HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 11 DECEMBER 2025

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -

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

District and Borough Council Members
Councillor Kara Bishop, 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
Emma McDermott, VCSE Alliance
Jennifer Twist, VCSE Alliance

AGENDA

1. **Minutes of the meeting held on 18 September 2025** *(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 2025/26** *(Pages 17 - 76)*

6. **ESHT Capital Works Programme** *(Pages 77 - 80)*

7. **Re-Provision of Uckfield Day Surgery Unit** *(Pages 81 - 92)*

8. **NHS Sussex update** *(Pages 93 - 94)*

9. **Cardiology Transformation at East Sussex Healthcare Trust** *(Pages 95 - 106)*

10. **HOSC future work programme** *(Pages 107 - 112)*

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

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3 December 2025

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Next HOSC meeting: 10am, Thursday, 5 March 2026, County Hall, Lewes

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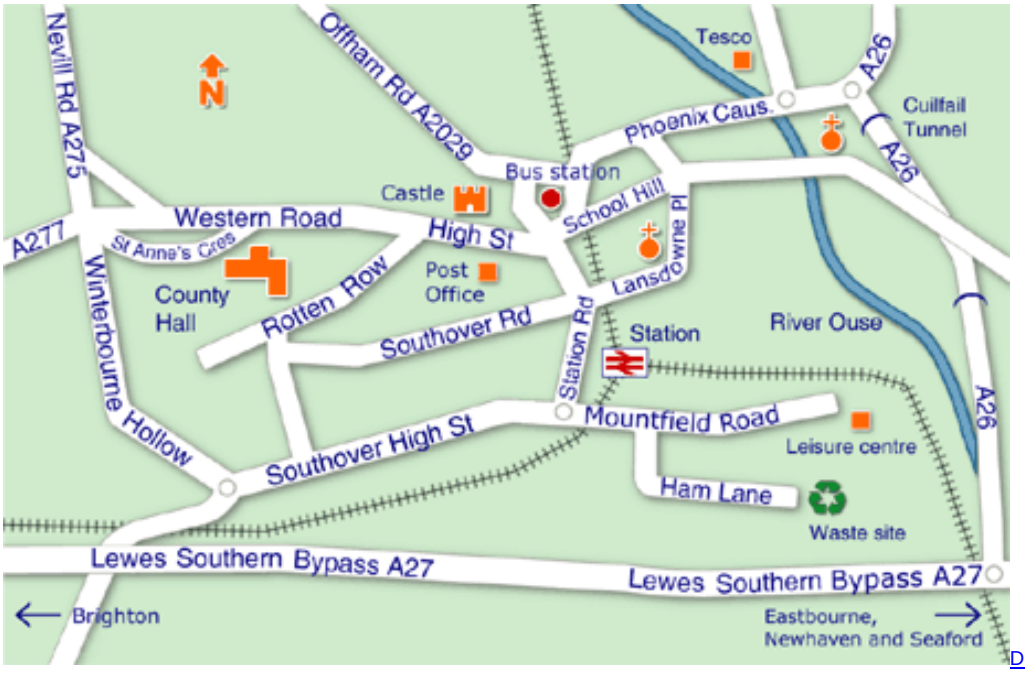

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 18 September 2025

PRESENT:

Councillors Colin Belsey (Chair), Councillors Abul Azad, Sorrell Marlow-Eastwood, Christine Robinson and Alan Shuttleworth (all East Sussex County Council); Councillor Kara Bishop (Eastbourne Borough Council), Councillor Christine Brett (Lewes District Council), Councillor Mike Turner (Hastings Borough Council), Councillor Graham Shaw (Wealden District Council) and Emma McDermott (VCSE Alliance)

WITNESSES:

East Sussex Healthcare NHS Trust (ESHT)

Simon Dowse, Director of Transformation, Strategy & Improvement

NHS Sussex

Jessica Britton, Deputy Chief Delivery & Strategy Officer and Director of Strategic Commissioning

Lizzie Izzard, Head of Children and Young People Mental Health Commissioning

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

Garry Money, Director of Primary Care

Kate Symons, Deputy Director of Primary Care

Dr Binodh Bhaskaran, Clinical Lead (via Teams)

Sussex Partnership Foundation Trust (SPFT)

John Child, Chief Operating Officer

Dr Anna Moriarty, Associate Clinical Director for CAHMS

LEAD OFFICER:

Claire Lee, Head of Policy

9. MINUTES OF THE MEETING HELD ON 26 JUNE 2025

9.1 The minutes of the meeting held on 26 June 2025 were agreed as a correct record.

10. APOLOGIES FOR ABSENCE

10.1 Apologies for absence were received from Councillor Terry Byrne and Jennifer Twist.

11. DISCLOSURES OF INTERESTS

11.1 There were no disclosures of interest.

12. URGENT ITEMS

12.1 There were no urgent items.

13. ACCESS TO GENERAL PRACTICE IN EAST SUSSEX

13.1 Garry Money, Director of Primary Care NHS Sussex, presented the report, which provided an update to prior reports regarding primary care performance and the services that Primary Care Networks (PCNs) provide across East Sussex, including access to GP appointments. The report existed in the context of national policy changes in the NHS, including changes to Integrated Care Boards (ICBs), NHS England, and the 10-year Health Plan, which would likely change the way general practice is contracted in the future. When compared to other counties, East Sussex had been performing well in terms of volume of appointments, but patient experience, service variation and connection between services remained areas to monitor for improvement.

13.2 The Committee asked what the long-term issues are for the recruitment and retention of staff.

13.3 Garry Money responded that recruitment decisions in general practice were made individually across the 156 practices, which were sometimes in competition with each other for staff. The Additional Roles Reimbursement Scheme (ARRS) enables specialists to work flexibly across practices within PCNs, but there was room for further integration in the local workforce, which may be achieved in the development of neighbourhood health teams. Difficulties with capacity have also stemmed from the segregation of roles and a lack of flexibility in the workforce, which has led to pressures on doctors and nurses in practices. This amounts to a loss of flexibility for patients too.

13.4 Dr Binodh Bhaskaran added that a training hub had been established that provided support to apprentices and students to use resources effectively to retain staff. He raised complications regarding finding training areas and having sufficient estates to host trainees and recently qualified staff, has become difficult, but the PCNs were working collaboratively to address this. He added that the Levelling Up Partnerships in Rother and Hastings was being used to support the expansion of necessary infrastructure, which aids the retention of staff in the area, and that these efforts should also be inclusive of non-clinical staff that support practices.

13.5 The Committee asked for an update on the development of the Seaford Health Hub, which had been in development for 6 years, as residents in Seaford have been allocated GP appointments in Eastbourne.

13.6 Garry Money confirmed that NHS Sussex would provide a response to this question outside of the meeting.

13.7 The Committee noted from the report that the clinical workforce shrank by 15FTE, whereas the non-clinical workforce increased by 23FTE, and asked what is being done to increase the clinical workforce.

13.8 Garry Money responded that there was no fixed level of staffing within GP practices, and an increase in non-clinical workforce could, for instance, be to correct a deficit in the workforce. The goal was for clinical staff in practices to spend as much time as possible with patients, but there were other practical issues for recruiting and retaining a workforce which are beyond the control of GP practices, such as affordable housing and local facilities. Recruitment and retention of staff in practices was a challenge, especially when practices were in competition with each other and other healthcare providers such as hospital trusts, and it was important for NHS organisations to collaborate on workforce planning.

13.9 The Committee asked when and where in the County enhanced access hours appointments were being offered by GP practices.

13.10 Garry Money confirmed that the ICB were unable to provide data for all 12 PCNs, as the totality of minutes offered varied across PCNs and practices, the data does show a sustained level of service over time.

13.11 The Committee asked what work is being undertaken to encourage the workforce to get vaccinated, as the uptake figures were low in the report.

13.12 Kate Symons responded that frontline health and social care workers were not included in the eligible groups for COVID-19 vaccination for winter 2025-26, so a drop in uptake was expected. Frontline health and social care workers remained eligible for the flu vaccination, and the ICB was working with each healthcare trust to increase flu vaccination uptake for frontline staff, with an aim for a 5% increase on the previous year.

13.13 Simon Dowse, Director of Transformation, Strategy & Improvement, added that work was being undertaken to frame messaging around vaccinations, including reassuring staff, and ensuring that vaccinations remain accessible. He stated that it was not easy to encourage people to get vaccinated, and that often data is skewed by staff receiving vaccinations outside of

the trust (e.g. through their GP), which was often missed in data. He explained that extensive communications are sent out to staff in the lead-up to winter to ensure questions about vaccinations are answered in the messaging.

13.14 The Committee asked how NHS Sussex are delivering the 10-year Health Plan through access to general practice, and what key issues they face.

13.15 Garry Money responded that access to general practice, and same-day or urgent care were key areas for delivering the 10-year Health Plan. Neighbourhood health and continuity of care were key focuses of the plan, which is something practices have been trying to deliver. There were changes anticipated in PCNs, due to the expiration of the initial 5-year PCN contract, however these had become fundamental to delivering primary care through the ARRS roles. The plan advanced the idea of neighbourhood working, which would be built around larger and more coherent geographies than PCNs currently were. In the context of cuts to non-clinical costs in the ICB though, there remained a key question of how to deliver this with fewer non-clinical staff.

13.16 Dr Binodh Bhaskaran added that key issues experienced across Sussex include managing frailty, as many of the population needing care are frail and vulnerable. Bringing care closer to home, as in the 10-year plan, could improve support for those people, but would need to involve working with community trusts and the VCSE sector. Hastings and Rother had been announced as areas that would be part of a national programme to support neighbourhood working.

13.17 The Committee asked if, in circumstances where patients experience adverse reactions to vaccines, this is kept in patients' records.

13.18 Garry Money responded that record keeping is a basic requirement of all GP practices, and Binodh Bhaskaran added that this is part of the duty of care that practices have for their patients, regardless of vaccination status. Dr Bhaskaran noted that self-limited adverse reactions to the COVID-19 vaccine have been observed in approximately 5% of the total people who received it, due to their immune system reaction. The decision to receive the vaccine remained an individual one, and the risks should be assessed between individuals and their healthcare professionals where patients do have certain risk factors.

13.19 The Committee asked what work the ICB is undertaking to mitigate health inequalities in end of life care in Hastings, and whether health data in future reports can be broken down by area in East Sussex.

13.20 Garry Money confirmed the ICB maintained an active programme with the hospice alliance, to enable access to palliative and specialist care for East Sussex residents. He confirmed that data is collected from the five ICTs in East Sussex, and future data can be presented at that level. Hastings and Rother were set up as a single neighbourhood, for the establishment of neighbourhood health teams in the area, which would be undertaking work to address health inequalities.

13.21 The Committee commented that the VCSE sector had found engagement with GP practices to be irregular, and asked what the ICB and the VCSE sector could do to support further engagement by GPs in neighbourhood working.

13.22 Garry Money replied that practices work with Healthwatch and the voluntary sector to deliver improvements and acknowledged there was some variation in delivery between practices, due to resource capacity. GPs conduct assurance but, despite constraints on resources, often have delivered improvements that they have not been asked to. The task of the ICB was to therefore ensure that these improvements become more wide-spread. Part of the reason for this variation in service stemmed from PCNs grouping practices into silos, whereas

previously practices would group together naturally to form co-working arrangements and share good practice. He expressed hope that neighbourhood health working would reinvigorate co-working between practices, as well as working with VCSEs to make improvements. Further information could be shared with the Committee when the programme was launched.

13.23 The Committee asked how patient voice contributed to the quality improvement programme.

13.24 Kate Symons responded that patient experience surveys and collecting data were important to deliver improvements. Metrics used in the report came from patient experience surveys, including a survey of over 10,000 residents, and this was being used to facilitate conversations about service improvements. Receiving further feedback from patients was key to identify and address variation in services, as part of quality improvement. Garry Money added that the ICB were due to launch a new programme for patient engagement and experience, working with Healthwatch and the VCSE sector.

13.25 The Committee asked what system is used by GP practices to triage same-day appointments.

13.26 Garry Money responded that every practice operated a triage process, but the appearance of this process may be different in different areas. In some cases, GP practices encouraged patients to complete a form which would be triaged, or patients would receive a call back with appointment information, and the ICB was monitoring how practices triaged patients. Part of practices' contractual agreements specifies that patients should not be told to call back for an appointment, so practices would always follow up with patients after triage.

13.27 Binodh Bhaskaran outlined how a practice in Bexhill operated a triage system whereby the reception team were trained in care navigation and supported by a paramedic to direct patients to the correct support; they received approximately 350 online questions per week which would then be triaged to a pharmacist, nurse, GP or other services as appropriate. How the triage process operated was dependent on the workforce and the skills available, so this system may not be applicable to all practices. Practices receive calls from patients, but also from healthcare professionals and carers, so triage systems were encouraged to manage the demand.

13.28 The Committee asked what will be done to ensure access to the NHS for patients that are digitally excluded, given that East Sussex has one of the highest proportions of over-85s nationally.

13.29 Garry Money responded that the development of the NHS app was a key priority for the government; the app was intended to be the primary route of usage for the majority of people, and most people would be able to access the NHS through this route, but this did not mean it was the only route. The ICB have been working with Healthwatch, the VSCE sector and patients to ensure that patients can still access services without the app, to mitigate digital exclusion.

13.30 Binodh Bhaskaran added that many older people are digitally literate and can use the app to access their medical records. Practices in East Sussex have set up hubs in town centres to upskill people in using the NHS app, but this work was ongoing.

13.31 The Committee asked what future planning is being undertaken to build new GP practices, to cope with new people moving into the area if new housing is built under the direction of a Mayor.

13.32 Garry Money responded that housing remained a constant topic of discussion, but that ultimately what decisions on new health facilities were considered on the unique circumstances of each development, and the ICB worked closely with district and borough councils on this. He confirmed that there were practices in East Sussex undergoing reviews to improve capacity or

facilities, but this is dependent on resources available and staffing needs. He added that the role of the ICB is to be a strategic commissioner, meaning that they would need to consider what health facilities would be needed for any new housing developments.

13.33 The Committee expressed a view that developers should be responsible for the building of new health facilities around large developments. In areas like Telscombe Cliffs, the number of GP practices has reduced in recent years from four to one, for an area of 23,000 people, so the Committee stressed that the ICB must ensure that infrastructure is in place for new developments.

13.34 The Committee asked what the impacts the rural/urban split in East Sussex has on unwarranted variation in access to GPs, and what the areas for improvement are, including through neighbourhood working.

13.35 Garry Money responded that GP practices in rural areas are a lot more knowledgeable about their area and patients than the ICB, but there have been difficulties, with rural practices sometimes unable to keep up with wider developments in practice. This has previously included changes to dispensing practices, for example. He stated that the aim for incoming neighbourhood health changes should create support for rural areas, by enabling feedback from rural areas and co-working for the wider population.

13.36 Ashley Scarff added that integrated community teams (ICTs) are coterminous with the areas for district and borough councils, who are directly engaged in their operation. This is partially due to housing needs and developments and their role as a local planning authority, which means the ICB will find it useful to be involved with the mayoral authority at a strategic level in the future. The ICB have been investigating inequalities and unwarranted variations in services, through actions like working with Healthwatch and considering the role of the wider determinants of health, including housing. The 10-year plan set out the new role of the ICB as that of a strategic commissioner, so health inequalities and variation in services would be considered as part of that role.

13.37 The Committee asked what the variation is in digital access across the county, how digital access is spreading between practices and what initiatives the ICB has for improving digital access.

13.38 Garry Money clarified that there are public reports available to see digital access in the county. He stated that GP practices aim to focus on outcomes: for example, calling you back to follow-up, rather than telling you to call the practice back. He noted that while technology can help to an extent, there is a limit to its benefits, as this was dependent on developments being joined up, to streamline working.

13.39 The Committee RESOLVED to:

1) note the report; and

2) request a focused update report on general practice issues at an appropriate date.

14. NHS SUSSEX UPDATE

14.1 Ashley Scarff delivered an update from NHS Sussex regarding national and county-wide changes to the NHS, including some service changes. This included the following updates:

- The publication of the Government's 10 Year Health Plan, which had three main strands which were well aligned with the strategic direction of NHS Sussex and the Sussex health and care system as set out in its five year strategy, 'Improving Lives Together'.
- The ICB had set out its commissioning intentions for year 1 (2026/27) of the 10-year Health Plan.
- The ICB were working on developing neighbourhood health services for East Sussex and the wider area, they planned to use ICTs to deliver integrated community health services together with social care, and incorporate broader health determinants like employment and education in planning to meet population health and care needs.
- The National Neighbourhood Health Implementation Programme has allocated East Sussex with a focus on Hastings and Rother as one of its 44 pilot areas.
- It has been confirmed that NHS Sussex will be combining with NHS Surrey Heartlands to form a single ICB from April 2026, driven by the national requirement for ICBs to reduce their non-clinical costs by 50%.
- The procurement process was underway for a new community audiology provider. They were planned to be in place by January 2026 and the go-live for the new end-to-end pathway would be April 2026.
- Births have been suspended at Crowborough Birth Centre by the Maidstone and Tunbridge Wells NHS Trust. All antenatal and post-natal services continue to operate from the centre. The ICB is working with the Trust to understand service issues and plans.

14.2 The Committee asked when changes to posts within the ICB would be known.

14.3 Ashley Scarff answered that the ICB would continue to operate as two organisations, until 1 April 2026, and that any changes to officers would be announced as soon as possible. Ian Smith had been appointed as the Chair of the ICB, and chief officer announcements were due in the coming months, but so far there had been delays nationally to ICB changes.

14.4 The Committee asked how the 10-year plan and neighbourhood health teams would deliver improved access to services in deprived areas of the county.

14.5 Ashley Scarff responded that local delivery of health through ICTs is clearly set out in the 10-year plan; it was expected that the plan would amplify services at the community level. He explained that the learning opportunities from the new neighbourhood teams in Hastings and Rother would support future teams to deliver better health outcomes, particularly around health inequalities. The system hoped that these teams would highlight issues experienced by residents across the county, and could be used for wider mobilisation of neighbourhood healthcare.

14.6 The Committee asked how the ICB were involving system partners, including the VCSE sector, in changes to the system at appropriate governance levels to ensure coherence.

14.7 Ashley Scarff affirmed that the ICB recognises and values the VCSE sector for their support, and that in comparison to some other areas of the country, NHS Sussex is embedding partner engagement into their processes. However, the ICB were always conscious of creating a governance burden to system partners, so have been investigating more alliances and

collaborative ways of working (like ICT leadership groups, provider alliances, community teams) to facilitate discussion.

14.8 The Committee enquired about how well other hospitals were prepared to manage additional demand, following the closure of Crowborough Birthing Centre.

14.9 Ashley Scarff responded that the centre is part of a broader network of maternity services, which is well prepared to resource additional births, as the number of births at Crowborough Birth Centre were relatively low. The scheduled births were being rescheduled to other centres, and the ICB were working with trusts and provider partners to do this.

14.10 The Committee noted that ICTs have been built on the footprints of district and borough councils and asked what would happen to these after local government reorganisation.

14.11 Ashley Scarff responded that once more information was known about local government reorganisation, the ICB will consider the impact of that on the footprint of the ICTs, noting that PCNs did not have the same boundaries as the ICTs, but that this was not currently being reconsidered.

14.12 The Committee RESOLVED to:

1) note the verbal update from NHS Sussex; and
2) consider whether it would like to receive further updates or reports on any of the issues raised under this item.

15. CHILDREN AND YOUNG PEOPLE MENTAL HEALTH UPDATE

15.1 Jessica Britton, Deputy Chief Delivery & Strategy Officer and Director of Strategic Commissioning NHS Sussex, introduced the report, which provides information about the mental health transformation programme, the work of mental health support teams and neurodevelopment pathways in East Sussex. She highlighted significant increased demand for services in the neurodevelopment pathway, and a change in patterns for the support needed by children and young people.

15.2 The Committee noted that approximately 60,000 children in East Sussex have a diagnosable mental health condition, representing a 66% increase since 2021, and asked what is being done to expand mental health support teams in schools to support these young people, and whether the establishment of i-Rock hubs is being considered in other areas in the county.

15.3 Jessica Britton responded that mental health support teams were part of a national programme for ensuring equal access to mental health services, and the system identified the schools enrolled according to where support was most needed. The system was working with schools to maintain the 65% coverage, but there was to be no further investment in those teams for the time being, as the system was working to ensure the goals of the mental health teams were aligned with early help and support set out in the mental health transformation programme. It was a core priority for the system to ensure a holistic approach to support for children and young people, before increasing support to 100% coverage. The system was exploring the expansion of i-Rock hubs and access to early help.

15.4 Lizzie Izzard, Head of Children and Young People Mental Health Commissioning NHS Sussex, added that i-Rock was viewed as core part of the mental health transformation

programme, providing quick advice and support for access to services. She explained the expansion of this across East Sussex would need to consider how it can best support children and young people in local areas, as it may not be suited to all of them, but would be used to develop the core offer. The service was intended to be preventative, so that children's immediate needs could be met without them escalating, but the ICB is mindful not to medicalise all children while offering them support.

15.5 The Committee expressed concern that the waiting time for neurodevelopmental pathways is 645 days and asked how this was being addressed.

15.6 Jessica Britton confirmed that this waiting time is longer than it should be, but that this was also a national issue being investigated by a national taskforce. Teams in the system had been working to develop a model to triage young people, to signpost residents to support, and the system was working with schools to expand available support while children waited for an assessment. This was developed in partnership with professionals, schools, the VCSE sector and children and young people with experience of the pathway. It was expected that a new assessment model will be finalised by June 2026, to work to reduce that waiting list.

15.6 John Child, Chief Operating Officer SPFT, responded that the transformation of CAHMS services included the early help support offer, to make sure that services were being as productive as possible while providing similar outcomes in different areas. The Trust had developed neurodevelopmental assessment hubs, containing neurodevelopment assessment teams, which contain specialists in different neurodivergences, in order to make best use of resources and ensure best outcomes. Previously, assessments had been carried out by CAHMS specialists, so these hubs were to make the best use of resources to carry out the assessments.

15.7 Anna Moriarty, Associate Clinical Director for CAHMS SPFT, added that the Trust has developed a support-whilst-waiting offer, to help families to access support from the community, VCSE sector and education without a diagnosis.

15.8 The Committee asked what barriers there are to accelerating and improving access to services for patients, including the expansion of i-Rock hubs.

15.9 John Child noted that constraints on resources in the NHS and local government mean that the trust has a gap between demand and resources. Thousands of young people have been referred to the neurodevelopmental pathway, but due to resource constraints the trust did not have the clinical capacity to see patients in the neurodevelopmental pathway within a reasonable timeframe.

15.10 The Committee asked how school environments impact on demand for CAHMS.

15.11 Lizzie Izzard assured the Committee that the neurodevelopmental programme and mental health support teams in schools have been working with ESCC to support children. However, the school environment often is not tailored to neurodiverse children, particularly children with autism, so the ICB have been working with schools through the Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme to develop learning environments that are supportive of children with SEND.

15.12 Jessica Britton added that many children are referred to the pathway through schools, and the mental health schools' team and PINS are a large part of supporting that.

15.13 The Committee noted that initial assessments happen within 28 days and asked what the qualifications of staff conducting assessments are.

15.14 Lizzie Izzard confirmed that all assessments are completed by professionals with mental health qualifications, from the multi-disciplinary teams. Support workers may join an assessment

but would always be accompanied by a qualified professional and would not carry out an assessment independently.

15.15 The Committee asked how children are referred internally to the pathway.

15.16 John Child clarified that internal referrals are where a clinician within the pathway has identified that a patient needs a treatment from a specialist, and external referrals are where children are referred to the pathway from outside, such as from their GP or school.

15.17 The Committee raised feedback from residents that some parents were unhappy with their children being discharged from treatment and asked how carers and families are engaged prior to discharge from treatment.

15.18 Anna Moriarty noted that CAHMS and SPFT offered episodic care, which centres on goal-based outcomes. The trust aimed to have conversations about the limitations of their service early on with families to ensure that goals are obtainable, and this formed part of ensuring that all care offered is working towards a goal to ensure best use of resources. This less routine and systematic support would be utilised in the new clinical model, and support would be reviewed if patients were not making progress towards them.

15.19 The Committee asked if there are any figures available from before 2022 and whether the NHS has received any negative feedback about the neurodevelopmental pathway.

15.20 John Child confirmed that the earliest available inclusion data was from after 2022, as previously data for CAHMS and the neurodevelopmental pathway were grouped together. These were separated in 2022 to better understand the scale of demand for different assessments.

15.21 Anna Moriarty responded that the trust welcomes constructive feedback, and though the themes of qualitative feedback have not been provided in the report, the quantitative data provided indicates that the responses are mostly positive. The trust have been working with a limited data set so far but have started to issue QR code feedback forms to raise the response rate.

15.22 The Committee asked what work mental health support teams were doing in schools, and if there was a larger programme to help students understand anxiety and develop resilience.

15.23 Lizzie Izzard clarified that MHSTs are a national programme following a national model. As set by NHS England, MHSTs consist of four educational mental health practitioners. The first year a team is established, those four practitioners are in training at university and entering the mental health workforce, overseen by a manager and clinical supervision. One team covered approximately 8,500 students across a cluster of schools, as set by NHS England, and the roll out was planned to target areas of most need, with an aim to have full coverage of Sussex by 2030. She added that a whole school approach would be needed to effectively support students, and the teams were working with schools to train staff who work with children daily, to ensure that they were equipped to centre students' emotional and mental health in educational settings.

15.24 The Committee asked, if there is one team per 8,500 pupils, whether they are able to support all students that need support and whether the support offer covers colleges too.

15.25 Lizzie Izzard responded that the ICB are using their teams to meet need the best they can, including outreach work to schools to identify where the most need is. Where this need has been identified, the MHSTs offer one-to-one support for students that need it most. This is set

out in the wider national programme to reach 100% coverage by 2030, but other services like CAMHS and i-Rock are still available to deliver support. The service supported children up to age 18, including further education and colleges. John Child added that schools also commission their own mental health initiatives and internal support for students.

15.26 The Committee asked what will happen for children requiring in-patient care following the announced temporary closure of the Chalkhill unit.

15.27 John Child responded that Chalkhill is a general adolescent in-patient unit and that children requiring more specialist admissions – such as psychiatric intensive care or eating disorder admission – access inpatient care outside the local area. The decision to close Chalkhill was made over a planned period of time (3 months), so as not to disrupt continuity of care for the young people in the unit. He clarified that the closure was due to sustained improvements to the unit not having been made, key clinical roles being vacant and the need to ensure that care remains safe, especially as there had a shift in care needed, toward children with much higher needs, more complex emotional needs, and neurodiversity. He confirmed that SPFT will undertake a programme of work which will include a review of the clinical model to ensure it meets the needs of children and young people, skill mix and facilities to support patient needs, recruitment to key clinical roles and an opportunity to improve the environment of the building. He stressed that this was a temporary closure, and it was the Trust's full intention for the centre to reopen. He confirmed that young people would not be admitted to adult inpatient facilities and that the approach to bed finding via the Provider Collaborative would not change.

15.28 The Committee asked when it was expected that there would be long term improvement in young people's mental health services that residents expect to see.

15.29 John Child answered that there were significant ongoing changes in the NHS, and public services were operating under tight financial constraints. The trust were working to improve early intervention and prevention services, to keep children in schools and reduce impact on families. This was particularly important in the context of neurodevelopmental challenges, to prevent escalation and greater cost later on. That is not to disregard current complex needs, but prevention will ease pressures for the future.

15.30 Anna Moriarty added that the THRIVE framework, which enabled partners to give residents the knowledge of what help is available, was key to helping young people to access support as soon as possible. This was a large part of early intervention, but also following up with further specialist support as soon as possible was necessary to prevent escalating need.

15.31 The Committee RESOLVED to:

1) Note the report; and
2) Schedule a progress report on neighbourhood mental health support teams to a future meeting.

16. HOSC FUTURE WORK PROGRAMME

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

16.2 The Committee RESOLVED to:

1) Schedule the reports on NHS Sussex Winter Plan 2025, ESHT Cardiology Transformation Programme and the ESHT Capital Works Programme to its December 2025 meeting; and

2) Receive a progress report on the implementation of the new Audiology contract, Neighbourhood Mental Health teams, and EDGH Paediatrics Model at its meeting in March 2026.

17. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

17.1 None

The meeting ended at 12.52 pm.

Councillor Colin Belsey

Chair

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**11 December 2025**
By:	**Deputy Chief Executive**
Title:	**NHS Sussex Winter Plan 2025/26**
Purpose:	**To provide an overview of the NHS Sussex Winter Plan 2025/26.**

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 2025 to April 2026 and was approved by the NHS Sussex Integrated Care Board.

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 main 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 four key pillars as part of this:

- Acute and in hospital care
- Primary and community care
- Sound clinical and operational management; and
- Oversight, governance and escalation

2.2. The plan also includes analysis of demand and capacity modelling to close bed gaps, learning from the Winter Plan 2024/25, targets for Winter 2025/26, communications and engagement plans, and an assessment of risks to the successful delivery of the plan, including wider structural changes in the health system.

2.3. The full Winter Plan as approved by the ICB is attached as **Appendix 1** for information, which highlights the Sussex-wide 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. This includes summaries of risks and lessons learned from the winter 2024/25 in its final pages.

3. Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider and comment on the NHS Sussex Winter Plan, and agree whether it wishes to receive a feedback report at its June meeting.

PHILIP BAKER
Deputy Chief Executive

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Sussex Health&Care

Sussex Winter Plan

November 2025 - March 2026

Version Board Final

Improving Lives Together

Introduction

An overview of the 2025/26 winter plan

This pack sets out at a high level the key elements which underpin each of the four pillars.

The approach to Winter 25/26 in Sussex builds on learning from previous years and identified risks (see appendix) 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 plan aims to build on and strengthen existing programmes of work, and wherever possible to link into the longer term aims of our agreed system strategy.

This winter plan is based on four pillars

The key objective for this winter will be to support people to stay well and maintain patient safety and experience, by focusing on a small number of high impact areas.

To achieve this, we have developed a Winter Plan around four pillars:

Pillar One Acute and In Hospital Care	Pillar Two Primary and Community Care	Pillar Three Sound Clinical and Operational Management	Pillar Four Oversight, Governance and Escalation
• Patients using Urgent and Emergency care services • Patients waiting for a Mental Health bed • Patients awaiting discharge • Managing elective care demand • Workforce	• Improving vaccination rates, including health care professionals • Proactive identification and care planning for patients with highest needs (including care/nursing home residents) • Proactive approach to support patients at risk of respiratory illness • Improving Flow through intermediate care services • Increased utilisation of virtual health solutions	• Winter Operating Model • Effective management of Clinical risk and IPC • Clear co-ordination across the system and rapid routes of escalation for operation issues • Operational Pressures Escalation Levels (OPEL) Framework utilisation • System MADE Event • Communications plan	• Robust oversight of the delivery of the winter plan • Clear routes of escalation for strategic issues • Stress testing of the plan • Equality Health Impact Assessment (EHIA) • Quality Impact Assessment (QIA)

Principles

Underpinning the plan are the following principles designed to ensure that we maintain a focus on quality and safety over the period:

- **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 proactively** supporting the most vulnerable and those at highest risk to minimise exacerbation of illness
- **System resources will be targeted** in the areas where they will get the 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 across the system
- **Our clinical leaders will be at the heart of decision making** throughout the winter period

Identification of main areas of focus

The Winter Plan aligns to local priorities and key areas of national focus which have been identified through review of:

- The NHS Sussex Commissioning for Outcomes Improvement plan
- the National UEC Plan published 6th June 2025 – 7 improvement priorities
- the NHS 10 year plan, published 3rd July 2025 – Fit for the Future
- the Sussex Shared Delivery Plan (SDP) – Improving Lives Together

Alignment to our Shared Delivery Plan

The Sussex Winter Plan aligns with the system Shared Delivery Plan (SDP) priorities in several ways:

- **Integration and Coordination**: The winter plan emphasises joining up urgent and emergency care services, which aligns with the SDP priority of improving integrated, coordinated care outside of hospitals.
- **Virtual Health Pathways**: The expansion of virtual health pathways and maximising utilisation of virtual wards are key deliverables for 25/26. This aligns with the SDP priority of enhancing quality of care through focused intervention, preventive, and proactive care.
- **Alternatives to Hospital Admission**: The plan includes delivering alternatives to hospital admission, such as redirection into community based care, and senior decision-making at the 'front door'. This supports the SDP priority of reducing A&E attendances and improving demand management.
- **Best Practice in Hospital Patient Flow**: Ensuring best practice in hospital patient flow through consistent specialty response to ED and straight-to-specialty referral aligns with the SDP priority of improving patient flow and reducing the length of stay.
- **Discharge to Assess Principles**: Applying 'discharge to assess' principles and optimising admission avoidance initiatives align with the SDP priority of improving discharge processes and supporting patients' recovery at home.
- **Strategic Redesign and Delivery**: The winter plans focus on increasing access and moving more care into the community supports the SDP priority of delivering timely and appropriate care in the right place, first time.

This alignment helps ensure that delivery of the plan will support delivery of the SDP and in turn, the system strategy Improving Lives Together.

The challenge if we 'do nothing' (1/2):

Demand and Capacity Modelling

Demand and Capacity Modelling has been undertaken for General & Acute (G&A) Beds at our acute hospital sites to test their ability to manage possible winter pressures and the expected impact of our plans in mitigating those pressures, as follows:

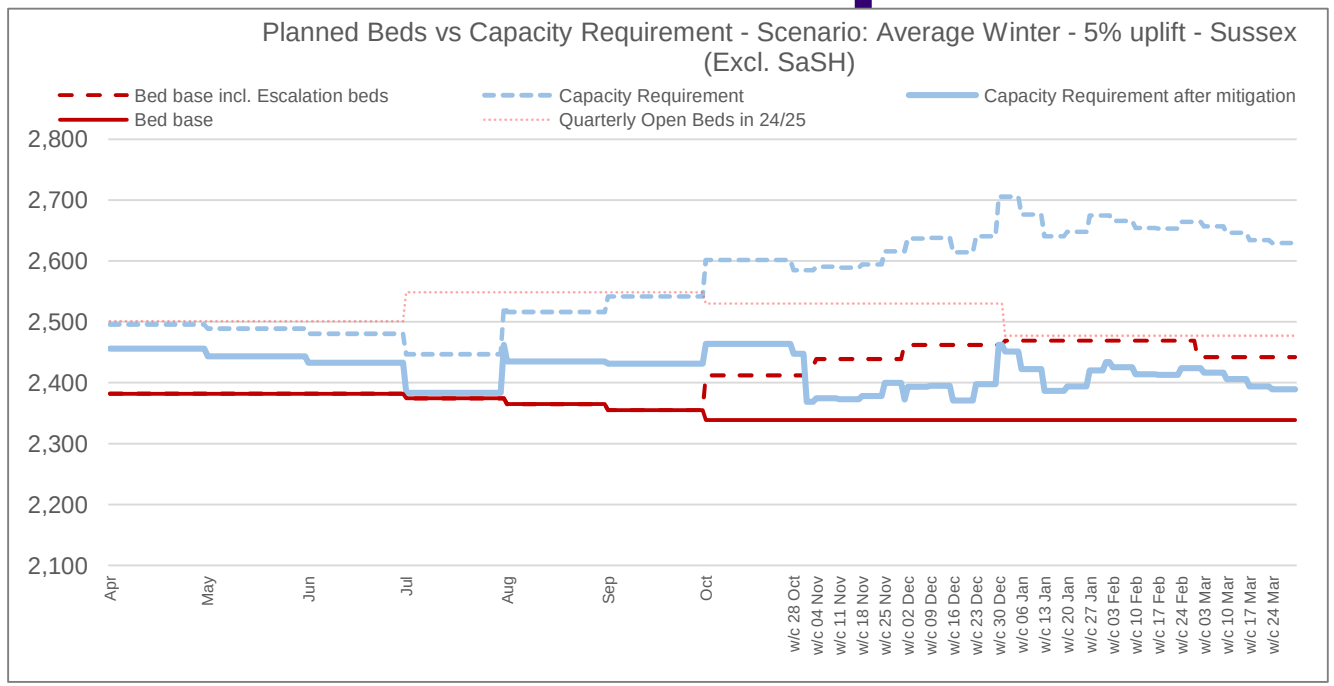
We have developed a 'statistical model' based on bed occupancy and likely scenarios for service demand based on possible levels of influenza (flu) and infectious disease in our community. This provides the 'bed gap' in a reasonable worst-case scenario.

The challenge if we 'do nothing' (2/2)

Current outputs of the model:

- The total number of core G&A beds available to the system in Sussex over the winter period is 2339. The total number of planned escalation beds is 123, giving a maximum bedded capacity of 2462.
- Before application of plans, the acute bed gap is a maximum projected gap of 243 beds, forecast in the last week of December. The Winter plans set out the actions being taken by system partners, intended to close this gap.
- With the confirmation of plans from system and providers we have applied their risk mitigated values to the winter bed plan.
- The impact of these plans have reduced the bed gap to 0.
- Provider impact against Key Performance trajectories have not been fully quantified and applied to projections. This will be done by Mid-October to ensure we have full visibility over any risks to delivery of key performance metrics committed to as part of the operating plan.
- Additional modelling will be done to support system MADE events in the drive to reduce occupancy to 80% to create January surge capacity.
- This would enable us to agree consensus expectation and targets for each partner's contribution to admission avoidance, reducing LoS and increasing discharge flow in order to achieve the 80% after the 2-week drive.

Winter Bed Plan Proposal

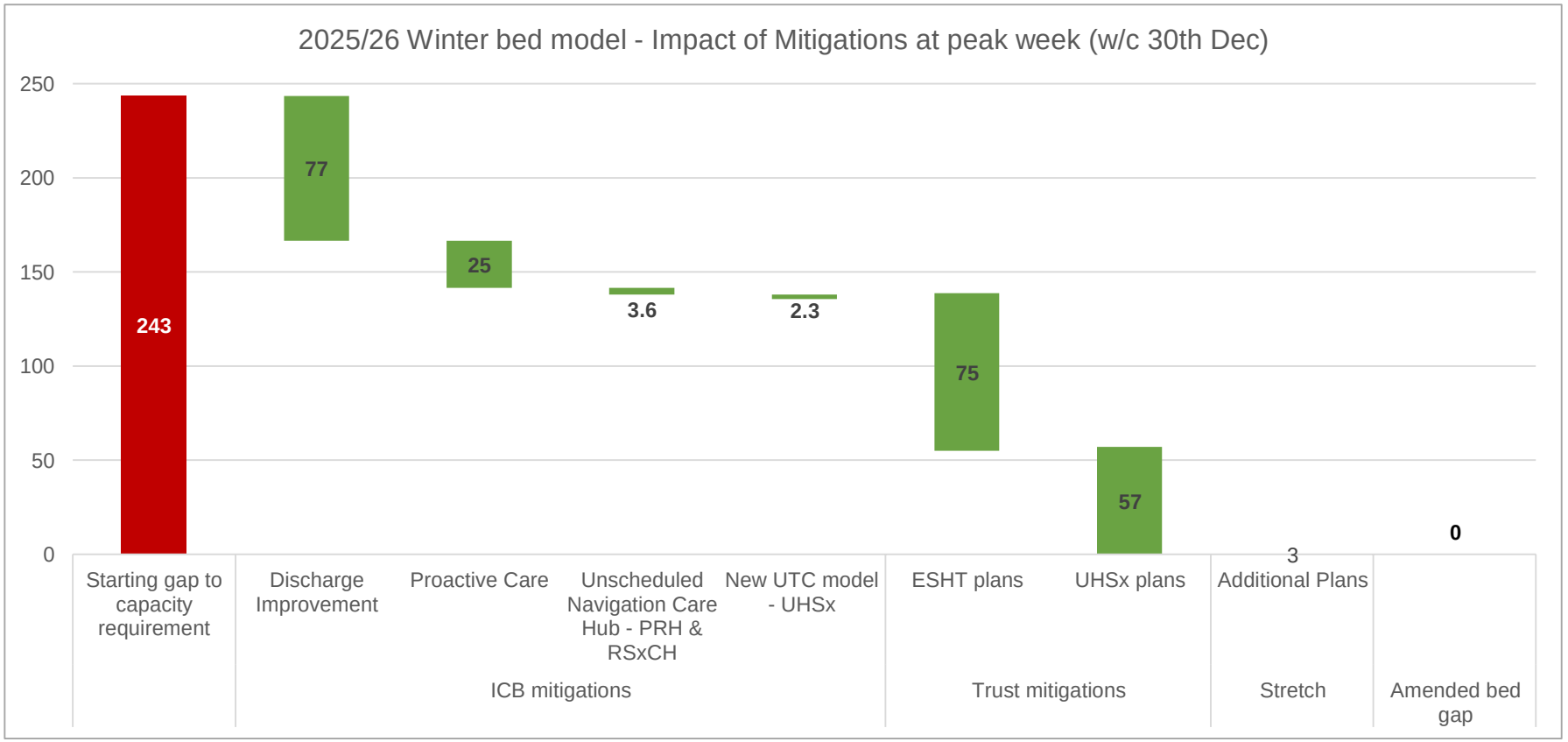


Peak Week and mitigations

	Sussex (Excl. SaSH)
	w/c 30 Dec
Bed Base (starting position)	2,462
Starting Capacity Requirement	2,705
Starting Gap to Capacity Requirement	243
(a) Pillar 1 - Acute and in-hospital care	215
Amended Gap	28
(b) Pillar 2 - Primary and Community Care	25
Amended Gap	0
(c) Additional plans	3
Amended Gap	0
(d) Planned Care Stoppages	
Amended Gap	0

- Initial Bed Modelling suggest a peak gap to capacity requirement of **243** beds.
- The following slide shows how this gap is mitigated through provider, ICB and system plans which breakdown as follows:
- Discharge improvement: **77** beds
- ESHT plans: **75** beds
- UHSx plans: **57** beds
- UHSx**: 6** beds linked to the impact of the Unscheduled care hub and the new UTC front door model.
- Proactive Care: **25** beds
- Additional plans: **3** beds which will include strengthening delivery plans for current schemes to reduce mitigated risk and impact of Exercise Aegis
- This leaves bed gap of **0** against capacity requirement, with highest risk in the week commencing 30th December
- The model currently projects lowest week average Occupancy to 89% in late December. It does not calculate periods of less than a week.

Breakdown of Mitigations



The above waterfall chart shows the impact of each part of the plan on mitigating the forecast bed gap at the peak week (w/c 30th Dec). Plans have mostly been assessed in terms of impact on bed days and adjusted to take account of lead in times and risk/efficacy factors.

These risk mitigated plans result in a closing of the bed gap for the peak week of Dec 30th

Pillar 1
Acute and in hospital care

Acute and in hospital care

Objective – Ensure Sussex residents have timely access to acute health and care services throughout the Winter

- Patients using Urgent and Emergency care services
- Patients waiting for a Mental Health bed
- Patients awaiting discharge
- Managing elective care demand
- Workforce

Patients using Urgent and Emergency Care (UEC) services

The latest UEC plan for 2025/26 was published on 6th June 2025, this sets out 7 priorities for the whole system that will have the biggest impact on UEC improvement this coming winter.

We will focus on these key areas:

- Reduce ambulance wait times for Category 2 patients to ensure consistent response below 30 minutes through the winter
- Meet the maximum 45-minute ambulance handover time standard, helping get more ambulances back on the road for patients
- Ensure a minimum of 78% of patients who attend A&E are admitted, transferred or discharged within 4 hours
- Reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time
- Reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission
- Reduce delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually
- Increase the number of children seen within 4 hours

Meet the maximum 45-minute ambulance handover time standard, releasing crews and supporting consistent delivery of the Category 2 response time below 30 minutes

Aim	**Meet the maximum 45-minute ambulance handover time standard, helping get more ambulances back on the road, improving response times for those patients in the community awaiting support.**
Current position	• At times of pressure, acute sites are not always able to achieve handover within 45 minutes.. When multiple hospitals are delayed, it leads to ambulances queuing up at different sites, which reduces the overall capacity of the ambulance service to respond to new emergencies in the community. • During the winter, the challenge intensifies. The increased number of patients with complex conditions, particularly the elderly, requiring conveyance and admissions puts increased pressure on both the ambulance service and emergency pathways.
Actions / Task	• **Establish a Dedicated Ambulance Handover Team:** This team, separate from the core ED staff, will be responsible for triaging and receiving patients from ambulances. This will allow paramedics to return to the road more quickly. • Any breach of the 45-minute ambulance handover standard will trigger SCC escalation via the OPEL framework.
Success Measures	• A sustained performance of meeting the 45-minute handover standard with a low percentage of breaches. • 100% of breaches escalated same-day through OPEL framework, with system response actions deployed. • A significant reduction in the number of ambulances queuing outside the hospital. • Improved morale for both ambulance crews and ED staff, who will no longer be managing congested departments.
Timeline	**September - October 2025:** Planning, resource allocation, and team training for the sites. **October 2025:** Improved Ambulance Handover protocols launched. **November 2025:** Rollout of improved communication protocols with social care. **December 2025:** Initial review of results and feedback for improvement **Ongoing:** Continuous monitoring, refinement, and scaling of the pilot to all relevant hospital sites.

Ensure a minimum of 78% of patients who attend A&E are admitted, transferred or discharged within 4 hours

Aim	**Ensure a minimum of 78% of patients who attend A&E are admitted, transferred, or discharged within 4 hours**. This is a core target in the **Urgent and Emergency Care (UEC) Plan** and is a crucial measure of an effective and responsive hospital.
Current position	Emergency departments across the system consistently experience challenges in achieving 78% for the 4 hr A&E standard. This results in some patients experiencing long delays to be seen and treated and congested emergency departments, which in turn can impact on Ambulance Handover times. The winter months put increased pressure on the system. The increased volume of patients with complex medical needs, particularly from flu and other respiratory illnesses, leads to a surge in admissions. This, combined with increased staff sickness creates a risk of increased breaches and long waiting times during this period.
Actions / Task	**Optimise the 'Front Door' Model:** Ensure there is a rapid triage and streaming process at the entrance of each ED. Patients should be directed to a dedicated **Same Day Emergency Care (SDEC)** unit for specific conditions or to an Urgent Treatment Centre (UTC) for less severe illnesses, reducing the number of patients waiting in the main ED. **Maximise direct access pathways:** Ensure there are clear direct access pathways, which enable patients to be referred or conveyed to inpatient or assessment services which best meet their needs, without passing through ED. **Minimise conveyance of patients who could be treated elsewhere:** Ensure there are clear alternative's to ED, with sufficient capacity, and the Directory of Services (DOS) is kept up to date. **Support patients to make appropriate choices when seeking care and support:** Ensure there are clear and consistent, easily accessible public facing communications to support residents in choosing the most appropriate service for their needs.
Success Measures	A consistent performance of 78% or higher on the 4-hour target. A significant reduction in ambulance handover delays. Improved staff morale in the ED and on the wards.
Timeline	Review and embed the new processes, with the goal of delivering agreed operating plan trajectories over the winter period and meeting the 78% target **by March 2026.** **Ongoing:** Continuous monitoring and refinement to maintain and improve performance.

Reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time

Aim	**Reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time.** This is a critical target that directly addresses patient safety and dignity. Prolonged waits in the ED are a key indicator of a strained system and are linked to poorer patient outcomes. By achieving this goal, we will improve patient experience, reduce pressure on ED staff, and ensure that our hospital is operating more efficiently.
Current position	Across the local health system, there are pressures on both acute hospital beds, mental health beds and community beds creating delays in admission. The winter months are a significant challenge. The increase in respiratory illnesses and complex medical cases leads to a surge in admissions, creating intense pressure on bed availability. This is often accompanied by an increase in staff sickness, further impacting patient flow and leading to a sharp rise in 12-hour waits.
Actions / Task	**Reduce pre discharge ready length of stay:** Revisit SAFER plans to ensure all actions are being taken to reduce delays at every stage in a patient's medical care pathway, with rapid clinical decision making, including consistent application of criteria led admission and discharge, minimising waits for diagnostic tests and associated reporting etc **Optimise use of 'Discharge Hub' or 'Lounge' including targets for patients moved to the lounge before midday:** Set and deliver clear targets for the number of patients to be moved to the discharge lounge by midday. Ensure clear pull and push model in place with nominated individuals each day in the lounge and on wards, working together to deliver this. **Escalate Blocked Beds:** Ensure there is a clear escalation policy for patients ready for discharge who are delayed for a non-clinical reasons.
Success Measures	The number of 12-hour waits for admission or discharge is consistently below 10% of total ED attendances. Reduced overcrowding in the ED, leading to a safer environment for patients and staff. A measurable improvement in the 4-hour ED target and ambulance handover times.
Timeline	Focus on embedding these changes and ensuring they are consistently applied to maintain and improve performance and deliver the trajectories committed to. Discharge lounge push/pull model to be in place by **31 October 2025** **Ongoing:** Continuous monitoring and refinement of the processes to ensure sustained performance.

Reduce the number of patients waiting for a Mental Health Bed

Aim	To reduce the number of people waiting for an inpatient psychiatric admission in both the community and in ED with a mental health need, waiting >12 hours from the 'decision to admit'
Current position	High numbers of patients are assessed as needing psychiatric admission in Sussex and we see a higher number of patients attending our emergency departments requiring Mental Health support than peer systems. Those patients requiring admission can experience long delays and extended waits in ED impacting on patient experience, quality of care and delaying the start of their treatment. Challenges with timely admission relation to high numbers of delayed discharges from Mental Health inpatient beds and high numbers of patients with a length of stay over 60 days.
Actions / Task	• All system partners commit to delivery of the existing mental health UEC & inpatient transformation delivery plan • SPFT to deliver internal Patient Flow Plan improvements, reducing Length of Stay. • Continue Executive led Quality Improvement weekly huddle focussed on addressing extended emergency department waits • Maximise capacity in services which provide an alternative to ED attendance for patients in mental health crisis including Staying Well services, Rapid Response, Blue Light Line, NHS 111, Text Sussex and SPFT Havens. • Local Authorities to work with SPFT to deliver the agreed trajectories to reduce the number of patients classified as CRFD with a focus on achieving agreed timeframes for referral, assessment and identification of funded services • Staying Well Services – to pursue clinician recruitment to enable all to operate full open access • Work with Sussex police, through RCRP programme to identify any further opportunities to reduce s.136 conveyance to ED
Success Measures	• Target of reducing ED attendances by 20% for 2025/26, using the 2024/25 activity baseline. The stretch target will be to reduce this by a further 8% by March 2026. • The average waiting time for a MH bed to be reduced from 7 days to 5.5 days by **March 2025.**
Timeline	• As above

Reduce delays in patients waiting to be discharged, starting with those waiting over 21 days after their discharge-ready-date (DRD)

Aim	To reduce the number of people who are medically fit in hospital beds and the length of time it takes to discharge these people from hospital from the date at which they become discharge ready.
Current position	As of Sunday 7 September, 530 people were in an acute bed and medically fit. The weekly average number of people delayed more than 21 days post their discharge ready date (DRD) in Q2 was 54 in Brighton and Hove, 56 in East Sussex and 36 in West Sussex.
Actions / Task	The focus will be on delivering the actions set out in our Commissioning for Outcomes Improvement Plan. Key elements are: • Fortnightly review of site-specific action plans, agreed across the system in September • Continue to seek opportunities to adopt trusted assessment and increase efficiency of discharge pathways • Embed early discharge planning, including earlier identification of patients with complex needs • Weekly review of Long Length of Stay (LLOS) patients, with regular reporting to the ICB escalation and flow meetings focused on patients delayed more than 21 days
Success Measures	• Reduction in 21+ day delays • A reduction in the number of beds occupied by people who no longer meet the criteria to reside (NCTR) • Fewer internal delays >48 hrs • An increase in the number of discharges before midday
Timeline	• Site plans have daily targets which are reviewed by system partners in a collective place-based forum fortnightly. By end March, the number of people who NCTR will be at 14.6% across the system.

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Increase the number of children seen within 4 hours of arrival at A&E

Aim	Increase the percentage of children seen within 4 hours of arriving at A&E. This aligns with the national Urgent and Emergency Care (UEC) Plan and is a key measure of timely access to high-quality care for paediatric patients.
Current position	The system is not currently able to see and treat all children within 4 hours. The winter months exacerbate this problem due to a surge in paediatric patients with respiratory illnesses, such as bronchiolitis, RSV and the flu. This increased demand, coupled with potential staff absences, puts pressure on paediatric emergency departments and other clinical services.
Actions / Task	**Establish a 'Paediatric Front Door' Model:** Implement a dedicated triage and streaming process at the entrance of A&E specifically for children. This would ensure they are directed to the most appropriate service, such as a paediatric Same Day Emergency Care (SDEC) unit or a dedicated children's waiting area, to reduce waiting times in the main emergency department. **Improve Inpatient Flow from Paediatrics:** Enhance the efficiency of paediatric inpatient wards to ensure timely discharges. This includes daily huddles to review patient status and plan for discharge, freeing up beds and preventing bottlenecks that affect A&E. **Ensure there are clear, fully resourced respiratory surge plans in place to expand capacity where required during seasonal spikes in activity.** Develop paediatric surge pathways for NHS 111 and ED triage, plus workforce escalation. **Establish clear outpatient pathways to avoid unnecessary ED attendances.**
Success Measures	All paediatric urgent calls/ED attendances managed within planned surge capacity Success will be measured by a consistent increase in the percentage of children seen within 4 hours.
Timeline	**September-October 2025:** Review current paediatric UEC pathway and identify opportunities to streamline front door processes. Formulate a detailed action plan and secure stakeholder agreement. **November 2025 - March 2026:** Implement the new processes and actively monitor performance.

Wider service resilience

In addition to maintaining performance in Urgent and Emergency care services it is critical that we also maintain good access to planned care services.

Two additional areas of focus are proposed in order to support this aim.

Managing Planned Care

Maintaining capacity and resilience in our workforce

Managing Planned Care

Aim	Maintain continuity of planned care, cancer and diagnostic services so that operating plan trajectories are delivered and patients who required planned procedures, cancer care or access to planned diagnostics can continue to do so
Current position	The system and providers are currently on track against operating plan metrics for elective care and UHSx has an agreed trajectory to eliminate waits over 65 weeks by the end of March 2026. While the system is performing well against the faster diagnostic standard for Cancer, the system is not yet able to treat all patients in line with the 62 day standard and pressures are seen in some diagnostic modalities. There is a risk that during surges in winter pressure, additional capacity is required in order to treat patients requiring urgent and emergency care, reducing capacity for patients requiring planned care, worsening existing delays for treatment.
Actions / Task	• Ensure we have efficient mutual aid process in place between NHS providers to balance pressures and maximise utilisation of capacity and maximise usage of Community Diagnostic Centres (CDCs) • Ensuring capacity operates at optimum levels through delivery of key productivity metrics • Manage demand via increased utilisation of Advice and Guidance (aim to get to 8% by March 2026) and advice and refer pilots • Utilise Cancer Alliance waiting list initiative funding (all providers) to ensure delivery of cancer waiting times • Protect planned care activity from operational pressures by creating ringfenced capacity at Sussex Surgical Centre at ESHT, UHSx High volume low complexity hubs and the use of ENT parallel lists at Hurstwood Park • Undertake forecasting and planning activity to mitigate impact of bed pressures e.g. shift activity from inpatient to daycase in January • Minimise risks of staff availability and loss of beds through robust IPC, implementation of Healthrota annual leave system for all consultants at UHSx. • Undertake patient transfers to the independent sector to provide additional capacity where required.
Success Measures	• System and providers stay on track with operating plan trajectories.Cancellations due to operational pressures are minimised.
Timeline	• Ongoing with aim of delivering agreed operating plan targets and 65ww trajectory by Ma**rch 2026**

Maintaining capacity and resilience in our workforce

Aim	As in previous years, 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.
Current position	Plans are in place across the system to support the resilience of the workforce, and these will continue into the winter period. Challenges include: • Lack of take up amongst staff re vaccination • Ongoing requirements for temporary staffing • Potential for disruption to activity caused by ongoing industrial action
Actions / Task	Specifically, during the winter period we will: • continue to manage and reduce the costs associated with our temporary workforce • Implement measures to reduce sickness absence across the system • increase uptake of flu vaccinations amongst staff, building on identified examples of good practice • enhance and activate agreed consultant and senior nurse rotas for ED, AMU, paediatrics during peak weeks • CEOs, CMOs, CNOs to maintain high visibility and leadership throughout December and January by routinely "walking the floor" Measuring Progress: • Sickness absence is reported monthly via the Integrated Commissioning Report • Temporary Staffing costs are monitored via the Southeast Temporary Staffing Collaborative and reported monthly • Flu vaccination uptake will be measured via systems linked to the overarching vaccination programme for the system
Success Measures	Success measures: • Maintenance of rolling average sickness absence rates with no peak over the winter period • Continued reduction in temporary staffing costs in line with submitted operating plans • At least 5% increase in uptake of flu vaccination amongst staff • Senior decision-makers present across surge periods; reduced delays in admissions
Timeline	• Ongoing monitoring with monthly reporting over the winter period

Pillar 2
Primary and community care

Primary and community care

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

- Improving vaccination rates, including health care professionals
- Proactive identification and care planning for patients with highest needs (including care/nursing home residents)
- Proactive approach to support patients at risk of respiratory illness
- Improving Flow through intermediate care services
- Increased utilisation of virtual health solutions.
- Maintain GP/primary care capacity across Christmas period with extended access and urgent care hubs.

Improving vaccination rates to prevent the exacerbation of illness and hospitalisation

Aim	To improve Covid-19 and flu vaccination rates for all eligible cohorts when compared to previous year.
Current position	**Flu uptake 2024/25:** • General population: Sussex – 60.7%; national – 51.1% • Frontline Health Care Workers: uptake is shown in the table, together with this year's target set by NHS England • **Covid-19 uptake last campaign (Spring):** Sussex – 59.2%; national
Actions / Task	• Each hospital has a staff vaccination plan which aims to improve uptake by 5% when compared to last year • For the general population we have asked the leadership group of each Integrated Community Teams to consider actions that improve uptake for the eligible population when compared to last year • A local communications campaign will be launched in line with national approach. It will also include local targed messaging to support uptake across eligible groups and provide myth busting information for communities who we know need additional support. • An outreach campaign will be implemented to target eligible people in population groups where uptake has been persistently low; addressing vaccine hesitancy and fatigue. • Targeted campaigns and IPC-led 'every contacts counts' approach
Success Measures	• Improve staff vaccination uptake (flu/COVID) by at least 5%. • Vaccination rates for general population for both Covid-19 and flu above the England average
Timeline	• Covid-19 vaccination programme runs from 1 October 2025 – 31 January 2026 • Flu vaccination programme 1 September 2025 (pregnant women and children), 1 Oct 2025 (all other cohorts) – 31 March 2026

Trust	Last years uptake	5% target	Overall uptake target
QVH	43.9%	5%	48.9%
SPFT	39.7%	5%	44.7%
SCFT	50.1%	5%	55.1%
ESHT	42.4%	5%	47.4%
UHSx	41.5%	5%	46.5%

Proactive Management of people who are known to have high and on-going needs

Aim: Identify and proactively support people who are most at risk of urgent care over winter. These people are frail, live with multiple long-term conditions, may be receiving palliative care etc. This cohort of people are described as having high and on-going needs and will be consistently identified using general practice registers in Sussex. By identifying them and supporting them differently, we aim to reduce the number of non-elective admissions to hospitals from care homes and residents in their own homes.

This will be enabled by an enhancement to an existing Locally Commissioned Services (LCS) and a risk stratification tool and methodology to be launched in Q3 2025, as follows:

- **John Hopkins Risk Stratification Tool** to identify patients at risk of admission consistently across each Integrated Community Team (ICT_ area.
- **Proactive care interventions:** Care planning using Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), Advance Care Planning / Personalised Care and Support Planning tools, structured medication reviews, anticipatory prescribing, falls prevention, enhanced care and ward round in nursing homes, connecting people to non-medical, support community-based activities and services to address practical, social, and emotional needs affecting their health and wellbeing, and optimising the use of urgent community response to manage care in the community.

The preventive and proactive care will be led by Primary Care Provider Collaborative and supported by NHS community providers, social care providers, voluntary, community and social enterprise organisations and hospices.

Outcome: 2% reduction in non-elective admission for over 65s with over two conditions.

Proactive approach to support patients at risk of respiratory illness

Aim	To improve winter readiness for people living with COPD in Sussex through targeted multi-agency events and workforce training, empowering patients to self-mange their condition, and reducing exacerbations and respiratory related admissions.
Current position	• **East and West Sussex** are preparing winter readiness events and training. Venues, target areas (with a focus on deprivation and isolation), and workforce for delivery are being confirmed. Events will be collaborative across providers and take the 'OPTIMISED' (see diagram below) approach. • In **Brighton & Hove** a funding bid is underway via the Health Innovation Network (HIN) Respiratory Transformation to proactively identify and support COPD patients at risk this winter. If successful, this project will also adopt the 'OPTIMISED' approach.
Actions / Task	• Finalise delivery model and align plans across providers. • Confirm stakeholder roles, expectations, and support required. • Agree governance and operational delivery mechanisms. • Finalise workforce training plans. • Ensure readiness of digital tools (e.g. Remote Monitoring onboarding).
Success Measures	• Number of patients onboarded to Remote Monitoring respiratory pathway • Reach and impact of winter events (attendance and interventions) • Uptake of vaccinations and smoking cessation support • Workforce engagement and completion of training • Reduction in COPD exacerbations and unplanned admissions
Timeline	• **By 31 August 2025**: Providers to confirm delivery plans • **Autumn 2025**: Winter readiness events delivered • **Early 2026**: Evaluation and reporting post-delivery

O	=	Optimise medication
P	=	Pulmonary Rehabilitation
T	=	Tobacco dependency services
I	=	Inhaler Technique
M	=	Max Vax cover
I	=	Increase physical activity
S	=	Support for psychological wellness
E	=	Education and self-management
D	=	Don't forget about Co-morbidities.

Improving flow through Intermediate Care Services

Aim	Increase in number of acute discharges onto appropriate pathways that reflect patient needs Increased capacity and more appropriate skill mix within intermediate care services
Current position	• The profile of acute discharges often reflects capacity within pathways 1 and 2 intermediate care services, rather than the profile of patient needs and there are significant issues with flow out of pathway 1 and 2 intermediate care services, related primarily to adult social are assessment capacity and onward home care capacity • There have also been historic issues with fragmented service models within pathway 1 intermediate care services, that have impacted on flow through these services, along with over prescription of care in acute settings.
Actions / Task	• Adopt 'pull leadership / describe not prescribe' approaches piloted in Eastbourne and St Richards across Sussex (successfully increased the number of patients discharged onto appropriate pathways). • Recent clinical audit evidenced opportunity to 'left shift' circa 20% of patents currently discharged into pathway 2 community beds into pathway 1 home-based intermediate care service. Rapidly develop local implementation plans for delivering this left shift, increasing capacity in pathway 1. • Reduce assessment times: Accelerate expansion of trusted assessment approaches across all three places • Enhance home first capacity and improve the co-ordination of service delivery across all three places.
Success Measures	• Reduction in average DRD delay days for patients with rehab needs in acute settings • Increase in percentage of pathway 0 discharges • Increase in percentage of pathway 1 discharges (left shift) • Reduced number and duration of delays within Home First pathway 1
Timeline	• October 2025 – TOCH learning event • **September 2025** – convene NHS and LA providers to agree left shift delivery plans • **December 2025** – test and develop locally determined Trusted Assessor approaches

Increased utilisation of Virtual Health Solutions

Aim	• Reduce A&E and hospital admissions/NCTRs by supporting patients to remain in their own homes. • Maintain a 285 Virtual Ward (VW) bed base throughout 2025/26. • Establish a Virtual Health (VH) Remote Monitoring hub, which engages fully with ICTs and other community services.
Current position	• 285 VW beds, 80% occupancy (>100% in periods of surge).
Actions / Task	• Integrate Virtual Ward beds across acute, primary care and community, optimising acuity with closer MDT working with acute providers. • Stand up remote Monitoring Hub model in time for winter • Mass onboard respiratory remote monitoring.
Success Measures	• Length of Stay (LoS) in VW will be less than 18% for 15+ days, i.e. majority LoS between 2-14days. • Trajectory set for Remote Monitoring/Hubs - 750 patients to be remotely monitored as part of virtual health programme . • Evaluation of Virtual Health recruitment campaigns through providers. • VH remote monitoring hub to demonstrably link with ICTs and speciality community services
Timeline	• Remote monitoring hub in place by **30th October 2025.** • 750 patients monitored by **March 2026**

Pillar 3
Sound clinical and operational management

Sound clinical and operational management

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

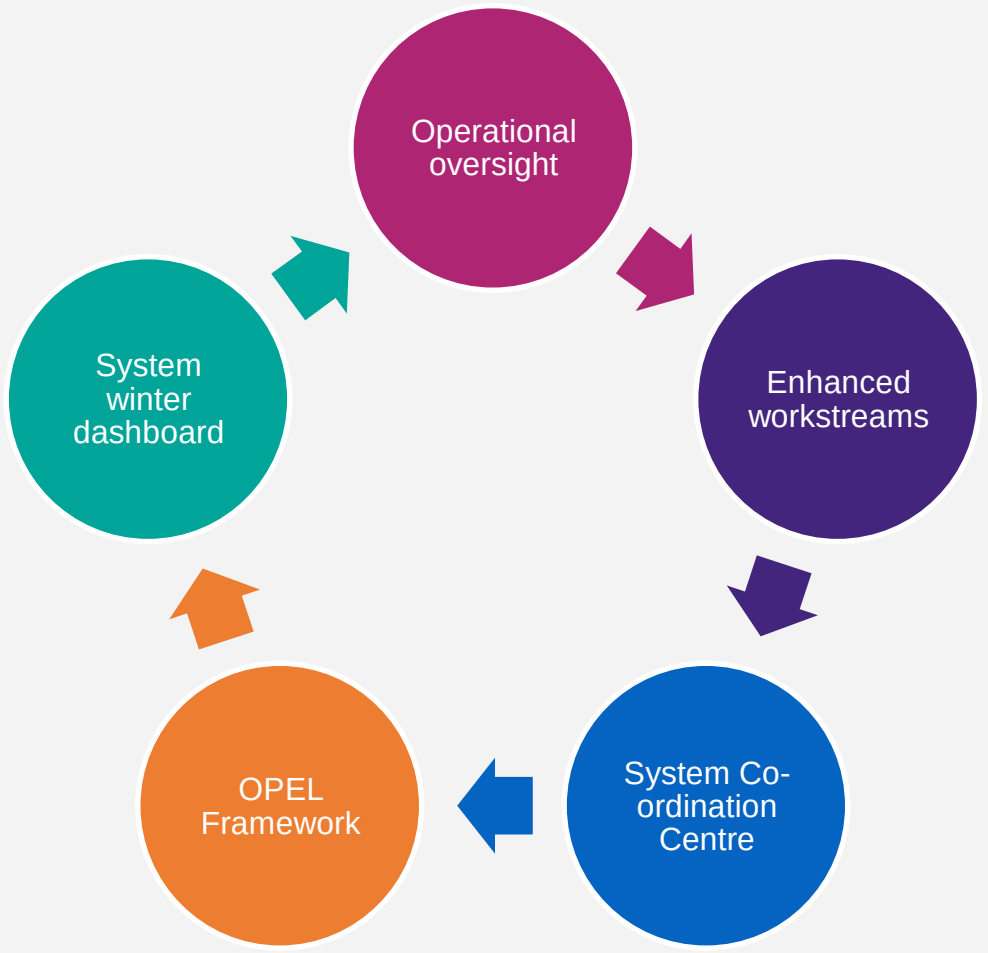
- Winter Operating Model
- Effective management of clinical risk and infection prevention and control
- Clear co-ordination across the system and rapid routes of escalation for operational issues
- OPEL Framework utilisation
- System MADE Event
- Communications plan

Winter Operating Model

In light of the operational challenges and associated risks anticipated this winter, it is important that the system's winter operating model delivers a responsive, well-coordinated and effective approach to delivery of the Winter Plan and management of surge pressures.

While our Winter Plan outlines what it is that we intend to deliver, the winter operating model describes how we will deliver it:

- The winter operating model will be informed by a combination of live, daily and weekly data and strategic intelligence reports.
- In addition, the System Co-ordination Centre (SCC) will consistently monitor and retain oversight of the operational status of the system. This will enable timely instigation of escalation if and when required.



Effective management of Clinical Risk and Infection Prevention and Control

Our aims: Delivering a Safe Winter

Clinical Risk

Effective management of Clinical risk is seen as key to the system's delivery of safe services over the winter period. As part of our winter preparedness, Sussex ICS are developing a Clinical Risk Framework to provide a structured approach for identifying, escalating, and managing risks to patient safety and quality of care during periods of increased pressure. The framework sets out clear triggers, governance arrangements, and escalation routes, ensuring risks are captured and triangulated with operational data, incident reports, and patient outcomes. This work will feed into our broader winter plan, supporting executive oversight, providing assurance, and enabling timely system responses to emerging pressures

Infection Prevention and Control

- Sussex Integrated Care System have an established clinical Infection Prevention cell represented by NHS Provider organisations including acute, community, ambulance and mental health trusts, Local Authority Health Protection Teams and NHS Sussex who provide subject matter expertise across the system and develop a standard framework for clinical quality improvement. The cell meets fortnightly with additional meetings as required to provide recommendations to Chief Nursing and Medical Officers.
- Sussex Infection Prevention cell will develop a revised Winter Surge plan for 2025/26 to for winter viral illnesses which includes national guidance recommendations implementation, risk assessment and provider implementation actions to support patient flow across providers.
- Sussex IPC cell will cascade UKHSA Winter Preparedness pack to adult social care settings to support provider resilience and preparedness across the Sussex system.
- Sussex Infection Prevention cell are developing a clinically led pathway to enable direct admission of flu patients into community bedded capacity for winter, as part of the UEC plan 2025/26. The pathway will be recommended to System CNO and CMOs during October 2025.

System Co-ordination Centre (SCC)

The SCC provides a central co-ordination service to providers of care across the ICS 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 co0ordinate 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 Operating Function

The System Co-ordination Centre (SCC) Winter Operating Function will run from 27th October 2025 to 31st March 2026. This will operate in link with the national SCC specification and will:

Our aims:

- 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 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.
- Working with EPRR teams to ensure adherence to planning, responses and recovery principles.

System-wide Collaborative Meetings

System weekly touchpoints

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
SCC Call			SCC Call		SCC Call	SCC Call
SE Regional Operations Centre (ROC) Call	ROC	ROC	ROC	ROC	ROC	ROC
West Sussex Touchpoint Call	West Sussex Touchpoint Call	West Sussex Touchpoint Call	West Sussex Touchpoint Call	West Sussex Touchpoint Call		
Brighton and Hove and PRH Touchpoint Call	Brighton and Hove and PRH Touchpoint Call	Brighton and Hove and PRH Touchpoint Call	Brighton and Hove and PRH Touchpoint Call	Brighton and Hove and PRH Touchpoint Call		
East Sussex Touchpoint all		East Sussex Touchpoint call		East Sussex Touchpoint call		

As well as the regular meetings listed above, a process is in place to stand up additional sessions of any of these meetings at short-notice if emerging issues arise which need a system coordinated response.

Risks to delivery of the Winter Operating Model

There is a risk that, due to the NHS Sussex ICB organisational transition programme and system providers also implementing change, workforce resources are likely to diminish during the winter period. We will be working with Surrey to ensure that we can maintain staffing resilience as we move into a clustered ICB.

Current Structure

There is currently sufficient resource in the ICB to deliver the Winter Plan as laid out.

Up to 50% (Approx) Staffing Reduction

Operational Change / Impact:

- Reduced SCC Collaborative Operational Working
- Working Relationships Impacted
- Reduced Daily Operational Meetings
- Reduced SCC Role Cover (Annual Leave / Sickness)
- Difficulty With 8am-6pm Requirement

Up to 70% (Approx) Staffing Reduction

Operational Change / Impact:

- Provider Engagement Via Direct Approach Only
- Removal of Daily Operational Meetings
- Reduced Surge and Resilience Planning
- Unable to Provide Monitoring / Reporting / Briefings
- Reduced SCC Operational Oversight / Assurance
- No SCC Role Cover (Annual Leave / Sickness)
- OC Mailbox / SCC Request Delays
- Staff Pressures / Wellbeing Risks
- Unable to Meet Minimum Operating Hours.

Co-ordination across the system and rapid routes of escalation for operational issues

Our aims:

The SCC monitor and oversee system operational pressures throughout winter. Where there are persistent rising pressures which existing plans are providing insufficient mitigation to, an additional System Co-ordination call will be convened, to include a multi-disciplinary team (MDT) from across the system.

The purpose of the MDT will be to consider the issues and, using the breadth of their expertise, develop solutions. Dependent on the issue members will be nominated to form a rapid improvement team.

This team will:

- **Respond in an agile way to emerging pressures**
- **Be led by senior clinical and operational 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.**

Utilisation of the 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 2024/26, co-ordinated 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. Should this occur, this will be managed through our year-round system EPRR infrastructure, with input from operational, tactical and strategic command as required.

Any breach of the 45-minute ambulance handover standard will automatically trigger escalation through the SCC under the OPEL framework. This ensures delays are rapidly addressed with a coordinated system response, supporting compliance with national expectations and maintaining patient flow.

Although primary care data isn't part of our OPEL framework, the ICB primary care team has a regular dialogue with practices to understand whether there are any on-the-day issues which require support, or mitigation, during the winter months. In addition, as part of our routine business, we review several indicators on a 'practice resilience matrix' which gives us an 'early warning sign' on which to act and proactively support practices who may be having operational issues.

System MADE Event

Our aims:

Plan and run a sequenced multi-agency discharge event (MADE) event over two weeks at the beginning of December 2025 (including weekends) and a recovery event in the weeks following the holiday period. The purpose of these events is to reduce bed occupancy to <80% by mid-December to create January surge capacity and improve flow in the system.

- **Week one** – Creating Community flow
- **Week two** – Creating Acute flow

These events will be based on a carefully sequenced plan, with actions which build each day in order to maximise impact across the system. Each provider will have areas of focus each day and the event will be planned in September/October to ensure key staff can be released in order to undertake assigned tasks over the period. The events will be designed around a rapid improvement methodology, allowing the plan to be flexed for maximum impact over each two week period, based on feedback and lessons learned, gathered on a daily basis.

Action:
A Task and Finish Group will be established during September 2025 to develop and design the event. Areas of focus will be determined by learning from previous events and assessing known operational pressures and / or any issues that emerge during the winter period

Monitoring Operational Pressures (1/2)

We proposed to use the following metrics as proxy measures for how well the system is coping with operational pressures and whether or not the system is achieving the plan's stated aims. These metrics will be shared at the SCC Calls:

Metric	Source	Frequency
A&E four-hour target	SHREWD	daily
Children in A&E four-hour target (new)	SHREWD	daily
Patients waiting over 12 hours in A&E	SHREWD	daily
Average length of stay (LoS)	Strategic Intelligence	monthly
NCTR	SHREWD / discharge dashboards	daily
Vaccination Rates	NHSE Federated Data Platform	monthly
Staff Sickness Levels	NHSE Workforce Intelligence Portal	monthly
Temporary Escalation Spaces	SHREWD	daily
Ambulance handover delays over 45 minutes	SHREWD SECAmb Power BI	daily

Monitoring Operational Pressures (2/2)

We proposed to use the following metrics as proxy measures for how well the system is coping with operational pressures and whether or not the system is achieving the plan's stated aims. These metrics will be shared at the SCC Calls:

Metric	Source	Frequency
Percentage of patients who are discharged after their discharge ready date (DRD) date (length of delay)	Discharge dashboard / Transfer of Care Hub	monthly
Category 2 patients waiting over 30 minutes for an ambulance	SHREWD	daily
Frailty – Avoidable admissions for over 65s, falls	ICT Dashboard	tcb
Utilisation of general virtual wards	SHREWD	daily
Numbers of practices signed up to proactive care vulnerable patient identification scheme	ABC	monthly
Patients waiting for a Mental Health bed in A&E for more than 24 hours	SHREWD	daily

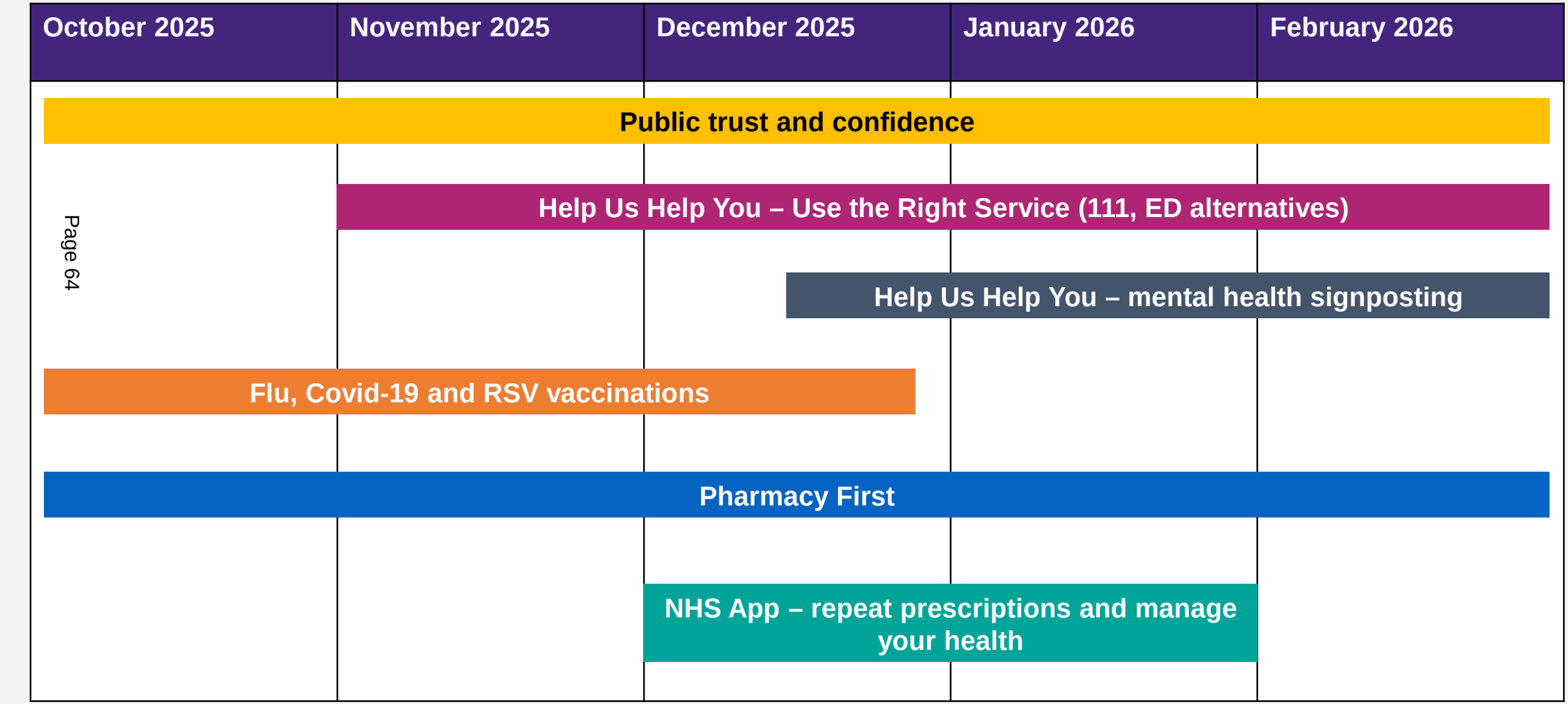
Winter in Sussex – communications and engagement approach

Aim	• To have a co-ordinated system wide communications and engagement approach, with planned activity to ensure that there are clear communications in place to support operational delivery and public confidence over the winter period.

Current position	**Planned activity:**
	• The communications and engagement approach reaches across these key areas in Sussex:
	  • **Public and stakeholder confidence** – focus to share assurance that plans are in place and how partners are working together to ensure that patients get the care they need over the winter period.
	  • **Promotion of key information and advice**:
	  • **Help Us Help You: Make the right choice** – including signposting to local services, encourage positive use of appropriate services, heavy promotion of Pharmacy First, NHS 111 (online and call), children's and adults' 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 as well as a large campaign to encourage staff take up of the vaccines.
	• There is also work underway to develop a targeted approach to service signposting ahead of winter in our ICT areas.

Actions / Task	• A detailed plan will include a range of communication and engagement channels and assets used by all partners, with consistency across the system, and work with community and voluntary partners. This will be in place in September.
Success Measures	• The planned activity builds on last year's activity and lessons learnt to consider what went well and what could have been improved. • There will be a range of measures articulated in the plan to set out the success outcomes we would want to achieve.
Timeline	• Show in the second slide

Winter communications and engagement approach - timings



Public and Patient Engagement

Our aims:

- With the support of our Public Involvement team and Healthwatch we will gather insight into patient experience over the winter months.
- We will obtain patient feedback through surveys, interviews, engagement roadshows and other methods.
- The findings will be analysed and shared in early 2026.

Pillar 4
Governance, Oversight and Escalation

Governance, Oversight and Escalation

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

- Robust oversight of the delivery of the winter plan
- Clear routes of escalation for strategic issues
- Stress testing of the plan

Robust oversight of the delivery of the winter plan

Our aims:

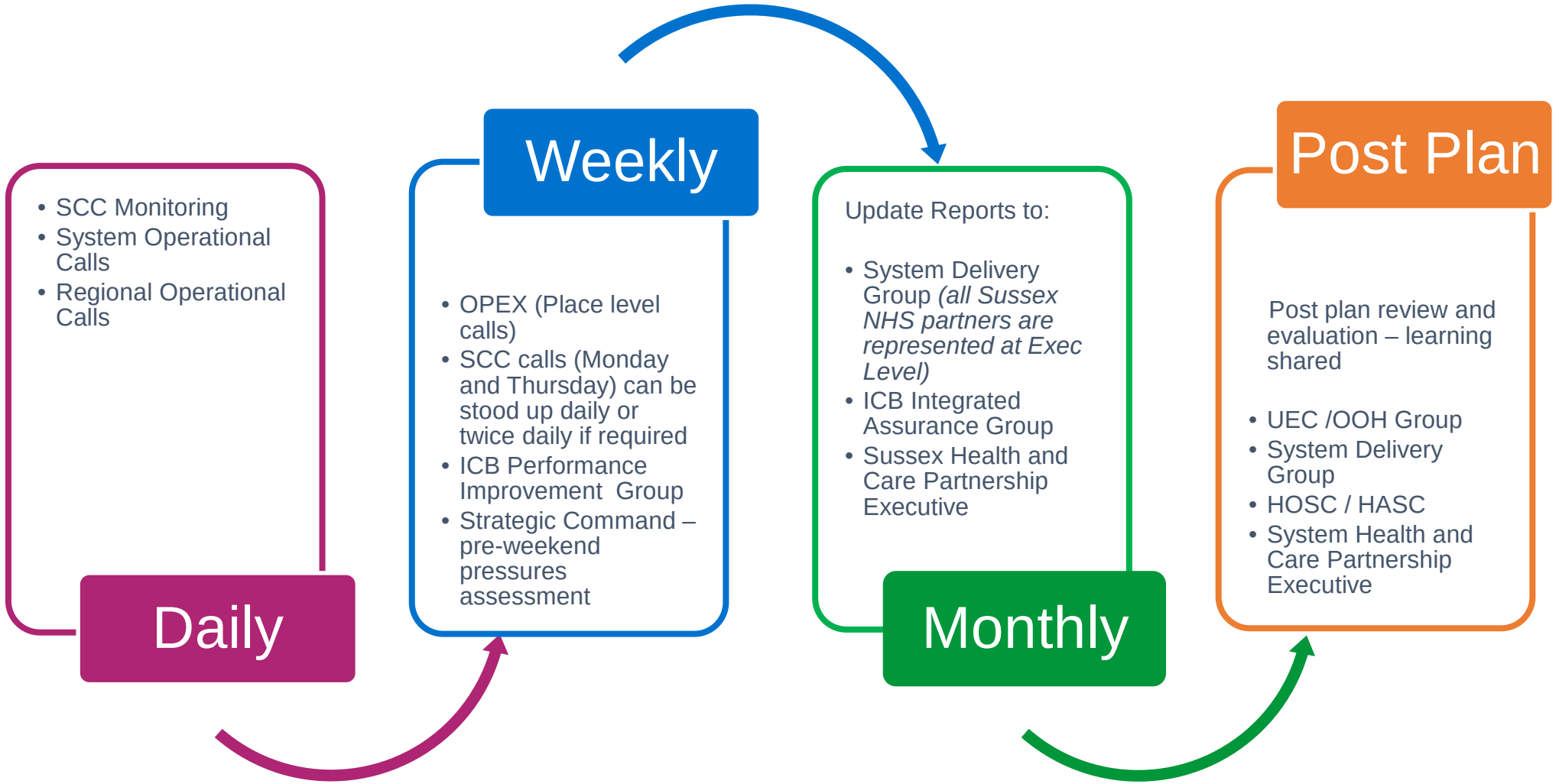
The system wide winter plan has been developed in partnership with organisations from across the system. The plan has been reviewed by the MDT senior leadership team of the ICB and is signed off through both the NHS Sussex Board and the Sussex Health and Care Partnership Executive. Individual provider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

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

An EHIA and QIA have been carried out to assess the impact of the plan.

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 for 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

Sussex Winter Plan Review and Monitoring timeline



Testing of the Winter plan – Response to Exercise Aegis

The Sussex Winter plan has been tested through participation in an NHS England South East Region Winter Resilience exercise (Exercise Aegis) on 8 September 2025. Sussex system was represented in exercise by NHS Sussex, University Hospitals Sussex NHS Trust, East Sussex Healthcare NHS Trust, Sussex and Surrey NHS Healthcare Trust, Queen Victoria Hospital NHS Foundation Trust, Sussex Community NHS Foundation Trust and South East Coast Ambulance Service

The event used a number of scenarios to test the plan and identified further tactical actions which system partners agreed will be taken to improve resilience, in particular at times of extremis. These will be further developed over the coming month. The include:

- Agreement to take a pro-active approach to IPC for Staff and Visitors, to be mobilised concurrently across all providers ahead of forecast peaks in infectious disease (to be led by IPC cell who will develop recommendations)
- Agreement to adopt a 'Making every contact count' approach across our health services to increasing uptake of Vaccinations across eligible population cohorts (work required to explore options around vaccine distribution to facilitate this – to be led by ICB)
- Agreement to develop a model for Respiratory hubs by converting MIU's to Respiratory Hubs at times of surge in respiratory illness (to be led by SCFT)
- Undertaking System-wide MADE events - over two sequential weeks pre Christmas and post New Year, sequenced with the first week focussed on achieving community flow, and the second week focused on acute flow (Planning to be coordinated by ICB, working with all relevant providers (Health, Social Care, VCSE, Hospice etc)

These actions will be developed at pace into clear delivery plans **by 31 October 2025**, through task and finish groups populated with appropriate partners from across the system. These actions are expected to help mitigate the risk of capacity within health services being breached at times of peak pressure, supporting delivery of safe services throughout the winter period.

Appendices

Risks and Lessons Learned

Identified Risks

Identified Risks to Winter Operations	
Workforce	There is a risk that workforce shortages - compounded by vacancies, sickness absence, annual leave and childcare during school holidays and low staff morale - may impact on the delivery of emergency, urgent and planned care services during Winter.
Industrial action	There is a risk that industrial action will have an adverse impact on delivery of the winter plan through knock-on effects on both urgent and emergency care activity as well as planned care activity.
Patient safety (clinical risk)	There is a risk that due to system pressures clinical risk may increase, impacting on patient safety
Capacity and demand in mental health services	There is a risk that waiting times for admission to an acute psychiatric hospital may be increased due to level of demand rising and prolonged lengths of stay due to flow challenges in the adult mental health pathway, impacting on clinical risk, patient safety and patient flow across the system in both acute hospital and community settings.
Capacity and demand- Infection Prevention and Control (IPC)	There is a risk that an increase in viral outbreaks including waves of covid, respiratory syncytial virus (RSV) and influenza will adversely impact system capacity and demand across Sussex health and care providers, resulting in poor patient experience, challenges around access to specialist beds and an increase in clinical risk.
Elective programme delivery	There is a risk to the delivery of the elective programme during times of extreme pressure on acute bed capacity and/or workforce constraints, which may result in cancellations. This is a risk to patient care and access to treatment.
Adverse weather	There is a risk of cold and inclement weather impacting on the volume and nature of presentations to hospital
Organisational transition	There is a risk that the substantial reorganisation across the NHS will impact on operational resilience across both ICBs and providers during the winter months, meaning that the system is not able to respond as quickly to emerging issues as would otherwise be possible.

Lessons Identified from 2024 / 2025 Winter Plan

Key Lessons Identified and Recommendations for Improvement

Lessons Identified	Recommendation	Adopted
Low uptake of vaccinations by health and social care workers (HCSW) increased the likelihood of sickness leading to staff shortages during the winter period which impacted on operational pressures.	Early engagement and work with Trusts to ensure that more robust plans are in place to offer vaccinations to the HCWS. Workshops planned for summer 2025 to prepare for covid and flu vaccination campaigns.	Workshops have been held with providers during Summer 2025
Integrated Community Teams (ICTs) focused on admission avoidance with the aim of testing ways of working, processes and outputs.	To align services provided by ICT providers at Neighbourhood to optimise prevention and proactive anticipatory care for people with highest and ongoing care needs supported by risk stratification tool. Ambition targets by ICTs to be agreed by end of September	Agreement of system-wide proactive care approach to support avoidance of admissions for patients with highest needs.
The Unscheduled Care Hubs stood up in both East Sussex and Brighton and Hove significantly increased the numbers of patients referred into community services such as Virtual Wards and UCR; and reduced conveyances to RSCH by 14%.	Expansion of Unscheduled Care Hubs	ESHT hub has been stood down due to lack of demonstrable impact following SECAMB evaluation. B&H hub (supporting RSCH) continues following demonstrable impact on ambulance conveyance reduction
Improvements made during the Reset Event were not maintained throughout the winter	Include a Reset Event in this year's Winter Plan – earlier planning to include sustainability measures and coordination of data collection.	A System-Wide MADE event will be held pre and post the Christmas and New year surge periods

Lessons Identified from 2024 / 2025 Winter Plan

Key Lessons Identified and Recommendations for Improvement

Lessons Identified	Recommendation	Adopted
The Systemwide Business Continuity Incident (BCI) process was tested during a period of significant pressure. It was not clear what the thresholds were to trigger a BCI	The process has been amended to include triggers based on the new Integrated operational pressures escalation levels (OPEL) framework which makes thresholds clearer	New BCI process signed off by system COOs – Sign off by System Delivery Group expected in October
An unexpected surge in demand due to flu and covid in the weeks following Christmas and the New Year created additional operational pressures.	Undertake earlier planning with public health to improve infection forecasting in relation to bed modelling.	Forecasting received from NHSE SE Region
There are currently a number of surge plans developed and produced throughout the year, the Winter Plan being one of them. There is a tension between providing assurance and an operational document.	Consider moving to an annual cycle of continuous seasonal planning model which would use operational data to trigger system-level responses to pressures at any time of the year.	Not adopted due to organisational transition

Glossary

Term	Meaning
111	111 is the NHS non-emergency number. It's a free service available 24/7 for urgent but not life-threating healthcare needs
A&E	Accident and Emergency
ACP	Advanced Care Planning
Acute	refers to a hospital
Ambulance Handover	the time taken for an ambulance crew to handover a patient to their destination
AMPH	Approved Mental Health Professional
AMU	Acute Medical Unity
Apex	APEX is a web-based application, which streams data night from the GP principal clinical system and is fully interoperable with EMIS Web and TPP SystmOne
aPP	advanced Paramedic Practitioner
ASC	Adult Social Care
BCI	Business Continuity Incident
BHCC	Brighton and Hove City Council
c2 / cat2	Category 2 - ambulance response category refers to emergency calls to ambulance services, such as stroke patients. They should be responded to within 18 mins
CLD	Criterial Led Discharge
COPD	Chronic Obstructive Pulmonary Disorder
CQ	Conquest Hospital
D2A	Discharge to Assess
DRD	discharge ready date
ED	Emergency Department
EDGH	Eastbourne District General Hospital
EHIA	Equality Health Impact Assessment
ENT	Ear Nose and Throat
EPRR	Emergency, Preparedness, Resiliance and Recovery
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare Trust
ExCo	Executive Committee
Flu	Influenza
HASC	Health and Adult Social Care Scrutiny Committee
HCSW	Health and Social Care Workers
Healthrota	a digital plaform for rostering clinical staff in hospitals
Home First	Home First is a service that provides supported discharge care to people back in their own home or usual place of residence
HOSC	Health Oversight Scrutiny Committee
HVLC hub	High Volume, Low Complexity
HWP	Happy with Plan
IAG	Integrated Assurance Group
ICB	Integrated Care Board
ICS	Integrated Care System
ICTs	Intergrated Community Teams
IRIS	Identification & Referral to Improve Safety IRIS is a specialist domestic abuse education, support and referral programme providing training to clinicians
KPIs	Key Performance Indicators
LA	Local Authorities
LCS	Locally Commissioned Service
LLoS	Long Length of Stay
LOS	length of Stay
MDT	Multi-disciplinary Team
MHA	Mental Health Act

Glossary of Terms cont/d ...

NCTR	No Criteria to Reside
NEL	Non-elective
NHS	National Health Service
NHSE	NHS England
OOH	Out of Hospital
OPEL	Operational Pressures Escalation Levels
P1, P2, P3, P4	There are four P (Pathway) categories, which relate to the clinical prioritisation of elective care patients
Paediatric	relating to a branch of medicine dealing wiht children and their diseases
PCN	Primary Care Network
Pharmacy First	Pharmacy First enables community pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions without the need to visit a GP.
Plexus	Plexus Care Record connects health and care records for practitioners in Sussex, providing them with the right information at the right time.
PRH	Princess Royal Hospital
Q1	Quarter 1
Q2	Quarter 2
Q3	Quarter 3
Q4	Quarter 4
QIA	Quality Impact Assessment
QVH	Queen Victoria Hospital
REAP	Resource Escalation Action Plan
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
ROC	Regional Operations Centre
RSCH	Royal Sussex County Hospital
RSV	respiratory syncytial virus RSV is a common cause of coughs and colds. RSV infections usually get better by themselves, but can sometimes be serious for babies and older adult
SAFER	The SAFER patient flow bundle: S - Senior Review A - All patients F - Flow E - Early Discharge R - Review
SaSH	Surrey and Sussex Hospitals

SCC	System Co-ordination Centre
SDEC	Same Day Emergency Care
SDGB	Sussex Discharge Oversight Board
SDP	Shared Delivery Plan
SECAmb	South East Coast Ambulance Service
SHCPE	Sussex Health and Care Partnership Executive
SI	Strategic Intelligence
SIDS	Sudden Infant Death Syndrome
SMR	Structured Medication Reviews
SPOC	Single Point of Contact
SRH	St Richards Hospital
SW	Social Worker
The System	Health and Social Care providers across Sussex
UCH	Unscheduled Care Hubs
UCR	Urgent Community Response
UEC	Urgent and Emergency Care
UEC / OOH	Urgent and Emergency Care / Out of Hospital Group
UHSx	University Hospitals Sussex
VCSE	Voluntary, Community and Social Enterprise
VH	Virtual Health
VW	Virtual Wards
WGH	Worthing Hospital
WLMDS	Waiting List Minimum Data Set
WSCC	West Sussex County Council

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**11 December 2025**
By:	**Deputy Chief Executive**
Title:	**ESHT Capital Works Programme**
Purpose:	**To provide the Committee with an overview of the East Sussex Healthcare Trust Capital Works Programme, detailing ongoing and planned the capital works at Conquest, Bexhill, and Eastbourne District General Hospitals.**

RECOMMENDATIONS

The Committee is recommended to:

1) **consider and comment on the report; and**
2) **consider whether to request a further report on any of the areas covered in the report.**

1. Background

1.1. On 18 September 2025, the HOSC requested a report providing overview of the ESHT Capital Works Programme, detailing any ongoing and future capital works at Conquest, Bexhill and Eastbourne District General Hospitals.

1.2. The HOSC last received a report on the capital works developments at its meeting in September 2023, where the Committee was provided information about the New Hospitals Programme; a £20 billion investment programme in hospital infrastructure to 48 hospital trusts nationally, including the East Sussex Healthcare NHS Trust (ESHT).

1.3. The Trust continues to deliver a comprehensive and wide-ranging capital works programme of the ESHT estate within the current fiscal year. This includes a range of clinical facilities, ongoing modernisation and refurbishment of current estates, major schemes, and a digital transformation programme.

1.4. This report provides the Committee with an update on significant ongoing and upcoming capital works ESHT is undertaking. ESHT is also undertaking a number of other capital development schemes, including those related to service configurations of Cardiology services, which the HOSC previously conducted a review of, which is addressed here and elsewhere on the agenda of this meeting.

2. Supporting information

2.1. ESHT has produced a report for the HOSC attached as **Appendix 1**. The report provides an overview of capital works that involve construction works across ESHT sites, and excludes digital transformation, which forms part of the wider-ranging programme.

2.2. The report includes information on:

- the opening of the Sussex Surgical Centre;
- the opening of the Sussex Endoscopy Unit;
- the phases of the Cardiology Transformation Programme;

- updates to diagnostics; and
- Critical infrastructure works.

3 Conclusion and reasons for recommendations

3.1 The Committee is recommended to consider and comment on the report and consider whether to request a further report on any of the areas covered in the report.

PHILIP BAKER
Deputy Chief Executive

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East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Capital Works Programme Update

1. Executive Summary

The Trust continues to deliver a comprehensive and wide-ranging capital works programme of the ESHT estate within the current fiscal year.

This includes a range of new clinical facilities such as the new Sussex Surgical Centre and Sussex Endoscopy Unit, together with ongoing progress on modernisation and adaptation/refurbishment of the current estate to improve and meet changing clinical requirements. This also includes major schemes such as the Cardiology Transformation programme and diagnostics facilities update viz-a-viz the CT scanner and Interventional Radiology replacements/upgrades at Conquest.

We also continue to replace ageing medical equipment at our hospitals. This is supplemented by often generous donations, from the various Friends charitable organisations at Eastbourne DGH, Conquest and Bexhill hospitals.

Furthermore, we continue to invest funding year on year in our estate to mitigate the effect of backlog maintenance/critical infrastructure risks at Eastbourne DGH, Conquest and Bexhill hospitals.

2. Background

At the request of HOSC, we have provided an update on capital projects for FY25/26.

This report is solely concerned with capital works programme that involve construction works i.e. the physical works to the ESHT property portfolio works across the ESHT estates and exclude digital e.g. Electronic Patient Record etc., all of which form part of a wide ranging and comprehensive ESHT capital program.

3. Main Report

a. Sussex Surgical Centre

The Sussex Surgical Centre (SSC), our new £40 million purpose-built unit, elective surgery hub, opened its doors in September 2025 to its first patients.

The unit, located at Eastbourne DGH, offers state-of-the-art care for day surgery patients across all our surgical specialties and is the product of more than three years of collaboration between our clinical and operational colleagues in our DAS division and the Estates and Facilities teams.

The Centre features four new operating theatres, comprehensive pre-assessment, admission, and recovery areas and will deliver around 7,000 planned procedures each year. Operating ten hours a day, five days a week, patients are able to undergo their procedure and return home to recover the same day. The creation of this new facility not only increases our capacity for same-day elective surgery but also frees up our existing theatres to carry out additional complex procedures.

b. Endoscopy

This new Sussex Endoscopy Unit (SEU) which is on the first floor of SSC, was completed in Autumn 2025. This facility will provide additional endoscopy capacity through four endoscopy suites and associated patient and staff facilities, along with new decontamination facilities.

c. Cardiology

Throughout FY 25/26 we have been undertaking the last of the comprehensive enabling moves (relocation of the Stroke Unit to Cuckmere) to enable the phased modernisation/refurbishment of the main Cardiology department at EDGH which will commence in Q4 of FY25/26 and run through next 15 months. The complex and comprehensive sequencing of the scheme is essentially broken into five main phases:

- Phase 1 is the refurbishment of East Dean into Cardiology Coronary Care Unit (CCU)
- Phase 2 creates Cath Lab 3, including the movement of the CQ equipment to EDGH. At the end of this phase, EDGH will have three functional Cath Labs.
- Phase 3 utilises the space previously occupied by CCU, to create a large Recovery bed space. Admin offices will also be reconfigured and refurbished.
- Phases 4 and 5 are due to commence in early 2027, and include a large bulk store, the refurbishment of Cath Lab 2 and creation of the Pacing Theatre

d. Diagnostics

Together with recent improvements in our X-ray department's equipment and facilities we are also carrying out major replacement/upgrades of diagnostic equipment, namely the CT scanner and Interventional Radiology, both at Conquest.

e. Critical Infrastructure Works

Together with its own £1.5million of ESHT allocated funding, we have secured £10.3 million of additional critical infrastructure risk capital funding from NHS England. We will utilise this funding to undertake a series of projects to reduce our critical infrastructure risks, for example electrical infrastructure and fire compartmentation works.

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**11 December 2025**
By:	**Deputy Chief Executive**
Title:	**Re-Provision of Uckfield Day Surgery Unit**
Purpose:	**To update HOSC on proposed changes at Uckfield Community Hospital Day Surgery Unit**

RECOMMENDATIONS

The Committee is recommended to:

Consider whether the service change proposals relating to Uckfield Community Hospital Day Surgery Unit set out in Appendix 1 constitute a 'substantial variation' to health service provision requiring statutory consultation with HOSC under health scrutiny legislation.

1. Background

1.1. East Sussex Healthcare NHS Trust (ESHT) provides day surgery activity at Uckfield Community Hospital in a unit equipped for elective procedures under local anaesthetic. The Day Surgery Unit (DSU) delivers approximately 13% of ESHT's overall day surgery activity. Surgery provided at the DSU in Uckfield includes vascular, maxillofacial, dermatology, ophthalmology and urology procedures.

1.2. Uckfield Community Hospital is a community building overseen by the Integrated Care Boad (ICB), NHS Sussex. ESHT leases space within it for the DSU as well as other services. The proposed changes to the DSU do not affect other services provided at Uckfield Community Hospital, by ESHT or other providers.

1.3. ESHT is proposing to relocate all DSU activity and staff at Uckfield to its two main acute hospital sites, Eastbourne District General Hospital (EDGH) and Conquest Hospital. This report includes an overview provided by ESHT of proposed changes to the Uckfield DSU, and evaluation of the 6-month pilot of the proposals conducted from December 2024 to June 2025. HOSC is asked to consider whether the proposals constitute a substantial variation to health service provision under health scrutiny legislation, requiring formal consultation with the HOSC.

2. Supporting information

Proposals for Uckfield Day Surgery

2.1. The report from ESHT is attached as **Appendix 1** and sets out the Trust's proposals for the reprovision of day surgery services at Uckfield Community Hospital, the case for change and evaluation of the pilot. ESHT has shared the outcomes and evaluation of the pilot with the ICB, which has endorsed the proposed change as being a benefit to patients.

Health Overview and Scrutiny Committee (HOSC) Role

2.2. When planning to make significant changes to services, NHS organisations are required to inform relevant local HOSCs. Under health scrutiny legislation, NHS organisations are required to formally consult HOSCs about a proposed service change that would constitute a 'substantial development or variation' to services for the residents of the HOSC area.

2.3. 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), the effect on a particular group or community, 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.

2.4. If HOSC agrees that the proposals do constitute a substantial change, the Committee will need to consider the plans in detail in order to respond to the NHS with a report and any recommendations. The Committee may wish to consider how it would undertake this task, which could be through establishing a Review Board to conduct a review on behalf of the full HOSC, with the Committee agreeing any recommendations before they are submitted to the NHS.

2.5. Where the HOSC does not consider a proposal to be a substantial variation to services there are alternative options for further scrutiny work if required, including submitting a written response to any public consultations, informal HOSC board meetings to scrutinise the proposals in more detail, and further reports to the Committee as the proposals are agreed and implemented.

3. Conclusion and reasons for recommendations

3.1. This report presents HOSC with proposals for the reprovision of day surgery services at Uckfield Community Hospital by closing the Day Surgery Unit and delivering activity instead at ESHT's main acute hospital sites.

3.2. The Committee is recommended to consider whether the service change proposals set out in **Appendix 1** constitute a 'substantial variation' to health service provision requiring statutory consultation with HOSC.

PHILIP BAKER
Deputy Chief Executive

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East Sussex Healthcare NHS Trust

Re-Provision of Uckfield Day Surgery Unit – Pilot Evaluation

HOSC Update – December 2025

1 BACKGROUND & INTRODUCTION

Scope

1.1 The paper is brought to HOSC for the purposes of 1) Sharing our internal decision-making process and rationale, and 2) Discussing this with HOSC members prior to full implementation.

1.2 This update is in relation to East Sussex Healthcare Trust's (the Trust's) Day Surgery Unit (DSU) activity at the Uckfield Community Hospital site and does not affect any other services at Uckfield Hospital, whether operated by the Trust, or by other providers.

1.3 The DSU activity contributes approximately 13% of Trust activity at the site. Other services provided by the Trust at the Uckfield site include an outpatient department, podiatry, physiotherapy and community dental services. These services are out of scope, and there are no proposed changes to these services as part of this paper.

1.4 Uckfield Community Hospital also provides services run by other NHS organisations in the area, such as Sussex Community NHS Foundation Trust (SCFT); and Sussex Partnership NHS Foundation Trust (SPFT). These services are also not within the scope of this paper

1.5 The Trust do not own or operate the Uckfield site. The building is a community resource overseen by the ICB. The Trust lease space at Uckfield for the provision of a number of services, one of which is the DSU and the subject of this paper.

Case for Change Summary

1.6 At Uckfield DSU, the Trust can only provide local anaesthetic surgical procedures, which limits both the number of conditions we see and the surgical specialties we cover.

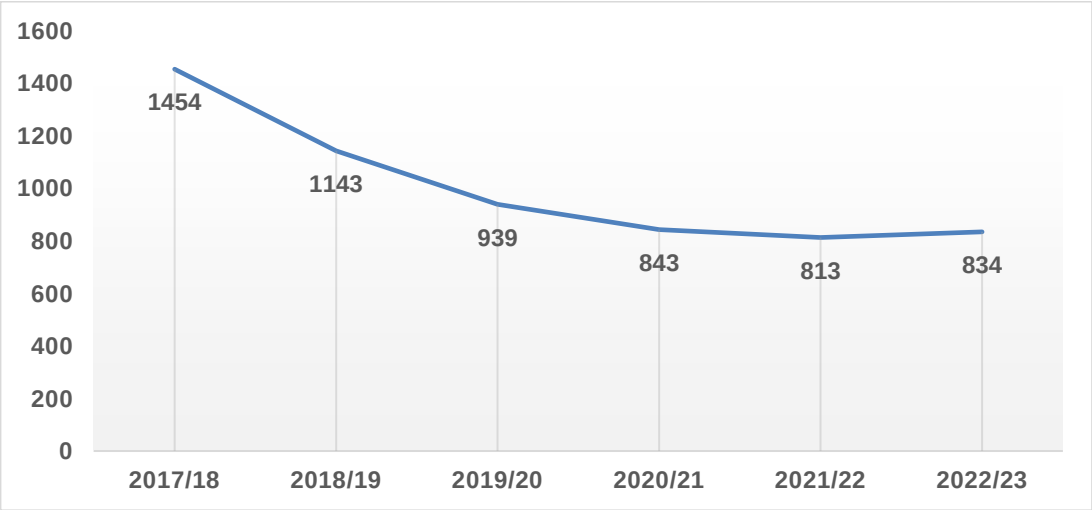
1.7 Uckfield DSU cannot safely support general anaesthetic or overnight care and does not carry out surgical procedures on patients with a higher risk of complications such as those with complex needs, certain disabilities, significant frailty and/or certain concurrent illnesses. In these cases, even day case procedures must be carried out in an acute hospital environment where the full scope of supporting clinical services is on site.

1.8 Activity at Uckfield had been reducing for a number of years, partly due to the safety criteria above, partly due to advancements in treatment meaning theatre environments were no longer required and this activity could take place in normal procedure rooms, and partly because some of the procedures that we previously carried out at Uckfield are no longer commissioned by the NHS.

1.9 The Trust were also providing DSU facilities and staff to support other NHS Trusts, such as Plastic Surgery lists for Queen Victoria Hospital (QVH). QVH served notice on plastics activity in April 2024, further reducing DSU activity.

1.10 For all these reasons, the case for change illustrated that DSU activity at Uckfield had fallen to approximately 800-850 patients per annum for the three years prior to this proposal, as figure 1 below shows.

Figure 1: Uckfield DSU Activity Since 2017/18



1.11 By the time the pilot started in December 2024, this had further reduced to approximately 650 cases per annum.

1.12 Due to the reduction in activity, Uckfield theatre sessions were not being well used. A snapshot audit was conducted for the development of the case for change, looking at utilisation rates at Uckfield DSU for 7 months between October 2023, and April 2024 showed that typical utilisation was around 60%. See figure 2 below.

Figure 2: Uckfield DSU Utilisation Oct 2023 – April 2024

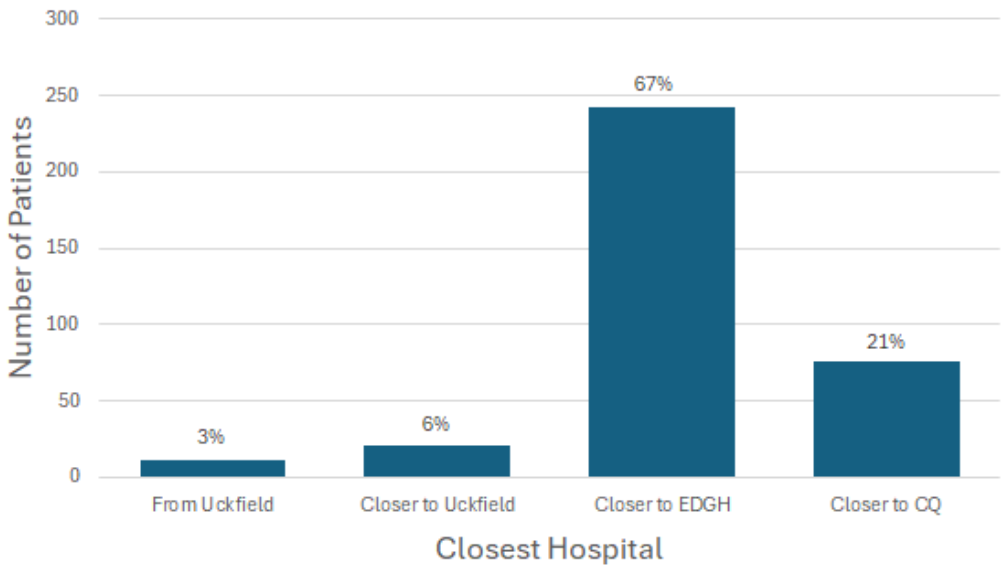
Month / Year	Actual Utilisation
Oct 2023	53.00%
Nov 2023	65.00%
Dec 2023	68.00%
Jan 2024	60.00%
Feb 2024	62.00%
Mar 2024	65.00%
Apr 2024	60.00%

1.13 This is against a utilisation target of at least 85%, which was unable to be achieved at Uckfield, and meaning that we were not making the best use of our capacity. This would have reduced further after the snapshot audit, due to the further fall in activity, and the noticed served on QVH Plastics activity in April 2024.

1.14 When we compare this to theatre utilisation at the acute hospitals, Eastbourne District General Hospital and Conquest Hospital Hastings, utilisation is around 82% across these sites.

1.15 We also know that of the patients accessing these services, almost 9 out of 10 patients lived closer to one of our main hospital sites, as shown in figure 3 below.

Figure 3: Combined Patient Location Analysis



1.16 The data above covers an approximately six month period, and is based on the combination of a postcode analysis conducted at the time the case for change was developed (showing 82% of patients lived closer the acute sites, and 3% lived in and around Uckfield), and then confirmed over the pilot period (which showed 88% of patients sampled lived closer to the acute sites, and 3% lived in and around Uckfield).

1.17 The Trust has also recently invested in £40m worth of additional state of the art day surgical capacity at the Sussex Surgical Centre, which would further reduce the activity at the Uckfield DSU.

1.18 A paper endorsed by HOSC as part of the case for investment in the Sussex Surgical Centre (SSC, but then known at the Elective Hub) identified at that time that 29% of activity at the Uckfield DSU would be better provided at the SSC. This would further reduce the activity at Uckfield DSU, making activity levels unsustainable.

Agreement of Case for Change & Pilot Project

1.19 The case for change was agreed by ESHT Board in August 2024, followed by conversations with the ICB who endorsed the principles of the case for change. A 6-month pilot period was agreed with the ICB as the next step.

1.20 In December 2024 we launched the 6-month pilot to test our proposal that overall productivity and patient experience would benefit from relocating our DSU activity and staff from Uckfield to our two main sites at Eastbourne and Hastings.

1.21 The pilot ran from December 2024 and finished in June 2025, after which we conducted a review of the initial data over the Summer of 2025. Showing that we did see and treat people as quickly as possible. The results of the pilot are summarised in section 2.

2 PILOT EVALUATION RESULTS

Operational Data

2.1 The evaluation of the pilot showed that the Trust was able to increase its capacity for elective pathways, increase our ability to pre-assess patients in a timely manner, and improve flexibility to provide capacity as operationally required, helping to prioritise urgent, cancer and general anaesthetic cases.

2.2 We were able to do this without negatively impacting activity in the specialties that were moved from Uckfield, and in some cases, we were able provide this activity in a more appropriate location (e.g. procedure rooms).

Patient Engagement and Access

2.3 Throughout the course of the pilot, we took soundings from patients who supported the move of services, with the strongest theme being that the acute sites were "clean" and "well equipped".

2.4 The evaluation also enabled us to confirm our initial analysis on travel impact, showing that:

- 88.3% of sampled patients were able to access treatment closer to their homes.
- The average travel distance across the sample decreased by 10.3 miles per journey.

- Of the 11.6% that lived closer to Uckfield 3.4% of patients were from Uckfield or the surrounding area:
  - 1.7% came from within Uckfield (<2miles)
  - 1.7% came from "around Uckfield" (<5miles).
- Only 6.7% patients in the sample needed to travel more than an additional 3 miles.
- At the time of the pilot, Uckfield DSU was seeing approximately 650 cases per annum. This would equate to approximately 43 patients a year travelling an additional 3+ miles.

2.5 During these conversations, no patient expressed a concern that their experience had been diminished by the move, nor were there concerns expressed about travel or access issues.

2.6 We have also triangulated this with our patient engagement team and confirmed that there was no negative feedback from PALS and Complaints stemming from the pilot.

Key Findings[1]

- Moving the staff and activity from Uckfield to the main sites did not reduce elective capacity across the Trust, and in some pockets, supported increasing it.
- Completed admitted pathways have increased during the pilot period compared with before the pilot.
- Long waiters (65+ weeks) have reduced over the course of the pilot period (Please note a direct comparison with before the pilot was not possible due to the Trust taking on 2000 cases from University Hospitals Sussex Foundation Trust (UHSx) at this time).
- All activity of the type provided at Uckfield has been re-provided on the main sites.
- Activity comparisons for particular specialties are largely in line with expectations, and have provided assurance that capacity has not reduced, and in some cases, capacity or productivity has improved.
- Some activity is now provided in a more appropriate environment, outside of a theatre setting, and on an outpatient procedure basis.
- Uckfield DSU staff have been deployed flexibly across DSU roles, and including supporting General Anaesthetic cases in main theatres and pre-operative Assessment.
- Uckfield DSU Staff provide at least an additional 24 pre-assessment slots per week, and more where staff are used flexibly to support this work, allowing us to have a larger pool of patients ready for surgery, including at short notice.
- The evaluation re-confirms that the majority (88.3% in this evaluation) of patients live closer to the acute sites than Uckfield, impacts travel times more for those who live near the acute sites, and impacts only 3.4% of patients who live in or near Uckfield (but does not stop them attending).

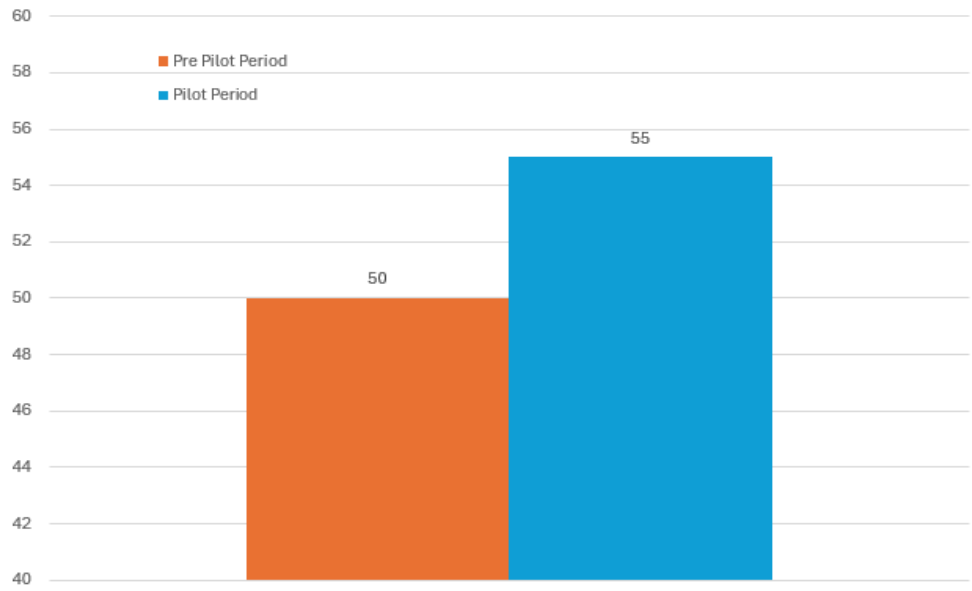
[1] *Please note that the case for change indicated that Uckfield DSU completed approximately 800-850 cases a year, with a reducing trend (approx. 650 at the time of the pilot launch). In comparison. the Trust completes in the order of 56,000 elective cases a year across all of its sites. Uckfield DSU therefore accounts for between 1.2-1.5% of total Trust elective activity. Seeing a statistically significant impact in Trustwide data is therefore unlikely as a result of the Uckfield DSU relocation alone*

Pilot Evaluation: Operational Performance

Activity & Performance

2.7 There has been a Trustwide increase in the number of completed admitted pathways over the period of the pilot.

Figure 4: Average admitted completed pathways per working day



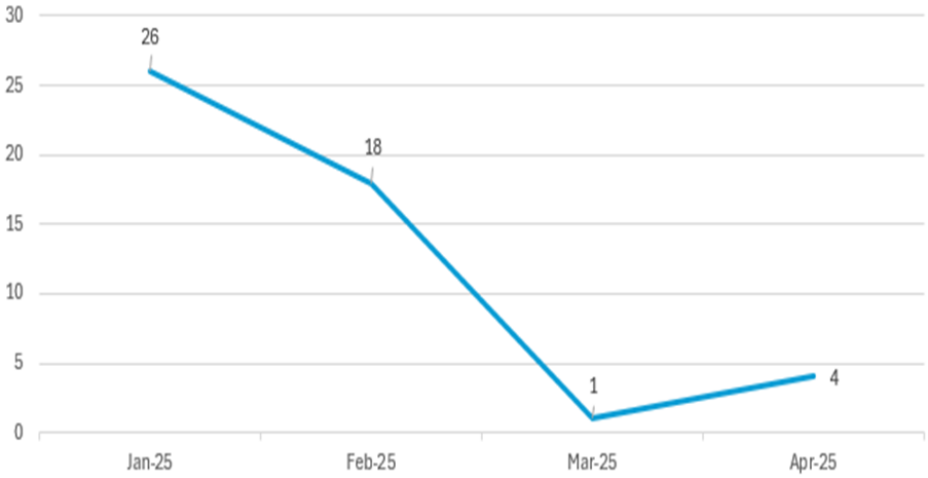
2.8 The average number of completed admitted pathways per working day over the baseline period was 50 per day, compared with 55 per day for the pilot period. An average improvement of 5 completed admitted pathways per day, or a 10% increase.

2.9 This indicates total surgical capacity increased, at least partly driven by productivity improvements.

Impact on 65+ Week Waiting List

2.10 During the pilot period the Trust has seen a general improvement in the number of long waiters. As show in the figure overleaf:

Figure 5: Number of 65 week waiters over the pilot period



2.11 There was a slight increase in 65+ week waiters in April 2025 in comparisons to March, although numbers remain small. This may be partly explained by leave over the Easter period

2.12 A validated 65+ week position could only be given up to April 2025 at the time the data was pulled for evaluation, however, we will continue to further monitor impact to waiting times over the course of implementation.

Activity Transferred from Uckfield DSU

2.13 The surgical specialties that were transferred from Uckfield DSU were Maxillofacial Surgery, Urology, Ophthalmology, Vascular Surgery, and Dermatology.

2.14 All Uckfield DSU activity was re-provided and rebooked at the EDGH site. No activity has been cancelled as a result.

2.15 Most specialties have seen an increase in capacity (more lists), activity (more patients), or productivity (more patients per list).

2.16 Maxillofacial surgery demonstrated an increase in cases with an average of 22 cases per week in the pilot, compared with 20 cases per week during the baseline, a 10% increase

2.17 Urology increased their productivity by increasing the number of cases on a list. This meant they could deliver the same level of activity with fewer lists, and this releases both consultant and theatre capacity for other clinical work. Urology ran on average 23 lists per week the baseline period to see the same level of activity as was achieved on only 21 lists in the pilot period, equating to a 9.5% increase in productivity.

2.18 Ophthalmology only carried out a very small number of lists at Uckfield (1-2 per month), and a large number of lists elsewhere, making any impact of this pilot on Ophthalmology data relatively small. However, ophthalmology ran on average an additional 1 list per week over the pilot compared with the pre-pilot period (an average of 24 lists per week during the pilot, compared with 23 in the baseline period), confirming that this pilot has not adversely impacted capacity.

2.19 Vascular ran 1 list per week on average during both the baseline and pilot periods, so there has been no reduction in vascular capacity as a result of the relocation. However, the average number of cases completed on those lists reduced from 3 in the baseline period, to 2 in the pilot period. Vascular have told us that this is a result of changed pathways, meaning that less complex patients are now seen in non-theatre settings. The theatre lists are now used for more complex patients, which would not have been possible at Uckfield. Please note: Vascular surgery is completed under a Service Level Agreement (SLA) with UHSx, giving the Trust less oversight and ownership of vascular pathways.

2.20 The Dermatology service identified that a significant proportion of activity going through Uckfield theatre environment did not require a theatre at all, and that they were able to move a significant proportion into appropriate procedure rooms. A direct comparison is therefore not possible. However, patients are able to access procedure rooms on an outpatient basis, meaning enhanced flexibility, and quicker treatment pathways, due to not having to wait for theatre availability in order for treatment to be provided. This also has the benefit of freeing up theatre capacity and seeing patients in a more appropriate environment. We will continue to monitor Dermatology pathways during implementation.

Impact on Pre-operative Assessment

2.21 During the pilot, one member of Uckfield DSU staff has provided a further two 12-patient pre-operative assessment clinics on the ward per week, accounting for an additional 24 patients per week.

2.22 Other Uckfield staff have also been able to provide additional pre-assessment clinics, on a flexible (ad-hoc) basis which has further increased our pre-operative assessment capacity.

2.23 This pilot has also supported with a Trust wide Pre-operative Assessment Improvement Project which has allowed us to standardise how we approach Pre-assessment across the Trust.

Post-Pilot Review

2.24 Following on from the results of the evaluation, the Trust's executive team reviewed the paper and came to the view that this is a change we should make permanently.

2.25 The evaluation was reviewed by the ESHT Board on 14 October 2025; who endorsed the findings of the evaluation and that the proposed change was a benefit to our patients and the populations we serve. The board agreed the executive view that that this is a change we should make permanently.

2.26 We discussed the outcome of the evaluation with the ICB, and the ICB Commissioning Group reviewed our evaluation on 14 October 2025. The evaluation findings were endorsed, and the ICB agreed that the proposed change was a benefit to our patients and the populations we serve.

We met with Uckfield staff following the evaluation to discuss our findings with them, what these mean for the direction of our thinking, and what this means for their role/position. We also continue to communicate and engage with our staff and plan to implement this change permanently following finalisation of our approach in December 2025.

Next Steps and ongoing engagement

2.27 We anticipate being in a position to finalise our plans in December 2025, and begin implementing this as a permanent change from the new year.

2.28 Over the course of this timeframe and beyond, we will continue to communicate further with our stakeholders over this period, and throughout the implementation phase, to ensure that we make the changes in the best way for our patients and populations, as well as to ensure that people have all the information they need to continue to access services, including information on travel reimbursement schemes where eligible, NEPTS, public transport, and car parking.

2.29 Following implementation and ongoing communications, we will bring an implementation update back to HOSC in June 2026.

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**11 December 2025**
By:	**Deputy Chief Executive**
Title:	**NHS Sussex update**
Purpose:	**To receive an update from NHS Sussex about changes to the ICB and other key areas.**

RECOMMENDATIONS

The Committee is recommended to:

1) **consider and comment on the verbal update NHS Sussex; and**
2) **consider whether it would like to receive further updates or reports on any of the issues raised under this item.**

1. Background

1.1. On 26 June 2025 the HOSC considered, as part of its regular work programme item, a verbal update from NHS Sussex on structural changes to the Integrated Care Board (ICB) being made in response to the Government reducing ICB running costs. At that meeting it was confirmed that NHS Sussex will be merging with NHS Surrey Heartlands, to form one ICB covering two health and care systems.

1.2. Having considered the update, the Committee agreed to continue to receive regular verbal updates on any further changes to the ICB at its future meetings.

1.3. The Committee received a further update on changes to the ICB and wider developments in national policy at its meeting on 18 September 2025. The Committee agreed at this meeting to continue to receive verbal updates on developments in the ICB at each of its future meetings.

2. Recommendations

2.1 The HOSC is recommended to comment on the NHS Sussex update and consider whether it would like to receive further updates or reports on any of the issues raised under this item.

PHILIP BAKER
Deputy Chief Executive

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**11 December 2025**
By:	**Deputy Chief Executive**
Title:	**Cardiology Transformation at East Sussex Healthcare Trust**
Purpose:	**To provide the Committee with an overview of progress made by East Sussex Healthcare Trust on the implementation of the Cardiology Transformation Programme.**

RECOMMENDATIONS

The Committee is recommended to:

1) **consider and comment on the report; and**
2) **consider whether a further report on any of the areas covered in the report is needed, or to conclude scrutiny of this issue.**

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1. Background

1.1. On 2 December 2021, the East Sussex HOSC considered a report by the local Clinical Commissioning Groups (CCGs), now NHS Sussex, on proposed changes to acute Cardiology services in East Sussex provided by the East Sussex Healthcare Trust (ESHT) at Eastbourne District General Hospital (EDGH) and Conquest Hospital, Hastings.

1.2. Health scrutiny legislation requires NHS organisations to consult HOSCs about substantial developments or variations to services for residents. The Committee resolved that the cardiology proposals constituted a 'substantial development or variation to services' requiring formal consultation by the CCGs/NHS Sussex with HOSC.

1.3. HOSC established a review board, comprised of Councillors Belsey, Di Cara, Marlow-Eastwood, Robinson and Turner, which considered a range of evidence from the NHS and other witnesses, and agreed a draft report and recommendations.

1.4. The report and recommendations were agreed by the Committee at its June 2022 meeting and subsequently received updates from ESHT at the HOSC meetings on 15 December 2022, providing an overview of ESHT's consultation findings and a response to the recommendations of the review board. The Committee requested at its meeting on 18 September 2025, a progress report be brought to this meeting to provide an overview and evaluation of the changes that have been made to Cardiology services.

2. Supporting information

2.1. ESHT has produced a report for the HOSC attached as **Appendix 1**. The report includes an update regarding the recommendations agreed by the HOSC in June 2022, as well as to provide additional context on the implementation plans and activities which have been undertaken since.

2.2. The report includes the following information:

- A response to the HOSC's recommendations from June 2022

- An overview of the implementation of the programme, including Cardiac Response Teams and 'hot clinics'
- An update on the current status of implementation
- An overview of the improvements and benefits of the transformation implemented
- An outline of the Benefits Realisation Plan and Key Performance Indicators, which will map the progress of the programme

3 Conclusion and reasons for recommendations

3.1 The Committee is recommended to:

1) consider and comment on the report; and

2) consider whether to request a further report on the Cardiology Transformation Programme, or any other topics identified in the report.

PHILIP BAKER
Deputy Chief Executive

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Cardiology Transformation at East Sussex Healthcare NHS Trust

HOSC Update – December 2025

1 INTRODUCTION

Background and Context

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

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

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

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

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

Purpose of this paper

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

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

2 HOSC RECOMMENDATIONS

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

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

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

Recommendation 1

The Committee endorses the proposed new clinical model for cardiology including:

- **Cardiology cath labs should be single sited**
- **That both Eastbourne DGH and Conquest hospital sites are viable sites**
- **There is potential for new services to improve patient care and outcomes via the 'Front Door' model and 'Hot Clinics'**
- **There will be better services for patients at either Emergency Department (ED) sites; and**
- **Other services provided at each of the hospitals will not be affected or downgraded by the proposals for cardiology.**

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

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

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

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

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

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

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

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

Recommendation 2

The Board recommends:

- **Further measures to support the recruitment and retention of staff are explored in collaboration with the Sussex ICS and other system partners, which address the workforce challenges of the service.**
- **Staff recruitment and retention is monitored to ensure the workforce challenges are being met and to assess whether additional measures to support recruitment and retention are needed.**

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

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

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

Recommendation 3

The Board recommends:

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

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

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

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

- **the communication and clear messaging of advice and guidance on travel support options, including accessing financial support, including the ability to claim back travel costs following appointments etc.**

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

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

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

- **the provision of information on the travel support available in referral letters via a separate leaflet or information sheet in an accessible format and links to the website.**

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

- **the CCG (now ICB) and ESHT explore processes to ensure patients are asked about their travel and access needs at the point of referral or at an appropriate point in the**

patient pathway.

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

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

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

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

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

- **actions to improve access via other transport alternatives (e.g. development of a shuttle bus service, volunteer transport services, community transport, taxi services, liaison with bus operators and the local authority etc.).**

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

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

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

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

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

Recommendation 4

The Board recommends:

- **Implementation of the proposals is undertaken as soon as possible, and consideration is given to mitigating the risks posed by workforce challenges and the development of other competing services to ensure no loss of services in the implementation plan.**
- **The Decision Making Business Case (DMBC) contains assurances that other services provided at the two hospitals will not be affected by the implementation of the proposals for cardiology.**

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

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

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

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

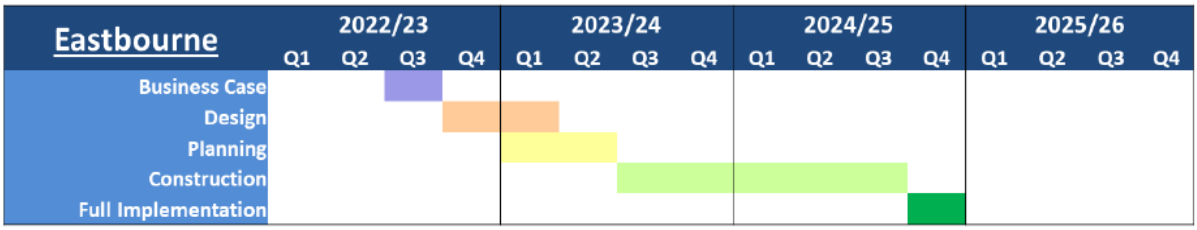
2.34 As per recommendation 1, it can be confirmed that there have been no negative impacts on the continuity or provision of other services as a result of this transformation programme.

3 IMPLEMENTATION PROGRESS

Original DMBC Implementation Timescales

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

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



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

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

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

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

Implementation Update

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

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

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

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

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

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

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

4 BENEFITS REALISATION

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

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

Current Improvements and Benefits

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

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

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

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

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

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

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

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

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

Benefits Realisation Plan

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

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

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

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

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

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

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**11 December 2025**
By:	**Deputy Chief Executive**
Title:	**Work Programme**
Purpose:	**To agree the Committee's work programme**

RECOMMENDATIONS

The Committee is recommended to review its work programme at Appendix 1 and agree any updates needed.

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1. Background

1.1 The work programme contains the proposed agenda items for future HOSC meetings and is included on the agenda for review at each committee meeting. It is an important tool in ensuring the correct focus and best use of the Committee's time in scrutinising topics that are of importance to the residents of East Sussex.

1.2 This report also provides an update on any other work going on outside the Committee's main meetings.

2. Work programme

2.1. The Committee is asked to review the items in the current work programme, attached as **Appendix 1** to this report, and discuss the future agenda items and other scrutiny work of the Committee for inclusion in the Committee's future work programme based on current priorities for scrutiny and the NHS.

2.2. The Committee is asked to consider any future reports or other work items that it wishes to add to the work programme, and whether to schedule or remove any of the items listed under the "Items to be Scheduled" section of the work programme for future meetings to be held later in the municipal year.

3. Conclusion and reasons for recommendations

3.1 The work programme sets out HOSC's work both during formal meetings and outside of them. The Committee is asked to consider its priorities in the context of NHS reforms and agree an updated work programme.

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Deputy Chief Executive

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Health Overview and Scrutiny Committee (HOSC) – Work Programme

Current Scrutiny Reviews		
Title of Review	**Detail**	**Proposed Completion Date**
To be agreed.		
Initial Scoping Reviews		
Subject area for initial scoping	**Detail**	**Proposed Dates**
To be agreed		To be agreed
List of Suggested Potential Future Scrutiny Review Topics		
Suggested Topic	**Detail**	
To be agreed	Subject to the announcement of NHS service reconfigurations impacting on residents of East Sussex.	
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: 12 January 2026

Reports for Information		
Subject Area	**Detail**	**Proposed Date**
To be agreed.		
Training and Development		
Title of Training/Briefing	**Detail**	**Proposed Date**
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 January 2026
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.	TBC

Future Committee Agenda Items		Witnesses
5 March 2026		
SECAmb CQC report	To receive a final update 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
Paediatric Service Model at Eastbourne District General Hospital (EDGH)	To receive a progress report on the changes made to Paediatric Service Model at EDGH after 18-20 months operation of the new model, to include an update on APNP staffing and the use of the former Scott Unit for paediatric services.	Representatives from ESHT
HOSC Review of the Provision of Audiology Services in East Sussex.	To receive a response from NHS Sussex to the HOSC Review of Audiology Services and the recommendations contained in the report of the Review Board agreed at the HOSC meeting held on 6 March 2025, and an update on the mobilisation of the over-55s hearing aid contract for Sussex.	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.	Policy and Scrutiny Adviser
25 June 2026		
Winter Plan 2025/26 update	To receive an update report on the Winter Plan for 2025/26 to review how the Plan was implemented this year and to highlight any learning or other issues to be taken forward into the next Plan or actioned separately.	Representatives from NHS Sussex, University Hospitals Sussex (UHSx), ESHT and SPFT.
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.	Policy and Scrutiny Adviser
17 September 2026		
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.	Policy and Scrutiny Adviser

10 December 2026		
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.	Policy and Scrutiny Adviser
Items to be scheduled – dates TBC		
Access to NHS Dentistry Services	To receive a further update report on the progress being made to improve access to NHS Dentistry services in East Sussex.	Representatives from NHS Sussex
Ophthalmology Transformation Programme	To receive an update report on the implementation of the ESHT Ophthalmology Transformation Programme when more detail is known about the plans for implementing phase 3 of the Programme. *Timing is dependent on ESHT implementation timescales and to be agreed with ESHT*.	Representatives from ESHT and NHS Sussex.
University Hospitals Sussex (UHSx), General Surgery and Neurosurgery	To receive an assurance report on the provision and safety of current general surgery and neurosurgery at UHSx Hospitals and in particular the Royal Sussex County Hospital (RSCH). To be programmed in liaison with NHS colleagues.	Representatives from University Hospitals Sussex (UHSx)
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
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