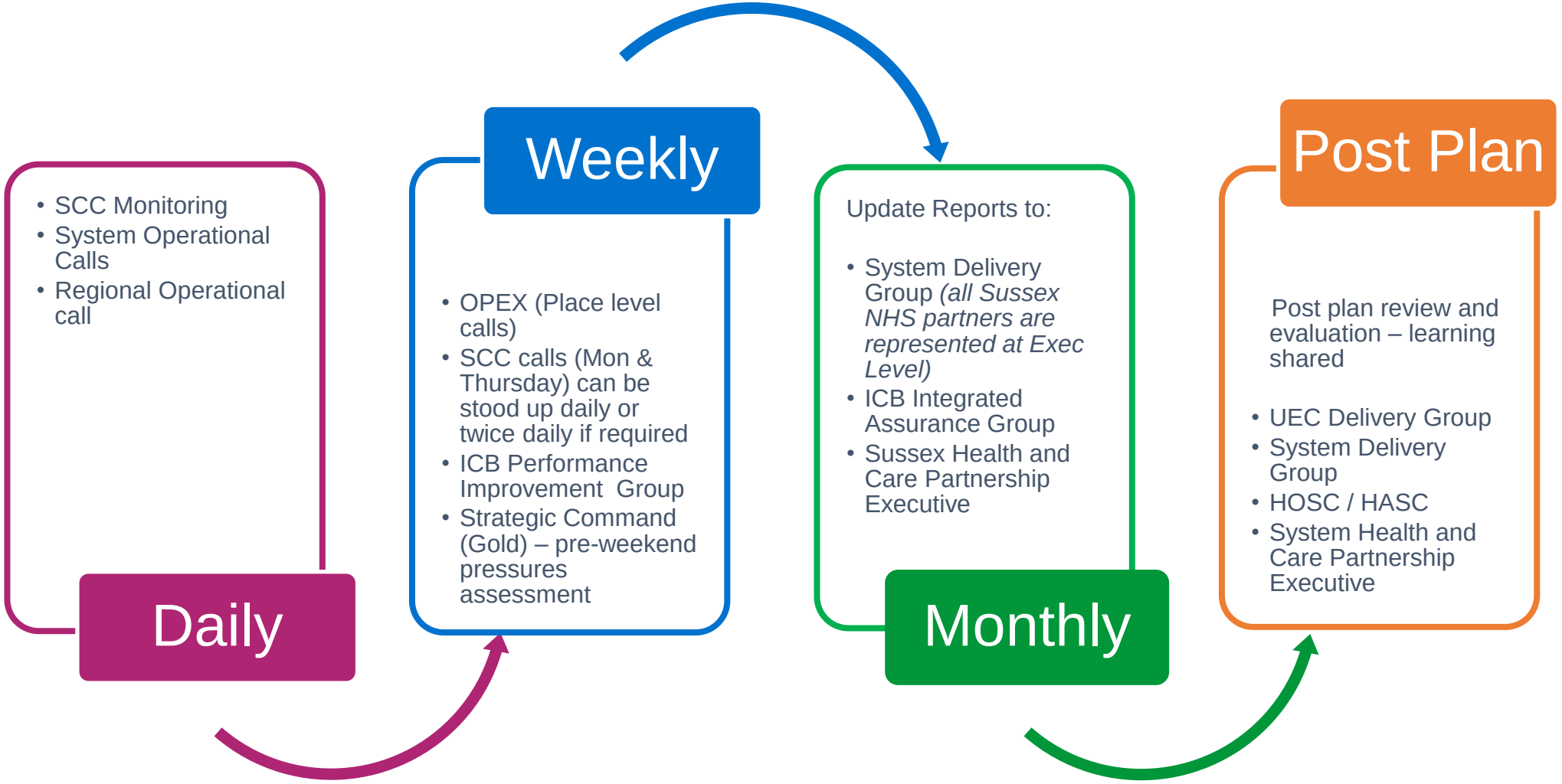
Governance and Oversight

The system wide winter plan has been developed in partnership with organisations from across the system. The plan has been reviewed by the MDT senior leadership team of the ICB and is signed off through both the NHS Sussex Board and the Sussex Health and Care Partnership executive. Individual provider winter plans are signed off through the boards of the relevant organisations and local authority HOSCs and HASCs undertake scrutiny of the winter plan once approved.

Responsibility for oversight, delivery and response to escalations is undertaken through the following forums and organisations.

Sussex Health and Care Partnership Executive	Responsibility for overall oversight of winter plan delivery
Sussex Delivery Group	Responsibility for oversight of NHS elements of winter plan delivery
NHS Sussex	Responsibility for development of the plan, driving delivery of pan system actions and coordinating a system response to escalations
System coordination centre	Responsibility day to day coordination of the system and rapid escalation of emerging issues
NHS Providers, LA partners, VCSE	Responsibility for day to day delivery of organisation specific elements of the plan

Oversight timetable over winter



Operational Pressures Escalation Levels (OPEL) framework

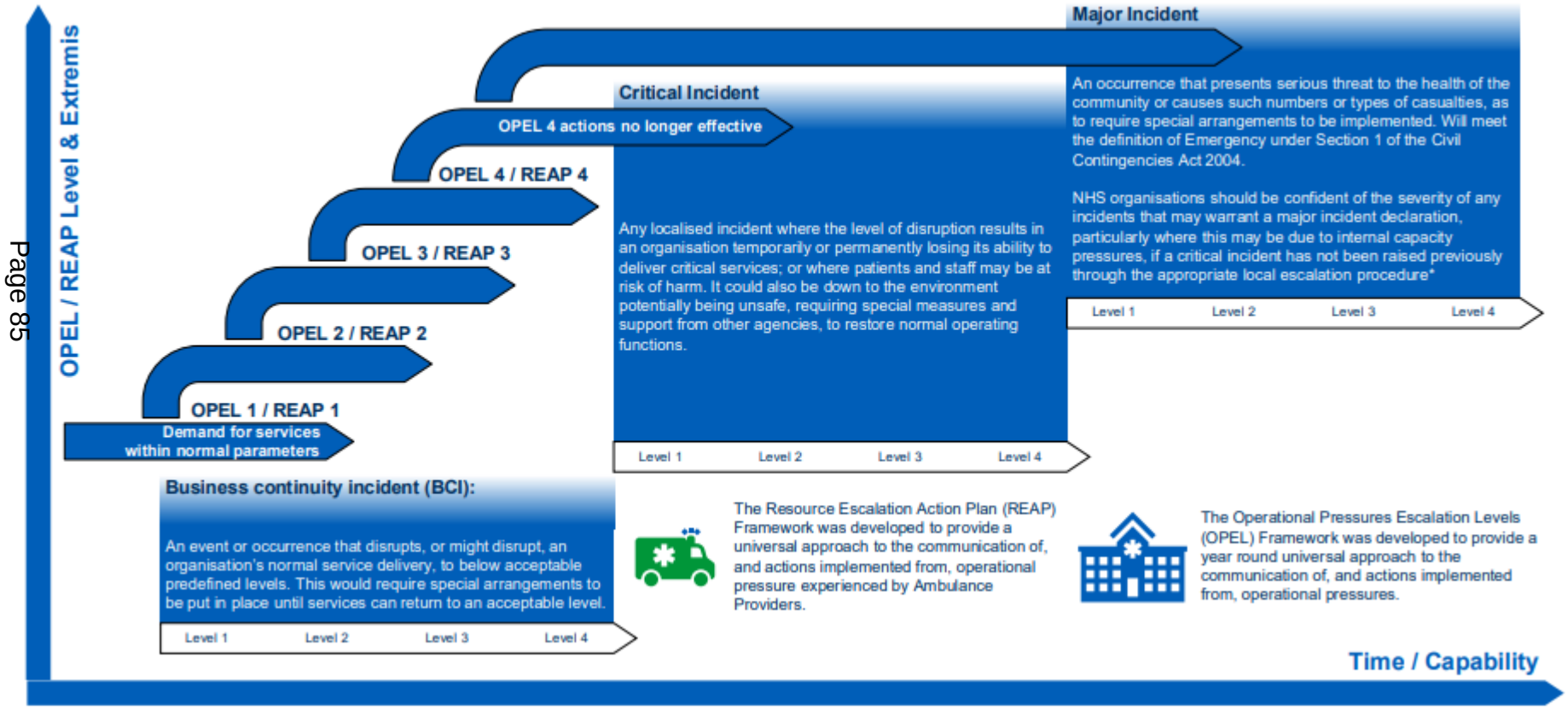
Where the activities and actions outlined in this winter plan prove insufficient to manage any surges in operational pressures, escalation and response in the Sussex system will be dictated by the application of the NHS England Integrated OPEL framework 2024/25, coordinated by the SCC which reviews OPEL levels on a daily basis. The OPEL framework aims to ensure patient safety, quality of care and overall outcomes and experience for all patients, setting out the actions which should be taken at different levels of operational pressure.

The OPEL framework focuses on managing operational pressures within the following NHS organisations and ensure that these pressures are responded to in a consistent manner by organisations across the system and are proportionately reflected and reported at a national level:

- **NHS Acute Hospital Trusts**
- **NHS (Health) Community Health Service providers (CHS)**
- **NHS Mental Health (MH) Partnership Trusts**
- **NHS 111**
- **ICSs**
- **NHSE Regional team**
- **NHSE National teams**

The Opel framework sets out the actions which should be taken at each level of escalation. Rising levels of OPEL pressure may prompt an Emergency Preparedness, Resilience and Response [EPRR] response as shown in the following slide. Should this occur this will be managed through our year round system EPRR infrastructure, with input from operational, tactical and strategic command as required.

OPEL to EPRR escalation



- Rising OPEL levels may result in the standing up of an EPRR incident, particularly where OPEL 4 actions (the highest level of OPEL) are no longer proving effective.
- Any pan system EPRR response will be coordinated by the ICB EPRR team, who in turn will liaise with regional and national NHS England EPRR teams as necessary

Appendices

Provider Winter Plans (summary level)

Provider Winter Plans

Objective – ensure that our providers have robust approach to overseeing delivery of the winter plan

- University Hospitals Sussex NHS Foundation Trust
- East Sussex Healthcare Trust
- Sussex Community Foundation NHS Foundation Trust
- Sussex Partnership Foundation NHS Foundation Trust
- Queen Victoria Hospital
- South East Coast Ambulance Service
- Surrey and Sussex Healthcare Trust

University Hospitals Sussex NHS Foundation Trust

University Hospitals Sussex is one of the largest NHS hospital trusts in the south of England, running seven hospitals across Brighton & Hove and West Sussex, include four acute hospitals at Chichester, Worthing, Brighton and Haywards Heath.

The Trust's areas of focus for this winter are:

1. Winter bed modelling, capacity and configuration
2. Increasing utilisation of Virtual Wards and SDEC
3. Optimising emergency pathways for frail elderly patients
4. Delivering safe patient Flow for winter through a focus on reducing discharge delays, reducing LoS etc
5. Managing IPC risks through the consistent adoption of a decision making framework.
6. Supporting staff health and well-being

Improving Lives Together

East Sussex Healthcare Trust

East Sussex Healthcare provide integrated acute and community care in East Sussex from two acute hospitals in Hastings and Eastbourne, and three community hospitals in Bexhill, Tye and Uckfield

The Trust's areas of focus for this winter are:

1. Reducing ambulance handover times through the standing up of an unscheduled care navigation hub, reducing unnecessary conveyances.
2. Improving Emergency Department 4 hour performance and strengthening operational site management through the adoption of a control centre approach.
3. Patient Flow – Reducing Length of Stay through application of SAFER.
4. Patient Flow – Reducing NCTR numbers through a focus on rehabilitation and reconditioning.
5. Full utilisation of Virtual Wards and expansion of the VW bed base.

Improving Lives Together

Sussex Community Foundation NHS Foundation Trust

Sussex Community NHS Foundation Trust is the main provider of community NHS health and care, across Sussex providing essential medical, nursing and therapeutic care to adults, children and families

The Trust's key areas of focus for winter are:

1. **Increasing capacity in Virtual Wards from 138 to 168**
2. **Timely decision making for Virtual Ward referrals through the recruitment of a GP; Remote Monitoring Nurse and Administrator aligned to One-Call**
3. **Reducing conveyances from SECAMB to secondary care through active participation in the unscheduled care navigation hubs and consultant review of Cat 3 and Cat 4 patients.**

Improving Lives Together

Sussex Partnership Foundation NHS Foundation Trust

Sussex Partnership NHS Foundation Trust, providing mental health, learning disability and neurodevelopmental services to people living in south east England. Our services are for children, young people, adults of working age and older people.

The Trust's key areas of focus for winter are:

1. **Maintaining the health and wellbeing of staff through winter**
2. **Continuous monitoring of urgent and inpatient care through demand and capacity modelling**
3. **Implementing a series of improvement initiatives to mitigate winter pressures including staying well services, blue light triage, Mental Health vehicles, Text Sussex, Crisis Home Treatment teams etc**
4. **Implementing the Mental Health OPEL Framework**
5. **Having clear operational management and escalation routes in place**

Improving Lives Together

Queen Victoria Hospital

Queen Victoria Hospital is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people who have been damaged or disfigured through accidents or disease.

NHS
Queen Victoria Hospital
NHS Foundation Trust

The Trust's key areas of focus for this winter are:

1. **Support the Sussex System elective care programme and long wait position by accepting the transfer of patients from UHSx and offering up vacant inpatient capacity**

2. **Ensure the 7 day minor injuries unit service is optimised along with non-elective trauma case capacity in order to reduce pressure on Emergency Departments across Sussex.**

Improving Lives Together

South East Coast Ambulance Service

South East Coast Ambulance Service is an NHS Foundation Trust that responds to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region.

The Trust's key areas of focus for winter are:

1. **Maintaining Ambulance Response Programme (ARP) performance standard**
2. **Workforce - Calculating abstraction and managing sickness absence**
3. **Specific Planning arrangements for the Christmas and New Year period**
4. **Maintain a clinically safe and effective service that meets the clinical needs of all our patients**
5. **Maintain patient safety at the centre of all Trust actions**

Improving Lives Together

Surrey and Sussex NHS Healthcare Trust

Surrey and Sussex NHS Healthcare Trust run East Surrey Hospital in Redhill, providing acute and complex services. In addition, we provide a range of outpatient, diagnostic and less complex planned services at The Earlswood Centre, Caterham Dene Hospital, Crawley Hospital and Horsham Hospital.

NHS
Surrey and Sussex Healthcare
NHS Trust

The Trust's key areas of focus for winter are:

1. **Improving bed availability though use of surge and super surge capacity and agile staff deployment.**
2. **Implementing strengthened frailty model of care**
3. **Maintaining patient flow with additional portering in place over winter months.**
4. **Infection Prevention Control**
5. **Staff Health and Wellbeing**

Improving Lives Together

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**12 December 2024**
By:	**Deputy Chief Executive**
Title:	**Changes to Paediatric Services at the Eastbourne District General Hospital (EDGH)**
Purpose:	**To consider an update report from East Sussex Health Trust (ESHT) on changes made to paediatrics services at EDGH under the new service model.**

RECOMMENDATIONS

The Committee is recommended to:

1) **note and comment on ESHT's update report at appendix 1;**
2) **note Healthwatch's report at appendix 2;**
3) **consider whether it wishes to receive any future updates on this issue.**

1. Background

1.1. On 14 December 2023 the HOSC considered a report from East Sussex Healthcare NHS Trust (ESHT) on changes to the Paediatric service model at the Eastbourne District General Hospital (EDGH). Both NHS Sussex and ESHT did not regard the changes as a substantial variation to services which would require formal consultation with HOSC, and the changes were considered to be operational differences in the way in which the services are provided.

1.2. Following concerns raised by the Committee and members of the public about the changes, the HOSC agreed to establish a Review Board to examine the impact of the changes to the Paediatric service model at EDGH more closely. The implementation of changes to paediatric services at the EDGH started on 8 January 2024 and the HOSC Review took place over a series of meetings held during February 2024.

1.3. At the HOSC meeting held on 7 March 2024 the Committee considered and agreed the report of the Review Board and it's thirteen recommendations regarding the changes to the paediatric service at EDGH. The HOSC also considered an update report on the implementation of the new service model from ESHT at this meeting. The Committee agreed to submit the review report to ESHT for consideration and a formal response to the recommendations made by the HOSC.

1.4. The HOSC subsequently received a formal response to its recommendations on 10 April 2024, which it considered alongside an update monitoring report at its meeting on 30 July 2024. Separately to the review conducted by HOSC, ESHT also commissioned an independent clinical review of the changes which found the new service model to be safe, and urgent and emergency care to be improved and sustainable. At that meeting HOSC agreed to receive a further update on the model for assurance at this meeting.

2. Supporting information

2.1. The report attached as **Appendix 1** provides an update on the new model having been in place for almost 12 months. This provides supporting data from the new model and an outline of additional actions ESHT has undertaken following the HOSC Review recommendations.

2.2. The report from ESHT shows that since implementation of the new model there has been a steady reduction in the number of children waiting over four hours in the emergency department

(ED), as well as in the average number of children per week transferred to Conquest Hospital in Hastings.

2.3. Attached at **Appendix 2** is a report produced by Healthwatch East Sussex to gain a young person's perspective on the paediatric facilities at EDGH following the recent changes. The report was conducted using the 15 Steps Challenge toolkits which were originally developed by the NHS Institute of Innovation and Improvement, in co-production with staff and service users to support patient and carer involvement in improving health services. The 15 Steps Challenge uses a variation on mystery shopping observational approaches to understand what service users and carers experience when they first arrive in a healthcare setting.

3. Conclusion and reasons for recommendations

3.1 The HOSC is recommended to consider ESHT's report on the operation of the new service model and to note the Healthwatch report to the HOSC review recommendations. The Committee is also asked to consider whether it would like to receive any further reports on this issue at future HOSC meetings.

PHILIP BAKER
Deputy Chief Executive

Contact Officer: Patrick Major, Scrutiny and Policy Support Officer
Tel. No. 01273 335133
Email: patrick.major@eastsussex.gov.uk

Update to Health Overview and Scrutiny Committee, December 2024
Paediatric Care in the Emergency Department (ED) at Eastbourne District General Hospital

1. Summary

1.1 This update report is the last in the series of briefings that we agreed to share with colleagues for assurance purposes following the HOSC review into the new model for paediatric care at Eastbourne District General Hospital. This marks the end of a successful nearly 12 months of operations.

As per our previous reports to HOSC, we are pleased to report continued positive progress with the model for paediatric care. This update covers two broad areas:

- Supporting data from the new model.
- Safety/Complaints and other matters for update since the previous update.

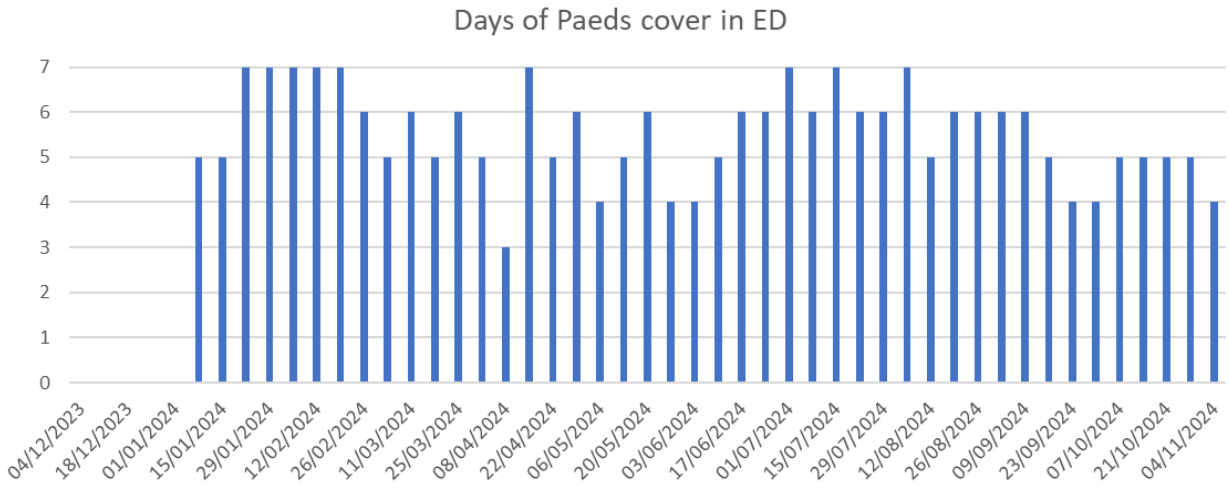
2. Supporting data

2.1 We have now had the benefit of 11 months of activity through the paediatric hub. As the graphs throughout the rest of this report show, we have a regular presence in ED, improving activity levels and a decreasing number of children needing referral to the Hastings site.

2.2 Figure 1 below shows that coverage has been consistently between 5 and 7 days per week, with the average from the figures below being 5.5 days per week. Importantly for over half the time of its operation (53%) the unit has been open between 6 and 7 days. On these days, any paediatric presentation to ED where a paediatric opinion is required, has immediate access to the service. As HOSC members will recall, prior to the new model, there was no paediatric specialists in ED.

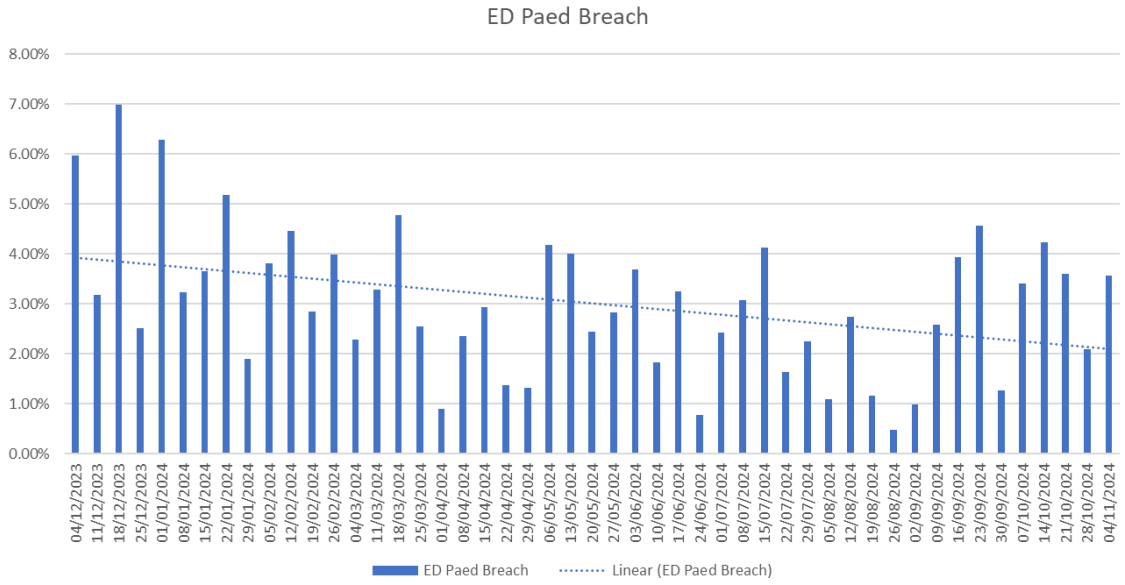
2.3 Members will recall that under the previous model, we regularly closed the assessment unit at short notice (weekends and during staff shortages) so the current has increased access and has brought less unpredictability to the planning of staff rotas/departmental cover.

Figure 1: Days per week with paediatric cover in the (ED) emergency department (max. 7)



2.4 Figure 2 shows that, since implementing the new model in early January, there has been a steady reduction in the number of children waiting over four hours.

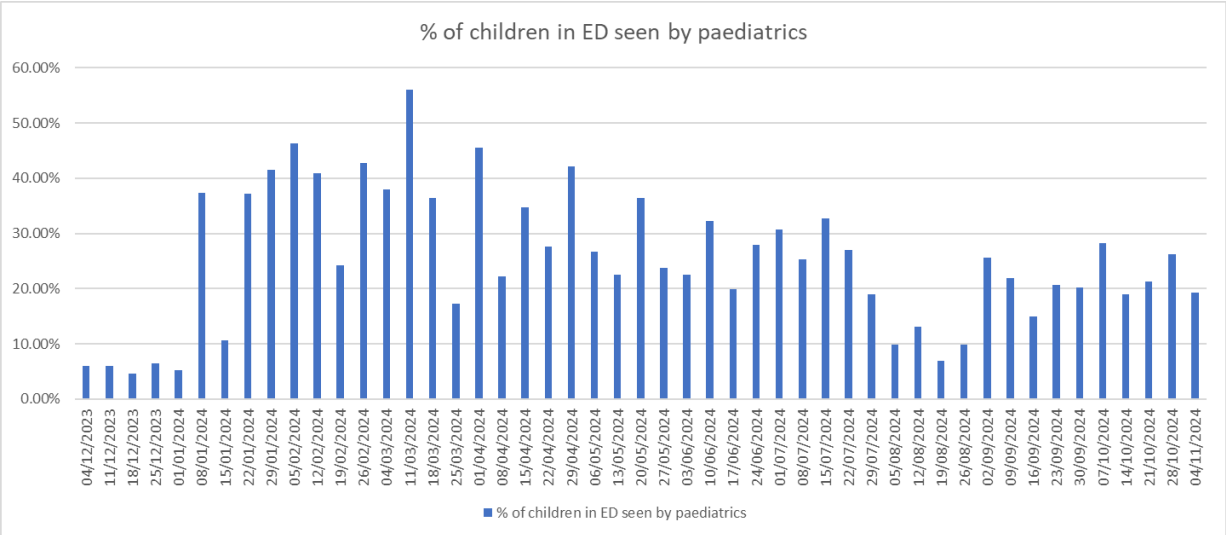
Figure 2: Percentage of children breaching the 4-hr ED standard



2.5 Members will recall that only a very small number of children (3%-4% typically have needed paediatric care/opinion in the ED, with the majority covered by ED nursing and/or consultant intervention) and for those who did, historically this would have taken place in another part of the site.

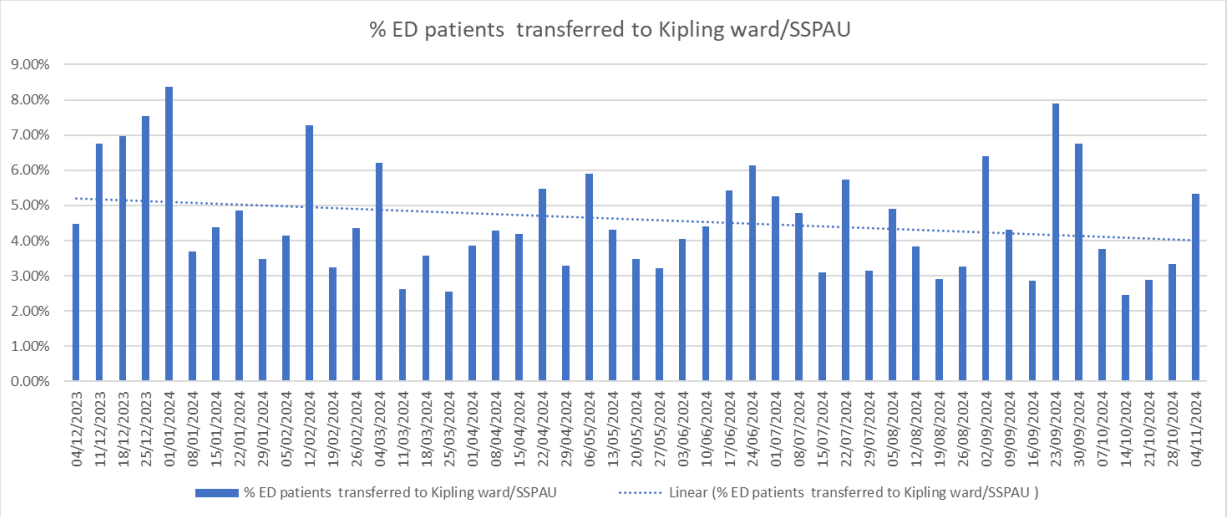
2.6 Figure 3 shows that, compared with volumes of children seen under the previous model, we are seeing increased numbers of children directly in ED, supporting the improvement in access to paediatric opinion that the model affords to local parents. It is worth noting that around 50% of children that present to ED are injuries (and so are typically treated by the Emergency Nurse Practitioners), about 30% of paediatric attendances can usually be managed through Primary Care/GP resource and therefore, on the current split of attendances, 20% of children needing specialist Paediatric input fits with the general profile we would anticipate.

Figure 3: Percentage of children seen in ED by paediatrics



2.7 Members will recall that one of the concerns put forward with regard to the new model is that it would result in an increase in paediatric cases going to our Hasting site. As Figure 3 shows, this has not been borne out by the results, with the trendline showing a reduction from an average of 5 a week to around 3 a week.

Figure 4: Percentage of children transferred for care in Hastings



3. Safety/Complaints and other matters

3.1 ***Safety/Complaints:*** We are happy to report that there have been no clinical patient safety incidents reported as regards this service, nor have there been any complaints as regards the new model.

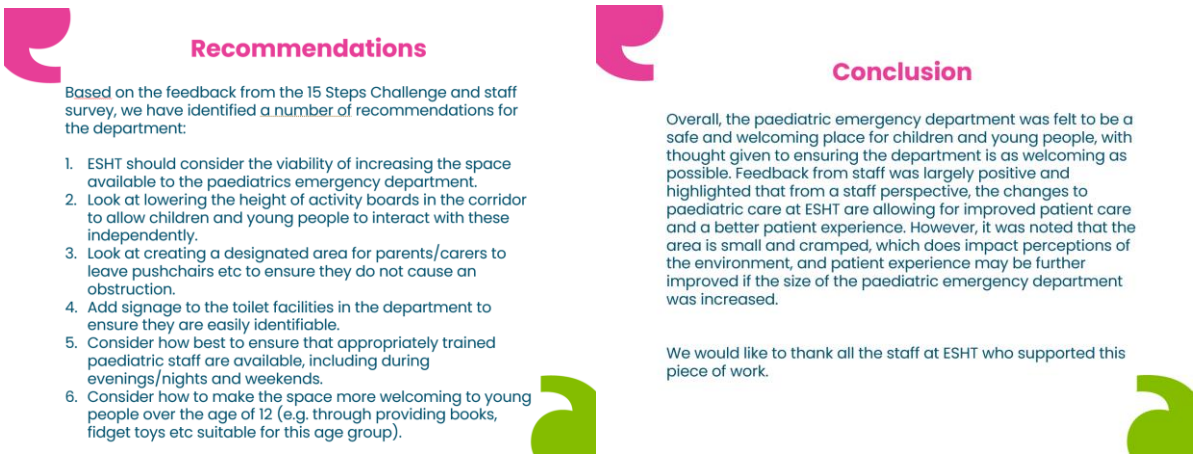
3.2 ***Future plans for paediatric services:*** The Division is in the process of formulating a paper for consideration that proposes reusing the Scott Unit space effectively. The options will be developed in line with Trust policy and a business case made to the executive team.

3.3 ***Second Healthwatch visit:*** Following the positive Healthwatch visit to the service earlier in the year, a second visit took place in October, specifically to gain a young person's perspective on paediatric facilities following the changes. It also sought to take in what staff thought of the changes and if there were any further improvements.

3.4 In a structured approach, the visit included a team of Healthwatch East Sussex staff and Young Healthwatch volunteers who undertook their review according to the 15 Steps Challenge in the department and considered the operation of the service across the four key areas set out in the *NHS 15 Steps Challenge Guide*: Welcoming; Safe; Caring and involving; and Well organised and calm.

3.5 We are pleased to append the full report to this summary and, as the recommendations and conclusions show, this was another positive report that recognises *"… the changes in paediatric care at ESHT are allowing for improved patient care and a better patient experience*". We note the recommendations and will look to act on these, insofar as we can – mindful of the estates constraints of the site. We again thank colleagues at Healthwatch for their rigorous engagement and healthy challenge to us as part of this work.

Figure 5: Summary recommendations & conclusions of Healthwatch '15 Steps Challenge'



4. Conclusions

4.1 As this is the final report of the agreed updates for HOSC, we would like to take this opportunity to thank Councillors and our partners for their respective roles in the review of the service changes we have implemented. We hope that the evidence and data we have provided – both internally from the activity analysis and externally that considered the model in context – has demonstrated that the intended benefit for the residents we serve has been manifest in the work we have undertaken.

Dr Matthew Clark
Clinical Chief of Division, Women's & Children

Ms Kaia Vitler
Divisional Director of Operations, Women's & Children

15 Steps Challenge, Paediatrics Emergency Department at EDGH

A report by Healthwatch East Sussex

What we did and why

We undertook this activity to gain a young person's perspective on paediatric facilities at Eastbourne District General Hospital (EDGH), following the recent changes to paediatric services at ESHT. We also aimed to understand what staff thought of the changes and if there were any improvements they felt could be made, via a short survey.

We used a team of Healthwatch East Sussex staff and Young Healthwatch volunteers to undertake the 15 Steps Challenge in the paediatric emergency department at EDGH.
Our team looked at the four key areas set out in the NHS 15 Steps Challenge Guide: **Welcoming; Safe; Caring and involving;** and **Well organised and calm.**

The team used a list of prompts, also taken from the NHS guidance, to structure our observations on what we felt worked well and what could be improved. We also looked to answer a series of questions which have been important areas of consideration for young people in our previous work.

15 Steps Challenge

What is the 15 Steps Challenge?

The 15 Steps Challenge toolkits were originally developed in 2012 by the NHS Institute of Innovation and Improvement, in co-production with staff and service users to support patient and carer involvement in improving our health services.

The 15 Steps Challenge uses a variation on mystery shopping observational approaches to understand what service users and carers experience when they first arrive in a healthcare setting.

A small '15 Steps Challenge team' visit wards and other service user areas and take note of their first impressions.

What we observed - Welcoming

What worked well:

- The space felt welcoming for children, and included a range of toys and activities for patients to engage with whilst waiting.
- The department was decorated in a welcoming, child-friendly way, with decorations on the walls and ceiling. The ceiling above the child and young people's resuscitation bays was also decorated, to make the area less intimidating.
- There was information on the walls of the waiting area, both for parents/carers and young people, and QR codes were being used on posters to give further information about a range of healthcare topics.
- Staff and volunteers all remarked that the staff were very welcoming towards us, and towards patients.

Volunteer (10) *– Staff are really nice and seem kind*

What we observed - Welcoming

What did not work well:

- The waiting area is quite small and cramped, with limited space to move around. This could cause issues for those with mobility issues, who use a wheelchair, or parents/carers with a pushchair.
- Activity boards (such as spot the difference etc) are located in the hallway of the department and are a positive addition to the space, however they are at adult eye level rather than child eye level. This means that a younger child would have to be lifted up to be able to interact with them.

What we observed - Safe

What worked well:

- The area was clean and well maintained. Hand gel was available on entrance to the department and was easily accessible.
- All staff were in uniform and had lanyards and/or job role on their uniform, ensuring that they were easily identifiable.
- Fire exit signs were clearly visible in the department.
- There was a large, gender-neutral toilet in the department, so that children and young people don't need to leave the area to use the toilet.

What did not work well:

- There is nowhere to leave pushchairs/child carriers. During our visit, a pushchair had been left in front of some of the waiting area seating, limiting the amount of seating available and potentially creating a hazard as people moved about the space.

What we observed – Caring and Involving

What worked well:

- Staff interactions with patients and their parents/carers were positive, and the area seemed calm.
- There was a bed in the main room which was separated by a curtain to ensure that patient privacy was maintained. There was also a second treatment room, which could also be used as a quiet area as needed.
- Child and young people resuscitation bays were separate from adult ones, and the ceiling of these bays had been decorated to make them less intimidating.

Volunteer (10) *- Privacy is being respected by having curtains too so that people can't see what they're doing there*

What we observed – Caring and Involving

What did not work well:

We were pleased to see the work that has gone into making the emergency department as welcoming as possible for children and young people. Feedback from our volunteers was that the area was still intimidating due to being an emergency department, however it's clear that thought has gone into making the department as calm and welcoming as possible.

Volunteer (14) *- The A&E is rather intimidating and would be especially for a child. Although to combat this they have toys, fidgets …*

Volunteer (10) *- Patients would probably feel scared, but happy to know there are things to do*

What we observed – Well organised and calm

What worked well:

- Being separate from the main A&E, the department itself was calm, and there was empty space in the waiting area.
- Each area of the department was well organised, with equipment having its own designated space.
- It was clear which members of staff were working in the department, and they were all clearly identifiable. The area is separate from the main A&E (down a short corridor), which helps to ensure that the space is only used for children and young people.

Volunteer (14) *- Organised for safety purposes and child anxiety needs*

What we observed – Well organised and calm

What did not work well:

- Although the area itself was calm, we could still hear the noise from the main A&E waiting area, which made the space feel less calm overall. There is another room that can be used as a quiet space, although as this is also a treatment room, this will not always be available.
- As the area is small, it can be difficult to move around, particularly if it is busy.
- Although there is a toilet in the department, there was no sign to identify it, meaning that people using the department may not realise that there is a toilet available for their use.

Volunteer (14) *- Unclear immediate signage to facilities*

What we observed – Other questions

As part of this visit, we looked to answer a series of questions that have been highlighted to us as important things to consider to ensure that children and young people can access a service, which were not already covered by the 15 Steps framework. This included:

1. How easy young people felt it was to locate the department
2. If it was clear where to sign in on arrival
3. How patients are collected for their appointment
4. If there are any quieter waiting areas that can be used by children and young people

We also asked volunteers to note how many staff were working in the department on the day, and how many patients were in the department during our visit.

What we observed – Other questions

1. Our volunteers felt that the department was easy to find on arrival, with staff confirming that patients and their parents/carers would be directed to this area.
2. Our volunteers said they would assume that you would sign in at the reception desk, but did not realise there were also sign in screens.
3. It was clear how patients were collected for their appointments once in the department, with all patients being collected by staff.
4. There is only one waiting area in the department, but there is another treatment room which could be used as a quiet space for children and young people who need it. However, because this is a treatment room, this will not always be available.

On the day of the visit, 5 members of staff were working in the department, and there were approximately 3 patients accompanied by their parents/carers.

Staff survey results

We also undertook a staff survey to understand the changes to paediatric care at EDGH from a staff perspective. We felt that department staff were well placed to understand the changes and how they may impact patients, and what could be done to improve patient experience.

We asked staff to feedback on the physical environment, the support they are given to provide care, what they thought of the recent changes to paediatric care, and if there are any changes they would like to see in relation to the care of children and young people.

We asked: I feel that the physical environment of this department supports young people aged 11 and under to feel welcome

All respondents either agreed or strongly agreed that the environment was suitable for young people aged 11 and under.

Staff felt that the department was decorated appropriately for this age group, and highlighted that toys are available in the waiting area:

"There are toys on the wall, we get some donations of toys that we keep in the waiting room"

"The unit has improved the experience I believe by being a separate part of A&E with child friendly decor, toys, etc"

We asked: I feel that the physical environment of this department supports young people aged 12 – 17 to feel welcome

Feedback for this question was mixed, with some staff feeling the environment was welcoming to this age group, while others disagreed. Some staff reported that there is less for older young people. One member of staff noted that it can be busy and noisy in the department:

"We do have [Nintendo] switches for young people but most charity "toys" are for children. We don't have much decoration for young people"

"I feel more separation from younger children would help"

"As a team we try to make patients feel as comfortable as possible to try to reduce anxiety by chatting to the children. Still a difficult environment coming through adult A&E and can be very busy and noisy in the paediatric unit"

We asked: I feel that the physical environment of this department is suitable for providing treatment to young people of all ages

All respondents either agreed or strongly agreed that the environment is suitable for providing treatment to young people of all ages. Staff highlighted that they work to ensure privacy for patients is maintained:

"Ideally, we would have even more space for separate rooms especially for teenagers/mental health patients - we do have one separate room we can use when doctors/nurse practitioners are not using it. We try to respect privacy as much as we can"

"We have a side room for privacy if needed"

"In the main room we have a bed to provide longer treatment"

We asked: I feel that I am supported to provide the best possible care for patients

All respondents agreed with this statement, and felt that improvements had been made to support patient care:

"Management have listened to the issues we had previously with no space to triage and assess children… privacy problems and lengthy waiting times, looking for space to triage or assess children and trying to respect privacy - this unit is an improvement"

"Now we have a bigger space we are able to give more in depth care to patients"

We asked: Have you been offered training around communicating with young people?

Responses were mixed to this question. Some members of staff said that they had received training around communicating with young people, while others said they had not. One member of staff said that while they had not had this training while at the trust:

"It has been a part of good children's nurse training and training courses".

We asked: What impact (if any) do you feel recent changes to paediatric care at ESHT have had on your work?

Overall, staff reported that recent changes to paediatric care have had a positive impact on their work, ensuring that children are seen by the appropriate member of staff and allowing them to have more space to work. Staff also highlighted the positive impact for patients through reduced wait times:

"The environment is less stressful, it feels better to be able to offer children and parents space. … We have more space to triage more than one child at a time now shortening waiting times and ensuring treatment is started if needed as soon as possible. Having nurse practitioners on most shifts shortens waiting times and ensures that a paediatric trained practitioner is reviewing the child"

We asked: What impact (if any) do you feel recent changes to paediatric care at ESHT have had on your work? (continued)

"Now having the bigger space we are able to get support from ANAP and paeds REG. This has had a positive impact in our team and the wider A&E team"

"I think the changes have been positive experience for younger people … waited times reduced"

However, it was highlighted that staff sometimes have to work overtime to support the admission of patients:

"Having to work over hours due to younger children needing admission (after surgery). There is no overnight facility in Eastbourne"

We asked: Are there any changes you would like to see in relation to caring for children and young people?

More modern/updated unit

Regular training/updates for ED doctors so that when a nurse practitioner is not on shift ED doctors have confidence in reviewing children. Ideally a nurse practitioner on every shift

Access to CAMHS after 7pm so that young people are not waiting all night potentially

Paediatric cover over the weekends too

More for young people

Recommendations

Based on the feedback from the 15 Steps Challenge and staff survey, we have identified a number of recommendations for the department:

1. ESHT should consider the viability of increasing the space available to the paediatrics emergency department.
2. Look at lowering the height of activity boards in the corridor to allow children and young people to interact with these independently.
3. Look at creating a designated area for parents/carers to leave pushchairs etc to ensure they do not cause an obstruction.
4. Add signage to the toilet facilities in the department to ensure they are easily identifiable.
5. Consider how best to ensure that appropriately trained paediatric staff are available, including during evenings/nights and weekends.
6. Consider how to make the space more welcoming to young people over the age of 12 (e.g. through providing books, fidget toys etc suitable for this age group).

Conclusion

Overall, the paediatric emergency department was felt to be a safe and welcoming place for children and young people, with thought given to ensuring the department is as welcoming as possible. Feedback from staff was largely positive and highlighted that from a staff perspective, the changes to paediatric care at ESHT are allowing for improved patient care and a better patient experience. However, it was noted that the area is small and cramped, which does impact perceptions of the environment, and patient experience may be further improved if the size of the paediatric emergency department was increased.

We would like to thank all the staff at ESHT who supported this piece of work.

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**12 December 2024**
By:	**Deputy Chief Executive**
Title:	**Ambulance Handovers at the Royal Sussex County Hospital (RSCH)**
Purpose:	**To provide the Committee with a progress update on the work being undertaken to reduce ambulance handover times at the RSCH.**

RECOMMENDATIONS

The Committee is recommended to:

1) **consider and comment on the update on hospital handovers at the RSCH; and**
2) **consider whether to request a further update.**

1. Background

1.1. Ambulance crews arriving at hospital Emergency Departments (ED) with patients requiring admittance must wait for ED clinical staff to handover the care of their patient before they may leave and respond to further calls.

1.2. The NHS national standard for hospital handovers is 15 minutes and there is an expectation of there being strictly no delays over 60 minutes and of hospital trusts aiming to avoid any over 30 minutes. Delays in hospital handovers result in ambulance crews having to stay with their patients rather than getting back on the road. It also means that patients may have to wait in sub-optimal conditions for assessment and treatment. Hospital handover delays had increased due to COVID-19 and the effects this has had on patient care and ambulance response times have been widely reported.

1.3. At several of its previous meetings the HOSC has considered reports on hospital handovers at the main hospitals for East Sussex patients, namely Eastbourne District General Hospital (EDGH), Conquest Hospital, Tunbridge Wells Hospital (Pembury), and the Royal Sussex County Hospital (RSCH). These reports showed that of these hospitals, the RSCH in Brighton tended to have a higher level of handover delays compared to others. RSCH continues to be a regional outlier in the length of handover delays.

1.4. At its meeting on 14 December 2023, the Committee heard that there was ongoing work to reduce handover delays at the RSCH. The Committee requested a report be brought to this meeting to update on that work.

2. Supporting information

2.1. The report attached as **Appendix 1** provides an update from University Hospitals Sussex NHS Foundation Trust on the issue of hospital handover times. It covers:

- The RSCH historical context;
- Current challenges in reducing ambulance handover times;
- Ongoing and planned Improvements initiatives at the RSCH.

3 Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider the report and decide whether future updates are needed on any of the areas covered in the report.

PHILIP BAKER
Deputy Chief Executive

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University Hospitals Sussex
NHS Foundation Trust

RSCH Ambulance Handover Compliance

Health Oversight and Scrutiny Committee, ESCC December 2024

Peter Lane, Hospital Director – Royal Sussex County Hospital

Ali Robinson, Deputy Divisional Director of Operations, Medicine

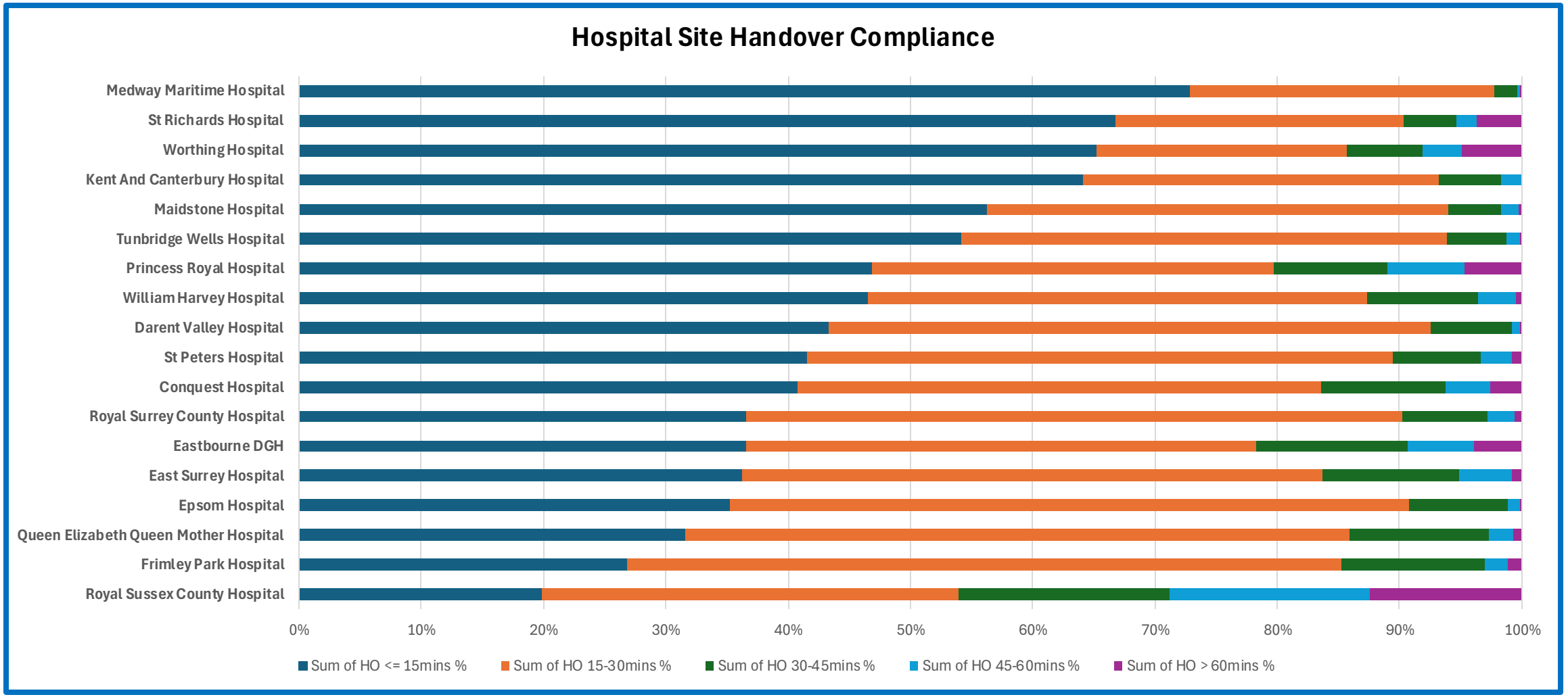
Summary

University Hospitals Sussex NHS Foundation Trust

- Royal Sussex County Hospital (RSCH) ambulance handover times continue to be significantly challenged compared to other hospitals in the region.
- This position has been the status quo for several years and is driven by a range of factors.
- We continue to deliver initiatives to mitigate the contributing factors, and these have delivered improvements – but we know more remains to be done.
- We have a clear plan to tackle some of the historical difficulties through this winter and for the future.
- Despite delays in handover times, RSCH rarely holds patients in the back of ambulances, when compared to in-vehicle holding times at other similar hospitals in the South East.
- Our £48 million reconfiguration of the Acute Floor and ED at RSCH will deliver significant improvements in the coming years.

Relative position

Date range: 01/10/24 – 31/10/24. Conveyances to EDs only.



RSCH context

In July, NHS England's *Emergency Care Improvement Support Team* and *Getting It Right First Time team* (GIRFT) reviewed our Emergency Department, Frailty and Acute Medicine services.

Following their visit, they:

- Highlighted areas of excellence including Ambulatory Care ED model nominated for HSJ award.
- Commended handover performance in overcrowded ED and how no patients held in ambulances.
- Recommended several system actions to improve discharge from the hospital and a rapid response to the high mental health demand within the ED.

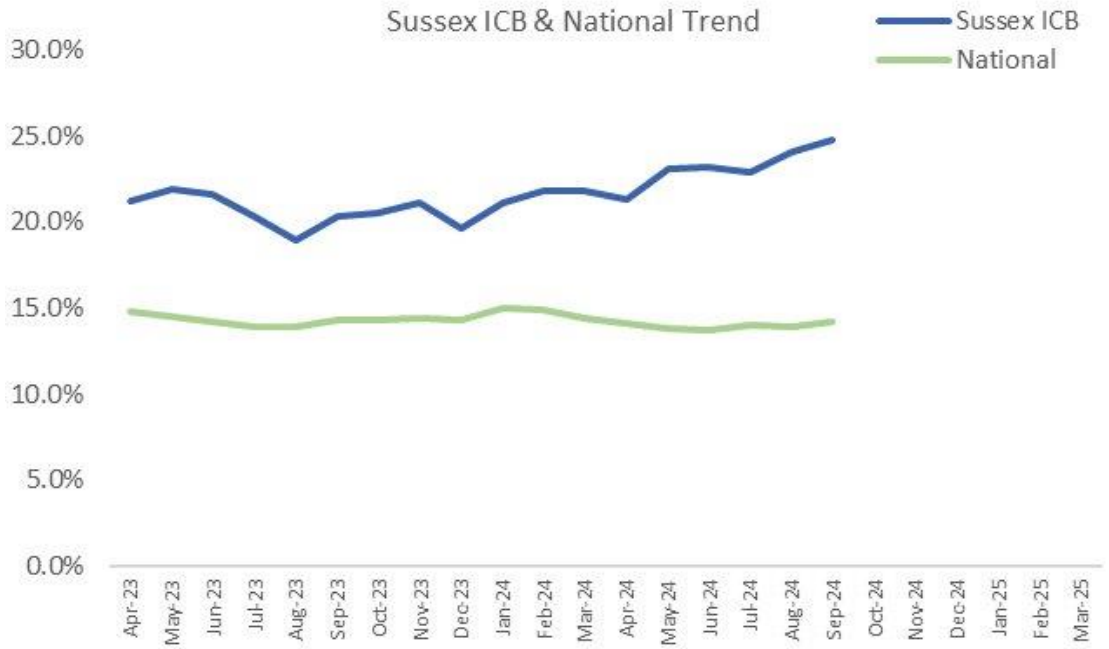
Positive notes	
RSCH	The SDEC is no longer bedded and has not been bedded for a number of weeks. A lot of hard work has gone into getting to this position. The trust must do everything in its power to please keep this up.
RSCH	The engagement of frontline staff across UEC is excellent and they are incredibly supportive of each other.
RSCH	New frailty SDEC shows positive signs of innovation
RSCH	Incredible, motivated staff working in the ED in appalling conditions. They are determined to do what ever is within their gift to improve areas they are trying to address, using a strong QI methodology. They are the trusts biggest asset.
RSCH	Older persons ward staff provide great care towards patients within a great environment
PRH	Clear plans for continuing to improve the acute medical pathways
PRH	Positive training environment for acute medicine
PRH	The frailty pathway is excellent with consistent and appropriate use of Rockwood scoring
PRH	Frailty team doing so much without appropriate resourcing or funding

No criteria to reside (NTCR)

Ambulance handover delays occur when flow of patients through hospital does not keep pace with A&E attendances and ward admissions.

While our front door never closes, discharging patients back home or to other care setting can be delayed or prevented by a range of factors.

These include availability of packages of social care, or community, nursing home, mental health places or care by other providers.

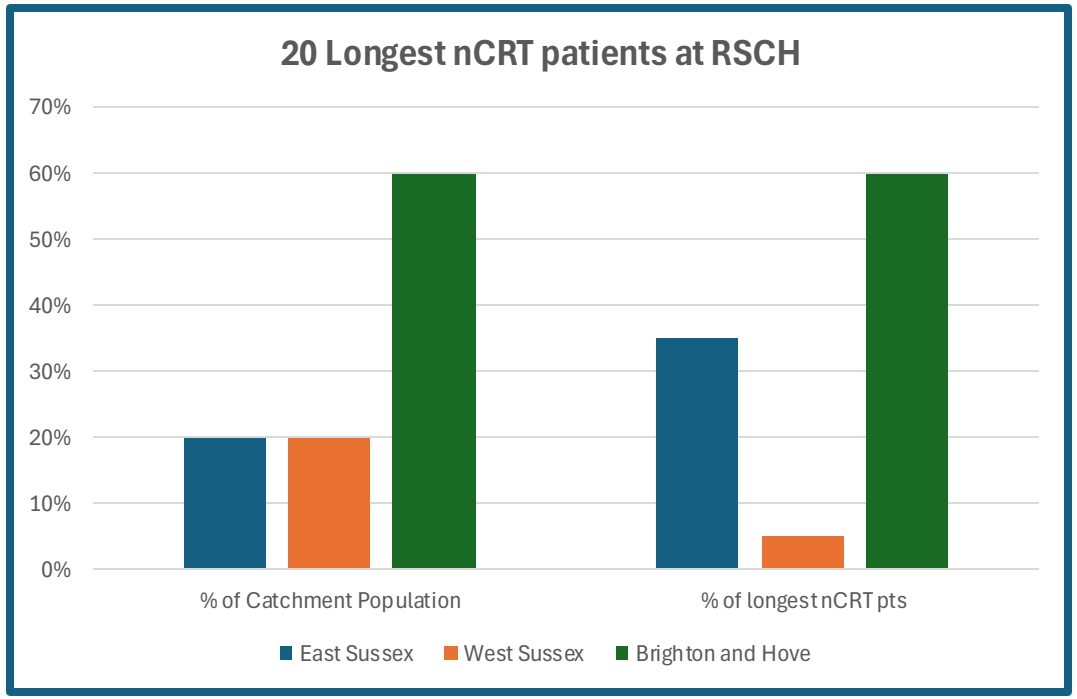


Patients who no longer require acute medical care but are unable to leave hospital are now known as NTCR patients – 'no criteria to reside'. Until recently they were called Medically Ready for Discharge patients. Sussex is an outlier for the number of NTCR patients currently in hospital, both in the region and nationally.

Our biggest challenges

The joint NHSE visit highlighted a number exceptional challenges within the Sussex system which contribute to overcrowding in the RSCH Emergency Department.

- **East Sussex decision to admit beds.** Patients awaiting these beds represent a disproportionate number of patients with non-medical need than the hospitals catchment.
- **Non-criteria to reside.** The ICB in Sussex ranks 42/42 nationally for the number of beds occupied by patients not requiring hospital admission. At RSCH this represents 16% (80) of all beds but up to 70% on some wards.
- **Mental health demand**. Approx. 13% of all ED attendances are for mental health conditions. 12 ED cubicle spaces are regularly occupied by long length of stay patients awaiting mental health inpatient beds.



Improvement initiatives

Current

RSCH initiatives 1/2

University Hospitals Sussex NHS Foundation Trust

A range of improvements are underway to improve flow throughout the system to improve handover compliance.

Surgical Assessment Unit

The SAU opened in October 2024 and is being expanded gradually in line with nursing recruitment.

- The SAU is a net increase of 12 trolley spaces and 12 chairs to the hospitals bed stock.
- 10% of all ED presentations are for abdominal pain.
- Ambulances can handover directly to SAU, bypassing ED.
- Greater surgical patient flow is being supported by a program of other improvements such as 24hr emergency surgery operating for lower acuity presentations.

Continuous flow model

In June 2024, the Medicine division implemented a continuous flow model.

- Patients are moved from ED to the ward independently of the number of discharges at set times.
- The model provides planned and consistent movement out of ED.
- In the first month post-implementation, 200 hours fewer hours were lost in ambulance handover.
- Surgical and Specialist divisions are due to go-live in December.
- An expected increase to total discharges is yet to occur.

RSCH initiatives 2/2

University Hospitals Sussex NHS Foundation Trust

Navigation hub

A multi-disciplinary team from SECAmb, adult social care, SCFT and UHSussex has been established in Falmer to support the decision making ahead of ambulnce conveyances to RSCH.

- Crews on scene call into the Navigation Hub for advice on whether to convey the patient to hospital, and if so, to what location.
- A joint audit between UHSussex and SECAmb suggested above a 20% opportunity in possible alternative conveyance locations.
- UHSussex clinical input started on 04/12.
- The hub is being trialled for the rest of the financial year.

Hospital Alternative Oversight Programme

The Medicine Division have established a Hospital Alternative Oversight Programme. Several initiatives already in progress are:

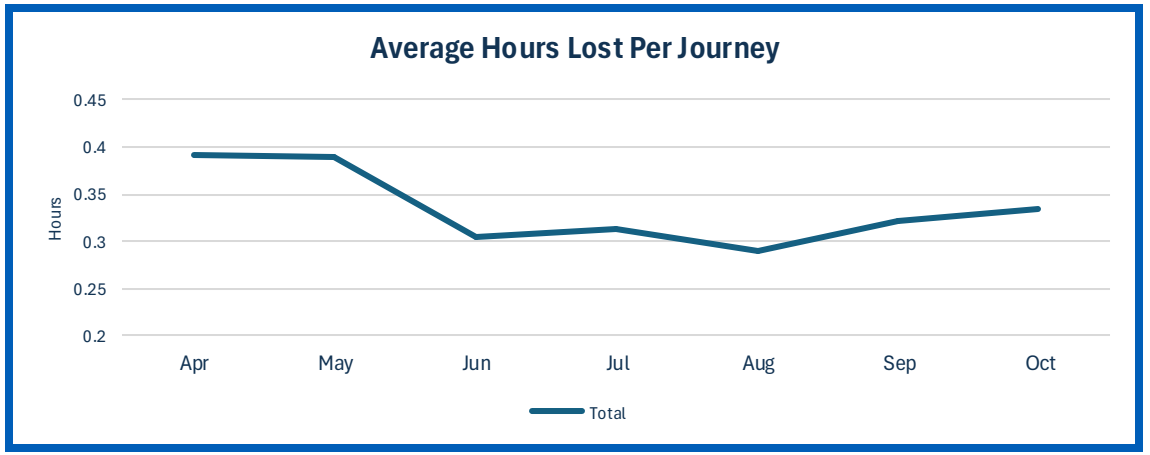
- Frailty Care Home Outreach & Red Bag Launch
- Integrated Front Door Therapies Team RSCH
- Deconditioning Prevention
- Virtual Health, both General Virtual Ward and Respiratory Home Monitoring Services
- Deconditioning Prevention
- Tiered Acuity Model

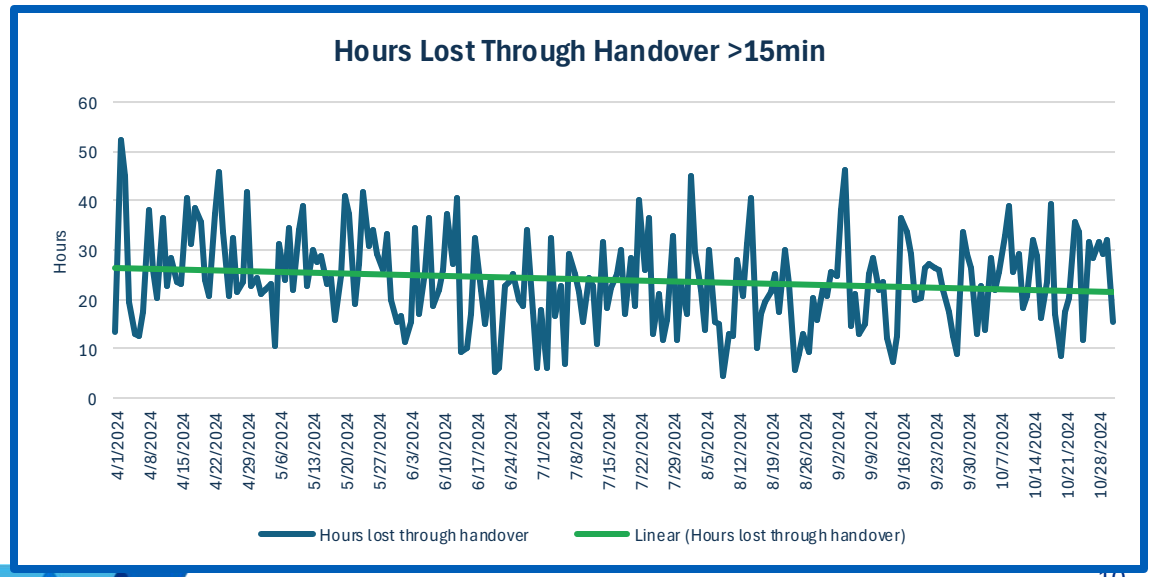
These initiatives are in collaboration with colleagues from the ICB, Sussex Community NHS Foundation Trust (SCFT), South Coast Ambulance (SECAmb) and Brighton & Hove City Council (BHCC).

Improvements so far

Despite ED overcrowding continuing to be stubbornly high, handover times have not regressed.

- The introduction of a new continuous flow model delivered immediate and measurable hours back to the ambulance service.
- Hours lost in handovers >15min is consistently reducing.
- The initiatives currently in progress will continue to improve performance.





Improvement initiatives

6 months +

Acute Floor Reconfiguration

University Hospitals Sussex NHS Foundation Trust

The £48m capital development programme will transform the Acute Floor and ED at RSCH.

- The first phase of the programme began in Summer 2024, reconfiguring some space vacated by services moving inot new hospital building. This phase scheduled to finish in 2025.
- The design will deliver more clinical spaces within ED, a larger RESUS area and more ambulance receiving bays.
- The estate will be brought up to modern standards and include spaces appropriately designed for mental health patients and those requiring a sensory space.
- UHSussex has consulted with key stakeholders including SECAmb on the operational delivery during the construction work and final design.

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**12 December 2024**
By:	**Deputy Chief Executive**
Title:	**University Hospitals Sussex NHS Foundation Trust (UHSx) colorectal surgery potential service change**
Purpose:	**To receive an overview of proposed changes to elective colorectal cancer surgery across UHSx hospital sites and consider whether the plans constitute a substantial variation in services.**

RECOMMENDATIONS

The Committee is recommended to consider whether the proposed service change proposals relating to University Hospitals Sussex NHS Trust colorectal cancer surgery set out in Appendix 1 constitute a 'substantial variation'.

1. Background

1.1 This report provides information about plans by University Hospitals Sussex NHS Foundation Trust (UHSx) to make changes to the provision of elective colorectal cancer surgery across their Sussex hospital sites. Colorectal & Lower Gastro-Intestinal (GI) is a specialty with growing demand and a long waiting list to receive treatment and colorectal surgery describes a number of surgeries that fix problems in the lower gut.

1.2 Current demand for colorectal cancer surgery at Royal Sussex County Hospital (RSCH) in Brighton significantly outstrips the available capacity. Patients are currently experiencing a sub-optimal service due to lack of capacity resulting in a number of short notice cancellations and increased waiting times for surgery.

1.3 UHSx are proposing to relocate all Elective Colorectal & Lower GI Cancer Surgery and Stoma Reversal Surgery from RSCH to the Worthing site, creating a centre of excellence for Colorectal Cancer Surgery delivered across Worthing and St Richard's (Chichester) hospitals. Approximately 45% of patients that would be affected by this change live in East Sussex. Affected East Sussex patients would continue to receive the majority of their care at RSCH or their local hospital and would only be required to go to Worthing for their surgery treatment. These proposed changes will not affect patients treated for colorectal cancer by East Sussex Healthcare NHS Trust (ESHT). More details of the planned changes are included as Appendix 1 to this report.

HOSC's role

1.4 When planning to make significant changes to services, NHS organisations are required to inform local Health Overview & Scrutiny Committees (HOSCs). Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change that would constitute a 'substantial development or variation' to health services for the residents of the HOSC area.

1.5 There is no national definition of what constitutes a 'substantial' change. Factors such as the number or proportion of patients affected, the nature of the impact (positive or negative) and the availability of alternative services are often taken into account in coming to an agreement between the HOSC and the NHS on whether formal consultation is required. Should a HOSC consider that the plans constitute a substantial variation with the potential to have a negative impact on health services for local residents, it may wish to explore the change plans in greater detail and undertake a review.

1.6 Where the HOSC does not consider a proposal to be a substantial variation to services there are alternative options for further scrutiny work including submitting a written response any public engagement or consultation, and further reports to the Committee as the proposals are agreed and implemented.

1.7 The Brighton & Hove City Council HOSC considered a report on the proposed changes at a meeting on 20 November 2024 and it resolved that the proposals did not constitute a substantial variation in services and would instead represent a service improvement in terms of patient experience, outcomes and waiting times.

2. Supporting information

2.1. The report, which is attached as **Appendix 1** provides an overview of the current service, the proposed changes, the expected impacts and benefits and engagement with patients.

3. Conclusion and reasons for recommendations

3.1. The HOSC is recommended to determine whether it considers the proposed changes to be a substantial variation requiring further scrutiny.

PHILIP BAKER
Deputy Chief Executive

Contact Officer: Patrick Major, Scrutiny and Policy Support Officer
Email: patrick.major@eastsussex.gov.uk

University Hospitals Sussex
NHS Foundation Trust

Proposed change to Colorectal Cancer Surgery pathway

East Sussex HOSC chair briefing

Professor Katie Urch | Chief Medical Officer
Jackie Groves | Assistant Director – Major Projects
November 2024

Introduction

University Hospitals Sussex NHS Foundation Trust

- University Hospitals Sussex is one of the largest NHS Trusts and we have a large waiting list for patients
- Colorectal & Lower GI is a specialty with growing demand and a long waiting list to receive treatment
- Current demand for colorectal cancer surgery at RSCH significantly outstrips the available capacity
- RSCH is also a busy hospital dealing with large numbers of emergency surgeries
  - Elective Colorectal Cancer demand increases by approximately 5% a year – a national trend
  - Elective Colorectal non-Cancer surgery waiting list grew by 11%, comparing June 2024 with June 2023
- Conflicting emergency surgery demands, growing elective surgery demand and constrained capacity, means Colorectal & Lower GI is not able to meet its cancer or non-cancer elective activity demands.

Need for Change

University Hospitals Sussex NHS Foundation Trust

Currently, patients at RSCH can experience a sub-optimal service due to lack of capacity.

For example, we have:

- Far higher number of short notice cancellations
- Increased waiting times for treatment
- Growing patient waiting lists for colorectal cancer surgery

Between July 2023 – July 2024, there were 87 Colorectal & Lower GI surgery cancellations.
93% of these cancellations were made due to capacity issues

- This is stressful for patients, delays treatment and provides a poorer patient experience

Waiting longer for surgery may:

- Increase poorliness (acuity)
- Require increasingly complex procedures
- Extend recovery times
- Increase length of stay in hospital
- Increase risk of harm

Colorectal / Lower GI service at RSCH

University Hospitals Sussex NHS Foundation Trust

- Colorectal surgery describes a number of surgeries that fix problems in the lower gut. This can include organs such as the bowel, colon, rectum, and anus.
- Colorectal or Lower Gastro-Intestinal (GI) cancer is also called colon or bowel cancer
- Around 5,500 patients are referred to RSCH on the Urgent Suspected Cancer pathway for colorectal/lower GI each year – and around 200 patients will need surgery for colorectal/lower GI cancer
- Around 100 patients would return to have a temporary stoma bag reversal procedure
- **This means our proposed change in the pathway for elective colorectal cancer surgery would affect an average of seven patients a week**; five new colorectal cancer patients and two stoma reversals

Our Proposal

University Hospitals Sussex NHS Foundation Trust

- We are proposing to relocate all Elective Colorectal & Lower GI Cancer Surgery and Stoma Reversal Surgery from RSCH to the Worthing site, creating a centre of excellence for Colorectal Cancer Surgery delivered across at Worthing and St Richard's hospitals

- Our proposal includes investment in new theatre and bed capacity and associated surgeon, anaesthetic, nursing, therapies and other workforce requirements to meet the additional demand in Worthing.

- We would increase the number of consultant surgeons, and they would also perform on-call emergency cover in Brighton which would also help address other known challenges.

- The proposal would deliver a specialised team of colorectal elective cancer surgeons consistently performing more than 30 surgeries per year, exceeding the minimum threshold recommended by national guidance and leading to anticipated clinical outcomes.

Proposed pathway

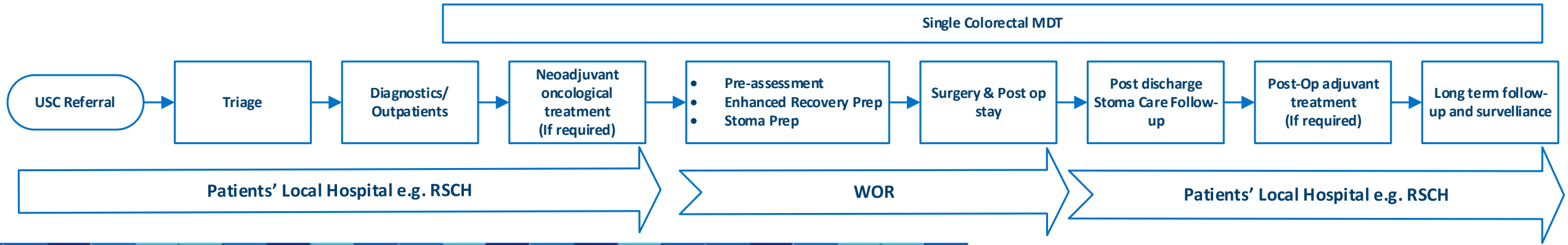
University Hospitals Sussex NHS Foundation Trust

Patients will continue to receive the majority of their care at RSCH, or their local hospital. This includes:

- Diagnostic element of their pathway
- All pre or post-operative Oncology treatment
- Ongoing long-term surveillance and follow-up

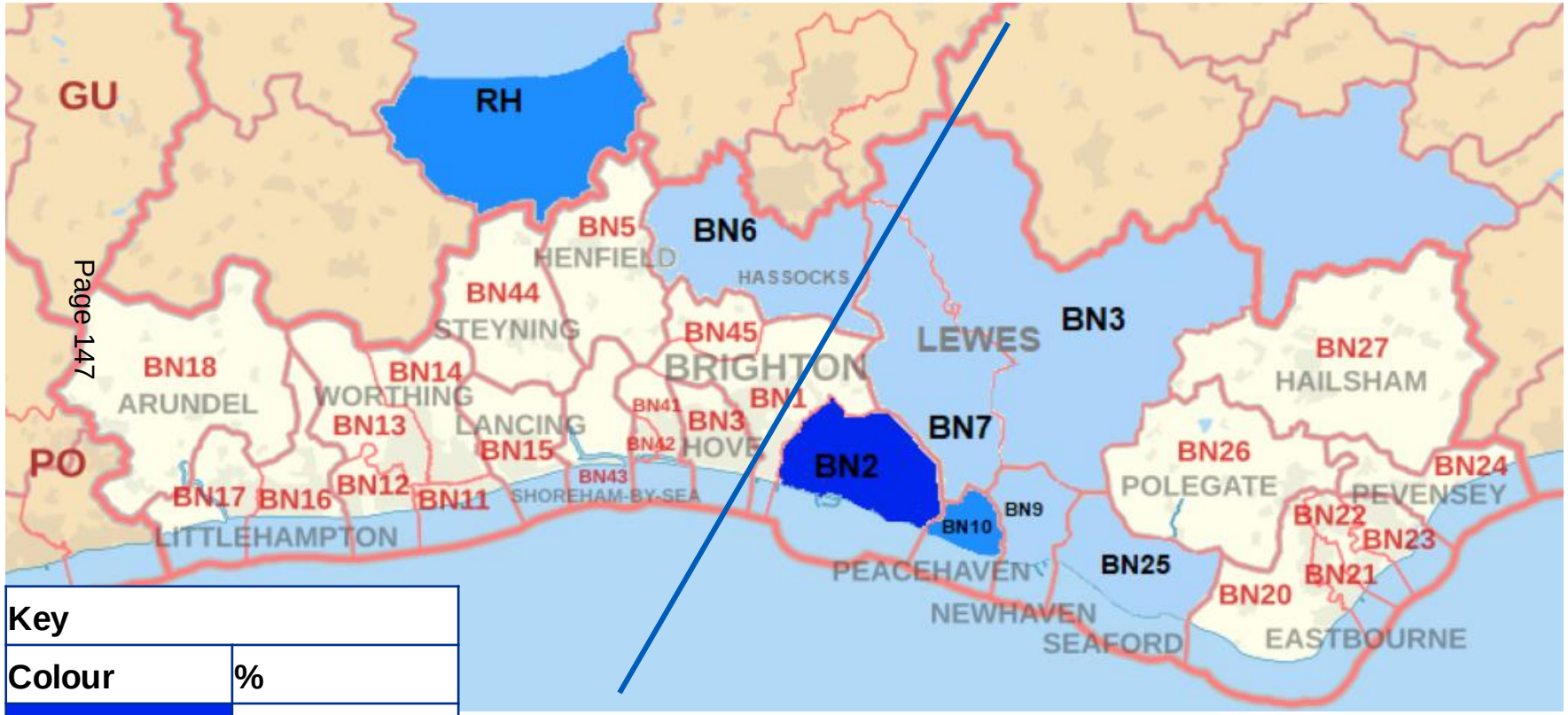
<u>Patients would only go to Worthing for their surgery treatment</u>

- The new standardised pathway would encompass the best elements of current pathways, such as the enhanced recovery model used in Worthing, as well as other national best practice opportunities.
- The standardised pathway would strive to minimise the impact on patients caused by moving surgery away from a patient's “local” site.



Patients affected

Around 45% of affected patients live in East Sussex, mainly from BN7, BN8, BN9 and TN22 postcodes. (TN22 is the area around Uckfield).



Key	
Colour	%
	>10.1%
	5.1-10%
	<5%

Short postcode	Patients per postcode	Percentage by postcode / %
BN2	48	15.95
RH15	21	6.98
BN10	18	5.98
RH16	15	4.98
BN7	14	4.65
BN8	14	4.65
TN22	13	4.32
BN6	12	3.99
BN9	11	3.65
RH17	11	3.65
BN25	4	1.33
RH19	2	0.66
CR3	1	0.33
HS1	1	0.33
NG11	1	0.33
RH18	1	0.33
TN33	1	0.33
TN38	1	0.33
TN40	1	0.33

Benefits

University Hospitals Sussex NHS Foundation Trust

Benefit	Current State	Future State
Release of capacity on RSCH site	Lack of capacity leading to late cancellations of surgery	4 theatre sessions per week 4.4 beds per day
Reduction in length of stay for RSCH patients due to timelier access to surgery and Enhanced Recovery Model at Worthing	Current length of stay at RSCH above average	Length of stay reduced to meet national standards
Reduction in length of stay for the RSCH stoma reversal patients	Current length of stay at RSCH above average	Length of stay reduced to meet national standards
More timely reversal of temporary stomas (where medically appropriate)	Current RSCH wait average – 12-18 months	Significantly reduced wait time – improving outcomes for patients
Improved patient experience from reduced cancellations, reduced length of stay and timelier access to Stoma reversals	Cancellations are highly stressful and can increase risk of harm	Better experience with a new service designed to meet demand with capacity
Increased Level 1 bed capacity on Clapham Ward, to reduce impact on Critical Care	Colorectal cancer uses RSCH Intensive Therapies Unit (ITU) capacity	Proposal would minimise use of critical care in Worthing due to timelier access to surgery and enhanced recovery model

Patient and Carers Engagement

University Hospitals Sussex NHS Foundation Trust

A full case for change highlighting patient benefits has been provided to NHS Sussex Integrated Care Board (ICB).

The Equality impact Assessment / Due Regard document is Appendix 2 in the Cover Report in committee papers.

To inform the decision-making process, we have developed a staged patient engagement plan to provide an opportunity for feedback from patients, carers and their representatives.

Stage 1 – In August 2024, all patients that underwent colorectal cancer surgery at RSCH in the last year were contacted via text and given the opportunity to respond to a survey on the potential surgery move. Both quantitative and qualitative responses were sought.

Stage 2 – In September, a Patient Focus Group was set up with invitees from Healthwatch, Carers Association, ICB, Trust Governors, EDI, patients and charities to provide feedback on the proposal and to discuss options to mitigate concerns. Trust participants included the Director of Patient Experience and Engagement, Chief of Surgery and Trust Programme Director.

Stage 3 – A further patient engagement workshop is currently being organised to update stakeholders on the proposal and hold a workshop on how best to improving patient information leaflets and accessibility of the Trust Patient Transport Policy.

Almost 40% of patients (47 patients out of 122) that had colorectal cancer surgery in Brighton last year responded to the survey.

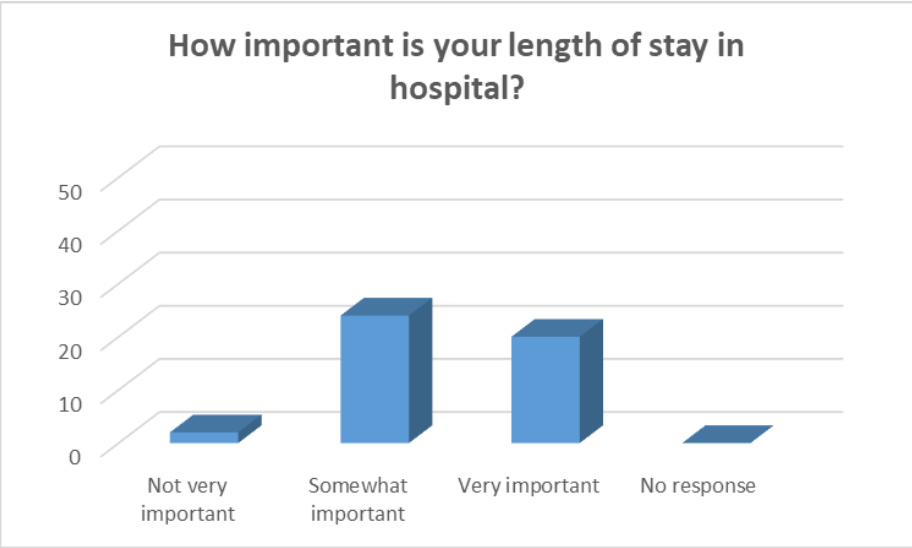
Overall, feedback was positive to the move if it brought the anticipated benefits.

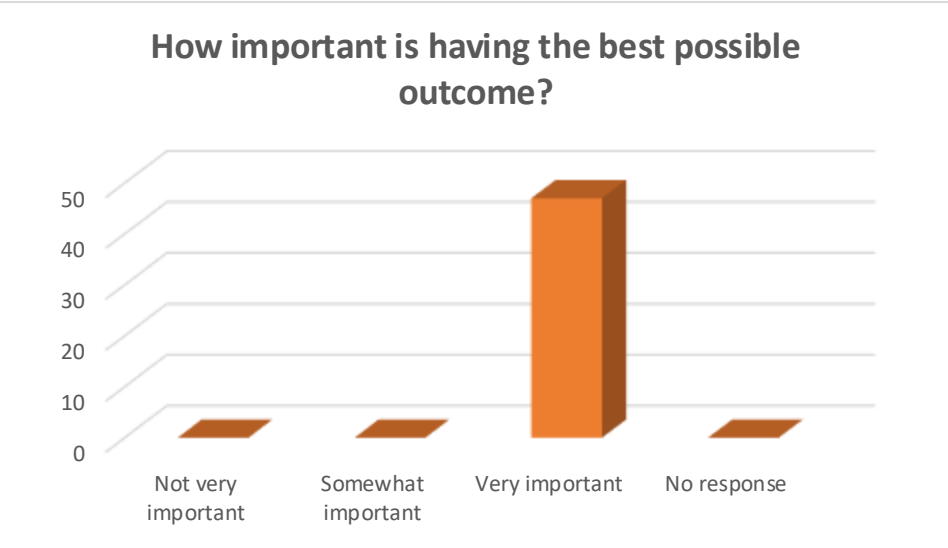
The most important criteria for patients were:

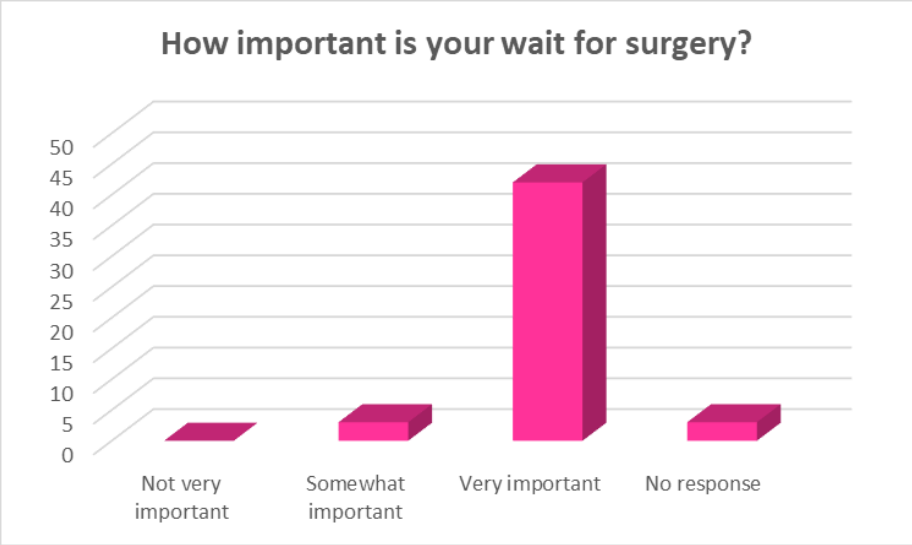
- Length of time to surgery
- Outcomes from surgery

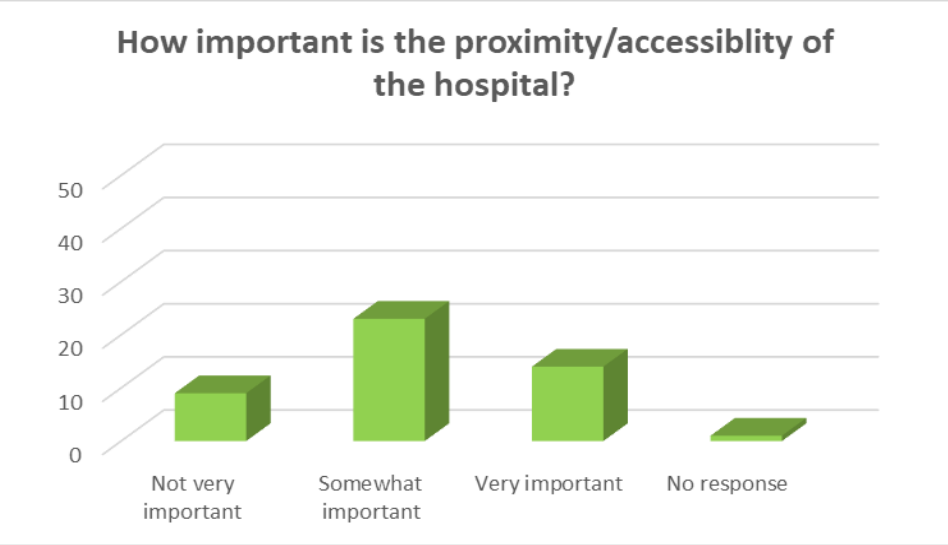
'I think the worst thing would be going into your day of surgery and it being cancelled, so if there's more a chance the surgery will go ahead at a different location then this is really important' **Patient feedback**

Patient views









Patient feedback

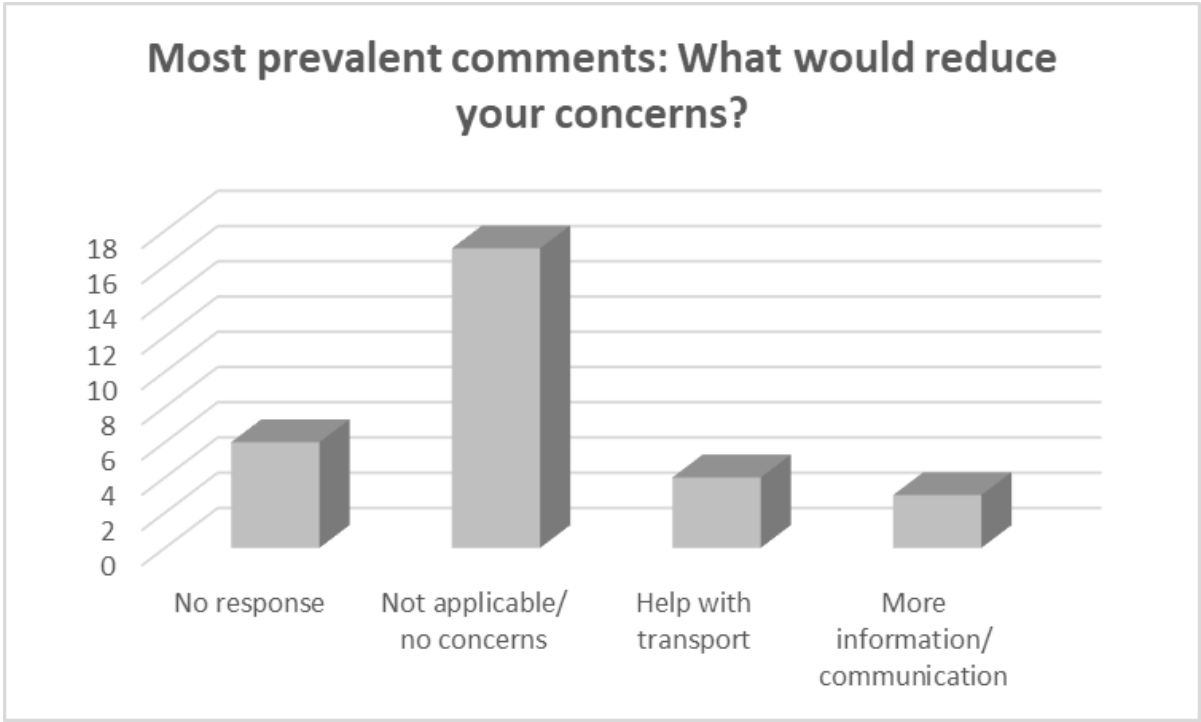
I myself had my Colorectal surgery cancelled on the day at Brighton due to capacity issues. It was extremely stressful as I was very concerned about delays to my treatment.

I would be happy to attend a hospital out of area if this meant my reversal surgery could happen quicker.

I agree with the strategy that provides centres of excellence as a priority over geographical distances.

Lives are at stake when cancer surgery is cancelled or delayed. Anything that can reduce this risk should be considered

A new unit in the existing hospital would be much more accessible



How have we responded to feedback?

University Hospitals Sussex NHS Foundation Trust

Communication

- A new patient information leaflet will be developed to help with communication.
- This will be reviewed by a lay panel and available printed and online.

Understanding impact on different patient groups

- A full equality impact assessment was undertaken.
- Patients at higher risk of colorectal cancer, or stoma management, would be better supported by the enhanced recovery model

Transport

- Reviewed the research base to understand who might be disadvantaged, including protected characteristics
- Identified that reduced length of stay would benefit patients who are carers, and those who care for them
- Reviewed Transport Policy and information – identified access issues, including for patients with language or neurodiversity barriers – so will develop a brochure for patients to receive at their appointment. This would also be available online, with language conversion tools.
- Patient transport is available for patients whose medical and other needs mean that this is necessary.

In Summary …

University Hospitals Sussex NHS Foundation Trust

- Our proposal is to relocate all Elective Colorectal & Lower GI cancer surgery and Stoma Reversal Surgery from RSCH to Worthing Hospital, creating a high-volume centre of excellence for Colorectal Cancer Surgery

- This proposal would impact a small number of patients (approximately seven patients a week), but for these patient the benefits would be significant:
  - Timelier access to surgery
  - Fewer late cancellations of surgery
  - Surgery at specialist centre
  - Reduced length of stay in hospital
  - Enhanced Recovery Model
  - Improved patient experience and outcomes
  - Care at local hospital, except for surgery

Health Overview and Scrutiny Committee (HOSC) – Work Programme

Current Scrutiny Reviews		
Title of Review	**Detail**	**Proposed Completion Date**
Review of the Provision of Audiology Services in East Sussex.	Following consideration of a report at the HOSC meeting held on 30 July 2024, the Committee agreed to undertake a review of the provision of Audiology Services in East Sussex. This follows concerns and issues raised with HOSC about the provision and access to services, including the treatments for earwax removal. The review board is comprised of Councillors Azad, Belsey, Marlow-Eastwood, Robinson (Chair) and Shuttleworth.	March 2025

Initial Scoping Reviews		
Subject area for initial scoping	**Detail**	**Proposed Dates**
To be agreed.	To be agreed.	To be agreed

List of Suggested Potential Future Scrutiny Review Topics	
Suggested Topic	**Detail**
To be agreed.	

Scrutiny Reference Groups		
Reference Group Title	**Subject Area**	**Meetings Dates**
Sussex Partnership NHS Foundation Trust (SPFT) HOSC liaison group	Regular informal meetings with SPFT and other Sussex HOSC Chairs and Vice Chairs to consider the Trust's work and other mental health issues. Membership: Cllrs Belsey and Robinson	Next meetings: January 2025 and April 2025
Reports for Information		
Subject Area	**Detail**	**Proposed Date**
Inappropriate behaviour of NHS staff	Following media reports that there were national problems with inappropriate staff behaviour in the NHS, to provide a briefing on the extent of the issue in East Sussex and what is being done to address problems if they were known to exist.	2024
Training and Development		
Title of Training/Briefing	**Detail**	**Proposed Date**
Visit to Ambulance Make Ready station and new Operations Centre – East.	A visit to the new Medway Make Ready station and new Operations Centre for 999 and 111 services once the new centre is operational.	Autumn / Winter 2024
Visit to the new Inpatient Mental Health facility at Bexhill	A visit to the new Inpatient Mental Health facility due to be built at a site in North East Bexhill to replace the Department of Psychiatry at Eastbourne District General Hospital (EDGH).	TBC but likely 2025

Future Committee Agenda Items		Witnesses
6 March 2025		
Ophthalmology Transformation Programme	An update report on the implementation of the ESHT Ophthalmology Transformation Programme including the development of services at Bexhill Hospital and the implementation of HOSC recommendations on transport and access measures made as part of the review of these transformation programmes	Representatives from ESHT and NHS Sussex.
SECAmb CQC report	A report on the progress of South East Coast Ambulance NHS Foundation Trust (SECAmb) improvement journey and exiting the Recovery Support Programme (RSP).	Representatives from SECAmb
Access to NHS Dentistry Services	An update report on the progress being made to improve access to NHS Dentistry services in East Sussex.	Representatives from NHS Sussex
HOSC Review of Audiology Services in East Sussex	To consider the report of the Review Board undertaking the review of Audiology Services in Eats Sussex.	Chair of the Review Board and Representatives from NHS Sussex
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser
26 June 2025		
Non-Emergency Patient Transport Service (NEPTS)	To receive an update report on the implementation and mobilisation of the new contract for Non-Emergency Patient Transport Services (NEPTS) in Sussex.	Representatives from NHS Sussex.
Access to Primary Care Services – GPs and Primary Care Network (PCN)	An update report on the working being undertaken to improve access to GP services and appointments in East Sussex, including Primary Care Network (PCN) performance and services provided.	Representatives from NHS Sussex.
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser

18 September 2025		
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser
11 December 2025		
NHS Sussex Winter Plan 2025/26	A report on the NHS Sussex Winter Plan 2024/25 and associated risks covering the preparations that are being made for the coming peak demand winter season.	Representatives from NHS Sussex, ESHT and other Trusts
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Scrutiny Adviser
Items to be scheduled – dates TBC		
UHSx CQC report.	To receive an update report on University Hospitals Sussex NHS Foundation Trust's (UHSx) response to the August 2023 CQC inspection report (with a particular focus on the actions being taken at Royal Sussex County Hospital on patient safety).	Representatives from UHSx
Hospital Discharge and Admission Prevention	To receive a report on the work being undertaken to improve hospital discharge including the models being elsewhere, and the work on virtual wards and other measures to prevent hospital admissions.	Representatives of ESHT and NHS Sussex.
Cardiology transformation Programme	An update report on the implementation of the ESHT Cardiology transformation Programme including the transport and access recommendations and measures made as part of the review of this transformation programme. *Note: Timing is dependent on ESHT implementation timescales.*	Representatives of ESHT and NHS Sussex.
Transition Services	A report on the work of East Sussex Healthcare NHS Trust (ESHT) Transition Group for patients transitioning from Children's to Adult's services	Representatives of ESHT

Implementation of Kent and Medway Stroke review	To consider the implementation of the Hyper Acute Stroke Units (HASUs) in Kent and Medway and progress of rehabilitation services in the High Weald area. *Note: Timing is dependent on NHS implementation process*	Representatives of NHS Sussex/Kent and Medway ICS
Adult Burns Service	A report outlining proposals for the future of Adult Burns Service provided by Queen Victoria Hospital (QVH) in East Grinsted. *Note: provisional dependent on NHS England's plans*	NHS England and QVH
Sexual Assault Referral Centre (SARC)	A report on proposals for re-procurement of Sussex SARCs *Note: provisional dependent on NHS England's plans*	NHS England
Specialised Children's Cancer Services – Principal Treatment Centres (PTCs)	To receive an update report from NHS England, London and South East on implementation of the changes to the Specialised Children's Cancer Services – Principal Treatment Centre located in south London which serves East Sussex. *Note: timing of the report will be dependent on the implementation of the changes which are not due until 2026 at the earliest.*	NHS England, London and South East

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