Sussex Health&Care

Sussex Winter Plan

November 2024 - March 2025

Improving Lives Together

Winter plan 24/25 - Overview

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

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

Prevention and case finding

Same day urgent care

Improvements in discharge to support patient flow

Sound operational management

Oversight, governance and escalation

Winter plan 24/25 - Overview

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

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

Principles and risk measures

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

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

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

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

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

The challenge for this winter

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

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

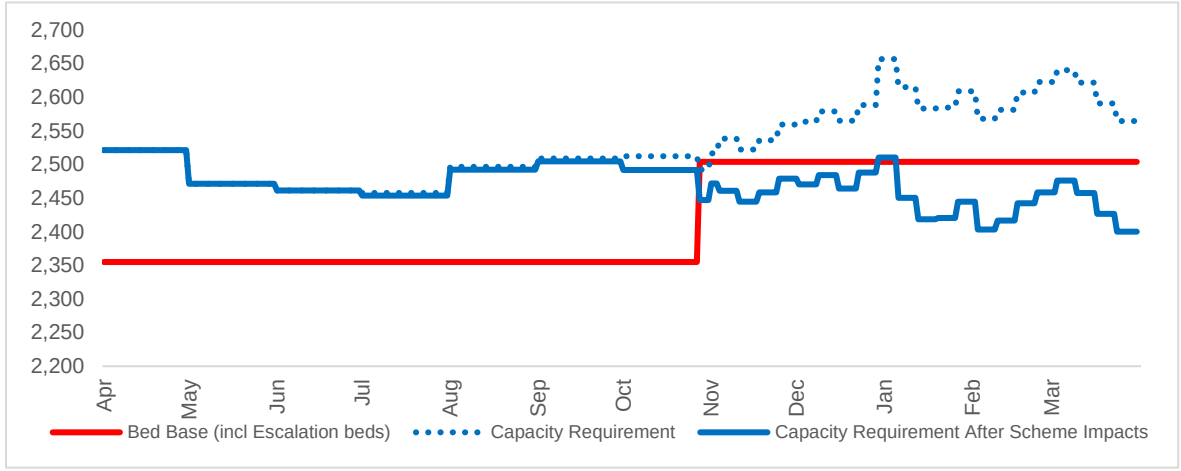
	Sussex
	w/c 06 Jan
Bed Base (starting position)	**2,504**
Starting Capacity Requirement	**2,657**
Starting Gap to Capacity Requirement	**164**
(a) Discharge Plan	**-120**
Amended Gap	**45**
(b) UEC and Frailty Demand Reduction Plans	**-28**
Amended Gap	**17**
(c) Local Place based plans	**-11**
Amended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

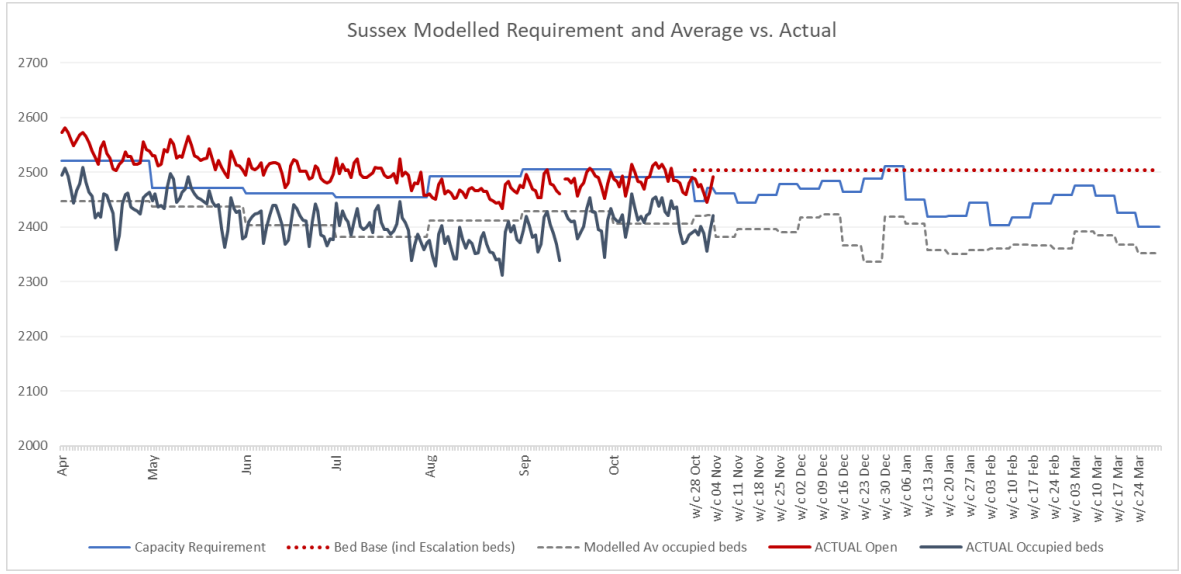
The challenge for this winter

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

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

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





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Bridging the Gap

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

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

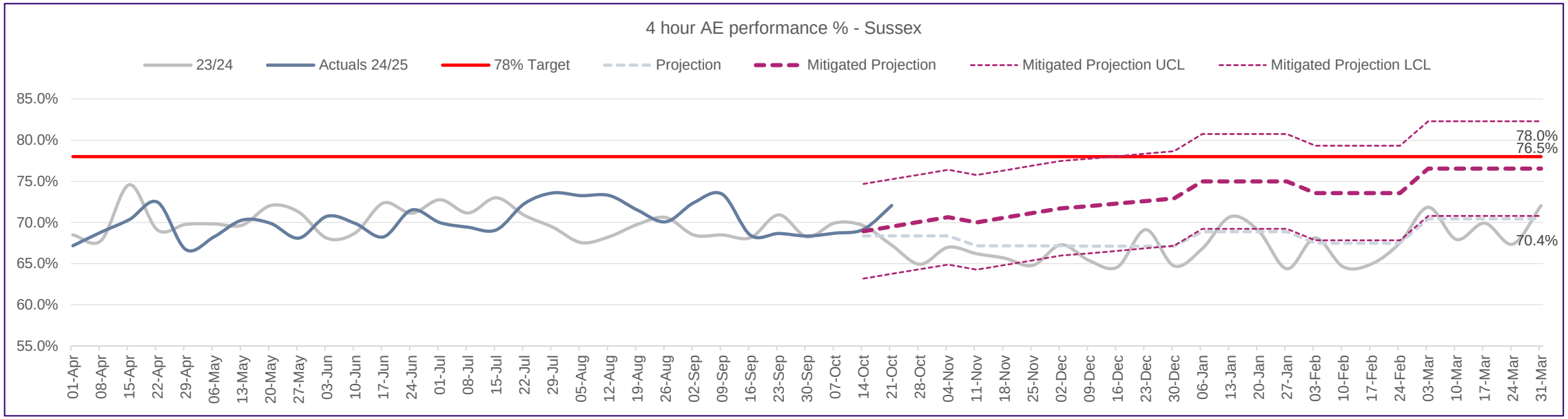
Measure	Projection Mar-25	Target	Gap
A&E 4-hour	76.50%	78.00%	1.5 p.p
12 Hours in dept.	2.20%	0	-2.2 p.p
Average LoS	8.7	8.3	0.4
NCTR	780	726	54

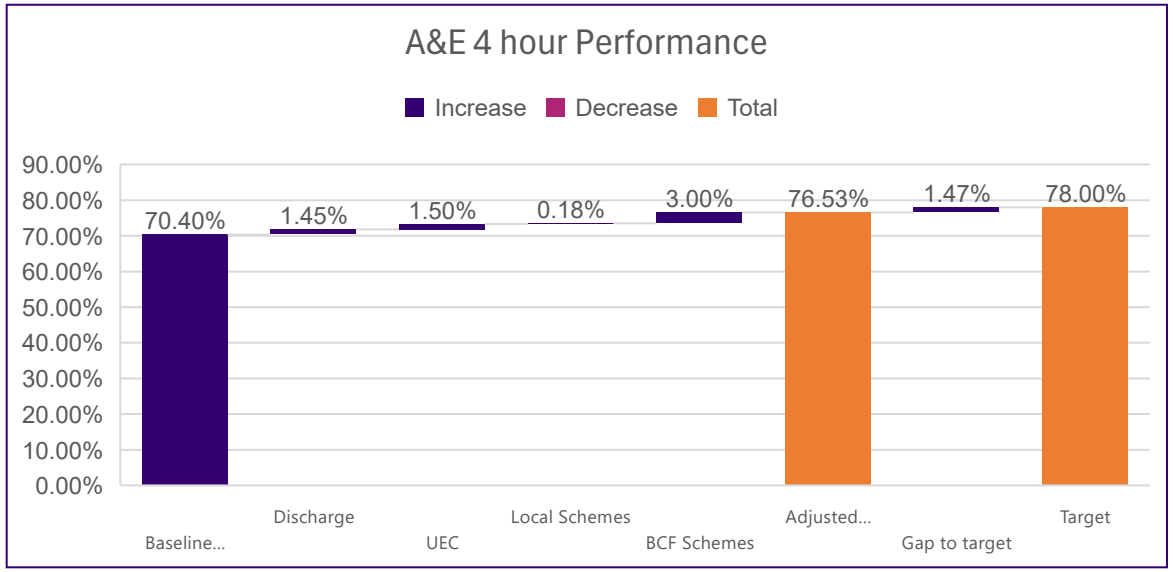
The modelled impact has been applied to the baseline trajectories for the following metrics:

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

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

Bridging the Gap – A&E 4 Hour





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

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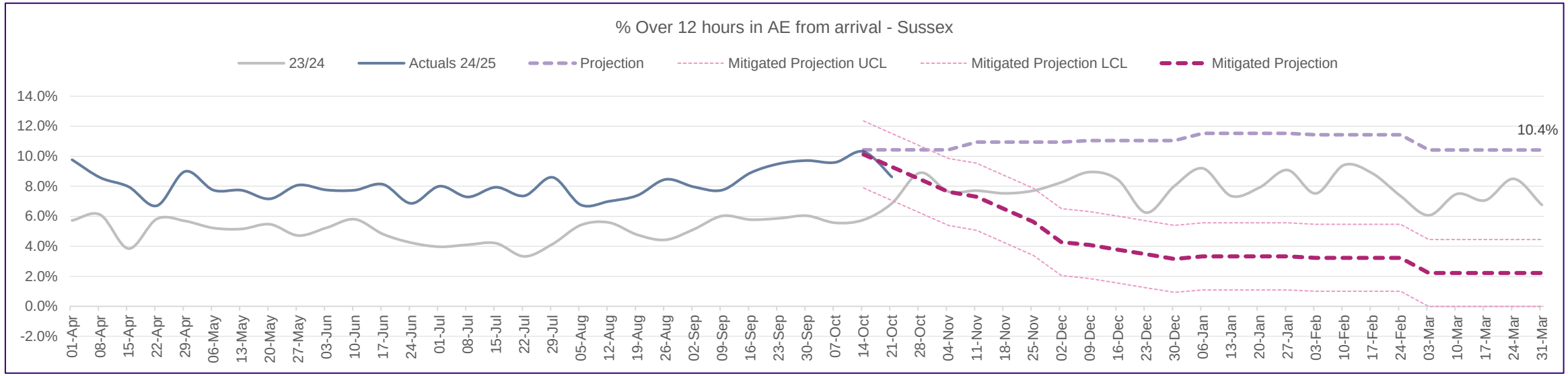
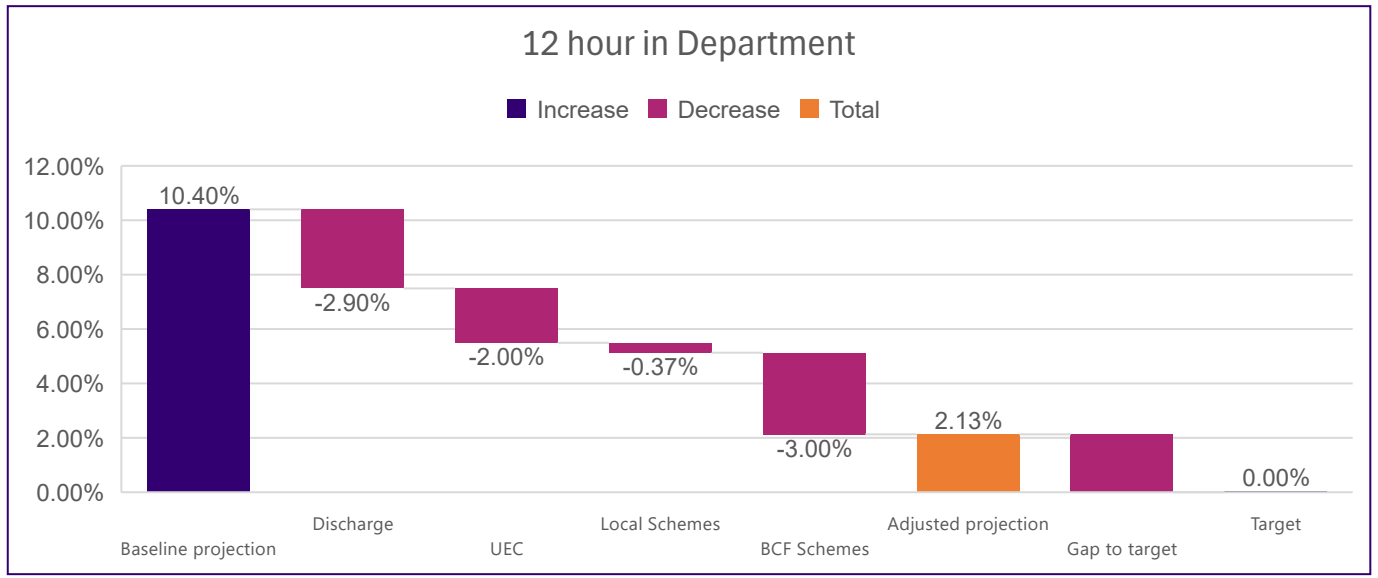
Bridging the Gap – 12 Hour in department





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

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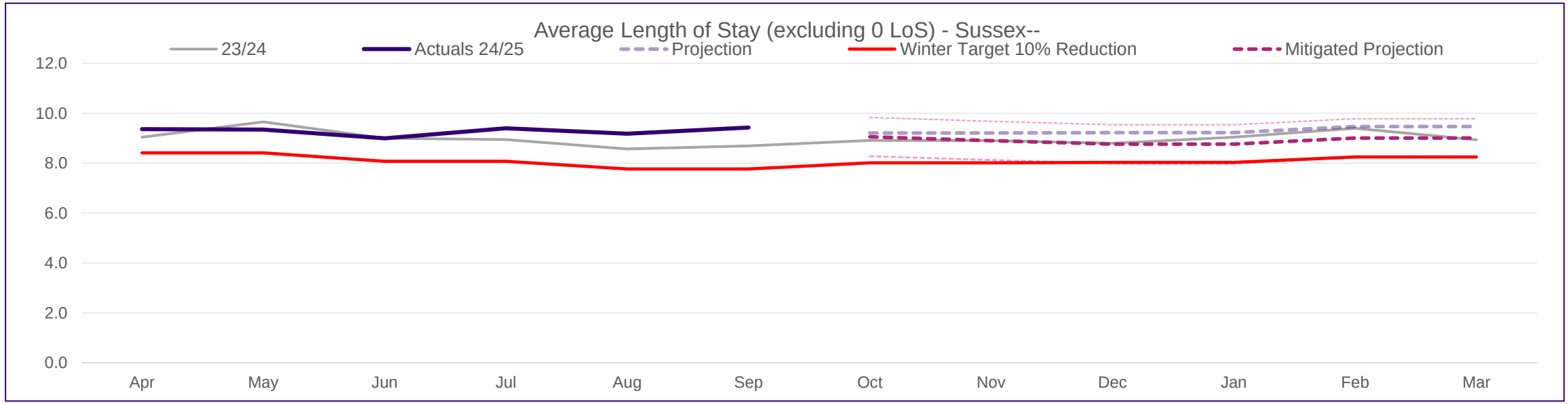
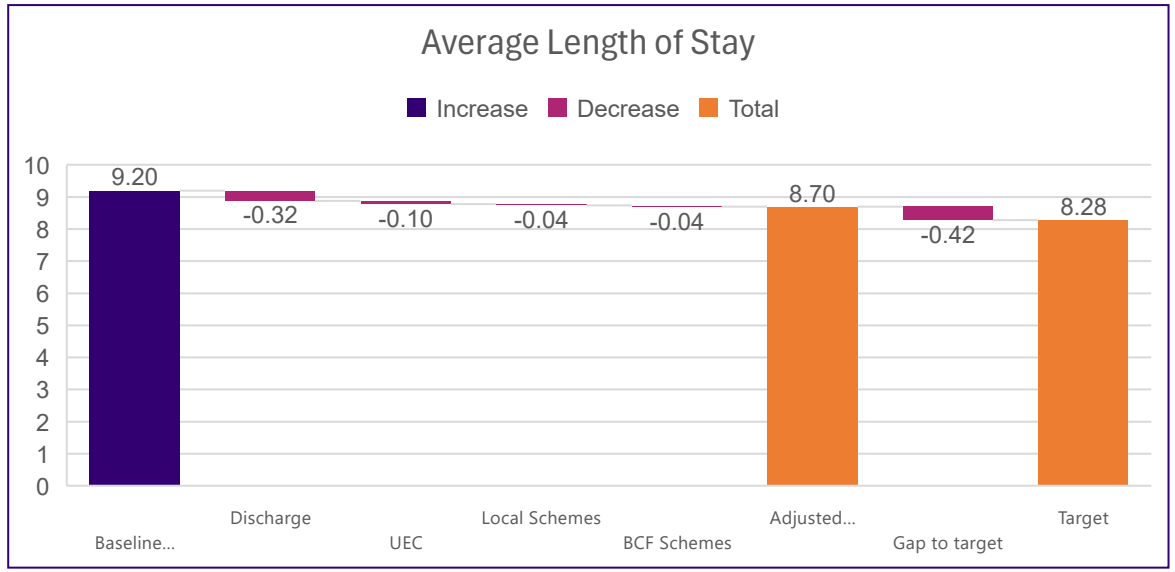
Bridging the Gap – Average LOS





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

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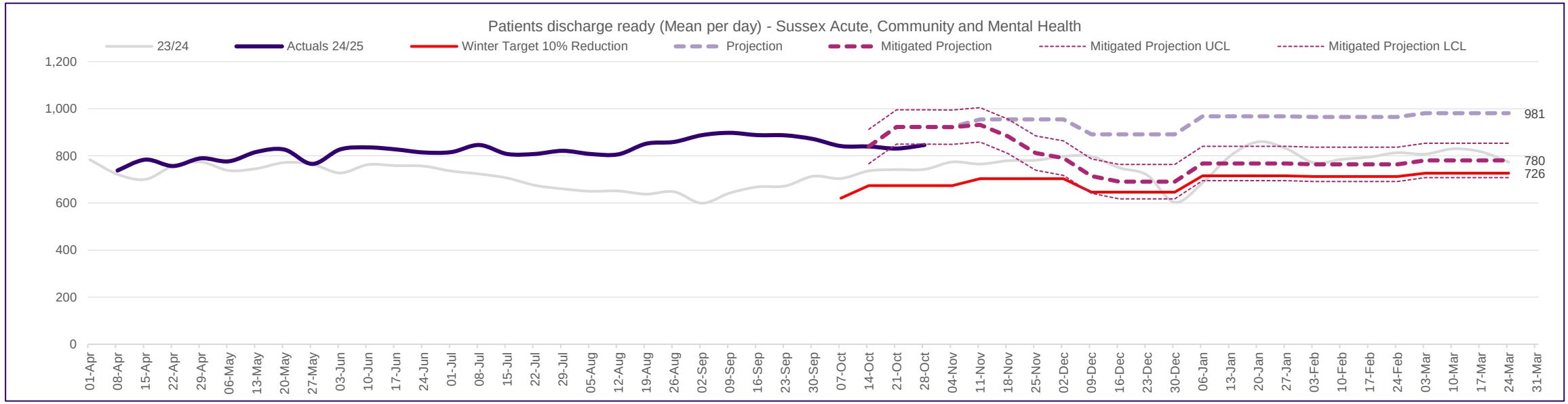
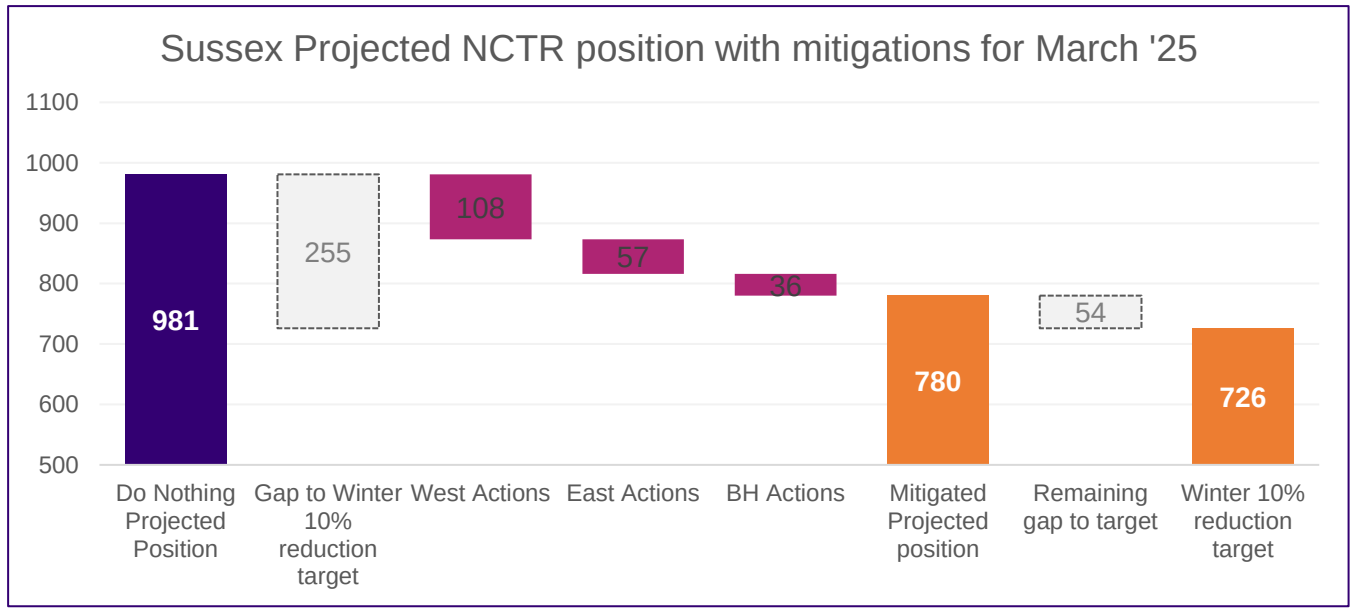
Bridging the Gap – NCTR





Projection Mar-25	780
Target	726
Gap	54

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Workforce and Wellbeing

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

All providers are taking action to address these key aims.

Our aims:

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

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

Pillar 1
Prevention and Case Finding

Prevention and Case Finding

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

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

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Vaccination

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Vaccination Programme

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

COVID vaccination

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

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

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

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Vaccination Programme

COVID vaccination

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

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

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

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

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

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

Vaccination Programme

Flu vaccination

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

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

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

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

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

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

Vaccination Programme

RSV vaccination

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

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

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

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

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

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

Case finding and proactive care

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Case finding

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

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

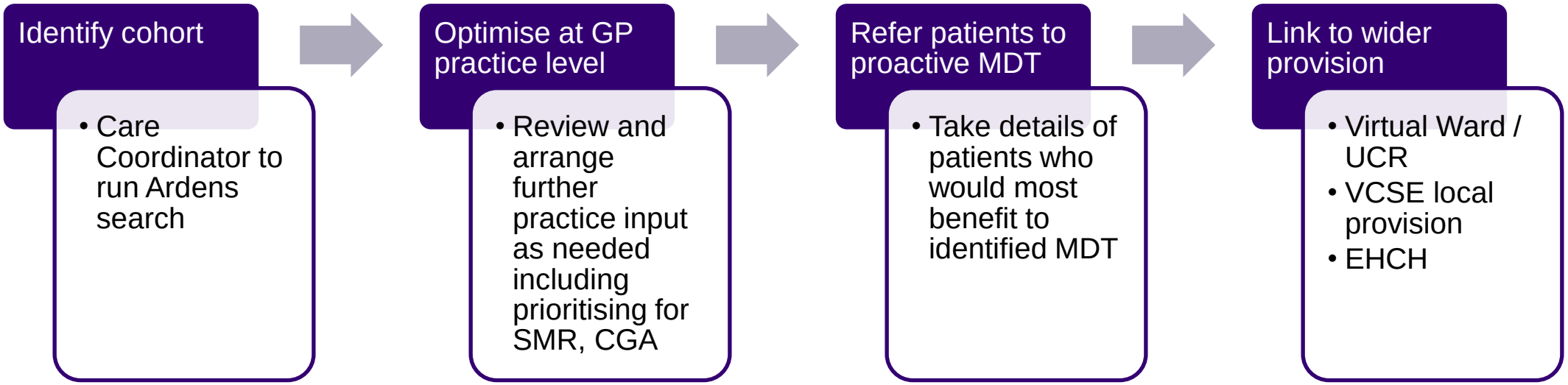
- Identifying at risk individuals at practice level, prioritising for optimisation and working with proactive teams to ensure the right support is in place to avoid admission
- Optimising Voluntary and Community Sector support, reprofiling existing resource to focus on at risk patients
- Ensuring that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

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

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

Proposed approach

A standardised approach that is tailored to local assets



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

ICT proactive care approach

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

Examples of the Tests of Change agreed to date include:

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

Place level plans

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Place level plans

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

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

Communications and Engagement

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Communications and engagement approach

Supporting people to stay well

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

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

Help us help you stay well this winter

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

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

Communications and engagement approach

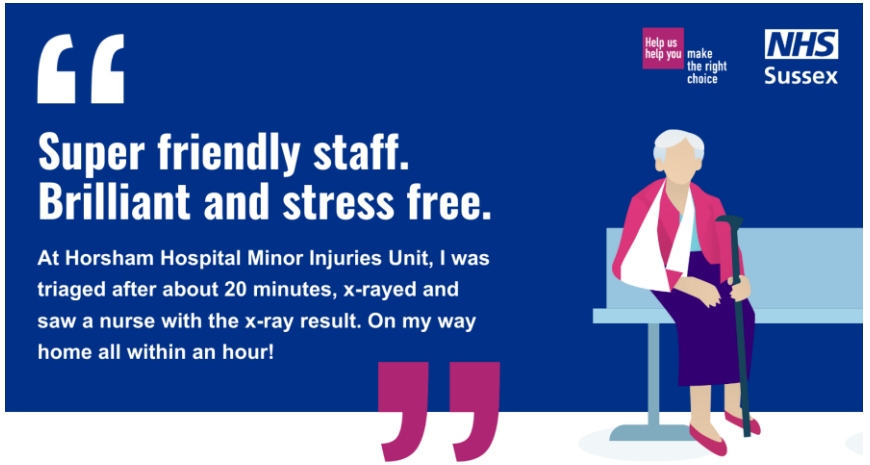
Supporting people to stay well

System coordination

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

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

Help us help you stay well this winter



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Pillar 2
Same day urgent care

Same Day Urgent Care

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

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

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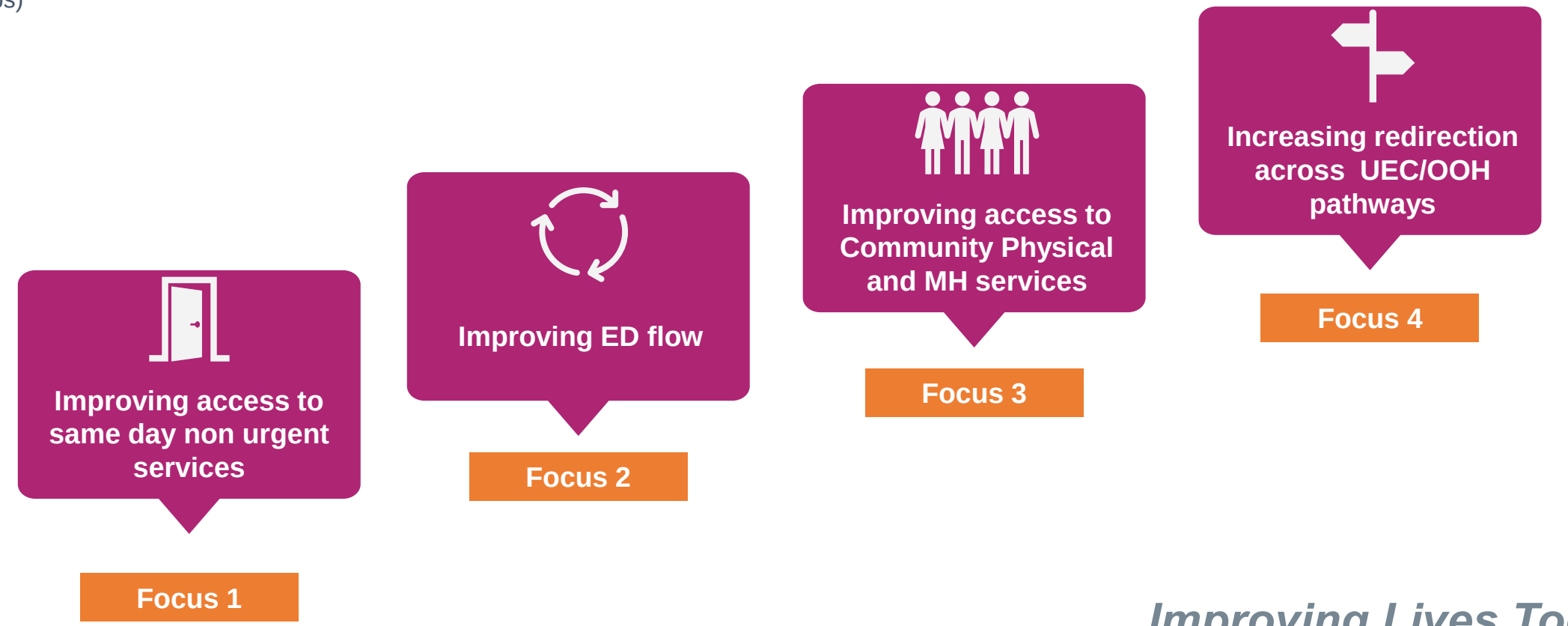
Same Day Urgent Care

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

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



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Improving access to same day non urgent services

Our aims

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

Our aims in detail:

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

Improving Emergency department flow

Our aims

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

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

Improving access to community physical and mental health services

Our aims

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

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

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

Our aims

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

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

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

Pillar 3
Improvements in discharge to support patient flow

Improvements in discharge to support patient flow

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

Improving Lives Together

Improvement to discharge

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

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

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

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

Immediate improvement priorities

4 key discharge workstreams for winter

Implement the SAFER patient flow bundle

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

Support patients to stay active whilst in hospital

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

Optimise the Transfer of Care Hub (TOCHs)

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

Develop a needs-based demand and capacity model

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

Improvement Priority 1: Implement the SAFER patient flow bundle

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

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

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

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

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

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

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

Pillar 4
Sound operational management

Sound operational management

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

Improving Lives Together

Monitoring and Escalation Routes

System Co-ordination Centre (SCC)

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

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

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

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

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

SCC Winter Standard Operating Function

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

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

Improving Lives Together

MDT Rapid Improvement Team (M-RIT) operating model

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

Respond in an agile way to emerging pressures

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

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

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

Improving Lives Together

Protecting the delivery of Planned Care

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

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

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

Pillar 5 Governance, Oversight and Escalation

Improving Lives Together

Governance, Oversight and Escalation

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

Improving Lives Together

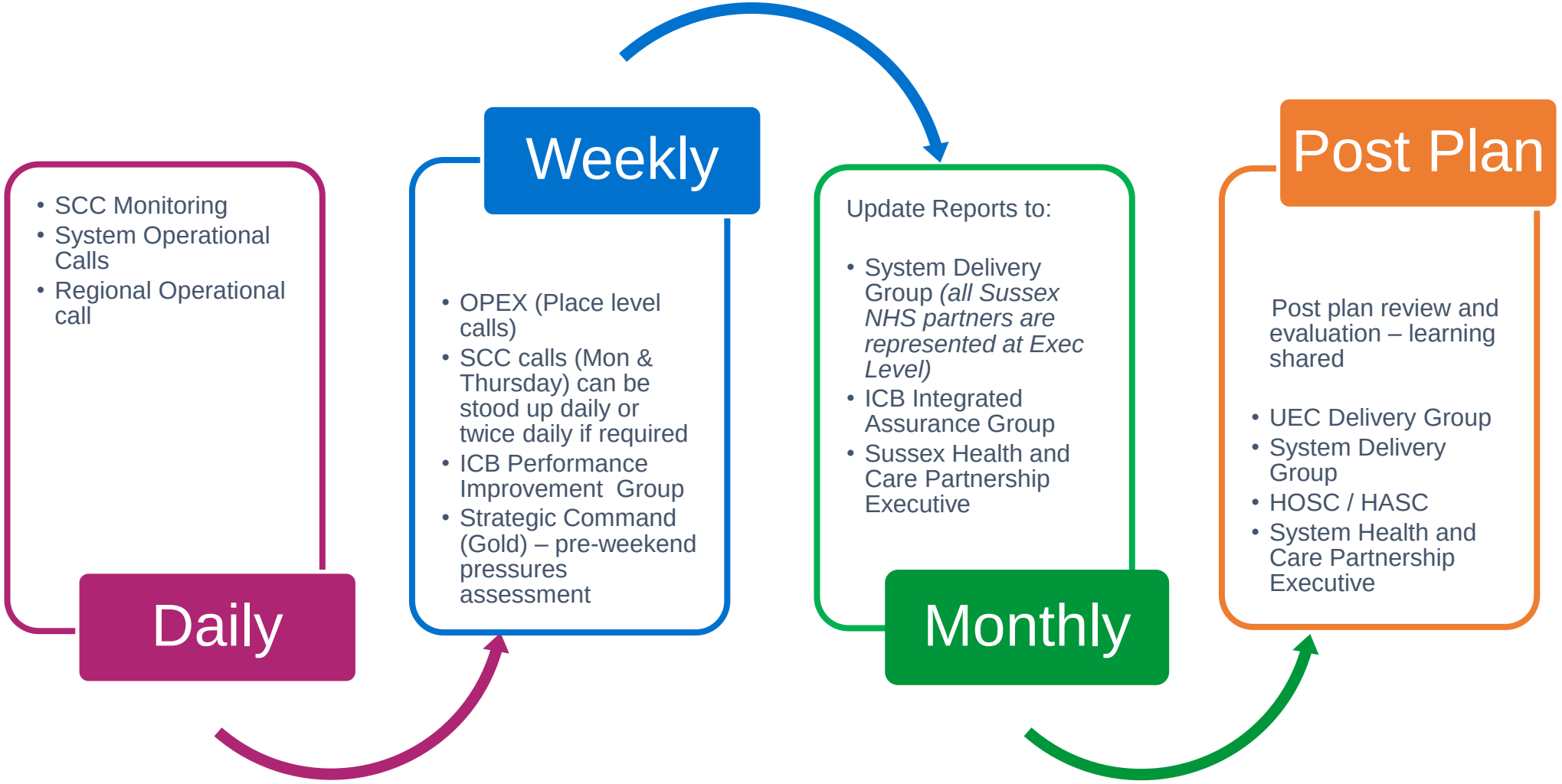
Governance and Oversight

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

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

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

Oversight timetable over winter



Operational Pressures Escalation Levels (OPEL) framework

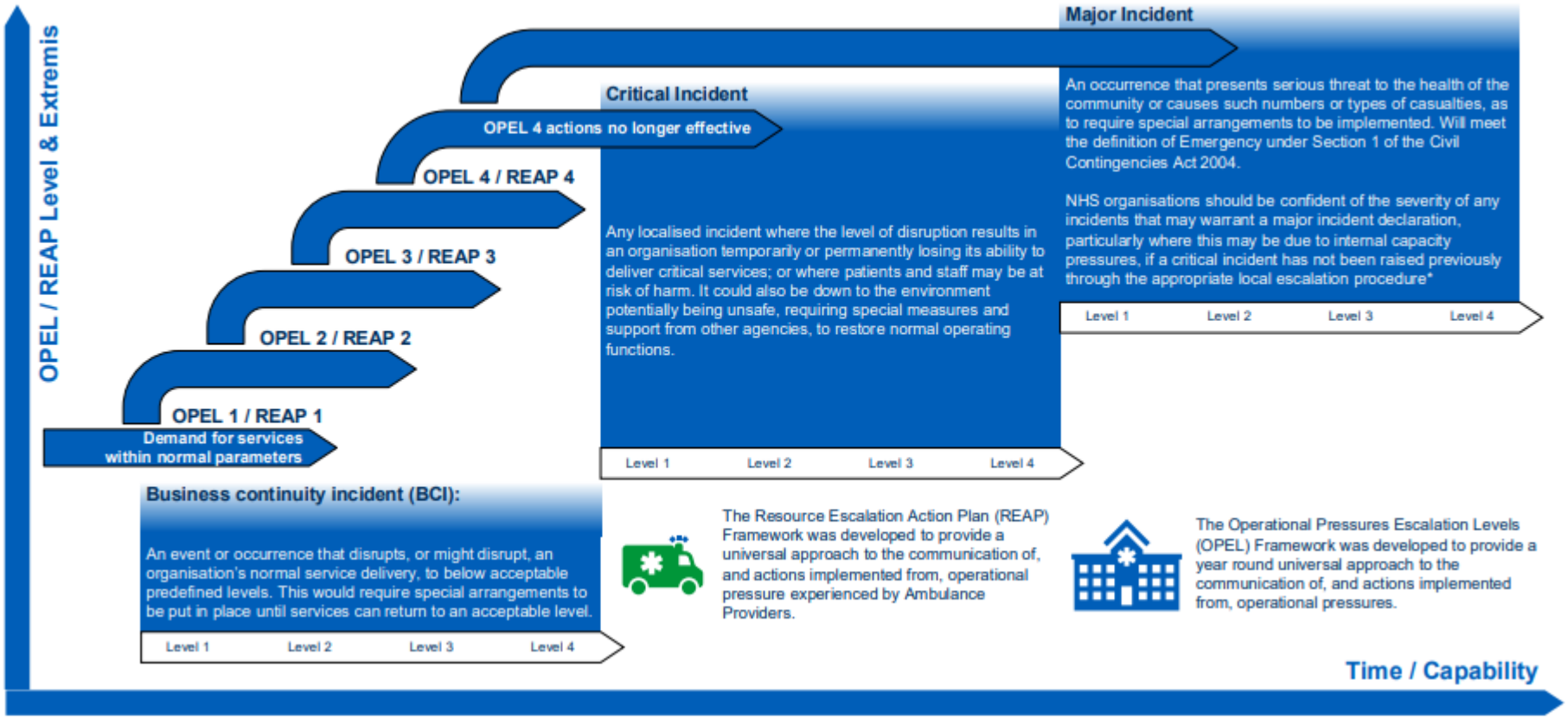
Where the activities and actions outlined in this winter plan prove insufficient to manage any surges in operational pressures, escalation and response in the Sussex system will be dictated by the application of the NHS England Integrated OPEL framework 2024/25, coordinated by the SCC which reviews OPEL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

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

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

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

OPEL to EPRR escalation



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

Appendices

Provider Winter Plans (summary level)

Provider Winter Plans

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

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

Improving Lives Together

University Hospitals Sussex NHS Foundation Trust

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

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

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

Improving Lives Together

East Sussex Healthcare Trust

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

NHS
East Sussex Healthcare
NHS Trust

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

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

Improving Lives Together

Sussex Community Foundation NHS Foundation Trust

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

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

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

Improving Lives Together

Sussex Partnership Foundation NHS Foundation Trust

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

NHS
Sussex Partnership
NHS Foundation Trust

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

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

Improving Lives Together

Queen Victoria Hospital

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

NHS
Queen Victoria Hospital
NHS Foundation Trust

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

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

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

Improving Lives Together

South East Coast Ambulance Service

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

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

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

Improving Lives Together

Surrey and Sussex NHS Healthcare Trust

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

NHS
Surrey and Sussex Healthcare
NHS Trust

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

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

Improving Lives Together