Brighton & Hove City Council

HEALTH OVERVIEW & SCRUTINY COMMITTEE ADDENDUM

4.00PM, WEDNESDAY, 10 JULY 2024

COUNCIL CHAMBER, HOVE TOWN HALL

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ADDENDUM

Sussex Health&Care

Urgent and Emergency Care

Brighton & Hove HOSC

July 2024

Improving Lives Together

Introduction

We know that patients attending the emergency department at Royal Sussex County Hospital do not always receive timely care. The departments faces challenges in meeting the 4 hr A&E standard, and more patients experience ambulance handover delays, wait for more than 12 hours, and experience long waits for admission than at other Emergency Departments across Sussex. The long term plan to improve the flow of patients through the Emergency Department is through a rebuild of the department which is expected to progress over the next 3 years. Alongside this are a series of shorter term improvement actions which we have summarised in the following slides.

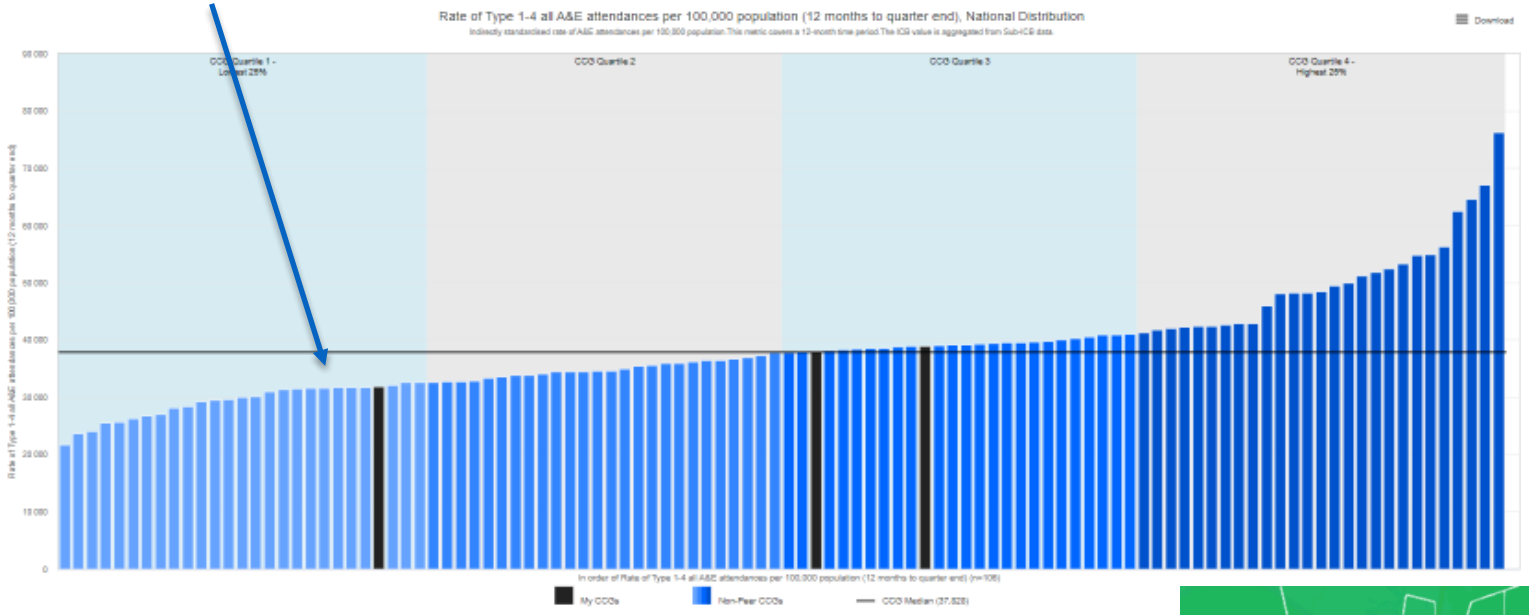
Key points to note include:

- Partners including the local authority and the Voluntary, Community and Social Enterprise (VCSE) sector continue to work with the NHS to provide services in the community to reduce attendances and ensure patients are seen in the right settings.
- The use of Virtual Wards and Community Urgent Community Response services, along with enhanced primary care is being expanded to reduce the number of emergency attendances and admissions.
- Several commissioned services are provided at the front door of the Emergency Department to support same day discharge.
- NHS partners and the City Council are working in acute, community and mental health settings to ensure that patients are discharged in a timely manner with the aim of improving flow through the hospital. More work is being done by the City Council to improve assessment times for care across all settings working within a multi-disciplinary team co-located in the same room at the hospital as part of the Transfer of Care Hub.
- The ICB is also working with Health and Care partners to deliver the Improving Lives Together strategy through the development of Integrated Community Teams working at neighbourhood level. The initial focus will be on delivering proactive care to the most complex and vulnerable patients with the aim of reducing avoidable exacerbations of ill-health and improving the quality of care for older people. This includes the delivery of proactive support for people living in care homes.

Community Care: Preventing A&E attendances and hospital admissions

Attendances

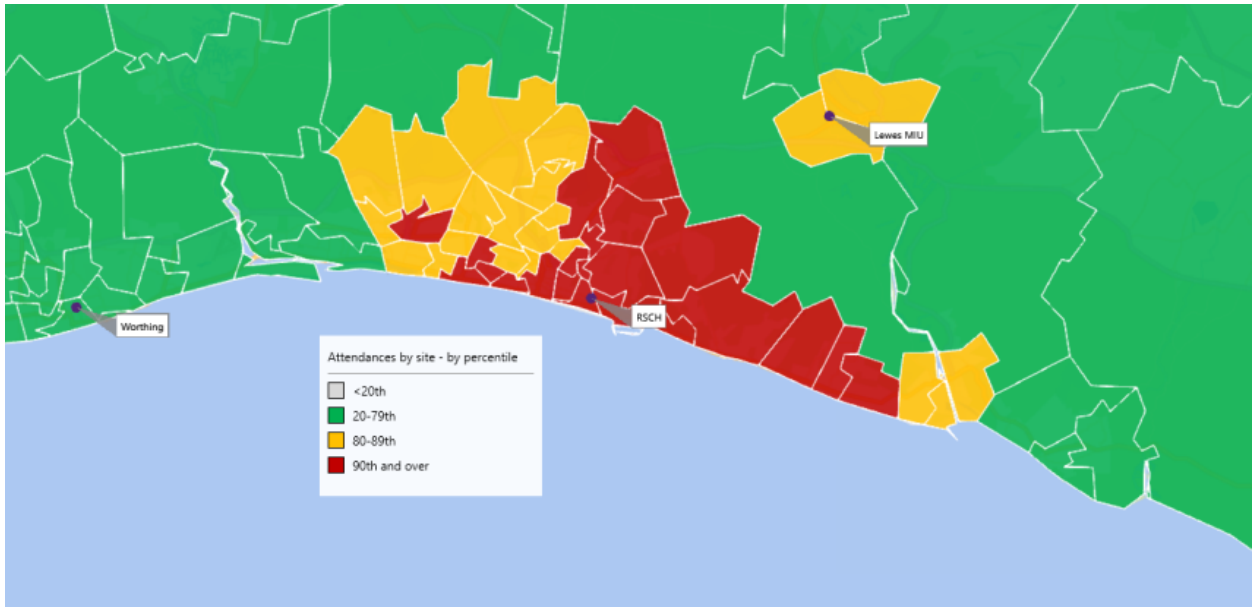
In 2023/24 people in Brighton and Hove were less likely to attend the Emergency Department than elsewhere in the country (in the lowest quartile nationally).



Some of the main reasons the people who do chose this service over others includes:

- Proximity to hospital
- Living in areas with high rates of deprivation
- Being of working age and/or student population
- Homelessness
- Complexity of need

The table (right) shows A&E attendances by percentile at RSCH between March 2023 and April 2024 by Middle Layer Super Output Areas (MSOA). Super Output Areas (SOAs) are a set of geographical areas developed following the 2001 census. They are used to give a set of areas of consistent size, whose boundaries would not change (unlike electoral wards). Middle Layer Super Output Areas (MSOAs) on average have a population of 7,200.



Actions Supporting People Away from ED

A key area of system focus is developing schemes to better support our people outside of having to attend ED. These include:

- Enhancing Primary Care
- High Intensity User Services
- Urgent Community Response Teams
- Virtual Wards
- Teams at the Urgent Treatment Centre and Front Door of ED to get people to the right place in the right time

Primary Care

- **General service provision:** 1319 Enhanced Access GP appointments are offered in Brighton per week*. This is in addition to the average 139000 appointments per month (up from 117,766 per month pre pandemic). Additional services are in place to offer alternatives to GP care where appropriate, including Pharmacy First, Walk in Centre, Enhanced Care in nursing homes; use of 111 and the walk in centre. The safe space works in the nighttime economy to offer care for patients *in situ* and prevent conveyance to hospital wherever possible. A number of initiatives including the staying well service, VCSE and open access services, and the Havens support flow and alternatives to inpatient admission for patients with mental health issues. To support this work further the relationship between the Havens and Mental Health Liaison Team based at RSCH is being strengthened to ensure a proactive pull of these patients from the acute Trust where appropriate.

- **Targeted service provision:** Several services have been commissioned to address the needs of specific patient groups and reduce the chance of accessing acute care. For example, a dedicated GP practice for the homeless ensures they have access to the same primary medical care as any other Brighton resident. Falls prevention services are offered to those at risk; VCSE support is targeted at High intense users of acute services (case study on subsequent slide); the VCSE offers proactive support to the most vulnerable by connecting them to health and care services across the city, empowering them to identify early health and social care needs; and finally, our Brighton place based transformation partnership programme, led by the City Council, supports adults experiencing multiple disadvantages.

Future actions

As part of our strategy *Improving Lives Together* we will roll out Integrated Community Teams across Health and Care at neighbourhood level to:

- Provide more proactive, personalised care with support from a multidisciplinary team of professionals for patients who may have more complex needs in the community to reduce admissions or in hospital to facilitate timely discharge.
- Build on our assets, and social capital by mobilising our communities working with our partners including the VCSE to enhance prevention including improving immunisation and vaccinations and enable self-management where appropriate.

* 19785 minutes calculated at 15 min per appointment according to British Medical association Guidelines. However, slots should be tailored to meet local population needs and will vary depending on the type of appointment being offered

High Intensity Users

Research has shown a clear link between high intensity use (HIU) of emergency services and wider inequalities. High intensity use is greatest in areas of deprivation, and across all age groups it is associated with issues such as homelessness, being out of work, mental health conditions, drug and alcohol problems, criminality, and loneliness and social isolation. Based on NHS England HIU principles, HIU services offer people with high attendance at ED, psychosocial support, crisis planning, and signposting within their own community.

In Brighton and Hove we commission a HIU service provided by the British Red Cross. To date the service has provided support to 47 clients who had been identified as frequent users of services. 33% of clients reside in Core20 areas (the most deprived 20% of the national population as identified by the national index of multiple deprivation (IMD)). The table to the right shows the impact of working with these clients both before and after intervention, showing significant reduction on ED attendances, admissions into hospital, and ambulance conveyances.

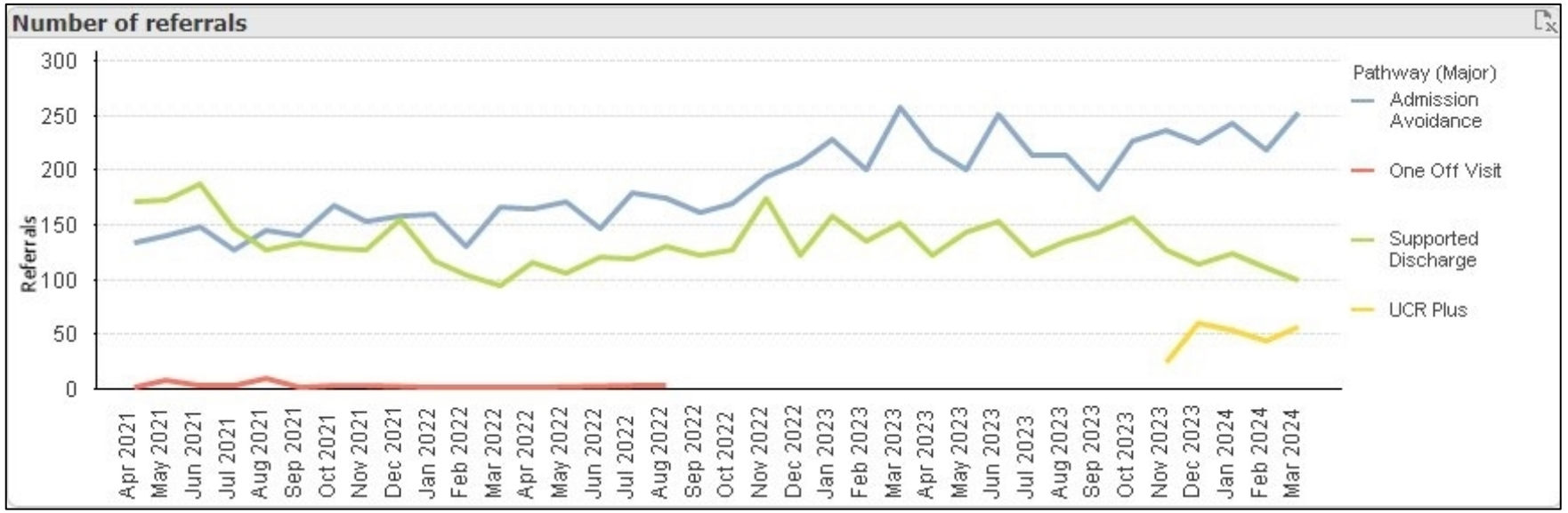
	A&E Attendances	Hospital Admissions	Ambulance Conveyances
Comparable time frame pre support	403	86	177
Comparable time frame post support	258	64	80
Total reductions	-145	-22	-97
% Variance	-36%	-26%	-55%

Urgent Community Response

Sussex Community NHS Foundation Trust (SCFT) provides a comprehensive Admission Avoidance service for patients across Brighton & Hove. The pathway is delivered via the Urgent Community Response (UCR) service which is a multi-disciplinary team including a GP, nurses, therapists, pharmacist and health and care workers.

B&H UCR receives an average of 300 admission avoidance referrals per month from a wide range of sources including primary care, 111, South East Coast Ambulance Service (SECAmb) and nursing and residential care homes (see table below) . The service aims to see all urgent patients within 2 hours, achieving 88% in May 2024 against a target of 75%. Most referrals within UCR require admission avoidance support, with a significant increase in referrals since 2022. The recently implemented UCR Plus supports patients with a higher acuity on a Virtual Ward pathway - referrals for this service are all admission avoidance. UCR also supports patients coming out of hospital on a supported discharge pathway.

Since March 2024, SCFT has been working with SECAmb on a pilot for UCR staff to have direct access to the SECAmb portal, which enables staff attend to lower category call patients directly and support the wider urgent care system. A total of 83 patients have been seen and treated by UCR, enabling patients to stay in their own home and avoid unnecessary admissions to hospital.



Plans are in place to expand the number of patients UCR can treat each day via the Virtual Ward model which enables patients to be under the care of a UCR GP and receive treatment and care they would ordinarily receive in hospital.

Virtual Wards

A Virtual Ward is a safe and efficient alternative to NHS bedded care. Virtual wards support patients who would otherwise be in hospital to receive the acute care and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

In Brighton and Hove, Sussex Community NHS Foundation Trust (SCFT) operates the virtual ward. Table one shows the referrals in recent months. This year there has been a significant focus on increasing from supported discharge to admissions avoidance, as demonstrated in table two.

The SCFT Virtual Ward team consists of a dedicated General Practitioner, Nursing and Therapy and a wider support team of Pharmacy/ administrative staff. All face-to-face care is provided by the Virtual Ward team including medical interventions such as prescribing, TTOs and communication. Going forward, the intention is for the acute hospital to provide advice and guidance for the patients under the care of the General Virtual ward GP and will be part of the Multi-Disciplinary Team where necessary.

Table one: Referrals into Virtual Wards (Brighton)

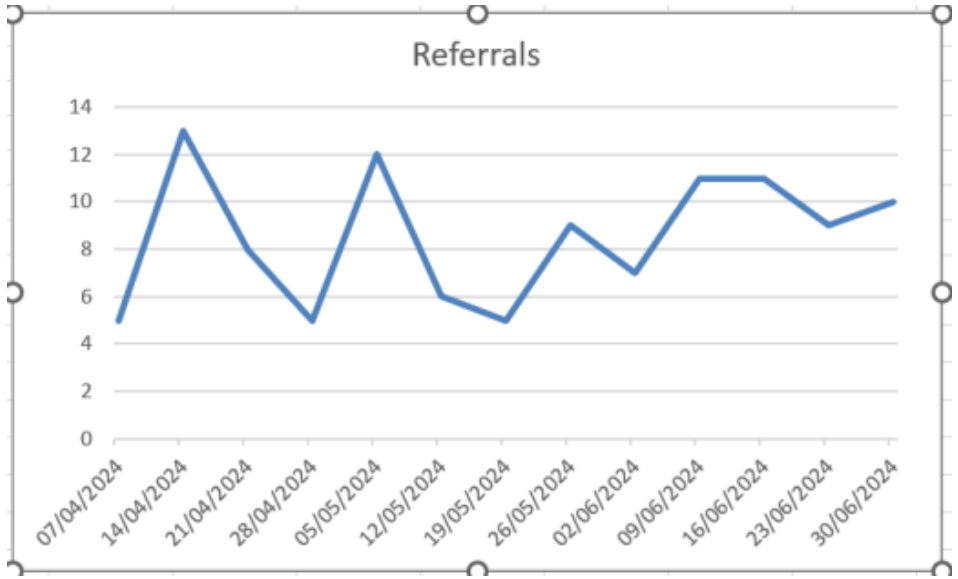
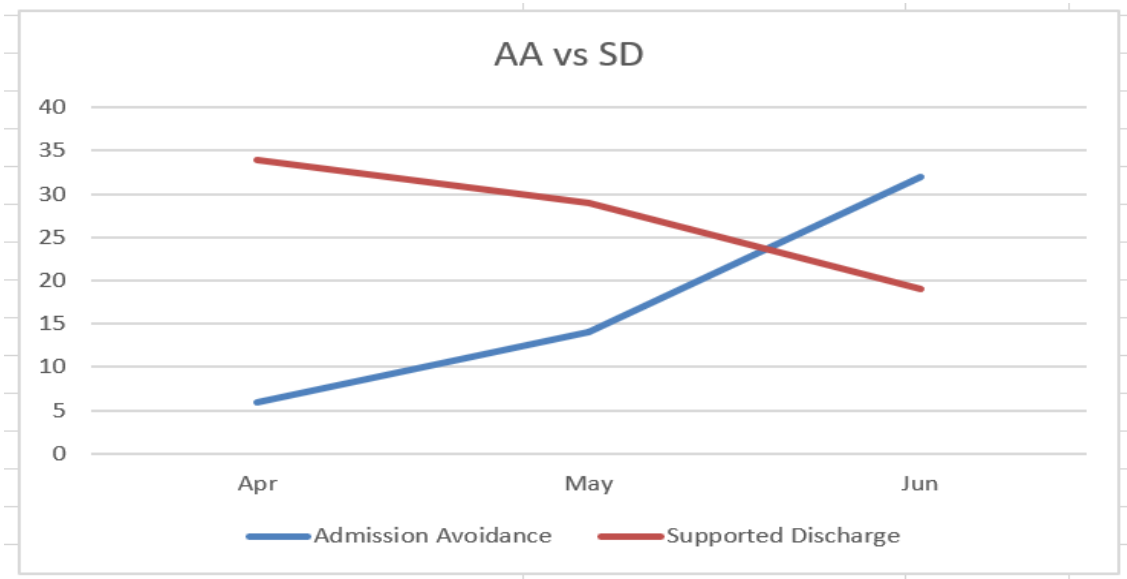


Table two: Split between Admissions Avoidance (AA) and Supported discharge (SD)



Front door at the Emergency Department and Hospital Journey

Front Door at the Emergency Department (ED)

These are the teams we work with to support people who present at ED but could be better supported in a different way:

Urgent Treatment Centre at the Front door of the ED: Care navigators work in partnership with adult social care to identify social care needs and other need such as housing. This includes engaging with the ambulance service during handover.

Admission Prevention Team: A multidisciplinary front door admission prevention team led by the City Council works with the NHS to support patients to facilitate same day discharge by providing care, social prescribing, emergency care packages as required. In April 2024, 160 patients were discharged from the front door with 83% of patients screened return home; 6% of patients were referred to short term beds to get the support they needed before going home; and 11% of patients had complex health needs and were admitted.

Housing Team and Duty to refer: The City Council housing officer is linked to the front door and co-located within the hospital to respond to those who are homeless or vulnerable from a housing perspective. Sussex homeless data highlighted that the largest proportion of homeless attendances (approximatley 40%) is for ‘Psychosocial / Behavioural Change’, and the effects of alcohol and/or drug use

Additional primary care appointments at the front door: Face to face and virtual primary care appointments are available 7 days a week to support those patients who present at the hospital with conditions which are more appropriately managed in primary care.

RSCH Emergency Department Challenges

- Maintaining and delivering the 4 hour Standard of Care - In June 2024 – 55% of patients seen and left within 4 hours, against a national operating target plan for 2024/25 of 78%.
- Supporting Timely Ambulance Handovers - 10% of patients arriving by ambulance waited over 60 minutes for handover in June 2024.
- High numbers of patients waiting in ED for longer than12 hours:
- Whilst between May 22 and April 2024, attendances in ED remained stable, we have seen a 16% increase in admissions from ED into the hospital itself in the last quarter.
- Constrained estate housing our emergency department which results in corridor care.

Internal Actions to Improve UEC at RSCH

- Continuous Flow Model: transfer patients from ED to wards at planned interval times to ensure early movement from ED each morning.
- Ambulatory Clinical Decision Unit (ACDU) utilisation: improvement cycles based on Plan Do Study Act (PDSA) are ongoing to improve utilisation.
- Emergency Ambulatory Care Unit (EACU) utilisation: to create capacity and increase flow from ED to assessment areas.
- Opening Surgical Assessment Unit LA6: which will reduce the surgical demand in ED.
- Pharmacy First: redirection of patients to pharmacy services.
- Implementation of regular huddles: huddle agendas in place, occurring daily at 09:00 and 15:30 to enable patients to be streamed to the right service.
- Reducing the time at which ‘Wardable’ patients are discharged from Critical Care: Early identification of potential ‘wardable’ patients to enable planning and transfer within hours.

Timely and effective discharge from hospital

Enabling Discharge

There are a range of schemes in place to support effective discharge:

- **Home to settle services:** NHS Sussex commissions VCSE to provide transport and practical support for those going home.

- **Carer hub:** the hub is co-located at the hospital with link workers to facilitate discharge and support for carers.

- **Multidisciplinary Transfer of Care Hub:** Adult social care workers are physically co-located in the same workspace as NHS staff at the hospital to facilitate a multi-disciplinary team (MDT) approach to discharge.

- **Discharge to Recovery back home:** An MDT team supports patients to go home as soon as they are ready. This includes therapist, nurses and social care workers who provide support and assess patients level of need.

- **Optimising all available community capacity and ensuring timely flow out of the capacity**: The City Council has commissioned a number of reablement beds; 5 beds for people who are homeless, 7 Mental Health beds and 8 physical health discharge to assess beds. NHS Sussex commissions 58 beds and commissions Urgent Community Response from the SCFT. UCR enables patients to go back home on a HomeFirst pathway while waiting for adult social care to assess and source packages of care.

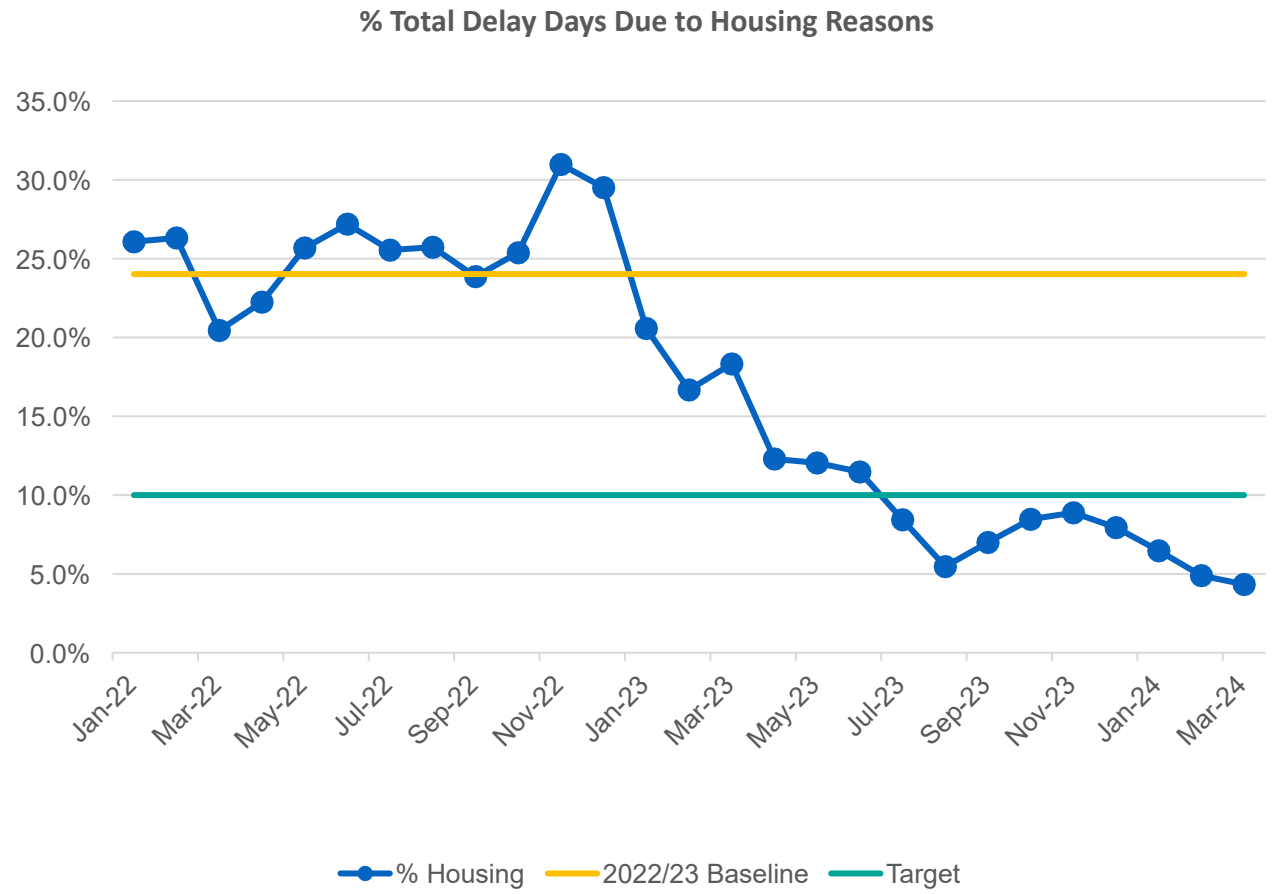
- **Responding to delays related to Housing and Mental health**– see next slide

Sussex Mental Health Housing Programme

Poor housing is associated with poorer physical and mental health outcomes. With this in mind, Sussex Partnership NHS Foundation Trust has committed to delivering the Sussex Mental Health Housing Strategy. This strategy is underpinned by evidence of the impact on mental health of poor-quality housing. NICE recommend that housing interventions are made accessible within health settings as part of a holistic treatment offer.

What SPFT are doing:

- Expanding the integrated housing workforce (11 Housing Specialists) within SPFT which has successfully reduced housing related delays to discharge from 30% to less than 10%. This integration of a housing workforce to enable colocation of staff with Local Authority (LA) housing departments allows direct access to statutory housing functions (social housing allocations, homelessness duties etc). This includes the development of MoU with all District and Boroughs & the City Council.
- Expand the Trust's Supported Tenancies scheme in 25/26 by a further six tenancies- building on the outputs from the two Mental Health Quality Summits.
- Developing a case for change to repurpose inpatient rehabilitation beds as supported housing model- underway.



Further SPFT initiatives planned and underway to support the Mental Health UEC pathway

1. THE HAVEN	A review has made a series of recommendations which will be implemented to optimise the work of Havens to support flow and alternatives to inpatient admission. This will include developing a strengthened relationship between the Haven and MHLT and proactive pull of patients from RSCH.	By March 25
2. HIGH INTENSITY USERS	Approach to HIU in Brighton will be developed as part of the emerging system plan for HIU, building on audit work already undertaken.	By March 25
3. CERN PATHWAY	Programme of work to develop the Complex Emotional Needs (CEN) pathway to support different outcomes for patients with complex emotional needs, including work to maximise use and effectiveness of the Lighthouse.	Dec 2024
4. BLUE LIGHT SERVICES	Reimagining of the offer to police, other partners (and the public) in light of RCRP. Coproducing a new model based on the positive impact of the BLT service in NWS to support rapid advice and guidance and hear/see and treat (including community based mental health assessments undertaken 24/7).	Phase 1 March 2024 Phase 2 Oct 2024
5. MH VEHICLES	Phased procurement and roll out of the nationally funded mental health response vehicles (MHRV). The vehicles will be staffed by SPFT Blue Light Services Staff (qualified staff and support worker with additional physical health training) and provide 24/7 assessment and triage in the community.	Phase 1 - March 2024 Go live Phase 2- Sept 2024-March 2025
6. SMHL/ NHS 111 PRESS 2 FOR MH	Continued review of the SMHL NHS111 press for mental health service to optimise as far as possible including development of a SPoA within the current contracted envelope. Potential to include Compassionate calls within this initiative and combine existing resources providing telephone based clinical advice and guidance.	March 2024
7. CRHTT	Working with the CRHTs to establish a new clinical model, supporting rapid assessment, facilitated discharges and therapeutic home treatment, reducing unwarranted variation and the potential for access inequity.	Phased steps to be defined. Full implementation planned for Sept 2024

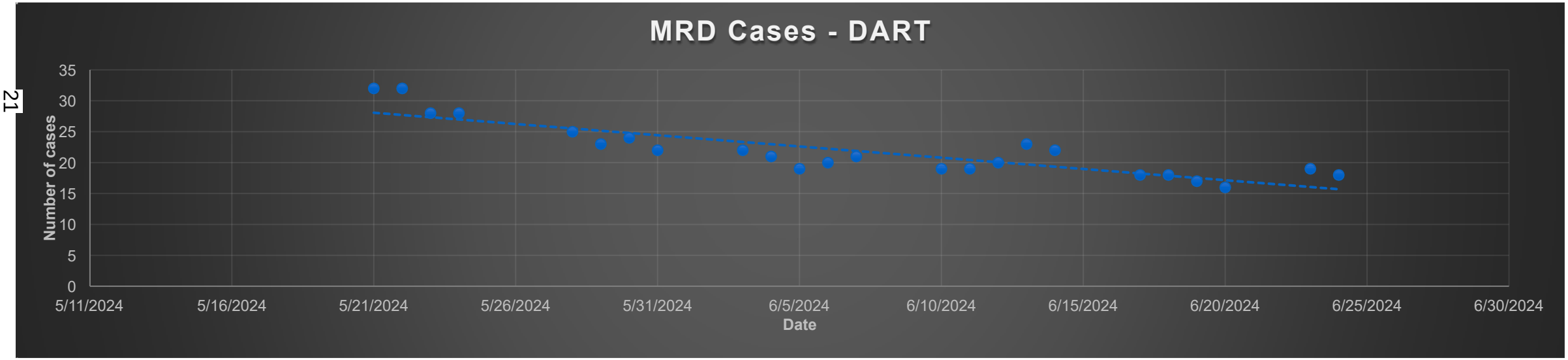
Further SPFT initiatives planned and underway to support the Mental Health UEC pathway

10. WINDING DOWN EOU	SPFT to work alongside UHSx to wind down the EOU and aim to reduce attendance.	October 2024
11. ADMISSION AVOIDANCE	Clinical Complex Case Review (CCR) MDT of patients waiting for informal admission in the Haven and in ED to be established and review trusted assessor approach / role of the CRHT in gatekeeping admission.	July 2024
12. PRIOTISATION FOR ADMISSION	Ambition to gradually reduce the amount of time people wait for admission whilst waiting in the EOU where possible. Currently the approach has been a risk-based, clinically prioritised approach, working across the Sussex mental health system to manage the demand for inpatient care based on patient need.	By July 24
13. LOS QI – MILL VIEW	Quality Improvement work is being rolled out to Caburn ward and will be extended to wider Mill View Hospital wards in the coming months to support a reduction in LOS and improve flow.	Q1-2

The role of Adult social care in supporting flow

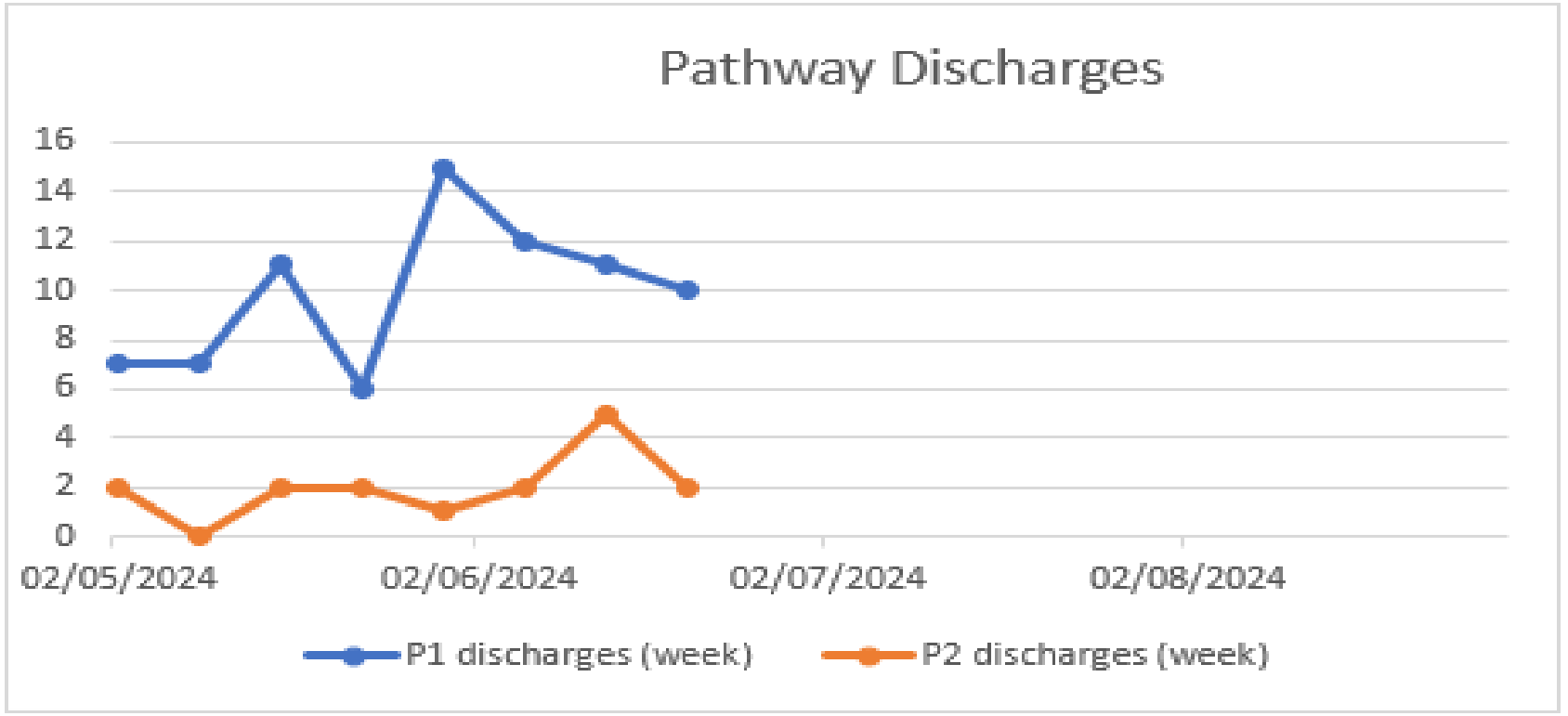
Brighton and Hove City Council (BHCC) are currently managing on average 180 active cases across two teams. These are the Acute Hospital Social Work Team and Community Team covering Pathway 1 (Discharge to Assess) and Pathway 2 (step down/rehabilitation beds).

BHCC have a recent average of 20 service users being NCTR (delayed).



B&H Hospital Discharge pathways

There has been recent good flow from Pathway 1 (Discharge to Assess via Urgent Community Response) & Pathway 2 (step down/rehab beds).



B&H Adult Social Care – Improvement actions undertaken

Our improved position can be related to a number of actions being put into place such as:

- Short term redeployment of Care Managers and Social workers from other parts of Adult Social Care.
- A locum Social Worker to support to work both in the hospital setting and community to reduce waiting times for assessment.
- Development of a Trusted Assessor Pilot in conjunction with Sussex Community NHS Foundation Trust which has commenced. This enables clinical staff based in our partner organisation to undertake Care Act assessments on behalf of BHCC, to improve outcomes and reduce delays on post hospital pathways.
- Increase in the Craven Vale reablement beds from 8-12 (end of May 2024). This service is fully utilised with an average length of stay of 27 days, after which the individual returns home with low level support or independently.

Admission Prevention Team (APT), which has been operational for 1 year and this team has been based in Patient Handover area and corridor in A&E (RSCH). The APT focuses on same day discharge and admission avoidance and recent data showed:

- Over 1500 patients screened.
- 6% of patients screened are supported to step down beds (new pathway).
- 54% of patients screened are discharged (over 700 patients).

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 8

Subject: **Winter Peformance 2023-24**

Date of meeting: **10 July 2024**

Report of: **Chair of the Health Overview & Scrutiny Committee**

Contact Officer: **Giles Rossington, Policy, Partnerships & Scrutiny Team Manager**

Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: All wards

Key Decision: No

For general release

Note: Urgency

By reason of the special circumstances below, and in accordance with section 100B(4)(b) of the 1972 Act, the Chair of the meeting has been consulted and is of the opinion that this item should be considered at the meeting as a matter of urgency.

Note: Reasons for urgency

The special circumstances for non-compliance with Council Procedure Rule 3, Access to Information Procedure Rule 5 and Section 100B(4) of the Local Government Act 1972 (as amended), (items not considered unless the agenda is open to inspection at least five days in advance of the meeting) were that NHS colleagues were obliged to follow pre-election period guidance for the NHS, which meant that they were unable to contribute to reports published within the General Election pre-election period.

1. Purpose of the report and policy context

1.1 This report provides the committee with information on the performance of the local health & care system across winter 2023-24.

2. Recommendations

2.1 Overview & Scrutiny notes the contents of this report and its appendices.

3. Context and background information

3.1 Health & Care systems typically experience a surge in activity during the winter months. This is partly due to seasonal infectious illnesses (flu, norovirus); but also because colder weather exacerbates a range of pre-existing problems (e.g. respiratory and circulatory conditions). Extreme weather may also lead to greater levels of activity. The presence of Covid presents an additional risk at the current time. Increases in demand for services can put a severe strain on systems, most obviously emergency healthcare. This is particularly the case when systems are at or near to capacity at all times of the year.

3.2 In order to manage this seasonal demand surge, health & care systems are required to develop whole system (e.g. Sussex) winter plans. In November 2023, NHS commissioners and BHCC Health & Adult Social Care (HASC) presented on Sussex winter planning to the Brighton & Hove Health & Wellbeing Board: https://democracy.brighton-hove.gov.uk/documents/s194243/Sussex%20Health%20Care%20Winter%20Approach%202023-24.pdf It was agreed that a follow-up report outlining performance against this plan would be reported to the HOSC in summer 2024 (see the information provided by NHS Sussex in Appendix 1).

4. Analysis and consideration of alternative options

4.1 Not relevant to this information report.

5. Community engagement and consultation

5.1 Not relevant to this information report.

6. Financial implications

6.1 Not relevant to this information report.

7. Legal implications

7.1 There are no legal implications to this report.

Name of lawyer consulted: Elizabeth Culbert Date consulted (dd/mm/yy):

8. Equalities implications

8.1 None directly to this report for information.

9. Sustainability implications

9.1 None directly to this report for information.

10. Health and Wellbeing Implications:

10.1 None directly to this report for information.

Other Implications

11. Procurement implications

11.1 None identified.

12. Crime & disorder implications:

12.1 None identified.

13. Conclusion

13.1 Members are asked to note health and care system performance across the past winter and to note the lessons learnt for future planning.

Supporting Documentation

Appendices

1. Information on system performance winter 2023-24 provided by NHS Sussex.

NHS Sussex

Sussex Health and Care Winter Plan 2023/24: Evaluation

Report for Health Overview and Scrutiny Committee

July 2024

Improving Lives Together

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Sussex Health and Care Winter Plan: Evaluation

1.0 Introduction

The Sussex Health and Care Winter Plan 2023/24 (Sussex Winter Plan 2023/24) was presented to the Health and Wellbeing Board in November 2023.

The Sussex Winter Plan 2023/24 is a whole system health and social care plan, that recognises the interdependencies of the system and its partners to meet the needs of the local population. There is a national requirement to undertake winter planning each year, to provide assurance that the system and partners have the necessary measures in place to deliver health and care for the local population.

The purpose of the Sussex Winter Plan 2023/24 was to develop a comprehensive and aligned system approach to ensure that the Sussex system achieved NHS England (NHSE) and local objectives, namely:

- Continue to maintain or improve the quality and safety of services.
- Ensure timely access to services for the entire population, supported by a clinical risk-based focus at times of surge in demand.
- Focus on the most vulnerable and at risk.
- Take forward learning from previous Sussex winter planning in 2022/23.

This report evaluates the impact and effectiveness of the Sussex Winter Plan 2023/24 and identifies learning and enhancements to strengthen planning for winter 2024/25.

2.0 Evaluation Process

The Sussex Winter Plan 2023/24 incorporated NHSE requirements to focus on the three key priorities of demand management, admissions avoidance, and hospital flow. The delivery of these priorities was underpinned by actions in a series of cross-cutting workstreams.

This evaluation considers:

- The success of workstream actions in managing system pressures (sections 3-7).
- The effectiveness of demand and capacity modelling to identify areas of risk (section 8).
- System partner feedback on the plan and its effectiveness.

3.0 Demand Management: Workstreams Review

3.1 Optimising 111 Usage

The operating model in place during winter 2023/24 included NHSE funded resilience support from Vocare to provide call answering for approximately 10% of calls per month to help the service be as responsive as possible for local people. Call handling performance was challenged during peak demand during December 2023 - January 2024, with the average time to answer calls at 348 seconds (January 2024). Performance improved towards the end of winter and was sustained into 2024/25 with average time to answer at 176 seconds (April 2024). Noting the improvement, the national benchmark for average call answering of 111 calls is 127 seconds.

A further improvement plan has therefore been developed by 111, containing actions to be taken forward during 2024/25. This includes improvements to call handling, optimisation of Directory of Services (DoS) profiles to ensure people are offered or signposted to the right service for them, and improvement of clinical pathways.

3.2 Optimising Primary Care Resource (including Community Pharmacy and Vaccinations)

3.2.1 General Practice (GP)

One of the focus areas in Sussex to support our overall offer to patients over winter, was to additionally invest in providing extra capacity across primary care. In addition to the regular number of appointments offered by GP practices in Sussex, investment was made to provide extra appointments during winter, particularly over the festive period. Further winter PCN funding provided over 27,000 additional appointments that were available over the duration of the scheme (January – March 2024). More than 18,000 (68%) of these were face to face appointments that took place on the same day as they were booked.

In addition, NHS Sussex has also invested in providing GP practices with further demand and capacity tools to support their understanding and management of services, including over winter. APEX is a GP analytics platform, providing an interactive overview of clinical data. The platform drives quality improvements across primary care, increases the use of Advanced Primary Care roles to support patients, and provides further enhancements to cloud-based telephony. APEX usage will continue to be optimised in 2024-25. Currently, 154 General Practices across Sussex have fully on-boarded, with a further 15 completing this process.

Place	Total Practices in Place	Onboarded to APEX
Brighton & Hove	31	31
West Sussex	76	76
East Sussex	49	47
Total	156	154

3.2.2 Community Pharmacy

The Pharmacy First scheme went live on 31 January 2024, enabling Community Pharmacists to supply prescription-only medicines (when clinically appropriate) to treat seven common health conditions, without requiring a GP visit. 288 of 293 (98%) Community Pharmacies in Sussex have signed up to provide the service.

86 of 157 (55%) General Practices are directing patients to Community Pharmacy, utilising the digital referral pathway which has been established to enable general practices who utilise the EMIS patient record system to refer patients directly to community pharmacy from their patient record, expediting the process for the patient:

Place	Total GP surgeries utilising digital referral by place	% GP practices by place
Brighton & Hove	19 of 31	61%
West Sussex	38 of 51	75%
East Sussex	29 of 75	39%

3.2.3 Seasonal Vaccinations

Seasonal vaccination uptake was optimised during winter 2023/24, with a successful flu and covid vaccination campaign undertaken across Sussex. Final uptake figures for the flu vaccination in the community for those aged over 65 was 79.3% and aged over 65 (at risk) was 82.8%.

407,726 covid vaccinations were delivered across Sussex during the autumn and winter 2023 campaign:

- 0.1% above the regional (southeast) uptake of 59.7%.
- 6.1% above the national uptake of 53.7%.

3

The evaluation notes that Sussex experienced a reduced impact of flu and covid in hospital settings during winter 2023-24, in comparison with recent years.

3.3 High Intensity Users (HIU)

The British Red Cross (BRC) provide HIU services in Sussex to support patients who frequently attend the Emergency Department (five or more attendances in a 12-month period). 11,450 patients had more than five Emergency Department attendances in 12 months between January and March 2024.

HIU services provide health coaching and social prescribing to reduce Emergency Department presentations and admissions, working in partnership with acute physicians. Whilst full winter data is yet to be evaluated by BRC, the service note a positive impact for Brighton HIU patients and NHS services, from October to December 2023 as follows:

	A&E Attendances	H Admissions	Conveyances	
Comparable time frame pre support	97	24	61	
Comparable time frame post support	34	10	20	
Total reduction	-63	-14	-41	
% Variance	**-65%**	**-58%**	**-67%**	
				Total
Comparable time frame pre support	£40,546	£60,696	£22,387	**£123,626**
Comparable time frame post support	£14,212	£25,290	£7,340	**£346,842**
Total savings	-£26,334	-£35,406	-£15,047	**-£76,787***

4.0 Admissions Avoidance: Workstreams Evaluation

4.1 Admissions Avoidance Single Point of Access (AASPA)

AASPA provides a single, consistent access point for ambulance crews, Emergency Operations Control (EOC) and NHS111 to access alternatives to conveyance and admission for patients in the community, supporting people at home. The service includes Urgent Community Response services, Virtual Wards (VW) and is integrated with the Sussex Home Visiting Service (SHVS) to expand options out of hours.

AASPA was expanded to include care homes for winter 2023/24 with pilots undertaken across both West Sussex and Brighton and Hove places. Frequent caller data and usage is currently being reviewed to determine the outcome of these pilots. Further expansion plans for AASPA will be drawn out through 2024/25 operational planning, underpinned by the Sussex Urgent and Emergency Care Shared Delivery Plan Priorities for 2024/25.

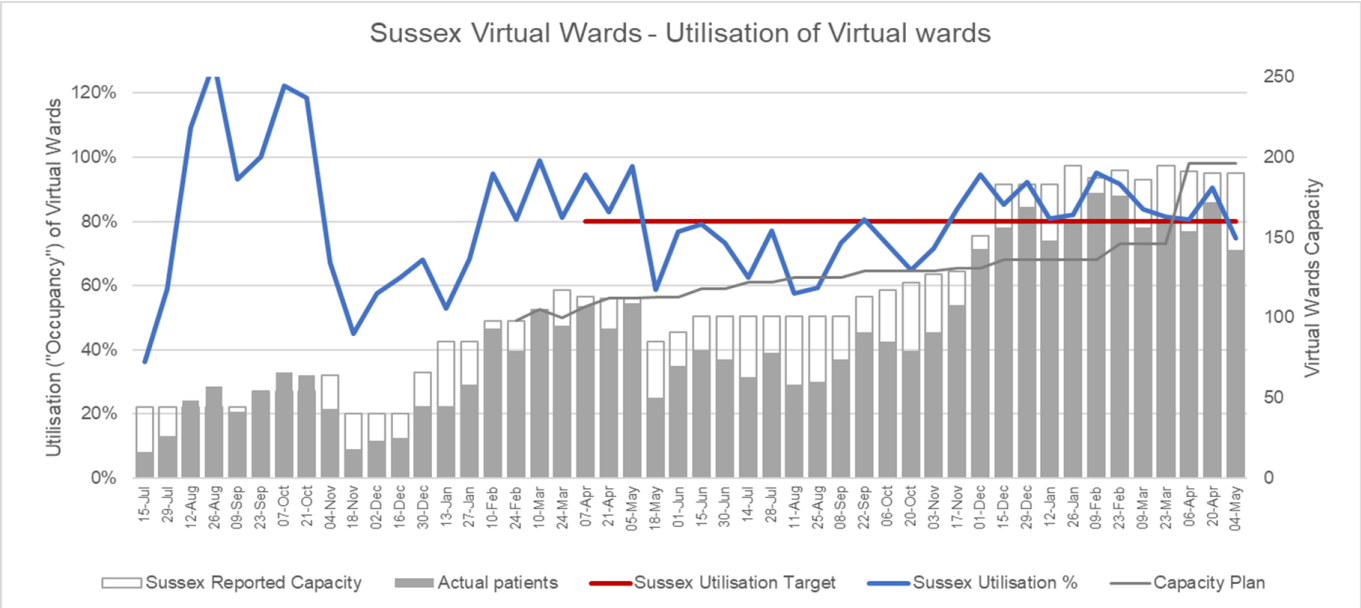
4.2 Urgent Community Response (UCR)

All Sussex Community NHS Foundation Trust (SCFT) UCR teams have now gone live with SECAmb portal access, enabling the community team to view patients within the list of category 3 and category 4 calls received by the ambulance services who are awaiting a response and who may be suitable to receive their support in the community and avoid hospital conveyance. The UCR teams can extract patients directly from the SECAmb wait list and provide a response from their community service, reducing demand on the ambulance service and improving the response to those patients.

4.3 Virtual Wards

Virtual Wards are a safe and efficient alternative to NHS bedded care. Virtual wards support patients, who would otherwise be in hospital, to receive the care and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

Virtual ward capacity and occupancy targets were achieved during winter 2023/24:



Delivery of the NHSE trajectory plan was completed at the end of November 2023 with virtual ward capacity increasing to 156 beds across Sussex against a baseline capacity plan of 131 beds.

Capacity increased further during winter, reporting a position of 192 beds against a plan of 146 capacity, and 92.2% occupancy, exceeding the national metric of 80% (February 2024).

Whilst good progress was made in winter, Sussex remains an outlier, with 12 beds per 100,000 population, compared to the national average of 23 beds per 100,000. Sussex Virtual Health providers are currently reviewing the virtual health model and considering opportunities to reconfigure and increase capacity in 2024/25. This includes a review of additional virtual ward pathways, remote monitoring, and digital procurement.

Regional evaluations have been completed to review the effectiveness of virtual wards and findings demonstrate that 23% of patients in a virtual ward, achieved a more independent social outcome and patients recover quicker, feel safe, supported, and have improved quality of life. 2.5 times fewer patients treated on a virtual ward are readmitted to frailty beds and patients are five times less likely to acquire infection.

These findings are reflected in the Sussex virtual ward services. No Sussex virtual ward patients are waiting for packages of social care, and when referred early in their treatment needs, the length of stay on virtual ward is 1-13 days only. Feedback confirms that Sussex patients feel they recover quicker at home and that they receive a personalised care approach. Sussex virtual wards also demonstrate low readmission rates and no reported serious incidents.

5.0 Hospital Flow: Workstreams Evaluation

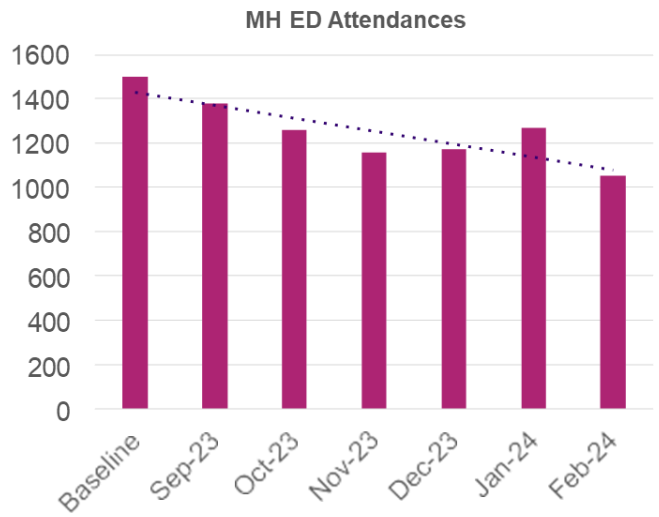
5.1 Emergency Department (ED) Improvement Plans

ED improvement plans were implemented at both University Hospitals Sussex NHS Foundation Trust and ESHT to support delivery and improved performance against the 4-hour standard during winter 2023/24. This work will continue throughout 2024/25. Whilst performance was challenged during winter, Sussex achieved the national standard of 76% at the end of March 2024, compared with a national performance rate of 73.9%. There was variance in performance at place and work continues to support improvements locally.

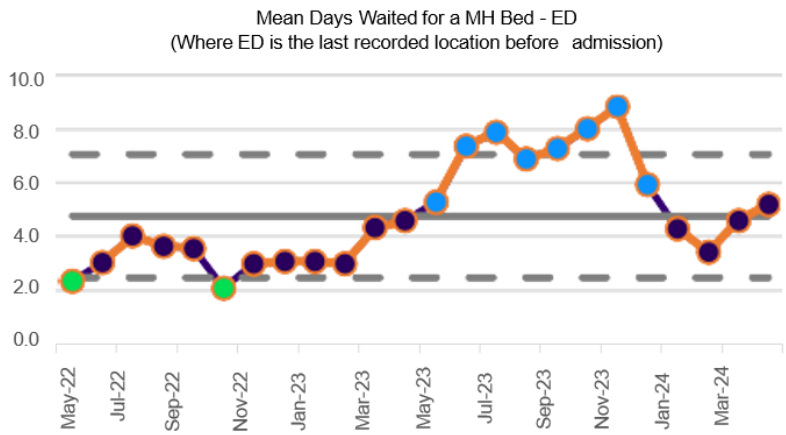
ED improvement plans continue to focus on leadership, optimisation of Clinical Decision Units and Same Day Emergency Care provision, improving discharge flow and, continuation of robust governance and assurance structures to track delivery during 2024/25.

5.2 Mental Health Improvement Plan

The mental health improvement plan commenced in July 2023. During winter, the system saw a decrease in mental health patient ED attendances:



Partners are working towards meeting the 20% reduction in Mental Health ED attendances by March 2025. There has also been a sustained reduction in the average waiting time for a mental health bed over winter. This further supports the targeted 20% reduction by March 2025.



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Many initiatives supporting improved access to mental health services this winter have continued for 2024/25. This includes Sussex Mental Health Line, signposting guidance on provider websites and 'Text Sussex'; a messaging service providing free and confidential mental health support from trained volunteers. A partnership between SPFT and the voluntary sector, also improved access to Sussex 'Staying Well' crisis cafes, including open access models (walk-in) in Brighton and Crawley and same-day appointment services in Worthing and Eastbourne.

5.3 Community Flow Improvement Plan

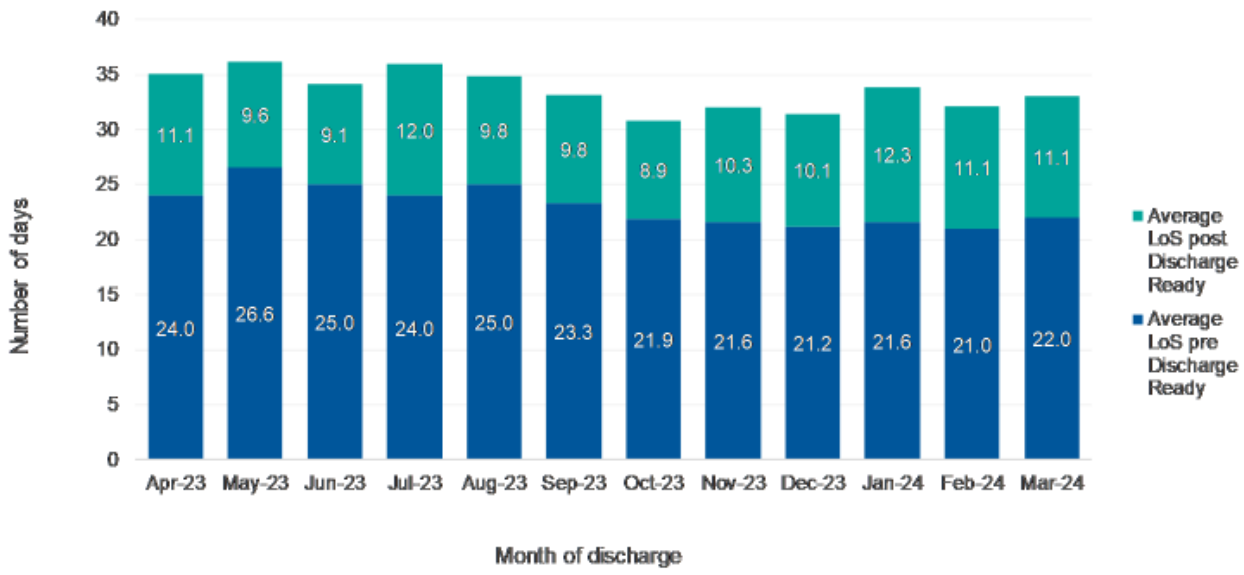
Both ESHT community and SCFT saw improvements to flow in intermediate care units following the implementation of long length of stay meetings, appointment of Discharge Support Assistants and improved ways of working. Average length of stay (ALOS) reductions seen through 2023 in the run up to winter were as follows:

Location	May 2023 ALOS	December 2023 ALOS	Improvement
SCFT Intermediate Care	34.4 days	29.9 days	4.5 days
ESHT Rehabilitation Wards	30.98 days	23.45 days	7.53 days

5.4 Discharge Improvement Plan

Sussex Health and Care were part of the NHSE discharge front runner programme and have implemented a number of improvements. System partners have adopted the Transfer of Care Hub (TOCH) model within each place and TOCH managers have been appointed to lead each hub. This provides joined up multi-disciplinary support to plan and support appropriate discharge for local people. Escalations from the TOCHs were incorporated into the winter operating model and an integrated acute and community transfer of care dashboard is in development. This enables the multidisciplinary teams to carry out discharge planning and make informed decisions for onward care to best support patients.

The graph below demonstrates the average length of stay for discharge ready patients in the acute setting and this remains a key area of focus.



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6.0 Clinical Pathways: Workstreams Evaluation

6.1 Urgent Community Response Plus GP Pilot (Brighton and Hove and West Sussex)
In November 2023, UHSx and SCFT developed an out of hospital urgent frailty response pathway across Brighton and Hove. The Urgent Community Response (UCR) teams support people to receive care at home and avoid admission to hospital. The 'UCR plus GP' pilot brings together existing UCR multi-disciplinary teams with dedicated senior clinical decision-making GPs. Inclusion of general practitioners ensures the UCR teams can support patients who are more unwell, enabling patients to be cared for in their usual residence and reducing hospital admissions. The following findings are noted:

- 297 referrals were received over an 8-week period in Brighton and Hove. Of these, 73 patients avoided admission into hospital through UCR plus GP.
- 11.5% of patients referred were admitted to hospital with an average length of stay of 2.6 days.
- Referrals were mostly higher acuity patients.
- The UCR Plus GP pathway will continue via the virtual health programme in 2024/25.

6.2 Paediatrics
Respiratory Syncytial Virus (RSV) is a known paediatric risk in the winter period. Epidemics tend to start in October and last for several months, peaking in December. Actions were completed across winter to manage the increased prevalence of RSV, including:

- Overview of paediatric capacity across the region with a clear plan to manage paediatric critical care capacity during surge periods.
- Acute Trust plans to proactively mitigate risks.
- Escalation process for mutual aid and key contact information sharing.

These actions were successful, and outbreaks of RSV were managed effectively during winter across Sussex.

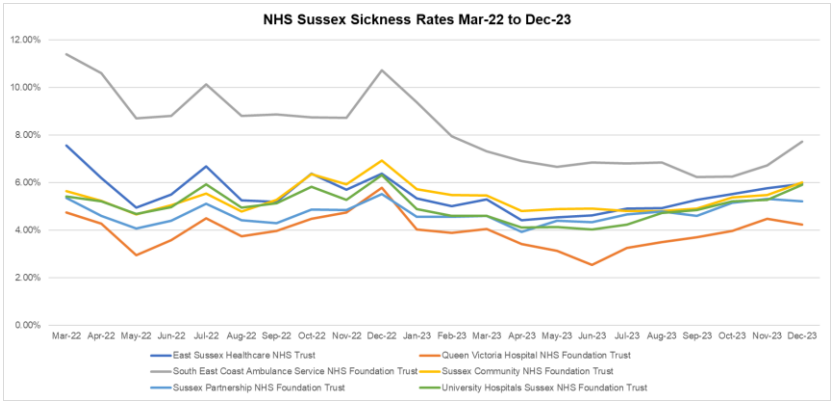
6.3 Critical Care
Critical care surge planning was in place for both adults and children across Acute Trust sites during the winter period and this was available to be stood up as required.

7.0 Wider Workstreams Evaluation

7.1 Workforce and Wellbeing
Recruitment campaigns focussed on hard-to-fill posts such as healthcare assistants, staff nurses, bank, and volunteer staff. Other initiatives included e-rostering system use and forecasting of data, based on winter 2022/23 fill rates and demand. Recruitment campaigns were successful across providers during winter. Providers ensured regular wellbeing assessments were available for staff, with access to occupational health and employee assistance programmes (EAP) as needed.

Workforce sickness absence data for Sussex for December 2023 (latest data) showed a reduction in the average sickness rate to 5.84%, compared to a December 2022 average of 6.94%.

Sussex Health and Care Sickness Rates By Partner



7.2 Infection Prevention and Control (IPC)

The following actions were successfully implemented, supporting Sussex Health and Care to manage IPC outbreaks during winter 2023/24:

- Development of a Winter Infection Prevention Plan to support learning from 2022/23.
- Development of IPC Surge Plan for winter viral illnesses.
- Delivery of training for health and social providers, including a Link Practitioner development day and Winter Preparedness Training.
- NHS Sussex Infection Prevention Specialist Team provided expert advice to health and social care settings and conducted reviews of provider IPC policies.
- Attendance at bi-weekly regional NHSE IPC meetings to support with horizon scanning and regional escalation as required.
- Daily review of IPC related bed closures and outbreak situation to support patient flow.

7.3 Local Authorities

In Brighton & Hove, there was additional investment to support those who were homeless during winter 2023/24, including a severe weather scheme and council funded homeless and mental health beds. The carers' link workers project was extended over winter, with link workers raising carer awareness and supporting unpaid carers to continue in their caring role, across primary and secondary care. There was also an additional focus to resource post-discharge pathways.

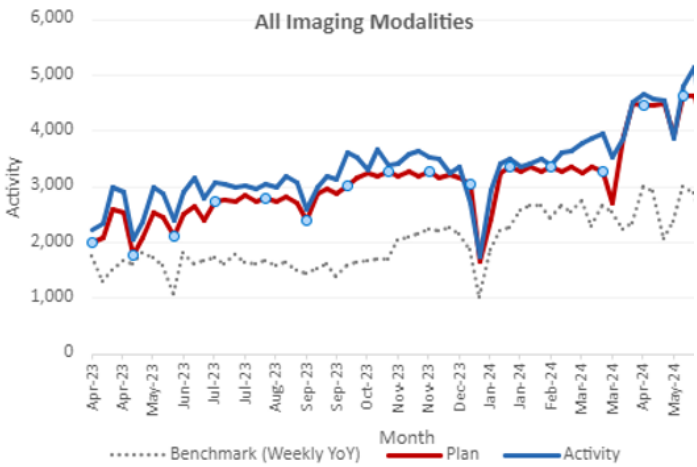
Work continues with ongoing targeted action in Brighton and Hove including the dedicated homeless GP practice; improving on falls prevention for those at risk; VCSE support for high intensity users of acute services; VCSE proactive support to the most vulnerable, connecting people to health and care services across the city, empowering people to identify early health and social care needs; and the place based transformation partnership programme led by the City Council to support adults with multiple compound needs..

7.4 Planned Care

Work was undertaken throughout winter to maintain as much elective activity as possible with a focus on treating those patients who had experienced very long waits. University Hospitals Sussex NHS Foundation Trust delivered a significant reduction in the number of patients waiting over 78 weeks for treatment, although just missed delivering against its nationally agreed target.

Sussex Health and Care delivered against its national target to reduce the number of cancer patients waiting over 62 days for treatment and University Hospitals Sussex NHS Trust was commended by NHS England for the improvements it made in the second half of 2023/24.

The following graph demonstrates the increase in all Sussex Clinical Diagnostic Centre (CDC) activity for imaging:



The Brighton CDC at Falmer is now operating at near full capacity for all services. Imaging capacity is being fully utilised. This enables hospital imaging services to focus more on acute diagnostic activity and significantly adds to the overall system capacity for imaging in Sussex, provider quicker access for local people.

7.5 Industrial Action

Periods of industrial action affected all aspects of the health and social care system during the winter period. There were 16 days of industrial action between December 2023 and February 2024, affecting healthcare providers in Sussex from several healthcare workers unions, plus action undertaken by education and transport workers unions. A Christmas / New Year and Industrial Action Plan was implemented as an addendum to the Winter Plan to ensure a coordinated response and management of the actions that needed to take place to mitigate any risks that emerged during the action. This ensured Sussex was able to maintain access to safe services during these periods.

7.6 Communications

A system communications and engagement plan was developed with partners to ensure clarity and support of operational delivery over winter. The plan focused on winter demand, industrial action, and public messaging. Media activity included coverage on TV and radio, social media, advertising and promotion through community and voluntary partners. This was successfully achieved and there were high levels of positive engagement for the messages.

8.0 Demand and Capacity Modelling

Development of the Sussex Winter Plan 2023/24 was underpinned by demand and capacity modelling that utilised core bed and escalation bed data, provided by acute partners.

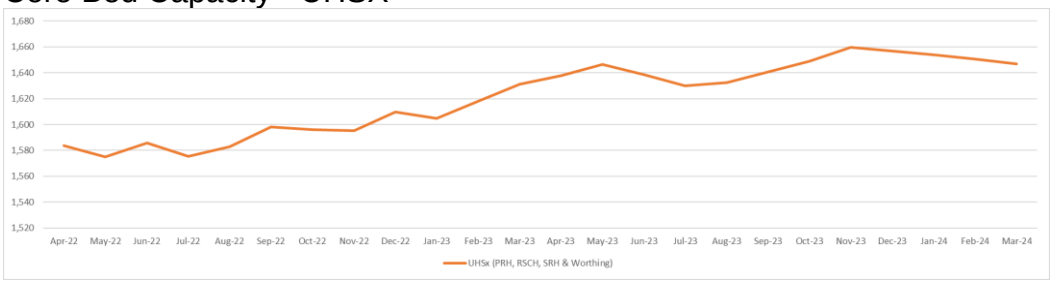
The model enables additional schemes to be put in place to meet the likely need for inpatient care. These schemes included the following:

- Discharge Improvement Schemes.
- Virtual Wards.
- Additional Capacity Schemes.
- Admission Avoidance Schemes.

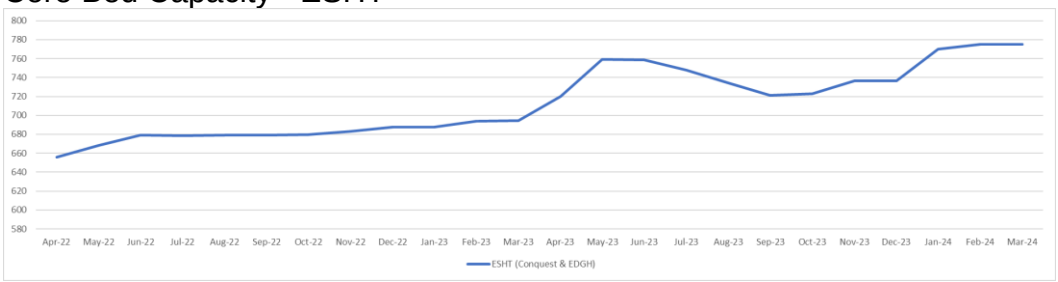
Bed occupancy across Sussex acute sites, remained high at an average of 97% throughout winter and capacity was significantly challenged during and after the peak period. Providers accommodated the increased demand during winter by using additional escalation capacity, virtual wards, admission avoidance and discharge improvement schemes.

There was an increase in core beds open, with 2,405 average core beds open during November 2023 – March 2024 across Sussex, compared to 2,297 beds open during November 2022 – March 2023.

Core Bed Capacity - UHSX

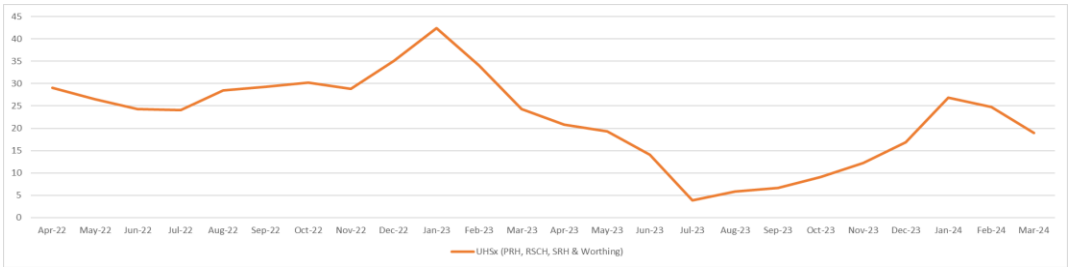


Core Bed Capacity - ESHT

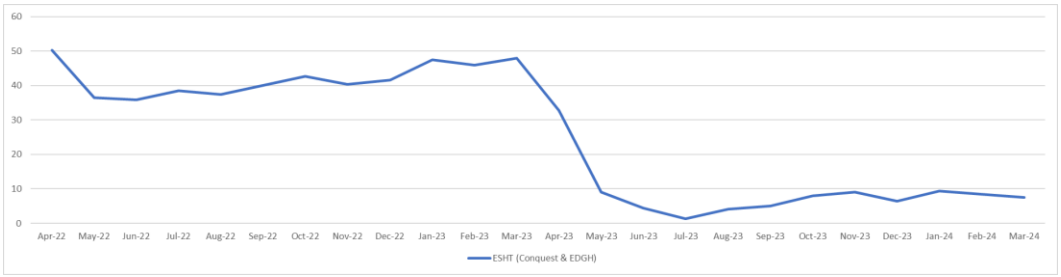


The increase in core bed usage is noted as the reason fewer escalation beds were open during winter 2023/24 (average of 15 beds during November 2023 – March 2024, compared to November 2022 – March 2023 average of 36 beds).

Escalation Bed Capacity - UHSX



Escalation Bed Capacity – ESHT



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9.0 Learning from the Winter Plan

9.1 Winter Workstream Actions

66 actions were included within the Sussex Winter Plan 2023/24 and implementation was monitored throughout winter. Each action was assigned a status of 'achieved', 'partially achieved' (with ongoing work continuing in 24/25) or 'not achieved'.

Two thirds of the Sussex Winter Plan 2023/24 actions were fully achieved during the winter period. 20 actions were partially achieved during winter and these actions will be progressed further in 2024/25. A number of these actions are now identified as business as usual (BAU) activity rather than providing additionality for winter in isolation. Four actions were not progressed during winter due to resource constraints or due to the action requiring further development to progress (impact of these was therefore not measured)

Priority Workstream	Actions achieved	Actions partially achieved	Actions not achieved	Total
Demand management	2	5	0	7
Admission Avoidance	9	2	1	12
Hospital flow	19	4	2	25
Clinical pathways	2	3	1	6
Other pathways	10	6	0	16
Total	42 (63.7%)	20 (30.3%)	4 (6%)	66 (100%)

Whilst some initiatives were not achieved within the winter period, concentrating on agreed priority areas for rapid improvement over winter, mitigated significant risks and resulted in a range of positive achievements for the system and its partners, whilst managing winter pressures.

9.2 Stakeholder Evaluation of the effectiveness of the Sussex Winter Plan 2023/24

Feedback was sought from key stakeholders regarding the development of the plan and its effectiveness in achieving it aims and objectives. Themes arising from stakeholder feedback recognised:

- The operating model supported the system to respond effectively during winter 2023/24.
- Detailing of the objective of the plan may help clarify its use as an operational tool (supporting management during winter) or an assurance provision of planned activities.
- A central repository of provider activities and clarification of roles and responsibilities of system partners may be beneficial.
- Workforce capacity challenges remain a key focus during peak periods of surge.
- The benefit of alignment between system demand and capacity modelling and individual provider modelling.

10.0 Next steps

Learning from evaluation of seasonal plans is routinely incorporated in future planning and the Sussex Winter Plan 2023/24 is no exception. Learning has also already been widely shared with Sussex Health and Social Care partners in local forums and meetings. All action from the evaluation will be completed prior to winter planning for 2024/25.

11.0 Conclusion

The purpose of the Sussex Winter Plan 2023/24 was to develop a comprehensive and aligned system approach to ensure that the Sussex Health and Care system continued to maintain and improve the quality and safety of services, whilst ensuring focus on the most vulnerable members of the local population and ensure timely access to services for the entire local population.

Based on the findings of this evaluation, the Sussex Winter Plan 2023/24 has been successful, noting the learning that this evaluation has provided and the opportunity to refine and make further improvements for future years.