Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date: **18 November 2026**

Time: **4.00pm**

Venue: **Council Chamber, Hove Town Hall**

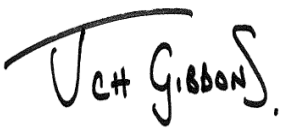
Members: **Councillors:** Wilkinson (Chair), Evans (Deputy Chair), Oliveira, Hill, Hogan, Galvin, Parrott, Simon, Winder and Baghoth; **Cooptees:** Nora Mzaoui (CVS), Mary Davies (OPC), Geoffrey Bowden (Healthwatch)

Contact: **Luke Proudfoot**
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Chief Executive
Hove Town Hall
Norton Road
Hove BN3 3BQ

Date of Publication - Tuesday, 10 November 2026

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.

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

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

10 MINUTES 7 - 16

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 08 July 2026 (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 2026;
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 6th November 2026.

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 MATERNITY SERVICES AT THE ROYAL SUSSEX COUNTY HOSPITAL (2026) 17 - 44

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

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

15 SURREY & SUSSEX WINTER PLANNING 2026-27 45 - 82

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

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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BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 8 JULY 2026

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Wilkinson (Chair)

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

Other Members present: Geoffrey Bowden (Healthwatch), Nora Mzaoui (VCS), Mary Davies (Older People's Council)

PART ONE

1 PROCEDURAL BUSINESS

1(a) substitutes

1.1 There were no substitutes. Cllrs Baghoth and Hogan sent apologies.

1(b) Declarations of Interest

1.2 Cllr De Oliveira declared an interest in Item 8, NHS Change, noting that his partner is employed at NHS Surrey & Sussex.

1(c) Exclusion of Press & Public

1.3 The press & public were not excluded from the meeting.

2 MINUTES

2.1 The minutes of the meeting of 22 April 2026 were agreed as an accurate record.

3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

We're looking at 3 issues today. First, I've asked the hospital trust to come and present on their plans to reconfigure the acute floor at the Royal Sussex County Hospital. This is a major capital project that has already seen the creation of new surgical and medical assessment units. We are now entering the phase where the hospital's emergency department is being

revamped. We all know that improvements to A&E are urgently needed and I'm sure we all welcome the reconfiguration. Members will be keen to know what improvements are being made and how this will improve patient experience and the conditions that emergency department staff have to deal with every day.

However, rebuilding an emergency department while still running services from the same building is a challenging prospect and I wanted to give members the opportunity to seek assurances that everything possible is being done to minimise the impact on patients of what will be a long and complex build. While this is the hospital trust's project, health and care system partners have an important role to play in working together to reducing unnecessary admissions and discharge delays during the build, and members may have questions for NHS commissioners and for adult social care as well as for University Hospitals Sussex.

Second, we have an item on cancer diagnosis and treatment. This is an update requested by committee members following a presentation at last November's committee. This item will also be led by University Hospitals Sussex.

Finally, we have our regular update from NHS Surrey & Sussex Integrated care Board on changes to the local NHS commissioning landscape.

4 PUBLIC INVOLVEMENT

4(a) public question from Jo

4.1 Cllr Evans read out the public question at Jo's request: How does Southdown redesign of services demonstrate empowering mental health service user voices when their feedback and complaint portal is designed too small to hold complaints and AI is used to change the meaning of complaints into inaccurate versions of those complaints?

4.2 The Chair told members that he had forwarded the question to Southdown who manage the services in question and had received the following response:

Southdown's complaints process uses a Microsoft Customer Voice form, which includes a 4,000-character field for describing a complaint. This is normally sufficient for people to explain their concerns. Where additional information is required, it can be submitted by email and is retained in full as part of the complaint record. In some cases, people choose to submit their complaint by email rather than using the form. Where this happens, the service manager enters the complaint into the Microsoft Customer Voice form on the complainant's behalf. If the original email exceeds the 4,000-character limit of the relevant form field, the full email is retained within the complaint record and considered as part of the investigation.

In all cases, complaints are explored using all the information we receive. Information recorded within the complaints system is used to support acknowledgement and response correspondence. Where the length of a complaint exceeds the capacity of a relevant field within the system, a summary is used instead, while the full complaint remains available to inform the investigation. This approach is explained to the complainant and is not intended to alter the meaning of the complaint, only to summarise its content. Supporting software may be used to produce this summary and, if the complainant feels it is inaccurate, the summary can be updated.

4(b) public question from Mr Gary Vallier

4.3 Mr Vallier asked: The independent NHS investigation into WellBN has now identified actual and potential harm arising from prescribing practices affecting children and young people in Brighton. For many months HOSC declined to pursue questions about local safeguarding arrangements on the basis that an investigation was underway.

Now that the report has been published, what specific scrutiny activity will HOSC undertake to examine the wider system issues identified, including relationships between schools, youth services, primary care and specialist gender services?

4.4 The Chair responded:

Thank you for your question. I note the publication of the NHS England review. The review has identified serious issues regarding the clinical approach to care by some GPs at the WellBN practice and I welcome the actions taken by NHS England and NHS Surrey & Sussex as set out in the report.

Following today's meeting, I will discuss with committee members whether this is an issue they wish to scrutinise in depth. I will consider whether it is appropriate to scrutinise NHS Surrey & Sussex Integrated Care Board's role in commissioning and overseeing local primary care services. This may include inviting the ICB to attend a future meeting.

5 MEMBER INVOLVEMENT

5.1 A member letter was received from Cllr Mitchie Alexander, Cabinet Member for Communities, Equalities, Public Health and Adult Social Care. Cllr Alexander attended to present her letter which reads

I have been having various conversations recently with advocate groups for people with learning disabilities and autism and also direct conversations with people with learning disabilities and/or autism.

They tell me that they find the waiting area in A&E very, very difficult due to their autism and in fact one man told me that he avoided going to A&E because he couldn't face the busy waiting room and in the end his medical condition got suddenly worse, due to the fact that his issue couldn't be dealt with when it first arose.
Can the chair and the committee members ask UHSx to please include within the designs of the new A&E, at least one 'quiet, autism friendly' room. Where someone with certain needs, such as a learning disability or autism can wait to be assessed.

The impact of being very unwell and/or in a lot of pain is extremely heightened for a person with learning disabilities and/or autism and this could be better managed by having a quiet space available to them, whilst they wait for an assessment.

The redesign of the A&E department is the perfect opportunity to consider persons in our city with complex needs and how the area can include provision in the future for those with more

complex needs, so that their wait for assessment can be more manageable for them and their carers and indeed for the other people waiting in the communal area for medical assessments.

5.2 The Chair responded, thanking Cllr Alexander for her letter and agreeing to raise this important subject with representatives of University Hospitals Sussex NHS Foundation Trust when the plans to reconfigure the acute floor of the Royal Sussex County Hospital were discussed later in the meeting.

6 ROYAL SUSSEX COUNTY HOSPITAL: ACUTE FLOOR RECONFIGURATION

6.1 This item was presented by Nigel Kee, University Hospitals Sussex NHS Foundation Trust (UHSx) Chief Delivery Officer; Nikki Mead, Transformation Programme Manager; Craig Marsh, Head of Nursing, Acute Floor; and Stephen Mardlin, Royal Sussex County Hospital (RSCH) Hospital Director.

6.2 Mr Kee told members that the acute floor at RSCH needed to be reconfigured to improve capacity and bring services up to modern standards. Ms Mead added that the reconfiguration would provide an improved environment for all patients, including people with dementia, people with learning disabilities and neurodiverse people. There will be more quiet areas and a 76% increase in individual cubicles, which will reduce noise and provide for adjustable lighting to help patients feel comfortable. The capacity and the footprint of waiting areas will be increased and they will be spilt into different sections so not everyone has to wait in the same space for treatment. Earlier clinical triage will help identify those who need additional support to wait. Colour will be used to split the area into zones, helping patients orientate through the department. There has also been a focus on the materials used, recognising that some vulnerable patients struggle with glare from walls or similar issues.

6.3 Mr Marsh told the committee that staff and patient feedback has informed the reconfiguration plans. For example, the creation of separate waiting areas will allow patients to progress in their waits, moving from general to more specific areas once their needs have been identified. This is something that many patients value. Close attention has been paid to ensuring that the new environment works for staff, with additional staff facilities and equipment storage.

6.4 Mr Kee added that there are other significant, but less visible, elements of the reconfiguration, including an upgrade of digital services and improvements to ventilation systems. The new acute floor will provide more privacy and dignity for patients, more capacity, better infection control and better trauma care. Ms Mead outlined the timeline for completion of the Phase 2 enabling works and of Phases 2 and 3 of the build. The work is expected to complete in 2030.

6.5 Cllr De Oliveira stated that system pressures such as discharge delays and a lack of mental health acute beds meant that improvements to the acute floor would not necessarily address the local crisis. Mr Kee responded that it was important that, in addition to the reconfiguration, there are better pathways for patients, recognising that some people do not need to be treated in the emergency department. The trust is working closely with partners to tackle the system pressures identified by Cllr De Oliveira. Ms Mead added that she agreed that additional capacity is not a panacea; people presenting at A&E who require a mental health bed, and discharge flow are identified as major project risks.

6.6 Mary Davies (Older People's Council) praised the Phase 1 facilities that have already been opened. She asked whether an Equality Impact Assessment (EIA) could be shared with the committee. Ms Mead replied that an EIA for Phases 2 and 3 was being developed as part of the project business case. Once complete, this can be shared with the committee. ACTION

6.7 Cllr Parrott questioned the degree to which patients had been involved in the reconfiguration plans. Mr Kee responded that he welcomed the challenge around patient voice. The trust recognises the importance of involving patients at all stages of the reconfiguration. Mr Marsh noted that it is particularly difficult to capture patient views of emergency services. He works closely with nursing staff and via an Emergency Department Patient Forum to get information. Mr Mardlin added that he had recently attended the West Integrated Community Team (ICT), to discuss how to use ICT and GP practice-level data on admissions to better understand patterns of admission and where best to intervene to reduce unnecessary admissions. This is a key element of improving the experience of those people who do need to use emergency services.

6.8 Geoffrey Bowden (Healthwatch) queried whether there was sufficient capital funding to deliver the programme of changes. Ms Mead replied that the programme is in a strong position. There is contingency funding and some aspects of the programme have already been delivered within budget.

6.9 Cllr Evans told members that she had recently attended A&E on a weekday afternoon and had found it chaotic, with far too many people waiting in an unsuitable environment. She contrasted this with the reception at the Louisa Martindale Building, where a very large space is underused. Cllr Evans questioned whether it was possible for the trust to maintain clinical capacity and sufficient waiting space for the duration of the works and queried the 2030 end date. She also asked about engagement with staff and unions, making the point that staff in some hospitals report that permanent staff are treated differently to staff working temporarily or on rotation. Mr Kee replied that relations with staff are good. The trust does not discriminate between permanent and temporary staff. UHSx is confident it can meet the 20230 target for completion of works. However, there is always the possibility that this may be impacted by geopolitical factors beyond the trust's control. Mr Marsh added that recent weeks had been very challenging, with the trust going into business continuity at one point. Patient pathways need to be improved, and this work should not wait for the reconfiguration to be completed. If people are waiting in A&E for many hours to be seen, then they probably should not be in A&E and would be better served being directed elsewhere for treatment. Mr Marsh explained some of the measures taken to engage staff. Mr Mardlin explained that the recent heat wave had impacted hospital services, both because some equipment did not function properly in the high heat and humidity and because South East Coast Ambulance Service was overwhelmed with demand. This meant that it took them longer to reach and convey patients, leading to patients arriving in hospital with their conditions more acute than they should have been. Whilst the weather had subsequently cooled somewhat, the heatwave had a knock-on effect which was still being felt in the following week.

6.10 Nora Mzaoui (CVS representative) asked about access and wayfinding to A&E and about the use of sub-waiting areas. Mr Kee replied by acknowledging that more needs to be done in terms of improving wayfinding. In terms of sub-waiting areas, some patients do dislike this, but there are real advantages in being able to progress patients to less crowded waiting areas that are appropriate for their medical needs. Ms Mead added that sub-waiting areas should only be used for different stages of a patient's treatment journey – patients should not

simply be moved from waiting area to another. Wayfinding is a challenge. However, the staff at the Louisa Martindale reception are excellent and can help direct and sometimes accompany patients to A&E.

6.11 Cllr Winder asked about the role of GPs in improving A&E. Mr Kee responded that the business of A&E inevitably makes it harder to deliver good clinical outcomes and positive patient experience. GPs have a key role to play in avoiding unnecessary A&E attendance and admissions and the trust is committed to working with local GP practices via city ICTs to reduce unnecessary attendances.

6.12 Cllr Hill asked questions about RSCH performance in terms of corridor care and ambulance handover times. Mr Kee replied that the trust is working hard to reduce incidents of corridor care and is receiving national support for this. Mr Marsh responded that, unlike many other trusts, UHSx has a policy of not delaying ambulance handovers by making patients wait in ambulances when there are no beds available for them. However, this can mean that more people have to be accommodated in corridors.

6.13 Cllr Hill asked a question about out of hours capacity at the early pregnancy unit. Mr Kee agreed to take away this question. Mr Kee subsequently confirmed that the Early Pregnancy Unit is open 24/7 and can be accessed by patients self-presenting as well as via the Emergency Department.

6.14 Cllr Simon asked about the lack of natural light in the ED. Ms Mead replied that the use of lightbox skylights has been successfully trialled in the AMU and will be rolled out across ED.

6.15 Cllr Simon asked about people waiting in the ED for a mental health bed after presenting at A&E. Mr Kee replied that Sussex Partnership NHS Foundation Trust (SPFT) has an improvement plan to reduce these presentations, and UHSx is working in partnership with SPFT on this. Ms Mead added that the current area used for people waiting for a mental health bed is not replicated in the reconfiguration plans. This is an issue that needs to be addressed by the entire local health and care system.

6.16 Cllr Simon asked about work with the most deprived communities around admission prevention. In response, Tanya Brown-Griffith (NHS Surrey & Sussex) outlined neighbourhood health improvement plans, including the development of neighbourhood hubs. Mr Mardlin added that the trust is committed to working closely with ICTs across the city to understand and address local community needs.

6.17 Cllr De Oliveira asked how confident the trust could be in its modelling. Mr Kee responded that UHSx uses national tools to model capacity and demand. Ms Mead added that the modelling for the reconfiguration project was based on a 10 year forecast for demand which uses current activity as a baseline and allows for significant demographic growth.

6.18 Mr Bowden raised the issue of police bringing people in mental health crisis into A&E as a Section 136 place of safety. Mr Kee replied that there will be SPFT presence at the reconfigured site, but not a dedicated space to house people waiting for admission into acute mental health beds as is currently the case. UHSx will continue to work with Sussex police to manage the issue raised by Mr Bowden.

6.19 Cllr Parrott noted that providers across the local health and care system face significant challenges, including performance problems at UHSx, SPFT and council adult social care. This is important context when thinking about reconfiguration project risk and risk mitigations.

6.20 Cllr Wilkinson asked about reconfiguration project risks in a scenario where discharge delays worsened and further put pressure on ED. Mr Kee replied that there is no loss of ED bed space during reconfiguration, so this is not necessarily a greater risk during Phase 2 and 3 than it is currently. However, UHSx operates a number of acute sites and spare capacity in other hospitals can potentially be used to relieve pressure on RSCH.

6.21 Cllr Wilkinson asked about plans to engage with particularly vulnerable groups, including people with learning disabilities, people with autism and people with dementia, in advance of Phases 2 and 3 of the reconfiguration. Mr Kee responded that engagement plans are in place. Ms Mead added that the main disruption will be from mid-2027 onwards so there is still some time to focus on community engagement.

6.22 RESOLVED – that the report be noted.

7 CANCER DIAGNOSIS AND TREATMENT JULY 2026 UPDATE

7.1 This item was presented by Nigel Kee, Chief Delivery Officer, and by Dr Sarah Westwell, Lead Cancer Clinician, UHSx. Mr Kee and Dr Westwell outlined recent performance across a number of cancer metrics, including the national waiting times targets. Issues highlighted included:

- A focus on better data collection which supports earlier diagnosis and holistic support
- A multi-disciplinary team approach is key to effective cancer care in many instances, but needs to be used appropriately as it can slow the delivery of care for people with relatively straightforward treatment pathways
- Recent improvement in access for endoscopy
- A focus on patient follow-ups, with personalised follow-up offers that fit around individual patients' lives
- Better use of Patient Recorded Outcome Measures to drive service improvement
- The development of the Sussex Cancer Centre is on track and will deliver many benefits, including a consolidation of radiotherapy machines, with the 6 units currently situated across Sussex being based at the centre plus an additional unit that has recently been purchased
- The consolidation of LGI surgery at Worthing has been very successful
- The introduction of analytical AI for diagnosis of non-malignant skin cancers has been successful, increasing capacity. There is further potential for this technology to be accessed through primary care.

7.2 Cllr Evans asked about people from the most deprived communities tending to present for treatment at a later point. Dr Westwell replied that this is a complex issue, with multiple factors impacting screening rates. Services need a detailed understanding of individual communities in order to understand what specific improvements need to be made.

7.3 Cllr Parrott noted that skin cancer rates are particularly high in over-75s, which is also the group with the highest levels of digital exclusion. Making access to these services digitally is consequently risky. It can also be very difficult for people to manage complex treatment

regimes; having a named nurse can really help. Dr Westwell replied that cancer pathways have traditionally been designed around the needs of doctors and nurses and need instead to be designed around the needs and abilities of patients.

7.4 Cllr Simon asked for more information about improvements to patient follow-ups. Dr Westwell responded that the standard approach is often based around annual appointments with consultants irrespective of whether this makes sense in each individual case. A more stratified approach to follow-up will adopt approaches that are appropriate to each individual's needs.

7.5 Cllr Simon asked why skin cancer performance is an outlier and queried why AI was being used to drive improvement. Dr Westwell replied that there are increasing numbers of skin cancer due to climate change and poor understanding of the risk of developing melanoma. Improving services is particularly challenging because there is a marked variation in presentation across the seasons, with many more people discovering and presenting with potential melanomas in the summer months which can lead to services being overwhelmed. Using AI in this context is appropriate: AI is significantly better and much quicker than humans for some purposes, for example in the identification of unambiguously non-malignant growths. Around 93% of patients seeking diagnosis do not have malignant growths.

7.6 Cllr Winder asked about public confidence in screening. Dr Westwell acknowledged that this is an issue. There is scope to do more, for example by looking to bundle screening for different cancers and by doing focused engagement with low take-up communities.

7.7 Mr Bowden asked why there is no screening programme for prostate cancer. Dr Westwell replied that there is no reliable test for prostate cancer. In addition, prostate cancer is not a single disease; some cancers are very aggressive, but others are not. Identifying and treating non-aggressive cancers may not always be the best option.

7.8 Cllr Hill asked whether the messaging on screening and on prevention was always effective, noting that different approaches may need to be taken for the TNBI population or for young people. Sr Westwell agreed. Services have much to learn from the success of the HPV vaccination programme.

7.9 RESOLVED – that the report be noted.

8 NHS CHANGE: JULY 2026

8.1 This item was presented by Tanya Brown-Griffith, NHS Surrey & Sussex. Ms Brown-Griffith informed the committee of recent NHS developments including the development of an Integrated Needs Assessment for Surrey and Sussex; the development of a 5-year Strategic Commissioning Plan; work on neighbourhood health; and the NHS Excellence award recently given to the East Brighton Integrated Community Team.

8.2 Cllr Parrott commented that recently introduced ADHD assessment pilot seems to be working well and has received good feedback. Cllr Hill asked about the future of the pilot and enquired whether people can transfer onto it. Ms Brown-Griffith agreed to provide a response outside of the meeting.

8.3 Cllr Simon asked how the focus of each neighbourhood health area is agreed. Ms Brown-Griffith replied that each ICT will develop a delivery plan. These will be informed by Joint Strategic Needs Assessment data, Commissioning and Health data jointly agreed by ICT partners and the Sussex Neighbourhood Alliance before being signed off by the Health & Wellbeing Board.

8.4 Cllr Galvin raised concerns about the potential closure of the Sussex Eye Hospitals. Nigel Kee (UHSx Chief Delivery Officer) replied that UHSx was conducting a strategic review of ophthalmology. The trust had written to the HOSC about this in April. No decisions have yet been reached on the long term future of services. However, significant maintenance needs to be undertaken at the Sussex Eye Hospital which will require the temporary relocation of some services to Southlands Hospital.

8.5 RESOLVED – that the report be noted.

The meeting concluded at 8.20pm

Signed Chair

Dated this day of

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 14

Subject: **Maternity Services at the Royal Sussex County Hospital**

Date of meeting: **18 November 2026**

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

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

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

Ward(s) affected: (All Wards);

Key Decision: No

For general release

Glossary	
University Hospitals Sussex NHS Foundation Trust (UHSx)	UHSx is an NHS acute trust which manages hospitals in Brighton, Haywards Heath, Worthing, Shoreham and Chichester
Amos Review	Baroness Amos chaired the National Maternity and Neonatal Enquiry which reported in June 2026
Ockenden Review	Ockenden reviews are a series of investigations, chaired by Donna Ockenden, of maternity services at individual NHS trusts, including Shrewsbury & Telford (2022), Nottingham (2026) and Leeds (2026 – not yet concluded)
Care Quality Commission (CQC)	The CQC is the national NHS and social care regulator. Part of its duties is to inspect individual NHS services, including maternity

1. Purpose of the report and policy context

1.1 This report provides information about maternity services at the Royal Sussex County Hospital (RSCH). It includes some context about the recently concluded Amos review of maternity services, the Ockenden maternity reviews, and Care Quality Commission (CQC) inspections.

1.2 Information provided by University Hospitals Sussex NHS Foundation Trust (UHSx) is included as Appendix 1 to this report.

2. Recommendations

2.1 Health Overview & Scrutiny Committee notes the report.

3. Context and background information

3.1 UHSx provides consultant-led maternity units at each of its 4 Sussex general hospital sites, RSCH in Brighton, Princess Royal in Hayward's Heath, Worthing, and St Richard's in Chichester. In recent years, maternity and neonatal services have received a good deal of attention via the Amos National Maternity and Neonatal Enquiry and a series of Ockenden reviews of services at individual trusts. The Amos review and the Ockenden Nottingham review both include national recommendations for improvement at all NHS maternity and neonatal units. UHSx was one of 12 NHS trusts inspected as part of the Amos review, and an Ockenden review of UHSx services has recently been announced. In addition, the CQC regularly inspects and rates maternity services, with reports on UHSx published in 2021 and 2025. More information on all of these processes is provided below.

3.2 Amos Review

3.2.1 In 2025, Baroness Valerie Amos was appointed to chair a National Maternity and Neonatal Investigation. The Amos team inspected services across 12 individual trusts, using the information gathered to make recommendations for national improvement. The 12 trusts were selected for a variety of reasons including feedback from patients, but also to ensure the review included a wide range of services in terms of geography and patient demographics. The review was published on 30 June 2026. It includes a series of national recommendations which must be considered by all NHS acute trusts. The report and recommendations can be accessed here: NMNI-Final-Report-and-Recommendations.pdf

3.2.2 In addition to the national report, the Amos review also published reports on each of the trusts it inspected. These do not include trust-specific recommendations but do include comments on trust performance and feedback from staff and from bereaved families. The UHSx report is available here: University-Hospitals-Sussex-NHS-Foundation-Trust-Report.pdf

3.2.3 Amos notes that UHSx does well in terms of maternity safety metrics. For example, the UHSx neonatal mortality rate per 1000 live births was 2.1 for the year ending December 2025, which is lower (i.e. better) than the national average and the rate for comparable trusts.

3.2.4 However, Amos also notes that in the 12 months ending Dec 2025, only 48.5% of neonatal nursing shifts at RSCH were staffed in line with guidance and service specifications. This is lower than the national average and also lower than UHSx units at Chichester and Worthing.

3.2.5 The review team reported that RSCH maternity feels cramped; that there are some real practical difficulties in running maternity services across 4 relatively distant hospital sites; that a learning culture appears not to be fully embedded across services; that staff morale is low and is impacted by negative media coverage; and that staff express concerns about staffing levels.

3.2.6 Bereaved families praised aspects of RSCH services highlighting the work of community midwives, communication, and the kindness of staff, and sensitive and culturally appropriate services for some Black and racially minoritised communities. Families also made some negative comments about UHSx services, including noting that families weren't listened to, that services appear overstretched, and that some people for whom English is not their first language experienced problems communicating with staff.

3.3 Ockenden Review

3.3.1 The Ockenden Reviews are a series of independent reviews of maternity services at individual trusts. A review of Shrewsbury & Telford NHS Hospital Trust reported in 2022, and a review of Nottingham University NHS Hospitals Trust was recently published. A reviews has recently commenced at Leeds and one is planned at UHSx. There is no single rationale for the establishment of an Ockenden Review, and the reasons for reviewing UHSx have not yet been disclosed. However, Ockenden Reviews to date have focused on trusts with serious performance concerns.

3.3.2 **Nottingham Review.** The Ockenden Review of maternity services at Nottingham University NHS Hospitals Trust made a number of recommendations for service improvement Findings, conclusions and essential actions from the independent review of maternity services at Nottingham University Hospitals NHS Trust. Some of these are specific to the Nottingham acute trust, but others are recommendations for trusts across England. The national recommendations are lengthy, covering themed areas including listening to women and families; workforce planning and safe staffing; training; risk assessment during pregnancy; incident investigation and family involvement; governance; culture; and post death care.

3.3.3 Details of and timelines for the UHSx Ockenden Review have not yet been finalised and the trust will consequently not be able to discuss plans for this review with the HOSC.

3.4 Care Quality Commission (CQC)

3.4.1 The CQC is the national NHS and social care regulator, responsible for inspecting hospital services. In December 2021, the CQC published inspection reports on all UHSx maternity units, rating Chichester, Worthing and Hayward's Heath as Requires Improvement, and Brighton as Inadequate (the CQC rates services as either Inadequate, Requires Improvement, Good, or Outstanding). In January 2022, Brighton & Hove HOSC received a report on UHSx improvement planning in response to the CQC inspection report. This was followed up with an update report in October 2022, with UHSx reporting good progress across its maternity improvement targets. There was a further update to HOSC in November 2024.

3.4.2 The most recent CQC inspection of RSCH maternity was published in December 2025, rating RSCH maternity as Requires Improvement, an improved position from the previous inspection, but still with areas of under-performance.

3.5 UHSx, alongside all NHS trusts managing maternity and neonatal services, is required to develop plans to address the national recommendations in the Amos Review and the Nottingham Ockenden Review, as well as reflecting on the comments on trust performance included in the UHSx-specific Amos report. UHSx must also respond to CQC inspection report recommendations. Information provided by the trust which outlines their approach to maternity and neonatal improvement 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 for this information report.

6. Financial implications

6.1 No direct financial implication arising from this information only report.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted: 09/11/26

7. Legal implications

7.1 There are no direct legal implications arising from this report which is to note.

Name of lawyer consulted: Victoria Simpson Date consulted 09/11/26

8. Risk implications

8.1 None for this information report.

9. Equalities implications

9.1 None directly for this information report.

10. Sustainability implications

10.1 None identified.

10. Health and Wellbeing Implications:

10.1 None directly for this information 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 update on RSCH maternity services.

Supporting Documentation

1. Appendices

1. Information provided by UHSx.

University Hospitals Sussex
NHS Foundation Trust

Maternity service update

BHCC HOSC – 18 November 2026

Chief Medical Officer – Professor Katie Urch
Medical Director (Women, Children's & Clinical Support Services division) – Dr Timothy Taylor
Deputy Director of Midwifery – Dr Jenny Davidson

Managing Director (Women, Children's & Clinical Support Services division) – Oliver White
Hospital Director, Royal Sussex County Hospital – Stephen Mardlin MBE

Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

Today's briefing

1. Our service and current performance
2. Improvement journey
3. CQC and Amos findings
4. National learning and our response
5. Listening to women, families and staff
6. The Independent Maternity Review, chaired by Donna Ockenden
7. Current safety and quality at RSCH
8. Discussion



Our maternity and neonatal service

One service supporting communities across Sussex

- Around 9,000 babies a year
- Consultant-led maternity units in Brighton, Haywards Heath, Worthing and Chichester
- Community maternity and home birth services
- Specialist and personalised care for women with more complex needs
- Trust-wide safety, governance and improvement arrangements

Royal Sussex County Hospital

- Maternity care for Brighton and surrounding communities
- Specialist care for some of the most premature and seriously unwell babies in the region
- The only Level 3 Surgical Neonatal Intensive Care Unit (NICU) in Sussex
- One of only 14 neonatal intensive care units providing neonatal surgery in England

Recognising harm and listening to families

Every instance of avoidable harm is one too many

Our ambition is to provide the safest possible care for every woman and baby.

We know we do not always get things right.

Some women, birthing people, babies and families have experienced care or outcomes that fell below the standards they should expect.

We are deeply sorry when this happens, and our thoughts and deepest condolences remain with families who have experienced the tragic loss of a baby or harm while in our care.

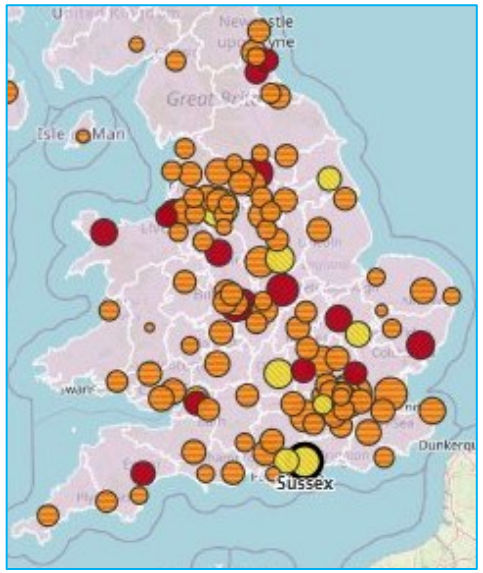
Before we look at the wider evidence

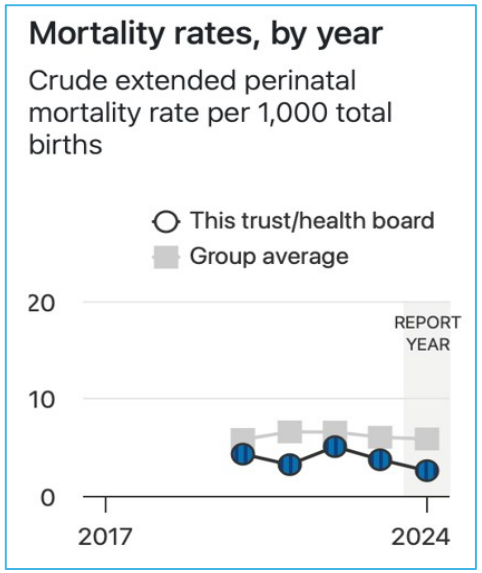
The data we share today in no way diminishes the experiences of individual families, or the terrible impact of harm or loss.

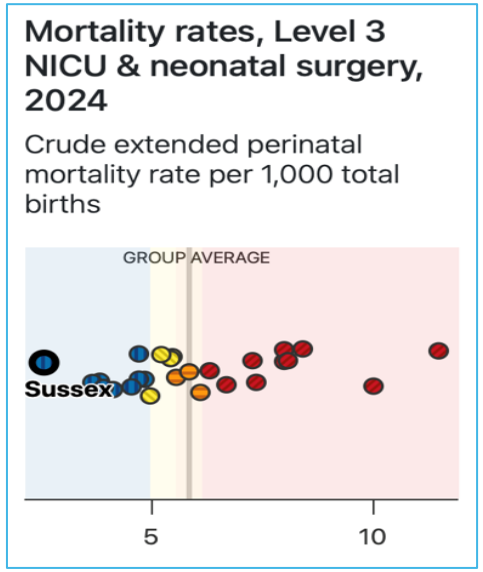
We share it to help the Committee understand how our services are performing overall, and where further improvement is needed.

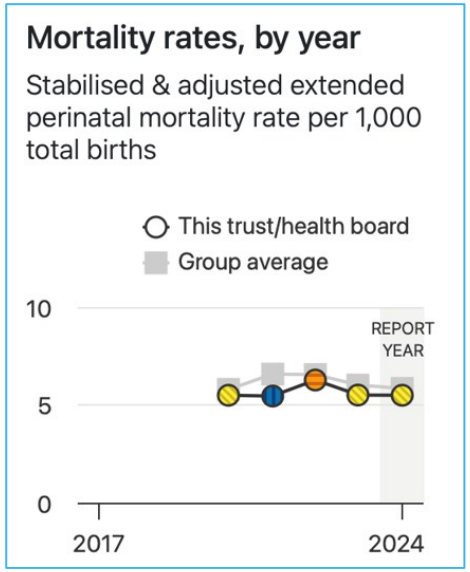
How do we compare to other maternity services?

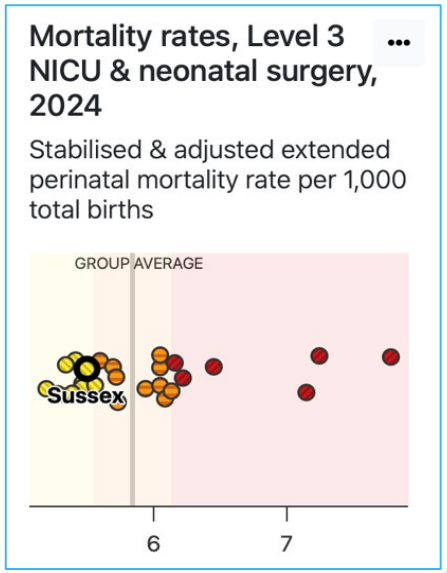
University Hospitals Sussex compares favourably to other maternity providers











Mortality rate compared with the group average

- Over 15% lower
- 5 to 15% lower
- Within 5%
- Over 5% higher
- Suppressed due to small numbers

*MBRRACE-UK is nationally recognised source of maternity safety benchmarking data, enabling reliable comparison of outcomes across NHS maternity services

What does the wider evidence tell us?

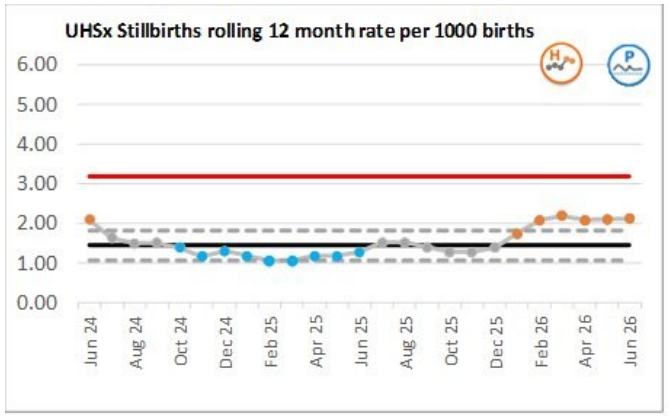
Independent evidence provides important assurance about our overall outcomes

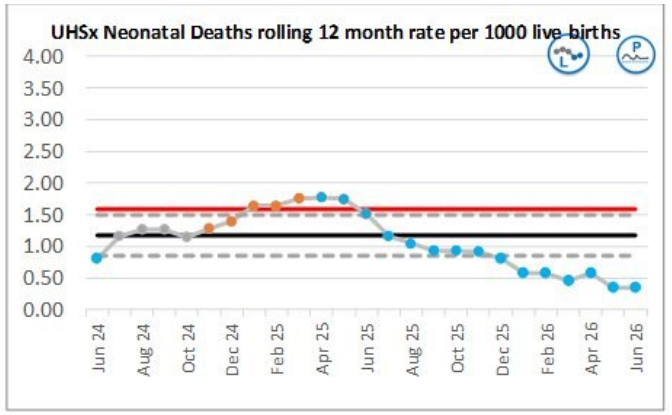
Stillbirths - rate is below national benchmark. July 2026 review concluded no concerns about care contributed to outcomes.

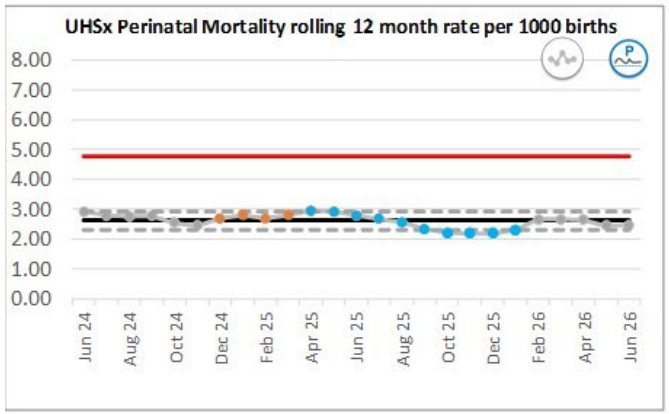
Neonatal deaths - sustained reduction. Less than half national rate. Last occurrence April 2026, before that none since November 2025.

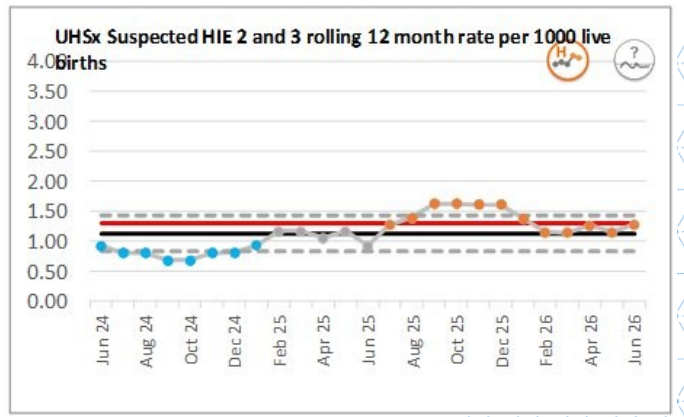
Perinatal mortality - stillbirths and neonatal deaths combined are much lower than national rates at 2.64/1000 births vs 4.77/1000 births.

Suspected Hypoxic Ischemic Encephalopathy - HIE and / or brain injury rates are currently equal to national average.









Experience of women and families

Overall feedback is positive, but individual experiences vary

Women commonly value

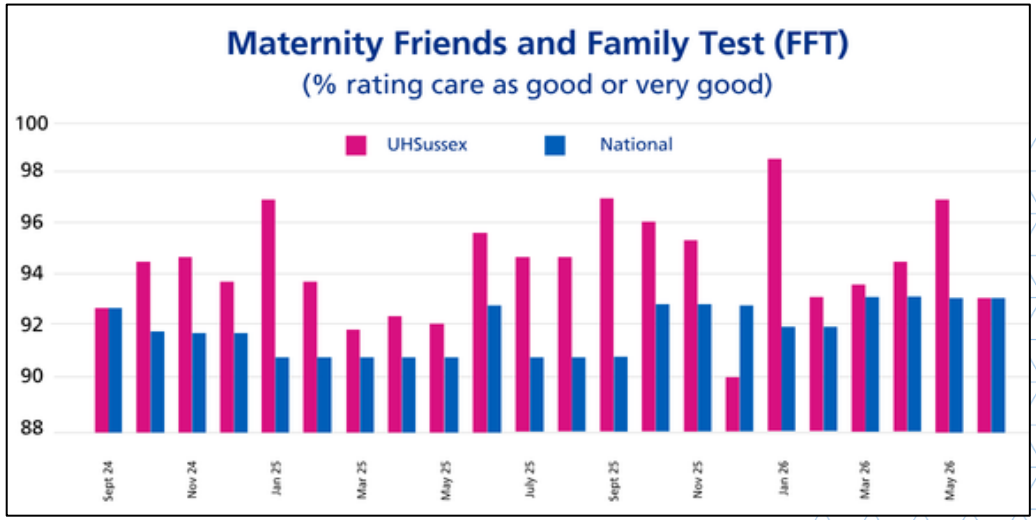
- Kind and compassionate staff
- Feeling supported and reassured
- Involvement in decisions

Women also tell us to improve

- Communication and consistency
- Responsiveness and waiting times
- Postnatal care and environment
- Listening when concerns are raised

Positive survey findings matter, but averages can obscure individual poor experiences.





Our improvement journey

Substantial progress has been made, with more still to do

2021

- RSCH maternity rated *Inadequate* by CQC
- Leadership, staffing, governance and safety assurance required

2022 onwards

- Entered NHS England's Maternity Safety Support Programme (MSSP)
- Original CQC "must do" and "should do" actions completed
- Improvement supported and independently monitored by NHS England

2025

- RSCH maternity improved to *Requires Improvement*
- MSSP said, "demonstrable improvements from ward to board noted by all stakeholders"

What has changed across the service?

Significant investment has strengthened our workforce, leadership and services

Workforce

- Midwifery vacancies reduced from 22% in 2022 to near-full establishment
- Birthrate Plus approved and fully funded, with recruitment underway to enhanced staffing model

Leadership and safety

- Site-based multidisciplinary leadership teams
- Stronger executive safety oversight and governance
- Enhanced safety forums and learning arrangements



Care and support

- Specialist maternity telephone triage.
- Improved bereavement care and facilities.
- Enhanced support for vulnerable women and families.
- Improvements co-produced with the Maternity and Neonatal Voices Partnership.

How have we responded to the RSCH CQC report?

Most actions completed and further improvement underway

Changes now embedded

- Audit findings routinely inform clinical guidance and practice
- Enhanced maternity triage using the Birmingham Symptom-specific Obstetric Triage System
- Planned caesarean lists moved away from the labour ward
- Improved monitoring and escalation of delays to induction of labour
- Dedicated maternity pharmacist recruited

Further work in progress

- Completing and ratifying remaining policies, with 77% now live
- Introducing digital clinical-record audits
- Increasing leadership visibility and staff support

Estates

- Infection prevention concerns identified during the inspection have been addressed.
- Wider constraints within Sussex House require a longer-term plan

What did the Amos review tell us?

Strengths and important areas requiring attention

Positive findings

- Strong performance against several safety measures
- Neonatal mortality below national and comparable Trust rates
- Examples of kindness, communication and culturally appropriate care



Areas requiring attention

- Neonatal staffing at RSCH
- Maternity and neonatal estate
- Consistency of learning
- Listening and responding to families
- Staff morale and workforce pressures
- Communication where English is not a family's first language

Neonatal care and staffing at RSCH

Significant investment has strengthened the workforce, with specialist training continuing

What Amos reported

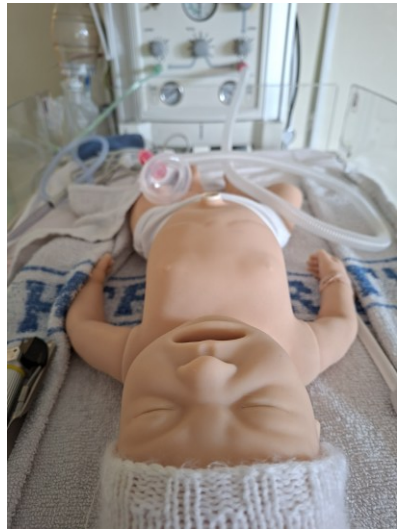
- 48.5% of shifts met the Qualified in Specialty (QIS) neonatal staffing standard in 2025
- The report does not specify the methodology or data source underpinning this figure

What we can evidence

- Previous funded workforce deficit addressed through NHS England investment
- Funded nursing establishment now meets British Association of Perinatal Medicine standard
- Shift fill rates are consistently above 90%
- Specialist neonatal nurse development remains a priority

Building capacity

- Seven nurses currently completing specialist training
- Further cohort planned for early 2027
- QIS workforce expected to reach approximately 60% by January 2027



National learning from maternity reviews

Reviews identify recurring themes across maternity services

- Listening to women and families
- Safe and sustainable staffing
- Risk assessment and escalation
- Multidisciplinary training
- Leadership and governance
- Incident investigation and learning
- Culture and staff voice
- Bereavement care



We have reviewed more than 200 national recommendations and consolidated the relevant actions within our improvement programme.

One comprehensive improvement programme

Our Maternity and Neonatal Improvement Plan (MNIP) brings all learning together

Sources of learning

- CQC, Amos and national Ockenden recommendations
- NHS England
- Incidents, complaints and mortality reviews
- Women, birthing people, families and staff

How delivery is assured

- Actions prioritised by safety risk
- Named accountable leads
- Evidence required before closure
- External input and challenge
- Reporting through executive governance and Trust Board



Listening and responding to women and families

Women and families must be central to improvement

- Family involvement in incident and mortality reviews
- Open communication following safety incidents
- Family Liaison and bereavement support
- Complaints and feedback informing improvement
- Partnership with the Maternity and Neonatal Voices Partnership
- Engagement with seldom-heard communities
- Accessible information and interpreting support

We must listen particularly carefully when families tell us they were not heard or their concerns were not acted upon.

Public confidence, families and staff

Maintaining confidence during a period of intense scrutiny is increasingly challenging

Impact on women and families

- Increased anxiety about maternity care among some expectant families
- More time needed in consultations to discuss concerns and provide reassurance
- Increased requests for intervention, including caesarean birth
- Some women choosing care outside their local maternity service

Impact on staff and services

- National conversation, sustained scrutiny and media coverage affects morale and wellbeing
- Sustained scrutiny and adverse coverage can have a significant emotional impact on staff
- Increased risk of sickness, burnout and retention pressures

Our priority is to support women and families to make informed choices,
while supporting our staff to continue providing safe, compassionate care.

Independent Sussex Maternity Review

Supporting families, staff and learning throughout the review

- Chaired by Donna Ockenden, families and staff will be able to contribute independently
- Established following representations from bereaved and harmed families
- Opportunity for families to seek answers to unresolved questions
- Preparatory work is underway, with the formal scope and Terms of Reference being finalised

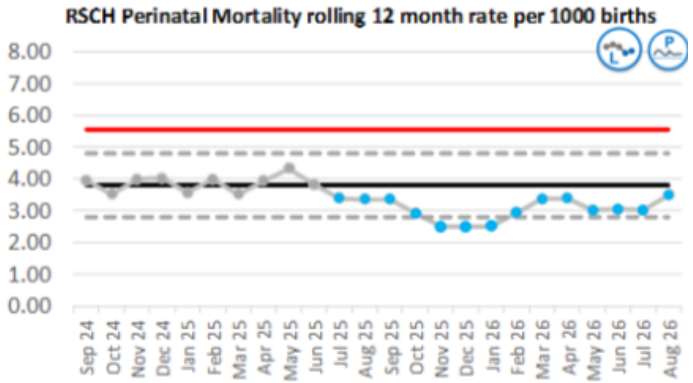
Our commitment

- Cooperate openly and transparently
- Dedicated review support, with Department of Health and Social Care funding
- Support staff and protect frontline clinical capacity
- Feed emerging learning directly into our improvement programme

We will act on learning as it emerges, rather than wait for the final report.

Summary – maternity and neonatal care at RSCH today

Current evidence provides important assurance, alongside areas for continued improvement



Safety, outcomes and experience

- Outcomes compare favourably with national benchmarks
- Perinatal mortality rate consistently better than national average

Women and families

- Women consistently describe compassionate and supportive care
- Overwhelming majority of service-user feedback is positive
- Some poor individual experiences continue to inform improvement

Service capability

- Sussex's only Level 3 Neonatal Intensive Care Unit
- Funded neonatal nursing establishment now meets the relevant standard
- Continued investment in specialist neonatal skills

Taken together, the evidence provides important assurance about the overall safety and quality of our care at RSCH, while identifying areas where further improvement is required.

Summary – our challenges and priorities

We have made significant progress, but important challenges remain

Public confidence and service resilience

- Managing the impact of national focus on maternity
- Increasing complexity of care and changing demand
- Delivering a sustainable service while meeting changing national standards

Estates and facilities

- Maternity and neonatal environments are constrained
- Longer-term solutions need to support safe, modern and resilient care
- Rising elective C-Sections and theatre capacity

Staffing and morale

- Sustained scrutiny and review activity is placing additional pressure on staff
- Recruitment, retention, wellbeing and support for colleagues are key priorities
- Continued need to grow specialist maternity and neonatal skills and resilience

Our commitment to local women, babies and families

University Hospitals Sussex NHS Foundation Trust

Safe care today. Continuing improvement for the future.

What the evidence shows

- Most women and babies receive safe, compassionate and high-quality care
- Outcomes and experience measures provide important assurance
- Our teams remain committed to excellent care every day

What we recognise

- Some families experienced care that fell below expected standards
- Workforce, estate and consistency challenges remain
- Families and staff must continue to be heard

What we will do

- Maintain focus on safe care every day
- Act on CQC, Amos and emerging IMR learning
- Be transparent with families, HOSC and our communities

Discussion

Health Overview & Scrutiny Committee

Agenda Item 15

Subject: **Surrey & Sussex Winter Planning 2026-27**

Date of meeting: **18 November 2026**

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

Contact Officer: **Name: Giles Rossington, Scrutiny 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 Surrey & Sussex Integrated Care Board) 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 Surrey & 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 2027 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 Surrey & 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 2026 to April 2027. 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 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 10/11/2026 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 10.11.2026 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 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 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 Surrey & Sussex Integrated Care Board on health and care system planning for winter 2025/26.

Supporting Documentation

1. Appendices

Information provided by NHS Surrey & Sussex Integrated Care Board on system winter planning 2026-27

NHS
Surrey and Sussex

Surrey and Sussex Winter Plan

Maintaining patient safety, access and system resilience through winter

November 2026 - March 2027



Introduction

An overview of the 2026/27 winter plan

Our objective:

Support people to stay well and maintain safe, timely access to urgent, emergency and planned care by reducing avoidable demand, improving flow and discharge, protecting critical capacity, and responding rapidly to operational pressures.



Our plan is built around four questions

- **What is the challenge?**
  Demand is expected to exceed available capacity during peak periods, compounded by respiratory illness, workforce constraints, discharge delays and pressure across ambulance, mental health, community and planned-care pathways.
- **What are we focusing on?**
  A small number of interventions with the greatest impact on prevention, admission avoidance, hospital flow, discharge, ambulance responsiveness and workforce resilience.
- **What are we doing about it?**
  Provider and system actions spanning primary and community care, ambulance and NHS 111, acute and mental health services, discharge, vaccination and planned-care protection.
- **How will we manage it?**
  Clear provider accountability, routine oversight, agreed triggers and escalation, clinical risk leadership, dynamic modelling and executive assurance.

An overview of the 2026/27 winter plan (2)

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
- **System partners will optimise the use of existing commissioned services and resources** to maximise capacity, improve outcomes and deliver the greatest possible benefit within available funding.





An overview of the 2026/27 winter plan (3)

We are aligned to our Strategic Commissioning Plan priorities:

- **Integration and Coordination**: The winter plan emphasises **prevention** and **proactive** joining up urgent and emergency care services, which aligns with our 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 26/27. This aligns with our 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 our 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 our 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 our 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 our 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 ICB strategy and in turn, the Surrey & Sussex Implementation Plan.

An overview of the 2026/27 winter plan (4)

The 26/27 ICB winter plan is based on four pillars:

Pillar One

Prevention, proactive care & demand management

Support people to stay well, identify deterioration earlier & reduce avoidable demand on urgent and emergency care.

- Vaccination and infection prevention
- Primary Care & Community
- Community Pharmacy
- Proactive identification of high-risk populations incl children's & young people
- Frailty, care home and anticipatory care planning
- Respiratory prevention and remote monitoring
- Targeted support to reduce inequalities and avoid deterioration
- Self-care, communications and mental health crisis alternatives

Pillar Two

Urgent care access, admission avoidance and system flow

Ensure people receive timely care in the most appropriate setting & improve flow across ambulance, urgent care, hospital and mental health pathways.

- Alternative pathways and admission avoidance
- Optimal appropriate use of Pharmacy First
- Urgent, emergency and mental health care flow
- Rapid assessment, treatment and specialist access
- Hospital flow, bed capacity and escalation resilience
- Intermediate care, discharge and Home First
- Virtual wards, community capacity and recovery support
- Elective care and workforce resilience

Pillar Three

Safe and Resilient Services

Maintain safe, sustainable services through seasonal peaks while protecting workforce, critical capacity and planned care.

- Workforce capacity, deployment and staff wellbeing
- Infection control and seasonal vaccination
- Clinical risk, IPC and quality oversight
- Winter surge and escalation preparedness
- Mental health, critical care and specialist capacity resilience
- Protection of planned care, cancer and diagnostics
- Business continuity, adverse weather and major incident readiness

Pillar Four

Winter Operating Model, System Oversight / Governance

Robust oversight of the delivery with clear accountability and agreed escalation triggers to identify pressure early and coordinate an effective response

- Demand, capacity and bed modelling
- Provider-led operational management
- System coordination and mutual aid
- OPEL, escalation and MADE event arrangements
- Clinical risk, IPC and quality oversight
- Communications, assurance and Board reporting

**Provider winter plans set out detailed ownership, milestones and delivery arrangements. This system plan provides the collective strategic framework, intended impact and assurance route, with delivery monitored through provider governance and coordinated through the system operating model where cross-system action is required.*

The Winter challenge

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 in previous years a statistical model based on bed occupancy and likely scenarios for service demand has been used. The output displays incremental requirements of each type of bed and tracks actual usage against this plan. As more data is accumulated, actuals can be inputted to refine the model and understand outputs in near real time. By utilising the ability to change parameters, “what if” scenario model can also be affected during the winter period

The combined bed model enables a system wide modelling process to be undertaken which identifies;

- Bed base
- Expected growth.
- Planned and unplanned usage
- Requirement of respiratory beds according to IPC projections
- Criteria to reside projections
- ”Other” variations as they become apparent.



Associated Risks

I. Demand may exceed available acute capacity during peak weeks, with the final position dependent on validated provider and commissioner mitigations.
II. Flow and discharge constraints amplify pressure, particularly where people remain in hospital after they are ready to leave.
III. Ambulance availability and response are affected by deployed capacity, avoidable conveyance and hospital handover delays risking C2 delivery.
IV. Respiratory illness, norovirus and workforce absence may occur concurrently, reducing capacity as demand rises.
V. Mental health, paediatric, critical-care and planned-care pathways remain vulnerable when the whole system is under pressure.

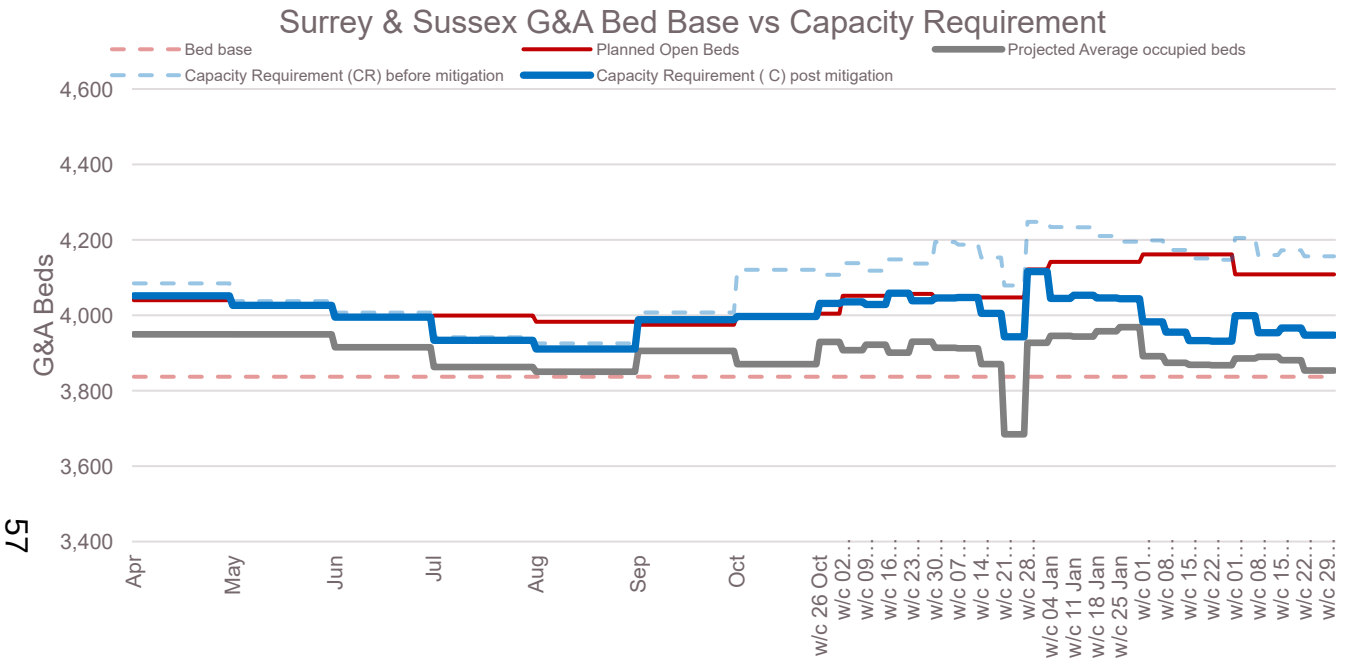
The Winter challenge

What lessons identified from 2025 / 2026 told us:

- Respiratory illness and norovirus can increase sharply after Christmas.
- 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.
- High staff sickness can coincide with peak operational demand.
- Mutual aid may become limited when multiple organisations escalate simultaneously.
- Ambulance, paediatric, critical-care and infection-control pressures can occur together.
- Improvements delivered through short-term reset activity must be sustained.
- Business continuity triggers and escalation thresholds must be unambiguous.
- Infrastructure, severe weather, road disruption and technology failures must be planned for alongside clinical demand.



Winter Bed Plan Proposal

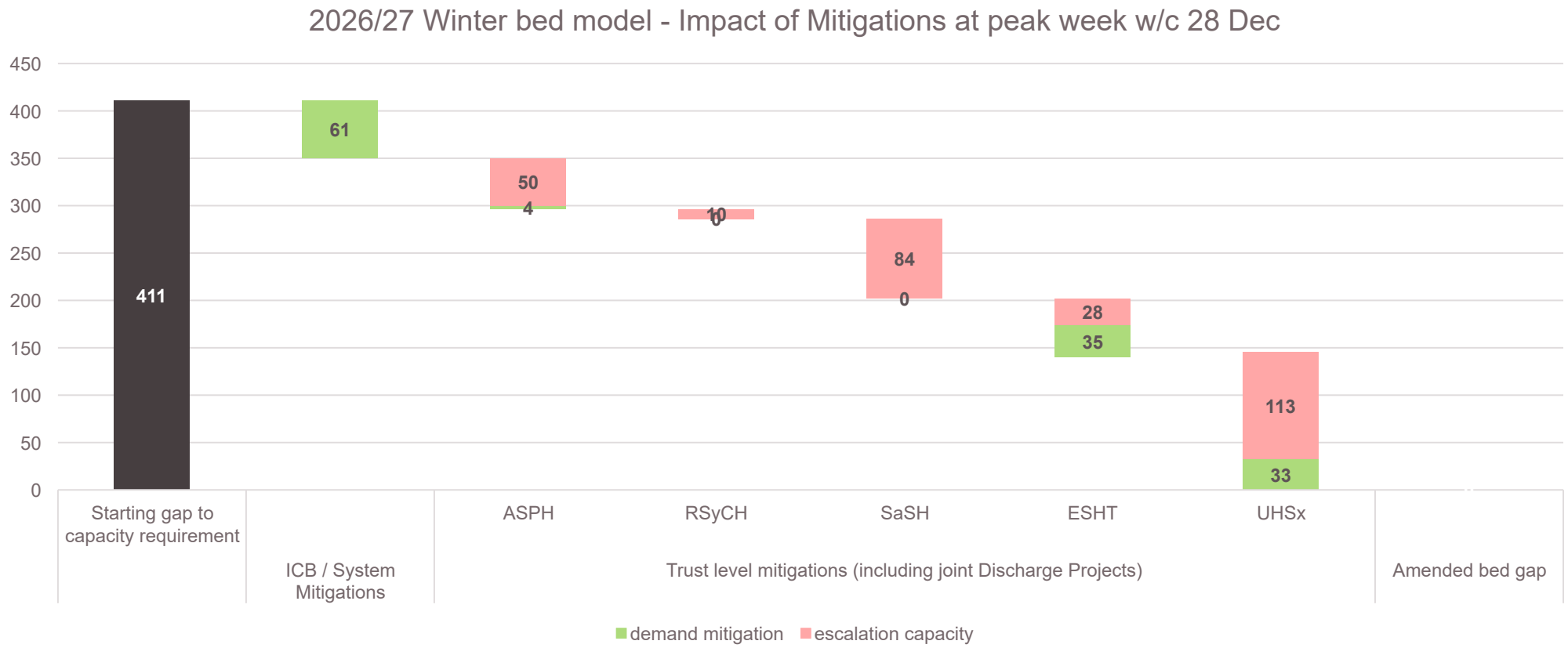


Peak Periods	w/c/ 30 Nov	Surrey & Sussex w/c 28 Dec	w/c 01 Mar
Key periods with highest unmitigated gap to Capacity requirement			
Starting Scenario			
Bed Base	3,837	3,837	3,837
Unmitigated Capacity Requirement	4,194	4,248	4,205
Unmitigated Gap	357	411	368
Acute:			
Planned Capacity Increase	209	285	271
In-hospital Demand Reduction	87.5	71.3	100.5
Amended Gap	60	55	-4
Primary and Community Care:			
Demand Reduction	61	61	106
Amended Gap	0	6	109
Remaining Gap	**0.0**	**0.0**	**0.0**

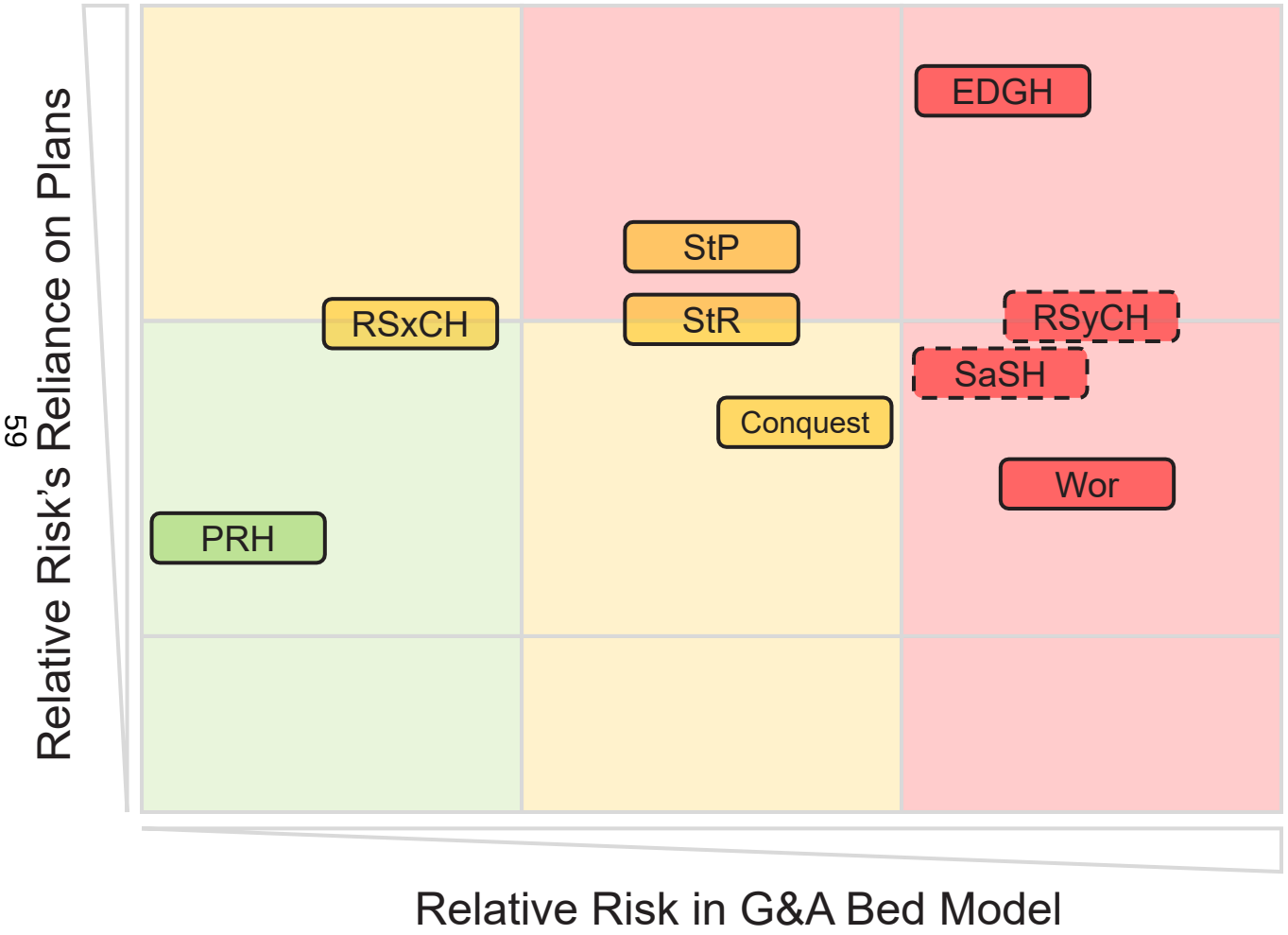
- Initial Bed Modelling suggest a peak gap to capacity requirement of **411** beds during w/c 28th December with two other key pressure points, in late November and early March
- ICB and system plans which during our peak pressure week deliver a risk adjusted impact of:
  - Provider plans (risk adjusted, including Discharge Projects)
    - ESHT: **63** beds, SASH: **84** beds, ASPH: **54** beds, RSFT: **10** beds, UHSx: **146** beds
    - Conversations continue with trusts about planned escalation and escalation capacity and the MTP bed plans. We await confirmed impact of demand management projects from SaSH
  - Proactive Neighbourhood Care, Community Flow and Virtual Wards: **61** beds
- This leaves bed gap of **0** against capacity requirement in the week with highest modelled risk, **28 December**
- There is sustained risk in November, which presents a risk if projects experience delay in implementation or impact
- The model is set up to adjust and help plan for winter respiratory disease scenarios when flu projections are released
- The following slides illustrate where the bed deficits are expected with mitigations through each provider.

Breakdown of Mitigations

- The below waterfall chart shows the impact of each part of the plan on mitigating the forecast bed gap at the peak week (w/c 28th Dec).
- Not all plans have been shared and aligned to the modelling methodology to allow input into the demand and capacity model
- These risk mitigated plans result in a closing of the bed gap for the peak week of Dec 28th (tbc)



Site's relative risk in G&A Bed Model



Eastbourne District General Hospital (ESHT)

Demand in 26/27 has been high and the unmitigated projection exceeds maximum observed capacity. Reliant on System and Trust plans, which need to show impact before winter Risk may be less is recent reduction in demand sustains

Royal Surrey County Hospital

Demand has been high in 26/27 so far and capacity is close to maximum observed. The projected winter increase in pressure may require additional system flexibility. Awaiting risk mitigated trust actions to reduce demand which may help alleviate this risk

SaSH

Closure of 21 beds from Magenta and an additional 20 for Infection Control, creates pressure. Summer demand higher than previous years but reduced from a peak in July. Awaiting risk mitigated trust plans to reduce demand but with pressures potentially arriving in early November they will need to impact soon. Relative risk limited by historical numbers of exceptional escalation beds.

Worthing Hospital (UHSx)

Demand has been high in Summer, but has dropped in September, risk dependent upon whether this lower level remains. If not, projected demand exceeds historical max capacity. Plans on mitigation and planned escalation close gaps but risk remains.

StRichard's and Conquest carry risk into winter and demand management actions need to deliver or demand will come close to maximum observed beds

StPeter's saw high levels of demand in early summer which have since reduced, risk remains high as planned beds are close to maximum observed open beds at this site.

RSxCH pressures are not always shown in the data as it shows signs of being a supply limited system, its risk is likely higher than model values show

Modelling provides an indication of risk based on historical trends, available information and informed assessment. All factors open for discussion and refinement.

Executive Assurance Summary



Plan Position:

A comprehensive Surrey and Sussex system plan has been developed around four delivery pillars, bringing together prevention and proactive care, urgent-care access and system flow, safe and resilient services, and a clear winter operating model. Delivery is focused on optimising existing commissioned services and resources within the available financial envelope.

Assurance:

Provider winter plans have been received across all major pathways and are supported by system-wide demand and capacity modelling. On current risk-adjusted assumptions, identified provider, community and system mitigations are sufficient to close the modelled peak bed gap and address the forecast capacity requirement during the highest-risk week commencing 28 December

Ongoing Winter Preparation:

Provider mobilisation and governance arrangements must be completed and operational. A Winter MDT Group will be established from 1 November, bringing together vaccination, IPC, EPRR, community and acute leads to oversee readiness, risks and delivery. Meetings will be held fortnightly from November, moving to weekly during peak winter periods.

Routine reporting will be provided to the weekly ICB informal executive meeting to support ongoing executive oversight, rapid escalation and senior decision making where required, alongside periodic reporting to the Integrated Assurance Committee throughout the winter period, focussed on assurance of plan delivery.

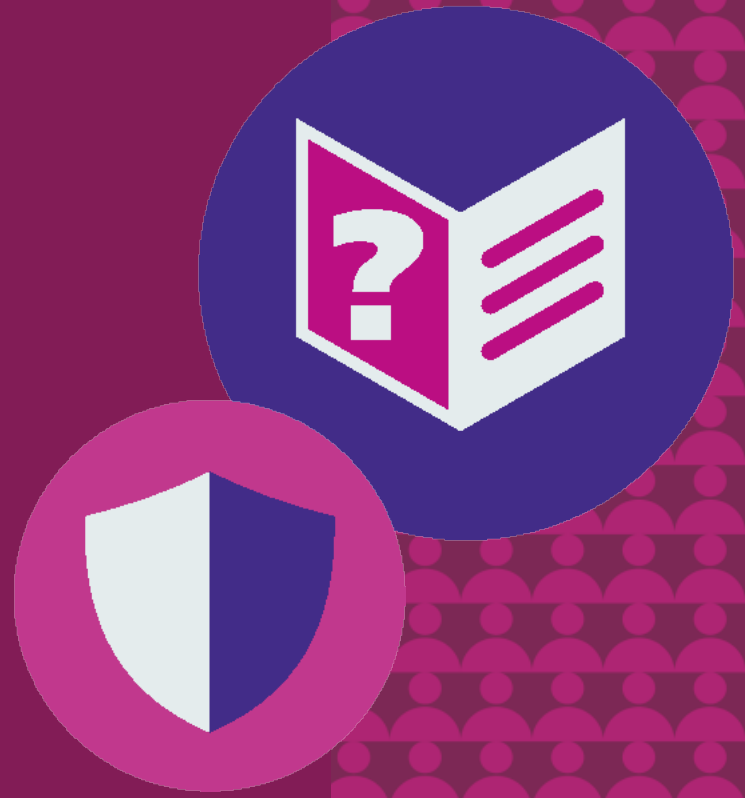
Residual Risks:

Residual risks remain relating to timely delivery of planned mitigations, workforce availability, respiratory illness and norovirus, ambulance handover delays and Category 2 performance, discharge flow, specialist capacity, planned-care disruption, mutual-aid availability and the quality and timeliness of operational data. These risks require ongoing management through the agreed winter operating model, clinically led risk balancing and escalation arrangements.

Pillar 1: Prevention, proactive care & demand management

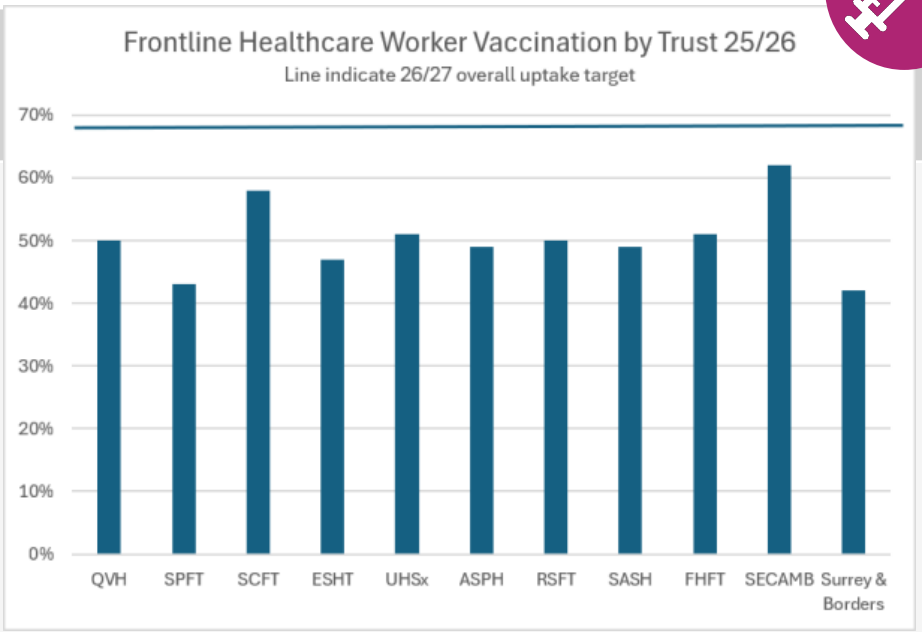
Support people to stay well, identify deterioration earlier & reduce avoidable demand on urgent and emergency care.

- Vaccination and infection prevention
- Primary Care & community
- Proactive identification of high-risk populations incl children's & young people
- Frailty, care home and anticipatory care planning
- Respiratory prevention and remote monitoring
- Targeted support to reduce inequalities and avoid deterioration
- Self-care, communications and mental health crisis alternatives



Improving vaccination rates to prevent the exacerbation of illness and hospitalisation (2026-27)

Aim	To improve Covid-19 and flu vaccination rates for all eligible cohorts when compared to previous year.
Current position	**Flu uptake 2025/26:** • Increase in uptake for all cohorts except for >65-year-olds compared with 2024-25 • Highest increase among pregnant cohort • 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 26):** Surrey & Sussex – 53.2%; national – 49.7%
Actions / Task	• Each hospital has a staff vaccination plan which aims to improve uptake by frontline healthcare worker to try to achieve the target set by NHSE for 26/27 • For the general population, the ICB is working with PCPCs and local pharmacy to maximise delivery to eligible cohorts. There is additional focus to reach those who may be homeless and the ICB is working with local public health teams to maximise opportunities • A local communications campaign will be launched in line with national approach. It will also include local targeted 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.
Success Measures	• Improve staff Flu vaccination uptake • Improve vaccination rate for those inpatients over 21 days who are being discharged to care homes • Vaccination rates for general population for both Covid-19 and Flu above the England average
Timeline	• Covid-19 vaccination programme runs from 1 October 2026 – 31 January 2027 • Flu vaccination programme 1 September 2026 (pregnant women and children), 1 Oct 2026 (all other cohorts) – 31 March 2027



Primary and Community care



- ✓ A **£19 million Neighbourhood Health investment** is being delivered through provider partnerships to implement proactive care for 1% of the population through Integrated Neighbourhood Teams. Whilst not winter-specific, this additional capacity will come on stream during the second half of 2026/27 and will support admission avoidance and system resilience. Investment is targeted according to **population at highest risk of admission, recognises health inequalities, and creates additional local service capacity.**
- ✓ Up to **£7 million** has been identified to strengthen and create **additional same-day urgent primary care capacity in General Practice**. This is intended to manage surges in demand over the winter months and minimise any capacity constraints Monday to Saturday in General Practice across Surrey and Sussex.
- ✓ The primary care winter response will create **around 200k more same day appointments** for patients requiring support from General Practice for respiratory conditions and other common conditions observed in these months. This additionality will be integrated with **NHS 111 pathways,** helping more people receive care closer to home. In addition to Pharmacy First, the ICB will also commission **additional capacity from community pharmacies** for key areas such as **asthma**.
- ✓ **A comprehensive vaccination campaign** is in place across the ICB for **influenza (flu), RSV and covid-19.** For flu there will be **a dedicated weekend and bank holiday response** arrangements which will cover rapid clinical assessment, antiviral prescribing and outbreak management for care homes, reducing avoidable deterioration and pressure on urgent and emergency care services. For covid-19 the ICB continues to work with all providers to **secure a provider network, able to deliver vaccines to the whole population**. RSV is accounted for within Provider plans and identified as a key area of focus for 2026/27.
- ✓ Community services will maximise **UCR, Virtual Ward, Hospital at Home and reablement capacity** to support admission avoidance, timely discharge via **Discharge to Assess models of care** and improved system flow throughout winter
- ✓ Community Provider partnerships will coordinate primary care, community services, pharmacy, local authorities and voluntary-sector partners, with proactive support focused on people with **frailty, multiple long-term conditions, palliative or end-of-life** care needs, and **care-home residents**.

Primary and Community care



Delivery approach

- Delivered through Primary Care Provider Collaboratives, GP Federations, PCNs and place-based partnerships working alongside community, pharmacy, local-authority and voluntary-sector partners.
- Targeted investment will focus on areas with the greatest population need, health inequalities, urgent-care demand and workforce pressure.
- Monthly assurance will monitor additional access, population reach, impact on urgent demand, inequalities and delivery of planned outcome
- Alongside delivery, the ICB will review proactive-care investment, outcomes and delivery models to inform a more consistent, evidence-based approach to winter commissioning for 2027/28.

Anticipated contribution

- Additional primary care investment is expected to generate approximately 200,000 additional general practice appointments over winter (October to March). Modelling suggests this could contribute to avoiding around 6,700 A&E attendances.
- The wider place-based programme, including the focused primary-care winter response, aims to contribute to: a 10% reduction in avoidable admissions for agreed high-risk cohorts

Enhancing Community Support

Aim	• Reduce A&E and hospital admissions/NCTRs by supporting patients to remain in their own homes. • Maintain Virtual Ward (VW) bed base. • Further enhanced UCR Services
Actions / Task	• Optimise admission avoidance with direct VW access via SPOA. • Increase technology monitoring patients to reduce 'hand-offs' and conveyance. • Increase diagnostic capability. • Increase patients treated on alternative care pathways for Falls, Head Injury, Community Acquired Pneumonia (ambulance categories 3 & 4). • Reablement support - increase in number of beneficiaries, enabling more individuals and their families to maintain wellness at home to avoid admissions (Better Care Fund)
Success Measures	• Length of Stay (LoS) in VW • Diagnostic capability • 2 hr UCR responses • Patients treated on alternative pathways • Number of patients benefiting from Reablement

System high-impact prevention actions



Targeted action across vaccination, proactive care, primary care, community services, navigation and mental health will help people stay well, identify deterioration earlier and reduce avoidable urgent and emergency care demand.

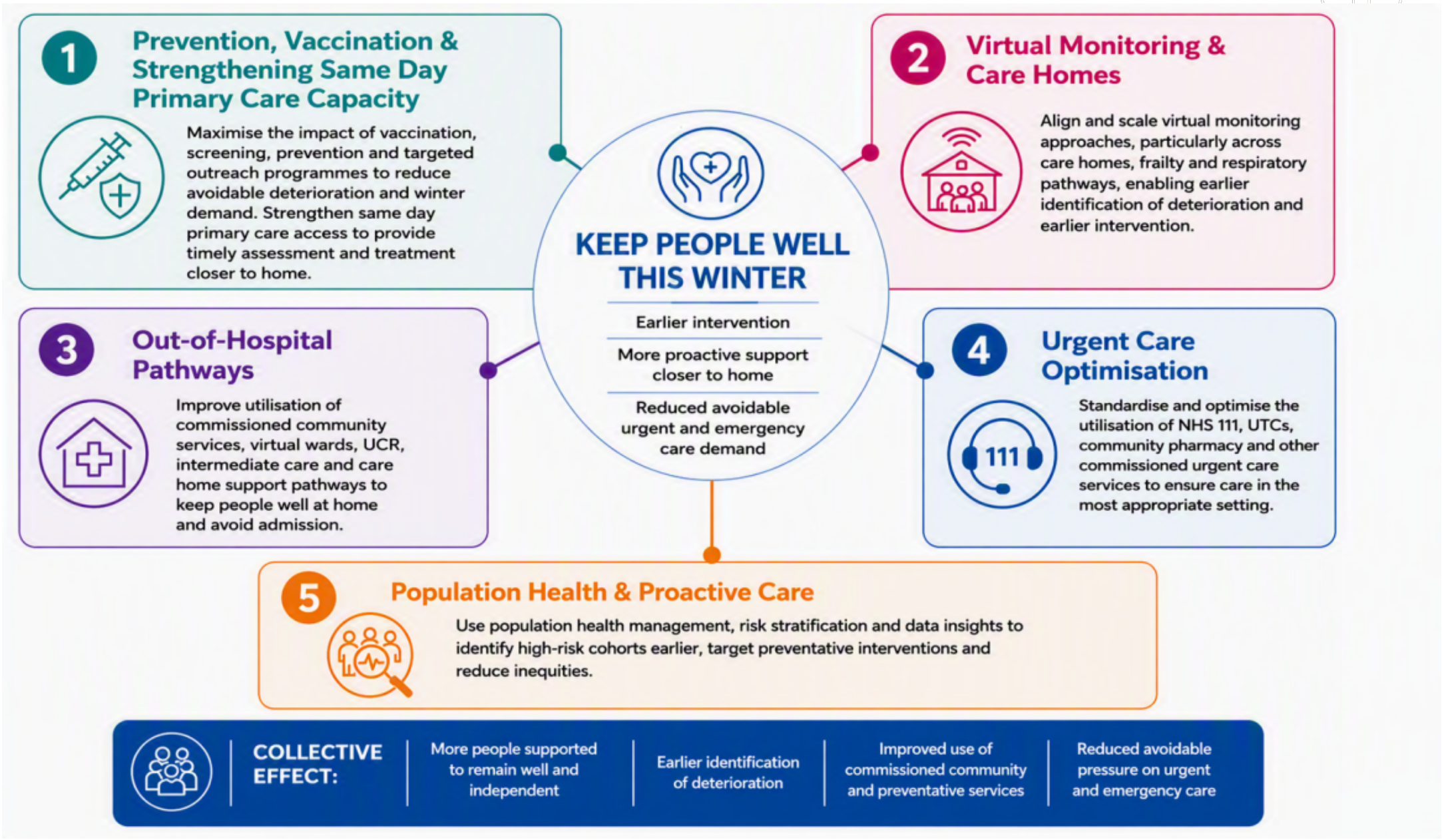
Area	High-impact action	Intended winter impact
Vaccination and IPC	Targeted vaccination, outreach and early seasonal surveillance	Reduce illness, admission and workforce disruption
Proactive care	Identify and support people with frailty, multimorbidity, care-home and end-of-life needs	Reduce deterioration and avoidable admission
Primary care access	Additional same-day capacity targeted to highest-need areas	Provide earlier care and reduce avoidable UEC demand
Virtual and community care	UCR, virtual wards, remote monitoring and Hospital at Home	Avoid conveyance and admission; enable earlier discharge
Respiratory pathways	Prevention, monitoring and earlier community intervention	Reduce respiratory exacerbation and hospital demand
Navigation	NHS 111, Pharmacy First, DoS and UTC pathway use	Direct people to the appropriate service first time

Communication & Engagement

A coordinated system communications plan supports delivery throughout winter, bringing together public communications, stakeholder engagement and internal staff messaging. Activity will:

- ✓ Promote vaccination and wider winter health messages.
- ✓ Help people stay well and access the most appropriate service.
- ✓ Provide consistent signposting, including alternatives to urgent and emergency care where appropriate.
- ✓ Align public, stakeholder and staff communications across system partners.
- ✓ Respond to emerging operational pressures with timely, consistent messaging.
- ✓ Support public understanding, trust and confidence in NHS services throughout winter.

ICB Priority Commissioning Areas



Pillar 2: Urgent care access, admission avoidance and system flow



Support people to stay well, identify deterioration earlier & reduce avoidable demand on urgent and emergency care.

- Alternative pathways and admission avoidance
- Urgent, emergency and mental health care flow
- Rapid assessment, treatment and specialist access
- Hospital flow, bed capacity and escalation resilience
- Intermediate care, discharge and Home First
- Virtual wards, community capacity and recovery support
- Elective care and workforce resilience

Urgent care access, admission avoidance and system flow

- ✓ Provider winter plans have been shared setting out high-impact actions and commitments across acute, ambulance, mental health and paediatric pathways. Delivery will focus on improving timely access, reducing prolonged waits, supporting ambulance responsiveness and strengthening flow through to discharge.



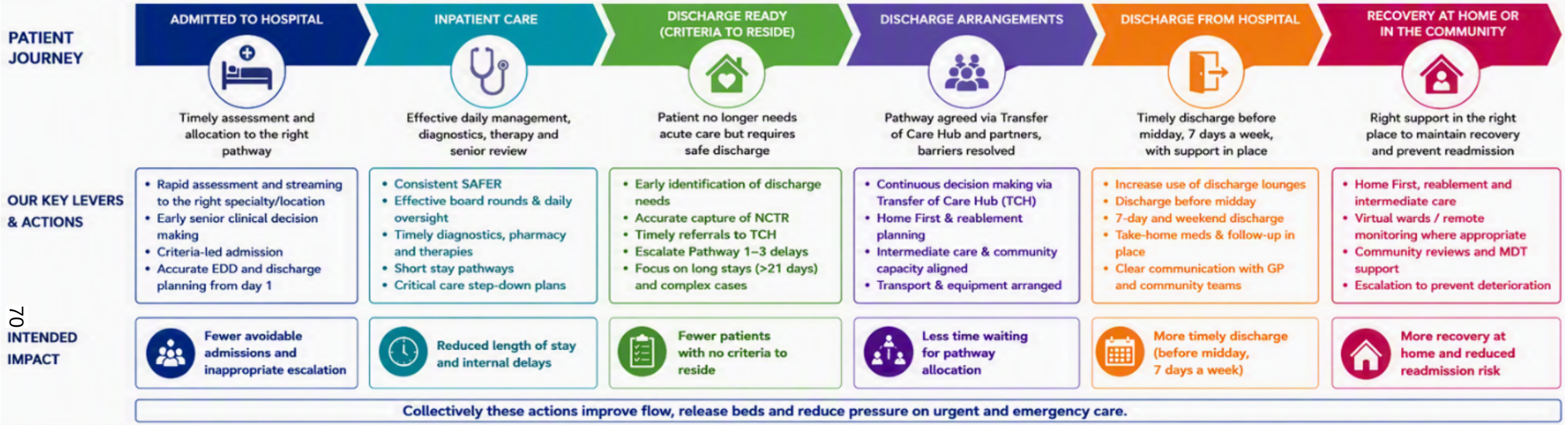
Priority	High-impact actions / commitments	Intended winter impact
Improve four-hour performance and reduce 12-hour waits /eradicating corridor care	Rapid front-door assessment and streaming; improved use of UTC, SDEC and frailty pathways; earlier senior and specialty decision-making; improved inpatient flow; Discharge to Assess; action to minimise corridor care	At least **78% of patients admitted, transferred or discharged within four hours**; fewer prolonged ED waits, avoidable admissions and episodes of corridor care
Meet the 45-minute ambulance handover standard and support Category 2 response	Strengthen ambulance handover arrangements; maintain operational oversight of delays; escalate sustained handover pressure through agreed provider, SCC and OPEL routes	Faster release of ambulance crews; fewer ambulances queuing at hospital sites; improved ambulance availability and Category 2 responsiveness
Reduce patients waiting over 12 hours for admission or discharge	Apply SAFER consistently; improve board rounds and criteria-led discharge; optimise discharge lounges and discharge before midday; escalate blocked beds; strengthen seven-day discharge and reduce Pathway 0 delays	Fewer 12-hour waits; reduced length of stay and NCTR; improved bed availability, discharge flow and patient experience
Reduce waits for a mental health bed	Maximise crisis and community alternatives to ED; strengthen liaison and home-treatment pathways; maintain senior oversight of extended waits; reduce mental health length of stay and CRFD; improve coordination with local authorities	Fewer avoidable mental health ED attendances; shorter waits following the decision to admit; fewer prolonged ED stays and improved mental health bed flow
Increase the number of children & young people seen within four hours	Dedicated paediatric triage and streaming; paediatric SDEC and outpatient alternatives; improved inpatient flow; respiratory surge plans and workforce escalation arrangements	More children assessed and treated within four hours; fewer avoidable admissions; sufficient paediatric capacity during seasonal respiratory peaks
Community pharmacy access & urgent care navigation	Maximise utilisation of Pharmacy First and community pharmacy referral pathways with increased referrals for minor illness and rollout of additional independent prescribing pathways as they become nationally available	More patients receive timely assessment and treatment through community pharmacy, reducing avoidable demand on general practice, NHS 111, UTCs and emergency departments.

Provider priorities across the urgent-care pathway

Urgent-care pathway	Provider priorities and commitments	Intended winter impact
Earlier intervention and alternatives to hospital	Expand UCR, Hospital at Home, virtual wards and remote monitoring; strengthen care-home escalation, frailty, respiratory, palliative and proactive-care pathways; increase use of ambulance See and Treat, Hear and Treat and alternative referral pathways. DoS optimisation & profile standardisation.	More people supported safely at home (via appropriate DoS selection where relevant); fewer avoidable ambulance conveyances, ED attendances and hospital admissions; increased capacity for earlier supported discharge
NHS 111, ambulance and urgent-care navigation	Maintain NHS 111 resilience, clinical validation of ED dispositions and direct booking; maximise appropriate use of Pharmacy First through the existing seven pathways and rollout of national independent prescribing pathways; improve access to SPOA, UCR, UTC, SDEC, frailty and mental health pathways; strengthen clinical decision-making across ambulance control rooms and virtual care hubs	More patients directed to the appropriate service first time; increased management of minor illness through community pharmacy; reduced avoidable ambulance dispatch, ED attendance and conveyance; improved access to commissioned alternatives to ED
Front door and first 72 hours	Strengthen rapid assessment, streaming and senior clinical decision-making; increase UTC, SDEC, frailty and ambulatory-care utilisation; improve specialty in-reach, diagnostics and short-stay pathways; implement paediatric and mental health alternatives	Improved four-hour performance; fewer 12-hour waits and episodes of corridor care; increased same-day discharge; fewer avoidable admissions and shorter stays.
Inpatient flow and site operations	Optimise board rounds, SAFER, criteria-led discharge and expected dates of discharge; strengthen seven-day medical, therapy, pharmacy and diagnostic support; improve site-control arrangements, critical-care step-down and management of escalation capacity	Reduced inpatient delays and length of stay; improved critical-care and acute bed availability; more reliable flow during peak demand
Discharge and recovery	Strengthen Transfer of Care Hubs, Home First, discharge lounges, continuous decision-making and escalation of Pathway 1 to 3 delays; reduce NCTR and long stays; align reablement, intermediate-care and patient-transport capacity with predicted demand	More timely discharge, including before midday and at weekends; reduced NCTR and long length of stay; increased acute capacity and fewer patients delayed after becoming discharge-ready

Flow Discharge & Capacity Impact

Drawing on provider plans and discharge commitments, the system will focus on reducing delays throughout the inpatient pathway, minimising time patients remain in hospital after they no longer meet the criteria to reside and releasing capacity safely ahead of winter



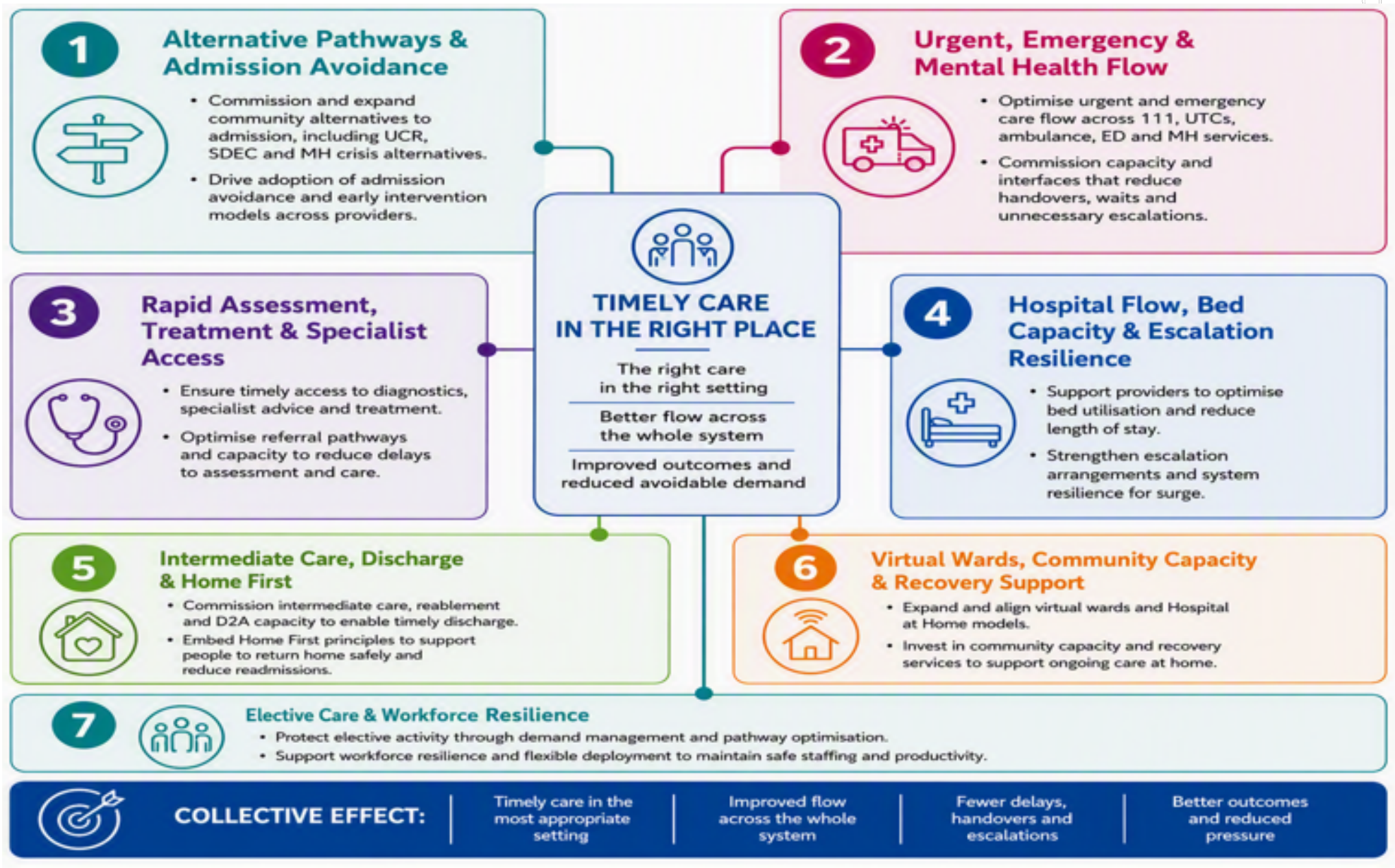
Collective impact

- ✓ Earlier identification and resolution of inpatient delays, fewer patients remaining in hospital after they are discharge-ready, improved seven-day discharge and more effective use of community capacity will release beds and support closure of the modelled peak capacity gap.
- ✓ Provider plans specifically include board-round optimisation, criteria-led discharge, increased discharge-lounge use, seven-day discharge, Transfer of Care Hub improvements, Home First, long-length-of-stay reviews, NCTR reduction and stronger critical-care step-down arrangements.

KEY MEASURES OF SUCCESS (WINTER 26/27)

- At least 78% of patients admitted, transferred or discharged within 4 hours.
- Reduce the proportion of patients waiting over 12 hours in ED (ambition: <10% of attendances).
- Reduce the number of patients waiting over 24 hours in ED for a mental health admission.
- Compliance with 45-minute ambulance handover standard and improved Category 2 response.
- Reduced average length of stay and NCTR.
- Increased discharge before midday and at weekends.
- Increase the number of children seen within 4 hours.

ICB Priority Commissioning Areas



Pillar 3: Safe and Resilient Services

Maintain safe, sustainable services through seasonal peaks while protecting workforce, critical capacity and planned care.

- Workforce capacity, deployment and staff wellbeing
- Clinical risk, IPC and quality oversight
- Winter surge and escalation preparedness
- Mental health, critical care and specialist capacity resilience
- Protection of planned care, cancer and diagnostics
- Business continuity, adverse weather and major incident readiness

Workforce capacity and resilience

Providers will strengthen clinical cover during peak periods. Provider winter plans and system workforce arrangements set out commitments to maintain safe staffing, manage absence and workforce gaps, strengthen senior cover during peak periods, and support staff wellbeing. Delivery will be monitored through existing workforce, sickness, temporary-staffing and vaccination reporting.

✓ **Proactive action to plan and deploy the workforce:**

- Produce rosters at least six weeks in advance and actively manage known gaps and predictable periods of absence.
- Maintain substantive recruitment in hard-to-fill / high-vacancy areas, supported by bank or temporary staffing where required.
- Align workforce capacity and senior clinical cover with forecast winter demand.

✓ **Active management of sickness and workforce resilience**

- Monitor sickness absence, attendance and temporary-staffing use through established reporting.
- Implement measures to reduce sickness absence and maintain safe staffing.
- Continue to manage temporary-workforce costs in line with operating plans.
- Provide targeted wellbeing and attendance support during periods of pressure.
- Enhance agreed consultant and senior nurse rotas across ED, AMU and paediatrics during peak weeks.
- Maintain senior decision-makers in priority clinical areas.
- Escalate material staffing gaps through provider operational and command arrangements.

✓ **Providers will support staff and maintain visible leadership**

- Promote workforce vaccination and improve frontline uptake (+5% on 2025/26)
- Maintain visible executive, medical and nursing leadership during December and January.
- Use secured external expertise and GIRFT support to strengthen delivery capability.
- Continue staff wellbeing and supportive absence-management arrangements.





Protecting planned, cancer and diagnostic care

Aim: Maintain access to essential planned care while balancing urgent and emergency pressures and protecting the capacity required to deliver agreed trajectories. Provider plans set out actions to protect planned, cancer and diagnostic care through winter, including ring-fenced capacity, improved productivity, mutual aid and use of additional capacity, with active forecasting and risk-balancing where urgent and emergency pressures threaten delivery

Core principle: protect planned care wherever possible, with active risk balancing where winter pressure threatens access, quality or operating-plan delivery.

Protect capacity

- Create ring-fenced capacity where possible and minimise cancellations caused by operational pressure.
- Use robust inpatient capacity planning to balance urgent, elective, cancer and critical-care risk.
- Shift appropriate activity from inpatient to day case where this protects delivery.

Essential planned activity maintained

Maximise productivity and utilisation

- Operate capacity at optimum levels through agreed productivity measures.
- Maximise Community Diagnostic Centre capacity and diagnostic throughput.
- Increase use of Advice and Guidance and advice-and-refer approaches to manage demand.

More patients treated within existing capacity

Use mutual aid and additional routes

- Maintain efficient mutual-aid arrangements between NHS providers.
- Use Cancer Alliance waiting-list initiative funding to support cancer waiting-time delivery.
- Use independent-sector capacity and patient transfers where required.

Pressure balanced across available capacity

Protect delivery from winter disruption

- Use forecasting to anticipate bed and workforce pressure and adjust activity proactively.
- Reduce loss of beds and workforce through robust IPC and outbreak response.
- Maintain oversight of elective, cancer and diagnostic trajectories and cancellations.

Reduced disruption and delay

Measures of success Providers remain on track with operating-plan trajectories, cancellations arising from operational pressure are minimised, and critical diagnostic and cancer capacity is protected.

Effective management of Clinical Risk and Infection Prevention and Control

Our aims: Delivering a Safe Winter

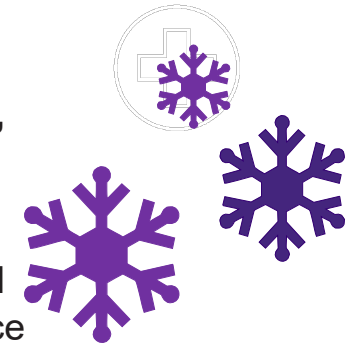
Clinical Risk

Effective management of Clinical risk is seen as key to the system's delivery of safe services over the winter period, and will be managed through the ICB Risk assurance process.

Infection Prevention and Control

- Clinical Infection Prevention cell will be reviewing and developing winter planning to support a standard system approach. The cell is represented by NHS providers including mental health, acute and community providers, Ambulance and Local Authorities to review provider and system winter plans, share best practice and provide a subject matter expert group.
- The group will review local national guidance recommendations, risk assessment and implementation plans to support patient flow.
- The IPC cell will cascade UKHSA Winter Preparedness pack to adult social care settings to support provider resilience and preparedness across the Surrey & Sussex system.
- Health and Social care staff and Inpatient flu vaccination plans will be reviewed to support an improved vaccination uptake across eligible groups
- IPC will form part of the routine Winter MDT oversight cadence

Readiness for seasonal and exceptional pressures



Provider winter plans, service resilience arrangements and the system risk assessment set out actions to anticipate, manage and recover from seasonal surges and exceptional disruption, protecting patient safety, workforce capacity and continuity of essential services.

- **Respiratory illness and infectious disease:** Providers will maintain vaccination, IPC, surveillance, testing, isolation and cohorting arrangements, with enhanced cleaning and outbreak response to minimise avoidable illness, workforce absence and loss of capacity.
- **Workforce pressures:** Plans describe forward rostering, sickness and attendance management, recruitment, bank and overtime arrangements, flexible deployment and escalation of staffing shortfalls to maintain safe services during demand peaks and predictable periods of absence.
- **Mental health, paediatric and critical-care resilience:** Providers will maintain crisis alternatives, specialist clinical support, paediatric respiratory surge arrangements, critical-care step-down processes and escalation routes where demand exceeds available specialist capacity.
- **Ambulance, NHS 111 and transport continuity:** Service plans set out workforce, fleet, command and surge arrangements, including clinical validation, flexible resource deployment, business continuity and additional oversight during severe weather or exceptional demand.
- **Planned, cancer and diagnostic care:** Providers will use forecasting, ring-fenced capacity where possible, mutual aid, productivity measures, Community Diagnostic Centres and independent-sector capacity to minimise cancellations and protect delivery during operational pressure.
- **Estates, digital and infrastructure disruption:** Plans include escalation arrangements for power, heating, estates, cleaning, portering, fleet and fuel resilience, together with digital downtime procedures and command arrangements to maintain essential services.
- **Adverse weather and wider disruption:** Providers will monitor weather alerts, road-network impacts and infrastructure risks, activating business-continuity and command arrangements where local pressures cannot be managed through routine operational processes.
- **Clinical risk and patient safety:** The Clinical Risk Framework will provide common triggers, governance and escalation routes, using operational intelligence, incident information and patient outcomes to support clinically led risk balancing and timely executive action.

Earlier identification of emerging risk, defined service-level responses and clear escalation arrangements will help sustain safe staffing, protect critical capacity and maintain essential services through seasonal peaks and exceptional disruption.

Pillar 4: Winter Operating Model, System Oversight / Governance



Robust oversight of the delivery with clear accountability and agreed escalation triggers to identify pressure early and coordinate an effective response

- Demand, capacity and bed modelling
- Provider-led operational management
- System coordination and mutual aid
- OPEL, escalation and MADE event arrangements
- Clinical risk, IPC and quality oversight
- Communications, assurance and Board reporting

Winter operational management and system response

A single, data-led operating model supports provider-led action, objective escalation and coordinated system response by exception

THE SCC OPERATING CYCLE



SEE

Monitor SHREWD and FDP as the primary operational picture for provider and system pressure.

ASSESS

Triangulate trends, risks and recovery plans; identify deterioration or recovery off track.

ACT

Convene relevant partners, coordinate mutual aid and escalate by exception when needed.

ASSURE

Track actions, ownership, recovery trajectory, continuing risk and de-escalation status.

Provider action first

Providers apply local OPEL actions, surge arrangements and recovery plans. Local ownership remains unless wider coordination is required.

System coordination by exception

The SCC coordinates when local actions are insufficient, recovery is off track, several pathways are affected, or mutual aid and risk balancing are required.

Data quality is operationally critical

Complete, timely and reliable provider data is fundamental to the timing and proportionality of SCC decisions and assurance.

LOCAL ACTION FIRST → **SYSTEM ACTION WHEN NEEDED**

Shared operational picture | Clear triggers | Recorded actions | Defined recovery

Data Quality is Operationally Critical

The SCC will monitor escalation through SHREWD (& FDP) and base its response on the picture displayed.



1 SUBMIT

Providers maintain complete, timely and accurate SHREWD (& FDP) data

2 MONITOR

SCC uses SHREWD (& FDP) as the primary lens for pressure and escalation

3 TRIGGER

Data identifies thresholds, deterioration and recovery off-track

4 RESPOND

SCC follows the agreed OPEL, Continuity escalation processes

5 ASSURE

Actions and de-escalation are tracked against reliable data

FUNDAMENTAL REQUIREMENT: SHREWD (& FDP) data must be complete, current and reliable.
Inaccurate or late data can give an incorrect system picture and compromise the timing or proportionality of the SCC response.

Escalation, governance and assurance

Connected OPEL and EPRR arrangements provide a clear route from local pressure to coordinated response, recovery and learning

ONE OBJECTIVE ROUTE FROM PRESSURE TO RECOVERY

1. PROVIDER RESPONSE

Local command, OPEL, surge and recovery actions. Provider ownership of risk and operational delivery.

2. ESCALATE BY EXCEPTION

Local actions exhausted, recovery off track, cross-system risk or support required.

3. COORDINATED RESPONSE

Validate the picture, convene partners, coordinate mutual aid, record actions and brief region.

4. OVERSIGHT & ASSURANCE

Track actions, risk, recovery trajectory, escalation status and de-escalation criteria.

5. RECOVER & LEARN

Apply stand-down criteria, review the response and capture learning and improvement actions.

OPEL and EPRR are connected but distinct

OPEL 4 can prompt additional scrutiny and coordinated action, but does not automatically constitute a business-continuity, critical or major incident. Provider incident declaration remains an EPRR decision based on impact and local arrangements.

Operating infrastructure

Focused Surrey and Sussex touchpoints • Rapid stand-up when triggers are met • On-call response • SBAR, action and risk logs • Shared patient-flow and escalation processes

MONTHLY ASSURANCE AND LEARNING

Trigger and risk | Actions taken | Mutual aid or incident response | Outcome and recovery | Continuing risk | Learning and improvement

Winter Partnership, Oversight and Assurance Cadence

Routine touchpoints stay focused, with rapid stand-up when pressure requires

Surrey System

- Monday 09:00
- Friday 09:00
- Report by exception
- Focus on recovery, tipping points and support required

Sussex System

- Monday 09:30
- Friday 09:30
- Report by exception
- Focus on recovery, tipping points and support required

Dynamic response

- Additional calls can be stood up at short notice if escalation triggers are met. Cadence can increase during sustained pressure,
- Regional touchpoints align to confirmed NHSE arrangements
- Out-of-hours response through on-call arrangements

Single point of contact: sysxicb.oc@nhs.net
In-hours monitoring 09:00 to 17:00, Monday to Friday

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 EXCO. The plan will ultimately be signed off through the NHS Surrey & Sussex Board. Individual provider winter plans are signed off through the boards of the relevant organisations and subject to individual Board Assurance Statement Process.

Local authority Health Oversight Scrutiny Committees (HOSCs) and Health and Adult Social Care Scrutiny Committee (HASC) will 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.

NHS Surrey and Sussex	→ Responsibility for overall oversight of winter plan delivery
NHS Surrey and Sussex executive	→ Responsibility for oversight of NHS elements of winter plan delivery
ICB Winter MDT	→ Responsibility for development of the plan, driving delivery of pan system actions and coordinating a system response to escalations
System coordination centre	→ Daily operational pressure management is provider-led, ICB will provide 24/7 on-call support (escalation by exception). SCC In-hours monitoring 09:00 to 17:00, Monday to Friday
NHS Providers, LA partners, VCSE	→ Responsibility for day-to-day delivery of organisation specific elements of the plan