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

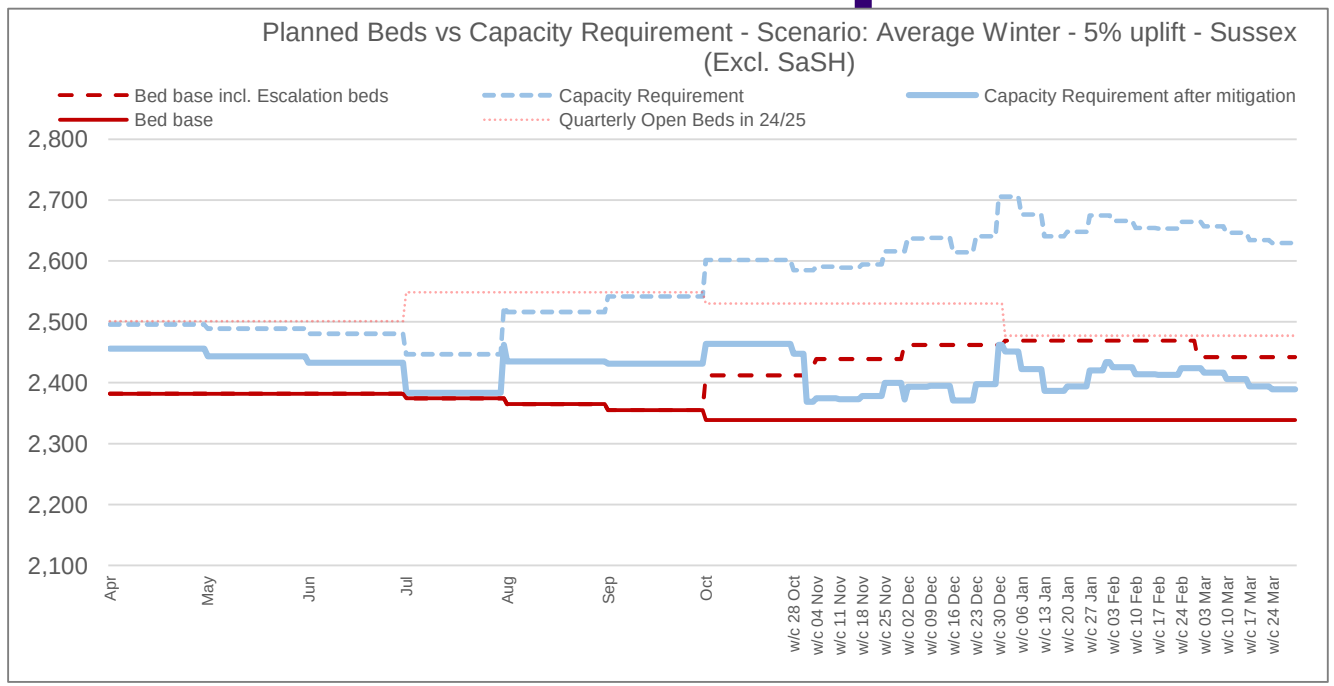
We have developed a 'statistical model' based on bed occupancy and likely scenarios for service demand based on possible levels of influenza (flu) and infectious disease in our community. This provides the 'bed gap' in a reasonable worst-case scenario.

# 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

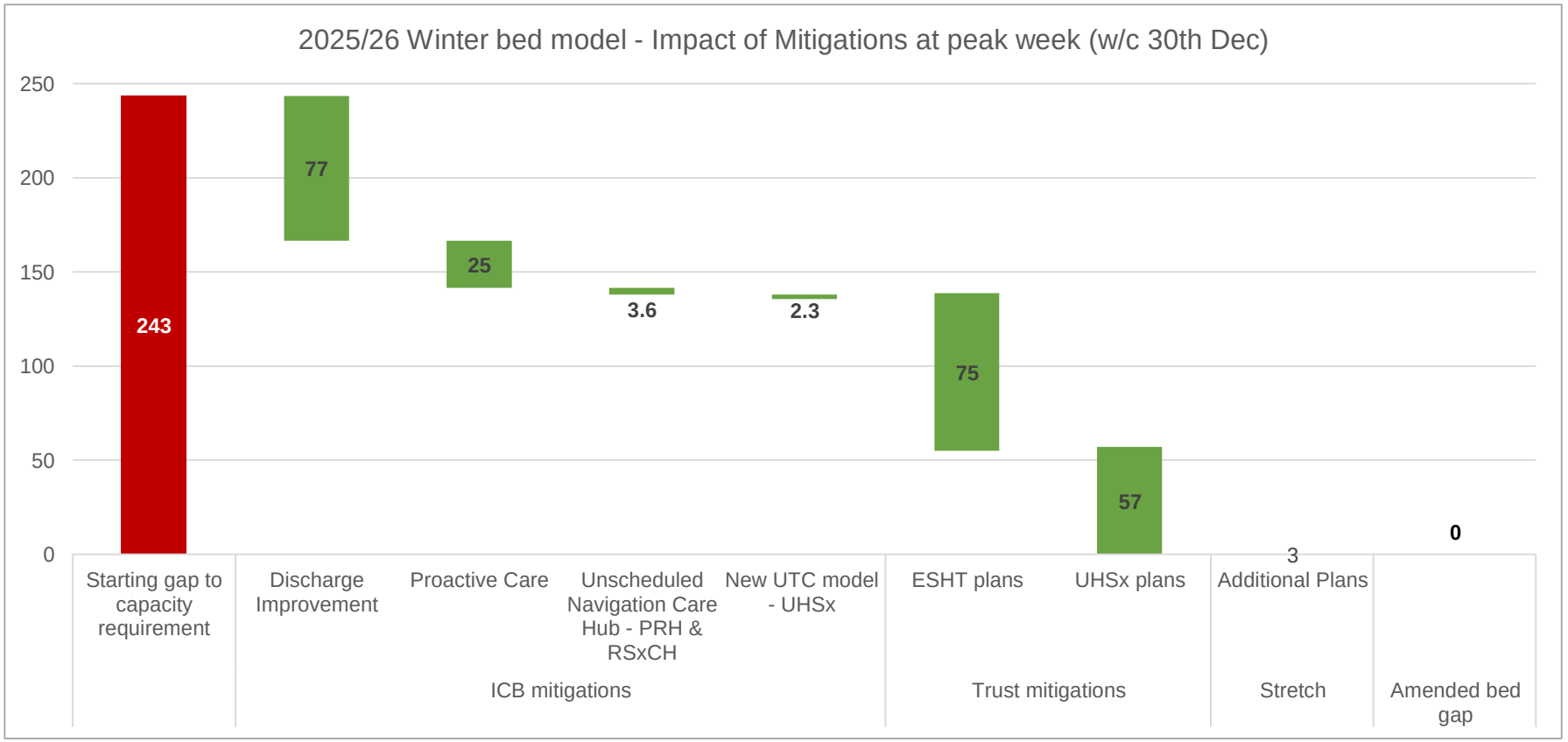



## Peak Week and mitigations

| | 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

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| **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.<br>• 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.<br>• 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.<br>• 100% of breaches escalated same-day through OPEL framework, with system response actions deployed.<br>• A significant reduction in the number of ambulances queuing outside the hospital.<br>• 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.<br>**October 2025:** Improved Ambulance Handover protocols launched.<br>**November 2025:** Rollout of improved communication protocols with social care.<br>**December 2025:** Initial review of results and feedback for improvement<br>**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

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| **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.<br>**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.<br>**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.<br>**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.<br>A significant reduction in ambulance handover delays.<br>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.**<br>**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

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| **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<br>**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.<br>**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.<br>Reduced overcrowding in the ED, leading to a safer environment for patients and staff.<br>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**<br>**Ongoing:** Continuous monitoring and refinement of the processes to ensure sustained performance. |

## Reduce the number of patients waiting for a Mental Health Bed

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| **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<br>• SPFT to deliver internal Patient Flow Plan improvements, reducing Length of Stay.<br>• Continue Executive led Quality Improvement weekly huddle focussed on addressing extended emergency department waits<br>• 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.<br>• 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<br>• Staying Well Services – to pursue clinician recruitment to enable all to operate full open access<br>• 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.<br>• 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)

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| **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:<br>• Fortnightly review of site-specific action plans, agreed across the system in September<br>• Continue to seek opportunities to adopt trusted assessment and increase efficiency of discharge pathways<br>• Embed early discharge planning, including earlier identification of patients with complex needs<br>• 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<br>• A reduction in the number of beds occupied by people who no longer meet the criteria to reside (NCTR)<br>• Fewer internal delays >48 hrs<br>• 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

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| **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.<br>**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.<br>**Ensure there are clear, fully resourced respiratory surge plans in place to expand capacity where required during seasonal spikes in activity.**<br>Develop paediatric surge pathways for NHS 111 and ED triage, plus workforce escalation.<br>**Establish clear outpatient pathways to avoid unnecessary ED attendances.** |
| **Success Measures** | All paediatric urgent calls/ED attendances managed within planned surge capacity<br>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.<br>**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

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| **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)<br>• Ensuring capacity operates at optimum levels through delivery of key productivity metrics<br>• Manage demand via increased utilisation of Advice and Guidance (aim to get to 8% by March 2026) and advice and refer pilots<br>• Utilise Cancer Alliance waiting list initiative funding (all providers) to ensure delivery of cancer waiting times<br>• 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<br>• Undertake forecasting and planning activity to mitigate impact of bed pressures e.g. shift activity from inpatient to daycase in January<br>• Minimise risks of staff availability and loss of beds through robust IPC, implementation of Healthrota annual leave system for all consultants at UHSx.<br>• 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

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| **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:<br>• Lack of take up amongst staff re vaccination<br>• Ongoing requirements for temporary staffing<br>• Potential for disruption to activity caused by ongoing industrial action |
| **Actions / Task** | Specifically, during the winter period we will:<br>• continue to manage and reduce the costs associated with our temporary workforce<br>• Implement measures to reduce sickness absence across the system<br>• increase uptake of flu vaccinations amongst staff, building on identified examples of good practice<br>• enhance and activate agreed consultant and senior nurse rotas for ED, AMU, paediatrics during peak weeks<br>• CEOs, CMOs, CNOs to maintain high visibility and leadership throughout December and January by routinely “walking the floor”<br>Measuring Progress:<br>• Sickness absence is reported monthly via the Integrated Commissioning Report<br>• Temporary Staffing costs are monitored via the Southeast Temporary Staffing Collaborative and reported monthly<br>• Flu vaccination uptake will be measured via systems linked to the overarching vaccination programme for the system |
| **Success Measures** | Success measures:<br>• Maintenance of rolling average sickness absence rates with no peak over the winter period<br>• Continued reduction in temporary staffing costs in line with submitted operating plans<br>• At least 5% increase in uptake of flu vaccination amongst staff<br>• 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

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| **Aim** | To improve Covid-19 and flu vaccination rates for all eligible cohorts when compared to previous year. |
| **Current position** | **Flu uptake 2024/25:**<br>• General population: Sussex – 60.7%; national – 51.1%<br>• Frontline Health Care Workers: uptake is shown in the table, together with this year's target set by NHS England<br><br>• **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<br>• 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<br>• 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.<br>• An outreach campaign will be implemented to target eligible people in population groups where uptake has been persistently low; addressing vaccine hesitancy and fatigue.<br>• Targeted campaigns and IPC-led 'every contacts counts' approach |
| **Success Measures** | • Improve staff vaccination uptake (flu/COVID) by at least 5%.<br>• 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<br>• 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

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|---|---|
| **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.<br>• 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.<br>• Confirm stakeholder roles, expectations, and support required.<br>• Agree governance and operational delivery mechanisms.<br>• Finalise workforce training plans.<br>• Ensure readiness of digital tools (e.g. Remote Monitoring onboarding). |
| **Success Measures** | • Number of patients onboarded to Remote Monitoring respiratory pathway<br>• Reach and impact of winter events (attendance and interventions)<br>• Uptake of vaccinations and smoking cessation support<br>• Workforce engagement and completion of training<br>• Reduction in COPD exacerbations and unplanned admissions |
| **Timeline** | • **By 31 August 2025**: Providers to confirm delivery plans<br>• **Autumn 2025**: Winter readiness events delivered<br>• **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<br>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<br>• 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).<br>• 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.<br>• Reduce assessment times: Accelerate expansion of trusted assessment approaches across all three places<br>• 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<br>• Increase in percentage of pathway 0 discharges<br>• Increase in percentage of pathway 1 discharges (left shift)<br>• Reduced number and duration of delays within Home First pathway 1 |
| **Timeline** | • October 2025 – TOCH learning event<br>• **September 2025** – convene NHS and LA providers to agree left shift delivery plans<br>• **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.<br>• Maintain a 285 Virtual Ward (VW) bed base throughout 2025/26.<br>• 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.<br>• Stand up remote Monitoring Hub model in time for winter<br>• 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.<br>• Trajectory set for Remote Monitoring/Hubs - 750 patients to be remotely monitored as part of virtual health programme .<br>• Evaluation of Virtual Health recruitment campaigns through providers.<br>• VH remote monitoring hub to demonstrably link with ICTs and speciality community services |
| **Timeline** | • Remote monitoring hub in place by **30th October 2025.**<br>• 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**

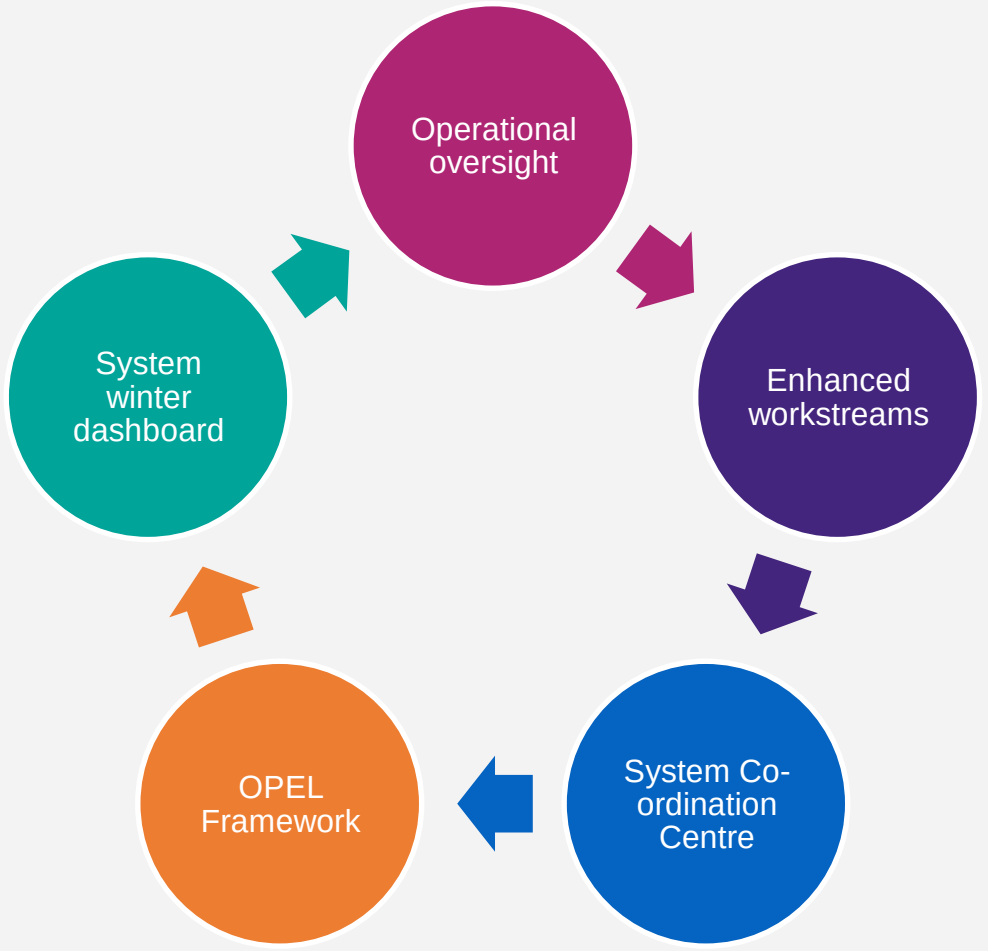
- Winter Operating Model
- Effective management of clinical risk and infection prevention and control
- Clear co-ordination across the system and rapid routes of escalation for operational issues
- OPEL Framework utilisation
- System MADE Event
- Communications plan

# 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<br>SECAmb Power BI | daily |

## Monitoring Operational Pressures (2/2)

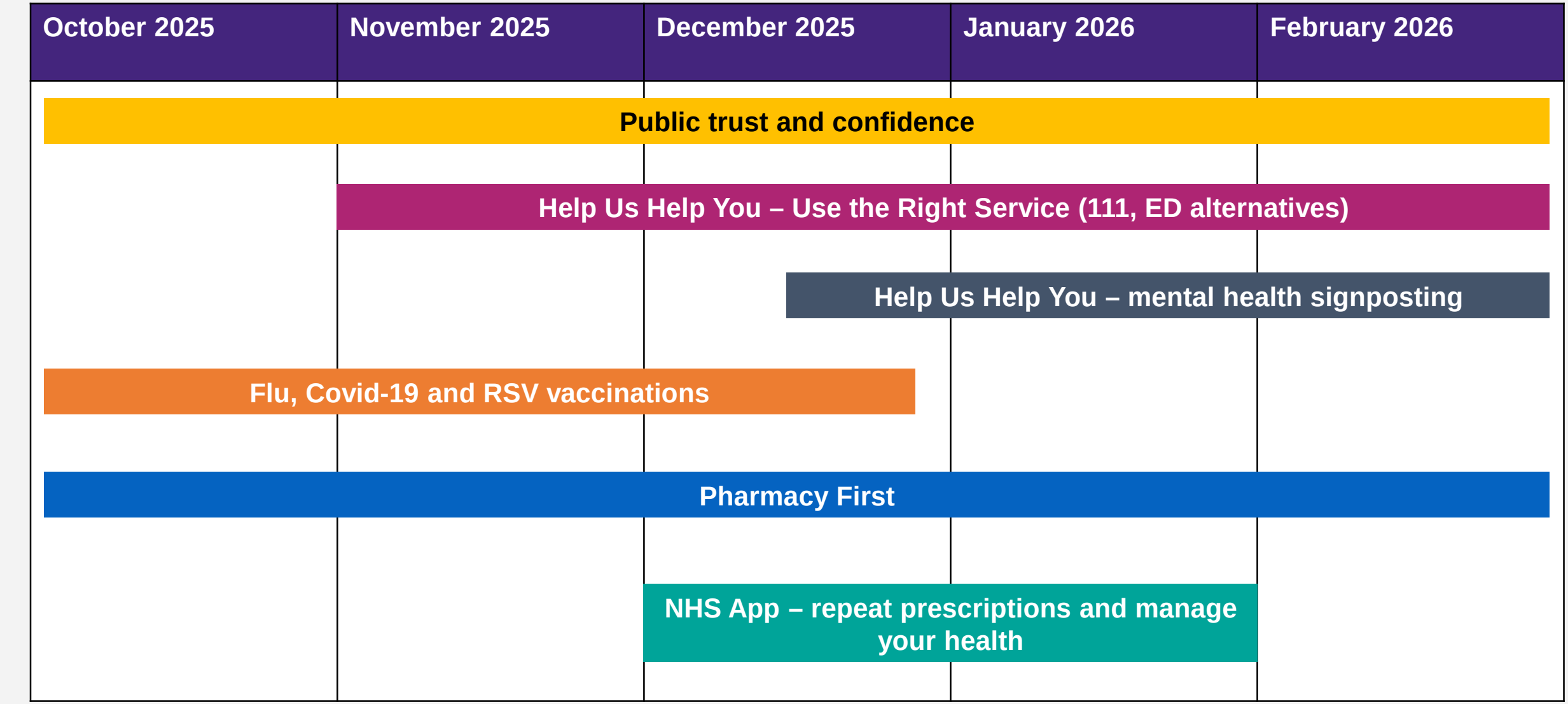
We proposed to use the following metrics as proxy measures for how well the system is coping with operational pressures and whether or not the system is achieving the plan's stated aims.  These metrics will be shared at the SCC Calls:

| 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:**<br>• The communications and engagement approach reaches across these key areas in Sussex:<br>  • **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.<br>  • **Promotion of key information and advice**:<br>  • **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.<br>  • **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.<br>  • **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.<br>• 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.<br>• 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

## Daily

- SCC Monitoring
- System Operational Calls
- Regional Operational Calls

## Weekly

- OPEX (Place level calls)
- SCC calls (Monday and Thursday) can be stood up daily or twice daily if required
- ICB Performance Improvement Group
- Strategic Command – pre-weekend pressures assessment

## Monthly

Update Reports to:

- System Delivery Group *(all Sussex NHS partners are represented at Exec Level)*
- ICB Integrated Assurance Group
- Sussex Health and Care Partnership Executive

## Post Plan

Post plan review and evaluation – learning shared

- UEC /OOH Group
- System Delivery Group
- HOSC / HASC
- System Health and Care Partnership Executive

# 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.<br><br>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<br>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<br>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<br>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:<br>S - Senior Review<br>A - All patients<br>F - Flow<br>E - Early Discharge<br>R - Review |
| SaSH | Surrey and Sussex Hospitals |

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| 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 |