Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date:	**19 November 2025**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:**Wilkinson (Chair), Evans (Deputy Chair), Hill, Hogan, Lademacher, Mackey, Oliveira, O'Quinn, Parrott and Simon **Co-optees** Nora Mzaoui (CVS), Mary Davies (Older People's Council) and Geoffrey Bowden (Healthwatch)
Contact:	**Giles Rossington** Scrutiny Manager 01273 295514 giles.rossington@brighton-hove.gov.uk

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AGENDA

PART ONE **Page**

9 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.

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10 MINUTES 7 - 22

To consider the minutes of (i) the previous Health Overview & Scrutiny Committee meeting held on 09 July 2025; and (ii) the special Health Overview & Scrutiny Committee meeting held on 26 September 2025 (copy attached).

11 CHAIR'S COMMUNICATIONS

12 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 13th November 2025.
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 6th November 2025.

13 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(a) **Petitions:** To receive any petitions submitted to the full Council or to the meeting itself.
(b) **Written Questions:** A list of written questions submitted by Members has been included in the agenda papers (copy attached).
(c) **Letters:** To consider any letters submitted by Members.
(d) **Notices of Motion:** To consider any Notices of Motion.

14 SUSSEX WINTER PLANNING 2025-26 — 23 - 84

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

15 CANCER DIAGNOSIS AND TREATMENT — 85 - 108

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

16 NHS CHANGE — 109 - 114

Standing Item – Update from NHS Sussex Integrated Care Board on recent and upcoming changes to local NHS services (copy attached).

17 NHS OVERSIGHT FRAMEWORK 2025-26: UPDATE FROM SUSSEX PARTNERSHIP NHS FOUNDATION TRUST — To Follow

(to follow)

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

18 CHALKHILL TEMPORARY CLOSURE — 115 - 124

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

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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

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Date of Publication - Tuesday, 11 November 2025

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 9 JULY 2025

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Wilkinson (Chair)

Also in attendance: Councillor Evans (Deputy Chair), Cattell, Hill, Parrott, Simon, Guilmant and Asaduzzaman

Other Members present: Nora Mzaoui (CVS), Geoffrey Bowden (Healthwatch), Mo Marsh (Older People's Council)

PART ONE

1 PROCEDURAL BUSINESS

1(a) Declaration of Substitutes

- Cllr Asaduzzaman attended as substitute for Cllr O'Quinn
- Cllr Guilmont attended as substitute for Cllr Mackey
- Apologies were received from Cllr De Oliveira and Cllr Hogan.

1(b) Declaration of Interests

1.2 There were none.

1(c) Exclusion of the Press & Public

1.3 RESOLVED – that the press & public be not excluded from the meeting.

2 MINUTES

2.1 The minutes from the 08 April 2025 meeting were agreed as an accurate record.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

This is the first meeting of the HOSC since our May Annual Council meeting and my first meeting as Chair. I'd like to express my thanks for all the work done by the previous Chair,

Theresa Fowler. Some committee members have changed also, and I would like to welcome Sam Parrott and Jacqui Simon to the committee.

We have 3 items for discussion today:

The HOSC had a report in November 2024 on what the Sussex health and care system planned to do to manage additional demand across winter 24-25. Partners have come back to committee today to update members on how the system coped and what lessons have been learnt for future years.

In September 2024, the HOSC held a special meeting to look at Sussex Partnership Trust plans to close its specialist in-patient dementia ward at Mill View hospital, re-purposing the space as an acute mental health ward. The Trust is returning to HOSC today to provide an update on how these plans are progressing.

We also have a report on children & young people mental health services. I know that this is an issue that is of concern to HOSC members and to many families across the city. Young people's mental health is also a Sussex and a Brighton & Hove priority for improvement, so I think it is important that the HOSC has opportunities to hold partners to account for their performance and to learn about improvement planning.

In addition, there has been lots of recent national activity in the NHS which will have local implications. There is a letter from Cllr Hill about changes to Integrated Care Boards on the agenda today. We have also had the publication of the NHS 10 year plan. I will ask for members to be briefed on this important strategic document.

Some of you may already have seen that Dr George Findlay, CEO of University Hospitals Sussex NHS Foundation Trust has just announced that he will be stepping down as Trust Chief Executive. I'd like to take the opportunity to thank George for his engagement with the HOSC; he has consistently found the time in his incredibly busy schedule to attend HOSC meetings and to answer our many questions with patience and good humour.

We have also recently learnt that it is likely that both Healthwatch England and local Healthwatch organisations may be abolished. This is concerning news. Healthwatch Brighton & Hove provides really important services locally, ensuring that local people have up to date information about health and care services, sharing people's experiences of services with commissioners and providers, and supporting individuals to navigate their way through a very complex landscape. I know that members of this committee, as well as many other local individuals and organisations, feel very strongly about the abolition of Healthwatch. If members feel it would be helpful for me to write to the Secretary of State on behalf of the committee, I would be happy to do so and will ask support officers to coordinate something.

Finally, I know that many people are worried about the tender process for primary care services for people living in Whitehawk. These services have been provided by Wellsbourne Healthcare Centre, but the contract is currently being re-tendered.

This is a live tender process, and there are legal restrictions which mean that the commissioners and the potential providers of the service are currently unable to discuss details of the contract or the tender in public. This is frustrating, as I know people have questions that need to be answered, but I recognise that the legal position is clear.

I will nonetheless consider whether there is anything that the HOSC can do in the short term – I'm conscious that if we wait until commissioners are able to talk to us, the contract will have been awarded and it will be too late to make concerns known.

4 PUBLIC INVOLVEMENT

4.1 There were no public questions.

5 MEMBER INVOLVEMENT

5.1 Cllr Hill presented a member letter:

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.

5.2 The Chair responded:

I do agree that these are important issues, and I am happy to invite NHS Colleagues to explain the proposed changes at the next HOSC meeting. I will also ask for this to include a brief explanation of the NHS 10 Year Plan and what this may mean for local people's healthcare.

I would also like to note that all members of Brighton Council Overview & Scrutiny committees should have recently received an invitation to a special scrutiny meeting on 31 July to talk about devolution and local government reorganisation with the Leader of the Council. How the emerging new model of local government in Sussex aligns with changing NHS organisational structures is certainly something we can discuss at this meeting.

6 WINTER PERFORMANCE 2024-25

6.1 This item was presented by Nicki Smith, Director of Emergency Preparedness, Resilience & Response; Tanya Brown-Griffith, Director for Joint Commissioning and Service Integration, Brighton & Hove; and Dr Andy Hodson, Deputy Chief Medical Officer, Sussex Integrated Care Board (ICB). Steve Hook, BHCC Director of Adult Social Services; John Child, Chief Operating Officer, Sussex Partnership NHS Foundation Trust were also in attendance.

6.2 Ms Smith told the committee that the health & care system had generally performed well across winter 2024-25. Specific successes included:

- Category 2 ambulance response times
- Covid vaccination rates for health and care staff
- Unscheduled Care Hubs at Brighton and Polegate providing specialist support to ambulance paramedics
- Virtual wards (with more than 80% of 'beds' utilised)
- Cohort Identification programme – working with GPs to identify and support people at the highest risk of hospital admission
- Escalation Framework – this was implemented ahead of time and worked well.

6.3 Areas of focus for future planning include:

- Hospital discharge
- Long length of stay in hospital beds
- Improving performance against the 4 hour A&E target
- Increasing awareness of respiratory disease
- Better staff uptake of flu vaccination
- Better targeting of communications at specific 'at risk' audiences or communities.

6.4 Ms Brown-Griffith spoke about the local actions over last winter including 30 out of 31 GP Practices signed up to the locally commissioning identification of people most of risk of admission and supporting in community. In addition, Integrated Community Teams have been busy delivering prevention actions at a neighbourhood level including Community Health check days and a physical health hub in the East of City. Going forward it would be helpful if the NHS works closely with the Council and specifically with councillors to maximise messaging about take-up of the Flu vaccine, screening and NHS Health Checks ahead of Winter 25/26.

6.5 Members asked questions about issues including: vaccination rates for healthcare workers; delays in discharge from hospital beds; people attending A&E with non-emergency mental health problems; support for the digitally excluded; and measures to enhance staff wellbeing.

6.6 RESOLVED – that the report be noted.

7 CHILDREN & YOUNG PEOPLE MENTAL HEALTH SERVICES

7.1 This item was presented by John Child, Chief Operating Officer; and Anna Moriarty, Associate Clinical Director for CAMHS, Sussex Partnership NHS Foundation Trust. Also in attendance were Claudia Griffith, NHS Sussex Chief Delivery & Strategy Officer; Lizzie Izzard, NHS Sussex Head of Children & Young People Mental Health Commissioning; and Emma Sharpe, the council's Schools Mental Health Lead.

7.2 Ms Griffith outlined the structure of children & young people mental health services, and the roles played by NHS providers, the local authority and schools in delivering services. Ms Griffith told the committee that:

- There have been recent improvements in waiting times for wellbeing services
- Waiting times for CAMHS (child & adolescent mental health services) remain high but are falling
- There has been a significant increase in demand for neurodevelopmental CAMHS in recent years, and there are long waits for assessment. Services acknowledge the negative impacts of these waits on young people and their families
- Transition from young people's services to adult services is recognised as of key importance
- Services recognise the key role that service user experiences can have in service transformation
- Improvement priorities include early intervention, better crisis services and the development of improved pathways for neurodevelopmental CAMHS.

7.3 Members asked questions about issues including: waiting times for young people in care; workforce capacity; referrals for eating disorders; support for young people who are waiting for assessment; involvement of young people in service planning; transition planning; support for parents; pilot work on ADHD and autism pathways; and gender dysphoria.

7.4 John Child agreed to share additional data with the committee on eating disorder services. Claudia Griffith suggested that the committee might consider a future item focusing on eating disorders/healthy weight, to be jointly presented by NHS and council Public Health services.

7.5 RESOLVED – that the report be noted.

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

8.1 This item was presented by John Child, Chief Operating Officer; and by Laura Murphy, Divisional Director of Nursing & Quality, Sussex Partnership NHS Foundation Trust (SPFT).

8.2 Mr Child explained the rationale for closing inpatient acute mental health beds in Brighton & Hove, telling the committee that city demographics meant that the bed space was better used for acute mental health beds, with dementia bed needs to be met by units in Uckfield and Worthing and by investment in community services. Mr Child told members that:

- Brunswick Ward (Mill View) had closed on October 2024
- Palmeira Ward opened in May 2025
- Drop-in sessions were held for families and carers potentially impacted by the move of dementia beds. There has been regular contact with families throughout the process
- Family concerns about additional travel are acknowledged and there has been work undertaken to ensure that travel support options are well signposted
- Affected staff have been kept informed throughout as have the relevant Trade Unions. Most staff have opted to continue working at Mill View
- Work is ongoing to strengthen community dementia services across East Sussex, with an emphasis on admission avoidance
- Since the changes have taken place, average length of stay in acute inpatient dementia beds has reduced

- Since the changes have taken place, social workers have reported increased travel times
- Delays in discharge remain a major problem across acute mental health care. The average wait for discharge from acute dementia beds to residential care is around 20 days.

8.3 Members asked questions about issues including: virtual mental health wards; health inequalities; care for people with dementia on general wards; respite services for carers; delays in sharing the Quality Impact Assessment on the changes with the committee; trauma-informed practice; and preventative approaches to dementia care.

8.4 RESOLVED – that the report be noted.

The meeting concluded at 6.22pm

Signed Chair

Dated this day of

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

2.00pm 26 SEPTEMBER 2025

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Wilkinson (Chair)

Also in attendance: Councillor Evans (Deputy Chair), Hill, Hogan, Mackey, Oliveira, Parrott and Simon

Other Members present: Geoffrey Bowden (Healthwatch), Mo Marsh (Older People's Council)

PART ONE

9 PROCEDURAL BUSINESS

9.1 No members attended as substitutes. Cllrs O'Quinn and Cattell and Nora Mzaoui sent apologies.

9.2 Geoffrey Bowden (Healthwatch Brighton & Hove) declared a personal interest as Healthwatch had been involved in evaluation of the bids for the Whitehawk APMS contract.

9.3 RESOLVED – that the press & public be not excluded from the meeting.

10 CHAIR'S COMMUNICATIONS

10.1 The Chair gave the following communications:

This is a special meeting to look at issues relating to the procurement of a new GP contract for Whitehawk. As members will be aware, there has been lots of concern voiced about the way in which this tender has been conducted from people living in East Brighton, local Councillors, community groups and the MP for Brighton Kemptown. I have also been contacted by members of the HOSC requesting scrutiny of this issue.

Reflecting this interest, we have some public questions today. These are very welcome, and I hope that we'll be able to get answers to at least some of the questions posed later in today's meeting. If that's not possible, I will ensure that we continue to explore these issues until all these questions are answered. I've also had representations from Councillors who don't sit on this committee but who do represent Whitehawk and adjoining areas who are keen to take part in today's meeting. I've invited these

members to join today's teams call – they are welcome to ask questions as guests of the committee.

It's clear that there have been problems with this procurement. This is evident from the advisory report of the Independent Patient Choice & Procurement Panel, which is included in the papers for this meeting. I'm keen to learn what went wrong and what can be improved, not just in terms of the formal tender process, but also in terms of community and stakeholder engagement before the tender started.

It's important to note that the ICB has commissioned an external review of the procurement process, which is due to report this autumn. This external review is welcome, not least because it may consider matters not considered in the Patient Choice & Procurement Panel report. This is because Panels are only able to respond to specific issues raised by bidders and can only focus on potential breaches of NHS procurement rules. To be clear about the decision to consider this item today: we could have delayed scrutiny until this report is published. However, there is so much community concern about this issue that I thought it was essential to meet as soon as possible. The committee can always revisit this matter when the external review has been published.

In consequence, I have asked NHS Sussex Integrated Care Board who are responsible for commissioning local GP services to attend this special meeting, and I'm grateful that we have the ICB's Chief Executive, Adam Doyle, and Chief Integration and Primary Care Officer, Amy Galea, here today as well as Lola Banjoko, the ICB Deputy Chief Integration and Primary Care Officer. Adam has unavoidable commitments later today and will have to leave the meeting if it runs past 3:30, but Amy and Lola Banjoko will be able to stay on if required.

There are a couple of potential constraints on our discussion today. Firstly, we need to be mindful that the ICB has commissioned an external review of the procurement and that that review is still underway. The ICB representatives will not be able to make any statements or comments in public which they consider could potentially influence or prejudge the review's findings. Secondly, there are significant elements of any tender process that must be treated as confidential because they include commercially sensitive information, including about the providers who have submitted bids. This is a real concern, which is also relevant to the outcome of this much-needed procurement.

We do have the facility to go into confidential session today and – given the nature of the subject matter – I will keep under review whether it is necessary to do so. However, because this is an issue of such community concern, I do want to discuss as much as we can in public. This may mean that we have to keep discussion fairly high level and won't be able to dive into details as much as we'd like to. We don't want to come in and out of confidential session, so I will take as much as I can in public before going into Part 2 session if we need to.

I think it may be helpful to set out the areas that I think we should be able to cover, at least in part, in public session today.

Firstly, the committee will want to enquire as to why the decision was made to go to competitive tender for this contract. Even when everything runs smoothly, competitive

tender is an expensive and potentially disruptive process, and we will have questions about the rationale for, and the costs involved in this decision.

Secondly, we will want to hear what engagement prior to the formal tender process was undertaken with patients, local residents and community organisations, and whether this was a sufficiently robust process.

Thirdly, Whitehawk is not a typical area of our city: there are really high levels of deprivation there, but also a real community spirit and lots of community organisations that play a vital role. The committee will want to know what account was taken by NHS Commissioners of the special nature of Whitehawk and how this was reflected in thinking about the contract. For instance, how was social value factored into the design of the new contract?

Fourthly, the Independent Patient Choice & Procurement Panel has already published its review – this is included as Appendix 1 to the committee report. However, we've recently been informed that NHS Sussex has also commissioned an independent review of the tender. We'll have questions about why this second review is required, who is leading it, whether it will consider all the issues identified by the panel review, when it is expected to report, and whether the report will be made public.

There is clearly public concern about the way that the formal tender process, and in particular the evaluation of bids, was conducted. This is an important area of enquiry. However, there are some real issues of commercial confidentiality here, and I'm not sure we're likely to get very far in terms of discussing these details in public session and in advance of the NHS Sussex-commissioned review reporting. We may be better advised to wait until the review has concluded if that means that we can scrutinise issues in public session at a later meeting.

11 PUBLIC INVOLVEMENT

11(a) Public Question from Mr William Barry

11.1 Mr Barry asked the following question:

My name is William Barry I'm a 70 year old veteran and I am a longstanding patient at the Wellsbourne centre, and have been so happy with the services I have received there, that I chose to remain even when I moved out of area, rather than switch to my nearest GP service. I have been outraged at the way the procurement process has played out, not least because there didn't seem to be any consultation process to speak of, no one seemed to care what the patients think, and I have written previously to councillors and to the Health Secretary Wes Streeting to express my dismay and anger!

I understand from campaigners that the procurement was judged by an NHS England panel to be deeply flawed, and has therefore been at least paused. I would like to be reassured that this pause will turn into a complete halt, and that we will be able to keep our fantastic GP service exactly as it is. Whitehawk has had such problems with GP provision for in the past, when the figures show that health inequalities persist at such a high level in our city, why would we risk swapping such a successful community interest service for a 'for profit' provider!?

11.2 It was agreed that a written response to this question would be provided. The following response from NHS Sussex Integrated Care Board was subsequently shared with Mr Barry:

Thank you for sharing your feedback on the services you have been receiving from Wellsbourne Healthcare CIC. We can share that we regularly review patient satisfaction alongside performance data, and this was taken into account with the development of the new seven year contract. The new contract was designed to set clear outcomes expected from a provider to address health inequalities in the Whitehawk area, alongside the high quality primary medical services that a provider would be expected to deliver.

NHS Sussex undertook the procurement in line with the Provider Selection Regime 2023 (PSR 2023) after initial discussions with the current provider could not agree a position, and then after an understanding of the market after the recent procurement for a new contract for the Brighton Station Health Centre.

On 24 July, the ICB made a decision to stop the procurement for this new contract for GP services in the Whitehawk area of Brighton and Hove and we are considering how we can best ensure high quality services for the local population for the future. A key part of this is the independent review that we have commissioned and we will consider the next steps after the conclusion of this.

Separately, we have agreed a contract extension with Wellsbourne Healthcare CIC to continue providing services for the next 12 months. NHS Sussex has responsibility to ensure access to primary medical services for the Whitehawk population, and this extension ensures uninterrupted patient care while we commission the independent review and determine next steps.

In developing our next steps to this, we will reconsider how best to engage with the local community, specifically those registered with the practice.

11(b) Public Question from Mr James Joughin

11.3 Mr Joughin asked the following question:

Polly Toynbee's article in The Guardian suggests that the tender process for Wellsbourne Healthcare was unnecessary and that all the subsequent confusion could've been avoided. Can we be told what the costs to the system have been? That is, the extra costs for the ICB in running the tender and evaluating the proposals and running three internal appeals, extra costs for the existing practice in preparing its proposal and then defending itself from all the fallout, staff lost amidst the uncertainty, even meetings like this having to be called?

Can we hope that the perverse outcome that shocked patients and the community will give the ICB second thoughts before they embark on the next phase of this process?

11.4 It was agreed that a written response to this question would be provided. The following response from NHS Sussex Integrated Care Board was subsequently shared with Mr Joughlin:

> We are sorry for your concerns about the process.
>
> NHS Sussex undertook the procurement in line with the Provider Selection Regime 2023 (PSR 2023) after initial discussions with the current provider could not agree a position, and then after an understanding of the market after the recent procurement for a new contract for the Brighton Station Health Centre. The new contract set clear outcomes expected from a provider to address health inequalities in the Whitehawk area. Through robust contract monitoring our responsibility would have been to ensure that this was delivered, as well as access to high quality primary medical services.
> In terms of cost, procurement processes are part of ICB core business. We did not bring in any additional resource or incur additional costs to run the process to date. Any future procurement will also be delivered by ICB teams.
>
> Additional costs have only been incurred in relation to the independent review to date. The review has been commissioned by NHS Sussex to ensure transparency, accountability, and continual improvement in the procurement stage of the commissioning cycle. The findings will help inform future procurement activity and offer actionable insights and learning opportunities for staff within NHS Sussex.

12 MEMBER INVOLVEMENT

12.1 There was no formal member involvement. However, the Chair noted that he had been approached by Cllr Williams and Cllr Fishleigh, both asking to ask questions of NHS partners. The Chair agreed that the members should attend the committee is guests so they could put their questions directly to NHS Sussex Integrated Care Board.

13 WHITEHAWK ALTERNATIVE PROVIDER MEDICAL SERVICES (APMS) CONTRACT

13.1 This item was presented by Adam Doyle, Chief Executive; and by Amy Galea, Chief Integration and Primary Care Officer, NHS Sussex Integrated Care Board (ICB). Lola Banjoko, ICB Deputy Chief Integration and Primary Care Officer, was also in attendance.

13.2 Mr Doyle told members that, some years ago, there had been a good deal of fragility in the Brighton & Hove primary care system. In response to this, commissioners had instituted 3 Alternative Provider Medical Services (APMS) contracts, at Arch GP practice, Brighton Station, and at Whitehawk. APMS contracts do require regular review to ensure that they continue to deliver value for money and a quality service in terms of both the primary care map for Brighton & Hove and for Sussex as a whole. The Brighton practices are the only practices in Sussex holding APMS contracts.

13.3 Amy Galea told the committee that the Whitehawk APMS contract includes a standard NHS general practice contract element plus a deprivation premium. The current Whitehawk contract was let in April 2018 for a period of 5 years. The contract has been under review for some time, and in April 2023 was extended for an additional year to

give more time to agree future arrangements. As part of discussions, the current provider, Wellsbourne Health Community Interest Company (Wellsbourne), was offered a new contract but declined to accept this within the funding envelope available. Subsequently, the ICB published a Prior Information Notice (PIN) indicating to the market that it was minded to proceed to tender at a stated value. There was market interest in this, and the ICB began the tender process.

13.4 The tender process was paused when it became evident that there was a discrepancy between the contract value and the current staffing costs submitted by Wellsbourne. During the pause, all bidders were made aware of the potential for the contract to generate income in additional to the core contract value, via Quality Outcome Framework (QOF) and Locally Commissioned Services (LCS) payments.

13.5 The tender process was resumed, and in March 2025 the ICB announced its intention to award the contract to a different provider. Wellsbourne challenged this decision on 2 occasions, citing perceived flaws in the procurement process. After the ICB reiterated its intention to award, Wellsbourne asked for review by the Independent Patient Choice and Procurement Panel (the panel). This was agreed, and the panel investigated Wellsbourne's complaints, publishing its advisory report in July. The panel report's main recommendation was that the ICB should suspend the tender and re-start it from the Invitation To Tender (ITT) stage. The ICB has subsequently announced that it will commission a wide-ranging external review of the tender process. The ICB has also extended the current APMS contract by an additional 12 months.

13.6 Mr Doyle told members that the review report will be published, potentially with some redactions of commercially sensitive information. The report will initially be presented to the ICB's Audit Committee and will also be shared with NHS England. The review will include all aspects of the tender process, including all the issues highlighted by the panel report. It will also look at engagement. Once the report has been published, the ICB will need to consider its next steps.

13.7 The Chair asked why there wasn't more exploration of a direct award to the current provider, particularly given how deeply embedded Wellsbourne is in the local community. Ms Galea responded that it was not possible to go into detail about the ICB's conversations with Wellsbourne. However, the ICB does have a duty to provide value for money, and it should be noted that there was interest from the market in the contract at its advertised value.

13.8 The Chair asked whether a direct award was still a potential outcome here? Mr Doyle replied that he did not wish to pre-empt the review findings. However, there will be a number of options open to the ICB and this includes direct award.

13.9 Cllr Evans noted that there has been lots of praise for the work that Wellsbourne has done, including in the past from the ICB. However, in a short period of time, a decision was made to go to competitive tender. It remains unclear what happened here. Mr Doyle acknowledged that Wellsbourne did very constructive work on the Integrated Community Team (ICT) programme, as did many localities across Sussex. Mr Doyle is seeking clarification on what occurred in terms of any offer of a direct award, but his current understanding is that Wellsbourne declined an offer because of the level of funding proposed.

13.10 Cllr Evans noted that the situation where APMS contracts are regularly reviewed, but General Medical Services (GMS) contracts are not, is unsatisfactory. The committee should consider lobbying for APMS to be brought in line with GMS in this respect to help provide stability.

13.11 Cllr De Oliveira asked for the timeline of the review. Mr Doyle replied that the review provider will be announced in the next week. The review is expected to take 10-12 weeks, with a report published in early 2026.

13.12 Cllr De Oliveira asked a question about the pre-tender engagement. Ms Galea replied that this was focused on an online survey asking people to recount their experiences of receiving services. The survey was open to everyone in the area, reflecting the fact that Wellsbourne provides services for local residents who are not necessarily registered at the practice. In addition to the online survey, there were 4 in-person meetings, plus specific engagement with local voluntary and community sector organisations. 56 survey responses were received. Cllr De Oliveira queried whether a digitally led approach to engagement was the best choice for Whitehawk where many people are digitally excluded. Mr Doyle responded by acknowledging that there has been some negative community feedback regarding engagement. The ICB will look very at what the review has to say on the engagement process, and will learn the appropriate lessons. Ms Galea added that it was important to recognise that the ICB regularly collects community feedback on the services it commissions: the data from the specific Whitehawk survey forms only part of the data it used to inform its thinking around the APMS contract.

13.13 Cllr Fishleigh (attending as a guest) asked whether it was possible to just abandon the tender. Mr Doyle replied that this was a possible outcome, but the ICB would need to be assured that this was the best course of action, and will need to wait for the review to report before making any decision about the future of the tender.

13.14 Cllr Fishleigh asked how patient satisfaction was assessed for other bidders to the contract. Mr Doyle replied that there was a process for capturing this information as part of the tender bid evaluation. The review will look at how robust this was.

13.15 Geoffrey Bowden (Healthwatch) explained the role that Healthwatch Brighton & Hove has played in the bid evaluation process. Ms Galea confirmed to the committee that the review will look closely at the processes adopted in terms of the evaluation of bids.

13.16 Cllr Hogan noted her disappointment that the review process had not yet begun. Mr Doyle acknowledged this but stressed that it was important that due process was followed. To be of value the review needs to be both rigorous and independent and these arrangements do take time to agree.

13.17 Cllr De Oliveira asked whether the review report would include extracts from the minutes of the bid evaluation meetings. Mr Doyle replied that he is committed to do everything possible to be transparent, but some material may be commercially sensitive.

13.18 Cllr Hill asked about reported statements made by Wellsbourne. Ms Galea replied that she was not in a position to speak for Wellsbourne. She noted that procurement rules do restrict what bidders for a contract can say in public.

13.19 Cllr Hill asked a question about some providers purportedly lacking access to details of Locally Commissioned Services. Ms Galea responded that there may not have been total clarity about this in the tender documents. However, the successful bidder for a contract of this type would be expected to have a good understanding of how to access information.

13.20 Cllr Hill asked about details of a question in the Invitation To Tender documents relating to bidders communicating with patients. Ms Galea replied that the ICB believe that they followed good practice here. However, the panel report has queried this, so this will be one of the areas that the review will focus on.

13.21 Cllr Evans noted that it is not uncommon for some larger bidders for contracts to be expert making pitches, but sometimes less expert at actually delivering services. Cllr Evans also noted that having only 56 responses to the online survey is disappointing when there are more than 8000 people on Wellsbourne's patient list.

13.22 Cllr Evans asked why there was the APMS contract has only a minimum weighting for social value. Mr Doyle responded that it is important to look at the contract weighting in the round: the social value element is low, there is a high rating for health inequalities which addresses similar issues. This is an area that the review will focus on.

13.23 Cllr De Oliveira asked whether the ICB would apologise to the local community for its mistakes in the tender. Mr Doyle replied that he was committed to ensuring that the investigation of the tender is both swift and thorough. This is important for local people. He would be happy to apologise for flaws in the tender process if the review requires this.

13.24 Cllr Simon commented on the poor response to the engagement survey and queried whether the ICB had involved community groups to assist with outreach and how many people had been involved in the in-person engagement sessions. She also asked what the data from the survey had been used for. Ms Galea responded that community groups had been involved and that the survey data was used to inform the contract specifications, for example in terms of the weighting in the contract for health inequalities. Ms Galea agreed to provide details of the number of people attending in-person sessions.

13.25 The Chair asked whether a full chronology of the tender process would be included in review report. Mr Doyle confirmed that it would be.

13.26 Cllr Mackey asked a question about whether the principles of the Marmot review had informed the contract specifications. Mr Doyle replied that the contract specification did indeed focus on health inequalities in line with Marmot principles.

13.27 Cllr Parrott asked whether the ICB was committed to re-engaging with the local community, and said that Councillors would be happy to assist with this. Mr Doyle replied by saying that it was clear that there was a need to have an open conversation with the local community. He welcomed the offer to co-design this with Councillors.

13.28 There was discussion of whether the lead reviewer could be invited to a future HOSC the review is discussed. It was agreed that attendees should potentially include Mr Doyle, the lead reviewer and a representative of NHS England.

13.29 Cllr Evans asked why the ICB would not apologise now rather than waiting for the completion of the review, as it is clear from the panel report that significant mistakes were made. Mr Doyle replied that there are various views on the panel's recommendations. This is why it is so important to have an external review which looks at the whole tender process.

13.30 The Chair thanked the presenters for their contributions.

13.31 RESOLVED – that the report be noted.

14 PART TWO PROCEEDINGS

The meeting concluded at 3.43pm

Signed Chair

Dated this day of

Health Overview & Scrutiny Committee

Agenda Item 14

Subject: **Sussex Winter Planning 2025-26**

Date of meeting: **19 November 2025**

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

Contact Officer: **Name: 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

1. Purpose of the report and policy context

1.1 Integrated Care Systems (e.g. the Sussex Integrated Care Partnership) are required to produce annual winter plans. Winter plans aim to ensure that the local health and care system effectively manages additional demand across the winter months.

1.2 The Sussex winter plan has been ratified and circulated. The strategic approach underpinning the plan is being presented to the Health Overview & Scrutiny Committee (HOSC) for information and comment (see Appendix 1). A follow-up report will come to the HOSC in spring/summer 2026 to update the committee on actual system performance over the winter period and on lessons learnt.

2. Recommendations

2.1 That the Health Overview & Scrutiny Committee notes the contents of this report, and – if it wishes – makes comment on it.

3. Context and background information

3.1 The overall purpose of the Sussex-wide winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the winter period to meet the needs of the local population. The winter planning period covers the period November 2025 to April 2026. The plan supports local systems to remain resilient and able to manage demand surge effectively, maintain patient safety, and support delivery of the relevant business plan objectives and locally agreed system improvements during this period.

3.2 Health and care systems typically experience increased demand pressures during the winter months due to a number of factors including:

- Seasonal illnesses (e.g. flu, norovirus)
- Covid 19
- Extreme weather (e.g. falls in icy conditions)
- Exacerbation of respiratory illnesses and a range of long-term conditions due to cooler weather
- Ongoing impact from the cost-of-living crisis affecting the most vulnerable in the local population to keep well

3.3 Health and care systems have been planning systemically for winter surge pressures for a number of years, and typically a key part of this process is assessing how well the previous year's plans met demand and using learning from this to inform the subsequent year's planning.

4. Analysis and consideration of alternative options

4.1 Not applicable to this report for information.

5. Community engagement and consultation

5.1 None undertaken for this information report.

6. Financial implications

6.1 Any additional costs resulting from the Sussex-Wide Winter Plan will need to be met from within identified resources across NHS Sussex and the Council.

6.2 Winter pressures cause significant financial strain across Health & Social . Current budget forecasting accounts for anticipated increased demand over this period. However, budget forecasts may be subject to variation later in the year due to the unpredictable nature of the impact on services during the winter.

Date 03/11/2025 Ishemupenyu Chagonda

7. Legal implications

7.1 The Council's Health Overview & Scrutiny Committee has delegated to it the statutory responsibility of reviewing and scrutinising matters relating to the planning, provision and operation of health services in Brighton & Hove.

7.2 While the Winter Plan appended to this report is a high-level strategic plan as opposed to a proposal to make specific changes to existing healthcare provision, it nonetheless has potential to impact on the lives of the people of Brighton & Hove. As a result, this Committee is invited to consider the appendix and - if it wishes - to make comment on the matters reported on.

Date 4.11.2025 Victoria Simpson

8. Equalities implications

8.1 The aims of effective collaborative winter plan arrangements are to ensure that local health and care systems are able to continue to deliver the services that have been developed to meet the needs of the local population. Cold weather disproportionately affects our most vulnerable residents, and the Sussex Wide Winter Plan seeks to ensure that resources are targeted to support those at greatest risk. Specific services will be further developed to support delivery of the Plan during the winter period and equality impact assessments will be undertaken to support the development of those specific services.

9. Sustainability implications

9.1 The Sussex-Wide winter plan considers how best to use NHS and local authority resources across Sussex in order to cope with seasonal demand surges for health and care services. Any negative carbon impacts of these plans (e.g. through people potentially having to travel further from home to access services where local capacity is stretched) need to be considered. However, this needs to be balanced against the risks to individuals of not being able to access appropriate health or care.

10. Health and Wellbeing Implications:

10.1 Health and wellbeing implications are addressed in Appendix 1.

11. Conclusion

11.1 Members are asked to note information provided by the NHS Sussex Integrated Care Board on Sussex health and care system planning for winter 2025/26.

Supporting Documentation

1. Appendices
Information provided by NHS Sussex Integrated Care Board on system winter planning 2025-26.

Sussex Health&Care

Sussex Winter Plan

November 2025 - March 2026

Version Board Final

Improving Lives Together

Introduction

An overview of the 2025/26 winter plan

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

The approach to Winter 25/26 in Sussex builds on learning from previous years and identified risks (see appendix) to ensure a robust framework for system oversight with a focus on the key actions all system partners are taking to deliver continued access to safe services.

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

This winter plan is based on four pillars

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

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

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

Principles

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

- **System partners will work together** to ensure timely access to services for the entire population, supported by a clinical risk-based focus at times of surge in demand
- **We will prioritise proactively** supporting the most vulnerable and those at highest risk to minimise exacerbation of illness
- **System resources will be targeted** in the areas where they will get the greatest impact or in the areas of greatest need
- **We will protect the wellbeing of our workforce**
- **System partners will work together** to balance clinical risk across the system
- **Our clinical leaders will be at the heart of decision making** throughout the winter period

Identification of main areas of focus

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

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

Alignment to our Shared Delivery Plan

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

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

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

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

Demand and Capacity Modelling

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

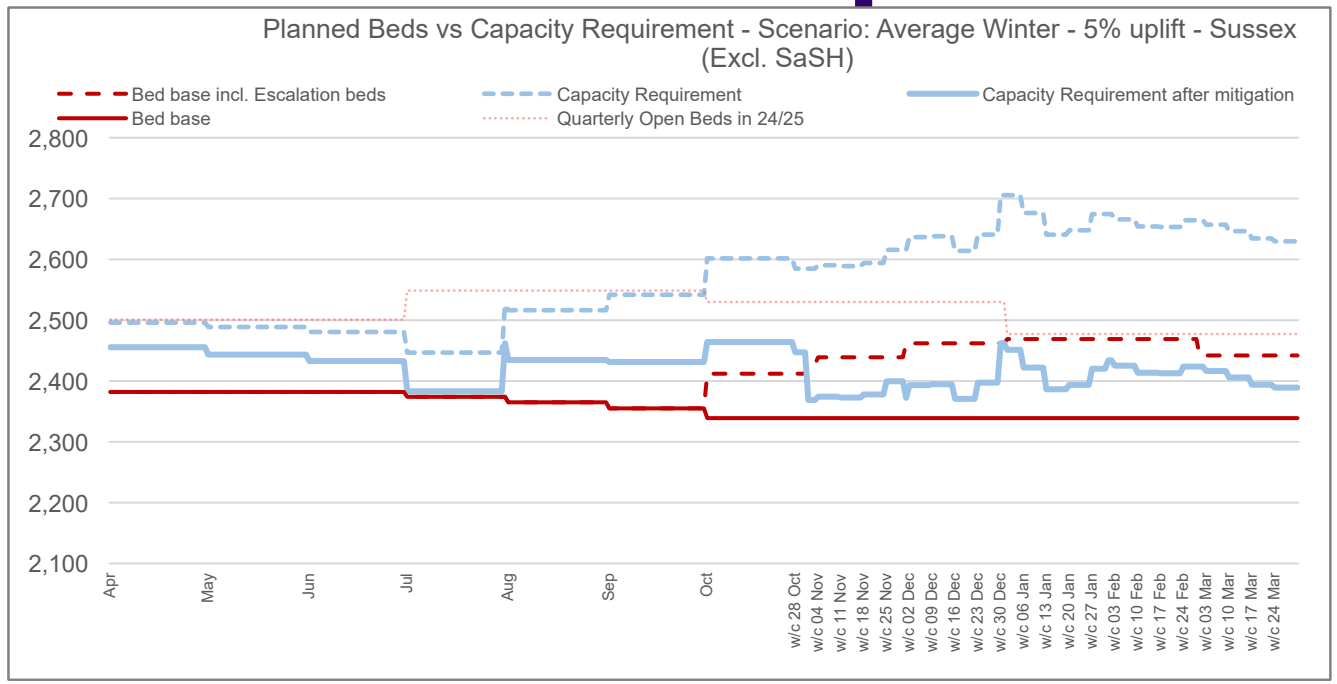
We have developed a 'statistical model' based on bed occupancy and likely scenarios for service demand based on possible levels of influenza (flu) and infectious disease in our community. This provides the 'bed gap' in a reasonable worst-case scenario.

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

Current outputs of the model:

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

Winter Bed Plan Proposal

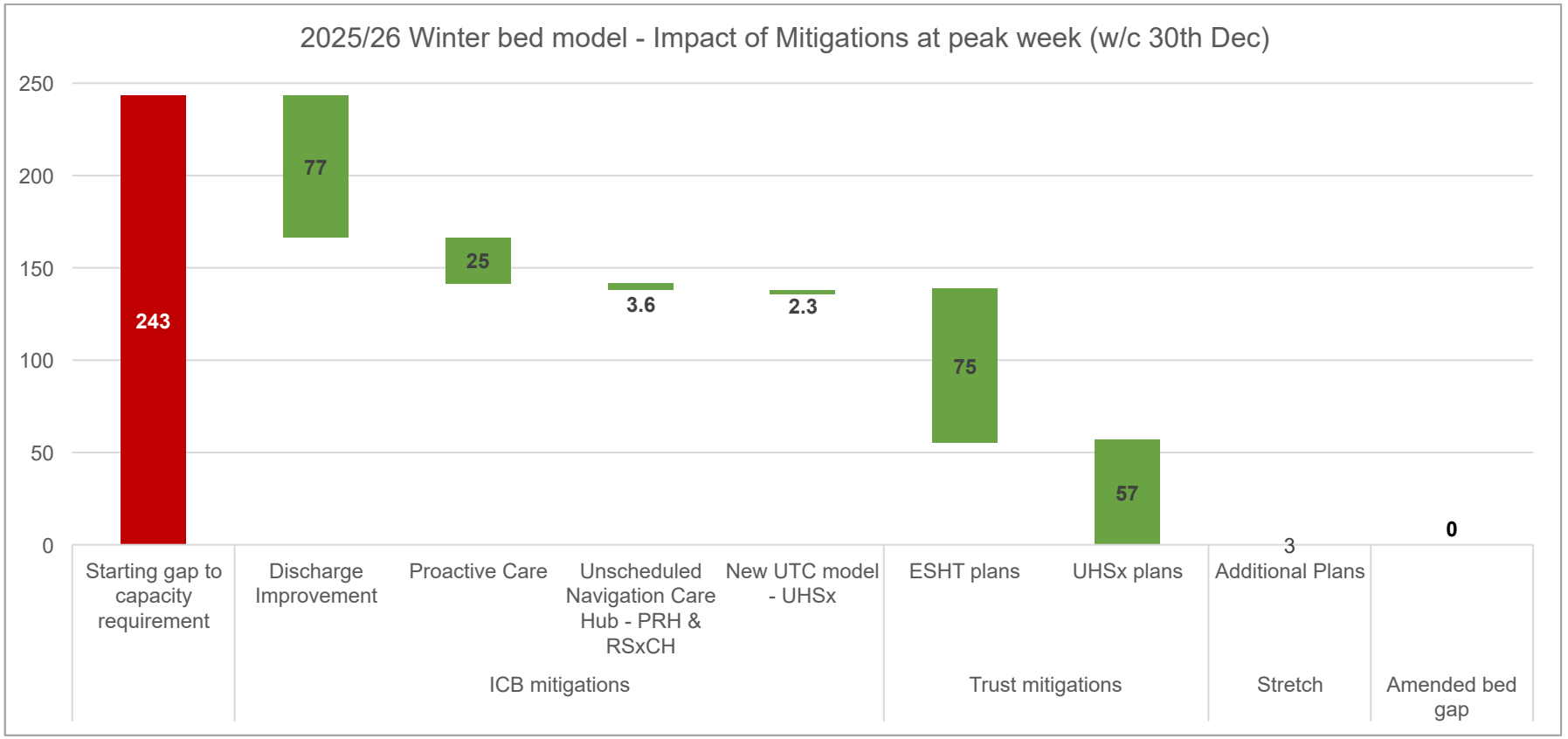


Peak Week and mitigations

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

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

Breakdown of Mitigations



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

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

Pillar 1
Acute and in hospital care

Acute and in hospital care

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

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

Patients using Urgent and Emergency Care (UEC) services

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

We will focus on these key areas:

- Reduce ambulance wait times for Category 2 patients to ensure consistent response below 30 minutes through the winter

- Meet the maximum 45-minute ambulance handover time standard, helping get more ambulances back on the road for patients

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

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

- Reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission

- Reduce delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually

- Increase the number of children seen within 4 hours

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

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

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

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

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

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

Reduce the number of patients waiting for a Mental Health Bed

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

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

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

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

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

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

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

Wider service resilience

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

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

Managing Planned Care

Maintaining capacity and resilience in our workforce

Managing Planned Care

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

Maintaining capacity and resilience in our workforce

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

Pillar 2
Primary and community care

Primary and community care

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

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

Improving vaccination rates to prevent the exacerbation of illness and hospitalisation

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

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

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

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

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

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

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

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

Proactive approach to support patients at risk of respiratory illness

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

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

Improving flow through Intermediate Care Services

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

Increased utilisation of Virtual Health Solutions

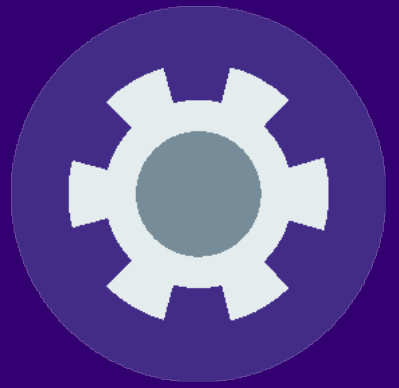
Aim	• Reduce A&E and hospital admissions/NCTRs by supporting patients to remain in their own homes. • Maintain a 285 Virtual Ward (VW) bed base throughout 2025/26. • Establish a Virtual Health (VH) Remote Monitoring hub, which engages fully with ICTs and other community services.
Current position	• 285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

Pillar 3
Sound clinical and operational management

Sound clinical and operational management

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

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

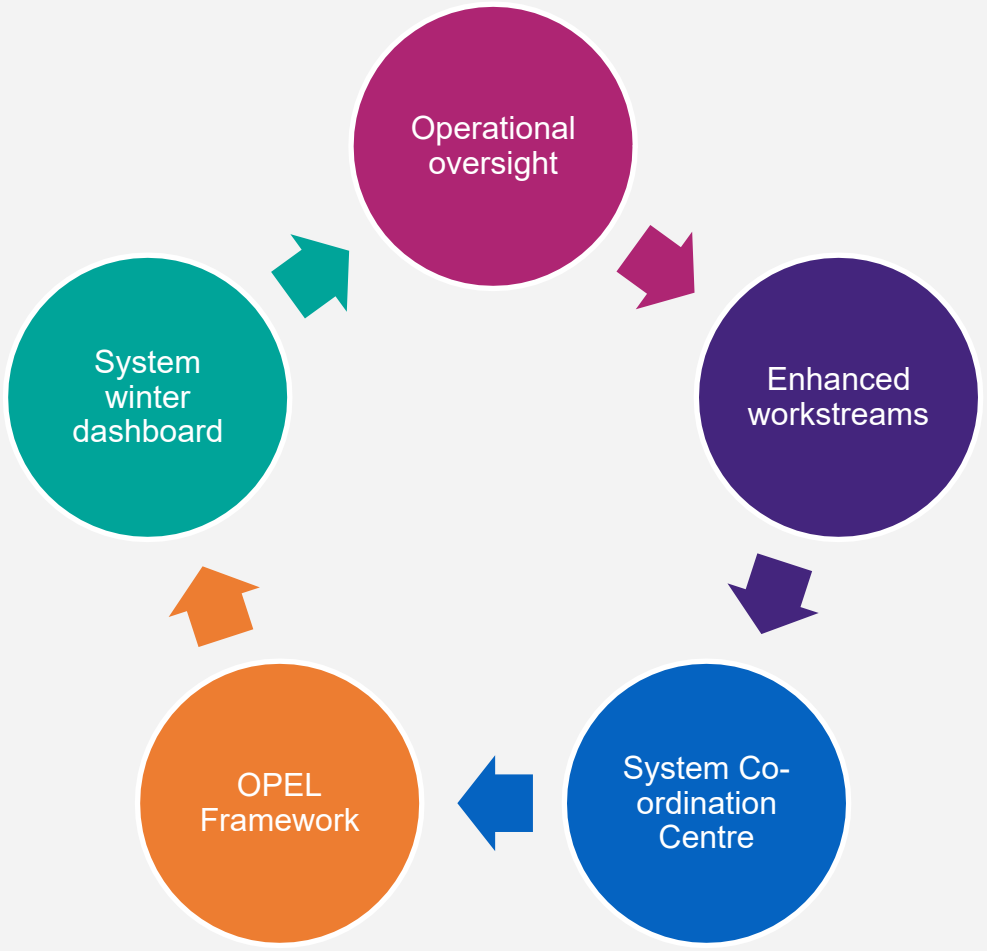


Winter Operating Model

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

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

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



Effective management of Clinical Risk and Infection Prevention and Control

Our aims: Delivering a Safe Winter

Clinical Risk

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

Infection Prevention and Control

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

System Co-ordination Centre (SCC)

The SCC provides a central co-ordination service to providers of care across the ICS footprint, supporting maintenance of access to services and delivery of safe care.

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

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

The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow. Where an individual provider is facing pressures which threaten the safe delivery of services, which it is unable to mitigate through its own internal actions, the SCC will co0ordinate actions across the wider system, and potentially beyond the system footprint to help disperse pressures and return the system to a state of balance.

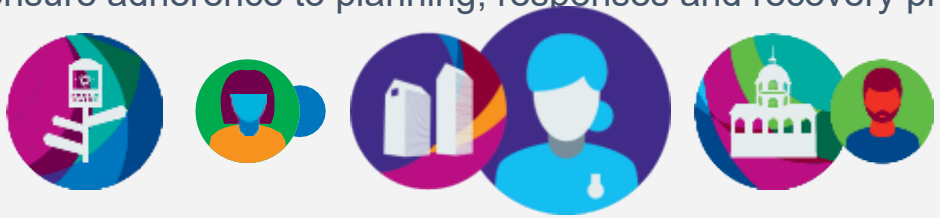
The SCC also links into the NHS England South East Regional Coordination Centre ensuring that the system is able to rapidly respond to national and regional asks or escalations over the winter period and escalate requirements for support if required.

SCC Operating Function

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

Our aims:

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



System-wide Collaborative Meetings

System weekly touchpoints

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

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

Risks to delivery of the Winter Operating Model

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

Current Structure

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

Up to 50% (Approx) Staffing Reduction

Operational Change / Impact:

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

Up to 70% (Approx) Staffing Reduction

Operational Change / Impact:

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

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

Our aims:

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

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

This team will:

- **Respond in an agile way to emerging pressures**
- **Be led by senior clinical and operational leaders who have experience in responding to escalations**
- **Use data and intelligence to understand the root cause of issues and draw on relevant expertise from across the ICB and the Sussex system**
- **Mobilise further resources where necessary to develop a rapid improvement approach to addressing issues.**

Utilisation of the OPEL Framework

Where the activities and actions outlined in this winter plan prove insufficient to manage any surges in operational pressures, escalation and response in the Sussex system will be dictated by the application of the NHS England Integrated OPEL framework 2024/26, co-ordinated by the SCC which reviews OPEL levels on a daily basis. The OPEL framework aims to ensure patient safety, quality of care and overall outcomes and experience for all patients, setting out the actions which should be taken at different levels of operational pressure.

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

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

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

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

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

System MADE Event

Our aims:

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

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

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

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

Monitoring Operational Pressures (1/2)

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

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

Monitoring Operational Pressures (2/2)

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

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

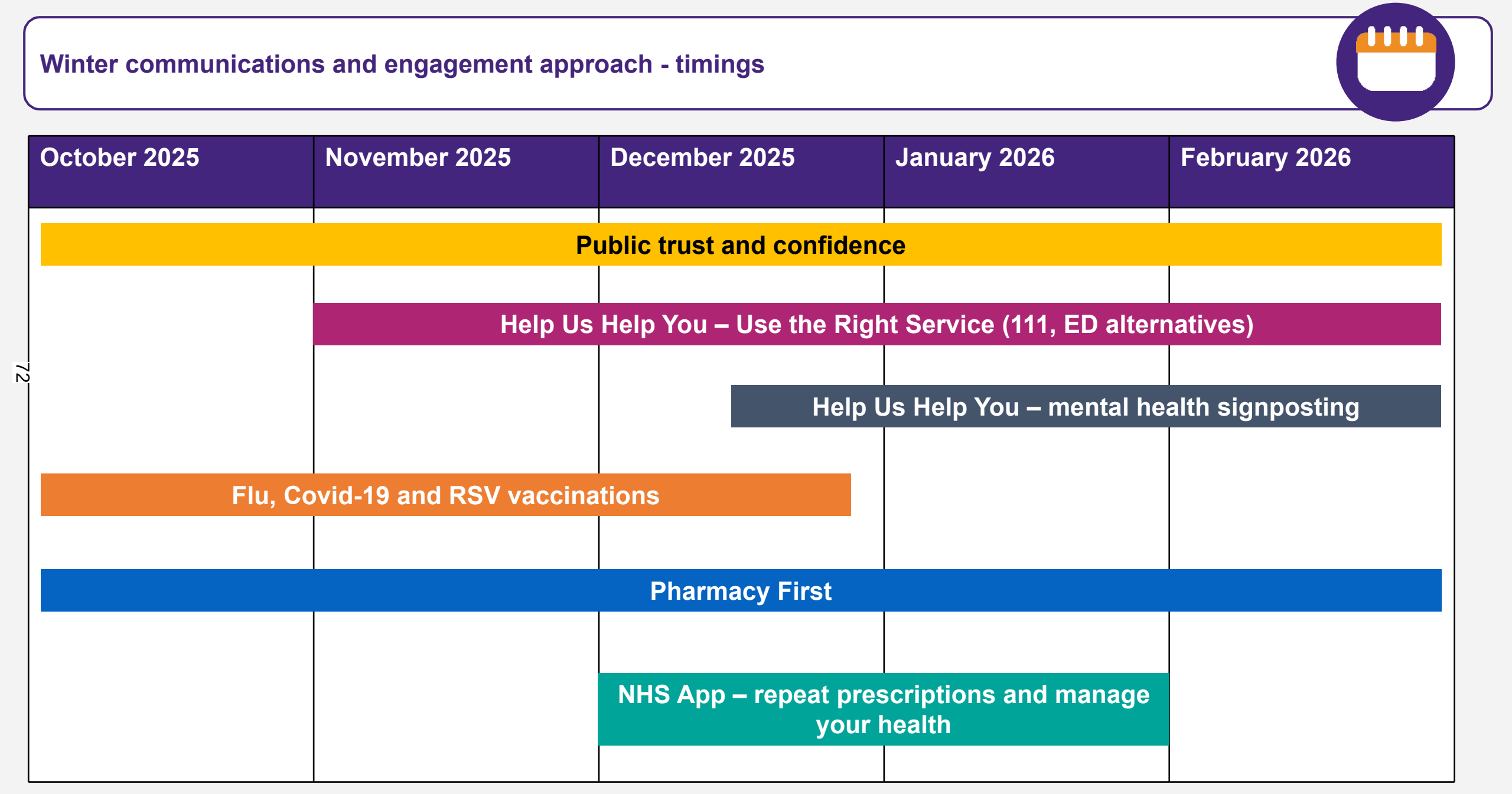
Winter in Sussex – communications and engagement approach

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

Current position	**Planned activity:**
	• The communications and engagement approach reaches across these key areas in Sussex:
	  • **Public and stakeholder confidence** – focus to share assurance that plans are in place and how partners are working together to ensure that patients get the care they need over the winter period.
	  • **Promotion of key information and advice**:
	  • **Help Us Help You: Make the right choice** – including signposting to local services, encourage positive use of appropriate services, heavy promotion of Pharmacy First, NHS 111 (online and call), children's and adults' respiratory conditions, repeat prescriptions, and mental health advice and support.
	  • **Help Us Help You: Stay warm and well** – including information to look after yourself and others to stay well over winter, including information provided by local authorities focused on heating and community support.
	  • **Help Us Help You: Stay protected** – a focus on vaccination to encourage uptake for Covid, Flu and RSV. This covers the public as well as a large campaign to encourage staff take up of the vaccines.
	• There is also work underway to develop a targeted approach to service signposting ahead of winter in our ICT areas.

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

Winter communications and engagement approach - timings



Public and Patient Engagement

Our aims:

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

Pillar 4
Governance, Oversight and Escalation

Governance, Oversight and Escalation

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

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

Robust oversight of the delivery of the winter plan

Our aims:

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

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

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

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

Sussex Winter Plan Review and Monitoring timeline

Daily

- SCC Monitoring
- System Operational Calls
- Regional Operational Calls

Weekly

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

Monthly

Update Reports to:

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

Post Plan

Post plan review and evaluation – learning shared

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

Testing of the Winter plan – Response to Exercise Aegis

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

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

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

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

Appendices

Risks and Lessons Learned

Identified Risks

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

Lessons Identified from 2024 / 2025 Winter Plan

Key Lessons Identified and Recommendations for Improvement

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

Lessons Identified from 2024 / 2025 Winter Plan

Key Lessons Identified and Recommendations for Improvement

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

Glossary

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

Glossary of Terms cont/d …

NCTR	No Criteria to Reside
NEL	Non-elective
NHS	National Health Service
NHSE	NHS England
OOH	Out of Hospital
OPEL	Operational Pressures Escalation Levels
P1, P2, P3, P4	There are four P (Pathway) categories, which relate to the clinical prioritisation of elective care patients
Paediatric	relating to a branch of medicine dealing wiht children and their diseases
PCN	Primary Care Network
Pharmacy First	Pharmacy First enables community pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions without the need to visit a GP.
Plexus	Plexus Care Record connects health and care records for practitioners in Sussex, providing them with the right information at the right time.
PRH	Princess Royal Hospital
Q1	Quarter 1
Q2	Quarter 2
Q3	Quarter 3
Q4	Quarter 4
QIA	Quality Impact Assessment
QVH	Queen Victoria Hospital
REAP	Resource Escalation Action Plan
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
ROC	Regional Operations Centre
RSCH	Royal Sussex County Hospital
RSV	respiratory syncytial virus RSV is a common cause of coughs and colds. RSV infections usually get better by themselves, but can sometimes be serious for babies and older adult
SAFER	The SAFER patient flow bundle: S - Senior Review A - All patients F - Flow E - Early Discharge R - Review
SaSH	Surrey and Sussex Hospitals
SCC	System Co-ordination Centre
SDEC	Same Day Emergency Care
SDGB	Sussex Discharge Oversight Board
SDP	Shared Delivery Plan
SECAmb	South East Coast Ambulance Service
SHCPE	Sussex Health and Care Partnership Executive
SI	Strategic Intelligence
SIDS	Sudden Infant Death Syndrome
SMR	Structured Medication Reviews
SPOC	Single Point of Contact
SRH	St Richards Hospital
SW	Social Worker
The System	Health and Social Care providers across Sussex
UCH	Unscheduled Care Hubs
UCR	Urgent Community Response
UEC	Urgent and Emergency Care
UEC / OOH	Urgent and Emergency Care / Out of Hospital Group
UHSx	University Hospitals Sussex
VCSE	Voluntary, Community and Social Enterprise
VH	Virtual Health
VW	Virtual Wards
WGH	Worthing Hospital
WLMDS	Waiting List Minimum Data Set
WSCC	West Sussex County Council

Brighton & Hove City Council

Scrutiny Report Template

Health Overview & Scrutiny Committee

Agenda Item 15

Subject: **Cancer Diagnosis and Treatment**

Date of meeting: **19 November 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 presents information on local performance in terms of diagnosis and the early treatment of cancer (see Appendix 1). The report was requested by the HOSC Chair as improving cancer performance is both a national and a local NHS priority.

2. Recommendations

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

3. Context and background information

3.1 Improving the detection and treatment of cancer is both a national and a local priority. Lord Darzi's 2024 Independent Investigation of the National Health Service notes that the UK continues to have appreciably higher cancer mortality rates than other countries. The Darzi report identifies an urgent need to improve national cancer diagnosis and to reduce waiting times for treatment. There are national cancer targets, including the 62-day referral to treatment standard, the 28-day faster diagnosis standard and the 31-day treatment standard.

3.2 Locally The Sussex Integrated Care Strategy, Improving Lives Together, lists improving cancer services as one of the five strategic priorities for Brighton & Hove: “we will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and underserved communities where rates of early diagnosis and screening uptake are lower” (p37).

3.3 Appendix 1 to this report contains information provided by NHS Sussex Integrated Care Board and University Hospitals Sussex NHS Foundation Trust. This paper includes data on Sussex and Brighton & Hove performance against the national cancer targets as well as details of local plans to improve performance in some areas.

4. Analysis and consideration of alternative options

4.1 Not relevant for this information report.

5. Community engagement and consultation

5.1 None directly undertaken for this information report.

6. Financial implications

6.1 No direct financial implications identified as arising from this information report.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted: 05/11/2025

7. Legal implications

7.1 This report is on a topic which sits within this Committee’s remit as the body with responsibility for scrutinising provision of healthcare services in the area of Brighton & Hove. No legal implications have been identified in this ‘for noting’ report.

Name of lawyer consulted: Victoria Simpson Date consulted 5/11/2025

8. Equalities implications

8.1 There are significant health inequalities in terms of the incidence of cancer across different communities, screening and diagnosis, access to timely treatment and outcomes. People from the most deprived communities are less likely to use screening services, more likely to present as an emergency, and less likely to have positive outcomes than people from less deprived areas. Cancer incidence and mortality is also related to age, with more than 50% of cancer deaths in the over-75 age group.

9. Sustainability implications

9.1 None identified.

10. Health and Wellbeing Implications:

10.1 These are addressed in the body of the 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 the measures being taken to improve the diagnosis and timely treatment of cancer locally.

Supporting Documentation

Appendices

1. Information provided by NHS Sussex Integrated Care Board and University Hospitals Sussex NHS Foundation Trust.

Background Documents

1. Lord Darzi's report on the NHS (2024) Independent investigation of the NHS in England - GOV.UK

Cancer performance in Brighton and Hove -Diagnosis to Treatment

Purpose of the report and policy context

The purpose of this paper is to report on cancer performance in Brighton and Hove, specifically looking at diagnosis to treatment times. Data is presented which allows comparison within Sussex and nationally, and highlights areas where improvement work is required to meet the national cancer performance standards.

Recommendations
Committee to note the information provided on the performance against the nationally agreed cancer performance targets and to note the actions articulated in the Commissioning Intentions for the system in 2026/7 (in line with the NHS 10 Year Health Plan)

Context and background information:

- **Cancer Performance Targets**
- **System actions to support sustainable recovery of cancer performance at University Hospitals Sussex NHS Foundation Trust**

Context and background

The earlier a cancer can be diagnosed and treatment commenced, the wider the treatment options and the greater the chance of making a good recovery. For example, in the UK the 5-year survival rate for people diagnosed with bowel cancer at stage I, where the cancer is small and has not spread is 85%, compared to just 10% when diagnosed at stage IV where the cancer is metastatic and has spread to at least one other organ. A recent BMJ paper looking at the impact of delay on mortality concluded that even a four-week delay of cancer treatment was associated with increased mortality across surgical, systemic treatment, and radiotherapy indications for the seven cancers in the study.
https://www.bmj.com/content/371/bmj.m4087

There are several points that facilitate the optimisation of this patient journey, and efforts are centred around:

- **Early diagnosis** – via screening programmes and symptom awareness (as measured by the staging of cancers – early stage is identified as stage 1 or 2)
- **Faster diagnosis** – via timely access to diagnostic tests (as measured by the 28 day* faster diagnosis standard)
- **Timely initiation of treatment** – via consultant led services for surgery, anti-cancer drug therapy and/or radiotherapy (as measured by the 31-day and 62-day* treatment standards)
- **See Appendix 1 (section 3.0) for details of the cancer waiting times (CWT) standards and the national operating plan targets against these standards for 2025/26*

The paper will place University Hospitals Sussex NHS Foundation Trust's (UHSx) performance in context of the national position and within the local system, as well as the wider Surrey and Sussex Cancer Alliance (SSCA) footprint.

The paper concentrates primarily on the diagnosis to treatment rates for cancer patients at UHSx and presents data highlighting the current experience of cancer care within the Brighton and Hove population, as this is considered of most interest to the Health Overview and Scrutiny Committee.

Summary of Cancer Outcomes:

There is a known data lag in terms of understanding overall cancer patient outcomes. However, the following headlines are provided in the context of available data regarding survivorship.

- **One year survival –** In January 2020 (latest available data) the proportion of people that survive cancer for at least one year after diagnosis in the Brighton and Hove population was **74.6%**. This was below the Sussex average (75.4%), but equal to the national average at 74.6%.

- **Five year survival** – In January 2016 (latest available data) the proportion of people that survive cancer for at least five years after diagnosis in the **Sussex** population was 56.4% compared to a national position of 55.7% (0.7% higher). **NB** This data is not available for the Brighton and Hove population.

However, it is recognised that the relative positions in Sussex against the national standards and outcomes should be considered in context of an aging population. University Hospitals Sussex cover a population of circa 1.28 million, with patients aged over 65 representing 13.7% of the population in Brighton and Hove and 22.9% in West Sussex compared to 18% nationally. Furthermore, 3.6% of Brighton and Hove patients are aged over 80 years, with 6.9% aged over 80 years in West Sussex compared to 5% nationally. *See Appendix 1 (section 2.0).*

It should also be acknowledged that referral rates for a suspected cancer diagnosis have also increased exponentially over recent years, whilst conversely conversion rates to a cancer diagnosis have remained relatively flat. *More detail is available in Appendix 1 to the paper (section 1.0)*.

Indeed, over the 2025 summer period, UHSx reported that suspected skin cancer referrals increased by over 30% in comparison to the same period in 2024 and remained higher for a longer period which led to their skin service generating a significant backlog of patients over 62 days – this is now on the decline.

National Cancer 'Tiering' Programme Support

During 2024/25, UHSx were placed by the national cancer 'tiering' system into Tier 1[1]. This resulted in a significant number of improvements being made by the Trust to recover their position and as a result a compliant performance trajectory was submitted to NHS England to achieve the CWT targets by the end of March 2026. This resulted in UHSx exiting Tier 1 status and is currently in Tier 2 which still renders significant NHSE oversight and scrutiny.

2025/26 Planning Requirements

Planning requirements for the system's cancer patients in 2025/26 included the following key

1

areas. Work is ongoing in these areas, aimed at supporting the management of cancer referral demand and enabling faster diagnosis in the highest volume tumour sites (breast, lower gastro-intestinal (GI), gynaecology, urology):

- **Relocating Lower GI (LGI) cancer surgery from the RSCH site to Worthing** – this was successfully completed in the summer of 2025 and all patients requiring LGI cancer surgical intervention are now treated in Worthing, thereby designating Worthing as a Centre of Excellence for Colorectal Cancer Surgery. Improvement in cancer performance is now forecast, starting with improved 31-day Surgery performance following the appointment of four new cancer surgeons who are now all in post. The focus is now turning to the middle part of the pathway at point of diagnosis to 'decision to treat'. FDS performance for LGI is now performing 10% higher than the national average.

- **Maximising care for low-risk patients in non-cancer settings, including maintaining Faecal Immunochemical Testing (FIT) in lower GI pathways**. This is in place and delivering improvement in FDS performance, with UHSx performing at 10% higher than the national average. Use of FIT is high amongst referring GPs, and the FDS 'nurse-led' process is functioning well.

- **Embedding low risk pathways for post-menopausal bleeding of patients on hormone replacement therapy.** This is in place with patients now able to have a trans-vaginal ultrasound in the community, in advance of being referred into secondary care – with this ultrasound report in place there is the opportunity to place patients onto an alternative non-cancer 'bleeding on HRT' pathway. It should be noted that during 2025/26, gynaecology has been the most improved tumour site in UHSx, having significantly reduced its backlog and delivering excellent FDS and 31-day Surgery compliance. reducing its backlog by circa 90 pts and delivering excellent FDS and 31-day surgery compliance. The focus is now on the treatment part of the pathway to help improve 62-day compliance.

- **Streamlining breast pain pathways and increasing operative capacity** – this is in place, but work continues to improvement the management of patients, which is dependent on ensuring that GP referrals are received with sufficient clarity regarding the symptoms of concern. The Trust are in discussion with the 'East Kent pilot' which is allowing patients to self-refer and if referring with only pain, this allows patients to avoid mammography and triple assessment.

- **Improving tele-dermatology in urgent suspected skin cancer** - capacity for tele-dermatology has improved, however it remains insufficient to meet the increased referral demand that has been observed this year. Once the skin cancer service in UHSx has fully recovered, revised demand and capacity modelling will be completed. However, a tactical commissioning model for suspected skin cancer demand in 2026/27 will be required to help meet the summer peak demand.

- **Implementing nurse or Allied Health Professional-led local anaesthetic biopsy in the prostate cancer pathway** – training is on-going to support full implementation of this pathway across UHSx diagnostic sites.

2

Cancer Waiting Times (CWT) standards

In order to set the context around the current positions against cancer waiting times standards, a more detailed explanation of the standards and the current operational targets against these are provided in Appendix 1 (section 3.0).

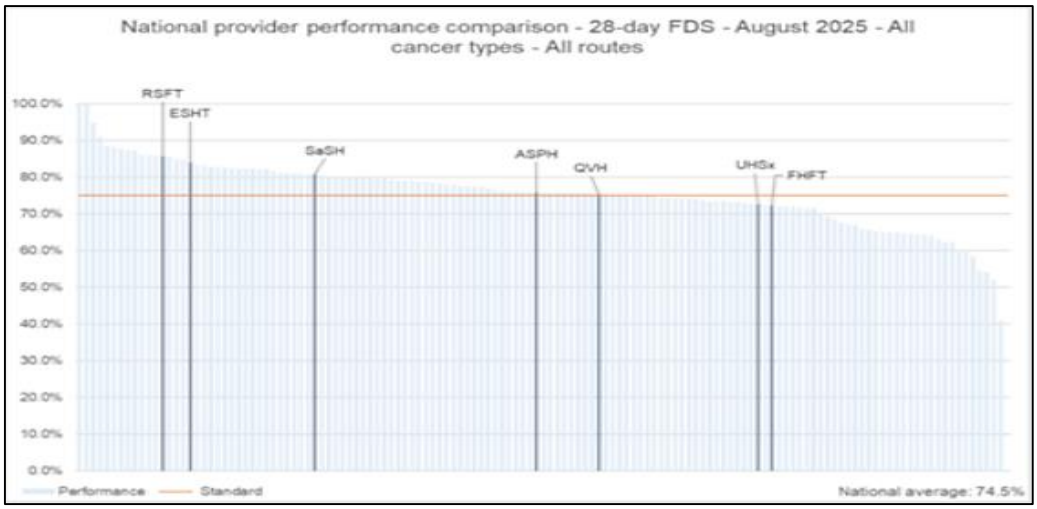
National Picture:

The 28-day faster diagnosis standard is one that has tended to be met nationally, and the year average is 76.6% (against the current operational standard of 75%), albeit this measure was narrowly missed in August (74.6%) which is likely due to seasonal variation.

The 31-day treatment standard achieved 91.6% nationally in August, a figure that has remained consistent over the past year (91.2% average). Unsurprisingly when this metric is considered by modality, drug therapy exceeds the 96% target at 98.4% average, whereas surgery and radiotherapy fall somewhat short, at 85.3% and 87.3% average respectively.

The national figure for August for the 62-day treatment standard was 69.1% (year average September 2024 to August 2025 is 68.7%) against the operational standard of 85%. **NB** *75% target by March 2026.*

The current CWT position at UHSx is challenging in comparison with other providers both nationally and within the Sussex system, as well as within the overall Surrey and Sussex Cancer Alliance footprint. This is demonstrated in the charts below showing their relative positions against the FDS and 62-day treatment standard.



The above chart demonstrates that there is a 13.4 percentage point gap across the Surrey and Sussex system, with wide variation remaining amongst providers as compared nationally. The position in August 2025 demonstrates that UHSx are below the 75% standard, a deterioration from their significantly improved position at the beginning of 2025/26.

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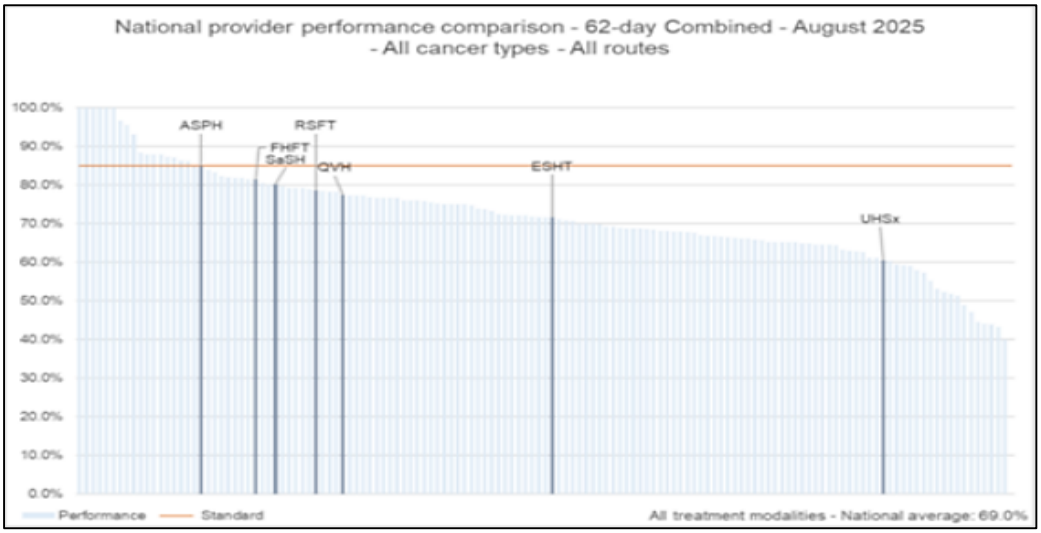


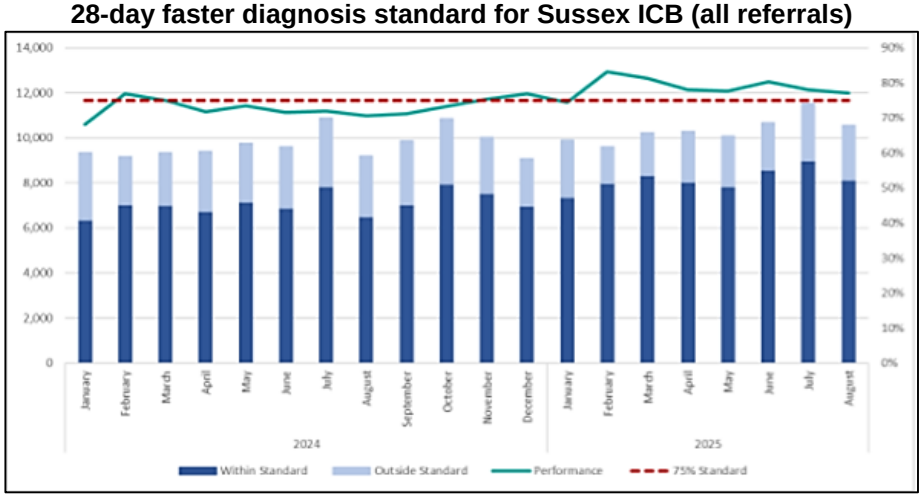
Similarly, wide trust variation remains in the 62-day standard for August 2025, with a 24.4 percentage point gap. None of the Surrey and Sussex Trusts met the 85% standard, however all but UHSx and East Sussex Healthcare NHS Trust (ESHT) met the 75% ambition.

Commentary regarding the 'unvalidated' September position at UHSx is provided in the Appendix. *(section 3.0)*

Sussex ICB Picture:

Following a significant period of underperformance across Sussex against the FDS performance in 2024/25, Trusts have worked hard to recover their positions, (including specific 'tiering' support from NHSE to UHSx to recover their position). Sussex is now ahead of national performance for 28-day FDS at **77.0%** in August (77.2% year average). The target has been met for nine of the past ten months and has exceeded 80% on three occasions.

28-day faster diagnosis standard for Sussex ICB (all referrals)



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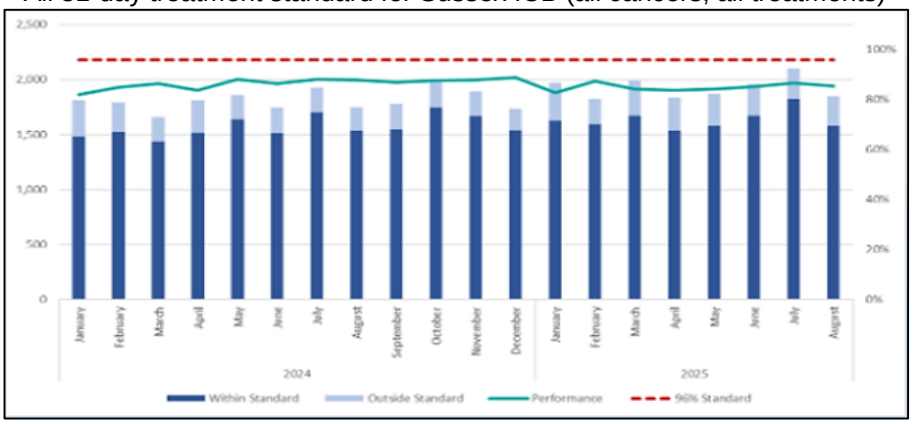
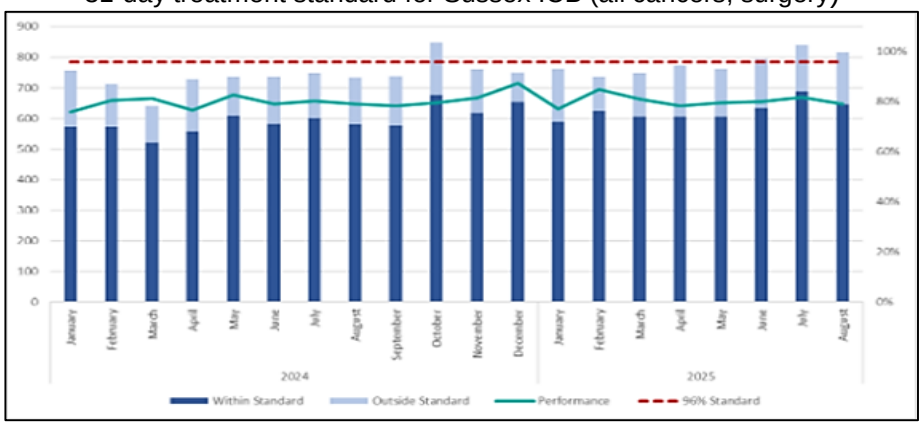
From a Sussex perspective, regrettably the 31-day treatment standard has declined in August, achieving **85.3%** (year average 85.8%), which remains considerably behind national performance (91.6%). Drug therapy performance was 94.5% and has shown a decline this year compared to last (98.0% 2024 average vs 95.6% 2025 average year to date) and has failed to reach target for the past four months. Surgery performance for August was 79.2% (year average 80.7%) and radiotherapy performance was 78.7% (year average 75.3%).

This variance is demonstrated in the below charts:

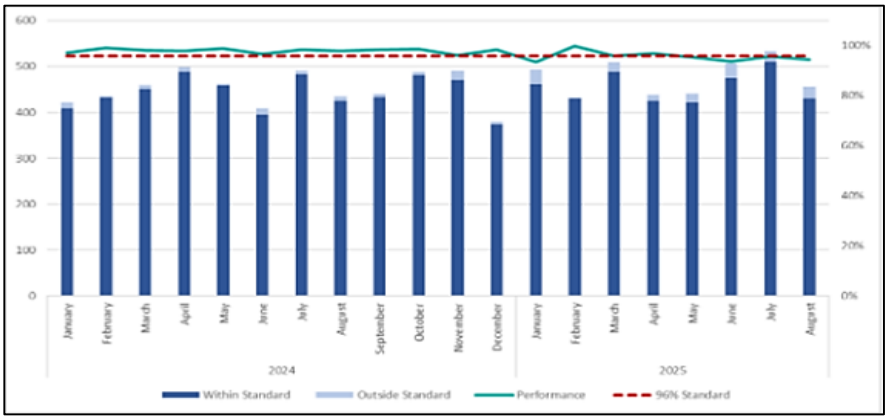
All 31-day treatment standard for Sussex ICB (all cancers, all treatments)



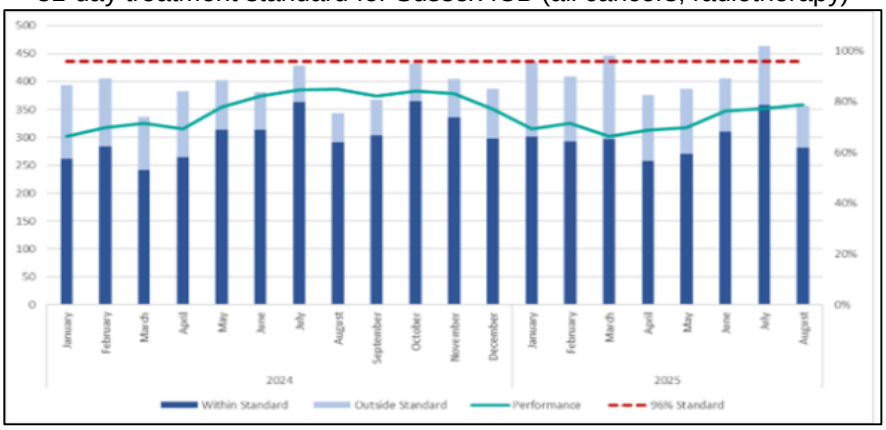
31-day treatment standard for Sussex ICB (all cancers, surgery)



31-day treatment standard for Sussex ICB (all cancers, anti-cancer drug regimen)

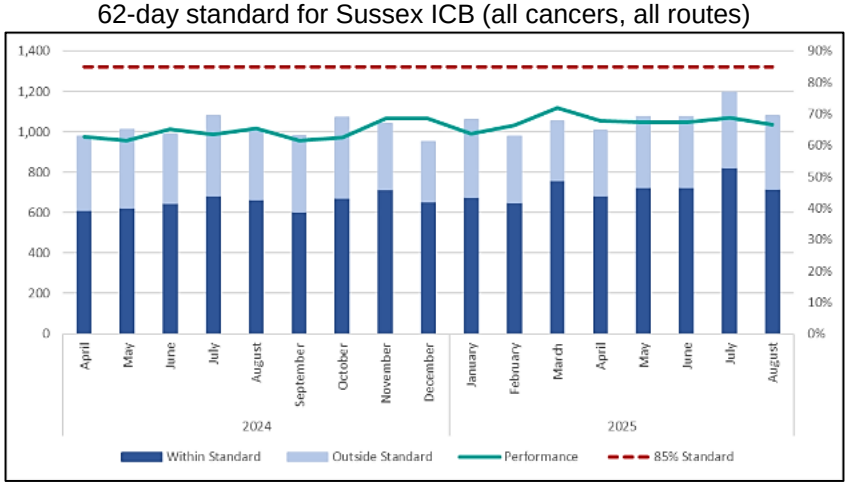


31-day treatment standard for Sussex ICB (all cancers, radiotherapy)



Breakdown by treatment modality is available by provider, but not at sub-ICB level. *See Appendix 1 (Section 3.0)*. Latest available data for Sussex performance against the 62-day standard shows ongoing performance below the 75% ambition for 2025/26. In March 2025, the position improved to 72% but has been on a declining trajectory since then.

62-day standard for Sussex ICB (all cancers, all routes)



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UHSx Performance - Brighton and Hove Population:

From a 28-day performance perspective, and despite the improvements seen by UHSx in March 2025, there has been a recent decline in the Trust's 28-day FDS position, with this reducing from 74.3% in July to 72.5% in August, reversing the compliant position achieved by the Trust in the previous five months. This decline is mainly due to the Brighton and Hove position of 69.1% versus the West Sussex position which is 75.8%.

NB For context, had the Trust's overall skin FDS performance achieved national average performance, FDS aggregate performance would be 78% in this period. Indeed, October FDS performance (pre-validated) is currently tracking at 76.7%, which is a strong indicator that recovery in being observed and delivery of 80% against the FDS standard is forecast to be achieved by December month end.

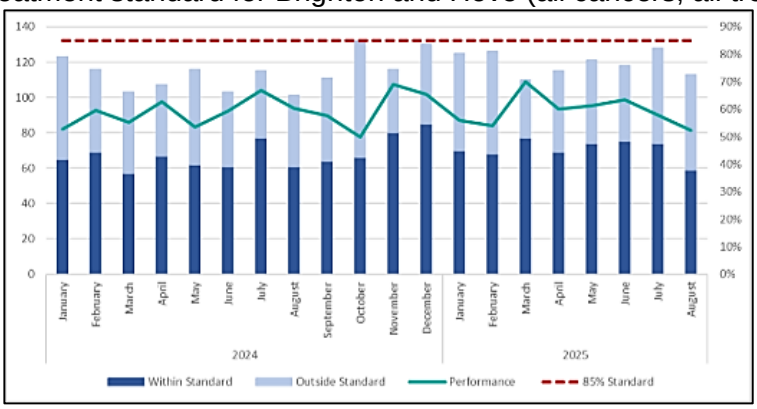
In order to effectively focus the paper on treatment and care outcomes for the Brighton and Hove population, the following sets out data representative of the previous 'CCG population', where the majority of reportable cancer treatment and care for these patients takes place under the team at Royal Sussex County Hospital. This is highlighted in comparison to the previous West Sussex 'CCG population', where a high proportion are treated by the teams at Worthing and St Richard's Hospitals (noting that the north West Sussex population may also be treated at Surrey and Sussex Healthcare NHS Trust (SASH).

The 62-day performance at UHSx for August was **60.4%** (year average 61.1%) whilst data for Brighton and Hove shows August 62-day performance was **52.2%**, (year average 59.6%), which is considerably behind the West Sussex population at 69.1% (year average 66.5%).

For comparison the East Sussex population (served by East Sussex Healthcare NHS Trust) reported 67.1% in August (year average 69.5%).

This variation suggests an inequity in referral to treatment times for patients living in Brighton and Hove compared to those living elsewhere in the UHSx catchment area (recognising that the West Sussex comparison is indicative only given that a small proportion will be treated at SASH).

62-day treatment standard for Brighton and Hove (all cancers, all treatments)

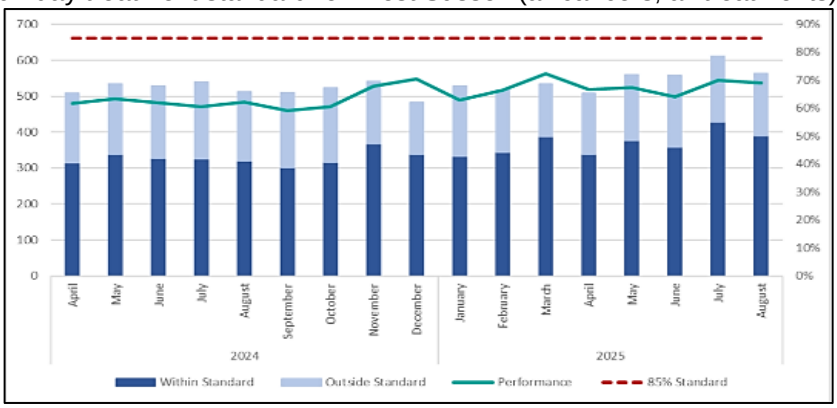


62-day combined performance has deteriorated year on year in the Brighton and Hove population

7

from an average of around 60% in 2024 to 52.2% (August 2025).

62-day treatment standard for West Sussex (all cancers, all treatments)



The 62 day combined performance for the West Sussex population has remained more stable, at an average level of 68% during 2025/26. Specific performance challenges within the cancer pathways impacting on the Brighton and Hove population are described in detail within Appendix 1 (section 4.0). Conclusions drawn from this analysis are that the most challenged tumour sites for treatment and care currently at the Trust are the **breast** and **skin** and **lower GI** pathways, alongside major challenges in Radiotherapy provision which remains a key factor affecting the overall delivery of the cancer treatment standards.

System actions to achieve sustainable improvement

The following section of the paper will describe the Sussex system's strategic actions and the operational activities that are underway and ongoing with all Sussex Trusts.

National Call for focused reset on 62-day cancer performance

The national cancer team has recently launched a rapid cancer improvement challenge this autumn/winter in response to the slowing of progress across 28-day and 62-day cancer performance during the summer months. Significant recovery is expected to be seen by December 2025. The Surrey and Sussex Cancer Alliance will continue to provide support to UHSx for cancer improvement work especially around FDS and 62-day performance.

This work includes

- Joint weekly/fortnightly tumour site improvement groups with UHSx divisional teams. Each group will operate under a structured improvement plan to monitor progress and drive delivery.
- The use of the Cancer Pathway Analyser tool at UHSx. This analytical tool will enable the identification of key causes of delay within cancer pathways at the trust, using real patient data.
- Completion of the pathway analysis in November and reviewing the findings through dedicated workshops, with agreed actions from the analysis incorporated into existing improvement plans for implementation.
- The Tumour sites which will be of primary focus at UHSx will be Breast, Lower GI, Lung and Urology

8

SSCA will also continue to fund a number of roles and projects at UHSx that are integral to the effective delivery and ongoing improvement of cancer pathways.

Improvement plans underway at UHSx in key tumour sites

The Trust is committed to achieving 80% FDS and 75% 62-day performance by the end of March 26. In the short term, 62-day performance may remain fragile while the Skin backlog is addressed and newly appointed Breast and Lower GI surgeons take up their posts, which will increase theatre capacity and support sustained improvement.

Breast - Increasing Breast operative and diagnostic capacity - Two new surgeons starting in Quarter 3 will increase operative capacity. The Trust will also ensure newly referred patients are seen by day 7, which will improve overall performance and make a significant contribution to the Trust's compliance given the number of patients referred

Skin – Skin is significantly challenged during the summer due to seasonal variation with referrals peaking 30% higher than 2024. Significant capacity has been generated through insourcing and outsourcing activities, and recovery is progressing and should be recovered by end of November.

Lower GI – Access to surgery is forecast to improve following the relocation of Cancer Surgery from Royal Sussex County Hospital site to Worthing Hospital, and this will improve further over the next few months following full establishment of surgeons in post by mid November. Endoscopy capacity has also improved, with sufficient colonoscopy access expected to deliver a further improved FDS position.

Sussex ICB Commissioning Intentions 2026/27

In line with the new **NHS 10 Year Health Plan**, actions will be focused on achieving the three key shifts; moving care from hospital to community, from analogue to digital and from sickness to prevention. More details are provided in the ICB's recently published Commissioning Intentions document.

From a cancer perspective, the following initiatives continue to be prioritised:

GP 'Direct Access' Diagnostic Pathways

The ICB's Commissioning Intentions document 2026/27 sets out some key ambitions around increasing the proportion of cancers diagnosed at stage I and II, in line with the NHS Long Term Plan aim to have 75% of cancers diagnosed at these early stages by 2028. Greater opportunities for our GP colleagues/referrers to access diagnostic tests (particularly within Community Diagnostic Centres across Sussex) is central to this and means that patients with non-cancer findings do not enter an 'urgent suspected cancer' pathway. Plans are already underway this year to increase the opportunities for GPs to have direct access pathways to specialist diagnostics (e.g., CT/MRI) for patients with a low suspicion of lung, pancreatic and brain cancers.

In addition, initiatives are underway aimed at reducing low yield endoscopy services, in order to expand the use of alternative 'imaging' diagnostics and enable greater capacity in endoscopy services, e.g., for diagnosing bowel cancers at an earlier stage.

Breast Pathway Improvement Plans

The predominant issues with the breast pathway as identified in the data are timely access to surgery and timely access to radiotherapy. The national focus on improving 62-day performance by the end of December 2025, being led by the SSCA, will prioritise focused action on the breast pathway, alongside the ongoing work by UHSx to deliver sustainable improvements in the Trust's radiotherapy provision. The Trust have been advised within the 2025/26 Commissioning Intentions by Specialised Commissioning colleagues that 'it is expected to deliver in line with national radiotherapy access standards, with 96% of patients starting radiotherapy treatment within 31 days of a decision to treat by 1st April 2026'.

Skin Pathway Improvement Plans

All Sussex Trusts are working towards increasing the use of tele-dermatology in the skin pathway, to enable streamlining of the diagnostic pathway and to create the necessary capacity for more timely access to treatment for patients diagnosed with malignant melanoma and squamous cell carcinoma.

In the longer term, in recognition of the continued system and workforce challenges across all elective dermatology care in Sussex, the ICB is moving forward with the transformation of the dermatology services by developing a new 'integrated care' model and specification for a Community Dermatology Service. It intends to procure a redesigned service across Sussex, to commence in April 2027.

Radiotherapy Improvement Plans

Radiotherapy provision is delivered by UHSx to the majority of the Sussex population and commissioned by the NHSE Specialised Commissioning Team as all forms of radiotherapy are considered 'specialised services' that require national oversight.

The radiotherapy service has struggled to meet increased demand observed in the past 18 months and deliver treatment to patients within cancer waiting time targets. The situation has been declining since 2023.

The Trust reported a workload increase of >11% in 2024/25, with treatment activity being similar to the 2019/20 levels. However, due to the introduction of more hypofractionation (a type of radiation therapy that delivers a higher dose of radiation per session, shortening the overall treatment time compared to conventional fractionation) particularly in breast, this means new patient numbers are now significantly higher than in 2019/2020. High Breast screening uptake and a move towards more breast conserving surgery (which necessitates radiotherapy) are driving factors for the increased demand.

In 2019/20 the service was planning to deliver care to an average of 240 patients per month, and this has subsequently risen to an average of 280 per month in 2024/25. There is a waiting list ranging between 650 to 800 patients at any one time, with a 14% overall increase in demand since 2019 and a 30% increase in breast activity specifically.
In September, there were around 400 patients in the radiotherapy backlog, with these patients

waiting more than 31 days for their treatment. This has reduced by around 50 patients in the last 3 months, with almost all the backlog coming from the breast and prostate cancer pathways.

The ICB has been working with Specialised Commissioning colleagues and UHSx to improve radiotherapy treatment for its patients. University Hospitals Sussex is currently progressing the following key actions:

- Radiotherapy mutual aid capacity agreements with other hospitals such as Royal Surrey Hospital and including London hospitals. Whilst patient uptake has been relatively high, some patients are unwilling (for understandable reasons) to be treated too far away from where they live. Inequality is being reviewed by the service.
- Use of the Independent sector is in place
- A weekly reduction in radiotherapy backlog numbers to support recovery
- A strategy to improve radiotherapy productivity including plans for optimising use of estates and LINAC machines

Since April, over 150 patients have been referred and treated to other radiotherapy centres. As the breast and prostate backlog reduces, what remains is higher complexity which other centres are not able to support thereby resulting in patients still waiting several months for their treatment to commence.

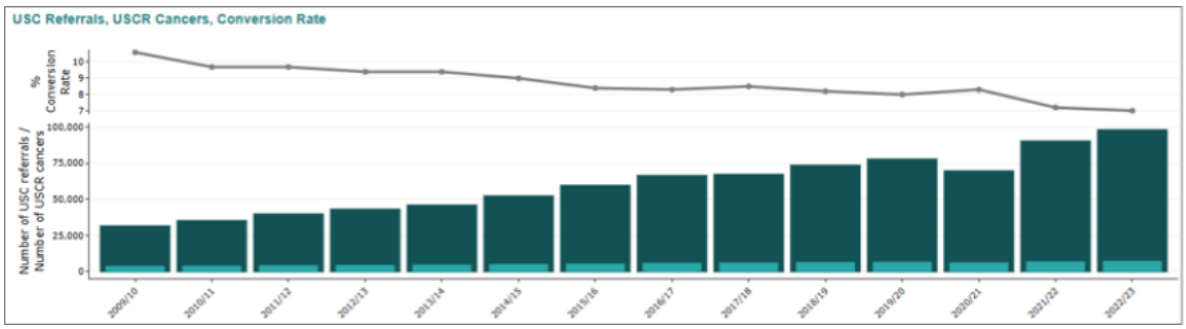
A radiotherapy improvement plan is in place and with over £1.5m funding secured in the Summer 2025, the service is slowing recruiting into an improved workforce profile which intertwined with a linac replacement programme over the coming 3 years will enable increased productivity and help meet increased demand.

Supporting Documentation

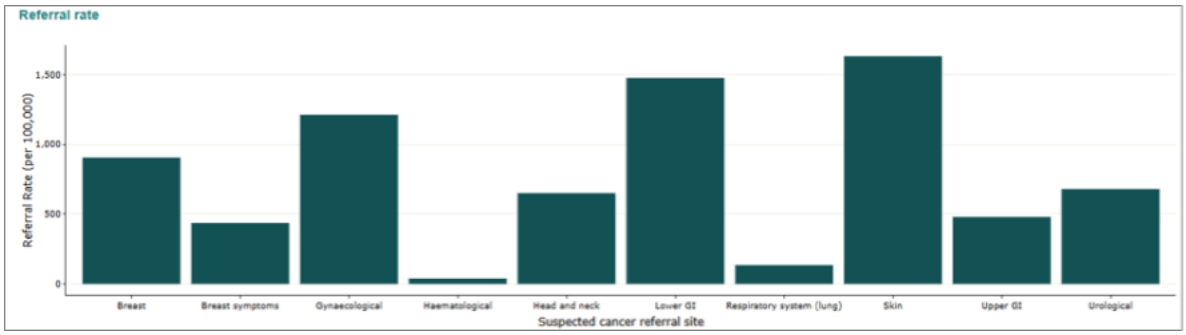
Appendix 1 – Summary data to support the paper

1.0 REFERRAL RATES IN SUSSEX

The below chart broadly demonstrates the increasing rate of urgent suspected cancer referrals received by the Sussex system, together with a corresponding decline in conversion rates (latest available analysis 2022/23).



The below chart for the 2022/23 period identifies the tumour sites with the highest referral rates, namely skin, lower GI, gynaecology and breast.



NHS Digital/national disease registration service

2.0 POPULATION: AGE

Based on GP registers in May 2025, East Sussex CCG had the highest proportion of patients who were aged over 65% at 26% and of those aged over 80, at 7.7%, which was well above national average.

Metric	NHS Frimley ICB - D4U1Y	NHS Surrey Heartlands ICB - 92A	NHS Sussex ICB - Brighton and Hove CCG	NHS Sussex ICB - West Sussex CCG	NHS Sussex ICB - East Sussex CCG	SSCA	England
Population	852,962	1,148,845	332,860	949,500	577,239	3,861,406	63,773,098
Aged 65+	137,263	217,042	45,611	217,419	150,018	767,353	11,475,460
Aged 80+	39,027	66,003	11,999	65,638	44,399	227,066	3,156,883

12

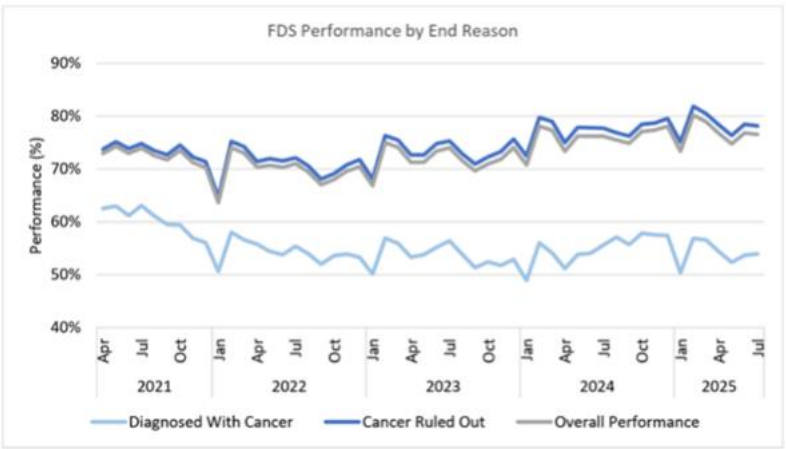
% aged 65+	16.1%	18.9%	13.7%	22.9%	26.0%	19.9%	18.0%
% aged 80+	4.6%	5.7%	3.6%	6.9%	7.7%	5.9%	5.0%

3.0 CANCER WAITING TIMES STANDARDS

The 28 Day Faster Diagnosis Standard (FDS)
The 28 day faster diagnosis standard aims for a maximum of four weeks (28 days) from receipt of an urgent GP (or other referrer) referral for suspected cancer, breast symptomatic referral, or urgent screening referral, to the point at which the patient is told they have cancer, or cancer is definitively excluded.

The operational standard is currently set at 75% and the NHSE ambition is for 80% compliance by March 2026, and for this to be maintained in 2026/27.

Nationally and locally this standard is routinely met, however the ruling out of cancer (around 93% of referrals) is generally easier and faster than ruling in. Performance against FDS for those with cancer ruled out has steadily increased since 2022 to nearly 80% whilst performance for those diagnosed with cancer has slightly decreased to below 60%, resulting in the difference in performance levels between the two populations increasing slightly.



www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2025/09/CWT-FDS-Statistics-on-End-Reason.pdf

Optimising the quality and completeness of referrals that are received will help to ensure the referral is processed with minimal delay.

Current FDS position at UHSx:
From a UHSx perspective, September FDS performance reported during week commencing 3rd November, shows UHSx FDS performance static at 72.1% (down from 72.5% in Aug). This position is primarily driven by challenges observed in the Skin pathway throughout the summer period where referral demand exceeded worst case scenario modelling reaching in excess of 30% above 24/25 peak demand – this was observed across the organisation and led to the Trust backlog reaching a peak in September. Significant recovery work has taken place throughout the second half of Sept

and throughout October, and full recovery is forecast to be complete by November month end.

The 31 Day Treatment Standard
The 31 day treatment standard aims for a maximum of 31 days from decision to treat/earliest clinically appropriate date to treatment of cancer. The standard applies to:
1) all first definitive treatment for Cancer
2) all subsequent treatment modalities
3) treatment categories: anti-cancer drug, radiotherapy, and surgery.
The operational standard is set at 96% and achieved 91.6% nationally in August.

The 62 Day Treatment Standard
The 62 day treatment standard aims for a maximum of 62 days from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer, breast symptomatic referral, urgent screening referral, or consultant upgrade to first definitive treatment of cancer.

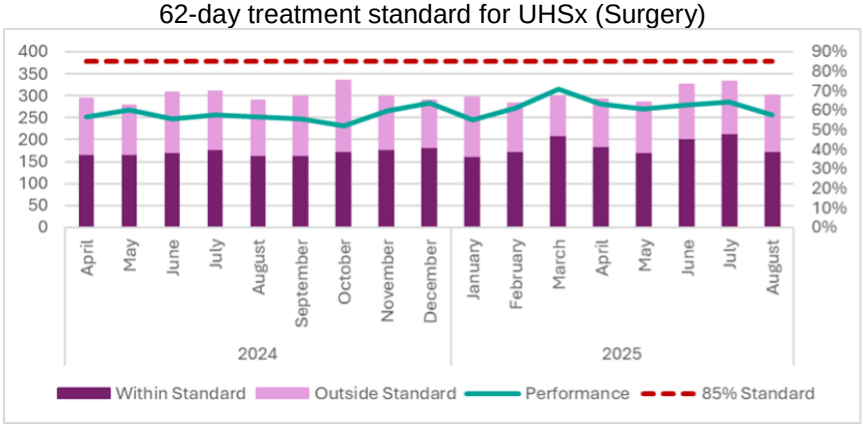
The operational standard is 85% and has not been met since December 2015. Achieving this standard is reliant on high performance of the other two standards.
The current operational target for 62-days is set at 75% to be achieved by March 2026.

62-day treatment standard for UHSx (all cancers, all treatments)

Year	Month	Within Standard	Outside Standard	Performance
2025	January	327	239	57.7%
	February	326	211	60.7%
	March	375	170	68.8%
	April	336	191	63.8%
	May	343	217	61.2%
	June	348	232	60.0%
	July	390	232	62.7%
	August	344	226	60.4%

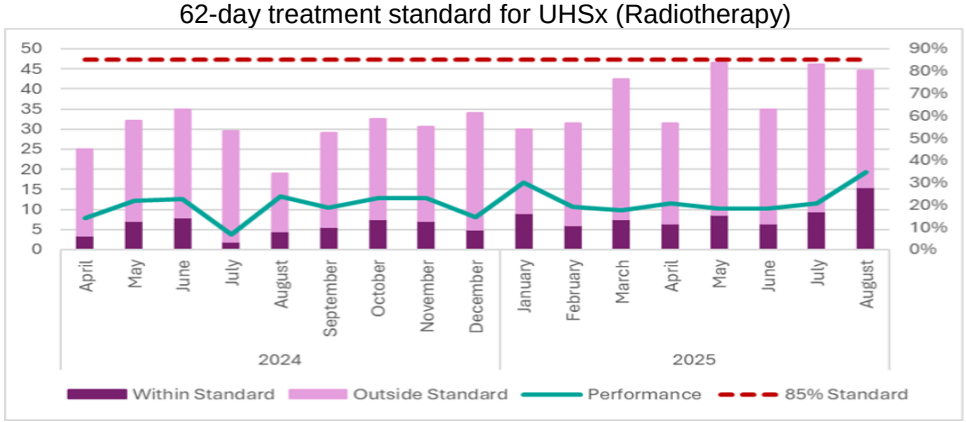
NB Unvalidated data in September demonstrates 62-day performance at UHSx has further reduced in September to **59.6%.** This was forecasted by the Trust in August but has been observed in September due to the specific challenges within the skin pathway together with some non-recurrent capacity challenges in Urology (which are since recovered). 62-day performance in UHSx is forecast to improve month on month to March 2026.

62-day treatment standard for UHSx (Surgery)



Year	Month	Within Standard	Outside Standard	Performance
2025	January	163	134	54.9%
	February	174	109	61.5%
	March	211	88	70.7%
	April	185	107	63.4%
	May	173	113	60.5%
	June	204	121	62.8%
	July	215	119	64.4%
	August	174	127	57.8%

62-day treatment standard for UHSx (Radiotherapy)



Year	Month	Within Standard	Outside Standard	Performance
2025	January	9	21	30.0%
	February	6	26	19.0%
	March	8	35	17.6%

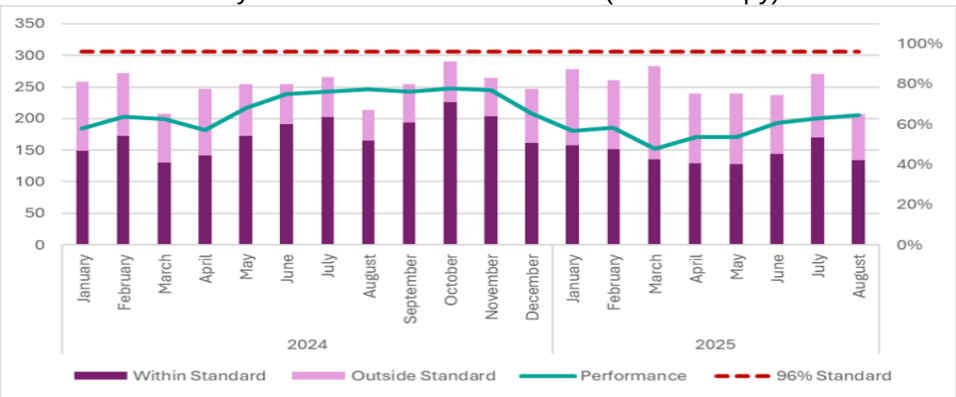
15

	April	7	25	20.6%
	May	9	38	18.3%
	June	7	29	18.6%
	July	10	37	20.7%
	August	16	29	34.8%

UHSx 31-day performance

Drug therapy performance at UHSx against the 31-day standard was 89.5%, showing a declining position from mostly meeting target in 2024 (year average 96.7%) to a year-to-date average of 92.3%. Surgery performance for August was 71.8% (year average 72.9%) and radiotherapy performance was 64.7% (year average 63.3%). This reflects that there is some recovery of the radiotherapy position following a declining performance in the early part of the year – as detailed in the below chart.

31-day treatment standard for UHSx (Radiotherapy)



Year	Month	Within Standard	Outside Standard	Performance
2025	January	158	120	56.8%
	February	152	109	58.2%
	March	135	148	47.7%
	April	129	111	53.8%
	May	128	111	53.6%
	June	144	93	60.8%
	July	170	100	63.0%
	August	134	73	64.7%

4.0 SPECIFIC PERFORMANCE WITHIN CANCER PATHWAYS (TUMOUR SITE LEVEL) FOR BRIGHTON AND HOVE

In order to further understand the position for Brighton and Hove patients, the following charts provide an insight into how specific tumour sites are currently performing within UHSx compared to the previous year, as well as showing their relative impact on overall delivery by the Trust for cancer

16

patients in the Brighton and Hove population.

The following chart demonstrates that in August 2024, the most challenged pathway for providing timely diagnosis to Brighton and Hove patients was gynaecological cancer, followed by lower GI. Skin cancer diagnosis rates were positively contributing to the overall Trust performance by 1.3 percentage points (pp) times greater than the target. By August 2025, the position regarding confirmed skin cancer diagnosis had significantly deteriorated, now showing a poorer position for these patients as well as a negative impact on overall Trust performance.

28-day FDS Pathway	Impact Aug-24	Impact Aug-25
Brain/Central Nervous System	0.1	0.0
Breast	-0.1	2.4
Children	0.1	0.1
Gynaecological	-6.5	-0.5
Haematological	0.0	-0.1
Head & Neck	0.5	1.6
Lower Gastrointestinal	-4.1	-1.5
Lung	0.1	0.0
Other		0.0
Sarcoma	0.1	0.1
Skin	1.3	-6.4
Upper Gastrointestinal	-0.4	-0.9
Urological	0.0	-0.8

31-day combined performance has not changed significantly year on year from 84% in Brighton and Hove (August 2025).
In August 2024 the pathways with the largest negative pp impact were breast, lung and lower GI.
In August 2025 the pathways with the largest negative impact were overwhelmingly breast and skin, with significant deterioration in skin and notable improvements in lung.

31-day combined Pathway	Impact Aug-24	Impact Aug-25
Brain/Central Nervous System	0.0	0.1
Breast	-3.3	-5.7
Children		0.0
Gynaecological	-1.3	-0.3
Haematological	0.3	-0.7
Head & Neck	-0.4	0.2
Lower Gastrointestinal	-2.2	-0.1
Lung	-3.2	-0.2
Other	0.1	0.0
Sarcoma	0.1	0.0
Skin	-1.1	-4.3
Upper Gastrointestinal	-0.3	0.2
Urological	-0.5	-1.6

17

31-day combined performance by treatment modality shows that the overwhelming challenge was in surgery and radiotherapy, with improvements in radiotherapy but further deterioration in surgery. **By modality and pathway, the top three impact pathways in August 2025 were; skin surgery (-4.3pp), breast radiotherapy (-3.1pp) and breast surgery (-2.8pp).**
These three pathways total over 10 percentage points detraction from the 96% target.

31-day combined Pathway	Impact Aug-24	Impact Aug-25
Drug	0.8	-1.8
Other	0.0	0.1
Palliative	0.5	0.4
Radiotherapy	-5.7	-2.7
Surgery	-7.3	-8.4

In terms of the 62 day combined pathways for the Brighton and Hove population, the chart below demonstrates that in August 2024, the pathways with the largest negative impact on overall performance were lower GI, with further notable negative impacts, particularly from breast and urology.

Conversely, by August 2025 the pathway with the largest negative impact was overwhelmingly breast, whilst stabilisation in lower GI, and improvements in urology.

However, the subsequent 62 days chart further demonstrates that whilst treatment phase for skin cancer patients is able to partially recover (due to the nature of skin cancer first definitive treatment most often recorded with removal of a malignant lesion) it has unusually remained non-compliant. Other pathways such as breast, urology and lower GI are shown where the targets for treatment at 62 days remain challenged.

62-day combined Pathway	Impact Aug-24	Impact Aug-25
Breast	-6.4	-14.1
Gynaecological	-3.8	-1.6
Haematological	-0.8	-1.6
Head & Neck	-3.7	-4.2
Lower Gastrointestinal	-10.4	-5.8
Lung	0.1	-3.3
Other	-0.9	0.0
Skin	0.6	-2.8
Upper Gastrointestinal	-2.6	-3.3
Urological	-5.8	-7.1

[1] NHS cancer tiering is a system for classifying trusts based on their performance in cancer waiting times, allowing NHS England to provide targeted support and is a key part of the Elective Recovery Plan

Agenda Item 16

Report to B&H Health Overview & Scrutiny Committee

November 2025

NHS Sussex Integrated Care Board (ICB) Update

Summary

This paper summarises the progress in implementing change across the NHS to enable us to improve the health outcomes, reduce the health inequalities and secure the best value for money from the delivery of high-quality NHS services.

The paper outlines several key foundations to enable this; through the organisational change and our transition to a Surrey and Sussex ICB; through our operational delivery such as our winter plans, and through planning for the future and service transformation such as ICT development and a major services review, and commissioning intentions for 2026-27.

Recommendation(s) to the Board

The B&H Health Overview & Scrutiny Committee is asked to note the update.

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1 NHS Sussex Transition

Earlier this year on 13 March, the Government announced significant changes to the structure of the NHS, aimed at strengthening roles and reducing duplication so more funding can be directed to the frontline care of patients.

As part of this NHS reform, Integrated Care Boards (ICBs) had been directed to significantly reduce their operating costs by an average of 50% and focus on their critical role as strategic commissioners.

After careful consideration, the Boards of the NHS Sussex and NHS Surrey Heartlands ICBs concluded in May 2025 that the only practical way to reliably fulfil their statutory and legal duties within the nationally-determined running cost allocation of £19 per head of weighted population, was to expand their geographical footprint across Sussex and the whole of Surrey (including the Surrey Heath and Farnham areas of Surrey currently covered by the NHS Frimley ICB).

A joint ICB Transition Programme has been established across Surrey and Sussex to lead and coordinate the organisational change required to deliver the nationally required reforms and mandated savings. There are two clear areas of focus – the work to create a new Surrey and Sussex Integrated Care Board from 01 April 2026, and the work to reduce the current organisations' collective workforce to operate within the national ICB allocations.

Progress on the reductions remain dependent upon some national decisions and funding for the staff redundancies. These dependencies have introduced unavoidable

delays to the commencement of formal staff consultation and has limited our ability to meet the original timescales of completing the ICB restructuring by December 2025.

However, progress continues towards the establishment of the new Surrey and Sussex ICB. Following the recent announcement of the appointment of Ian Smith as the Chair of NHS Surrey Heartlands and NHS Sussex Integrated Care Boards from 1 October 2025, Karen McDowell has now been appointed as Chief Executive Officer and started in role on 15 October 2025. Karen has been the Chief Executive Officer at NHS Surrey Heartlands for the last two years, having also been Deputy Chief Executive prior to this. Karen's career in the NHS spans more than 30 years where her extensive experience covers a breadth of areas and includes Deputy Chief Executive and Chief Finance Officer roles across Surrey, south west London and Manchester. As well as being a member of the Chartered Institute of Management Accountants (CIMA), Karen is also a strong advocate for tackling health inequalities, which includes her work as a trustee and volunteer for a voluntary organisation that works to tackle multiple disadvantage in east Surrey.

Further to this Karen has appointed Mark Smith as Deputy Chief Executive of the two organisations, and Ian is currently undertaking a recruitment process for Non-Executive Directors to support the transition to a new organisation.

An Executive consultation has been launched across Surrey Heartlands and Sussex ICBs for a joint Executive team, with posts expected to be confirmed by mid-December.

A Mutually Agreed Resignation Scheme launched in September has now concluded across the NHS Sussex and NHS Surrey Heartlands ICBs. The ICBs are working to manage the impact of these departures, including careful consideration of the work that needs to be prioritised, so that we can continue to deliver for our population.

In addition to workforce schemes, the Joint Transition Committee is overseeing the formal preparations and assurance processes for the launch of a new ICB and the shutdown of the two existing organisations. This includes work on systems and processes, governance, and ways of working.

Supporting staff remains a key commitment, and we continue to take proactive steps to engage staff. This includes the availability of practical advice, training and support. We are working closely with our Staff Networks and Trade Unions to ensure our staff feel heard, valued, and supported throughout this time.

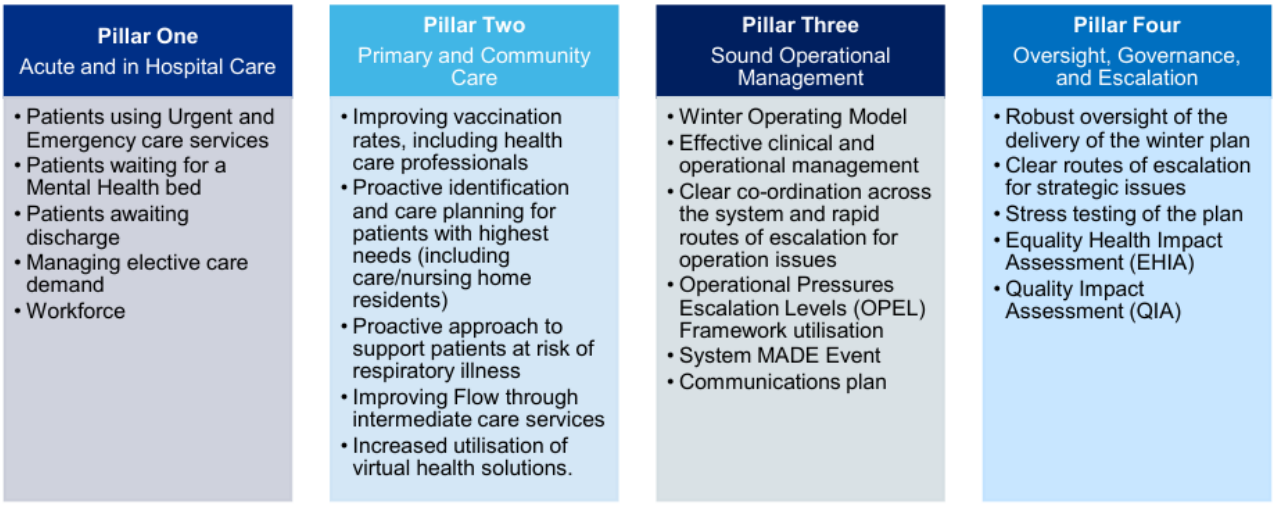
2 Delivering our operational plans for this year

2.1 Winter Plans

Over the summer, the system has been working to prepare our winter plans for the months ahead.

The development of the plan has been clinically led and will have strong clinical oversight of its implementation. Based on lessons identified from the review of last year's plan and identification of areas of greatest impact, there is a firm focus within the plan on proactive care, risk stratification and vaccination programmes (particularly for staff), alongside other key actions that reflect key areas of focus such as managing patients in Emergency Departments who are awaiting Mental Health services.

Along with locally agreed actions to address the capacity challenges, the ICB has agreed four system focus areas that draw on best practice. These focused areas aim to reduce demand on our services, ensure people receive the right care from the right organisation at the right time and are supported to return to their normal place of residence at the earliest opportunity. The four focus areas are:



3 Delivery of the Sussex Health and Care Integrated Care System's Five-Year Strategy

3.1 Neighbourhood Health

The Sussex Health and Care Integrated Care System's five year strategy, Improving Lives Together, outlines the commitment of all health and care partners in Sussex to work together to deliver integrated community teams (ICTs) through the provision of proactive and preventive care, to grow and develop the health and care workforce and to ensure they have the digital tools to enable them to provide the very best care for the Sussex population.

Since the last HWBB ICB update regarding the progress on the development of ICTs, all seven ICTs have held multi-disciplinary team workshops, which have been hugely productive. These workshops brought together our front-line colleagues in the 24 neighbourhood teams across West Sussex, with the primary goal to enhance their ways of working, particularly around supporting those with the highest and ongoing needs within our communities.

The workshops introduced the John Hopkins Adjusted Clinical Groups (JHACG) System, the NHS recommended tool for segmentation and risk stratification which will allow a standardised approach across Sussex using health and social care data. The initial focus of the Sussex-wide roll out is on adults aged 65 and older with evidence of two or more frailty concepts. The initial focus on a relatively small cohort is allowing teams to develop ways of working, with intentions for teams to move down the patient need groups once ways of working are developed, embedded and ready.

In Sussex, Hastings and Rother has been selected as one of the 43 pilot sites nationally for the National Neighbourhood Health Implementation Programme (NNHIP) and Crawley has been selected as part of a regional NHSE South East Regional Neighbourhood Health Accelerator programme. This programme provides an opportunity for our teams to be frontrunners in the implementation of neighbourhood health in line with the government's 10 Year Health Plan.

With regards to the NNHIP, it is important to reflect that each of the three Sussex 'Places' — Brighton and Hove, East Sussex, and West Sussex - submitted applications to the NNHIP. The applications included a total of 76 signatures from constituent organisations demonstrating wide endorsement and commitment of our ICT development. These included Chief Executives from NHS Sussex, local authorities, NHS Trusts, Primary Care Network (PCN) Clinical Directors, and leaders from Voluntary Community and Social Enterprise (VCSE) and hospice alliances, community pharmacy, and ambulance.

In addition, the NHSE South East Regional Neighbourhood Health Accelerator programme is aimed at developing collective leadership for integrated, community-focused health improvement; accelerating progress on neighbourhood health opportunities through evidence-based action learning and fostering collaboration across organisational boundaries to reduce inequalities and deliver joined-up care.

We will be working to share the learning from these two programmes as well as rolling out a locally developed leadership development programme for all 13 ICT Leadership Groups.

3.2 Major Services Review

System partners, under the direction of the Sussex NHS Committee in Common (CiC), have also been leading a significant service change programme as part of a major services review (MSR). It follows the case for change which highlighted that without service transformation by 2034/35, activity volumes across all points of delivery would increase significantly. There is also recognition that the NHS system in Sussex remains materially over its fair-share allocation of funding as determined by NHS England (NHSE).

The MSR has become the Sussex-wide vehicle for delivering large-scale service transformation and marks a recognition from Sussex Health and Care system partners of the need to move from reactive, institution-centric models of care to integrated, prevention-focused delivery led at place and neighbourhood level.

In September the NHS Sussex Board approved the new care models for Rehabilitation and Intermediate Care (RIC) and Urgent and Emergency Care (UEC), including clarifying the role of ICTs within each of those models. The care models demonstrate clear benefits for our population alongside financial benefits achieved through more cost-effective use of resources.

The vision for RIC in Sussex is to enable and support individuals to recover or adjust, to achieve their full potential and to live as full and active lives as possible. The key shifts in the new model of care is to move from the current model where poor communication, lack of discharge support, and inconsistent follow-up care are common experiences, to one which achieves the following:

- Adopts an integrated needs led assessment approach to undertake triage, assessment and matching of need
- Clear pathways of care for hyperacute, acute and specialist rehabilitation
- Integrated intermediate care services (short term rehabilitation and reablement) with both bed-based and home-based support offers which can offer proactive step-up care and admission avoidance as well as support on discharge
- Clear pathways for ongoing care, with both community rehabilitation and self-care services
- Personalised care and support at its core

The vision for UEC is for everyone in Sussex to be able to easily access safe, high-quality and sustainable UEC, at the right place and time to best meet their needs. The key shifts in the new model of care is for both physical health and mental health services to address the current fragmented model of care, where our residents report poor care environments, long waiting times, poor communication, inequalities in access and poorly understood alternatives to attending an Emergency Department, to one which achieves the following:

- Supporting and directing the public to seek advice and guidance before choosing which service best meets their needs
- More effective, digitally enabled navigation and triage, early in the pathway (including consult and complete options)
- Easily accessible community care options, on offer 7 days per week to manage the majority of activity requiring face-to-face or virtual support
- Acute hospital services (e.g. Emergency Departments, Same Day Emergency Care (SDEC) or Assessment Units) reserved for the treatment of patients whose needs can only be met in that setting
- Access to specialist clinical advice and guidance where an individual's care pathway is unclear
- Neighbourhood health services which adopt active pull models to support known patients with the highest needs or ongoing needs, who present in acute settings, back into the community at the earliest opportunity

The new model of care is set out in the NHS Sussex Commissioning Intentions for 2026/27 setting out the formal expectations for ICTs and providers, taking account of the system readiness to adopt the new models and building on the existing improvement work underway in the system.

In addition, a pre-consultation business case (PCBC) will be developed to establish the service change required and potential options to be considered through public consultation.

3.3 Commissioning Intentions

NHS Sussex recently published its Commissioning Intentions for 2026/27, following significant engagement over the last two months to engage partners, ensuring the intentions reflect the key issues of importance to our Sussex residents and ensure it is ambitious in our aim to improve outcomes for local people whilst ensuring it is achievable for next year.

The intentions are based on the direction set out in our jointly agreed system strategy Improving Lives Together, the major service review case for change and the 10 Year Health Plan. They focus on ensuring our commissioning supports delivery of the ambitions articulated within those strategies and in particular, how we accelerate neighbourhood health and deliver high performing, cost effective acute services.

The commissioning intentions are purposefully ambitious and reflect a desire to move forward at pace. They focus on the service transformations which we consider are necessary to address what our population needs from NHS services in Sussex and the changes in approach to service delivery which will support that.

4 Conclusion

Overall, there continues to be significant progress in implementing change across the NHS to enable us to improve the health outcomes, reduce the health inequalities and secure the best value for money from the delivery of high-quality NHS Services.

Brighton & Hove City Council

Scrutiny Report Template

Health Overview & Scrutiny Committee

Agenda Item 18

Subject: **Chalkhill – Temporary Closure**

Date of meeting: **19 November 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 presents information on Sussex Partnership NHS Foundation Trust (SPFT) plans to temporarily close Chalkhill Hospital, an inpatient acute unit for young people located in Hayward's Heath. The temporary closure will enable SPFT to redesign the clinical service model for the hospital, to recruit staff, and to make physical improvements to the building

1.2 Additional information, provided by SPFT, is included as Appendix 1.

2. Recommendations

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

3. Context and background information

3.1 Chalkhill delivers a Tier 4 General Adolescent Unit inpatient mental health service (CAMHS). Chalkhill is run by Sussex Partnership NHS Foundation Trust (SPFT) and is a 12-bedded mixed gender inpatient unit where children and young people are admitted if they require assessment and treatment for acute mental health needs. The unit is located in the grounds of the Princess Royal Hospital, Hayward's Heath.

3.2 In October 2023 Chalkhill was inspected by the Care Quality Commission (CQC), and the CQC's inspection report made a number of recommendations for improvement. Subsequently, SPFT has sought to implement these recommendations, alongside internally identified improvement actions. The CQC carried out a further unannounced inspection in August 25 and raised concerns regarding patient safety. Due to lack of sustained improvement, the Trust made the decision to temporarily close Chalkhill

3.3 The temporary closure will allow the trust to undertake the following activities:

- Redesign the clinical model to ensure the clinical offer is suitable to meet the needs of the children and young people who require inpatient care, following changes in overall acuity and in clinical presentation taking into account national and regional best practice
- Recruit to key clinical leadership roles including the Consultant Psychiatrist / Responsible Clinician and Nurse Consultants
- Complete a programme of organizational development for the new leadership team once recruitment has been completed.
- Undertake estates work to improve the inpatient environment of Chalkhill to ensure it reflects the needs of the patient group

3.4 The trust has made additional investments in community services to enhance opportunities to treat young people at home while Chalkhill is closed. For young people who do require inpatient admission, SPFT is able to place into young people's units in Surrey, Hampshire and Kent and the processes of bed searching remain unchanged. The nearest unit for people from Brighton & Hove is located at Horley on the Surrey/Sussex border. No young people will be placed on adult wards.

3.5 At the time of writing Chalkhill currently has 3 young people admitted. There are detailed clinical plans in place to support either community discharge or transfer to another inpatient unit as required by the proposed closure date in early December 2025.

3.6 There is currently no date set for Chalkhill to reopen. The reopening will be dependent on planned building works and recruitment to key clinical roles. However, SPFT has been clear that the closure is temporary, and it fully intends to reopen. It is anticipated that bed numbers in the refreshed unit will be similar to current levels, although the details of this will be determined by the new clinical model. Given the uncertainty about the re-opening date, current Chalkhill staff will be permanently rather than temporarily redeployed across other clinical services

3.7 SPFT has begun engagement with staff and service users. There will be further engagement with service users to develop the refresh plans, using co-design principles.

3.8 More information, provided by SPFT, is included as Appendix 1.

4. Analysis and consideration of alternative options

4.1 Not relevant for this information report.

5. Community engagement and consultation

5.1 None directly undertaken for this information report.

6. Financial implications

6.1 None identified for this information report.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted: 10/11/25

7. Legal implications

7.1 The Council's Health Overview & Scrutiny Committee has statutory responsibility for reviewing and scrutinising matters relating to the planning, provision and operation of health services in Brighton & Hove. As a result, it is the correct body to scrutinize the changes to healthcare provision described in this Report.

Name of lawyer consulted: Victoria Simpson Date consulted 11/11/2025

8. Equalities implications

8.1 None directly for this information report.

9. Sustainability implications

9.1 None identified.

10. Health and Wellbeing Implications:

10.1 These are addressed in the body of the 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 SPFT plans to temporarily close Chalkhill hospital in order to refresh the clinical model, recruit additional staff and make physical improvements to the unit.

Supporting Documentation

Appendices

1. Information provided by SPFT

Mental health, learning disability and neurodevelopmental care

NHS
Sussex Partnership
NHS Foundation Trust

SussexPartnership.nhs.uk

Brighton and Hove HOSC November 2025

Chalkhill update

University Hospital Association
MEMBER

Our vision
Delivering great care and improving outcomes together

Chalkhill background

- Chalkhill is a 12-bedded mixed-gender inpatient ward in Haywards Heath for 12-18-year-olds who have acute mental health needs
- We offer assessment and treatment of a wide range of mental health difficulties and needs
- CQC inspection in 2023 identified recommendations for improvement which SPFT has sought to implement alongside internally identified improvements
- Further inspection in August 2025 raised concerns
- SPFT made the decision to temporarily close the unit due to lack of sustained improvement and to provide an opportunity to put in place required changes
- It remains our intention to re-open the ward in due course.

Changes required during temporary closure

Sussex Partnership NHS Foundation Trust

- Redesign the clinical model to ensure it meets the needs of the children and young people who require inpatient care, following changes in overall acuity and in clinical presentation
- The new clinical model to reflect national and regional best practice and be informed and coproduced by young people and their families.
- Recruit to key clinical leadership roles
- Complete a programme of organisational development for the new leadership team once recruitment has been completed
- Undertake building work to improve the inpatient environment and reflects the needs of the patient group.

Actions and mitigations

- During 12-week window to closure we have been working closely with young people, their families and carers
- Clinical plans are in place to support either community discharge or transfer to another inpatient unit by December 2025
- Additional investment in community services to treat young people at home during period of temporary closure
- Engaging with staff to redeploy to alternative roles
- Specific actions underway to make changes and identified improvements:
  - Engagement plan with young people, families and carers to shape new clinical model
  - Recruiting psychiatrist to lead new care model design
  - New workforce model design underway in line with Quality Network for Inpatient CAMHS standards
  - Benchmarking visits to other services to see best practice
  - Draft building work designs under review
  - Governance structures being established to oversee progress

Thank you for your time

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NHS Foundation Trust

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Our vision
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