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.

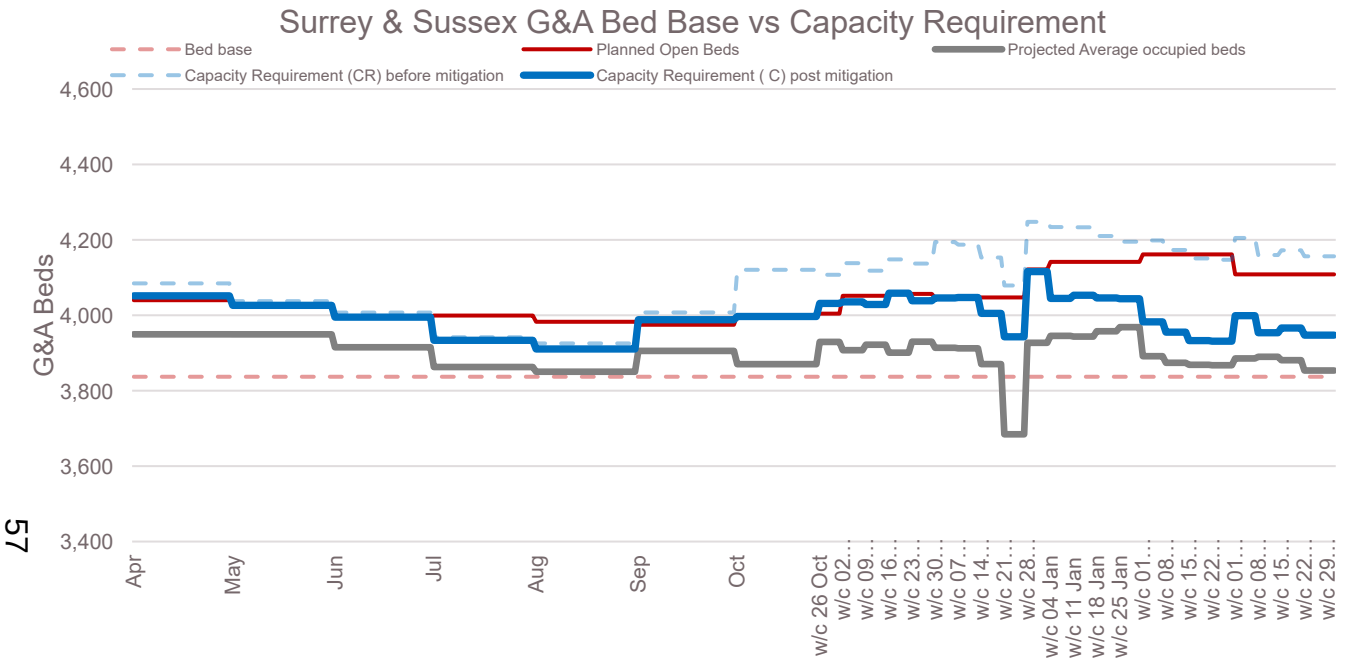
The Winter challenge

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

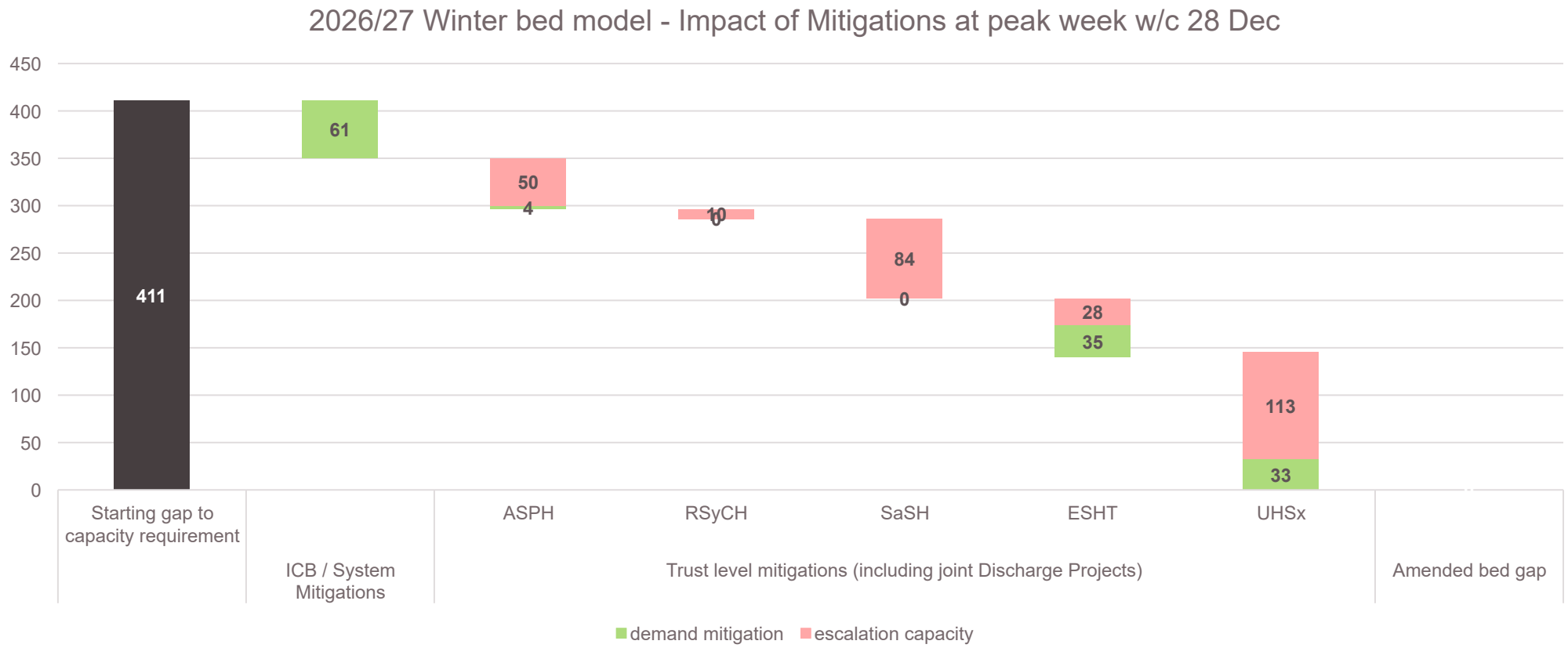


Peak Periods	w/c/ 30 Nov	Surrey & Sussex w/c 28 Dec	w/c 01 Mar
Key periods with highest unmitigated gap to Capacity requirement			
Starting Scenario			
Bed Base	3,837	3,837	3,837
Unmitigated Capacity Requirement	4,194	4,248	4,205
Unmitigated Gap	357	411	368
Acute:			
Planned Capacity Increase	209	285	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**

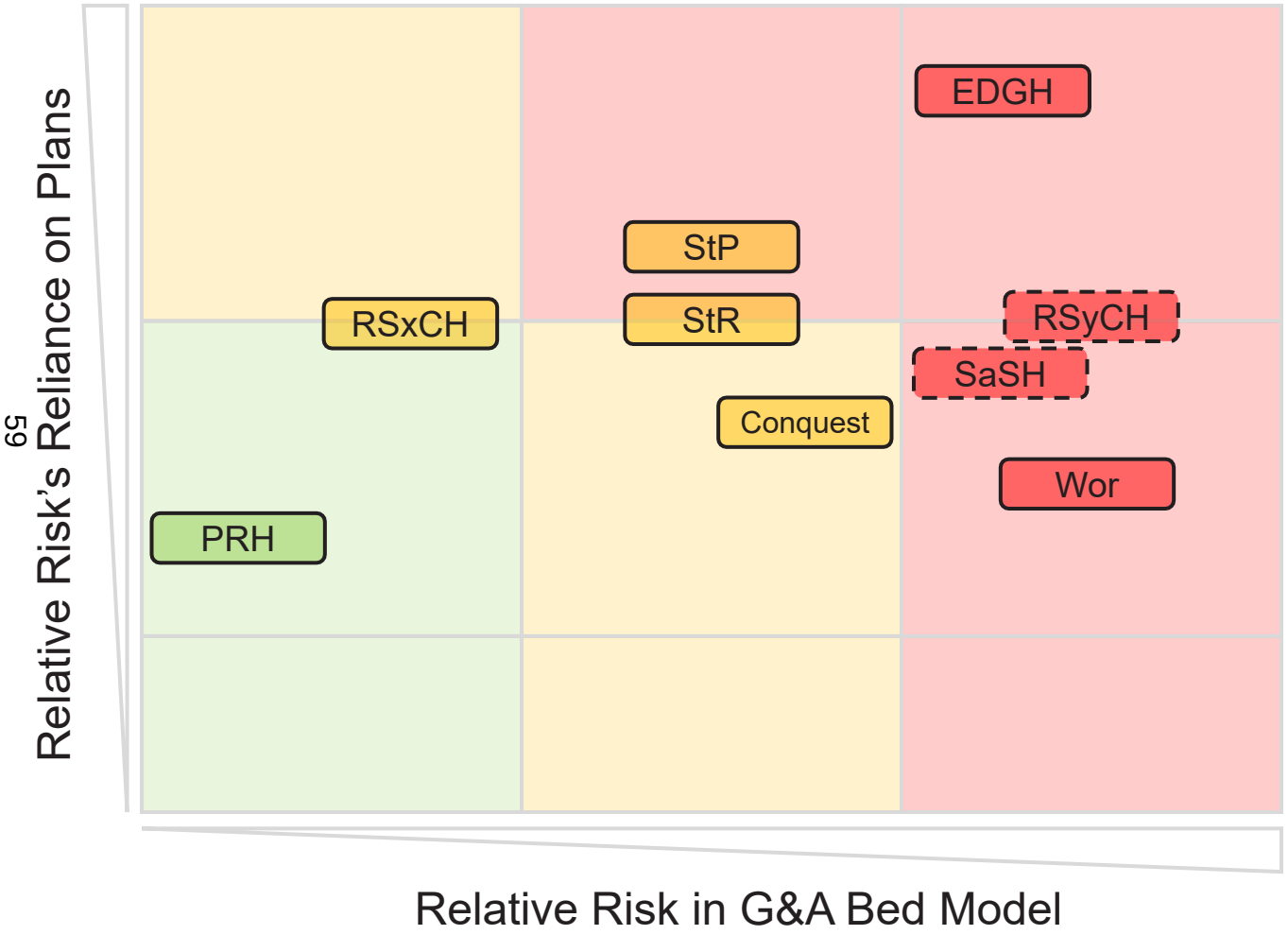
- Initial Bed Modelling suggest a peak gap to capacity requirement of **411** beds during w/c 28th December with two other key pressure points, in late November and early March
- ICB and system plans which during our peak pressure week deliver a risk adjusted impact of:
  - Provider plans (risk adjusted, 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.

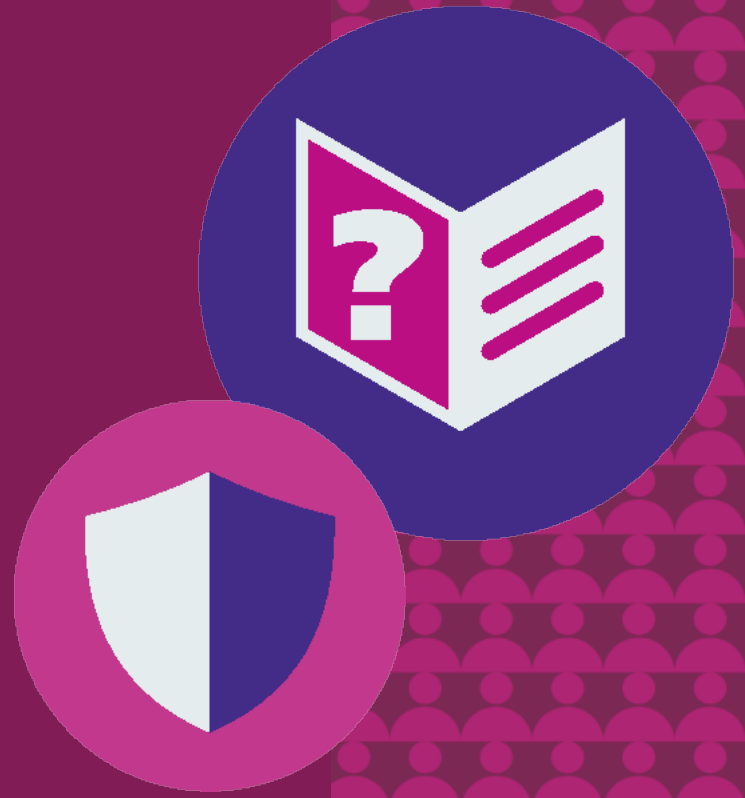
Residual Risks:

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

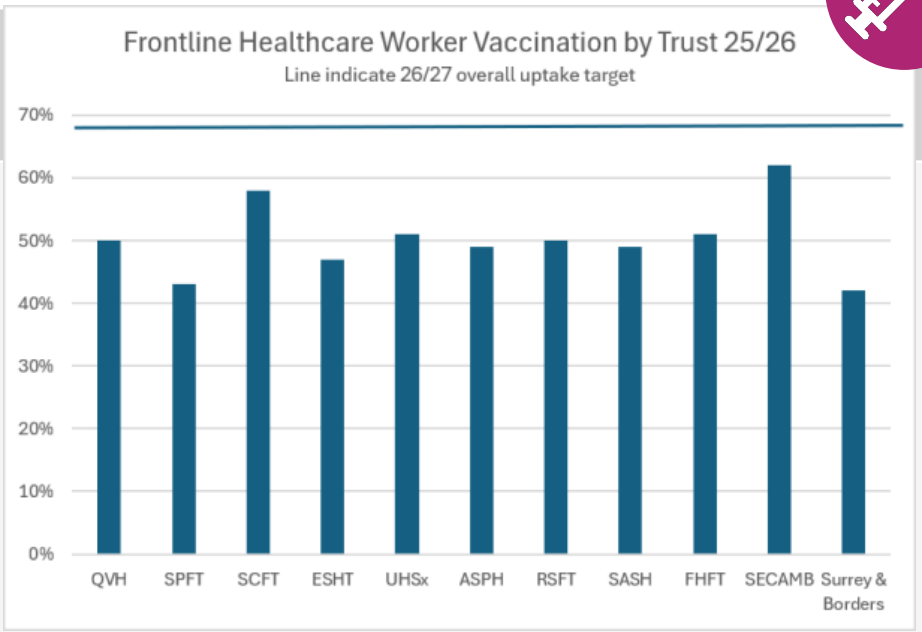
Support people to stay well, identify deterioration earlier & reduce avoidable demand on urgent and emergency care.

- 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.

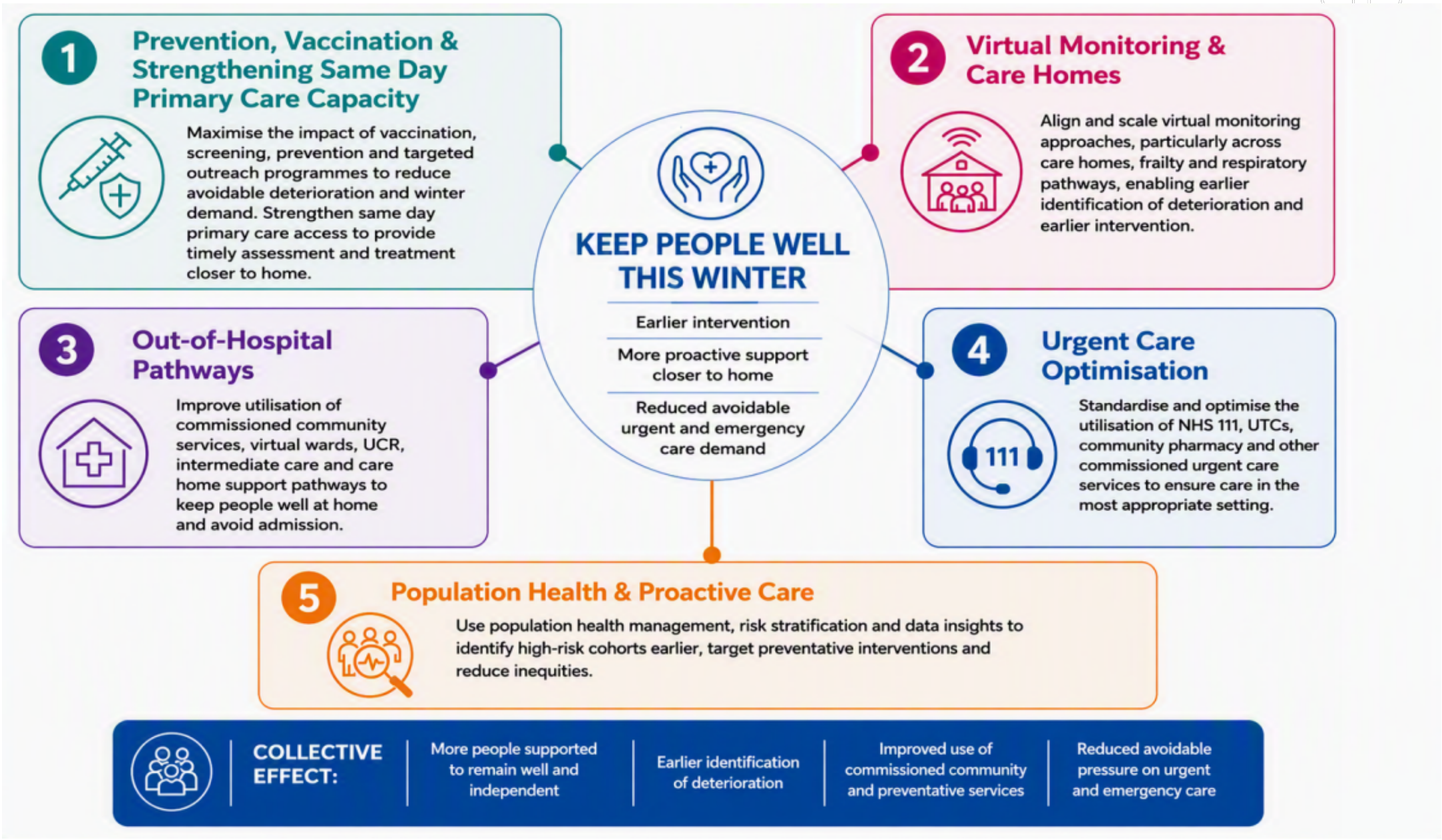
Area	High-impact action	Intended winter impact
Vaccination and IPC	Targeted vaccination, outreach and early seasonal surveillance	Reduce illness, admission and workforce disruption
Proactive care	Identify and support people with frailty, multimorbidity, care-home and end-of-life needs	Reduce deterioration 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.



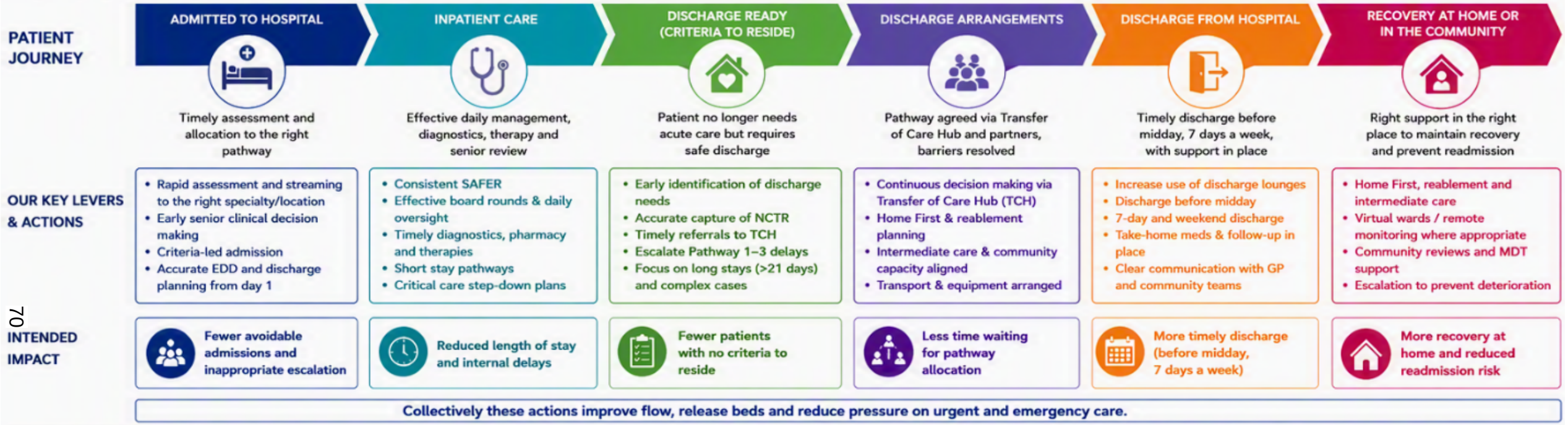
Priority	High-impact actions / commitments	Intended winter impact
Improve four-hour performance and reduce 12-hour waits /eradicating corridor care	Rapid front-door assessment and streaming; improved use of UTC, SDEC and frailty pathways; earlier senior and specialty decision-making; improved inpatient 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



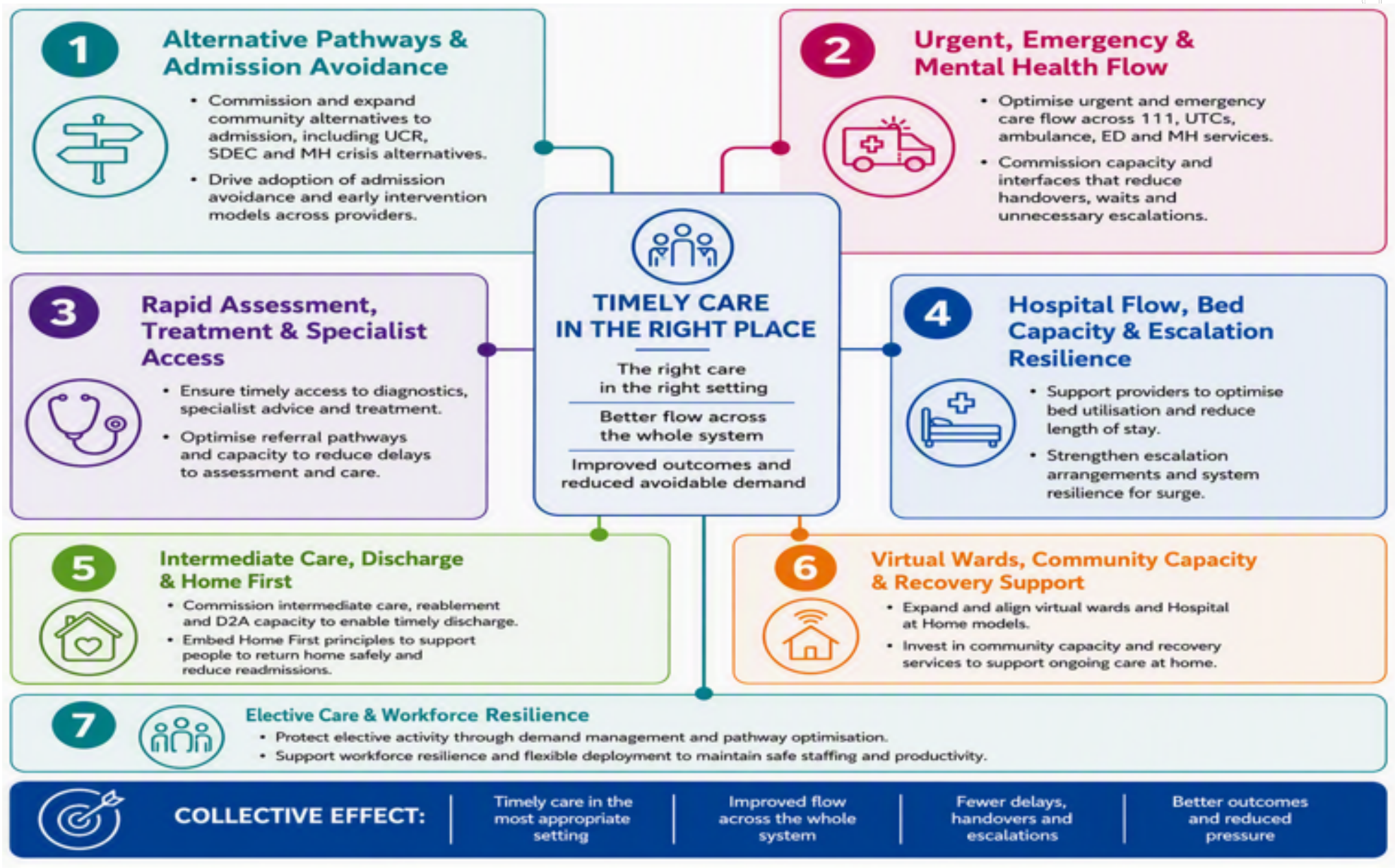
Collective impact

- ✓ 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

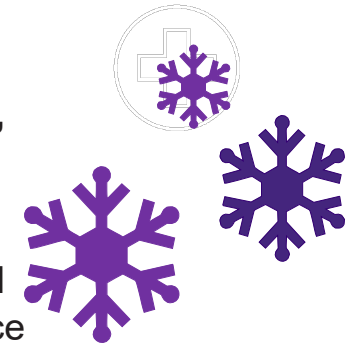
Clinical Risk

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