Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date:	**9 July 2025**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:**Wilkinson (Chair), Evans (Deputy Chair), Cattell, Hill, Hogan, Mackey, Oliveira, O'Quinn, Parrott, Simon and Asaduzzaman **Co-optees** Mo Marsh (Older People's Council), Nora Mzaoui (CVS) and Geoffrey Bowden (Healthwatch)
Contact:	**Luke Proudfoot** Overview & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

Agendas and minutes are published on the council's website www.brighton-hove.gov.uk. Agendas are available to view five working days prior to the meeting date.

Electronic agendas can also be accessed through our meetings app available through ModernGov: iOS/Windows/Android

This agenda and all accompanying reports are printed on recycled paper

AGENDA

PART ONE **Page**

1 PROCEDURAL BUSINESS

(a) **Declaration of Substitutes:** Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare:
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

2 MINUTES **7 - 14**

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 23 April 2025, (copy attached).

3 CHAIR'S COMMUNICATIONS

4 PUBLIC INVOLVEMENT

To consider the following items raised by members of the public:

(a) **Petitions:** To receive any petitions presented by members of the public to the full Council or to the meeting itself;
(b) **Written Questions:** To receive any questions submitted by the due date of 12noon on the (insert date) 2017.
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the (insert date) 2017.

5 MEMBER INVOLVEMENT **15 - 18**

(a) A member letter has been submitted by Cllr Raphael Hill (copy attached).

6 WINTER PERFORMANCE 2024-25 **19 - 44**

Report of the Chair of the Health Overview & Scrutiny Committee (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

7 CHILDREN & YOUNG PEOPLE MENTAL HEALTH SERVICES

Papers to follow

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

8 UPDATE ON CHANGES TO CITY ACUTE IN-PATIENT DEMENTIA BED PROVISION **45 - 48**

Report of the Chair of the Health Overview & Scrutiny Committee (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fourth working day before the meeting.

Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.
Infra-red hearing aids are available for use during the meeting. If you require any further information or assistance, please contact the receptionist on arrival.

FURTHER INFORMATION
For further details and general enquiries about this meeting contact Luke Proudfoot, (01273 295514, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

WEBCASTING NOTICE
This meeting may be filmed for live or subsequent broadcast via the Council's website. At the start of the meeting the Chair will confirm if all or part of the meeting is being filmed. You should be aware that the Council is a Data Controller under the Data Protection Act 1998. Data collected during this web cast will be retained in accordance with the Council's published policy.

Therefore, by entering the meeting room and using the seats in the chamber you are deemed to be consenting to being filmed and to the possible use of those images and sound recordings for the purpose of web casting and/or Member training. If members of the public do not wish to have their image captured, they should sit in the public gallery area.

ACCESS NOTICE
The Public Gallery is situated on the first floor of the Town Hall and is limited in size but does have 2 spaces designated for wheelchair users. The lift cannot be used in an emergency. Evac Chairs are available for self-transfer and you are requested to inform Reception prior to going up to the Public Gallery. **For your own safety please do not go beyond the Ground Floor if you are unable to use the stairs.**
Please inform staff on Reception of this affects you so that you can be directed to the Council Chamber where you can watch the meeting or if you need to take part in the proceedings e.g. because you have submitted a public question.

FIRE / EMERGENCY EVACUATION PROCEDURE
If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by council staff. It is vital that you follow their instructions:

- You should proceed calmly; do not run and do not use the lifts;
- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and
- Do not re-enter the building until told that it is safe to do so.

Date of Publication - Tuesday, 1 July 2025

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 23 APRIL 2025

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Fowler (Chair)

Also in attendance: Councillor Wilkinson (Deputy Chair), Cattell, Evans, Galvin, Hill, Hogan, Mackey and O'Quinn

Other Members present: Geoffrey Bowden (Healthwatch), Nora Mzaoui (CVS), Mo Marsh (OPC)

PART ONE

32 PROCEDURAL BUSINESS

32(a) Substitutes

32.1 There were no substitutes

32(b) Declarations of Interest

32.2 There were none.

32(c) Exclusion of Press & Public

32.3 RESOLVED – that the Press & Public be not excluded from the meeting.

33 MINUTES

33.1 RESOLVED – that the minutes of the 29th January 2025 meeting be accepted as an accurate record.

34 CHAIR'S COMMUNICATIONS

34.1 The Chair gave the following communications:

We have 2 items on the agenda today. The first item is a presentation on plans to develop the Royal Sussex County Hospital emergency floor, including A&E. I recently had a tour of the hospital and was shown plans to make capital improvements, and I wanted to give the committee the opportunity to explore these also.

I'm sure that members may have all sorts of questions that relate to A&E. I want to keep this session as focused as possible on plans to develop the site and what this will mean for clinical outcomes and patient experience. There will be opportunities to explore other concerns members may have later in the year, but I'm conscious that we won't have the time or all the right NHS colleagues in the room to do justice to issues such as the experience of people with mental health issues who present for treatment at the Royal Sussex.

The second agenda item is a paper on the NHS palliative care offer to Brighton & Hove residents. This was something that committee members requested following Jo Harvey-Barringer's presentation to the HOSC last year on the care her partner received in the last weeks of her life. The presentation covers the entirety of the NHS palliative care offer, not just care in hospital.

I also wanted to let members know that Cllr Grimshaw and I recently visited the walk-in centre near Brighton station. We met managers and clinical staff and learnt lots about how the centre works. We were really impressed with what we saw. The walk-in centre is a great resource, and it is important that more people know about it, particularly as a potential alternative to A&E.

I also wanted to remind everyone that April is Bowel Cancer awareness month. Bowel cancer is one of the most common cancers, but if it is detected early there are effective treatments available. There is loads of information available online or at your local GP surgery where you can also pick up a self-test kit.

Finally, we have today, as always, lots of NHS colleagues joining the meeting. I just wanted to remind members that many of our guests are doctors or clinicians, and some of them will be taking time out from their clinics to attend this meeting. To make the most of their time I would ask committee members to keep their questions and comments on topic and as succinct as possible.

35 PUBLIC INVOLVEMENT

35.1 There was one public question, from Mr Adrian Hill. Mr Hill asked:

> Brighton & Hove has some of the worst air quality in the UK. However, the city has some of the most relaxed regulations on emissions.
> Studies show that ⅓ of all asthma cases in cities similar to ours are caused by air pollution. Air pollution is also a significant cause of heart disease, lung cancer, diabetes, developmental problems in children and dementia.
> Could the NHS do more to request that the council implement air quality improvements effectively without delay?

35.2 The Chair responded:

> NHS partners have informed me that they are currently refreshing the NHS Green Plan for Sussex. The refresh draws on recent work across the country on improving air quality by the introduction of Clean Air Zones and other measures, recognising the key role air quality plays in health. The NHS will work closely with partners, including the city council, to implement its Green Plan. I will provide more details of this ongoing work to you in writing, and this will also be included in the minutes of this meeting. NHS partners

are happy to meet with you to explore this issue in more detail, and the HOSC support officer can help to arrange this.

Additional written information was provided by NHS Sussex:

We are currently working on our Green Plan Refresh in Sussex and hope to reflect some more challenging perspectives on improving air quality in it for the agreement of local NHS partners. This is going to emphasise the importance of work being undertaken in places such as London, Birmingham and Bradford. The most critical elements of the work undertaken in the Clean Air Zones (CAZs) are the profound impacts upon the health of our most vulnerable communities.

By themselves, these impacts should be sufficient for NHS colleagues to be able to actively support not just the establishment of CAZs in Sussex but also to promote wider air quality initiatives. Some of these are set out in the ICS Clean Air Framework published by Global Action Plan and Boehringer Ingelheim. The evidence points clearly towards much reduced exposure to kerbside emissions, fewer visits for children with respiratory conditions to hospitals, fewer visits to General Practice for people with respiratory conditions in older age groups, and improved air quality for some of the most deprived communities.

Accepting that the more significant elements of a plan to improve air quality require longer term change and wider commitment, we are hoping that the NHS can prioritise certain shorter-term actions. The Green Plan Refresh will recommend that partners:

- Promote, champion and agree annual targets for virtual consultations, virtual interventions, remote diagnostics, and point of care testing, increasing the percentage of non-face to face outpatient appointments to 25% of all outpatient appointments by April 2030.
- Ensure that all of our new Integrated Care Teams have access to a private, designated area or 'Community Hub' for patients to access conferencing tools to meet with medical professionals who are based in acute hospitals.
- Ensure that all patient facing staff in our Integrated Care Teams have access to information and online training on air pollution and its impact on health.
- Ensure that patients being treated for cardiovascular and respiratory disease and patients that are more at risk of the health effects of air pollution have access to information on health issues related to air pollution which includes advice on how to reduce their exposure to air pollution and ways to reduce their contribution to air pollution.
- Work with public health colleagues and educational institutions to gather data on air pollution levels across Sussex and, by April 2028, make this available to patients on the websites of all NHS organisations.

36 MEMBER INVOLVEMENT

36.1 There were no member questions.

37 PLANS FOR CAPITAL DEVELOPMENT OF ROYAL SUSSEX COUNTY HOSPITAL EMERGENCY DEPARTMENT

37.1 This item was presented by Mark Edwards, Chief of Service, Medical Division, and by Dr George Findlay, CEO of University Hospitals Sussex NHS Foundation Trust (UHSx).

37.2 Mr Edwards told members that the Royal Sussex County Hospital (RSCH) Emergency Department (ED) was outdated, with the current configuration not fully meeting service needs. £62 million of capital funding has been allocated to make improvements to ED; some of this work has already been completed, some is in progress and some will start soon. The works will modernise the ED environment, increase ED capacity and substantially increase capacity in the Urgent Treatment Centre (UTC), improve clinical adjacencies of services and improve the environment for staff and patients. Works will be staged as the RSCH needs to continue to provide a full range of services on site at all times during the build.

37.3 A new Surgical Assessment Unit has already been created, and a Medical Assessment Unit is due to open in October 2025. Works on Resuscitation, Majors, and Patient Assessment & Triage (PAT) areas will all begin soon.

37.4 Cllr Cattell asked why ED wasn't included in the 3Ts development of the RSCH site. Dr Findlay responded that ED was never part of the 3Ts business case. However, the ED improvements now being delivered are only possible because of additional space freed in the hospital by the opening of the Louisa Martindale Building.

37.5 Cllr O'Quinn asked whether the ED changes would improve the environment for people with mental health problems. Mr Edwards responded that the key to better supporting people with mental health issues was for the health and care system to work more effectively to minimise A&E attendance in the first place – for example via better community crisis support and more robust community mental health pathways. The Trust would be happy to come to a later meeting of the HOSC to form part of a system presentation on the work ongoing to reduce the number of people presenting at A&E with mental health problems.

37.6 Cllr O'Quinn asked whether the changes would bring additional scanner capacity. Mr Edwards replied that there would be an increase in CT scanners.

37.7 Cllr Hill asked whether staffing levels would be reviewed at each stage of the works. Dr Findlay agreed that this was important: staffing levels will be regularly reviewed to ensure that there is always a safe level of staffing.

37.8 Cllr Hill asked whether the use of corridor care was improving. Dr Findlay responded that it is – there are still busy days where some patients have to wait in the corridor area, but there are far fewer days when this is required. Mr Edwards added that the last 90 days have seen a significant reduction in corridor use.

37.9 In response to a question from Cllr Hill on a 'well-led' developmental review, Dr Findlay replied that reviews are commissioned by the Trust as a tool for learning and improvement.

37.10 In reply to a question from Mo Marsh (Older People's Council) on mental health and the use of A&E as a Section 136 Place of Safety, Dr Findlay told the committee that there will always be people at A&E who have mental health problems – the challenge is in getting them swiftly into the appropriate services.

37.11 Nora Mzaoui (CVS) asked a question about staffing. Mr Edwards responded that the Trust constantly monitors demand across the RSCH site and will move staff around to meet this demand.

37.12 In response to a question from Ms Mazaoui about access to ED, Dr Findlay responded that there are limitations in terms of the site being on a hill. However, the improvements mean that there is now step-free access to ED via the Louisa Martindale Building.

37.13 Ms Mzaoui asked a question about patient privacy and dignity. Dr Findlay responded that the new works will address this important issue.

37.14 Cllr Wilkinson asked whether the increase in ED capacity will be sufficient to enable the Trust to meet its 4 hour A&E wait target. Mr Edwards responded that the changes will support work to improve performance against the target, particularly in terms of increasing UTC and PAT capacity.

37.15 Geoffrey Bowden (Healthwatch) asked about the increase in programme costs from an original £48M to the current £62M. Dr Findlay responded that this is the result of the inflation of building costs. The Trust has made additional capital commitments to meet this challenge.

37.16 RESOLVED – that the report be noted.

38 NHS PALLIATIVE CARE OFFER FOR PEOPLE IN BRIGHTON & HOVE

38.1 This item was presented by Lola Banjoko, NHS Sussex; Steve Bass, Lead Nurse, Palliative and End of life Care, University Hospitals Sussex NHS Foundation Trust; Lisa O'Hara, Nurse Consultant, Palliative & End of Life Care, Sussex Community Foundation Trust; Lisa Barrott, Chief of Nursing Care, Southern Hospice Group; Tiritega Mawaka, Deputy Director, All-Age Continuing Care, NHS Sussex; and Helen Cobb, Senior Manager, Community Commissioning & Transformation, NHS Sussex.

38.2 Ms Banjoko outlined the local palliative care system, explaining how services link across acute, primary and community settings, including Martlets hospice, and how the system aims to identify people who may benefit from palliative support at an early a stage as possible, with the collective aim to ensure their end of life care is as good as possible.

38.3 Councillor O'Quinn welcomed the report and highlighted her support of the use of ReSPECT. In response to a question from Cllr O'Quinn on hospice care, Ms Banjoko and Ms Mawaka told the committee that the Integrated Care Board (ICB) works closely with Martlets to ensure that there is both bedded and homecare support available for people who do not necessarily have specialist palliative care needs, as well as Martlets providing specialist care.

38.4 In answer to question from Cllr Wilkinson on integrated working, Mr Bass told the committee that a multidisciplinary approach is central to care delivered in the acute trust, with doctors, nurses and occupational therapists working seamlessly together, and also working very closely with ward services such as physiotherapy and dieticians. An NHS Sussex Palliative and End of Life Care Oversight Group brings all organisations and services together to share information and co-ordinate responses. Mr Bass and Ms O'Hara reiterated the multidisciplinary approach taken between the organisations delivering end of life care in the city. Lisa O'Hara added that Sussex Community NHS Foundation Trust (SCFT) and University Hospitals Sussex NHS Foundation Trust (UHSx) meet together fortnightly to plan how to improve services. This is in addition to weekly meetings with local hospices.

38.5 In response to a question from Cllr O'Quinn regarding the use of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment), Ms O'Hara responded that the local system is recognised as a national leader in training of ReSPECT. This includes SCFT maintaining a permanent ReSPECT trainer post.

38.6 In answer to a question from Cllr Wilkinson on how palliative care is coordinated, Ms Banjoko replied that the system is looking to move to a model of integrated care teams (ICTs) working out of neighbourhood hubs. The embedding of PEoLC into ICTs is currently being piloted in Crawley.

38.7 Cllr Cattell asked what lessons had been learnt from the experiences of Jo Harvey-Barringer, a local resident who recently presented to the HOSC on the care her partner received in the latter stages of her life. Mr Bass responded that system partners have reflected on Jo's experiences and are looking at the liver disease pathway used in West Sussex as a possible model. This would potentially include having a palliative care presence in the hospital emergency department to ensure that people who have a need for palliative support, irrespective of diagnosis, are picked up as early as possible.

38.8 Cllr Mackey asked how services are evaluated. Ms Banjoko responded that there are a number of measures in place and that work is currently ongoing to standardise evaluation approaches across Sussex. Metrics measured include the percentage of people dying at home and the number of readmissions following discharge from hospital. Mr Bass added that there is also a focus on learning from complaints and on learning from independent reviews of deaths.

38.9 In response to a question from the Chair about carers experience, Ms Barrott told members that there was support available for carers, including from the Hospice at Home team and from district nurses. It may not always be feasible to support patients at home; services work with carers so they understand what can and cannot be delivered.

38.10 Geoffrey Bowden (Healthwatch) noted that it must be difficult to provide end of life care. Mr Bass agreed, telling the committee that training and learning are key: there is a need to train people across services, so they know how to support people at the end of their lives. It is also important to involve patient groups in the design of end of life pathways. Ms O'Hara added that work is underway to redesign the liver disease pathway following the recent HOSC focus on this issue.

38.11 Nora Mzaoui asked a question about support for people with specific cultural or religious needs. Ms O'Hara replied that services are focused on understanding the requirements of different faiths and cultures: training includes videos from a range of faith leaders explaining the requirements of their faith. Ms Banjoko highlighted that theICB commissions GPs to support patients in filling out 'ReSPECT' forms which can provide essential information on patients' cultural and religious requirements. Ms O'Hara added that there is active recruitment onto focus groups of people from Black and Racially Minoritised communities with lived experience of palliative care.

38.12 In response to a question from Cllr Hill on LGBT+ training, Ms Barrott and Mr Bass told the committee that services seek to adopt a holistic approach to people's care, with staff encouraged to be curious about what matters to each individual. Ms O'Hara added that sheworks closely with SCFT's LGBT+ network to ensure that PEoLC approaches are fully inclusive.

38.13 In response to a question from Cllr Wilkinson on where data is collected and made available, Ms Banjoko told members this area was currently being explored, working with hospices and public health colleagues in the local authorities.

38.14 In response to a question from Cllr Wilkinson on accessing information about services Ms Banjoko explained we have developed a booklet with information about services available. Helen Cobb explained that this resource is available via each of the three "place-based" carers hubs. Helen Cobb added that a new "Respecting Faith and Culture in End of Life Care" resource has been developed to support staff delivering end of life care, and this will be shared during 'Dying Matters Awareness Week', w/c 05 May 2025, in line with this year's theme of 'The Culture of Dying Maters'. Presenters confirmed that they would be happy to give the committee a further update as work on palliative care develops

38.15 RESOLVED – that the report be noted.

The meeting concluded at 7.30pm

Signed Chair

Dated this day of

Letter to July 2025 Health Overview and Scrutiny Committee

Dear HOSC members,

Since 2022, Brighton & Hove has been part of the NHS Sussex Integrated Care Board (ICB), one of 42 ICBs in England. As part of the plan to abolish NHS England, funding for ICBs is being cut by 50%. The Chair of NHS Sussex, Stephen Lightfoot has put forward plans to merge the Sussex ICB with the Surrey Heartland ICB to realise cost savings necessary to make this 50% cut possible. This is based on the need to now operate within an annual cost of £18.76 per head of population which is not possible within the current ICB framework.

I would therefore like to have a future item to this committee which would allow us to ask questions of senior members of the integrated care board so as to help us and the public understand the implications of this change. This is likely to have wide reaching consequences. I have concerns that such a large integrated care board means there could be a lack of local connection. There will be issues with the new Sussex strategic authority boundaries which will not be coterminous with the new ICB proposal.

I have attached a letter by Stephen Lightfoot which goes into more detail which I recommend members read.

Cllr Raphael Hill, Green Party Councillor for Round Hill Ward

-

[Type here]

Sackville House
Brooks Close
Lewes
East Sussex BN7 2FZ

To

By email:

E-mail: stephenlightfoot@nhs.net
mark.smith25@nhs.net
Website: www.sussex.ics.nhs.uk

22 May 2025

Dear Partner,

Re: ICB COST REDUCTION PROPOSAL

Further to our discussions recently, we are writing to share the latest position following the recent announcements that NHS Integrated Care Boards (ICBs) would need to reduce their running costs significantly in line with changes to NHS England and the Department of Health and Social Care.

Since then we have received information that we would need to operate within an annual cost of £18.76 per head of population, and a national Model ICB Blueprint has been shared setting out functions and responsibilities for ICBs for the future. This guidance reinforces our role as strategic commissioners, with a strong focus on improving population health, reducing inequalities, and ensuring access to high-quality care. It also signals a shift in how we operate, with some delivery responsibilities increasingly transitioning to providers or other partners.

In response, much work has been underway to consider the future form and how we could meet the reductions by Quarter 3 of this financial year as required.

For Sussex with a weighted population of 1.876 million people, this would mean that the annual NHS Sussex running costs would have to be reduced by 53% from £76 million to £35 million by 31 December 2025, whilst still retaining all of our existing statutory functions and legal duties.

We have worked rapidly and diligently to design a minimum viable ICB organisation for Sussex, but the lowest cost to build this would be £46 million. It is clear from the work completed to date that we cannot deliver our current ICB statutory responsibilities safely or reliably with a cost base of less than £46 million. Furthermore, this new structure would have significantly reduced capacity in all of its functions, no 'place based' resource to deliver neighbourhood health and limited capacity to engage with system partners.

We would also expect that this Sussex option would not be agreed by NHS England as the cost is 30% higher than the £18.76 per head of population requirement and it does not meet the latest NHS England guidance that all Integrated Care Boards must have a population of at least 2 million people.

As an alternative option, the combined Sussex and Surrey weighted population (including Farnham and Surrey Heath) is 3.06 million and provides a running cost budget of £57 million. Our NHS Sussex executive team met with the NHS Surrey Heartlands executive team last week and have developed a Sussex and Surrey ICB minimum viable ICB organisation within the required cost base of £57 million. This option will retain the capacity, capability and resilience to deliver the core ICB functions, as well as some 'place based' resource to work with and commission services with the new unitary authorities in the Sussex and Surrey footprint.

The proposal includes the retention of two separate Integrated Care Partnerships, one for Sussex (which is currently called the Sussex Health & Care Assembly) and one for Surrey (which is currently combined with the Surrey Health & Wellbeing Board) so that an independent focus can be maintained on the population health needs in each of the two proposed Mayoral authorities.

Alongside this core approach, we are also strengthening collaboration across the South East region to explore how services can be delivered more efficiently and consistently at scale. By identifying functions that can be delivered once across the region, we aim to reduce duplication, enhance quality, and make the best use of our collective resources. This approach builds on a strong tradition of regional cooperation and shared learning, ensuring that every pound spent delivers maximum benefit for our patients.

The NHS Sussex Board reviewed the two main options at its meeting on 21 May 2025 and agreed by a majority vote to submit the Sussex and Surrey ICB proposal to NHS England for approval at the end of next week. The NHS Surrey Heartlands ICB Board also met on 21 May and unanimously agreed to submit the same proposal to NHS England.

We have been working closely with our system partners, and we do appreciate that the three upper tier local authorities in Sussex would prefer to retain an NHS Sussex Integrated Care Board that is coterminous with the proposed Sussex Combined Mayoral Authority footprint, but in our view, this is simply not possible with the national constraints on maximum running costs and minimum population size for each ICB.

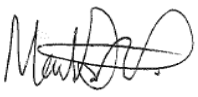
This is a pivotal moment for our system. We are responding to national imperatives but remain focused on how we can do this in the best possible way, and how these new arrangements can help us to continue to strengthen the focus on improving the health outcomes and reducing the health inequalities for the Sussex population.

We are committed to keeping you informed and involved throughout this journey. Your partnership and insights are vital as we work together to deliver better outcomes for our communities.

We will share more over the coming weeks but in the meantime, if you have any questions or would like to discuss this further, please do not hesitate to get in touch.

Thank you for your continued support.

Yours sincerely,



Stephen Lightfoot
Chair

Mark Smith
Interim Chief Executive Officer

On behalf of NHS Sussex

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 6

Subject: **Winter Performance 2024-25**

Date of meeting: **09 July 2025**

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

Contact Officer: **Name: Giles Rossington, Scrutiny Manager**

Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

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 2024-25. Appendix 1 to this report includes information provided by health and care system partners on winter planning and performance 2024-25. The report will be presented to the committee by representatives of the Sussex Integrated Care Board (ICB), city council Adult Social Care, and by University Hospitals Sussex NHS Foundation Trust (UHSx).

2. Recommendations

2.1 Health Overview & Scrutiny Committee 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, as is the case locally.

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 2024, system partners presented on Sussex winter planning to the Brighton & Hove HOSC. It was agreed that a follow-up report outlining performance against this plan would be reported to the HOSC in summer 2025 (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 No financial implications have been identified in this report to note.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted 30.06.25

7. Legal implications

7.1 No legal implications have been identified in this report, which is for noting only.

Name of lawyer consulted: Victoria Simpson Date consulted 30.06.25

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

1. Appendices

1. Information on system performance winter 2023-24 provided byhealth and care system partners.

2. Background documents

1. 20 November 2024 HOSC report on the Sussex system winter plan 2024-25 (Public Pack)Agenda Document for Health Overview & Scrutiny Committee, 20/11/2024 16:00

Brighton and Hove City Council Health Overview and Scrutiny Committee (HOSC)

Winter Plan Review and Evaluation Report – June 2025

Introduction

1. The Sussex ICS Winter Plan 2024/25 focused on supporting the population to stay well while maintaining patient safety and experience. The plan was structured around five key pillars, which are explained in more detail in Section 2 of this report:

    - Prevention and case finding
    - Same day urgent care
    - Improvements in discharge to support patient flow
    - Sound operational management
    - Oversight, governance and escalation

2. The approach to the development of the plan built on lessons learned from previous years. It outlined the key actions to be taken by NHS Sussex and system partners across the ICS to maintain access to safe services during the winter period.

3. The plan drew on a core set of actions developed over the previous year, informed by data analysis and supported by a clearly defined system oversight model based on clinical risk.

4. The Urgent and Emergency Care (UEC) Improvement Plan and Discharge Plans, which formed the foundation of the Winter Plan, were developed collaboratively with partners and providers across the system. The final Winter Plan was approved by the NHS Sussex ICB in November 2024.

5. Update reports on progress against the plan were provided to WSCC Health and Adult Social Care Scrutiny Committee (HASC), Brighton Health Overview and Scrutiny Committee (HOSC) and the East Sussex Health Overview and Scrutiny Committee (HOSC) in November 2024.

6. Demand and capacity modelling was carried out by the NHS Sussex Business Intelligence Team, informed by data analysis from previous years' winter performance. The modelling reviewed bed occupancy using a series of demand assumptions and predicted likely gaps between capacity and demand. The impact of planned mitigations outlined in the plan was also modelled to ensure those gaps identified could be mitigated by the planned actions being undertaken within the workstreams supporting the five pillars.

7. As a result of the modelling, several schemes were identified as having an expected impact on performance over the winter period, such as A&E four-hour performance, patients waiting over 12 hours in A&E, the average length of stay and the number of patients with a 'no criteria to reside' (NCTR) status. These were monitored throughout the winter period by the ICB Resilience and Strategic Intelligence teams using SHREWD data platform and national data streams.

8. The Winter Plan included an outline of the Winter Operating Model for system oversight via the System Co-ordination Centre (SCC), and governance and escalation routes.

9. Each provider outlined their high-level actions, which were underpinned by their organisational plans, within the overarching Winter Plan. Providers will complete internal reviews of their action plans.

10. In addition to the Winter Plan, a Reset Event was scheduled for the two weeks leading up to, and two weeks post, the Christmas and New Year bank holidays. This did not form part of the initial plan but was requested by the System Oversight Board following receipt of the plan. This was also evaluated as part of the review of the Winter Plan and details are included in the report below.

11. Each of the five Pillars were reviewed by workstream leads to determine whether they were effective in maintaining performance, patient safety and experience. The demand and capacity modelling has been reviewed against actual performance to determine accuracy. A system debrief session was held on 30th April 2025 to gain insight into what went well, what did not go so well, and what could be fed into future planning. A provider survey was conducted, alongside a patient discharge experience survey, to give further insight into the success of the Winter Plan.

12. This report outlines the results of the review and evaluation of the plan which took place the end of March 2025, which immediately followed the cessation of the period covered by the Winter Plan.

1 WINTER PLAN REVIEW OUTCOMES

13. The following sections of the report contain the detailed outcomes of the Winter

Plan review set out in the key areas summarised above, describing each of the key measures and pillars, what worked well and areas for improvement.

2.1 Demand and Capacity Modelling

14. Demand and capacity modelling was carried out the by NHS Sussex Strategic Intelligence team in conjunction with provider plans, using a series of assumptions based on previous years increased activity due to known winter pressures on the bed capacity and therefore the predicted gap in demand. The identified gap was modelled against the winter schemes, and interventions to test whether they would mitigate the bed gap and what impact they might have on system performance. To support decision making a small number of metrics were identified to act as a proxy for clinical risk and these were added to a separate Single Health Resilience Early Warning Database (SHREWD) dial so that they could easily be monitored.

15. The demand and capacity modelling indicated a starting gap of 164 beds at the peak demand in the first week of January 2025 and that the actions described in the Winter Plan would close the gap to 6 beds (figure 1). Until the end of December the bed occupancy broadly followed the modelled average. In January and February 2025, the occupancy rose significantly to an average of 85 beds above the modelled capacity requirement, due to higher number of beds occupied by patients with flu. Additional recorded capacity classified as "general and acute (G&A) beds opened" was not accounted for in the original model and therefore not included in the analysis. This should be addressed in future models. Further planning will be undertaken with Public Health teams to improve infection forecasting in relation to the bed modelling.

Figure 1: Predicted Bed Gap Following Modelling 2024/25

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

For Brighton and Hove, the winter bed plan modelling indicated that based on bed occupancy and a series of demand assumptions, a reasonable scenario would result in a starting gap of 16 beds at Princess Royal Hospital (PRH) in the second week of March (winter peak) and a zero bed gap at the Royal Sussex County Hospital (RSCH). The modelling indicated that the starting bed gap at PRH would be reduce to two beds at PRH by the mitigating actions.

Throughout the winter period at both hospitals, the number of beds occupied fluctuated close to the modelled average beds occupied. In both PRH and RSCH bed occupancy dropped during the Christmas and New Year period.

In early January 2025 the system saw a spike in influenza (flu) admissions which increased pressure on beds. PRH flu admissions peaked at 25 in February but recovered by the end of February. However the number of admissions at RSCH fluctuated significantly over the winter and averaged at 25 which a peak of 76 in the first week of January 2025. Flu could have been an underlying cause of the slight increase in January 2025, but it was not the cause of the ongoing pressures.

16. A small number of metrics were agreed as proxy measures of the system resilience. These were monitored throughout the winter period. A summary of the performance from each one is given below:

2.1.1 Four-hour A&E performance target

17. Four-hour A&E performance target remained close to season trends, with performance at 69.5% in the last week of March 2025 and an overall monthly performance of 73.8%, against the 78% target (please see table 1 below). This benchmarked as upper quartile performance nationally.

TABLE 1 - 4 HR PERFORMANCE IN A&E

A&E - percentage of patients managed within 4 hours						
Period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Sussex ICB	78.3%	78.4%	77.3%	76.6%	75.0%	73.8%
National	75.2%	76.3%	74.2%	73.0%	72.1%	71.1%
Change from Previous Period	↑	↑	↓	↓	↓	↓
3 Period Continuous Change	↑	↑			↓	↓
Rank	6/42	8/42	4/42	4/42	10/42	11/42

It was projected that the completion of the actions in the Winter Plan would result in increased levels of performance at both RSCH and PRH, however the target performance of 78% was not reached. At year end, performance was 73.4% at RSCH and 69.8% at PRH.

A&E - percentage of patients managed within 4 hours						
Period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
UHSx (Mapped)	71.9%	69.2%	68.1%	69.4%	70.2%	71.5%
National	75.2%	76.3%	74.2%	73.0%	72.1%	71.1%
Change from Previous Period	⬆	⬇	⬇	⬆	⬆	⬆
3 Period Continuous Change						⬆
Rank (SE Region)	13/17	15/17	16/17	16/17	16/17	14/17

2.1.2 12 Hour stay in A&E

18. The 2024/25 actual performance for the 12 Hour Stay in A&E metric was broadly unchanged over winter and has held at around 7-9% over the past 12 months. This is up from around 4-6% in 2023/24. There was a spike to around 12% during December and January. (At the time writing this report national data was unavailable).

In Brighton and Hove the number of patients waiting in A&E for over twelve hours remained broadly unchanged compared to 23/24, implying that the improvements planned have not materialised. However, an improvement was seen at RSCH in March 2025 with them ending the winter period only slightly above their mitigated target of 10.1% at 10.7%. PRH performance remained unchanged over Winter with a peak in mid-January of 14%. Performance has since decreased, ending the year at 9/7% against it's mitigated target of 9.7%

2.1.3 Average length of stay (LoS)

19. The average length of stay (LoS) increased in December and began to decrease from January, and did not meet the reduction target (8.7 days) by the end of the winter period. The Sussex length of stay in the last week of March was 9.8 days.

Average Length of Stay at RSCH was lower than last year over winter and well below the mitigated target of 12.5 days. It was slightly above the 10% winter reduction target of 10.7 days at 11.2 days.

Average length of stay at PRH however, increased over winter, peaking in January 2025 at 11 days. Which is higher than in 23/24 position and well above the mitigated projection of 8.2 days, ending the year at 9.5 days in March 2025, implying that the mitigation actions did not have an impact.

2.1.4 Ambulance response times (Category 2 incidents)

20. Data shows that the South East Coast Ambulance Service (SECAmb) improved

their performance position from 5th of 11 Ambulance Trusts to 2nd of 11 Ambulance trusts, for Category 2 performance, during the period October 2024 – March 2025 (please see table 2 below). SECAmb response times within Sussex ICS, for five out of the six winter months, were faster than the national average. The national target was for category 2 calls to be responded to within 30 minutes. SECAMB achieved this in 3 out of 6 months over the winter period and responded to category 2 calls between 12 and 15 minutes faster than the national average over the final quarter of the year.

Table 2: Ambulance Response Times (Cat 2)

Ambulance response times (Category 2 incidents)						
Period	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
Sussex ICB	00:33:32:00	00:26:39:00	00:29:55:00	00:30:31:00	00:28:28:00	00:32:12:00
National	00:33:25:00	00:27:24:00	00:36:02:00	00:42:15:00	00:42:26:00	00:47:26:00
Target/Standard Not Met If	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00
Change from Previous Period	↑	↓	↑	↑	↓	↑
3 Period Continuous Change	↑					
Rank	5/11	5/11	5/11	2/11	3/11	2/11

2.1.5 No Criteria to Reside (NCTR)

21. Across Sussex we continue to see a high number of patients remaining in inpatient beds despite being defined as either Not Meeting Criteria to Reside (NCTR) or are Clinically Ready for Discharge (CRFD).

22. There are a range of reasons for why discharge is delayed for these patients. Examples include waiting for NHS community care, waiting for social care, waiting for residential care, and waiting for non-clinical processes to be completed, such as prescription medications being prescribed.

23. Pillar 2 of the Winter Plan focused on improving discharge to support patient flow and aimed to reduce the number of patients residing in acute, community and mental health beds.

24. The local ambition to reduce NCTR numbers by 33% by the end of March 2025 was not achieved. However, there was an improvement compared to the 'Do-Nothing' position. Sussex NCTR position (acute, community and mental health) was 847 in the last week of the March 20224/25 compared to the 'Do-Nothing position of 983, an improvement of 14%. However, this was significantly higher (193) than the ambition set out in the winter plan, indicating the actions set out in the winter plan did not have the desired impact. There was an improvement in the week before Christmas which coincided with the RESET event, however the numbers increased again from January.

The local position in Brighton and Hove mirrored that of Sussex with both trusts not achieving their ambition.

Nationally University Hospitals Sussex (UHsx) is one of the Trust's with the highest percentage of beds occupied by NCTR patients.

Percentage of beds occupied by patients who no longer meet the criteria to reside						
Period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
UHSx	20.8%	18.7%	18.3%	19.4%		
National	13.9%	13.7%	13.9%	13.5%	13.5%	13.1%
Change from Previous Period	⇩	⇩	⇩	⇧		
3 Period Continuous Change			⇩			
Rank	101/119	93/119	98/119	95/118		

25. In Sussex the percentage of beds occupied by NCtR patients was 20.7% for March 2025, which was considerably higher than the national average of 13.1% with the Sussex ICB performing between 40th to 42nd out of 42 ICBs (see table 3 below).

Table 2 - Percentage of bed occupied by NCTR patients

Percentage of beds occupied by patients who no longer meet the criteria to reside						
Period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Sussex ICB	22.3%	23.5%	24.2%	23.2%	21.5%	20.7%
National	13.9%	13.7%	13.9%	13.5%	13.5%	13.1%
Change from Previous Period	⇩	⇧	⇧	⇩	⇩	⇩
3 Period Continuous Change						⇩
Rank	41/42	42/42	42/42	42/42	40/42	41/42

- Despite significant efforts over the past year to decrease the number of patients occupying beds or services that no longer have any criteria to reside (NCTR), Sussex remains the most pressured system in the country for 14+ NCTR bed occupancy across acute sites and remains at 42 against national benchmarking.
- Long term sustained action continues to be focussed on reducing both the number of discharge-ready patients and their length of stay, both pre and post discharge ready).
- Providers and Local Authorities across Sussex have recently developed a set of place based site level discharge improvement plans, with a view to reducing the number of NCTRs across each acute, community and mental health settings to a Sussex baseline position of 14.3% by March 26.
- Provider stakeholders from across health and social care have set out a series of key actions they will collectively undertake during 25/26 to support the reduction in NCTRs.

- Plans and actions are nuanced across place sites, reflecting the diversity of Sussex but range from:-

    - Recruiting additional Social Worker, therapies and HomeFirst Staff
    - Implementing SAFER across all acute wards/divisions
    - Criteria Led Discharge – Increasing Pathway 0/1s over 7-day model.
    - Increased capacity within Community Reablement Services
    - Implementation of Choice Policy pan Sussex

- The plans were formally signed off at the Discharge Oversight Board on Friday 13 June, but recognised that the plans were fluid and would need to be reviewed by place-based Boards monthly and flexed/amendment regularly to meet changing needs of targets and overall areas of improvement.

2.2 Workstream Pillars: Pillar 1 – Prevention and Case Finding

26. The objective of the Prevention and Case Finding pillar was to support our population, including NHS staff, to stay well and ensure the system had proactive care in place for those most at risk.

2.2.1 Workforce and Wellbeing

27. The Chief People Officer (CPO) group oversaw the aims of this workstreams.

Notable achievements:

- Staff networks were developed to create and promote a culture of wellbeing, dignity, respect and inclusion for all.
- Over 18,500 healthcare workers self-declared as having received either a Covid and/or flu vaccination, reducing staff sickness absence over the winter period.
- Staff absences over winter decreased slightly from 5.7% in 2023/24 to 5.6% in 2024/25, improving workforce resilience over the winter period.

2.2.2 Vaccination Programme

Access & Inequalities (A&I) Programme Autumn / Winter 2024 – 25 (AW24-25)

- The core aim of the Covid-19 Vaccination Access and Inequalities (A&I) Programme was to reduce the gap in vaccination uptake by eligible individuals and cohorts within population groups who experience health inequalities, and link population groups and areas of need to preventative healthcare and support. The objective was to:

    - remove barriers and increase access to vaccinations for those populations who could not or struggled to access core services.
    - build confidence in vaccinations and wider health services among individuals and groups who may not typically have taken up vaccinations or engage with

health services through standard approaches.

- In Sussex, the AW24-25 Covid-19 A&I programme targeted areas of deprivation and low uptake and our rural populations with outreach services. In planning the programme of clinics and communications and engagement work we reviewed areas of lower covid-19 vaccination uptake in Autumn/ Winter 23, against other agreed measures including Core 20 Index of Multiple Deprivation (IMD), ethnicity, health deprivation, disability and percentage of people aged 65 and over. Broadly these areas overlaid – there is a clear corelation between areas of lower uptake and those facing inequalities/disadvantages of different kinds.
- Based on this analysis our A&I programme focused on the following geographic areas:
  - West Sussex – in and around coastal areas in Bognor, Littlehampton, Worthing, Lancing, and areas in Crawley;
  - East Sussex – in and around coastal areas of Eastbourne, Hailsham, Polegate, Bexhill and Hastings;
  - Brighton & Hove – the city, with some additional focus on the east.

  Within these areas there were differences in the local population (for example, specific vulnerable groups such as Gypsy, Roma and Traveller communities (GRT), homeless, asylum seekers; different levels of deprivation and different health inequalities, etc) that required a tailored local approach.

- There is currently a competitive procurement process for outreach services in Autumn/Winter 2025-2026 (AW25-26) East Sussex, West Sussex and Brighton & Hove.

- These services will deliver Covid vaccinations and clinics which could be temporary offsite clinics (formerly known as pop ups) or using roving vehicles. Scope of delivery will depend on specific local population needs and which other providers are delivering locally (such as PCNs or community pharmacies) and will build on any learning from previous outreach programmes.

Brighton & Hove

Brighton & Hove GP Federation

- This was the first time Brighton & Hove GP Federation had delivered A&I clinics. The Fed used its extensive experience and knowledge of population needs in B&H to develop an effective programme to address health and vaccine inequalities in the city. They utilised existing strong links with community partners and VCSEs, GP practices and the local authority.

- Using a roving vehicle they delivered vaccines to homeless people, working closely with Arch Healthcare. They also ran enhanced roving service clinics focused on key communities which included LGBTQ+, GRT, those living in deprived areas, specific in the east of Brighton and ran quiet sessions. This included offering MECC activity.
- Throughout planning and delivery the Fed worked in close partnership with the local authority and VCSEs the Hangleton and Knoll Project, the Trust for Developing Communities (who jointly ran a comms and engagement project – see below).
- A total of 41 clinics were run, delivering 2,161 vaccinations.
- MECC activity included blood pressure checks, atrial fibrillation check, pulse, wellbeing advice
- It was important to work flexibly, adapting the projects to deliver more enhanced roving clinics when it was clear there was less need for the number of clinics for homeless people.
- Useful learning for the future included – LGBTQ+ sessions were highly valued reaching people who would otherwise not have been vaccinated (very safe space), clinics at Asda Marina and Whitehawk were very successful; other less successful clinic venues will be reviewed for future programmes.

Trust for Developing Communities/Hangleton & Knoll Project

- TDC and HKP worked in close collaboration with B&H Federation and local authority public health to facilitate and promote vaccination clinics, vaccine benefits and answer vaccine hesitancy questions. Key targets were Core20 neighbourhoods and underrepresented groups. Activities included events, online comms, face to face conversations, newsletter, poster, flyer and leaflet distribution.
- Their previous comms and engagement experience was used effectively to plan and deliver the project. Building on trusted relationships was key to reaching those who are less engaged. Collaborative working was essential, as was ongoing communication between key stakeholders.
- We also invested in several targeted pre-Spring communication and engagement projects in Brighton and Hove run by TDC & HKP, Impact Initiatives and Together Co.

28. The vaccination programme was a key element in protecting our population. The programme focused on three areas and aimed to maximise the uptake of COVID, Flu and RSV Vaccinations. The eligible cohorts for each vaccine were identified by the Joint Committee of Vaccinations and Immunisation (JCVI).

29. The campaign ran from October 2024 to March 2025 (this is a rolling programme and 2024/25 was the first year for this vaccination campaign), the results of which are laid
out in figures 2 and 3 below:

Figure 2: Sussex total for each vaccination campaign

Sussex Total			
Vaccination Programme	Pts Eligible in Sussex	Vaccines administered as at 31st Mar 2025	Percentage (of eligible population)
Covid Booster	606,834	344,287	56.70%
Flu	1,013,363	571,179	56.36%
RSV	93,231	61,240	65.69%

Figure 3: Vaccination results by area

Brighton and Hove			
Vaccination Programme	Pts Eligible in Brighton and Hove	Vaccines administered as at 31st Mar 2025	Percentage (of eligible population)
Covid Booster	78,660	39,943	50.80%
Flu	144,481	70,103	48.52%
RSV	9,386	5,747	61.23%

East Sussex			
Vaccination Programme	Pts Eligible in East Sussex	Vaccines administered as at 31st Mar 2025	Percentage (of eligible population)
Covid Booster	210,705	113,887	54.10%
Flu	336,579	189,665	56.35%
RSV	34,670	22,085	63.70%

West Sussex			
Vaccination Programme	Pts Eligible in West Sussex	Vaccines administered as at 31st Mar 2025	Percentage (of eligible population)
Covid Booster	307,279	183,717	59.80%
Flu	532,303	311,411	58.50%
RSV	46,582	31,739	68.14%

Notable achievements:

- Uptake across all three vaccinations (Covid, Flu, and RSV) was above the national average for both COVID and Flu as outlined below:
    - COVID - Sussex 53.6% vs National 44.5%
    - o Flu – Sussex achieved above the national averages for each of the cohorts eligible for a flu vaccination
    - RSV – Sussex 66.4% vs National 63.7% (as of 12 June 25)
- There were 526 eligible older adult care homes with residents eligible for a COVID vaccination - 100% of which were offered a covid vaccination
- An internal MDT weekly meeting was established to provide leadership and oversight of performance and planning over the Winter Vaccination Campaign.

Areas for improvement:

- Uptake for both flu and covid vaccinations across health and social care staff was lower than in previous years; with a few acute trusts not offering on-site staff vaccination which may have impacted on uptake. At the end of the 24/25 Autum/Winter Campaign this was represented in Sussex Staff vaccinations being ranked nationally as 15th out of 42 ICBs for Covid and 19th out of 42 ICBs for Flu.
- Healthcare Support Workers (HCSW) were not included in the Joint committee on Vaccination and Immunisation (JCVI) eligible cohort which caused some mixed messaging about the eligibility of vaccinations for Winter 24/25. It is uncertain if HCSW staff will be included in the JVCI cohort for this Winter, but earlier work with Trust CPOs to ensure that plans are in place to offer vaccinations to the HCSW will be carried out, including workshops planned in Summer to prepare for Autumn and Winter covid and flu vaccination campaigns.
- Early and active engagement with key stakeholders will be crucial to the success of the Vaccination Campaigns

2.2.3 Prevention and Case Finding

30. The Cohort Identification and Multi-disciplinary Teams (MDT) programme was introduced to support winter preparedness and to build links between GP practices and community teams in the management of patients at higher risk of admission to hospital and increased GP appointments.

31. The approach was to identify the cohort of patients at primary care level and optimise their care by referring them to a proactive MDT and link them the wider service provisions such as virtual wards or voluntary sector services. The programme was well received and there is an appetite to continue and enhance it further.

Notable Achievements:

- 138 out of 156 practices across Sussex signed up to the programme
- Practices with existing community team relationships implemented new processes smoothly
- Workshops were delivered to support frontline staff
- GP practices reported that the MDTs alleviated pressure on their services.

Areas for improvement:

- A small number of practices did not sign up to the programme
- Consider sign up on a Primary Care Network (PCN) basis to reduce pressure on community teams.
- Improve the consistency of services in each MDT
- Improve access to prescribers in community teams
- Quantifying the impact of the programme has not been possible, but work is underway with our business intelligence team to ascertain if there is any

noticeable impact between the practices that participated and those that did not.

Of the 138 / 156 practices who signed up to the programme across Sussex 119 submitted returns for all three months of the programme. Therefore, the dataset is still provisional.

2.2.4 Place Based Integrated Community Teams plans

32. The Integrated Community Teams (ICT) included a wide range of stakeholders across the Sussex system including providers, local authorities, public health and Voluntary, Community and Social Enterprise (VCSE) services. Over winter the ICTs in each Place, tested a range of initiatives described as ICT Neighbourhood Level Tests of Change. The key focus was on prevention, admission avoidance, and testing new ways of working.

Brighton and Hove Tests of Change

ICT:	Initiative:	Delivery:	Expected Outcomes:
West	Community Health Days at St Richards Community Centre with a focus on prevention activities.	Offering a range of medical and non-medical interventions, for example: BP checks, social prescribing, housing/benefits advice.	Increase in preventative interventions Increase in carer awareness & dementia support Increase in uptake in vaccinations Increase in community/neighbourhood support Reduction in social isolation
East	Weekly Community Health Hub: PCN led Health Hub at Robert Lodge in one of our CORE20 areas.	Health Hub: MDT support offered, clinical and non-clinical including VCSE partners e.g., East Sussex Fire Service for holistic needs assessment.	Increase in uptake in vaccinations Increase in carer awareness and dementia support Increase in community/neighbourhood support Reducing the need for ED attendances Reduction in social isolation
West	Frailty Pilot: Collaboration between the Hangleton and Knoll Project, Goldstone PCN and Hove Medical Centre.	MDT support for 10 moderately frail patients (Rockwood 6). Proactive holistic clinical and non-clinical assessments, integrating with VCSE, ASC, Housing, and MSK pathways.	Increase in uptake in vaccinations Increase in carer awareness and dementia support Increase in community/neighbourhood support Reduction in digital exclusion Reducing the need for ED attendances Reduction in social isolation

Notable Achievements:

- Integrated working on preventative and proactive care for a targeted cohort provided greater assurance on delivery
- Targeted communications improved engagement
- Volunteer expertise is effective to providing relevant support and advice
- Adopting learning from previous years enabled the VCSE network to grow a wider membership
- The Proactive Care Huddle reduced avoidable hospital admissions, enabling healthcare professionals to strengthen existing pathways.

Areas for Improvement:

- The need to move from siloed pilots with small cohorts of complex patients, with time-limited action to support individuals and communities, at scale and embedding this business-as-usual system change resulting in improved outcomes and experience for the local population.
- Ensuring awareness of the non-NHS range of provision by service providers
- Optimising preventive – community asset which is valued by the population
- Optimising the offer of volunteer support across the system.

Brighton and Hove ICT

Winter 2024-2025 test of change schemes provided an opportunity for key partners to come together in a multi-disciplinary approach, across organisations to focus on an identified cohort that are most likely at risk of health deterioration over winter. Community events and webinars took place to create awareness of available local service provision, following the events and the feedback received from attendees and those involved in the events, recommendations were made on how to improve targeted comms and engagement. A directory of services across health and social care was circulated widely to all stakeholders to support awareness and referral processes to a suite of local services 'supporting people through winter and beyond'.
East ICT Partnership Group established a health hub in Robert Lodge within one of our Core20 areas of the city. The hub model responded directly to local health data and community feedback delivering a range of health and wider determinants activities.
West Hove ICT frailty pilot focused on a local target priority cohort testing a proactive, multiagency interventions to better support complex health needs in the community and reduce risk of the need for urgent care services. Each person received a total 360 assess, MDT working and links to VCSE and ASC services.

2.2.5 Communications and Engagement

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

- **'Helping you this Winter' –** shared assurance that partners were working together to ensure plans, services and systems were in place so that patients would get the care they needed.
- **'Help us to help you' –** targeted campaigns promoting key information, advice and public health messaging.

Notable achievements:

- Clearly branded (recognisable) system-relevant campaign for 'Let's Get You Home', with positive and impactful team collaboration and creativity to assure members of the public that plans were in place and partners were working together to ensure they get could get the care they needed over the winter period. A combination of national and locally created assets were shared to promote key health information and advice.
- Using real people to tell the story worked well.
- Strong media relationships as well as Sussex Partnership Community NHS Trust communications team relationships and coordination.
- Intelligent linking of local activity to national/regional communications as well as the system mental health campaign, focussing on discharge.
- Consistent media coverage, partner communications, granular operational communications combined with national marketing worked well.

Areas for Improvement:

- More proactive targeting of specific audiences and geographies could be done using social listening, insights and service data to enable communication via their preferred method, such as Instagram or WhatsApp.
- More could be done to make the messaging more diverse to reach people in their first / preferred language, which may not be English.
- Targeting working aged adults around getting repeat prescriptions in time for bank holidays, or when an A&E is busy and highlighting alternative services.

2.3 Workstream Pillars: Pillar 2 - Same Day Urgent Care

The objective of the Same Day Urgent Care programme was to ensure patients received rapid access to the service which best met their needs. The approach focused on 4 key areas:

- Improving access to same day non urgent services
- Improving ED flow
- Improving access to community physical and mental health services
- Increasing redirection across Urgent and Emergency Care (UEC)/Out of Hospital (OOH) pathways

Notable achievements:

<u>Unscheduled Care Navigation Hubs (UCNHs)</u>

- Two UCNH pilots were developed at pace between July and December 2024 – with support from SECAmb, UHSx, SCFT and ESHT – in Brighton & Hove and East Sussex. The hubs are located at SECAmb's Brighton and Polegate Make Ready Centres, respectively.
- The aim of the UCNHs are to reduce ambulance callouts and conveyances to our

local EDs by reviewing patients awaiting a category 3 or 4 ambulance response both pre and post-dispatch; and referring them to alternative acute, community, primary, mental health and voluntary-based admission avoidance services.

- The Sussex UCNHs are staffed by a multidisciplinary team (MDT) of senior clinicians from acute, ambulance and community NHS Trusts operating together either virtually, or in the same room. The knowledge and trusted assessor status each clinician has of their own services and pathways enables the UCNH to access alternative services far more effectively and efficiently than paramedic crews have traditionally been able to do themselves.
- In the case of the Brighton Hub, this includes either an ED or Frailty Consultant from UHSx and a virtual link into a GP located in SCFT's OneCall. SCFT also provides periodic on-site support via a Urgent Community Response (UCR) Advanced Care Practitioner (ACP).

-
- Between 4th December 2024 and 30th April 2025, The Brighton Hub had 1,100 discussions with patients resulting in 824 patients who would have been conveyed to ED receiving another outcome. These outcomes included a See and Treat from the crews on scene (using the hub's additional clinical knowledge); a referral to UCR or Virtual Ward; a conveyance to a non-ED service like SDEC; a GP referral; or, for mental health patients, a referral to the Blue Light Line. The majority of the other patients were conveyed to ED, due to their high acuity, but the hub was able to contact ED ahead of time to ensure they were medically expected, speeding up their journey through ED.
- Analysis of the Brighton Hub suggests that of these 824 patients, 38%, or 313, would have been admitted for an average of 9.3 days, increasing their risk of decompensation, costing UHSx 2,911 additional bed days, and increasing the need for Pathway 1 discharge support from UCR.
- The Brighton hub has therefore helped reduced conveyances to ED, improved patient flow, improved patient experience and outcomes, and improved SECAmb's category 1 and 2 response times by freeing up their crews to attend additional patients. It is also estimated that the hub has saved the system more than £560k over 5 months.
- This has helped to improve flow and increase redirection of patients across Urgent and Emergency Care (UEC) / Out of Hospital (OOH) pathways.

- Strengthened links between Urgent Treatment Centres (UTCs) and Primary Care
- Increased awareness and use of Same Day Emergency Care (SDEC) as an alternative to admission
- NHS111 patient satisfaction improved during winter, which correlated to response times improving.
- Virtual Ward (VW) capacity increased to over the 250-bed target
- 300 additional referrals from primary care into VW, with 80% of VW beds utilised, which avoided patient admission to hospital.

Areas for improvement:

- Variation in UTC models across sites led to inconsistencies in patient experience
- Workforce challenges affected GP availability at some UTC sites
- Clearer governance structures needed to ensure SDEC spaces are used as intended
- Agree clinical pathways for palliative care in VWs
- Improve Acute hospital referrals to VWs
- Expansion of Unscheduled Care Hub into West Sussex and weekend operation.

2.4 Workstream Pillars: Pillar 3 – Improvement in discharge to support patient flow

34. The objective of Pillar 3 was to reduce the number of patients who reside in acute, community and mental health beds to improve patient experience, outcomes and system flow.

Notable achievements:

- A reduction from 22.3% to 20.7% in the number of NCTR and Clinically Ready for Discharge (CRD) patients in the Sussex system during the pre-Christmas and New year period.
- System coalesced around an agreed plan
- Sustained reduction through to the end of Q4 in relation to mental health CRD patient numbers
- SAFER bundle implemented. SAFER is a tool used to reduce delays for patients in adult inpatient wards (excluding maternity). The SAFER bundle blends five elements of best practice: **S**enior Review of **A**ll patients, **F**low, **E**arly Discharge and **R**eview. When followed consistently, the length of stay reduces, and patient flow and safety improve.
- Therapy model supporting optimising mobilisation and independence in acute hospitals commenced.

Areas for improvement:

- Transfer of Care Hubs (TOCHs), which coordinate the discharge of patients waiting to leave hospital and who require post discharge support, were not fully optimised during the winter period as they were relatively early in their maturity.
- Some identified investment to improve capacity over winter was not fully utilised in a timely manner.
- Surge planning and discharge optimisation should be a rolling programme rather than only facilitated over winter.
- Embed surge planning into overall site improvement planning and system improvement plans

- Ensure site focussed improvement planning is at the heart of delivery
- Build on impact reviews of historical investment
- Ensure there is capacity flexibility across the system to be immediately responsive.

2.5 Workstream Pillars: Pillar 4 – Sound Operational Management

35. The objective of Pillar 4 was to ensure that we had robust operational management in place with clear coordination across the system and routes for escalation where required.

Notable achievements:

- The System Coordination Centre (SCC) function to improve patient care was achieved in line with the SCC Operational Specification and acted as the single point of access with NHS England – South East region enabling timely cascades of information both into and out of the system.
- The Winter Operating Model was effective in ensuring that system partners came together regularly to discuss emerging issues and escalate where necessary.
- Daily Situational Reports to NHS Sussex Chiefs enabled top level oversight throughout the winter and rapid intervention where necessary.

Areas for improvement:

- The Systemwide Business Continuity Incident (BCI) Process in relation to system pressures was tested during the peak of system demand in January and several key lessons were identified. This document has now been updated to include recommendations agreed at the subsequent debrief and incorporate the new OPEL framework triggers.
- Implementation of a debriefing process to be used following OPEL 4 declarations.

2.6 Workstream Pillars: Pillar 5 – Governance, Oversight and Escalation

36. The objective for Pillar 5 was to ensure that we had a robust approach to cover delivery of the winter plan, with clear routes for escalation where issues are encountered.

Notable Achievements:

- The ICS was the first in the country to implement and roll out the new OPEL 24/26 framework.

- Winter Plan progress updates were provided to relevant governance forums throughout the winter period.

Areas for Improvement:

- Look at the frequency of and approval routes for reporting to the ICB governance groups to provide assurance, to improve efficiency and effectiveness of reporting.
- Review the plan with the SCC stakeholders more frequently throughout the course of the Winter Plan period.

2.7 The Reset Event

37. The Reset Event ran for four weeks from 19th December 2024 to 15th January 2025 (with a break for the Christmas week). The purpose of the event was to bring together providers of Health and Care to agree and undertake rapid improvement actions to support patient flow during this period of peak pressures.

38. The event concentrated on the efforts to prepare and recover from operational pressures which typically arise over the Christmas period. Eight interventions were grouped into five workstreams with an objective to reduce the bed occupancy to 93% by 24th December and then to reset the occupancy position in the beginning of January 2025. The objective was to maintain patient flow during this period so that those individuals requiring rapid access to emergency care and in particular, and emergency admission, could receive care and treatment in a timely manner.

39. Each workstream had dedicated leadership from the ICB with an executive Senior Responsible Officer (SRO) and MDT from the system to drive the operational and clinical expectations. Each provider nominated leads to drive the interventions within their own organisations.

Notable Achievements:

- Good engagement at an executive level via twice weekly panels, which supported focussed working on key issues
- Choice Policy agenda promoted to ensure early discharge planning and that patients were aware of their planned onward journey in a timely fashion
- Positive coordination from communications teams
- Clinically led focus on specific areas in acute settings
- Increased flexibility in criteria (SCFT/SPFT)
- Delivery of sub 92% bed occupancy on 26th of December which created sufficient capacity to manage patient flow over the Christmas and new year period, avoiding the system needing to declare a major incident, which was observed in a number of other parts of the country.

Areas for improvement:

- Early engagement with stakeholders to agree and formalise the process in

advance of initiation of reset event.

2.8 Winter Plan Survey

40. The Winter Plan survey was conducted between 8th and 23rd April 2025. This went out to all system partners as a precursor to the Winter Plan debrief session in order to give people the opportunity to feedback their observations of the effectiveness of the plan. 21 responses were received from across our system partners, which is an increase on previous years.

Notable findings:

- The average score for the effectiveness of the plan was 6.26 out of a possible 10.
- The key areas of focus or pillars where respondents observed the greatest impact were 'communications and engagement' and 'improvement to discharge and flow'.
- The key areas of focus or pillars where respondents observed the least impact were 'the vaccination programme' and 'governance and oversight'.
- The average score for implementing the Winter Plan within their team / services was 6.70 out of 10.
- The greatest barriers to implementation of the plan were identified as 'operational pressures' and 'workforce challenges'

Improvement Suggestions:

- More involvement from digital colleagues.
- Review the meeting cadence or consider move to one daily touchpoint meeting to reduce the burden on colleagues across the system.
- Stand up a Winter Plan Forum attended by all system partners to start the planning process earlier in the year
- Greater cooperation between providers
- Include more about Neighbourhood Care.

2.10 Winter Plan Debrief

41. The Winter Plan Review and Evaluation Debrief was held on 30th April 2025 with representation from system partners and ICB workstream leads.

42. Representatives agreed that the plan had identified the main risks to the system during the winter and anticipated activity was as expected in the most part. One exception was that of an increased demand for acute and community beds caused by Flu and respiratory diseases which were higher than anticipated in January and February of 2025.

What went well

- The winter operating model was effective in bringing together system partners in times of pressure and felt responsive and supportive. Implementation of the new OPEL framework and use of the SHREWD data platform enabled 'live' system situational awareness for all partners.
- The roll out of the Unscheduled Care Hubs and the increase in virtual ward capacity were notable achievements.

Areas for Improvement:

- The cohort for patients eligible for vaccinations was changed with late notice
- Increase the uptake of vaccination amongst healthcare workers.
- The quality of care provided to patients who were cared for in temporary escalation spaces should be reviewed.
- There was little improvement in the ability of the system to discharge patients who no longer needed to be in hospital (NCTRs).

Recommendations for Improvement:

- Create a common set of triggers for escalation based on the new OPEL framework.
- Improve NCTR numbers.
- Work to eradicate patients being cared for in temporary escalation spaces.
- Improve awareness of respiratory diseases and expected impact for modelling.
- Move to an annual or continual surge plan based on agreed triggers.
- Review the winter operating model meeting cadence to avoid duplication.

3 CONCLUSION

43. Although the Sussex health and social care system faced a challenging winter, it performed strongly against national benchmarks, particularly in relation to the four-hour A&E targets and Ambulance Cat 2 response times (see tables in Section 2). However, the mitigations put in place to, discharge patients who no longer met the criteria to reside, reduce average lengths of stay, and 12 hour waits in A&E, did not have the level of anticipated impact.

44. In line with previous winters, some patients were cared for in temporary escalation spaces and waited too long in our emergency departments for admission and this will be a critical area of focus for our Winter Plan in 2025/26.

The surge in demand due to flu and Covid in the weeks following Christmas and the New Year created further operational pressures. Improving vaccination rates will be another critical area of focus for our Winter plan in 2025/26.

45. A full and comprehensive review of the Winter Plan has been carried out, and key

lessons have been identified. These will be used to inform future planning.

46. Planning for Winter 2025/26 will commence in June 2025.

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item

Subject: **Update on changes to city acute in-patient dementia bed provision**

Date of meeting: **09 July 2025**

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

Contact Officer: **Name: Giles Rossington, Scrutiny Manager**

Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: (All Wards);

Key Decision: No

For general release

1. Purpose of the report and policy context

1.1 In September 2024, the HOSC considered Sussex Partnership NHS Foundation Trust (SPFT) plans to reconfigure its acute in-patient mental health beds within the city. The plans included closing 10 acute in-patient dementia beds at Mill View Hospital; reconfiguring the space to provide an additional 15 acute mental health beds; and enhancing East Sussex community dementia services.

1.2 At the September 2024 meeting, HOSC members requested an update on implementation of these changes at a subsequent meeting, to specifically include the experiences of staff and carers and an assessment of any impact of the changes on social care or on the residential care sector. SPFT will present on these issues at the HOSC meeting.

2. Recommendations

2.1 That Health Overview & Scrutiny Committee note the contents of this report.

3. Context and background information

3.1 Sussex Partnership NHS Foundation Trust (SPFT) provides mental health services across Sussex, operating in both community and acute settings. The majority of SPFT services are commissioned by the Sussex Integrated Care Board (ICB). SPFT and the ICB identified an opportunity to improve access to acute mental health care for the City's population and to make financial efficiencies by reconfiguring Trust acute in-patient beds at Mill View Hospital (MVH) in Hangleton.

3.2 Brunswick Ward at MVH was a 10 bed mixed gender unit providing specialist in-patient dementia care. Demand for beds at Brunswick from Brighton & Hove residents was historically very low and the majority of patients supported there were typically East or West Sussex residents. Brighton & Hove, with a young population coupled with robust community dementia services, typically has low levels of demand for acute dementia beds, but very high demand for adult acute mental health beds. In contrast, there is higher demand for dementia services in East and West Sussex, reflecting their older demographics.

3.3 SPFT's plan was to close Brunswick Ward, re-purposing the space as a 15 bed acute mental health ward using capital funding secured via NHS England - with a focus on improvements within the urgent care pathway. City residents requiring dementia beds would be admitted to specialist dementia inpatient provision at Trust provision in Worthing or Uckfield. There would also be investment in East Sussex community dementia services, with a focus on improving services which reduce acute admissions.

3.4 Brunswick Ward has now been closed, and the space has been re-purposed to provide a female acute mental health space, Palmeira Ward, which opened in May 2025. More information on implementation of the change plans and on the emerging data from the new services will be provided by SPFT at the HOSC meeting.

4. Analysis and consideration of alternative options

4.1 Not relevant to this report for information.

5. Community engagement and consultation

5.1 None directly for this information report.

6. Financial implications

6.1 No direct financial implications from this information report.

Name of finance officer consulted: I . Chagonda Date consulted (30/06/25):

7. Legal implications

7.1 No legal implications have been identified in this Report, which is for noting only.

Name of lawyer consulted: Victoria Simpson Date consulted 30.06.25

8. Equalities implications

8.1 As this is a report for information rather than decision there are no implications to report.

9. Sustainability implications

9.1 As this is a report for information rather than decision there are no implications to report.

10. Health and Wellbeing Implications:

10.1 As this is a report for information rather than decision there are no implications to report.

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 Sussex Partnership NHS Foundation Trust's information updating the committee on the implementation of plans to reconfigure city acute mental health beds (originally considered by the HOSC in September 2024).